September 11, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

Re: 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 (CMS-1784-P)

Dear Administrator Brooks-LaSure:

The Association of Rehabilitation Nurses (ARN) – representing approximately 4,500 rehabilitation nurses and more than 14,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Calendar Year (CY) 2024 Medicare Physician Fee Schedule Proposed Rule (CMS-1784-P).

Rehabilitation nurses base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. ARN members practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices.

Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, social, spiritual, and safety needs. We lead and coordinate rehabilitation, restorative care, and community reintegration for populations across all age groups and ethnicities across the care continuum, from ambulatory care to hospice. Rehabilitation nurses begin to provide care to individuals, their families, and caregivers soon after the onset of a disabling injury or chronic illness and continue to provide specialty care, patient and family education, and care transition planning that empowers these individuals to return home, work, and/or school. Rehabilitation nurses, in collaboration with interdisciplinary teams, provide comprehensive, population-specific care management to access health care services, adaptive technology and equipment, and community resources.

For these reasons, the policies included in this proposed rule are important to our members who provide rehabilitative care for Medicare beneficiaries.

Payment for Caregiver Training Services

ARN was pleased to see that CMS proposed to make payment for caregiver training services (CTS) by establishing payment for CPT codes 96202 (Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes) and 96203 (each additional 15 minutes). Additionally, the agency proposed payment for three new CPT codes:

- CPT code 9X015 (Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes),
- CPT code 9X016 (each additional 15 minutes), and
- CPT code 9X017 (Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers).

ARN supports this proposal as we understand the critical role that caregivers play in the recovery process and overall well-being of patients. ARN members provide training to caregivers every day to ensure that patients receive consistent and appropriate care even after they leave a hospital or other health care facility. Training caregivers has many benefits, including better patient outcomes and reduced complications and hospital readmissions. Therefore, we are pleased to see that CMS is proposing to establish payment for these services that are already being provided for patients and their caregivers.

Many issues of care are extensively medically based treatments that require an understanding of the process and not just the use of a device or piece of equipment. When there is a proper understanding of the underlying issues, pathophysiology, and cause for treatment, outcomes are undoubtedly enhanced. As such, ARN members would like to share the following scenarios where they frequently provide caregiver training:

- Caregiver training services for bladder and bowel management prevent readmission by enabling families and caregivers to assist the patient in the basic needs of elimination. Bladders that are not emptied appropriately can cause distention, pain, infection, renal failure and even rupture. Bowels that are not emptied appropriately can cause impact bowel obstruction, and dehydration all of which require readmission.
- Tube feeding training for caregivers prevents aspiration, decreases the need for frequent home health visits, and offers families and caregivers confidence in providing the basic need of nutrients to their loved one. The process of teaching feeding delivery and medication administration may take several sessions of education as this is a skilled nursing service.
- Transfer techniques are not uncommon in the rehabilitation setting to teach families and caregivers the skill and safety requirements for transferring a patient from bed to chair or

commode. Some patients require mechanical devices to complete the transfer, others require slide boards or other devices to ensure a safe transfer. Transfer teaching is critical to prevent injury to both the patient and the caregiver. Teaching transfer skills to caregivers prevents readmission due to falls or injury.

- Discussing different methods used for suctioning, particularly focusing on understanding the most effective ways to clear an airway, and determining the level of treatment or intervention that might need to be adjusted based on specific circumstances, such as when dealing with a situation involving bleeding.

ARN recognizes that only qualified health care professionals, such as advanced practice nurses (nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives), can bill these services. ARN believes that registered nurses (RNs) must be allowed to practice to the full extent of their education and abilities. We recognize that CMS does not have the authority to allow RNs to bill Medicare; however, we ask that the agency work with Congress to grant RNs the ability to bill Medicare for their services in order to optimize healthcare delivery and improve patient access to quality care.

Services Addressing Health-Related Social Needs

CMS is proposing to pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care. Through these proposed measures, CMS acknowledges the vital role and skills of these healthcare professionals and the need for holistic patient care. The agency recognizes the evolving landscape of healthcare delivery where team-based, comprehensive patient care is essential.

Community Health Integration Services

CMS is taking steps to recognize the valuable services that community health workers (CHWs) provide when assisting Medicare beneficiaries with services not typically reimbursed on the MPFS. Specifically, CMS is proposing to create two new HCPCS codes to describe 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." In the nursing space, home health workers typically fill this role; however, they may not have expertise in rehabilitation. ARN believes there is a definite need for transitioning patients when in their own environment as the difference between inpatient and home care is a gap that is not well filled.

SDOH Risk Assessment

CMS has proposed to establish HCPCS code GXXX5 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5–15 minutes). This new G code recognizes the additional time and resources that providers spend on assessing SDOH factors that could impact a patient's treatment. ARN members witness firsthand how social and environmental factors can significantly impact a patient's health outcomes and treatment plans. Therefore, we applaud the agency for recognizing the significance of SDOH assessments in patient care, particularly the rehabilitation process.

ARN members report that case managers are tasked with a documentation tool for determining SDOH but SDOH evaluations are ongoing during patient care. Patients do not always disclose all their barriers until they become comfortable with the provider. The nurse must continually ask questions and work

with the patient on a personal and emotional level to fully grasp the SDOH that may affect their treatment plan and safe discharge.

Additionally, when treating someone who is experiencing homelessness, treatment plans must change. Nurses and case managers must work to find a proper discharge destination, such as shelters or assisted living. If the patient is being sent back to a homeless situation the care team must become more creative to ensure proper DME can be utilized in the patient's unique environment. One ARN member had a patient who lived on a boat, and after seeking more information, they discovered that the patient did not live on a typical houseboat but rather an older style small fishing boat. The care team had to develop a safety plan and a method to get the patient back on his boat with his new devices for mobility. They were also able to locate a community volunteer with a dingy boat that could transport our patient to his anchored fishing boat along with his new DME.

ARN members support the creation of this code as it will highlight the importance of SDOH and patient outcomes and reduce readmission rates associated with SDOH. While we support this code, we urge CMS to ensure the documentation process reflects the necessary information needed in assessing SDOH to not create more workflow burden for an already stressed healthcare system.

Principal Illness Navigation

CMS has proposed to create HCPCS codes and payment to describe Principal Illness Navigation (PIN) services associated with the care of patients with 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." ARN members have firsthand experience navigating the complex landscape of healthcare resources, especially when working with patients with physical disabilities and chronic conditions that place them at significant risk. This is a multifaceted challenge with many activities that rehabilitation nurses are already performing as they work to identify and connect patients with appropriate clinical and support resources.

ARN envisions many activities that would fall under the scope of PIN services. For example, a spinal cord injury (SCI) is a rare occurrence; however, there are a significant number of individuals who do not have access to effective treatment and education. This is particularly true if the patient is not treated in a SCI-specialty clinic, they may not have access to SCI care or SCI specialists. Under these circumstances, there are a number of individuals who reach out to specialty organizations for help as the process is very difficult to navigate.

Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Expansion of Supervising Practitioners

ARN was pleased to see CMS' proposal to allow cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR) services to be provided under the supervision of a physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS), consistent with Section 51008(a) and 51008(b) of the Bipartisan Budget Act of 2018. This will undoubtedly enhance patient access to care and improve collaborative care. Many ARN members are nurse practitioners and clinical nurse specialists and allowing them to supervise rehabilitation services can help expand access to care for rehabilitation patients. This is particularly important as we see a growing workforce shortage, especially in rural and underserved areas. This provision will help to reduce wait times and increase patient access to medical necessary rehabilitation services. Moreover, by involving advanced practice nurses in supervising rehabilitation services, the overall healthcare team can function more efficiently,

leading to better care coordination and patient outcomes. The continuum of care is enhanced by PA, NPs, and CNSs with knowledge of rehabilitation that can continue the patient's rehabilitation past the inpatient experience. Monitoring for complications that could cause a re-admission as well as progress toward discharge of care falls well under the expertise of these professionals. **For these reasons, ARN urges CMS to finalize this proposal.**

Moreover, CMS will also continue the flexibilities as implemented during the COVID-19 public health emergency that allows for direct supervisions of CR, ICR and PR services through virtual presence to include audio/visual communications (excluding audio-only). These flexibilities will remain in effect until December 31, 2024. **ARN supports this proposal and urges CMS to extend this flexibility on a permanent basis.** ARN and the rehabilitation nurses we represent have seen the benefit of these flexibilities firsthand, both for rehabilitation patients and providers. Patients with limited mobility and/or access to transportation benefit from being able to access care virtually. When it is difficult to get to care settings, patients will not seek care until far into a complication that could have been halted earlier had the patient been able to connect virtually with a provider for treatment advice. Additionally, there is a distinct advantage to observing patients within their natural environment. This approach enables the healthcare provider to assess interactions within that specific environment, including with equipment, adaptations currently in use, or potential enhancements that will work in their setting.

By better enabling providers to provide care from anywhere they are, patients will be better able to receive care where they are. This will also secure access to services for individuals who do not have access to rehabilitation specialists and services. ARN believes this flexibility is another important tool to expand access to care, particularly in areas where there are significant nursing workforce shortages.

Thank you for the opportunity to provide these comments. If you have any questions, please contact ARN's Health Policy Associate, Jeremy Scott at jscott@dc-crd.com. We thank you for your consideration.

Sincerely,

Mary Ellen Hatch, MSN RN CRRN FARN