the accuracy of ambulance fee schedule payments. We invite comments on our proposal to implement the new OMB delineations and the updated RUCA codes as discussed above beginning in CY 2015, for purposes of payment under the Medicare ambulance fee schedule.

C. Clinical Laboratory Fee Schedule

In the CY 2014 PFS final rule with comment period (78 FR 74440–74445, 74820), we finalized a process under which we would reexamine the payment amounts for test codes on the Clinical Laboratory Fee Schedule (CLFS) for possible payment revision based on technological changes beginning with the CY 2015 proposed rule, and we codified this process at § 414.511. After we finalized this process, Congress enacted the PAMA. Section 216 of the PAMA creates new section 1834A of the Act, which requires us to implement a new Medicare payment system for clinical diagnostic laboratory tests based on private payor rates. Section 216 of the PAMA also rescinds the statutory authority in section 1833(h)(2)(A)(i) of the Act for adjustments based on technological changes for tests furnished on or after April 1, 2014 (PAMA's enactment date). As a result of these provisions, we are not proposing any revisions to payment amounts for test codes on the CLFS based on technological changes and are proposing to remove § 414.511. Instead, we will establish through rulemaking the parameters for the collection of private payor rate information and other requirements to implement section 216 of the PAMA.

D. Removal of Employment Requirements for Services Furnished ''Incident to'' Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Visits

1. Background

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) furnish physicians' services; services and supplies incident to the services of physicians; nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services; and services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs. They may also furnish diabetes self-management training and medical nutrition therapy (DSMT/MNT), transitional care management services, and in some cases, visiting nurse services furnished by a registered professional nurse or a licensed practical nurse. (For additional information on requirements for furnishing services in RHCs and FQHCs, see Chapter 13 of the CMS Benefit Policy Manual.)

In the May 2, 2014 final rule with comment period (79 FR 25436) entitled ''Prospective Payment System for Federally Qualified Health Centers; Changes to Contracting Policies for Rural Health Clinics; and Changes to Clinical Laboratory Improvement Amendments of 1988 Enforcement Actions for Proficiency Testing Referral,'' we removed the regulatory requirements that NPs, PAs, CNMs, CSWs, and CPs furnishing services in a RHC must be employees of the RHC. RHCs are now allowed to contract with NPs, PAs, CNMs, CSWs, and CPs, as long as at least one NP or PA is employed by the RHC, as required under section 1861(aa)(2)(iii) of the Act.

Services furnished in RHCs and FQHCs by nurses, medical assistants, and other auxiliary personnel are considered ''incident to'' a RHC or FQHC visit furnished by a RHC or FQHC practitioner. The regulations at § 405.2413(a)(6), § 405.2415(a)(6), and § 405.2452(a)(6) state that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC. Since there is no separate benefit under Medicare law that specifically authorizes payment to nurses, medical assistants, and other auxiliary personnel for their professional services, they cannot bill the program directly and receive payment for their services, and can only be remunerated when furnishing services to Medicare patients in an ''incident to'' capacity.

2. Provisions of Proposed Rule

To provide RHCs and FQHCs with as much flexibility as possible to meet their staffing needs, we are proposing to revise § 405.2413(a)(5), § 405.2415(a)(5) and § 405.2452(a)(5) and delete § 405.2413(a)(6), § 405.2415(a)(6) and § 405.2452(a)(6) to remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC to allow nurses, medical assistants, and other auxiliary personnel to furnish incident to services under contract in RHCs and FQHCs. We believe that removing the requirements will provide RHCs and FQHCs with additional flexibility without adversely impacting the quality or continuity of care.

E. Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models

1. Background and Statutory Authority

Section 3021 of the Affordable Care Act amended the Social Security Act to include a new section 1115A, which established the Center for Medicare and Medicaid Innovation (Innovation Center). Section 1115A tasks the Innovation Center with testing innovative payment and service delivery models that could reduce program expenditures while preserving and/or enhancing the quality of care furnished to individuals under titles XVIII, XIX, and XX of the Act. The Secretary is also required to conduct an evaluation of each model tested.

Evaluations will typically include quantitative and qualitative methods to assess the impact of the model on quality of care and health care expenditures. To comply with the statutory requirement to evaluate all models conducted under section 1115A of the Act, we will conduct rigorous quantitative analyses of the impact of the model test on health care expenditures, as well as an assessment of measures of the quality of care furnished under the model test. Evaluations will also include qualitative analyses to capture the qualitative differences between model participants, and to form the context within which to interpret the quantitative findings. Through the qualitative analyses, we will assess the experiences and perceptions of model participants, providers, and individuals affected by the model.

In the evaluations we use advanced statistical methods to measure effectiveness. Our methods are intended to provide results that meet a high standard of evidence, even when randomization is not feasible. To successfully carry out evaluations of Innovation Center models, we must be able to determine specifically which individuals are receiving services from or are the subject of the intervention being tested by the entity participating in the model test. Identification of such individuals is necessary for a variety of purposes, including the construction of control groups against which model performance can be compared. In addition, to determine whether the observed impacts are due to the model being tested and not due to differences between the intervention and comparison groups, our evaluations will have to account for potential confounding factors at the individual level, which will require the ability to identify every individual associated