ANA
AMERICAN NURSES ASSOCIATION
8515 Georgia Avenue, Suite 400
Silver Spring, Maryland 20910-3492
301 628-5000 • Fax 301 628-5001
www.NursingWorld.org

September 6, 2013

Honorable Marilyn Tavenner, MHA, RN
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS–1600–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

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

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

The American Nurses Association (ANA) welcomes the opportunity to provide comments on this proposed rule. As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses (RNs), ANA is privileged to represent its state and constituent member associations, organizational affiliates, and individual members. As you are no doubt aware, RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of healthcare settings. ANA members also 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).

ANA's comments on the MFS NPRM will be focused on sections F. Medicare Telehealth Services, G. Physician Compare, H. "incident to" Billing, and I. Complex Chronic Care Management Services. In a preface to ANA's comments on section I. is a discussion of the nomenclature with respect to health care levels of planning as it is evolving with respect to electronic health records. The NPRM uses terms synonymously that are in the process of being refined to become distinct. Attention to this issue by CMS may preclude industry confusion that might otherwise occur in the future.

F. Medicare Telehealth Services for the Physician Fee Schedule

ANA commends CMS for its work in elaboration of the Medicare Fee Schedule to incorporate telehealth services. ANA comments are focused on sections F.1 Billing and Payment and F.4. Telehealth Frequency Limitations.

F. Medicare Telehealth Services for the Physician Fee Schedule
- 1. Billing and Payment for Telehealth Services
  - b. Current Telehealth Billing and Payment Policies

ANA recommends expansion of the originating sites list to include school-based health clinic facilities. This would enhance the economical use of available and evolving communication

technologies and resources to support school-based clinics for telehealth services for Medicaid patients. Further, innovative repurposing of such school-based clinics to provide community health services can also support evaluation, treatment, and follow-up care of Medicare patients via access to remote clinicians.

ANA recommends correction of the oversight in the approved distant site practitioner list to include certified registered nurse anesthetists (CRNAs) as approved distant site practitioners.

4. Telehealth Frequency Limitations

In Section F. CMS has proposed continuing to limit long term care (LTC) telehealth visits to no more than one single visit every 30 days. Significantly, this limit can result in additional unnecessary transports for office or emergency department visits, additional opportunities for patient injury and significant transportation costs especially for the immobile and disabled patient. In light of the evolving mobile health (m-health) technologies, robotics, and miniaturization of telecommunications tools and medical devices, as well as the increasing complexity and co-morbidities of skilled nursing facility (SNF)/LTC patients, ANA recommends that any limit on LTC telehealth visits should be set to one visit per 10 days. An additional benefit of such enhanced access to telehealth services enables clinicians to recoup and redesignate travel time to providing direct care and telehealth services in offices and other locations.

G. Physician Compare Web site

1. Background and Statutory Authority

In compliance with PPACA §103311(a)(2), CMS must report measures collected under PQRS through the Physician Compare website. ANA recommends that future PQRS measure development opportunities use sufficiently broad language so as to include all eligible professionals. Health care teams include physicians, APRNs, physician's assistants, and other eligible professionals. Discipline specific language, exclusive of any eligible professional limits the effectiveness and efficiency of the team, while also limiting patient access and preferences. ANA encourages CMS to replace all instances in which "physicians" appears alone in the text with the phrase "physicians and other eligible professionals" or simply "eligible professionals" omitting "physicians" as redundant. As it currently reads, the NPRM requires that "Physician Compare provides a robust and accurate portrayal of physician's performance," excluding other eligible professionals from that criterion (among others).

As stated on p. 43353 of the NPRM, CMS has a particular interest in measures of continuity and coordination of care. ANA encourages CMS to use measures that go beyond simple one-way handoff measures (e.g., specialist received consult: yes/no). Instead, measures should address the patient-centered outcomes of care coordination, as well as the processes, and structures upon which those outcomes depend. (Examples of such measures would include, respectively, outcome: patient attended follow-up appointment with eligible professional/specialist; process: patient selected eligible professional/specialist of choice based on his/her preferences; and structure: patient access to transportation to attend appointments.)

CMS proposes to institute "Processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of the patient." ANA recommends that CMS include within that attribution a breakout of all eligible professionals providing patient care within a given practice. In additional, CMS ought to include other licensed clinicians (e.g., RNs acting as care coordinators) whose practice is integral to providing the essential elements of patient centered, effective, and efficient care.

PPACA §10331(d) requires CMS to obtain input from multiple stakeholder groups in selecting quality measures for Physician Compare. CMS data from calendar year 2011 indicate that 100,585 APRNs provided covered services to Medicare beneficiaries and directly billed Part B carriers. Those APRNs represented 9% of all eligible professionals in the program. ANA offers to assist CMS in its mandated outreach though communication with its 30 Organizational Affiliate (OA) member organizations representing nursing specialties, 5 of which directly represent eligible professionals. ANA and its OA members can provide CMS with valuable information on what to measure and how to measure it. These insights can allow data reported on Physician Compare to best inform consumers of the highest quality of care available to them.

2. Public Reporting of Physician Performance Data

ANA appreciates the changes made in 2013 to the Physician Compare website, as reflected in section G2 of the NPRM. These changes allow users to more easily search for eligible professionals. Using simple heuristics users can access a list of eligible professionals appropriate to their given needs. Unfortunately, in actual use the website redesign falls short of its overall capabilities. On August 22, 2013, a member of the ANA staff used this site to conduct a simple search of eligible professionals providing primary care within 5 miles of downtown Washington, District of Columbia (ZIP code 20001) using the keyword search term "primary". This test identified 264 Healthcare professionals among six categories. The first category, "Family Practice, General Practice, Geriatric Medicine, Internal Medicine & Primary Care Healthcare Professionals" listed 40 physician providers, but did not include any type of APRN among the eligible professionals in that or any other returned category. A second search using the keyword "nurse" for the same ZIP code returned a list of 143 Healthcare professionals including 15 CNSs and 16 NPs, all of whom provide primary care services. Of interest, the topmost category "Family Practice, General Practice, Geriatric Medicine, Internal Medicine & Primary Care Healthcare Professionals" included the same 40 physicians, but does not include non-physician providers.

During Calendar Year 2012, there were 35,080 NPs and 637 CNSs awardees under the Primary Care Incentive Program (PCIP) instituted through PPACA §5501(a). Since there were nearly four times as many MD winners as APRNs, ANA might have expected to find 66 APRNs in the "nurse" and "primary" searches. ANA requests that CMS correct the Physician Compare website to include APRNs among the primary care providers listed in the category "Family Practice, General Practice, Geriatric Medicine, Internal Medicine & Primary Care Healthcare Professionals" in order to give users a fair and equitable list of the full range of eligible professionals providing that level of care.

3. Future Development of Physician Compare

ANA and the Association of periOperative Nurses (AORN) collaboratively reviewed the proposed changes to the physician fee schedule for 2014, with specific attention to the proposal for a new physician quality reporting option. Under the newly proposed option, an eligible professional's participation in a "qualified clinical data registry" might meet the CMS requirement that the eligible professional participate in quality reporting. Our review did not find any problems with non-physician eligible professionals' eligibility and opportunity for advancement in the registry space; however, we encourage CMS to include perioperative APRNs as an established area of practice. Our review suggests that perioperative APRNs would fit well among any or all of the following areas of the practice areas: Cardiovascular Surgery, Colon/Rectal Surgery, Neurosurgery, Surgery-General, Transplant Surgery, as they relate to the perioperative area. Our assessment might be incorrect if these areas of practice refer to a health care organization's Cardiovascular Surgery department and not the Perioperative/Operating Room setting. Additionally, perioperative APRNs that work in settings such as Cardiovascular, Orthopedics, or Obstetrics & Gynecology departments might accompany physicians into the operating room, which begs the question of how to capture and record registry data for APRNs in those settings. We collectively look forward to any guidance CMS might offer on that question.

Section H. "Incident to billing"

Section H of the MFS NPRM proposes changes in the regulations regarding "incident to" billing by APRNs and physician assistants (PAs). The NPRM notes that

> . . . . the Medicare regulations for ''incident to'' services and supplies do not specifically make compliance with state law a condition of payment for services and supplies furnished and billed as an incident to a practitioner's services. The proposed amendments to our regulations would rectify this situation and make compliance with state law a requirement for all ''incident to'' services. In addition to health and safety benefits we believe would accrue to the Medicare patient population, this approach would assure that federal dollars are not expended for services that do not meet the standards of the states in which they are being furnished, and provides the ability for the federal government to recover funds paid where services and supplies are not furnished in accordance with state law.

"Incident to" services have been a part of Title 18 since the beginning of Medicare. And the question of "incident to" billing for APRN services surely dates back to at least 1997 when APRN participation in Medicare Part B was clarified in the Balanced Budget Act. Because of the regulatory language construct noted by CMS, in effect, we have been observing a long running demonstration project that has tested the effects of lifting the state scope of practice constraint. CMS intends to end the demonstration, but it offered no documentation of the value of any health and safety benefits accruing to Medicare beneficiaries nor was an estimate supplied for the value of any recoveries that Medicare might anticipate. ANA recommends that the proposed regulatory revisions in this section not be adopted. We have several preferred alternatives.

The NPRM cites the Office of Inspector General report entitled ‘‘Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services’’ (OEIOEI–09– 06–00430). Although this report found that services provided and billed to Medicare by auxiliary personnel ‘‘. . . who did not possess the required licenses or certifications . . . . ” there was no mention of any deleterious effects caused by either APRNs or PAs. In fact, there was no mention at all regarding any of the four roles of APRNs. The OIG report noted that where there were suspicious patterns of "incident to" billing "[t]hese nonphysicians did not possess the necessary licenses or certifications, had no verifiable credentials, or lacked the training to perform the service. . . . . These nonphysicians . . . had no verifiable credentials; and/or had not received the appropriate training to perform the services . . ." APRNs and PAs were not the problem.

What the OIG recommended but CMS demurred was a requirement that physicians who bill services to Medicare that they do not personally perform identify the services on their Medicare claims by using a service code modifier. The modifier would allow CMS to monitor claims to ensure that physicians are billing for services performed by nonphysicians with appropriate qualifications. A proper set of modifiers by taxonomy would allow estimation of the magnitude of "incident to" billings. It would also act to diminish inappropriate delegation of tasks to unqualified personnel. And it would not involve any changes in claims forms. ANA concurs with that recommendation. If nothing else it would finally enable CMS to measure the extent of "incident to" billing in Medicare Part B and its distribution across qualified personnel in physicians' offices.

ANA further recommends that "incident to" billing essentially be eliminated from Medicare Part B for services provided by APRNs. As noted in Section H. "As the services commonly furnished in physicians' offices and other nonfacility settings have expanded to include more complicated services, the types of services that can be furnished ‘‘incident to’’ physicians' services have also expanded." These complicated services go beyond CMS's directive that [incident to] services [are] "an integral, *although incidental* (italics added) part of the physician's professional services, and they must be performed under the physician's *direct supervision* (italics added). When it comes to more complicated services, accountability demands that claims from a physician practice should specifically identify the performing clinician if that person is not the same as the billing clinician. CMS is also moving in this direction in its strong suggestions that Medicare Part D prescriptions use the National Provider Identifier (NPI) of the individual prescribing clinician rather than the NPI of a practice with two or more clinicians. In the short run ANA recommends introduction and use of the "incident to" modifiers to prepare for the needed evaluation of the ongoing demonstration described above.

The reason ANA makes these recommendations goes beyond CMS's regulatory purview, but to lead to further Part B program improvements that can only be enacted through legislation. First, one notes that Medicare is a national program. Funding for Medicare Part B is based on payroll taxes levied at identical rates across the nation. Part B premiums and the deductible are also set on a national basis. The federal government runs two other national health benefits programs: the Veterans Health Administration program and the Department of Defense Medical Benefits for members of the Armed Services. Both programs effectively have a national scope of practice for APRN services. Medicare Part B warrants the same policy. The IOM Future of Nursing report also recommended that registered nurses everywhere in the U.S. should practice to the full extent of their education and training. To promote and ensure the access of Medicare (and Medicaid)

patients to the widest choice of competent, cost-effective health care providers, principles of equity would suggest that this patient choice should be promoted by policies ensuring that full, evidence-based practice is permitted to all providers regardless of geographic location. CMS has the responsibility to promulgate rules and policies that promote Medicare and Medicaid beneficiaries' access to appropriate care, and therefore can ensure that its rules and polices reflect the evolving practice abilities of licensed providers.

A final recommendation to Congress is to complete the payment revolution began in 1992 with the conversion to the Resource Based Relative Value System (RBRVS) method of determining Medicare approved charges. The remaining differentials in Medicare allowances for services from NPs, CNSs, and PAs should be eliminated. Medicare used to go along with payment differentials by specialty or experience in the form of the customary and prevailing reasonable charge determination method. The physician community agreed to renounce that approach when it acquiesced to the introduction of RBRVS. A novice family practitioner gets the same allowance as an experienced neurosurgeon when it comes to a level 3 initial office visit. The allowance for all docs in a given Medicare locality is the same if it's billed as the same service, regardless of the preferences of the patient (or the physicians, for that matter.) A service is a service. One notes that Medicare Part B now provides coverage of CRNA and CNM services at 100% of the Medicare Fee Schedule. The same services provided by NPs or CNSs only get paid 85% of the MFS amounts. This defied the RBRVS logic. A service ought to be paid as a service, regardless of the eligible professional providing that service.

Princeton Professor of Economics, Uwe Reinhardt, testified before the Senate H.E.L.P. Subcommittee on Primary Health and Aging in January 2013 that the differential had no further justification. He also noted that even the authoritative Medicare Payment Advisory Commission (MedPAC) could not find a theoretical foundation for the existing payment differentials for identical primary-care services rendered by primary-care physicians and by non-physician primary-care givers. Dr. Reinhardt called for eliminating these differentials in public insurance programs and for private health insurers as well. Elimination of the differential is well overdue.

Nomenclature with respect to health care levels of planning

Generally, but most particularly as it applies to section *I. Complex Chronic Care Management Services*, ANA recommends that CMS adopt the final forms of the definitions of the terms "care plan," "plan of care," and "treatment plan" as articulated by the Health Level 7 (HL7) Patient Care Working Group (PCWG). PCWG is currently engrossed in a domain analysis model for care coordination. While this model has not been balloted nor has the group finalized the definitions, the overall gestalt is that the definitions are hierarchical. ANA has proposed the following definitions for their consideration. ANA requests that CMS also consider adopting the definitions presented below. We have also provided a brief clinical example to help to illustrate the distinctions envisioned for this model.

Care Plan: A patient-centered care plan is a dynamic, consensus-driven plan that represents all of a patient's, designated caregiver's, and professional healthcare team members' prioritized concerns, goals, and planned interventions. It serves as a blueprint shared by all professional care team members and the patient and designated caregiver(s) to guide the patient's care. A Care Plan represents one or more Plan(s) of Care and serves to reconcile and resolve conflicts among the various Plans of Care developed during a specific patient's continuum of care. Unlike the

Plan of Care, a Care Plan includes the patient's life goals and enables professional care team members to prioritize interventions. The Care Plan also serves to enable longitudinal coordination of care. Care Team Members (including patients, their caregivers, eligible professionals, registered nurses, other clinicians) will be the primary users of the **Care Plan**.

> We use the clinical example of Sam, a 67 year old male who has partnered with his preferred healthcare professionals to create an overarching care plan that addresses his prioritized concerns, goals, and planned strategies and activities to meet his wellness and existing disease management objectives.

Plan of Care: A patient-centered, clinician driven and episodic plan that focuses on a specific health concern or closely related concern. It represents a specific set of related conditions that are managed or authorized/certified by a clinician or provider. The Plan of Care represents a single set of information that is generally developed independently; however, is congruent with the goals identified by the patient/designated caregiver(s). The Plan of Care serves as a basis for care continuity during transitions of care within settings, between settings, and across health states. The Plan of Care is a bidirectional living document that encourages input from all professional team members across all care settings. When two or more Plans of Care exist, the Care Plan becomes the source of truth for reconciliation.

> For Sam in our clinical example, a recent use of healthcare resources involved an emergency room visit for injuries sustained in a fall from a ladder. Because Sam sustained several fractures, a plan of care was developed to focus on meeting expected outcomes of full recovery from his fractures through the delivery of effective and efficiency healthcare services, beginning with his initial emergency room experience. That plan of care was congruent with Sam's overarching care plan and it identified that various clinical services needed to be coordinated and sequenced to optimize Sam's care from immediate treatment of his injuries through recovery. Several distinct team clinicians, e.g., dentist, orthopod, and physical therapist would prepare Sam's treatment plans. Although each treatment plan focused on different components of care, each was congruent with the plan of care.

Treatment Plan: A patient-centered, domain-specific plan managed by a single discipline and consistent with the Plan of Care, including the patients/designated caregiver(s) goals. It focuses on a specific treatment or intervention.

> In executing Sam's plan of care with respect to recovering from his injury that lead to the team's oral surgeon and clinical nutritionist collaborating to prepare a detailed treatment plan addressing Sam's facial fractures and requisite diet changes. The team orthopedic surgeon developed a detailed treatment plan related to Sam's upper arm fractures and pain management, while the physical therapist's treatment plan targeted rehabilitative therapies.

Consistent with its charge, PCWG suggests primary users, but does not assign or recommend governance as part of its definitions. ANA recommends that CMS assign governance for each element to the patient. The patient is the most knowledgeable member of the care team as regards his or her needs; however, (s)he will require regular technical consultation to ensure

those needs are met with the highest level of efficiency, effectiveness, and for the lowest cost. For that reason, the patient ought to assign stewardship of the care plan, plan of care, and treatment plan to the appropriate team member(s) as necessary. Team members to whom the patient assigns stewardship might include eligible professionals, but should not be limited to those clinicians. There are regular and appropriate times when clinicians would offer services more consistent with the patient's level of needs. For instance, registered dietitians and speech and language pathologists might be more appropriate to address swallowing difficulties after a stroke or a RN specializing in complementary and alternative medicine might be a more appropriate steward for a patient experiencing unresolved chronic pain. In each scenario, the care plan and its components remain patient centered, because they remain under the patient's governance.

ANA recognizes that such a change in governance would require changes in language around payment models; however, these changes are relatively easy in comparison to the changes that would be necessary to incorporate patient governed care into the current culture of health care. Although these challenges would be considerable, ANA believes that their outcomes would be worth the efforts.

I. Complex Chronic Care Management Services

ANA applauds CMS for recognizing the inherent value of complex chronic care management services by proposing new HCPCS G-codes and welcomes the opportunity to provide comments on how RNs and APRNs are skilled providers of these services.

For many years, ANA has stressed the fundamental importance of care coordination and transitional care for our patients, the pivotal role that RNs and APRNs play, and how chronic care and case management are integral parts of nursing practice. Many RNs and APRNs provide complex chronic care management as a key component of their nursing practice, in various nursing roles and across all health care settings.

ANA's Nursing Scope and Standards of Practice[1] lists RN and APRN competencies that are integral to complex chronic care management. For instance, Standard 5A of the Nursing Scope and Standards of Practice states that "The registered nurse coordinates care delivery" and details six related competencies:

The registered nurse:

- Organizes the components of the plan.
- Manages a healthcare consumer's care in order to maximize independence and quality of life.
- Assists the healthcare consumer in identifying options for alternative care.
- Communicates with the healthcare consumer, family, and system during transitions in care.
- Advocates for the delivery of dignified and humane care by the interprofessional team.
- Documents the coordination of care.

[1] American Nurses Association. (2010). Nursing: Scope and Standards of Practice, 2nd edition, Standard 5A. Silver Spring, MD: Nursesbooks.org, 32-46.

The advanced practice registered nurse has additional competencies including:

- Provides leadership in the coordination of interprofessional health care for integrated delivery of healthcare consumer care services.

RNs and APRNs are skilled in developing plans of care and outcomes identification. RNs and APRNs are experts in health teaching and health promotion using information technologies (including electronic health records).

APRNs use prescriptive authority, procedures, referrals, treatments, and therapies in complex chronic care management. APRNs are skilled in assessment and evaluation.

1. Patient Eligibility for Separately Payable Non-Face-to-Face Complex Chronic Care Management Services

A growing number of APRNs are enrolled as Medicare and Medicaid providers. For 2011, CMS reported that 63,985 nurse practitioners, clinical nurse specialists and certified-nurse midwives directly billed Medicare Part B carriers. Many of these APRNs serve as primary care providers, particularly for underserved populations and in rural areas, and are thus charged with ensuring their patients receive appropriate, well coordinated care. These APRNs deserve to see their efforts rewarded when they provide complex chronic care management services for their sickest and most complex patients. Nurse-run clinics can manage patients with complex chronic conditions effectively and efficiently, ensuring that patients obtain the general and specialty care necessary.

Given the increasing level of primary care services billed directly by Medicare non-physician providers, and the growing emphasis on true team-based care, ANA urges CMS to clarify that complex chronic care management services can be provided by "physicians or other qualified healthcare professionals." CMS should employ provider-neutral language elsewhere in the NPRM, as well, wherever this is appropriate. This should be changed uniformly throughout the proposed regulation, to reflect current practice. The many instances in the proposed regulations where CMS refers solely to current ***physician*** payments or practices implies a disregard for those 100,585 APRNs who also provide primary care, anesthesia services, and complex chronic care management for at least 30 percent of the Medicare fee-for-service population.

We agree with CMS that "Furnishing care management with multiple chronic conditions requires complex and multidisciplinary care modalities." However, as noted above in our comments regarding nomenclature with respect to health care levels of planning, APRNs and RNs develop and revise care plans, plans of care, and treatment plans. CMS should change the phrase "Regular physician development and/or revision of care plans" to "Regular clinician development and/or revision of care plans."

CMS should change the definition of complex patient from beneficiaries with "two or more chronic conditions" to "four or more chronic conditions." This would better target Medicare beneficiaries with the greatest need for care management. This change would concentrate care management services on the 37% of Medicare beneficiaries with 4 or more chronic conditions of eligible beneficiaries rather than also including the 32% of Medicare beneficiaries with one or

two chronic conditions.[2] Medicare spending per beneficiary for those more complicated beneficiaries 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.

The definition of complex patient should also consider the beneficiary's functional ability. The Annual Wellness Visit includes a review of the beneficiary's functional ability and level of safety as well as assessing ADLs and IADLS in the health risk assessment.

2. Scope of Complex Chronic Care Management Services

With the coming dramatic increase in America's older population over the next 40 years, families will continue to provide the principal support for Medicare beneficiaries. ANA has long recognized the invisible roles of family caregivers, and those family participants should be explicitly recognized by CMS. Complex chronic care management plans must address family caregivers, many of whom provide complex medical or nursing tasks including managing multiple medications, providing wound care, and operating specialized medical equipment.[3]

3. Standards for Furnishing Complex Chronic Care Coordination Services

ANA applauds the CMS recognition that APRNs and PAs can perform roles that include and are appropriately scaled to meet management services provided by the practice. CMS should also recognize that RNs can provide those services, and "registered nurses" should be added to this section of the proposed regulations. In particular, the proposed regulations in this section should read, in part, "All practitioners including registered nurses, advanced practice registered nurses or physician assistants, involved in the delivery of complex chronic care management services must have access at the time of service to the beneficiary's EHR . . ."

4. Billing for Separately Payable Complex Chronic Care Management Services and Obtaining Informed Consent from the Beneficiary

Comprehensive, coordinated care management cannot be provided by just one member of the health care team. Frequent communication is needed to improve quality of care and reduce unnecessary rehospitalizations and emergency department visits. ANA recognizes CMS interest in the prudent purchase of complex chronic care management services and its decision to only count once the time for a meeting of two of more patient clinicians involved in coordinating the patient's care. However, more care will be needed in the promised development of relative value units (RVUs) for complex chronic care management to accurately reflect the resource based inputs of all of the members of the clinical team addressing the patient's needs.

6. Complex Chronic Care Management Services Furnished Incident to a Physician's Service under General Physician Supervision.

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[2] Chronic Conditions Chartbook: 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.

[3] http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf

ANA does recommend that complex chronic care management services under the proposed regulations should be reserved for more complex patients. However, CMS should expand its thinking beyond the anachronistic view that only physicians are qualified for management and care coordination. The term it proposes involves "management" services rather than clinical or medical services. In its discussion of this topic CMS has proposed that patient-centered medical homes might be able to furnish complex chronic care management services. ANA is not opposed to medical homes providing complex chronic care management services. ANA also believes that there are other organizational structures that could also provide these services. Those include nurse-led clinics, multi-specialty group practices, accountable care organizations, etc. The future for clinicians is working in multidisciplinary teams, and it is not necessary that all members of such teams will be employed by a single practice, much less a single physician practice. If nothing else, there are thousands of self-employed physicians who will remain self-employed even as they meaningfully contribute to one or more patient-centered teams. The services described in the proposed regulations go far beyond medical care, and include patient counseling and education, explanation of and solicitation of informed medical consent, among other non-traditional and non-clinical services. They do include team building and effecting cooperation and collaboration among team members. These are not skills reserved for physicians only. CMS is lead by a professional who has to manage a wide variety of complex medical and population health issues, in addition to effecting cooperation and collaboration among competing stakeholders. One notes that in the history of CMS (and HCFA) Senate-confirmed Administrators there have been just as many Registered Nurses as there have been physicians.

CMS also needs to take into account the growing numbers of APRN owned "house calls" practices that serve homebound patients in rural and urban areas which currently provide complex chronic care management to the most vulnerable Medicare beneficiaries. These APRN led practices must be also be eligible for the counting the time spent by clinical staff such as RNs furnishing care management outside of the practice's normal business hours toward the one hour requirement.

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 feel free to contact Peter McMenamin, PhD, Senior Policy Fellow, ANA Nursing Practice and Policy, at peter.mcmenamin@ana.org, or (301) 628-5073.

Sincerely,

Debbie Dawson Hatmaker, PhD, RN, FAAN
Chief Professional Practice Officer
American Nurses Association

cc: Karen A. Daley, PhD, MPH, RN, FAAN
President
Marla J. Weston, PhD, RN, FAAN
Chief Executive Officer