September 9, 2023

Comments of the American Academy of Ambulatory Care Nursing Submitted by Rachel Start, MSN, RN, NEA-BC, FAAN, AAACN President

Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program- Proposed Rule

The American Academy of Ambulatory Care Nurses (AAACN) is pleased to offer comments on the proposed rule related to the FY24 Physician Fee Schedule, Part B Payment and coverage policies, Medicare Shared Savings program requirements and Medicare Provider and Supplier Enrollment policies as well as Basic Health Program rules. AAACN is the only specialty nursing association that focuses on excellence in ambulatory care nursing and represents more than 3,000 registered nurses who practice in diverse ambulatory care settings, such as outpatient surgery, dialysis centers and primary care and specialty practice clinics.

GENERAL COMMENTS

The mission of AAACN is to advance the art and science of ambulatory care nursing. To that end, we have promulgated standards of practice in ambulatory care nursing along with a number of curricula to support high quality nursing practice (See Attachments). Review of these standards and scope of practice will demonstrate to CMS the wide range of services provided by RNs to support patient care.

First, we would like to highlight the need to recognize the services provided to patients by RNs in primary care environments. Given the call to move to interdisciplinary and team-based care models, we have seen an increase in RNs serving on primary care and specialty practice teams.

Current reimbursement policies fail to recognize the contributions of RNs in providing pre-visit planning, health and wellness education, chronic care management, and transition care management services. RNs are also instrumental in the provision of annual wellness visits. RNs delivering these services should be acknowledged as qualified providers who can and already are providing these services. In addition to the services mentioned above, contributions of RNs on care management teams through managed care Medicaid demonstration projects and through the Shared Savings program are also undervalued and often unrecognized.

It is AAACN's position that RNs should be acknowledged as providers of service delivery as opposed to part of the indirect charge as is the current practice under the Physician Fee Schedule.

For example, CMS's inclusion of RNs as "auxiliary staff" under the Physician Fee Schedule (PFS) contributes to lack of recognition of valuable nursing services provided by RNs in these settings and their impact on patient outcomes. Additionally, lumping RNs with other health care team members as part of the indirect cost component when calculating RVUs (as described on page 52284 of the Federal Register notice) also fails to recognize the independent practice of nursing by the RN, as opposed to other team members whose practice is a delegated practice (i.e. LPNs and Medical Assistants). To that end AAACN also recommends that RNs be removed from the Direct Supervision requirement and move to general supervision, recognizing their licensure, education, and training, which is very different from non licensed team members.

Lack of reimbursement for RN services has led to a pervasive lack of understanding by policy makers, medical providers, practice managers, and most importantly consumers, of how the practice of the RN contributes to high quality, safe, cost effective care.

NEW CPT CODE PROPOSALS

RVU VALUE FOR CARE MANAGEMENT CODES

AAACN is pleased that CMS is working to identify gaps in appropriate coding and payment for care management/coordination and primary care services under the PFS. As stated above, these services often provided by RNs are significantly undervalued. This is especially the case for clients needing behavioral health support services. **Therefore, AAACN recommends that the RVU value be increased for 99484 and G0323.** We recommend an additional 20 min code be implemented much like the CCM model of 99490 and 99439. These patients require considerable time and investment to address their needs, and although there are CoCM codes, not all of them require case review with a psychiatric medical provider but they do require additional time in behavioral health care management services.

NEWLY PROPOSED CODES

AAACN is also pleased that CMS is considering additional CPT codes to provide payment for important screening and services such as screening for social determinants, navigation services for principal illness, and community integration services. Many of these services are already being performed by RNs. Services provided by an RN should be acknowledged through these reimbursement mechanisms. Specific recommendations and comments on each of these new proposed codes is presented in more detail below.

SDOH SCREENING

The impact of social determinants on health (SDOH) is well documented. However, the medical care system has historically not addressed these issues, nor have payors acknowledged efforts to identify or address these factors. SDOH screening is an essential part of providing whole person care. However, screening alone is insufficient to assure that patients experiencing social determinant factors that negatively impact their health are

being addressed. Therefore, any screening assessment should also have documentation and follow up of referrals to address these needs and funding to support community resource provision. In proposing a new CPT code for Community Integration Services, CMS provides one mechanism to assure that any screening concerns are addressed. However, these assessments also overlay activities of care management and transition care management services (and follow through on issues identified in the annual wellness visit), often provided by RNs and not concurrent with the E/M visit by the medical provider.

Therefore, we recommend removal of the requirement for SDOH assessment to be conducted by the practitioner on the same date as an E/M visit and the beneficiary should not be subject to a copayment for this assessment.

Additionally, CMS should acknowledge that these assessments may be conducted as part of pre-visit planning by RNs, Social Workers, or others. in preparation for the visit with the medical provider or during their regular interactions with at-risk patients. Flexibility on when the SDOH assessment (and referrals) can be completed would provide additional opportunities for more in-depth screening as the care coordinator or other professional interacts with the patient and capitalizes on the relationships built over time to identify needs and develop action plans with the patient for resolution.

Further, these conversations often take more than 5–15 minutes and trying to rush this valuable interaction by incorporating it into a visit will be a disservice to the patient. Given the volume of patients seen in a given day and limited time to address these factors, this requirement may result in merely a “checklist” approach to assessment which will not serve the patient, assist the practice in meeting quality standards, or meet CMS’ intent of improving the health of the community.

Rather, SDOH screening conducted by RNs or other qualified professionals can convey recommendations to the provider based on this assessment to develop a collaborative plan of care to address any concerns identified during the screening.

Allowing the SDOH screening to be billable as part of an Annual Wellness visit is laudable for all of the above reasons and CMS, by proposing to eliminate any copayment is acknowledging the need to remove any financial barrier to the patient for obtaining this service. As stated above, this should be extended for all SDOH screening assessments.

COMMUNITY INTEGRATION SERVICES

CMS in the newly proposed Community Integration Services code acknowledges the benefit of the services that a community health worker can provide to support SDOH.

As described on page 52326 of the Federal Register notice, CMS states "For CY 2024, we are considering how we could better recognize, through coding and payment policies, when members of an interdisciplinary team, including CHWs, are involved in treatment of Medicare beneficiaries." **AAACN would like to use this opportunity to again stress that there are other members of the interdisciplinary team, namely RNs, whose contributions are not fully recognized for their role in care coordination and care management services provided to Medicare beneficiaries.**

We would like to draw attention to the scope and standards of practice documents included in this submission, which outline many of the services described as being conducted by CHWs, such as facilitating "access to healthcare through community-based services that are necessary to alleviate barriers to care that are interfering with a practitioner's ability to diagnosis or treat an illness or injury" *are also being performed (and not explicitly recognized) by RNs engaged in care coordination, transition care and care management functions on the interdisciplinary team*. **Thus, RNs should also be included on the list of qualified personnel who *may* conduct the initial CHI visit and oversee provision of these services.**

As described by CMS, CHWs need to be connected to a team. While community health workers are respected community members and understand community cultural norms, and resources, they are not prepared to address medical or other health related questions. To ask the medical provider to address these kinds of inquiries and to serve in this role is unrealistic given the heavy volume loads of most medical providers. CMS is proposing that these services be "incident to" the physician (as is the case as cited in the Medicare Benefit Policy Manual). **Therefore, we recommend that CHW service provision should be provided under the supervision of a qualified health professional supporting care management activities**, **including, but not limited to registered nurses. Consider the following modification of language:**

GXXX1 *Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner,* ***including a registered nurse or clinical social worker;***

These types of services billed "incident to the physician" have significant complexity for documentation, tracking of consent, concurrent billing of other codes, contracting and payment for services of CHWs and importantly, lack of standardized electronic tracking and billing systems. While it is helpful to retain RVUs in the practice to recognize the efforts of the physician and team it raises questions of whether "incident to" is the most efficacious way to provide these valuable services.

CCM and TCM services (as well as AWVs) are currently billed "incident to the physician" as described in the Medicare Benefit Policy Manual. **AAACN requests that CMS consider exploring the opportunity to update the Policy Manual to consider care coordination and care management activities that may be provided independently by RNs within their licensed scope of practice.**

Furthermore, we call your attention again to the scope and standards for RNs practicing in Chronic Care and Transition Management roles, which include many of the activities outlined as being provided by CHWs.

Ideally, any need for CHI or other chronic care management services for patients over 65 years of age should be identified in the Welcome to Medicare and/or Annual Wellness (AWV) visits. Clearly, there are ongoing issues with patients recognizing the value of AWV as well as chronic care management services. Therefore, CMS should consider removing the patient co-pay for Chronic Care Management services to reduce barriers to these services for patients with financial challenges. Additionally, SDOH needs that might be supported by CHI services may be identified as part of Transition Care Management (TCM) or other behavioral health services, which are often provided by RNs. Given that the education, preparation and regulation of CHW is variable, pairing this role with RNs and Social Workers would provide support and supervision for the CHW role and solidify the connection with the MD and care team, without adding significant burden to the physician.

OTHER CONSIDERATIONS
Alternatively, instead of adding a new G code to the CPT list of codes for SDOH screening, CMS might consider just increasing the RVU value (and payment) for E/M visits, Annual Wellness Visits, Chronic Care Management and Transition Care management codes and requiring that SDOH screening occur as part of these services.

PRINCIPLE ILLNESS NAVIGATION SERVICES
CMS proposes to better account for services involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel. Principal Illness Navigation Services include patient-centered assessment, care coordination, contextualizing health education, building patient self-advocacy skills, health system navigation, facilitating behavioral change, providing social and emotional support and facilitating access to community-based services to address unmet social needs. AAACN believes these services are complex and require significant training and knowledge, and especially given the variability in CHW preparation, that at a minimum these services should be provided in conjunction and under the supervision of a registered nurse.

ADDITIONAL COMMENTS

Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (the Act) (section II.D.)
HEALTH AND WELLBEING COACHING
CMS is proposing to add the following three Health and Well-being Coaching services to the Medicare Telehealth Services List for CY24:
• CPT code 0591T (*Health and well- being coaching face-to-face; individual, initial assessment*);
• CPT code 0592T (*Health and well- being coaching face-to-face; individual, follow-up session, at least 30 minutes*); and
• CPT code 0593T (*Health and well- being coaching face-to-face; group (2 or more individuals), at least 30 minutes*) as well as

HCPCS code GXXX5 (*Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5–15 minutes)*

AAACN thanks CMS for recognizing that evidence exists that nurses are qualified to provide these services and proposes that RNs providing these services should be acknowledged for delivering these services, as they fall within the independent scope of practice of the RN. We would be interested in working with CMS to explore how we can support development of additional evidence on the impact of these services being provided by RNs through telehealth capabilities.

Additionally, extending the flexibilities for audio only telehealth services that were in effect under the Public Health Emergency is a beneficial and welcome proposal.

Advancing Access to Behavioral Health (section II.J.) p 52361

CMS is proposing to codify the coverage provisions for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) among the list of providers offering behavioral health services. Again, we highlight that many RNs are serving as behavioral health care managers in outpatient settings and offer valuable services to support behavioral health teams, as well as clients engaged in medication assisted therapy for substance use. Under the current reimbursement provisions, these services are not being acknowledged. Therefore we recommend that CMS consider adding an additional descriptor to HCPCS code G0323 to capture effort of a RN behavioral health care manager, if present on the team.

Sincerely,

Rachel Start, MSN, RN, NEA-BC, FAAN
AAACN President

Attachments:
Scope and Standards of Practice for Professional Ambulatory Care Nursing, 10th edition

Core Curriculum for Ambulatory Care Nursing, 4th edition