CLINICAL EXPERTISE
NURSING PRACTICE
SYSTEMS INNOVATION

NACNS

National Association of Clinical Nurse Specialists

June 25, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244–8013

ATTN: CMS–5517–P

Dear Sir/Madam:

As the voice of more than 72,000 clinical nurse specialists (CNS), the National Association of Clinical Nurse Specialists (NACNS) exists to enhance and promote the unique, high value contribution of the CNS to the health and well-being of individuals, families, groups, and communities, and to promote and advance the practice of nursing. We, therefore, appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposal regarding ***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 FR 28161). NACNS supports modifications in the healthcare payment system, specifically those that provide equity for reimbursement for all providers who serve Medicare patients.

CNSs are licensed registered nurses who have graduate preparation in nursing (master's or doctorate) as a clinical nurse specialist. They have unique and advanced level competencies that meet the increased needs of improving quality and reducing costs in our healthcare system. CNSs provide ***direct patient care*** across the lifespan – from primary care to acute care and wellness to illness – including assessment, diagnosis, and management of patient healthcare issues.

The CNS is one of the four advanced practice registered nurse (APRN) categories recognized by the National Council of State Boards of Nursing, individual state boards of nursing, and the American Nurses Association. The role is built on clinical expertise and its nationally accepted competencies articulate the scope of this clinical practice, including the diagnosis and treatment of acute or chronic illness in an identified population with emphasis on specialist care.

The clinical nurse specialist has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres overlap and interrelate, but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity.

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She or he may work independently or as part of a multidisciplinary healthcare team. CNSs are leaders of change in healthcare organizations, developers of scientific evidence-based programs to prevent avoidable complications – including preventing hospital acquired infections, reducing length of stays, and preventing hospital readmissions – and coaches of those with chronic diseases to prevent hospital readmissions. They serve as coordinators of specialized care, and implementers of evidence-based care within/between organizations to facilitate quality improvement, patient safety, and lower healthcare costs. CNSs prescribe medications, durable medical equipment, and medical supplies, as well as order, perform, and/or interpret diagnostic tests including lab work and x-rays. They also may instruct registered nurses and other healthcare professionals working in clinical settings.

Repeatedly, APRNs have demonstrated a high quality of service within the Medicare program. CNSs are recognized for Part B participation in Medicare, Title 18, and may independently bill for these services. They also are eligible for the ***Affordable Care Act's*** Medicare Primary Care Incentive Program. The implementation of these regulations will give CMS the opportunity to recognize the utilization of APRNS, including CNSs, **at their full scope of practice.** Specifically, we are referencing 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. With the expected increase of beneficiaries from 40 million to approximately 80 million in the next few years, it is crucial that CMS set the stage for offering quality, cost-effective healthcare services provided by APRNS, including the CNS.

NACNS is a member of the APRN Workgroup, a coalition of organizations that represent APRNs. NACNS supports the comments submitted by this coalition and have reinforced many of these points within our own comments that follow.

IMPACT ON SMALL PRACTICES

NACNS is concerned that the final rule may put in place regulations that could create problems for small practices attempting to implement the new provisions. Generally, NACNS can support the "cut-off" for the low volume threshold (100 Medicare patients *and* $10,000 in Medicare charges) as reasonable, but we ask that CMS clarify in the final rule that this cut off level will not be used to penalize practices. We suspect that due to the workflow and patient types with whom the CNS and perhaps other APRNs work that it might be better to have a 100 Medicare patients **or** $10,000 in Medicare charges as the cut off. CNSs are specialists and while they may provide primary care and ambulatory care services, they also may provide higher acuity care to certain patients. In addition, there is a risk that practices that provide services to more pediatric and/or women's health Medicare patients and/or private pay patients may not meet this threshold, and yet would benefit from being included in the scope of this regulation. Because of this, we ask that these "exclusions" and others in the proposed regulation be clearly identified and implemented as waivers to assist all practices in the value based payment endeavor regardless of clinician makeup or size.

GUIDELINES AND REQUIREMENTS FOR CERTIFIED EHR TECHNOLOGY

The National Association of Clinical Nurse Specialists supports the creation of incentives for advancing healthcare information. However, we also strongly urge that CMS include in the guidelines/requirements for certified electronic health record (EHR) technology, a requirement for inclusion of providers

other than physicians. The current software that is available often does not allow providers, other than physicians, to make entries or be identified as a provider. This is clearly a design flaw and one that will limit the full and cost-effective use of all healthcare providers within the Medicare system. It is essential that value-based payment endeavors actually credit the correct provider. This is particularly true with hospital EHR systems, the site where the majority of CNSs practice.

It is essential that the final regulations require that EHRs identify the clinical work of all CMS providers. In addition, it is critical that the companies that develop EHR systems be required to utilize APRNs, specifically CNSs, as participants and consultants in the development of EHR software.

FINANCIAL AND TECHNICAL ASSISTANCE IN ADOPTING AND USING CERTIFIED EHR TECHNOLOGY

CMS recognizes the statutory limits on APRNs to participate fully 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***. 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. NACNS understands 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 also know that many APRNs, including CNSs, have and continue to make efforts to adopt and use certified EHR technology despite the lack of financial incentives available to other providers. NACNS believes that those who can adopt such technology should have the option to participate in the advancing care information performance category in 2017. We also urge the agency to use its full authority to provide financial and technical assistance to support APRNs in adopting and using this technology.

SERVICE PROVIDED TO A PATIENT

The below comments 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)
- 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, CMS proposes to reweight the remaining performance categories. The rule proposes two reweighting options; both 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.

As part of the APRN Workgroup, NACNS brought forth this concern in the Workgroup's November 15, 2015, comments 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 FR 59102). At that time, we strongly urged the agency to ensure that each service provided to a patient be associated with the actual provider of the service, rather than masked by the billing procedures of a group practice. We

emphasized that the problems associated with practices such as incident-to billing are well recognized: obscuring the actual provider, seriously undermining the ability of CMS to calculate accurately cost and quality performance and hindering providers from being individually responsible and accountable for the care they deliver to patients.

NACNS reaffirms its concern that CMS must implement a new payment system that is designed to incentivize high quality, value-based services that clearly and consistently identify the *actual provider of a service*, as well as to ensure that Medicare claims do the same. While we believe the agency should support efforts to eliminate incident-to billing, NACNS also has recommended the use of modifiers to identify when a line item in a claim was provided incident-to as well as the licensure of the actual rendering provider. This recommendation is consistent with the third principle of the ***Healthcare 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 calculate accurately value-based performance adjusters at a provider-specific level, which will undermine the accuracy of MIPS performance scoring.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

NACNS requests that CMS give APRNs the same opportunities as physicians in the development, implementation, and evaluation of clinical practice improvement activities (CPIA). In addition, any certification processes recognized should include those used by APRNs as well as physicians. These specifications should undergo a public comment period prior to the MIPS program finalization in order to ensure that these activities remain relevant and applicable to APRNs as well as to physicians.

We believe this action is important despite the section of the proposed rulemaking that notes that for the first year of the program MIPS eligible clinicians must designate a yes or no response for meeting CPIAs. NACNS is concerned about the practice beyond the first year of the program. It is important that CMS identify how the agency will assign credit for meeting CPIAs in future years and whether CMS will develop specifications as they do for quality measures.

DEFINITION OF PHYSICIAN-FOCUSED PAYMENT MODELS

NACNS is disappointed to read that CMS was not proposing to broaden the definition of physician-focused payment models (PFPM) to include other healthcare providers. We urge CMS to reconsider including APRNs in the definition since APRNs can and do lead payment and care delivery models. Furthermore, the Institute of Medicine recommends that government policy expand opportunities for nurses to lead collaborative healthcare improvement efforts, and prepare and enable nurses to lead changes that advance healthcare.[1] 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

[1] 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.

health systems, chief nursing officers, chairs of regulatory bodies and advisory committees, and have taken many other positions with a wide range of responsibility.

CRITERIA FOR PHYSICIAN-FOCUSED PAYMENT MODELS

As part of the proposed criterion for promoting better care coordination, protection of patient safety and patient engagement, CMS also should require that the Physician-Focused Payment Model Technical Advisory Committee 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.[2] The IOM report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."[3] Moreover, the IOM states with regard to one type of APM, the accountable care organizations (ACOs), that "ACOs that use APRNs, [including CNSs] and other nurses to the full extent of their education and training in such roles as 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."[4]

If you have any questions or require additional information, please feel free to contact Melinda Mercer Ray, MSN, RN, NACNS Executive Director, at 703-929-8995 or via email at mray@nacns.org.

Sincerely yours,

Sharon Horner, PhD, RN, MC-CNS, FAAN
President

[2] IOM (Institute of Medicine). The Future of Nursing: Leading Change, Advancing Health (Washington, DC: The National Academies Press, 2011), 69.
[3] IOM op. cit. p. 7-8.
[4] IOM op. cit. p. 3-41.