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September 4, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–1631–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 Federal Register 41686 (July 15, 2015).

Dear Acting Administrator Slavitt:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the proposed rule referenced above, published in the Federal Register on July 15, 2015. As the only full-service professional organization representing the interests of the nation's 3.4 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1]

ANA participated in an APRN workgroup that reviewed the rule, developed comments and submitted a letter to the Centers for Medicare and Medicaid Services (CMS) regarding numerous provisions in the proposed rule. The comment letter addressed the following points:

- Expressed support for the steps CMS has taken to further include all stakeholders, including APRNs and the public, in the creation and evaluation of relative value unit values for all new, revised, and potentially misvalued codes
- Encouraged CMS to include APRNs as covered advance care planning (ACP) providers
- Recommended that CMS establish modifiers to be used to identify both when a line item in a claim was provided incident-to as well as the licensure of the actual rendering provider
- Asked CMS to expand the provision offering incentives from hospital organizations to physicians by allowing APRN practices in the geographic areas of the incentivizing hospital organization to receive such incentives
- Requested that CMS ensure equal treatment among APRNs and Physicians Under Clinical Practice Improvement Activities

[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

- Asked CMS to refrain from public reporting of performance rates on measures on the Physician Compare website unless they have been vetted by all appropriate eligible professionals affected by the measure
- Requested that the search function on the Physician Compare Website be more inclusive of all qualified healthcare providers
- Requested the involvement of APRNs in the development of alternative payment models and promote full scope of practice in models
- Requested that provider neutral oversights be corrected in final rule
- Recommended replacing the term "Nonphysician" with "APRNs" or "Part B Healthcare Practitioners" in publication of the final rule

In addition to supporting the comments articulated in the letter referenced above, ANA offers the following comments.

Advance Care Planning

For 2015, two new Current Procedural Terminology (CPT) codes were created to describe ACP services: CPT code 99497 and CPT code 99498. However, the codes were not recognized for reporting and payment purposes. In response to comments received on this arrangement, CMS is proposing to recognize these CPT codes and provide separate payment for CPT codes 99497 and 99498.

ANA supports the proposal to include ACP codes in the recently proposed 2016 Medicare Physician Fee Schedule. Through this action CMS recognizes that ACP services are essential to delivering high-quality care in a manner that fully aligns with the goals and desires of the patient. This proposal, if finalized, would help ensure that patient care preferences are understood by health care providers, and that patients receive their preferred care when facing complex, serious health care issues.

ACP consultations focus on patient preferences and are entirely voluntary on the part of the patient. Research has shown the importance of ACP in achieving results such as better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress and depression. ACP is a particularly important tool for Medicare beneficiaries with multiple chronic illnesses and for the family members and other caregivers involved with making medical decisions and providing care.

Further, the value of ACP has been widely recognized. The Centers for Disease Control and Prevention has acknowledged the importance of ACP, and the 2014 Institute of Medicine (IOM) report, "Dying in America," highlighted the importance of honoring individual preferences. This IOM report included payment for ACP as a key recommendation. ANA supports this important step to improve care for Medicare beneficiaries.

While ANA supports the agency's proposal to cover medically necessary advance care planning, we request that APRNs be included on the list of professionals whose advance care planning services are covered by Medicare. APRNs play an important role in providing this service to patients. Totaling more than 340,000 healthcare professionals, the primary interests of APRNs include patient wellness

and improving patient access to safe and cost-effective healthcare services. Including APRNs as covered advance care planning providers would promote competition, patient access to care, consumer choice, patient safety and lower healthcare costs.

Clinical Practice Improvement Criteria

The proposed rule describes the clinical practice improvement activities (CPIA) required by statute, including care coordination (defined as "timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth"). Care coordination and transitional care services are essential to advancing the delivery of health care and furthering the priorities of the National Strategy for Quality Improvement in Health Care: better care; better health; and reduced costs. Further, health information technology (HIT) is essential to effectively collecting, sharing and analyzing data and promoting the accessibility of health information for providers, patients, families and caregivers. For example, it is important that clinicians (including eligible providers and other clinicians on the team across care settings) have access to patient-centered longitudinal care plans that allow clinical teams to provide effective and efficient clinical care, including care coordination – a goal set forth in the Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap drafted by the Office of the National Coordinator for Health Information Technology (ONC). Unfortunately full interoperable exchange of health information between eligible professionals across the continuum of care is not yet available. ANA therefore recommends that when the clinical practice improvement requirements are finalized, they reflect the then current state of electronic health record interoperability and health information exchange as it continues to evolve.

We appreciate the opportunity to share our views on this matter. If you have questions regarding comments on CPIA or MIPS, please contact Kelly Cochran, Policy Advisor, Health Information Technology (kelly.cochran@ana.org; 301.628.5040). For other questions please contact Jane Clare Joyner, Senior Policy Fellow (janeclare.joyner@ana.org; 301.628.5083).

Sincerely,

Debbie Hatmaker

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer