June 27, 2016

Submitted via www.regulations.gov

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-5517-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: CMS-5517-P – Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (81 Fed.Reg. 28162 May 9, 2016)

Dear Mr. Slavitt:

On behalf of the undersigned organizations, we are pleased to provide comments on the proposed rule for Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (81 Fed. Reg. 28162, May 9, 2016).

Advanced Practice Registered Nurses (APRNs) include Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Clinical Nurse Specialists (CNSs), and Nurse Practitioners (NPs). 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.

CMS Should Use Its Full Authority to Waive Policy Barriers to the Use of APRNs in Alternative Payment Models

We urge the Centers for Medicare & Medicaid Services (CMS) to ensure that all of these initiatives be developed, implemented, and evaluated consistent with robust patient access to APRN services under Medicare. We remain concerned with the extent to which APRNs will be able to participate in the new Alternative Payment Models (APMs) under development. Although NPs, CRNAs, and CNSs were included in the description of APMs under Medicare Access and CHIP Reauthorization Act (MACRA),[1] there is no requirement that APMs include APRNs in their networks as independent providers eligible for direct billing and participating in potential incentives such as shared savings or quality bonuses. If the networks for Federally-facilitated Exchanges are any example, our organizations have witnessed many instances in which healthcare carriers have excluded APRNs from their networks. Similarly, CMS indicates that the Comprehensive Primary Care Plus could be considered an advanced APM. CMS indicated that NP practices would be able to participate in the original prototype demonstrations (Comprehensive Primary Care initiative), but among the 2000 primary care practices selected, not a single NP practice was among them.

The Medicare agency should use its full authority to waive policy barriers to the use of APRNs in APMs. Such barriers include physician supervision requirements, narrow definitions of the term "physician" that exclude APRNs otherwise acting within their scope of practice in a state, and impairments to credentialing and privileging APRNs and to applying their full leadership capabilities in Medicare facilities. Waiving such burdensome barriers to the use of APRNs will enhance access to care, ensure quality healthcare delivery, and contribute to cost savings. The need for access to APRN services is crucial for the 40 million beneficiaries now in Medicare and for the 80 million beneficiaries who are expected to be in Medicare in the future. APRNs are the solution to developing improvements to quality, access, and cost-efficiency in healthcare. Implementation should be executed with that in mind.

Confirm that Exclusions in the Rule are Treated as Waivers and Not Penalties

We ask that the final rule does not create problems for small practices attempting to implement the new provisions. While the "cut-off" for the low volume threshold (100 Medicare patients and

[1] Pub L. 114-10.

$10,000 in Medicare charges) does not seem unreasonable for APRN practices comprised predominantly of Medicare patients, we ask that you verify that this participatory cut off will not penalize practices with more pediatric, women's health, Medicaid or private pay patients. We ask that these "exclusions" and others in the proposed regulation be clearly recognized, identified and implemented as waivers to assist the practices in making ends meet, and that every effort is made to incentivize all practices in the value based payment endeavor regardless of clinician makeup or size.

ADVANCING CARE INFORMATION PERFORMANCE CATEGORY

Require the Inclusion of APRNs in Guidelines and Requirements for Certified EHR Technology

As you create incentives for advancing care information, we ask that you include in the guidelines /requirements for certified electronic health record (EHR) technology, a requirement for the inclusion of providers other than physicians. In current software being used, there often is no ability for clinicians other than physicians to make entries or take credit for the care they have provided. The assumption in these programs suggests that only physicians see patients and provide care. As you are aware, NPs for instance, are primary care providers with their own panels and practices, yet many EHR systems assume only physicians provide documented care. In these cases, APRNs have no legitimate way to document their practice or their outcomes. This is particularly a problem in hospital EHR systems. Requiring APRNs to be participants/consultants in the development of the EHR software and to be recognized as providers in the software would assist health systems to be more inclusive of all clinicians and substantiate transparency in the software that is certified by CMS for utilization in the Quality Payment program.

CMS Should Use Its Full Authority to Provide Financial and Technical Assistance to Support APRNs in Adopting and Using Certified EHR Technology

We appreciate the agency's recognition of the statutory limits on APRNs to fully participate in the Medicare and Medicaid EHR incentive payments available under the American Recovery and Reinvestment Act of 2009 and the Health Information Technology for Economic and Clinical Health Act (HITECT Act). As stated in the preamble of the proposed rule, these restrictions have made it more difficult for many APRNs to adopt and use certified EHR technology and contributed to the relatively small number of NPs who have attested to the Medicaid EHR Incentive Program. We understand that there is not extensive evidence as to whether sufficient measures are available to MIPS-eligible APRNs under the advancing care information performance category. However, we know that many APRNs have and continue to make efforts to adopt and use certified EHR technology, despite the lack of financial incentives available to other providers, and we believe those who can adopt such technology should have the option to participate in the advancing care information performance category in 2017. We urge the agency to use its full authority to provide financial and technical assistance to support APRNs in adopting and using this technology.

Reweighting Proposals Underscore the Need for CMS to Ensure that Each Service Provided to a Patient is Associated with the Actual Provider of the Service

The comments below relate to the following sections of the MIPS Program Sections:

- E.5.g. Advancing Care Information Performance Category (pp. 28215-28234);
- E.5.g.8.a.iii. Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists (p. 28233); and
- E.6.b.2.c. Redistributing Performance Category Weights (p. 28271)

If APRNs or other MIPS eligible clinicians are unable to participate in the advancing care information performance category, the agency proposes to reweight the remaining performance categories. The rule proposes two reweighting options. If a clinician has at least three scored measures, either submitted or calculated from administrative claims, in the quality performance category, the rule proposes to reassign the weights of the performance categories without a score entirely to the quality performance category – potentially resulting in 75 percent of the Composite Performance Score (CPS) being determined by the quality performance category. The rule also proposes an alternative that would reassign the weight of the performance

categories without a score proportionately to each of the other performance categories for which a clinician receives a performance score.

Both proposed reweighting options would increase the importance of the quality performance category in determining the CPS, creating a significant problem for those APRNs who provide care in practices in which their services are subject to incident-to billing. We raised this concern in our November 15, 2015, comments to you in response to CMS-3321-NC, Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (80 Fed. Reg. 59102; October 1, 2015). At that time we strongly urged the agency to ensure that each service provided to a patient is associated with the actual provider of the service, rather than masked by the billing procedures of a group practice. We referred to previous comments we submitted September 8, 2015, in response to CMS-1631-P, Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions for Part B for Calendar Year 2016 (80 Fed. Reg. 41686, July 15, 2015), emphasizing that the problems associated with practices such as incident-to billing are well recognized: obscuring the rendering provider, seriously undermining the ability of CMS to accurately calculate cost and quality performance and hindering providers from being individually responsible and accountable for the care they render patients.

As we stated last November, we continue to believe that a new payment system that is 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 reflect the rendering provider. While we believe the agency should support efforts to eliminate incident-to billing, we also have recommended the use of modifiers to identify both when a line item in a claim was provided incident-to as well as the licensure of the actual rendering provider. As we have noted, this recommendation is consistent with the third principle of Health Care Payment Learning & Action Network APM Framework Draft White Paper, which states "[t]o the greatest extent possible, value-based incentives should reach providers who directly deliver care." Without establishing a mechanism to ensure transparency and clearly identify the actual provider of a service, it will be impossible to accurately calculate value-based

performance adjusters at a provider-specific level, which will undermine the accuracy of MIPS performance scoring.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

Ensure that Specifications for Clinical Practice Improvement Activities Undergo Proper Stakeholder Comment from APRNs

While CMS states that for the first year of the program MIPS eligible clinicians must designate a yes or no response for meeting clinical practice improvement activities (CPIA), we are unsure about how CMS will assign credit for meeting CPIAs in future years and whether CMS will develop specifications as they do for quality measures. 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, [2] physicians who are governed by medical specialty boards could report quality measures through a medical Maintenance of Certification Program and receive an incentive payment for doing so, but such incentive payment programs were denied to APRNs engaged in analogous professional recertification. We request that the agency afford APRNs the same opportunities as physicians in the development, implementation, and evaluation of CPIAs, and that any certification processes so recognized include those used by APRNs as well as physicians. As such, we ask that any specifications undergo a public comment period prior to finalization for the MIPS program in order to ensure that these activities remain relevant and applicable to APRNs as well as physicians.

DEFINITION OF PHYSICIAN-FOCUSED PAYMENT MODELS

Do Not Exclude APRNs from the Definition of Physician-Focused Payment Models

We were very disappointed to read that CMS was not proposing to broaden the definition of physician-focused payment models (PFPMs) to include other healthcare providers. We urge CMS to reconsider including APRNs in the definition. We remind the agency that APRNs can

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

and do lead payment and care delivery models. Furthermore, the Institute of Medicine (IOM) recommends that government policy expand opportunities for nurses to lead collaborative healthcare improvement efforts, and prepare and enable nurses to lead changes that advance health.[3] Increasingly, the healthcare industry is recognizing APRNs for their leadership role in clinical, educational and academic, executive, board, legislative, and regulatory domains. In addition to their roles as expert healthcare professionals, APRNs are CEOs of hospitals and health systems, chief nursing officers, chairs of regulatory bodies and advisory committees, and have taken many other positions with wide spans of responsibility.

CRITERIA FOR PHYSICIAN-FOCUSED PAYMENT MODELS

Committee Should Evaluate Whether Physician-Focused Payment Models Promote Full Scope of Practice

As part of the proposed criterion for promoting better care coordination, protection of patient safety and patient engagement, CMS should also require that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) evaluate whether PFPMs support and encourage APRNs to practice to their full professional education, skills, and scope of practice. PFPM applicants should be required to document how they will include APRN services, and how they will use APRNs to the fullest extent of their training. Our policy recommendation corresponds with a recommendation from the IOM's report titled *The Future of Nursing: Leading Change, Advancing Health*, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs.[4] The IOM report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."[5] Moreover, the IOM states with regard to one type of APM, the accountable care organizations (ACOs), that "ACOs that use APRNs and other nurses to the full extent of their education and training in such roles as

[3] IOM (Institute of Medicine). The Future of Nursing: Leading Change, Advancing Health (Washington, DC: The National Academies Press, 2011), see Recommendation #2: Expand opportunities for nurses to lead and diffuse collaborative improvement efforts, p.11 and Recommendation #7: Prepare and enable nurses to lead change to advance health, p. 14.

[4] IOM (Institute of Medicine). The Future of Nursing: Leading Change, Advancing Health (Washington, DC: The National Academies Press, 2011), 69.

[5] IOM op. cit. p. 7-8.

health coaching, chronic disease management, transitional care, prevention activities, and quality improvement will most likely benefit from providing high-value and more accessible care that patients will find to be in their best interest."[6]

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,

Academy of Medical-Surgical Nurses, AMSN
American Association of Colleges of Nursing, AACN
American Association of Critical-Care Nurses, AACN Critical Care
American Association of Neuroscience Nurses, AANN
American Association of Nurse Anesthetists, AANA
American Association of Nurse Practitioners, AANP
American Association of Occupational Health Nurses, AAOHN
American Association of Post-Acute Care Nursing, AAPACN
American College of Nurse-Midwives, ACNM
American Nurses Association, ANA
American Society of PeriAnesthesia Nurses, ASPAN
Association for Radiologic and Imaging Nurses, ARIN
Association of Pediatric Hematology/Oncology Nurses, APHON
Association of periOperative Registered Nurses, AORN
Association of Public Health Nurses, APHN
Association of Rehabilitation Nurses, ARN
Association of Women's Health, Obstetric and Neonatal Nurses, AWHONN
Dermatology Nurses' Association, DNA
Gerontological Advanced Practice Nurses Association, GAPNA

[6] IOM op. cit. p. 3-41.

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

National Organization of Nurse Practitioner Faculties, NONPF

Oncology Nursing Society, ONS

Organization for Associate Degree Nursing, OADN

Public Health Nursing Section, American Public Health Association, APHA PHNS