

November 16, 2018

Submitted via www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-3346-P
P.O. Box 8010
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-3346-P – Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Proposed Rule (83 Fed. Reg. 47686 September 20, 2018)

Dear Ms. Verma:

On behalf of the undersigned organizations, we are pleased to provide comments on the Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Proposed Rule (83 Fed. Reg. 47686 September 20, 2018).

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 units, and in the community, APRNs are crucial to access to care and patient safety. We thank CMS for the steps it has taken in reducing regulatory burdens in healthcare, including removing from sub-regulatory guidance the exclusion of practitioners who are not physicians from serving on Medicare Contractor Advisory Committees. However, federal policy barriers to APRN practice continue to exist, impairing access to services, impeding patient choice, and raising healthcare costs.

As CMS is seeking public comments on additional regulatory reforms for burden reduction in future rulemaking, 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
- Equity in reimbursement in educational settings for APRNs.

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 in order to improve the outcomes of Medicare recipients. 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

Improving participation of eligible APRN Medicare Part B practitioners ensures patient access to quality care, helps save on healthcare costs, and increases patient choice. We maintain that Medicare recipients should have full access to all APRN roles as these providers 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 to examine regulatory burdens, we ask the agency to act to address barriers to the use of APRNs; these barriers 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. Hospital medical staffs must be representative of all types of health professionals who require clinical privileges to practice, including APRNs as authorized by state law. Balanced representation of health professionals on hospital medical staffs will benefit a wide range of patients, including Medicare beneficiaries, and local communities. Each professional on a medical staff should have access to full clinical, admitting and voting privileges, and be able to serve on hospital committees addressing care provided in the facility. CMS’ leadership in this important administrative process will permit more patients to receive the high-quality, cost-effective services of APRNs.

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

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.

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 APRN workforce. 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 or lower cost, or greater value or access to healthcare. APRNs must hold their own license in each state; therefore, their practice is regulated and does not require additional supervision. 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

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.

In numerous previous comments to CMS and to Congress, our organizations have repeatedly pointed out what we believe is an anticompetitive policy that is contrary to the department's goal of improving transparency and will undercut efforts to improve quality by holding providers accountable for the care they deliver to patients. The practice of physician "incident to" billing of services furnished by APRNs and clinicians other than physicians is inconsistent and incompatible with a merit-based payment structure focused on the quality and value of the services provided to beneficiaries. We continue to believe it is essential for consumers, payers, overseers of program integrity, and policy makers to have clear and accurate information on which to assess providers' performance. "Incident to" billing of services directly contradicts these goals, obscuring the provider who is actually accountable for services delivered to patients. The resulting inability to identify the clinician who provides the care is an obstacle to accurately measuring the quality of care and assessing the value of innovative practice models.

Members of the Medicare Payment Advisory Commission (MedPAC) have also recognized the inherent problems with "incident to" billing. At its recent October 4-5, 2018, meeting, the Commission agreed to consider a recommendation to Congress that "incident to" billing of Medicare services be eliminated. Commissioners recognized the same inequities and confusion that our organizations have emphasized and that other policy experts have acknowledged. In a January 8, 2018, Health Affairs blog, "The Integrity of MACRA May Be Undermined By 'Incident To Billing' Coding," Peter I. Buerhaus, Ph.D., RN, FAAN, director of the Center for Interdisciplinary Health Workforce Studies at Montana State University College of Nursing, and his colleagues demonstrate the problems that the policy creates in a value-based payment system. Dr. Buerhaus and his colleagues propose that CMS "adjust Medicare billing procedures so that claims submitted for payment must identify the NPI [National Provider Identifier] of the clinician who actually provided the service."

Our organizations maintain that qualified providers should be required to bill directly for the services they personally provide under their own provider numbers. In the past we have suggested that, if it is not considered feasible to eliminate "incident-to" billing, a minimum step to gain a better understanding of the extent and nature of the practice and its interaction with other payment reforms would be to revise current claims requirements to ensure that the actual rendering provider is clearly identified on every claim. When a service is billed under a provider number other than that of the rendering provider, an appropriate modifier should be required to ensure the claim is clearly identified as an "incident to" claim. In particular, box 24J on the claim form should include the actual rendering provider's National Provider Identifier (NPI) – and not the NPI of an attending or supervising provider.

As we have pointed out, this isn't a new idea: in its August 2009 report, "Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services" (OEI-09-06-00430), the HHS Office of Inspector General recommended that CMS "require physician who bill services to Medicare that they do not personally perform to identify the services on their Medicare claims by using a service code modifier." The Inspector General notes that requiring use of a modifier would allow CMS to monitor claims to ensure that physicians or other qualified providers are billing for services performed by providers with appropriate qualifications.

Finally, HHS should acknowledge the inherent anticompetitive effects of “incident to” billing. The current disparity in Medicare payment to physicians and to APRNs when they provide the same service creates a highly questionable economic incentive that influences professional practice and patient care, at additional unnecessary cost to the government. Based on licensure and without regard to outcomes of care, this payment structure violates a basic principle of value-based payment – that a single payment is based on a specific service, not the clinician who provides the service. We urge HHS to work with our organizations and members of Congress to revise current law to eliminate this inappropriate, indefensible disparity.

Promote Equity in Reimbursement in Educational Settings for APRNs

In order to make health care more accessible and reduce barriers to educational opportunities, we request that CMS promote equitable reimbursement in educational settings for APRNs. Equitable treatment in payment is critical to the smooth delivery of health care and to the development of the health care workforce. For example, CNMs have a long history of educating and training obstetrics and gynecology residents and interns in major academic institutions across the United States. These interdisciplinary education models seek to improve access, quality, and safety throughout the health care continuum and their role in reforming the health care system is vital. Existing Medicare statute, rules and guidelines are silent on whether CNMs or other APRNs can be reimbursed for time spent supervising and instructing medical residents and interns. Special payment rules authorized under section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b)) only detail how physicians can be reimbursed for time spent supervising and instructing residents and interns in teaching facilities. We strongly encourage CMS to revise its payment rules to include CNMs and other advanced practice nursing providers as resident teachers so that they may appropriately document and reimburse for billable services.

Additionally, we encourage CMS to establish equitable policies for teaching physicians and APRN clinical preceptors. Recent changes to Medicare’s Evaluation and Management (E/M) Service Documentation guidelines fail to acknowledge the critical role of APRN clinical preceptors and the APRN students they supervise.⁵ Earlier this year, CMS implemented a change allowing medical students to document services in a medical record where upon the teaching physician verifies all student documentation in the medical record rather than re-documenting the work. This change does not apply to other members of the care team, including APRN preceptors and has the unintended consequence of increasing the disparity between the documentation standards required for teaching physicians and APRN preceptors. To ensure equity in documentation requirements for all evaluation and management visits, we recommend including all APRN preceptors in the definition of “teaching physician” and/or substituting the term with “teaching provider or teaching clinician.” We also request that APRN students be allowed to document services in the medical record, as failure to do so threatens the availability of clinical placements for APRN students due to the administrative burden of having to re-document work.

⁵ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4068CP.pdf>

We also request that CMS amend anesthesia payment rules to allow 100 percent payment for one anesthesiologist teaching two student registered nurse anesthetists (SRNAs). Regardless of whether a teaching CRNA or teaching anesthesiologist is involved in the cases with SRNAs, the teacher is providing 100 percent of an anesthesia service to each patient and should be able to bill for 100 percent of the fee for each case.

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

Sincerely,

American Academy of Nursing, AAN
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 Pediatric Nurse Practitioners, NAPNAP
National League for Nursing, NLN
National Organization of Nurse Practitioner Faculties, NONPF