

September 11, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid
Department of Health and Human Services
Attn: CMS-1676-P
PO Box 8016
7500 Security Blvd.
Baltimore, Maryland 21244-8016

RE: CMS-1676-P - Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B to CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program (82 Fed. Reg. 33950, July 21, 2017)

The American Association of Nurse Practitioners (AANP), representing more than 234,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment in response to the CY 2018 Updates to the Quality Payment Program (82 FR 33950).

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 89.2% 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.

Telehealth (82 FR 33970):

CMS proposes the addition of five new telehealth coverage codes and the removal of the GT modifier. We support the appropriate expansion of telehealth services as well as the removal of the GT modifier where it is duplicative of other claims information. We encourage CMS to utilize telehealth services wherever applicable in demonstrations and incentive payment models to increase participation by appropriate providers such as NPs and decrease burdens on patients and providers.

Remote Patient Monitoring (82 FR 33975):

CMS requests comment on separate payment for remote patient monitoring (CPT 99091), which is currently assigned a bundled procedure status. We support the separate payment for this and other remote patient monitoring codes, and believe that they can be an effective way to increase patient participation in their own health care and reduce unnecessary face-to-face patient visits. This is particularly true for patients in medically underserved areas or who have difficulty with transportation.

CMS requests feedback on situations where this code would be reported separately, and noted that it is currently bundled with the chronic care management codes (CCM). Medicare's description of CCM codes is specific to patients with two or more chronic conditions expected to last 12 months or until the death of the patient. We note that the remote patient monitoring codes could be useful for patients not suffering from any chronic conditions, or suffering from only one chronic condition, and would be useful outside the realm of CCM.

Evaluation and Management (E&M) Documentation Requirements (82 FR 34078):

CMS proposes reducing the administrative burden on clinicians by reducing the history and physical (H&P) documentation requirements for E&M services. 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 the H&P is important to treating the patient and maintaining adequate documentation of patient status. 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 incorporated and facilitated the documentation of H&Ps. We ask that as these revisions take place, that CMS consults and receives feedback through advisory panels and working groups that include all clinicians, including NPs, to ensure that these revisions are conducted in a manner that reduces administrative burden while maintaining an appropriate level of documentation.

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Care Coordination Services (82 FR 34083):

CMS proposes the creation of two new bundled care codes for RHCs and FQHCs for General Care Management (GCCC1) and Psychiatric Coordination of Care Management (GCCC2). We support the creation of these bundled codes. We commend CMS for recognizing the importance of nurse practitioners in the group of primary care practitioners that are authorized to initiate and direct the care of patients receiving these services.

Appropriate Use Criteria (AUC) (82 FR 34091):

CMS proposes to move the start date of the AUC program back one year to January 1, 2019 and proposes measures to align AUC with MIPS by including the use of AUC as a high-weight improvement activity and by aligning the AUC hardship exceptions with the ACI hardship exceptions in MACRA. We support the proposal to move the start date of the AUC program back one year in order to give clinicians an opportunity to prepare for the program and evaluate qualified clinical decision support mechanisms. We also agree with the CMS proposals to align AUC with MIPS and to continue to encourage participation in MIPS through further rulemaking.

Medicare Shared Savings Program (MSSP) (82 FR 34105):

CMS proposes to remove the attestation requirement for the assignment of beneficiaries in FQHCs and RHCs in accordance with the 21st Century Cures Act. This change would allow any service provided in an FQHC or an RHC to be treated as a primary care service. We believe that this is a necessary step to increase participation in the MSSP and that this proposal benefits patients, providers and facilities. Additionally, Section 3302 of the PPACA, which governs accountable care organizations, 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 throughout the Shared Savings Program. We also support CMS’ proposal to add new chronic care management and behavioral health codes to the definition of primary care services in the MSSP.

CMS asked for feedback on how to get RHCs and FQHCs more involved and increase participation in the Shared Savings Program. In that light, we also support measures to lower the nominal risk standards for RHCs and FQHCs in the Shared Savings Program, and CMS’ proposal to modify the documentation requirements for the initial application to the MSSP, which would encourage greater participation in the MSSP.

Value-Based Reimbursement:

As noted in this proposed rule, the programs that initiated the transition to value-based reimbursement (PQRS, Medicare EHR incentive program, VM program) are being phased out with the implementation of MACRA. CMS proposes to lower the reporting threshold for the final year of PQRS to align with the reporting requirements for MIPS,¹ and notes that one of the reasons for this proposal is to aid clinicians in gauging their readiness and transitioning successfully to MIPS.² CMS also proposes changes to the VM program and the EHR incentive program to further align the end of those programs with the beginning of MIPS. We support these proposals and agree with CMS that smoothing the transition to MIPS is an important goal. However, we continue to be very concerned, as we have stated in our MACRA comment letter, that these efforts will be erased if CMS persists with its proposal to increase the low-volume participant threshold to \$90,000 Part B charges billed and 200 Part-B enrolled Medicare beneficiaries treated.³

CMS has repeatedly stressed the importance of providing a smooth transition for clinicians into MACRA, but simultaneously seems to seek to decrease participation in MACRA by breaking the links between programs. We support CMS’ efforts to ease the administrative burdens on clinicians as they transition to value-based reimbursement but believe that these efforts need to be focused on increasing participation in these programs, not on excluding clinicians who are allowed to participate.

Medicare Diabetes Prevention Program (MDPP) Expanded Model (82 FR 34129):

We agree that the proposed program in principle has much to offer and we encourage the proposed expansion of this program. We are pleased that nurse practitioners, who diagnose and treat diabetes on a daily basis, will be an integral part of this program.

¹ 82 FR 33950, 34099.

² *Ibid.*

³ 82 FR 30010, 30017. (\$90,000 Part B charges billed and 200 Part-B enrolled Medicare beneficiaries treated).

We agree with the CMS proposal that a patient who develops diabetes during the program would not be excluded from the program and would be allowed to make up sessions on a virtual basis. We agree that a patient who develops diabetes during the program should not be excluded from the program because the services offered patients can slow the progression of diabetes, and in the case of type-2 often reverse the disease process. We are concerned, however, that the billing and documentation process under MDPP will discourage clinicians from participating in the model. We encourage CMS to develop a more streamlined and less cumbersome process to ease the administrative burdens under this model.

MACRA Patient Relationship Categories and Codes (82 FR 34128):

Current “incident to” billing practices undermine the foundations of value-based reimbursement. 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 to value-based reimbursement. Alternatively, we propose the creation of a billing modifier that would identify the provider of the service being billed to ensure the accuracy of billing and claims data. This solution has recently been adopted by a major insurer on all of their commercial claims.

The proposed rule discusses the introduction of patient relationship categories and codes under the MACRA legislation, which we believe presents an opportunity to address this issue. MACRA states that the Secretary shall develop patient relationship categories and codes that “define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.”⁴ We believe that this section of MACRA can be implemented in a fashion that would identify the actual provider of the service billed in an “incident-to” encounter. In the CY 2018 Physician Fee Schedule proposed rule⁵, CMS has proposed to begin implementing patient relationship codes, and we believe that the inclusion of this information is an opportunity to create a modifier that would identify the clinician that is actually performing the service.

Relative Value Scale Update Committee (RUC):

The majority of nurse practitioners are Medicare providers who have a vested interest in regulations impacting Medicare providers and their patients. It is not clear that input was provided by nurse practitioner representatives in recommending appropriate changes to the fee schedule. Nurse practitioners have had little opportunity to participate in RUC activities. The fee schedule recommendations from the RUC impact all clinicians, thus it is important that all clinicians, including nurse practitioners, have input in that process. The nurse practitioner community has long advocated for accuracy and transparency in billing processes undertaken as they relate to the care of their patients. It is our sincere desire that as adjustments are being made, nurse practitioner care will be reflected in the data collection and billing processes that deal with their care.

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

⁴ Public Law 114-10, 129 Stat. 125.

⁵ *Ibid*, 34128.