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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS–5517–P  
P.O. Box 8013  
Baltimore, MD 21244–8013

Submitted via: <http://www.regulations.gov>

**Re: 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 [CMS–5517–P]**

The National Nurse-Led Care Consortium (NNCC) appreciates the opportunity to offer Centers for Medicare and Medicaid Services (CMS) these comments on the proposed rule to implement the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The National Nurse-Led Care Consortium (NNCC) is a 501(c)(3) nonprofit public health organization that seeks to advance all forms of nurse-led care through policy development, technical assistance, and innovative programing. One of the types of centers NNCC represents is nurse-managed health clinics (sometimes called nurse-managed health centers or NMHCs). Section 254c-1a of the Public Health Service Act defines the term ‘nurse-managed health clinic’ as a “nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center (FQHC), or independent nonprofit health or social services agency.”<sup>1</sup> Recent estimates indicate that there are approximately 500 nurse-managed clinics nationwide, including birthing centers and nurse-led school-based clinics. NMHC care is directed by nurse

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<sup>1</sup> 42 U.S.C.A. § 254c–1a(a)(2) (West 2012).

practitioners and other advanced practice nurses offering a wide range of primary care, health promotion, and disease prevention services to low-income, vulnerable patients living in medically underserved areas. Nationally, NMHCs record about 250,000 patient encounters each year. The majority of NMHC patients are either Medicaid recipients, uninsured or self-pay.

Because many NMHCs are affiliated with schools of nursing, NMHCs also help to build the capacity of the community-based health care workforce by acting as teaching and practice sites for nursing students and other health professionals. Each academically-affiliated NMHC provides clinical placements for an average of 50 to 60 students a year.<sup>2</sup> These students include graduate and undergraduate nursing students, as well as medical, physician assistant, and social work students, among others. Students participating in post-clinical focus groups express a high level of satisfaction with NMHC-based clinical placements, commenting that their experience in NMHCs highlighted the need to reduce health care disparities and respect patient diversity.<sup>3</sup>

Outcome data from managed care organizations and academic research journals show that NMHCs provide accessible high quality care that is also cost effective. The nurse practitioners in NMHCs can manage 80 to 90 percent of the care provided by primary care physicians without referral or consultation.<sup>4</sup> According to a 2011 meta-analysis of peer-reviewed articles regarding the quality of nurse practitioner-provided care, primary care nurse practitioners continually produced patient health outcomes comparable to those of primary care physicians.<sup>5</sup> With respect to cost, NMHC patients typically have higher rates of generic medication fills and lower hospitalization rates than patients of similar providers.<sup>6</sup> Additionally, elderly and disabled people with access to NMHCs visit emergency rooms less often than those without access.<sup>7</sup>

The proposed rule establishes MIPS, which consolidates components of the Physician-Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Records (EHR) Incentive Program for eligible professionals. The section below details some concern for retail clinics within the rule.

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<sup>2</sup> NNCC, 2012 NNCC Membership Survey (2012)

<sup>3</sup> Institute for Nursing Centers, Feedback From Student Focus Group Surveys Administered by the Institute for Nursing Centers in 2009 (2009).

<sup>4</sup> Munding, M.O. (1994). Advanced-practice nursing -- good medicine for physicians? *New England Journal of Medicine*, 330(3), 211-214.

<sup>5</sup> Newhouse N.P., Stanik-Hutt J., White, K.M., Johantgen, M., Bass E.B., Zangaro G., Wilson R.F., Fountain L., Steinwachs D.M., Heindel L., Weiner J.P. (2011). Advanced practice nurse outcomes 1990-2008: a systemic review. *Nursing Economic*, 29(5) Published Online Before Release, available at: <http://www.nursingconomics.net/cgi-bin/WebObjects/NECJournal.woa>.

<sup>6</sup> Hansen-Turton, T. (2005). The nurse-managed health center safety net: a policy solution to reducing health disparities. *Nursing Clinics of North America*, 40, 729-738.

<sup>7</sup> Glick, D. F., Thompson, K. M., & Ridge, R. A. (1999). Population-based research: The foundation for development, management, and evaluation of a community nursing center. *Family & Community Health*, 21(4), 41-50.

## General Comments

NNCC urges CMS to ensure that all initiatives developed under MIPS support full access to nurse practitioners (NP) and other types of advanced practice nurses (APN), including certified nurse-midwives (CNM), certified registered nurse anesthetists (CRNA), and Clinical Nurse Specialists (CNS). NPs and APNs play a significant role in ensuring Medicare and other patients have access to cost effective, high quality healthcare. Although NPs and APNs were included in MACRA's description of APMs,<sup>8</sup> there is no requirement that APMs include NPs and other APNs in their networks as independent providers eligible for direct billing and participation in potential incentives, like quality bonuses. Making NPs and APNs eligible to participate is a good first step, but it does not go far enough. For example, CMS has stated that the Comprehensive Primary Care Plus (CPC+) could be considered an advanced APM. NPs were eligible to participate in the original CPC+ prototype, but among the 2,000 primary care practices selected, not a single NP practice was among them. Not having NPs and APNs represented discourages consumer choice and limits the reach of any potential APM. It also may raise costs.

In order to ensure patients have access to NPs and APNs, NNCC recommends that CMS take steps to remove polices within the proposed rule that discourage or limit the use of NPs and APNs. Such barriers include physician supervision requirements, the narrow definition of the term "physician" which excludes NPs and APNs otherwise acting within their state scope of practice, and impairments to credentialing and privileging APNs. Additionally, NNCC recommends that CMS make the inclusion of eligible APNs mandatory in APMs. Waiving unnecessary barriers to the use of NPs and APNs will enhance access to care, ensure quality healthcare delivery, and contribute to cost savings. NP and APN services are crucial for the 40 million beneficiaries currently enrolled in Medicare, as well as the 80 million beneficiaries who are expected to be in Medicare in the next ten years. These providers need to be part of any strategy for improving quality, increasing access, and reducing costs.

Along the same lines, NNCC requests that CMS broaden the definition of physician-focused payment models (PFPMs) to include other healthcare providers, such as NPs. NPs provide high quality care and possess the education and training needed to lead payment and care delivery models. These providers are essential if effective policies are to be instituted to address Medicare's challenges around access and cost. In order to reach their full potential, NPs and need to be fully recognized in MIPS. One way to achieve this is to broaden the PFPM definition.

As part of the proposed criterion for promoting better care coordination, protection of patient safety and patient engagement, **NNCC requests that CMS require the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to evaluate whether PFPMs support and encourage APNs to practice to their full professional education, skills, and scope of practice.** In order to accomplish this, NNCC requests that the proposed rule require PFPM applicants to document how they

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<sup>8</sup> Pub L. 114-10.

will include APN services, and how they will use APNs to the fullest extent of their training. The Institute of Medicine's (IOM) report entitled, *The Future of Nursing: Leading Change, Advancing Health*, outlines several ways patient access to care may be expanded, quality improved, and costs reduced through greater use of APNs.<sup>9</sup> The report specifically recommends, "advanced practice registered nurses should be able to practice to the full extent of their education and training."<sup>10</sup> Moreover, the IOM informs, "ACOs that use APNs 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."<sup>11</sup>

## Specific Comments

### I. Low-volume providers

The proposed rule excludes clinicians whose patient volume does not exceed a low-volume threshold from the definition of an MIPS eligible clinician. The "low-volume threshold" is defined as an individual MIPS eligible clinician or group who, during the performance period, has Medicare billing charges less than or equal to \$10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. In order to assess performance for individual MIPS eligible clinicians, CMS proposes to use a combination of the billing Tax Identification Number (TIN) and National Provider Identifier (NPI). MIPS eligible clinicians that want to have their performance assessed as part of a group will be identified by the group's billing TIN. Groups submitting information together must do so for all four performance categories under MIPS.

In order to more accurately assess performance, **NNCC requests that CMS issue a clarification stating that when clinicians have chosen to have their performance assessed at the group level, the low-volume threshold will also be determined at the group level.** Under this formula, patient totals for a single group TIN will include all of the providers using that group TIN to meet the \$10,000 in Medicare billing charges or 100 Part B-enrolled Medicare beneficiaries threshold. Additionally, **NNCC requests that CMS create a process through which safety-net providers, such as NMHCs, can apply for a waiver of the low-volume threshold.** Although the percentage of Medicare beneficiaries seen at NMHCs is relatively small, these patients are most often low-income, vulnerable individuals with multiple chronic health problems. NMHCs are the only health care access point available to many of these patients and the services they receive are critical to their health and well-being. Establishing a waiver process will ensure that NMHCs and other safety-net providers are not punished for caring for the most vulnerable Medicare patients. Additionally, it will further CMS' goal of driving quality improvement across the broadest range of MIPS eligible clinician types and specialties.

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<sup>9</sup> IOM (Institute of Medicine). *The Future of Nursing: Leading Change, Advancing Health* (Washington, DC: The National Academies Press, 2011), 69.

<sup>10</sup> IOM op. cit. p. 7-8.

<sup>11</sup> IOM op. cit. p. 3-41.

## II. Quality

Quality is 50 percent of the MIPS score, and the proposed rule allows clinicians to choose six measures from a range of predetermined options designed to accommodate different specialties and practice settings. The score would be based on Medicare claims and uses 40 episode-specific measures. There will also be significant credit given under MIPS for participation in accountable care organizations (ACOs) or patient-centered medical homes (PCMHs).

NPs and APNs play an integral role in health quality outcomes and are in an important position to assess the effectiveness of value-based care initiatives for underserved patients, while improving quality metrics. However, NPs and APNs have been excluded from ACOs and PCMHs in the past. In order for the MIPS strategy to successfully measure the impact of the value based approach, it will need to include goals and measures that fully embrace NPs and APNs.

Research shows that optimal use of NPs can lower the total cost of care, reduce emergency department (ED) utilization and improve care outcomes.<sup>12</sup> In light of this evidence, it is essential that the MIPS quality measurements incorporate quality measures that incentivize the utilization of providers that have shown the ability to close gaps in care and improve care coordination. **Therefore, NNCC requests that CMS incentivize the use of APNs and, wherever possible, make the inclusion of NPs mandatory.**

Another critical element in the measurement of quality metrics is the evaluation of outcomes based on claims connected to each patient. **NNCC urges CMS to ensure that claims data be attached to the provider who actually ordered a needed test or closed a gap in care.** This will allow NPs and APNs to be fully recognized for contributions they make, especially related to the performance of at-risk physicians and ACOs. Such an approach encourages the broader provider team to care for patients in a coordinated manner that supports improvements in quality outcomes measures.

## III. Advancing Care Information

NNCC is pleased that NPs and APNs are eligible to be scored on the advancing care information component of MIPS. However, NNCC is disappointed that NPs and APNs are not eligible for incentives through the Medicare Electronic Health Records (EHR) Incentive Program, which includes Meaningful Use measures. The Office of the National Coordinator has stated, "NPs are an integral part of the changing healthcare landscape...With access to care being expanded....through the Affordable Care Act,

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<sup>12</sup> Maria, Schiff et al. The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care, National Governors Association, (2012); Christine E. Eibner et al., Controlling Health Care Spending in Massachusetts: An Analysis of Options, RAND Corp. (Aug. 2009); and Jennifer A. Coddington & Laura P. Sands, Cost of Health Care and Quality Outcomes of Patients at Nurse-Managed Clinics, 26 Nurs. Econ. 75, 75-83 (2008).

NPs must transition to meaningful use of EHRs...in order to meet this demand and provide better, higher quality care.<sup>13</sup> NPs and other APNs continue to make efforts to adopt and use certified EHR technology, despite the lack of financial incentives available to other providers. The fact that NPs and APNs are not eligible for EHR incentives seriously weakens the reach and the effectiveness of the portion of the proposed rule dedicated to advancing care information. **NNCC urges CMS to revise the proposed rule so that NPs and APNs can obtain EHR incentives.**

CMS has requested comment on how to estimate the proportion of physicians who are meaningful EHR users for purposes of reducing the weight of the advancing care information component for the total composite performance score. NNCC supports a threshold of 75 percent under the proposed scoring methodology for this component, but again stresses that NPs and APNs should be included in the EHR methodology.

Finally, CMS has also requested comment on how to link HIT to outcomes. One suggestion is to tie interoperability and health information exchange (HIE) to reduced readmission rates and ED visits. The exchange of health information has a direct impact on clinicians' ability to manage transitions that may lead to a readmission or ED visit.

#### **IV. Clinical Improvement Activities**

Clinical practice improvement is 15 percent of the MIPS composite performance score. The proposed rule offers a number of ways clinicians may obtain credit for this component, such as participating in a nationally-recognized medical home, an Alternative Payment Model (APM), or by performing a combination of approved activities. Activities given a weighting of "high" are worth 20 points, while activities given a weighting of "medium" are worth 10 points. Clinicians must earn 60 points to receive full credit for this component.

NMHCs and other nurse-led practice types, such as nurse-led clinics, support clinical practice improvement in a number of ways. For example, NPs in retail clinics provide health screenings that are instrumental in enabling providers to satisfy HIT quality measures. Nurse-led retail clinics also support improved primary care health outcomes by synchronizing medication refills, conducting comprehensive medication reviews, performing chronic care monitoring, and facilitating after hours care. Finally, many NMHCs have established internal policies and procedures based on clinical best practices and have created EHR prompts that encourage providers to follow clinical best practice recommendations. **NNCC requests that CMS broaden the clinical practice improvement activities definition so that primary care support services offered in nurse-led retail clinics are counted under MIPS.**

**Additionally, NNCC requests that CMS ensure that Clinical Practice Improvement Activities undergo proper stakeholder comment from NPs and APNs.** While the proposed rule 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

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<sup>13</sup> [https://www.healthit.gov/sites/default/files/onc\\_databrief\\_no11\\_may\\_2013.pdf](https://www.healthit.gov/sites/default/files/onc_databrief_no11_may_2013.pdf)

(CPIA), it is unclear how CMS will assign credit for meeting CPIAs in future years and whether CMS will develop CPIA specifications as they do for quality measures. NNCC requests that where possible, processes used by NPs and APNs be treated the same as the processes used by physicians. In previous Physician Fee Schedule rules, physicians could report quality measures through a medical Maintenance of Certification Program and receive an incentive payment. Such incentive payment programs were denied to NPs and APNs engaged in analogous professional recertification. NPs and APNs should be afforded the same opportunities as physicians in the development, implementation, and evaluation of CPIAs. Therefore, any specifications should undergo a public comment period prior to finalization in the MIPS program in order to ensure that these activities remain relevant and applicable to NPs and APNs, as well as physicians.

## V. Resource Use

The proposed rule outlines a strategy for utilizing the Resource Use category to reinforce appropriate care and enhanced health outcomes. The category is also designed to incorporate Part D costs into a future total-cost-of-care metric based on episodes of care and patient condition groups. **NNCC urges CMS to include Part D costs in the resource use performance category for MIPS.** Total per capita cost should include costs for Parts A, B and D. Measuring only two parts of the program does not capture the full resource use picture. Carving Part D spending out of the calculation misses an opportunity to impact prescribing behavior in a way that maintains clinical quality while reducing costs.

Under the proposed rule, MIPS eligible clinicians have no incentive to appropriately manage Part D spending. MIPS eligible clinicians need to be accountable for all of their Medicare expenses. This will discourage cost shifting and other activities that may undermine MACRA.

On behalf of NNCC, I would like to thank CMS for the opportunity to submit these comments. If you have any questions, please contact me at (215) 731-7140 or [tine@nncc.us](mailto:tine@nncc.us).

Sincerely,



Tine Hansen-Turton  
NNCC CEO