September 4, 2012

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1590-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review, and Other Revisions to Part B for CY 2013.

To Whom It May Concern:

On behalf of the National Nursing Centers Consortium (NNCC), I thank you for the opportunity to comment on the proposed rule Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review, and Other Revisions to Part B for CY 2013 (CMS-1590-P).

The NNCC is a non-profit member organization of nonprofit, nurse-managed health clinics (sometimes called nurse-managed health centers or NMHCs). The Affordable Care Act (P.L. 111-148) defines the term ‘nurse-managed health clinic’ as a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center (FQHC), or independent nonprofit health or social services agency. Currently there are about 250 NMHCs in operation throughout the United States. NMHCs provide a full range of health services, including primary care, health promotion, and disease prevention, to low-income, underinsured, and uninsured clients. Approximately 58% of NMHC patients are either uninsured, Medicaid recipients, or self-pay. Because many NMHCs are affiliated with schools of nursing, NMHCs help to build the capacity of the health care workforce by acting as teaching and practice sites for nursing students and other health professionals. Also, several NMHCs are FQHCs.

Outcome data from managed care organizations and academic research journals show that NMHCs provide accessible, high quality care that is also cost effective. The nurse practitioners
in NMHCs can manage 80-90% of the care provided by primary care physicians without referral or consultation.¹ Also, according to a 2011 meta-analysis of peer-reviewed articles regarding the quality of nurse practitioner-provided care, primary care nurse practitioners produce patient health outcomes comparable to those of primary care physicians.² In terms of cost effectiveness, NMHC patients experience higher rates of generic medication fills and lower hospitalization rates than patients of similar providers.³ Additionally, elderly and disabled people with access to NMHCs visit emergency rooms less often than those without access to NMHCs.⁴

Responses to Proposed Rule

Section II. Provisions of the Proposed Rule

H. Primary Care and Care Coordination

We strongly support the supplemental payment for care coordination for patients after discharge from the hospital. We believe you have covered the care coordination responsibilities that should be included. As to the medical home certification needed to qualify for this supplemental payment, our NMHCs have gone to great expense to be certified by the National Committee for Quality Assurance, the Joint Commission, and other certifying bodies. It would not improve the efficiency or effectiveness or care to have them go through an additional certifying process. We believe that the Center for Medicare and Medicaid Services (CMS) should accept existing accreditation by reputable bodies. CMS should not require the highest certification possible as a condition for receipt of the supplemental payment. Often the higher certifications require information technology, not yet available to some NMHCs or many rural primary care providers.

We urge you to address the need for hospitals to advise primary care providers of an impending discharge so the needed care coordination can be implemented. Hospitals rarely notify primary care providers upon a patient's discharge. When hospitals do notify providers regarding discharge, they often notify the collaborating physician rather than the actual provider of care, leaving other types of primary care providers without valuable information on their patients. Medicare should require hospitals to notify primary care providers of discharge and transmit the discharge documents as a condition of being paid for the hospitalization.

J. Payment for New Preventive Services

The commentary to the draft regulations read: “One method for ensuring that any targeted payment for primary care services would constitute a minimum level of care coordination and continuous assessment under the MPFS would be to pay physicians for services furnished in an

“advanced primary care practice” that has implemented a medical home model supporting
patient-specific care (Emphasis added). A number of nurse practitioner-managed clinics and
practices are presently providing the five “comprehensive primary functions” and have NCQA
certification. We do not believe that CMS should require Level 3 NCQA to qualify for payment as
the five comprehensive primary care functions are being delivered by practices certified at Level
1 and NCQA has recently revamped the levels to strengthen these requirements in all levels. A
more comprehensive payment for advance primary care practice would go a long way to help
transform and strengthen primary care in our country, but payment should be inclusive of nurse
practitioners and other providers running NCQA-certified practices.

L. Ordering of Portable X-Rays

NNCC’s members applaud CMS for proposing regulation to clarify that non-physician
practitioners and physicians other than MDs and DOs, acting within the scope of their Medicare
benefit and State law, are allowed to order portable X-ray services.

Section III. Other Provision of the Proposed Regulation

C. Durable Medical Equipment (DME) Face-to-Face Encounters and Written Orders Prior
to Delivery

Timing of Documentation of Face-to-Face Encounters and Documentation
We applaud the proposal that a face-to-face encounter and its documentation, for the
prescription of ordering DME, should occur 90 days previous to, or 30 days after the order is
written. This allows for patients to obtain access to necessary equipment while preventing waste
and abuse, as the need for the DME can be continually monitored by the patient’s provider.

Use of Telehealth
We also applaud the acceptance of telehealth as a reasonable means for conducting the face-
to-face encounter by a nurse practitioner, clinical nurse specialist, physician assistant, or
physician. The United States is suffering a primary care provider shortage. It is difficult to get
timely appointments with provider’s and nearly impossible to get same-day appointments.
Particularly for patients receiving home health, leaving the home to attend an appointment may
be a severe hardship due to mobility and health restrictions. Allowing for telehealth encounters
recognizes that primary health care is being provided in this way.

Physician Documentation of Face-to-Face Encounters Performed by a Nurse Practitioner,
Clinical Nurse Specialist, or Physician Assistant
It is in the best interest of patient care and the efficiency of health care practices to have the
physician documentation of an encounter be as simple and straightforward as practicable.
Therefore, it is our strong recommendation that CMS choose having the encounter faxed to the
collaborating physician, have the physician rubber stamp the encounter, and then fax it back to
the provider.

Option 1 is not a realistic option. Physicians do not have time to fill out additional paperwork,
and requiring them to fill out a formal attestation is not a good use of health care provider time,
especially when a much simpler and less time consuming method is available. Further, this
would require they search through the medical record to find why the patient requires DME, also not an efficient use of time.

Option 2 is also a poor option. If Option 2 was implemented as the required method of documentation, the entire medical record would have to be provided to the physician. A physician working in a collaborative relationship with a rural nurse practitioner might be 100 miles or more away from where the nurse practitioner’s practice. The nurse practitioner would have to figure out a way to securely deliver the entire file to the physician, leaving room for parts of the file to go missing or end up in the wrong hands. Not every practice has electronic health records, or if they do they may not use the same vendors so physician and the nurse practitioner would not be able to share records because their respective systems do to “communicate” with each other and thus cannot share information. Figuring out a system to provide the entire file would be costly and inefficient, and do nothing to promote the goals of reduced waste, fraud, and abuse. Physical distance, HIPAA regulations, and technological barriers make Option 2 a poor choice.

Option 3 provides all of the information needed for a physician to make a well-reasoned determination that the submitting provider has made the appropriate DME recommendation. Option 3 also promotes transparency and reduces the chance for fraud, waste, and abuse. By providing the physician with the actual encounter, this method proves the need for DME while promoting efficiency in process. We suggest a slight augmentation to Option 3: allow the physician to document in ways other than providing initials. A stamp saying “DME approved by Physician XX,” or any similar signal that the physician received and reviewed the encounter should suffice.

Supplier Notification
Similar to our response above regarding Physician Documentation, our member clinics believe strongly that efficiency of process enhances effectiveness of care. As such, Option 1 is recommended for supplier notification. In fact, that is the current informal practice being utilized in many of our member clinics. Under Option 1, the provider who is responsible for the patient’s care remains responsible for the ordering of the DME. Option 2 is not a good option. As our member clinics have told us, there is no way for them to verify that the DME order was submitted unless the providers fax it to the supplier themselves. Option 4 is unrealistic, as patients who require DME are often homebound and asking them to get to a DME supplier themselves is a burdensome request.

Covered Items
Since the passage of the Affordable Care Act (ACA), our member clinics have struggled to get basic DME to their Medicare patients. Canes, walkers, oxygen, and nebulizers have been denied because of lack of physician documentation of the encounter, forcing patients to wait days or weeks to get needed equipment. As expressed earlier in this comment, restricting nurse practitioner, clinical nurse specialist, and physician assistant practitioners from providing DME without physician signature does not further the goal of reduced waste, fraud, and abuse. In addition, there is no evidence that these specific provider categories have created or increased waste, fraud, or abuse. We request that, when setting the rules on DME equipment that needs physician documentation of an encounter, the parameters be as flexible as possible in order to protect the integrity of the Medicare program without burdening these talented practitioners with unnecessary regulation. A set dollar amount, perhaps $2,000, seems the most appropriate way to accomplish this.
Physician Payment
We are very supportive of the $15 fee available to the consulting physician for doing this work. We suggest also providing payment to the nurse practitioner, clinical nurse specialist, and physician assistant conducting the encounter and ensuring its process to the supplier, as the regulation unduly burdens these providers, as well as the physicians.

General Comments
Section 6407(b) of the ACA, codified at §1834(a)(11)(B) of the Social Security Act (SSA) has been interpreted to read that certain DME requires a face-to-face encounter with a nurse practitioner, clinical nurse specialist, physician assistant, or physician and that the encounter must be documented by a physician. Section 1834(a)(11)(B) was enacted by the ACA to further the laudable goal, “to reduce, the risk of fraud, waste, and abuse.” Requiring a face-to-face encounter with a nurse practitioner, clinical nurse specialist, physician assistant, or physician, is a reasonable precautionary measure and potentially could help achieve a reduction in fraud and waste. However, provisions that restrict an appropriate provider’s ability to order and quickly obtain the DME necessary for patients is not solved by additional physician documentation that restricts access to DME by provider-type. An additional provider sign off on a nurse practitioner’s DME order will do nothing to further this goal.

There is no need for a DME double-standard: States that require collaborative prescriptive agreements between nurse practitioners and physicians do not require that said physician look at each prescription the nurse practitioner writes. It already exerts an undue burden on patients, nurse practitioners, and physicians to require physicians to document an encounter for DME and does not follow any collaborative model of care. Rather, the DME documentation requirement follows the extinct practice of supervision of nurse practitioners for prescription writing. Nurse practitioners are competent, capable, providers of primary care and yet under this statutory and regulatory scheme cannot prescribe diapers or asthma inhalers for their homebound patients without a physician documenting an encounter.

We appreciate the opportunity to comment.

Very truly yours,

Tine Hansen-Turton, MGA, JD, FAAN, FCPP
Chief Executive Officer
National Nursing Centers Consortium