

January 1, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-5522-FC; CMS-5522-IFC
P.O. Box 8016
7500 Security Blvd
Baltimore, MD 21244-80162

RE: Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year (82 FR 53568, November 16, 2017).

Dear Administrator Verma:

The American Association of Nurse Practitioners (AANP), representing more than 234,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment in response to the CY 2018 Updates to the Quality Payment Program (QPP) (82 FR 53568).

NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs practice in nearly every health care setting including clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia. It is important to note that 89.2% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

After reviewing the final rule, we thank CMS for finalizing many proposals that will ease the burden on clinicians and assist the transition to value-based reimbursement. Proposals such as lower reporting thresholds for small and rural practices; bonuses for small or rural practices; bonuses for complex patients; allowing the use of 2014 certified CEHRT; and ACI exceptions, all ease the path for small and rural clinicians to participate in MIPS.

We thank CMS for adopting these proposals. However, these measures will have no impact if the clinicians that would benefit from the proposals are excluded from participation in MIPS. We support the implementation of these proposals, but are concerned that their impact will be negligible in the presence of increasing the low-volume threshold. Clinicians should be supported in ways that assist them to

transition and implement value-based reimbursement, and policies should encourage and reward this transition. CMS should not exclude clinicians who are willing and prepared to participate in the program.

Throughout the final rule CMS was consistent in using provider neutral language. However, in other materials regarding QPP CMS uses the term “physician” in situations where other qualified health professionals, including nurse practitioners, are authorized to provide care under the Medicare program. The use of the term “physician” in these instances confuses patients and providers as to which clinicians are authorized to provide care under the Medicare program and undermines the scope of practice and quality of care provided by nurse practitioners. This could lead to unfair restraints on practice and decreased access to care for patients. It is important that during rulemaking and in all other correspondence, CMS does not continue to utilize the word “physician” when other qualified health professionals are authorized to provide a service.

Merit-Based Incentive Payment System (MIPS) Low-Volume Threshold and Opt-In Option

We appreciate that CMS is striving to ease the burden of MIPS on clinicians, and we support many of the provisions in this final rule. However, we remain concerned about the complexity of the program and that the increase in the low-volume threshold will exclude too many practices and clinicians from participating in MIPS. CMS has stated that one of its primary objectives is to develop a flexible program that is not one-size-fits-all, allowing all clinicians to participate in ways that are best for them, their practice, and their patients.¹ Since reimbursement under the fee schedule will plateau and phase-out for clinicians who are not able to participate in the QPP, it is important for CMS to continue to decrease the complexity of the program which should not be at the expense of clinicians wishing to participate.

Based on CMS estimates of the impact of the low-volume threshold, 134,000 additional clinicians would be excluded from MIPS.² CMS estimates that only 58,004 nurse practitioners³ would be able to participate in MIPS in 2018. As a comparison, there were 89,732 nurse practitioners who were eligible participants as individuals or groups in PQRS in 2015, and that number has been steadily increasing.⁴ CMS has stated that they want to “build upon the foundation that has been established which provides a trajectory for clinicians to value-based care,”⁵ but it is hard to determine how decreasing MIPS participation in year two of the program fulfills this objective. In addition, it is unclear what will happen to clinicians who are exempt from participation as the program moves forward and fee-for-service is phased out. We ask that you explain how clinicians not participating in MACRA will continue to be reimbursed under the Medicare program.

Provider participation in the QPP was supposed to coincide with the end of PQRS, the Medicare EHR incentive program, and the value-based payment modifier (VM). Raising the low-volume threshold breaks the links between these programs and the QPP and stifles the transition to value-based reimbursement. The trajectory of PQRS reporting has been steadily increasing. For nurse practitioners, participation grew from 32.6% in 2012 to 67% in 2015.⁶ We remain concerned that those clinicians not participating because they did not meet the threshold would forfeit their ability to receive similar yearly payments because other incentive programs phased out with the implementation of MACRA. We again ask CMS to revisit the low-volume threshold in future performance years to ensure that all eligible providers have the opportunity to participate in MIPS.

¹ 82 FR 30010, 30012.

² *Ibid.*, 30024.

³ 82 FR 53568, 53936.

⁴ 2015 PQRS Experience Report, pages 20 and 28. (The total number of eligible NPs including ACO participation was 113,445.)

⁵ 82 FR 30010, 30013

⁶ 2015 PQRS Experience Report, Table A7

In this final rule, CMS also requested feedback on a proposed option for clinicians below the low-volume threshold to “opt-in” to MIPS beginning in the 2019 performance year. We support an option for clinicians to “opt-in” to MIPS, but we do not believe that the “opt-in” option should be based on the low-volume threshold in this final rule. Any clinician that would like the opportunity to participate in the program should be given the option to do so.

CMS expressed concern that this option would add another layer of complexity for clinicians, would cause problems with low-volume clinicians having an adequate number of benchmarked quality measures, and would lead to only high-performing clinicians opting into the program. We do not agree with CMS’ concerns regarding the “opt-in” option. First, we do not agree that the being given the option leads to complexity. Clinicians that choose to “opt-in” to the program are making a proactive choice to participate and decide that the benefits to participating are greater than any added complexity. CMS can also delineate clear guidelines to these clinicians on how to “opt-in” to the program which will ease any administrative burden. Second, we do not feel that there would be too few benchmarks for clinicians opting-in to the program. We feel that the benchmarks are currently low enough where most clinicians that choose to enter the program will not have an issue exceeding them. Third, CMS suggests that there will be too many high-performing clinicians opting-in to the program. We disagree and feel that CMS should be rewarding and encouraging high-performing clinicians, not erecting barriers to prevent them from entering the program.

We believe that any clinician who is eligible to participate in MIPS should be given a realistic path to do so and that the focus should be on increasing, not decreasing, participation in MIPS. We request the opportunity to work with CMS to develop ways to ease the burden on practitioners while also encouraging participation in both tracks of the QPP.

Virtual Groups

As CMS develops parameters for virtual groups, we urge CMS to consider how all eligible clinicians, including NPs, can be treated equally under this program. It was our understanding that virtual groups would be an option for clinicians who did not meet the low-volume threshold and we are very concerned that CMS has not adopted this interpretation of virtual groups. We request that CMS continue to examine the formation and implementation of virtual groups ensuring equity and taking into account variability in patient case-mix and practice needs.

We appreciate that CMS realizes that there are barriers regarding the development of a technical infrastructure required for successful implementation of the virtual groups within MIPS, and we support the proposal to provide technical assistance for the 2018 and 2019 performance years. As CMS identifies requirements for virtual groups and the mechanisms for implementation, we request that NPs be included in all planning and development aspects, particularly as part of the user groups and listening sessions. We believe that NPs must be active participants in the development of the EHR software and be recognized as providers within the EHR software database. This would assist in ensuring that accurate data in relation to outcome measures is captured for the actual clinician who provided the service. This reinforces transparency and enables proper system development and operations certified by CMS for utilization in virtual groups. In this vein, we believe that accurate data and reporting of clinicians will additionally be supported by EHR incentives for Certified EHR technology and interoperability for virtual groups in the MIPS program.

We have concerns related to the 2018 performance period and the short timeframe that clinicians would have to elect to join a virtual group. Clinicians have to elect to join a virtual group for the 2018

performance period by December 31, 2017; that will provide very little time for a clinician to make an informed decision related to participation. While we acknowledge that CMS did attempt to address this issue by moving the date back from December 1, 2017, we still do not feel that this provided clinicians with enough time to make this determination. We recommend that CMS move the election deadline back for this year to give clinicians an opportunity to review the virtual group guidelines, and make informed decisions regarding joining a virtual group. We also ask that CMS include examples of virtual group arrangements and contracts in the sub-regulatory guidance for review prior to the virtual group election deadline.

Certified Electronic Health Record Technology (CEHRT)

CMS has made many practical suggestions regarding the use of CEHRT in this final rule and its applicability to the QPP. However, there are barriers within many Electronic Medical Record (EMR) systems that are still geared to the concept that only a physician documents the patient's condition and the services performed, particularly in hospital systems. We suggest that CMS require software products to be "nurse practitioner inclusive" to be certified by CMS. One step toward accomplishing this goal is including nurse practitioners on the Health Information Technology Advisory Committee. We also ask that CMS ensure that there is high-quality, free and low-cost CEHRT for all clinicians, particularly those in small practices, who may not have the financial ability to invest significant money on CEHRT.

Facility-Based Measurement

We thank CMS for delaying the implementation of facility-based measurement until the 2019 performance period. While we appreciate that the goal of instituting facility-based measurement is to ease the burden on clinicians reporting under MIPS, we have concerns that the proposed methods would provide facility-based clinicians with an unfair advantage over non-facility clinicians. For example, the proposal would allow facility-based clinicians to evaluate their score under the facility measurement and under the individual MIPS measurement and select the higher of the two. This is an option not available to other providers. We encourage CMS to continue to explore and implement options to equalize benefits for clinicians in all settings.

Topped Out Measures

While CMS largely finalized the topped out measures proposal, we remained concerned about the practice of retiring topped out quality measures, particularly those that are indispensable to the treatment of patients with certain conditions. It is our understanding that less important quality indicators will replace those currently deemed to be the most important indicators simply because they are being met and used by too many providers. According to your data, a significant proportion of clinicians are already topped out in the most important indicators. In that case, it would appear, according to your suggested scoring that clinicians are to be penalized for topping out, rather than rewarded for consistently meeting those quality activities in the scoring of their care.

While we believe that clinicians who have not topped out a measure should be able to report on that measure, and have the opportunity to improve and receive a full performance score, we feel it would be counterproductive to lower the scores of clinicians who have met the goal. It is our opinion that topping out should be rewarded, not penalized. Perhaps clinicians who have topped out measures could submit additional less reported measures via some sort of a bonus structure. While we recognize the practicality of a numeric scoring system to evaluate quality, as health care providers we must continue to concentrate

on keeping patients healthy. It is imperative that we clearly focus on measures that reflect the quality of care provided, notwithstanding if they have been topped out.

Cost Category

In the proposed rule, CMS asked for comment regarding whether the cost performance category should be weighted at 0% or 10% in the 2018 performance period, with the caveat that cost must be weighted at 30% in the 2021 payment period via statute. At that time, we recommended scoring cost at 10% in 2018 to ease that transition and we thank CMS for adopting this proposal in the final rule. However, we also note that the Secretary may have additional flexibility to smooth this transition in future years. While section 1848(Q)(5)(i)(II)(aa) of the Act does require a cost performance category weight of 30% beginning on the 2021 payment year, the Secretary is also given the authority to re-weight MIPS performance categories. Section 1848(q)(5)(F) of the Act authorizes the Secretary to re-weight MIPS performance categories if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician involved. CMS has utilized this authority to re-weight scoring in the first two years of the program and create scoring exceptions for specific groups of clinicians.

Since CMS is continuing to develop the episode-based measures that will be used for the cost performance category (as required by statute) we suggest the Secretary would have the authority to re-weight the cost category in the 2019 performance period. CMS has noted that feedback on the new measures that are being developed will be available in the summer of 2018, and that CMS will propose to adopt episode-based measures that are currently in development in future rulemaking. Given the complicated nature of the development of these measures, we want to ensure that clinicians have an opportunity to fully understand the cost measures prior to using them to account for 30% of a clinician MIPS score. We would also like to note that the episode-based cost measures that were field tested in October 2017 were largely related to surgical practice and would not be applicable to primary care clinicians. It is important that CMS develop and test episode-based cost measures that are applicable to all clinicians. Since the sufficiency and applicability of these measures is yet to be determined, and the measures themselves are still in development, we suggest that the Secretary use his flexibility to lower the cost performance score from 30% in the 2019 performance year to create a smoother transition to cost scoring.

Billing Accuracy and Provider Accountability

In the interest of accurate evaluating and accountability, we feel it is important to address an overarching practice that can influence outcomes in the MACRA programs. Current “incident to” billing practices undermine the foundations of value-based reimbursement. Simplifying these billing guidelines to require practitioners to bill under their own billing ID for the services that they perform will lead to administrative simplification and more accurate data, which is essential in the transition to value-based reimbursement. Alternatively, we propose the creation of a billing modifier that would identify the provider of the service being billed to ensure the accuracy of billing and claims data. There is an opportunity to implement this modifier under the MACRA legislation, which states that the Secretary shall develop patient relationship categories and codes that “define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.”⁷ CMS has begun implementing patient relationship codes in the 2018 Physician Fee Schedule final rule, and we believe that the inclusion of this information is an opportunity to create a modifier that would identify the clinician that is actually performing the service.

⁷ Public Law 114-10, 129 Stat. 125.

Alternative Payment Models

We encourage you to continue to determine ways that nurse practitioner practices can also be incentivized to participate in the Alternative Payment Models. While many NP practices and clinics are nationally certified Patient Centered Medical Homes (PCMHs) and many more meet the standards for PCMHs, it is important to have more recognition and participation in other APM tracks. We encourage you to incentivize nurse practitioners to become and to join Accountable Care Organizations (ACOs) and to incentivize ACOs to include nurse practitioners as full partners in their value-based payment programs. For example, in the Shared Savings Program, the Secretary has broad waiver authority which can be utilized to waive the definition of physician and allow assignment of beneficiaries who are only seen by nurse practitioners. We also support the proposal to lower the APM risk amount for small and rural practices to encourage greater participation in the APM track.

As CMS continues to expand the scope of APMs to involve payers other than Medicare, we encourage CMS to ensure that the payers selected to participate are inclusive of all clinicians, and are following all provider non-discrimination rules and regulations. Ensuring that all providers can fully participate in these APMS will increase participation in MACRA and further the goals of value-based reimbursement.

We again wish to comment on the proposal that Other Payer Advanced APM determinations will be made one year at a time. It is critical that a stable business environment is created for ongoing practice. Clinicians should be assured that when they enter an APM they will be able to do so for a period that is long enough to recognize the benefits for their practice and patients. This cannot realistically be achieved in a single year. APMs should be able to implement their guidelines to meet the needs of their patients without the fear that they will not meet the MACRA guidelines on an annual basis.

Extreme and Uncontrollable Circumstances

We appreciate that CMS has recognized the significant burden that events that occurred during 2017 (Hurricanes Harvey, Irma and Maria and the California wildfires) had on clinicians practicing in the affected areas. We support the interim final rule which grants clinicians in affected areas exceptions to the MIPS reporting requirements without the need to submit a request.

CMS requested further feedback on how to apply their extreme and uncontrollable circumstances policy moving forward. We believe that a modified case-by-case approach would be the best method. This way certain emergency declarations would always trigger the exception, removing the guesswork from the clinicians in those affected areas, but CMS would also make other determinations on a case-by-case basis to ensure that the guidelines are not applied too strictly in unforeseen circumstances. Additionally, many clinicians from non-affected areas left their practices to assist in the relief efforts and it is important to ensure that these clinicians are not burdened as a result of their efforts. CMS should ensure that clinicians that assisted in the affected areas are able to obtain relief from the QPP reporting requirements if they are burdened as a result.

We thank you for the opportunity to comment on this final rule and interim final rule. As we look towards the implementation phase of this rule, we urge you to continue to remain cognizant of the critical role that NPs play in our healthcare system. They are the healthcare provider of choice for millions of Americans and must be fully integrated into the evolving value-based reimbursement system. We look forward to an ongoing dialogue to ensure NPs and their patients are able to take full advantage of the programs in this system. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

David Hebert
Chief Executive Officer