



August 31, 2016

Honorable Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Submitted electronically to [regulations.gov](http://regulations.gov)

Re: CMS-1654-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

Dear Acting Administrator Slavitt:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the proposed rule concerning the calendar year (CY) 2017 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model. As the only full-service professional organization representing the interests of the nation's 3.6 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 health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.<sup>1</sup> ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

ANA offers comments on three of the many sections of the Medicare Fee Schedule Notice of Proposed Rule Making. First, ANA concurs with proposed revisions with respect to supervision

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<sup>1</sup> The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

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requirements for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) practitioners. Second, ANA further concurs with the recommendation that Medicare Advantage (MA) providers and suppliers must enroll in Medicare in an approved status in order to provide health care items or services to a Medicare Advantage enrollee. This new requirement, however, should be immediately followed by tabulating the resulting data to document both the per beneficiary specialty distribution of individual Medicare Advantage plans' clinical workforces and enhance the counts of specialty groups that serve Medicare patients solely through Medicare Advantage plans. Third, registered nurses and APRNs alike are disappointed that The Centers for Medicare and Medicaid Services (CMS) is using imprecise, physician-centric writing in proposing a beneficiary polling approach to incorporate beneficiary preferences into the Accountable Care Organization (ACO) assignment process. In some cases this loose language could lead to beneficiary alienation and potential disruptions of pre-existing patient-clinician relationships.

### ANA Comments

With respect to the proposed change in care management supervision requirements in RHCs and FQHCs (beginning on page 46377) ANA fully supports the revision of §405.2413(a)(5) and §405.2415(a)(5) to state that services and supplies furnished incident to Transitional Care Management (TCM) and Chronic Care Management (CCM) services can be furnished under general supervision of a RHC or FQHC practitioner. With the proposed exception to movement from "direct" to "general" supervision, the direct supervision requirement would apply only to auxiliary personnel furnishing TCM or CCM incident to services, and would not apply to any other RHC or FQHC services.

ANA also supports the proposed requirements in §422.204(b)(5) and associated sections that Medicare Advantage providers and suppliers enroll in Medicare in an approved status in order to provide health care items or services to a Medicare enrollee who receives his or her Medicare benefit through an MA organization. This requirement would apply to network providers and suppliers; first-tier, downstream, and related entities (FDR); providers and suppliers participating in the Program of All-inclusive Care for the Elderly (PACE); suppliers in Cost Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs); providers and suppliers participating in demonstration programs; providers and suppliers in pilot programs; locum tenens suppliers; and incident-to suppliers. ANA further suggests that CMS tabulate provider counts by specialty (using CMS specialty designations) and publish periodically the MA enrollee/provider ratios for each MA plan. Further, CMS should develop a de-duplicated count of MA providers by specialty that do not also bill Medicare Part B for services provided to non-MA enrollees. This would enable the Department of Health and Human Services (HHS) and CMS to provide estimates by specialty of the clinician workforce that serves Medicare patients solely through Medicare Advantage.

ANA has repeatedly suggested to HHS and CMS that notices of proposed rule-making and other regulatory issuances should eliminate physician-centric language. While the most common Part B provider is a physician, CMS data indicate that 43 percent of Part B providers are neither

physicians nor doctors of osteopathy. One in nine Part B providers is an advanced practice registered nurse. The third most common Part B provider group is Nurse Practitioners.

Nonetheless, in the discussion regarding “Incorporating Beneficiary Preference into ACO Assignment,” the suggested beneficiary polling would be based on asking beneficiaries about their “main doctor.” Over the course of six pages of the instant NPRM “main doctor” is referenced nineteen times. The fifth and sixth references modify the choice to be “main doctor” or the other healthcare provider they believe is responsible for their overall care. Mention number eight offers “main doctor” or primary healthcare provider. An analysis of 2010 Medicare claims data from fee-for-service beneficiaries found that had the Medicare Shared Savings Program Assignment methodology been used with respect to all primary care providers, 3 percent of all fee-for-service beneficiaries would have been assigned to a nurse practitioner.<sup>2</sup> In 2017 that would be more than one million fee-for-service beneficiaries.

In its initial (2011) letter to CMS regarding ACOs, ANA cautioned that with respect to both the communications from CMS and marketing materials from an ACO or one of its physicians, beneficiaries may not genuinely understand that participation in the ACO is voluntary, despite the requirement that this qualification be included in beneficiary communications. Beneficiaries who identified a “main doctor” could be subsequently notified they had been assigned to the ACO of that physician. Beneficiaries could easily interpret assignment as a direction from Medicare that they can no longer seek care from their APRN outside the ACO. Use of the imprecise physician-centric language may lead to beneficiary alienation and disruption of a pre-existing patient-clinician relationship. We urge CMS to revise the language to avoid miscommunication.

If you have questions, please contact Peter McMenamin, Ph.D., Senior Policy Advisor-ANA Health Economist, Health Policy ([peter.mcmenamin@ana.org](mailto:peter.mcmenamin@ana.org)).

Sincerely,



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Executive Director / Executive Vice President

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President  
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer

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<sup>2</sup> Yong-Fang Kuo, Figaro L. Loresto, Jr., Linda R. Rounds and James S. Goodwin, *Health Affairs*, 32, no.7 (2013):1236-1243.