September 3, 2024

Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-1850

Submitted electronically at www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments [CMS-1807-P]

Dear Administrator Brooks-LaSure:

The American Nurses Association (ANA) appreciates the opportunity to comment on calendar year (CY) 2024 Physician Fee Schedule (PFS) proposed rule. ANA applauds the continued commitment to health equity and expanding access to quality health care from the Center for Medicare & Medicaid Services (CMS) in the PFS. To achieve these goals, it is critical that CMS and the PFS recognize the value of nurses and nursing practice. As the agency works to finalize the proposed provisions, ANA urges CMS to:

- **appropriately and adequately value the nurse through adequate payment and recognition in billing codes, facility payments, and demonstration programs;**
- **make permanent flexibilities for services provided through telehealth;**
- **provide resources and recognize the role of the nurse in providing social determinant of health (SDOH) and other patient screening;**
- **encourage through appropriate reimbursement the administration of vaccines;**
- **continue to provide incentives to bolster the nursing workforce in all programs under the agency's purview; and**
- **make appropriate changes for the Quality Payment Program (QPP) to capture nurse practice.**

ANA is the premier organization representing the interests of the nation's over 5 million registered nurses (RNs) through its state and constituent member associations, organizational affiliates, and the individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four Advanced Practice Registered Nurse (APRN) roles: nurse practitioner, certified nurse midwife, clinical nurse specialist, and certified registered nurse anesthetist. ANA is dedicated to partnering

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with health care consumers to improve practice, policies, delivery models, outcomes, and access across the health care continuum.

Nurses are critical to a robust health care system. Nurses meet the needs of patients and provide quality care that leads to better health outcomes for all patients. Moreover, nurses are critical to coordinated care approaches for Medicare beneficiaries in all care settings. Patient-centered care coordination is a core professional standard for all RNs and is central to nurses' longtime practice of providing holistic care to patients.

ANA appreciates CMS' thoughtful consideration of the below comments on the proposed rule, that keep central the value and role of the nurse.

1) **CMS must mitigate cuts to the conversion factor to ensure that nurse providers are supported.**

CMS proposes to lower the conversion factor for CY 2025 from $33.2875 to $32.3562. This is a drop of $.93 or 2.79% from CY 2024. Additionally, since calendar year 2000, the conversion factor has been reduced by around $4.26 in real dollars which does not take inflation into account. If one takes inflation into account,[1] the cut would be $7.80 per Relative Value Unit (RVU).[2] ANA understands that CMS is bound by budget neutrality statutes and the agency does not have the authority to raise the conversion factor to levels past the Congressionally mandated neutrality, but these cuts are troubling. APRNs already receive 15% less than physicians in Medicare for doing the same work, and this cut only makes it harder for APRNs to practice. This is especially true in lower paying medical specialties, such as primary care, where NPs make up a significant percentage of the workforce and are a lynchpin of access to care in many areas. The lower conversion factor makes it economically very difficult for NPs to go into primary care which exacerbates the current shortage of primary care providers. **ANA encourages CMS to use its authority to mitigate the cuts to the conversion factor which will ensure that entry into practice is financially viable for all practitioners.**

2) **CMS must appropriately value the nurse as it determines PE RVUs.**

ANA is confused as to why some APRNs are included in the determination of Practice Expense (PE) RVUs and some are not. Table 1, in the proposed rule, lists specialties excluded from the rate setting calculation. This table includes lines for nurse practitioners and certified clinical nurse specialists. ANA understands why nurse anesthetists are not included in the exclusion as anesthesia operates under a different fee schedule, but CNMs are also not excluded from the calculation. CNMs are reimbursable directly through Medicare and their exclusion diminishes the work that they do for their patients. This is even more true through the setup for the file where CMS states that it excludes "certain specialties, such as NPPs paid at a percentage of the PFS." These "NPPs" include CNMs and they therefore should have been included in the exclusion list.

[1] The Federal Reserve Bank of Minneapolis provides a calculator to determine how the value of money has changed over time. Inflation Calculator: Federal Reserve Bank of Minneapolis. https://www.minneapolisfed.org/about-us/monetary-policy/inflation-calculator. Accessed August 2024

[2] That number was derived by multiplying the cut in real dollars of the conversion factor by the value of the current dollar as determined by the Federal Reserve Bank of Minneapolis.

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CMS is in the fourth and final year of its clinical pricing update. Staff, and especially nurses, have long been undervalued in the fee schedule and these updates help raise the value of the nurse so that it is more in line with the value they bring both to their employer, whether it is a facility or medical practice, or to the patients that are in their care. ANA thanks CMS for raising these rates by around 50 percent, but this is only one step. CMS proposes to review clinical labor pricing every four years and the value of the nurse should continue to rise with every review. Nurses are consistently undervalued across all settings and regular reviews should show that the payment rate for nurses is not commensurate with the work they are doing for Medicare patients. Nurses are the practitioners with whom patients have the most contact and as a result, nurses are more familiar with their patients than almost any other practitioner. **As a result, nursing care should be valued more highly than it is today and even with the greatly appreciated pricing update, the value of nursing care is still undervalued in today's healthcare system.**

The issue is that RNs are mentioned in ten separate rows in Table 5 which has the proposed CY 2025 clinical labor pricing. The rate per minute for nurses varies from $.52 per minute to $.81 per minute. This brings uncertainty to the fee schedule as the value of the nurse fluctuates depending on the situation, which is not true for any other practitioner mentioned in the table.

3) **CMS must make permanent flexibilities for telehealth services.**

ANA has long been a proponent of expanding telehealth services and the COVID-19 public health emergency (PHE) provided the impetus for Medicare to greatly expand these services. Telehealth is an essential part of care for many Americans, especially those with limited mobility or those in rural areas. Many rural areas have few, if any, practitioners within a reasonable driving distance and the ability of these practitioners to see patients throughout their state has greatly improved the care that these patients receive.

There are times when patients have questions for their practitioner, and these can be answered remotely. These appointments, which can be very difficult to get have in-person, have allowed these patients to speak with their practitioners when they need care. ANA agrees that many procedures must be done in person, but there are many preventative patient encounters where the patient does not have any procedures or tests done. These encounters can be done virtually and continuing to do them is extremely beneficial to Medicare beneficiaries.

While telehealth use has decreased since the end of the PHE, it is still widely used, and NPs are among the most extensive users of telehealth. **Therefore, ANA implores CMS to use their authority to either extend or make the COVID-19 PHE telehealth flexibilities permanent.** Where CMS does not have the authority to make these flexibilities permanent, ANA continues to work with Congress on permanency.

In addition to promoting general telehealth flexibilities, ANA has been working to support our members in their use of telehealth and offers comments on a number of specific CMS proposals.

a) *CMS should waive the analogous in person criteria and add continuous glucose monitoring (CPT code 95251) to the permanent telehealth list.*

CMS received a request to add CPT code 95251 to the telehealth list (*Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours;*

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analysis, interpretation and report), but does not agree with adding it to the telehealth list stating that it does not fulfill the second criteria of the list and is not analogous to an in-person service. While it is true that there is no analogous in person service to CPT code 95251, this code was designed to be performed virtually. Additionally, this service can be done in person, but the cost would be excessive per patient, and is therefore performed virtually as one nurse can monitor multiple patients. Monitoring is an essential preventive measure and not allowing it is detrimental to the health of many Medicare beneficiaries. **Because of this intentional virtual component, CMS should waive the analogous in person criteria and add CPT code 95251 to the telehealth list.**

b) *CMS must ensure that any changes to remote cardiovascular and pulmonary rehabilitation continue to include APRNs.*

CMS received a request to move cardiovascular rehabilitation services, CPT codes 93797 and 93798, and pulmonary rehabilitation services, CPT codes 94625 and 94626 to from the provisional telehealth list to the permanent telehealth list. ANA believes that these services can be done remotely but does not oppose CMS' view that studies should be conducted before these are added to the permanent list. NPs are currently allowed to perform these services remotely and **ANA would urge CMS to ensure that any changes in what is allowable under remote rehabilitation continue to include NPs, and other APRNs**.

c) *CMS must not move the health and wellbeing coaching codes to the permanent telehealth list.*

CMS received a request to move CPT codes 0591T-0593T to the permanent telehealth list. These are currently category III CPT codes that Medicare does not reimburse, and ANA does not support changing these to category I codes. **As these codes are not currently reimbursable and likely will not be for the near future, ANA does not support adding these to the permanent telehealth list.** Additionally, adding these to the permanent telehealth list might give the impression that the status of the codes will be changed, and, at this time, it is unclear if that will happen.

d) *CMS should give time for additional study of caregiver training codes before adding them to the permanent telehealth list.*

CMS received a request to add HCPCS code 97550 and CPT code 97551 to the permanent telehealth list. CMS disagreed with this request but proposed to add the codes to the provisional list along with other caregiver training codes.[3] **ANA agrees with CMS' logic of adding these codes to the provisional list since they are very new, and this gives CMS time to study whether they can be done effectively via telehealth.**

e) *CMS must include the Preexposure Prophylaxis (PrEP) of Human Immunodeficiency Virus (HIV) codes to the permanent telehealth list.*

CMS proposes national rates for PrEP, specifically HCPCS codes G0011 and G0012. These preventative codes are essential to ending HIV and adding them to the telehealth list will be an

[3] CPT codes 97550, 97551, 97552, 96202, 96203

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invaluable tool for practitioners to use in their daily work. **ANA strongly supports this addition to the telehealth list.**

f) Audio Only Visits for Opioid Treatment Programs (OTPs).

CMS proposes to make permanent flexibilities put in place during the COVID-19 PHE and further extended through previous rulemaking to better align OTPs with other telehealth requirements. These flexibilities are only allowed where they also align with DEA and SAMHSA requirements and laws. ANA agrees with CMS' assessment that continuing these flexibilities will promote access to treatments that may not be available if video were required as part of the appointment. **ANA strongly supports making permanent audio only visits for OTPs.**

4) <u>CMS should continue to permit remote supervision of and communication with patients.</u>

During the Covid-19 PHE, CMS allows many practitioners to supervise other practitioners and communicate with patients via remote communications systems, which generally require audio/video capabilities. The end of the PHE has ended some of these flexibilities, but CMS is proposing to allow some to continue. ANA offers specific comments on the proposals below.

a) CMS should allow and reimburse for audio only communications with patients.

CMS proposes to allow audio only communications as long as the reporting practitioner also has the ability to tend to their patient via appropriate audio/video communications systems. ANA supports this policy and agrees that as long as the practitioner has audio and video capability then the encounter should be reimbursable by CMS. There are times when the patient does not feel comfortable and requiring a video component during a telehealth encounter could discourage a patient from having their necessary medical visits with their practitioner. **ANA also agrees that the practitioner must have audio/video capabilities for all patients. Without this capability, it would be impossible to treat patients via telehealth and patient care would suffer.**

b) CMS must make proposed distant site requirements permanent.

CMS proposes to extend the flexibility created during the COVID-19 PHE that allows practitioners using telehealth to list the distant site as their medical practice, rather than their home address, through the end of the CY 2025. ANA supports this extension as it protects practitioner's privacy and defends them against some of the violence that they still see at the facility but does not think that extending this on a year-to-year basis is sustainable. Rather, **ANA would urge CMS to make this distant site requirement permanent as it will improve the mental health and well-being of practitioners who practice via telehealth.**

c) CMS must make virtual direct supervision permanent.

CMS proposes to extend the COVID-19 PHE flexibility allowing virtual direct supervision through December 31, 2025, with the use of audio/video technology. **ANA thanks CMS for extending this definition of supervision but would urge CMS to make virtual direct supervision permanent.** ANA agrees with CMS that the supervising practitioner must be available by audio/video interactive communications and thinks that there is not much, if any, difference between being physically in

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the room supervising and being in a different room but supervising the practitioner via audio/video communication.

ANA also believes that the supervising practitioner must use common sense when they decide if they should be physically in the room or not. CMS has concerns about risky procedures or adverse events arising, and ANA agrees that situations like this do occur. As a result, if the supervising practitioner is concerned about adverse events, then they should physically be present. ANA has never believed that audio/video communications should replace in-person care and there are cases where being physically present in the room is necessary. This is one of these cases, but since it is case dependent, **ANA does not believe that CMS should issue regulations based on the small number of cases where being physically present is required.**

d) CMS must adopt its proposed definition of direct supervision.

CMS proposes to extend the definition of direct supervision to include some services that can be directed virtually. These services are considered low risk and are not usually done by practitioners, rather they are done by auxiliary personnel. **ANA supports this change in definition as it will allow RNs to practice at the top of their license** and, at the same time, not have to ensure that an additional practitioner, who is reimbursed by Medicare, is in the room while they are treating patients.

This proposal would save many hours and allow all healthcare workers, whether they are reimbursed by Medicare or not, to practice medicine at the top of their license in a safe way that guarantees patients receive the highest quality of care. The billing practitioners do not have to run around between patients, and all other providers can ensure that their patients are being treated, when necessary, without having to call the practitioner.

5) <u>ANA appreciates the agency's thoughtful review and valuation of CPT codes.</u>

ANA thanks CMS for reviewing hundreds of new CPT codes and offers comments on the specific codes below.

a) Covid Immunization Administration (CPT Code 90480)

The RUC recommended a work value of 0.25 for CPT code 90480. CMS proposes to accept the RUC valuation and ANA thanks CMS for accepting the RUC recommendation.

b) Annual Alcohol Screening (HCPCS Codes G0442 and G0443)

CMS proposes to accept the RUC recommended work values of 0.18 for G0442 and 0.60 for G0443. ANA thanks CMS for accepting the RUC recommendations.

c) Annual Depression Screening (HCPCS Code G0444)

CMS proposes to accept the RUC recommended work value of 0.18 for G0444. ANA thanks CMS for accepting the RUC recommendation.

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d) CMS must finalize its proposal to add new caregiver training services codes to the telehealth list.

CMS proposes three new HCPCS codes for caregiver training services: GCTD1, GCTD2, and GCTD3. ANA supports the creation of these new codes but would like to ensure that all qualified healthcare providers can be reimbursed for these services. This can be done through either their own or the employer/facility NPI. RNs are trained in the work done by caregivers, and they are fully qualified to provide the training necessary for these caregivers. CMS must ensure that nurses can provide the training services and are reimbursed for the work provided.

Additionally, when caregivers need assistance, they do not call the physician. Nurses will be the first point of contact for most caregivers, and they will be the ones who answer the vast majority of the questions. In many cases, the nurse is the only practitioner who the caregivers correspond with and if the nurse cannot answer the question, it's likely that the physician will also be unable to answer the questions without examining the patient. The nurse can instruct the patient if escalation, such as a visit to urgent care or the emergency room, is necessary.

CMS further proposes to value these codes via crosswalk to similar CPT codes. These crosswalks are to different caregiver training codes and are logical comparisons. ANA would recommend that CMS review these crosswalks next year to ensure that the valuations are proper and that the work is not substantially different. **ANA thanks CMS for adding these codes to the telehealth list. These codes do not require patient interaction, and are lesson based.**

6) <u>CMS must allow nurses and other clinicians to determine the appropriate provision and billing of suicide safety planning.</u>

CMS is proposing modifications to safety planning interventions (SPI), which are determined by clinicians and the patient to provide the patient with strategies and support if they experience thoughts of harming themselves or others. The agency proposes to only reimburse for this important pre-discharge step as an add-on to E&M or psychotherapy visits and if it furnished by the same provider for the visit the SPI is being added. Further, CMS would limit reimbursement for SPIs to 20 minutes. ANA is concerned that the proposed provisions would pose unnecessary limitations on providers, which will only serve to impact the ability of patients to go through the critical step for patients in crisis.

Rather, CMS must allow payment for SPIs as part of any visit—allowing clinicians to determine the need for an SPI independent of the initial visit type or reason. Paying for SPIs as part of E&M or psychotherapy visits is unduly restricting clinicians who should be able to order an SPI whenever a patient with elevated suicide risk is identified. Further limiting the provision of this service is the proposal that the same provider for the initial visit furnish the SPI. In practice, clinicians often utilize other clinicians in the care team for SPIs and other discharge planning. Clinicians on the care team such as APRNs and RNs often are the ones who have the ability and time to work through an SPI with a patient, building the critical trust relationship we discuss above. Last, CMS is limiting the creation of an SPI to 20 minutes, which just further, unnecessarily constrains clinicians working to ensure the safety of patients when they leave the care setting. **As such, ANA urges CMS not to finalize its proposals to limit how SPIs are billed, the duration of a reimbursable SPI encounter, and restricting which clinician provides the SPI to patients. CMS must allow**

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clinicians, such as nurses, to use their expertise and training to determine when to order an SPI and the time needed to appropriately conduct an SPI with patients.

7) **CMS must support nurse providers for social determinant of health screenings.**

CMS published a broad RFI regarding services addressing health related social needs. ANA would encourage CMS to add reimbursement to the SDOH Z codes. Currently, there is no reimbursement attached to the codes so practitioners might ask patients the questions, but there is no incentive to ask multiple times if patients do not answer questions the first time. Nurses remain the most trusted professionals,[4] but that trust takes time to build. **Reimbursing practitioners for SDOH Z codes would encourage nurses, and other practitioners, to return to the SDOH questions after patients have had time to get to know their nurses and there is a relationship between the nurse and the patient.** This relationship is tantamount as patients may be more open with their nurse and more willing to answer questions.

CMS also seeks input on what auxiliary personnel that are not adequately captured in current coding and payment structures. This is particularly important for the provision of Community Health Integration (CHI) services. ANA urges standardization of SDOH screening and recognition of the nurse as part of all care teams. We urge CMS to make explicit that RNs, who are currently identified as auxiliary personnel in the healthcare billing structure, be included in any approach to assess for SDOH. RNs' scope of practice encompasses holistic, patient-centered care and are best situated to conduct SDOH risk assessments to capture each individual patient's needs and conditions. In practice for CHI services, often other physician and nonphysician personnel lack the education, training, and dedicated time. Whereas, RNs have all three and are especially trained and adept at working with non-licensed staff and cross continuum care making them critical in leading the care team for CHI services.

Moreover, we encourage CMS to not only include them as billing providers for these assessments but remove any regulatory barriers such as supervision requirements. Nurses are best positioned to build the critical relationships with patients needed to identify and determine SDOH barriers—and have the clinical expertise and training to create appropriate care plans that seek to address those barriers and needs. **As such, as CMS considers services addressing health related social needs, ANA encourages the agency to make explicit the RN role in conducting SDOH assessments.**

8) **CMS must finalize its proposal to reimburse OTPs for SDOH assessments and recognize the role of the nurse in identifying patient risks and barriers.**

CMS proposes to reimburse OTPs at the non-facility fee to conduct SDOH health risk assessments to identify any unmet patient needs. CMS is right to propose this to ensure any barriers and challenges that could jeopardize a patient's successful enrollment and completion of an OTP program are identified from the onset of care. ANA urges the agency to finalize its proposal to support and resource this important patient service. However, we also urge that CMS make sure the important role of the nurse is reflected in the final parameters of how providers are reimbursed. As we note above, nurses training and education keep them central in building the needed

[4] *Ethics Ratings of Nearly All Professions Down in U.S.* Megan Brenan and Jeffrey M. Jones. https://news.gallup.com/poll/608903/ethics-ratings-nearly-professions-down.aspx. Accessed August 13, 2024.

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relationships with patients that allow for real assessment and determination of SDOH risks and barriers.

ANA also encourages CMS to allow for unit billing for these assessments. Identifying SDOH risks and barriers is too critical to patient care to constrain this service to a set time. As we note above, often it takes patients time to establish the trust needed to share any barriers they face. RNs must be reimbursed for these critical services for the time it takes to furnish these services.

ANA appreciates CMS' proposals to continue to address SDOH, especially for vulnerable patient populations such as the one served by OTPs. **As such, we encourage the agency to finalize its proposal to provide reimbursement for OTPs conducting SDOH risk assessments and encourage the agency to structure the reimbursement to most adequately support the nurses who are critical to ensuring patients are appropriately screened.**

9) **CMS must finalize its proposals related to reimbursing G2211 with other preventative services.**

CMS has monitored the use of G2211 and proposes to allow billing of G2211 on the same day as with other preventative services. **ANA strongly supports this proposal and believes that it will greatly improve the take-up of these preventative services.** For the past year, patients required additional visits with their practitioner to receive some of these preventative services as they were not reimbursable on the same day as G2211, and that is detrimental to public health. Patients do not have unlimited time to visit their practitioners, and depending on their profession the time taken to visit their practitioner might be unpaid. Allowing the two services on the same day eliminates these concerns and allows patients to receive all of their care, preventative and otherwise, during one encounter. This will also improve efficiency as office personnel will not have to figure out the purpose for the visit and then encourage the patient to return for a follow-up visit.

10) **CMS should finalize their Enhanced Care Management proposal.**

CMS proposes to adopt coding and payment policies to advanced primary care management (APCM) services when the practitioner is the focal point for all needed health care services and responsible for primary care. APRNs, specifically certified nurse midwives (CNMs), NPs and CNSs will be some of the practitioners who are the focal point and provide primary care to Medicare beneficiaries and will be among the most common users of these codes. ANA thanks CMS for specifically including APRNs in the list of practitioners who will be reimbursed for enhanced care management.

In order to reimburse clinicians for the work they are doing under this new system, CMS proposes to create three new G codes depending on the complexity of the care for the patient. ANA strongly supports these new codes as they can accurately be used to show the unique work that is being done for these patients. ANA also agrees with CMS that these codes should be reported once per month per patient as the practitioner and not be time based but has concerns about the valuation of the codes.

ANA has concerns that the values are not commensurate with the work that is being done. This could discourage clinicians from even talking to their patients about enhanced care management and result in less take up of the program than intended. Additionally, APRNs receive

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only 85% of the reimbursement that physicians receive for the same work which can occasionally lead to APRNs avoiding certain procedures for business reasons which only hurts patient care. In some areas of the country, NPs make up a significant proportion of primary care practitioners and CMS should encourage them take part in this program. Increasing the reimbursement for the G codes is an excellent way to encourage NPs, CNSs, and other non-physician providers, to take part in this program.

ANA supports CMS' proposal that the practitioner be responsible for the patient's primary care and be the focal point for their health care services. Having one practitioner be the lead will reduce mistakes and lead to more efficiency. The lead practitioner will have access to all of their patient's information at all times and can then make sound decisions based on that information as opposed to some cases today where practitioners do not have their patient's full medical information and can make mistakes because they do not have the full information, There are many practitioners who will take the time and ensure that they have all of their patient's information, but that takes time, and in some cases money, which results in lower efficiency and poor use of time by both practitioners and auxiliary personnel.

CMS proposes that not all of the elements in the enhanced care are required for the practitioner to be reimbursed for the G code. ANA supports this proposal as the needs of the patient might change from month to month and the elements of the code do not. There might be months where the practitioner spends very little time with the patient, and there may be months where the practitioner spends more time with the patient, but the standard amount provides certainty for both the patient and the practitioner. Additionally, the practitioner will not feel the need to "check the box" and perform all the elements of the code just to be sure they are reimbursed. This saves everyone time as the practitioners will spend their time treating patients who need help instead of wasting time filling elements of codes that are not necessary.

ANA also agrees with the different levels of enhanced care being used. Practitioners think in these terms as E/M codes also start with level one and then become more complex as the number rises. ANA does not believe that there will be confusion between this and other coding structures as the proposal clearly delineates where the lines between levels one, two, and three occur, but as previously stated, does think that there needs to be separate reimbursement for the SDOH Z codes that nurses will ask their patients about to determine if the patient is in category two or three.

a) *CMS should finalize the elements of the Enhanced Care Management codes with minor exceptions*

ANA agrees with the elements of the codes and thinks that they quantify for the work well. The elements themselves show that, other than possibly the first visit, it would be nearly impossible to perform all the elements every month as initiation visits and care transitions are not necessary every month. Depending on the patient, care transitions might almost never be necessary.

ANA strongly agrees with the need for consent from a patient to take part in these programs. While these are excellent ideas, there are times where patients want to retain control of their healthcare and the need for consent allows this to happen. ANA would urge that CMS require that consent be written, and depending on the health of the patient, maybe require an additional signatory. This would both show that the patient really does want the care and help ensure that the practitioner is not taking advantage of a patient who might not understand what is being offered.

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ANA would suggest that CMS should modify the requirement for 24/7 availability. ANA does not oppose 24/7 care but, does believe that depending on the hour of the day, a reasonable amount of time should be allotted to respond to patients. For example, if the practitioner is asleep, they need enough time to wake up and review the patient's charts before speaking to them. ANA would also suggest that if the practitioner is unreachable, then a previously agreed upon alternate should be allowed to respond to the patient.

There are a number of required care elements in the plans, and ANA agrees that all these are necessary elements for care and should be included in any final proposal.
CMS proposes a patient-population level management element for the service. While ANA supports the proposal, ANA would want to ensure that the work already being performed by nurses can count as this element. The element looks for gaps in care or risks to the patient's wellbeing. Much of this work is being done by nurses when they talk to patients and ask about SDOH. While it may take time to reach the answers, the bonds that nurses forge with their patients are an integral part of care and that should be accounted for in this element.

b) CMS should ensure that duplicative services in Enhanced Care Management are not expanded to the extent that clinicians will not enroll in the program

In chart 22, CMS provides a list of CPT codes that are substantially duplicative to the services being provided. As a result, CMS proposes that practitioners should not be reimbursed for these services if they are provided during the same month as the APCM services. ANA does not oppose this list of codes and services but believes that CMS should be extremely careful in adding services that will not be reimbursed separately. While these codes are essentially covered in APCM, there are many codes that have some elements covered by APCM services and some elements that are not covered. ANA would like to ensure that CPT codes with elements not covered by APCM services are not included in the APCM bundle as practitioners would either not provide the necessary services knowing they would not be reimbursed for it, or risk being investigated for fraud if they provide the service elements not included in APCM and then submit for separate reimbursement.

11) CMS must ensure that Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) are adequately reimbursed for their work.

RHCs and FQHCs serve a vital role in the health care system, but they are sometimes not reimbursed properly for their work. ANA strongly supports the continued work of these institutions and offers the following comments.

a) CMS must align payments under one payment system

CMS is seeking comment on how to improve transparency and predictability regarding which HCPCS codes are considered care coordination services. **ANA would suggest that any services which are partially paid for under the PFS and partially paid under RHC or FQHC payment rates be considered care coordination and therefore should be reimbursed under one payment system.** ANA does not have a position as to which payment system should be used for reimbursement, but strongly urges CMS to choose one payment system and use it throughout Medicare.

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Having only one system for payment will lower overhead costs and will, therefore, save administrative time and money. With costs rising across the healthcare system, and nationwide, the ability to save money is key to practitioners being able to continue to provide the necessary care, especially in rural and remote areas.

Having only one set of rules for telehealth will also allow practitioners to provide remote care instead of having to worry if the care is reimbursed and under what circumstances. Telehealth has been a great boon to those in rural areas where there are few practitioners, and even fewer specialists. Physicians have largely been congregating in urban areas and NPs are attempting to fill the gap in rural areas. There are some rural areas where NPs provide significantly more than half of primary care and a significant amount of specialty care as well. The ability of these practitioners to see patients and not have to worry about whether it is reimbursable depending on the payment system will help make running practices and seeing patients significantly easier for these practitioners.

Only using one payment system provides predictability and also reduces stress for the practitioner. Knowing how they will be reimbursed means that the practitioner will not have to take the time to figure out which payment system to use and the time saved in this manner can be used to treat patients.

Practitioners are well aware that there are different payment systems and sometimes will be reimbursed in different ways, but when there is a question as to which system is used, it results in wasted time trying to figure out which is the proper system, and then, if the wrong system is billed, there could be additional time spent trying to fix the mistakes that were made.

b) *CMS must extend the telehealth flexibility allowing remote direct supervision in RHCs and FQHCs.*

CMS proposes to extend the COVID-19 PHE flexibility and allow remote direct supervision in RHCs and FQHCs as long as the supervising practitioner is immediately available. **ANA supports this extension and believes that telehealth is vital to our nation's health.** This is even more true in rural areas where there is a shortage of practitioners and patients may face physical distances and barriers making it difficult to access needed care. Requiring the supervising practitioner to be physically present would delay care in many instances. Furthermore, ANA agrees with CMS that this supervision requires audio/video technology. The supervising practitioner must be able to see what is happening for them to accurately supervise what is occurring virtually.

12) <u>CMS must continue reimbursement for preventative vaccines and administration.</u>

Vaccines are a vital part of our nation's health. Vaccines improve population health including for frontline nurses at the point of care. CMS reimburses practitioners for a number of vaccines, but the list does not cover all available vaccines. **ANA urges CMS to reimburse practitioners for all necessary vaccines including those necessary for possible future pandemics.**

a) *CMS continue vaccine reimbursements and reimburse for all vaccines*

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CMS currently reimburses practitioners for administering a variety of different vaccines. ANA thanks CMS for this reimbursement and for tying the reimbursement to the Medicare Economic Index (MEI). Costs for these vaccines are constantly rising and the annual adjustments allow practitioners to offer these vaccines without having to weigh the public health of vaccination against the costs of running a business.

Medicare does not cover Mpox at this time, and cases of this virus are once again rising. If Medicare covered this vaccination, and any possible boosters, it would greatly increase the percentage of the population who are vaccinated against Mpox and help provide a more robust defense to the spread of the dangerous virus.

b) Expand Hepatitis B Vaccine Coverage

ANA continues to strongly support vaccine access for all individuals.[5] CMS' proposed expansions to hepatitis B vaccine (HBV) access is an exciting and critical advancement for the Medicare program. This expansion brings Medicare into alignment with current clinical guidelines and follows the recommendations of the Advisory Committee on Immunization Practices (ACIP).[6]

CMS proposes changing how Hepatitis B vaccinations can be ordered by eliminating the need for a physician to determine the patient's vaccination status. APRNs are fully qualified to determine vaccination status and ANA fully supports the proposal to allow non-physicians to determine vaccination status. ANA also strongly agrees with CMS that a physician order is not required for HBV to be covered, again aligning with current evidence. This means patients will be able to more easily access vaccines through pharmacies and their APRNs. Adding HBV to the list of vaccines covered at 100 percent reasonable cost for rural health clinics (RHCs) and federally qualified health centers (FQHCs) will help alleviate barriers for these especially underserved populations. CMS' changes to HBV will increase parity for provider reimbursement and decrease barriers for patients across the Medicare program.

c) CMS must reimburse clinicians in the proposed fee schedule for drugs covered as additional preventative services (DCAPS)

CMS proposes a fee schedule for the newly created DCAPS category based on existing Medicare Part B drug pricing mechanisms. CMS' reasoning is that this keeps drug pricing consistent through fee schedules. Additionally, CMS proposes to reimburse clinicians for administration and supply costs using the current pricing mechanism. **ANA agrees with this reasoning as it reduces confusion and supports the creation of the new schedule and pricing mechanism.**

d) CMS must cover Mpox vaccinations

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[5] American Nurses Association, *Position Statement: Immunizations*, Updated May 9, 2023, available at: https://www.nursingworld.org/~499e0b/globalassets/docs/ana/final-immunizations-position-statement-nov-2021updated050923.pdf.

[6] Mark K. Weng, et al., *Universal Hepatitis B Vaccination in Adults Aged 19–59 Years: Updated Recommendations of the Advisory Committee on Immunization Practices — United States, 2022*, Centers for Disease Control and Prevention, available at: http://dx.doi.org/10.15585/mmwr.mm7113a1.

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As previously stated, mpox vaccinations are not currently reimbursed by Medicare. **ANA strongly encourages CMS to reimburse clinicians for these vaccinations and would also urge the creation of a g code to track and then reimburse for these vaccinations.** Within the last few years, COVID-19 vaccinations were added to the list of reimbursable vaccinations and that demonstrates the precedent that CMS has the authority to add vaccines to the fee schedule.

13) **CMS should implement proposals to streamline the Medicare Diabetes Prevention Program.**

ANA continues to support the Medicare Diabetes Prevention Program (MDPP) as an evidence-based behavioral intervention accessible to patients as a preventative service. ANA agreed with CMS in last year's proposed rule that the program should be fee-for-service. The proposal this year to remove the bridge payment aligns with the move to fee for service and ensures clinicians are paid for each session. CMS also proposes this year to update the MDPP to match the 2024 update to CDC's Diabetes Prevention Recognition Program (DPRP).[7] ANA supports the integration of CDC's standards and applauds the collaboration between agencies in order to create the highest quality program with the most current data. As nurses are key to patient education and coaching, they remain critical for the success of the MDPP, nurses remain overburdened with reporting which directly impacts time spent with patients. **ANA agrees that streamlining data reporting by aligning with the DRPR is an important step and encourages CMS to continue investigating ways that coaches can spend more time counseling and less on administrative burdens.**

Additionally, the continued flexibilities drawn from the COVID-19 PHE are important to ensure access and success for patients. The option to self-report weight at check-ins during synchronous video or time stamped photos will keep patients on track even if they are physically far from their provider or have a schedule change. Similarly, the makeup sessions allowed on the same scheduled day supports consistency which is critical in weight loss programming. The change to use CPT modifier 79 to prevent a rejection of this claim both reduces unnecessary administrative burden and supports the lived experience of patients. **ANA also agrees with CMS that as Artificial Intelligence (AI) continues to grow in healthcare there must be a careful eye toward its improper use. AI simply cannot provide the back-and-forth trust-building conversation, problem solving, and planning of a coach in the MDPP.**

14) **CMS should continue to implement the Universal Foundation in the Medicare Shared Savings Program but must create processes to accurately count the impact of nurses.**

ANA strongly supports CMS' National Quality Strategy in order to advance health equity and increase the quality of health care delivery. The shift to truly person-centered, safe, quality care along the entire life cycle is an important and necessary step forward. The nursing profession is imperative to the success of the Strategy's eight goals. From advancing health equity to driving innovation, nurses are at the core of quality and safety.

ANA specifically applauds the Universal Foundation for streamlining quality measures to produce better data and free resources to solve core health inequity issues. The Universal Foundation's

[7] Centers for Disease Control and Prevention, *Diabetes Prevention Recognition Program: Standards and Operating Procedures*, June 1, 2024, available at: https://www.cdc.gov/diabetes-prevention/media/pdfs/legacy/dprp-standards.pdf.

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building block approach allows flexibility for different populations and care settings to see their specific equity and access gaps while reducing documentation burden. ANA firmly supports the proposed APM Performance Pathway (APP) Plus quality measure set as it incrementally incorporates the Adult Universal Foundation measure set over the next three years. Additionally, the implementation of the Digital Quality Measurement Strategic Roadmap holds eCQMs as the gold standard and must be fully utilized to strike the correct balance. This balance between gathering the necessary data to improve care delivery and relieving documentation burden is critical for nurses as they are the ones implementing person-centered quality measures. Nurses are the frontline of patient care, watching for clinical changes or deterioration, coordinating care with other providers, and counseling patients and their family on treatment plans, all while balancing administrative burden. Providing equitable care to patients has long been an ethical imperative for the nursing profession and again, it will be RNs implementing CMS' important health equity measures. As nurses coordinate care and coach their patients, they are best positioned to identify the most common socioeconomic and sociodemographic barriers their patients face. Nurses are key partners in CMS' effort to ensure that quality measures truly capture the needs of all patients and provide the highest quality care for the best value.

However, the current payment policy still does not account for the value of RNs and their impact on patient outcomes. ANA encourages CMS to look for ways to properly recognize the value of nurses and ensure adequate compensation for nurses and their employers. CMS must collect data to show the impact of nursing care on patients, reflect the role of the nurse in identifying and addressing health disparities, and ensure both RNs and APRNs are recognized and captured within quality programs and value-based care more broadly. For example, in last year's Fee Schedule, CMS updated its methodology to ensure patients that utilize APRNs for primary care can also be assigned to an ACO. **ANA urges CMS to continue finding ways to remove outdated restrictions within the statutory limitations that exist and work with Congress to expand access to high-quality APRN care.**

15) **ANA applauds CMS' proposals to invest in ACOs and the healthcare workforce in the prepaid shared savings program.**

ANA encourages CMS' work in the Shared Savings Program to further advance Medicare's value-based care strategy of growth, alignment, and equity. The focus on primary care is especially critical as robust primary care reduces adverse outcomes and the growing role APRNs play in filling primary care deserts across the country.[8] Rural and underserved areas continue to face substantial barriers to primary care, increasing emergency room overcrowding and health inequities. To meet CMS' goal of all Medicare beneficiaries in an accountable care relationship by 2030, there must be removal of outdated barriers for APRNs and investments that set ACOs up for success when facing underserved populations. NPs are naturally trained to provide coordinated care, which is the basis for ACOs. Also, **ANA strongly supports the proposed health equity benchmark to close an important gap for ACOs serving dual eligible beneficiaries.** As CMS notes, the start-up costs for ACOs are a main barrier and those dedicated to underserved communities need advance investment payments and the highest adjustments to be successful.

[8] Carol Davis, *Why Nurse Practitioners are a Solution to Rural Healthcare Challenges,* HealthLeaders Magazine, September 11, 2023, available at: https://www.healthleadersmedia.com/nursing/why-nurse-practitioners-are-solution-rural-healthcare-challenges.

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The nurse staffing crisis directly impacts the delivery of quality care, nurse burnout rates, and even workplace violence rates. ANA supports many approaches to achieving appropriate staffing, including the use of enforceable minimum nurse staffing ratios as an approach to reduce patient harm and improve quality outcomes and to ensure the creation of an optimal work environment that supports the recruitment and retention of nurses. However, strategies must be paired with payment investments. **ANA strongly supports CMS' proposal in this proposed rule to include advance investment payments to support a robust healthcare workforce.** Quarterly payments will allow leadership to continuously adjust as workforce needs vary greatly by region and setting. However, CMS must work closely with participating ACOs so as not to surprise an ACO with the recouping of funding as they launch this new initiative. ACOs need consistent support to advance holistic quality care and meet CMS' bold goals by 2030.

16) **ANA supports many proposals for the Quality Payment Program (QPP) but strongly disagrees with CMS removing the Personal Protective Equipment (PPE) improvement activity.**

ANA appreciates CMS' thoughtful proposals regarding the QPP. While we are generally supportive of the proposed provisions, we offer refinements below that urge the agency to ensure nurses' clinical expertise is central in all measures. At the same time, ANA is very concerned about CMS' proposal to remove the MIPS improvement activity of implementing a PPE plan. CMS must not finalize this proposal. Another lesson we must learn from the COVID-19 pandemic is full preparation for healthcare workforce safety. In the absence of a final COVID-19 Standard from OSHA and possible years of waiting for OSHA's final Infectious Disease Standard, there are not enough protections currently in place. I**t is dangerous to assume that PPE plans are being updated and implemented when nurses consistently reported lack of PPE or being forced to reuse PPE**.[9] Supply chain issues persist, and the strategic national stockpile is not currently equipped for another public health emergency. Data shows that reusable respirators are safer for healthcare workers and reduce costs in the long-term.[10] Yet reusable respirators are not included in the PPE improvement activity. CMS promises future improvement activities that enhance and maintain PPE plans. IA_ERP_4 should not be removed until CMS has an enhanced improvement activity to replace it. ANA strongly urges CMS to continually assess and account for nurses and healthcare workforce safety, as these needs are ongoing and far from obsolete.

a) Public health exchange measures

Public health nurses are a critical part of our healthcare infrastructure serving entire communities in many initiatives including health education, immunizations, opioid crisis response and much more.[11] Investments in quality public health infrastructure and data collection and necessary to

[9] American Nurses Foundation, *Personal Protective Equipment Survey Part 2*, August 2020, available at: https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/what-you-need-to-know/ppe-survey-2/

[10] Eric Toner, MD, et al., *The Major Role of Reusable Respirators in Increasing Respiratory Protection for Future Infectious Disease Emergencies: A Stakeholder Discussion*, Johns Hopkins Bloomberg School of Public Health: Center for Health Security, April 25, 2024, available at: https://www.centerforhealthsecurity.org/sites/default/files/2024-07/2024-07-reusablerespirators.pdf

[11] American Nurses Association, *Public Health Nursing*, available at: https://www.nursingworld.org/practice-policy/workforce/public-health-nursing/.

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support the necessary work of public health nurses. ANA supports CMS' proposal to include public health clinical data exchanges under the Promoting Interoperability Performance Category for MIPS clinicians. Nurses have uplifted many hard lessons learned during the COVID-19 pandemic including how public health data had long lags and was generally dyssynchronous impacted their response ability and led to mistrust in institutions. We simply must implement better practices now in order to prepare for future public health emergencies. The data collection proposed in this rule is an important step in this direction. As we know nurses are the ones implementing reporting and building the relationships of trust necessary with patients, working with public health nurses will determine the success of these measures as they coordinate with all levels of public health agencies and their communities. ANA urges CMS to work with the Council of Public Health Nursing Organizations in developing these measures and further work on strengthening public health data and processes.[12]

b) Patient-Reported Outcome Measures

As previously stated, nurses are integral to quality measures due to their trust building, education, and care coordination with patients. The conversations necessary to patient-reported outcome measures (PROM) and patient-reported outcome performance measures (PRO-PMs) lie directly within the nurse expertise especially when driving reductions in health inequities. Providing equitable care to patients has long been an ethical imperative for the nursing profession. Nurses embrace diversity and engage in equity focused care, while working to remove unconscious biases to effectively promote meaningful patient outcomes. Ultimately, nurses are key in designing, directing, and delivering care that appropriately meets the needs of patients, improves access to needed care, promotes positive outcomes, and reduces disparities.

The value and impact of PROMs is clear, but each facility currently has its own capacity, process, and definitions. These measures must have support for implementation and a connected strategy.[13] The proposed principles of Feasible Implementation, Accessible, and Patient Engagement should lead the additional principles as they determine the success of PROMs. As nurses set the gold standard in PROM and PRO-PMs, CMS must work with nurses to finalize the universal principles in this proposed rule. Nurses are already implementing frameworks that directly increase responses and CMS must incorporate these findings in their final principles.[14] ANA encourages CMS to utilize nurse feedback on conditions specific PROMs, such as consulting Psychiatric Mental Health Nurses (PMHN) for Inpatient Psychiatric Facilities and the techniques collecting and utilizing PROMs in their practice.

c) New measures and new improvements

ANA agrees with CMS adding a new COVID-19 vaccination status measure as this will continue to build resilience for the next public health emergency. Data has proven to be critical for public health nurses and the entire nursing workforce when responding to rapidly evolving infectious

[12] Council of Public Health Nursing Organizations, available at: https://www.cphno.org/.
[13] Stine Thestrup Hansen, et al., *Nurses' Experiences When Introducing Patient-Reported Outcome Measures in an Outpatient Clinic: An Interpretive Description Study*, Cancer Nursing Journal, March 2021, available at: https://pubmed.ncbi.nlm.nih.gov/32217877/.
[14] Jennifer Woody, et al., *Use of Patient-Reported Outcomes: Rationale and Clinical Implementation*, The Journal for Nurse Practitioners, February 16, 2022, available at: https://www.npjournal.org/article/S1555-4155(22)00005-8/abstract

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diseases. As mentioned above, ANA remains firmly committed to utilizing vaccines to eliminate preventable diseases and urging all individuals to receive vaccines in accordance with the best and most current evidence.

Nephrology nurses are dedicated to their patients but especially to ending the disparities in transplant access for their patients with End-Stage Renal Disease (ESRD). ANA supports CMS' proposed new measure addressing these disparities by collecting transplant waitlist data. There are stark racial and ethnic disparities in access to kidney transplants.[15] CMS must work directly with nephrology nurses who have on the ground knowledge of these impacts on their patients. Data collection will be coming from these nurses but there must be follow up to collect their feedback on solutions or disparities will remain.

ANA also supports CMS' proposed new improvements to create feedback loops with specialists. As stated above, APRNs are playing a larger and larger role in primary care and the CNS workforce is also growing. APRNs are specially trained in holistic care and utilizing this expertise will improve quality patient centric care. It is up to CMS to gather this unique input and scale up interventions across its programs.

17) <u>CMS must finalize proposals to expand colorectal cancer screening.</u>

ANA supports CMS' expanded coverage of colorectal cancer (CRC) screening as this disease is on the rise, especially in rural and underserved communities. Access points such as following the critical guidance of the U.S. Preventive Services Task Force (USPSTF) and their application of a Grade A for this preventative service means patients can get the screening as there is no cost sharing. There must be constant updates according to the best and current evidence, so ANA agrees with the removal of the barium enema coverage as this aligns with direct feedback CMS has received from on the ground stakeholders. Finally, ANA thanks CMS for continuing to include NPs and CNSs in the language as they represent critical access points for underserved communities and provide high-quality care including CRC screening.

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Thank you for the opportunity to submit comments on this proposed rule. If you have any questions, please contact Tim Nanof, Vice President, Policy and Government Affairs, at tim.nanof@ana.org or (301) 628-5166.

Sincerely,

Debbie Hatmaker

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cc: Jennifer Mensik Kennedy, PhD, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, ANA Chief Executive Officer

[15] American Kidney Fund, *Access to Kidney Transplants*, available at: https://www.kidneyfund.org/kidney-health-for-all/kidney-transplants.

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