
September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244-1850

**Re: Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts**
**[CMS-1770-P] RIN 0938-AU81**

Dear Administrator Brooks-LaSure:

On behalf of the American Association of Colleges of Nursing (AACN), the national voice for academic nursing, thank you for the opportunity to provide comments on the CY 2023 Physician Fee Schedule Proposed Rule. AACN works to establish quality standards for nursing education, assists schools in implementing those standards, influences the nursing profession to improve health care, and promotes public support for professional nursing education, research, and practice. AACN represents more than 850 member schools of nursing offering a mix of baccalaureate, graduate, and post-graduate programs at public and private universities nationwide[1].

AACN has a vested interest in improving our nation's health and health care. For over five decades, the association has championed professional nursing education to ensure that Registered Nurses (RN) and Advanced Practice Registered Nurses (APRN), including nurse practitioners (NPs), certified nurse-midwives (CNMs), certified registered nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs), are prepared to provide evidence-based, cost-effective, and high-quality care. Within AACN member schools, more than 120,000 nursing students are currently enrolled in APRN programs and will serve as our nation's next generation of expert providers[2].

AACN commends the Centers for Medicare and Medicaid Services' (CMS) continued efforts to reduce restrictive and unnecessary regulatory burdens and eliminate unneeded expenditures; while increasing patients access to affordable, high-quality care. We appreciate the opportunity to provide comments on the proposed rule that specifically eliminates regulations hindering healthcare delivery by impeding highly qualified clinicians' scopes of practice.

[1] About the American Association of Colleges of Nursing. Retrieved from: https://www.aacnnursing.org/About-AACN
[2] 2021-2022 Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, DC: American Association of Colleges of Nursing.

**AACN offers the following recommendations for CMS' consideration to improve upon proposed changes in the CY 2023 Medicare Physician Fee Schedule Proposed Rule:**

- Address the social needs of beneficiaries under Medicare Part B within the community health worker workforce and ambulatory services;
- Continue to remove all barriers to practice allowing for full practice authority;
- Finalize the proposal to allow Nursing Facilities (NF) services to be furnished and billed by the appropriate practitioner;
- Improve population health through Accountable Care Organizations (ACOs) with a focus on building the shared saving program and Trusted Exchange Framework and Common Agreement;
- Address potential barriers to Certified Electronic Health Record Technology (CEHRT) adoption and implementation and Pain Management;
- Continue the improvement of the National Plan and Provider Enumeration System (NPPES) platform for all clinicians and accommodate nursing's unique identifiers with prescriber addresses within the Medicare Provider Enrollment, Chain, and Ownership System (PECOS);
- Utilize National Provider Identifier (NPI) numbers for all APRNs to eliminate the fraud of incident-to billing; and
- Further nursing leadership in health care and health policy.

Each of these recommendations will be discussed in turn.

**Recommendation: Address the social determinants of health of beneficiaries under Medicare Part B within the community health worker workforce and ambulatory services.**

AACN applauds CMS for acknowledging the key role of community health workers (CHWs) in reducing health disparities and improving community health outcomes. As we continue to evaluate the nation's healthcare workforce capacity and pandemic preparedness efforts, it is important to highlight how CHWs bridge the gap between communities and healthcare systems.

CHWs are valuable members of the healthcare workforce that possess first-hand knowledge of the health needs of their community. The term "CHW" may include different titles and positions such as family service worker, lay health advocate, or community health educator[3]. CHWs often function alongside other healthcare providers such as physicians, nurses, and social workers to address the health and social needs of local community members. CHWs are often employed by community-based organizations; however, CHWs are increasingly being directly employed by hospitals and health systems as team-based models of care become more common[4].

AACN agrees that CHWs are uniquely equipped to address the social determinants of health within communities, as CHWs provide patients with the education, support, and resources they need to navigate complex health and social systems. For example, when COVID-19 first struck

[3] John, J. A. S., Mayfield-Johnson, S. L., & Hernández-Gordon, W. D. (Eds.). (2021). *Promoting the Health of the Community: Community Health Workers Describing Their Roles, Competencies, and Practice*. Springer International Publishing.
[4] Malcarney, M. B., Pittman, P., Quigley, L., Horton, K., & Seiler, N. (2017). The changing roles of community health workers. *Health Services Research*, 52, 360-382.

New York City, CHWs stepped up and provided critical support to the city's neediest residents, ensuring they had access to not only healthcare but also housing, food, and unemployment services [5].

Due to their valuable skill set, cultural competency, and community familiarity, CMS should recognize the important role CHWs play in providing high quality health care in rural and underserved communities. Recognizing and increasing their role will enable CHWs to more readily access nursing and other health professionals. AACN believes increasing streams of funding for CHW services, which may include offering Medicare reimbursement, is a necessary step forward in integrating CHWs into current models of care.

**Recommendation: Continue to remove all barriers to practice allowing for full practice authority.**

The demand for nurses is growing faster than average for most occupations, with the Bureau of Labor Statistics projecting the need for RNs to increase 9% and for APRNs to increase 45% by 2030, representing the need for an additional 398,200 jobs[6]. The National Academy of Medicine report, *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* recommendation states*:*

> *Conclusion 3-2: Eliminating restrictions on the scope of practice of advanced practice registered nurses and registered nurses so they can practice to the full extent of their education and training will increase the types and amount of high-quality health care services that can be provided to those with complex health and social needs and improve both access to care and health equity.*[7]

AACN fully supports allowing all clinicians to practice to the full extent of their education and training. According to the American Association of Nurse Practitioners, states that restrict an NP's ability to practice are typically associated with healthcare disparities, higher chronic diseases burdens, shortages especially within primary care, and higher costs of care[8]. NPs who obtain full practice authority are more likely to practice in rural and underserved areas and improve workforce recruitment and retention. As such, AACN encourages CMS to continue to work to remove barriers to full practice authority for RNs and APRNs.

**Recommendation: Finalize proposal to allow Nursing Facilities (NF) services to be furnished and billed by the appropriate practitioner.**

AACN commends CMS for its proposed plan to allow appropriate practitioners, which include APRNs such as NPs and CNSs, to bill for split (or shared) emergency visits taking place at a

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[5] Peretz, P. J., Islam, N., & Matiz, L. A. (2020). Community health workers and Covid-19—addressing social determinants of health in times of crisis and beyond. *New England Journal of Medicine*, 383(19), e108.

[6] U.S. Bureau of Labor Statistics. (2022). Occupational Outlook Handbook- Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Retrieved from: https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[7] National Academies of Sciences, Engineering, and Medicine. 2021. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/25982.

[8] AANP, Full Practice Authority (April 2022) https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief

Nursing Facility (NF). This proposal allows for initial or subsequent NF visits by new or existing patients to be furnished and billed by APRNs, regardless of whether an initial comprehensive assessment was performed[9]. Higher education institutions are well positioned to contribute to the expansion of healthcare delivery and compliment the ongoing work occurring in the healthcare system relating to full practice authority.

AACN strongly supports APRNs billing directly for the services they provide to patients. AACN maintains that APRNs be allowed to practice to the full extent of their education and training and applauds CMS for supporting full practice authority for APRNs and other healthcare providers. As team-based models of care become more common, it is imperative that APRNs are effectively utilized for their ability to provide evidence-based, cost-effective care to Medicare beneficiaries.

**Recommendation: Improve population health through ACOs with a focus on building the shared saving program and Trusted Exchange Framework and Common Agreement.**

ACOs provide coordinated, high-quality, and cost-effective care to underserved Medicare beneficiaries and play a key role in managing population health[10]. In 2022, CMS reported that 483 ACOs provided care for nearly 11 million beneficiaries[11]. AACN strongly supports CMS' proposed plans to improve population health through the Shared Savings Program, which incentivizes health systems, providers, and other healthcare groups to voluntarily come together and form ACOs[12]. AACN also supports the Trusted Exchange Framework and Common Agreement (TEFCA), which will allow for improved exchange of electronic health information and care coordination within ACOs.

AACN believes ACOs are an efficient solution to cutting healthcare costs and providing accountable, equitable care to Medicare beneficiaries. It is imperative that NPs be permitted to participate in ACOs without restrictions on their patients. This would eliminate the need for an NP's patient to visit a primary care physician each year in order to be assigned to an ACO. We applaud CMS for acknowledging the role of ACOs in addressing the social determinants of health (SDOH) and including nurse case managers as a solution to improve screening for the SDOH in communities. AACN strongly believes RNs and APRNs are key in advancing care coordination in ACOs, especially in the care of underserved and rural communities.

**Recommendation: Address potential barriers to CEHRT adoption and implementation and Pain Management.**

Nurses have historically provided the community access to safe and high-quality healthcare through a holistic approach, including the use of alternative nonpharmacologic treatment for pain. As we move forward with the pain management recommendations, it is important that we

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[9] https://www.federalregister.gov/d/2022-14562/p-854

[10] Centers for Medicare and Medicaid Services, 2021 Accountable Care Organizations (ACOs) https://www.cms.gov/medicare/medicare-fee-for-service-payment/aco

[11] https://www.cms.gov/files/document/2022-shared-savings-program-fast-facts.pdf

[12] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about

include the experiences of RNs who have historically provided non-opioid pain management care. AACN and our members schools educate nurses, including APRNs, on the indication and use of non-opioid alternatives, such as multi-modal pain management services and restorative therapies.

As healthcare shifts from episodic, provider-based, fee-for-service care to team-based, patient-centered care, nurses are positioned to not only contribute to, but to lead transformative changes by being valued members of the interprofessional team. This requires a new or an enhanced set of knowledge, skills, and attitudes focused on patient-centered care, care coordination, data analytics, and quality improvement[13]. To achieve cost-effective outcomes, electronic health records must provide correct attestation to all MIPS eligible providers treating this population. As far as defining chronic pain, AACN supports the 2019 HHS taskforce, NIH, and SAMSA's recommendations. These recommendations have provided an essential way of detecting, monitoring, and understanding chronic pain treatment efforts in accordance with high-quality care for patients.

AACN supports the initiative to expand the availability of nonphysicians who specialize in pain, including physical therapists, psychologists, and behavioral health specialists. Giving all health professionals the opportunity for interprofessional education would require support from the stakeholder's educational communities. This course of action is also in line with the 2019 expansion of MIPS eligible providers to include physical therapists, occupational therapists, clinical psychologists, qualified speech-language pathologists, qualified audiologists, and registered dietitians or nutrition professionals[14]. This expansion is one step toward achieving provider-neutral language. The next step is to ensure equitable representation of MIPS eligible providers on all federal committees and task forces.

**Recommendation: Continue the improvement of the National Plan and Provider Enumeration System (NPPES) platform for all clinicians and to accommodate nursing's unique identifiers with prescriber addresses within the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).**

The NPPES platform is crucial to ensuring that data can remain current and is useful for understanding the state of the healthcare workforce. This platform allows National Provider Identifier (NPI) numbers to be issued and can serve as a standard for assessing workforce and Public Health Emergency readiness. In 2019, the *Journal of Nursing Informatics* reported that nursing's contributions to the health and care of patients and communities is often hard to measure or even invisible[15]. The lack of visibility is due to not having unique identifiers for nurses, and, without this, further improvement for our nation's nursing workforce will be difficult.

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[13] Salmond, S. W., & Echevarria, M. (2017). Healthcare Transformation and Changing Roles for Nursing. *Orthopedic Nursing*, 36(1), 12-25. Retrieved March 12, 2019

[14] QPP.cms.gov. (2019). How do we determine MIPS eligibility? Retrieved from https://qpp.cms.gov/participation-lookup/about?py=2019. Accessed 12 Mar 2019.

[15] Sensmeier, J., Androwich, I., Baernholdt, M., Carroll, W., Fields, W., Fong, V., Murphy, J., Omery, A. & Rajwany, N. (Summer 2019). The value of nursing care through use of a unique nurse identifier. *Online Journal of Nursing Informatics* (OJNI), 23(2). Available at http://www.himss.org/ojni

In July 2021, the U.S. Department of Labor reported a decrease in healthcare employment by over 500,000 individuals since February 2020[16]. In addition, it is projected that over 200,000 newly hired nurses will be needed annually through 2032 to meet the growing demand and replace retiring nurses[17]. Hospitals and health systems need to be able to identify nurses in resource planning systems, such as PECOS, for documentations, education, research and implications for adoption, and even additional policy recommendations or changes. In June 2022, *Health Affairs* reported, "*Using a novel approach that relies on prescriptions to identify indirectly billed visits, we estimated that the number of all NP or PA visits in fee-for-service Medicare data billed indirectly was 10.9 million in 2010 and 30.6 million in 2018*"[18].

As mentioned in the *Journal of Nursing Informatics*, the use of nursing resources can be informed from the nurse identifier to be able to note the availability of the direct care time and costs per patient and the relationship established from that contributing characteristic, patients, and nursing cost[19]. Though AACN supports implementation of the NPI as a data standard, it is critical that the NPPES system be updated to accommodate the growing number of healthcare clinicians, nurses, and even students. Moreover, there are notable difficulties when individuals update NPI records after changing employers or roles. Updates to this process are needed to allow for a more seamless transition from one employer, or healthcare position, to another. It is imperative that CMS make improvements to the NPPES platform to ensure that the data remains current and is useful for understanding the state of the healthcare workforce.

**Recommendation: Utilize NPI for all APRNs to eliminate the fraud of incident-to billing.**

All healthcare clinicians, including nurses, who conduct electronic transactions and transmit health information, are strongly encouraged to obtain an NPI. As NPIs are associated with individuals for the duration of their career, students who are enrolled in healthcare training and education are encouraged to obtain that NPI number. NPIs are crucial in the advancement of the distribution of healthcare providers, categorizing specialty and demographics while contributing to other areas of employment. The growing need to be able to record and track the contributions of RNs to patient care and the outcomes of care are crucial and can advance the state of the nursing workforce[20].

In its June 2019 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommends requiring APRNs and Physician Assistants (PAs) to bill directly for services provided, thus eliminating "incident-to" billing. In addition, MedPAC recommends that HHS refine specialty designations for APRNs and PAs to give Medicare a greater account of the services provided by these clinicians, giving Congress the ability to target resources toward

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[16] Employment Situation Summary (bls.gov) https://www.bls.gov/news.release/empsit.nr0.htm

[17] https://www.aha.org/fact-sheets/2021-05-26-fact-sheet-strengthening-health-care-workforce

[18] By Sadiq Y. Patel, Haiden A. Huskamp, Austin B. Frakt, David I. Auerbach, Hannah T. Neprash, Michael L. Barnett, Hannah O. James, and Ateev Mehrotra (June 2022) Frequency of Indirect Billing to Medicare for Nurse Practitioner and Physician Assistant Office Visits, *Health Affairs*, 10.1377/hlthaff.2021.01968

[19] Sensmeier, J., Androwich, I., Baernholdt, M., Carroll, W., Fields, W., Fong, V., Murphy, J., Omery, A. & Rajwany, N. (Summer 2019). The value of nursing care through use of a unique nurse identifier. *Online Journal of Nursing Informatics* (OJNI), 23(2). Available at http://www.himss.org/ojni

[20] Chan, Garrett K. and Cummins, Mollie R. and Taylor, Cheryl S. and Rambur, Betty and Auerbach, David and Meadows-Oliver, Mikki and Cooke, Cindy and Turek, Emily A. and Pittman, Patricia, An Overview and Policy Implications of National Nurse Identifier Systems: A Call for Unity and Integration. Available at SSRN: https://ssrn.com/abstract=4133274

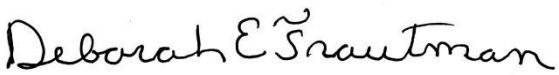
primary care.[21] The NPI would lead to simplification and more accurate attestation for providers caring for patients. Moreover, in times of public health emergencies, NPI numbers can further assist in the understanding of healthcare labor markets and dynamics of supply and demand.

**Recommendation: Further nursing leadership in health care and health policy.**

The National Academy of Medicine Report, *The Future of Nursing 2010-2030: Charting a Path to Achieve Health Equity*, highlights how nurses bring integral insight and value to health care and the health systems they support. It is warranted and imperative that nurses are given leadership roles both throughout the health system and in health policy, to share their insight and further the redesignation of quality care in the United States. Further, the Federal Advisory Committee Act (FACA),[22] enacted to ensure that advice by various advisory committees is objective and accessible to the public, requires that, "in the selection of members for the advisory committee, the agency will consider a cross-section of those directly affected, interested, and qualified, as appropriate to the nature and functions of the advisory committee". Therefore, it is necessary that CMS advisory committees and boards appoint nursing professionals to use their experience and critical knowledge to contribute to the formation of new policy and regulations.

Thank you for your consideration of AACN's comments on the CY 2023 Physician Fee Schedule Proposed Rule. The reduction of burdens for clinicians, providers, patients, and their families are timely, essential, and critical to improving our healthcare systems efficiency, safety, and innovation. Please consider AACN an ally in this endeavor. If our organization can be of any assistance, please contact AACN's Director of Policy, Dr. Colleen Leners at cleners@aacnnursing.org.

Sincerely,



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[21] Medicare Payment Advisory Commission. (June 14, 2019). Report to Congress: Medicare and the Health Care Delivery System. Retrieved from http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf
[22] General Services Administration (41 CFR § 102- 3.60(b)(3))