Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192)
Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI)
Comments to be submitted through online form.

1) **Streamline Regulatory Requirements**

Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

Since the start of the COVID-19 public health emergency (PHE), telehealth has been operating under expiring waivers which have a defined expiration date. Every time this date approaches, practitioners are concerned that telehealth regulations will return to where they were before the PHE. This results in uncertainty for the practitioner and the possibility that the patient will need to find a new practitioner if they are not within a reasonable distance. Additionally, many Medicare patients have difficulties with mobility, and removing telehealth options could mean that they are unable to see their practitioner when they require care. **Making these waivers permanent would remove administrative burdens. Before the PHE there were extremely limited cases where telehealth could be utilized, and if these waivers are not made permanent, practitioners will have to spend time looking at the regulations for each telehealth visit to determine whether this telehealth visit is reimbursable through Medicare.**

One other area where administrative burdens could be simplified without compromising patient safety is through the standardization of terms. In the calendar year 2024 Physician Fee Schedule proposed rule, the Centers for Medicare and Medicaid Services (CMS) proposed to remove distinctions between provider types and just use the term *practitioner*. This meant that Advanced Practice Registered Nurses (APRNs) were explicitly included when CMS discussed provider types, instead of the prior standard of excluding APRNs unless they were specifically named as providers. CMS later finalized this proposal in the final rule. While CMS has started using *practitioner*, not all federal agencies are doing so, and it is unclear if all of HHS' subagencies have changed their terminology. This results in confusion as the practitioner is required to check what healthcare insurance the patient has, and this can delay treatment, as it may be unclear who is authorized to treat the patient.

Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and providers?

2) **Opportunities to Reduce Administrative Burden of Reporting and Documentation**

What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?

Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number.

3) **Identification of Duplicative Requirements**

Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?

How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?
CMS should work closely with the Drug Enforcement Administration (DEA) on their proposed rules for prescribing via telemedicine. The proposed rules released by the DEA are onerous and make it difficult for practitioners to prescribe controlled substances remotely. ANA encourages CMS to work with the DEA to align these Congressionally required regulations with current best practices. That would include not requiring patients and practitioners to be physically located within the same state. General telehealth rules require that both the practitioner and patient be physically located in states where the practitioner is licensed. That is a much more practical solution than requiring practitioners or patients to cross state lines to see patients. This is especially true in regions, such as Washington, DC, where many people live and work in different states. Many practitioners also maintain offices in different jurisdictions, and requiring both practitioners and patients to be physically located in the same state makes the practice of medicine more difficult.

How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

CMS should continue to lead in telemedicine. **The waivers that were granted at the beginning of the COVID-19 PHE were critical to the continuation of care at that time and have been shown to be very effective in ensuring patients receive necessary care**. Many Medicare beneficiaries are older, and they may have issues with mobility. Allowing these patients to receive care from their practitioners virtually has allowed them to continue receiving the care they need. ANA agrees that not all patient encounters can or should be virtual, but there are many cases, especially in behavioral health, where telemedicine is vital and must be continued.

ANA also believes that not all behavioral health visits should have an audio and video requirement. While seeing a patient on camera is definitely preferable to just hearing a voice, there are times when patients are in crisis and they either do not have video capability or do not want to be on camera. In cases like this, ANA believes that video requirements should not be required, even though they can give the practitioner more information.

4) **Additional Recommendations**

We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

Medicare should allow all practitioners to practice at the top of their license. APRNs are bound by out of date and pointless regulations. These affect the work done by nurses and greatly reduce their utility and ability to practice medicine at the top of their license. ANA has specific policy proposals that would reduce the regulatory burden on nursing and looks forward to working with the Administration on ways to deregulate the nursing profession. Two barriers faced by APRNs are related to scope of practice and collaborative agreements.

Due to regulatory barriers, APRNs, including nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives CNMs, and certified registered nurse anesthetists (CRNAs), face real barriers to practicing medicine at the top of their license due to outdated regulations. The Administration has the authority to provide FPA for APRNs that provide care to patients who receive health care coverage through federal programs by creating a program similar to the Veteran Affairs' (VA's) National Standards of Practice—which defines a consistent scope of practice and responsibilities across all VA facilities. National standards in other care settings would allow APRNs to practice at the top of their license while seeing patients covered by federal insurance programs. These standards would only cover patients covered by federal insurance programs and would not require other payers to follow federal rules. The care provided by APRNs to Medicare beneficiaries is comparable to the care provided by physicians. There is also legislation introduced in Congress, The Improving Care and Access to Nurses Act (ICAN), that would remove many

of these barriers, but ANA would strongly encourage the Administration to remove these barriers without waiting for Congressional action.
Providing full practice authority to APRNs would be an excellent way to ensure that APRNs can practice at the top of their license. ANA urges the Administration to remove all barriers that prevent nurses from doing so and ensure that patients have access to care from trusted nurse clinicians in their communities.

Collaborative agreements fulfill a regulatory requirement placed by many states on APRN practice, which require an agreement between a physician and an APRN for either a limited period (transition to practice) or granting permission to practice. **Many of these requirements were relaxed by the Trump Administration during the COVID-19 public health emergency (PHE) with no demonstrable negative effect on patient care. ANA believes that the flexibilities provided during the pandemic should be made permanent.** These do not relate to the APRNs' scope of practice, and there is no evidence to suggest that these collaborative agreements protect patients. Additionally, these transition-to-practice requirements are becoming increasingly difficult to initiate and maintain as increasingly primary care physicians and psychiatrists decline to offer them and undercut APRN practice. Additionally, mergers and acquisitions prevent physicians from signing agreements with APRNs who are not employed by the parent organization, creating additional barriers to practice.

Supervision requirements are very similar to collaborative agreements and generally require that a physician sign off on an APRN's work. Currently, many states allow APRN practice without unnecessary supervision requirements[1]. During the COVID-19 PHE, the Trump Administration rightfully relaxed these supervision requirements without any discernible difference in patient care. **ANA maintains that these relaxed supervision requirements should become permanent.**