June 16, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Re: CMS Regulatory Reform for Economic Recovery

Dear Administrator Verma:

In an Executive Order issued on May 19, 2020, President Trump directed heads of federal agencies to review the regulatory standards that were temporarily waived during the COVID-19 emergency, and to identify any that would promote economic recovery if made permanent. The declaration of emergency enabled the Centers for Medicare and Medicaid Services (CMS) to grant temporary regulatory relief to support the healthcare system in responding to an unprecedented set of demands arising from the COVID-19 pandemic.

I am writing on behalf of the American Nurses Association (ANA) to share comments about a number of these measures, as CMS conducts its review under the Executive Order. ***ANA urges CMS to make permanent regulatory reforms expanding telehealth access; and reducing barriers to care provided by Advanced Practice Registered Nurses (APRNs). We have also identified several regulatory flexibilities that should expire when the emergency ends, to ensure access and quality.***

In the comments below, ANA 1) Discusses the key role of healthcare delivery in the U.S. economy, and for post-pandemic economic recovery; 2) Identifies regulatory reforms that should be made permanent, specifically for telehealth and APRN practice; and 3) Highlights emergency flexibilities that CMS should allow to expire.

1. A Robust Healthcare Workforce is a Critical Component of Economic Recovery

The coronavirus pandemic shined a bright light on the U.S. healthcare system, revealing certain systemic weaknesses, but also clearly demonstrating the centrality of healthcare delivery within the U.S. economy. While parts of the system were dedicated to the COVID-19 response, other parts contracted or closed, resulting in a cascade of lost jobs and lost hours worked. For instance, typical non-pandemic emergency room visits declined by 42 percent in April 2020, compared to the previous month.[1] The Bureau of Labor Statistics reported that 1.2 million jobs in ambulatory care were lost in April, along with 135,000 hospital jobs.[2] As elective procedures were canceled or postponed, healthcare workers were furloughed or laid off. In primary care, office visits dramatically decreased under local shut-down orders

[1] Centers for Disease Control and Prevention. Impact of the COVID-19 Pandemic on Emergency Department Visits. June 3, 2020. Accessible online at https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm?deliveryName=USCDC_425-DM29706
[2] Bureau of Labor Statistics. Current Employment Statistics Highlights, April 2020. May 8, 2020. Accessible online at https://www.bls.gov/ces/publications/highlights/2020/current-employment-statistics-highlights-04-2020.pdf

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or because patients feared going to the doctor. Although telehealth options gradually opened capacity, clinicians were not always certain they would be paid for virtual care.[3]

Employment in health care has increased somewhat as some regions of the country began to reopen in May 2020.[4] However, economic recovery continues to be inextricably linked with continued COVID-19 response, and with a return to normal in all other parts of the healthcare system. The healthcare system needs a full capacity of workers, especially nurses, to respond to COVID-19 spikes and outbreaks, while meeting the needs of patients who delayed care or have new care needs. Employers in other sectors of the economy must be able to rely on accessible healthcare providers to ensure their employees can return to their workplaces, including manufacturing sites, schools, and offices. In order for more rural communities to expand economically, they also must have adequate healthcare resources to attract and retain new businesses and families. These needs are even more pressing as rural communities rebuild and restart after the pandemic. Telehealth will help increase access, but it is well documented the APRNs lead the clinician team in many rural areas and in some they are the sole practitioner. Therefore, APRN practice authority goes hand in hand with effective telehealth delivery.

2. CMS Should Use Its Regulatory Authority to Expand Telehealth and APRN Care Permanently

During the pandemic, telehealth waivers demonstrated the value of virtual care, expanding access to non-COVID as well as COVID care, and enhancing the safety of health care workers and patients.

ANA has heard from frontline nurses who cite telehealth as a key innovation that aided their COVID-19 response. CMS heard this evidence directly from frontline nurses as well, during conference calls with the nursing community that were held regularly during the emergency.

The flexibilities in Critical Access Hospitals (CAHs) and Skilled Nursing Facilities (SNFs), and with in-home hospice care, are illustrative, and point to opportunities for permanent reforms. In these settings, telehealth, combined with expanded APRN scope of Medicare practice, demonstrated how nursing capacity is uniquely integral to virtual care delivery. Given access to appropriate technology, APRNs in states with full practice authority were able to help many patients safely overcome access barriers.

ANA believes that telehealth delivery models enabled by the emergency waivers are appropriate for the post-pandemic environment, and can be expanded further, to improve access not only in rural areas, but in appointment-shortage urban and suburban areas as well. ANA urges CMS to retain and expand telehealth coverage and reimbursement. In addition, CMS should work with federal and state partners to drive additional improvements, in particular, widespread adoption of telehealth tools that patients and providers can use effectively. This includes the permanent removal of originating site restrictions and payment for audio-only telehealth services where broadband is not available. We also caution that provider capacity to offer telehealth should not be deemed a substitute for in-person staff capacity to meet the needs of walk-in patients and patients who lack telehealth capabilities or proficiency.

[3] See The Commonwealth Fund. Primary Care and the COVID-19 Pandemic. April 22, 2020. Accessible online at https://www.commonwealthfund.org/blog/2020/primary-care-and-covid-19-pandemic

[4] Bureau of Labor Statistics. Current Employment Statistics Highlights, May 2020. June 5, 2020 Accessible online at https://www.bls.gov/web/empsit/ceshighlights.pdf

To maximize the benefits of telehealth capacity, CMS should also retain the emergency waivers specific to APRN practice in CAHs, SNFs, and hospice. The waivers of federal rules were welcomed in many states, protecting access to care for particularly vulnerable patients during the pandemic response. This delivery innovation should continue on a permanent basis, consistent with state practice authority.

Similarly, ANA supports permanent regulatory action to remove other federal barriers to APRN care, guided by the positive results of flexibilities implemented during the emergency. Examples of specific additional reforms include: Permitting nurse practitioners (NPs) to supervise diagnostic tests performed by other clinicians (as provided in the May 8, 2020, Interim Final rule)[5]; enhancing and clarifying Medicare payment for APRNs engaged in infectious disease prevention, as seen with COVID-19 testing and contact tracing operations; extending the provision that Medicare patients in hospitals do not have to be under the care of physician, which improves access to acute care in areas of physician shortages, and potentially expands roles for APRNs in acute care.

ANA is pleased to note that CMS' advocacy for the critical role of APRNs during the emergency led to positive results in a number of states where outdated practice restrictions were lifted, temporarily or permanently. We hope CMS will continue in this influential leadership role to encourage more states to remove APRN barriers, consistent with the Administration's 2018 blueprint Reforming America's Healthcare System Through Competition and Choice.[6]

3. CMS Should Avoid Permanent Regulatory Changes That Could Undermine Access and Quality

A number of CMS waivers were appropriate to enable the health care system to manage capacity in a pandemic, but are not appropriate to continue after the emergency ends. For instance, in areas of the country experiencing COVID-19 surges, flexibilities to adjust hospital operations and relax administrative burdens were absolutely essential to meet extraordinary demands. As those demands recede and in areas that did not experience surges, some rules and protocols should be restored and enforced in the interest of patient access and quality.

ANA is particularly concerned about flexibilities that allow health care facilities to shift clinical roles within a setting, without regard to whether staffing is adequate in that facility as a whole. In a surge situation, these waivers may have supported short-term strategies to meet unprecedented volume and types of patient needs. However, continuing to allow these practices in a non-surge environment may perpetuate and lock-in pre-existing staffing shortages. Facilities could be enabled to continually shift scarce staff across units and departments, without being expected to address ongoing capacity challenges.

In the long term, such practices could undermine staff stability, clinical quality, continuity of care, and patient experience, especially in areas that have ongoing workforce shortages. In addition, facilities could have disincentives to develop capacity for future emergencies. As the Administration prioritizes economic recovery, it is also important to consider how certain waivers may have an unintended consequence of promoting job stagnation and contraction in the healthcare sector. The following are

[5] 85 Federal Register 27550 (May 8, 2020).
[6] U.S. Department of Health and Human Services, U.S. Department of Treasury, and U.S. Department of Labor. Reforming America's Healthcare System Through Competition and Choice. 2018. Accessible online at https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html

examples of such waivers, which should expire at the end of the emergency or sooner in unaffected areas:

- *Relaxed requirements for RNs to develop and keep current a nursing care plan for each patient*. Engagement in care planning is a core aspect of nursing practice[7], as well as indicative of quality care and patient experience.
- *Suspension of requirements for hospitals to account for adequate numbers of RNs in outpatient departments*. This flexibility potentially incentivizes staff-shifting across departments and units, without regard to underlying staff sufficiency in the facility as a whole.
- *Waivers of nurses having to conduct on-site reviews for home health and hospice patients*. Safe in-person care should be an option for all home health and hospice patients and families. Further, nurse supervision of other home health and hospice staff is enhanced by on-site presence. In states with restrictive telehealth rules, it is especially important for in-home providers to have sufficient nurses to make appropriate in-home visits.
- *Relaxed clinical staff presence at rural health centers and federally-qualified health centers*. CMS should continue to work with federal and state partners to develop a robust healthcare workforce for rural and underserved areas. Facilities should also be held to pre-pandemic staffing standards to maximize patient access.

ANA is the premier organization representing the interests of the nation's 4 million RNs, through its state and constituent member associations, organizational affiliates, and individual members. ANA members also include the four advanced practice registered nurse roles (APRNs): Nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).[8] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

If you have questions, please contact Brooke Trainum, JD, Assistant Director of Policy and Regulatory Advocacy, at (301) 628-5027 or brooke.trainum@ana.org.

Sincerely,

Debbie Hatmaker

Debbie Hatmaker, PhD, RN, FAAN
Acting Chief Executive Officer

cc: Alex Azar, Secretary, Department of Health and Human Services
Ernest Grant, PhD, RN, FAAN, ANA President

[7] See American Nurses Association. Nursing: Scope and Standards of Practice, Third Edition. 2015. Under Standard 3, RNs are expected to identify "expected outcomes for a plan individualized to the healthcare consumer or the situation." Standard 4 requires development of "a plan that prescribes strategies to attain expected, measurable outcomes." Standards 5 and 6 cover implementation and evaluation of progress toward goals and outcomes.

[8] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife, and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.