October 2, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
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Baltimore, Maryland 21244-1850

RE: CMS-1736-P - Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician Owned Hospitals

The American Association of Nurse Practitioners (AANP), representing more than 290,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment in response to the fiscal year 2021 updates to the Hospital Outpatient Prospective Payment System.

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 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), nursing facilities (NFs), schools, colleges and universities, 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.

Nurse practitioners currently provide a substantial portion of the high-quality[1], cost-effective[2] care that our communities require, and will continue to do so to meet the needs of their communities. As of 2018, there were more than 145,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[3] Over 82% of NPs are accepting Medicare patients and over 80% are accepting Medicaid patients.[4]

We appreciate the actions taken by CMS staff, including waiving Medicare and Medicaid barriers, to further enable nurse practitioners, and other clinicians, to meet the health care needs of their communities during the COVID-19 Public Health Emergency (PHE). NPs have been on the front lines of caring for patients throughout this pandemic, and these actions have been important for improving their capacity to

[1] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[2] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[3] https://www.cms.gov/files/document/2018-mdcr-providers-6.pdf.
[4] 2017 AANP National Nurse Practitioner Sample Survey.

deliver necessary health care to their patients. Below please find our comments on specific sections in this proposed rule.

Proposal To Allow General Supervision of Outpatient Hospital Therapeutic Services Currently Assigned to the Non-Surgical Extended Duration Therapeutic Services (NSEDTS) Level of Supervision

In this proposed rule, CMS is proposing to change the generally applicable minimum required level of supervision by a physician or nonphysician practitioner (including nurse practitioners) for NSEDTS from direct supervision to general supervision for services furnished by all hospitals and CAHs. Under the current structure, the general minimum supervision standard is direct supervision provided by NPs, physicians and other nonphysician practitioners. As noted by CMS, the direct supervision requirement is currently waived for the duration of the PHE. This proposed rule would permanently authorize nurse practitioners, physicians and other nonphysician practitioners to provide general supervision as the minimum required standard for NSEDTS, as opposed to the current standard of direct supervision.

We support the proposal to require a minimum level of general supervision, as opposed to direct supervision, because it will reduce burden on providers, patients and facilities and provide greater flexibility to deliver outpatient therapeutic care. Nurse practitioners supervise therapeutic services throughout hospitals and CAHs. This will provide greater flexibility to manage patients under their care, particularly in rural and underserved communities.

Cardiac and Pulmonary Rehabilitation

In this rule, CMS is proposing to permanently authorize direct supervision of cardiac rehabilitation, intensive cardiac rehabilitation and pulmonary rehabilitation to be performed via audio/video technology, as currently authorized during the PHE. The Bipartisan Budget Act of 2018, which was signed into law on February 9, 2018, contains a provision that authorizes nurse practitioners to supervise cardiac and pulmonary rehabilitation beginning in 2024. We urge the Secretary to use his authority under the PHE to waive the requirements that cardiac and pulmonary rehabilitation must only be directly supervised and ordered by physicians. This will provide facilities with the ability to authorize NPs to order and supervise cardiac and pulmonary rehabilitation and provide greater access to these medically necessary, but underutilized services until this provision comes into effect.

Based on their education and clinical training, NPs are fully qualified to order and supervise these services. This obsolete barrier to care harms patients by causing unnecessary delays in treatment. CMS has recognized that cardiac rehabilitation improves long-term patient outcomes, but is underutilized.[5] Cardiac rehabilitation has been shown to decrease hospitalizations, increase adherence to preventive medication, improve overall health and reduce the need for costly care.[6] Thus, it is important that all authorized providers are able to order and supervise this clinically effective and cost-saving treatment.

Additional Waivers for Consideration

Pursuant to the PHE, CMS has also waived the requirement for CAHs that a "doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH" at § 485.631(b)(2). In approving the waiver, CMS stated that this would allow CAHs to utilize NPs to the fullest extent possible.[7] We recommend that CMS make this policy

[5] 82 FR 50784, 50800.
[6] https://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_493752.pdf.
[7] https://www.cms.gov/files/document/covid-hospitals.pdf.

permanent in future rulemaking to provide additional flexibility to CAHs to meet the needs of their patients and communities. Making this policy permanent is consistent with section 5 of Executive Order 13890 on *Protecting and Improving Medicare for Our Nation's Seniors* which directs the Secretary to eliminate burdensome conditions of participation that limit health care providers, such as NPs, from practicing to the top of their education and clinical preparation.[8]

We thank you for the opportunity to comment on this proposed rule. 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

[8] https://www.federalregister.gov/documents/2019/10/08/2019-22073/protecting-and-improving-medicare-for-our-nations-seniors.