

September 11, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid
Department of Health and Human Services
Attn: CMS-1678-P
P.O. Box 8013
7500 Security Blvd.
Baltimore, Maryland 21244-8013

RE: CMS-1678-P - Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (82 Fed. Reg. 33558, July 20, 2017)

The American Association of Nurse Practitioners (AANP), representing more than 234,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment in response to the CY 2018 Updates to the Hospital Outpatient Prospective Payment System (82 FR 33558).

NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs practice in nearly every health care setting including clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia. It is important to note that 89.2% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

Supervision of Outpatient Therapeutic Services in Critical Access Hospitals (CAHs) (82 FR 33649):

CMS proposed to reinstate the nonenforcement of direct supervision instruction for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for CY 2018 and 2019.¹ We agree with this proposal and thank CMS for recognizing the burden that this supervision requirement places on CAHs and small rural hospitals.

CMS has requested information on other regulatory burdens that could be alleviated, and we would like to note that there are other supervision requirements that are in place that are equally burdensome and could be alleviated through enforcement moratoriums.

¹ 82 FR 33558, 33649.

As CMS noted in the proposed rule, they are not aware of any quality of care complaints during the six years that the moratorium on enforcement has been in place in critical access hospitals. Rural health clinics and federally qualified health centers have similar access and staffing issues, and moratoriums on the supervision requirements in those facilities would be equally beneficial to providers and patients. In the proposed rule, CMS also noted that a review of the partial hospitalization program found that over half of the patients were not receiving the intensity of treatment required under the program. CMS stated that providers should have flexibility in rendering services under the program. Allowing nurse practitioners to create the treatment plan, supervise and direct patients in the partial hospitalization program would allow hospitals to utilize them to the full extent of their education and clinical preparation, leading to increased flexibility and greater oversight.

CMS has also recently proposed to cancel a model cardiac rehabilitation incentive payment program that would have removed the physician ordering and supervision requirements on cardiac rehabilitation services in participating geographic areas, allowing NPs to order and supervise cardiac rehabilitation. This provision was supported by a broad coalition of health care entities, multiple health systems and various provider organizations. The continuation of programs such as these, as well as, the development of future payment models that remove unnecessary supervision requirements, will provide facilities with the flexibility to use their clinicians to the full extent of their education and clinical preparation and provide the highest quality care to their patients.

Supervision requirements remain in place in a wide variety of settings including comprehensive outpatient rehabilitation facilities, inpatient rehabilitation facilities, skilled nursing facilities and hospitals. Nurse practitioners are educated and clinically trained to provide these services and are essential providers in each of these settings, and the supervision requirements that remain in place are unnecessary burdens on these facilities. While many of these supervision requirements would require legislative fixes, we ask that CMS consider issuing nonenforcement instructions and guidance in a wider array of settings to alleviate unnecessary burdens on these facilities, patients and clinicians.

Provider Neutral Language

Throughout this proposed rule, CMS uses the term “physician” in situations where other qualified health professionals, including nurse practitioners, are authorized to provide care under the Medicare program. This includes references to services provided in office settings, the ordering of labs and drugs and the request for information, among others. The use of the term “physician” in these instances confuses patients and providers as to which clinicians are authorized to provide care under the Medicare program and undermines the scope of practice and quality of care provided by nurse practitioners. This could lead to unfair restraints on practice and decreased access to care for patients. It is important that during rulemaking and in all other correspondence, CMS does not continue to utilize the word “physician” when other qualified health professionals are authorized to provide a service.

We thank you for the opportunity to comment on this proposed regulation. We look forward to discussing these issues with you. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

David Hebert
Chief Executive Officer