January 17, 2020

Submitted via PatientsOverPaperwork@cms.hhs.gov

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
7500 Security Boulevard
Baltimore, MD  21244

RE: Request for Feedback on Scope of Practice

Dear Administrator Verma:

The undersigned organizations representing Advanced Practice Registered Nurses (APRNs) and education, appreciate the opportunity to provide comment on CMS’ request for feedback on the 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. We applaud Section 5 of the President’s Executive Order (EO) #13890 on Protecting and Improving Medicare for Our Nation’s Seniors and look forward to working with CMS on implementing this section of the EO. We appreciate actions that CMS has already taken to reduce regulatory burdens on APRNs and their patients and have included further recommendations consistent with this request for feedback.

The APRN Workgroup is comprised of organizations representing Certified Nurse-Midwives (CNMs) experts in primary care, maternal and women’s health; Clinical Nurse Specialists (CNSs) offering acute, chronic, specialty and community healthcare services; Certified Registered Nurse Anesthetists (CRNAs) who provide the full range of anesthesia services as well as chronic pain management; and Nurse Practitioners (NPs) delivering primary care, acute, chronic, specialty and community healthcare. As of 2017, over 182,000 APRNs were treating Medicare patients, making it essential that CMS remove barriers to care for APRNs and their patients. In every setting and region, for every population particularly among the rural and medically underserved, America’s growing numbers of highly educated APRNs advance healthcare access and quality improvement in the United States and promote cost-effective healthcare delivery.

As CMS seeks feedback on the elimination of regulatory and sub-regulatory requirements that prevent providers from practicing to the top of their license, we want to bring to your attention several specific regulatory barriers to the practice of APRNs that impair patient access to health care, impede patient choice, and raise health care costs. Our proposals below are consistent with the EO, the CMS 2018 Rural Health Strategy,¹ and the Trump Administration’s report on “Reforming America’s Healthcare System Through Choice and Competition.”² In the report, the Administration recommended reforming scope of practice laws to “allow all healthcare providers to practice to the top of their license, utilizing their full skill set.”³ In making this recommendation, the report highlighted economic analysis which showed that authorizing APRNs to practice to the top of their license would lower health care costs and increase access to care, particularly in rural and underserved communities.⁴ This report builds off years of analysis

---

3 Ibid, at page 36.
4 Ibid, at page 35.
from organizations such as the Federal Trade Commission\(^5\) and the National Academy of Medicine (formerly the Institute of Medicine)\(^6\) showing that restrictive scope of practice laws impede competition and drive up health care costs. Both the American Enterprise Institute and the Brookings Institution also released reports in 2018 that recommended removing restrictions that prevent APRNs from practicing to the top of their license.\(^7\) \(^8\) Accordingly, we offer the following recommendations:

- Remove costly and unnecessary physician certification, order and referral requirements;
- Remove costly and unnecessary physician supervision requirements; and
- Update facility conditions of participation to authorize APRNs to practice to the full scope of their education and clinical training.

**Remove costly and unnecessary physician certification, order and referral requirements**

Under the Social Security Act, Medicare covers services provided by APRNs if they are authorized to provide the service under State law and if Medicare covers the service when provided by a physician.\(^9\) While these “physicians’ services” are covered when provided by APRNs in virtually all Medicare covered benefits and settings, there are a few outlier Medicare benefit categories that require APRNs and their patients to obtain certifications, referrals or orders from physicians, even when the APRN is managing the patient’s care and is authorized to provide the service under State law. These include home health certifications, recertifications and documentation of face-to-face assessments,\(^10\) certifying that patients need therapeutic shoes for the treatment of their diabetes,\(^11\) certifying that patients are terminally ill and in need of hospice care,\(^12\) ordering cardiac and pulmonary rehabilitation,\(^13\) certifying patients for medical nutrition therapy\(^14\) and certifying home infusion therapy plans of care. We encourage CMS to remove these outdated barriers to practice which delay access to treatment for patients and prevent APRNs from practicing to the top of their education and clinical training.

**Remove Costly and Unnecessary Physician Supervision Requirements**

We recommend that CMS eliminate unnecessary requirements for physician supervision of APRNs as described below.\(^15\) Given the growing population of persons in the United States requiring healthcare, particularly among Medicare eligible populations, physician supervision requirements stand in the way of deploying the vast APRN workforce. Unnecessary requirements for physician supervision, such as facility Conditions of Participation that require physician supervision of CRNA anesthesia services and which prevent NPs and CNSs from supervising cardiac and pulmonary rehabilitation,

---

\(^5\) [https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy](https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy)


\(^9\) 42 U.S.C. § 1395x(s)(2)(k)(ii) (nurse practitioners and clinical nurse specialists); 42 U.S.C. § 1395x(bb)(1) (certified registered nurse anesthetists); 42 U.S.C. § 1395x(gg) (certified nurse-midwives);

\(^10\) 42 C.F.R Part 424, 42 C.F.R Part 440, 42 C.F.R Part 484.

\(^11\) Medicare Benefit Policy Manual Chapter 15, Section 140.

\(^12\) 42 C.F.R. § 418.22.

\(^13\) Pulmonary rehabilitation- 42 C.F.R. § 410.47, Cardiac Rehabilitation- 42 C.F.R. § 410.49.

\(^14\) 42 C.F.R. § 410.132.

contribute to duplication and waste in the healthcare delivery system. There is no evidence that supervision requirements contribute to higher quality, lower cost, greater value, or access to healthcare. APRNs must hold their own license in each state; therefore, their practice is regulated and does not require additional supervision. On the contrary, ample evidence points to the value provided by APRNs.

Our request corresponds with a recommendation from the NAM report titled The Future of Nursing: Leading Change, Advancing Health, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs. The NAM report specifically recommends that, “advanced practice registered nurses should be able to practice to the full extent of their education and training.”

**Update facility conditions of participation to authorize APRNs to practice to the full scope of their education and clinical training**

In addition to removing costly and unnecessary supervision requirements within facilities as noted above, we encourage CMS to continue to update other facility conditions of participation to ensure that APRNs are authorized to practice to the top of their license in all settings. This includes updating the conditions of participation in skilled nursing facilities to authorize APRNs to perform the admitting assessment and all other mandatory assessments and the conditions of participation in inpatient rehabilitation facilities to authorize APRNs to perform the required face-to-face visits. This will provide facilities with greater flexibility to care for their patients, which will be particularly impactful in rural and underserved areas.

We thank you for the opportunity to comment on the request for feedback. Should you have any questions regarding these matters, please feel free to contact Ralph Kohl, Senior Director of Federal Government Affairs, American Association of Nurse Anesthetists, at 202.484.8400, rkohl@aanadc.com.

Sincerely,

American Academy of Nursing
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American Association of Nurse Practitioners
American College of Nurse-Midwives
American Nurses Association
American Organization for Nursing Leadership
Gerontological Advanced Practice Nurses Association
National Association of Nurse Practitioners in Women’s Health
National Association of Pediatric Nurse Practitioners
National League for Nursing
National Organization of Nurse Practitioner Faculties

---

16 NAM op. cit.
17 NAM op. cit., p. 9.