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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-3321-NC
PO Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

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 Administrator Slavitt:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the Request for Information (RFI) referenced above, published in the Federal Register on October 1, 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]

Merit-based Incentive Payment System Identifier and Exclusions

The RFI seeks comment on what specific identifiers should be used to identify Merit-based Incentive Payment System (MIPS) eligible professionals (EPs) for determining eligibility, participation and performance under the MIPS performance categories.

ANA recommends that there be a single system of identifiers used in health care operations. That system is the National Provider Identifier (NPI) system including both the individual and group identifiers. ANA is concerned that we will be taking a step backwards with the reintroduction of multiple identifiers. For example, HIPAA was passed in 1996, in part to eliminate the confusion caused by multiple insurance carriers and State government agencies issuing identification

[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.

numbers to individual clinicians and groups. Multiple identifiers inhibit the development and analysis of quality performance data for individual clinicians that might otherwise be possible if there were a single unique identifier for every individual clinician.

The RFI's consideration of some new alternative identifiers suggests there is already dissatisfaction with the NPI Tax Identification Number (TIN) options that have been drafted into use. There need not be a new system. The existing NPI architecture already encompasses an NPI for groups of clinicians. TINs are designed and maintained by the Internal Revenue Service, but TINs only partially map into the framework of multiple, potentially overlapping groups of aligned clinicians. Each of those individual groups could be identified with a group NPI. The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) need to become more committed to funding, upgrading and maintaining the NPI system. In part, because of the government's lack of commitment to the NPI, private market health insurers have been reluctant to incorporate NPIs into their own data processing and continue to issue their own insurer-specific identifiers. Thus, continuing and compounding the problems that HIPAA was designed to correct.

What is needed is a resolve on the part of HHS and CMS to maintain the NPI as a disciplined data set with rules and expectations with respect to NPI holders, e.g., they will update their NPI information promptly as it changes such as new addresses or new associates. HHS/CMS should promulgate solid maintenance standards and assure that sufficient funds are dedicated to keeping NPI data accurate and up-to-date. When appropriately maintained, the NPI could be an important element in the development of workforce planning. A well-functioning NPI system would make it possible to fulfill the requirement of the Public Health Services Act (42 U.S.C. §242k) that directs the Secretary of Health and Human Services through the National Center for Health Statistics to collect statistics on ". . . utilization of health care, including utilization of ambulatory health services by the specialties and types of practice of the health professionals providing such services." HHS contends that the National Ambulatory Medical Care Survey—a survey of non-federal office based physicians--fills this mandate. Ambulatory health services providers occupy a much wider universe than simply non-federal office based physicians alone. NPI could become the basis of a more comprehensive system of health workforce data if HHS and CMS were committed to improving and maintaining the system. NPI upgrades could include a more user-friendly system that allows clinicians to quickly update information on changes in business addresses and accruals or separations of affiliated clinicians. Another suggestion would be to mandate a delay in Medicare/Medicaid payment for clinicians whose NPI entries are incorrect. Such a requirement may prompt more clinician attention to maintaining accurate information in their NPI records.

HHS and CMS should commit to improving the NPI system and wean identification of individual clinicians and groups away from the use of TINs. HHS and CMS should create and enforce standards for timely and accurate information in NPI records with a minimum of annual updates to reflect changes in the prior year.

ANA recently discussed the use of NPIs in responding to a request for comments from the Office of National Coordinator for Health IT (ONC) concerning the 2016 Interoperability Standards Advisory: Best Available Standards and Implementation Specifications. ANA's letter to ONC, dated November 6, 2015, supported a unique clinician identifier, such as the NPI, to capture data

across care settings. Using the NPI in this way would promote the use of data analytics to better inform a learning health system. As noted in the letter, the NPI is the recommended standard identified in the 2016 Interoperability Standards Advisory for the interoperability need of representing a care team member (health care provider).

In the agency's effort to select and operationalize a specific identifier to associate with individual MIPS eligible providers, ANA strongly urges 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 pointed out in comments submitted September 8, 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),[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, ANA has recommended that CMS 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.

We appreciate the opportunity to share our views on this RFI. If you have questions please contact Peter McMenamin, Senior Policy Advisor-ANA Health Economist (peter.mcmenamin@ana.org).

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

[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.