NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services Attention: CMS-1345-P P.O. Box 8013
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Submitted electronically to http://www.regulations.gov

Re: **Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations.** File Code: **CMS-1345-P (Posted April 7, 2011)**

Dear Administrator Berwick:

The National Association of Clinical Nurse Specialists welcomes the opportunity to offer comments on the proposed rule that would implement section 3022 of the Affordable Care Act (ACA) of 2010, containing provisions relating to Medicare Accountable Care Organizations (ACOs). Our comments below echo many of the points made by the American Nurses Association.

Clinical Nurse Specialists (CNSs) are advanced practice registered nurses (APRNs), who are licensed registered nurses with graduate degrees, at the master's and/or doctoral level in a specialty. They have unique and advanced level competencies that can meet the increased needs of ACOs in improving quality and reducing costs. They are ***leaders*** of change in health organizations, ***developers*** of evidence-based programs to prevent avoidable complications, ***coaches*** of those with chronic diseases to prevent hospital readmissions, ***facilitators*** of teams in acute care and other facilities to improve the quality and safety of care and ***researchers*** seeking evidence-based interventions to improve the outcomes of care. One of the transitional models in the ACA was developed by Dr. Mary Naylor demonstrating that advanced practice registered nurses in the role as directors of care coordination during care transitions offer the potential for successful outcomes and reduced health care costs.[1] This model is based on previous work done by Dr. Dorothy Brooten that showed that hospitalization and improved outcomes were realized when CNSs were used to transition premature infants home.[2]

[1] Naylor, M.D., Brooten, D.A., Campbell, R.L., Maislin, G., McCauley, K.M., Schwartz, J.S. (2004). Transitional care of older adults hospitalized with heart failure: A randomized controlled trial. *Journal of the American Geriatric Society, 52*(5), 675-684.
[2] Brooten D, Brown LP, Munro BH, York R, Cohen SM, Roncoli M, et al. Early discharge and specialist transitional care. Image J Nurs Sch. 1988; 20:64-8.

NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

NACNS supports the proposed rule's vision of a patient-centered care delivery model that improves quality of care while seeking greater efficiencies and savings. Cost and quality must be addressed if our nation is to position our healthcare system to meet the needs of our population now and into the future. Our ultimate goal is to find ways to gain value while providing high quality care.

From this perspective, NACNS believes that CMS has largely neglected to include the contributions of nursing in its provisions and parameters describing integrated practice in general, and the ACO in particular. Care coordination is a building block on which much of the ACO quality improvement and cost control provisions are built. And care coordination is a core competency for the nursing profession; it is what nurses, and specifically clinical nurse specialists, do. Yet the proposed rule largely disregards the contributions of professional nursing in both clinical services and patient management, and as a result, loses the opportunity for real cost savings. Lastly, this oversight has the potential to ignore the needs of the many Medicare beneficiaries who call nurse practitioners (NPs), clinical nurse specialists (CNSs) and certified nurse-midwives (CNMs) their "primary care provider." This can create confusion that threatens patient choice and the patient-provider relationship.

Clinical Nurse Specialists have tested many models for improving care quality and coordination from a patient-centered perspective. Nurses have met with success after success in designing and implementing care coordination protocols and practices that improve patient outcomes and save money. NACNS's comment to the proposed ACO regulation addresses some of the ways in which these "lessons learned" might help CMS design ACOs to achieve their desired purpose.

Specifically, NACNS recommends, and discusses in detail, modifications in the proposed rule to address the following:

1. Clinical Nurse Specialists and Registered Nurses provide care coordination and patient-centered care as a core professional nursing standard of practice
2. Clinical Nurse Specialists' and Registered Nurses' innovations in care delivery models offer principles and experience to guide successful care coordination and quality improvement, particularly with high risk and vulnerable populations.
3. Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives are essential primary care providers.
4. Financial and systemic incentives should be required for care coordination to assure that it is properly designed and implemented by qualified healthcare professionals with experience in care coordination.

NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

Qualifications and skills of successful care coordinators

Recommendation: NACNS recommends that CMS adopt the National Coalition on Care Coordination[1]definition of care coordination as "... a person-centered, assessment-based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator" [Section 425.4, "Definitions," p. 19641]. The key to this definition is *a health professional who serves as the lead care coordinator.* The care coordinator should be a health professional from any of several different disciplines for most patients; however, for many, a registered nurse is often the best care coordinator.

Rationale: NACNS endorses use of a care coordinator to assure that the needs of patients are identified and met, and to support providers. A care coordinator should be a health professional from any of several different disciplines for most patients; however, for many, a registered nurse is often the best care coordinator. Registered nurses (RNs) are educated to provide care coordination and have the knowledge, skills and competencies to serve in this role. Care coordination is one of the standards of professional nursing practice to which *all* RNs are held.

Research indicates that CNSs are able to prevent readmissions as documented in a study of discharge planning from hospital to home care for the elderly. The studies showed fewer readmissions and fewer days of re-hospitalization in the group who received the service from the gerontological CNSs. [3] Studies have also shown that programs developed by CNSs assist congestive heart failure patients with self-care to prevent hospital readmissions [4], [5], [6], [7], [8]

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[3] Naylor, M.D., Brooten, D.A., Campbell, R.L., Maislin, G., McCauley, K.M., Schwartz, J.S. (2004). Transitional care of older adults hospitalized with heart failure: A randomized controlled trial. *Journal of the American Geriatric Society, 52*(5), 675-684.

[4] Newman, M. (2002). A specialist nurse intervention reduced hospital readmissions in patients with chronic heart failure. *Evidence-Based Nursing, 5*(2), 55-56.

[5] Creason, H. (2001). Congestive heart failure telemanagement clinic. *Lippincott's Case Management*, July/August, 146-156.

[6] Knox, D. & Mischke, L. (1999). Implementing a congestive heart failure disease management program to decrease length of stay and cost. *Journal of Cardiovascular Nursing,* 14(1), 55-74.

[7] Ryan, M. Improving self-management and reducing readmissions in heart failure patients. *Clinical Nurse Specialist,* 23(4) 216-221.

[8]Newman, M. (2002). A specialist nurse intervention reduced hospital readmissions in patients with chronic heart failure. *Evidence-Based Nursing, 5*(2), 55-56.

NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

Transitions in Care requirements should provide more specific guidance

Recommendation: NACNS recommends that additional, specific guidance be included in section 425.5 (d)(15)(ii)(B)(5) of the proposed rule, consistent with the requirements of ACA section 3026 ("Community Based Transitional Program"), regarding the mechanisms in place for coordination of care as part of the required elements for patient-centered care in an ACO [p.19645].

Rationale: The use of transitional care has proven to be very effective in reducing readmissions, increasing the time between discharge and readmission or death, and in reducing health care costs. The transitional care model is a vital component of care coordination directed by an advanced practice registered nurse.[9]

NACNS is pleased to note that transitions in care among providers, whether inside or outside the ACO, are an essential principle for patient-centered care in the proposed rule. [p. 19548; proposed rule Section 425.5(d)(15)(ii)(B)(5)(i), p.19645] The statutory inspiration for its inclusion in the ACO proposed rule appears to be Section 3026 of the ACA, "Community Based Transitional Program," in the same Part III of Title III in which the "Medicare Shared Savings Program" section appears ("Encouraging Development of New Patient Care Models"). ACA Section 3026 lists those interventions that improve the likelihood of successful transition for high-risk Medicare beneficiaries between a hospital and a community-based organization.

CMS should likewise include these interventions to provide further guidance to ACOs regarding strategies for care coordination and patient-centeredness [pp. 19547-8; proposed rule Section 425.5(d)(15), p. 19645]. Currently, the proposed rule calls for processes for transition of care to be in place but provides little guidance as to successful principles for implementation, based on a concern that the requirement will be overly prescriptive. Yet NACNS believes evidence-based protocols should be included in the NPRM to better establish expectations for ways in which ACOs can meet required principles. The Section 3026 elements that might be adopted now or in future rulemaking are:

> "(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity;
> (ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or deteriorating condition;
> (iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the primary

[9] Naylor 2004

caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers;
(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) through the provision of self- management support and relevant information that is specific to the beneficiary's condition; and
(v) Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support)."

CMS has requested comments on whether additional patient-centered criteria should be added to the proposed rule [p.19549]. NACNS recommends that the change proposed above be reflected in section 425.5 (d)(15)(ii)(B)(5) of the rule regarding the mechanisms in place for coordination of care as part of the required elements for patient-centered care [p.19645].

Leadership pertaining to quality issues within the ACO is exclusive to physicians and does not permit appropriately qualified health professionals, including registered nurses, to assume such roles.

Recommendation: NACNS recommends that Section 425.5(d)(9)(iii) be amended 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."

NACNS further recommends that Section 425.5(d)(9)(v) be amended to read: "(v) A ~~physician-directed~~ quality assurance and process improvement committee must oversee an ongoing action-oriented quality assurance and improvement program...." [p.19644

Rationale: Section 1899(b)(2)(F) of the ACA requires ACOs, as a requirement for eligibility, to "have in place a leadership and management structure that includes clinical and administrative systems." This is followed by section (G), which adds: ''The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies." These two sections appear to be the basis for the Secretary's requirement for an ACO's application to include physician-led "clinical management and oversight" and a "physician-directed quality assurance and process improvement committee."

However, the ACA does not include a statutory provision requiring physician leadership of ACO clinical management and oversight, nor for quality assurance and process improvement. The inference made by the proposed regulatory provision -- that a physician is automatically more qualified than other healthcare professionals to lead such processes -- is not supported by research or in practice. Engagement in these activities is not part of a health professional's state scope of practice. Leading quality assurance and process improvement activities are competencies developed by a professional and there are multiple health care professionals who make significant contributions to and lead quality assurance and improvement programs across the health care delivery system.

The health care quality literature, clinical practice and managerial evidence support the role of Clinical Nurse Specialists, as highly qualified professionals to lead clinical management and oversight committees and other quality assurance and process improvement mechanisms within institutions and organizations. The Institute of Medicine, in its 2011 report "The Future of Nursing: Leading Change, Advancing Health," recommends that nurses be full partners with physicians and other healthcare professionals and that nurses should act as leaders in implementing systems such as ACOs.[10] This is true across the spectrum of institutions and organizations regardless of size, geographic location, patient demographics, and other defining characteristics.

Clinical Nurse Specialists lead clinical teams, including physicians and nurses, to implement evidence-based system-wide changes to reduce infections, medical errors and costs in acute care facilities, as well as reduce hospital-acquired conditions. Studies have shown a decrease in complications and costs by reducing pain and decreasing expensive ICU days when CNSs develop evidence-based practice guidelines to effectively address pain and to reduce the incidence of preventable pulmonary complications including ventilator acquired pneumonia another source of high costs. [11],[12], [13]At the Mayo Clinic and Cleveland Clinic CNSs lead system-wide efforts to improve the care and lower costs.

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[10] Institute of Medicine (IOM). 2011. *The Future of Nursing: Leading Change, Advancing Health*, Washington, DC: The National Academies Press.

[11] Hanneman, Sl, et.al. The indirect patient care effect of a unit-abased clinical nurse specialist on preventable pulmonary complications. *American Journal of Critical Care*, 2(4), 331-338.

[12] Murray, T. (2005).Ventilator-associated pneumonia as a nurse-sensitive outcome: the role of the clinical nurse specialist in the development and implementation of clinical systems to reduce ventilator associated pneumonia. *Clinical Nurse Specialist*, 19(2), 80.

[13] Vollman, K. (2006) Ventilator-Associated Pneumonia and Pressure Ulcer Prevention as Targets for Quality Improvement in the ICU.*Critical Care Nursing Clinics of North America*, 18(4), 453-467

NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

Patient-centeredness principles in the proposed rule measure only physicians' clinical or service performance. The rule should also include measures of nursing processes and outcomes to seize a crucial opportunity for improving care and service over time. [Section 425.5(d)(15)(ii)(B)(9), p. 19645]

Recommendations: ANA recommends that Section 425.5(d)(15)(ii)(B)(9) be amended to read: "(9) Internal processes in place for measuring clinical or service performance by ACO professionals and registered nurses across the practices, and using these results to improve care and service over time." [p.19645]

Rationale: The proposed rule's patient-centeredness principles appropriately recognize that the performance of care providers must be measured in order to provide opportunities to analyze and compare outcomes with the purpose of improving future care delivery. Only physicians' work is measured, though, despite registered nurses' integral clinical and service functions within an ACO that bear directly on the quality and safety of care, as well as the patient's experience of care. These contributions are ignored; however, using existing data collection efforts specifically aimed at measuring nursing performance can change this.

ANA's National Database of Nursing Quality Indicators (NDNQI®) is a nationally recognized program that collects and evaluates unit-specific nurse-sensitive data from hospitals in the United States and abroad. Participating facilities receive unit-level comparative data reports to use for quality improvement purposes.

As of April 2011, NDNQI® has been adopted by almost 2000 hospitals in the United States and internationally. This is approximately one-third of American hospitals where nurse- specific data is already being collected and analyzed to permit performance assessment and improvements in patient care. Furthermore, CMS's Hospital Inpatient Quality Reporting (IQR) Program (formerly the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)) now includes a focus on measuring nursing quality. Beginning in FY2010, the CMS requirement includes hospital reporting on whether or not nurses participate in a systematic clinical database registry for nursing-sensitive care. Participation in the ANA's NDNQI® database satisfies CMS's reporting requirement.

Given that there are widely adopted and validated clinical measures that directly assess nursing-specific care at the unit level, the inclusion of a measuring requirement for registered nurses in ACO hospitals will contribute substantially to a better understanding of how care can be improved, while not imposing a significant burden on ACOs to collect

this data. (More information about NDNQI® is available at https://www.nursingquality.org.)

In multiple instances the proposed rule unnecessarily refers only to physicians, e.g. the assignment methodology, physician-directed quality programs and the post-discharge physician visit. This perpetuates a system overly dependent on physicians when the burgeoning growth of the Medicare population demands innovative models of care that utilize a wide array of health care professionals. This physician-centric perspective, reflected throughout the proposed rule, runs counter to the goal of building patient- centered interdisciplinary teams.

Recommendation: NACNS recommends that the proposed rules be more inclusive of APRNs, and specifically NPs and CNSs in clinical, management and leadership aspects of the ACO such as assignment, quality assurance and quality measures such as the 30-day post-discharge visit. The ACO will need to promote the use of NPs and CNSs as well as other health care professionals to meet the needs of beneficiaries. If the ACO rule is to establish the framework for many other future versions of the Shared Saving Program – demonstration projects, etc. – then in order for it to be effective and respectful of beneficiaries' individual needs and choices, it must be non-discriminatory and non-preferential toward different types of providers.

Rationale: A truly reformed healthcare system must acknowledge an evolved healthcare workforce if we are to meet the goal of the "triple aim." There are approximately 250,000 APRNs and 900,000 physicians (MDs/DOs) in the US. In 2009, 92,472 APRNs participated directly in Medicare Part B. Many serve Medicare (and Medicaid) patients who often struggle to access care. Many physicians no longer accept Medicare patients because of low reimbursement. The Joint Commission reported that poor communication was the number one cause of sentinel events. Building patient-centered, team-based care requires "a combination of frequent, substantial communication; a deep base or shared goals and knowledge; and mutual respect.... In other words, teamwork requires more than just having other staff more effectively support physicians. It involves building and sharing a collective identity as a true team."[14] This relational and communications coordination among healthcare professionals improves patient care, safety and satisfaction.

The Federal Trade Commission in recent letters to members of the Florida House of Representatives and Texas Senate regarding legislation that would remove constraints on APRN-physician supervision arrangements stated that removing these restrictions would

[14] Chesluk, B.J., Holmboe, E.S. (2010) How Teams Work – Or Don't – in Primary care: A Field study on Internal Medicine Practices." Health Affairs 29(5):p. 875.

be procompetitive and provide greater consumer access to health care, in particular for the underserved populations, including rural or inner-city patients or the elderly. Removing these restrictions would allow APRNs to practice to the full extent of their education and training.[15], [16] It is critical that the current barriers in the ACO proposed regulations be removed to fully utilize CNSs and other APRNs. Their services are needed to improve the quality, lower the costs and increase access.

Assuring adequate funding and staffing for ACO's care coordination function and care coordinators

Recommendation: NACNS recommends that CMS develop ACO program applications that require organizations to include a detailed plan for maintaining and enhancing care coordination activities across all settings in which assigned beneficiaries receive Medicare covered services. In addition, the application must document the qualifications of proposed care coordination staff (or job titles), and the care coordination experience required prior to hiring, placing, or securing the services of those personnel. Further, the applications must clearly document the care coordination funding levels over the course of the three-year contract, and monitoring steps that will be implemented to assure adequate staffing by experienced personnel for the duration of the project.

Rationale: The twin objectives for the ACO program are reductions in the cost of care for Medicare patients and improvement in the quality of care delivered to those patients. The novelty in this approach is that there are direct financial incentives to encourage the accomplishment of both goals. The linchpin to accomplishing those goals, however, is care coordination. For this reason, it is important that organizations that apply for ACO status must be prepared to properly support the care coordination function and the on-the-ground employees/contractors/partners that will be responsible for care coordination. Care coordination is such an important aspect for ACO success that regulatory parameters for its implementation should not be sacrificed in the name of providing "flexibility" to the ACO. Some guidance should be available to set minimum standards, reflecting evidence- based practice. In developing a quality assurance plan for ACO beneficiaries, a great deal of attention will be paid to clinical services and the plans for organizing multi-disciplinary health care professional teams. In all likelihood, most if not all such professionals will understand the need for care coordination and the functions that are entailed. But we know today that much care is uncoordinated despite the understanding and good intentions of the clinicians involved.

[15] FTC Staff Letter To The Honorable Daphne Campbell, Florida House of Representatives, Concerning Florida House Bill 4103 and the Regulation of Advanced Registered Nurse Practitioners (March 2011)
[16] FTC Staff Letter To The Honorable Rodney Ellis and The Honorable Royce West, The Senate of the State of Texas, Concerning Texas Senate Bills 1260 and 1339 and the Regulation of Advanced Practice Registered Nurses (May 2011)

Because of the importance of care coordination from the outset, it is recommended that applicant organizations be required to document that aspect of their proposal with specific names, dates, and schedules to assure its proper function. With the experience gained from both the Physician Group Practice (PGP) and Medicare Coordinated Care Demonstrations, CMS should establish specific guidelines and budget parameters that must be met by ACO applicants before additional consideration of any proposal. ACOs should not be allowed to fail because they did not plan carefully enough to support their care coordinators and the care coordination function.

Patient Choice of Providers

CMS specifically solicits comments on the kinds of providers that should or should not be included as potential ACO participants; the potential benefits or concerns regarding inclusion or non-inclusion of certain providers; and other ways in which the Secretary's discretion could be employed to allow the independent participation of providers not specifically mentioned in the statute.

The utilization of advanced practice registered nurses (APRNs) to provide primary care services cannot be called "innovative" or "new," given that they have delivered professional health services for decades. Extensive data documents the safe, cost-effective and high quality care they provide. APRNs have the education, skills and experience to meet the needs of Medicare beneficiaries. While NPs and CNSs are cited as "ACO professionals" in the ACA, presumably recognizing their role as primary care providers, all four APRN roles – NPs, CNSs, CNMs, and CRNAs – bill Medicare Part B for primary care services for both beneficiaries who are age 65 and older, as well as those who have disabilities. Too often, though, healthcare systems are not structured to maximize the potential of this rapidly growing component of the healthcare workforce. Removing barriers to practice in federal (as well as state) laws and regulations can unleash the potential of APRNs to help achieve the "triple aim" of improving the health of the population; enhancing the patient experience of care (including quality, access, and reliability); and reducing, or at least controlling, the per capita cost of care.

The "plurality" assignment methodology described in the proposed rule unnecessarily negates primary care services provided by ACO participants other than certain primary care physicians and therefore distorts the complete assessment of who provides a beneficiary's care.

Recommendation: The ACA specifies in section 1899:''(c) Assignment Of Medicare Fee-For-Service Beneficiaries To ACOs. — The Secretary shall determine an appropriate

method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A)." NACNS fully understands that assignment refers only to ACO professionals who are doctors of medicine and osteopathy, and that these are further limited to certain categories of primary care practice. Further, the methodology does not include the second part of the statutory "ACO professional" definition that includes nurse practitioners, clinical nurse specialists, and physician assistants. However, NACNS believes that the Secretary may have inadvertently created a situation that artificially separates some patients from their preferred primary care provider, in her statutory discretion to determine "an appropriate method to assign Medicare beneficiaries."

NACNS recommends that the proposed methodology that uses the plurality of ACO physician primary care services to make beneficiary assignment be revised. CMS can abide by the statutory requirement by basing assignment on utilization of primary care services provided by an ACO professional. *Any* primary care service provided by an ACO professional should be enough to trigger assignment, as long as some other ACO participant has provided the plurality of primary care services to that beneficiary.

Thus, the assignment methodology comports with the statutory requirement, while preserving patients' relationship with their preferred primary care provider, as long as that primary care provider is an ACO participant, including APRNs, or at least an ACO professional.

Rationale: As described in the proposed rule, a beneficiary will be assigned to an ACO if an ACO's primary care physicians provide the plurality of the beneficiary's primary care services. A Medicare beneficiary who received the plurality of his or her primary care services from an APRN would not be assigned to an ACO, even if that beneficiary's APRN was affiliated with the ACO. This scenario holds the potential to disrupt continuity of care and the patient-provider relationship. Under this proposed revision, a beneficiary who received the plurality of services from an APRN participating in an ACO would be eligible for assignment based on any primary care services provided by an ACO primary care physician. At the same time, the patient would be able to continue to receive primary care services from the APRN, or other ACO participant from whom they receive a plurality of that care. This recommended modification meets the ACO's goals of preserving continuity of care and patient choice, while still honoring the purpose for which the "plurality rule" was presumably based, that is, keeping beneficiaries aligned with one ACO.

Without such a change to the "plurality rule," a beneficiary who receives the plurality of primary care services from his or her APRN who is not affiliated with an ACO would

simply not be assigned to an ACO. While this would still promote continuity of care and preserve the relationship between the patient and his or her primary care APRN provider, it would potentially deprive the patient (and CMS) of the hoped for benefits of that beneficiary being part of the ACO.

Section 1899(b)(2)(D) of the Act requires participating ACOs to "include primary care ACO professionals that are sufficient for the number of Medicare FFS beneficiaries assigned," and that the ACO will have a minimum of 5000 such beneficiaries. For systems that currently depend heavily on health care professionals other than primary care physicians to provide primary care services, the current assignment methodology may pose a problem in their ability to fulfill this eligibility requirement. Thus, an additional benefit of a change to the proposed "plurality rule" would be that it would permit smaller organizations to form ACOs by potentially increasing the number of eligible beneficiaries for which assignment may be made.

Multiple nationally recognized organizations that create quality standards for patient care have adopted clinician-neutral language to designate primary care providers. The Joint Commission's recently adopted Standards and Elements of Performance (EPs) for the Primary Care Medical Home Option (supplemental to its Ambulatory Care Accreditation Program) uses provider neutral language throughout, by referring to "primary care clinicians." [17]The EPs reflects a truly patient-centered care environment, where the organization allows each patient to designate his or her primary care clinician (EPs for PC.02.01.01). The qualification is that the "primary care clinician has the educational background and broad-based knowledge and experience necessary to handle most medical and other health care needs of the patients who have selected them, including resolving conflicting recommendations for care" (EP for HR.03.01.01).

Similarly, both the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home recognition program[20] and URAC's Patient-Centered Health Care Homes Program has moved to clinician-neutral language to describe primary care providers. CMS should reflect the growing national consensus among influential quality organizations that place nurse practitioners and other qualified clinicians squarely within the category of primary care providers within the patient-centered medical/health home. This should be the case whether reflected in ACO primary care providers or in any other programs, demonstrations or pilots sponsored by CMS. Adopting a more narrow interpretation of primary care providers conflicts with the approach of multiple national

[17] Approved Standards and Elements of Performance (EPs) for The Joint Commission Primary Care Medical Home Option. May 19, 2011. Available at http://www.jointcommission.org/assets/1/18/Primary_Care_Home_Posting_Report_20110519.pdf

standard-setting organizations, as well as real-world practice. Further, it rejects a significant pool of qualified primary care providers who are available to help ameliorate the country's primary care workforce shortage.

The revised alignment algorithm, which is part of the Pioneer ACO Model to be offered by the Center for Medicare and Medicaid Innovation, as described in the Request for Application accompanying the *Federal Register* notice of May 20, 2011 [Vol. 76, No. 98, pp. 29250-1], includes nurse practitioners and physician assistants in the definition of primary care providers, for purposes of "beneficiary alignment." This reflects the rationale offered above for changes in the ACO proposed rule's "plurality" calculations. We urge CMS to, at a minimum, create continuity between the two programs – the Shared Savings Program and the ACO Pioneer Model – to the full extent permitted by the ACA. NACNS believes that its proposed revision of the ACO "plurality rule" achieves both these aims and urges CMS's adoption.

Innovative models of community based care, in addition to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), are not among those delivery systems for which the ACO can receive incentives for including.

Recommendation: NACNS recommends that the final rule facilitate the inclusion of innovative models of care, recognized and supported in other provisions of the ACA, which are led by providers other than physicians. NACNS recommends that the incentives relevant to FQHCs and RHCs also be applied to nurse managed health centers (NMHC), and school based health centers (SBHC).

Rationale: CMS has proposed that an ACO can receive an increase in its shared savings rate for including a strong FQHC and/or RHC presence. The rationale for providing incentives to include a strong FQHC and/or RHC presence within the structure of an ACO applies to NMHCs and SBHCs as well. Like FQHCs and RHCs, these are innovative models of community-based care that focus on outreach, disease prevention and patient education. They provide high quality, cost effective care to underserved populations.

In the Acronyms section in the introduction to the proposed rule, CMS has defined the abbreviated terms NP and CNM but failed to include the acronyms for clinical nurse specialist, CNS. Particularly since CNSs are one of the APRN roles specified as ACO professionals, we urge CMS to include the abbreviation for CNSs in the list introducing the final rule.

NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

Conclusion

NACNS strongly supports the move to a patient-centered healthcare delivery system based on interprofessional collaboration and a focus on improving the quality and coordination of care. We are disappointed that the proposed regulation implementing the ACO shared savings program does not recognize the essential role clinical nurse specialists, registered nurses and the other APRNs play in achieving these goals.

A cornerstone competency of nursing is care coordination, an element at the core of the ACO's purpose to improve care quality and control costs. In addition, clinical nurse specialists, registered nurses and the other APRNs are acknowledged leaders in developing transitional care models, chronic disease management programs and other initiatives that help keep costs down while improving patients' quality of care. These very programs are among those that will help to reduce adverse drug events, emergency department utilization, and hospital readmissions, among the most expensive potentially avoidable expenditures in the Medicare budget. Quite simply, a de-emphasis on nursing will dramatically reduce both an ACO's chance of success and CMS's chance to save money.

In its recent report, *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine's independent committee of national experts in healthcare concluded that nurses

> are poised to help bridge the gap between coverage and access, to coordinate increasingly complex care for a wide range of patients, to fulfill their potential as primary care providers to the full extent of their education and training, and to enable the full economic value of their contributions across practice settings to be realized. In addition, a promising field of evidence links nursing care to high quality care for patients, including protecting their safety. Nurses are crucial in preventing medication errors, reducing rates of infection, and even facilitating patients' transition from hospital to home.[18]

NACNS appreciates the opportunity to comment on CMS's proposed rule. NACNS stands ready to provide whatever assistance CMS may need in order to capitalize on clinical nurse specialists' unique contributions to patient care and the interprofessional care team. To do so will help assure that ACOs are truly accountable to the patient, to the provider, and to the taxpayers who support the Medicare system.

Sincerely,

Stephen Patten MSN, RN, CNS, CNOR
President, NACNS

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[18] Institute of Medicine (IOM), p. S-3.