September 11, 2017

Submitted via www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1676-P
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1676-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program; Proposed Rule (82 Fed.Reg. 33950 July 21, 2017)

Dear Ms. Verma:

On behalf of the undersigned organizations, we are pleased to provide comments on the Request for Information (RFI) in the Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program; Proposed Rule, (82 Fed.Reg. 33950, July 21, 2017).

We appreciate the Centers for Medicare & Medicaid Services' (CMS) commitment to reducing regulatory burdens in healthcare. Advanced Practice Registered Nurses (APRNs) include Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Clinical Nurse Specialists (CNSs), and Nurse Practitioners (NPs). APRNs play a significant role in ensuring patient access to high quality healthcare that is cost-effective, and practice without physician supervision in many states. At the bedside, in the operating room, on the hospital floor, and in the community, APRNs are crucial to access to care and patient safety. However, federal policy barriers to APRN practice continue to exist, impairing access to services, impeding patient choice, and raising healthcare costs.

As the Agency examines the regulatory burdens associated with healthcare, we want to bring to your attention several specific regulatory barriers to the use of APRNs that impair patient access to our members' services, impede patient choice, and raise healthcare costs. We offer the following recommendations:

- Remove credentialing and privileging barriers to practice and care,
- Remove costly and unnecessary physician supervision requirements,
- Establish modifiers on claims to identify incident-to billing and acknowledge the licensure of the rendering provider,

- Reform policy definitions of the word "physician" so that patients have access to the services of qualified APRNs, and
- Remove from subregulatory guidance the exclusion of practitioners who are not physicians from serving on Medicare Carrier Advisory Committees.

Remove Credentialing and Privileging Barriers to Practice and Care

We appreciate CMS's ongoing efforts to enhance Medicare Part B services and payment opportunities to eligible Medicare non-physician practitioners, particularly to APRNs. These CMS efforts align with recommendations in *The Future of Nursing: Leading Change, Advancing Health*, the milestone 2010 report of the Institute of Medicine [now the Health and Medicine Division of the National Academy of Medicine (NAM)].[1]

Because the APRN roles have a wide-ranging impact on providing patient-centered, accessible, and affordable care, *The Future of Nursing* recommends eliminating regulatory barriers that prevent APRNs from practicing to their full scope. Permitting APRNs to practice to the full extent of their education and training could help build the necessary workforce to satisfy the healthcare needs of an increasing number of people with access to health insurance, as well as contribute unique APRN expertise and skills to the delivery of patient-centered healthcare. Steps have been taken at both federal and state levels, but barriers to expanding APRN scope of practice remain. Improving participation of eligible APRN Medicare Part B practitioners ensures patient access to quality care, helps save on healthcare costs, and increases patient choice.

As CMS continues examining regulatory burdens, we ask the agency to consider those barriers to the use of APRNs that impair patient access to our members' services. We are concerned with credentialing and privileging requirements, such as 42 C.F.R. § 482.22 Condition of participation: Medical staff and 42 C.F.R. § 482.1(a)(5) Basis and Scope, which hinder APRNs ability to deliver essential services, otherwise permitted under state law.

For example, in place of the current unnecessary, regulatory credentialing and privileging decisions we seek consideration of:

- Requirements that medical staffs be representative of all healthcare professionals authorized to provide services under the Medicare program including APRNs.
- Elimination of the list of providers who may have membership or participate in leadership on the medical staff, and instead allow those roles to be available to the healthcare professionals who are most qualified and appropriate to fill them.
- Uniform procedures for the consideration of applications for credentials including prompt (60-day) determinations.
- Requirements that applicants be notified in writing of the disposition of their applications.

[1] National Academy of Medicine. The Future of Nursing: Leading Change, Advancing Health (Washington, DC: The National Academies Press, 2011).

Remove Costly and Unnecessary Physician Supervision Requirements

We recommend that the Medicare agency eliminate requirements for physician supervision of APRNs.[2] Given the growing population of persons in the United States requiring healthcare, particularly among Medicare eligible populations, physician supervision requirements stand in the way of deploying the vast workforce of APRNs. Unnecessary requirements for physician supervision of APRNs contribute to duplication and waste in the healthcare delivery system. There is no evidence that supervision requirements contribute to higher quality, lower cost, or greater value or access to healthcare. On the contrary, ample evidence points to the value provided by APRNs.

Our request corresponds with a recommendation from the NAM report titled *The Future of Nursing: Leading Change, Advancing Health*, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs.[3] The NAM report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."[4]

Establish Modifiers on Claims to Identify Incident-to Billing and to Acknowledge the Licensure of the Rendering Provider

As we have stated in previous comments, we believe that a payment system designed to incentivize high quality, value-based services must clearly and consistently identify the provider responsible for actually rendering a service, as well as ensure that Medicare claims accurately identify the rendering provider. While we have encouraged the elimination of "incident to" billing, we also recommend the use of modifiers to identify the individual rendering the service in addition to the billing number of the provider under whom the service is billed.

Current "incident to" billing practices undermine the foundation of value-based reimbursement. Without establishing mechanisms to ensure transparency and clearly identifying the actual provider of a service, it will be impossible to accurately calculate value based performance indicators at a provider-specific level. As CMS examines the use of value-based measures in various programs, we ask that you take our suggestions under consideration when evaluating this process.

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[2] 42 C.F.R.§ 482.52 -- Condition of participation: Anesthesia services; 42 C.F.R. § 416.42(b)(2) -- Conditions of Coverage: Surgical Services; 42 C.F.R. § 485.639 -- Conditions of Participation: Surgical Services. 42 C.F.R. § 482.12(c)(1)(i), (c)(2),(c)(3), (c)(4)--Condition of participation: Governing body; 42 C.F.R. § 482.22(b)(3), (c)(5)(i)--Condition of participation: Medical staff; 42 C.F.R. § 482.1(a)(5) Basis and Scope. 42 C.F.R. § 482.22(b)(3), (c)(5)(i) Condition of participation: Medical Staff; 42 C.F.R. §485.631.

[3] NAM op. cit.

[4] NAM op. cit., p. 9.

Reform Policy Definitions of the Word "Physician" So that Patients have Access to the Services of Qualified APRNs

We appreciate the efforts that CMS has made to ensure that the extent of the advanced education and clinical preparation of APRNs and health care professionals other than physicians are fully recognized and reflected in the practice and payment policies of federal health programs, consistent with the laws of the states in which they are licensed and practice. However, the current regulatory definition of "physician" in many regulations is so narrow that it interferes with the ability of APRNs to act within their scope of practice. CMS should use its authority to expand the definition of "physician" to include APRNs and reduce these regulatory barriers. We believe it is critical for CMS to reaffirm its commitment to ensuring full patient access to the services of APRNs in the Medicare program and beyond as you develop, implement and evaluate new payment structures. The move to a value-based system that emphasizes prevention, wellness, and care-coordination speaks to the expertise of registered nurses and APRNs. We firmly believe that system-wide reform should truly embrace a team-based approach, which is critical to the practice of health care. In recent years, this message has been echoed by the National Academy of Medicine, the National Governors Association, the Federal Trade Commission, and many other leading authorities that have noted the importance of ensuring nurses are full partners with other health professionals in healthcare redesign.

Remove from Subregulatory Guidance the Exclusion of Practitioners Who are Not Physicians from Serving on Medicare Carrier Advisory Committees

We urge CMS to remove the subregulatory guidance that excludes practitioners who are not physicians from serving on Medicare Administrative Contractors' (MACs) Carrier Advisory Committees (CAC). Specifically, we note that Exhibit 3 of the Section 13.8.1 of the Medicare Program Integrity Manual specifically states, "Do not include other practitioners on this committee," which ultimately precludes APRNs from participation. [5] We urge removal of this clause from the manual. As an important provider community of more than 340,000 members, we are troubled by multiple instances where MACs have exceeded their authority by issuing local coverage determinations (LCD) that contradict existing CMS regulation and policy and scope of practice under state law that harm patient access to vital and medically necessary services. As CACs are crucial in the development and review of LCDs, it is imperative that practitioners such as APRNs are represented on CACs to ensure that the LCD process reflects evidence-based policies, the perspective of practitioners who are not physicians, and protect robust patient access to medically necessary APRN services under Medicare.

We thank you for the opportunity to comment on the proposed rule. Should you have any questions regarding these matters, please feel free to contact Ralph Kohl, Senior Director of

[5] Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations, Rev. 608, August 4, 2015, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c13.pdf and http://www.cms.gov/manuals/downloads/pim83exhibits.pdf.

Federal Government Affairs, American Association of Nurse Anesthetists, at 202.484.8400, rkohl@aanadc.com.

Sincerely,
American Association of Colleges of Nursing (AACN)
American Association of Nurse Anesthetists (AANA)
American Association of Nurse Practitioners (AANP)
American College of Nurse-Midwives (ACNM)
American Nurses Association (ANA)
American Organization of Nurse Executives (AONE)
Gerontological Advanced Practice Nurses Association (GAPNA)
National Association of Clinical Nurse Specialists (NACNS)
National Association of Nurse Practitioners in Women's Health (NPWH)
National Association of Pediatric Nurse Practitioners (NAPNAP)
National League for Nursing (NLN)
National Organization of Nurse Practitioner Faculties (NONPF)