

October 5, 2020

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

RE: CMS-1734-P: Medicare Program; CY 2021 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; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IOR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

Dear Administrator Verma,

The American Association of Nurse Practitioners (AANP), representing more than 290,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment on the CY 2021 Physician Fee Schedule (PFS) proposed rule. We appreciate CMS taking the initiative to remove federal barriers that prevent NPs and other clinicians from practicing to the full extent of their education and clinical preparation in this proposed rule, particularly the section on the supervision of diagnostic tests. We thank CMS for working to reduce burdens 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 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 Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs), nursing facilities (NFs), schools, colleges and universities, 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.

Nurse practitioners currently provide 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 2018, there were more than 145,000 NPs billing for Medicare services, making NPs the largest and fastest

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

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

growing Medicare designated provider specialty.³ Over 82% of NPs are accepting Medicare patients and over 80% are accepting 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 the primary care workforce, with that percentage growing annually.⁶

We appreciate the actions taken to waive Medicare and Medicaid barriers, to further enable nurse practitioners, and other clinicians, to meet the health care needs of their communities during the COVID-19 Public Health Emergency (PHE). NPs have been on the front lines caring for patients throughout the pandemic, and these important actions have improved their capacity to deliver necessary health care to their patients. Below please find our comments on specific sections of this proposed rule.

1. Telehealth and Other Services Involving Communications Technology (section II.D.)

- *Proposed Permanent Additions to the Medicare Telehealth Services List on a Category 1 Basis (84 FR 50097)*

CMS is proposing to add nine services to the Medicare telehealth services list on a Category 1 basis for CY 2021 (GPC1X, 90853, 96121, 99XXX, 99483, 99334, 99335, 99346, 99348). We agree with CMS that these codes are similar to current Category 1 codes and that the addition of these codes on a temporary basis during the PHE has increased health care access while minimizing the risk of disease exposure. **We support the permanent addition of these codes to the Medicare telehealth services list.**

- *Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services from the Medicare Telehealth Services List (85 FR 50098)*

CMS is proposing to create a new Category 3 for the temporary coverage of codes on the Medicare telehealth services list. CMS proposes that coverage of these codes would expire at the end of the calendar year in which the PHE expires. We agree with CMS that creating a list of Category 3 codes will provide additional time to evaluate the coverage of codes that were not previously considered for the Medicare telehealth services list, and extending the coverage timeframe after the PHE will provide more stability for clinicians utilizing those codes. **However, we recommend that CMS cover these codes for a more defined timeframe, such as a year after the PHE expires.** This will provide more stability to clinicians and patients utilizing these services to adjust to the end of the coverage period.

- *Nursing Facility (NF) Telehealth Frequency Limitation (85 FR 50111)*

We appreciate that CMS has issued a waiver for the telehealth frequency limitations in NFs in order to minimize disease exposure during the pandemic. While CMS is proposing to make this policy permanent, **we would recommend continuing the policy for a year after the end of the PHE in order to further evaluate the policy.** We agree that telehealth has a vital role in the treatment of NF patients, however further study outside of the context of the PHE would better ensure that this policy is properly tailored to best meeting the needs of NF patients.

³ <https://www.cms.gov/files/document/2018-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.

- *Comment Solicitation on Continuation of Payment for Audio-Only Visits (85 FR 50113)*

COVID-19 forced a rapid shift in patient treatment to ensure that patients could be seen and treated safely. The expansion of telehealth has been an essential lifeline for NPs to prevent the spread of COVID-19 while meeting the routine health care needs of their patients. The telehealth flexibilities issued by CMS have allowed clinicians to pioneer new methods of care delivery in order to limit unnecessary patient contact. In addition to preventing unnecessary in-person contact, telehealth has been critical to ensure that patients that require in-person care are able to receive that treatment.

A critical component of these flexibilities has been CMS reimbursement for audio-only visits. Previous rules required telehealth visits to be conducted using technology with audio-video capabilities, which restricted patients' access to treatment. Without covering audio-only telehealth, vulnerable patients without access to audio-video technology faced a challenging decision to delay or not receive care or risk exposure to COVID-19 in an in-person setting. Research shows that NPs are more likely to practice in rural areas and areas of lower socioeconomic and health status^{7,8,9}. In an AANP membership survey conducted in August, our members reported that the three most significant barriers to telehealth adoptions were patient connectivity issues, patient access to technology and the internet and patient comfort with technology.¹⁰ For patients experiencing these issues, the coverage of audio-only visits will be an important component of telehealth after the expiration of the PHE. **We recommend that audio-only services be covered under the PFS permanently.**

- *Direct Supervision by Interactive Telecommunications Technology (84 FR 50115)*

CMS is proposing to extend the policy adopted during the PHE that the definition of direct supervision includes “virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology.” The proposed extension would be the later of the calendar year in which the PHE ends or December 31, 2021. While this temporary policy during the PHE has helped minimize disease exposure, we continue to have concerns about the overutilization of “incident-to” billing. This was also expressed by MedPAC in their June 2019 report, and the extension of this policy would likely exacerbate that concern. If CMS extends this policy, **we recommend that it be limited to circumstances where the billing practitioner is supervising clinical staff that is not authorized to bill the Medicare program directly.**

- *Comment Solicitation on PFS Payment for Specimen Collection for COVID-19 Tests (84 FR 50116)*

CMS is requesting feedback on the extension of the temporary coverage of CPT code 99211 when clinical staff assess symptoms and collect specimens for purposes of COVID-19 testing, and the billing practitioner did not furnish a higher level E/M service on the same day. **We recommend that CMS extend coverage of this code for one year after the end of the PHE, recognizing that certain communities may still be controlling COVID-19 after the end of the PHE.**

⁷ Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *Journal of General Internal Medicine*, 4–6. <https://doi.org/10.1007/s11606-017-4287-4>.

⁸ Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. *Journal of the American Medical Association*, 321(1), 102–105.

⁹ Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. *Medical Care Research and Review*, *Epub ahead*. <https://doi.org/10.1177/1077558718793070>

¹⁰ <https://www.aanp.org/practice/practice-related-research/research-reports/nurse-practitioner-covid-19-survey-2>

2. Care Management Services and Remote Physiologic Monitoring Services (section II.E.)

Care coordination, care planning and other care management services are ingrained in NP practice. We are encouraged to see that CMS continues to emphasize increasing the utilization of chronic care management and transitional care management services.

- *Transitional Care Management (TCM) (85 FR 50120)*

CMS is proposing to authorize 15 additional codes related to end-stage renal disease treatment and chronic care management which could be billed concurrently with TCM. **We support this proposal.**

- *Home Health Certification and Care Plan Oversight HCPCS Codes*

We urge CMS to revise the category II Healthcare Common Procedure Coding System (HCPCS) codes G0179, G0180 and G0181 currently utilized to report home health services to include NPs, CNSs and PAs consistent with Section 3708 of the CARES Act. The descriptors for these codes use the terms, “physician re-certification,” “physician certification” and “physician supervision,” respectively. CMS noted in a recent MLN Matters article that NPs, CNSs, and PAs are authorized to bill for these codes, and that changes to the code descriptors were forthcoming.¹¹ We request that CMS make these changes expeditiously.

3. Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic (section II.F.)

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 support the decision to substantially maintain the E/M coding and billing guidelines adopted in last year’s final rule. 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.

COVID-19 has had a significant negative economic impact on nurse practitioners and other health care providers. Our members report layoffs, furloughs and hours being cut as a result of COVID-19. Waiving the budget neutrality requirements temporarily will help support practices during this challenging time. **We recommend that the Secretary use his authority under the PHE to waive the PFS budget neutrality requirement so that clinicians in certain specialties do not experience a decrease in reimbursement.**

- *Revaluing Services That Are Analogous to Office/Outpatient E/M Visits (85 FR 50124)*

CMS is proposing to revalue services for which the values are closely tied to the values of office/outpatient E/M visit codes. These services include: end-stage renal disease monthly capitation payment services; TCM services; maternity services; assessment and care planning for parents with cognitive impairment; emergency department visits; therapy evaluations; and behavioral healthcare services. **We support the revaluing of these services as proposed.**

¹¹ <https://www.cms.gov/files/document/2020-05-07-mlnc.pdf>.

4. Scopes of Practice and Related Issues (section II.G.)

- *Supervision of Diagnostic Tests by Certain NPPs (85 FR 50146)*

CMS is proposing to cover the supervision of diagnostic tests, including psychological and neuropsychological tests, by NPs, CNSs, CNMs and physician assistants as authorized by state law. CMS has implemented this policy on a temporary basis during the PHE and it has been essential to increasing much needed testing capacity. This proposal is consistent with Section 5 of Executive Order (EO) #13890 on “Protecting and Improving Medicare for Our Nation’s Seniors.” We applaud the continued work of CMS to remove federal barriers to practice on NPs. While Medicare already authorizes NPs to order and perform diagnostic tests, prior to this interim policy NPs were not authorized to be reimbursed for the supervision of diagnostic tests performed by other clinical staff. **We agree with CMS that this policy change enables practices where NPs are supervising other health care personnel to increase their testing capacity and maximize the utility of their clinical workforce and support this proposal.**

Maintaining this policy after the end of the PHE will enable NPs and their practices to continue to meet the diagnostic testing needs of their patients and communities. Additionally, this is consistent with how CMS regulates NPs in ordering and performing diagnostic tests, “physician services”, or “incident to physicians’ services” by deferring to the NPs’ authority to provide health care under state law. CMS has stated that they do not intend to impose additional restrictions on NPs in excess of state law, and removing this barrier is consistent with that statement of purpose.

AANP’s Scope of Practice policy states that “NP practice includes, but is not limited to, 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.”(emphasis added)¹² Examples of NP-led care which involves the supervision of other clinical staff performing diagnostic tests include, but are not limited to, NP-owned practices, nurse-managed health clinics, Patient-Centered Medical Homes and PACE program interdisciplinary teams. NPs are also often the primary clinicians supervising clinical staff performing diagnostic tests in settings such as RHCs, FQHCs, community health centers and critical access hospitals.

CMS has requested feedback on the state landscape related to NPs supervising other clinical staff performing diagnostic tests. Currently, twenty-two states and D.C. are Full Practice Authority (FPA) states because their licensure laws allow full and direct access to NPs.¹³ 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. However, NP authority to supervise diagnostic testing is not limited to these states. NP scope of practice regulations typically state that NPs are responsible for the management, diagnosis, assessment, evaluation, treatment and care planning for their patients (of which performing and supervising diagnostic tests is a component) without specifically listing each individual service they are authorized to provide. NPs are then authorized to supervise and delegate tasks which they are authorized to provide (including

¹² <https://www.aanp.org/advocacy/advocacy-resource/position-statements/scope-of-practice-for-nurse-practitioners#:~:text=NP%20practice%20includes%2C%20but%20is,counseling%3B%20and%20educating%20patients%20and.>

¹³ <https://www.aanp.org/advocacy/state/state-practice-environment.>

diagnostic testing) to other clinical staff.¹⁴ As noted in this proposed rule, CMS has long recognized the authority of NPs to order and perform diagnostic tests.

We have cited to a list of select examples of state regulations authorizing NPs to supervise diagnostic testing, including psychological and neuropsychological testing. We reiterate that these are examples meant to illustrate to CMS that the proposal to authorize NPs to supervise diagnostic testing is consistent with state regulations. **We again support this proposal and thank CMS for continuing to remove barriers to practice placed on NPs.**

- *Medical Record Documentation (85 FR 50148)*

CMS is clarifying that the policy adopted in the CY 2020 PFS final rule that authorizes billing clinicians to review and verify documentation added to the medical record for their services by other members of the medical team also applies to therapists and therapy students. **We appreciate this clarification and agree with this interpretation of the CMS medical record documentation policy.** We would also like to again 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 in the CY 2020 PFS final rule. That policy has reduced the burden on precepting APRNs and PAs, reduced discrepancies between physicians, APRNs and PAs and improved coordination among teaching clinicians and their students. It is important that CMS continue to apply any barrier removals for teaching physicians and medical students to NP preceptors and NP students equally.

- *Additional Removal of Federal Barriers to Practice*

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.

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. As mentioned above, 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.

¹⁴ Examples include Colorado (3 CCR 716-1:1.13-D); Pennsylvania (49 PA ADC § 21.282a.); Idaho (24.34.01 – Rules of the Idaho Board of Nursing); Minnesota (MN ST § 148.171, subd. 11); New Mexico (NM ST § 61-3-23.2; NM ST § 61-3-3(M)(8)); Montana (http://boards.bsd.dli.mt.gov/Portals/133/Documents/nur/aprn_sop_documents.pdf, incorporating AANP’s Scope of Practice Policy); Illinois (68 ILAC § 1300.440; 68 ILAC § 1300.20); Washington (WA ST 18.360.010, WA ST 18.79.270, WA ST 18.79.260); Iowa (IA ADC 641-41.1(5)(n)(136C) (supervision of fluoroscopies); Oregon (OAR 337-010-0037)(supervision of fluoroscopies); Connecticut (CT ADC § 17b-262-611); Oregon (OAR 410-133-0060, school-based psychological testing).

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. 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 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 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. CMS has waived many of these restrictions during the PHE and we look forward to continuing to work with CMS to permanently retire these barriers to care.

5. Valuation of Specific Codes (section II.H.)

- *(53) Bundled Payments Under the PFS for Substance Use Disorders (HCPCS Codes G2086, G2087, and G2088) (85 FR 50172)*

CMS is proposing to revise the opioid use disorder bundled payment codes to be inclusive of all SUDs. We agree with CMS that changing the code descriptors to include all SUDs will expand access to medically necessary treatment services for patients with SUDs and **support this proposal.**

6. Modifications related to Medicare Coverage for Opioid Use Disorder (OUD) Services Furnished by Opioid Treatment Programs (OTPs) (section II.I.)

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 initially authorized to prescribe medication-assisted therapies (MATs) after taking the necessary training and obtaining the required DEA waiver to do so for a period of five years. Recognizing the importance of NPs in delivering MAT, Congress made this temporary authority permanent in the SUPPORT Act.

NPs are deeply committed to helping solve the opioid crisis. SAMHSA has reported that over 14,000 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. Since the passage of CARA, studies have found that NPs have greatly increased patient access to MAT, particularly in rural and underserved communities. In rural communities, NPs or physician assistants (PAs) were the first waived clinicians in 285 rural counties covering 5.7 million residents.¹⁵ The Medicaid and CHIP Payment and Access Commission (MACPAC) found that the number of NPs prescribing buprenorphine for the treatment of opioid use disorder (OUD) and the number of patients with OUD treated with buprenorphine by NPs increased substantially in the first year they were authorized to obtain their MAT waiver, again with a greater impact in rural areas and for Medicaid beneficiaries.¹⁶

¹⁵ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00859>.

¹⁶ <https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/>

Since the end of these study periods, the number of DATA-waived NPs has grown significantly, increasing the number of NPs providing MAT to patients suffering from opioid use disorder.

Accordingly, **we support the proposed implementation of the SUPPORT Act coverage of OUD treatment services furnished in OTPs including the following specific provisions:**

- *Definition of OUD Treatment Services (85 FR 50202)*

CMS is proposing to add naloxone to the definition of OUD treatment services so that OTPs participating in the Medicare program can be reimbursed for dispensing naloxone. **We support this proposal.**

- *Periodic Assessments (85 FR 50207)*

CMS is proposing to permanently allow periodic assessments to be performed “via two-way interactive audio-video communication technology, provided all other applicable requirements are met” as is currently allowed during the PHE. The increased availability of telehealth during the pandemic has been essential for clinicians, such as NPs, treating patients with substance use disorder. **We support this proposal.**

CMS is not proposing to continue to make add-on payments for audio-only visits after the PHE but is seeking feedback on this policy. As mentioned above, NPs have reported that coverage of audio-only visits has been important for patients who lack access to the necessary technology for audio-video visits, or for patients who have difficulty using audio-video technology. This is also the case for NPs who are treating patients with substance use disorder. **We believe that coverage of audio-only visits for these patients should be made permanent.**

7. Payment for Primary Care Management Services in RHCs and FQHCs (section III.C.)

CMS is proposing to authorize RHCs and FQHCs to furnish and bill for principal care management services G0264 and G0265. We agree that RHCs and FQHCs providing care management to patients with a single high-risk disease or chronic condition should be authorized to bill for these services. **We support this proposal.**

8. Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs) (section III.F.)

As in previous years, CMS is proposing to align the Medicaid Promoting Interoperability Program with the MIPS program and 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. **We support this proposal and the continued alignment of program requirements across Medicare and Medicaid programs.**

9. Medicare Shared Savings Program (MSSP) (section III.G.)

- *Revisions to the Definition of Primary Care Services Used in Shared Savings Program Beneficiary Assignment (85 FR 50241)*

We appreciate that CMS has increased flexibility within the MSSP by expanding the telehealth services that qualify as primary care services for beneficiary assignment on a temporary basis during the PHE. **We support the addition of these codes to the permanent definition of primary care services.** However, despite being recognized as ACO professionals, the claims-based assignment pathway requires an NP’s patient to receive at least one primary care service provided by a “primary care physician” (as defined by

42 CFR § 425.20 or with the specialty designation in 42 CFR § 425.402(c)) each year for the patient to be assigned to an ACO.

Effective in 2019, CMS amended the voluntary alignment pathway to authorize a patient to select an NP as their primary care provider in an MSSP ACO and be assigned to the ACO without requiring that duplicative physician visit. This change provided greater opportunity for NPs and their patients to join and establish MSSP ACOs. However, the claims-based assignment barrier still exists. It is important to note that in its FY 2021 Budget in Brief, HHS estimates that basing ACO-assignment on a broader set of primary care providers, including nurse practitioners, will better reflect our current primary care workforce and lead to \$80 million in savings for the Medicare program over ten years.¹⁷ Section 3302 of the PPACA, governing 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. By waiving the definition of “physician” in title XVIII of the Act, the Secretary could remove these unnecessary burdens on NPs and their patients. **We request that CMS amend this regulation to authorize beneficiary assignment for primary care services provided by NPs as well as primary care physicians. Removing this barrier will improve flexibility for beneficiary assignment during the pandemic and beyond.**

10. Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D drug under a prescription drug plan or an MA–PD plan (section III.K.)

As noted by CMS, the SUPPORT Act requires that electronic prescribing for controlled substances under Medicare Part D be implemented by January 1, 2021. Despite this requirement, CMS recognizes that the COVID-19 pandemic has placed an unexpected burden on clinicians that could make compliance with this requirement difficult. Accordingly, **we support the proposal to extend the implementation date to January 1, 2022** and appreciate that CMS has recognized the potential burden on clinicians. We encourage CMS to provide technical assistance and resources for clinicians in order to streamline this transition.

11. Medicare Diabetes Prevention Program (MDPP) expanded model Emergency Policy (section III.O.)

We support the MDPP emergency policies which authorize patients to obtain MDPP services more than once in their lifetime, increase the number of virtual make-up sessions and allow for the delivery of virtual MDPP sessions. While this proposal would apply these policies only during section 1135 waiver events, **we encourage CMS to consider making these changes permanent to provide that additional flexibility to patients outside of PHEs.**

12. CY 2021 Updates to the Quality Payment Program (section IV.)

- *MIPS Value Pathways (MVPs) (85 FR 50277)*

In this proposed rule, CMS is proposing to refine the MVPs and change the effective date to 2022. CMS is also proposing further collaboration with clinicians to continue to develop and refine MVPs. **We support the delay of the implementation date and look forward to further work with CMS to ensure that the health care provided by NPs is accurately reflected in the MVPs.** We also agree with CMS on maintaining the traditional MIPS participation track in conjunction with the development of MVPs and making MVP participation optional. We also support increased involvement with patients in MVP development. Nurse practitioners deliver patient-centered health care and involving the patient voice in this program will be important to the development of meaningful MVPs.

¹⁷ <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf> (page 84).

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.

We also appreciate that this proposed rule focuses on clinician choice in determining whether to join an MVP, as clinician assignment was a concern when this was initially proposed. As CMS is aware, there is only a single specialty designation for nurse practitioners within the Medicare program. One of the initial 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.

As mentioned above, AANP and the nurse practitioner community look forward to working closely with CMS on how to best identify, develop and refine the appropriate MVPs for nurse practitioners. 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.

- *CAHPS for MIPS Survey (85 FR 50292)*

As CMS revises the CAHPS for MIPS Survey **we recommend updating two questions in order to ensure they are provider neutral**, consistent with the rest of the survey. Question 24 asks the patient if they have received care from any specialists and refers to the specialist solely as “doctors.” NPs also provide care in specialty settings and we recommend that CMS change the language in that question to refer to “providers” instead of “doctors.” We also recommend a similar change in question 38 which asks the patient if they are taking medication prescribed by a doctor. Nurse practitioners are authorized to prescribe medication in all fifty states and the District of Columbia, and we recommend changing the terminology in question 38 to say “provider” instead of “doctor” consistent with the rest of the survey.

- *Promoting Interoperability Category (85 FR 50302)*

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 2018 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 34% of MIPS eligible NPs, PAs, CRNAs, and CNSs reported data individually for the Promoting Interoperability Category. CMS also notes that the most commonly reported measure set was not available in 2019, possibly leading to lower participation, and that the COVID-19 pandemic may also impact participation. 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.** 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.

Conclusion

We thank you for the opportunity to comment on this proposed rule and your continued efforts to remove barriers to care placed on nurse practitioners. 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