



8515 GEORGIA AVENUE, SUITE 400  
SILVER SPRING, MARYLAND 20910-3492  
301 628-5000 • FAX 301 628-5001  
[www.NursingWorld.org](http://www.NursingWorld.org)

KAREN A. DALEY, PhD, MPH, RN, FAAN  
PRESIDENT

MARLA J. WESTON, PhD, RN  
CHIEF EXECUTIVE OFFICER

August 24, 2010

Donald Berwick, MD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1503-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

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

Re: **Medicare Program; Payment Policies Under the Physician Fee  
Schedule and Other Revisions to Part B for CY 2011; Proposed Rule.**  
CMS-1503-P; RIN 0938-AP79. 75 Fed.Reg. 40039 (July 13, 2010).

Dear Administrator Berwick:

The American Nurses Association (ANA) welcomes the opportunity to offer comments on this proposed rule. The ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses, the single largest group of health care professionals in the United States. We represent RNs in all roles and practice settings, through our state and constituent member nurses associations, and organizational affiliates. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and advocating before Congress and regulatory agencies on health care issues affecting nurses and the public. Our members include Advanced Practice Registered Nurses (APRNs) such as Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs).

ANA offers comments on the specific sections of this proposed rule as indicated below.

## **II. Provisions of the Proposed Rule for the Physician Fee Schedule**

### *ANA Supports Comments Submitted By The RUC*

For several years, the ANA has participated in the American Medical Association/ Specialty Society RVS Update Committee, commonly known as the RUC, as a voting member of the Health Care Professionals Advisory Committee (HCPAC). The RUC

HCPAC is responsible for making relative value unit (RVU) recommendations for services which are provided exclusively by non-physician practitioners.

As the only nursing society approved to directly participate in the RUC HCPAC, the ANA is charged with representing the interests of the entire nursing profession, including advanced practice registered nurses who may enroll as direct Medicare providers. In addition, ANA participates as a member of the RUC Practice Expense Subcommittee. Staff RNs often account for a significant portion of the clinical staff time and expenses included within the practice expense component of RVUs.

CMS' rule contains numerous proposals regarding current and recent RUC recommendations, procedures, and methodology. We understand that Dr. Barbara Levy, now chair of the RUC, is submitting detailed comments responding to those proposals. We were given an opportunity to provide input on those comments. We would like to express the ANA's full support of the RUC's comments on this proposed rule.

## **V. Provisions of the Patient Protection and Affordable Care Act of 2010**

### **J. Section 3114: Improved Access for Certified Nurse-Midwife Services**

ANA welcomes this effort to provide equitable reimbursement. The Affordable Care Act (ACA) increases payment for CNM services, effective January 1, 2011, to 80 percent of the lesser of the actual charge or 100 percent of the physician fee schedule amount.

The Centers for Medicare Services (CMS) is further specifying in the regulations that Medicare pays CNMs for professional services in all settings, as well as services and supplies furnished incident to those services, and that CNMs are authorized to furnish diagnostic tests that fall under their state scope of practice without regard to the levels of physician supervision required under the diagnostic tests benefit.

CNMs serve a critical role as primary care providers for women throughout the lifespan and regulatory changes that will unleash the potential of this group of providers are critically needed to fill the gaps in primary care. The language in this section is a significant step forward, as is recognizing the varied settings where care is provided.

### **Q. Section 4103: Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan**

#### **b. Proposed Revisions to Part 410, Subpart B—Medical and Other Health Services**

##### **(1) Definitions —*Health professional***

ANA proposes that CNMs be added to the list of "health professionals" of the interim regulations. ANA is pleased that the ACA recognizes the contribution of APRNs and CNSs among those "health professionals" authorized to provide care under the "annual wellness visit" provisions of the law. The flexibility in the type of healthcare professional who can conduct prevention plan services will enhance both accessibility and patient satisfaction. The availability of the full spectrum of qualified healthcare professionals in

providing such services increases overall efficiency in the patient visit, and results in high quality outcomes.

While the law and the interim regulation appropriately designate APRNs, CNSs and physician assistants (PAs) as “health professionals” available to provide wellness services, the omission of CNMs appears to be an oversight that could significantly affect access to care for women. It is a common misapprehension that Medicare does not provide midwifery services to its beneficiaries, but this is not supported by the data. In fact, a higher proportion of Nurse Midwife services of the services directly billed to Medicare Part B were for primary care services compared to CNSs, who are included in the definition of a primary care professional. Based on the 2008 APRN data from CMS, there were approximately \$530 million covered PCP services provided by APRNs. On average, nurse practitioners (NPs) primary care approved charges were at 58 percent, nurse midwives (CNMs) were at 45 percent, CNSs were at 27 percent, and CRNA's were less than 1 percent.

In calendar year 2008, APRNs experienced the following volume of designated primary care services:

Approved charges	Services	APRN role
\$517,754,711	8,939,043	NP (nurse practitioner)
\$11,904,470	201,576	CNS (clinical nurse specialist)
\$595,285	14,206	CNM (certified nurse midwife)
\$190,829	3,104	CRNA (certified registered nurse anesthetist)

ANA believes that this oversight – omitting CNMs from the definition of “healthcare professional” -- should be rectified by the interim regulations. In doing so, CMS will be respecting those Medicare beneficiaries that prefer to access primary care services from CNMs.

## **R. Section 4104: Removal of Barriers to Preventive Services in Medicare**

The ANA appreciates this proposed section. Health promotion and disease prevention are hallmarks of nursing, and have been since the dawn of professional nursing.

### **1. Definition of “Preventive Services”**

- Pneumococcal, influenza, and hepatitis B vaccine and administration.

In 2008, the Advisory Committee on Immunization Practices (ACIP) recommends that all persons 60 years of age and older without medical contraindications should receive a dose of herpes zoster vaccine. Therefore, this vaccine should be included in the list of immunizations covered under preventive services, and when section § 410.160(b) is updated, to include this important vaccine. While it does not have a current USPSTF

rating, even as the proposed included vaccines do historically, the ACIP's recommendation should be respected. ANA is a liaison member to the ACIP, and promotes immunization for public health and patient safety as part of its Bringing Immunity to Every Community initiative.

## **2. Deductible and Coinsurance for Preventive Services**

ANA commends the addition of § 405.2449 in applying the new preventative services definition to the definition of Federally Qualified Health Center services, especially since many of these centers APRNs provide care in these settings, and in some cases constitute a majority of the medical staff.

## **S. Section 5501: Expanding Access to Primary Care Services and General Surgery Services**

### **b. Proposed Primary Care Incentive Payment Program (PCIP)**

ANA appreciates the inclusion of non-physician practitioners in the rule, as it is an important example of the widespread recognition of the important role NPs are playing in providing primary care. However, as stated earlier in these comments, CNMs must be included in the definition of nonphysician practitioners with primary care specialty designation for Medicare enrollment. CNMs are not recognized in the statute even though some provide primary care services for more than 60 percent of their total approved charges. It bears repeating that the national Medicare CNM experience was at 45 percent in 2008.

ANA stresses the importance of inclusion of CNMs in rules regarding primary care and wellness services for their decades-old commitment to caring for women and their families. From the early days of the Frontier Nursing Service, when nurse-midwives traveled on horseback to serve the families of Appalachia, CNMs have provided family-centered, community based care with a focus on health promotion. For many women, their CNM is their primary care provider. When establishing regulations intended to increase access to primary care services, CNMs should be designated primary care providers.

We appreciate the opportunity to comment on this important rule. If we can be of further assistance, or if you have any questions or comments, please feel free to contact Eileen Carlson, RN, JD, Associate Director, ANA Government Affairs at [Eileen.carlson@ana.org](mailto:Eileen.carlson@ana.org) or 301-628-5093.

Sincerely,



Mary Jean Schumann, MSN, MBA, RN, CPNP  
Chief Programs Officer  
American Nurses Association