



June 27, 2016

Honorable Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5517–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Submitted electronically to www.regulations.gov

Re: [Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule](#)

Dear Acting Administrator Slavitt:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the proposed rule, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model Incentive (APM) under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. As the only full-service professional organization representing the interests of the nation's 3.6 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 (APRN) roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).¹

I. Certified Electronic Health Information Technology and Interoperability and Future Proposed Advancing Care Information Health IT Measures

The Notice of Proposed Rulemaking (NPRM) seeks comment on how the requirements for the use of certified EHR technology (CEHRT) within APMs could evolve to support expanded participation in organizations supporting Health Information Exchange (HIE). With regard to this issue, we urge CMS to include in guidelines for CEHRT a requirement for attribution of the work of non-physician providers, such as APRNs. Current software programs, particularly those used in hospital EHRs, should ensure that clinicians other than physicians are able to make entries or sufficiently attribute the care they have provided.

¹The 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.

In addition, we urge CMS to avoid any guidance that would assign to the nurse the role of acting as a scribe for physicians. Like physicians, nurses are involved in direct patient care that drives outcomes and quality. Limiting the ability of nurses to provide such care by shifting the entry of data from the physician to the nurse could have a significant, detrimental impact on the quality of care delivered to patients. We urge CMS to keep these limitations in mind when creating incentives for advancing care information, and to promote transparency in software certified by CMS for use in the Quality Payment program.

We support efforts to advance interoperability, including requirements to assure that the users of certified electronic health record (EHR) technology implement the technology in a manner that supports and does not interfere with or block the electronic exchange of health information among health care providers and with patients. Interoperability is essential to improve quality and promote care coordination.

The Office of the National Coordinator for Health Information Technology (ONC) has asked private sector partners (including health information technology developers, health systems, and provider, technology and consumer organizations) to sign an [Interoperability Pledge](#) addressing three shared commitments around interoperability including consumer access, no data blocking and standards. The [April 19th letter from ANA to ONC](#) articulates ANA's commitment to the three shared principles around interoperability including consumer access, no data blocking and standards.

CMS also calls for *Meaningful Use Prevention of Information Blocking and Surveillance Demonstrations for MIPS Eligible Clinicians, EPs, Eligible Hospitals, and CAHs*. ANA is generally supportive of the attestation requirements CMS is proposing that would consist of three statements related to health information exchange and information blocking to provide the Secretary “with adequate assurances that an eligible clinician, eligible provider, eligible hospital, or CAH has complied with the statutory requirements for information exchange” (pages 28172, 28386).

The proposed rule states:

We additionally seek comment on the concept of a holistic approach to health IT—one that we believe is similar to the concept of outcome measures in the quality performance category in the sense that MIPS eligible clinicians could potentially be measured more directly on how the use of health IT contributes to the overall health of their patients. Under this concept, MIPS eligible clinicians would be able to track certain use cases or patient outcomes to tie patient health outcomes with the use of health IT.

In making this request, CMS recognizes that “technology and measurement for this type of program is currently unavailable” (pages 28217-28218).

ANA supports initiatives to advance the “concept of a holistic approach to health IT” and “directly link health IT adoption and use to patient outcomes,” but strongly encourages the development of these innovative measures to be based upon data and research that demonstrates their reliability and validity. ANA also advocates for the inclusion of additional advancing care information measures, when feasible, to be based upon the seamless capture of this data from documentation that is already being recorded in the EHR, as opposed to adding additional documentation burdens that may take away from time spent providing direct care.

II. MACRA Effects on APRNs Enrolled as Medicare Part B Providers: Loss of existing incentive programs with limited opportunity for continued participation

APRNs enhance value for patients and provide excellent care where it is most needed. In every setting and region, particularly for populations in rural and medically underserved areas, APRNs advance both access to health care and the delivery of high quality, cost-effective healthcare. To date, their services have not been effectively utilized and at best have only partially been recognized.

As of January 2016 there were 205,038 APRNs enrolled as Part B providers; 6,022 certified nurse-midwives are included in the total, but are not eligible for Medicare Access and CHIP Reauthorization Act (MACRA) programs. APRNs had been overlooked, i.e., not included, in the Medicare EHR program and they were not scheduled to be eligible for the Value Based Modifier program until 2019. Ostensibly the switch to MACRA could offer new Part B incentive opportunities not previously available to APRNs. APRNs in all four roles had participated in the [Physician Quality Reporting System](#) (PQRS). In 2013, 56,006 APRNs (including 804 CNMs) were awarded \$5,674,574 in PQRS incentive payments for high quality.

ANA is concerned that prospective participation in MIPS will be an empty promise for most APRNs. The threat to their participation lies in the size thresholds: at least 100 Part B patients and at least \$10,000 in Medicare approved charges. As was evident in Table 63 from the NPRM, average approved charges per individual clinician (across the APRN roles) range from \$26,000 to nearly \$34,000, compared to the average across all Part B clinicians of \$95,366. In fact, more than half of the APRN Part B providers will be excluded because of small practice size. The CMS Open Payments Data from 2014 were used to review the approved charges and Part B patient counts for each of the four APRN roles. Summary data are presented in the table below:

Table A

Role	2014 Open Payment Data #NPIs	median clinician patient counts	2014 <\$10,000 or <100	Effective Exclusion %	2016 Part B provider count	Projected exclusions based on 2016 enrollment
CNM*	753	21	730	100%	6,022	6,022
CNS	2,042	80	1,207	72.6%	3,386	2,459
CRNA	39,100	141	12,662	42.3%	50,889	21,538
NP	73,816	109	37,655	59.2%	144,781	85,695
Total	115,711	xxxxx	52,254	53.8%	205,078	110,430

* Automatically excluded. 99.3% would be excluded for not exceeding the size thresholds.

The patient counts of the median clinician in each role give an indication of the generally small size of practices. The data were also adjusted to reflect the absence of many APRN practices from the Open Payments Data because of very small patient counts. When the effective exclusion percentages were applied to the 2016 provider counts, more than half of APRNs will be excluded from MIPS at the outset. (There may be higher patient counts and approved charges for APRNs in 2017 as practices grow in size. There will also be continuing growth in the number of APRNs enrolled as Part B providers, so average sizes could actually get smaller as well.)

Had CNMs been included in MACRA, 99.3% would have been excluded because of low numbers of Medicare Part B patients. As it is, more than 40% of CRNAs can expect to be excluded; nearly 60% of NPs will be excluded; and nearly three quarters of CNSs will be excluded. The opportunity to earn Medicare EHR bonuses

through MIPS will likely be unrealized, as most APRNs will continue to be excluded regardless of their EHR status. For many APRNs who are Part B providers, MACRA will offer no replacement incentive programs for recognizing quality and efficiency. ANA urges CMS to use its full authority to provide financial and technical assistance to include APRNs in adopting and using this technology”

III. APRN Services Unrecognized

The [White Paper on an Alternative Payment Models Framework](#) (Framework), issued by CMS Health Care Payment Learning & Action Network (LAN) in October 2015, enunciated several principles regarding payment and value. Principle 3 states that to the greatest extent possible, value-based incentives should reach providers who directly deliver care. This principle is violated in “incident to” billing, and the NPRM does not take steps to specifically further implement Principle 3. As a result, APRNs’ MIPS Composite Scores will be biased downward because services provided to Part B beneficiaries but billed incident to a physician service will be attributed to physicians rather than to the APRNs who actually serve those patients.

ANA continues to recommend that CMS establish modifiers to be used to identify both when a line item in a claim was provided incident-to as well as the National Provider Identifier (NPI) /licensure of the actual rendering provider. As CMS noted in its response to the 2015 Physician Fee Schedule NPRM, more and more of those services are not the incidental items that physicians would not separately itemize on a claim back in the 1960s. As CMS moves toward increasing the value component of Part B payment, Principle Three should be paramount. For NPs and CNSs, “incident to” primary care services may have contributed to physicians’ Medicare Primary Care Incentive payments (PCIP) while leaving some of those APRNs short of the 60% threshold needed to qualify for those incentive payments. Among the 52,062 NPs enrolled as Medicare Part B providers in 2010 and eligible for PCIP in calendar year 2012, there were 35,080 awardees, more than two thirds of the eligible NPs. NP winners of PCIP awards received \$49,693,372. Three quarters of NPs might have received PCIP awards but for unrecognized “incident to” services. NPs are certainly primary care providers.

IV. APRN participation in APMs

Although NPs, CRNAs, and CNSs were included in the description of APMs under MACRA, 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. It has long been the case that private health insurers have not credentialed APRNs in their networks. If the networks for qualified health plans (QHPs) in Federally-facilitated Exchanges (FfEs) are any example, APRN participation in APMs is not guaranteed. It appears that this pattern of excluding APRNs in network designs is repeating itself with respect to the FfEs. The [American College of Nurse-Midwives surveyed QHPs in 2014](#) with respect to their inclusion of CNMs in the Exchanges. They found that 20% of the QHPs did not contract with CNMs, and 40% of plans listing CNMs in provider directories included them in an obstetrician-gynecologist section making them invisible to patients searching for midwives. (Similarly, CMS itself exhibited this type of behavior. While CMS indicated that NP practices were eligible to participate in the initial Comprehensive Primary Care initiative, 2000 primary care practices were enrolled in five states, but not one of them was run by an NP. We urge CMS to keep this outcome in mind when structuring and implementing APMs.

A further challenge of this exclusionary behavior is that APRNs who have pre-existing relationships with patients who elect to join such a QHP will not be credentialed into that QHP’s networks, and will be considered out-of-network providers. Clearly, this raises the effective cost-sharing rates for their patients, thus jeopardizing existing patient-clinician relationships.

There is also a question of the coverage of APMs across the country. MACRA implicitly appears to assume that eligible providers will have the opportunity to choose to participate with one or more APMs in their geographic area of practice. The development of necessary provider organizations with sufficient capitalization in all localities in the U.S. is also not guaranteed. APMs located in rural areas are likely to be rarities. The opportunities for an enrolled APRN Medicare Part B provider to meaningfully join an APM may be severely limited based on both rural location and on the lack of welcoming behavior with respect to APM networks.

V. Merit-based Incentive Payment System Identifier and Exclusions

ANA continues to urge CMS to ensure that each service provided to a patient is associated with the actual provider of the service. As pointed out in ANA [comments submitted September 4, 2015](#), in response to CMS' proposed rule revising payment policies under the Medicare Part B fee schedule for calendar year 2016 (80 Fed. Reg. 41686, July 15, 2015), 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.

The importance of this issue is highlighted by the reweighing proposals in this NPRM. If MIPS eligible clinicians are unable to participate in the advancing care information performance category, CMS proposes to reweigh the remaining performance categories. Such a proposal increases the importance of the quality performance category in determining the composite performance score (CPF) and would create a significant problem for APRNs whose services to Part B beneficiaries are billed "incident to."

It is essential to consistently and clearly identify the eligible provider actually accountable for rendering the service in order to incentivize high quality, value-based care, as well as attribution to the members of the clinical team actually providing services in order to inform a "Learning Health System." We urge CMS to support efforts to eliminate "incident to" billing. In addition, we recommend that CMS establish modifiers to identify when a line item in a claim was provided "incident to" as well as the licensure and NPI of the actual rendering provider. Again, this is consistent with the third principle of Health Care Payment (LAN) Framework that states "[t]o the greatest extent possible, value-based incentives should reach providers who directly deliver care." 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.

VI. Clinical Practice Improvement Activities

MIPS eligible clinicians must designate a yes or no response for meeting clinical practice improvement activities (CPIA) during the first year. It is unclear, though, how CMS will assign credit for meeting CPIAs in future years and whether CMS will develop specifications as they do for quality measures. It is essential that CMS treat processes used by APRNs in the same manner as processes of 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. Such incentive payment programs, however, were denied to APRNs engaged in analogous professional recertification. We request that CMS afford APRNs the same opportunities as physicians to develop, implement, and evaluate CPIAs, and that any certification processes

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

recognize those used by APRNs as well as physicians. Prior to finalization for the MIPS program, we urge CMS to ensure that these activities remain relevant and applicable to APRNs as well as physicians by having specifications undergo a public comment period.

VII. Physician-Focused Payment Models

We urge CMS to reconsider the decision against broadening the definition of physician-focused payment models (PFPMs) to include APRNs. APRNs can and do lead payment and care delivery models. In addition, the Institute of Medicine (now the National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division) recommended 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 The healthcare industry is increasingly recognizing APRNs and other nurses 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 and other nurses serve as CEOs of hospitals and health systems, Chief Nursing Officers (CNOs), chairs of regulatory bodies and advisory committees, and many other positions with wide spans of responsibility.

VIII. Expansion of MIPS-Eligible Clinicians

During the first and second year for which MIPS applies to payments (and the performance period for such years) a MIPS eligible clinician is defined by statute. However, the statute also provides flexibility to the Secretary to specify additional eligible clinicians (as defined in section 1848(k)(3)(B) of the Act) as MIPS eligible clinicians in the third and subsequent years of MIPS. ANA urges the Secretary to use this authority to include CNMs as eligible clinicians.

We appreciate the opportunity to share our views on this matter. If you have questions, please contact Mary Beth Bresch White, Director, Health Policy (marybreschwhite@ana.org).

Sincerely,



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

³IOM (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.