Headquarters
4501 College Blvd, #225
Leawood, KS 66211-1921
816-756-3140
Fax: 816-756-3144

NATIONAL RURAL HEALTH ASSOCIATION

Government Affairs Office
1025 Vermont Avenue
Suite 1100
Washington, D.C. 20005
202-639-0550
Fax: 202-639-0559

January 16, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244

RE: Scope of Practice Request for Information Pursuant to the President's Executive Order (EO) #13890 on Protecting and Improving Medicare for Our Nation's Seniors

Dear Administrator Verma,

The National Rural Health Association (NRHA) is pleased to offer comments on the CMS's request for information on Scope of Practice seeking additional input and recommendations regarding elimination of specific Medicare regulations that require more stringent supervision than existing state scope of practice laws, or that limit health professionals from practicing at the top of their license. As always, we appreciate your continued commitment to the needs of the 62 million Americans residing in rural areas and look forward to our continued collaboration to improve health care access and quality throughout rural America.

The NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses and patients. We work to improve rural America's health needs through government advocacy, communications, education and research.

We appreciate CMS' continued emphasis on narrowing the gap between rural patients and providers. In collaboration with NRHA policy partners, this letter outlines suggestions and recommendations that we believe will strengthen the ability of rural communities to recruit and retain qualified workforce to serve rural Medicare beneficiaries in a location close to where they live. Being able to allow Advance Practice Practitioners (APP) to work at the top of their license will benefit all rural Medicare beneficiaries. Accordingly, NRHA applauds your efforts in this regard and offer our ideas to follow on how to streamline federal regulations to accomplish these goals.

1. Encourage Flexibility and Efficiency by Removing Costly and Unnecessary Supervision Requirements:
    a. CRNA services--CMS should remove costly and unnecessary requirements relating to physician supervision of CRNA anesthesia services. These requirements are more restrictive than most state requirements and impede local communities from implementing the most innovative and competitive model of providing quality care.
    b. Certified Nurse Midwives (CNM)—CMS should remove costly and unnecessary requirements relating to physician supervision of CNM services, for the same reasons as required for CRNAs.

c. Cardiac Rehabilitation—APRNs and PAs should be able to provide direct supervision of cardiac rehabilitation services as required by current Cardiac Rehabilitation Conditions of Participation.
d. Eliminate federal requirements for physician supervision/collaboration applicable to Physician Assistants (PA) and Advanced Practice Nurse Practitioners (APRN). When the RHC program was created (1977), most states had not established laws/regulations governing PA or APRN practice making federal standards appropriate. However, there are now laws and regulations governing PA/APRN practice in all 50 states making federal requirements unnecessary.

2. Change § 482.52 Condition of participation: Anesthesia services per the following edits:

(a) Standard: Organization and staffing. The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by:

(1) A qualified anesthesiologist.

(2) A Doctor of Medicine or osteopathy (other than an anesthesiologist).

(3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law.

(4) A certified registered nurse anesthetist (CRNA), as defined in § 410.69(b) of this chapter, ~~who, unless exempted in accordance with paragraph (c)of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed~~ or

(5) An anesthesiologist's assistant, as defined in § 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

* * * * *

~~(c) Standard: State exemption. (1) A hospital may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law. (2) The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time and are effective upon submission.~~

3. Definition of “Employee” in a Rural Health Clinic (RHC). Federal regulations require that the owner of the RHC "employ" at least one PA or one APRN as part of the RHC survey and certification process. The term employ has been interpreted by CMS to mean a W-2 relationship. We believe the term employ means "use or utilize" and the tax status of the individual was not the intent. We believe it is appropriate for RHCs to be required to use or utilize PAs or APRNs at least half-time, but the nature of their employment relationship should be whatever arrangements are permissible under state law/state regulatory mechanism.

4. APRN and PAs to Order Home Health and Skilled Nursing Services. CMS should Authorize PAs and APRNs to order home health and/or Skilled Nursing Services. PAs and APRNs are currently unable to order home health and skilled nursing services for Medicare patients, even though they can order the same services for non-Medicare patients. The lack of authorization under the Medicare program disrupts continuity of care and may result in Medicare beneficiaries experiencing a delay or denial in accessing home healthcare and Skilled Nursing. Ensuring PA

and APRNs are recognized to order home healthcare and skilled nursing services will increase access and promote continuity of care, particularly in rural and other medically underserved communities where a PA or APRN may be the only healthcare professional on-site. Additionally, the ability of PA or APRNs to conduct the required face-to-face initial home health visit promises greater efficiency and reduced costs.

5. Authorizing PAs and APRNs to order diabetic shoes: PA and APRNs serve as primary care providers for Medicare patients suffering from diabetes and routinely prescribe insulin, manage complex conditions, and order required medical equipment. While PA and APRNs are authorized to order DME, outdated Medicare statute excludes diabetic shoes and requires a physician to certify the need. These Medicare requirements result in additional physician visits of a PA and APRN's diabetic patient, an additional barrier to care and added costs. With the aging population and increasing prevalence of diabetes – particularly in rural America – authorizing PA and APRNs to certify and order diabetic shoes is necessary to remove barriers to care and allow PAs to practice to the top of their license.

6. Assignment of patients treated by a PA to Accountable Care Organizations (ACOs). PA and APRNs are recognized in the Medicare Shared Savings Program (MSSP) as "ACO professionals," yet their patients cannot be assigned to an ACO as beneficiaries unless patients undertake an additional administrative process to name the PA or APRN as their ACO professional. Removing this barrier will enable Medicare beneficiaries who receive their primary care from PAs or APRs to be assigned to MSSP ACOs without arbitrarily requiring the patient to see a physician. It will also encourage ACO formation by helping healthcare providers attain enough beneficiaries to participate. Through these changes, ACO assignments will be more effective for beneficiaries and providers in rural communities that suffer from acute physician shortages, also allowing patients in rural areas to benefit from innovation in our healthcare delivery system.

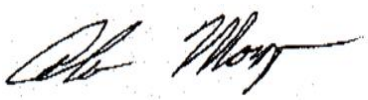
7. Authorizing PAs to receive direct payment: PAs are the only health professionals authorized to bill Medicare for their services who can't receive direct reimbursement for those services. This inability to be directly paid often leads to increased administrative burden and necessitates complex billing arrangements while also limiting the flexibility of PAs to work in new and evolving practice and care models. This is a burden in rural areas, where PAs may be hindered in serving the community due to the lack of direct payment. For example, PAs who own rural health clinics (RHC) are unable to receive direct payment for diagnostic services excluded from the RHC bundle but mandated by Medicare, forcing these PAs to provide the services without being reimbursed. AAPA requests statutory language to authorize PAs to receive direct payment from Medicare.

8. Support Optimal Team Practice (OTP): Optimal Team Practice occurs when PAs, APRNs, physicians, and other medical professionals work together to provide quality care without burdensome administrative constraints. To support OTP, states should eliminate the legal requirement for a specific relationship between a PA, APRN, physician or any other healthcare provider for PAs or APRNs to practice to the full extent of their education, training and experience. OTP will make it easier for PA and APRNs to practice at the top of their license in rural and other medically underserved communities where there are not enough physicians to care for patients.

9. Rural Health Clinic as a Telehealth Distant Site. Relaxation of telehealth requirements so that RHCs can be the "distant" site for the actual delivery of the care and not just the "originating" site for the telehealth encounter.

Thank you for the chance to offer comments on this request for information, and for your consideration on our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to care. If you would like additional information, please contact Brock Slabach at bslabach@nrharural.org, or 816-423-8201.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association