

September 10, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid
Department of Health and Human Services
Attn: CMS-1693-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-8016

RE: CMS-1693-P - Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B to CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability (83 Fed. Reg. 35704, July 27, 2018)

Dear Administrator Verma,

The American Association of Nurse Practitioners (AANP), representing more than 248,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment in response to the CY 2019 Updates to the Physician Fee Schedule and Quality Payment Program.

NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs practice in nearly every health care setting including clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia. It is important to note that 86.6% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

We appreciate the steps that CMS has taken to reduce burden on clinicians in this proposed rule and look forward to continued work with CMS on issues related to Patients Over Paperwork and other initiatives. We would particularly like to highlight additional actions that CMS can take to reduce documentation burden for NP preceptors and NP students located on pages 3-5 of this comment letter. CMS recently reduced the documentation burden for teaching physicians and is proposing to reduce additional burdens in this proposed rule. It is imperative that documentation burdens also be relieved for NP preceptors and their students. This is an issue of high importance to NPs and the entire health care workforce, and we request that you implement the following proposals.

1. Lifting Restrictions Related to Evaluation and Management (E/M) Documentation

A. Eliminating Extra Documentation Requirements for Home Visits (83 FR 35835)

We agree with CMS that the decision regarding where a visit occurs is best decided between the practitioner and the patient. We support removing the requirement that a practitioner must document why an at home visit is medically necessary.

B. Eliminating Prohibition on Billing Same-Day Visits by Practitioners of Same Group and Specialty (83 FR 35835)

We support the proposal to eliminate the prohibition on billing same-day visits by practitioners of the same group and provider specialty code. Under current Medicare billing guidelines, all nurse practitioners are categorized as Medicare specialty code 50, regardless of their population or clinical foci. This leads to frequent claim denials for billing same-day visits when NPs practice together in a group, even if they are practicing in different specialties. While not mentioning nurse practitioners in the proposed rule, nurse practitioners also face the same issue of referring patients to other NPs in the same practice. NPs have this same issue with new and established patient visits.

2. Documentation Changes for Office or Other Outpatient E/M Visits and Home Visits

A. Providing Choices in Documentation- Medical Decision-Making, Time or Current Framework (83 FR 35835)

CMS proposes the reduction of the administrative burden on clinicians by reducing the documentation requirements for E/M services. The proposal would allow clinicians to document an E/M visit using the current guidelines, medical decision-making (MDM), or time, with the documentation requirements of a current level two visit.

While we agree that the 1995 and 1997 guidelines can use revision, we caution that reducing the documentation requirements too far could have adverse effects. The documentation of an E/M visit is important to treating the patient and maintaining adequate documentation of patient status. Histories and physicals (H&Ps) are not only important to the clinician documenting the care but also to any other clinicians or facilities treating the patient currently and in the future. Additionally, the increased use of electronic health records has eased the documentation of H&Ps.

We request that CMS consult and receive feedback through advisory panels and working groups that include all clinicians, including NPs, to ensure that they are conducted in a manner that reduces administrative burden while maintaining an appropriate level of documentation.

B. Removing Redundancy in E/M Visit Documentation (83 FR 35838)

We support the proposals to allow NPs and other clinicians to verify documentation already in a medical record, or entered by staff into the record, instead of the clinician having to redocument the work. We recommend that CMS implement the same changes recently made for teaching physicians¹ to all E/M documentation. This would authorize NPs and other clinicians to verify prior documentation in the record for the history, physical exam, and MDM. The clinician would still perform, or re-perform, the exam and MDM but would be authorized to verify prior documentation of those activities and not have to re-document prior work. (See page 3).

¹ CMS Transmittal 3971 on February 2, 2018 later amended by Transmittal 4068, May 31, 2018.

Additionally, CMS should apply this change immediately for teaching NPs (NP preceptors) and their NP students. As we note below, CMS created a disparity in documentation between teaching physicians and teaching NPs (preceptors) that has had unintended consequences. NP students are already licensed health professionals with extensive experience documenting patient care. NP preceptors should be authorized to verify information that NP students have entered into the medical record, instead of having to re-enter that medical information themselves. CMS can rectify the disparity between teaching physicians and NP preceptors in this rulemaking by applying the same E/M documentation standard to all E/M visits, which would then apply to NP preceptors verifying E/M documentation entered by their NP students.

C. Minimizing Documentation Requirements by Simplifying Payment Amounts (83 FR 35839)

CMS proposes to collapse payment rates and create one blended payment for new and established patient visits respectively. Under this new blended rate (with associated add-on codes), CMS projects that NPs on average would receive an overall payment increase of approximately 3% for their E/M visits. While we appreciate CMS working to simplify billing and documentation for NPs and other clinicians, we do have some concerns about the impact that this change would have on practitioners in specialty settings and those that are treating patients with a particularly high acuity.

We ask that as CMS moves forward with any changes to E/M documentation and billing, that it be conducted in a way that does not dissuade clinicians from seeing the most vulnerable and acute patients. We also ask that CMS ensure that any changes to coding and billing be equal for NPs and other clinicians. For example, if CMS moves forward with this billing structure NPs must be able to bill for the add-on code GCG0X for inherent visit complexity in specialty settings. CMS must ensure that this code, and any other codes that are created, are able to be billed by NPs.

3. Teaching Physician Documentation Requirements for Evaluation and Management Services (83 FR 35848)

A. Issue

Prior to March 5, 2018 for billable E/M services, all clinical preceptors (teachers) had to re-document the clinical notes of medical students (MS), nurse practitioner (NP) students and physician assistant (PA) students. The release of Centers for Medicare & Medicaid Services (CMS) Transmittal 3971 (subsequently Transmittal 4068), revised the Medicare Claims Processing Manual, effective March 5, 2018, to allow teaching physicians to verify in the medical record any student documentation of the components of E/M services, rather than re-document the work. CMS unfortunately did not apply this same burden reduction to NP and PA preceptors even though they fill the same role as teaching physicians.

The updated policy removed burdens for teaching physicians but had the unintended consequence of exacerbating the disparity among teaching physicians and precepting (teaching) NPs and precepting (teaching) PAs. This has already led to an unwillingness of facilities to train NP and PA students, and it did not help alleviate the shortage of NP and PA preceptors. While we understand that the initial action had the intent of burden reduction, the unintended consequences put NP and PA preceptors at a significant disadvantage in relation to teaching physicians. We know this was not a goal of CMS as it would be contrary to the CMS Patients Over Paperwork initiative.

The nature of the health care workforce has changed since CMS last enacted rules related to teaching physicians. There are currently 248,000 NPs in the workforce and 26,000 NP graduates in 2016-2017, all

of whom required NP preceptors.² NPs are the fastest growing provider specialty in the Medicare program and are on pace to be the largest provider specialty within a year.³ This will have a particularly large impact on primary care as approximately 85% of all NP graduates go into primary care⁴ and NPs comprise approximately one quarter of our primary care workforce.⁵ It is imperative that CMS apply the burden reduction in Transmittal 4068 to NP and PA preceptors. This will ensure parity for all teaching clinicians so that our health care workforce is able to meet the needs of our growing and aging population.

B. Recommendations

Since the teaching physician guidance has already gone into effect, and the negative impacts are already being felt by NP preceptors, PA preceptors and their students, it is imperative that CMS enact documentation parity among teaching physicians, NP preceptors and PA preceptors as quickly as possible. We believe there are two actions that CMS can take, either one of which would remedy this disparity quickly for all teaching clinicians:

Action 1: Apply the Teaching Physician Documentation Requirements to All E/M Visits

In the 2019 Physician Fee Schedule proposed rule⁶, CMS is already proposing to reduce documentation redundancy for all E/M visits. By applying the new teaching physician requirements from Transmittal 4068 to all E/M visits, CMS can reduce documentation redundancy for all E/M visits, including E/M visits that are documented by NP and PA students and verified by NP and PA preceptors. CMS can accomplish this through its current fee schedule rulemaking and have it go into effect immediately.

This recommendation is consistent with CMS' proposal in the proposed rule as well as the Patients Over Paperwork Initiative. This action would immediately fix the disparity between teaching physicians and NP and PA preceptors, have a significant positive impact on the development of our health care workforce, and would reduce unnecessary documentation burden for all teaching clinicians including NP preceptors and PA preceptors.

Action 2: Enact Documentation Parity Between NP and PA Preceptors and NP and PA Students, and Teaching Physicians and Medical Students

CMS can also take the step of recognizing the role of NP preceptors and PA preceptors and students by including them in the regulations and guidance that currently exists for teaching physicians and medical students. In order to do this, CMS would need to do two things concurrently in order to prevent any further disparities:

- *Define Teaching Physician to Include NP and PA Preceptors*

CMS can include NP preceptors and PA preceptors in the definition of "teaching physician." The Secretary has the explicit statutory authority to define "teaching physician" and the Secretary can define "teaching physician" to include NP and PA preceptors. We would recommend using the phrase "teaching clinician" which is a more inclusive term that recognizes the role of other providers in training

² <https://www.aanp.org/images/documents/about-nps/npfacts.pdf>.

³ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2016/Downloads/PROVIDERS/2016_CPS_MDCR_PROVIDERS_6.pdf

⁴ <https://www.aanp.org/images/documents/about-nps/npfacts.pdf>.

⁵ [Rural And Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners](#), Hilary Barnes, Michael R. Richards, Matthew D. McHugh, and Grant Martsolf, Health Affairs 2018 37:6, 908-914.

⁶ 83 FR 35704, 35838.

our health care workforce. If CMS feels that this change must be done through rulemaking, CMS can utilize its waiver authority or issue a nonenforcement instruction to its carriers to enact the teaching physician burden reductions for NP and PA preceptors immediately to ensure there are no further disparities in clinical training opportunities.

- *Define Student to Include NP and PA Students*

CMS can interpret the word “student” in Transmittal 4068 to include NP and PA students. “Student” is not defined in regulation, and the existing definition of “student” in the Medicare Claims Processing Manual⁷ includes NP and PA students. Interpreting “student” to include NP and PA students could be accomplished through issuing guidance, would not require rulemaking, and is consistent with the existing CMS definition of “student.”

C. Conclusion

The mission of CMS to put patients first in all their programs is indicative of its continuing support of increasing quality and decreasing costs for the health of the nation. It is imperative that all students (medical, PAs and NPs) are on a level playing field when it comes to securing a slot with a preceptor or clinical rotation sites. Allowing NPs and PAs who precept students to use the students’ note in documentation ensures that work load is not a limiting factor in precepting students.

CMS is aware of the importance of NPs and PAs in meeting the nation’s healthcare demands, most importantly the rural and underserved communities.⁸ CMS has made a point to be inclusive of NPs and PAs in other programs, such as QPP, and should do the same in this instance because NP and PA preceptors perform the same roles as teaching physicians. We respectfully request that CMS create parity among NP preceptors, PA preceptors and teaching physicians by either reducing the documentation burdens for all E/M visits, and/or redefining “student” and “teaching physician” simultaneously to include NP and PA students and preceptors.

4. Recognizing Communication Technology-Based Services (83 FR 35725)

AANP has been supportive of CMS’ efforts to increase the ability of NPs and other clinicians to use telehealth, remote patient technology, and communication technology-based services to assist in care delivery. While we are generally supportive of expanding the number of telehealth services that are reimbursable, this must be done in a manner that includes all qualified health care professionals, including nurse practitioners. We ask that CMS ensure that all qualified health care professionals, including nurse practitioners, are authorized to bill for these new codes.

In that vein, we ask CMS to amend proposed CPT codes 994X6, 994X0, 99446, 99447, 99448 and 99449.⁹ The proposed codes are all currently described as services provided by a “consultative physician” which would appear to omit other qualified health care professionals such as nurse practitioners. These proposed code descriptions exclude NPs and other qualified health care professionals from billing the codes when they are the consultative clinician providing the assessment or management service.

The reference to “consultative physician” excludes other qualified health care professionals, including NPs, and we ask that you change this language to “consultative qualified health care professional.” NPs

⁷ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.

⁸ <https://www.nejm.org/doi/full/10.1056/NEJMp1801869>.

⁹ 83 FR 35704, 35725.

are the fastest growing provider specialty for Medicare patients¹⁰ and they must be included in all new billing codes to further CMS' goal of leveraging technology to improve patient care.

5. Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders (83 FR 35730)

We support the creation of a bundled episode of care for management and counseling treatment for substance use disorders, but strongly disagree with the CMS language that indicates a “billing physician” would need to lead the care team.¹¹ The proposed rule later uses the term “billing practitioner” and suggests a structure similar to the Behavioral Health Integration codes (which authorize NPs to lead the care team and bill accordingly). We hope the reference to billing physician is an oversight. CMS must ensure that NPs will be authorized to lead the care team for any new bundled codes for the management and counseling treatment for substance use disorders.

Nurse Practitioners (NPs) are educated in pharmacologic, pathophysiologic, psychologic and sociologic aspects of pain treatment that includes the diagnosis and treatment of patients with addictive diseases including those acquired from overdosing with opioids and other schedule drugs. The pharmacodynamics, therapeutics and management of controlled drugs including opioids is a part of both baccalaureate nursing education and graduate advanced practice nursing education. NPs hold prescriptive authority in all 50 states and the District of Columbia and have been providing high quality health care to patients for over half a century. With the passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016, nurse practitioners were authorized to prescribe medication-assisted therapies (MATs) after taking the necessary training and obtaining the required DEA waiver to do so.

Since CARA passed, AANP has provided MAT training to over 5,600 NPs and SAMHSA has reported that over 6,200 NPs have obtained a MAT waiver. This demonstrates that NPs are committed to using MAT to assist their patients suffering from opioid abuse and granting NPs the authority to obtain MAT waivers has been a success. NPs have risen to the challenge of combatting our nation's opioid epidemic and must be authorized to perform, lead, and be reimbursed for substance use disorder services to the full extent of their education and clinical training.

6. CY 2019 Updates to the Quality Payment Program

A. Low-Volume Threshold and Low-Volume Threshold Opt-In (83 FR 35887)

We thank CMS for recognizing that many clinicians, including NPs, would like to participate in the MIPS program. We support the proposals to add the 200 covered services low-volume threshold criteria, and the opt-in option for clinicians meeting at least one of the three low-volume threshold criteria. The new Part B covered services low-volume threshold coupled with the opt-in option should increase the number of NPs that are authorized to participate in MIPS. We continue to encourage CMS to ensure that all clinicians that are eligible to participate in MIPS are able to do so and this is a positive step in that direction.

We also appreciate that CMS is taking steps to streamline the QPP website to improve the usage for clinicians. We would recommend that CMS change the name of the voluntary participation option to ensure that clinicians do not confuse that option with opt-in participation. Since a voluntary participant is

¹⁰ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2016/Downloads/PROVIDERS/2016_CPS_MDCR_PROVIDERS_6.pdf

¹¹ 83 FR 35704, 35731.

only reporting data, we would suggest changing that category to “Voluntary Reporting” to ensure this is not confused with “Opt-in Participation.”

B. MIPS Performance Periods (83 FR 35893)

We agree with the proposal to maintain the MIPS performance periods from year two of the program. This will provide consistency for participating clinicians and a substantial sample size on quality and cost data to continue to improve patient care.

C. Episode Based Cost Measures (83 FR 35902)

We encourage CMS in future years to field test and implement episode-based cost measures that are more pertinent for primary care clinicians. CMS is currently looking into episode-based cost measure development for chronic conditions, and it is important that these be developed and implemented in future years. In doing so, we ask that CMS ensure that the cost measures that are developed are applicable to as many patients as possible to ensure that NPs can use this option in the cost performance category.

D. Promoting Interoperability Category for Nurse Practitioners (35933)

We agree with CMS’ proposal to continue to allow NPs to reweight the Promoting Interoperability category to zero, unless the NP opts to send in data, until CMS is able to analyze the data for the first performance period.

7. “Incident To” Billing:

While it is our opinion that “incident to” billing should be discontinued, we also note that the billing guidelines related to “incident to” services could be amended by regulation or guidance to ensure that all practitioners bill under their own billing ID for the services that they provide. In the transition to value-based reimbursement, it is important that the most accurate data is obtained to document and evaluate practitioners and the services they provide.

Current “incident to” billing practices undermine the foundation of value-based reimbursement. They prevent nurse practitioners from reaching MIPS volume thresholds and prevents HHS from obtaining accurate data. Simplifying these billing guidelines to require practitioners to bill under their own billing ID for the services that they perform will lead to administrative simplification and more accurate data which is essential in the transition to value-based reimbursement. Alternatively, we propose the creation of a billing modifier that would identify the provider of the service being billed. This would ensure accuracy of billing and claims data.

8. Provider Neutral Language

It is important that in rulemaking and all other correspondence, CMS does not continue to utilize the word “physician” when other qualified health professionals are authorized to provide a service. The use of the term “physician” in these instances confuses patients and providers as to which clinicians are authorized to provide care under the QPP and other Medicare programs and undermines the scope of practice and quality of care provided by nurse practitioners. NPs are the second largest (and fastest growing) specialty in the Medicare program and the third largest specialty of MIPS clinicians. Any policies that omit NPs could result in serious disruption to the Medicare program and the QPP. This could lead to unfair restraints on practice, decreased access to care, and increased burden on healthcare systems.

9. Request for Information on Opioid Abuse (83 FR 35730)

In this proposed rule, CMS requested additional feedback on steps that CMS could take to combat opioid abuse. Below are a few suggestions that CMS should incorporate to help combat opioid abuse.

Many providers have difficulty prescribing non-pharmacologic pain treatments due to a lack of available options. Since many insurers base their coverage criteria on CMS policies, incorporating alternatives to opioids such as physical therapy and massage therapy in prescription recommendations will help increase their availability. These recommendations should be consistent among all applicable entities (e.g. health plans, CMS, FDA) to increase the availability of non-pharmacologic pain treatments. CMS should also work with plans to produce incentives to cover more non-pharmacologic pain treatments. Creating pain treatment models through the Innovation Center would be one avenue to form these programs. Additionally, it is extremely important that any programs or incentives created are available to all providers, including nurse practitioners.

AANP is a strong supporter of provider education, and CMS should work with health plans (and other stakeholders such as SAMHSA and the FDA) to create consistent provider education materials for the prescription of opioids and how to manage opioid abuse. It is important to ensure that providers have the most up to date information regarding opioid abuse, while also mitigating the burden on providers that can result from inconsistent educational materials.

10. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange (83 FR 36006)

In this proposed rule, CMS included a request for information (RFI) on promoting interoperability and electronic healthcare information exchange by revising the conditions of participation (COP) for hospitals and other Medicare and Medicaid providers. We support the goals of interoperability and improving data exchange so that patients and providers have access to the patient's health information. We applaud the goals of the Trusted Exchange Framework which will help bridge gaps in care and improve our ability to leverage the data contained in health records to improve patient care. In order for these initiatives to reach their potential, it is important that CMS take steps to ensure that all clinicians, including NPs, are involved in the development and implementation of the programs, and are able to participate and share health information.

A. Nurse Practitioner Inclusion

CMS has made many practical suggestions to improve the use of certified-electronic health record technology (CEHRT) for clinicians. However, there are barriers within many CEHRT systems that are still geared to the concept that only a physician documents the patient's condition and the services performed, particularly in hospital systems. We suggest that CMS require software products to be "nurse practitioner inclusive" to be certified by CMS. This will help improve the documentation and transmission of medical records by removing prompts within the CEHRT that unnecessarily request a physician signature.

CMS has made improvements in including NPs in their CEHRT initiatives, and it is vital that this trend continues. We encourage CMS to continue to incentivize providers, including NPs, to adopt CEHRT to continue to spur progress on CEHRT adoption and interoperability. NPs should be included in the development and implementation of CEHRT initiatives and one step toward accomplishing this goal is to include them on health technology advisory committees.

B. Clinician Burden

A number of the questions in this RFI focus on the issue of clinician burden, which is an important consideration as we increase the prevalence and usage of CEHRT. CMS recognized in the development of the Quality Payment Program (QPP) that NPs and other clinicians were excluded from participating in the Medicare EHR Incentive Program and may have less familiarity with the requirements of CMS EHR initiatives. While utilization of CEHRT has certainly increased among NPs, we still believe that CMS should provide technical assistance to providers and ensure that there is high-quality, free and low-cost CEHRT for all clinicians, particularly those in small practices, who may not have the financial ability to invest significant money on CEHRT.

C. Non-Electronic Medical Information Sharing:

CMS asked if under revised COPs, non-electronic forms of communication should be allowed to be shared if the receiving provider cannot receive the information electronically. We believe that this should be allowed, particularly considering difficulties that continue to exist with CEHRT interoperability. Obtaining up to date patient health information is imperative for a clinician to provide appropriate treatment, and we do not want to create a scenario where that is jeopardized solely due to technical issues.

D. Program Alignment:

CMS asked if hardship exceptions, such as those allowed under the QPP, should also be allowed under revised COPs. We believe that any new regulations should be aligned across programs. If COPs are inconsistent with participation requirements in the QPP and other CMS programs, that will result in confusion, administrative burdens, and significant compliance difficulties. In a similar vein, we are concerned that new COP requirements related to CEHRT will be burdensome on clinicians who are not eligible to participate in the QPP. We continue to encourage CMS to lower the low-volume threshold and create an opt-in option for the QPP, so that clinicians who invest in CEHRT and meet CMS requirements have an opportunity to participate and receive payment bonuses for their efforts.

We thank you for the opportunity to comment on this proposed regulation. We look forward to discussing these issues with you. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

David Hebert
Chief Executive Officer