



American Association of
NURSE PRACTITIONERS™

The Voice of the Nurse Practitioner®

July 7, 2020

The Honorable Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5531-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-5531-IFC; Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

Dear Administrator Verma,

On behalf of the American Association of Nurse Practitioners (AANP), and the more than 290,000 nurse practitioners (NPs) in the United States, we appreciate the opportunity to comment on this interim final rule. We appreciate that the CMS staff has been working tirelessly to address the needs of clinicians, providing flexibilities in record time. We specifically commend CMS for quickly implementing Section 3708 of the CARES Act which permanently authorizes nurse practitioners to order and certify for Medicare and Medicaid home health services. We look forward to continuing to work with CMS to improve the ability of clinicians to provide the care their patients need during, and after, this pandemic.

NPs are advanced practice registered nurses (APRNs) 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 schools and school-based clinics, hospitals, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), 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. NPs complete more than one billion patient visits annually.

Our members are on the front lines of treating patients with COVID-19 and meeting the other health care needs of their patients. The flexibilities and waivers issued by CMS have improved care delivery for patients directly impacted by this virus, as well as patients with other medical conditions that need to be addressed during this pandemic. Below are our comments in response to this interim final rule.

1. Supervision of Diagnostic Tests by Certain Nonphysician Practitioners

We appreciate CMS authorizing NPs to be reimbursed for supervising the performance of diagnostic tests, including psychological and neuropsychological tests¹, for the duration of the public health emergency. While Medicare already authorizes NPs to order and perform diagnostic tests, prior to this interim final rule NPs were not authorized to be reimbursed for the supervision of diagnostic tests performed by other clinical staff. We agree with CMS that this enables practices where NPs are supervising other health care personnel to increase their testing capacity and maximize the utility of their clinical workforce.

Maintaining this policy after the end of the public health emergency will enable NPs and their practices to continue to meet the diagnostic testing needs of their patients and communities. Additionally, this is consistent with how the CMS regulates NPs in ordering and performing diagnostic tests, “physician services”, or “incident to physicians’ services” by deferring to the NPs’ authority to provide care under state law. CMS has stated that they do not intend to impose additional restrictions on NPs in excess of state law, and removing this barrier is consistent with that statement of purpose.

2. Care Planning for Medicare Home Health Services

We greatly appreciate that CMS made the permanent implementation of section 3708 of the CARES Act a priority. CMS has emphasized that implementing section 3708 was “imperative” so that “NPs, CNSs, and PAs would be able to practice to the top of their state licensure to certify eligibility for home health services, as well as establish and periodically review the home health plan of care.”² We look forward to continuing to work with CMS to ensure that the home health care process works seamlessly for NPs and their patients and upholds the Congressional intent of retiring needless barriers to care for nurse practitioners and creating greater access for patients.

Below are recommendations on specific regulatory language updates consistent with section 3708 of the CARES Act. These recommendations seek to ensure that there is no confusion in the implementation of this legislation. We also have three broader recommendations for CMS in the promulgation of these regulations:

1. We request that CMS amend the newly defined term “allowed practitioner” to say “authorized practitioner.” “Authorize” is the terminology used in the CARES Act. This more accurately reflects the authority of NPs, CNSs, and PAs to provide home health care services to their patients.
2. We recommend the regulatory changes noted below, specifically in sections 424.22 and 484.2, to ensure that the statutory intent is maintained in the regulations. Our recommendations are consistent with CMS regulation of nurse practitioners. CMS has stated that the agency does “not intend to introduce new burdensome requirements to address situations where there is no State

¹ 85 FR 27550, 27555, (May 8, 2020).

² *Ibid.*, at 27572.

requirement for collaboration.”³ CMS has clarified this interpretation in § 410.75, which is incorporated into the regulatory text below, and recognized this interpretation in the interim final rule.⁴ Additional references to collaboration are unnecessary and may lead to an overly restrictive interpretation of the regulations, inconsistent with the CARES Act.

3. We also note that some states still have regulatory language regarding home health that mirrors the pre-CARES Act language. Thus, in certain states NPs are authorized to perform the face-to-face assessment, but are still required by state law to confirm their patients to physicians to certify the face-to-face. We request that CMS ensure that this rulemaking cannot be inferred to limit the authority of an NP to perform the face-to-face assessment in this circumstance.

We have added our specific recommendations in **bold** within the current regulatory language as noted below:

42 CFR § 409.43(c)

(C) Includes an attestation (relating to the physician's **or authorized practitioner's** orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.115) responsible for furnishing or supervising the ordered service in the plan of care; and

(D) Is copied into the plan of care and the plan of care is immediately submitted to the physician **or authorized practitioner**; or

(ii) A referral prescribing detailed orders for the services to be rendered that is signed and dated by a physician **or authorized practitioner**.

(2) *Final percentage payment signature requirements.* The plan of care must be signed and dated—

(i) By a physician **or authorized practitioner** as described who meets the certification and recertification requirements of §424.22 of this chapter; and

(ii) Before the claim for each episode (for episodes beginning on or before December 31, 2019) or 30-day period (for periods beginning on or after January 1, 2020) is submitted.

(3) *Changes to the plan of care signature requirements.* Any changes in the plan must be signed and dated by a physician **or authorized practitioner**.

42 CFR § 409.43(d)

(d) *Oral (verbal) orders.* If any services are provided based on a physician's **or authorized practitioner's** oral orders, the orders must be put in writing and be signed and dated with the date of

³ 63 FR 58814, 58872, (November 2, 1998). We note that 42 CFR 410.75(c)(ii) references a process of collaboration required by CMS “[i]n the absence of State law governing collaboration[.]” However, since this language is now twenty-two years old and every state has laws governing collaboration, including states where none is required, this language is no longer necessary.

⁴ 85 FR 27550, 27555, (May 8, 2020).

receipt by the registered nurse or qualified therapist (as defined in §484.115 of this chapter) responsible for furnishing or supervising the ordered services.

42 CFR § 409.64(a)(ii)

(ii) The hospital, CAH, SNF, or home health agency had submitted all necessary evidence, including physician **or authorized practitioner** certification of need for services when such certification was required;

42 CFR § 410.170(b)(1)

(b) **Physician Certification.** (1) For home health services, a physician **or authorized practitioner** provides certification and recertification in accordance with §424.22 of this chapter;

42 CFR § 424.22(a)(1)(v)(A)(2)

(2) The certifying nurse practitioner (as defined at §484.2 of this chapter), certifying clinical nurse specialist (as defined at §484.2 of this chapter), or a nurse practitioner or a clinical nurse specialist who is working in accordance with State law ~~and in collaboration with a physician or in collaboration with an acute or post-acute care physician~~ with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health **in accordance with State law.**

AANP Note: As noted above, Section 3708 of the CARES Act does not include a collaboration requirement. While it was not the reported intent of CMS, the language in § 424.22 that states “in accordance with State law and in collaboration with a physician” could imply that there is a collaboration requirement being imposed, which is contrary to the intent of the CARES Act. Accordingly, we request that the language in § 424.22(a)(1)(v)(A)(2) be amended as noted above.

42 CFR § 484.2

Nurse practitioner means an individual as defined at §410.75. ~~(a) and (b) of this chapter, and who is working in collaboration with the physician as defined at §410.75(c)(3) of this chapter.~~

AANP Note: As noted above, the reference to collaboration is not necessary in this definition, which already incorporates 42 CFR § 410.75.

42 CFR § 484.50(d)(5)(i)

(i) Advise the patient, representative (if any), the physician(s) **or authorized practitioner(s)** issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered;

42 CFR § 484.55(a)(2)

(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician **or authorized practitioner** who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

42 CFR § 484.110

The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) **or authorized practitioner(s)** issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically.

(a) *Standard: Contents of clinical record.* The record must include:

(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician **or authorized practitioner** orders;

Additional Coding and Form Changes: We also urge CMS to revise the category II Healthcare Common Procedure Coding System (HCPCS) codes G0179, G0180 and G0181 currently utilized to report home health services. The descriptors for these codes use the terms, “physician re-certification,” “physician certification” and “physician supervision,” respectively. CMS noted in a recent MLN Matters article that NPs, CNSs, and PAs are authorized to bill for these codes, and that changes to the code descriptors were forthcoming. We request that CMS make these changes expeditiously.

Additionally, home health form CMS-485, while not required, is often used to certify home health, and uses the term “Attending Physician” in the signature block. We ask the agency to update this form to be provider neutral in accordance with the CARES Act to eliminate any confusion about the authority of NPs, CNS, and PAs to provide, order and certify home health services for beneficiaries.

3. **Medicare Shared Savings Program (MSSP)- Expansion of Codes Used in Beneficiary Assignment**

We appreciate that CMS has increased flexibility within the MSSP by expanding the telehealth services that qualify as primary care services for beneficiary assignment. However, despite being recognized as ACO professionals, the claims-based assignment pathway requires an NP’s patient to receive at least one primary care service provided by a “primary care physician” (as defined by 42 CFR § 425.20 or with the specialty designation in 42 CFR § 425.402(c)) each year for the patient to be assigned to an ACO. While

this restriction does not prevent individual nurse practitioners from joining an ACO, it prevents their patients from being assigned to an ACO through claims-based assignment, and any benefits that result from such participation, unless the NP sends their patient to receive a primary care service from a “primary care physician” (as defined by 42 CFR § 425.20 or with the specialty designation in 42 CFR § 425.402(c)).

Effective in 2019, CMS amended the voluntary alignment pathway to authorize a patient to select an NP as their primary care provider in an MSSP ACO and be assigned to the ACO without requiring that duplicative physician visit. This change provided greater opportunity for NPs and their patients to join and establish MSSP ACOs. However, the claims-based assignment barrier still exists. It is important to note that in its FY 2021 Budget in Brief, HHS estimates that basing ACO-assignment on a broader set of primary care providers, including nurse practitioners, will better reflect our current primary care workforce and lead to \$80 million in savings for the Medicare program over ten years.⁵ Removing this barrier will improve flexibility for beneficiary assignment during the pandemic and beyond.

4. Payment for Audio-Only Telephone Evaluation and Management Services

We appreciate that CMS has listened to stakeholders regarding the importance of covering audio-only evaluation and management services. Without covering audio-only telehealth, vulnerable patients without access to audio-video technology faced a challenging decision to delay or not receive care or risk exposure to COVID-19 in an in-person setting. Particularly for patients in rural areas and areas of lower socioeconomic and health status who may have limited access to the reliable infrastructure and audio-video technology, the coverage of audio-only visits will be an important component of telehealth moving forward. We recommend that CMS maintain coverage of these services after the end of the public health emergency.

5. Improving Care-Planning for Medicaid Home Health Services- 42 CFR § 440.70

As mentioned above, we appreciate the work of CMS to prioritize implementation of section 3708 of the CARES Act. For Medicaid, this provides immediate relief for both home health and the ordering of supplies, equipment and appliances which were significant barriers for nurse practitioners and their patients. The swift implementation of these provisions has streamlined the process of NPs obtaining home health care and supplies, equipment and appliances for their patients which has been essential during this pandemic.

Below is one recommended change to the regulatory language in 42 CFR § 440.70 that would clarify that NPs, physician assistants, certified-nurse-midwives and clinical nurse specialists are also authorized to perform the face-to-face assessment when the beneficiary is being admitted to home health after an acute

⁵ <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf> (page 84).

or post-acute stay. This change will better align this provision with the Medicare language in 42 CFR § 424.22(a)(1)(v)(C).

§ 440.70(f)(3)(v)

Current Text: “For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.”

Recommended Text: For beneficiaries admitted to home health immediately after an acute or post-acute stay, a physician, physician assistant, nurse practitioner, clinical nurse specialist or certified nurse-midwife with privileges who cared for the patient in the acute or post-acute facility.

Conclusion

The actions taken by CMS have removed barriers to care and improved the ability of NPs to meet the needs of their patients during this pandemic. We particularly appreciate CMS’ swift implementation of section 3708 of the CARES Act which permanently retires federal barriers to Medicare and Medicaid home health care and look forward to continued partnership with CMS. Please contact MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529 for further discussion.

Sincerely,

David Hebert
Chief Executive Officer