

February 4, 2015

Marilyn Tavenner  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1461-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

Submitted electronically to <http://www.regulations.gov>

Re: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations  
File Code: CMS-1461-P (Published December 8, 2014)

Dear Administrator Tavenner:

On behalf of the American Nurses Association (ANA), we are pleased to offer our comments on the Medicare Shared Savings Program (MSSP): Accountable Care Organizations proposed rule. As the only full-service professional organization representing the interests of the nation's 3.1 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 healthcare 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.<sup>1</sup> 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).<sup>2</sup>

ANA supports and commends the agency's efforts to move from a volume-based system to one centered on value and quality. As such, ANA appreciates the opportunity to provide comments on the proposed rule.

### **Summary of Comments**

- ANA appreciates the Centers for Medicare and Medicaid Services' (CMS) proposal to revise the definition of ACO professional. ANA also urges CMS to reward – or otherwise encourage or incentivize – ACOs that share their savings with APRNs, who are ACO professionals.

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<sup>1</sup> <http://www.bls.gov/ooh/healthcare/registered-nurse.htm>.

<sup>2</sup> The Consensus Model for APRN Regulation defines four APRN roles: certified registered nurse anesthetist; certified nurse-midwife; clinical nurse specialist; certified nurse practitioner. 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.

- ANA agrees with CMS' proposal to take into consideration primary care services furnished by nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) in its beneficiary assignment methodology.
- ANA is pleased that CMS is accepting comments on waivers of certain Medicare payment or other program requirements that may be necessary to ensure the continued success of the MSSP and urges CMS to consider the following waivers:
  - A waiver of the skilled nursing facility (SNF) three-day stay requirement for all MSSP entities.
  - A waiver of the homebound requirement for home health care, which would help to ensure all beneficiaries are receiving the care they require.
  - A waiver of the home health certification requirement that would allow NPs and CNSs to certify the patient need for home health services. Although physicians currently are the only medical professional allowed to certify home health services, to improve access to home health care, APRNs, particularly NPs and CNSs, should be permitted to certify the need for home health care. It is important to note that legislation has been proposed to make this change in statute, and physicians, health and hospital systems, and others in the provider community support the change, as it will facilitate access to care.
  - A waiver of the current requirement that would allow APRNs to conduct the initial SNF assessment and subsequent SNF visit requirement. Current law dictates that only a physician may perform the initial SNF assessment and visit every 60 days, however, it is within APRNs' scope of practice to perform such assessments and to allow APRNs to do so would help ensure continuity of – and access to care.

**ANA encourages CMS to reward, encourage or incentivize ACO entities that share their savings with APRNs.**

**Comment to CMS:** We commend CMS for proposing to revise the definition of ACO professional by removing the requirement that an ACO professional be an ACO provider/supplier and clarifying that an ACO professional is an individual who bills for items or services he or she furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant. The MSSP promotes accountability for a patient population and fosters coordination of items and services under Medicare parts A and B. We appreciate CMS' recognition of APRNs and the important role they play in the provision of quality, coordinated care to beneficiaries. *ANA recommends that CMS consider an ACO demonstration waiver that would also allow NPs and CNSs to become ACO participants, able as other ACO physician and hospital participants to share in the ACO's savings achieved during the demonstration.*

APRNs have a long history of providing care to patients that leads to improved patient outcomes, increased access to care, enhanced patient safety, and greater cost savings. In addition to the direct provision of health care, APRNs play an integral role in managing and coordinating care for patients, particularly those with chronic disease, multiple co-morbid conditions, and other complexities. Care management and coordination are core tenets of accountable care and APRNs are essential to the foundational architecture of an ACO and its subsequent success in improving patient outcomes, enhancing the delivery and quality of care, and reducing costs. As such, given the breadth of APRNs' education and training, and in an effort to foster greater care coordination among ACO models, ANA encourages CMS to reward – or otherwise encourage or incentivize – ACO entities that share their savings with APRNs.

**The two-step beneficiary assignment process should include the primary care services rendered by APRNs.**

**Comment to CMS:** ANA applauds CMS for proposing to include non-physician practitioners in Step 1 of the beneficiary assignment methodology. ANA agrees with CMS that the MSSP beneficiary assignment methodology should be aligned with the primary care emphasis outlined in provisions of the Patient Protection and Affordable Care Act (ACA). ANA is pleased that by including non-physician practitioners, particularly NPs and CNSs, in Step 1 of the beneficiary assignment process, CMS is acknowledging that APRNs serve as primary care providers. APRNs provide essential care to patients and play an important role in the provision of primary care services, often serving as the beneficiary's sole primary care provider, particularly in rural or underserved areas.

The utilization of APRNs to provide primary care services is not a new practice, given that APRNs have delivered professional health services to patients for decades. Further, it is well-documented that APRNs deliver the same, high quality of care as primary care physicians. Additionally, as the shortage of physicians grows – at the same time an estimated 10,000 people a day turn 65 and the number of newly insured Americans increases – APRNs are positioned to help address this growing demand and provide high quality care to Medicare beneficiaries and those with commercial insurance. ANA appreciates CMS' recognition of the primary care services rendered by APRNs and the proposal to include the primary care services rendered by NPs and CNSs in Step 1 of the assignment methodology.

*ANA supports the inclusion – in Step 1 of the beneficiary assignment methodology – of NPs and CNSs that provide primary care services.*

**The Medicare SNF three-day stay requirement is antiquated and hinders beneficiary access to post-acute care.**

**Comment to CMS:** ANA is pleased CMS is requesting comments on a waiver of the SNF three-day rule. ANA urges CMS to waive the three-day rule requirement for all beneficiaries who are treated by entities that participate in the Medicare ACO program. Pursuant to §1861(i) of the Social Security Act, for a beneficiary to be eligible for SNF coverage under Medicare, a beneficiary must have a three-day inpatient hospital stay; any time spent in observation does not count towards the three-day threshold. ANA agrees with CMS that a waiver of the three-day rule could allow ACOs to “realize cost savings and improve care coordination.” The three-day stay requirement frequently prevents beneficiaries from receiving the right care at the right time in the right setting. Often, beneficiaries require immediate SNF care, but are delayed due to the three-day rule. These beneficiaries are retained in the hospital for longer than necessary. The antiquated three-day rule harms patients by delaying necessary care while also wasting hospitals' precious resources. All entities that participate in the ACO program should be permitted to manage patients' care and determine the appropriate care setting based upon each patient's needs. A waiver of the three-day rule for all ACO entities would likely result in improved patient outcomes and reduced health care costs.

To ensure growing and continued success of the ACO models, ANA supports a waiver of the SNF three-day rule for ACOs participating in the MSSP. ACOs are committed to delivering high-quality care to Medicare beneficiaries and should be afforded the opportunity to transition patients to the most appropriate post-acute setting without obstacles.

*ANA encourages CMS to provide a waiver of the three-day rule to all ACO entities, specifically, the Pioneer ACOs, MSSP ACOs, and the Advance Payment ACOs.*

**The home health homebound requirement prevents beneficiaries from receiving medically reasonable and necessary care.**

**Comment to CMS:** ANA applauds CMS for requesting stakeholder feedback on the home health homebound requirement. Under current Medicare requirements, coverage for home health services is permitted only if a beneficiary meets the homebound requirements. ANA urges CMS to waive the homebound requirement, as the homebound requirement detrimentally affects beneficiaries by restricting access to medically necessary care on the basis of beneficiaries' ability to leave the home.

According to [www.Medicare.gov](http://www.Medicare.gov), home health care is “usually less expensive, more convenient, and just as effective as care provided in a hospital or skilled nursing facility (SNF).”<sup>3</sup> Hence, it is nonsensical that a Medicare regulation exists that forces beneficiaries be admitted to more costly facilities to receive skilled care that could have been provided at home. A waiver of the homebound requirement should apply to all home health agencies providing services to Medicare beneficiaries. Home health care is appropriate for both homebound and non-homebound beneficiaries. The current law impacts not only patients and their families, but also the health and well-being of the Medicare program, and the implementation of a waiver of the homebound requirement would result in improved patient outcomes, fewer hospital and SNF admissions, and increased savings for the Medicare program. ANA recommends CMS revise the regulations to establish clearly that Medicare home health coverage is not contingent on the beneficiary being homebound.

*ANA supports a waiver of the home health care homebound requirement and believes a waiver would result in improved patient outcomes and reduced costs to the Medicare program.*

**It is within APRNs' scope of practice to certify home health services for patients.**

**Comment to CMS:** As previously stated, ANA appreciates CMS' request for stakeholder feedback on waivers and welcomes the opportunity to suggest additional waivers to CMS. Given that APRNs are authorized to certify patients for post-hospitalization extended care services in SNFs,<sup>4</sup> the authority to certify patients for home health care also should be expanded to APRNs. Eliminating this arbitrary barrier through a waiver process has the potential to reduce costs and improve care coordination. Current law provides that no Medicare coverage is permitted for home health services unless a physician certifies the beneficiary's need for skilled home health care; however, non-physician providers, such as APRNs, have the knowledge and skills to refer patients to – and certify them for – home health care services. APRNs receive advanced education and training, which equips them with the knowledge and experience to refer patients for home health services. APRNs increasingly are playing a very important role in health care delivery – both in the direct provision of care and through coordinating and management efforts, ensuring patients receive access to the care they need in a safe and efficient manner. Health and hospital systems no longer think of “discharging” patients when they leave the inpatient setting but are focused on ensuring “hand-offs” or “coordinating next phase of care.” APRNs already work with patients and families in their transition from the inpatient setting to home health care and empowering them to certify patients for

<sup>3</sup> <http://www.medicare.gov/what-medicare-covers/home-health-care/home-health-care-what-is-it-what-to-expect.html>

<sup>4</sup> <http://campaignforaction.org/sites/default/files/Removing-Barriers-Home-Hospice.pdf>

home health care further ensures coordination of care and communication, while also freeing physicians to focus on other patient care. As noted in the summary, physicians, health and hospital systems, and other providers support this change, as in the changing health care delivery system the archaic siloed certification requirements can impede access to care.

Utilizing APRNs to the full extent of their scope of practice ensures access to quality care while creating greater continuity of care, increasing efficiency of services, and helping to reduce overall Medicare costs.

*ANA urges CMS to waive the requirement that only a physician can certify home health for Medicare beneficiaries and allow APRNs, particularly NPs and CNSs within the MSSP, to certify home health.*

**It is within APRNs' scope of practice to perform an initial SNF patient assessment and subsequent visits.**

**Comment to CMS:** ANA appreciates the request for stakeholder feedback on additional waivers that would benefit the MSSP. ANA urges CMS to grant a waiver to allow patients to have an APRN conduct their initial SNF assessment in addition to subsequent visits. Current Medicare regulations dictate that a SNF resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits in a SNF after the initial visit may alternate between personal visits by the physician and visits by a NP, CNS or PAs.<sup>5</sup>

Care coordination is the building block on which much of the ACO quality improvement and cost control provisions are built. ANA encourages CMS to consider the contributions of the nursing profession in the post-acute setting and allow APRNs perform the initial SNF assessment and subsequent patient visits. Current Medicare law permits qualified non-physician practitioners to provide certain defined beneficiary visits prior to and after the physician performs the initial visit. Further, in Nursing Facilities (NFs), states have the option of allowing a NP, CNS, or PA who is not an employee of the facility but who is working in collaboration with a physician to perform any required physician task in a NF. As with the waiver for physician certification of a beneficiary's need for skilled home health care, waiving the current requirement and allowing APRNs to conduct the initial SNF assessment and follow-up patient visits would remove an arbitrary barrier and facilitate greater care coordination and continuity of care.

APRNs have the education and training to perform the initial comprehensive assessment in addition to subsequent visits, necessary for the diagnosis or treatment of an illness or injury. ANA encourages CMS to implement a waiver that allows APRNs to practice to the full extent of their scope of practice.

*ANA urges CMS to waive the current requirement that only a physician may perform the initial SNF assessment and delegate subsequent required visits, and allow patients to have an APRN conduct their initial SNF assessment in addition to subsequent visits.*

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<sup>5</sup> 42 C.F.R. §483.40(c)(1); 42 C.F.R. §483.40(c)(4).

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ANA appreciates the opportunity to comment on CMS' proposed rule. ANA and the nursing community stand ready to provide whatever assistance CMS may need in order to leverage nursing's unique contributions to the provision of direct patient care and further APRNs' role in ensuring the success of the MSSP by expanding the role they can play in the provision and coordination of care for Medicare beneficiaries under ACOs. If you have questions, please contact Andrea Brassard, Director, Health Policy ([andrea.brassard@ana.org](mailto:andrea.brassard@ana.org) or 301.628.5043).

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