September 7, 2017

Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1678-P, P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically to http://www.regulations.gov

Re: CY 2018 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B [CMS-1676-P]

Dear Administrator Verma:

The American Nurses Association (ANA) welcomes the opportunity to provide comments to the proposed Medicare rule referenced above. Our comments focus on the following two issues related to the Physician Payment Fee Schedule: the removal of unnecessary, costly, and burdensome regulations prohibiting equal practice authority across the primary care spectrum, and the concomitant need to modify "incident to" billing.

ANA is the premier organization representing the interests of the nation's 3.6 million registered nurses (RNs) through its constituent and state nurses associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes and access across the health care continuum.

[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

I. ANA Encourages CMS to Remove Burdensome Regulations Prohibiting Equal Practice Authority

CY 2018 revisions to the Physician Fee Schedule maintain outdated language requiring physician supervision of APRNs.[2] In addition, CY 2018 revisions maintain terminology referencing the selection of a "main doctor" and do not adopt provider-neutral language elsewhere throughout the regulation.

These requirements and terminology have no basis in academic literature and regulates an issue which 33 states and the Department of Veterans Affairs[3] have determined is unnecessary. The requirement is also costly and burdensome, because it inserts unnecessary providers into the provision of a patient's care.

Decades of research have demonstrated the safety, efficacy, and quality of care provided by APRNs, especially in relation to that provided by other providers. Indeed, a 2018 study of the National Practitioner Databank[4] found that APRNs were half as likely as Physician Assistants to be the target of a malpractice claim, and ten times less likely as Physicians.

CMS regulation of this issue is analogous to the federal government requiring relators supervise home inspectors in order for consumers to qualify for FHA loans. While realtors and home inspectors both work in the same area, the comparison is apples and oranges—each have different scopes of practice, education, and training. As the National Academy of Medicine concluded in its "Future of Nursing" report, "the contention that APRNs are less able than physicians to deliver care that is safe, effective, and efficient is not supported by the decades of research that has examined this question."

II. ANA Encourages CMS to Modify "Incident to" Billing

CY 2018 revisions to the Physician Fee Schedule maintain "incident to" billing, which requires APRNs to mark their services as provided only "incident to" the care of a physician. "Incident to" billing is costly and unnecessary as outlined by the reasons provided *supra*. "Incident to" billing, furthermore, obfuscates the true provider of services to beneficiaries and comprises a large barrier to transparency in the CMS payment system.

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[2] 42 C.F.R.§ 482.52 -- Condition of participation: Anesthesia services; 42 C.F.R. § 416.42(b)(2) -- Conditions of Coverage: Surgical Services; 42 C.F.R. § 485.639 -- Conditions of Participation: Surgical Services. 42 C.F.R. § 482.12(c)(1)(i), (c)(2),(c)(3), (c)(4)--Condition of participation: Governing body; 42 C.F.R. § 482.22(b)(3), (c)(5)(i)--Condition of participation: Medical staff; 42 C.F.R. § 482.1(a)(5) Basis and Scope. 42 C.F.R. § 482.22(b)(3), (c)(5)(i) Condition of participation: Medical Staff; 42 C.F.R. §485.631.

[3] With the exception of Certified Registered Nurse Anesthetists

[4] A national repository of malpractice claims data

Various APRN provider groups have encouraged CMS to adopt the use of modifiers in "incident to" billing to identify the individual actually providing the services being billed for. This will allow for better transparency within the billing system as well as future study of the costs/outcomes/quality of APRN-provided care. While ANA would rather see the elimination of "incident-to" billing, we also support incremental progress in the form of modifiers.

We appreciate the opportunity to share our views related to the PPFS CY 2018 proposed rule-making and welcome the opportunity to discuss these issues in greater detail. If you have questions, please contact Mary Beth Bresch White, Director, ANA Health Policy, at 301.628.5022 or marybreschwhite@ana.org.

Sincerely,

Debbie Hatmaker

Debbie Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer