

September 2, 2014

Submitted via www.regulations.gov

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1612-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: CMS-1612-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule (79 Fed.Reg. 40318 July 11, 2014)

Dear Ms. Tavenner:

On behalf of the undersigned organizations, we are pleased to provide comments on this proposed rule, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 (79 Fed.Reg. 40318, July 11, 2014).

Advanced Practice Registered Nurses (APRNs) include Certified Nurse-Midwives, Certified Registered Nurse Anesthetists (CRNAs), Nurse Practitioners (NPs), and Clinical Nurse Specialists. APRNs play a significant role in ensuring patient access to high quality, cost effective healthcare. We thank the agency for the opportunity to comment on the provisions in this proposed rule.

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 the types of healthcare professionals who treat patients in addition to physicians. In order

to accurately represent those providing care, we request that CMS utilize provider neutral language. We note the recommendation from the Institute of Medicine's (IOM) report titled *The Future of Nursing: Leading Change, Advancing Health*, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs.¹ The IOM report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."² Including APRNs and using consistent terminology will reduce ambiguity that could lead to unintended consequences and misunderstandings that may result in further practice barriers for APRNs.

Process for Valuing New, Revised, and Potentially Misvalued Codes Should be More Inclusive of All Types of Qualified Healthcare Professionals

We appreciate 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. As the agency is aware, a significant share of Medicare providers are ineligible for representation as voting members on the AMA-RUC. This includes APRNs.³ Among the three options proposed by the agency, we prefer the first option where work and malpractice expense relative value units and direct practice expense inputs for all new, revised, and potentially misvalued codes are placed into a proposed rule for public comment, thus making the process for reviewing current procedural terminology codes for payment of Medicare services more transparent and inclusive of the public interest as well as all types of healthcare professionals, including those who are not physicians. Furthermore, we suggest that the process be adequately funded so that CMS is able to lead this effort.

Substitute Provider Arrangements Should Be the Same for Both Physicians and Providers that are Not Physicians

¹ IOM op. cit.

² IOM op. cit., p. 9.

³ See for example Mathews AW and McGinty T, "Secrets of the system: physician panel prescribes the fees paid by Medicare." Wall Street Journal, Oct. 26, 2010. Retrieved Aug. 14, 2014, from <http://online.wsj.com/news/articles/SB10001424052748704657304575540440173772102>.

The current locum tenens system makes a clear and inappropriate distinction between physicians and non-physician providers who provide the same service. Simply put, APRNs and many healthcare professionals who are not physicians, but are nonetheless highly qualified Medicare providers, must undergo a far more onerous bureaucratic burden in order to obtain, or to serve as, substitute qualified providers than physicians. In this way, the current system presents a costly barrier to the use of qualified healthcare professionals such as APRNs.

Making the system as burdensome as it is now puts at risk a facility's ability to meet changing demand or supply of qualified healthcare professionals, such as APRNs, to deliver healthcare services in instances when the original provider gets sick, must take emergency leave, or is called up for deployment by the U.S. Armed Forces. We request that CMS form a working group that includes all types of qualified healthcare professionals, including APRNs, to yield a process that provides for the even-handed treatment of physicians and non-physician providers.

Allow Search Function to be More Inclusive of All Qualified Healthcare Providers on Physician Compare Website

We continue to be concerned about the imbalance of information in the "Physician Compare" website and ask that the Secretary takes steps to enable patients to find providers other than physicians when certain types of practices are being searched. For instance when primary care providers are searched, nurse practitioners (primary care providers) are not included in that search category and when the term "anesthesiology" is used, CRNAs are not included. In the instance of NPs, one can only find these health care professionals if they search specifically for them. While the preamble to the "Physician Compare" site does speak to other health care providers, even the name of the site is not inclusive. "Provider Compare" or "Health Care Provider Compare" for instance, is a more inclusive term that would reflect the website's ability for beneficiaries to search for all eligible health care providers. In addition, while we understand and appreciate the need to provide consumers with as much data driven information as possible, we urge the Secretary to utilize data resources that are inclusive, have been fully vetted and are widely accepted among the provider community represented on the website. Like the Physician Quality Reporting System (PQRS), other data resources must allow for consumers to easily

compare a variety of providers on the same scale in order to provide clear and appropriate information for healthcare providers and their patients.

Do not Publicly Report Non-PQRS Measures on the Physician Compare Site Unless 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 from CMS-approved qualified clinical data registry (QCDR) for public reporting on the Physician Compare website. 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 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 to 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 as well as minimize the risk of alienating market competitors.

Support Proposal Adding Several New Codes to Telehealth Services

In section II.E. of the proposed rule, we endorse the proposal to add several new codes to the list of Medicare telehealth services, which would increase access to health care among vulnerable and otherwise underserved populations. APRNs, as the chosen providers to millions of Medicare beneficiaries in rural and underserved areas, applaud your efforts to increase access to care to these individuals. We further encourage the expansion of originating sites so that APRNs may serve more patients by utilizing telehealth to deliver care. We also urge the Secretary to ensure that all eligible telehealth providers are included in the process of determining best practices and modifications to this growing health care tool. As the Secretary continues to add more codes to the list of eligible services we ask that the APRN community be included as a resource in providing feedback and consultation.

Provide Clarification of How Contracted Employment Arrangement Would Affect “Incident to” Process in Federally Qualified Health Centers and Rural Health Clinics

In section III.D. of the proposed rule, CMS attempts to provide Federally Qualified Health Centers and Rural Health Clinics with more staffing flexibility by allowing additional providers to provide needed care under contract, rather than under current employment arrangements by these facilities. While we would encourage the increase in staffing and thoroughly understand the need for expanding the ability to provide health care in these settings, we are concerned about the loss of benefit packages that would no longer be expected by, and available to, individuals if under contract to, rather than employed by a given clinic. We would like to know if this issue has been completely vetted, and how clinics would compensate for this loss of compensation for individuals providing the “incident to” services under contract rather than as an employee.

We thank you for the opportunity to comment on the proposed rule. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

American Association of Colleges of Nursing, AACN
 American Association of Critical-Care Nurses, AACN Critical Care
 American Association of Heart Failure Nurses, AAHFN
 American Association of Neuroscience Nurses, AANN
 American Association of Nurse Anesthetists, AANA
 American Association of Nurse Practitioners, AANP
 American College of Nurse-Midwives, ACNM
 American Nephrology Nurses Association, ANNA
 American Nurses Association, ANA
 American Organization of Nurse Executives, AONE
 American Psychiatric Nurses Association, APNA
 American Society of PeriAnesthesia Nurses, ASPAN
 Association of periOperative Registered Nurses, AORN
 Association of Rehabilitation Nurses, ARN

Dermatology Nurses' Association, DNA
Developmental Disabilities Nurses Association, DDNA
Emergency Nurses Association, ENA
National Association of Clinical Nurse Specialists, NACNS
National Association of Hispanic Nurses, NAHN
National Association of Nurse Practitioners in Women's Health, NPWH
National Association of Pediatric Nurse Practitioners, NAPNAP
National Gerontological Nurses Association, NGNA
Oncology Nursing Society, ONS
Preventive Cardiovascular Nurses Association, PCNA
Society of Urologic Nurses and Associates, SUNA
Wound, Ostomy and Continence Nurses Society (WOCN)