August 24, 2022

Submitted electronically via regulations.gov

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-3419-P
7500 Security Boulevard
Baltimore, MD 21244

**RE: CMS-3419-P – Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates Proposed Rule (87 Fed.Reg. 40350, July 6, 2022)**

Dear Administrator Brooks-LaSure:

On behalf of the undersigned organizations representing Advanced Practice Registered Nurses (APRNs) and advanced practice nursing education, we appreciate the opportunity to comment on this proposed rule; Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates (87 Fed.Reg. 40350, July 6, 2022).

The APRN Workgroup is comprised of organizations representing Advanced Nursing Education, Certified Nurse-Midwives (CNMs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetists (CRNAs), and Nurse Practitioners (NPs). As of 2020, over 233,000 APRNs were treating Medicare patients, making it essential that the Centers for Medicare & Medicaid Services (CMS) remove barriers to care for APRNs and their patients. America's growing numbers of highly educated APRNs advance healthcare access, quality improvement and cost-effective healthcare delivery across all settings, regions and populations, particularly among the rural and medically underserved. According to the Medicare Payment Advisory Commission (MedPAC), APRNs (and PAs) comprise approximately one-third of our primary care workforce, and up to half in rural areas.[1]

We support the creation of the new Rural Emergency Hospital (REH) designation and recommend that CMS ensure that APRNs are able to practice to the full extent of their education and clinical training in these facilities. Specifically, we recommend that CMS remove any

[1] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)

physician supervision requirements of APRNs in the proposed CoPs.[2] Physician supervision requirements of APRNs are not explicitly mentioned in the Consolidated Appropriations Act (CAA) of 2021 (Pub. L. 116-260), and are ineffective in advancing the safety of patients. Furthermore, such requirements drive up costs for rural hospitals at a time when rural facilities operate on razor thin margins. Rural communities are disproportionately impacted by health care inequities, which are exacerbated when communities experience rural hospital closures. However, when rural hospitals do close, APRNs continue to provide much-needed care in those communities. According to the Government Accountability Office, "from 2012 to 2017, the availability of all physicians declined more among counties with closures (16.2 percent) compared to counties without closures (1.3 percent)" whereas "[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent)."[3] These supervision requirements do not advance health equity and could impact access to care, especially at a time when there is a labor shortage. Removing supervision requirements will strengthen the healthcare workforce to ensure timely delivery of quality services and care and will address long-standing barriers to practice, all of which will improve health equity and increase access to care.

As rural and underserved areas increasingly rely on APRNs, removing barriers to our practice will help countless Americans as well as financially distressed rural healthcare facilities. Removing barriers to APRN practice aligns with recommendations from the New England Journal of Medicine.[4] This also aligns with the National Academy of Medicine's (NASEM) 2011 recommendation, "[a]dvanced practice registered nurses should be able to practice to the full extent of their education and training."[5] NASEM reinforced this recommendation in their 2021 *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* report which recommended that "all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality, and value."[6]

Additionally, we noted that the information collection review (ICR) section of the proposed rule still uses the term "mid-level practitioner" when referring to APRNs and certain other health care providers. APRNs are licensed, independent practitioners who work throughout the entire health care spectrum from health promotion and disease prevention to diagnosis and treatment of patients with acute and chronic illnesses. The "mid-level" label originated decades ago and is not compatible with APRN licensure. It is important to note that the United States Department of Health and Human Services (HHS) has stated they are no longer using the term 'mid-level providers' given the 'increasingly critical and advanced roles that PAs and APRNs play within the clinic environment."[7]

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[2] For example, physician supervision requirements of CRNAs as proposed in § 485.524(d)(3)(ii).

[3] https://www.gao.gov/assets/gao-21-93.pdf.

[4] Frogner, Fraher, Spetz, Pittman, Moore, Beck, Armstrong and Buerhaus. (2020) Modernizing scope-of-Practice regulations – Time to Prioritize Patients. *New England Journal of Medicine.382;7.*p591-593

[5] National Academy of Medicine. *The future of nursing: leading change, advancing health*. Washington, DC: The National Academies Press, p. 3-13 (pdf p. 108) 2011.

[6] https://www.nap.edu/resource/25982/FON%20One%20Pagers%20Lifting%20Barriers.pdf

[7] 84 FR 7714, 7728 (see footnote 42).

The term fails to recognize the established scope of practice for APRNs and their authority to practice to the full extent of their education and clinical preparation. It confuses health care consumers and is not a true reflection of the APRN role. The term "mid-level practitioner" implies an inaccurate hierarchy within clinical practice. APRNs have a steadfast reputation for safe practice and the provision of high-quality care. It is well established that patient outcomes for APRNs are comparable to that of physicians. CMS should fully retire the use of this term as it is outdated language that does not reflect the quality of care provided by APRNs and their role in the health care system. We strongly encourage CMS to fully transition to the use of the practitioner's professional title (e.g. nurse practitioner) or to utilize the term "advanced practice providers" when necessary and remove all references to 'mid-level practitioner' within regulations, guidance and information collection instruments.

We appreciate the opportunity to provide our recommendations on this proposed rule. Should you have any questions, you can reach out to Romy Gelb-Zimmer, Senior Associate Director of Federal Regulatory and Payment Policy at rgelb-zimmer@aana.com or (202) 484-8400. Thank you for your consideration and we look forward to hearing from you.

Sincerely,

American Academy of Nursing, AAN
American Association of Colleges of Nursing, AACN
American Association of Nurse Anesthesiology, AANA
American Association of Nurse Practitioners, AANP
American College of Nurse-Midwives, ACNM
American Nurses Association, ANA
Gerontological Advanced Practice Nurses Association, GAPNA
National Association of Clinical Nurse Specialists, NACNS
National Association of Nurse Practitioners in Women's Health, NPWH
National Association of Pediatric Nurse Practitioners, NAPNAP
National League for Nursing, NLN
National Organization of Nurse Practitioner Faculties, NONPF