

September 24, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid
Department of Health and Human Services
Attn: CMS-1694-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-1850

RE: CMS-1695-P - Medicare Program; Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (83 Fed. Reg. 37064, July 31, 2018).

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 fiscal year 2019 updates to the Hospital Outpatient Prospective Payment System (83 FR 37064).

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.

Proposal and Comment Solicitation on Method To Control for Unnecessary Increases in the Volume of Outpatient Services (83 FR 37138)

We support the Administration's efforts to equalize reimbursement for evaluation and management services provided in a clinician office setting with a hospital outpatient setting. The proposal would lower costs for beneficiaries and increase the ability of freestanding clinician offices to compete in the health care marketplace. AANP has long supported the proposition that a service is a service, and services should be reimbursed equitably regardless of setting or provider type. We continue to urge the administration to pursue opportunities for payment parity among all services provided by qualified health care providers, including nurse practitioners.

Additionally, in this proposed rule, CMS referenced the difference between the "physician office setting" and hospital outpatient departments. We request that CMS use the term "clinician office setting" in

rulemaking and correspondence to acknowledge that other providers, such as nurse practitioners, also own their own practices and are impacted by this policy. The use of the term “physician” in these instances confuses patients and providers as to which clinicians are authorized to provide care under the Medicare program 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 disruption to the Medicare program and the QPP. In this particular instance, this could lead to unfair restraints on practice, decreased access to care, and increased burden on health care systems.

Advisory Panel on Hospital Outpatient Payment (HOP Panel)

The HOP Panel has the authority to evaluate and advise CMS on the appropriate supervision level for hospital outpatient services. In the 2018 OPPTS rulemaking, the HOP Panel recommended, and CMS finalized, a nonenforcement instruction for the direct supervision of outpatient therapeutic services in critical access hospitals and small rural hospitals.¹ In this rulemaking, CMS noted that there were no complaints regarding quality of care during the six years that the moratorium was in place.

While there are no similar proposals in this proposed rule, we continue to urge CMS and the HOP Panel to utilize this authority to reduce unnecessary burdens on practitioners, such as NPs, in outpatient facility settings such as comprehensive outpatient rehabilitation facilities, rural health clinics, federally-qualified health centers, and the partial hospitalization program. Nurse practitioners are educated and clinically trained to provide these services and are essential providers in each of these settings. The supervision requirements that remain in place are unnecessary burdens on these facilities. Facilities should be authorized to utilize NPs to the full extent of their education and clinical preparation, which would lead to increased flexibility and decreased duplicative treatment.

Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

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.

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.

¹ 82 FR 59216, 59390.

CMS has made improvements in including NPs in their CEHRT initiatives. 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. One step toward accomplishing this goal is to include NPs on health technology advisory committees.

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 use of CEHRT. In the development of the Quality Payment Program (QPP) CMS recognized 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. CMS should continue to provide technical assistance to providers, thus ensuring that there is high-quality, free and low-cost CEHRT for all clinicians. This is certainly important for practitioners in small practices who may not have the financial ability to invest significant money on CEHRT.

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 when 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; we do not want to create a scenario where that is jeopardized solely due to technical issues.

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 the QPP and other CMS programs, confusion, administrative burdens, and significant compliance difficulties will result. 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 and request for information. 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