



December 21, 2011

Marilyn Tavenner, MHA, RN
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-3244-P
PO Box 8010
Baltimore, Maryland 21244-8010

Re: Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation

Dear Administrator Tavenner:

AARP is pleased to provide comments on the proposed rule on “Reform of Hospital and Critical Access Hospital Conditions of Participation.” Access to affordable, quality care has long been a top priority for AARP. Central to achieving this objective is assuring an adequate supply and mix of quality health care providers and allowing these professionals to provide care to consumers to the full extent of their education and training. AARP supports policies which enable an adequate supply and mix of health providers and policies which remove federal and state barriers to practice to provide consumer access to care. AARP supports the Centers for Medicare and Medicaid’s (CMS) underlying intention to remove burdensome provisions while reducing costs and ensuring quality care.

The problems facing our health care system -- which include an aging population with increasingly complex conditions, an inadequate supply of providers, and skyrocketing costs -- require modernized approaches to care delivery. This includes the participation and contribution of all health professionals to the full extent of their training and education as part of the health care team. CMS should encourage this approach at every opportunity and be mindful of the impact these proposed changes may have on consumers and providers. Below we outline a series of questions, comments and suggestions aimed at strengthening various provisions included in the proposed rule.

Comments

Subpart A –Revisions to Allow Flexibility and Eliminate Burdensome CoPs

§482.22—Medical staff

Under this provision, CMS proposes to “provide hospitals the clarity and flexibility they need under federal law to maximize their staffing opportunities for all practitioners, and particularly non-physicians, under their individual States’ laws” by allowing practitioners who are not part of a medical staff to be considered for privileging. In removing the requirement of staff membership before one may be allowed to practice in a given facility, the revision may create opportunities for increased access to care for consumers—particularly in medically underserved areas in which

qualified advanced practice registered nurses (APRNs) and physician assistants (PAs) provide care. The change might also present opportunities for increased professional collaboration between physicians, nurses, physician assistants and pharmacists, among others. The change can improve quality of care and outcomes for consumers.

However, in leaving this discretion to the recommendation of the medical staff and the hospital's governing body, resistance may still exist, even where state law allows. One example of this is the independent provider practice that is not supervised by physicians. Furthermore, the regulation's reference to the possible establishment of separate "categories" of non-physician membership has the potential to simply reaffirm the status quo and render meaningless the very maximization of staffing opportunities for all practitioners that CMS seeks to achieve through its proposed changes. It should be noted that under current Joint Commission standards, hospitals can privilege PAs and APRNs as less than active medical staff and without staff membership. Only active medical staff can admit patients and have voice and vote in staff governance. Thus, PAs and APRNs can be voted off staff rosters individually and categorically, and without recourse.

AARP strongly encourages CMS to modify the proposed regulation to clearly and succinctly state qualified health professionals be eligible for clinical privileges, admitting privileges, and medical staff membership including voting privileges and that hospital policies assure that the process for making these decisions are transparent, objective and timely. This modification would be a significant step forward for consumer access, quality, and efficiency of care. Such modification would also bring the regulation in line with the recommendations of the landmark 2010 report of the Institute of Medicine (IOM), *The Future of Nursing: Leading Change Advancing Health*. The IOM report calls on CMS to: "amend or clarify the requirements for hospital participation in the Medicare program to ensure that advanced practice registered nurses are eligible for clinical privileges, admitting privileges, and membership on medical staff."

§482.23—Nursing services

The proposed provision allows for the preparation, administration, documentation and signing of medications and biologicals by staff other than physicians, and eliminates required special training of clinicians in the administration of blood transfusions and intravenous medications. AARP supports the possible opportunities for APRNs, PAs, pharmacists, and other licensed providers to practice to the full extent of their education and training.

§482.23(c)(6)—Self-administration of medications

The proposed provision encourages patient-centered, consumer-directed care by permitting hospitals to allow patients and their family caregivers the opportunity to self-administer certain medications. AARP believes this provision would encourage patient and family caregiver education as well as medication reconciliation in care transitions.

§482.24—Medical record services

AARP supports the expanded eligibility of qualified practitioners to authenticate verbal orders, but we request clarity around the definition of "another practitioner who is *responsible* for the patient." The definition of "responsible" could have practice implications for multiple providers and may increase costs by adding unnecessary physician supervision.

Administrator Tavenner

December 21, 2011

Page 3

§485.602 and §485.635—Critical Access Hospitals

The regulation recognizes the crucial issues of workforce shortages and access to care in rural areas in proposing to allow Critical Access Hospitals (CAH) to contract with providers unaffiliated with a particular CAH. AARP believes this increased flexibility will allow for increased beneficiary access to care by a variety of qualified providers.

Subpart C—Other Options Considered

§482.24—Medical record services

CMS proposes to maintain its current requirement that the authority to conduct a history and physical (H&P) remains solely with physicians. Consumers' access to care would be improved if the eligibility to conduct these was expanded to other qualified providers. Allowing only physicians to conduct H&Ps—even though PAs and all four categories of APRNs are qualified to conduct H&Ps through their education and training—could result in delays in diagnosis and treatment in areas where there are not enough physicians. Furthermore, allowing other qualified providers to conduct H&Ps could be more cost-effective than the required physician time. In fact, the IOM Future of Nursing report recommended APRNs be eligible for hospital clinical privileges, admitting privileges, and hospital medical staff membership and also be permitted to perform admission assessments, which include H&Ps. The regulation should be modified to include PAs and APRNs.

AARP appreciates this opportunity to comment and would be pleased to work with CMS and through our states offices to continue safeguarding patient health and helping to ensure high-quality, high-value care for consumers. If you have any questions, please feel free to contact Winifred Quinn on our staff at (202) 434 3956.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs