CLINICAL EXPERTISE
NURSING PRACTICE
SYSTEMS INNOVATION

NACNS

National Association of Clinical Nurse Specialists

September 4, 2018

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

ATTN: CMS–1693–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 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program*** (83 FR 35704).

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 health care delivery system by improving quality while also reducing costs in the system. CNSs provide direct patient care, including assessment, diagnosis, and management of patient health care 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 health care, 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 2019 physician fee schedule (PFS) to enhance Medicare Part B services and payment opportunities to Medicare non-physician practitioners, particularly to CNSs and other APRNs.

BUNDLING EPISODE OF CARE FOR MANAGEMENT AND COUNSELING TREATMENT FOR SUBSTANCE USE DISORDERS

NACNS applauds CMS' decision to seek comment on both creating a bundled episode for substance use disorders (SUD) and identifying non-opioid alternatives for pain management. NACNS appreciates CMS' more assertive approach to addressing the opioid public health emergency. While most of the agency's preventive action to date has focused on limiting post-discharge opioid prescriptions, the CY 2019 PFS proposal encourages practitioners to adopt other methods of pain management. This indicates a broad desire to expand the scope of prevention and avert future cases of misuse.

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Efforts to address the growing concerns surrounding the misuse of opioids have the potential to overshadow the need for compassionate, individualized pain management. This presents an ethical dilemma as nurses struggle to reduce pain and suffering while balancing the potential dangers of opioids to both individuals and society. The opioid crisis highlights the complexities of pain management, especially in vulnerable pain populations, such as older adults and those with chronic diseases, including mental illnesses and substance use disorders. NACNS supports the removal of barriers to accessing safe, effective, pain management for these populations. More research on non-opioid pain management and opioid use is critical.

NACNS advocates for thoughtful, varied, and individualized approaches to acute and chronic pain management using a combination of opioid, non-opioid pain medications, as well as non-pharmacologic interventions. NACNS believes that pain management should be focused on the strategic and judicious use of opioid medications. NACNS encourages policy makers, health care providers and members of the public to begin to view opioids as a tool to alleviate specific types of pain in specific situations, but not demonize its use or the patients who require these medications to alleviate specific types of pain. To this end, NACNS calls for more research on the appropriate use of opioids, as well as the use of non-opioid pain medications, pain assessment instruments/tools that focus on improved functionality, and interventions to alleviate pain.

Since the Centers for Disease Control and Prevention released its recommendation for opioid use in chronic pain, there has been a wealth of attention on the topics of misuse and addiction, but far less concentration on the effective management of acute or chronic pain with opioid alternatives. The NACNS Position Statement *The Role of the Clinical Nurse Specialist in Addressing Opioid Prescribing and Pain Management Concerns Related to the National Opioid Crisis* discusses how the CNS can facilitate the many, much-needed efforts to address the opioid crisis in a comprehensive manner, maintaining the patient's health and safety as a core principle. The CNS is distinctively prepared to help reduce inappropriate or unsafe opioid use while supporting effective, multi-modal pain management. Abating the societal devastation of opioid misuse and addiction requires a comprehensive, multifactorial approach that includes evidence-based pain management care, clinician education, and systems-level changes to the current opioid-based pain management practice.

Additionally, the NACNS holds that non-pharmacological interventions can provide beneficial effects on function and/or pain that may be seen after the completion of therapy. These interventions include exercise, multidisciplinary rehabilitation, acupuncture and mind-body and mindfulness practices, and may improve function and pain across multiple chronic pain conditions. There is research supporting clinical strategies that focus on use of non-pharmacological therapies as preferred interventions for chronic pain. NACNS posits, however, that more research on sustainability of effects beyond the immediate post-treatment period is needed, particularly for conditions other than low back pain. Additionally, NACNS suggests in its position statement that reimbursement of non-pharmacological interventions can be challenging. It is crucial to work with payers to improve coverage for these interventions to enhance safe, high-quality pain management for our patients.

IMPROVING CLINICAL EDUCATION IN PAIN MANAGEMENT

NACNS commends CMS' intent to expand beyond prevention and focus on increasing access to treatment. CMS' openness to creating a bundled episode for opioid treatment and counseling could help

streamline services and payment for those struggling with addiction. However, what seems to be missing from this early proposal is a mention of how to equip providers to better manage patients in recovery from opioid use disorder. As per the NACNS Position Statement *The Opioid Crisis – A Universal Health Care Concern*, NACNS urges CMS to provide eligible practitioners with the tools they need to help patients to recovery. NACNS calls for increased education related to pain, pain management, and the use of opioids for all health care staff.

EXPANDING E-PRESCRIBING

NACNS endorses CMS' proposal to include two new measures under the E-Prescribing objective based on electronic prescriptions for controlled substances: Verify Opioid Treatment Agreement, and Query of Prescription Drug Monitoring Program (PDMP).

NACNS supports the use of opioid treatment agreements as an important part of the prescription of opioids for pain management. Treatment agreements help patients understand their role and responsibilities for maintaining compliance with terms of the treatment. In our NACNS Position Statement *Clinician Approach to Opioid Misuse and Addiction*, we assert that "[b]est practice at this time suggests that clinicians ought to integrate a systematic, patient-centered process that includes information-gathering, more frequent monitoring, a concerted effort at patient education, and a pointed review of the opioid treatment agreement."

NACNS agrees with CMS that querying a PDMP is beneficial to optimal prescribing practices. In the previously cited NACNS position statement on Misuse and Addiction, NACNS states that PDMPs, "are promising clinical tools to address prescription drug misuse and addiction. These programs are designed to monitor prescribing and dispensing of controlled substances and can provide a prescriber or pharmacist with critical information regarding a patient's prescription history. This information can have a direct impact on reducing a patient's risk for overdose and provide an opportunity to intervene with patients who are misusing medications."

While more than 2 million Americans have an opioid use disorder, less than 20% receive appropriate treatment for their disorder. NACNS advocates that increasing access to SUD treatment, including medication-assisted treatment (MAT) with narcotic medications, is essential to effectively address the prescription drug misuse problem. The two new CMS proposed measures based on electronic prescriptions for controlled substances will assist MAT providers to ensure that individuals can safely take these medications as long as needed – a few months, one to five years, or for life.

That said, NACNS notes CMS' awareness that not all Merit-based Incentive Payment System eligible clinicians are able to prescribe controlled substances. Since the passage of the ***Balanced Budget Act of 1997*** (P.L. 105–33), CNSs have been allowed to directly bill their services, under Part B participation in Medicare, including the services of prescribing and managing MAT to beneficiaries. Prescriptive authority, with lawful prescriptive authority for controlled substances, is within the scope of practice of CNSs. Currently CNSs have the state-level authority to prescribe pharmacotherapeutics in 39 states. However, under the ***Comprehensive Addiction and Recovery Act of 2016*** (CARA, Pub. L. 114-198), CNSs have not been extended permission to prescribe MAT to treat an opioid use disorder. (See CARA, Title III, Section 303, which amends Section 303 of the ***Controlled Substances Act*** by adding to the criteria of a "qualifying practitioner".) NACNS argues that as many qualified prescribers as possible are essential to treat patients who are struggling in this nationwide crisis. NACNS urges CMS to prioritize allowing at-risk

beneficiaries, for prescription drug abuse, access to clinical nurse specialists who are lawful prescribers of MAT.

STREAMLINING EVALUATION AND MANAGEMENT PAYMENT AND REDUCING CLINICIAN BURDEN

NACNS advocates for the simplification of evaluation and management (E/M) documentation requirements as part of efforts to reduce administrative burden for practitioners. NACNS agrees with CMS' proposal that allowing clinicians to choose to document office/outpatient E/M visits using medical decision-making or time, versus applying the current E/M documentation guidelines, could streamline E/M documentation. Likewise, we back CMS' proposed rule seeking to expand current options by allowing practitioners to use time as the governing factor in selecting visits level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit.

NACNS also favors the agency's rule trying to expand current options regarding the documentation of history and exam, by permitting practitioners to focus on documenting interval history since the last patient exam, or on pertinent items that have not changed, rather than re-documenting information. Similarly, we support CMS' desire to allow health care providers to review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering the information.

However, NACNS is wary about the proposed change to payment for office visits. Currently Medicare payment rates for new patients range from $76 for a Level 2 office visit to $211 for a Level 5 visit. By consolidating payment variation in office visit levels to one blended Medicare payment, as per the agency's proposed rulemaking, the single rate for new patients would be about $135, and that for established patients would be $93. The change yield gains for practitioners who specialize in routine care, while diminishing payment for health care professionals who primarily serve complicated patients.

For providers of complicated patients, the proposed cuts via consolidating payments may challenge the recommendations of the Medicare Payment Advisory Commission (MedPAC). In its June 2018 Report to the Congress: Medicare and the Health Care Delivery System, MedPAC proposed increased reimbursement for ambulatory E/M services, arguing that the services require extensive time and intensity by practitioners, and that such services are already undervalued: "Ambulatory evaluation and management (E&M) services, such as office and hospital outpatient visits, are essential for a high-quality, coordinated health care delivery system. These visits enable clinicians to diagnose and manage patients' chronic conditions, treat acute illnesses, develop care plans, coordinate care across providers and settings, and discuss patients' preferences. E&M services are critical for both primary care and specialty care. The Commission is concerned that these services are underpriced in the fee schedule for physicians and other health professionals ("the fee schedule") relative to other services, such as procedures. This mispricing may lead to problems with beneficiary access to these services . . ."

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.

GROWING COMMUNICATION TECHNOLOGY-BASED SERVICES

CMS proposes to pay separately for two new demarcated practitioners' services that are furnished using communication technology. One service would be Brief Communication Technology-based Services, and the other would be Remote Evaluation of Recorded Video and/or Images Submitted by the Patient (i.e., store and forward). Providers could be paid for the Brief Communication Technology-based Service when they conduct a virtual check-in with beneficiaries via telephone, or by other telecommunications devices, to decide whether an office visit or other service is needed.

NACNS believes that the new codes – as suggested in this rulemaking when also applied to remote interprofessional consultations, acute stroke telehealth services, and web-based counseling for SUD – could restructure the encounter process, significantly reshaping how patients and providers interact in managing chronic and low acuity conditions. We concur with CMS that this proposal is a step in the right direction to increase efficiency for practitioners and convenience for beneficiaries. The virtual check-in represents an advance in health care regarding the quantity and quality of information that can be conveyed via communication technology. As APRNs, CNSs are qualified to optimize patient outcomes, implement evidence-based practice, close the access to care gap, and enhance quality of care through cost-effective and creative means. The CNS role has been strengthened by the availability of health information technology, allowing enhanced analytic capabilities, mobile and cloud-based service integration, and access to myriad databases to strengthen impacts on outcomes. NACNS stands ready to assist CMS as it examines and develops other program's delineations, such as extending virtual check-ins to new patients, as well as established patients, and the possibility of requiring a specific documented informed consent notation in each virtual check-in health record.

Virtual check-ins will present a revenue stream for health care professionals, and we appreciate CMS' care to shun establishing telehealth incentives that would influence a practitioner's decision to not bring a patient into the office if needed. Yet, NACNS is concerned that the suggested reimbursement for e-visits is inadequate. The rulemaking states that "Medicare would pay $14 per visit in the first year for these communication technology-based services, compared with $92 per visit for the corresponding established patient visits."

REINFORCING INTERPROFESSIONAL SERVICES

In an ongoing effort to recognize the complexities of treating chronic conditions with a patient-centered approach, CMS' rulemaking proposes two new codes for Interprofessional Internet Consultation allowing payment for certain clinician to clinician services:

- CPT 994X0 interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes
- 994X6 interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time

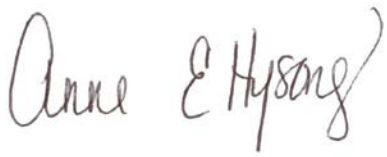
NACNS supports these efforts. Care coordination is a critical contribution to a patient's well-being and is one area where change is achievable in the near-term. NACNS holds that care coordination payment

must be consistent across all qualified health professionals delivering high-value care coordination activities. 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.

The CNS is in the ideal position to lead collaboration within and across health care 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.

NACNS is committed to work with CMS to develop a health care 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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