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August 29, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P
P.O. Box 8013
Baltimore, MD 21244-8013

Sent via email to: <http://www.regulations.gov>

Re: Medicare Program; Revision to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identification Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015

Dear Administrator Tavenner:

ANA welcomes the opportunity to provide comments with respect to this Request for Information. 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. ANA members include advanced practice registered nurses (APRNs) such as nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), and certified nurse-midwives (CNMs).

Encourage the Use of Broader Provider Language that Includes APRNs

Throughout the preamble of the proposed rule, CMS uses the terms "physician" and "physician services," even in instances when the agency may also be referring to APRNs. We are concerned that the use of physician-centric language in the proposed rule does not appropriately reflect all of the types of healthcare professionals who treat patients in addition to physicians. ANA strongly recommends that, except in provisions that relate ONLY to physician care, that CMS use terminology that clearly reflects APRNs and the broader provider community. The use of terms such as "practitioner" or "provider" is preferable since these terms do not necessarily refer to only one type of practitioner.

We note the recommendation from the Institute of Medicine's (IOM) report, The Future of Nursing: Leading Change, Advancing Health that outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs. The IOM report specifically recommends that, "advanced practice registered nurses

should be able to practice to the full extent of their education and training.” Using more inclusive terminology will reduce ambiguity that could lead to unintended consequences and may result in greater utilization of APRN services.

ANA’s specific comments on the MFS NPRM will be focused on sections II.F. Potentially Misvalued Services under the Physician Fee Schedule, II.G. Chronic Care Management (CCM), III. J. Physician Compare Website, and III.K. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System. ANA and its subsidiary, the American Nurses Credentialing Center, which is the accrediting body for continuing nursing education and a joint accreditor with the American College of Continuing Medical Education and the American College of Pharmacy Education, will submit separate comments regarding proposed revisions to section III.I. Reports of Payments or Other Transfers of Value to Covered Recipients.

II.B. Potentially Misvalued Services Under the Physician Fee Schedule

The process for valuing new, revised, and potentially misvalued codes should be more inclusive of all types of qualified healthcare professionals. ANA appreciates that CMS is seeking feedback from stakeholders who are not participants in the American Medical Association Relative Value Update Committee (AMA-RUC) process on valuing new, revised, and potentially misvalued codes. APRNs, along with a large number of other Medicare providers, are ineligible for representation on the AMA-RUC as voting members.

Among the three options proposed by the agency, ANA prefers the first option. Under that option proposed work and malpractice expense (MP) relative value units (RVUs) and direct practice expense (PE) inputs for all new, revised, and potentially misvalued codes would be published in a proposed rule for public comment. Input would be solicited from all types of healthcare professionals, including those who are not physicians. This would make the process for reviewing the Medicare relative values of Current Procedural Terminology (CPT) codes for specific services more transparent and inclusive of the public interest. Furthermore, we suggest that the process be adequately funded so that CMS is able to directly lead this effort.

II.G. Chronic Care Management (CCM)

1. Valuation of CCM Services – GXXX1

ANA reiterates its September 2013 concern that this service should be better targeted to more seriously ill Medicare patients for whom improved care coordination would be more likely to improve quality and reduce costs. As proposed, however, Chronic Care Management services will be available to Medicare beneficiaries with as few as two (or more) chronic conditions. Under this criterion nearly 70 percent of all beneficiaries would be eligible for this service. ANA recommends increasing the number of chronic conditions to four to better target Medicare resources to beneficiaries with the greatest need for chronic care management. Specifically, for those more complicated beneficiaries (with four or more chronic conditions) Medicare spending

per beneficiary is 50% higher than spending for those with only one or two chronic conditions. Beneficiaries with 4 or more chronic conditions also accounted for 90% of Medicare hospital readmissions.

2. CCM and TCM Services Furnished Incident to a Physician's Service under General Physician Supervision

Both HHS and CMS have acknowledged that wherever possible the use of provider neutral language is to be preferred in composing regulations. ANA, therefore, must object to the exclusionary language in the title of this section. ANA membership includes many APRNs who own their own "house calls" practices and provide care for the most vulnerable Medicare beneficiaries. These APRNs are providing clinical services—albeit at the mandated 15% discount from the approved charges for physicians who provide the same service. ANA encourages CMS to use the more expansive term "practitioner" rather than "physician" when discussing services performed by both APRNs and physicians.

ANA concurs that CCM services might often be performed after hours when the practice owner—physician or APRN—is not in the office. ANA is extremely concerned that the expanded authorization for "general supervision" rather than "direct supervision" will provide an even greater incentive for physicians to require that any evaluation and management service performed by an APRN in their practice be billed as "incident to" a physician service. This could serve to reduce transparency in billing data and diminish accountability for services provided to Part B patients.

ANA reiterates its September 2013 recommendation that CMS eliminate "incident to" billing for APRNs. Knowing that this change requires legislative action, ANA strongly recommends as an initial step that CMS introduce and use "incident to" modifiers to prepare for the needed evaluation of "incident to" billing fraud and abuse. Testimony presented to the Medicare Payment Advisory Commission in April 2013 was based on a substantial number of reports that ANA's APRN members had resigned or were fired from physician practices that billed APRN provided services "incident to" when the Medicare beneficiary was seen with no physician in the office. (MedPAC April 5 meeting transcript http://www.medpac.gov/transcripts/0413_meetingtranscript.pdf, p 493-495)

3. Scope of Services and Standards for CCM Services

ANA supports the CMS expectation that continuity of care management must be integrated and fully supported in every health care setting with an electronic health record that promotes interprofessional team communications, including the healthcare consumer as part of the team, and enables clinical monitoring and effective care planning. However, the mandate for clinicians to use 2014 Edition certified EHR solutions is untenable and should be removed in light of the problems associated with today's lack of interoperability and standardization of data and information. Those generating or receiving electronic discharge summaries, clinical documentation, and patient-centered plans of care may not be using such certified technologies for a multitude of reasons and should not be penalized for that unavailability.

III. J. Physician Compare Website

In the Affordable Care Act, Congress chose to label a website of Medicare Part B provider information as “Physician Compare,” even though it was anticipated that information on additional Part B providers would also be included. It might properly have been called the “Medicare Part B Non-Institutional Provider Compare” website. Despite the fact that 39% of Part B providers are clinicians other than physicians, Physician Compare retains a decidedly physician-centric orientation. “Medicare Provider Compare” would have been a more appropriate provider-neutral appellation, and set the tone for provider equality in online search capabilities. The current version is deficient in that regard.

ANA staff conducted keyword searches with respect to Physician Compare based on observations associated with the Washington, DC area. Those keyword searches only appear to yield physician entries despite logical inferences that APRNs might also be providing the same services in question. For example, a search for “kids” yields 163 pediatricians, but no pediatric nurse practitioners. A search for “anesthesia” yields 390 physicians: 172 Anesthesiologists, 60 Critical Care (Intensivists), 127 General Surgeons, 16 Interventional Pain Management specialists, and 15 Pain Management specialists, but no CRNAs. A search for “pain management” yields the first 390 from “anesthesia” plus 281 additional physicians in five additional physician specialties. For more than one decade pain management has been recognized in the Medicare Carrier Manual as a service that can be provided by CRNAs but Physician Compare did not find them under that keyword. Finally, a search for “primary care” with respect to Washington, DC did yield some information on 17 certified nurse-midwives, in addition to 82 FPs, 13 GPs, 27 geriatricians, 41 internists, 23 OBGYNs, and 163 pediatricians, but no NPs or CNSs. A Washington, DC keyword search for “nurse” yields the 17 certified nurse-midwives, in addition to 71 Certified Registered Nurse Anesthetists, 10 Clinical Nurse Specialists, and 191 Nurse Practitioners. CMS data on the primary taxonomies of NPs enrolled as Part B providers in 2012 indicated that 85% selected as their primary taxonomy one of the NP primary care taxonomies, so one might have expected the primary care keyword search to yield at least 162 NPs in DC.

In fact, the current version of Physician Compare only yields the single, generic specialty label for APRNs in the system. Physicians, on the other hand, often have two or more specialties listed with their Physician Compare information. Among secondary specialties listed for the 127 general surgeons in Washington, DC were vascular surgery, colorectal surgery (proctology), ophthalmology, critical care (intensivists), surgical oncology, plastic and reconstructive surgery, gastroenterology, thoracic surgery, pediatric medicine, emergency medicine, internal medicine, preventive medicine, and obstetrics/gynecology. Some physician records include three specialties. This is a function of the design of the enrollment application, the CMS 855i form. In “Section 2: Identifying Information, D. Medical Specialties, 1. Physician Specialty” 60 physician specialties are listed (including “Undefined physician type”). Physician enrollment applicants are asked to identify a single Primary specialty and multiple Secondary specialties. For non-physicians, 16 occupations are listed (including “Undefined non-physician practitioner type”).

Non-physician applicants are directed to select only one occupation title. Those applicants that might want to select more than one occupation—e.g., a nurse practitioner who is also separately licensed as a clinical nurse specialist—are required to submit a separate CMS 855i application for each.

Finally, for those Medicare beneficiaries who dutifully type in “nurse practitioner” or “certified registered nurse anesthetist” into the appropriate field on the Physician Compare search page for Washington, DC, they will be admonished, “You may want to consider Primary Care Physicians in your area,” along with listings for 51 primary care physicians. CMS might be inferred to be casting doubt on the beneficiaries’ original choice, and even expressing a government preference for physicians over non-physician practitioners. Further, because of Medicare section 1833(a)(1)(O)—the provision that CMS pays 15% less for NPs and CNSs—Medicare is missing the opportunity to save Trust Fund dollars.

ANA noted deficiencies in the search capabilities of Physician Compare in its response to last year’s Medicare Fee Schedule NPRM. That may be why the certified nurse-midwives are now searchable under Primary Care. That is merely a very modest first step to bringing Physician Compare into the provider neutral posture that should be required of all Medicare/Medicaid and other HHS websites. ANA recommends that the enrollment application process also be refined to provide a provider neutral enrollment process. The Medicare Part B benefit package is not prioritized; claims for services enter the adjudication process in the order of their receipt rather than by an ordering based on provider specialty. The current Physician Compare website compromises beneficiaries’ ability to transparently access provider information. It is a disservice to nearly 40% of Part B providers who offer covered services to the beneficiary population.

III. K. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

ANA urges CMS to not publicly report Non-PQRS Measures on the Physician Compare Site unless and until they have been vetted by all appropriate eligible professionals affected by the measures. We are concerned that CMS is proposing to include non-PQRS measures for public reporting on the Physician Compare website from CMS-approved qualified clinical data registry (QCDR). Many QCDR’s have been developed by physician specialty societies and are not currently subject to a transparent interdisciplinary consensus evaluation process. If CMS-approved QCDR’s allow the submission of non-PQRS measures for public reporting on the Physician Compare website on behalf of all eligible professionals regardless of their affiliation with the physician specialty society or association, we suggest that CMS develop rules and guidelines for measure stewards who develop non-PQRS measures housed in QCDRs. Such rules and guidelines will serve to inform the public of the development of non-PQRS measures and permit involvement of other eligible professionals in the development of these measures, and minimize the risk of alienating market competitors.

American Nurses Association
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ANA looks forward to continuing activities with CMS related to improving the quality of health care provided to all in America. We appreciate the opportunity to share our views on this matter. We would be happy to speak with HHS and/or CMS leadership and staff further. Please contact Peter McMenamin, PhD, Senior Policy Fellow, ANA Department of Health Policy, at peter.mcmenamin@ana.org, or (301) 628-5073.

Sincerely,

A handwritten signature in cursive script that reads "Debbie D. Hatmaker".

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