American Nurses Association

8403 Colesville Road, Suite 500
Silver Spring, MD 20910
+1 (301) 628.5000
ana.org

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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; Calendar Year (CY) 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

The American Nurses Association (ANA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) CY 2026 Physician Fee Schedule (PFS) 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 PFS recognize the value of nurses and nursing practice. As the agency works to finalize the proposed provisions, ANA urges CMS to:

- Ensure fair valuation of nurses through adequate payment and recognition in billing codes, facility payments, and demonstration programs,
- preserve and expand telehealth coverage for nurses and other clinical specialties,
- acknowledge nurses' critical role in conducting social determinants of health (SDOH) and other patient screening,
- include nurses in conversations to determine approaches to address chronic disease, bolster prevention, and integrate emerging technology, and
- update the Quality Payment Program (QPP) to accurately reflect and capture nursing practice.

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 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, the federal agencies, and healthcare systems.**

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' restatement and encourage the agency to broaden their approach and standardize terms throughout the agency and the federal healthcare system. We recognize that CMS generally uses "practitioner," but this is not always the case. Other federal agencies continue to use outdated and incorrect terms like mid-level provider, which we appreciate that CMS no longer uses. The lack of consistency throughout federal government guidance and regulations leads to confusion as practitioners do not know whether they are allowed to treat patients depending on which federal insurance plan they are covered by or in the facility where the practitioner is located. **As such, it is imperative that CMS work to standardize all terms within the agency and encourage consistency across all federal health agencies and systems.**

2. **CMS must ensure that providers are reimbursed for services appropriately.**

ANA believes that all nurses, APRNs, and healthcare providers deserve appropriate reimbursment for healthcare services they provide. Therefore, ANA appreciates CMS' thoughtful review and valuation of CPT codes, the expanded use of add-on codes for evaluation and management (E/M) encounters, and the opportunity to answer CMS' requests for comment.

a. Combination COVID-19 Vaccine Administration (90480, 9X61X)

CMS proposes to place a procedure status of "X" on CPT codes 90480 and 9X61X, making them ineligible for reimbursement under the PFS. While we generally oppose the inclusion of vaccine codes that are not reimbursed, we do agree with CMS' determination that these particular codes are not reimbursable. CPT code 90480 is currently reimbursed through other CMS policies and practitioners should not be reimbursed twice for the same service. CPT code 9X61X was not created for reimbursement, rather it was created for tracking purposes only. As there are no practice expense (PE) inputs or reimbursements associated with this code, ANA does not oppose the status of "X" being placed on this code. **As such, ANA urges CMS to finalize its proposal.**

b. Remote Monitoring (99091, 99474)

Of the 19 remote monitoring codes CMS valued in the PFS, ANA surveyed CPT codes 99091 and 99474. CPT code 99091 did not meet the survey threshold and will therefore have to be resurveyed. Additionally, the efficiency adjustment was applied to this code which lowered the Relative Value Units (RVU) by 0.03. **ANA thanks CMS for not accepting the RUC recommendation of 0.70 but also does not agree with CMS applying the efficiency adjustment to this code**. The efficiency adjustment is applicable when practitioners become more comfortable with the work, and it takes less time while becoming easier. This is not applicable when there are time-based codes and the

amount of time it takes to provide the service does not change. CPT code 99091 is a time-based code and therefore the efficiency adjustment should not apply and the original work RVU of 1.10 should be used for the code. **For CPT code 99474, ANA thanks CMS for accepting the RUC recommendation of 0.18.**

c. *Immunization Counseling (90XX1, 90XX2, 90XX3)*

CMS proposes to give the Immunization Counseling codes 90XX1, 90XX2, and 90XX3 the status of "I" which would make them not valid for Medicare reimbursement purposes. CMS states that these codes are already reimbursable by Healthcare Common Procedure Coding System (HCPCS) codes G0310-G0313 (G codes). However, the RUC recommended that CMS use the CPT codes instead and delete the G codes. The G codes are currently eligible for Medicaid reimbursement, but not Medicare reimbursement. To ensure consistency across both programs and that clinicians receive appropriate reimbursement for immunization counseling, **ANA urges CMS to adopt the RUC recommendations and replace the G codes with the new CPT codes, along with the RUC valuations of these codes.**

d. *Respiratory Syncytial Virus (RSV) Monoclonal Antibody Administration (96380, 96381)*

CMS proposes to accept the RUC recommendations for the RSV Monoclonal Antibody Administration codes of 0.28 work RVUs for CPT code 96380 and 0.17 work RVUs for CPT code 96381. **ANA agrees with these recommendations and urges CMS to finalize its proposal.**

e. *CMS must expand the use of add-on codes for Evaluation and Management (E/M) Encounters.*

CMS proposes to expand the use of HCPCS code G2211. The expanded definition would allow practitioners to bill Medicare for its use as an add-on code with the home or residence E/M code family. ANA has long believed that practitioners must meet their patients where they are. Practitioner time and work for an E/M visit does not change whether the work is being done in the office or in the patient's home. **ANA strongly supports this change and believes that the expanded use of G2211 will allow more Medicare beneficiaries to receive access to proper care.**

f. *CMS must not delete HCPCS code G0136.*

HCPCS code G0136 (Administration of a standardized, evidence-based social determinants of health (SDOH) risk assessment tool, 5 to 15 minutes) is used by practitioners to determine patient backgrounds. CMS proposes to delete the code saying that it is already included in other E/M codes. ANA opposes the deletion of HCPCS code G0136. This code is essential because SDOH elements of the code not necessarily covered by other HCPCS codes, but the assessments are critical in identifying a patient's pre-existing and chronic conditions. The current Administration is focusing on ensuring a healthier American public and this code is a small piece of keeping people healthy. Retaining and reimbursing G0136 ensures nurses have the necessary time and resources with their patients to identify all medical and nonmedical factors impacting their overall health. **As such, ANA strongly opposes the proposed deletion of G0136.**

CMS also proposes to delete the HCPCS code G0136 from the definition of "primary care services" used for beneficiary assignment in the Medicare Shared Savings Program (MSSP). CMS states that they believe that the resource costs described by code G0136 are already accounted for in "existing codes, including but not limited to evaluation and management visits."[1] However, it is unclear if other codes do adequately account for each portion of HCPCS G0136. CMS must be more specific as to how G0136 Code is accounted for before proposing to delete it from the definition of primary care services used for beneficiary assignment. **ANA strongly believes that a standardized, evidence-based SDOH risk assessment tool is a critical component of patient care and urges CMS to not finalize its proposal to remove the G0136 from the HCPCS.**

g. CMS should appropriately reimburse healthcare services provided in urgent care settings.

CMS seeks comment on whether separate coding and payment is needed for E/M visits at urgent care centers. ANA recognizes the critical role urgent care centers play in the healthcare system and encourages CMS to pursue the creation of separate coding for these facilities. Urgent care centers provide a vital service as they reduce emergency room (ER) congestion, lowering costs and allowing ERs to focus on treating more acute need. Moreover, urgent care centers utilize APRNs, who provide high quality care and ensure patients have access to high quality primary and other needed services. Patient use of these facilities is growing rapidly. According to the Urgent Care Association, around 6,000 urgent care centers have opened in the last eight years and nearly 90% of the US population lives within a twenty-minute drive of an urgent care center.[2]

ANA believes that add-on codes would be a practical solution for reimbursement. The work being done by the practitioner is similar to work being done in other care settings, and the creation of new codes can be a complex and time-consuming process. A new add-on code reflecting the place of service would be significantly simpler than a whole new code set, and it would remove the confusion around reimbursement valuation. This approach would allow better resourcing for providers in urgent care settings, enabling them to continue to serve patients in their respective communities in the most appropriate setting. **ANA encourages CMS to pursue appropriate reimbursements through separate coding and payment for services provided in urgent care centers.**

3. 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.

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[1] Centers for Medicare & Medicaid Services. (2025, July 16). *Medicare and Medicaid programs; CY 2026 payment policies under the physician fee schedule and other changes to Part B payment and coverage policies; Medicare shared savings program requirements; and Medicare prescription drug inflation rebate program* [Proposed rule]. Federal Register, 90(135), 41358–41455. https://www.federalregister.gov/documents/2025/07/16/2025-13271/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other#h-576

[2] (n.d.). *Urgent Care Data*. Urgent Care Association. Retrieved August 19, 2025, from https://urgentcareassociation.org/about/urgent-care-data/#next

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 in the PFS. 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.**

4. **CMS must preserve and expand access to telehealth.**

ANA has long been a proponent of expanding telehealth services, and the COVID-19 public health emergency (PHE) provided the impetus for Medicare to greatly expand these services. Telehealth is an essential part of care for many Americans, especially those with limited mobility or those in rural areas. Many rural areas have few—if any—practitioners within a reasonable driving distance, and allowing these practitioners to treat patients anywhere in their state has greatly improved care for those patients.

There are times when patients have questions for their practitioner, and these can be answered remotely. These appointments, which can be very difficult to have in-person, have allowed these patients to speak with their practitioners when they need care. ANA agrees that many procedures must be done in person, but there are many preventative patient encounters where the patient does not have any procedures or tests done. These encounters can be done virtually and continuing to do them improves access for Medicare beneficiaries.

Telehealth continues to be widely used since the end of the pandemic, and NPs are among the most extensive users of telehealth.[3,4] Therefore, ANA implores CMS to use their authority to either extend or make the COVID-19 PHE telehealth flexibilities permanent. In the areas where CMS does not have the authority to make these flexibilities permanent, ANA continues to work with Congress on permanency.

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[3] Adolph, N., Patel, B., & Glass, R. (2025, March 7). *Mid-level prescribers, telehealth, and digital health applications in patient access to care*. IQVIA. Retrieved August 18, 2025, from https://www.iqvia.com/locations/united-states/blogs/2025/03/mid-level-prescribers-telehealth-and-digital-health-applications

[4] The healthcare specialties that use telehealth the most. (2023, September 21). *Definitive Healthcare*. Retrieved August 18, 2025, from https://www.definitivehc.com/resources/healthcare-insights/top-telehealth-specialties

In addition to promoting general telehealth flexibilities, ANA continues to support our members in their use of telehealth and offers comments on a number of specific CMS proposals in the above-captioned rule.

a. *CMS must update the definition of direct supervision.*

CMS proposes to permanently change the definition of direct supervision to allow direct supervision where the supervising practitioner is available immediately via audio/video communications, with the exception of 10- and 90-day global period codes. This change is long overdue and follows other changes to supervision requirements since the start of the COVID-19 PHE. **ANA strongly supports this change and thanks CMS for allowing remote direct supervision.**

b. *CMS should permanently adopt remote flexibilities for direct supervision requirements for federally qualified health centers (FQHCs) and rural health centers (RHCs).*

CMS proposes to permanently adopt the relaxed flexibilities for direct supervision requirements for FQHCs and RHCs. Under this proposal, the supervising practitioner must be immediately available to provide assistance and direction—either virtually or in-person. ANA has previously supported the extension of remote direct supervision requirements and welcomes this permanent solution. We agree with CMS that this type of supervision requires audio/video technology, so that the supervising practitioner can see and hear the encounter. These remote flexibilities are particularly needed in rural areas where there are practitioner shortages and patients may live very far away from care providers or RHCs. Without remote direct supervision, there could be delays in needed care when the supervising practitioner is required to be present. **As such, CMS must finalize its proposal to relax direct supervision requirements for FQHCs and RHCs.**

c. *CMS must remove the distinction between services on the provisional and permanent telehealth lists.*

CMS proposes to remove the distinction between services on the provisional telehealth list and permanent telehealth list. This would create one list that would include all approved telehealth procedures. As we have noted, many practitioners started seeing telehealth patients during the COVID-19 PHE and, at this point in time, have the necessary experience to determine what procedures can be done safely via telehealth and what procedures must be done in person. **ANA agrees with this change and supports merging the telehealth lists into one.**

d. *CMS must remove the frequency limitations on telehealth.*

CMS proposes to remove the frequency limitations that have been part of telehealth regulations. These limitations restrict the number of telehealth visits a patient can have, resulting in patients not receiving needed care. We appreciate CMS' approach to this issue, as it follows the rationale for removing the provisional telehealth list. ANA holds that practitioners are best positioned to determine if a procedure should be furnished via telehealth. **As such, ANA supports removing the frequency limitations in telehealth and urges CMS to finalize its proposal.**

e. *CMS must continue allowing practitioners to use their office address even when they see patients from a home office.*

In the CY 2025 PFS final rule, CMS continued their policy of not requiring practitioners to list their home address as a site of service for billing when they see patients remotely through telehealth technologies. This policy currently is set to sunset on December 31, 2025, if CMS does not act. However, the current CY 2026 PFS proposed rule does not address continuation of this policy. If this policy were allowed to take effect, it would result in a chilling effect on telehealth. For their personal safety, practitioners do not want to have their home addresses listed as a site of service. Listing home addresses unnecessarily removes important privacy protections for practitioners that likely will result in driving them away from using telehealth to provide critical healthcare services for patients. **CMS must continue the policy of exempting practitioners home addresses from being listed as sites of service.**

f. CMS should change the definition of "visit" to include telehealth visits for FQHCs and RHCs.

In the proposed rule, CMS offers two proposals on how to handle the payment of telehealth visits for FQHCs and RHCs in the event that Congress no longer authorizes payments for telehealth services. One of these proposals would expand the definition of a "visit" at an RHC or FQHC to also include encounters furnished through real-time, interactive, audio and video telecommunications technology, or telehealth visits. This approach of expanding the definition of "visit" to include telehealth visits is proactive and ensures that telehealth services by FQHCs and RHCs would be permanently covered for Medicare beneficiaries. ANA has long advocated for CMS to use its regulatory authority to make telehealth flexibilities permanent, rather than waiting for an act of Congress. CMS can do so by adopting the proposal to expand the definition of "visit."

CMS' other proposal in this rule for telehealth payment for FQHCs and RHCs would temporarily facilitate payment for telehealth visits with an approach that aligns with methodology used before and after the COVID-19 PHE, which would allow RHCs and FQHCs to continue to bill for telehealth visits by reporting HCPCS code G2025 on the claim. This would only be a temporary fix, creating uncertainty for patients and providers in the long term and only serve to postpone the need for future regulatory changes. ANA strongly believes that telehealth flexibilities should be made permanent and not implemented on a temporary basis. CMS must be proactive and not wait for an act of Congress.

By permanently changing the definition of visit to include telehealth visits for RHCs and FQHCs, CMS would permit many patients in rural areas to receive care from the practitioner of their choice and ensure these providers are reimbursed accordingly. Currently, many rural areas face access challenges, which telehealth helps to improve—especially for patients with limited mobility, lack of access to reliable transportation, or do not have paid time off from their jobs. **Therefore, ANA supports CMS' proposal to expand the definition of "visit" for FQHCs and RHCs to include telehealth visits.**

5. CMS should finalize its HCPCS code system for care coordination services for FQHCs and RHCs.

ANA welcomes CMS' consideration of our comments last year, where we suggested a streamlined system to create more transparency in which Healthcare Common Procedure Coding System (HCPCS) codes are considered care coordination services. Last year, ANA suggested that any

services which are partially paid for under the PFS and partially paid under RHC or FQHC payment rates be considered care coordination and therefore should be reimbursed under one payment system.[5] Streamlining HCPCS code system for care coordination helps lower overhead costs--by reducing administrative burden--and reduce provider stress--by enabling more predictability. In response to our comments and others, CMS is proposing to adopt services established and paid under the PFS, and designated as care management services, as care coordination services for purposes of separate payment for RHCs and FQHCs. **ANA urges CMS to finalize this proposal to streamline HCPCS code system for care coordination services for FQHCs and RHCs, as it will reduce provider stress and lower both administrative and financial burdens for providers.**

6. **CMS must finalize the creation of add-on codes to further the integration of advanced primary care and behavioral health.**

CMS proposes to create an add-on code that would facilitate providing complementary behavioral health integration (BHI) by removing time-based requirements for Advanced Primary Care Management (APCM) services. ANA agrees with CMS that creation of an add-on code will reduce documentation requirements on practitioners. ANA further believes that reducing burdens on practitioners will lead to better care for patients.

Additionally, CMS believes that removing these requirements will encourage more practitioners to provide BHI services. ANA agrees with this assessment. Removing documentation requirements will not only streamline the care being given to beneficiaries, but it will also lower the burden on practitioners by not having to train new staff in these requirements. **As such, ANA urges CMS to expand the use of add-on codes to facilitate BHI.**

CMS also proposes adopting add-on codes for APCM services that would facilitate billing for BHI and Psychiatric Collaborative Care Management (CoCM) services when RHCs and FQHCs provide advanced primary care. **ANA is pleased to see CMS' proposal which will simplify billing for both BHI and CoCM services in RHCs and FQHCs.** We encourage CMS to finalize this proposal.

7. **CMS must include all preventative services in APCM model bundles.**

CMS seeks information on how the APCM model can be used for prevention services. ANA agrees that integration of primary care and preventative services is an excellent way to ensure that Medicare beneficiaries remain healthy, as annual physicals and visits to primary care providers are essential in preventing avoidable healthcare conditions.

CMS specifically seeks comment on APCM bundles and what they should include. ANA would strongly recommend that the bundles contain as many preventative care services as possible. These not only have the benefit of keeping patients healthy, but also the additional benefit of lowering long term costs to the Medicare program. In the request for comment, CMS specifically mentions annual wellness visits. ANA implores CMS to include these in the APCM bundles. One of

[5] American Nurses Association. (2024, September 3). Comment letter on CY 2025 Physician Fee Schedule proposed rule [CMS-1807-P]. https://www.nursingworld.org/globalassets/docs/ana/comment-letters/ana-comment-letter-cy-2025-pfs-2024-09-03-final.pdf

the fundamental ways that practitioners can prevent chronic disease and other conditions is through annual wellness visits.

APRNs, specifically NPs, are critical to the provision of primary care to Medicare beneficiaries nationwide. CMS should use its regulatory authority to ensure that APRNs are included in APCM networks and are recognized and reimbursed for the primary and preventative care that they are trained to do. **As CMS looks at ways to utilize the APCM model to support prevention, ANA urges the agency to keep the nurse central and include all preventative services in APCM model bundles.**

8. **CMS must include APRNs in their proposed Ambulatory Specialty Model tests.**

CMS proposes two new Ambulatory Specialty Models (ASMs), one for heart failure and one for lower back pain. While certain physicians will participate in these ASMs, APRNs are excluded from participating. CMS notes that this exclusion is due to existing regulatory language. However, the agency is creating new regulatory language to implement this model, so that language can also encompass APRNs—which they have authority to do. By excluding this whole class of providers from participating in these ASMs, CMS is putting APRNs at a disadvantage and hurts reimbursement for APRNs from a conversion factor perspective. **Therefore, CMS should expand this program so that APRNs who specialize in any of the required fields of medicine can participate.**

Additionally, participation for qualifying physicians in the ASMs is mandatory. Providers must be able to choose whether to opt into these ASMs, since these ASMs can pose large changes for providers. **CMS must make participation voluntary rather than mandatory for qualifying providers and expand the list of providers who qualify to participate in the ASMs to include APRNS.**

9. **CMS should adopt the proposed extension of COVID-19 PHE flexibilities and amendments to the weigh-in system and online components of MDPP.**

ANA continues to support the Medicare Diabetes Prevention Program (MDPP) as an evidence-based behavioral intervention available to patients as a preventative service. CMS proposes several changes to the MDPP to increase program uptake, including introducing new definitions, addressing operational barriers for weight collection requirements, extending COVID-19 PHE flexibilities, and including a test program of an asynchronous delivery system. CMS proposes extending MDPP COVID-19 PHE flexibilities through December 31, 2029. These flexibilities allow providers to deliver MDPP sessions through virtual distance learning options and permit beneficiaries to self-report their own weight for virtual MDPP sessions. These changes are beneficial in promoting continued access to MDPP, especially for beneficiaries who live in areas where there are limited in-person MDPP suppliers.

Additionally, CMS proposes amending MDPP to allow for more flexibility in uploading weight requirements. Currently, patients are required to submit their weight on the day of a MDPP session, and they are limited to reporting their non-in-person weigh-ins through a photograph or video of their digital scale from home. CMS' proposal would allow a mandatory weigh-in to take place within two days of a MDPP session and permit beneficiaries to self-report their weight from a reasonable location, such as a temporary lodging, fitness center, hotel or medical facility. This

proposal will allow for more flexibility for patients to submit their weight, no matter their location. This will help meet patients where they are. Further, CMS proposes to allow a mandatory weigh-in to take place within two days of an MDPP session, as opposed to the current date of session weigh-in requirement. This proposed change will allow for more flexibility for patients to submit their weight. Currently, patients are limited to reporting their non-in-person weigh-ins through a photograph or video of their digital scale from home, limiting patients' ability to self-report their weight when away from home. **ANA appreciates CMS's proposed revisions to the MDPP that allow for greater patient flexibility while maintaining the integrity of the program and, as such, we urge the agency to finalize the proposed changes.**

Finally, CMS has proposed to test the addition of MDPP coverage for an online asynchronous delivery modality system. ANA supports making MDPP more accessible for both patients and providers, which asynchronous delivery can provide. However, there is a burden on organizations to obtain a separate online organization code than the organizational codes used for their other delivery modes from the Centers for Disease Control and Prevention (CDC). The process of getting separate online organization codes from CDC must not place too high of a burden on providers to discourage participation in the asynchronous delivery modality MDPP test. **ANA supports the MDPP online asynchronous delivery modality system test, as long as providers are not overly burdened by obtaining online organization codes.**

10. CMS must encourage CDC to reinstate electronic case reporting registration.

CMS reports in the proposed rule that the CDC has recently paused electronic case reporting (ECR) registration and onboarding of new healthcare organizations (HCOs) to develop a more efficient, automated process. As a result, CMS proposes to suppress the Electronic Case Reporting Measure from MIPS scoring to avoid undue adverse consequences for MIPS eligible clinicians and hospitals. The Electronic Case Reporting Measure requires eligible clinicians to attest that they are actively engaged with public health authorities for electronic infectious disease case reporting in applicable public health jurisdictions. While ANA appreciates that CMS is looking out for clinicians who are unable to meet metrics due to the CDC's pause on ECR registration for HCOs and understands that there needs to be a more efficient and automated ECR process, we are concerned that the CDC has paused onboarding and registration for ECR.

Case reporting in general is pivotal for public health. ECR saves valuable time and eases this burden for both providers who suspect the case and those who manage these cases and outbreak control at state and local health departments. Health agencies and departments must know about cases of infectious diseases in a timely manner in order to have a timely and appropriate response, and ECR can speed up this process and provide more complete information. At the same time, the use of ECR greatly reduces reporting burden on the provider.

Even without ECR, providers are still required to report cases—they will have to do so manually. So, in public health jurisdictions with ECR, ECR reduces the burden on providers, from sending traditional case reports. ECR systems reduce the amount of information a provider may have to input when compared to traditional case reporting, while still meeting their legal reporting requirements. Traditional case reporting burdens, depending on the disease and jurisdiction, can consist of many laborious processes, such as contacting the infectious disease reporting hotline at their state or local health department, filling out paper or electronic forms, faxing or emailing necessary medical records, and mailing or giving discs or copies of certain medical records such

as x-ray films. These processes pose a large time and administrative burden for diagnosing practitioners and medical staff, and in applicable jurisdictions, ECR can lessen this burden by automatically reflexing the data.

Pausing ECR registration and onboarding of new healthcare organizations will have a negative impact on health department staff, especially public health nurses. ECRs can often provide more timely information than a traditional paper case report can, due to the real time transmission of an electronic case report to the health department. Health department staff are notified faster and can take proper precautions and prepare to control an outbreak, including providing real time updates about relevant lab results, a patient's level of infectiousness, or drug resistance test results. **Due to the importance of ECR for public health purposes and its ability to reduce reporting burden on providers, CMS should encourage CDC to reinstate its ECR registration while the new system is being developed.**

11. **CMS should codify Merit-Based Incentive Program System (MIPS) payment adjustment for Spanish-preferring patients.**

CMS is proposing the codification of a policy previously finalized in the CY 2024 PFS final rule to require an entity to administer the CAHPS for MIPS Survey Spanish translation to Spanish-preferring patients. Language accessibility is a cornerstone to providing quality patient care. Ensuring that patients can receive and respond to the Consumer Assessment of Healthcare Provider and Systems (CAHPS) in their preferred language will help improve data collection for MIPS. **Therefore, ANA supports the codification of the translation of the survey to be able to administer the CAHPS for MIPS Survey Spanish translation to Spanish-preferring patients.**

12. **CMS must continue to measure and consider SDOH and Health Equity.**

ANA remains especially concerned about the removal of health equity–initiatives throughout the CY2026 PFS proposed rule. Nurses and APRNs are essential to frontline care, routinely addressing health disparities linked to social risk factors. Eliminating or reducing focus on SDOH undermines progress toward a healthcare system centered on prevention and chronic disease management. This shift is a step backward in the national effort to transform health outcomes for all. **Therefore, CMS must continue to measure and consider SDOH and health equity across its programs.**

SDOH screenings—such as assessments for food insecurity and utility needs—are vital tools for identifying non-medical factors that directly affect health outcomes, readmissions, and overall care quality. Research shows that up to 80% of an individual's health is shaped by social, behavioral, and environmental factors, far exceeding the influence of clinical care alone.[6] 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 on individuals and the health care delivery system. When practitioners have a full picture of a patient's circumstances, they can proactively assess these risks and intervene earlier to improve outcomes.[7] Thus, collecting and acting on SDOH data is critical for

[6] Tiase, V., DeGraff Crookston, C., Schoenbaum, A., & Valu, M. (2022). Nurses' role in addressing social determinants of health. *Nursing, 52*(4), 32-37. https://doi.org/10.1097/01.NURSE.0000823284.16666.96
[7] Magoon, V. (2022). Screening for social determinants of health in daily practice. *Family Practice Management, 29*(2), 6-12. https://www.aafp.org/pubs/fpm/issues/2022/0300/p6.html

improving patient centered care quality, reducing healthcare costs and unnecessary utilization, addressing differences in patient outcomes, and driving cost-effective care delivery.[8,9]

Nurses are uniquely positioned to lead efforts to address SDOH, as they are often the first clinical point of contact for patients. Incorporating social needs into care is both a professional responsibility and an ethical imperative, as outlined in the Code of Ethics for Nurses.[10,11] 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.[12] When nurses screen for and respond to these needs, patients benefit from more personalized care, improved discharge planning, and enhanced connections to community resources.

Rather than removing SDOH-related measures, CMS should consider incentivizing practitioners to fully capture and implement them—transforming data into actionable care interventions and catalyzing healthcare innovation by integrating social service partners. This approach aligns with the Administration's commitment to drive industry level progress, efficiency, prevention, and patient-centered care- priorities outlined in the Executive Order to Make America Healthy Again (MAHA), and the Center for Medicare and Medicaid Innovation's vision to test care models that leverage prevention strategies.[13]

a. CMS must not remove Screening for Social Drivers of Health from Alternative Payment Model Performance Pathway (APP Plus) quality measures.

CMS proposes to remove the Screening for Social Drivers of Health measure from APP Plus quality measures with the rationale that this measure no longer addresses a high-priority measure. The Screening for Social Drivers of Health measure tracks the percentage of patients 18 years or older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety should be considered a high-priority measure.

Since so much of an individual's health is influenced by social, behavioral, and environmental factors, providers must collect and act on this data for improving person-centered care quality,

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[8] Liu, M., Sandhu, S., Joynt Maddox, K. E., & Wadhera, R. K. (2024). Health equity adjustment and hospital performance in the Medicare value-based purchasing program. *JAMA, 331*(16), 1387-1396. https://jamanetwork.com/journals/jama/fullarticle/2816811.

[9] Sandhu, S., Liu, M., & Wadhera, R. K. (2022). Hospitals and health equity — Translating measurement into action. *The New England Journal of Medicine, 387*(26), 2395-2397. https://doi.org/10.1056/NEJMp2211648

[10] Rojas Smith, L., Parish, W. J., Beil, H. A., Chepaitis, A. E., Clayton, M. L., & DePriest, K. N., et al. (2023). Accountable Health Communities (AHC) model evaluation: Second evaluation report. RTI International. https://www.cms.gov/priorities/innovation/data-and-reports/2023/ahc-second-eval-rpt

[11] American Nurses Association. 2025. Code of Ethics for Nurses. https://codeofethics.ana.org. Accessed August 2025.

[12] ISPOR. (2025, March 10). The Role of Social Determinants of Health (SDoH) Data in Improving Risk Predictions. ISPOR 2025 Poster Session 5. https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-5/the-role-of-social-determinants-of-health-sdoh-data-in-improving-risk-predictions

[13] Ferguson, T. (2025, May 5). The Undoing of SDoH Reporting: What Case Managers Need to Know About CMS's FY 2026 Proposed Rollbacks. CMSA. https://cmsa.org/the-undoing-of-sdoh-reporting-what-case-managers-need-to-know-about-cmss-fy-2026-proposed-rollbacks/

reducing healthcare costs and utilization, addressing differences in patient outcomes, and driving cost-effective care delivery.[14] For reasons mentioned in the introductory paragraphs, **it is imperative that CMS not remove the Screening for Social Drivers of Health from the APP Plus quality measures.**

b. CMS must not remove the health equity adjustment from the Accountable Care Organization (ACO) Quality Score.

In the CY 2023 PFS final rule, CMS adopted a health equity adjustment (HEA) for ACO quality scores. It provides additional bonus points to ACOs that perform well on quality measures and excel in delivering care in underserved areas or to patients who are eligible for the Medicare Part D Low-Income Subsidy or are dually eligible for both Medicare and Medicaid. In the above-captioned rule, CMS is proposing to remove the HEA from the ACO quality score due to supposed duplicative incentives for ACOs to meet quality performance standards under the HEA in the shared savings program, the eCQM/MIPS CQM reporting incentive, and the Complex Organization Adjustment.

Even though CMS references that all 13 of the ACOs that received the HEA bonus points also met the criteria for the eCQM/MIPS CQM reporting incentive, performing well in underserved areas does not necessarily mean that an ACO will meet the quality standards for the eCQM/MIPS CQM reporting incentive based on the APP Plus criteria. Therefore, keeping the HEA as part of the ACO quality score, in addition to the eCQM/MIPS CQM reporting incentive, would continue to appropriately reward providers who consider all aspects of a patient's health.

Additionally, since CMS is proposing to remove the SDOH measure from the APP Plus, the eCQM/MIPS CQM reporting incentive will have minimal health equity focus, and instead only focus on diabetes and high blood pressure control, breast cancer and depression screenings, consumer assessment of healthcare providers and systems, and hospital-wide unplanned readmission rates. This fails to acknowledge factors outside the four walls of a facility that impact patient's health, as we note above. CMS must continue the HEA to award providers that ensure underserved populations receive high-quality, whole person care. **CMS must ensure practitioners are reimbursed for critical SDOH risk assessments.**

c. CMS must not remove the "Achieving Health Equity" improvement category from the Quality Payment Program (QPP).

CMS proposes to remove the SDOH-specific improvement activities category from the QPP, *"Achieving Health Equity,"* and replace it with a new subcategory, *"Advancing Health and Wellness."* ANA remains concerned about replacing an equity-focused category with one centered on wellness. Equity focused activities address a broader range of issues than wellness alone. Assessing food insecurity, housing instability, and utility needs is critical for identifying non-medical factors that strongly influence health outcomes, readmission rates, and overall care quality, and are factors that affect all people regardless of race, ethnicity, income and geographic location. If CMS moves forward, we urge that the agency **adds** the wellness category rather than **supplant** the existing SDOH-specific category, and that the agency allows for adequate time and

[14] Sandhu, S., Liu, M., & Wadhera, R. (2022). Hospitals and Health Equity—Translating Measurement into Action. New England Journal of Medicine, 387(26). https://doi.org/10.1056/NEJMp2211648 8 Centers for Medicare & Medicaid Innovation. (n.d.).

input from subject matter experts to develop the wellness category effectively. **For these reasons, ANA strongly opposes the removal and supplantation of any health equity–specific measures from the improvement activities performance category in the QPP.**

13. CMS should finalize more flexibility for nurse-led groups and the inclusion of the improvement of activities changes in the QPP.

For the 2026 performance year, CMS is prioritizing the stability of the Quality Payment Program (QPP) by continuing to evolve the Merit-based Incentive Payment System (MIPS) through the MIPS Value Pathways (MVPs) and improving alignment across programs.

For nursing practice, the proposed QPP changes for 2026 reflect a broader shift toward greater autonomy, accountability, and flexibility for APRNs and nursing-led groups. ANA commends CMS for its ongoing efforts to remove practice barriers and supports many of the proposed changes. However, ANA has recommendations regarding newly proposed quality measures, detailed below.

a. CMS must allow more reporting flexibility for nurse-led groups.

CMS proposes easier group reporting for small practices (≤15 clinicians), including primary care teams with APRNs during the MVP registration process. (i.e., CMS would not make this determination for them.) CMS cites that this proposal would support provider groups in their transition to MVP reporting and would help these groups assess their need to participate as subgroups and ultimately ease participation requirements. APRNs in **small, multispecialty groups** gain flexibility by not being forced into subgroup reporting, making MVP participation more accessible to nurse-led and APRN-inclusive practices. **ANA supports this proposal as it would make participation in the MVP more accessible to nurse-led and APRN inclusive practices.**

b. CMS must shift towards measures that reflect more comprehensive accountability.

CMS is proposing the inclusion of new quality measures into primary healthcare, such as an oral health risk assessment, cognitive impairment screening, delayed diagnosis of venous thromboembolism metric, and a new data collection field within patient safety reporting systems for Artificial Intelligence (AI).

Specifically, ANA recognizes that oral health is essential to overall health promotion and disease prevention. Including an oral health risk assessment as a quality measure is critical to building an integrated, holistic approach to patient health assessments. Cognitive health affects medication management, self-care, and the ability to live safely at home. Nurses routinely assess cognitive function and use this information to develop individualized care plans. Quality measures focused on cognitive function are highly relevant to nursing practice and are crucial for identifying patients at risk for adverse outcomes. CMS should ensure that any new cognitive health measures are practical for routine use and reflect real-world care delivery. Further, venous thrombosis is a serious, potentially life-threatening complication that often requires hospitalization and long-term treatment. Measuring delays in diagnosis aligns with nursing priorities to improve clinical outcomes and reduce complications.

Lastly digital tools, including AI-enabled algorithms for patient safety and risk monitoring, can enhance early detection of patient deterioration, reduce provider cognitive burden, streamline

workflow, and improve data consistency among providers. ANA supports integrating AI to enhance safety; however, **it is essential that clinical decision-making must remain clinician-led—not AI-led.** CMS must establish clear guardrails to prevent overreliance on AI and minimize algorithmic bias, which could cause missed risk signals or false-positive alerts. It is also critical that nurses are involved in designing, validating, and implementing technologies that directly affect their practice and patient safety. ANA supports the expansion of the proposed improvement activities and strongly urges CMS to collaborate directly with nurses in developing and implementing these tools to ensure they generate clinically meaningful data.

Overall, the proposed changes will give nurses more opportunities to demonstrate the quality of their care through preventive services, chronic disease management, and holistic health promotion. **ANA supports CMS's shift toward more comprehensive accountability by combining cost metrics with patient-reported outcomes and urges that measures remain provider-agnostic without obscuring the vital role of nurses.**

14. **ANA appreciates CMS for engaging stakeholders in addressing challenges, fostering innovation, and promoting the health of our nation.**

Throughout the proposed rule, CMS includes several Requests for Information (RFIs) seeking stakeholder perspectives on a number of key issues in the Medicare program. ANA is grateful for the opportunity to provide input on these RFIs and to elevate the nursing perspective. ANA urges CMS to work closely with nurses as they seek and identify innovative approaches to addressing challenges in the nation's health care delivery system.

a. *ANA holds that CMS should consider standardized nursing data and provider-agnostic metrics when measuring nutrition and well-being.*

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Well-being and nutrition measures can provide a more comprehensive approach to disease prevention and health promotion. CMS seeks comment on well-being and nutrition measures, as well as an RFI to gather comments on continued advancements to digital quality measurement and on the use of the Fast Healthcare Interoperability Resources (FHIR) to evaluate how clinicians exchange health information.

Nutrition is a cornerstone of health and a longstanding focus of nursing assessment and care planning. Assessing and addressing nutritional status is essential for preventing complications and supporting overall health. **ANA supports the inclusion of nutrition-related quality measures, provided they are based on validated and reliable tools that allow for consistent, person-centered assessment.**

Well-being is an equally important, though more complex, dimension of health. It encompasses physical, mental, and spiritual domains —and is inherently subjective. While ANA supports the exploration of well-being as a quality measure, any measure in this area must be based on empirically validated tools and be culturally sensitive and inclusive of diverse patient populations. **We ask CMS that these measures complement—not replace—existing SDOH-related measures.**

Nurses play a central role in care delivery, quality monitoring, and health information exchange. Their clinical expertise, particularly in functional, psychosocial, and cognitive assessment—and

their role in efficient data transfer—make nursing perspectives essential in shaping quality metrics that reflect real-world practice and improve outcomes. ANA commends CMS for its focus on strengthening interoperability to enhance care coordination, reduce administrative burden, and enable more connected, patient-centered care. However, interoperability must include standardized nursing data to ensure the visibility and utility of nursing assessments, interventions, and outcomes across the continuum of care. ANA emphasizes that any new quality measures must be validated, evidence-based, and reliable to ensure clinical accuracy and relevance. **Measures must be provider agnostic and applicable across all care settings, while still recognizing the unique contributions of nursing professionals.**

b. *ANA believes that CMS should incorporate nursing data, workplace violence prevention, nursing-sensitive outcomes, and SDOH when adopting interoperability and digital quality metrics*.

CMS issued an RFI on Digital Quality Measurement in CMS Quality Programs, including the Medicare Shared Savings Program. To strengthen interoperability in meaningful ways, CMS should promote the adoption of standardized nursing data models and ensure interoperability is supported across all phases of care—assessment, planning, implementation, and evaluation. Electronic health record systems must enable the structured and codified capture of nursing data, allowing it to be exchanged seamlessly across care settings. In addition, data exchange should integrate both clinical and SDOH information to support actionable, holistic care planning.

Greater interoperability, which includes nursing data, will lead to several important benefits. It will improve care planning by providing more complete and accurate patient information, streamline documentation workflows to enhance nursing satisfaction, and support the development of a health learning system driven by nursing expertise. Importantly, it will also advance the integration of SDOH data by linking sociodemographic data with targeted clinical interventions tailored to the needs of diverse patient populations. **As such, ANA supports promoting interoperability as a performance category that captures nursing data.**

Additionally, CMS asks about any additional concerns to consider when developing FHIR-based reporting requirements for systems receiving quality data. **ANA believes CMS should consider workplace violence prevention, nurse-sensitive outcomes, and SDOH, while developing FHIR-based reporting metrics and requirements.**

One in four nurses experience workplace abuse.[15] A digital quality measure that captures workplace violence prevention and mitigation will improve safety for both clinicians and patients, as these incidents directly affect providers' ability to deliver care. CMS should adopt a common measurement framework with standardized definitions to enable comparisons across organizations. Digital reporting of these metrics will support transparency and targeted improvement. To be effective, the measures should include incident-based reporting with the victim's healthcare role and the type, source, and severity of the violence, and documentation of prevention and mitigation actions. These systems should consider integration of nursing assessments documenting a patient's risk of violence from the EHR. By going further and capturing

[15] American Nurses Association. (n.d.). *Prevent workplace violence in the workplace* [PDF]. https://www.nursingworld.org/globalassets/practiceandpolicy/work-environment/endnurseabuse/workplace-violence-policy-handout---final.pdf

these measures, CMS can evaluate which strategies are most effective at preventing and controlling workplace violence.

CMS should also develop digital measures that capture nurse-led interventions that can be standardized across settings. Nurse-led efforts —such as fall prevention, pressure injury prevention, and care coordination—have a measurable impact on patient outcomes and quality of care. Digital metrics that assess the effectiveness of these interventions will inform value and support wider adoption. Nurse-led evidence-based programs can produce meaningful cost-savings. For example, a nonrandomized control trial of a nurse-led fall-prevention toolkit, reduced falls by 15% .[16] Although Medicare does not reimburse for hospital acquired falls, a prior fall is the most significant risk factor for recurrent falls.[17] Medicare spends $29 billion a year on non-fatal falls among older adults;[18] prioritizing nurse-led interventions like fall-prevention, can reduce Medicare costs.

Last, as noted above, ANA does not support CMS's proposal to eliminate any SDOH or health equity measures. However, if CMS were to finalize its plan to remove these measures, CMS must develop new digital measures that account for all factors impacting a patient's health. Existing SDOH measures help ensure that whole, person-focused care remains both measurable and cost effective. CMS should develop and maintain digital quality measures to ensure that SDOH and health equity are being effectively evaluated and meaningfully incorporated into care delivery and payment.

c. Nurses must be at the forefront of CMS strategies for chronic disease prevention and management.

ANA appreciates the Administration's steadfast focus on advancing a healthier American public. The Administration's prioritization of prevention and management of chronic disease is a key approach to reach that goal.

Nurses, who spend the most time with patients,[19] play a key role in the prevention and management of chronic disease. As the most trusted healthcare professional,[20] nurses often receive information from patients that may not be shared with other practitioners. This insight,

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[16] Dykes, P. C., Burns, Z., Adelman, J., et al. (2020). Evaluation of a patient-centered fall-prevention tool kit to reduce falls and injuries: A nonrandomized controlled trial. *JAMA Network Open, 3*(11), e2025889. https://doi.org/10.1001/jamanetworkopen.2020.25889

[17] Choi, N. G., Marti, C. N., Choi, B. Y., & Kunik, M. M. (2023). Recurrent falls over three years among older adults age 70+: Associations with physical and mental health status, exercise, and hospital stay. *Journal of Applied Gerontology, 42*(5), 1089–1100. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10081943/

[18] National Center for Injury Prevention and Control (U.S.) (2020). Cost of older adult falls. https://stacks.cdc.gov/view/cdc/122747

[19] Butler, R., Monsalve, M., Thomas, G. W., Herman, T., Segre, A. M., Polgreen, P. M., & Suneja, M. (2018). Estimating time physicians and other health care workers spend with patients in an intensive care unit using a sensor network. *The American Journal of Medicine, 131*(8), 972.e9–972.e15. https://doi.org/10.1016/j.amjmed.2018.03.015

[20] American Nurses Association. (2025, January 10). American Nurses Association celebrates the power of nurses: Nurses take the #1 spot on Gallup's annual poll for 23 years straight. https://www.nursingworld.org/news/news-releases/2025/american-nurses-association-celebrates-the-power-of-nurses-nurses-take-the-1-spot-on-gallups-annual-poll-for-23-years-straight/

when communicated to the broader care team, can significantly improve the treatment and management of chronic conditions that may otherwise be overlooked. ANA would encourage the Administration to include nurses in its Make America Healthy Again (MAHA) commission work and to ensure that nurses are part of the conversation.

To make this possible, there must be enough nurses available to see and educate patients. Chronic understaffing in hospitals often leads to gaps in care and poorer outcomes. CMS should use its regulatory authority to enforce proper nurse staffing at hospitals and other facilities so that Medicare beneficiaries receive the comprehensive care they need.

CMS specifically seeks comment on whether resources to perform services are captured in the fee schedule code set. CMS should look at providing reimbursement for the social determinants of health Z codes to ensure that patients' needs are being met. If these codes are reimbursed, practitioners would be better resourced to spend the necessary time getting to know their patients and their conditions. Nurses are the key to these codes due to the time they spend with their patients, but there are pressures from the facility that do not allow nurses to talk and understand their patients. Adding reimbursement to these codes would remove the pressure for practitioners to spend as little time as possible with their patients and encourage all practitioners to understand their patient's backgrounds and their unique needs.

CMS is also seeking comment on remote monitoring and wearable devices. Nurses are highly trained and well-qualified to monitor patients using these technologies, and CMS should leverage nursing expertise to improve patient health outcomes. To support this, remote monitoring services must be reimbursed appropriately. Without proper reimbursement, employers and facilities may view remote monitoring as a cost burden, creating pressure on nurses and other practitioners to minimize time spent on these activities. This would discourage the use of remote monitoring and undermine its potential benefits for patient care.

Last, CMS must ensure that any innovative models or other approaches fully reimburse providers for services provided. For APRNs, participation in these models is hindered by outdated regulatory barriers. Specifically, "incident to" billing, which occurs when an APRN bills payors under a physician or other provider National Provider Identifier (NPI) to receive a higher Medicare reimbursement rate. This is a massive roadblock for APRNs looking to participate in payment models or other CMS-led programs as the patients they are managing are then not directly attributed to them, along with any of the positive outcomes from innovative approaches to address patient health needs such as managing chronic diseases.

This system reflects an earlier era, before APRNs received the advanced training and clinical experience they have today. "Incident to" billing has very strict oversight parameters and places the physician at the forefront of the medical team. This may have been true in the past, but it is not necessarily true today. Care coordination and other interdisciplinary care models are becoming increasingly commonplace, and APRNs are often leading these efforts within their scope of practice. Medicare beneficiaries have become increasingly reliant on APRNs, leading the Medicare Payment Advisory Commission (MedPAC) to recommend eliminating "incident to" billing.[21]

[21] Medicare Payment Advisory Commission. (2019). *Improving Medicare's payment policies for advanced practice registered nurses and physician assistants*. https://www.medpac.gov/improving-medicares-payment-policies-for-advanced-practice-registered-nurses-and-physician-assistants/

MedPAC has verified that eliminating "incident to" billing will not change the quality of care or how it is delivered.[22] Additionally, "incident to" billing creates inflated claims, crediting physicians in instances when APRNs have often conducted the bulk of the work.

"Incident to" billing also has a direct impact on RN care, as the care they provide is only captured under the physician NPI. RN work is essential in many aspects of modern medicine, including remote patient monitoring and ambulatory care, but that work is hard to see as Medicare, and most other payors, only reimburse under the physician NPI and not under the RN NPI.

As CMS explores strategies to address the nation's chronic health challenges, it is essential that nurses remain at the center of these efforts. ANA and the nursing community are prepared to partner with CMS to advance high-quality, whole person-centered care nationwide.

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,

Bradley Goettl, DNP, DHA, RN, FAAN, FACHE
Chief Nursing Officer

cc: Jennifer Mensik Kennedy, PhD, MBA, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, ANA Chief Executive Officer

[22] *Ibid.*,