August 31, 2023

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1784-P –Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies, and Basic Health Program; Proposed Rule (88 Fed.Reg. 52262, August 7, 2023)

Dear Administrator Brooks-LaSure:

On behalf of the undersigned organizations representing Advanced Practice Registered Nurses (APRNs) and advanced practice nursing education, we appreciate the opportunity to comment on this Propose Rule: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies, and Basic Health Program; (88 Fed.Reg. 52262, August 7, 2023).

The APRN Workgroup is comprised of organizations representing Advanced Nursing Education, Certified Nurse-Midwives (CNMs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetists (CRNAs), and Nurse Practitioners (NPs). As of 2020, over 233,000 APRNs were treating Medicare patients, making it essential that the Centers for Medicare & Medicaid Services (CMS) remove barriers to care and not implement policies that impose additional barriers to care for APRNs and the patients they serve. America's growing numbers of highly educated APRNs advance healthcare access, quality improvement and cost-effective healthcare delivery across all settings, regions and populations, particularly among the rural and medically underserved.

Telehealth

We appreciate the agency's proposal to swiftly implement the telehealth provisions included within the Consolidated Appropriations Act (CAA) of 2023. We support the provisions within the proposed rule which aim to consolidate the categories of codes, and better align the codes with the timelines established by the CAA, 2023. This will reduce confusion for patients and providers as the telehealth landscape continues to evolve.

Section II.D.e.2 proposes to implement section 4113(d)(1) of section FF, Title IV, Subtitle B of the CAA, 2023which delays the requirement of an in-person visit with a provider within 6 months prior to the initial mental health telehealth service, and again at subsequent intervals as the Secretary determines appropriate.[1] The in-person requirements for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of a mental health disorder would be delayed until January 1, 2025.We strongly support the delay of the in-person requirement for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder.

We also continue to encourage CMS to not impose requirements for in-person services beyond what is statutorily required. As noted by the agency in this proposal, one of the primary goals is to "conform to all statutory requirements without unnecessary restrictions on beneficiaries' access to telehealth care."[2] For patients seeking mental health treatment, the issues which prevent them from accessing care existed prior to the pandemic and will continue to exist beyond its duration. It is important to ensure the provisions intended to maintain program integrity do not also inhibit patient access to care. If a provider within their clinical judgement believes a patient requires an in-person visit, an APRN or other provider may schedule that in-person service, regardless of the minimum requirements established by the rule. APRNs have the education and clinical training required to treat patients as they deem necessary, and we believe the regulatory requirements should allow providers to assess a patient's needs, and use their clinical judgement to determine the appropriate treatment for a patient. This will ensure that patients have the access to care they need while balancing the requirements of the statute and program integrity.

In section II.D.2.a., CMS is continuing to consider revisions to the policies governing direct supervision via use of two-way audio/video communications technology. In this proposal, CMS has stated its concerns with an immediate return to the pre-PHE standard of direct supervision which requires the physical presence of the supervising provider. The agency cites new patterns of practice, and potential barriers to access, as concerns regarding a reversion to the pre-PHE standard. The agency believes that providers will "need time to reorganize their practice patterns established during the PHE to reimplement the pre-PHE approach to direct supervision without the use of audio/video technology."[3] In light of these concerns, CMS is proposing to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024.

We appreciate the agency's attention to the potential overutilization of these flexibilities, and the negative impacts which could result from improper usage. We continue to have concerns about the overutilization of "incident-to" billing, which would be exacerbated by making certain provisions of this policy permanent. Establishing the virtual presence flexibility for services performed by auxiliary personnel is an appropriate extension of this policy. However, we do not believe this policy should be extended to services performed by APRNs, who are able to directly

[1] Federal Register :: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program
[2] Ibid
[3] Ibid

bill Medicare for services. This would exacerbate the usage of 'incident-to' billing, which does not align with CMS' stated goals of transparency and accountable care.

The concerns over 'incident-to' billing were also expressed by the Medicare Payment Advisory Commission (MedPAC) in their June 2019 report[4]. MedPAC recommended "eliminating incident to billing for APRNs", which would "update Medicare's payment policies to better reflect current clinical practice."[5] The extension of this policy would likely exacerbate the overutilization of incident-to billing and increase Medicare spending. If CMS extends this policy, **we recommend that it be limited to circumstances where the billing practitioner is supervising clinical staff who are not authorized to bill the Medicare program directly, consistent with MedPAC's recommendations.**

Principal Illness Navigation (PIN) Services

We appreciate that CMS is better identifying and value practitioners' work in helping patients navigating the healthcare system by proposing payment for Principal Illness Navigation (PIN) Services. We request that CMS require as condition of paying for services as part of the PIN Services (CPT codes GXXX3 and GXXX4) that the individual billing for these services ensure that all applicable APRNs--CNMs, CNSs, CRNAs, and NPs—are identified and included in the services that are recommended for the patient and caregiver. As more than 40 percent of Medicare beneficiaries receive their care from APRNs, we believe it is crucial that the billing practitioner include all appropriate types of APRNs and to fully recognize and account for all their services that each type of APRN provides as part of this service. Furthermore, the action of including all APRNs as part of this service is in line with CMS's strategic plan to advance health equity as it helps ensures access to needed healthcare services. This is crucial as more than 57 million Americans live in rural areas, and many APRNs treat patients in rural and underserved areas where there are no or limited physician counterparts available.

E/M Updates- RUC

In section II. F.c., the agency requests comment about evaluating E/M services more regularly and comprehensively. Specifically, CMS is "also interested in whether commenters believe that the current AMA RUC is the entity that is best positioned to provide -recommendations to CMS on resource inputs for work and PE (Practice Expense) valuations, as well as how to establish values for E/M and other physicians' services; or if another independent entity would better serve CMS and interested parties in providing these recommendations."[6] We greatly appreciate CMS posing this question, as we firmly believe that healthcare equity must also include equitable representation of APRNs in the valuation process. We do not believe that the AMA RUC is the entity best positioned to provide recommendations to CMS on resource inputs for work and PE valuations, as well as how to establish values for E/M and other physicians' services.

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[4] jun19_medpac_reporttocongress_sec.pdf
[5] *Ibid.*
[6] Ibid

Since the AMA RUC was established in 1991, there has been a significant increase in Medicare patients who receive treatment from APRNs. The valuations established by this process no longer represent the valuation of services for just physicians, but all providers who bill Medicare. Despite this, the RUC does not allow for full APRN participation in the valuation process, instead relegating the interests to be represented by the Health Care Professionals Advisory Committee (HCPAC), which only has one seat on the RUC.

Outstanding recommendations issued by both the United States Government Accountability Office (GAO)[7] and the Medicare Payment Advisory Commission (MedPAC)[8], call for better data and transparency to improve accuracy within the valuation process. Therefore, we respectfully request CMS develop an equitable valuation process which allows full participation by APRNs to better reflect the clinicians providing care to Medicare beneficiaries. This change would align the valuation process with CMS' strategic pillars of advancing health care equity, engaging partners, and driving innovation.[9]

Policies Addressing Social Determinants of Health (SDOH)

The APRN Workgroup appreciates and supports the focus of CMS on addressing SDOH through the Medicare PFS proposed rule. As noted in the National Academy of Medicine (NAM) *Future of Nursing* report "nurses work in areas that are underserved by other health care providers and serve the uninsured and underinsured."[10] Addressing SDOH is intrinsic to APRN practice, and we look forward to working closely with CMS to continue to address these issues. Below are specific areas of the proposed rule which we support:

- ***Medicare Shared Savings Program (MSSP) Attribution***

In section III.G., CMS is proposing to create a new step three for beneficiary assignment to the MSSP with an expanded assignment window to better account for patients who receive their primary care from an NP, CNS, or PA. According to CMS, based on their analysis of the assignable patient population this would support access to the MSSP for underserved beneficiaries, including those who are disabled, low-income subsidy beneficiaries, and beneficiaries who reside in areas with higher area deprivation index scores. Accordingly, this policy would align with CMS' priorities in the CMS Framework for Health Equity (2022–2025).[11] We support CMS efforts to better include patients seen by APRNs into the MSSP and other advanced payment models, and appreciate the agency's focus on the impact that this would have on health equity.

- **Caregiver Training Services**

In this proposed rule, CMS is proposing to establish an active payment status for CPT codes 96202 and 96203 (caregiver behavior management/modification training services) and CPT codes 9X015, 9X016, and 9X017 (caregiver training services under a therapy plan of care established by a PT, OT, SLP). These new codes would create a reimbursement mechanism for clinicians training caregivers consistent with the patient's plan of care. Better integrating caregivers into the patient's plan of care is essential to the

[7] GAO-15-434, Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy
[8] jun18_ch3_medpacreport_sec.pdf
[9] CMS Strategic Plan | CMS
[10] NASEM: The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity P.103
[11] 88 FR 52443.

patient's well-being and long-term health. We appreciate CMS' recognition of the importance of caregiver training and support this proposal.

- **Community Health Integration Services**

CMS is proposing to create two new G codes for community health integration services performed by "auxiliary personnel", including community health workers, under the general supervision of the billing practitioners, including APRNs. We also request that CMS recognize all four types of APRNs as the billing practitioners in this role. The goal of these codes is to provide increased recognition of the impact of social needs on patients' health. As noted above, addressing SDOH and providing whole-person centered care is a core component of APRN practice. Accordingly, we support this proposal which will help support clinicians to address SDOH in their patients' plans of care.

We appreciate the opportunity to provide our recommendations on this request for information. Should you have any questions, you can reach out to Romy Gelb-Zimmer, Senior Associate Director of Federal Regulatory and Payment Policy at rgelb-zimmer@aana.com or (202) 484-8400. Thank you for your consideration and we look forward to hearing from you.