CLINICAL EXPERTISE
NURSING PRACTICE
SYSTEMS INNOVATION
NACNS
National Association of Clinical Nurse Specialists

September 11, 2017

Ms. Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244 –8013

ATTN: CMS-1677-P

Dear Ms. Verma:

As the voice of more than 72,000 clinical nurse specialists (CNS), the National Association of Clinical Nurse Specialists (NACNS) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) ***Medicare Program Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program; Proposed Rule*** (82 FR 33950***)***.

CNSs are licensed advanced practice registered nurses (APRN) who have graduate preparation (master's or doctorate) in nursing as a clinical nurse specialist. They have unique and advanced level competencies that meet the increased needs of a changing healthcare delivery system by improving quality while also reducing costs in the system. CNSs provide direct patient care, including assessment, diagnosis, and management of patient healthcare issues. They are leaders of change in health organizations and developers of scientific evidence-based programs to prevent avoidable complications. Their leadership has been demonstrated in several areas, such as in preventive and wellness care, behavioral healthcare, and care to those with chronic conditions, including diabetes. CNSs are facilitators of multidisciplinary teams in acute and chronic care facilities to improve the quality and safety of care.

CNSs are eligible clinicians providing Medicare services and, as such, NACNS welcomes CMS' ongoing efforts in the proposed CY 2018 physician fee schedule to enhance Medicare Part B services and payment opportunities to Medicare non-physician practitioners, particularly to CNSs and other APRNs.

MEDICARE TELEHEALTH SERVICES

NACNS supports the CMS proposal to add several codes to the list of telehealth services for CY 2018, such as:

- CPT code 90785 (Interactive Complexity);
- CPT codes 96160 and 96161 (Health Risk Assessment);
- HCPCS code G0506 (Care Planning for Chronic Care Management); and
- CPT codes 90839 and 90840 (Psychotherapy for Crisis).

NACNS also favors the proposal to eliminate the required reporting of the telehealth modifier for professional claims as an effort to reduce administrative burden for practitioners.

MEDICARE DIABETES PREVENTION PROGRAM EXPANDED MODEL

Several studies document that Clinical Nurse Specialists have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness. NACNS backs CMS' proposed rule to implement the Medicare Diabetes Prevention Program (MDPP) expanded model starting in 2018. Additionally, NACNS promotes CMS' intention to develop a separate model under the Center for Medicare & Medicaid Innovation authority to test and evaluate MDPP services that are exclusively furnished virtually.

CARE COORDINATION SERVICES AND CHRONIC CARE MANAGEMENT SERVICES

NACNS encourages CMS' continued implementation and expansion of care coordination models. Care coordination is a critical contribution to a patient's well-being and is one area where change is achievable in the near term. Care coordination payment should be consistent across all qualified health professionals delivering high-value care coordination activities. All qualified providers should be able to perform a common set of tasks with supporting documentation. All members of the healthcare team should be accountable and transparent.

The CNS plays an essential role in care coordination and transitions of care that result in reduced hospital length of stay, fewer hospital readmissions and hospital-acquired conditions (HACs). The CNS role is particularly significant in care coordination for patients with complex chronic conditions. The NACNS Chronic Care Task Force report demonstrates that CNSs have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness and readmissions. Several studies document their efforts in the care of the chronically ill, including those with heart failure, asthma and epilepsy. In addition, CNSs have developed and demonstrated the effectiveness of their community programs that identify those with COPD early, slowing down the progression of their disease.

The CNS is in the ideal position to lead collaboration within and across healthcare settings. With overlapping spheres of influence that affect the patient, nursing practice and system components of care, CNSs are versatile in their approach to managing patients with chronic conditions and to serve as the bridge between disciplines. Effective management of this patient population presents opportunities for the CNS to contribute to reducing costs for the patient and the system.

A review of the CNS core competencies supports the centrality of the function of care coordination within the CNS role. The CNS is educated and prepared to be, not only a participant in care coordination, but also to partner with other providers in the leadership role for care coordination. With the expansion of the nation's aging population, a population that has been identified to have higher risk for chronic conditions and multiple chronic conditions, it is imperative that all healthcare providers, including the CNS, be able to practice at the full scope of their practice in order to meet the impending gap in healthcare needs.

ELECTRONIC HEALTH RECORDS

NACNS advocates for interoperability and inclusion of recognized terminologies supporting nursing practice and person-centered care within electronic health records (EHR) to achieve shareable and comparable data and improve outcomes. To attain the goal, NACNS urges CMS to establish EHR provisions that collect data specific to the interventions for all providers including APRNs and, specifically, CNSs.

At present, the EHR measurement is limited to one group of eligible providers using a subset of a core set of measures. It is important that an evaluation of the capability to exchange data in an interoperable manner include all clinicians on the interprofessional care team, particularly as it relates to care coordination, including transitional care. This is essential to improve patient safety and reduce excessive cost due to avoidable HACs and 30-day readmissions. The exchange of data between providers and all healthcare settings is essential. The need to escalate steps to achieve interoperable, interprofessional, patient-driven care plans that are longitudinal in nature reflecting the lifespan of the patient and family will be achieved when recognized terminologies supporting person-centered care and nursing practice are integrated into information technology solutions.

REQUEST FOR INFORMATION

In addition to the payment and policy proposals, NACNS specifically appreciates the opportunity to respond to CMS' Request for Information regarding solutions to improve healthcare delivery by making the system more effective, simple, and accessible while maintaining program integrity, quality, and safety. NACNS will address CMS' interest in solutions promoting operational flexibility, enhancements of patient care, support of the healthcare provider-patient relationship in care delivery, and facilitation of patient-centered care.

NACNS endorses the recommendations in ***The Future of Nursing: Leading Change, Advancing Health***, the milestone 2010 report of the Institute of Medicine [now the Health and Medicine Division (HMD) of the National Academy of Medicine]. Because the APRN roles have a wide-ranging impact on providing patient-centered, accessible, and affordable care, ***The Future of Nursing*** recommends eliminating regulatory barriers that prevent APRNs from practicing to their full scope. Permitting APRNs to practice to the full extent of their education and training could help build the necessary workforce to satisfy the healthcare needs of an increasing number of people with access to health insurance, as well as contribute unique APRN expertise and skills to the delivery of patient-centered healthcare. Steps have been taken at both federal and state levels, but barriers to expanding APRN scope of practice remain. Improving participation of eligible APRN Medicare Part B practitioners ensures patient access to quality care, helps save on healthcare costs and increases patient choice.

To those ends, NACNS offers the following recommendations regarding several regulatory barriers affecting APRNs:

- Remove credentialing and privileging barriers to practice and care;
- Remove costly and unnecessary physician supervision requirements;
- Establish modifiers on claims to identify incident-to billing and acknowledge the licensure of the rendering provider;
- Reform policy definitions of the word "physician" so that patients have access to the services of qualified APRNs; and

- Remove from sub-regulatory guidance the exclusion of practitioners who are not physicians from serving on Medicare Carrier Advisory Committees.

REMOVE CREDENTIALING AND PRIVILEGING BARRIERS TO PRACTICE AND CARE

NACNS is concerned with credentialing and privileging requirements that hinder APRNs ability to deliver essential services, otherwise permitted under state law. For example, in place of the current unnecessary, regulatory credentialing and privileging decisions we seek consideration of

- Requirements that medical staffs be representative of all healthcare professionals authorized to provide services under the Medicare program including APRNs;
- Elimination of the list of providers who may have membership or participate in leadership on the medical staff, and instead allow those roles to be available to the healthcare professionals who are most qualified and appropriate to fill them;
- Uniform procedures for the consideration of applications for credentials including prompt (60-day) determinations; and
- Requirements that applicants be notified in writing of the disposition of their applications.

REMOVE COSTLY AND UNNECESSARY PHYSICIAN SUPERVISION REQUIREMENTS

NACNS recommends that CMS eliminates requirements for physician supervision of APRNs. Given the growing population of persons in the United States requiring healthcare, particularly among Medicare eligible populations, physician supervision requirements stand in the way of deploying the vast workforce contained with the supply of APRNs. Unnecessary requirements for physician supervision of APRNs contribute to duplication and waste in the healthcare delivery system. There is no evidence that supervision requirements contribute to higher quality, lower cost, or greater value or access to healthcare. On the contrary, ample evidence points to the value provided by APRNs.

ESTABLISH MODIFIERS ON CLAIMS TO IDENTIFY "INCIDENT TO BILLING" AND TO ACKNOWLEDGE THE LICENSURE OF THE RENDERING PROVIDER

A payment system designed to incentivize high-quality, value-based services must clearly and consistently identify the provider responsible for actually rendering a service, as well as ensure that Medicare claims accurately identify the rendering provider. While in prior comments to CMS NACNS encouraged the elimination of "incident to" billing, we also recommend the use of modifiers to identify the individual rendering the service in addition to the billing number of the provider under whom the service is billed.

Current "incident to" billing practices undermine the foundation of value-based reimbursement. Without establishing mechanisms to ensure transparency and clearly identifying the actual provider of a service, it will be impossible to accurately calculate value-based performance indicators at a provider-specific level.

REFORM POLICY DEFINITIONS OF THE WORD "PHYSICIAN"

NACNS appreciates efforts that CMS has made to ensure that the extent of the advanced education and clinical preparation of CNSs and other APRNs are fully recognized and reflected in the practice and payment policies of federal health programs, consistent with the laws of the states in which the clinicians

are licensed and practice. NACNS urges CMS to use its full authority to waive regulatory barriers to APRN practice where narrowing the definition of the term "physician" interferes with the ability of APRNs to act within their scope of practice.

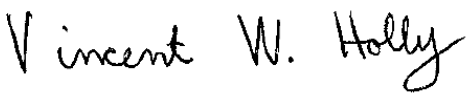
It is critical for CMS to reaffirm its commitment to ensuring maximum patient access to the services of APRNs in the Medicare program and beyond as the agency develops, implements and evaluates new payment structures. Key to establishing a value-based system emphasizing prevention, wellness and care coordination is the expertise of CNSs and other APRNs. An interprofessional, team-based approach is critical to the practice of healthcare within system-wide reform. In recent years, this message has been echoed by the National Academy of Medicine, the National Governors Association, the Federal Trade Commission, and many other leading authorities that have noted the importance of ensuring nurses are full partners with other health professionals in healthcare redesign.

REMOVE FROM SUB-REGULATORY GUIDANCE THE EXCLUSION OF NON-PHYSICIAN PRACTITIONERS FROM SERVING ON MEDICARE CARRIER ADVISORY COMMITTEES

NACNS advocates the removal from sub-regulatory guidance the exclusion of practitioners who are not physicians from serving on Medicare Administrative Contractors' (MACs) Carrier Advisory Committees (CAC). Note that Exhibit 3 of Section 13.8.1 of the Medicare Program Integrity Manual states, "Do not include other practitioners on this committee," thus precluding APRNs from participation. NACNS urges the removal of this clause from the manual. As a vital provider community, NACNS is troubled by multiple instances where MACs have exceed their authority by issuing local coverage determinations (LCD) that contradict existing CMS regulation and policy as well as scope of practice under state law. These situations harm patient access to vital and medically necessary services. As CACs are crucial in the development and review of LCDs, it is imperative that practitioners such as APRNs are represented on CACs to ensure that the LCD process reflects evidence-based policies, the perspective of practitioners who are not physicians, and to protect robust patient access to medically necessary APRN services under Medicare.

NACNS is committed to work with CMS to develop a healthcare system that addresses the most significant issues facing quality patient care today – issues that clinical nurse specialists tackle every day. If you have any questions or require additional information, please feel free to contact Melinda Mercer Ray, NACNS Executive Director, at 703-929-8995 or via email at mray@nacns.org.

Sincerely yours,



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