

November 20, 2017

Seema Verma  
Administrator  
Centers for Medicare and Medicaid  
Department of Health and Human Services  
Attn: CMS-5524-P  
PO Box 8016  
7500 Security Blvd.  
Baltimore, Maryland 21244-8016

**Re: Centers for Medicare and Medicaid Services: Innovation Center New Direction**

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 comment on CMS' Request for Information (RFI) on the new direction for the CMS Innovation Center (Innovation Center).

NPs are advanced practice registered nurses (APRNs) 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.

CMS requested feedback on seven questions in this RFI. Our responses to those questions may be found below. We look forward to working with CMS on innovative ways to improve health care quality and patient outcomes, and reduce costs in the Medicare and Medicaid programs.

**1. Do you have comments on the guiding principles or focus areas?**

We agree with CMS that choice, competition, reduction of regulatory burden, patient-centered care, data-driven insights and transparent model design and evaluation are important guiding principles for the Innovation Center. The suggestions that we provide in this document follow those guiding principles and are important components of future care models.

Small Scale Testing: Since CMS is putting an emphasis on voluntary models, there is less concern that participants will find the models to be cumbersome. Qualified clinicians that would like to participate in the models should have an opportunity to do so. It is our opinion that this will provide increased opportunity for all providers to participate, accelerate the implementation of value-based care and provide CMS with more actionable data moving forward.

Program integrity: As we have stated in previous comments, current “incident to” billing practices lead to inaccurate data collection since the visit is not attributed to the clinician that performs the service. While it is our opinion that “incident to” billing should be discontinued, we also note that the billing guidelines related to “incident to” services could be amended by regulation or guidance to ensure that all practitioners bill under their own billing ID for the services that they provide. In the transition to value-based reimbursement, it is important that the most accurate data is obtained to document and evaluate practitioners and the services they provide.

Current “incident to” billing practices undermine the foundation 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. CMS has indicated that the MACRA patient relationship codes could be used in this fashion. This would ensure the accuracy of billing and claims data which is an important component in the transition to value based reimbursement. We look forward to further work with CMS on this issue.

## **2. What model designs should the Innovation Center consider that are consistent with the guiding principles?**

One model design that is consistent with the guiding principles is the nurse managed health clinic (NMHC). CMS specifically requested examples of models that would increase opportunities for clinicians serving Medicaid and CHIP populations, and the NMHC is consistent with this purpose. This model would also be effective in the Medicare and dual-eligible populations. NMHCs are clinics managed by nurse practitioners where most of the services are provided by nurses with a focus on providing comprehensive primary care and wellness services to underserved and vulnerable populations. The NMHC model includes community outreach to ensure that the care is patient-centered and incorporates social determinants of health. Although not a necessary component, this model also has, in the past, had the added benefit of partnering with schools, colleges and universities to serve as clinical training sites to grow the health care workforce.

The NMHC is an effective care model that is consistent with the CMS guiding principles for health care innovation. It can be adapted for use to provide comprehensive care for specific populations, such as beneficiaries with diabetes, or with a focus on behavioral health and combatting the opioid epidemic. A possible payment structure for an NMHC would involve a global payment model that considers the need for services such as preventive care, long-term support, counseling and alternative pain management.

CMS could also incorporate waivers such as those mentioned below, as well as waivers such as the Next Generation ACO Model Telehealth Waiver which allows the telehealth originating site to be a beneficiary’s home. These would provide additional flexibilities for the NMHCs to provide comprehensive care in the most cost-efficient manner. We believe that the NMHC model is consistent with the goals of the Innovation Center and should be considered as a framework for new demonstrations.

### **3. Do you have suggestions on the structure, approach, and design of potential models?**

An overarching goal of future care models should be to support and create models that provide equal opportunity for all clinicians and their patients to participate. One way to increase participation is to include nurse practitioners as full participants in the model. This is an important consideration given the increased emphasis on private-public partnerships on future care models because some insurers, despite statutory authorization, still do not allow nurse practitioners to participate in their alternative payment models (APMs). We encourage CMS to put an emphasis on incorporating models that allow all authorized clinicians, including nurse practitioners, to participate equally when considering what models to include in the Quality Payment Program APM track, as well as in the development of new models.

In that vein, we encourage CMS to continue to increase access for nurse practitioners and their patients to be full participants in the Medicare Shared Savings Program. Section 3302 of the PPACA, which governs ACOs, grants the Secretary broad waiver authority as “necessary to carry out the provisions of this section,” and explicitly allows the Secretary to waive requirements of title XVIII of the Act. By waiving the definition of “physician” in title XVIII of the Act, the Secretary could remove these unnecessary burdens on NPs and their patients.

APMs and demonstrations that utilize nurse practitioners to the full extent of their education and clinical training have demonstrated consistent success in both improving patient outcomes and generating cost savings. Examples of this success include the Independence at Home demonstration and medical home models. We urge CMS to continue to develop models such as these with a primary care focus. As we have stated, it is important to note that over 89% of nurse practitioners are certified in primary care.

### **4. What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?**

We believe that care should be patient-centered and increasing the role of patients in future models is an important goal of the Innovation Center. Allowing patients to directly contract with the provider of their choice can be an important component of a patient-centered care model that encourages greater patient participation. However, we caution that moving toward models centered around price sensitivity could impact the quality of care and lead to limitations in coverage that do not contribute to the patient’s well-being. Care models that incorporate price shopping need to have appropriate safeguards to ensure that patients continue to receive high-quality care.

### **5. How can CMS further engage beneficiaries in development of these models and/or participate in new models?**

We encourage CMS to continue to hold listening sessions and workgroups that discuss the goals of the Innovation Center and to provide more frequent updates on the status of the models. This includes ensuring that all clinicians, including nurse practitioners, are involved in the discussions related to the development of the models and quality measures. While the annual model reviews that CMS releases are very informative, it would also be helpful to have more frequent and targeted information focusing on the day to day aspects of practicing under one of these innovative models. This would be beneficial to clinicians considering future care models and the ways that they can institute best practices for future success in patient care.

### **6. Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?**

CMS requested feedback on payment waivers that should be considered to help healthcare providers innovate care delivery as part of a model test. As a means of increasing provider choice, CMS also suggested reducing regulatory burdens on clinicians participating in the recommended models.

We strongly support the recommendation. Implementing waiver authority in future models will give NPs increased flexibility to provide the best possible care to their patients in the most cost-effective manner.

Reduction of regulatory burden supports the CMS Guiding Principles. As we have mentioned in previous comments, nurse practitioners are hindered in their ability to provide Medicare and Medicaid services by an outdated regulatory framework that limits access to care, decreases flexibility, and increases cost. For example, CMS recognized that physician order and supervision requirements were reducing access to cardiac rehabilitation and waived these regulations in the proposed cardiac rehabilitation incentive payment model that authorized nurse practitioners to provide these services. While that model may not come into effect as proposed, for other reasons, the reduction of those regulatory barriers was widely supported among stakeholders. That framework can be replicated for other settings and treatments.

For instance, waiving physician certification and documentation requirements in home health and hospice care will reduce unnecessary paperwork and provide nurse practitioners and their patients with additional flexibility and timely access to care. We believe that these are important components to any future care models related to home health and hospice care and will provide CMS with the best opportunity to maximize the efficiency and success of these models. We suggest that CMS create a waiver to ensure that patients of nurse practitioners have access to vital health care services, such as home health, by authorizing NPs to certify their patients' need for them.

Similarly, many other treatments and settings still have unnecessary order and supervision requirements that limit nurse practitioner ability to provide high-quality care in the most efficient and cost-effective manners. Waiving these requirements for models involving skilled nursing facilities, rehabilitation facilities, hospitals, rural health clinics and federally-qualified health centers would provide participating facilities with much-needed flexibility to innovate. We have enclosed a document with other regulatory burdens that could be waived as components of model tests.

**7. Are there any other comments or suggestions related to the future direction of the Innovation Center?**

We continue to urge CMS to ensure that all clinicians, including nurse practitioners, are heavily involved in the transition to value-based reimbursement. Nurse practitioners play a critical role in the Medicare and Medicaid programs, and with the transition away from fee-for-service it is imperative that new care models and value-based arrangements utilize nurse practitioners to the full extent of their education and clinical training. The waiver authority granted to CMMI provides an important opportunity to utilize the skills of nurse practitioners in innovative ways to provide the best possible care to their patients.

We thank you for the opportunity to comment on CMS' New Direction for the Innovation Center. We look forward to continued discussion with CMS on ways to provide high-quality innovative care to beneficiaries. 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

Enclosure