AMERICAN NURSES ASSOCIATION

8515 Georgia Avenue, Suite 400
Silver Spring, Maryland 20910-3492
301 628-5000 • Fax 301 628-5001
www.NursingWorld.org

Karen A. Daley, PhD, MPH, RN, FAAN
President

Marla J. Weston, PhD, RN
Chief Executive Officer

September 14, 2010

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health &Human Services
Attention: Randy Throndset
CMS -1510-P
P.O. Box 1850
Baltimore, MD 21244-1850

Submitted electronically to http://www.regulations.gov

Re: **Medicare Program; Home Health Prospective Payment System Rate Update for CY2011; Changes in Certification Requirements for Home Health Agencies and Hospices Proposed Rule** (75 FR 43236-43306)

Dear Administrator Berwick:

The American Nurses Association (ANA) welcomes the opportunity to offer comments on this proposed rule. The ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses, the single largest group of health care professionals in the United States. We represent RNs in all roles and practice settings, through our state and constituent member nurses associations, and organizational affiliates. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and advocating before Congress and regulatory agencies on health care issues affecting nurses and the public. Our members include Advanced Practice Registered Nurses (APRNs) such as Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs).

Home Health Face-to-Face Encounter.

ANA supports APRNs certifying for home health care. Current law requires that a plan of care furnishing home health services be established and periodically reviewed

by a physician in order for Medicare to pay for those services. CMS notes that the Affordable Care Act (ACA) does not amend that statutory requirement.

While we fully understand that CMS is constrained by existing law from expanding the certification requirement to qualified health care practitioners other than physicians, nevertheless, we would like to point out that this could likely change in the future. The decision about whether home health services are warranted should be made by the provider who is most familiar with the patients' health care needs and home environment, and in many cases, that is the APRN managing the patient's care.

ANA strongly supports the Home Health Planning and Improvement Act (H.R. 4993/S.2814) which would change the outdated provision that speaks only to physicians. This proposed change would ensure that seniors and disabled citizens have timely access to home health services under Medicare by allowing NPs, CNSs, CNMs and PAs to order those services in accordance with state law.

CMS believes that "the face-to-face encounter statutory provision was enacted to strengthen physician accountability." Advanced practice registered nurses are fully licensed professionals who practice within their legal authority and are accountable to their certifying bodies, professional societies, state licensing bodies, and to their patients. With the anticipated change in the statutory provision, we expect that APRNs will be subject to whatever regulations are deemed appropriate to strengthen accountability of the clinician delivering the services.

The Affordable Care Act acknowledges the role of APRNs

ANA is pleased that the Affordable Care Act acknowledges the role of non-physician practitioners and specifically identifies the nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM). The Act and the regulations refer to these providers working in collaboration with the physician in accordance with state law.

In most states, APRNs are recognized as independent practitioners. "Independent" practice refers to the ability and responsibility of a provider to utilize the knowledge, skills, judgment and authority to practice to the full extent of his/her education and licensure. *Independent* should not be interpreted to mean "in a vacuum," nor is *independent* practice defined by the place of employment, the business model of the practice, or the method of reimbursement. Like physicians, APRNs collaborate and consult with many other health care providers, often on a daily basis, requesting consultations, and referring patients for specialized care. APRNs, like physicians, should be permitted to do so freely, without the requirement of written collaboration agreements.

Autonomous practice results in more efficient care

ANA understands that the regulations proposed, which spell out requirements for timing and signature by the physician, are a result of outdated statutory language. As we continue to work toward a more efficient healthcare system, however, it is critical to understand the impact of the existing law and aspects of the resulting regulations. The

inability of APRNs to certify Medicare patients for home health care, and the resulting requirements to obtain physician signatures (for patients the physicians may rarely see) results in inconvenience for patients and families, delayed and fragmented care, and eventually, increased cost to the system. This is particularly true in underserved urban and remote rural areas, where APRNs are often the only providers delivering vital healthcare services. In the words of ANA members,

- "…as a palliative care nurse practitioner, I cannot order palliative home health services for patients requiring complex symptom management…My patients suffer needlessly and often return to the hospital for pain crises because they do not have a symptom management specialty-trained home health nurse providing this care."
- "Orders/referrals lay on the physician's desk for days while the patient waits in rehab or long term care."
- "My practice is an outpatient surgical practice where I often see patients with wounds that are delayed in healing or patients that require wound packing and dressing. If I have no physician to sign my request for home health I have to have patients return to the office for my staff to do their wound care until it can be set up via home health. This is NOT patient friendly and remember that these are often older or ill patients. This costs the patients time and money to make a return trip to the office (that they often do not have) simply to make sure their wounds are cared for properly."
- "I work in a Acute Rehabilitation Unit and all of our patients are discharged with HHC services and not being able to order the services has severely limited my care for my patients. We have delays in discharges because we have to wait for our medical director to sign off on orders, but he doesn't come in daily because I'm there."

Proposed New Requirements Affecting Hospice Certifications and Recertifications

The ACA requires that on and after January 1, 2011, a hospice physician or nurse practitioner (NP) must have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient prior to the 180 recertification, and prior to each subsequent recertification. The hospice physician or NP must attest that such a visit took place.

CMS proposes that the face-to-face attestation and signature be either a separate and distinct area on the recertification form or a separate and distinct addendum to the recertification form. In addition, the recertification attestation should include the name of the patient visited, the date of the visit and be signed and dated by the physician or NP who made the visit.

Timing of visits. To implement these requirements, CMS proposes that hospice physicians or NPs make these required visits no more than 15 calendar days prior to the 180-day recertifications and subsequent recertifications. This stipulation of this brief time period will be very difficult for some hospices to meet. Particularly in rural areas and where hospices serve a large geographic area, the travel time required to make these visits can be significant. This problem, combined with a shortage of physicians and nurse-practitioners, leads us to request that CMS consider a longer period of time – perhaps 30 days - to complete these visits.

Telehealth The home health regulations referred to earlier specify the use of telehealth, subject to certain requirements. ANA supports the use of telehealth in a variety of settings and would ask CMS to clarify that telehealth can be used to meet the hospice requirements, as well.

Coding. Questions have been raised about the coding of these visits, if symptom management is a part of the visit. We ask CMS to clarify the requirements for documentation and coding in such circumstances.

We appreciate the opportunity to comment on this important rule. If we can be of further assistance, or if you have any questions or comments, please feel free to contact Lisa Summers, CNM, DrPH, Senior Policy Fellow, ANA Department of Nursing Practice & Policy at lisa.summers@ana.org or 301-628-5058.

Sincerely,

Marla Weston, PhD, RN
CEO, American Nurses Association