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December 21, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9937-P
PO Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: CMS-9937-P – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 – Proposed Rule (80 Fed. Reg. 75488 December 2, 2015)

Dear Administrator Slavitt:

On behalf of the American Nurses Association (ANA), we are pleased to provide comments on CMS-9937-P – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 – Proposed Rule (80 Fed. Reg. 75488 December 2, 2015). As the only full-service professional organization representing the interests of the nation's 3.4 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1]

Inadequate Network Adequacy Standards for APRNs

ANA has serious concerns regarding the approaches proposed in the Benefit and Payment Parameters notice for 2017.

- By endorsing a continuation of existing private insurance practices CMS endorses extending discrimination against APRNs.
- The continued exclusion of APRNs from credentialing into private QHP networks violates Public Health Services Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5).[2]

[1]The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

[2] Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law.

- Patients of the resulting out-of-network APRNs face higher copayment rules, potentially disrupting patient/clinician relationships.
- CMS sanctioning of exclusion of APRNs endorses anti-competitive practices within Federally Facilitated Exchanges (FFEs).
- ANA is encouraged by the proposed rules for maintenance of up-to-date and accurate provider directories, but based on recent evidence, strict enforcement of those rules will be required.

As reported in the 2017 Proposed Rule, CMS is anticipating a final statement from the National Association of Insurance Commissioners (NAIC) regarding a Network Adequacy Model Act that would highlight and perhaps resolve the issues of promulgating network adequacy protections. CMS proposes that FFEs would rely on State reviews for network adequacy in States in which an FFE is operating, provided that HHS determines that the State uses an *acceptable quantifiable network adequacy metric commonly used in the health insurance industry* to measure network adequacy, approved by HHS. While this might prove an adequate approach with respect to hospitals and physicians, **zero** APRNs has been the all too often "quantifiable network adequacy metric commonly used in the health insurance industry" regarding credentialing APRNs into private health insurance networks. In a July 17, 2013 letter to CMS Administrator Marilyn Tavenner, ANA cited numerous studies from the literature documenting private health insurers' common practice of ignoring, if not distaining the inclusion of APRNs into private health insurance networks. These practices have continued despite research documenting the high quality of services provided by APRNs (and the high patient satisfaction therewith).

The American College of Nurse-Midwives surveyed QHPs in 2014 with respect to their inclusion of CNMs in the Exchanges. The findings[3] suggest that historical patterns of practice involving credentialing APRNs have been adopted by the QHPs.

- Twenty percent of plans do not contract with CNMs to include them in their provider networks.
- Seventeen percent of plans do not cover primary care services offered by CNMs.
- Fourteen percent of plans indicated they impose restrictions on CNM practice that conflict with their scope of practice under state laws and regulations.
- Twenty-four percent of plans will not cover CNM professional services provided in a birth center and 56% will not reimburse CNMs for home birth services.
- Ten percent of plans that contract with CNMs do not list them in their provider directories, making them invisible to potential and current enrollees.
- Forty percent of plans listing CNMs in their provider directories only list them under the obstetrician-gynecologist category, which may make it difficult for women searching for "midwives" to find them.

No evidence has been advanced of any more inclusive approach to credentialing any of the other APRN roles exhibited by QHPs in general.

[3]American College of Nurse-Midwives. September 2014. Ensuring Access to High Value Providers: ACNM Survey of Marketplace Insurers Regarding Coverage of Midwifery Services.

One observes a different pattern in credentialing exhibited by the single largest health insurer in the health insurance industry: Medicare Part B. In 2013 the third largest clinical specialty of enrolled Medicare Part B providers was "nurse practitioners" with 64,696 individual NPs providing services directly billed to Medicare carriers using NP NPIs. In PQRS records CMS identified another 17,864 NPs whose services apparently were billed "incident to." CMS records from PQRS for 2013 indicate there were 52,111 CRNAs providing services to fee-for-service Part B beneficiaries. There were no carriers reporting zero APRN participation. All of Medicare's Part B carriers are also private health insurers. They process enrollment applications from APRNs and vet the applicants' education and other credentials. This is not a novel or exceptionally onerous task. Given that there are more than 300,000 practicing APRNs in the country there should be no QHPs approved that do not include APRNs in their FFE networks.

The challenge of QHPs without APRNs or severely limited numbers of APRNs in their proposed networks is that such practices can disrupt existing patient/clinician relationships and can impose a financial barrier to new patient/clinician relationships with APRNs. If APRN participation is limited by QHP credentialing practices APRNs will be relegated to out-of-network status. Patient cost-sharing for those patients who do want to elect to receive services from an APRN will be higher. In fact, at least one QHP has been reported as providing no out-of-network coverage. Given that APRNs in all four of the APRN roles can provide Essential Health Benefits, this can reduce patient access to mandated health services. This is not a recipe for service to QHP enrollees. Further, while the proposed rules would allow a patient's out-of-network charges for covered services provided in in-network facilities to be included with respect to the patient's annual out-of-pocket limit, out-of-network APRN office services would not be included. And, as the CNM survey has shown out-of-network places of service can also include birthing centers.

Finally, federal acquiescence in QHP discriminatory policies essentially endorses anti-competitive behavior on the part of QHPs. Many observers believe that preventing potential competition between physicians and APRNs is at the root of discriminatory health insurer behavior. Instead CMS should be enforcing section 2706 by requiring FFEs and QHPs to encourage and invite APRNs to apply for credentialing in their networks. All applicants should be vetted on a level playing ground.

The proposed rules for provider directories are an improvement. However, as the CNM survey has shown the current operation of some provider directories has passed over certified nurse-midwives. This has also been the case with CMS's own "Physician Compare" website. APRNs have been omitted and/or not included under reasonable key words or phrases such as "primary care." All in-network providers ought to have their directory information included accurately and in a timely manner. Patient key word searches should not otherwise be filtered by clinical specialty. Notices of change of office address or practice hours or acceptance of new patients submitted by providers to the relevant QHP ought to be posted within one month of receipt by the QHP.

We appreciate the opportunity to share our views on this matter and welcome the opportunity to discuss these issues in greater detail. If you have questions, please contact Peter McMenamin, Ph.D., Senior Policy Advisor-Health Economist at peter.mcmenamin@ana.org or 301-628-5073.

Sincerely,

Debbie Hatmaker

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer