

September 27, 2019

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

RE: CMS-1715-P - Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations (84 FR 40482).

Dear Administrator Verma,

The American Association of Nurse Practitioners (AANP), representing more than 270,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment on the CY 2020 Physician Fee Schedule proposed rule. We appreciate CMS taking the initiative on reducing clinician burden in this proposed rule, particularly the section on the review and verification of medical record documentation. We thank CMS for working to reduce burden on health care providers and their patients and look forward to continuing to work together to achieve these goals.

NPs are advanced practice registered nurses (APRNs) 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 long-term care facilities, 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. NPs complete more than one billion patient visits annually and approximately one third of all Medicare patients receive care from a nurse practitioner.

Nurse practitioners are currently providing a substantial portion of the high-quality¹, cost-effective² care that our communities require, and will continue to do so to meet the needs of their communities. As of

¹ <https://www.aanp.org/images/documents/publications/qualityofpractice.pdf>.

² <https://www.aanp.org/images/documents/publications/costeffectiveness.pdf>.

2017, there were more than 130,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.³ Based on Medicare's claims data, approximately one out of every three Medicare patients receives billable services from a nurse practitioner. Over 82% of NPs are accepting new Medicare patients and 80.2% are accepting new Medicaid patients.⁴ NPs have a particularly large impact on primary care as approximately 73% of all NP graduates deliver primary care⁵. NPs comprise approximately one quarter of our primary care workforce, with that percentage growing annually.⁶ Below please find our comments on specific sections in this proposed rule.

1. Telehealth Services (84 FR 40517)

We support the addition of codes GYY1-GYY3 for office-based treatment of opioid use disorder (OUD) to the fee schedule and the addition of the face-to-face portions of those codes to the telehealth list.

2. Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (84 FR 40518)

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.

NPs are deeply committed to helping solve the opioid crisis. Since CARA passed, SAMHSA has reported that over 11,000 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. Accordingly, we support the proposed implementation of the SUPPORT Act coverage of OUD treatment services furnished in OTPs including the following specific provisions:

- CMS requested feedback on the addition of intake activities, physical examinations, initial and periodic assessments, and treatment plan preparation to the definition of OUD treatment services furnished by OTPs. We support the addition of these items as patients receiving treatment for OUD frequently require care coordination, care planning and additional wraparound services. Incorporating intake activities, patient assessments and other care coordination activities will aid OTPs in providing holistic care to this patient population.
- We support CMS using its authority to set the copayment amount at zero for OUD services furnished by an OTP.
- We also support the proposal to authorize OTPs to furnish substance abuse counseling, individual and group therapy via telehealth when clinically appropriate by licensed health care practitioners, including NPs. This will provide greater access to patients in needs of these services.

³ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/Downloads/PROVIDERS/2017_CPS_MDCR_PROVIDERS_6.PDF

⁴ 2017 AANP National Nurse Practitioner Sample Survey.

⁵ <https://www.aanp.org/about/all-about-nps/np-fact-sheet>.

⁶ [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.

3. Bundled Payments Under the PFS for Substance Use Disorders (84 FR 40542)

We support the creation of bundled episode of care payments for management and counseling treatment for substance use disorders (proposed GYYY1-GYYY3). We also support the proposal that counseling, therapy and care coordination can be provided by professionals who are qualified to provide the services under state law and within their scope of practice “incident to” a billing clinician who is responsible for managing the patient’s overall care. We also support the suggestion of a structure similar to the Behavioral Health Integration codes which authorize NPs to manage the patient’s overall care and bill accordingly. These codes will authorize NPs to lead the care team under these proposed new bundling codes and increase access to these necessary services. As with the proposed OTP services, we also support the proposal to allow the individual therapy, group therapy, and counseling services included in GYYY1-GYYY3 to be provided via telehealth when clinically appropriate.

While we support these proposed new bundled episode of care payments, we also believe that they should be closely monitored to ensure that they have the intended effect of increasing access to management and counseling treatment for patients with substance use disorders.

4. Review and Verification of Medical Record Documentation (80 FR 40547)

We would like to thank CMS for recognizing and addressing the disparity between student documentation requirements for teaching physicians and their students and those for advanced practice registered nurse (APRN) and PA preceptors and APRN and PA students. As you recall, Transmittal 3971 enacted documentation changes solely for teaching physicians and their students. This guidance had the unintended consequence of disenfranchising PA and APRN clinical preceptors by excluding them from applying this guidance in their clinical practice, thus heightening the challenge of securing preceptors for APRN/PA students when teaching clinicians are in short supply.

The rule you have proposed will authorize all APRNs/PAs and physicians to verify rather than re-document work for all E /M services by all members of the medical care team (including APRN/PA students). This will remove the disparity and lead to parity among providers and burden reduction for all clinicians. We thank you for this amendment.

We do note however, that while the new rule appears to be all inclusive, in the proposed regulatory language APRN and PA students are not specifically mentioned, though the intent of the proposed rule would be all inclusive for all members of the medical care team, including APRN and PA students. We feel it would be helpful to include APRN and PA students specifically in the list of providers that can enter information into the medical record and have it verified by the billing clinician. This would help to avoid misunderstanding in the future implementation of this rule. We also note that the term “verify” that is used to refer to signing and dating medical records in this proposed rule may be misconstrued as imposing other performance requirements. We encourage CMS to remove the term “verify” and simply use the term “sign/date” in the final regulatory language.

We thank you again for addressing this important issue and supporting parity of medical record documentation requirements for APRNs, PAs, and physicians. We are available as a resource to help address any further challenges and ensure broad adoption of these important CMS initiatives.

5. Care Management Services (40548)

Care coordination, care planning and other care management services are ingrained in NP practice. We are encouraged to see that CMS has put an emphasis on increasing the utilization of chronic care management and transitional care management services. CMS proposes to simplify the typical care plan language by adopting the phrase “interaction and coordination with outside resources and practitioners

and providers” in lieu of the current language which states “community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identify the individuals responsible for each intervention.” We support this proposed new language as it simplifies the care plan requirements while also ensuring that these vital services remain included in the care plan. We also support the proposal to authorize CPT codes 99457 and 994X0 (chronic care remote physiologic monitoring services) to be furnished under the general supervision of a physician or other qualified health care professional, such as a nurse practitioner, instead of requiring direct supervision.

We are concerned however, about the proposed creation of a principal care management code for clinicians treating only one chronic condition for a patient. As CMS notes in this proposal, there is concern that this could lead to separate payment of care management for a single chronic condition by multiple providers for the same patient. This could lead to fragmented care which is not the intent of chronic care management. While we appreciate that CMS is attempting to fill gaps in care for patients with one chronic condition, we would encourage CMS to initially incorporate a PCM, or similar code, in a pilot program to fully understand how the code would be utilized.

6. Comment Solicitation on Opportunities for Bundled Payments Under the PFS (84 FR 40556)

As CMS considers expanding the concept of bundled payments under the PFS, we believe the agency should ensure that any new bundled payments under the PFS are either optional for clinicians, or first implemented in pilot programs so that their impact can be fully assessed. Additionally, we request that as CMS develops new bundled payments, CMS ensures that NPs are authorized to be managing clinicians for patients receiving services through the bundle and able to bill accordingly.

7. Payment for Evaluation and Management (E/M) Services (84 FR 40670)

In this proposed rule, CMS is proposing significant changes to the documentation and billing of E/M services, consistent with the recommendations of the CPT Editorial Panel. We appreciate the willingness of CMS to continue to receive feedback from the clinician community on the best mechanisms for improving E/M coding. E/M coding is very important for nurse practitioners, as approximately 80% of services that NPs bill to the Medicare program are E/M services.

We accept these proposed changes and believe they improve on the changes finalized in last year’s PFS final rule. They address many of the concerns we had with the changes to E/M coding and documentation in last year’s PFS final rule. These changes will reduce documentation burden on clinicians, while not lowering documentation quality. The revised payment structure for E/M services should continue to increase the value of primary care services while not unintentionally discouraging specialty providers or providers with particularly acute patient panels. We look forward to continuing to work with CMS on initiatives that lower the documentation burden on clinicians and improve the accuracy and quality of health record documentation.

8. Ambulance Coverage Services- Physician Certification Statement

Nurse practitioners are qualified to certify when a patient meets the medical necessity requirements for nonemergency, scheduled, repetitive ambulance services, as well as nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis. We agree with CMS that the documentation requirements should focus on the medical necessity of the transport and utilize maximum flexibility in how that information is conveyed.

While we support increasing flexibility and reducing the burden on the provision of medically necessary ambulance services, we disagree with proposed 42 CFR § 410.40(e)(2)(i) which maintains the

requirement that a physician certification statement must be obtained for a nonemergency, scheduled, repetitive ambulance service. NPs also service as the primary care providers for patients requiring these services and should be authorized to certify that they are medically necessary. Section 1861(s)(7) of the Social Security Act does not mandate that a physician certify the medical necessity of ambulance transport. The statute defers to the Secretary to promulgate medical necessity requirements via regulations. Accordingly, we request that CMS amend the proposed regulation to authorize NPs to certify when a nonemergency, scheduled, repetitive ambulance service is medically necessary for a patient.

9. Intensive Cardiac Rehabilitation

This proposed rule implements Section 51004 of the Bipartisan Budget Act of 2018 which added covered conditions for intensive cardiac rehabilitation. That same legislation also authorizes NPs to supervise cardiac and pulmonary rehab starting in 2024. However, NPs are still not authorized to order cardiac and pulmonary rehabilitation for their Medicare patients. NPs are fully qualified based on their education and clinical training to order and supervise these services and this obsolete barrier to care harms patients by causing unnecessary delays in treatment. CMS has recognized that cardiac rehabilitation improves long-term patient outcomes but is underutilized.⁷ Cardiac rehabilitation has been shown to decrease hospitalizations, increase adherence to preventive medication, improve overall health and reduce the need for costly care.⁸ Thus, it is important that NPs be authorized to order and supervise this clinically effective and cost-saving treatment.

The intent of Congress was to increase access to these services. We request that CMS continue to work to expand access to cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation by authorizing NPs to order and supervise these services and expedite the implementation date for providing these services.

10. Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs) (84 FR 40702)

CMS is proposing to require that Medicaid EPs report on any 6 eCQMs that are relevant to their scope of practice, regardless of whether they report via attestation or electronically in order to align these reporting requirements with MIPS reporting requirements. We support this proposal and the continued alignment of program requirements across Medicare and Medicaid programs.

11. Medicare Shared Savings Program (MSSP) (84 FR 40705)

We appreciate the changes that CMS made to the MSSP last year which provided greater flexibility for patients to choose their primary care providers (including NPs) for the purpose of assigning a beneficiary to an ACO. We strongly supported this decision to improve the ability of beneficiaries to select their providers of choice and believe this will have a positive impact on MSSP participation.

As the MSSP continues to be modified, we encourage the Secretary to use his waiver authority to remove barriers to practice for NPs that inhibit care coordination and mandate unnecessary visits, inconsistent with the goals of the MSSP. Section 3302 of the PPACA, which governs the MSSP, grants the Secretary broad waiver authority as “necessary to carry out the provisions of this section,” and explicitly allows the Secretary to waive requirements of title XVIII of the Act. This authority could be utilized to remove barriers to NPs and their patients such as those requiring physicians to certify home health care plans of care, order cardiac and pulmonary rehabilitation, or certify the need for therapeutic shoes for patients with

⁷ 82 FR 50784, 50800.

⁸ https://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_493752.pdf.

diabetes. Implementing these waivers into the MSSP would improve care coordination and increase flexibility for accountable care organizations participating in the program.

12. Open Payments (84 FR 40714)

In this proposed rule, CMS is implementing changes mandated by the SUPPORT Act that add NPs, CNSs, CRNAs, CNMs, and PAs as covered recipients under the Open Payments program beginning in 2022. As CMS incorporates NPs into the Open Payments program, we do want to note some differences in terminology between NPs and physicians to ensure that there is no confusion regarding future reporting requirements.

CMS is proposing to consolidate the current regulations which differentiate between accredited/certified and unaccredited/non-certified continuing education programs into one category called “medical education programs.” Since we believe the statutory intent was to include NPs in the Open Payments program in the same manner as physicians, we would like to note that NPs do not refer to “medical education programs” but to “continuing education programs.” We wanted to clarify this terminology difference to ensure that there is no confusion regarding educational programs subject to the reporting requirements.

13. Deferring to State Scope of Practice Requirements (84 FR 40724)

CMS has recognized that since the creation of the Medicare program, the health care field has diversified and other qualified health care providers, such as NPs, are providing a substantial amount of care as the primary care providers for Medicare and Medicaid beneficiaries. As noted by CMS, Medicare policies and regulations have been updated in recent years to authorize NPs and other providers to provide services within the extent of their scope of practice as defined by state law. Accordingly, AANP supports the position that providers should be authorized to practice to the top of their license and supports policy proposals that remove federal barriers to practice and defer to state law and state scope of practice.

As noted previously, in 2017, there were more than 130,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.⁹ Based on Medicare’s claims data, approximately one out of every three Medicare patients receives billable services from a nurse practitioner. Continuing to revise the Medicare and Medicaid regulations to defer to state scope of practice requirements is consistent with the intent of the Social Security Act and will continue to increase access to care for Medicare and Medicaid beneficiaries.

Removing federal restrictions on NP practice improves access to care for patients, particularly in rural areas, reduces unnecessary complications, lowers costs and improves quality of life. Currently, twenty-two states and D.C. are considered Full Practice Authority (FPA) states because their licensure laws allow full and direct access to NPs. No state has ever moved away from FPA once it has been enacted. In FPA states, NPs are authorized to practice to the full extent of their education and clinical training without a regulated relationship with a physician. In these states, the remaining statutory and regulatory barriers to care for NPs and their patients are federal restrictions in the Medicare and Medicaid programs. Even in states that still require an NP to have a formal relationship with a physician, the Medicare and Medicaid restrictions are often more stringent than those imposed at the state level.

As CMS continues to pursue the policy of deferring to state scope of practice, we have identified other areas of the Medicare and Medicaid programs where barriers to care by NPs for their patients still exist.

⁹ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/Downloads/PROVIDERS/2017_CPS_MDCR_PROVIDERS_6.PDF

Deferring to state scope of practice requirements in these regulations would substantially benefit Medicare beneficiaries. These barriers inhibit access to care for patients seeking care in lower cost settings for services, such as home health and home infusion, by requiring that physicians establish and oversee plans of care for patients. These regulations require physicians to order or supervise cost-effective treatments and services, such as home health care, diabetic shoes and cardiac and pulmonary rehabilitation, that lower the rates of costly complications, hospital admissions and readmissions. They also prevent facilities from utilizing NPs to the full extent of their education and clinical training, such as in rural health clinics and skilled nursing facilities. We have highlighted these barriers in response to multiple requests for information through the Patients Over Paperwork initiative and look forward to continuing to work with CMS to reduce these barriers to care.

14. Deferring to State Scope of Practice Requirements: Ambulatory Surgical Centers (ASCs) (84 FR 40724)

In this proposed rule, CMS requested feedback on ASC regulations that could be revised to authorize nurse practitioners (and other nonphysician practitioners) to practice to the top of their licenses within ASCs. We encourage CMS to standardize the language used in the ASC patient admission, assessment and discharge regulations throughout all the ASC conditions of participation. That language authorizes admissions, assessments and discharges to be completed by a “physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy.”

Other ASC regulations restrict the performance solely to physicians, such as the regulations regarding ordering of pharmaceutical services and performance of procedures. NPs have prescriptive authority in all 50 states and perform procedures within their state scope of practice. Thus, NPs should also be authorized to perform these activities within ASCs and we encourage CMS to amend the regulations accordingly.

15. Deferring to State Scope of Practice Requirements: Hospice (84 FR 40724)

Under the “Deferring to State Scope of Practice Requirements” section of this proposed rule, CMS asked specific question regarding nurse practitioners, and other providers, that provide care to beneficiaries enrolled in hospice. CMS requested feedback on the role of non-physician practitioners, including NPs, in delivering safe and effective hospice care to patients, as well as state level requirements for supervision and physician co-signatures. Our responses to those inquiries are below. We look forward to further work with CMS regarding the removal of barriers to care for hospice patients.

A. The Role of Nurse Practitioners in Hospice Care

As you know, NPs are “attending physicians” under the hospice care statute. In this role, NPs are responsible for transitioning the patient into hospice and developing a plan of care for the patient in coordination with the hospice interdisciplinary group. This is an essential role given that the “attending physician” is the provider with the most experience and knowledge regarding the patient’s medical history. In this role, and as members of the hospice interdisciplinary team, NPs are responsible for patient assessments; 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.

However, despite being designated as “attending physicians”, NPs are not authorized to provide the initial certification that a patient is terminally ill and in need of hospice care. The very nature of hospice care and the terminally ill state of hospice patients demands that this process take place as expeditiously as possible. This hospice certification requirement is an unnecessary restriction on NPs that does not benefit the patient, complicates the hospice selection process and can lead to unnecessary health care costs as the

patient is awaiting placement in hospice care. As CMS continues to defer to state of practice and looks at ways of improving care coordination within the hospice care program, we strongly encourage CMS to find ways to authorize NPs to provide the initial certification that patients are terminally ill and in need of hospice care.

B. Supervision and Physician Co-signature State Level Requirements

As mentioned previously, twenty-two states and D.C. are considered Full Practice Authority (FPA) states because their licensure laws allow full and direct access to NPs. No state has ever moved away from FPA once it has been enacted. In FPA states, NPs are authorized to practice to the full extent of their education and clinical training without a regulated relationship with a physician. No states require direct supervision of nurse practitioners. In states that mandate that an NP has a relationship with a physician it is rare that states require that a collaborating physician supervise an NP or co-sign their orders. We encourage CMS to remove the existing federal barriers and defer to state hospice requirements for the provision of care by NPs to hospice patients.

16. CY 2020 Updates to the Quality Payment Program

A. MIPS Value Pathways (MVPs) (80 FR 40734)

In this proposed rule, CMS is proposing a new pathway for clinician reporting and evaluation under MIPS referred to as the MIPS Value Pathways (MVPs). This proposed structure would go into effect in 2021 and would be organized around clinician specialty or health condition and encompass a set of related measures and activities. As noted by CMS, the most significant change would be that MIPS eligible clinicians would no longer be able to select quality measures or improvement activities from a single inventory. Instead, the available quality measures and improvement activities would be organized around a clinician specialty or condition.

We support CMS in its goals to reduce clinician burden and revise the MIPS program to make it more meaningful for clinicians and patients. We agree that CMS should continue to pursue ways to unify the four MIPS performance categories so that they are not siloed, as there is significant overlap between all four. However, we are concerned about the proposed design of the MVPs, and specifically how clinicians would be assigned to an MVP.

As CMS is aware, there is only a single specialty designation for nurse practitioners within the Medicare program. One of the ways that CMS proposed to assign a clinician to an MVP would be through the Medicare provider specialty reported on their Part B claims data. For nurse practitioners (and other APRNs and PAs) there is only one Medicare specialty designation, and this designation does not provide meaningful information regarding the clinician's specialty or patient population. This was noted in the MedPAC June 2019 Report, where MedPAC recommended that CMS refine the specialty designation for APRNs and PAs.

We strongly urge CMS to not implement this program without substantial feedback from AANP and the nurse practitioner community on how to best identify the appropriate MVPs for nurse practitioners. If CMS does decide to implement MVPs beginning in 2021, we request that CMS allow providers to select their own MVP, with all clinicians having the same assignment methodology. This would be particularly important for primary care providers, including NPs, who treat patients for a variety of conditions and may fit into multiple MVPs. We are committed to working with CMS on positive revisions to the Quality Payment Program and we are available for further discussions on the MVPs and any other refinements to the Quality Payment Program. AANP has been supportive of CMS efforts to increase provider

participation in value-based care programs. We will continue to work closely with the agency on this policy objective.

B. Promoting Interoperability Category (80 FR 40776)

In prior rulemaking, CMS has exempted NPs, PAs, CNSs and CRNAs from mandatory reporting on the Promoting Interoperability category because many of these clinicians were not eligible for the Medicaid and Medicare EHR Incentive programs. CMS stated that it did not have evidence regarding the presence of sufficient measures applicable to these clinicians. CMS planned to analyze the data from the 2017 submission period and re-evaluate this decision.

As noted in this proposed rule, CMS analyzed the data and found that most MIPS eligible clinicians reported the Promoting Interoperability category as a group. CMS data showed that approximately 4% of MIPS eligible NPs, PAs, CRNAs, and CNSs reported data individually, and more than 2/3 of these clinicians did not report for the Promoting Interoperability category. Accordingly, CMS is proposing to continue the existing policy of allowing NPs, PAs, CRNAs, and CNSs to reweight this category. We support this proposal until CMS can obtain more robust data. Also, now that providers who previously did not meet the low-volume thresholds for MIPS participation have the opportunity to opt-in to the program, it would be important to evaluate the data from this provider population. We continue to encourage the agency to provide technical assistance to providers with the goal of increasing EHR adoption and familiarity with Promoting Interoperability reporting requirements for all clinicians.

17. “Incident To” Billing:

While not addressed in this proposed rule, we would like to comment on “incident to” billing, particularly considering the June 2019 MedPAC report which recommended the elimination of “incident to” billing for APRNs and PAs. “Incident to” billing is an anticompetitive policy that is contrary to the goals of improving transparency and undercuts efforts to transition to value-based reimbursement and improve quality by holding providers accountable for the care they deliver to patients. We 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. For example, MIPS performance data must be reported on Physician Compare via statute, yet much of that data will be misattributed due to “incident to” billing, thus reducing its utility. Requiring practitioners to bill under their own billing ID for the services that they perform will lead to increased provider participation in value-based reimbursement programs that rely on claims data, administrative simplification and more accurate data which is essential in the transition to value-based reimbursement.

Members of the Medicare Payment Advisory Commission (MedPAC) have also recognized the inherent problems with “incident to” billing. In its June 2019 Report, MedPAC recommended that Congress abolish “incident-to” billing for APRNs. MedPAC staff noted in their comments that this would improve the quality of Medicare billing data and estimated that it would save the Medicare program \$1-5 billion dollars over five years compared with current law.¹⁰

We believe that there is also action that CMS can take to discontinue the practice of “incident to” billing. In the past we have suggested that if it is not considered feasible to eliminate “incident-to” billing, a minimum step would be to revise current claims requirements to ensure that the actual rendering provider is clearly identified on every claim. When a service is billed under a provider number other than that of the rendering provider, an appropriate modifier should be required to ensure the claim is clearly identified as an “incident to” claim. As noted in the MedPAC report, there is precedent for the inclusion of the

¹⁰ <http://medpac.gov/docs/default-source/default-document-library/jan-2019-transcripts.pdf?sfvrsn=0>, at page 146.

rendering provider's NPI number and usage of a claim modifier in the commercial insurance market to identify when services are being billed "incident to". We look forward to working with CMS on ways to address the issues with "incident to" billing in a fashion that does not increase burden on clinicians.

We thank you for the opportunity to comment on this proposed rule. 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