



August 29, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1717-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children’s Hospitals-Within-Hospitals [CMS–1717–P]

Dear Administrator, Verma,

The American Association of Colleges of Nursing (AACN) offers the following comments on the CMS proposed rule, *Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs* [CMS–1717–P].

As the national voice for baccalaureate and graduate nursing education, AACN has a vested interest in improving health and health care throughout the nation. For more than five decades, AACN has established quality standards for professional nursing education to ensure that Registered Nurses (RN) and Advanced Practice Registered Nurses (APRN; which include Nurse Practitioners (NPs), Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Nurse Specialists (CNSs)) are prepared to provide evidence-based and cost-effective care. Within AACN member schools, more than 100,000 nursing students are currently enrolled in APRN programs and will serve as our nation’s next generation of expert providers.¹

AACN appreciates the opportunity to comment on: *Section X. A. Proposed Changes in the Level of Supervision of Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals (CAHs): For CY 2020, we are proposing to change the minimum required level of supervision from direct supervision to general supervision for all hospital outpatient therapeutic services provided by all hospitals and CAHs. This proposal would ensure a standard minimum level of supervision for each hospital outpatient service furnished incident to a physician's service.*

Inclusion of Certain Outpatient Therapeutic Services

AACN strongly supports this proposed change in the required level of supervision from direct supervision to general supervision for all hospital and CAH outpatient therapeutic services. We request further definition and clarification that this proposed change would include granting non-physician providers the ability to order and supervise therapeutic services such as cardiac and pulmonary rehabilitation services. Additionally, chemotherapy and radiation therapy should not be

¹ 2018-2019 Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, DC: American Association of Colleges of Nursing.



exempted from this proposal. In general, these services do not require direct supervision and non-physicians, such as NPs are clinically trained to provide high quality, timely care to patients.

Increasing access to quality cardiac rehabilitation care is vital to saving thousands of lives. Heart disease kills approximately 610,000 Americans every year and is the cause of one in four deaths.² However, only 20 percent of eligible cardiac patients receive cardiac rehabilitation services which reduce cardiovascular deaths and hospital readmissions.³ Women, minorities, and patients with lower socioeconomic status are even less likely to participate in cardiac rehabilitation.⁴ Chronic obstructive pulmonary disease (COPD) is included amongst chronic lower respiratory diseases as the fourth leading cause of death in the United States, yet less than three percent of Medicare patients with this progressive lung disease receive pulmonary rehabilitation.⁵

Removing the direct supervision requirement for all hospitals and CAHs, in effect, increases access to lifesaving therapeutic services, including cardiac and pulmonary rehabilitation, chemotherapy, and radiation therapy, especially for the medically underserved patient populations.

Correct Provider Attestation and Remove “Incident-To” Billing

In addition to providing clarification on the definition of hospital outpatient therapeutic services and the scope of the proposed changes, AACN recommends correcting provider attestation and removing “incident-to” billing. As stated, the proposal “*would ensure a standard minimum level of supervision for each hospital outpatient therapeutic service furnished incident to a physician's service in accordance with the statute.*”

In its June 2019 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommends requiring APRNs and PAs to bill directly for services provided, thus eliminating “incident-to” billing. In addition, MedPAC recommends that the Secretary refine specialty designations for APRNs and PAs to give Medicare a greater account of the services provided by these clinicians, giving Congress the ability to target resources toward primary care.⁶ Requiring each MIPS-eligible provider to be identified by a unique virtual group participant identifier, Tax Identification Number (TIN), and National Provider Identifier (NPI) would lead to administrative simplification and more accurate attestation of providers caring for patients. These identification numbers can be used in recognizing and eliminating redundancies in the payer system, including “incident-to” billing.

This recommendation is aligned with CMS’ efforts to reduce barriers to beneficiaries’ access to care and find cost-effective solutions to improve coding and documentation requirements for Medicare and Medicaid payment.

Thank you for considering these comments in response to *Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs* [CMS–1717–P]. AACN strongly believes in putting patients first in a health care system that supports a diverse workforce able to provide high-quality, accessible, and affordable care. We

² CDC, NCHS. Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed Feb. 3, 2015.

³ <https://www.heart.org/en/health-topics/cardiac-rehab/cardiac-rehab-faq>

⁴ https://millionhearts.hhs.gov/files/Cardiac_Rehab_Infographic-508.pdf

⁵ <https://www.ncbi.nlm.nih.gov/pubmed/30417670>

⁶ Medicare Payment Advisory Commission. (June 14, 2019). Report to Congress: Medicare and the Health Care Delivery System. Retrieved from http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

American Association
of Colleges of Nursing



look forward to continuing to work with CMS in reducing unnecessary burdens for clinicians, providers, patients, and their families. If our organization can be of any assistance, please contact AACN's Director of Policy, Dr. Colleen Leners at cleners@aacmnursing.org.

Sincerely,

Deborah E. Trautman

Deborah E. Trautman, PhD, RN, FAAN
President and Chief Executive Officer