

January 28, 2019

The Honorable Alex M. Azar II
Secretary
Department of Health and Human Services (HHS)
200 Independence Avenue, SW
Washington, DC 20201

Re: Draft: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Secretary Azar,

The American Association of Nurse Practitioners (AANP), representing more than 248,000 nurse practitioners (NPs) in the United States, thanks HHS for the opportunity to provide comment on the draft of the “Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.”

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. 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.

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.

We support the overall goals of this draft strategy and appreciate the work that HHS has done on this initiative. Below is feedback on the draft strategy including feedback on specific recommendations. We look forward to continued work with HHS on reducing clinician burden related to health IT and EHRs.

Provider Neutral Language

Throughout this document, HHS alternated between using the terminologies “provider” or “clinician” and using the terminology “physician.” It is important that during rulemaking and in all other correspondence, HHS does not continue to utilize the word “physician” when other qualified health professionals are authorized to provide a service. The use of the term “physician” in these instances confuses patients and

providers as to which clinicians are authorized to provide care under the Medicare programs and undermines the scope of practice and quality of care provided by nurse practitioners. This could lead to unfair restraints on practice, decreased access to care, and increased burden on healthcare systems if HHS guidance incorrectly indicates that only physicians are authorized to perform a specific service.

Clinical Documentation Strategies

Strategy 1: Reduce Regulatory Burden Around Documentation Requirements for Patient Visits

We agree with HHS that one of the primary sources of burden on clinicians is not the health technology used to document patient care; the burden is the underlying documentation requirements themselves. In this draft report, HHS highlighted recent actions that they have taken to reduce documentation burden on clinicians including removing redundant evaluation and management (E/M) documentation requirements and requirements for admission orders in inpatient rehabilitation facilities. In this strategy, HHS makes four recommendations to reduce regulatory burden around documentation of patient visits: reduce overall regulatory burden; leverage data already in the electronic health record (EHR); obtain ongoing stakeholder input; and waive documentation requirements for participants in alternative payment models. We appreciate the work that HHS has done to reduce documentation burden and we support all of these recommendations.

However, despite recent burden reductions, nurse practitioners still face significant documentation burdens within the Medicare and Medicaid programs that inhibit patient access to care. Below are examples of these documentation burdens and suggestions for how HHS can relieve the burden and improve patient access to care. HHS can relieve these burdens immediately by issuing enforcement moratoriums as rulemaking takes place. We continue to look forward working with HHS on this initiative.

- **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. 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.

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.

- **Documentation Parity Between NP and PA Preceptors and NP and PA Students and Teaching Physicians and Medical Students/Residents**

As HHS highlighted in this document, they recently released guidance to allow teaching physicians to verify in the medical record any student documentation of the components of E/M services, rather than re-document the work. HHS unfortunately did not apply this same burden reduction to NP and PA preceptors even though they fill the same role as teaching physicians.

The updated policy removed burdens for teaching physicians but had the unintended consequence of exacerbating the disparity among teaching physicians and precepting (teaching) NPs and precepting (teaching) PAs. This has already led to an unwillingness of facilities to precept NP and PA students, nor did it help to alleviate the shortage of NP and PA preceptors. While we understand that the initial action had the intent of burden reduction, the unintended consequences put NP and PA preceptors/clinical teachers at a significant disadvantage in relation to teaching physicians. We know this was not a goal of HHS as it would be contrary to the HHS Patients Over Paperwork initiative.

HHS can reduce this burden for NP preceptors and PA preceptors and students by including them in the regulations and guidance that currently exists for teaching physicians and medical students. In order to do this, HHS would need to do two things concurrently in order to prevent any further disparities:

- *Define Teaching Physician to Include NP and PA Preceptors/Clinical Teachers*

HHS can include NP preceptors and PA preceptors in the definition of "teaching physician." The Secretary has the explicit statutory authority to define "teaching physician" and the Secretary can define "teaching physician" to include NP and PA preceptors. We would recommend using the phrase "teaching clinician" which is a more inclusive term that recognizes the role of other providers in educating our health care workforce. If HHS feels that this change must be completed through rulemaking, it can utilize its waiver authority, or issue a nonenforcement instruction to its carriers to enact the teaching physician burden reductions for NP and PA preceptors as well. We encourage this to be accomplished immediately.

- *Define Student to Include NP and PA Students*

HHS can interpret the word "student" in Transmittal 4068 to include NP and PA students. "Student" is not defined in regulation, and the existing definition of "student" in the Medicare Claims Processing Manual¹ includes NP and PA students. Interpreting "student" to include NP and PA students could be accomplished through issuing guidance and is consistent with the existing HHS definition of "student" and would not require rulemaking.

¹ <https://www.HHS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.

HHS is aware of the importance of NPs and PAs in meeting the nation's healthcare demands, most importantly the rural and underserved communities.² HHS has made a point to be inclusive of NPs and PAs in other programs, such as QPP, and should do the same in this instance because NP and PA preceptors perform the same roles as teaching physicians. We respectfully request that HHS create parity among NP preceptors, PA preceptors and teaching physicians by redefining "student" and "teaching physician" simultaneously to include NP and PA students and preceptors.

- **Comprehensive Outpatient Rehabilitation Facilities (CORFs)**

NPs are important providers in CORFs, yet they are still prevented from practicing to the fullest capacity of their license. In CORFs, there are unnecessary restrictions that inhibit access to care and create additional administrative burdens within the setting. Physicians are still required to establish and certify a patient's plan of care, which are unnecessary documentation requirements that delay access to 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.

- **Outpatient Medicaid Psychiatric Services**

Medicaid coverage of organized outpatient programs for psychiatric treatment is primarily covered as an outpatient hospital service or a clinic service. 42 CFR § 440.20 states that hospital outpatient services must be provided "by or under the direction of a physician or dentist"; however, there is no statutory requirement that this be the case. Clinic services do have statutory language that states that the services are provided under the direction of a physician³; however, the Medicaid Provider Manual has overly stringent and unnecessary requirements that inhibit access to patient care. The Medicaid Provider Manual has interpreted this language to mean that a physician has to see the patient at least once, prescribe the type of care provided and periodically review for continued care.⁴ These documentation requirements increase clinician burden and removing these requirements is consistent with the clinical burden reduction initiatives.

We request that HHS amend 42 CFR § 440.20 to authorize hospital outpatient services to be provided under the direction of a nurse practitioner. We also request that HHS amend the Medicaid Provider Manual to defer to States and the clinics in determining how the physician direction requirement is implemented. HHS has the regulatory authority to take both of these actions which will lead to greater access to psychiatric services for the Medicaid population.

Strategy 2: Continue to Partner with Clinical Stakeholders to Encourage Adoption of Best Practices Related to Documentation Requirements

We agree with HHS that it is important to continue to partner with clinical stakeholders to encourage the adoption of best practices to improve documentation requirements. In order for these initiatives to reach their potential, it is important that HHS take steps to ensure that all clinicians, including NPs, are involved in the development and implementation of the programs.

² <https://www.nejm.org/doi/full/10.1056/NEJMp1801869>.

³ 42 U.S.C. 1396d(a)(9).

⁴ Medicaid Provider Manual, Section 4320- Clinic Services.

Strategy 3: Leverage Health IT to Standardize Data and Processes Around Ordering Services and Related Prior Authorization Processes.

We support efforts to improve data standardization and processes related to ordering services and prior authorization processes. HHS recommended the adoption of standardized templates, and while these can be useful in reducing documentation burden, it is imperative that any templates use provider-neutral language to ensure that they can be completed by nurse practitioners and other qualified clinicians. We look forward to working with HHS on the creation of tools to better streamline order and prior authorization processes.

We also support the principle of the proposal in the recent Medicare Advantage and Medicare Part D proposed rule which would require Plan D sponsors to require a real-time benefit tool (RTBT). We agree with CMS that while current formulary and benefits information is valuable, improved information is required to enable clinicians to provide their patients with useful information regarding real-time cost and coverage information for medications. Greater implementation of RTBTs will lead to better decision-making between providers and patients regarding therapies available through patients' Part D plans. We also believe that these efforts should be extended outside of the pharmaceutical space and into the prior authorization and order processes for medical equipment, diagnostic testing and surgical procedures.

However, we are concerned that other proposals related to increased usage of prior authorization and step therapy in order to control drug costs would be averse to this initiative. While we share the goal of reducing the costs of prescription medications, these processes shift the burden onto providers and their patients. HHS has rightly acknowledged the burden that prior authorization places on providers and we look forward to working with HHS on solutions that do not delay patient access to care and increase the already burdensome prior authorization requirements that providers face.

One way that this can be achieved is for uniform prior authorization requirements across health plans. Providers contract with commercial insurers, Medicaid managed care organizations, Medicare Advantage plans, and fee-for-service Medicare and Medicaid along with other insurance options. Keeping track of different prior authorization and utilization review requirements among all plan types is cumbersome and confusing. As the industry improves upon electronic prior authorization, this is an opportunity to create better standardization of prior authorization requirements industry wide. Standardization will ease the burden on providers and ensure that all health plans are utilizing appropriate clinical guidelines.

Health IT Usability and the User Experience

Recommendation 1: Better Align EHR System Design with Real-World Clinical Workflow

HHS has made many practical suggestions to improve the use of EHRs for clinicians. However, there are barriers within many EHR systems that are still geared to the concept that only a physician documents the patient's condition and the services performed, particularly in hospital systems. We suggest that HHS require software products to be "nurse practitioner inclusive" to be certified by HHS. This will help improve the documentation and transmission of medical records by removing prompts within the EHR that unnecessarily request a physician signature.

EHR Reporting

Recommendation 2: Incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians.

As we mentioned previously, using provider-neutral language throughout all documentation is important and referencing physicians in the title of this recommendation excludes other health care providers, such

as NPs. In the development of the Quality Payment Program (QPP), CMS recognized that NPs and other clinicians were excluded from participating in the Medicare EHR Incentive Program and may have less familiarity with the requirements of CMS EHR initiatives. HHS must ensure that any further innovative uses of health IT and any new incentive programs are available to nurse practitioners.

We thank you for the opportunity to work with HHS and ONC on clinician burden reduction and we look forward to continued discussion on these topics. 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 flourish extending to the right.

David Hebert
Chief Executive Officer