August 12, 2019

Submitted via www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-6082-NC
P.O. Box 8010
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-6082-NC – Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork (84 Fed. Reg. 27070 June 11, 2019)

Dear Ms. Verma:

On behalf of the undersigned organizations, we are pleased to comment on the Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork (84 Fed. Reg. 27070 June 11, 2019).

We appreciate the Centers for Medicare & Medicaid Services' (CMS) commitment to reducing administrative burdens on clinicians and the patients they serve. 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.

As CMS seeks public comments on ways to reduce unnecessary administrative burdens, we offer the below recommendations to remove regulatory barriers of APRNs that impair patient access to our members' services, impede patient choice, and raise healthcare costs. These recommendations include:

- Remove credentialing and privileging barriers to practice and care,
- Remove costly and unnecessary physician supervision requirements,
- Address incident-to billing and acknowledge the licensure of the rendering provider,
- Provide 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 APRNs 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. The leadership of CMS is important in this administrative process will permit more patients to receive the high-quality, cost-effective services of APRNs.

In place of the current unnecessary, regulatory credentialing and privileging decisions we seek consideration of the following:

- Requirements that medical staffs include APRNs.
- Eliminate 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.

[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 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, lower cost, 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]

Address Incident-to Billing and to Acknowledge the Licensure of the Rendering Provider

In 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, undercutting 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 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. As a result of these practices, the 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.

Recently, members of the Medicare Payment Advisory Commission (MedPAC) have also recognized the inherent problems with "incident to" billing. In MedPAC's June 2019 report to Congress the Commission formerly requested that Congress act to retire incident to billing practices. Commissioners recognized the same inequities and confusion that our organizations

[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.

have emphasized and that other policy experts have acknowledged. The report acknowledges the cost savings to the health care system and the greater transparency that will be achieved by doing away with this practice. 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 physicians 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.

While the MedPAC report made its recommendation to Congress, our organizations believe that there are steps that CMS can take in the interim to address "incident-to" billing. 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. This would be a very small added step to a provider transaction that is already required.

Finally, CMS' Patients Over Paperwork initiative presents an excellent opportunity to address the inherent anticompetitive effects of APRN scope restrictions, as discussed in Reforming America's Healthcare System Through Choice and Competition.[5] Specifically, HHS should consider administrative steps to remove the barriers created by the "incident-to" billing requirement. 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. APRNs have a long history of educating and training medical residents and interns in 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 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

[5] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf

reimbursed for time spent supervising and instructing residents and interns in teaching facilities. We strongly encourage CMS to revise its payment rules to include APRNs as resident teachers so that they may appropriately document and reimburse for billable services.

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 request for information. 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 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

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