The Improving Care and Access to Nurses (ICAN) Act
Section-by-Section

Title I: Removal of Barriers to Practice on Nurse Practitioners (NPs) and for Other Purposes

Sec. 101: Expanding Access to Cardiac Rehabilitation Programs and Pulmonary Rehabilitation Programs Under the Medicare Program

In 2018, Congress passed legislation which authorized NPs, clinical nurse specialists (CNSs) and physician assistants (PAs) to supervise cardiac and pulmonary rehabilitation starting in 2024. However, these clinicians are still not authorized to order cardiac and pulmonary rehabilitation for Medicare patients. **This section would authorize NPs, CNSs and PAs to order cardiac and pulmonary rehabilitation.**

Sec. 102: Permitting Nurse Practitioners to Satisfy Documentation Requirement for Coverage of Certain Shoes for Individuals with Diabetes

NPs provide the full range of care to patients with diabetes, but federal law requires that the NP must send a patient who needs therapeutic shoes to a physician to certify that need. Additionally, according to current statute, the certifying physician must be the provider treating the patient's diabetic condition going forward. These barriers often lead to delays in accessing needed items and undermine care continuity. **This section would authorize NPs and PAs to certify the need for therapeutic shoes for patients with diabetes.**

Sec. 103: Improvements to the Assignment of Beneficiaries Under the Medicare Shared Savings Program (MSSP)

NPs are recognized in the MSSP as "Accountable care organization (ACO) professionals", yet federal law requires that a patient receive one primary care service from a physician in order for the patient to be assigned to an MSSP ACO based on their claims data. A recent CMS regulation created a "voluntary alignment" pathway where patients can choose an NP as their primary care provider in an MSSP ACO and be assigned to the ACO without the aforementioned visit requirement. However, this does not apply when a patient is assigned to an MSSP ACO based on their claims data. This results in misalignment of MSSP incentives. **This section would authorize the claims-based assignment to MSSP ACOs of NP, PA and CNS patients without requiring the patient to receive a primary care service from a physician.**

Sec. 104: Expanding the Availability of Medical Nutrition Therapy Services Under the Medicare Program

Nurse practitioners are qualified to refer patients to dietitians or nutrition professionals for medical nutrition therapy, but Medicare requires these referrals to come from a physician. Medical nutrition therapy has been shown to be an effective and affordable way to help control and prevent diabetes complications, leading to better care for patients and lower costs for health systems. **This section would authorize NPs, CNSs and PAs to refer Medicare patients to dietitians or nutrition professionals for medical nutrition therapy.**

Sec. 105: Preserving Access to Home Infusion Therapy

Even though NPs are "applicable providers" who can be the attending care provider for a patient receiving home infusion therapy, Medicare still requires NPs to have a physician establish and review the patient's plan of care. NPs are authorized to establish and certify home health care plans of care, but this home infusion barrier limits the ability of NPs to obtain home infusion services for their patients. This barrier often leads to delays in care delivery and undermines care continuity. **This section would authorize NPs and PAs to establish and review home infusion plans of care for Medicare patients.**

Sec. 106: Increasing Access to Hospice Care Services

NPs serve as attending providers, establish and review care plans and perform face-to-face assessments for hospice patients. However, they are not yet authorized to certify and recertify patient eligibility for hospice care. Instead, they must find a physician to certify eligibility at an additional cost. Additionally, NPs are currently only authorized to bill for certain hospice services when they are serving as the attending physician for a patient, while this limitation does not apply to physicians. **This section would authorize hospice care programs to accept certification and recertification of eligibility orders from nurse practitioners for Medicare beneficiaries, and align the billing provisions for NPs and physicians working for a hospice program**.

Sec. 107: Streamlining Care Delivery in Skilled Nursing Facilities (SNFs) and Nursing Facilities and Authorizing Medicare and Medicaid Patients to Be Under the Care of a Nurse Practitioner in a Hospital

Medicare regulations for SNFs do not authorize NPs to perform admitting examinations for SNF patients. Currently, they are only authorized to perform alternating required monthly/bimonthly assessments. Also, SNF care must be provided under the supervision of a physician. This practice restriction tends to undermine continuity of care. **This section would remove the requirement that SNF care be provided under the supervision of a physician and authorize NPs to perform admitting examinations and all required patient assessments.**

Additionally, during the COVID-19 Public Health Emergency, CMS waived the requirement that every hospital patient be placed under the care of a physician, enabling NPs in hospitals to practice to the top of their license. This enables hospitals to optimize their workforce strategies. **This section would make this waiver permanent and authorize Medicare and Medicaid patients admitted to a hospital to be under the care of a nurse practitioner.**

Sec. 108: Improving Access to Medicaid Clinic Services

Medicaid requires that clinic services be provided under the direction of a physician. **This section would improve access to care for Medicaid beneficiaries by authorizing a Medicaid patient receiving outpatient clinic services to be under the direction of an NP.**

Title II: Removal of Barriers to Practice on Certified Registered Nurse Anesthetists

Sec. 201: Amendments to Section 1861 of the Social Security Act

CMS has not explicitly permitted CRNAs to bill Medicare for evaluation and management (E&M) services. In addition, Section 140.4.3 of the Medicare Claims Processing Manual, states that Medicare will reimburse for reasonable and necessary medical or surgical services furnished by CRNAs if they are legally authorized to perform these services in the State in which the services are furnished.[1] However, CRNAs are not being reimbursed for these services by Medicare. **This section would require CMS to clarify that CRNAs can be reimbursed by Medicare for E&M services.**

Sec. 202: Revision of Conditions of Payment Relating to Services Ordered and Referred by Certified Registered Nurse Anesthetists

CRNAs are legally authorized to provide anesthesia services and related care to the extent authorized by the State in which the services are furnished. Further, Medicare Part B is permitted to pay for anesthesia services and related care furnished by a CRNA who is legally authorized to perform the services by the State in which the services are furnished. While CRNAs are not expressly prohibited from ordering and referring Medicare services by legislation or by regulation, services that CRNAs order and specialists to whom they refer patients are not being reimbursed under Medicare. **This section would require CMS to clarify that CRNAs can order, certify, and refer medically necessary Medicare services when legally authorized by the state in which the services are furnished.**

Sec. 203: Special Payment Rule for Teaching Anesthesiologists

The proposed language amends the "Special Rule for Teaching Anesthesiologists[2]" by adding student nurse anesthetists (SRNAs). Anesthesiologists teaching two SRNAs would be reimbursed at 100 percent, as they are for physician residents.
This section implements changes that promote parity in Anesthesia education by amending anesthesia payment rules to allow 100 percent payment for one Anesthesiologist teaching two SRNAs.

Sec. 204: Removing Unnecessary and Costly Physician Supervision

This section permanently removes physician supervision of CRNAs under Medicare Part A Conditions for Participation.

Sec. 205: CRNA Services as Medicaid-Required Benefit

This section would include non-medically directed CRNA services as a mandatory benefit under the Medicaid program allowing 100 percent direct payment made under the Medicaid fee schedule amount.

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[1] Medicare Claims Processing Manual. Available here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.
[2] Section 1848(a) of the Social Security Act (42 U.S.C. § 1395w-4(a)).

Title III: Removal of Barriers to Practice on Certified Nurse-Midwives

Sec. 301 Improving Access to Training in Maternity Care

Currently teaching physicians can bill for instruction and supervision of an intern or resident in training in obstetric programs, while CNMs frequently play this teaching role without a mechanism to be paid for this service. **This section would authorize CNMs to bill for services related to training medical interns and residents in obstetrics in teaching facilities.**

Sec. 302. Improving Medicare Patient Access to Home Health Services Provided by Certified Nurse-Midwives

CNMs are advanced practice registered nurses with specialized education in women's health care and midwifery. CNMs are trained to offer comprehensive care to women through every phase of their lives and continuing well beyond menopause. CNMs are authorized to be Part B Medicare providers and they deliver high-quality, evidence-based and cost-effective primary health care services for women. Current regulations require that CNMs have a physician document their home health care services. **This section would require CNMs to be included alongside nurse practitioners, clinical nurse specialists and physician assistants as Part B Medicare providers eligible to certify and recertify a Medicare beneficiary for home health services without being subject to physician supervision.**

Sec. 303. Improving Access to DMEPOS for Medicare Beneficiaries

This section authorizes CNMs to issue a prescription or written order for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries as well as provide face-to-face encounters without being subject to physician supervision.

Sec. 304. Technical Changes to Qualifications and Conditions of Certified Nurse-Midwives' Services

This section updates the name of the entity responsible for the national certification of a Certified Nurse-Midwife from the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council to the American Midwifery Certification Board or its successor organization.

Title IV: Improving Federal Health Programs for all Advanced Practice Registered Nurses

Sec. 401: Revising the Local Coverage Determination Process Under the Medicare Program

This section directs CMS to take the following actions:

a) **Enforce existing law:** Ensure that LCDs do not contain language or provisions that limit or deny the free choice of a patient to obtain health services from any institution, agency, or person, including a health care provider who is qualified and acting within the scope of that provider's state license or certification, with respect to Medicare participation, reimbursement, coverage of services or indemnification;

b) **Bring recourse:** Develop a process by which a Medicare beneficiary or an adversely affected health care provider has recourse for filing a claim prior to the finalization of a LCD;

c) **Provide transparency:** Require that each Medicare Administrative Contractor (MAC) provide free of charge to a Medicare beneficiary or to an adversely affected health care provider, any internal rule, guideline, protocol, or other criterion which was relied upon in making its LCD, as well as an explanation of the scientific or clinical judgment for the LCD, and the identification of medical or scientific experts whose advice was obtained on behalf of the MAC; and

d) **Levy penalties when necessary:** In the case of a failure by a MAC to comply with the provisions of this paragraph, the Secretary of Health and Human Services shall impose a civil monetary penalty in the amount of $10,000 for each day for each individual with respect to which such a failure occurs.

Sec. 402: Locum Tenens

A provision of the Medicare statute allows for payment to be made to a physician for services furnished by a substitute physician, also referred to as a locum tenens or a fee-for-time compensation arrangement, if the first physician is unable to perform the services. The physician compensates the substitute provider pursuant to an agreement, and the services furnished by the substitute physician are indicated on the Medicare claim using a Q6 modifier. **This section allows the Medicare locum Q6 modifier to be available to CRNAs and other APRNs.**