UnityPoint Health

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January 17, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, DC 20201

RE: Scope of Practice - Implementation of Executive Order (EO) 13890: Protecting and Improving Medicare for Our Nation's Seniors

Submitted electronically via PatientsOverPaperwork@cms.hhs.gov

Dear Administrator Verma:

UnityPoint Health ("UPH") appreciates the opportunity to provide comments in response to the President's Executive Order (EO) #13890 on *Protecting and Improving Medicare for Our Nation's Seniors*. Through more than 32,000 employees, our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, western Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

UnityPoint Health respectfully offers the following comments.

GENERAL COMMENTS

Section 5 of EO 13890 requires reforms to the Medicare program to "eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession."

Comment: UnityPoint Health is a strong proponent of enabling providers to practice at the top of their licensure, and we appreciate the regulatory flexibilities that have been granted thus far. We would like to reiterate that this topic comprised a hefty percentage of the recommendations that we offered in our comment letter[1] to the *Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork (CMS-6082-NC).* Of note, as an integrated health system, issue impacting

[1] *PatientsOverPaperwork_UPH_8-12-19.pdf,* comment tracking number 1k3-9bkr-iktt

scope of practice are common across all settings of care – hospitals, ambulatory settings, home health and hospice – and also are sometimes differentiated in rural service areas. We support CMS' continued review of those comments to identify other actionable scope of practice barriers.

PHARMACISTS AS PROVIDERS

Pharmacist-provided patient care services are not currently covered by Medicare Part B but are covered by other payers, including several Medicaid programs.

Comment: UnityPoint Health would encourage CMS to remove the barriers to pharmacists spending more time with their patients and practicing at the top of their profession by reimbursing pharmacist-provided patient care services under Medicare Part B. As valued healthcare professionals, pharmacists bring unique expertise as a member of interdisciplinary teams and to direct patient care services.

Generally, we urge CMS to leverage pharmacists' expertise broadly under Medicare. Areas for greater flexibility would include:

- Utilization of inclusive provider language in rulemakings and sub-regulatory guidance rather than defaulting to the list of providers in section 1848(k)(3)(B) when delineating the clinicians that can provide Medicare services;
- Expansion of service models utilizing pharmacist-provided patient care services using CMS Innovation Center data;
- Issuance of a Center for Medicaid & CHIP services information bulletin enabling and encouraging payers (e.g., Medicaid) to utilize pharmacists to better address needs for patients; and
- Incorporation and/or testing of a demonstration at the CMS Innovation Center in rural and Medically Underserved Areas/Populations ("MUAs/Ps") focused on optimizing medication use and health outcomes as part of coordinated care delivery, including pharmacists. These models could be incorporated as workstreams into current Advanced Alternative Payment Models or demonstrations within the CMS Innovation Center.

In terms of specific recommendations to allow pharmacists to practice at the top of their license, we would also urge CMS to revisit supervision, billing, and coding requirements to:

- Implement a general supervision requirement versus direct supervision for services delivered by highly-trained pharmacists;
- Align Medicare supervision and service requirements with the most robust pharmacist state scopes of practice, specifically taking into account:
    - Collaborative practice agreements;
    - Pharmacist prescribing;
    - Pharmacist prescribing based on the results of a rapid diagnostic test;
    - Naloxone;
    - Tobacco cessation aides;
    - Hormonal contraception; and

  - Pharmacogenomics;
- Clarify physicians and other qualified practitioners can bill for "incident-to" services provided to Medicare beneficiaries by pharmacists at levels higher than Evaluation and Management (E/M) Code 99211;
- Clarify the ability of pharmacists and pharmacies to provide Diabetes Self-Management Treatment ("DSMT") services;
- Ensure pharmacists can engage in remote patient monitoring, telehealth, and other telecommunications technologies;
- Require the inclusion of the pharmacist National Provider Identifier ("NPI") on all claims or add a pharmacist modifier to provide greater visibility into the contributions of pharmacists to the health outcomes of Medicare beneficiaries; and
- Implement regulations, and work with other agencies as needed, to ensure that pharmacists are fully and effectively engaged in combatting the opioid crisis. This would include enabling pharmacists to be considered DATA-waived providers pursuant to the Comprehensive Addiction and Recovery Act.

RELIEF FOR EMERGENCY CARE BARRIERS

Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by the US Congress in 1986 as part of the Consolidated Omnibus Reconciliation Act (COBRA) to address the problem of "patient dumping."

Comment: EMTALA was passed into law more than 30 years ago at a time when the practice of medicine was much different in terms of staffing, technology and use of advanced practice providers. Hospitals, particularly Critical Access Hospitals (CAHs) and those located in rural areas, continually grapple with physician shortages. This is particularly true for Emergency Departments, and hospitals have increasingly turned to advanced practice providers for an onsite presence in providing emergency care. While EMTALA permits emergency care to be provided by advanced practice providers within the scope of the license as determined by the states, the EMTALA statute and corresponding regulations supersede state licensure with respect to certifying patient transfers. In particular, EMTALA requires consultation between an Advanced Registered Nurse Practitioner (ARNP) and a Doctor of Medicine or Osteopathy to certify the transfer of a patient. We would request that this provision be reconsidered to respect state licensure and scope of practice laws.

Iowa, in addition to several other states, allow for independent practice by an ARNP (655 – 7.1 IAC). The Iowa Board of Nursing outlines an ARNP's scope and practice to include healthcare services to Iowans of all ages in primary and/or ambulatory, acute, and long-term settings. The ARNP practices within their scope of practice based upon their educational background and the standards and guidelines established by their national certifying body (i.e. American Nurses Credentialing Center, American Academy of Nurse Practitioners). In Iowa, an ARNP may practice independently. However, an ARNP may have a collaborative agreement with a physician or physicians if their practice so warrants, but this agreement is not a requirement of the Iowa Board of Nursing.

The EMTALA consultation requirement for patient transfers requires collaboration in each case

regardless of ARNP knowledge and experience. This requirement does not allow independent practice, imposes an undue delay in providing care, and has financial implications for hospitals that are already operating on thin margins. A natural delay is created when any provider is required to consult with another provider; therefore, potentially delaying critical treatment which is one of the core principles EMTALA is based upon. Iowa hospitals utilizing ARNPs in Emergency Departments are also faced with paying an additional provider specially for on-call services to the ARNP. We would request that CMS work with Congress to remove this requirement from statute and regulation. In the meantime, and if possible, we would request that CMS consider implementing a demonstration to test the waiver of this requirement for CAHs or rural hospitals with 100 or fewer beds that are located within a HPSA to enable ARNPs to practice at top of licensure. This waiver would be similar in nature to the nonenforcement instruction issued by CMS for physician supervision requirements in CAHs and small rural hospitals. We appreciate your consideration of this request for additional relief.

We are pleased to provide comments to the elimination of federal regulatory requirements that create barriers to practicing at top of state licensure. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs
UnityPoint Health