August 30, 2022

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically to www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts [CMS-1770-P]

Dear Administrator Brooks-LaSure:

The American Nurses Association (ANA) appreciates the opportunity to provide comment on the Centers for Medicare & Medicaid Services' (CMS') proposed federal fiscal year 2023 Physician Fee Schedule (PFS). ANA applauds the agency's continued focus on health equity and other provisions that promote access and quality in the health care system, as seen in the proposed provisions of the above-captioned rule. However, ANA continues to urge CMS to ensure the value of the nurse and nursing services are reflected adequately and appropriately in the PFS. As the agency determines which provisions to finalize for the CY 2023 PFS, through this comment letter we urge CMS to:

1) **incentivize nurse pay in proposals to update clinical labor pricing;**
2) **support access to and payment of services provided through telehealth technologies;**
3) **accept CPT recommendation for cognitive behavioral therapy monitoring;**
4) **strengthen access to behavioral health care services, substance use disorder treatment, and chronic pain management;**
5) **support provider participation and health equity in the Medicare Shared Savings Program;**
6) **refine and develop quality measures that appropriately capture nursing care, screen for social determinants of health, and other provisions that result in improved patient outcomes and provider payment strategies; and**
7) **continue to seek key stakeholder engagement on the potential of designating intermediaries to collect and report on continuing education activities in the MIPS program.**

ANA is the premier organization representing the interests of the nation's over 4.3 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and 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. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full

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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.

Nurses are clinicians critical to a robust health care system able to meet the needs of patients and are vital to ensuring the provision of quality care that leads to better health outcomes for all patients. Moreover, nurses are critical to coordinated care as 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. Nurses also reflect the people and communities they serve—allowing them to recognize the challenges faced by their patients and ensure that their patients receive culturally competent, equitable health care services.

1. **CMS must incentivize nurse pay in proposals to update clinical labor pricing.**

ANA thanks CMS for the agency's recent work in updating clinical labor pricing. Nurses and other non-physician providers (NPPs) have been drastically undervalued for many years and this update sheds light on the value that nurses bring to the healthcare system. However, as updates to practice expense (PE), it is likely that physicians or hospitals will be the direct beneficiaries, rather than NPPs. We urge CMS to address clinical labor rates in a way that benefits NPPs more directly.

Addressing NPP pay could help alleviate staffing shortages. Specifically, nurses today feel overworked and underpaid[1] and the pricing update is one way that CMS could encourage increases in nurse pay which would help both in nurse recruitment and retention of current employees. The raising of the clinical labor rates should not be seen as a windfall to either the physician or the hospital.

Therefore, ANA encourages CMS to amend the clinical labor pricing update and pass some of the increase to NPPs as compensation for their work. Nurses and other NPPs do critical work and provide care that is not provided by physicians. Without these providers, patients would not receive the quality care that nurses provide in all patient settings.

In particular, ANA has concerns about table 5 in the proposed rule. That table lists registered nurses (RNs) as their own category for labor pricing, but then also includes RNs in eight other categories of clinical labor with other practitioners. These providers are generally related to nursing but are not necessarily RNs. This raises the question of where the clinical labor of the RN is included. ANA recommends having RNs identified uniquely and removing the RN option from the other categories. Leaving RNs in other categories would only make the clinical labor update more confusing and, as some of the categories are reimbursed at a lower rate than the proposed RN rate, it could end up disadvantaging RNs in the long term. This could exacerbate the current staffing shortage and worsen patient care.

2. **CMS must support access to and payment of services provided through telehealth technologies.**

ANA supports the telehealth waivers that have been in place since the beginning of the COVID-19 public health emergency (PHE) and believes that these waivers should continue to be extended. Currently,

[1] Murthy, V. Confronting Health Worker Burnout and Well-Being. 2022. https://www.nejm.org/doi/full/10.1056/NEJMp2207252?query=featured_home (Accessed August 25, 2022).

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many of the waivers are subject to rolling PHE extensions which are creating unnecessary uncertainty in practice. ANA believes that use of these waivers has led to better patient outcomes.[2] Primary care is one area where telehealth waivers should be extended, so that patients can access their primary care providers, including APRNs, for brief visits as appropriate. Additionally, for patients who have mobility concerns, ending telehealth access could be a disincentive to see their practitioner, which could result in worse health outcomes.

ANA also supports CMS' decision to continue with the telehealth flexibilities for an additional 151 days after the end of the PHE. ANA supports extending the flexibilities past that date and believes that the current proposal is a good start. Additionally, ANA believes that the flexibilities should remain in place until the end of all current PHEs. The proposed rule would end the telehealth flexibilities 151 days after the end of the COVID-19 PHE, but the current Monkeypox outbreak has led to the declaration of an additional PHE. The flexibilities should remain in place until the end of all current PHEs and not just the original COVID-19 PHE.

ANA is aware that there are broad swaths of the country where broadband technology is either unreliable or unavailable. However, this is not reason alone to remove telehealth as an option for patients. The CPT code set includes telephone-only encounters, which can be appropriate for patient's simple questions. ANA agrees with the agency that, if the issue is more complicated, it is best for patients to be evaluated in-person.

Moreover, ANA supports CMS' proposal to add additional procedures to category 3 of the telehealth list. This will give providers and CMS time to determine if these procedures can typically be performed remotely and whether they should be added to either category 1 or 2 on a permanent basis. Specifically, ANA strongly supports placement of telephone E/M codes into category 3 as many nurse practitioners are in primary care or in positions where they see patients requiring these codes.

CMS is proposing to add three G-codes to the Medicare telehealth list as category 1 codes. ANA supports the addition of these three codes as category 1 codes and thanks CMS for specifically including NPPs in the code descriptors.

CMS generally requires that telehealth have audio and visual components with the exception of mental health visits. ANA supports this exemption and even though video capability is beneficial in mental health cases, there are times when that is not an option, and the key component of many mental health visits are the conversations between the practitioner and patient.

3. **CMS should accept the recommendation to have the remote therapeutic monitoring: cognitive behavioral therapy monitoring (CPT code 989x6) be contractor priced.**

In its October 2021 meeting, the CPT Editorial Panel created CPT code 989X6 and deleted two existing category III codes. In the following Relative Value Scale Update Committee (RUC) meeting, in January 2022, societies presenting at the RUC commented on how the technology is quickly evolving. Additionally, there were no invoices presented that could be used as a basis for reimbursement. As a result, the RUC panel recommended that CPT code 989X6 be contractor priced. CMS proposes to accept this recommendation and states that there is no professional work involved in this code and is PE only.

[2] Albritton, J. Video Teleconferencing for Disease Prevention, Diagnosis, and Treatment. 2022. https://www.acpjournals.org/doi/abs/10.7326/M21-3511?journalCode=aim (Accessed August 25, 2022.)

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ANA supports this recommendation but believes that this code may have to be reviewed again in the coming years as the technology stabilizes.

4. **CMS must finalize proposals that strengthen access to behavioral health care services, substance use disorder treatment, and chronic pain management for beneficiaries.**

CMS is proposing to amend the direct supervision requirements under "incident to" regulations and allow furnishing of behavioral health services under general supervision. ANA strongly supports this proposal and believes that Medicare should not restrict clinicians from practicing to the full extent of their license—which only results in better care provided to patients.[3] As such, ANA urges CMS to finalize its proposal to amend the direct supervision requirements.

CMS also proposes several provisions related to substance use disorders and opioid treatment programs (OTPs). ANA urges the agency to finalize proposals that would provide better payment for OTPs through billing for alternative sites and better reflection of counseling services. The association also encourages CMS to adopt its proposal to pay for the initiation of buprenorphine through telehealth technologies. Nurses understand the importance of these technologies to reach patients—especially in rural and underserved areas. The ongoing opioid epidemic has real and severe impact on beneficiaries and ANA supports CMS action to strengthen access to care.

Last, ANA urges the agency to support beneficiary access to all methods of chronic pain treatment and management—including alternatives to oral opioids. Nurses, given their role in the health care delivery system and relationship with patients and their families, understand the importance of and are integral to that access by leading coordinated care approaches for beneficiaries, including coordinating chronic pain management. Specifically, CMS is proposing to bundle certain payments for chronic pain management and treatment to recognize team-based approaches for beneficiary care. ANA supports CMS' proposal to bundle these payments and encourages the agency to fully recognize the role of the nurse in these approaches, including person-centered planning and other care coordination tasks. This is especially important if the agency incorporates health literacy and other patient-specific care plans to the bundles. Nurses are critical to ensuring patients are fully informed by educating and advocating on behalf of patients as they navigate care provided to them.

5) **CMS must support provider participation and health equity in the Medicare Shared Savings Program.**

CMS is proposing several provisions aimed at increasing provider participation in the Medicare Shared Savings Program Accountable Care Organizations (ACOs). As a payment model, ACOs seek to recognize the provision of high-quality care and positive outcomes achieved through coordinated approaches by physicians, APRNs, RNs, and other health care providers. However, initial participation in these models can be prohibitive for rural providers and other providers with more restricted financial resources. These providers need support that allows greater participation in ACOs and other shared savings models that result in additional resources for patient care with time. CMS is right to recognize this and propose support for greater provider participation in these models. Additional resources resulting from model participation can provide better patient-centered care coordination through hiring additional clinicians to care teams, such as nurses. Further, additional resources and addressing patients' needs outside of

[3] Birch, K. Psychiatric Nurse Practitioners as Leaders in Behavioral Health Integration. 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7525267/ (Accessed August 25, 2022).

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care facilities, such as food and housing, which is critical to reinforcing patient-centered care approaches and addressing health equity challenges.

As noted above, nurses are key in coordinated care approaches that lead to better quality care for patients and are best able to recognize the socioeconomic and sociodemographic barriers faced by their patients. As such, ANA strongly supports policy changes that reward clinical care that drives desired health quality outcomes. While ANA urges CMS to finalize provisions that support provider participation in ACOs and other shared savings care models, the association continues to urge CMS to adopt attribution models that recognize all clinicians involved in patient care in ACOs and other payment models. Recognizing all eligible individuals for shared savings and payments would better serve the key goals of accountable care to improve the delivery of care and achieve better health outcomes.

6) **CMS must continue to refine and develop quality measures that appropriately capture nursing care, screen for social drivers of health, and other provision that result in improved patient outcomes and provider payment strategies.**

a) **ANA Supports Addition of New Measures in the Quality Payment Program.**

ANA generally supports CMS' ongoing refinement and development of measures in the Merit-based Incentive Payment System (MIPS) Quality Payment Program and other programs. We believe the inclusion of measures that capture nursing care components will lead to improved valuation methods and payment strategies. For instance, many value-based payment arrangements reward outcomes to which RNs contribute significantly through care coordination and patient education. Yet RN value added is not accounted for transparently in payment policy.

Nurses are leaders in implementing processes that further quality patient care and highlight existing opportunities to address gaps in care delivery, leading to measurable improvements. As the agency looks to identify areas in care delivery that result in or exacerbate health disparities, we encourage CMS to consider the care that nurses provide that support quality and equity goals for all settings.

b) **CMS Must Finalize Proposed Additions to Screen for Social Determinants of Health.**

ANA especially appreciates and urges CMS to finalize the proposed addition of the Screening for Social Drivers of Health measure. This measure would capture the extent to which adult patients are asked about their social needs, e.g., food, housing, transportation, which are found to drive health outcomes. The task of conducting screening for social drivers of health is appropriate for nurses in any setting. We support the addition of this measure and related measures in MIPS.

However, we encourage CMS to monitor and study implementation to gain a profile of clinical practices that report on the measure, who within the practice is performing the screening itself, and to identify potential implications for promoting team-based care. In addition, it would be useful to understand if the screening question for utilities is sufficient to capture access to telehealth modalities. We also urge CMS to consider adopting the Screening Positive version of the measure for MIPS, and to develop a companion measure to document if the practice coordinates care based on patient responses, e.g., connecting patients with community resources.

c) **CMS Must Finalize the Addition of the Adult Immunization Status to the Quality Reporting Program.**

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ANA also supports addition of the measure for Adult Immunization Status, which captures the percentage of adult patients who are up to date on several routine vaccinations, such as influenza, pneumococcal, and tetanus. ANA believes that it is imperative for everyone to receive immunizations for vaccine-preventable diseases, as vaccines are critical to infectious disease prevention and control.[4]

Given the role of nurses in vaccination efforts, ANA believes it is very appropriate for CMS to expand immunization reporting with the Adult Immunization Status measure. ANA's position statement on immunization calls on nurses to advocate for, educate, and advise patients to adhere to recommended vaccination schedules. Nurses are expected to explain individual risk and benefit as well as public health implications. Patients' fears and questions can then be acknowledged and answered with evidence-based information.[5]

Under the COVID-19 public health emergency, CMS and Medicare administration have been critical to public health efforts, by mandating provider vaccination and financing widespread immunization, especially in vulnerable populations. Quality measurement in this enterprise, along with public health surveillance, has played an appropriate part in efforts to slow the spread of COVID-19 and save lives. We believe it is appropriate to extend this partnership in public health to improve immunization rates overall in Medicare populations.

d) CMS Must Base Determinations of APM Participants on Individual-level Participation.

CMS requests comment on a potential transition to making quality payment determinations in all Alternative Payment Models (APMs) and Other Payer Advanced APMs based on Individual-level participation, rather than Entity-level. We strongly endorse this approach and urge CMS to consider the transition as soon as feasible. As suggested in the proposed rule, an Entity-level approach allows APM Entities to narrow their clinical participant list for the purpose of attribution or payment amounts. When this occurs, APM payments may fail to recognize the values of the full range of clinical expertise that drives high performance in original Medicare. ANA strongly agrees that recognizing all eligible individuals would better serve the key goals of accountable care, such as working together to improve care, health outcomes, and costs.

7) ANA Supports CMS Exploring Designation of Intermediaries to Report on CE, with Ongoing Stakeholder Engagement

ANA thanks CMS for soliciting information about the potential for streamlining collection of quality information related to clinician continuing education. As a preliminary matter, we request that in future discussions and rulemakings CMS use the broader term "continuing education (CE)," which covers non-physician clinicians such as APRNs who also report MIPS-relevant learning experiences to CMS.

ANA supports CMS' exploration of how CE accrediting organizations can serve as intermediaries for the purposes of capturing CE activity that meets MIPS specifications. Use of qualified intermediaries can potentially reduce clinician burden, supporting their educational activities and allowing them to focus on their patients. We support that goal.

[4]ANA. Immunization. Position Statement. 2021. Accessible online at https://www.nursingworld.org/~497165/globalassets/docs/ana/immunization-position-statement-062921.pdf]
[5] Ibid.

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Additionally, ANA would be pleased to join stakeholder organizations, including other nursing and APRN representatives, to inform a proposal as it is developed. Our in-house CE program leaders and our related entity the American Nurse Credentialing Center (ANCC) can contribute to this ongoing effort. The ANCC Nursing Continuing Professional Development (NCPD) Accreditation program is the leader in nursing professional development accreditation and has strategic partnerships with Accreditation Council for Continuing Medical Education (ACCME) and Accreditation Council for Pharmacy Education (ACPE) in its Joint Accreditation program. It will be critical for CMS to understand how nursing CE programs and accreditors currently manage their data about APRN and RN learners. Modifications might be required in order for chosen intermediaries to be effective in reducing administrative burdens on APRNs. We would be pleased for opportunities to learn more about how ANA can support this initiative.

ANA appreciates the opportunity to submit these comments and looks forward to continued engagement with CMS. Please contact Ingrida Lusis, Vice President, Policy and Government Affairs, at (301) 628-5081 or Ingrid.Lusis@ana.org, with any questions.

Sincerely,

Debbie Hatmaker

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cc: Ernest Grant, PhD, RN, FAAN, ANA President
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