January 17, 2020

Seema Verma, MPH
Administrator
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850
PatientsOverPaperwork@cms.hhs.gov

Re: Feedback on Scope of Practice

Dear Administrator Verma:

LeadingAge, ElevatingHome, and the Visiting Nurse Association of America (VNAA) appreciate the opportunity to provide feedback on the President's Executive Order (EO) #13890 on Protecting and Improving Medicare for Our Nation's Seniors specifically as it relates to scope of practice and the ability of health professionals to practice at the top of their licenses.

The mission of LeadingAge is to be the trusted voice for aging. Our over 6,000 members and partners include nonprofit organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

ElevatingHOME and its subsidiary VNAA, share the mission of advancing high-quality, patient-centered health care that starts in the home. ElevatingHOME members are mission-driven home health and hospice providers serving rural, urban and underserved communities across the nation. ElevatingHOME members provide cost-effective and compassionate care to the most vulnerable individuals, including older people and persons with disabilities.

We wish to express support and recognition for the work that CMS has already done through the ongoing *Patients Over Paperwork* initiative. This work includes but is not limited to removing unnecessary burdens and restrictions in supervision and scope of practice requirements across a broad range of Medicare programs and regulations through multiple payment rules in the past couple of years.

We also recognize that finding areas in which CMS can effect change at the federal level that are impactful is challenging since much of the regulatory authority for scope of practice, licensure, and supervision authority lies with states. We appreciate that CMS is trying to assess where barriers exist at the federal level so that providers across our continuum can deliver care in the most effective manner. We encourage CMS to continue to particularly consider the need of providers in rural and underserved

areas[1] and to continue to create waivers and other exemptions for these providers in order to facilitate care delivery in these difficult to serve areas.

All of our members are committed to a more integrated approach to service delivery. To achieve that goal, most of our members recognize the need to offer a wide range of services, across the continuum. Increasingly, the people we serve use multiple types of services and supports as they move through our systems. Thus, our members may provide home care, residential options, nursing home or post-acute services, palliative, and hospice care; most importantly, we all recognize the need for robust coordination of services and information. We encourage CMS to engage with us and other stakeholders in a broader discussion on how scope of practice, licensure, conditions of participation, and other regulatory structures should evolve to enable the flexibility needed to efficiently and effectively provide these broad range of services and achieve our (and CMS') end goals of integration and true care coordination.

Specific Recommendations

Home Health

One barrier that we hear about from our members falls under the home health care benefit in the Medicare and Medicaid programs. Under the current Medicare and Medicaid structure, nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNMs) and clinical nurse specialists (CNSs) must find a physician to document that a face-to-face assessment has taken place, and have the physician certify and recertify the plan of care. NPs, PAs, CNMs and CNSs that are the primary care providers for patients enrolled in the home health benefit are not able to initiate or make necessary adjustments to medication or treatment without obtaining a physician signature. This process delays access to treatment and puts patients at risk for avoidable complications that lead to increased emergency department visits and hospitalizations and increased health care costs. Delays in care 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.[2]

CMS has recognized the nature of this barrier and has allowed for waivers of these requirements for NPs in various Center for Medicare and Medicaid Innovation (CMMI) models including for the State of Maryland in their Total Cost of Care Model. While we applaud these initiatives and ask that they continue and are expanded into other models, we request that CMS act to ensure these barriers to practice and access are removed permanently by including support in CMS' budget request for the *Home Health Care Planning Improvement Act* (S. 296 and H.R. 2150). We would also support CMS considering these options for the *Medicare Home Health Flexibility Act* (H.R. 3127/S.1725) which would allow occupational therapists to conduct an initial or comprehensive assessment for an individual who is eligible for home health services if the physician's referral order does not include skilled nursing care but does include occupational therapy, physical therapy, or speech language pathology.

[1] For more on LeadingAge's positions on rural and underserved communities', see https://www.leadingage.org/legislation/leadingage-recommends-ltss-policy-changes-congress

[2] http://ahhqi.org/images/uploads/AHHQI_2018_Chartbook_09.21.2018.pdf

Hospice

Two other scope of practice issues that we ask for CMS to consider through waivers and the budget request process relate to the Medicare hospice benefit. Like the home health benefit, hospice providers would benefit from an expanded ability to utilize NPs and PAs in their practices. Given that we will continue to see physician shortages as our population ages and that we are already seeing shortages in certain areas of the country[3], the ability to use NPs and PAs to full extent of their license would not only expand access to care but also prevent a decrease in access to care. We recommend that NPs and PAs be allowed to certify the terminal prognosis. Additionally, PAs should be allowed to complete the face-to-face recertification (currently APRNS can complete the face-to-face though a physician must certify the terminal prognosis to accompany the re-certification). Both changes would require a legislative fix which we would request that CMS support through their budget request process and through considering waivers in CMMI models.

We recommend that CMS create a waiver under which hospice providers who experience hardship in employing masters-level (MSW) social workers may obtain an exception to the social work supervisory requirement. Most hospices around the nation service fewer than 100 patients per day[4] and many of these smaller providers are in rural areas that do not have access to MSW-prepared social workers. Many states do not require an MSW to obtain a state social work license. The hospice conditions of participation (COPs) exceed the standard that most state licensure laws impose for social workers. Additionally, the COPs allow a waiver to the requirement that hospice nursing services be provided directly when there is a shortage of qualified professionals so considering a waiver to increase access to social workers, another core member of the interdisciplinary team, would align with previous policy rationale.

We look forward to continuing to work with CMS on these issues. Please contact Mollie Gurian, Director of Hospice, Palliative, and Home Health Policy at mgurian@leadingage.org with any questions.

Sincerely,

Ruth Katz
Senior Vice President, Policy
LeadingAge

Kate Rolf
Board Chair
VNAA

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[3] https://www.aamc.org/system/files/2019-08/physician-supply-demand-through-2032.pdf and https://www.ruralhealthweb.org/about-nrha/about-rural-health-care

[4] https://www.nhpco.org/wp-content/uploads/2019/07/2018_NHPCO_Facts_Figures.pdf