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Submitted via www.regulations.gov

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1631-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: 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)

Dear Mr. Slavitt:

On behalf of the undersigned organizations, we are pleased to provide comments on this Request for Information (RFI) 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).

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

MACRA Implementation Should Ensure Robust Patient Access to APRN Services, and APRNs Should Be an Integral Part of its Planning and Implementation

We urge the Centers for Medicare and 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. As it implements the Medicare Access and CHIP

Reauthorization Act (MACRA),[1] the Medicare agency should use its full authority to waive policy barriers to the use of APRNs, particularly as it carries out Alternative Payment Models (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 in that light.

We also recommend that procedures and tools utilized to implement MACRA be kept simple and straightforward so that clinicians will be able to implement without detracting from delivering care to their patients. Further, we also recommend that the tools and procedures utilized reflect the practices of all providers and that APRNs be an integral part of the planning and implementation of this statute.

MIPS EP IDENTIFIER AND EXCLUSIONS

Ensure that Each Service Provided to a Patient is Associated with the Actual Provider of the Service

In the agency's effort to select and operationalize a specific identifier to associate with individual Merit-Based Incentive Payment System MIPS eligible providers (EPs), we strongly urge 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. As we pointed out in comments submitted September 8, 2015, in response to Centers for Medicare & Medicaid Services (CMS) proposed rule revising payment policies under the Medicare Part B fee schedule

[1] Pub L. 114-10.

for calendar year 2016 (80 Fed. Reg. 41686, July 15, 2015),[2] the problems associated with practices such as incident-to billing are well recognized. The practice of incident-to billing obscures 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.

A new payment system 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. With regard to the current payment system, we have recommended that Medicare establish 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. This recommendation is consistent with the third principle of Health Care Payment Learning & Action Network (LAN) Alternative Payment Model (APM) Framework Draft White Paper, which states "[t]o the greatest extent possible, value-based incentives should reach providers who directly deliver care."[3] Without establishing a mechanism to gather this type of clear data, CMS will be unable to accurately calculate value-based performance adjusters at a provider-specific level.

QUALITY PERFORMANCE CATEGORY—REPORTING MECHANISMS AVAILABLE FOR QUALITY PERFORMANCE CATEGORY

Performance Mechanisms Should be Subject to All Appropriate Stakeholders' Review in Order to Qualify for Use as a Reporting Mechanism for Quality Indicators

We urge CMS to maintain all PQRS reporting mechanisms under MIPS including claims-based reporting, and APRNs should not be forced to participate in a physician specialty association qualified clinical data registry (QCDR). Many QCDRs have been developed by physician specialty societies and are currently not subject to a transparent interdisciplinary consensus evaluation processes, which impair their credibility especially when those physician services are

[2] 80 Fed. Reg. 41686, July 15, 2015, see comments at http://www.regulations.gov/#!documentDetail;D=CMS-2015-0081-1697.

[3] See https://publish.mitre.org/hcplan/wp-content/uploads/sites/4/2015/10/2015-10-23-APM-Framework-White-Paper-FPO.pdf, page 7.

also provided by APRNs excluded from their QCDRs in important ways. By contrast with QCDR data that has not been subject to extensive interdisciplinary accountability, we strongly support the use of quality measures that are transparent, actionable, evidence-based, patient-centered and consensus-driven. Quality measures development, implementation and evaluation should take into account all appropriate stakeholders, including APRNs. For this reason, we specifically support measures that are endorsed by the National Quality Forum (NQF), which includes a wide variety of healthcare stakeholders and employs a rigorous process of accountability to assure validity and reliability.

QUALITY PERFORMANCE CATEGORY—DATA ACCURACY

Keep in Mind Fairness and Accuracy of Measures

We appreciate the agency's concern over data accuracy and believe that while this is important, CMS should also be concerned with the validity, importance and fairness of the measures in relation to maintaining data integrity. As stated earlier, we remind CMS that many QCDRs have been developed by physician specialty societies and are not subject to a transparent interdisciplinary consensus evaluation process. The Federal Trade Commission has noted that physician specialty societies use policy advocacy to impair or eliminate competition, increasing healthcare costs and reducing access to care without improving quality,[4] and Medicare recognition of physician specialty society sponsored QCDRs poses precisely the same anticompetitive and harmful risk. Furthermore, we oppose the agency propagating quality measures that have not met a legitimate stakeholder consensus development process. For these reasons, we specifically support measures that are endorsed by the National Quality Forum (NQF), which includes a wide variety of healthcare stakeholders and employs a rigorous process of accountability to assure validity and reliability.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

[4] Federal Trade Commission (2014, March). Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses. Retrieved from http://www.ftc.gov/system/files/documents/reports/policy-perspectivescompetition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

Do Not Include Participation in the Network of Plans in the Federally-Facilitated Marketplace as Part of the Subcategory of Promoting Health Equity and Continuity as Participation in a Network May be Beyond an EPs Control

We support the agency's efforts and goals in ensuring that Medicaid beneficiaries are included as part of the subcategory of promoting health and equity. Furthermore, we believe that patients benefit the greatest from a healthcare system where they receive easily accessible care from an appropriate choice of safe, high quality and cost-effective providers, such as APRNs. However, we have concerns about agency's proposal to include participation in a network of plans in the Federally Facilitated Marketplace as part of this subcategory. We note that healthcare carriers predominately determine providers to include in a network, and network participation is often not left up to the EP. For this reason, we would request that CMS not include participation in a network of plans in a Federally-Facilitated Marketplace as part of a subcategory of promoting health and equity.

Ensure Equal Treatment among APRNs and Physicians Under Clinical Practice Improvement Activities

As we noted in comments submitted September 8, 2015, in response to CMS's proposed rule revising payment policies under the Medicare Part B fee schedule for calendar year 2016 (80 Fed. Reg. 41686, July 15, 2015), we urge that the clinical practice activities capture and recognize the contributions of APRNs in every instance. 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,[5] 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 all APRNs the same opportunities as physicians in the development, implementation and evaluation of clinical practice improvement activities, and that any certification processes so recognized include those used by APRNs as well as for physicians.

DEFINITION OF PHYSICIAN-FOCUSED PAYMENT MODELS

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

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

We urge CMS to include APRNs in the definition of physician-focused payment model. We remind the agency that APRNs can 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.[6] 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

We are concerned to see that the newly appointed Physician-Focused Payment Model Technical Advisory Committee has no APRNs despite the fact that APRNs will be an integral part of whatever new payment models are developed. We request that the agency work with the U.S. Government Accountability Office to have proportional APRN representation on this Technical Advisory Committee and would be happy to offer nominations.

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

A criterion that the Physician-Focused Payment Model Technical Advisory Committee should consider in evaluating physician-focused payment models (PFPMs) is whether they support and encourage APRNs to practice to their full professional education, skills, and scope of practice. Applicants also should be required to document how will include high-quality, cost-effective APRN services, and how they will use APRNs to the fullest extent of their training. Our policy

[6] 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.

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.[7] The IOM report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."[8] Moreover, the IOM states with regard to one type of APM, the accountable care organization (ACO), that "ACOs that use APRNs 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."[9]

We thank you for the opportunity to comment on the request for information. 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,

American Academy of Nursing, AAN
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
National Association of Clinical Nurse Specialists, NACNS
National Association of Pediatric Nurse Practitioners, NAPNAP
National League for Nursing, NLN

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