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September 4, 2025

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically to www.regulations.gov

RE: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center (ASC) Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Administrator Oz,

The American Nurses Association (ANA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) CY 2026 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. ANA applauds the Administration's continued focus on prevention and identifying approaches to address chronic illness. To achieve these goals, it is critical that CMS and the HOPPS recognize the value of nurses and nursing practice. As the agency works to finalize the proposed provisions, ANA urges CMS to:

- standardize practitioner terms across CMS rulemaking,
- increase payments for sole community hospitals (SCHs) and essential access community hospitals (EACHs),
- recognize the nurse in telehealth and emerging healthcare technologies,
- increase payments for Esketamine self-administration and non-opioid pain relief,
- allow practitioners to determine appropriate care settings, and
- further enhance hospital price transparency in patient care.

ANA is the premier organization representing the interests of the nation's over 5 million registered nurses (RNs) through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating for healthcare issues that affect nurses and the public. ANA members also include the four Advanced Practice Registered Nurse (APRN) roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of healthcare settings. RNs provide and coordinate

patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members.

Nurses are critical to a robust health care system. Nurses meet the needs of patients and provide quality care that drives better health outcomes for all patients. Moreover, nurses are critical to coordinated care approaches for Medicare beneficiaries in all care settings. Patient-centered care coordination is a core professional standard for all RNs and is central to nurses' longstanding practice of providing holistic care to patients.

1. **Terms must be standardized across CMS and the Federal Government.**

CMS restated in the above-captioned rule that the term "practitioner" specifically includes all practitioners who receive Medicare reimbursement, including APRNs. We appreciate and support CMS' approach and encourage the agency to standardize terms throughout the agency and the federal healthcare system. We recognize that CMS generally uses "practitioner," but this is not always the case. We thank CMS for not using outdated and incorrect terms like mid-level provider, but these terms are still used by other federal agencies. This lack of consistency throughout the federal government leads to confusion as practitioners do not know whether they are allowed to treat patients depending on which federal insurance plan the patient is covered by or facility where the practitioner is located. **As such, it is imperative that CMS work to standardize all terms within the agency and work to ensure that standardization is consistent across all federal health agencies and systems.**

2. **CMS must appropriately resource SCHs and EACHs to bolster access to care in rural areas.**

CMS proposes to continue the current payment adjustment of 7.1% for all services paid under the OPPS to SCHs and EACHs. These types of hospitals provide essential care to many patients who otherwise would not have access to care in rural areas, which CMS recognizes through a special payment designation. A shortage of practitioners continues to challenge rural areas and APRNs remain critical in ensuring patient access to primary and other needed healthcare services.[1] This payment adjustment helps support rural facilities and their practitioners, as they do not have the same resources as urban and suburban facilities. **CMS is right to recognize the need for rural practitioners to receive additional resources, and ANA urges the agency to finalize its proposal to continue the current, increased payment adjustment for SCHs and EACHs.**

3. **CMS must make clear that APRNs can conduct virtual direct supervision of rehabilitation services in hospital outpatient settings.**

[1] Neprash HT, Smith LB, Sheridan B, Moscovice I, Prasad S, Kozhimannil K. Nurse Practitioner Autonomy and Complexity of Care in Rural Primary Care. Medical Care Research and Review, December 2021, Vol. 78, No. 6, pp. 684–692. Published online July 29, 2020. https://doi.org/10.1177/1077558720945913

In the above-captioned rule, CMS uses the term "physician" to describe which practitioners can supervise rehabilitation services in hospital outpatient settings. However, previous OPPS rules have specifically noted that APRNs are trained and authorized to supervise rehabilitation services. ANA is concerned that the use of physician in the current OPPS proposed rule adds uncertainty as to which practitioners are able to supervise these healthcare services. CMS must vigorously review the regulations and make clear that APRNs are eligible for Medicare reimbursement when they are supervising rehabilitation services.

Further, CMS notes that in the calendar year 2026 Physician Fee Schedule (PFS) Proposed Rule, virtual direct supervision will be made permanent except for where there is a global surgery indicator of 010 or 090.[2] CMS states that with this change, the definition of virtual direct supervision will be standard across both PFS and OPPS payments. ANA appreciates this move, as a standard definition of virtual supervision is key to reduce confusion as to which fee schedule the service is reimbursed under. **ANA urges CMS to continue to enact changes that make it clear that APRNs have supervision authority and streamline supervision definitions across Medicare.**

4. **CMS must balance the use of technology with clinical experience.**

In the proposed rule, CMS specifically asks about how technology can be used in the treatment of chronic disease. Technology is advancing rapidly especially in the use of software and digital tools – already improving care. Nurses and APRNs use these applications to remind patients to take medications, track symptoms, coordinate care, and manage complex and chronic conditions. When integrated into workflows, these tools help nurses identify risks easier, engage patients between visits, and streamline chronic disease management across settings.

However, adopting and using these technologies present costs for practitioners and practices, and these expenses should be reimbursed in the fee schedule. Licenses, integration, maintenance, training, and the clinical time nurses and APRNs spend reviewing data and exercising judgment are practice expenses that should be reimbursed. ANA supports reimbursement for software, and artificial intelligence (AI) as part of the practitioner toolkit. While technology cannot replace clinical expertise, it can inform assessment and decision making. When nurses or APRNs spend time reviewing outputs or applying decision-making, that work should be recognized in work RVUs, and related practice expenses should be reflected in payment. It is imperative that CMS balance the use of technology with practitioner discretion—and that the providers who adopt innovative, technology-based approaches are adequately resourced. ANA encourages CMS to work closely with nurses and APRNs, to develop sound approaches to integrating technology into chronic disease areas, and to lead in establishing appropriate use and reimbursement for these innovations in clinical settings. **ANA urges CMS to lead the way on innovative technology, while working with nurses to ensure its proper use and reimbursement in clinical settings.**

[2] These are terms used in coding to determine how long one has for follow up appointments. Any appointments related to the original procedure are not separately reimbursable if they occur during the global period.

5. **CMS must raise reimbursement for administration of Esketamine treatment.**

CMS proposes to increase reimbursement for Esketamine treatment for CY 2026 and to place Esketamine treatment into Ambulatory Payment Classifications (APCs) 1512 and 1517. This follows CMS' previous rulemaking that placed the reimbursement for this treatment into an APC, effectively raising payments for providers for the provision of this emerging therapy. This evolution in the agency's rulemaking is critical for APRNs. The Food and Drug Administration approved the use of Esketamine therapy for treatment-resistant depression in March 2019. Initially, Medicare placed two new payment codes in the OPPS for Esketamine administration (G2082 and G2083) into bundled payments of $789.89 for G2082 and $1,117.23 for G2083 in the non-facility setting for physicians. Under Medicare statute, APRNs (including NPs) receive 15% less reimbursement than their physician colleagues. The resulting, reduced amount that NPs were reimbursed for the treatment bundles was $671.32 for G2082 and $949.65 for G2083—which rendered reimbursement less than the cost of the Esketamine treatment. As such, NPs and other APRNS had unreimbursed costs if they administered Esketamine to their patients, effectively creating a barrier to access for patients in need of this therapy. ANA appreciates CMS for its thoughtful approach to resourcing Esketamine treatment since its approval and strongly supports the provisions in the proposed rule. Placing Esketamine into APC 1512 and 1517 covers the full, direct costs of the treatment for APRNs and other non-physician providers and bolsters access to treatment for Medicare beneficiaries. **CMS is right to propose a reimbursement increase for Esketamine treatment and ANA urges the agency to finalize the proposed provisions.**

6. **CMS must ensure that practitioners determine appropriate facility settings for patient procedures.**

In a request for information (RFI) within the proposed rule, CMS expresses concern that some procedures are being performed in the facility setting where there is the highest reimbursement rather than at the most appropriate facility for that procedure. ANA has long believed that the practitioner should decide where procedures should be performed—since determinations for the most appropriate care setting must be driven by clinical needs, not by financial incentives. Current reimbursement provisions have created financial incentives that are based on facility setting, which can lead to scrutiny that decisions were driven by reimbursement and not the needs of the procedure. However, these provisions were adopted through rulemaking based on CMS policy priorities and recognition of resources needed in various care settings and care teams. This is especially true in rural areas, where facilities receive higher reimbursement to appropriately and adequately resource to preserve access.

Where there are different choices of facility, and all of the facility options are equally viable, CMS must allow clinical decision-making to drive decisions—regardless of whether there is a perceived financial incentive. Clinical care teams, which include nurses, evaluate and determine the best care settings for the best needs of their patients. This evaluation is critical to the provision of high quality, person-centered care. **As such, ANA strongly believes that practitioners decide where a procedure should be performed and CMS must safeguard that decision-making.**

7. **CMS must increase reimbursement for non-opioid treatments for pain relief in outpatient and ASC care settings.**

CMS proposes to continue a temporary increase in payments for some non-opioid treatments for pain relief in the hospital outpatient and ASC settings through December 31, 2027. The proposed rule will continue increased payments for five drugs and six devices.[3] Opioids, while appropriate for some patient needs, can have dangerous side effects and their use should be limited to when they are absolutely necessary.[4] CMS' proposal to temporarily increase payments for certain non-opioids encourages practitioners to look at other treatment approaches for pain relief and management. This is especially critical since the current Physician Fee Schedule does not reimburse practitioners for non-opioid pain managements services, which ANA urges CMS to examine in future rulemaking. **ANA strongly supports CMS' proposal to increase payments on non-opioids and would encourage CMS to seek other opportunities within the Medicare program to reduce the use of opioids.**

8. **CMS must update requirements for hospitals to further enhance price transparency in patient care.**

CMS looks to expand on previous rulemaking and ensure hospitals continue to make public their chargemasters in easily readable formats. The previous rulemaking was promulgated during the first Trump Administration and ANA appreciates the agency for this important work. Making these public creates a more informed patient—allowing patients to make smarter decisions based on having more transparent information about the cost of their care. Nurses, who in their role not only advocate for but educate patients, support price transparency efforts that allow their patients to make informed care decisions without cost uncertainty.

CMS proposes to define terms within existing price transparency regulations, such as "tenth percentile allowed amount," "median allowed amount," and "ninetieth percentile allowed amount." Giving a more precise definition will provide patients with more accurate data and allow them to make more informed decisions. CMS also proposes to replace the estimated charges mentioned in the original rulemaking with actual charges. These proposed changes will give patients much more accurate information about the true costs of needed care.

Last, CMS also proposes that hospitals report their national provider identifier (NPI) in machine readable files. NPIs are how hospitals and practitioners are reimbursed by Medicare and most private insurance companies. NPIs currently are public and requiring their reporting in a format that allows for easy analysis and use. These proposed provisions serve to build on previous price transparency rulemaking and further empowers patients to understand the true costs of their care. **ANA supports efforts to increase price transparency for patients receiving care in hospital**

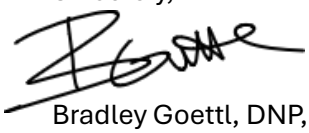
[3] See Table 82 of the proposed rule.

[4] Roger Chou, Judith A. Turner, Emily B. Devine, et al. The effectiveness and risks of long-term opioid therapy for chronic pain: A systematic review for a National Institutes of Health Pathways to Prevention Workshop. Annals of Internal Medicine, 2015, Vol. 162, pp. 276–286. Published online Feb. 17, 2015. https://doi.org/10.7326/M14-2559

settings and urges CMS to finalize the proposed requirements to further enhance price transparency in patient care.

ANA appreciates the opportunity to have this discussion and looks forward to continued engagement with CMS on shared priorities. Please contact Tim Nanof, ANA's Executive Vice President, Policy & Government Affairs at (301) 628-5166 or tim.nanof@ana.org with any questions.

Sincerely,



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