

November 16, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health & Human Services
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
200 Independence Avenue, SW, Room 415F
Washington, DC 20201

Re: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Dear Deputy Assistant Secretary Destro,

The American Association of Nurse Practitioners (AANP), representing more than 248,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment on ASPE's request for information on improving care for Medicare beneficiaries with social risk factors. We thank ASPE for their focus on improving the health of Medicare beneficiaries with social risk factors and we look forward to continuing to work together to achieve these goals.

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. They are experts in the provision of care to patients with social risk factors.

NPs practice in nearly every health care setting including clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, 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. It is important to note that 86.6% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

ASPE has requested feedback on how providers are working to improve health outcomes for Medicare beneficiaries, specifically those with social risk factors. Nurse practitioners are invested in improving community health and have answered the call of our nation's most pressing health care needs for beneficiaries with social risk factors, including fighting the opioid epidemic. As you are aware, with the passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016, NPs were authorized to provide medication-assisted treatment (MAT) after taking the necessary training and obtaining a DEA waiver. Since CARA passed, over 7,000 NPs have obtained their MAT waiver in order to provide much needed treatment to patients suffering from opioid use disorder. Based on the strength of the response from the NP and PA communities to this crisis, and the ongoing need for health care providers to provide MAT, this authorization was made permanent in the SUPPORT for Patients and Communities Act (H.R.

6). NPs are committed to improving the health and welfare of Medicare and Medicaid beneficiaries with social risk factors.

One of the primary issues impacting beneficiaries with social risk factors is a clinician shortage, particularly in primary care, that is being exacerbated by an aging population.¹ Nurse practitioners are currently providing a substantial portion of the high-quality², cost-effective³ care that our communities require, and will continue to do so to meet the needs of their communities. They are the fastest growing provider specialty in the Medicare program and are on pace to be the largest provider specialty within a year.⁴ “Eighty-four point nine percent” of NPs are accepting Medicare patients and 82.9% are accepting Medicaid patients.⁵ This will have a particularly large impact on primary care as approximately 85% of all NP graduates go into primary care.⁶ NPs comprise approximately one quarter of our primary care workforce, with that percentage growing annually.⁷ Early access to high-quality primary care is essential for Medicare and Medicaid beneficiaries with social risk factors. Nurse practitioners are well-positioned to meet their healthcare needs.

Nurse practitioners are educationally prepared to take a wholistic and patient-centered approach to health care which is grounded in their nursing roots. This approach addresses the social and environmental needs of these patients. This emphasis is essential when treating patients with social risk factors who have complicated needs that go beyond a medical evaluation and treatment. Nurse practitioners not only evaluate, diagnose and treat their patients, but also educate and empower patients to improve their self-care. They work with patients and their support systems to ensure that the patients’ needs are met by coordinating with social services resources, families and other health care providers. These concepts are ingrained in nurse practitioner preparation and are the backbone of care delivery models such as the patient-centered medical home, which deliver the comprehensive and coordinated care required for patients with social risk factors.

ASPE requested feedback on how to improve the collection and utilization of data on social risk factors. In their practice, NPs routinely identify and target the needs of their patients, provide care management and coordination, directly address their patient’s social needs, and integrate Medicare and Medicaid into their practices. However, the current structure of electronic health records often does not accommodate the incorporation of social risk factors documentation into the record. In addition, barriers continue to exist within federal programs that restrict care coordination and delay access to care for nurse practitioners’ patients.

Despite the need for nurse practitioners in our communities, and decades of evidence showing that NPs provide high-quality, cost-effective health care, NPs continue to be constrained in their ability to practice by outdated State and Federal statutes and regulations. Limiting the ability of qualified practitioners to practice to the full extent of their education and clinical training prevents our communities from meeting the needs of their at-risk patients. These unnecessary barriers deprive patients of their provider of choice, reduce access to needed treatments and services and lead to delays in care. These delays and barriers are particularly problematic for patients with social risk factors. We request that as a component of this study, ASPE recognize the importance of nurse practitioners in treating patients with social risk factors, and the

¹ Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Final Report, page 4. https://aspe.hhs.gov/system/files/pdf/167396/NP_SOP.pdf.

² <https://www.aanp.org/images/documents/publications/qualityofpractice.pdf>.

³ <https://www.aanp.org/images/documents/publications/costeffectiveness.pdf>.

⁴ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2016/Downloads/PROVIDERS/2016_CPS_MDCR_PROVIDERS_6.pdf

⁵ 2016 AANP National Nurse Practitioner Sample Survey.

⁶ <https://www.aanp.org/images/documents/about-nps/npfacts.pdf>.

⁷ Rural And Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners, Hilary Barnes, Michael R. Richards, Matthew D. McHugh, and Grant Martsolf, *Health Affairs* 2018 37:6, 908-914.

need to ensure that they are not constrained in meeting the health care needs of our most complex patients due to unnecessary statutory and regulatory barriers.

Barriers for NPs' patients within the Medicare and Medicaid programs that delay access to care and inhibit care coordination include: the Medicare and Medicaid home health benefit; patient access to diabetic shoes; hospice certifications; conditions of participations for skilled nursing facilities, hospitals, and rehabilitation facilities; and ordering and supervising cardiac and pulmonary rehabilitation. We have attached an addendum with detailed descriptions of these issues.

HHS has several tools at its disposal to enact these necessary changes, for instance:

- **many regulations are more restrictive than required under statute, such as skilled nursing facility (SNF) admissions that can be alleviated by HHS through rulemaking;**
- **HHS can issue enforcement moratoriums, such as that applied to supervision of outpatient therapy in critical access hospitals;**
- **it can use its regulatory authority to expand the definition of physician to include nurse practitioners, similar to the diabetes outpatient self-management training program, recognizing that much of the statutory language is outdated and not reflective of how care is currently delivered in the Medicare and Medicaid programs;**
- **it can ensure that any state waivers or future care models allow clinicians, including nurse practitioners, to practice to the full extent of their education and clinical training; and**
- **in those areas that are strictly defined by statute, such as hospice, HHS can highlight the negative impact of these restrictions so lawmakers are aware of the changes that need to be made.**

We thank you for the opportunity to comment on this request for information to improve health care for Medicare beneficiaries with social risk factors. We look forward to continued work ASPE to improve the health for patients with social risk factors. We would welcome an opportunity to engage in further discussions regarding the role of nurse practitioners in this initiative. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

A handwritten signature in black ink that reads "David E. Hebert". The signature is written in a cursive style with a long horizontal line extending to the right.

David Hebert
Chief Executive Officer

ADDENDUM

Below are some of the specific barriers that exist for nurse practitioners, their patients and their communities, and suggestions on how the Department of Health and Human Services (HHS) can relieve these barriers. Removing these barriers is necessary to increase patient access to care and improve the efficiency of our health care system by removing duplicative treatment, maximizing the efficiency of the health care workforce and reducing health care costs. We encourage HHS to implement these proposals to provide greater access to care for Medicare beneficiaries and improve community health. Following are barriers that need to be removed for NPs and their patients:

- **Decrease Administrative Burdens Within Medicare Home Health Services:**

Currently, NPs with patients who need home health care services must locate a physician who will document the nurse practitioner's assessment and provide a plan of care. Further, while NPs are authorized to perform a required face-to-face assessment of the patient's needs, the PPACA also requires that a physician document that the encounter has taken place. These delays in treatment jeopardize patient health, limit provider choice and the ability of NPs to compete in the marketplace, causing the Medicare program to incur additional costs by requiring the participation of additional providers. These delays are especially problematic for home health care patients who suffer from more chronic conditions and report more limitations on activities of daily living than the non-home health care Medicare beneficiary population.⁸

We suggest that HHS either broaden the definition of "physician" to include nurse practitioners or add "nurse practitioner" after "physician" in the regulatory language covering home health services for Medicare and Medicaid beneficiaries. The statutes governing home health services for Medicare beneficiaries do not define the word "physician" as it relates to those services. Thus, the Secretary has the discretion to revise the existing regulations to include NPs in that definition. Changes in definitions within the Medicare home health care regulatory framework would also apply to the Medicaid program.

- **Decrease Administrative Burdens for Medicare Patient Access to Diabetic Shoes:**

NPs treating a patient with diabetes must locate a physician to certify the patient's need for diabetic shoes. Currently, an NP's patient must undergo the following redundant multistep process to obtain their necessary treatment: the NP who is treating the patient with diabetes makes the initial determination that the patient needs diabetic shoes; then the NP must send the patient to a physician who then refers that patient to a podiatrist or other qualified individual to fit and furnish the shoes. NPs are authorized to be reimbursed for the treatment of patients with diabetes under the Part B program. They have demonstrated that they provide expert treatment and management of patients with diabetes without the need for physician supervision. Requiring a physician to certify that a patient requires diabetic shoes after the patient's NP has already made that determination leads to delays in treatment, inhibits the ability of NPs to compete in the marketplace, decreases patient choice, and increases costs to the Medicare program by requiring the participation of an additional provider.

We suggest that HHS broaden the definition of "physician" to include nurse practitioners or add "nurse practitioner" after "physician" in the regulatory language covering diabetic shoes for Medicare beneficiaries. The statute governing diabetic shoes for Medicare beneficiaries does not define the word "physician" as it relates to those services. Thus, the Secretary has the discretion to revise the existing regulations to include NPs in that definition.

- **Value-Based Reimbursement**

HHS and commercial insurers have made a commitment to shifting health care reimbursement from a volume-based system to a value-based system in an effort to improve both the quality and cost of care delivered in our communities. NPs have been actively involved in this transition and provide the high-quality, cost-effective health care incorporating social determinants of health that advanced payment models value, such as with the patient-centered medical home. However, barriers still exist within the claims-based assignment methodology of the Medicare Shared Savings Program and some commercial insurers still limit their value-based programs to physicians. It is essential that if we are going to continue the transition of our health care system to one that reimburses providers based on value, that these opportunities are available to nurse practitioners.

- **Hospice Certification:**

NPs are attending physicians under the hospice care statute, but despite this designation they are not authorized to provide the initial certification that a patient is terminally ill and in need of hospice care. The very nature of hospice care and the terminally ill state of hospice patients demands that this process take place as expeditiously as possible. This hospice certification requirement is an unnecessary restriction on NPs that does not benefit the patient and serves only to complicate the hospice selection process.

- **Skilled Nursing Facility (SNF) Admitting Examinations and Bi-Monthly Assessments:**

NPs are essential providers in SNFs. Studies have demonstrated that NP participation in SNFs has lowered overall costs and improved quality of care. Even though NPs provide high-quality care to SNF patients, they are still prevented from approving a SNF admission by not being authorized to perform the admitting examinations and every other monthly patient assessment. These are unnecessary restrictions on practice that go further than statutory requirements and inhibit access to care in SNFs. This diminishes a facility's ability to utilize available clinicians to the full extent of their education and clinical training.

It is important for HHS to recognize that many of these patients may be under the care of an NP, thus making them the most appropriate provider to direct that patient's care. We encourage HHS to explore options that would modernize SNF regulations to authorize providers, such as NPs, to admit and perform the admitting assessment and all monthly patient assessments.

- **Inpatient Rehabilitation Facilities (IRFs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs):**

As is the case in SNFs, NPs are important providers in IRFs and CORFs, yet they are still prevented from practicing to the fullest capacity of their license. In IRFs and CORFs, there are unnecessary restrictions that inhibit access to care and create additional administrative burdens within the setting. These restrictions include physician supervision, certification and establishing a patient's plan of care. We suggest that HHS recognize that many of these patients may be under the care of an NP, thus making them the most appropriate provider to document and direct that patient's care. Facilitating the full utilization of nurse practitioner skills in these facilities will contribute to the safety and well-being of their patients in an efficient and cost-effective manner.

- **Facility Conditions of Participation:**

In some hospitals and other facilities NPs are still not allowed to practice to the full extent of their education and clinical training. HHS should be sure that all the federal conditions of participation for hospitals and other facilities allow nurse practitioners to practice to the full extent of their license. This

includes serving as facility medical directors. HHS is the leader in the health care industry and such guarantees will have a significant impact on access and the provision of high quality cost effective care.

- **Cardiac and Pulmonary Rehabilitation (CR and PR):**

In 2018, Congress passed legislation which would authorize NPs to supervise cardiac and pulmonary rehab starting in 2024. However, NPs are still not authorized to order cardiac and pulmonary rehab for their Medicare patients. NPs are fully qualified based on their education and clinical training to order and supervise these services and this obsolete barrier to care harms patients by causing unnecessary delays in treatment. We request that HHS update the regulations for cardiac and pulmonary rehabilitation to authorize NPs to order these treatments for their patients, and also to expedite the implementation date of NPs being authorized to supervise these treatments through an enforcement moratorium.

- **Education:**

All nurse practitioners must complete a masters or doctoral nurse practitioner program and become nationally certified to become licensed to practice. Didactic and clinical courses prepare these advanced practice nurses with specialized knowledge and clinical competency to practice in primary care, acute care and chronic care settings, giving them advanced clinical preparation beyond their professional nursing education. For these reasons, nurse practitioners must continue to be an integral part of any policy development related to increased education and training opportunities for clinicians.

- **Combating the Opioid Epidemic:**

As mentioned above, with the passage of CARA in 2016, NPs were authorized to prescribe medication-assisted treatment (MATs) after taking the necessary training and obtaining the required DEA waiver to do so and this authorization was made permanent in the SUPPORT for Patients and Communities Act (H.R. 6).

However, current law stipulates that if a state requires an NP to maintain a collaborative or supervisory agreement with a physician in order to practice, that physician must also have a MAT waiver for the NP to provide MAT. This has proven to be a significant barrier, especially in rural and underserved areas, because very few physicians have obtained MAT waivers. NPs in these states, many of which are the most impacted by the opioid epidemic, have reported that despite going through the training and obtaining a MAT waiver they are still unable to provide MAT because they cannot locate a physician who also has a MAT waiver. This report should recommend revising this requirement, which the Secretary has the authority to do via regulation⁹, so that NPs who have completed the training and obtained their waiver can provide this medically necessary treatment without having to also locate physicians who have obtained the waiver.

- **Collecting and Modifying Data:**

It is important that nurse practitioners be an integral part of any data collecting, research activities and trials developed and implemented by HHS moving forward. This includes examination of social determinants of health, evidence-based practice, health care quality and disparities, and barriers to access to name a few examples. We encourage HHS to study the best way to utilize the health care work force and remind you that there is already sufficient evidence to support the utilization of nurse practitioners to the highest extent of their education and clinical training.

⁹ Public Law NO: 114-198, Sec. 303.

- **Network Adequacy:**

Our members have expressed concerns regarding their inability to become paneled with some MA plans, and to date there has been little to no enforcement of the non-discrimination policies. This is also true for commercial plans covered by section 2706 of the ACA. Provider non-discrimination is an important component to ensuring that patients can select their provider of choice and that communities have an adequate network of providers to meet their health care needs.

- **State Practice Environment:**

Currently, twenty-two states and the District of Columbia are considered Full Practice Authority (FPA) states because their licensure laws allow full and direct access to nurse practitioners. In FPA states, NPs are authorized to evaluate patients, diagnose, order, and interpret diagnostic tests, and initiate and manage treatments, including prescribing medications, without a regulated relationship with a physician. NPs are authorized to perform these functions in the remaining states, but these states restrict patients' access to nurse practitioners by limiting the practice setting or scope of NP practice, or requiring collaboration, supervision, delegation or team-management with an outside health discipline.

States with a restrictive practice environment limit patient choice and decrease competition in the marketplace. For example, on January 3, 2018 the Federal Trade Commission (FTC) wrote a letter in support of FPA legislation in Pennsylvania which the FTC stated would “benefit competition and healthcare consumers in Pennsylvania.”¹⁰ The letter cited a 2014 FTC report on advanced practice registered nursing (APRN) which found that “[S]cope of practice restrictions may eliminate APRNs as an important source of safe, lower-cost competition. Such a reduction of competition may lead to a number of anticompetitive effects.”¹¹

States that adopt full practice authority for NPs have also shown beneficial health care workforce trends. For instance, Arizona retired its version of an attestation requirement and transitioned to full practice regulation for all elements of NP practice in 2001. Workforce trend data from the Arizona Rural Health Office (ARHO) looking at the first five years following this regulatory change demonstrated a significant increase in the number of NPs in the state and serving in underserved areas. According to the ARHO report, “the number of Arizona licensed NPs in the state increase 52% from 2002 to 2007”, with the “largest percent increase of NPs occur[ing] in the rural-rural classified counties”.¹²

In addition to recommending reducing federal burdens on NPs, the report should encourage State partners to take similar steps. Reducing restrictions on NP practice will increase choice and competition in the marketplace, leading to improved access to care for patients.

¹⁰ https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-pennsylvania-state-house-representatives-regarding-likely/v180002_ftc_staff_comment_to_pa_state_house_re_house_bill_100_and_aprn-cnps.pdf

¹¹ <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf>.

¹² <http://azahec.uahs.arizona.edu/sites/default/files/u9/azworkforcetrendanalysis02-06.pdf>.