

April 19, 2016

The Honorable Joe Pitts
Chairman
House Energy and Commerce Committee
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Gene Green
Ranking Member
House Energy and Commerce Committee
Subcommittee on Health
2322 A Rayburn House Office Building
Washington, DC 20515

RE: Advanced Practice Registered Nursing (APRN) Organizations Comment for April 19, 2016, Hearing of the House Energy and Commerce Subcommittee on Health, “Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms”¹

Dear Chairman Pitts, Ranking Member Green and Members of the Subcommittee:

On behalf of the undersigned organizations representing Advanced Practice Registered Nurses (APRNs), we provide the following statement for the record in support of the Subcommittee’s hearing on April 19, 2016, titled, “Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms.”

As strong supporters for the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), our statement:

- Summarizes the role of America’s 350,000 APRNs in the Medicare program;
- Outlines activities APRNs have undertaken to implement MACRA, in particular its Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) provisions;
- Describes concerns that APRNs have had with implementation processes thus far; and,
- Recommends solutions.

America’s 350,000 APRNs Provide Excellent Care Where Care is Needed Most, Enhancing Value for Patients and Access to their Medicare Benefits

The APRN community is comprised of organizations representing Nurse Practitioners (NPs) delivering primary, acute and specialty care; Certified Registered Nurse Anesthetists (CRNAs) who provide the full range of anesthesia services as well as chronic pain management; Certified Nurse-Midwives (CNMs) expert in primary care, maternal and women’s health; and Clinical Nurse Specialists (CNSs) offering acute, chronic, specialty and community healthcare services. Totalling more than 350,000 healthcare professionals, including two of the ten largest categories

¹ Hearing background information at <https://energycommerce.house.gov/hearings-and-votes/hearings/medicare-access-and-chip-reauthorization-act-2015-examining-physician>, retrieved Apr. 18, 2016.

of Medicare Part B provider specialties according to Medicare claims data, our primary interests are patient wellness and improving patient access to safe and cost-effective health care 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.

When we expressed our support for MACRA, our comments to Congress stressed the importance of full participation of APRNs including the treatment of APRNs the same as physicians in the development, vetting, implementation and evaluation of quality measures and incentive reimbursement programs, and in the application of alternative payment models. We stated that Congress' bipartisan, bicameral legislative approach met those objectives in the interests of patient safety and of beneficial market competition for patient-centered innovations in healthcare delivery.

While we are grateful for the opportunity to provide testimony for the record, we recommend that the Subcommittee in the future consider inviting APRN witnesses to testify in the same way it invites representatives of physician organizations. APRNs are critical to patients, to the delivery of the Medicare program, and to the implementation of MACRA. CMS data from January 2016 indicate that 205,038 APRNs were enrolled as Medicare Part B providers. Additional APRNs who are employed by hospitals or work in Medicare Advantage plans and treat Medicare patients may not be enrolled as Part B providers. One in nine enrolled Part B providers is an APRN. Nurse practitioners are the third largest specialty in Part B after internists and family practitioners. CRNAs are the sixth largest specialty in Part B and outnumber anesthesiologists.² While APRN services are provided coast-to-coast among all patient populations, they are particularly crucial to populations that are rural or medically underserved, that have lower incomes than the national average, and that are more likely to be beneficiaries of Medicare, Medicaid or subsidized plans.

While APRN Organizations have Engaged in MACRA Implementation Activities, Improvements Can be Made in Ensuring the Views of All Part B Providers are Fairly Considered

APRN organizations have engaged at many levels in regulatory and policymaking processes associated with MACRA implementation, especially with respect to the MIPS and APMs provisions. These activities have included:

² Report on 2013 PQRS results posted by CMS at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>. Raw data identifying Part B providers posted by CMS at <https://data.cms.gov> and <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-02-22.html>. Numerical analyses conducted by Peter McMenamin, PhD, Health Policy Department, American Nurses Association, Aug. 13, 2015, and March 7, 2016, respectively.

- Developing and submitting comments to the FY 2017 physician fee schedule notice-and-comment regulatory rulemaking progress. Specific MACRA-related requests included:
 - Supporting equal treatment across provider groups in the development, evaluation and implementation of Clinical Practice Improvement Activities (CPIA) portion of the MIPS score;
 - Ensuring that APM “physician-focused payment models” treat APRNs the same as physicians in the delivery of the same services to patients, while being renamed “provider-focused payment models;”
 - Supporting Medicare recognition of APRNs to their full scope of practice as a valuable factor in developing and implementing APMs; and,
 - Ensuring all language associated with MACRA implementation is provider-neutral.

- Developing and submitting comments to the U.S. Department of Health and Human Services MACRA implementation request for information process. Specific MACRA-related requests included:
 - Supporting integrating APRNs into processes for development, implementation and evaluation of MACRA-driven payment and care delivery models;
 - Ensuring that each service provided to a patient is associated with the actual provider of the service, in relation to the MIPS eligible providers (EP) provisions;
 - Ensuring that all performance mechanisms be subject to all stakeholders’ transparent and public review and comment in order for them to qualify as reporting mechanisms for MIPS and APM quality indicators;
 - Supporting the fairness and accuracy of all measures associated with MIPS and APMs so that they do not impair or eliminate competition from among safe and qualified healthcare providers;
 - Excluding from quality measures the issue of whether an EP is a participant in the network of plans in a Federally Facilitated Marketplace, since such a determination is not entirely within the EP’s control;
 - Ensuring equal treatment among APRNs and physicians in the development, implementation and evaluation of CPIAs;
 - Including APRNs within the development, implementation and evaluation of Physician Focused Payment Models the same as physicians;
 - Engagement of healthcare professionals involved modestly in Medicare, such as pediatric nurse practitioners (who treat children with renal failure awaiting transplantation, and the children of adults with renal failure awaiting transplantation that qualify for Medicare coverage), as Medicare payment policies

adopted through MACRA are likely to migrate into Medicaid, CHIP and commercial health plans; and,

- Supporting APRN full scope of practice as a criterion for evaluating Physician-focused Payment Models. Such policy is recommended by the Institute of Medicine and helps to expand access, advance healthcare quality, and promote cost-effective healthcare delivery.

APRN organizations have also participated in the Healthcare Payment Learning and Action Network (LAN), but have been disappointed that notwithstanding several nominations so few APRNs have been selected by the LAN to coordinate and lead its panels and workgroups. Insufficient engagement of APRNs within LAN risks imperiling the success of payment reform initiatives that the LAN recommends – a critical issue since America’s APRNs provide care for hundreds of millions of Americans annually, including the vast majority of the Medicare population. We have also commented on the development and implementation of the Medicare Comprehensive Joint Replacement (CJR) demonstration project, arguably the first major APM established by the agency since the enactment of MACRA, which has been in operation since April 1, 2016.

APRN organizations await the publication of the MIPS and APM implementation proposed rule now under review at the Office of Management and Budget, Office of Information and Regulatory Affairs (OMB OIRA).

From APRN Experience Thus Far, How Might MACRA Implementation be Improved in the Interest of Medicare Patients and Other Critical Stakeholders

From the perspective of APRN organizations, the MACRA implementation record thus far scores a grade of “incomplete,” as the executive branch has not yet published a proposed rule implementing the MIPS and APM provisions of MACRA in advance of the approaching statutory deadlines. From the above issues, however, there are several that deserve priority consideration and oversight by the Congress:

1. **It is particularly important for Medicare to implement MACRA in all respects in a manner that incorporates the participation, views and contributions of APRNs the same as it does physicians.** Failing to do so imperils the implementation of these crucial payment reforms which are necessary to our country successfully ensuring access to care for the near-doubling of our Medicare patient population by 2030, just 14 years from now.
2. **Of all factors within MIPS, the Clinical Practice Improvement Activities (CPIA) portion is the least thoroughly developed, and stands to benefit the most from the full involvement and incorporation of APRNs the same as physicians.** To this point, we do not see evidence that Medicare is driving joint development and adoption of CPIAs among APRN and medical organizations. If the CPIAs are not arranged the same

way for different providers performing the same services for the same patient types, then such providers will yield different MIPS CPIA scores and be awarded different payment rewards and penalties – an unjustifiable outcome likely to sow confusion and discontent in the healthcare delivery marketplace and among patients.

3. **Also within MIPS, implementation of the Electronic Health Records – Meaningful Use (EHR-MU) portion should reflect neutrally upon providers such as those APRNs that (a) have been ineligible for EHR incentive payments under the High Tech Act in either Medicare or Medicaid, and/or (b) provide services such as anesthesia where the EHR systems are the responsibility of the facility not the provider.** Providers ineligible or inappropriate for participation in EHR-MU should not be scored lower on MIPS than providers that either by their nature or by act of Congress have been eligible and have been participating in EHR-MU.
4. **As the Department moves forward to implement policies around chronic care coordination we request that these policies be inclusive of APRNs.** As the chosen healthcare provider for their patients, APRNs are in charge of their chronic care coordination. We look forward to continued work with Congress to ensure that all Medicare providers, including APRNs, are able to provide and be reimbursed for this type of treatment.

Thank you for taking time to engage the public and the community of healthcare professionals through your hearing. We remain at your service, especially with respect to the implementation of this critical MACRA statute. If you have any questions, please contact Frank Purcell of the AANA at 202-741-9080, fpurcell@aanadc.com.

Sincerely,

American Association of Colleges of Nursing (AACN)

American Association of Nurse Anesthetists (AANA)

American Association of Nurse Practitioners (AANP)

American College of Nurse-Midwives (ACNM)

American Nurses Association (ANA)

Gerontological Advance Practice Nurses Association (GAPNA)

National Association of Clinical Nurse Specialists (NACNS)

National Association of Pediatric Nurse Practitioners (NAPNAP)

National League for Nursing (NLN)

National Organization of Nurse Practitioner Faculties (NONPF)

cc: Rep. Fred Upton, Chairman, House Energy and Commerce Committee
Rep. Frank Pallone, Ranking Member, House Energy and Commerce Committee
Members of the House Energy and Commerce Health Subcommittee