



**American Academy of Nurse Practitioners
American College of Nurse Practitioners
Gerontological Advanced Practice Nurses Association
National Association of Pediatric Nurse Practitioners
National Association of Nurse Practitioners in Women's Health
National Organization of Nurse Practitioner Faculties**

June 6, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Baltimore, MD 21244-8013

Attention: CMS-1345-P

Dear Dr. Berwick:

On behalf of the 140,000 nurse practitioners across the country represented by the undersigned organizations, we appreciate the opportunity to provide our comments on the April 7, 2011 proposed rule implementing Section 3022 of the Affordable Care Act relating to Medicare payments to providers of services and suppliers participating in Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program.

In general, we are extremely disappointed that the Centers for Medicare and Medicaid Services (CMS) has chosen to interpret Section 3022 in a manner that largely fails to recognize the education, clinical preparation, and current roles of nurse practitioners in designing and leading primary care practices that achieve the goals of improving patient care, enhancing quality, and lowering costs. While the proposed rule reflects the statutory requirement that includes nurse practitioners as "ACO professionals," it adopts a restrictive structure that fails to recognize nurse practitioners as fully authorized primary care providers, including our role in care coordination, quality improvement, and cost effectiveness. The current proposed language not only fails to recognize the workforce contributions that nurse practitioners bring to caring for Medicare beneficiaries, it falls significantly short of implementing the recent Institute of Medicine recommendation to utilize nurse practitioners to their full capacity and establishes marketplace restrictions that would prevent nurse practitioners from being full partners in ACOs.

The rule infers in many provisions that physicians are the only providers capable of leading change in these areas. As proposed, these regulations prevent nurse practitioners who are the principal providers of primary care services for many Medicare beneficiaries from having their patients aligned with an ACO, making it impossible for us to form and direct ACOs.

In a general discussion of eligibility and governance policies, the proposed rule recognizes that “the benefits of limiting eligibility need to be balanced against the prospect that such limitations could compromise potential innovations and forfeit the opportunity to assess new models that could potentially transform health care in ways that improve quality and beneficiary satisfaction while better controlling costs. More importantly, defining eligibility narrowly also has the potential to impede development of ACOs that include other provider and supplier types, especially those that provide services in rural and other underserved areas.”

We believe these regulations must be more inclusive of NPs in clinical, management and leadership aspects of the ACO such as assignment, quality assurance and quality measures. Nurse practitioners are recognized as essential primary care providers in Medicare: 71% of nurse practitioners provide care to Medicare beneficiaries, delivering more than 170.1 million Medicare services in 2009. In order to successfully transform health care delivery, ACOs must promote not only the use of NPs as primary care providers, but also the ability of NPs to develop and lead innovative practice structures that achieve better health, better quality, and lower cost.

It is likely that this rule will be seen as a framework for other versions of shared savings programs, both in federal programs and the private sector. Therefore, we believe that it is critical to recognize the education and clinical abilities of all providers, allowing all providers to practice to the full extent of their abilities and establishing a structure that is not unfairly preferential or discriminatory to any providers.

There are specific sections of the proposed rule that we believe must be modified to fulfill the intent of Congress under Section 3022 of the Affordable Care Act. The following issues and provisions are particularly important from the perspective of nurse practitioners, and we strongly urge to you address these matters in developing final regulations:

BENEFICIARY ASSIGNMENT

Section 1899(c) of the Act requires the Secretary to determine an appropriate method of assigning Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provide by an ACO professional. The proposed rule applies a narrow interpretation to this language that limits that approach to considering only those services provided by a physician as defined in section 1861(r)(1) of the Social Security Act.

This narrow approach devalues services provided by nurse practitioners and other primary care professionals who are not physicians. It ignores current practice in which Medicare fee-for-service beneficiaries in many states receive the plurality of their primary care services from nurse practitioners, many of who practice autonomously under their state law. The rule’s interpretation arbitrarily restricts the assignment of beneficiaries to ACOs particularly in geographic areas where there is a shortage of primary care physicians, and it effectively bars nurse practitioners from forming their own accountable care organizations. Such an exclusive interpretation is clearly inconsistent with the recognition of nurse practitioners as primary care providers throughout the Act and their explicit inclusion as ACO professionals.

Further, this interpretation limits the number of patients in many group practices who can be assigned to an ACO. It could have the effect of altering the actual mix of how services are provided between primary care professionals based on an arbitrary factor. Finally, it creates an incentive to “game the system” by making possible to exclude the attribution of individual patients by intentionally reducing the number of primary care services billed by a physician.

We believe it is clear that the Secretary has statutory flexibility to implement more preferable approaches. For example, it would be possible to design a system that could include beneficiaries in addition to those technically assigned under Section 1899(c), such as beneficiaries who receive a plurality of services from primary care professionals in an ACO or a group within the ACO.

Recommendation: Using the authority granted by the Act, amend Sections 425.6(a) and (b) of the rule in the appropriate places to strike references to “primary care physician(s)” or replace those references with “ACO professional.”

- Amend Section 425.6(a)(1) to read: “Medicare fee-for-service beneficiaries are assigned to an ACO based on their utilization of primary care services provided under this title by a ~~primary care physician~~ **an ACO professional** who is an ACO provider/supplier during the performance year for which shared savings are to be determined.”
- Amend Section 425.6(b) to read:
 - (b) Assignment methodology. CMS employs the following methodology to assign Medicare beneficiaries to an ACO:
 - (1) For each ACO, identify all ~~primary care physicians~~ **ACO professionals** as defined in §425.4 of this part who were an ACO participant during the performance year.
 - (2) At the end of each performance year, determine all beneficiaries who received services from ~~primary care physicians~~ **ACO professionals** in the ACO, as determined under paragraph (b)(1) of this section.
 - (3) Determine the total allowed charges for the primary care services (as identified by HCPCS code in the definition of primary care services under §425.4 of this section) that each of the beneficiaries identified in paragraph (b)(2) received from any provider or supplier during the performance year.
 - (4) For each beneficiary, add together the allowed charges for the primary care services provided by the ~~primary care physicians~~ **ACO professionals** (identified in paragraph (b)(1) of this section) in each ACO (identified in paragraph (b)(1) of this section).
 - (5) Assign a beneficiary to an ACO if the beneficiary has received a plurality of his or her primary care services, as determined by the sum of allowed charges for those services under paragraph (b)(4) of this section, from ~~primary care physicians~~ **ACO professionals** identified under paragraph (b)(1) of this section, who are an ACO participant.

Recommendation: Base the determination of “plurality of...primary care services” on the services of ACO professionals.

- Amend Section 425.6(b)(5) to read: “Assign a beneficiary to an ACO if the beneficiary has received a plurality of his or her primary care services, as determined by the sum of allowed charges for those services under paragraph (b)(4) of this section from ~~primary care physicians~~ **ACO professionals** identified under paragraph (b)(1) of this section, who are an ACO participant.”

CLINICAL MANAGEMENT AND OVERSIGHT

The proposed regulations establish a number of requirements for clinical management and oversight of ACO programs and functions. As noted above, the proposed provisions impose requirements that fail to recognize the education and experience of nurse practitioners in clinical care management, quality assurance, process improvement, and measuring clinical or service performance to improve patient care. Further, several provisions mandate structures and qualifications that create needless and inappropriate barriers to the ability of nurse practitioners to lead and manage cost-effective coordinated care systems.

- Amend Section 425.5(d)(9)(iii) to read: “Clinical management and oversight must be managed by a full time senior-level ~~medical~~ director who is physically present on a regular basis in an established ACO location, and who is a ~~board-certified physician and~~ **qualified healthcare professional** licensed in the State in which the ACO operates.”

QUALITY ASSURANCE

- Amend Section 425.5(d)(9)(v) to read: “(v) A ~~physician-directed~~ quality assurance and process improvement committee must oversee an ongoing action-oriented quality assurance and improvement program....”

CHRONIC CARE EVALUATION

- Amend Section 425.5(d)(15)(ii)(B)(9) to read: “(9) Internal processes in place for measuring clinical or service performance by physicians **and ACO professionals** across the practices, and using these results to improve care and service over time.”

There are many other provisions of the proposed rule that we believe need to be re-evaluated. We are concerned that the proposed rules do too little to protect nurse practitioners and their Medicare patients from potentially anti-competitive practices by ACOs. We are worried that the lack of requirements with regard to the equitable distribution of shared savings may not appropriately reward the ACO professionals who are responsible for generating those savings while improving the coordination and quality of primary care services.

However, the impact of these issues is not limited to nurse practitioners; we know that other respondents will address these and other concerns. As representatives of the nation’s nurse practitioners, we are seriously concerned that accountable care organizations will fail to achieve the vision of better care, better health, and lower cost if nurse practitioners are not able to participate fully and equally in their design and development.

We urge you in the strongest terms to reconsider these regulations and address the concerns that we have raised. Please do not hesitate to contact us if we can provide additional information or expertise that might help you in the design of this important program.

Sincerely,

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