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Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
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Submitted electronically to www.regulations.gov

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System and Policy Changes and Fiscal Year (FY) 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz,

The American Nurses Association (ANA) is pleased to submit the following comments in response to the above-captioned rule. ANA supports the Centers for Medicare & Medicaid Services' (CMS') goals for increasing access to care and creating a healthier public through the proposed provisions. While we appreciate CMS' thoughtful proposals, ANA urges the agency to consider our comments on the following as it finalizes this rulemaking:

- deregulation in the Medicare program
- physician procedure panels
- nursing education programs
- removal of the health equity and Social Determinants of Health (SDOH) quality measures
- vaccination coverage measures
- long-term care hospital QRP Measure Concepts RFI

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

We appreciate the agency's thoughtful consideration of our comments.

1) **ANA supports the Administration's efforts to deregulate healthcare and the nursing profession.**

The Administration has shown that they have a great interest in deregulation. ANA is happy to work with the Administration on this effort and look forward to further discussions with the Administration on these issues. Specifically, APRNs are bound by many out of date and pointless regulations, which only serve to reduce their ability to practice at the top of their license. As CMS looks for feedback on areas of deregulation, ANA has identified specific policy proposals that would reduce the regulatory burden on nursing and looks forward to working with the Administration on ways to remove that burden and deregulate the nursing profession.

a) Barriers to Full Practice Authority must be removed.

APRNs, including NPs, CNSs, CNMs, and CRNAs, face real barriers to practicing at the top of their license due to outdated regulations. The Administration has the authority to provide full practice authority to nurses who serve patients receiving healthcare through federal programs by creating a program similar to the Veteran Affairs' (VA's) National Standards of Practice—which defines a consistent scope of practice and responsibilities across all VA facilities. National standards in other care settings would allow APRNs to practice at the top of their license while seeing patients covered by federal insurance programs. These standards would only cover patients covered by federal insurance programs and would not require other payers to follow federal rules. The care provided by APRNs to Medicare beneficiaries is comparable to the care provided by physicians[1]. There is also legislation[2] introduced in Congress that would remove many of these barriers, but ANA strongly encourages the Administration to remove these barriers without waiting for Congressional action.

Providing full practice authority to APRNs is a commonsense approach to ensure that these clinicians can practice at the top of their license and increase patient access to these trusted providers**. ANA urges the Administration to remove all regulatory barriers that prevent APRN's from having full practice authority.**

b) Collaborative agreement and supervision requirements must be relaxed.

[1] American Association of Nurse Practitioners (n.d.). *Literature on Quality of Nurse Practitioner Practice*. Retrieved June 16, 2025, from https://www.aanp.org/advocacy/advocacy-resource/position-statements/quality-of-nurse-practitioner-practice

[2] S. 575 and H.R. 1317, *Improving Care and Access to Nurses Act*

Collaborative agreements fulfill a regulatory requirement placed by many states on APRN practice, which require an agreement between a physician and an APRN for either a limited period (transition to practice) or granting permission to practice. **Many of these requirements were relaxed by the Trump Administration during the COVID-19 public health emergency (PHE) with no demonstrable negative effect on patient care. ANA believes that the flexibilities provided during the pandemic should be made permanent.** These do not relate to the APRNs' scope of practice, and there is no evidence to suggest that these collaborative agreements protect patients. Additionally, these transition-to-practice requirements are becoming increasingly difficult to initiate and maintain as primary care physicians and psychiatrists continue to decline to offer them in many cases, undercutting APRN's opportunities to provide care. Additionally, mergers and acquisitions prevent physicians from signing agreements with APRNs who are not employed by the parent organization, creating additional barriers to practice.

Additionally, supervision requirements are very similar to collaborative agreements and generally require that a physician sign off on an APRN's work. Currently, many states allow APRN practice without unnecessary supervision requirements[3]. During the COVID-19 PHE, the Trump Administration rightfully relaxed these supervision requirements without any discernible difference in patient care. **ANA maintains that these relaxed supervision requirements must become permanent.**

2) **CMS must include nurse input on any Operating Room (OR) and Non-OR Procedure Panels.**

The proposed rule contains provisions related to physician panels, which are used to determine which procedures do or do not require an OR based in part on what hospital resources are required and/or consumed for the procedure. **ANA agrees with the idea of using procedure panels to make these determinations but calls on CMS to require that they include nurse representatives.** Nurses are an integral part of the healthcare team, and RNs work closely with physicians in the OR and have firsthand knowledge and experience to know what hospital resources are needed for procedures. All too often, the nurse's insight is not included on these types of panels. Moreover, nurses and physicians have different roles as part of the care team and offer different, but important, perspectives on how procedures are performed. Omitting nurses from the panels only serves to discount their perspectives and results in decision making that does not fully capture the hospital resources needed. As the agency examines procedure panels focused on determining OR and non-OR procedures, it is vital that surgical nurses are required participants on these panels.

ANA further urges CMS to change the name of these panels to "practitioner panels." In the calendar year 2024 Physician Fee Schedule, CMS began using the term practitioner instead of physician. This term explicitly includes all practitioners involved in the delivery of healthcare services, including nurses. CMS was right to make that change and ANA encourages that agency to be consistent in its use of the term practitioner.

[3] NPs can practice in 39 states, CNS' and CNMs can practice in 28 states, and CRNAs can practice in 27 states

3) **CMS reasonable cost payment for nursing and allied health education programs should be maintained.**

Medicare has historically paid hospitals for Medicare's share of the costs that providers incur in connection with approved educational activities. These costs are separately identified and "passed through," that is, paid separately on a reasonable cost basis. Data from the calendar year 2022 were used to calculate the previous year's payment. This year, CMS proposes to base the FY 2026 payments on data from FY 2024, which is the most recent data available. ANA thanks CMS for continuing these payments. **As such, ANA recommends that CMS finalize its proposal to use the most recent data available to calculate the most accurate payments.**

4) **ANA strongly supports screening for Social Determinants of Health (SDOH) and health equity data collection.**

ANA strongly supports the continued collection and integration of Social Determinants of Health (SDOH) and health equity measures in CMS programs. We respectfully urge CMS not to eliminate these critical measures, but rather to enhance and support their implementation.

SDOH screenings—such as assessments for housing instability, food insecurity, economic stability, lack of transportation, economic hardship, and utility needs—are vital tools for identifying non-medical factors that directly affect health outcomes, readmissions, and care quality. In fact, up to 80 percent of an individual's health is influenced by social, behavioral, and environmental factors, far outweighing the impact of clinical care alone.[4] Unmet social needs can lead to downstream effects such as delayed care, poor chronic disease management, difficulty affording or adhering to medications, missed follow-up appointments, and increased financial strain. When practitioners have a full picture of a patient's circumstances, they can proactively assess these risks and intervene earlier to improve outcome.[5] Thus, collecting and acting on this data is critical for improving patient centered care quality, reducing healthcare costs and utilization, addressing differences in patient outcomes, and driving cost-effective care delivery.[6,7]

Nurses are uniquely positioned to lead this effort, as they are often the first point of contact for patients. Incorporating social needs into care is both a professional responsibility and an ethical imperative, as outlined in the Nursing Code of Ethics.[8,9] Moreover, the integration of social needs data can serve as a valuable tool for improving risk predictions in healthcare outcomes, supporting clinical decision making and mitigating harm to the patient.[10] When nurses screen for and respond

[4] Nurses' Role in addressing social determinants of health. 2022. Nursing2025, Accessed, May 2025.
[5] Screening for Social Determinants of Health in Daily Practice | AAFP
[6] Health Equity Adjustment and Hospital Performance in the Medicare Value-Based Purchasing Program – PMC, 2024. Health Equity Adjustment and Hospital Performance in the Medicare Value-Based Purchasing Program - PMC: Accessed May 2025.
[7] Hospitals and Health Equity — Translating Measurement into Action | New England Journal of Medicine. 2022. Hospitals and Health Equity — Translating Measurement into Action | New England Journal of Medicine: Accessed May 2025.
[8] Accountable Health Communities (AHC) Model Evaluation: Second Evaluation Report. May 2023. Accessed May 2025.
[9] American Nurses Association. 2025. Code of Ethics for Nurses. https://codeofethics.ana.org. Accessed May, 2025
[10] ISPOR - The Role of Social Determinants of Health (SDoH) Data in Improving Risk Predictions

to social needs, patients receive more personalized care, improved discharge planning, and enhanced connections to community resources.

Moreover, research shows that more than one-third of Medicare and Medicaid beneficiaries have at least one social need, and aligning social needs data with care delivery can reduce per-patient costs by at least $1,400.[11] Integrating SDOH into care improves outcomes and offers a compelling return on investment, both clinically and financially.[12] Moreover, meaningful clinical improvements and cost savings from screening and referral of social needs have led to better medication adherence, blood pressure control, and diabetes management and significantly less readmissions.[13,14,15]

Rather than removing SDOH-related measures, CMS should consider incentivizing hospitals and health systems to fully implement them—transforming data into actionable care interventions and catalyzing healthcare innovation that integrate social service partners. Doing so aligns with the Administration's commitment to drive industry level progress, efficiency, prevention, and patient-centered care, including priorities outlined in the Executive Order to Make America Healthy Again (MAHA), and the Center for Medicare and Medicaid Innovation center vision to test care models that leverage prevention.[16]

While we understand CMS's concerns about administrative burden, we emphasize that many healthcare organizations have already incorporated SDOH screening into admission processes and care coordination workflows.[17] Eliminating these measures without a transition plan could disrupt established care practices, undermine quality, and present ethical challenges.[18]

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[11] National Library of Medicine. *Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention*. Retrieved May 20, 2025, from https://pmc.ncbi.nlm.nih.gov/articles/PMC3874584/

[12] National Library of Medicine. *Return on investments in social determinants of health interventions: What is the evidence?* Retrieved May 20, 2025, from https://pmc.ncbi.nlm.nih.gov/articles/PMC11425055/

[13] National Library of Medicine (n.d.). *Potential benefits of incorporating social determinants of health screening on comprehensive medication management effectiveness*. Retrieved May 20, 2025, from https://pmc.ncbi.nlm.nih.gov/articles/PMC11522447/?utm_source=chatgpt.com

[14] National Library of Medicine. *Potential benefits of incorporating social determinants of health screening on comprehensive medication management effectiveness*. Retrieved May 20, 2025, from https://pmc.ncbi.nlm.nih.gov/articles/PMC11522447/?utm_source=chatgpt.com

[15]Health Affairs (n.d.). *Social Determinants Matter For Hospital Readmission Policy: Insights From New York City*. Retrieved May 20, 2025, from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01742?utm_source=chatgpt.com

[16] White House (2025, February 13). *ESTABLISHING THE PRESIDENT'S MAKE AMERICA HEALTHY AGAIN COMMISSION*. Retrieved May 20, 2025, from https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/

[17] The Undoing of SDoH Reporting: What Case Managers Need to Know About CMS's FY 2026 Proposed Rollbacks. 2025. The Undoing of SDoH Reporting: What Case Managers Need to Know About CMS's FY 2026 Proposed Rollbacks | CMSA: Accessed May 2025.

[18] The Undoing of SDoH Reporting: What Case Managers Need to Know About CMS's FY 2026 Proposed Rollbacks. 2025. The Undoing of SDoH Reporting: What Case Managers Need to Know About CMS's FY 2026 Proposed Rollbacks | CMSA: Accessed May 2025.

We urge CMS to continue its leadership in promoting health equity by:

- Preserving and expanding the use of SDOH and health equity measures,
- Incentivizing healthcare systems to turn data into meaningful care planning,
- Supporting frontline practitioners—especially nurses—in driving patient-centered innovation.

Nurses are ready and able to lead this transformation. Their increased involvement in SDOH data collection, interpretation, and care planning is essential to building a more effective high quality healthcare system.

a) CMS must not remove the Health Equity Adjustment from the Hospital Value Based Purchasing (VBP) Program.

In the FY 2024 IPPS/LTCH PPS final rule, CMS adopted a Health Equity Adjustment (HEA) for the Hospital VBP Program. It provides additional bonus points to hospitals that excel in delivering care to hard-to-reach patient populations, including those who are dually eligible for Medicare and Medicaid and located in rural areas. This measure requires hospitals to collect non-medical risk factor data (i.e. sociodemographic and social risk factor data) that health systems can use to improve clinical outcomes, patient experience, safety, and efficiency. Now, CMS is proposing to remove the HEA from the Hospital VBP Program, citing the need to simplify the VBP program and provide "clear incentives" to hospitals to improve quality of care for all patients and reduce burden on the Medicare program. As noted above, capturing health equity information is an essential step toward building a person-centered healthcare system—and one that fully recognizes the central role of nurses in achieving that goal. **ANA strongly opposes CMS' proposal to remove the HEA in the Hospital VBP Program.**

It is an essential step toward building a person-centered healthcare system—and one that fully recognizes the central role of nurses in achieving that goal.

b) CMS must retain the Hospital Commitment to Health Equity measure and the Screening for Social Drivers of Health and the Screen Positive Rate of Social Drivers of Health measures in the Hospital Inpatient Quality Reporting (IQR)

CMS is proposing to remove the Hospital Commitment to Health Equity measure, the Screening for Social Drivers of Health and the Screen Positive Rate of Social Drivers of Health measures from the Hospital IQR beginning with CY 2024 reporting period/FY 2026 payment determination. CMS cites the reason for the removal of these measures to be due to the costs associated with achieving a high score on the measures outweighing the benefit of its continued use in the program. CMS further notes that the burden of collecting the measure outweighs the benefits as they do not measure clinical outcomes directly. CMS wishes to focus directly on clinical outcomes and identify new metrics around prevention, nutrition and well-being instead. ANA strongly opposes the elimination of these measures from the Hospital IQR. While ANA supports the Administration's focus on clinical outcomes, achieving truly person-centered care requires hospitals to collect key data—particularly around social determinants of health—that fundamentally shape those

outcomes. **As such, ANA strongly opposes removal of health equity and SDOH measures from the Hospital IQR Program.**

c) CMS must retain the SDOH Measures in the Long-Term Care Hospital Quality Reporting Program.

CMS is proposing to eliminate four key SDOH screening measures that include living situation, food, and utilities, from the LTCH QRP Program starting with FY 2026. CMS cites administrative burden and cost concerns as reasons for this decision. However, the removal of these measures would represent a significant step backward in national efforts to improve health outcomes by addressing non-medical factors that contribute to patient well-being. Addressing the social needs of patients is not a burden, it is essential to deliver high-quality, ethical, and cost-effective care. **ANA urges CMS to reconsider this proposal and maintain its commitment to providing patient centered care by retaining SDOH measures in the LTCH QRP Program.**

5) CMS should remove the COVID-19 Vaccination Coverage Among Healthcare Personnel quality reporting measure.

As part of the Hospital IQR Program, the COVID-19 Vaccination Coverage Among Healthcare Personnel measure (HCP COVID-19 vaccination measure) requires Medicare inpatient hospitals to report monthly COVID-19 vaccination data for healthcare personnel (HCP). In the above-captioned rule, CMS proposes to remove the HCP COVID-19 vaccination measure from the IQR, citing that the costs outweigh benefits of its continued use. While ANA believes that HCP should be vaccinated in line with the most current Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) recommendations,[19] we do not believe that public reporting of HCP COVID-19 vaccination rates is an appropriate tool to assess the quality of inpatient hospital and long-term care hospital performance and have previously voiced opposition to the proposed inclusion of HCP COVID-19 vaccination rates as quality metrics for Medicare facilities. **As such, we support CMS' proposal to remove the HCP COVID-19 vaccination measure from the Hospital IQR Program.**

Moreover, the agency is right to remove the HCP COVID-19 vaccination measure from the IQR program, since the COVID-19 public health emergency (PHE) formally expired on May 11, 2023.[20,21] Currently, many states and facilities implement their own COVID-19 vaccination requirements for HCPs as needed. Hospital quality metrics and reimbursement should not be evaluated based on what percentage of HCP are vaccinated for a disease for which CMS no longer explicitly has a vaccination mandate.

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[19]American Nurses Association (n.d.). *Immunizations, ANA Position Statement*. Retrieved May 20, 2025, from https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/immunizations/

[20] Centers for Disease Control. *Immunizations, ANA Position Statement*. COVID-19 Public Health Emergency. Retrieved May 20, 2025, from https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html

[21]Centers for Medicare and Medicaid Services (2025, May 20). *Immunizations, ANA Position Statement*. Federal Register. https://www.federalregister.gov/documents/2023/06/05/2023-11449/medicare-and-medicaid-programs-policy-and-regulatory-changes-to-the-omnibus-covid-19-health-care

Due to the administrative burden, the financial costs, the end of the COVID-19 PHE, and the 2023 CMS withdrawal of COVID-19 vaccination requirements, it is only right to remove the HCP COVID-19 vaccination measure from the IQR program at this time. **ANA urges CMS to finalize its proposal to remove the HCP COVID-19 vaccination measure.**

6) **CMS must engage with nurses as they consider well-being measures in quality reporting programs.**

CMS is seeking input for quality measure concept feedback, citing well-being as a comprehensive concept that captures disease prevention and health promotion as it integrates mental and physical health. Well-being is difficult to conceptualize and measure as it is a subjective sum of many other personal and social domains. Any inclusion of well-being as a quality measure should integrate empirically validated tools for different populations and should not supplant exiting measures of SDOH. Nurses are ready and able to lead efforts that integrate well-being data into innovative care models. Increasing nurse involvement in data collection and decision-making related to new quality measures will help ensure that healthcare delivery remains effective, efficient, and centered on the whole patient. As CMS determines which measures and processes will be used to collect non-medical risk factors, we urge the agency to work closely with nurses to ensure that the collection of sociodemographic data is balanced with the delivery of patient-centered care. **ANA supports the inclusion of a quality measure related to well-being in addition to capturing measures of SDOH and not supplanting them.**

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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