

September 11, 2023

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-1784-P, 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**

Dear Administrator Brooks-LaSure,

The American Association of Nurse Practitioners (AANP), representing more than 355,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment on the Calendar Year 2024 proposed Medicare fee schedule. AANP is committed to empowering all NPs to advance high-quality, equitable care, while addressing health care disparities through practice, education, advocacy, research, and leadership (PEARL).<sup>1</sup> We appreciate the Agency's recognition of the importance of NPs, and the care they provide to their communities, within this proposed rule. We look forward to a continued partnership with CMS on advancing health equity through patient-centered care provided by NPs.

As you know, NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform more than one billion patient visits annually. Currently, twenty-seven states, the District of Columbia and two U.S. territories have adopted full practice authority, granting patients full and direct access to nurse practitioners.

NPs practice in nearly every health care setting including hospitals, clinics, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health care settings.

Nurse practitioners provide a substantial portion of the high-quality<sup>2</sup>, cost-effective<sup>3</sup> care that our communities require. As of 2021, there were over 193,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.<sup>4</sup> Approximately 42% of Medicare patients receive billable services from a nurse practitioner<sup>5</sup>, and approximately 80% of NPs are seeing Medicare and Medicaid patients.<sup>6</sup> According to the Medicare Payment Advisory Commission (MedPAC),

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<sup>1</sup> <https://www.aanp.org/advocacy/advocacy-resource/position-statements/commitment-to-addressing-health-care-disparities-during-covid-19>

<sup>2</sup> <https://www.aanp.org/images/documents/publications/qualityofpractice.pdf>.

<sup>3</sup> <https://www.aanp.org/images/documents/publications/costeffectiveness.pdf>.

<sup>4</sup> [data.cms.gov](https://www.data.cms.gov) MDCR Providers 6 Calendar Years 2017-2021.

<sup>5</sup> *Ibid.*

<sup>6</sup> [NP Fact Sheet \(aanp.org\)](#)

APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.<sup>7</sup>

NPs provide a substantial portion of health care in rural areas and areas of lower socioeconomic and health status. As such, they understand the barriers to care that face vulnerable populations on a daily basis.<sup>8, 9, 10</sup> They are also “significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians.”<sup>11</sup>

We appreciate that this proposed rule includes policies which recognize the importance of care provided by nurse practitioners. The proposals to adjust the assignment methodology within the Medicare Shared Savings Program (MSSP), and revise the conditions of coverage for pulmonary rehabilitation (PR), cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) to authorize NPs to supervise these services, are critical to ensuring equitable access to these services for beneficiaries. We strongly support these proposed changes, and the Agency’s recognition of the role of NPs in advancing health equity.

This rule also includes proposals to better identify, value, and reimburse NPs who provide comprehensive, patient-centered longitudinal coordinated care through the payable implementation of the G2211 code, and proposals to reimburse for principal illness navigation (PIN) services, Social Determinants of Health (SDOH) risk assessments, and community health integration (CHI) services. These proposals, which correctly recognize that care coordination is a service, are important to the transition to accountable care. Furthermore, we support the proposals to expand reimbursement for dental services, adjust reimbursement for preventative vaccination services, modernize coverage for behavioral health services, and delay implementation of changes to the split (or shared) time-based billing policy. Our detailed comments on specific sections of this proposed rule are included below.

### **Provisions of the Proposed Rule for the PFS**

- ***Payment for Medicare Telehealth Services Under Section 1834(m) of the Act; Requests to Add Services to the Medicare Telehealth Services List for CY 2024; CMS Proposal to Add New Codes to the List***

In this section, CMS proposes to add HCPCS code GXXX5 to the Medicare Telehealth Services List. This proposal is contingent upon finalizing the service code description as proposed in section II.E of the proposed rule. HCPCS code GXXX5 is a new, stand-alone code for the administration of a standardized, evidence-based SDOH risk assessment. As proposed, an NP would review a patient’s SDOH or identify

<sup>7</sup> [https://www.medpac.gov/wp-content/uploads/2022/06/Jun22\\_MedPAC\\_Report\\_to\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf) (see Chapter 2.)

<sup>8</sup> Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *Journal of General Internal Medicine*, 4–6. <https://doi.org/10.1007/s11606-017-4287-4>.

<sup>9</sup> Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. *Journal of the American Medical Association*, 321(1), 102–105.

<sup>10</sup> Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. *Medical Care Research and Review*, Epub ahead. <https://doi.org/10.1177/1077558718793070>

<sup>11</sup> <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/>

social risk factors that influence the diagnoses and treatments of their conditions. This would properly identify, and value, the work involved in administering an SDOH risk assessment as part of a comprehensive social history when it is reasonable and necessary in relation to an E/M visit.

**We agree with the establishment of the HCPCS GXXX5 code, and its addition to the telehealth services list.** We support the proper identification and valuation of the work involved in administering an SDOH risk assessment and agree it will better empower NPs to effectively meet patient's needs. The addition of this code to the telehealth services list will ensure that providers and patients have the necessary flexibility to conduct this assessment through the modality that best meets a patient's needs. As the Agency correctly identifies, this is a service which is sufficiently similar to services currently on the telehealth list, specifically E/M services, and therefore should be added to the telehealth services list.

- *Proposed Clarifications and Revisions to the Process for Considering Changes to the Medicare Telehealth Services List*

In this section, the Agency proposes changes which would modify the process for updating the Medicare telehealth services list, to improve clarity, and elucidate the difference between services which were added to the telehealth list based on COVID-19 PHE-related authorities versus services that were added temporarily on a Category 3 basis, which does not rely on any PHE-related authority. CMS created the Category 3 basis to consider changes to the telehealth services list in response to the significant expansion of remotely furnished services in response to the COVID-19 PHE.

The Agency correctly recognized that certain services delivered via telehealth may have a clinical benefit, but more time may be needed to develop additional evidence to support the permanent addition of these services to the telehealth list. **We agree that with the termination of the COVID-19 PHE there is a greater need to clarify the status of Medicare telehealth services.** This will be especially important for the Medicare telehealth flexibilities extended by the Consolidated Appropriations Act (CAA) of 2023 through the end of CY 2024. The new taxonomy and classification approach as proposed in this section will reduce confusion for providers and provide better clarification on the status of telehealth services.

- *Consolidation of the Categories for Services Currently on the Medicare Telehealth Services List.*

As stated above, we support the proposal to consolidate the categorization of telehealth codes. The redesignations of services to either "permanent" or "provisional" categories will help ease the confusion in the rapidly changing telehealth coverage landscape. The current categorizations can generate confusion as providers work to adapt their practices to coverage standards based on Agency rules and legislative changes. **Therefore, we concur with the Agency assessment that these redeterminations will provide greater clarity for patients and providers.**

- *Implementation of Provisions of the CAA, 2023; (1) Overview and Background*

In this section, CMS proposes to address the telehealth policies which were amended in the CAA, 2023. These include the flexibilities extended by section 4113 of the CAA, such as the temporary expansion of the scope of telehealth originating sites for services furnished via telehealth, continued payment for telehealth services furnished by rural health clinics (RHCs) and federally qualified health centers (FQHCs), delaying the requirement for an in-person visit with a physician or practitioner within 6 months prior to initiating mental health telehealth services, and again at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs and FQHCs, and continued coverage

and payment of telehealth services included on the Medicare Telehealth Services List as of March 15, 2020, until December 31, 2024.

**We appreciate and support the Agency’s implementation of these provisions of the CAA, 2023.**

Further, we support the stated goals of the Agency to “retain payment stability, reduce confusion and burden, and conform to all statutory requirements without unnecessary restrictions on beneficiaries’ access to telehealth care.”<sup>12</sup> Conforming to the statutory requirements, without imposing further undue and unnecessary restrictions on beneficiaries’ access to telehealth care, is of particular importance.

- ***In-person Requirements for Mental Health Telehealth***

This section proposes to implement section 4113(d)(1) of section FF, Title IV, Subtitle B of the CAA, 2023. This provision delays the requirement of an in-person visit with a provider within 6 months prior to the initial mental health telehealth service, and again at subsequent intervals as the Secretary determines appropriate, until 2025.

Additionally, section 4113(d)(2) delayed the in-person visit requirements for mental health visits furnished by RHCs and FQHCs via telecommunications technology. The Agency proposes to recognize this change by delaying the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunication technology under Medicare until January 1, 2025, rather than until the 152nd day after the end of the PHE, to conform with the CAA, 2023.

**We strongly support the delay of the in-person requirement for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder. We also continue to encourage CMS to not impose requirements for in-person services beyond what is statutorily required.** As noted by the Agency in this proposal, one of the primary goals is to “conform to all statutory requirements without unnecessary restrictions on beneficiaries’ access to telehealth care.”<sup>13</sup> For patients seeking mental health treatment, the issues which prevent them from accessing care existed prior to the pandemic and will continue to exist beyond its duration. It is important to ensure the provisions intended to maintain program integrity do not inhibit patient access to care. Providers can utilize their clinical judgment to assess if a patient requires an in-person visit. NPs have the education and clinical training required to make this determination, and we believe the regulatory requirements should enable providers to assess a patient’s needs and use their clinical judgement to determine the appropriate treatment for a patient. This will ensure that patients have the access to care they need while balancing the statutory requirements and program integrity.

- ***Originating Site Requirements***

This section proposes to implement section 4113(a)(2) of the CAA, 2023, to temporarily expand the telehealth originating sites for any service on the Medicare telehealth services list to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home, through December 31, 2024. **We support this proposal, as well as the permanent modification of the originating site requirements to allow patients and providers the necessary flexibility for the provision of telehealth services.**

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<sup>12</sup> 88 FR 52298.

<sup>13</sup> *Ibid.*



- *Audio-Only Services*

This section proposes to implement section 4113(e) of Division FF, Title IV, Subtitle C of the CAA, 2023, which requires the Secretary to continue to provide for coverage and payment of telehealth services via an audio-only communications system through December 31, 2024. This provision applies only to telehealth services specified on the Medicare telehealth services list under section 1834(m)(4)(F)(i) of the Act which are permitted to be furnished via audio-only technology as of the date of enactment of the CAA, 2023.

**We support the implementation of these flexibilities and strongly support the continued coverage of audio-only telehealth services.** A critical component of providing telehealth throughout the COVID-19 pandemic has been the CMS coverage of audio-only services. As noted above, research shows that NPs are more likely to practice in rural areas and areas of lower socioeconomic and health status. In an AANP membership survey conducted in August 2020, our members reported that the three most significant barriers to telehealth adoptions were patient connectivity issues, patient access to technology and the internet and patient comfort with technology.<sup>14</sup>

For patients experiencing these issues, the coverage of audio-only visits will be an important component of telehealth moving forward. It is important to recognize that individuals may face barriers including access to broadband and technology which may prohibit them from utilizing synchronous two-way technology. Coverage of audio-only telehealth is an essential lifeline for these patients, especially for the 96 million patients who live in the 8,057 primary health care professional shortage areas (HPSAs)<sup>15</sup> and may not have adequate access to a health care provider.

- *Place of Service for Medicare Telehealth Services*

In this section, the Agency is proposing changes to the place of service (POS) codes when a provider submits a claim for telehealth services, which is used to determine whether a service is paid using the facility or non-facility rate. The Agency is proposing that, beginning in CY 2024, claims billed with POS 10 be paid at the non-facility PFS rate. The Agency believes that this more accurately reflects providers' practice expenses (PE) as it relates to the provision of behavioral health services via telehealth. Claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) will continue to be paid at the PFS facility rate beginning on January 1, 2024.

We agree with the Agency that there are "few differences in PE when behavioral health services are furnished to a patient at home via telehealth as opposed to services furnished in-person."<sup>16</sup> It is important to recognize that regardless of a patient's location, providers are required to maintain the technological infrastructure for conducting these visits. This includes secure, two-way technology systems which are HIPAA compliant, devices, broadband, and other fixed costs such as electronic health records. These are necessary for providers regardless of the location of the patient receiving the services. **We appreciate the Agency's recognition of these PE realities in this proposal, and support the proposal that claims billed with POS 10 be paid at the non-facility PFS rate.**

However, we remain concerned that this proposal does not address practitioners who provide telehealth from their home and would be required to report their home address as the originating site. Recent

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<sup>14</sup> <https://www.aanp.org/practice/practice-related-research/research-reports/nurse-practitioner-covid-19-survey-2>

<sup>15</sup> [Shortage Areas \(hrsa.gov\)](https://www.hrsa.gov/shortage-areas)

<sup>16</sup> 88 FR 52300.

Agency guidance states that “during the PHE, CMS allowed practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. Even though the PHE is anticipated to end on May 11, 2023, the waiver will continue through December 31, 2023.”<sup>17</sup> However, many providers remain concerned with the uncertainty regarding Agency requirements for reporting after December 31, 2023. Requiring providers to list their home address will reduce patient access to telehealth services.

There are legitimate concerns for nurse practitioner 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.”<sup>18</sup> 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.”<sup>19</sup> **Therefore, it is of paramount importance 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.** This is directly aligned with the Agency’s stated goal of “protecting access to mental health and other telehealth services” and “accurately recognizing the resource costs of behavioral health providers, given shifting practice models.”<sup>20</sup>

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

In this section, the Agency proposes to remove certain telehealth frequency limitations for the duration of CY 2024. Specifically, the limitations for the subsequent inpatient visit codes 99231, 99232, 99233, the subsequent nursing facility CPT codes 99307, 99308, 99309, 99310, and the critical care consultation HCPCS codes G0508 and G0509. This will better align these codes with the other telehealth related flexibilities extended by the CAA, 2023.

**We support the removal of the telehealth frequency limitations on these codes for the duration of CY 2024 to better align the codes with the additional Medicare telehealth flexibilities.** As stated in previous telehealth comments, we believe that unnecessary telehealth limitations inhibit patient access, and limit a provider’s ability to meet individual patient’s needs. As the Agency assesses its telehealth regulations 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. NPs have the clinical expertise to determine when a patient requires an in-person examination, and we encourage the Agency to empower providers to make these clinical determinations.

- ***Other Non-Face-to-Face Services Involving Communications Technology under the PFS; Direct Supervision via Use of Two-way Audio/Video Communications Technology***

CMS is considering revisions to the policies governing direct supervision via use of two-way audio/video communications technology. As the proposal states, outside of the circumstances of the PHE, direct supervision requires the immediate availability of the supervising practitioner, but that supervising practitioner does not need to be present in the same room during the service. The immediate availability,

<sup>17</sup> [Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19](#)

<sup>18</sup> [New Surgeon General Advisory Sounds Alarm on Health Worker Burnout and Resignation | HHS.gov](#)

<sup>19</sup> *Ibid.*

<sup>20</sup> 88 FR 52262.

as established outside of the PHE, means in-person, physical, not virtual availability. However, to meet the need during the COVID-19 PHE, CMS amended the definition of “direct supervision as it pertains to supervision of diagnostic tests, provider services, and some hospital outpatient services, to allow the supervising provider to be immediately available through virtual presence using two-way, real-time audio/video technology, in lieu of the physical presence requirement. This temporary exception was aimed at ensuring consistent availability of services by clinical staff and other practitioners ‘incident-to’ the supervising providers own professional services.

Under current policy, as described in the CY 2021 final rule, after December 31, 2023, the pre-PHE rules for direct supervision would apply. As CMS described in the CY 2022 PFS final rule, this would mean the temporary exception allowing immediate availability for direct supervision through virtual presence would no longer apply after CY 2023.

In this proposal, CMS has stated its concerns with an immediate return to the pre-PHE standard of direct supervision which requires the physical presence of the supervising provider. The Agency cites new patterns of practice, and potential barriers to access, as concerns regarding a reversion to the pre-PHE standard. The Agency believes that providers will “need time to reorganize their practice patterns established during the PHE to reimplement the pre-PHE approach to direct supervision without the use of audio/video technology.”<sup>21</sup> In light of these concerns, CMS is proposing to continue to define direct supervision to permit the presence and “immediate availability” of the supervising practitioner (including NPs) through real-time audio and visual interactive telecommunications through December 31, 2024.

The proposal states that CMS is collecting additional information throughout the next year and is considering what is an “appropriate more permanent approach to direct supervision policy following the PHE for COVID-19.”<sup>22</sup> The Agency is soliciting comment on “whether we should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024.” Specifically, the proposal solicits input on whether “this flexibility would be more appropriate for certain types of services, or when certain types of auxiliary personnel are performing the supervised service.” CMS also states it’s interested in “potential program integrity concerns such as overutilization or fraud and abuse that interested parties may have in regard to this policy.”<sup>23</sup>

Within the solicitation of comment, the Agency poses a hypothetical approach for consideration in future rulemaking, which is to “extend or permanently establish this virtual presence flexibility for service that are valued under the PFS based on the presumption that they are nearly always performed in entirety by auxiliary personnel.” The Agency believes that “allowing virtual presence for the direct supervision of these services may balance patient safety concerns with the interest of supporting access and preserving workforce capacity for medical professionals while considering potentiality quality and program integrity concerns.”<sup>24</sup>

We appreciate the Agency’s attention to the potential overutilization of these flexibilities, and the negative impacts which could result from improper usage. We continue to have concerns about the overutilization of ‘incident-to’ billing, which would be exacerbated by making certain provisions of this policy permanent. Establishing the virtual presence flexibility for services performed by auxiliary personnel is an appropriate extension of this policy. However, we do not believe this policy should be extended to clinicians who are able to directly bill Medicare for services. This would exacerbate the usage

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<sup>21</sup> [88 FR 52302](#).

<sup>22</sup> *Ibid.*

<sup>23</sup> *Ibid.*

<sup>24</sup> *Ibid.*

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.<sup>25</sup> MedPAC recommended “eliminating incident to billing for APRNs”, which would “update Medicare’s payment policies to better reflect current clinical practice.”<sup>26</sup> 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.<sup>27</sup> 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.<sup>28</sup> **If CMS extends this policy, we recommend that it be limited to circumstances where the billing practitioner is supervising clinical staff who are not authorized to bill the Medicare program directly, consistent with MedPAC’s recommendations.**

- ***Payment for Outpatient Therapy Services, Diabetes Self-Management Training, and Medical Nutrition Therapy when Furnished by Institutional Staff to Beneficiaries in Their Homes Through Communication Technology; b. Proposal to Extend Billing Flexibilities for Certain Remotely Furnished Services Through the End of CY 2024 and Comment Solicitation***

In this section, CMS is proposing to continue to allow institutional providers to bill for outpatient therapy, diabetes self-management training (DSMT), and medical nutritional therapy (MNT) services furnished via telehealth through the end of CY 2024. This proposal would extend the COVID-19 PHE flexibilities which allowed these services to be furnished remotely via telehealth by institutional providers to beneficiaries in their homes. Bills for these services were submitted and paid either separately or as part of a bundled payment, when either personally provided by the billing practitioner or provided by institutional staff and billed for by institutions.

The Agency is seeking comment on billing and payment for telehealth services in institutional settings, including when these services are furnished by practitioners who have reassigned their rights to bill under and receive payment from the Medicare program (billing rights) to an institution. **We support the extension of these flexibilities and support their inclusion in the Medicare telehealth services list.** Authorizing providers to provide these services via telehealth expands access to underserved communities and increases flexibility.

**We continue to support regulatory and sub-regulatory actions by CMS that remove patient barriers and improve access for NPs’ patients to MNT.** While we understand that the current interpretation of CMS is that the MNT benefit requires a physician referral, we continue to encourage the Agency to use its authority to authorize NPs to refer for MNT. NPs are qualified to refer patients to dietitians or nutrition professionals for MNT and they provide expert treatment and management of patients with diabetes. For example, a recent study supported by the Center of Innovation to Accelerate Discovery and Practice Transformation at the Durham VA Health Care System, found that patients with diabetes managed by NPs and PAs received the same quality of care as patients managed by physicians, and had lower utilization and expenditure rates. The researchers found that “approximately \$74 million

<sup>25</sup> [jun19\\_medpac\\_reporttocongress\\_sec.pdf](#)

<sup>26</sup> *Ibid.*

<sup>27</sup> oi: 10.1377/hlthaff.2021.01968 HEALTH AFFAIRS 41, NO. 6 (2022): 805–813.

<sup>28</sup> *Ibid.*



could have been saved during the study year if utilization patterns of the entire cohort had more closely approximated those of NP and PA patients.”<sup>29</sup>

We appreciate that CMS has recognized the importance of NPs referring their patients for MNT, which is a component of the Nurse Practitioner Services Benefit Enhancement within the ACO REACH model. As stated by CMS “[m]edical nutrition therapy has been shown to be an effective and affordable way to achieve better care for patients and lower costs for health systems.”<sup>30</sup> We strongly encourage CMS to utilize its authority to remove this barrier to care and standardize this waiver across all applicable payment models.

We also encourage CMS to clarify that NPs are authorized to refer patients for MNT as a component of the Medicare initial preventative physical examination (IPPE) or the annual wellness visit (AWV). Under the SSA, Medicare covers IPPEs and AWVs when performed by NPs, the same as it would if those services were furnished by physicians.<sup>31</sup> The definition of IPPE includes “referrals with respect to screening and other preventative services”, and MNT is explicitly included in that definition.<sup>32</sup> The AWV similarly includes referrals for preventative counseling services aimed at improving disease management.<sup>33</sup> Thus, since the SSA states that Medicare covers IPPEs and AWVs when provided by NPs as it would when provided by physicians, and referrals for MNT are components of the IPPE and AWV, Medicare should cover MNT when a patient is referred by an NP as a component of an IPPE or AWV. This interpretation is consistent with the SSA and would increase access to MNT for Medicare beneficiaries.

### **Valuation of Specific Codes**

- ***Advance Care Planning (CPT codes 99497 and 99498)***

In this subsection, CMS proposes the RUC-recommended work RVUs of 1.50 for CPT code 99497, and 1.40 for CPT code 99498. These are the current values for these codes, which were surveyed for the April 2022 RUC meeting. The surveys were initiated after the Relativity Assessment Workgroup reviewed these codes, and recommended they be reexamined due to recent changes in evaluation and management services.<sup>34</sup> According to the available minutes from this meeting, the valuation for 99497 is the 25<sup>th</sup> percentile of the surveyed work RVUs, while the 99498 valuation is in between the 25<sup>th</sup> percentile work RVU of 1.00 and the median work RVU of 1.50.<sup>35</sup> These valuations are not adequate representations of the intensity of work performed by clinicians performing advance care planning services, and instead should be valued at the median recommended work RVUs.

The 99497 code is for “Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s),

<sup>29</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00014>.

<sup>30</sup> <https://innovation.cms.gov/media/document/aco-reach-rfa>, at page 77.

<sup>31</sup> 42 U.S.C. § 1395x(s)(K)(ii).

<sup>32</sup> 42 U.S.C. § 1395x(ww).

<sup>33</sup> 42 U.S.C. § 1395x(hhh)(2)(F). “The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.”

<sup>34</sup> 88 FR 52262.

<sup>35</sup> [April 2022 Meeting Minutes | AMA \(ama-assn.org\)](#)

and/or surrogate.”<sup>36</sup> It is important to note that advance care planning is distinctly different from other services billed by nurse practitioners and other providers. These conversations are centered on a patient’s care, and involve a patient, and their family, in the plan of care through a collective process with a provider. Often with a patient’s family, a provider will first have to review the history up to the point of the visit before proceeding forward with a discussion of the care plan. This is an intensive process for the provider, as they may be translating a patient’s complex medical history into understandable terms for their family members and surrogates. This can be difficult for a provider, as well as challenging for the individuals involved in the planning, and require a distinct, and intensive, skill set for a provider.

The discussion of the care plan itself is also an intensive process. The provider, the patient, and the patient’s family members and surrogates are challenged with navigating difficult, and sometimes emotionally complex, choices about a patient’s future health care needs. A provider is not only responsible for planning the patient’s care, but also often responsible for the task of helping the patient and their family navigate options for a patient’s future. In the discussion of the 99498 code, the RUC documents acknowledge that “When CPT code 99498 is reported, it is typically a much more difficult situation that requires extra time and effort beyond that required for the base code and usually includes the presence of family members. This add-on code is more intense than the first 30 minutes of advance care planning because the physician or qualified health care professional (QHP) is not just filling out forms but is working through contentious and difficult issues and educating the family members on all diagnoses to reach planning decisions.”<sup>37</sup>

We strongly agree that the 99498 code is billed during difficult situations and requires extra time and effort beyond the base code. However, the 99497 code represents a similar intensity in work as there is little distinction between the intensity of services performed under the 99497 as during the 99498. While the RUC traditionally values services at either the 25<sup>th</sup> or median surveyed work RVUs, this valuation of the 99498 code is at an interval between the 25<sup>th</sup> and the median work RVUs as surveyed. This is a distinct anomaly and does not appropriately value the intensity of these services. Additionally, these RUC recommended values are the existing values, which does not reflect that primary care delivery “has become significantly more complex for providers and patients.”<sup>38</sup> **Therefore, we believe that both codes, and their services, should be valued with the median recommended work RVUs.** Advance care planning directly aligns with the CMS strategic pillars of advancing health care equity and driving innovation by placing patients at the center of their care.<sup>39</sup> However, it is critical that these codes appropriately value a provider’s work in providing these services.

- **(26) Payment for Caregiver Training Services**

In the CY 2023 proposed and final rules, CMS did not establish payment for the new caregiver training codes which were recommended to CMS. The Agency solicited comments on these services, and potential patient benefits. In our comments, AANP supported the proposed codes, as we believe 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 as prescribed by a nurse practitioner or other health care provider. Therefore, we agree with this proposal that “that, in certain circumstances, caregivers can play a key role in developing and carrying out the treatment plan or, as applicable to physical, occupational, or speech-language therapy, the therapy plan of care (collectively referred to in this discussion as the “treatment plan”) established for the patient by the treating practitioner (which for

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<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*

<sup>38</sup> [The CMS Innovation Center’s Strategy to Support High-quality Primary Care | CMS](#)

<sup>39</sup> [CMS Strategic Plan | CMS](#)

purposes of this discussion could include a physician; nonphysician practitioner such as a nurse practitioner, physician assistant, clinical nurse specialist, clinical psychologist; or a physical therapist, occupational therapist, or speech-language pathologist). In this context, we believe Caregiver Training Services (CTS) could be reasonable and necessary to treat the patient's illness or injury as required under section 1862 (a)(1)(A) of the Act.”<sup>40</sup>

We agree that CTS are reasonable and necessary to treat a patient’s illness or injury, as they are a proactive solution which authorizes providers to use different techniques to provide patient centered care. We support the inclusion of nurse practitioners as health care providers authorized to establish a treatment plan under this proposal as a treating practitioner. We further support the flexibilities included within this proposal which would authorize a practitioner to train caregivers in a group setting with other caregivers who are involved in care for patients with similar needs for assistance to carry out a treatment plan. Training for all of the caregivers for the patient could occur simultaneously, and the applicable CTS codes would be billed once per beneficiary. This would allow providers flexibility within their training and maximize the availability of this service to caregivers.

**Therefore, we support the implementation of the 96202, 96203 as well as the 9X015, 9X016 and 9X017 codes.** The 9X015 code is important, as a group setting may not always be the most beneficial environment for a caregiver to receive this training. Certain patients may have specific needs which require more focused training, and the 9X015 code will allow providers discretion in choosing which service will best benefit patients and their caregivers. **We also strongly encourage the Agency to examine the establishment of a similar code within the 96202 and 96203 subset, to allow these services to be reimbursed individually rather than within a group setting.**

CMS is also seeking comment on whether CTS would be reasonable and necessary when furnished to caregivers in more than one single session, or to (presumably the same) caregivers by the same practitioner for the same patient more than once per year. We believe there may be scenarios in which a caregiver may require more intensive, or additional training beyond the initial session. While these circumstances may be limited, providers should have the necessary flexibility to provide and bill for these services, and document the necessity of the additional training which may be based off of a patient’s changing diagnosis or condition.

**We also support the designation of the 9X015, 9X016 and 9X017 codes as “sometimes therapy.”** We agree that when appropriate, they can be furnished by a nurse practitioner or other qualified health care provider under that provider’s plan of care. However, we are concerned that the proposed RVU for the 9X015 code may not accurately reflect the work and intensity of services provided by this code. This is an intensive service requiring a significant amount of planning, effort, and expertise from a provider. Accordingly, we support an immediate review of the valuation of these services to ensure the valuations reflect the work and intensity of services being delivered, and that undervaluation does not lead to underutilization.

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<sup>40</sup> 88 FR 52323.

- ***(27) Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)***

We appreciate recent CMS efforts to “identify gaps in appropriate coding and payment for care management/coordination and primary care services under the PFS.”<sup>41</sup> We agree with the importance of identifying and valuing the work of nurse practitioners and other providers when they are incurring additional time and resources coordinating patient care. This includes helping with serious illness navigation and identifying and removing health-related social barriers. These services are increasingly important, and as CMS notes within this proposal, are being performed more often. We strongly agree that “this work is not explicitly identified in current coding” and as a result, it is “underutilized and undervalued.”<sup>42</sup>

**Therefore, we support the proposal within this section to create new coding, which would “expressly identify and value these services for PFS payment, and distinguish them from current care management services.”**<sup>43</sup> We agree that these codes will support the CMS pillars for equity, inclusion, and access to care for the Medicare population, as well as “improve patient outcomes, including for underserved and low-income populations where there is a disparity in access to quality care.”<sup>44</sup> Nurse practitioners are particularly skilled in holistic, patient centered care and these codes will better empower NPs to provide these services.

- ***Community Health Integration (CHI) Services***

In this section, CMS proposes to establish separate coding and payment for CHI services. This proposal would create two new G codes describing CHI services performed by certified or trained auxiliary personnel, which may include a CHW, incident to the professional services and under the general supervision of the billing practitioner. Additionally, these CHI services could be furnished monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner’s ability to diagnose or treat the problem(s) addressed in the visit.

The CHI initiating visit would “be an E/M visit (other than a low-level E/M visit that can be performed by clinical staff) performed by the billing practitioner who will also be furnishing the CHI services during the subsequent calendar month(s).”<sup>45</sup> The CHI initiating visit would also be separately billed “(if all requirements to do so are met), and would be a pre-requisite to billing for CHI services” during which the billing practitioner would assess and identify SDOH needs that “significantly limit the practitioner’s ability to diagnose or treat the patient’s medical condition and establish an appropriate treatment plan.”<sup>46</sup> SDOH(s) may include but are not limited to “food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, when they significantly limit the practitioner’s ability to diagnose or treat the problem(s) addressed in the CHI initiating visit.”<sup>47</sup>

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<sup>41</sup> 88 FR 52325.

<sup>42</sup> *Ibid.*

<sup>43</sup> *Ibid.*

<sup>44</sup> *Ibid.*

<sup>45</sup> 88 FR 52327.

<sup>46</sup> *Ibid.*

<sup>47</sup> *Ibid.*



Upon completion of the CHI initiating visit, the subsequent CHI services would be performed by a CHW or other auxiliary personnel incident to the professional services of the practitioner who bills the CHI initiating visit. The same practitioner would furnish and bill for both the CHI initiating visit and the CHI services, and CHI services must be furnished in accordance with the “incident to” regulation at § 410.26. This section, as proposed, would not require an initiating E/M visit every month that CHI services are billed, but only prior to commencing CHI services, to establish the treatment plan, specify how addressing the unmet SDOH need(s) would help accomplish that plan, and establish the CHI services as “incident to” the billing practitioner’s service.

Due to concerns regarding potential fragmentation that could occur in addressing specific SDOH, CMS is proposing that only one practitioner per beneficiary per calendar month could bill for CHI services. This would “allow the patient to have a single point of contact for all their CHI services during a given month.”<sup>48</sup> Additionally, a practitioner could separately bill for other care management services during the same month as CHI services, “if time and effort are not counted more than once, requirements to bill the other care management service are met, and the services are medically reasonable and necessary.”<sup>49</sup> Finally, CMS is also seeking comment on whether the Agency should consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite initiating visit for CHI services, including, for example, an annual wellness visit (AWV) that may or may not include the optional SDOH risk assessment also proposed in this rule.

**We support the proposal to establish separate coding and payment for CHI services.** We agree that these are often integral to a provider’s services and would empower nurse practitioners to utilize the expertise of a team to manage a patient’s care. The procedure proposed by CMS to establish the initiating visit, and subsequent CHI services, will provide NPs the appropriate flexibility in providing these services. We also agree with the Agency’s concerns regarding fragmentation of care and support the proposed limitation on one provider per beneficiary billing the service per month. Noting that patients may have complex needs, we believe that the flexibility to bill for other care management services during the same month as CHI services is a necessary component of providing patient centered care.

**Finally, we believe that there are services other than an E/M visit performed by the billing practitioner which could serve as the prerequisite initiating visit. AWVs are an appropriate service for this initiating visit.** For some patients, this may be the only time during the year they interact with a health care provider. The ability to offer these services during the AWV is an additional opportunity for providers to proactively coordinate a patient’s care and should be an option for the initiating visit.

- ***Social Determinants of Health (SDOH) –Proposal to Establish a Stand-Alone G Code***

We agree with CMS that “there is increasing recognition within the health care system of the need to take SDOH into account when providing health care services”<sup>50</sup> as it is estimated that around 50 percent of an individual’s health is directly related to SDOH. Healthy People 2030 defines the broad groups of SDOH as “economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context, which include factors like housing, food and nutrition access, and transportation needs.”<sup>51</sup> We strongly agree that SDOH impact a patient’s overall health, access to care, and can their ability to adhere to a plan of care.

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<sup>48</sup> 88 FR 52330.

<sup>49</sup> *Ibid.*

<sup>50</sup> *Ibid.*

<sup>51</sup> [Healthy People 2030 | health.gov](https://www.health.gov/healthy-people-2030)

NPs are particularly skilled in whole-person, patient centered care which includes assessment of health-related social needs or SDOH in taking patient histories, assessing patient risk, and informing medical decision making, diagnosis, care and treatment. We agree that the taking of a social history is generally “in support of patient-centered care to better understand and help address relevant problems that are impacting medically necessary care”<sup>52</sup> and that “the resources involved in these activities are not appropriately reflected in current coding and payment policies.”<sup>53</sup> **Therefore, we support the proposal to establish a code to separately identify and value a SDOH risk assessment that is furnished in conjunction with an E/M visit.** This code will “identify and value the work involved in the administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit.” We agree that the SDOH risk assessment through a standardized, evidence-based tool can “more effectively and consistently identify unmet SDOH needs and enable comparisons across populations.”<sup>54</sup>

- *Principal Illness Navigation (PIN) Services*

In this section, CMS proposes new coding for PIN services. This proposal seeks to “better recognize through coding and payment policies when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient’s health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.”<sup>55</sup>

The PIN services are designed as a “parallel set of services to the proposed CHI services with a concentration on patients with a serious, high-risk illness” who “may not necessarily have SDOH needs, and adding service elements to describe identifying or referring the patient to appropriate supportive services, providing information/resources to consider participation in clinical research/clinical trials, and inclusion of lived experience or training in the specific condition being addressed.”<sup>56</sup> **We support this proposal and the establishment of these codes.** We agree there is a need for these parallel services to the proposed CHI services, but with a concentration on patients with a serious illness. As a patient’s chosen health care provider, NPs often serve as a patient’s primary point of contact within the health care system and assist them with navigating services. This will ensure that providers’ efforts in providing these services are recognized.

CMS is also seeking comment on whether the Agency should consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite initiating visit for PIN services, including, for example, an AWV that may or may not include the optional SDOH risk assessment also proposed in this rule. **We believe that there are services other than an E/M visit performed by the billing practitioner which could serve as the prerequisite initiating visit. AWVs are an appropriate service for this initiating visit.** For some patients, this may be the only time during the year they interact with a health care provider. The ability to offer these services during the AWV is an additional opportunity for providers to proactively coordinate a patient’s care and should be an option for the initiating visit.

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<sup>52</sup> 88 FR 52331.

<sup>53</sup> *Ibid.*

<sup>54</sup> *Ibid.*

<sup>55</sup> 88 FR 52332.

<sup>56</sup> *Ibid.*

- ***Evaluation and Management (E/M) Visits; Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation; Proposal for O/O E/M Visit Complexity Add-on HCPCS code G2211***

In the CY 2021 PFS final rule, CMS refined the O/O E/M visit complexity add-on code, GPC1X (which was replaced by HCPCS code G2211), to describe “intensity and complexity inherent to O/O E/M visits associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex condition.”<sup>57</sup> We strongly agree with its establishment, and that the code “reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M office visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of patients’ health care needs with consistency and continuity over longer periods of time.”<sup>58</sup> Coordination of care is an essential service provided by NPs. We further agree that the current E/M coding structure does not accurately represent these services, or authorize providers to be reimbursed for providing sustained, coordinated and longitudinal patient centered care.

**Therefore, we support the proposal to change the status of HCPCS code G2211 to make it separately payable by assigning the “active” status indicator, effective January 1, 2024.** This change reflects the December 31, 2023, end of the moratorium imposed by the Consolidated Appropriations Act, 2021 on Medicare payment under the PFS for HCPCS code G2211.<sup>59</sup> This critical change will complement the recent CMS efforts to ensure that primary care E/M services are appropriately valued under the PFS. This is directly aligned with the CMS National Quality Strategy, “A Person-Centered Approach to Improving Quality.”<sup>60</sup>

As providers of whole person, patient centered care, nurse practitioners often serve as the center of a patient’s care. We strongly agree with the Agency that there is an inherent complexity and intensity of services associated with O/O E/M visits which are part of ongoing, coordinated, longitudinal patient care. As noted by CMMI, “primary care delivery has become significantly more complex for providers and patients.”<sup>61</sup> Providers who build a longitudinal relationship to coordinate a patient’s care are assuming a greater responsibility for that patient’s care, including addressing SDOH, coordinating with other clinicians, and addressing their needs through continuity of care. We acknowledge that CMS has recently undertaken a sustained effort to accurately value E/M services after years of historic undervaluation, and we support these efforts.

The fee-for-service valuation process has historically struggled to properly reflect the time, intensity and work required to provide primary care. Along with the issues identified by CMS in subsection C, the coding and payment structure is better suited for identifying individual procedures, and is not designed to reflect the provision of coordinated and longitudinal care. CMS has recognized the importance of primary care, noting that “access to primary care is associated with improved patient outcomes, increased equity, and lower mortality/higher life expectancy at similar or lower total costs.”<sup>62</sup> Further, the recently released data on the Medicare Shared Savings Program (MSSP), which saved Medicare more than 1.8 billion

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<sup>57</sup> 85 FR 84569-84571.

<sup>58</sup> 88 FR 52352.

<sup>59</sup> *Ibid.*

<sup>60</sup> [The CMS National Quality Strategy: A Person-Centered Approach to Improving Quality | CMS](#)

<sup>61</sup> [The CMS Innovation Center’s Strategy to Support High-quality Primary Care | CMS](#)

<sup>62</sup> [The CMS Innovation Center’s Strategy to Support High-quality Primary Care | CMS](#)

dollars, highlights the importance of longitudinal, coordinated, whole-person care.<sup>63</sup> This data underscores the importance of ensuring that providers are able to bill for the provision of these services, and the importance of the G2211 code.

We appreciate that in this recent proposal, the Agency adjusted its assumptions on utilization to better reflect the billing of this code. However, we remain concerned that the assumptions remain high, and are not aligned with historical data regarding uptake and implementation of new codes. Finally, we recognize that the implementation of this code, and the potential impact on valuations of other services as a budget neutrality off-set, have been addressed in comments. We do not believe those considerations should have bearing on this long-awaited and overdue code, which should be addressed in the context of the construction of the entirety of the schedule itself, rather than the implementation of a specific primary care code.

- ***Request for Comment About Evaluating E/M Services More Regularly and Comprehensively; Should CMS consider valuation changes to other codes similar to the approach in section II.J.5. of this rule?; Finally, we are also interested in whether commenters believe that the current AMA RUC is the entity that is best positioned to provide -recommendations to CMS on resource inputs for work and PE (Practice Expense) valuations, as well as how to establish values for E/M and other physicians' services; or if another independent entity would better serve CMS and interested parties in providing these recommendations.***

We greatly appreciate CMS posing this line of inquiry, as we firmly believe that health care equity must also include equitable representation in the valuation process for nurse practitioners. We do not believe that the AMA RUC is the entity best positioned to provide recommendations to CMS on resource inputs for work and PE valuations, as well as how to establish values for E/M and other physicians' services. The AMA RUC does not allow all health care providers equitable participation during their process, and therefore, CMS should establish an independent entity which would better serve CMS and ensure that all health care providers, including nurse practitioners, who bill Medicare are included within the valuation process to ensure accurate valuations of services.

CMS has identified many of the issues with the RUC within the introduction to this subsection. In the request for comment regarding evaluating E/M services more regularly and comprehensively, the Agency notes that many stakeholders have recognized the need to rely on research and data outside of RUC, as well as the evolving practice of health care, including the many changes in the three decades since the resource-based relative value scale (RBRVS) was established. We believe that the historic issues with undervaluation of E/M services are directly aligned with the multiple issues within the overall valuation process, as these problems are not mutually exclusive. Therefore, CMS must reform the entirety of the valuation process to improve accuracy and ensure the updates are regular and comprehensive. These reforms must go beyond the PFS notice and comment period and be a wholesale transformation of an equitable process which is inclusive of all health care providers billing the Medicare program.

The AMA RUC was established in 1991, and as the Agency states within the questions, is based on the premise of establishing valuation for "physician services."<sup>64</sup> As noted on the RUC's website, "the RVS Update Committee (RUC) is a volunteer group of 32 physicians and other health care professionals who

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<sup>63</sup> [Medicare Shared Savings Program Saves Medicare More Than \\$1.8 Billion in 2022 and Continues to Deliver High-quality Care | CMS](#)

<sup>64</sup> 88 FR 52262.



advise Medicare on how to value a physician's work.”<sup>65</sup> However, since 1991, there has been a significant evolution in providers who bill the Medicare program. As of 2021, there were over 193,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.<sup>66</sup> Approximately 42% of Medicare patients receive billable services from a nurse practitioner<sup>67</sup>, and approximately 80% of NPs are seeing Medicare and Medicaid patients.<sup>68</sup> According to MedPAC, APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.<sup>69</sup> The valuations established during this process no longer represent the valuation of services for ‘physicians’, but all providers who bill Medicare.

Despite the evolution over the past 32 years, the RUC has made minimal changes to its composition to provide equitable representation for providers who bill Medicare. Despite representing the interests of the 355,000 NPs in the United States, AANP does not have a formal seat on RUC, which would allow for full participation in the valuation process. In fact, 22 of the 32 members of the RUC are appointed by the major national medical specialty societies.<sup>70</sup> The interests of the 12 “limited license practitioners and allied health professionals”<sup>71</sup> are represented by the Health Care Professionals Advisory Committee (HCPAC), which only has one seat on the RUC. It is important to note that nurse practitioners are not “limited licensed practitioners” but advanced practice registered nurses able to independently bill Medicare. The current valuation process is flawed based on its presumption of a valuation of “physician services”, rather than adequate valuations of services billed under the fee schedule by a diverse group of health care providers, including nurse practitioners. For example, the July 2023 data book released by MedPAC evaluated the type of allowed charges by service billed under the 2021 fee schedule, and their analysis shows that 51.8% of the allowed charges were E/M services.<sup>72</sup> However, the RUCs composition of specialty societies is not reflective of the distribution of services within the fee schedule, which directly impacts the data used for the valuation process.

Multiple official reports from government agencies and advisory committees have identified serious flaws within the RUC process, and CMS’ valuation of services. In May 2015, the United States Government Accountability Office (GAO) issued a report to Congressional Committees on *Medicare Physician Payment: Better Data and Greater Transparency Could Improve Accuracy*.<sup>73</sup> In this report, GAO states that “CMS’s process for establishing relative values embodies several elements that cast doubt on whether it can ensure accurate Medicare payment rates and a transparent process.”<sup>74</sup> The report identifies numerous flaws within the process, including potential conflict of interests, weaknesses with survey data which may undermine the accuracy of the RUC’s recommendations, and concludes that “CMS’s process for establishing relative values embodies several elements that cast doubt on whether it can ensure accurate Medicare payment rates and a transparent process.”<sup>75</sup> GAO also noted that “in the majority of cases, CMS accepts the RUC’s recommendations and participation by other stakeholders is limited”<sup>76</sup> and that “Given the process and data related weaknesses associated with the RUC’s recommendations, such

<sup>65</sup> [RVS Update Committee \(RUC\) News & Information | American Medical Association \(ama-assn.org\)](#)

<sup>66</sup> [data.cms.gov](#) MDCR Providers 6 Calendar Years 2017-2021

<sup>67</sup> *Ibid.*

<sup>68</sup> [NP Fact Sheet \(aanp.org\)](#)

<sup>69</sup> [https://www.medpac.gov/wp-content/uploads/2022/06/Jun22\\_MedPAC\\_Report\\_to\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf) (see Chapter 2.)

<sup>70</sup> [Composition of the RVS Update Committee \(RUC\) | American Medical Association \(ama-assn.org\)](#)

<sup>71</sup> [RVS update process booklet | AMA \(ama-assn.org\)](#)

<sup>72</sup> [July2023\\_MedPAC\\_DataBook\\_SEC.pdf](#)

<sup>73</sup> [GAO-15-434, Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy](#)

<sup>74</sup> *Ibid.*

<sup>75</sup> *Ibid.*

<sup>76</sup> *Ibid.*

heavy reliance on the RUC could result in inaccurate Medicare payment rates.”<sup>77</sup> As noted in the GAO report, “the reliability of work relative value recommendations may be undermined by survey respondents’ potential conflicts of interest.”<sup>78</sup>

These inherent conflicts in the valuation process led to a historic undervaluation of E&M services, which are a foundational aspect of the primary care system. The resulting negative impact on Medicare beneficiaries was identified by the MedPAC in the Commission’s 2018 Report to the Congress *Medicare and the Health Care Delivery System*. Chapter 3 of this report, entitled *Rebalancing Medicare’s physician fee schedule toward ambulatory evaluation and management services* stated that “this mispricing may lead to problems with beneficiary access to these services” which are “essential for a high-quality, coordinated health care delivery system.”<sup>79</sup> MedPAC’s report raises many of the same concerns as the GAO report, with the Commission stating that “to estimate clinician work time for specific services, CMS relies on data from surveys conducted by specialty societies that are reviewed by the RUC. We have concerns about these data; for example, the surveys have low response rates and low total number of responses, which raises questions about the representativeness of the results.”<sup>80</sup> The Commission stated that the systemic undervaluation of E&M services was partially “because the fee schedule is budget neutral, ambulatory E&M services become underpriced through a process of passive devaluation.”<sup>81</sup>

It is also important to acknowledge the impact of underrepresentation on health care equity. When nurse practitioners are not able to fully participate in the valuation process, the patients they care for are also not represented. This is particularly impactful for NPs, who are “significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians.”<sup>82</sup> MedPAC also found that, among all clinician types, NPs on average had the highest share of allowed charges associated with low-income subsidy (LIS) beneficiaries. “In 2019, 41 percent of the allowed charges billed by NPs who practiced in primary care were for LIS beneficiaries, as were 36 percent for NPs who practiced in specialty care compared with 28 percent for primary care physicians and PAs and 25 percent for specialty care physicians and PAs.”<sup>83</sup> A process which is not inclusive of clinicians providing care to these populations is inherently inequitable, and by proxy excludes their perspective as well.

The RUC process is also not transparent, which is in direct conflict with the CMS strategic pillars of engaging partners, advancing equity, and driving innovation. Under the strategic pillar of engagement, the Agency states it is a priority to “engage our partners and communities we serve throughout the policy making implementation process.”<sup>84</sup> However, the process used by the RUC to determine valuations is not a public process which ensures equitable representation of clinicians who bill the Medicare program. The meetings are not easily accessible to the public, as attendance requires application to and approval from the AMA. Importantly, this is only for an entity, or individual, to attend on an observatory basis. There is currently no open, publicly accessible option to participate in the RUC valuation process.

Furthermore, the participants use proprietary information which is not publicly available. While the votes and other materials are accessible online after a meeting, the surveys themselves, as well as the other

<sup>77</sup> *Ibid.*

<sup>78</sup> [GAO-15-434, Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy](#)

<sup>79</sup> [jun18\\_medpacreporttocongress\\_rev\\_nov2019\\_note\\_sec.pdf](#)

<sup>80</sup> *Ibid.*

<sup>81</sup> [jun18\\_ch3\\_medpacreport\\_sec.pdf](#)

<sup>82</sup> <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/>

<sup>83</sup> [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf) (Page 135).

<sup>84</sup> [CMS Strategic Plan | CMS](#)

documents used during the valuation process are not publicly available. There is no public opportunity for clinicians who do not have a formal RUC seat to actively participate in the valuation process.

This lack of public accessibility is not addressed by the comment process incorporated within the fee schedule, as the fee schedule itself often uses the valuations determined by the RUC as the basis for its rationale. While the public can comment through the Federal Register, they do not have access to the information used to determine valuations during the RUC process, resulting in an unfair advantage for those who do. This opacity results in inequitable access to a process which is utilized by CMS to make its valuation determinations. In fact, from 2011 to 2015, CMS agreed 69% of the time with the valuations set by the RUC.<sup>85</sup> GAO highlighted the inherent conflict in their report, noting that “stakeholder participation in CMS’s process is limited because of incomplete information regarding which services are undergoing RUC—and eventually CMS—review.”<sup>86</sup>

Both the GAO and MedPAC have called on CMS to make substantive changes to the valuation process, and the current RUC process cannot, and will not, meet the recommendations issued by GAO. In its 2015 report, GAO recommended “to help improve CMS’s process for establishing relative values for Medicare physicians’ services, the Administrator of CMS should incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by the Protecting Access to Medicare Act of 2014.”<sup>87</sup> In a 2022 update, GAO noted that “to close this recommendation, we need documentation that CMS has started to incorporate data more broadly into its process for establishing relative values and that it has a documented timeline and plan for how it will use the funds appropriated by the Protecting Access to Medicare Act of 2014. As of December 2022, we had not received this documentation.”<sup>88</sup>

Therefore, it is incumbent on the Agency to establish an equitable, accessible, and accurate valuation process which is reflective of the modern health care system. This must ensure that nurse practitioners, and other providers directly billing Medicare, can participate in the entirety of the valuation process, which must be transparent and accessible for all. This will align the valuation process with the CMS strategic pillars, MedPAC and GAO recommendations, and ensure the Agency is advancing health care equity, which must include an equitable representation and participation for nurse practitioners.

- ***Split (or Shared) Services***

We sincerely appreciate CMS’ efforts to engage on the issue of split (or shared) E/M services. **We support the proposal to delay the implementation of the definition of *substantive portion* as more than half of the total time performing the split (or shared) service until January 1, 2025.** We support the overall goal of this policy, which is to require transparency and ensure that nurse practitioners are billing for the visits they provide. Pursuant to the changes in the 2022 PFS, the -FS modifier has been implemented, and health systems are gathering the data on its usage and impact. We look forward to a better understanding of the impact and have continued to engage with members on the implementation of this process in their facilities.

However, it is important to note that we do continue to hear concerns from our members about the negative impacts of the proposed time-based standard, due to the 15% reimbursement disparity between nurse practitioners and their physician colleagues. Our concern with this proposal, and the time-based

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<sup>85</sup> [GAO-15-434, Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy](#)

<sup>86</sup> *Ibid.*

<sup>87</sup> [Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy | U.S. GAO](#)

<sup>88</sup> *Ibid.*

requirements, is that despite the best intention of CMS, there is an inherent incentive within the Medicare program for groups and practices to bill for services under a physician's NPI. Billing under a physician allows them to be reimbursed for the same service at a rate 15% higher than if billed by an NP. While we appreciate CMS' consistent recognition of the importance of the role of nurse practitioners, the proposal to move to time-based measurements without addressing the inequitable reimbursement structure may have a detrimental impact, which we understand is not the intent of CMS. Conversely, we have heard from members who have seen their facilities take a positive approach to this implementation and due to the modifier, gained better insight into the value and breadth of care being provided by NPs that was previously obscured. We believe additional time to review this information before making a final determination is the proper approach, and appreciate CMS for considering the input of stakeholders.

However, as mentioned above, the 15% disparity in reimbursement does have a negative effect on NPs and conflicts with true team-based care which should be focused on the needs of the patient and empower all clinicians to practice to the full extent of their education and clinical training. We strongly request the Agency to examine the inequitable reimbursement structure for services provided by nurse practitioners, including split (or shared) visits. We look forward to continued conversation with CMS on this topic and proactively working towards a solution which ensures NPs are treated equitably for the care they provide.

- ***Advancing Access to Behavioral Health Services***

As CMS states, the confluence of the COVID-19 PHE, opioid epidemic and behavioral health workforce shortages have led to an ongoing behavioral health crisis in the United States. According to HRSA, more than one-third of Americans live within mental health professional shortage areas.<sup>89</sup> Data demonstrates that nurse practitioners have been critical in filling access gaps and providing mental and behavioral health care to Medicare beneficiaries. A recent study published in *Health Affairs* found that from 2011-2019 the number of psychiatric-mental health NPs (PMHNPs) treating Medicare beneficiaries grew by 162%, compared to a 6% drop in psychiatrists during that same period.<sup>90</sup> The study also found that the proportion of all mental health prescriber visits provided by PMHNPs to Medicare beneficiaries increased from 12.5% to 29.8% during that same period, exceeding 50% in rural, full practice authority regions.<sup>91</sup> In addition, MedPAC analyzed the utilization and availability of behavioral health services for Medicare beneficiaries, and noted that between 2016 and 2021, there was a "shift in Part B behavioral health services from psychiatrists to NPs and PAs."<sup>92</sup> Additionally, according to AANP's 2020 National Nurse Practitioner Sample Survey, anxiety and depression are two of the top seven most commonly treated diagnoses by all NPs.<sup>93</sup> We appreciate CMS efforts to support the behavioral health workforce.

- ***Adjustments to Payment for Times Behavioral Health Services***

CMS is proposing to apply an adjustment to the work RVUs for the psychotherapy codes payable under the PFS which is estimated to result in an approximate adjustment of 19.1% for these services, implemented over a 4-year transition period. The rationale behind this adjustment is that behavioral health services have historically been undervalued, impacting behavioral health workforce shortages, and that the RUC valuation process does not appropriately value services that primarily involve person-to-person interactions with minimal equipment, supplies, and clinical staff relative to other services.<sup>94</sup> We agree

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<sup>89</sup> 88 FR 52366.

<sup>90</sup> <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00289>

<sup>91</sup> *Ibid.*

<sup>92</sup> [Congressional request: Medicare clinician and outpatient behavioral health services](#) (Slide 14)

<sup>93</sup> [Practice-related Research \(aanp.org\)](#).

<sup>94</sup> 88 FR 52367.



with CMS on this rationale, and that these are necessary and intensive services that have not been properly valued. **Accordingly, we support this proposal.**

- ***Updates to the Payment Rate for the PFS Substance Use Disorder (SUD) Bundle (HCPCS Codes G2086–G2088)***

NPs continue to be critical to addressing the opioid epidemic and provide vital and medically necessary treatment for OUD to patients across the country. After the passage of the *Comprehensive Addiction and Recovery Act of 2016* (CARA), studies found that NPs increased access to medication-assisted treatment in rural and underserved communities. One study found that NPs and PAs were the first waived providers in hundreds of rural counties, representing millions of individuals.<sup>95</sup> The Medicaid and CHIP Payment and Access Commission also found that the number of NPs prescribing MOUD and the number of patients treated with MOUD by NPs increased substantially in the first year they were authorized to obtain their Drug Addiction and Treatment Act (DATA) waiver, particularly in rural areas and for Medicaid beneficiaries.<sup>96</sup>

CMS is proposing to increase the current payment rate for the substance use disorder bundle (G2086 and G2087) to reflect two individual psychotherapy sessions per month based on the crosswalk to the work RVUs for CPT code 90834 instead of CPT Code 90832. This proposal would add 1.08 RVUs to the work value assigned to HCPCS codes G2086 and G2087. **We support CMS' proposal to value these codes at the crosswalk codes for bundled payments made for OUD treatment furnished by OTPs, since beneficiaries receiving buprenorphine outside of an OTP may have similarly complex needs.**<sup>97</sup> We agree with this assessment, and the need to support clinicians treating OUD in settings outside of OTPs.

- ***Comment Solicitation on Expanding Access to Behavioral Health Services***

As noted above, NPs provide care to a significant portion of LIS Medicare beneficiaries, many of whom also qualify for Medicaid. While we understand that this proposed rule concerns the Medicare program, addressing policies related to dual-eligibles is a paramount concern to ensure that these patients have comprehensive and non-fragmented care between the two programs.

In that vein, a barrier exists in the Medicaid coverage of organized outpatient programs for psychiatric treatment which are primarily covered as outpatient hospital services or clinic services. 42 CFR § 440.20 states that hospital outpatient services must be provided “by or under the direction of a physician or dentist.” However, there is no statutory requirement that this be the case. Clinic services do have statutory language that states that the services are provided under the direction of a physician<sup>98</sup>; however, the Medicaid Provider Manual has overly stringent and unnecessary requirements that inhibit access to patient care. The Manual has interpreted this language to mean that a physician must see the patient at least once, prescribe the type of care provided and periodically review for continued care.<sup>99</sup>

We request that CMS amend 42 CFR § 440.20 to authorize hospital outpatient services to be provided under the direction of a nurse practitioner. We also request that CMS amend the Medicaid Provider Manual

<sup>95</sup> <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00859>.

<sup>96</sup> <https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/>.

<sup>97</sup> 88 FR 52369.

<sup>98</sup> 42 U.S.C. 1396d(a)(9).

<sup>99</sup> Medicaid Provider Manual, Section 4320- Clinic Services.

to defer to States and the clinics in determining how the physician direction requirement is implemented. CMS has the regulatory authority to take these actions which will lead to greater access to psychiatric services for the dual-eligible population.

- ***Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services***

In the CY 2023 PFS proposed rule, AANP supported CMS' proposal to adopt a new interpretation of section 1862(a)(12) of the Act and expand coverage of dental services. Coverage of essential and preventative services for beneficiaries is essential to achieving health care equity, a goal which we share with CMS. We agree that dental services which are linked to, and substantially related and integral to the clinical success of certain other covered medical services should be covered by Parts A and B.

In this proposed rule, CMS is proposing to permit payment under Medicare Parts A and B for dental services inextricably linked to chemotherapy services, CAR T-cell therapy, or high-dose bone modifying agents when used in the treatment of cancer. CMS is also proposing that services ancillary to these dental services (ex. X-rays or anesthesia) also be covered. Given the increased risk of dental infections and other complications related to these therapies, as discussed in this proposed rule, we agree with CMS regarding the importance of covering dental services in conjunction with these treatments. **Accordingly, we support this proposal.**

- ***RHC and FQHC Policies***
  - ***Payment for Community Health Integration (CHI) Services in RHCs and FQHCs/(3) Payment for Principal Illness Navigation (PIN) Services in RHCs and FQHCs***

As noted in our comments in response to section II.E.4.(27) of this proposed rule, AANP agrees with CMS that the work of addressing SDOH is underutilized and undervalued, and we support the payment for CHI and PIN services. **Accordingly, we also support the proposal to expand the billable services under HCPCS code G0511 to include CHI and PIN to allow separate payment for these services when performed by RHCs and FQHCs.** RHCs and FQHCs are critical access points for patients in need of these services and ensuring that they are appropriately reimbursed for providing care coordination services will increase access and support their ability to provide these necessary services to their communities.

- ***Conditions for Certification or Coverage (CfCs); Proposed Changes to the RHC Conditions for Certification and FQHC Conditions for Coverage***

We appreciate the recognition from CMS on the importance of NPs to RHCs and FQHCs. According to HRSA, in 2022 there were over 12,000 FTE NPs in community health centers, who performed over 25 million in-person clinic visits, and almost 4 million virtual visits, more than any other individual clinician group.<sup>100</sup> In this proposed rule, CMS proposes to remove the specific certifying bodies for nurse practitioners from the regulatory language in § 491.2(1) and replace that language with the requirement that an NP “[i]s currently certified as a primary care nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners and possesses a master’s degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.” **We agree with CMS that removing the list of specific certifying boards will ensure that the requirements reflect the breadth of currently available certifications, because as noted by CMS, the current list does not reflect all the recognized**

<sup>100</sup> <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2022>.

**NP certifying bodies. However, AANP does make one recommendation to CMS to amend the end of the proposed regulatory text to read, "... and possesses a master's or doctoral degree in nursing." to ensure the text is inclusive of all NP graduate degrees.**

CMS also requested feedback on whether the definition of NPs should specify that an NP certification be in an area of primary care, or whether this distinction should be removed. We appreciate CMS reviewing the APRN Consensus Model and recognizing that "the NP scope of practice allows them to provide care to patients based on the acuity of the patient's needs, rather than the setting in which the services are administered."<sup>101</sup> NPs who are certified in acute care are clinically prepared to provide essential services within their scope of practice in RHCs and FQHCs. While the full scope of practice may differ between primary and acute care NPs, as stated in the APRN Consensus Model, "[b]oth primary and acute care CNPs provide initial, ongoing, and comprehensive care, includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases."<sup>102</sup> **This expertise is valuable in all settings including RHCs and FQHCs, and consistent with the APRN Consensus Model, we support removing the specification requiring NPs to be certified in primary care in the definition of § 491.2.**

We also appreciate CMS utilizing AANP resources and data as these are the most authoritative sources for information on nurse practitioners and the NP workforce. In that vein, we would like to provide one correction to the data point on page 52408 which states that "during the 2019-2020 academic year, approximately 12.9 percent or 45,795 NP graduates received certifications in non-primary care specialties." AANP workforce survey data indicates that in 2022, 12.9% of actively licensed NPs self-reported having at least one non-primary care certification.<sup>103</sup> During the 2019-2020 academic year there were 36,887 NP graduates, 2,553 of whom graduated from adult-gerontology acute care or pediatric acute care nurse practitioner programs, as reported by the American Association of Colleges of Nursing.<sup>104</sup> Again, we greatly appreciate CMS' interest and support for nurse practitioners and are available to provide additional information and data on the NP workforce to CMS to support the Agency's efforts.

- ***Staffing and Staff Responsibilities (§ 491.8)***

During the COVID-19 Public Health Emergency, and currently continuing until the end of 2023, CMS modified the requirement at 42 CFR 491.8(b)(1) that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, with respect to medical supervision of nurse practitioners to the extent permitted by state law.<sup>105</sup> Waiving these requirements in RHCs and FQHCs has provided needed workforce flexibility in rural and underserved communities, where there are consistent workforce challenges. This change is also consistent with the statutory definition of RHCs and FQHCs which includes non-physician directed clinics, and states that when an RHC or FQHC is not directed by a physician, it must have arrangements for physician involvement in accordance with State and local law.<sup>106</sup> **We strongly encourage CMS to make this flexibility permanent.**

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<sup>101</sup> 88 FR 52409.

<sup>102</sup> [https://www.ncsbn.org/public-files/Consensus\\_Model\\_for\\_APRN\\_Regulation\\_July\\_2008.pdf](https://www.ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf), at page 9.

<sup>103</sup> 2022 AANP National Nurse Practitioner Workforce Survey.

<sup>104</sup> American Association of Colleges of Nursing (AACN). (2022). *2021-2022 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington, DC: AACN.

<sup>105</sup> <https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf>.

<sup>106</sup> 42 U.S.C. 1395x(aa).

- ***Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Expansion of Supervising Practitioners***

CMS is proposing revisions to the PR and CR/ ICR regulations to codify the statutory changes made in section 51008 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123, February 9, 2018) (BBA of 2018) which authorizes NPs, CNSs and PAs to supervise these items and services effective January 1, 2024.<sup>107</sup>

**We support the proposals for implementation including the supervising practitioner standards in the manner proposed by CMS.** We greatly appreciate CMS implementing these regulations in a streamlined manner that reduces redundant regulatory language.

We also appreciate the discussion of the potential impact of this policy on patient access to PR, CR and ICR. We agree that this policy will provide additional flexibility for PR, CR and ICR programs to operate, and ensuring that NPs and other clinicians are authorized to practice to the full extent of their education and clinical training will help address workforce shortages. However, as discussed by CMS, significant patient access barriers remain to these programs which result in underutilization. CMS discusses research that has found that approximately 25-30% of eligible patients participate in CR, and that the participation rate for PR is even lower.<sup>108</sup> One of the factors referenced by CMS as a barrier to access is “a lack of referral or strong recommendation from a physician and inadequate follow-up or facilitation of enrollment after referral.”<sup>109</sup> As CMS is well aware, while NPs are now authorized to supervise PR, CR and ICR, they still are not authorized to issue referrals for Medicare patients outside of the ACO REACH Model.

We greatly appreciate CMS recognizing this disparity and including the NP Services Benefit Enhancement as an available waiver for ACO REACH model participants, which in part would authorize participating NPs to establish, review and certify CR and PR plans of care. As CMS notes in the waiver description, “[w]e believe that waiving this requirement to allow NPs to establish, review, and sign a written care plan for a REACH Beneficiary’s cardiac rehabilitation is necessary to test the ACO REACH Model. Such a flexibility is expected to increase an NP’s involvement in a REACH Beneficiary’s heart treatment, improving quality by easily connecting REACH Beneficiaries to these critical treatments when medically necessary and appropriate, and reducing cost by decreasing the number of clinician visits that a REACH Beneficiary would need to obtain these services.”<sup>110</sup> **We strongly encourage CMS to standardize this waiver across all relevant payment models, and to explore any other regulatory avenues that would remove this barrier for patients seen by NPs to increase participation in these critical programs.**

- ***Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)***

CMS is proposing to align the coverage for periodic assessments furnished by OTPs with the telehealth flexibilities described in section 4113 of the CAA, 2023, by proposing to extend the audio-only flexibilities for periodic assessments furnished by OTPs through the end of CY 2024. **AANP supports this proposal and agrees with CMS that extending these flexibilities will promote continued beneficiary access to these services.**

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<sup>107</sup> 88 FR 52413.

<sup>108</sup> 88 FR 52706.

<sup>109</sup> *Ibid.*

<sup>110</sup> <https://innovation.cms.gov/media/document/aco-reach-rfa>, at page 76.



**Medicare Shared Savings Program (MSSP) (section III.G.)**

In this proposed rule, CMS is proposing to make changes to the MSSP to build upon efforts in the CY 2023 PFS final rule that are expected to grow participation in the model. We appreciate that CMS has focused on addressing issues of health equity through the MSSP and other payment models, and support CMS' efforts to expand the MSSP to underrepresented populations, particularly by updating the beneficiary assignment methodology to better incorporate patients who see NPs as their primary care providers. NPs are very involved in the MSSP, and over 140,000 NPs are participating in MSSP ACOs, highlighting the critical need to address issues related to assigning patients seen by NPs to MSSP ACOs.<sup>111</sup> NPs are committed to treating patients of all backgrounds, including in rural and underserved communities, and the NP approach to providing whole-person, patient-centered care directly aligns with the MSSP and other payment models.

Research has also shown the positive impact of increased involvement of NPs in accountable care models. A recent study, entitled *"The Impact of Nurse Practitioner Care and Accountable Care Organization Assignment on Skilled Nursing Services and Hospital Readmissions"* found that "greater participation by the NPs in care delivery in SNFs was associated with a reduced risk of patient readmission to hospitals. ACOs attributed beneficiaries were more likely to obtain the benefits of greater nurse practitioner involvement in their care."<sup>112</sup> The article states that "[p]atients receiving E&M care from nurse practitioners in SNFs were less likely to experience hospital readmission than beneficiaries with no E&M care delivered by nurse practitioners"<sup>113</sup> and concludes that "increasing nurse practitioner care delivery in SNFs could help to improve outcomes for older adults receiving post-acute care."<sup>114</sup>

As noted in the NASEM report *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* "nurses work in areas that are underserved by other health care providers and serve the uninsured and underinsured."<sup>115</sup> It is important that the efforts to address the challenges facing underserved communities recognize the important role of nurse practitioners in addressing the diverse needs of these patients. Ensuring that vulnerable patients have the necessary access to care is a critical missing link in the health care system, and NPs are well positioned to provide care for these populations. NP education and clinical training prepares them to address the complex needs of patients, including the social determinants of health. NASEM highlights that "the role of nurses in these efforts is key, given their interactions with individuals and families in providing and coordinating person-centered care for preventive, acute, and chronic health needs within health settings, collaborating with social services to meet the social needs of individuals, and engaging in broader population and community health through roles in public health and community-based settings."

- *Revise the Policies for Determining Beneficiary Assignment (III.G.3)*

In section III.G.3., CMS proposes to create a new step three for beneficiary assignment to the MSSP with an expanded assignment window to better account for patients who receive their primary care from an NP, clinical nurse specialist (CNS), or physician assistant (PA), which would go into effect for the performance year beginning January 1, 2025. According to CMS, based on their analysis of the assignable

<sup>111</sup> <https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results/data>. (January 2022 Performance Year Financial and Quality Results).

<sup>112</sup> Meddings, J. Gibbons, JB, Reale, BK, et.al, The impact of nurse practitioner care and accountable care organization assignment on skilled nursing services and hospital readmissions. *Med Care*. 2023; 61:341-348

<sup>113</sup> *Ibid.*

<sup>114</sup> *Ibid.*

<sup>115</sup> NASEM: The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity.

patient population this would support access to the MSSP for underserved beneficiaries, including those who are disabled, low-income subsidy (LIS), and who reside in areas with higher area deprivation index (ADI) scores. Accordingly, this policy would align with CMS' priorities in the *CMS Framework for Health Equity (2022–2025)*.<sup>116</sup> **We support CMS efforts to better include patients seen by NPs into the MSSP and other advanced payment models and appreciate the Agency's focus on the impact that this would have on health equity.**

As described in this proposal, beneficiaries qualifying for the new step three would be assigned based on the plurality of allowed charges for primary care services during the expanded window for assignment. This new category of “assignable beneficiary” would also still have to receive at least one primary care service during the 24-month expanded assignment window from a Medicare-enrolled physician who is a primary care physician or who has one of the specialty designations included in § 425.402(c), as CMS has stated is statutorily required. The assignable beneficiary would then also have to receive at least one primary care service from an NP, CNS or PA participating in the ACO during the applicable 12-month assignment window. As CMS notes, these changes are built off the experiences and lessons learned from other payment models such as the ACO REACH and Next Generation ACO Models.<sup>117</sup> Notably, neither of these models contains the “pre-step” requirement which limits the ability of patients seen by NPs to be assigned to ACOs participating in those models.

We applaud these efforts and thank CMS for recognizing the importance of ensuring that patients who see NPs as their primary care providers have equitable access to these payment models. This proposal builds off previous efforts to better incorporate patients seen by NPs (and other clinicians in the MSSP), which are critical to achieving the goal of having every Medicare patient in an accountable care relationship by 2030. As you know, effective in 2019, CMS amended the voluntary alignment pathway to authorize a patient to select an NP as their primary care provider in an MSSP ACO and be assigned to the ACO without requiring a duplicative physician visit. This provided greater opportunity for NPs and their patients to join and establish MSSP ACOs. In its FY 2021 Budget in Brief, HHS stated that basing ACO-assignment on a broader set of primary care providers, including NPs, better reflects our current primary care workforce and would lead to \$80 million in savings for the Medicare program over ten years.<sup>118</sup>

CMS recently announced the data for the 2022 performance year of the MSSP, which found that the MSSP saved the Medicare program \$1.8 billion dollars compared to spending targets for the year, while also performing higher than average on quality measures compared to similarly sized clinician groups not in the program. In the announcement, we greatly appreciate CMS highlighting this proposal to assign more patients who receive primary care from NPs as a core proposal to continue to grow the MSSP program, particularly in rural and underserved communities, and provide more patients with access to coordinated, efficient, high-quality care provided by ACOs.<sup>119</sup>

As CMS recognizes in this proposed rule, expanding the assignment methodology to better account for patients seen by NPs would add a population of patients who have been historically underrepresented in the MSSP, such as those with a disabled Medicare enrollment type, those residing in areas with a slightly higher average ADI national percentile rank, and a larger shared with any months of Medicare Part D LIS enrollment. This is consistent with the June 2022 MedPAC report which found that, among all clinician

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<sup>116</sup> 88 FR 52443.

<sup>117</sup> 88 FR 52444.

<sup>118</sup> <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf> (page 84).

<sup>119</sup> <https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high>.

types, NPs on average had the highest share of allowed charges associated with low-income subsidy (LIS) beneficiaries. “In 2019, 41 percent of the allowed charges billed by NPs who practiced in primary care were for LIS beneficiaries, as were 36 percent for NPs who practiced in specialty care compared with 28 percent for primary care physicians and PAs and 25 percent for specialty care physicians and PAs.”<sup>120</sup> A report issued by the American Enterprise Institute also found that “[u]sing different data and methods, the studies described in this report consistently show that NPs are significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians.”<sup>121</sup> It is critical, and consistent with CMS priorities, to ensure these patients have equitable access to accountable care relationships which has not been adequately supported by the current assignment methodology.

In conversations with ACOs, particularly those who care for complex patient populations, serve rural and underserved communities, and deliver home-based care, they relayed that not fully including NPs in the current assignment methodology hinders their ability to participate in the program due to the difficulty in having all their patients obtain a physician visit. This proposed policy will not only increase beneficiary participation in the MSSP, but will also provide flexibility to ACOs to provide care in the manner that best meets their patients’ needs by reducing unnecessary administrative barriers. However, we are aware that some ACOs have raised concerns that adding more complex, low-income, disabled and ADI patients could impact their benchmarks. Since this policy is not proposed to go into effect until 2025, CMS has ample time to review the policy and modify risk adjustment and benchmark methodologies if the Agency deems necessary. The solution, however, should not be to delay the policy and continue to limit the access of these patients to ACOs. As CMS has recognized, these patients have been historically underrepresented in the MSSP for the past decade. The ability to enter an accountable care relationship should not be dictated by the complexity of your condition, your disability status or your zip code. As CMS has recognized, patients in these categories could often benefit the most by entering an accountable care relationship, and it is a matter of equity that they be able to do so.

CMS also seeks feedback on the length of the proposed expanded window and other policies that CMS should consider for future rulemaking on the assignment methodology with the goal of increasing the number of fee-for-service Medicare beneficiaries assigned to an ACO. First, regarding the length of the expanded window. **We appreciate and support CMS’ efforts to increase the MSSP participation of patients who see NPs as their primary care provider. Along those lines, we encourage CMS to consider revising the expanded assignment window to 36-months, which would align that window with the CMS definition of an established patient relationship.**<sup>122</sup> This is an already defined time frame and it would continue to assist towards increasing beneficiary participation in an ACO.

Second, while CMS has stated that the primary care service from a primary care physician pre-step is a statutory requirement, we do believe there is additional statutory flexibility. The waiver authority granted to the Secretary for the administration of the MSSP under 42 U.S.C. § 1395j(j)(f) states that “[t]he Secretary may waive such requirements of sections 1320a–7a and 1320a–7b of this title *and this subchapter* as may be necessary to carry out the provisions of this section.” (emphasis added) This

<sup>120</sup> [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf) (Page 135).

<sup>121</sup> <https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf?x91208>.

<sup>122</sup> <https://med.noridianmedicare.com/web/jeb/specialties/em/new-vs-established-patient> (“Individual who has received any professional services, E/M service or other face-to-face service (e.g., surgical procedure) from this provider or another provider (same specialty) in the same group practice within the previous three years.”)

provision grants the Secretary broad authority to waive requirements under Subchapter XVIII, including § 1395jjj(c)(1)(A) which contains the aforementioned physician visit requirement. We respectfully request that CMS utilize this authority to authorize a primary care service provided by an NP to meet this requirement. This will improve beneficiary assignment and encourage more NPs to join the MSSP, consistent with the Administration's goal of having all Medicare beneficiaries in accountable care relationships by 2030. Again, we thank CMS for their efforts and recognition of the importance of better incorporating NPs and their patients into the MSSP, and look forward to continued work with CMS on these efforts.

- ***Update the Definition of Primary Care Services Used in Beneficiary Assignment***

CMS is proposing to revise the definition of primary care services used in MSSP beneficiary assignment to include codes for smoking and tobacco-use cessation counseling services, remote physiologic monitoring, cervical or vaginal cancer screening, and office-based opioid use disorder services. CMS also proposes to add the following codes if finalized in this final rule: complex E/M services add-on HCPCS G2211, community health integration services, principal illness navigation services, SDOH risk assessment, caregiver behavior management training, and caregiver training services. **AANP supports the addition of these codes to the permanent definition of primary care services, as well as the addition of the proposed codes to the fee schedule as previously mentioned.**

- ***Seeking Comments on Potential Future Developments to Shared Savings Program Policies***

- *Additional Waivers and Benefit Enhancements*

As CMS considers additional ways of reducing barriers to care for MSSP beneficiaries and incentivizing greater clinician participation, **we strongly recommend that CMS make the NP Services Benefit Enhancement available to MSSP ACO participants.** CMS has recognized that authorizing NPs to practice to the full extent of their education and clinical training has a positive impact on health care equity. As stated previously, the ACO REACH model includes a “Nurse Practitioner Services Benefit Enhancement.” This waiver, which removes barriers for participating nurse practitioners, is one of five policies introduced to promote health equity and is “expected to reduce disparities in health such that those with the greatest needs and least resources receive the care they need.”<sup>123</sup> This waiver also focuses on increasing access to vital, yet underutilized, services such as cardiac and pulmonary rehabilitation, and medical nutrition therapy. Waiving unnecessary federal barriers to health care will provide our health care workforce with increased flexibility to meet their patient's needs and improve access in underserved communities, consistent with the principles of the *Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. We strongly encourage this benefit enhancement to be adopted within the MSSP using the authority granted in 42 U.S.C. § 1395jjj(f).

- *Prospective population-based primary care payment within MSSP*

AANP also appreciates CMS' recognition of the value of prospective population-based primary care payment within the MSSP. In March, AANP in conjunction with the Primary Care Collaborative and 25 other organizations sent a letter to CMS advocating for this approach.<sup>124</sup> **We reiterate our support for this prospective payment option and look forward to working with CMS to continue to support the participation and success of primary care practices within advanced payment models.**

<sup>123</sup> [ACO REACH | CMS Innovation Center](#)

<sup>124</sup> [https://thepec.org/sites/default/files/news\\_files/PCC%20NAACOS%20Sign%20On%20Letter%203.22.23%20FINAL\\_0.pdf](https://thepec.org/sites/default/files/news_files/PCC%20NAACOS%20Sign%20On%20Letter%203.22.23%20FINAL_0.pdf).



- **Medicare Part B Payment for Preventive Vaccine Administration Services (section III.H.)**

In comments in response to last year's PFS proposed rule, AANP supported the Agency's continued additional payment for in-home COVID-19 vaccinations with the proposed geographic and MEI updates. Nurse practitioners have been providing COVID-19 vaccinations in patient's homes throughout the pandemic, and this will continue to support those efforts. We also concurred with commenters referenced in the PFS who believe an in-home add-on payment would be beneficial for other preventative vaccines under Medicare Part B and look forward to further work with CMS on supporting these efforts. We appreciate CMS' serious consideration of these comments and further analysis on in-home vaccinations. We strongly agree with CMS that the at-home vaccination add-on code provides the greatest impact for hard to reach and underserved beneficiaries, and this is consistent with the experience of our members. **Accordingly, we strongly support the expanded availability of this add-on code for the other three preventative vaccines included in the Part B vaccine benefit.**

- **Medicare Diabetes Prevention Program (MDPP)**

In this proposed rule, CMS is proposing to extend the MDPP flexibilities that were authorized during the COVID-19 PHE for a period of four years until December 31, 2027. Specifically, CMS is proposing to extend the flexibility to authorize alternatives to the requirement for in-person weight management and the flexibility which eliminated the maximum number of virtual services. **AANP supports both proposals which will provide necessary flexibility to participants, particularly those in rural communities and with transportation or other barriers.** We also encourage CMS to permanently remove the "once in a lifetime" limit on MDPP participation. This is consistent with the recommendation made by the National Clinical Care Commission in their Report to Congress.<sup>125</sup>

- **Hospice: Changes to the Hospice Conditions of Participation**

We appreciate the Agency's acknowledgement of the importance of advancing health equity within the hospice conditions of participation. The very nature of hospice care and the terminally ill state of hospice patients demands that this process take place as expeditiously as possible. While NPs are attending physicians under the hospice care statute, despite this designation, they are not authorized to certify that a patient is terminally ill and in need of hospice care. We appreciate that CMMI addressed this issue within the ACO REACH Model's "NP Benefit Enhancement." In the enhancement, CMMI authorized NPs to provide the initial certification that a patient is terminally ill and in need of hospice care. The Agency states that "this flexibility is expected to provide a REACH beneficiary a more seamless transition to hospice care, reducing complexity in accessing hospice care and delays in placement and improving the quality of care for beneficiaries for whom such treatment is appropriate."<sup>126</sup>

**We agree with the stated impact of these changes and encourage CMS to explore options to better incorporate these flexibilities within the Hospice CoPs.** It is critical to ensure that hospice patients have equitable access to nurse practitioner provided care, and we respectfully request the Agency to utilize its "broad statutory authority for most provider and supplier types to establish health and safety regulations, which includes the authority to establish health and safety requirements that advance health equity for underserved communities."<sup>127</sup>

<sup>125</sup> <https://health.gov/sites/default/files/2022-01/NCCC%20Report%20to%20Congress.pdf>, at page 67.

<sup>126</sup> [ACO Realizing Equity, Access, and Community Health \(REACH\) Model Request for Application \(cms.gov\)](#)

<sup>127</sup> 88 FR 52262.

- *SDOH Risk Assessment in the Annual Wellness Visit*

As noted above, AANP supports the creation of a stand-alone G code (GXXX5) for SDOH Risk Assessment furnished in conjunction with an E/M visit. **Accordingly, we also support CMS adding a new SDOH Risk Assessment as an optional, additional element of the AWV with additional payment.** We also request clarification that FQHCs can bill for this service, since FQHCs are essential access points to screen patients for SDOH and connect them to community resources. We agree that SDOH risk assessments are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. These are critical assessments that can assist clinicians in better understanding their patient's health-related social needs, and an AWV can serve as a critical access point for this care.

- *Transforming the Quality Payment Program; Quality Payment Program Vision and Goals; Emphasizing the Importance of Value-Based Care*

As CMS states in this proposed rule, “[a]dvanced APMs can ensure that beneficiaries get the right care at the right time by reducing fragmentation between clinicians, which can reduce unnecessary duplication of services and preventable medical errors. Advanced APMs also support our goal that all Traditional Medicare beneficiaries be in a care relationship with clinicians accountable for quality and total cost of care by 2030, as outlined by the CMS Innovation Center strategy refresh.”<sup>128</sup> CMS requested feedback on incentives and policies that could be adopted to incentivize clinicians to join APMs in order to foster continuous improvement. Below are three recommendations to CMS to reduce fragmentation among clinicians, reduce unnecessary duplication of services, and incentivize NPs to participate in APMs.

First, as CMS has recognized through the adoption of the NP Services Benefit Enhancement in the ACO REACH model, NPs play a critical role in APMs, particularly in providing care to underserved populations. However, outdated policies in Medicare fee-for-service create barriers for NPs to provide certain services to their patients and these barriers result in duplicative care. **Particularly with the growth of the NP workforce and its importance to Medicare, it is important that CMS adopt policies such as the NP Services Benefit Enhancement across all APMs.** This will incentivize NPs and their patients to participate, while achieving the goals of reducing duplicative care and fragmentation.

Second, as mentioned above, NPs are the fastest growing Medicare provider group and they are essential to ensuring that patients across the country, and particularly in rural and underserved communities, have access to care. As such, it is critical that they are fully accounted for in APMs and do not face unnecessary barriers to participation. **We appreciate steps that CMS is taking to address such a barrier in the MSSP and strongly urge CMS to ensure that NPs are full participants in current and future APMs, and that their patients do not encounter barriers to assignment.**

Finally, APM reimbursement policies should be equitable and based on outcomes, quality and the ability to reduce health care spending, but not differentiated solely based on the licensure of the clinician providing the care, as in the Medicare fee-for-service program where NPs are reimbursed at 85% of the Medicare Physician Fee Schedule. **We encourage CMS to adopt payment policies in APMs that are equitable and provide a level playing field for all participating clinicians.** The Medicaid program has shown that reimbursement equity, coupled with the removal of practice barriers, can increase participation of NPs. A 2016 study found that, “NPs had 13% higher odds of working in primary care in

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<sup>128</sup> 88 FR 52557.

states with full scope of practice; those odds increased to 20% if the state also reimbursed NPs at 100% of the physician Medicaid fee-for-service rate. Furthermore, in states with 100% Medicaid reimbursement, practices with NPs had 23% higher odds of accepting Medicaid than practices without NPs. Removing scope of practice restrictions and increasing Medicaid reimbursement may increase NP participation in primary care and practice Medicaid acceptance.”<sup>129</sup>

- **Public Reporting on Compare Tool**

CMS is proposing to update the Compare websites to include utilization data related to specific conditions or services performed by each clinician or group respectively. As noted in this proposed rule, the information that would be placed on the website would be based off Medicare claims data. The overall goal of this proposal is to increase transparency and provide Medicare beneficiaries with a streamlined way to search for clinicians who provide a specific service. **While we support increased transparency and improved tools that enable patients to make informed health care decisions, we have significant concerns regarding the impact of this proposal on NPs due to ‘incident-to’ billing.**

As CMS is aware, when a service performed by an NP (or other clinician) is billed ‘incident-to’ a physician, that service is not attributable to the NP based on claims data. This significantly obscures the treatment provided by NPs to Medicare beneficiaries and leads to inaccurate attribution based on claims data. 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. 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.<sup>130</sup> For the purposes of the utilization data being publicly posted on the Compare website, this could lead to an inaccurate representation of which clinician is providing a service, putting NPs at a disadvantage. As a means of addressing issues of health care transparency, we continue to strongly recommend that CMS re-evaluate its current policies on ‘incident-to’ billing when a service is performed by a clinician (such as an NP) who is authorized to bill the Medicare program directly.

Additionally, we appreciate that CMS has updated the Compare website and combined the compare tools for different provider types under the “Care Compare” banner, and updated the terminology of the “Physician Compare” website to reflect the other clinician types (including NPs) who are represented on the site. We continue to encourage CMS to utilize provider inclusive language in all of its materials, and this update is a significant step in this direction. **Accordingly, we recommend that CMS update the current CFR references<sup>131</sup> of “Physician Compare” to utilize the current terminology of “Care Compare.”** While we acknowledge that 42 CFR 414.1305 which defines “Physician Compare” includes the parenthetical “(or a successor website)”, making this technical correction to the regulatory language will promote consistency with subregulatory guidance and marketing materials, and reduce confusion.

- **Individual QP Determination**

As CMS notes, under the current policy most eligible clinicians participating in Advanced APMs receive their qualifying participant (QP) determinations at the APM Entity Level. CMS’ concern is that by conducting this assessment at the group level, some clinicians may become QPs when they would not

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<sup>129</sup> H. Barnes, C.B. Maier, et al., “Effects of Regulation and Payment Policies on Nurse Practitioners’ Clinical Practices,” 74(4): 431-451, May 13, 2016. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5114168/>

<sup>130</sup> oi: 10.1377/hlthaff.2021.01968 HEALTH AFFAIRS 41, NO. 6 (2022): 805–813.

<sup>131</sup> “Physician Compare” is utilized in 42 CFR 414.1305, 414.1385, and 414.1395.

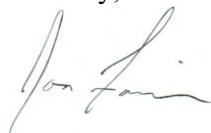
qualify individually, while other clinicians who would have qualified individually do not become QPs.<sup>132</sup> To address this issue, CMS is proposing to calculate Threshold Scores of QP determinations at the individual level for each unique NPI associated with an eligible clinician participating in an Advanced APM.<sup>133</sup>

**While we understand the rationale behind CMS calculating threshold scores at the individual NPI level, we are concerned that this would negatively impact NPs due to ‘incident-to’ billing.** As noted above, a service performed by an NP (or other clinician) is billed ‘incident-to’ a physician, that service is not attributable to the NP based on claims data. This significantly obscures the treatment provided by NPs to Medicare beneficiaries and leads to inaccurate attribution based on claims data. 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. 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.<sup>134</sup> We are concerned that this proposal could have the adverse effect of reducing NP participation as a QP, which is contrary to the goals CMS has expressed throughout this proposed rule, which we do not believe was the intent.

### Conclusion

AANP appreciates the opportunity to comment on the proposed Calendar Year 2024 Medicare Fee Schedule. We appreciate CMS recognizing the importance of nurse practitioners to the Medicare program throughout this proposed rule. We look forward to continued partnership with CMS towards the goal of equitable access to health care for Medicare patients. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, [msapio@aanp.org](mailto:msapio@aanp.org), 703-740-2529.

Sincerely,



Jon Fanning, MS, CAE, CNED  
Chief Executive Officer  
American Association of Nurse Practitioners

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<sup>132</sup> 88 FR 52618.

<sup>133</sup> 88 FR 52619.

<sup>134</sup> oi: 10.1377/hlthaff.2021.01968 HEALTH AFFAIRS 41, NO. 6 (2022): 805–813.