August 23, 2016

Honorable Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1651–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Submitted electronically to regulations.gov

Re: CMS–1651–P, End-Stage Renal Disease Prospective Payment System and other matters, 81 Federal Register 42802 (July 30, 2016)

Dear Acting Administrator Slavitt:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the proposed rule concerning the calendar year (CY) 2017 End-Stage Renal Disease (ESRD) Prospective Payment System and Quality Incentive Program (QIP). As the only full-service professional organization representing the interests of the nation's 3.6 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 is dedicated to partnering with health care consumers to improve practices, policies, delivery models, and outcomes and advance access to health care across the health care continuum.

We support the positions and recommendations set forth in the comment letter submitted by the American Nephrology Nurses' Association (ANNA), the leading professional association representing nephrology nurses.

[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.

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Of note, ANA supports ANNA's positions with regard to the proposed revision of the payment adjustments under the CY 2017 ESRD PPS and the proposed payment policy for renal patients with acute kidney injury (AKI). A number of the policies in the proposed rule concerning AKI, such as mechanisms to allow facilities to bill separately for non-renal dialysis care and to furnish vaccines, have the potential to advance care coordination, which is essential to improving the delivery of health care while reducing costs.

With regard to ESRD QIP, we reiterate ANNA's recommendation that CMS adopt evidence-based ESRD QIP measures that promote the delivery of high-quality care and improved patient outcomes. ANA also agrees that it is essential for CMS to work closely with stakeholders in the nursing community and the Kidney Care Quality Alliance when developing and implementing measures to improve the quality of care provided to ESRD patients. As ANNA notes, nephrology nurses are integral to the collection and processing of quality improvement data. In order to ensure that this essential perspective is represented during the development and implementation of quality measures, nurses remain an integral part of the development process.

We also want to highlight ANNA's emphasis on the need to include nurses in the development and implementation of the Comprehensive ESRD Care Model and other alternative payment models. Such payment models rely on effective collaboration and communication of the entire health care team to coordinate and transition care. RNs and APRNs often provide complex, chronic care management as a key component of their nursing practice across all health care settings. In order to reap the envisioned benefits of alternative payment models, including improving patient care while reducing costs, the knowledge and expertise of nurses must be recognized and fully utilized during the development and implementation of such models. The nursing perspective is invaluable to this process.

We appreciate the opportunity to share our views on this proposed rule and support the policies and positions set forth by ANNA. If you have questions, please contact Mary Beth Bresch White, Director, Health Policy (marybreschwhite@ana.org).

Sincerely,

Debbie Hatmaker

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Executive Director / Executive Vice President

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