American Academy of Ambulatory Care Nursing
Shaping Care Where Life Happens

September 5, 2024

American Academy of Ambulatory Care Nursing

Comments on

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 - Proposed Rule (File code CMS-1807-P)

The American Academy of Ambulatory Care Nurses (AAACN) is pleased to offer comments on the proposed rule related to the CY 25 Physician Fee Schedule, Part B Payment and coverage policies, Medicare Shared Savings program requirements as well as Basic Health Program rules. AAACN is the only specialty nursing association that focuses on excellence in ambulatory care and represents more than 1 million of the 4.7 million registered nurses who practice in ambulatory environments. Our members practice in settings such as:

- hospital-based outpatient clinics/centers,
- solo or group medical practices,
- ambulatory surgery and diagnostic procedure centers.
- telehealth service environments,
- university and community hospital clinics.
- military and veterans' administration ambulatory settings.
- nurse-managed clinics.
- managed care organizations.
- freestanding community facilities.
- care coordination organizations; and
- patients' homes (AAACN, 2017).

GENERAL COMMENTS

AAACN seeks to *Shape Care Where Life Happens* with a vision of *A healthier world through nursing excellence, leadership, and innovation, revolutionizing healthcare*. To that end, we have promulgated standards of practice in ambulatory care nursing along with a number of curriculums to support high quality nursing practice. To help CMS to better understand the role of ambulatory care nurses as well as the important services that ambulatory care nurses provide, we are including a variety of our documents that outline the scope and standards of ambulatory care nursing practice, as well as the role of ambulatory care nurses through service provision of care coordination and care management services. (AACN, 2017). We look forward to working with CMS to support specific acknowledgement of ambulatory care Registered Nurses (RNs) among the variety of existing and new services outlined in the proposed rule.

800-262-6877
aaacn@aaacn.org
PO Box 56 Pitman, New Jersey 08071-0056
www.AAACN.org

First, we would like to highlight the need to recognize the services provided to patients by RNs in ambulatory 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. However, unlike many other disciplines which have been highlighted under this and prior rulemakings as qualified to provide services under the PFS, Registered Nurses are included in the staff category of auxiliary personnel, an overall designation that includes a variety of licensed and non-licensed staff. We believe that this categorization fails to recognize RNs as qualified healthcare professionals and the high-level contributions to patient care that they make in team-based models of care. Furthermore, we are requesting that CMS to provide specific explanation about 1) why RNs and LPNs are bundled with other auxiliary (non-licensed staff) within the Physician Fee Schedule; and 2) why RNs are listed alongside other disciplines in the proposed CY 2025 clinical labor pricing tables, which are used to calculate *overhead* costs for RVU valuation. Are they considered interchangeable with the other disciplines listed on that line? And if so, why?

It is important for CMS; other members of the care team and the general public recognize that licensed nursing staff are a unique clinical discipline. In the case of RNs, these professionals are qualified by their licensure to practice nursing to *independently* through nursing assessment, care planning, patient education, and other interventions, such as patient and caregiver education, care coordination and care management services (NCQAC, 2019). AAACN recognizes that CMS has statutory limitations when designing the PFS, however, the mechanism by which this rulemaking calculates payments, with most services being billed incident to the physician, does not accurately reflect how care is being provided and undervalues the team based approached to care delivery.

Registered nurses have professional education, experience, training and demonstrated competencies in the care for patients with chronic conditions and in health promotion. These interventions include holistic assessment, client needs assessment, education, coaching, support, and direct nursing care as well as evaluating the human response to these interventions as well as the medical treatment plan. They are skilled in the education of patients, and coordination of care across settings, specialties, and populations, from prenatal and neonatal care to end-of-life care. They can recognize and respond to emergencies and can appropriately provide delegation and supervision to LPNs and non-licensed nursing staff for those acts which fall within their scope of practice and are delegate-able tasks.

Evidence is mounting that contributions of RNs in primary and specialty care contributes to cost-effective care delivery, high quality outcomes, enhanced patient safety, and improved patient satisfaction (Cleveland, 2019). RNs practicing at the full scope of their licensure, education and experience have the capacity to improve outcomes by supporting care delivery, care coordination, and care management activities across the health care continuum and community. However, current reimbursement policies fail to recognize the contributions of RNs in providing important services included within the PFS as well as other services provided by RNs that are not recognized as billable services. High value services provided by RNs include pre-visit planning, care management services for chronic, behavioral, and social conditions, and transition care management services as well as conducting annual wellness visits and advanced care planning services. Care coordination and care management are services for which RNs are most prepared to support teams to improve patient outcomes, and activities within these services fall in line with nursing practice. The 2021 Future of Nursing report highlights the need to deploy and engage RNs in care coordination and care management roles. AAACN holds that the RNs who are delivering these services should be acknowledged as qualified providers who can provide these services through the Medicare program. 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 considered to be acknowledged as providers of service delivery as opposed to only being considered clinical labor and part of the indirect charge as is the current practice under the Physician Fee Schedule.

CMS should recognize that the scope of practice differs between LPNs and RNs when defining qualified staff to conduct services on behalf of the physician or other medical provider. LPNs have a different scope of practice, which, we believe should always be overseen by a registered nurse. Often, LPN roles in ambulatory care are delegated by the physician, however, physicians are not prepared to delegate nursing practice acts for which the LPNs are trained and their license grants authority for practice. Furthermore, state licensure acts limit the LPN from independent practice.

RNs and LPNs should never be recognized as interchangeable with one another, with Medical Assistants, (or the reverse). Unfortunately, our members report this as a common problem in practice, where other non-licensed staff are confused as being "nurses" by other staff members, physicians, as well as patients. In many cases, our members report situations where unlicensed staff may be engaging in actions beyond their scope of training. Role confusion in practice is very real, and for team-based care to be truly effective, clarity of roles within the team is necessary. While AAACN is fully committed to team- based care and models that maximize all members of the team at their highest level of functioning, CMS needs to be aware of the challenges of persistent role confusion that exist in practice. Moving RNs and LPNs out from the "auxiliary" or "clinical staff" category along with other unlicensed staff members is one step to ameliorate this issue.

AAACN requests CMS to explain what would be necessary to move services provided by RNs out from under the PE element (or indirect costs) and for RNs to be recognized through the addition of the term Registered Nurse (RN) as a licensed healthcare professional qualified to provide certain services, such as Annual Wellness Visits (G0438/G0439), Advance Care Planning (99497, 99498), all care management services codes (CCM, BHI, CoCM, PCM, CHI, PIN), Health Coaching, Patient and Care Giver Education and Training, and Social Determinant and cardiac risk assessments. See Attachment A for a list of service codes listed under this proposed PFS that AAACN argues that these, with the exception of any medical orders for laboratory testing or immunizations as part of the AWV, these services fall within the independent practice of the registered nurse. We also purport that when performed by a registered nurse, these services should only require general supervision by the physician.

Recognizing current statutory limitations that exist for Medicare billing under the established language in the Social Security Act, AAACN ultimately argues that as many of these services fall within the registered nurse's license to practice nursing and that RNs, like other disciplines who have been acknowledged as being able to bill for services, should have the capacity to independently bill for these services.

DIRECT RESPONSE TO THE 2025 PHYSICIAN FEE SCHEDULE PROPOSED RULE

We fully support whole-person care and applaud CMS for the inclusion of additional preventative measures (Federal Register, 2024, p. in this rulemaking proposal. Based on the expertise of ambulatory care nurses, we offer the following specific recommendations on the proposed rule:

- Telecommunication Services: We support the proposed change in definition from requiring the provider to be "immediately available" to "virtual supervision by providers" for 99211 visits *that are conducted by RNs*. This would allow visits to be done virtually and we advocate for this to be a permanent change as well as the services being proposed as permanent additions to the telehealth services list, including, but not limited to, the Caregiver Training proposed service codes.
- Supervision requirements for specific billing codes when conducted by RNs**- Barring the ability to offer RNs the ability to independently bill for services that fall within their licensed scope of practice, we strongly advocate for an overall change in supervision requirements for billable services that are performed by RNs under 99211, Annual Wellness Visits (G0438/G0439), Advance Care Planning (99497/99498), Caregiver Training and Assessment (97550-97552, 96202-96203, 96161), Self-Care/Home management training (97535, 98960-98962). Again, many of the aspects of these services fall within the independent practice of nursing when conducted by registered nurses and should be acknowledged as such.**

- Caregiver Training Services (CTS): We fully support expanded caregiver training services and associated billing codes for providing caregiver training. RNs perform this education all the time in both inpatient and outpatient settings. Thus, AAACN believes RNs are the most qualified professionals to provide this training. The proposed rulemaking describes that this training will be conducted by the physician/medical provider, however the realities of practice in the ambulatory setting prevent this from being realistic. AAACN is concerned that the proposed language may allow providers to delegate this training to auxiliary staff members who may not be fully qualified to assess caregiver training needs and provide this training. Therefore, we urge that, ***for quality and safety of the patients and caregivers, language should be inserted in the final rule to ensure that caregiver training is provided only by those licensed healthcare professionals, such as Registered Nurses, who possess the knowledge, skills, and abilities to assess caregiver training needs and perform those services***. We also strongly advocate that when these services are provided by RNs, they fall within the independent scope of nursing practice and should be allowed to be performed under general supervision when conducted by RNs.

Services Addressing Health-Related Social Needs: (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services):
Community Health Integration Services (CHI)-Community Health Worker and Medical Assistant education and training is highly variable across settings and states leading to potential quality and safety issues. While these disciplines are valuable, and in some cases critical, members of the care team, it is important that role confusion is minimized and that services are provided by qualified members of the team. The realities of practice preclude medical providers from having dedicated time to provide supervision of staff providing CHI services. AAACN argues that Registered Nurses have specific education and training to serve as the ideal provider to support CHI services (AAACN, . Integrating CHWs into the team-based approach to care is essential and RNs are well suited to lead the team in provision of CHI to ensure a holistic approach to the patient's care, address clinical issues that are beyond the scope and training of the CHW role, and promote positive outcomes.

Social Determinants of Health (SDOH) Risk Assessment -We advocate for standardization of SDOH screening. While it is acceptable for unlicensed clinical staff to complete evidence-based assessment tools with patients, identification of patient needs and development of a plan to address these needs requires a different level of expertise. Conducting a thorough SDOH risk assessment also falls within the independent licensed scope of practice of RNs. Furthermore, RNs as part of their nursing assessment and vast knowledge of community resources, as well as ability to provide coaching and education to clients, can identify client needs and propose recommendations in collaboration with the medical provider. We also urge CMS to include incentives that capture the needs assessment, preventative education, and linkages to resources when client needs assessments are being performed by RNs. We appreciate that the regulations allow for the screening and assessment to be done prior to a visit, however, the requirement to concurrently bill with a visit can be onerous in practice. **Therefore, we strongly encourage the consideration of billing G0136 as a standalone code and billed under general supervision when completed by an RN.**

Principal Illness Navigation Services (PIN)- CMS has established that PIN are services that can be provided to medically complex, high-risk patients under general supervision requirements. Again, the realities of practice preclude the medical provider from having adequate time and training to conduct or oversee provision of these services. AAACN is also concerned that individuals who are conducting these services are adequately qualified to perform these services. Therefore, **we urge CMS to include language to ensure that these services *are provided by licensed healthcare professionals, such as RNs, who are qualified to perform and oversee these services when provided by non-licensed clinical staff***.

Cardiovascular Risk Assessment and Management: We fully advocate for billing/reimbursement codes to support preventative services to decrease the Atherosclerotic Cardiovascular Disease risks through teaching and coaching of modifiable risk factors. Again, RNs are qualified to administer evidence-based assessments, analyze client needs, and provide teaching and coaching for modifiable risk factors. **We strongly encourage CMS to**

make the proposed GCDRA and GCDRM codes as standalone codes and only requiring general supervision when performed by an RN.

- We support the outlined requirements for ASCVD Specific Risk Management; **however, we urge CMS to decrease the level of risk from > 15 to 7.5% to align with the** ASCVD Risk Estimator Plus tool by the American College of Cardiology (2019) whereby a score of 7.5% represents intermediate risk.
- **Under the code table (Federal Register, p. 61729) the definition of the GCDRM code does not describe who is qualified to conduct these services. We believe that GCDRM service provision should be limited to licensed healthcare professionals with the education and experience to provide this level of care management such as Registered Nurses and under general supervision requirements.** Allowing auxiliary personnel such as unlicensed assistive personnel would not ensure patients are receiving the needed level of clinical assessment planning and interventions to support risk reduction.

Office/Outpatient (O/O) E/M Visits: We advocate to allow G2211 to be considered as an add on code on the same day as an Annual Wellness Visit (AWV), vaccine administration or any Medicare Part B preventive service furnished in the office/outpatient setting. This should be a consistent billing option across all settings (RHCs, FQHCs, fee for service practices.

Care Coordination Services in RHCs and FQHCs: We advocate for payment parity for all care management services, in RHC and FQHC sites for the care of medical, behavioral, and socially complex patients. This would include elimination of the G0511 and G0512 code and adoption of the full complement of fee-for-service codes for CCM, BHI, CoCM, RPM, RTM, PCM, CHI, PIN including any new care management codes in the future, i.e. ASCVD and APCM proposed codes. CMS also needs to treat RHCs and FQHCs as the same as fee for service practices for services provided by RNs, such as AWVs.

Advanced Primary Care Management Services (APCM): While we are not certain that the addition of the three new HCPCS G-Codes would benefit our primary care patients that is not already captured under the existing care management codes (CCM, BHI, CoCM, RPM, RTM, PCM, CHI, PIN along with the additional proposed code of ASCVD), we advocate for any additional incentives and payment codes including within the EMR that reduces the administrative burden associated with current coding and billing rules. Reduction in the burden of time documentation and having methodologies to determine relative value of service would incentivize practices to offer these services. **However, we strongly encourage a modification to the requirements for Level 3 APCM. Limiting the category to only those who are dually eligible beneficiaries with QMB status is too limiting.** We agree that those beneficiaries with social determinant risk factors do have higher healthcare needs, however, **we recommend the requirements for this category include beneficiaries with at least one chronic condition AND one SDOH unmet need regardless of their dual eligibility or QMB status.**

Medicare Part B payments for preventative services: We advocate for increased adult immunizations (such as Tdap) as well as Preventative drugs such as HIV PrEP to be covered under the Medicare program.

Expand Colorectal Cancer Screening: We support expanded coverage of colorectal Cancer (CRC) screening and other measures that remove barriers for (all types of) cancer prevention and early detection, especially in rural and communities of color.

SUMMARY STATEMENT

CMS is to be applauded for recognizing significant reimbursement shortfalls for primary care services. The reimbursement shortfall, along with increasing pressure to improve quality, safety and experience has led to current primary care provider and staffing shortages and contributes to provider and staff burnout. For many years, primary care thought leaders (e.g. Thomas Bodenheimer, Edward Wagner) have advocated for the RN role in patient-centered primary care (Bodeheimer, 2002). However, current reimbursement methodologies fail to support true team-based care models that recognize the unique education, competency, and contributions of each team member to patient care delivery. For RNs and LPNs practicing in ambulatory settings, role confusion and lack of acknowledgement of the services they are qualified to provide is especially problematic. As stated above,

AAACN recognizes that CMS must promulgate rulemaking within statutory limitations within the Social Security Act. The addition of services outside the tradition provider visit, such as CCM, TCM, APCM and CHI services are important and are important aspects of care that need to be recognized to enhance patient outcomes and promote cost-effective care delivery, however the current "incident to" methodology creates significant administrative burden and fails to acknowledge the realities of practice. Busy primary care physicians are not equipped to provide even minimal supervision to Community Health Workers who have highly variable training and skills. Nor in the current model of care delivery which still requires high volume visits by the medical providers, is realistic to expect that the medical provider can oversee clinical staff, coordinate care management activities, cost-effectively conduct AWVs or conduct or oversee any of the newly proposed codes such as Caregiver Training and CHI. We believe that recognition of the important contributions that RNs provide needs to be acknowledged within the current statutory constraints. Therefore, we strongly encourage CMS to recognize Registered Nurses in the rules when possible and remove any requirements for direct supervision while performing all services that are intrinsic to the practice of nursing. We will be working to identify and support CMS through legislative action to achieve this goal.

AAACN would welcome the opportunity to partner with CMS to develop methodologies that better acknowledge the role and contributions of ambulatory care nurses and promote effective team-based care delivery. We thank CMS for the opportunity to provide comments on the proposed rule. If our organization can provide any additional information to assist CMS, please contact AAACN President, Stephanie Witwer, PhD, RN, NEA-BC, FAAN, 800-262-6877

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