August 28, 2018

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically to www.regulations.gov

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program [CMS-1693-P | RIN 0938-AT31]

Dear Administrator Verma:

The American Nurses Association (ANA) is pleased to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program. ANA's comments focus on proposals by CMS regarding: changes to coding for Evaluation & Management visits; changes to Medicare reimbursement for telehealth services; the creation of a bundled episode of care for substance use disorder treatment; and changes to the Quality Payment Program and Merit-based Incentive Payment System.

ANA is the premier organization representing the interests of the nation's 4.0 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. 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 including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists

(CRNAs).[1] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

I) Section II.I. Evaluation & Management (E/M) Visits

CMS proposes in *Section II.I.2. Evaluation & Management (E/M) Visits – CY 2019 Proposed Policies* to make several changes related to E/M documentation and payment. ANA has previously voiced its support for CMS' Patients Over Paperwork initiative to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience. ANA supports several of the proposals related to documentation of E/M visits and believes that these will move the Medicare system toward achieving the Patients Over Paperwork objectives, including:

- Changing the required documentation of the patient's history to focus only on the interval history since the previous visit;
- Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient; and
- Removing the need to justify providing a home visit instead of an office visit.

ANA urges CMS to use caution when considering some of the major changes it proposes with respect to combining level 2 through level 5 visits into a single reimbursement level. We appreciate that CMS estimates that NPs could receive an average 3-percent increase in reimbursement because of this change. We do, however, harbor deep concerns that despite this potential average increase, and despite the proposed inclusion of certain modifiers to account for acuity and patient complexity, this change could still result in negative outcomes. We are most concerned that this change could significantly impact NPs (including specialty NPs) and other practitioners who provide care to high acuity patients, which in turn could impact the quality of patient care and potentially result in adverse patient outcomes. ANA also has concerns regarding CMS' proposal to streamline E/M documentation guidelines by allowing clinicians to choose to document E/M visits using medical decision-making or time, or alternatively continue to use the current framework. ANA encourages CMS to consider that time spent does not necessarily translate into achieving quality outcomes. Decision-making difficulty is potentially a more definitive approach. The proposal to move to a system where

[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.

a provider would have to choose one or the other may not be a true representation of the visit. ANA encourages CMS to explore innovative strategies and algorithms to account for time spent and acuity of patients. The ability to leverage the paradigm of "document once and re-use many times" may be extended to the health information technology solutions to reduce documentation burden. We urge CMS to address these through an interdisciplinary workgroup of practitioners and stakeholders across the care continuum.

II) Section II.D. Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

CMS proposes in *Section II.D. Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services* to make several changes to current Medicare Part B reimbursement policies to expand reimbursement for certain telehealth services. ANA expresses its support for the expansion of telehealth services in general and believes that permitting Medicare Part B reimbursement for the services specifically named in this proposed rule would greatly benefit patients who might otherwise be unable to or deterred from seeking care and achieves the intent of the relevant sections of the 21st Century Cures Act.

ANA's comments to the Medicare Payment Advisory Commission (MedPAC) expressed our support to expand telehealth services to Medicare beneficiaries, especially in areas in which RNs and APRNs provide care. ANA encourages CMS to consider the role that RNs and APRNs play in providing these services to increase access to beneficiaries, while also recognizing that reimbursement is necessary to not only provide the services, but to also fill the void in certain specialties and geographies. ANA advocates that patient safety and privacy are at the forefront of any decision to expand telehealth services. ANA supports consideration for broadening the originating sites for telehealth services for acute stroke telehealth services, as every second counts in diagnosis and treatment of stroke. ANA comments to MedPAC also expressed consideration for expanding telehealth services for mental health and Substance Use Disorders (SUDs) to help overcome the opioid epidemic.

ANA strongly urges CMS to use provider-neutral language in its development of new telehealth codes. CMS' proposed new code CPT 994X6 (Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative **physician** including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time) is physician-focused and would seem to exclude APRNs as consultative providers. We urge CMS to modify the language used to describe this code from "consultative physician" to "consultative qualified health care professional".

We call attention for CMS, to the Raise the Voice: Edge Runner Initiative at the American Academy of Nurses, http://www.aannet.org/initiatives/edge-runners, highlighting several models of telehealth provision which clearly demonstrate the value in the expansion of telehealth services. Coalescing on common appreciation that health care in America today is inaccessible to many, expensive for most and fragmented for all, these nurse-driven innovation models offer alternatives. Examples include: care coordination models such as the 11th Street Family Health Services, based on trans-disciplinary care teams and community partnerships; the Aging in Place model which applies registered nurse care coordination and health promotion to support high quality services in the home; and telehealth initiatives, such as the Complex Care Center model which links providers through evidence-based and innovative solutions.

Each of the Edge Runner programs have demonstrated an improvement in patient outcomes and progress toward fundamental transformation in enabling our healthcare system to deliver the best possible care at an acceptable cost – moving American health care away from its current hospital-based, acuity-oriented, physician-dependent paradigm toward a patient-centered, convenient, helpful and affordable system.

III) Section II.D.7. Comment Solicitation on Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders

ANA applauds innovative strategies to solve the opioid epidemic, SUDs, and co-morbidities such as chronic pain and mental illness like the one that CMS proposes in *Section II.D.7. Comment Solicitation on Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders*. However, ANA has concerns with a bundled payment for an episode of care for treatment of SUDs if not fully vetted with providers, especially those with specialized training in diagnosing and treating SUDS, clinicians, providers with prescriptive authority, patient advocacy groups, facility administrators, and other interested stakeholders. Like other chronic conditions, there is no cure for SUDs, mental illness, and chronic pain. Patients are in a constant state of recovery, working with their providers to control the disease along with other comorbidities. Therefore, ANA does not recommend setting limits on payment periods or limiting the potential tools to help treat and allow patients to control recovery.

ANA recommends piloting the bundled payment for an episode of care for treatment of SUDs in acutely impacted areas. Moreover, provider groups should weigh in on specifics prior to the pilot to ensure all potential options are available to persons suffering from SUDs, including the incorporation of non-opioid treatments and therapies that compliment Medication-Assisted Therapy (MAT). ANA recommends that all evidence-based treatments should be available to treat patients who are suffering from SUDs, including medications, psychotherapies, and a

combination of these. Available effective treatments also include, but are not limited to, coverage of Complementary and Alternative Medicine (meditation, massage therapy, acupuncture, chiropractic manipulation, guided imagery, etc.), non-opioid medications, nerve blocks, psychotherapy, and counseling. Moreover, as feasible, therapies - especially counseling - should be available through virtual technologies, ensuring access for patients who are remote or face stigma for getting care.

APRNs and RNs are well positioned to provide services to patients in order to treat SUDs and related comorbidities such as mental illness and chronic pain. Nurses have for decades been providing care coordination services to patients for many different episodes of care, including many that are covered by Medicare or being studied by the Center for Medicare & Medicaid Innovation. RNs are best suited to continue this work throughout the treatment of and recovery from SUDs. Additionally, nursing roles are poised to practice to the full extent of their education and license in areas such as pain management, counseling for SUDs and mental illness, psychotherapy, and administration of SUD programs and methadone clinics. All roles and duties are currently being managed successfully by APRNs and RNs.

IV) Section III.H. CY 2019 Updates to the Quality Payment Program

CMS proposes in *Section III.H. CY 2019 Updates to the Quality Payment Program* to make several changes to the Quality Payment Program (QPP) and the Merit-based Incentive Payment System (MIPS) which seek to enable more Medicare Part B providers to participate in these programs through the opt-in process and the MIPS low-volume threshold. It is reasonable to assume, given CMS' estimates in Table 96, that these changes would result in a greater number of APRNs being eligible to participate in MIPS. Given, however, the unclear impact of these changes on APRNs and other specific groups of practitioners, ANA cannot support these changes *per se.* To this end, ANA urges CMS to identify a core set of data on MIPS and its various exclusions (including the low-volume threshold) to be updated annually in conjunction with the proposed rule to allow stakeholders to follow the impacts of those exclusions longitudinally, particularly as the Secretary expands eligible groups. Such a core data set would be a tremendous resource to members who want to participate actively in this important program and would better inform policy formulation. We would also like to indicate our willingness to work with CMS to determine the exact impact of these changes on APRNs.

More broadly, we urge CMS to not only implement policies which expand the participation of APRNs in MIPS and QPP, but to also implement policies which result in more equitable participation of APRNs in Medicare Part B. Ensuring parity of available resources, including incentives, across all settings and providers in which patients receive care is paramount to the

mission of quality and value-based patient care, and APRNs should have an equitable seat at this table given their role in patient-centered health care. For instance, NPs now have full practice authority in 23 states and prescriptive authority in all 50 states. ANA looks forward to engaging with CMS with the goal of ensuring this equitable treatment as Medicare Part B providers.

V) ANA Encourages CMS to Modify *Incident To* Billing

CMS' proposed revisions for the CY 2019 Physician Fee Schedule (PFS) maintain *incident to* billing, which requires APRNs to mark their services as provided only *incident to* the care of a physician. As ANA previously stated in comments regarding changes for the CY 2018 PFS:

> *Incident to* billing is costly and obfuscates the true provider of services to beneficiaries and comprises a large barrier to transparency in the CMS payment system. Various APRN provider groups have encouraged CMS to adopt the use of modifiers in *incident to* billing to identify the individual providing the services being billed for. This will allow for better transparency within the billing system as well as for future study of the costs, outcomes, and quality of APRN-provided care. While ANA would rather see the elimination of *incident to* billing, we would support incremental progress in the form of modifiers.

ANA welcomes the opportunity to further engage with CMS with respect to the proposed changes above, as well as the role of APRNs and RNs as Medicare Part B providers. If you have questions, please contact Kelly Cochran, MS, RN, Assistant Director of Health Policy, at (301) 628-5096 or kelly.cochran@ana.org, or Gregory Craig, Health Policy Advisor, at (301) 628-5395 or gregory.craig@ana.org.

Sincerely,

Debbie Hatmaker

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Chief Nursing Officer / Executive Vice President

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Loressa Cole, DNP, MBA, RN, NEA-BC, FACHE, ANA Chief Executive Officer