

September 08, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-1816

Submitted electronically to www.regulations.gov

RE: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements [CMS-1751-P]

Dear Administrator LaSure:

The American Nurses Association (ANA) is pleased to provide comments on the Centers for Medicare and Medicaid Services (CMS) CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, file code CMS-1752-P. ANA supports CMS' continued efforts to reduce unnecessary and burdensome regulatory barriers to ensure access to high-quality and affordable care during the COVID-19 Public Health Emergency (PHE) and beyond. For the CY 2022 Physician Fee Schedule rulemaking, this comment letter addresses:

- 1. Proposed Updates to Clinical Labor Pricing to Determine Practice Expense**
- 2. Protecting and Improving Access to Telehealth Services**
- 3. Proposed Valuations of Specific Codes**
- 4. Codes for Chronic Pain Management**
- 5. Proposed Additions of Primary Care Codes for Medicare Shared Savings Programs**

1. Proposed Updates to Clinical Labor Pricing to Determine Practice Expense

CMS proposes to update clinical labor pricing to maintain relativity with recent updates to supply and equipment updates. ANA agrees with this step as proposed, as we believe the updates will lead to more accurate reflections in the fee schedule of the value of nursing care and resulting practice expense.

2. Protecting and Improving Access to Telehealth Services

ANA appreciates CMS' flexibility and continued openness to waiving regulatory requirements in response to the PHE. One of the most significant areas of flexibility has been expanded telehealth, allowing many beneficiaries to gain or maintain access during the pandemic. Telehealth expansion during the PHE has created needed capacity for nurses, including advanced practice registered nurse

roles (APRNs) that provide high-quality care to and care coordination for patients, in the face of COVID-19 surges and worsening provider shortages in rural and other underserved areas.

ANA has long supported the nurses' role in the use of telehealth technologies to provide quality care to beneficiaries. Registered Nurses (RNs) and APRNs are frequently the sole providers for many communities across the country. We recognize and share CMS' perspective that covering telehealth technologies requires consideration of provider-patient relationships, equitable access to care, and safety. We continue to stress the importance of access to providers in both rural and urban communities, especially for mental health and behavioral health care services.

As noted in the proposed rule, 135 services were added to Medicare's telehealth payment list under PHE waiver authority. When the PHE expires, these telehealth services will once again be limited by the requirements of section 1834(m) of the Social Security Act. Yet, for beneficiaries and providers alike, certainty of payment and coverage will still be key to access and quality. CMS must prioritize continuity of coverage and payment parity for those telehealth services that improve access to equitable and quality care. In general, ANA supports the current proposal to extend certain telehealth flexibilities through 2023. This would allow for data analysis that can inform permanent additions to the telehealth list. ANA cautions that further extensions may be necessary, depending upon the course of the pandemic and other contingencies. Additionally, we urge CMS to take more definitive action on a number of telehealth services at this time.

Telehealth for Mental and Behavioral Health Care

ANA supports CMS' proposals to remove place and setting restrictions for telemental health services and recognizing the patient's home as an originating site, with the condition that in-person care is provided within six months of providing telehealth services to a patient and at least once every six months after. Within these parameters, we fully support deferring to practitioners' clinical judgment to recommend in-person versus virtual platforms. We encourage CMS to trust providers as well. We also support the proposal that an in-person service could be furnished by another practitioner of the same specialty or group as needed to ensure continuity of care.

Similarly, we support permanent coverage of interactive audio-only telehealth in the patient's home for mental health diagnosis, evaluation, or treatment; and for treatment of opioid use disorder in a patient's home when video is not available to the patient. We also support proposed regulatory changes to allow Medicare coverage of defined telemental health services delivered by federally qualified health centers (FQHCs), rural health Clinics (RHCs), and rural emergency hospitals.

However, we disagree with CMS' decision not to move forward now with permanent coverage for psychological testing (identified on Table 8 as 96130 and 96131) provided via telehealth. As CMS acknowledges elsewhere in the proposed rule, telehealth plays a significant role in providing access to mental health services across the country. Testing is a core mental health service that should be timely and easily accessed. We encourage CMS not to finalize this provision. Rather, the agency must review use of these codes and reconsider the ways telehealth testing enhances equity and access to appropriate care.

Available Data for Analysis of NP Care

ANA has identified a number of services that nurse practitioners (NPs) provide via telehealth which CMS should consider for permanent coverage as Category 3 services at this time. Specifically, utilization data is available for NP provision of: Neurological Service codes 95970, 95971, 95983 and 95984; Nursing Facility codes 99304-99306 and 99324-99328; and Home Services codes 99341-99345. We urge CMS to consider permanently allowing access to NPs via telehealth, as a strategy to expand workforce capacity as well as enhance patient access.

3. Proposed Valuations of Specific Codes

ANA disagrees with CMS' proposed valuation for Harvest of Upper Extremity Artery (codes 35XXO and 35600). This proposal is not consistent with the recommended values of the Relative Value Scale Update Committee (RUC). We support the RUC recommended values and the RUC's reasons for the recommendation.

4. Codes for Chronic Pain Management

CMS requests comments on possible creation of codes for chronic pain management including appropriate reduction of opioid dosing. We support CMS in considering separate codes for medically necessary activities involved in chronic pain management. Existing codes do not fully account for all of the clinical activities required for chronic pain management. We encourage creation of codes that capture nursing care involved in chronic pain management, such as care coordination. New codes that responsive to the care continuum would incentivize team-based care planning and care delivery, and lead to quality outcomes for patients.

5. Proposed Additions of Primary Care Codes for Medicare Shared Savings Programs

CMS proposes to amend regulations for the Medicare Shared Savings Program (MSSP) to expand permanently the codes that would be considered primary care for the purposes of beneficiary assignment to an MSSP. We support this change, which we believe will increase opportunities for APRNs to participate in ACOs and allow their patients to join MSSP programs. However, the claims-based assignment pathway requires an NP's patient to receive at least one primary care service provided by a primary care physician for the patient to be assigned to an ACO. We urge CMS to utilize its waiver authority to authorize beneficiary assignment for primary care services provided by NPs as well as primary care physicians. Removing this practice barrier would help expand APRN participation in alternative payment models.

ANA is the premier organization representing the interests of the nation's 4.3 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA members also include the four APRNs: NPs, clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). 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 appreciates the opportunity to submit these comments and looks forward to continued engagement with CMS. Please contact Ingrida Lusic, Vice President of Policy and Government Affairs at (301) 628-5081 or Ingrid.Lusic@ana.org, with any questions.

Sincerely,



Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer / EVP

cc: Ernest Grant, PhD, RN, FAAN, ANA President
Loressa Cole, DNP, MBA, RN, NEA-BC, FACHE, FAAN, ANA Chief Executive Officer