August 27, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1807-P 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

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 the CY 2025 Medicare Physician Fee Schedule Proposed Rule.

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). APRNs are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds, and in all settings. As of 2021, over 250,000 APRNs treated Medicare patients and over 40% of Medicare beneficiaries received care from an APRN.[1] 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. In recognition of the importance of APRNs to our health care system, the National Academy of Medicine (NAM) *Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* report urged that "all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality, and value."[2]

We appreciate that this proposed rule recognizes the important care provided by APRNs. The continued focus of CMS to utilize the fee schedule to address health care inequities is an important shift in Medicare policy, and we support CMS as the agency continues these efforts. Included below are our comments on the specific provisions of the proposed rule.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Changes to the Medicare Telehealth Services List; Caregiver Training

We support the addition of the caregiver training services codes to the Medicare telehealth list with a provisional status for CY 2025. We agree that adding these services on a provisional basis will allow additional time for the development of evidence of clinical benefit, and further encourage their utilization by providers.[3] These services are integral to providing patient centered care by ensuring patients' caregivers are properly trained, which will increase adherence to the plan of care provided by an APRN or other health care provider.

[1] data.cms.gov MDCR Providers 6 Calendar Years 2017-2021.
[2] https://www.nap.edu/resource/25982/FON%20One%20Pagers%20Lifting%20Barriers.pdf
[3] 89 FR 61627

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS proposes to remove the frequency limitations on Medicare telehealth subsequent care services in inpatient and nursing facility settings, and critical care consultations. When adding certain services to the Medicare telehealth list, the agency has included certain frequency restrictions on how often practitioners may furnish the service via Medicare telehealth. This included a limitation of one subsequent hospital care service furnished through telehealth every 3 days, one subsequent nursing facility visit furnished through telehealth every 14 days, and one critical care consultation service furnished through telehealth per day.

During the COVID-19 public health emergency(PHE) the agency suspended these restrictions, and has subsequently exercised enforcement discretion. In the 2024 proposed fee schedule, CMS solicited comments from interested parties on how practitioners have been ensuring that Medicare beneficiaries receive subsequent inpatient and nursing facility visits, as well as critical care consultation services since the expiration of the PHE.

We believe that unnecessary telehealth limitations inhibit patient access and limit a provider's ability to meet individual patient's needs. Therefore, we support the agency continuing to pause its pre-pandemic restrictions. This will empower providers and their patients to determine how to best utilize these services. As the Agency assesses its telehealth regulations by considering the way practice patterns have changed, we strongly encourage CMS to consider the effect these arbitrary limitations may have on patient access to care. APRNs have the clinical expertise to determine when a patient requires an in-person examination, and we support policies which empower providers to make these clinical determinations.

Audio-Only Communication Technology To Meet the Definition of "Telecommunications System"

Currently, in § 410.78(a)(3), CMS defines "interactive telecommunications system" as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Throughout the COVID-19 PHE, the agency authorized the use of audio-only communications technology to furnish services described by the codes for audio-only telephone evaluation and management services and behavioral health counseling and educational services.

We agree with the proposal to align the regulations to allow interactive audio-only telecommunications technology when *any* telehealth service is furnished to a beneficiary in their home (when the patient's home is a permissible originating site).[4] This will empower providers to utilize their clinical judgment on the best modality to provide a patient with the care they need in the manner they choose to receive it.

However, we do not agree with the proposed requirements that a distant site physician or practitioner must be technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. This is not a statutory requirement and limits patient access to medically necessary audio-only services. Therefore, we support the proposal to include coverage of audio-only services with the elimination of the technological capability requirements.

It is important to recognize that improvements to telehealth coverage do not fully address the structural access issues across the health care system. Many patients who prefer an in-person provider visit, or do not have the ability or resources to utilize telehealth technology, continue to lack adequate access to a provider within their community. While the changes to audio-only coverage are an important step forward, we encourage the agency to continue to focus on removing barriers for patients and providers.

[4] Ibid

Distant Site Requirements

CMS proposes to extend its policy for telehealth practitioners to bill from their currently enrolled location instead of their home address when providing telehealth services from their home. We appreciate the recognition of the importance of this policy, and support the proposed extension through CY 2025, though we encourage the Agency to adopt this position as permanent policy. There are legitimate concerns for APRN personal safety, and privacy, if they are required to list their home address as the originating site. A 2022 Surgeon General's Advisory addressing health worker burnout highlights that "among health workers in mid-2021, eight out of 10 experienced at least one type of workplace violence during the pandemic, with two-thirds having been verbally threatened, and one-third of nurses reporting an increase in violence compared to the previous year."[5] The advisory also notes that "Among 26,174 state, tribal, local, and territorial public health workers surveyed across the country during March-April 2021, nearly a quarter (23.4%) reported feeling bullied, threatened, or harassed at work."[6] Therefore, it is important for the Agency to formalize a policy which protects providers, and offers alternative options to requiring them to report their home address as the originating site.

Direct Supervision Via Use of Two-Way Audio/Video Communications Technology

In this section, CMS proposes to address the policies governing direct supervision utilizing two-way audio/video communications technology. For the duration of the COVID-19 PHE, CMS amended the definition of "direct supervision" to include the virtual presence through audio/video real-time communications technology.[7] Prior to the COVID-19 PHE, the supervising health care provider's physical presence was required. Due to the needs necessitated by the pandemic, CMS permitted a supervising clinician to be immediately available through a virtual presence using two-way, real-time audio/visual technology for diagnostic tests, incident-to services, pulmonary rehabilitation services, and cardiac and intensive cardiac rehabilitation services.[8]

CMS subsequently extended these direct-supervision flexibilities through December 31, 2024 to align them with the conclusion of other PHE-related flexibilities.[9] Establishing the virtual presence flexibility for services performed by auxiliary personnel is an appropriate extension of this policy. We do not believe this direct-supervision flexibility policy should be extended to services performed by APRNs and other advanced practice providers who are able to directly bill Medicare for services.

We remain concerned with the extension of direct-supervision flexibilities related to 'incident-to' billing. 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 MedPAC in their June 2019 report.[10] MedPAC recommended "eliminating incident to billing for APRNs", which would "update Medicare's payment policies to better reflect current clinical practice."[11] The extension of this policy would likely exacerbate the overutilization of 'incident-to' billing and increase Medicare spending. A recent study published in *Health Affairs* found that in 2018, 19.9 million visits performed by NPs were billed 'incident-to' comprising 35.6% of visits performed by NPs.[12] As noted by the researchers, within administrative claims data a service performed by an NP, but billed 'incident-to' a physician, is indistinguishable from a service performed by the physician directly.[13]

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[5] New Surgeon General Advisory Sounds Alarm on Health Worker Burnout and Resignation | HHS.gov
[6] *Ibid.*
[7] CMS-1744-IFC
[8] Ibid
[9] Ibid
[10] jun19_medpac_reporttocongress_sec.pdf
[11] *Ibid.*
[12] oi: 10.1377/hlthaff.2021.01968 HEALTH AFFAIRS 41, NO. 6 (2022): 805–813.
[13] *Ibid.*

Valuation of Specific Codes

We appreciate the agency's continued attention to improving the PFS valuation process. In this section, CMS "continues to welcome feedback from all interested parties regarding valuation of services for consideration through the rulemaking process."[14] We share many of the concerns identified by the agency, including the RUC and specialty societies objections to the agency's authority to determine valuations. We also agree that "for many codes reviewed by the RUC, recommended work RVUs have appeared to be incongruous with recommended assumptions regarding the resource costs in time."[15]

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)[16] and MedPAC[17], call for better data and transparency to improve accuracy within the valuation process. Therefore, we respectfully request for CMS to 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.

Expand Colorectal Cancer Screening

CMS is proposing to expand and update the coverage for CRC screening to reflect the most up-to-date clinical guidelines by removing coverage for the barium enema procedure, adding coverage for computed tomography colonography (CTC), and expanding the existing definition of a ''complete colorectal cancer screening'' to include a follow-on screening colonoscopy after a Medicare covered blood-based biomarker CRC screening test (described and authorized in NCD 210.3).[18] We support these proposals, and updates to the coverage of CRC screening to reflect the most up-to-date clinical guidelines. As CMS continues to evaluate new screening tools for coverage, it is essential that APRNs be authorized to order such screening tools for their patients, to ensure that all Medicare patients who meet the clinical criteria for such screenings can get access to the necessary screening. We also request that CMS continue to cover anesthesia services associated with follow-on screening colonoscopies furnished by APRNs as well to ensure that these live-saving procedures are safe and are utilized.

We thank you for the opportunity to comment on this proposed rule and your support of APRNs. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, American Association of Nurse Practitioners, msapio@aanp.org.

[14] 89 FR 61639
[15] Ibid
[16] GAO-15-434, Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy.
[17] 8 jun18_ch3_medpacreport_sec.pdf.
[18] 89 FR 61991.

Sincerely,

American Academy of Nursing

American Association of Colleges of Nursing

American Association of Nurse Anesthesiology

American Association of Nurse Practitioners

American College of Nurse-Midwives

National Association of Pediatric Nurse Practitioners

National League for Nursing

National Organization of Nurse Practitioner Faculties

National Association of Nurse Practitioners in Women's Health

Oncology Nursing Society