April 6, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Administration
7500 Security Boulevard
Baltimore, MD 21244

Re: [CMS–4190–P] RIN 0938–AT97 Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Submitted electronically to regulations.gov

Dear Administrator Verma:

The American Nurses Association (ANA) is pleased to provide written comments to the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), regarding the above-captioned proposed rule. The proposed rule specifically invites comment on administrative changes that could improve access to Medicare Advantage (MA) plans, including in rural areas.[1] We appreciate the opportunity to provide recommendations for improving access to MA plans in rural areas, including (1) expanding choice of in-network provider types; (2) removing federally-imposed supervision requirements preventing advanced practice registered nurses (APRNs) in MA plans from providing care to the full extent of their practice authority; and (3) revising MA network adequacy criteria and review processes to expand the number and roles of APRNs in MA plans.

Increasingly, Medicare beneficiaries are opting to participate in MA, enrolling in plans that offer an alternative to traditional Medicare fee-for-service. Many beneficiaries are attracted to MA plans because those plans offer additional benefits, such as more covered services and reduced cost-sharing. Overall, 34 percent of beneficiaries are in a MA plan. However, choices and enrollment patterns vary greatly across the country.[2] In rural areas, Medicare enrollees tend to

[1] 85 F.R. 9002, 9006 (February 18, 2020)
[2] Jacobson, Gretchen et al. Medicare Advantage 2020 Spotlight: First Look. Kaiser Family Foundation. October 2019. Accessible online at http://files.kff.org/attachment/Data-Note-Medicare-Advantage-2020-Spotlight-First-Look

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

lack access to the same number and range of high-rated, low-cost plans, compared to their counterparts in more urban areas.[3]
Provider shortage has been cited as a reason for the lower penetration of MA plans in rural areas. Limited numbers of providers create challenges for plans to form adequate networks. [4] To address this challenge, CMS proposes to relax the time-and-distance metrics that determine if enrollees will have access to providers located nearby to where they live. ANA also recommends the following actions CMS can take in order to increase access to MA plans.

Expand Choice of In-Network Provider Types

We urge CMS to also consider approaches that could expand enrollees' choice of in-network provider type**. Specifically, CMS should explore allowing plans to offer enrollees the option of receiving primary care from APRNs, such as nurse practitioners (NPs)**. Research shows that NPs provide primary care of comparable or higher quality than physicians.[5] Further, NPs are more likely to practice in underserved areas.[6]

Remove Burdensome Supervision Requirements

To expand APRN practice in MA, an additional option is to remove all federally-imposed supervision requirements for APRNs in MA plans. For example, 42 CFR §417.416 allows NPs to care for MA enrollees without *personal and direct* supervision requirements. However, other physician supervision provisions apply, specifically through reference to 42 CFR §405.2414 and §491. CMS should remove these restrictions and clarify in guidance to plans that APRNs can be engaged to provide care to the full extent of their practice authority under state rules.

Revise Network Adequacy Criteria and Review Processes

CMS should also consider possible changes to MA network adequacy criteria and review processes that could expand the number and roles of APRNs in MA plans. Current guidance cites "rare contracting with non-MD primary care providers in underserved counties to serve as the major source of primary care for enrollees."[7] However, this language is found in a Frequently Asked Questions passage about coding, and infers that NPs are typically considered "mid-level practitioners" rather than providers of primary care.

---

[3] Health Services and Resources Administration (HRSA). Insuring Rural America: Health Insurance Challenges and Opportunities. July 2018.
[4] Ibid.
[5] Medicare Payment Advisory Commission (MedPAC). Report to Congress. June 2019; Naylor, Mary D. and Kurtzman, The Role of Nurse Practitioners in Reinventing Primary Care. Health Affairs. May 2010; Mundinger, Mary O. et al. Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial. Journal of the American Medical Association. 2000;
[6] Van Vleet, Amanda and Julia Paradise. Tapping Nurse Practitioners to Meet Rising Demand for Primary Care. Issue Brief. Kaiser Family Foundation. January 2015.
[7] CMS. Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance. 2018.

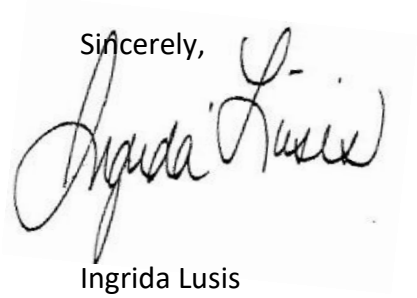
This language shows that MA provider contracting rules are out of step with the way many other plans engage with NPs to provide access to primary care. In a survey of Medicaid managed care providers, 70 percent of plans said they credential NPs as primary care providers.[8] Another study found that three out of four HMOs "credential NPs as [primary care providers], a substantial increase over previous years."[9]

Giving MA plan issuers similar flexibility to engage APRNs may provide added incentive to offer plans in areas with primary care shortages. ANA urges CMS to review current regulations and guidance for MA provider contracting and identify opportunities to remove barriers to APRN practicing to the full extent of their state license, especially in rural areas.

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).[10] 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, American Nurses Association, at (301) 628-5027 or brooke.trainum@ana.org.

Sincerely,



Ingrida Lusis
Vice President for Policy and Government Affairs

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

[8] Kaiser Family Foundation, Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans. March 2018.)
[9] Kaiser Family Foundation. Tapping Nurse Practitioners to Meet Rising Demand for Primary Care. January 2015.