DRAFT NP Roundtable comments on CMS-3267-P

April 8, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-3267-P
P.O. Box 8010
7500 Security Boulevard
Baltimore, MD 21244-8010

RE: CMS-3267-P – Medicare and Medicaid Programs; Part II—Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction

Dear Ms. Tavenner:

On behalf of the more than 155,000 nurse practitioners (NPs) across the country represented by the undersigned organizations, we appreciate this opportunity to comment on the Proposed Rule addressing regulatory provisions to promote program efficiency, transparency, and reduce regulatory burdens in the Medicare and Medicaid programs (78 Fed. Reg. 9216; February 7, 2013). As in the past, we support the Administration's efforts to reduce procedural burdens on providers, but in finalizing these regulations we urge you to be aware of other rules, procedures, and instructions that often prevent health care providers from performing the full range of services they are educated and clinically prepared to deliver. Many of these policy statements reflect an outdated approach focused more on control of payment for services than on the provision of more efficient high quality care for patients.

Nurse practitioners and other advanced practice registered nurses (APRNs) have long supported Medicare regulatory reform that aligns national policy with state scope of practice, supports the promotion of healthcare delivery consistent with patient and community need, allows for cost savings associated with delivery systems innovation, and is consistent with the recommendations of the Institute of Medicine. We appreciate the agency's efforts to revise hospital conditions of participation, but this is only one of the areas when federal policy fails to enable NPs to provide patient care at the full extent of their education and clinical preparation.

In comments we submitted December 23, 2011, on CMS-9070-P, "Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reductions," we urged you to eliminate unnecessary requirements for physician oversight that contribute to duplication and waste in healthcare delivery and to revise the definition of the term "physician" to enable APRNs to provide the full range of services they are prepared to deliver. We are disappointed that they agency has failed to address these issues in the previous rulemaking or in this latest proposal, and we once again ask you to do so.

Physician oversight requirements
Medicare's requirements for oversight of APRN services needlessly hinder patient access to care and increase healthcare costs without improving the safety or the quality of patient care. As

highly trained practitioners with advanced degrees, nurse practitioners and other APRNs provide evidence-based, safe, quality care in hospitals, critical access hospitals, ambulatory surgery centers, skilled nursing facilities, and other health care facilities, all of which are associated with unnecessary federally mandated oversight requirements. Patients may have access to care denied or delayed, especially in rural and medically underserved areas where a nurse practitioner is available, educated and skilled to provide the service, but there is no physician to meet oversight requirements. By applying standards that enable nurse practitioners to practice to the full extent of their licensure and scope under State law, Medicare will improve patients' access to the care they need.

We urge the Agency to initiate rulemaking that will remove burdensome physician oversight requirements of nurse practitioners and other APRNs where applicable and to seek legislation to eliminate such barriers in instances where a statutory change is required.

Definition of "physician"

Medicare currently covers and reimburses for services provided by nurse practitioners and other APRNs that are otherwise covered if furnished by a physician. Yet many areas of Medicare statute and regulation continue to treat nurse practitioners and APRNs differently than physicians with respect to ordering of services, oversight, clinical privileging, and other services and responsibilities. In many cases, Medicare coverage rules arbitrarily determine which "physician" services are restricted to doctors of medicine and osteopathy only and which are permissible for nurse practitioners and other APRNs to provide.

If patients are to obtain the care they need when they need it, there should be consistency in recognizing nurse practitioners throughout the Medicare regulatory structure. Nurse practitioners should be included in the definition of "physician," or listed with physicians as a qualified provider wherever the terms "physician" or "physician services" are used. This alignment provides beneficiaries with improved access and appropriate delivery of Evaluation and Management Services as well as timely provision of such services as home health and hospice care. For example, consistent with a specific recommendation in the 2010 Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*, legislation will shortly be reintroduced in Congress to authorize nurse practitioners to certify eligibility for Medicare home health care services, an activity that nurse practitioners can already undertake in relation to the provision of skilled long term care. However, while nurse practitioners can authorize an admission in skilled care facilities, a physician is still required to conduct an admitting physical examination (a skill clearly in the domain of nurse practitioner education and training). Revising the definition and use of the term "physician" to include nurse practitioners would alleviate these and other barriers that impede patient access to cost effective, high quality health care services.

We strongly urge the Agency to initiate rule making to revise Medicare regulations and policies to eliminate the restrictive use of the term "physician" by including nurse practitioners, consistent with licensing laws and regulations in the state in which the service is provided. Further, we urge the Agency to actively seek and support legislation in instances where a statutory change is required to recognize nurse practitioners and other APRNs as providing the same services as physicians.

Hospital Medical Staff (§ 482.22)

We are grateful for the additional clarification of the agency's current policies to provide hospitals with explicit flexibility to maximize their medical staff opportunities for all practitioners within the regulatory boundaries of State licensing and scope-of-practice laws. We agree that increased use of the services of NPs and other practitioners to provide the full range of care they are trained and licensed to furnish will allow them to meet the needs of their patients most efficiently and effectively.

However, as with previous regulations, we are concerned that the permissive nature of the proposed language does not go far enough. As proposed, the rule will "allow" but not require hospitals to eliminate barriers to privileging of nurse practitioners. While we recognize that each hospital must be able to structure its medical staff to meet the needs of the patients it serves, that flexibility should not extend to adopting or retaining policies that conflict with functions clearly authorized by State practice acts, restrict the ability of nurse practitioners to perform those functions, impose undue burdens on nurse practitioners, and delay patient treatment or limit access to care.

Nurse practitioners and other advanced practice nurses function with scopes of practice similar to those of their physician counterparts, yet they have no assurance hospitals will include them as full members of the medical staff. Such a situation cannot help but create an anticompetitive environment where physicians in a local community have significant authority over whether their nurse practitioner colleagues have access to hospital facilities. The denial of this access can force nurse practitioners or other APRNs out of a community, reducing patient choice of health professionals and eliminating competition.

We urge the agency to require that nurse practitioners and other providers who are granted clinical privileges be acknowledged as members of the medical staff with full voting rights. This requirement would provide clarity for hospitals, ensure that medical staffs are representative of the skilled professionals authorized by State law to practice in the nation's hospitals, and prevent anticompetitive behaviors that might diminish access to nurse practitioners' services.

We believe the agency should provide uniform standards and requirements for the consideration of all applications for appointment to the medical staff and granting of clinical privileges. These would include completing the application review and issuing a final determination no later than 60 days after a completed application is filed with the hospital by any clinician. The hospital should be required to notify an applicant in writing of the final determination. In the case of a decision by the hospital to deny the application, hospitals should be required to provide a full explanation of the rationale for the denial including specific information on which the hospital relied and notification of the applicant's rights to a hearing or to appeal the determination.

Outpatient Services (§ 482.54)

We support the proposed revision of conditions of participation governing outpatient services, to clarify that orders for outpatient services may be made by any practitioner who is responsible for the care of the patient, licensed in the State where he or she is providing patient care, acting within his or her scope of practice under State law, and authorized by hospital policies to order the applicable outpatient services. We strongly support the clarification that practitioners not appointed to the medical staff but who satisfy these criteria are able to order and refer patients for the appropriate outpatient services. We appreciate that these requirements would also apply

to all hospital services that may be offered on an outpatient basis, including services for which regulatory language might appear to impose more stringent limits as to the practitioners who are permitted to order outpatient services.

Critical Access Hospital (CAH) and Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) Physician Responsibilities (§§ 485.631(b)(2) and 491.8(b)(2))

We support the agency's proposal to revise the regulations for Critical Access Hospitals and those for Rural Health Clinics and Federally Qualified Health Clinics to eliminate the requirement that a physician must be onsite at least once in every 2-week period (except in extraordinary circumstances) to provide medical care services, medical direction, consultation and supervision. Eliminating this requirement is particularly important for facilities in geographically remote or isolated areas in which there may be a shortage of physicians. The agency's recognition of the ability of nurse practitioners and other staff in these facilities to provide critical medical services to patients without the supervision of physicians underscores the importance of eliminating burdensome supervision requirements related to other facilities and services.

Again, we appreciate the opportunity to comment on these proposed changes and to urge the agency, in response to the President's pledge to eliminate burdensome, obsolete rules, to specifically address areas of current regulations that prevent nurse practitioners from fully contributing to improving cost-effective patient care. We look forward to working with you and the administration to remove these barriers and enable nurse practitioners to participate fully in a more efficient health care system.

Sincerely,