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Submitted via www.regulations.gov

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1631-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: CMS-1631-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions for Part B for CY 2016; Proposed Rule (80 Fed.Reg. 41686 July 15, 2015)

Dear Mr. Slavitt:

On behalf of the undersigned organizations, we are pleased to provide comments on this proposed rule, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions for Part B for CY 2016 (80 Fed.Reg. 41686, July 15, 2015).

Advance Practice Registered Nurses (APRNs) include Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Nurse Practitioners (NPs), and Clinical Nurse Specialists (CNSs). APRNs play a significant role in ensuring patient access to high quality healthcare that is cost-effective. We thank the agency for the opportunity to comment on the provisions in this proposed rule. We also want to acknowledge that this is the first Physician Fee Schedule proposed rule since 2007 in which the Sustainable Growth Rate (SGR) does not threaten massive proposed cuts to providers. We thank the agency in its role in helping to secure a long-term solution to fixing the SGR.

Thank CMS for New Process for Evaluation of CPT Codes and Support Proposed Change to Eliminate the Use of Refinement Panels

We wish to acknowledge and thank CMS for taking steps to further include all stakeholders, including APRNs and the public, in the creation and evaluation of relative value unit (RVUs)

values for all new, revised, and potentially misvalued codes into a proposed rule for public comment. This includes the elimination of the Refinement panel which as stated in the proposed rule discussion, will allow for more direct stakeholder review and input and contribute to transparency in the process (p 41703).

Include APRNs as Covered Practitioners Providing Advance Care Planning

We support the agency's proposal to cover medically necessary advance care planning (p. 41773). APRNs can play a role in providing this important service, and should be included on the list of professionals whose advance care planning services are covered by Medicare. Totaling more than 340,000 healthcare professionals, our primary interests are patient wellness and improving patient access to safe and cost-effective healthcare services. In every setting and region, for every population particularly among the rural and medically underserved, America's growing numbers of highly educated APRNs advance healthcare access and quality improvement in the United States and promote cost- effective healthcare delivery. Including APRNs as covered advance care planning providers would promote patient access to care, consumer choice, patient safety and lower healthcare costs.

Establish Modifiers on Claims to Identify Incident-to Billing and to Acknowledge the Licensure of the Rendering Provider

CMS has proposed to revise the requirements of its incident-to policy at §410.26 so that the billing physician or provider must be the supervising physician or provider (p. 41785). We have specific observations about the agency's proposal and offer recommendations.

A significant motivation for physicians or providers to engage in incident-to billing is the payment disparity that exists between physicians and other providers. This payment disparity, based on licensure and without any grounds in the clinical data with regard to outcomes of care, amounts to statutory discrimination, and violates the guiding principle for the Resource Based Relative Value Scale that a single payment is established for a single service. We note as well

that there is inconsistency with how providers other than physicians are treated, with some receiving 100 percent of physician rates and other receiving a fraction of those rates. When the same care of the same quality is yielding the same outcomes from different Medicare qualified provider types, Medicare should render and recognize the same payment. We encourage CMS to advise the Congress to modify the pertinent statutes to ensure equitable payment among all providers whose scopes of practice permit them to render the same services.

Problems associated with the practice of incident-to billing are well established. Specifically, the practice obscures the rendering provider, seriously undermining CMS' ability to accurately calculate cost and quality performance and calls into question the agency's ability to operate fair and accurate value-based reimbursement approaches. This practice also potentially creates patient safety issues because of the discontinuity of care among providers. It creates the possibility for inadvertent billing mistakes based on misunderstanding of complicated requirements, which can lead to serious penalties for providers. It exacerbates the possibility for fraud by unscrupulous individuals who choose to not comply with applicable requirements; and creates liability issues for providers under whose numbers the services are billed, when they did not personally perform those services. Finally, it hinders providers from being individually responsible and accountable for the care they actually render.

We believe CMS should engage in a concerted effort to gather accurate data allowing an understanding of the extent and nature of incident-to billing before proposing any significant changes to its implementation. Our organizations request the opportunity to meet with CMS to discuss specific measures that CMS could take to ensure Medicare claims accurately reflect the rendering provider. We specifically recommend that CMS establish modifiers to be used to identify both when a line item in a claim was provided incident-to as well as the licensure of the actual rendering provider. Without establishing a mechanism to gather this type of clear data, not only will CMS be unable to examine the extent and nature of incident-to billing, but also will be unable to accurately calculate value-based performance adjusters at a provider-specific level.

Offer Proposed Incentives for Physicians to Employ Primary Care Providers Who Are not Physicians to APRN Practices as Well

We acknowledge that CMS is proposing to offer incentives from hospital organizations to physicians by providing funds to employ practitioners who are not physicians to provide primary care services in their offices. While we understand the motivation for this proposal, we feel that the same incentives should be offered to APRN practices in the geographic areas of the incentivizing hospital organization (p 41955). It is important that all eligible providers have equal opportunity to practice at the top of their license in order to provide access to high quality cost effective Medicare services.

Ensure Equal Treatment among APRNs and Physicians Under Clinical Practice Improvement Activities

We note that CMS references maintaining certification as part of clinical practice improvement activities (p. 41789). In developing clinical practice improvement activities, we urge that the clinical practice activities capture and recognize the contributions of APRNs in every instance. We ask that the agency treat processes used by APRNs the same as the processes taken by physician colleagues. In previous Physician Fee Schedule rules and in the Affordable Care Act,[1] physicians who are governed by medical specialty boards could report quality measures through a Maintenance of Certification Program and receive an incentive payment for doing so, but such incentive payment programs were denied to APRNs engaged in professional recertification. We would urge the agency to afford all APRNs the same opportunities in the development of clinical practice improvement activities, and that any certification processes so recognized include those used by APRNs as well as for physicians.

Do not Publicly Report Performance Rates on Measures on the Physician Compare Website Unless They have been Vetted By All Appropriate Eligible Professional Types Affected by the Measures

[1] The Patient Protection and Affordable Care Act of 2010, Pub.L. No. 111-148

CMS is proposing to publicly report qualified clinical data registries (QCDR) data annually in the year following the year the measures were reported for both eligible professional and group level measures, and that the measure performance rate will either be on the Physician Compare website or on the QCDR's website (p.41812). We have several reservations about the use of QCDR data that could be used to misinform healthcare industry stakeholders and the public, and to misallocate Medicare resources to the extent that such reporting drives reimbursement. We provide recommendations for the agency to consider.

Many QCDRs have been developed by physician specialty societies and are currently not subject to a transparent interdisciplinary consensus evaluation process, which impairs their credibility especially when those physician services are also provided by APRNs excluded from their QCDRs in important ways. By contrast with QCDR data that has not been subject to extensive interdisciplinary accountability, we strongly support the use of quality measures that are transparent, actionable, evidence-based, patient-centered and consensus-driven. Quality measures should take into account all appropriate stakeholders, including that of APRNs. For this reason, we specifically support measures that are endorsed by the National Quality Forum (NQF), which includes a wide variety of healthcare stakeholders and employs a rigorous process of accountability to assure validity and reliability.

Unlike the NQF, registries organized by physician specialty societies do not allow the development of consensus from a variety of stakeholders, including patients, in the development of their measures. When a physician specialty society registry under the guise of "quality" handles or reports data about its competitors without a validated and legitimate stakeholder consensus development process, the society creates a ripe climate for nonscientific, abusive, and anticompetitive market behaviors that the CMS must not endorse, support, or encourage. Again, we strongly oppose CMS authorizing public reporting of QCDR measures that fail to pass the professional and public accountability tests posed by the NQF consensus process.

Furthermore, public reporting on Physician Compare or a privately owned website by a QCDR of provider performance rates of an outcome measure should be thoroughly vetted for accuracy,

be appropriately risk adjusted, and have a reliable and rapid mechanism for challenging and removing inaccurate information from provider profiles on Physician Compare and privately owned QCDR websites. With respect to QCDRs and public reporting, information on privately owned websites should be held to the same standards as Physician Compare. In addition, information on these privately managed websites should not advance anti-competitive or defamatory behavior under the guise of "quality" such as publicly disclosing individual performance data by provider specialty within a group. If CMS allows non-PQRS measures from CMS-approved QCDRs to be publicly reported on the Physician Compare website on behalf of all eligible professionals regardless of their affiliation with the physician specialty society or association, CMS must develop and enforce rules and guidelines for measure stewards who develop non-PQRS measures housed in QCDRs. Such rules and guidelines should serve to inform and include the public in the development of non-PQRS measures, authorized full involvement of eligible professionals in the development of these measures and not just the sponsoring physician specialty society, and minimize the risk of prohibited anticompetitive behavior. There must be a mechanism for APRNs to participate in the development and reporting of measures by specialty physician organizations rather than require the APRN professions to duplicate the expensive infrastructure required to test and implement a parallel system evaluating the same Medicare services.

Allow Search Function to be More Inclusive of All Qualified Healthcare Providers on Physician Compare Website

We continue to be concerned about the imbalance of information in the "Physician Compare" website and ask that the Secretary takes steps to enable patients to find providers other than physicians when certain types of practices are being searched. For instance when primary care providers are searched, nurse practitioners (NPs, who are primary care providers) are not shown in that search category. When the term "anesthesiology" is entered, CRNAs are not shown. In the instance of NPs, one can only find these health care professionals if they search specifically for them. While the preamble to the "Physician Compare" site does speak to other healthcare providers, even the name of the site is not inclusive. Alternative names such as "Provider Compare" and "Healthcare Provider Compare," for instance, are more inclusive terms that would reflect the website's ability for beneficiaries to search for all eligible healthcare providers. In

addition, while we understand and appreciate the need to provide consumers with as much data driven information as possible, we urge the Secretary to utilize data resources that are inclusive, have been fully vetted and are widely accepted among the provider community represented on the website. Like PQRS, other data resources must allow for consumers to easily compare a variety of providers on the same scale in order to provide an equitable outcome for health care providers and their patients.

Involve APRNs in the Development of Alternative Payment Models and Promote Full Scope of Practice in Models

In advance of the agency issuing a request for information on alternative payment models (APMs) as part of Medicare and CHIP Reauthorization Act[2] implementation (pgs. 41879-41880), it is critical for the agency to keep the following issues in mind:

- First, in the development of alternative payment models and advisory groups, we cannot stress enough the importance of including eligible professionals as defined in section 1848(k)(3)(B), other than physicians, in the APM vetting and decision making processes.
- Second, as we note that CMS references "physician-focused payment models," in the preamble regarding discussion on APMs, we remind the agency that models of care continue to shift towards community based practices, which APRNs often lead. Therefore, we request that CMS allow for provider-focused payment models led by APRNs and other types of eligible professionals. APRNs practicing to the full extent of their training, education, and licensure consistent with state law would be ideal leaders for these innovative models. Limiting APRNs' ability to participate in these new reimbursement models will produce inefficiencies in care and potentially delay critical treatments to patients, especially those in rural areas with limited access to physicians.

Request that Provider-Neutral Oversights be Corrected in Final Rule

[2] Pub L. 114-10.

We are pleased to note that in general the agency adheres to provider-neutral language throughout the proposed rule, and that the rule clearly covers all Medicare Part B providers including APRNs. There are, however, incidences where the correct reference to Part B providers who are not physicians is made in one place - and in the next paragraphs the same reference lists only the term "physician." While most of these oversights appear to be in the discussion narrative such as on p. 41710, there are also examples within the proposed rule language that reflect the same oversights on pp. 41950 and 41953. We ask that all provider neutral language oversights be corrected in the final printing of the rule.

Utilize Term "Part B Healthcare Practitioners" When Referring to "Nonphysicians" Publication of the Final Rule for the Sake of Clarity

We suggest that CMS utilize the term "Part B healthcare practitioner" when referring to "nonphysicians" in the final rule for the sake of clarity. We note that there are many instances within this proposed rule in which CMS refers to the term "nonphysician practitioners" (see, for example, page 41895). A more accurate term would be "Part B healthcare practitioners" as these healthcare professionals have advanced credentials, provide the same service, provide the same high-quality care, and are bound to the same standards required under Medicare Part B as physicians.

We thank you for the opportunity to comment on the proposed rule. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

American Association of Colleges of Nursing, AACN
American Association of Neuroscience Nurses, AANN
American Association of Nurse Anesthetists, AANA
American Association of Nurse Practitioners, AANP
American College of Nurse-Midwives, ACNM

American Nurses Association, ANA

American Organization of Nurse Executives, AONE

Association of Community Heath Nursing Educators, ACHNE

Association of Nurses in AIDS Care, ANAC

Association of periOperative Registered Nurses, AORN

Association of Public Health Nurses, APHN

Gerontological Advance Practice Nurse Practitioners, GAPNA

National Association of Clinical Nurse Specialists, NACNS

National Association of Nurse Practitioners in Women's Health, NPWH

National Association of Pediatric Nurse Practitioners, NAPNAP

National League for Nursing, NLN