September 3, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically to www.regulations.gov

RE: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities [CMS-1809-P]

Dear Secretary Becerra:

The American Nurses Association (ANA) is pleased to submit the following comments in response to the above-captioned rule. ANA supports the Center for Medicare & Medicaid Services' (CMS') goals for advancing health equity, and we further urge the agency to improve access to care provided by advanced practice registered nurses (APRNs). ANA's comments below focus on:

- **Increasing the Reimbursement for Esketamine;**
- **Continued Allowance of Remote Services;**
- **Recognizing and Supporting the Vital Role of the Nurse in Addressing Maternal Health Challenges Through Obstetric-specific Conditions of Participation (CoP) Requirements;**
- **Continued Use of the Payment Adjustment for Domestically Produced Personal Protective Equipment (PPE);**
- **Use of Health Equity Quality Measures;**
- **Timeframe for Prior Authorization Approvals;**
- **Payment for HIV Pre-Exposure Prophylaxis (PrEP) in Hospital Outpatient Departments;**
- **Medicaid Policy; and**
- **Formerly Incarcerated Individuals Access to Medicare Benefits.**

1. CMS Must Increase Reimbursement for Esketamine

Esketamine is a nasal spray used to treat depression in adults when other depression treatments have not been effective. There are two different dose sizes used for Esketamine and as a result, when CMS started reimbursing practitioners for its use, two different G codes were created- G2082 and G2083. CMS proposes moving the Esketamine G codes into a higher APC which results in higher reimbursement

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for the two codes. Moving G2082 into a different APC raises the base reimbursement for the treatment about $400 and moving G2083 into a different APC raises the base reimbursement for the treatment about $700. **ANA thanks CMS for updating the payment rates and believes that they are long overdue.**

These updates are a step in the right direction for Esketamine to be a more fiscally viable option for nurse practitioners (NPs) to prescribe Esketamine. Under Medicare, NPs already receive 15% less in reimbursement for procedures than physicians. This is true even though they are doing the same work, and as a result there are some procedures that NPs are not able to do. Esketamine is currently one of these procedures. Currently, NPs lose money when they prescribe Esketamine. This is just on the direct cost of the product before any of their expertise or time is factored into the equation.

Even with losing money on Esketamine, NPs are still willing to prescribe it to their patients. According to the American Medical Association's RUC database, NPs are the second most common prescribers of Esketamine, after psychiatrists. This shows the importance that NPs place on their patients, and they deserve to be compensated fairly for their work.

2. CMS Must Continue Allowing Providers to Utilize Remote Services to Treat Patients.

Since the start of the COVID-19 PHE, CMS has greatly expanded the use of telehealth in Medicare. ANA understands that CMS is constricted by statute to what can be done remotely, and the telehealth flexibilities may be undone by Congressional inaction. ANA thanks CMS for continuing to allow telehealth where they have the authority to do so and appreciates the ability of our members to treat patients in this manner.

ANA strongly supports CMS' proposal to align remote services that are paid through the OPPS rule with remote services that are paid through the Physician Fee Schedule (PFS). Having only one system for payment will lower overhead costs and will, therefore, save money. With costs rising across the healthcare system, and nationwide, the ability to save money is key to practitioners being able to provide the necessary care, especially in rural and remote areas.

Having only one set of rules for telehealth will also allow practitioners to provide remote care instead of having to worry if the care is reimbursed and under what circumstances. Telehealth has been a great boon to those in rural areas where there are few practitioners, and even fewer specialists. Physicians have largely been congregating in urban areas and NPs are attempting to fill the gap in rural areas. There are some rural areas where NPs provide significantly more than half of primary care and a not insignificant amount of specialty care. The ability of these practitioners to see patients and not have to worry about whether it is reimbursable depending on the payment system will make running practices and seeing patients significantly easier for these practitioners.

a) Remote Mental Health

In the past few years, CMS finalized proposals regarding remote mental health treatment. These proposals generally required that practitioners seeing patients being treated for mental health issues have in-person visits at least once a year. There are exceptions to this rule, but it is currently scheduled to take effect on January 1, 2025.

Mental health is uniquely positioned regarding telehealth. Even if other procedures might need a practitioner to be in the same room as a patient, that is almost never true with mental health. Patients

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in crisis should never have to take the time to make an appointment for some date in the future. These patients need treatment immediately and as their practitioners can treat them remotely, and, if necessary, prescribe medication in the same manner. These remote visits are essential for patients to receive treatment when they are in their most vulnerable state.

In future rulemaking, CMS is looking to align remote mental health treatment paid under OPPS with remote mental health treatments paid under Medicare, mainly through the PFS. **ANA supports aligning the programs paid under different payment schedules.** This would allow mental health practitioners to treat their patients without having to worry if a patient's visits are reimbursable under a specific payment system. Practitioners would treat their patients whether or not they know if reimbursement is forthcoming, but knowing that they will be reimbursed provides peace of mind and allows practitioners to focus all of their energies on their patients instead of worrying if their practice is able to pay their bills.

b) Telehealth E+M

The CPT Editorial Panel created seventeen new codes for telehealth E+M services. CMS is proposing to not reimburse clinicians for use of these codes under the OPPS as these codes are not reimbursed under OPPS policy and have different codes that are reimbursable under OPPS for facility costs associated with outpatient E+M visits.

CMS is seeking comment on the resource costs associated with these services and whether separate coding should be developed to describe the resources used under these codes. **ANA supports new coding to describe the resources associated with these services as nurses and nursing care are frequently undervalued.** Nurses provide essential E+M services that physicians do not provide and this work should be accounted for in any new coding that is developed by CMS to reimburse practitioners. The undervaluing of nurses is included in both sections where CMS seeks comment. They are unfortunately considered a resource, and not their own healthcare provider, and even if they were not considered a resource under the practice expense (PE) portion of CPT codes, their work is not adequately described in the current CPT coding system.

c) Virtual Direct Supervision

In the calendar year 2025 PFS proposed rule, CMS proposes to extend virtual direct supervision through December 31, 2025. That proposal is relevant to the OPPS as CMS further proposes to apply this to the OPPS and to treat all virtual direct supervision uniformly under the PFS and the OPPS. **ANA has supported virtual direct supervision in the past and continues to do so for the calendar year 2025 rules.**

ANA is also pleased that CMS continues to emphasize that physicians are not the only clinicians qualified for virtual direct supervision. NPs and clinical nurse specialists (CNSs) are specifically included in those eligible to supervise and this will help alleviate the physician shortage that is happening nationwide.

3. **CMS Must Recognize and Support the Vital role of the Nurse in Addressing Maternal Health Challenges Through Obstetric-Specific Conditions of Participation (CoP) Requirements.**

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ANA applauds CMS for continued focus on addressing the maternal health challenges facing the nation. RNs, certified nurse midwives (CNMs), and NPs all play a key role in maternity care, and we urge CMS to keep them central in approaches to addressing these challenges. ANA appreciates CMS' thoughtful proposal to establish a targeted obstetrical services CoP for participating facilities. It is appropriate for CMS to exercise its oversight authority in this way to ensure that patients needing obstetric services have access to high quality care. Medicare or Medicaid coverage can only be meaningful if beneficiaries have true access to care.

a) CMS must provide incentives to hospitals to include APRN staff in all obstetric units.

CNM and NP practice continues to be unnecessarily restricted in many states due to outdated state licensing rules. These rules present a barrier to patients and their choice of provider. Health care coverage can only be meaningful if beneficiaries have true access to care. ANA believes that federal action is warranted to encourage state action on nurse licensing approaches that would expand scope of practice for APRNs, such as CNMs and NPs. As CMS determines new policy to address maternal health, it is critical to create incentives for states to remove practice barriers that result in reduced access to high value maternal health care services.

As CMS structures the obstetric-specific CoPs, ANA strongly recommends that the agency include incentives for hospitals to consider these clinicians as hospital staff with voting, admitting, and clinical privileges. For example, CNMs receive specialized education in women's health care and midwifery and are trained to offer comprehensive care to women through every phase of their lives. During a typical hospital labor and birth, a CNM can admit a pregnant person to the hospital, write medical orders, prescribe medications, manage labor and birth, deliver the baby, and provide postpartum care independently within the scope of CNM education and training. These providers are also vital to the provision of quality maternal health care services. As the American College of Nurse-Midwives notes, patients of CNMs have lower rates of c-sections, fewer episiotomies and higher rates of breastfeeding when they have access to these clinicians for their labor and delivery care.[1] These facts underscore the critical role that CNMs play in ensuring patient access to obstetric care, which is what CMS is attempting to address with the obstetric-specific CoP proposal.

Unfortunately, existing federal and state laws and regulations, as well as individual hospital bylaws and policies, create barriers that prevent patients from accessing CNMs as their provider of choice. While at times dictated by state regulations, most often the privileges of hospitals and medical systems are determined by their own rules dictating the types of providers who are allowed to admit patients and what services these providers may perform. Several states maintain that hospitals should not discriminate against nurse midwives seeking hospital privileges, while several others expressly limit admitting privileges to physicians only. In most states, there is no regulation concerning who may admit patients. Medicare regulations allow CNMs to secure medical staff membership if permitted by

[1] American College of Nurse Midwives. Removing Barriers to Midwifery Care: Hospital Privileges. https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007463/Removing%20Barriers%20to%20Midwifery%20Care%20Hospital%20Privileges%20FINAL.pdf#:~:text=The%20American%20College%20of%20Nurse,voting%2C%20admitting%20and%20clinical%20privileges. Accessed August 2024.

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state law, but do not mandate CNM membership.

Amending Medicare statute to include nurse midwives as members of "medical staff" under all Medicare CoPs would improve continuity of care, expand consumer choice and access to care, and increase cost-effectiveness within the Medicare program. Medicare is viewed as the "gold standard" and it sets precedents that are often followed by states and other insurers. As such, CMS must make this critical change to the CoP to increase access to CNMs relied on by patients.

b) CMS must ensure access and payment parity for APRNs to address persistent maternal health challenges.

In addition to including APRNs as medical staff in all obstetric units, as detailed above, patients must also have access to these trusted providers through inclusion in public and private payer provider networks and receive equitable payment for the services they provide. ANA urges CMS to develop payment models that account for and reward RNs, NPs, and CNMs for their high-value care and resulting high-quality birth outcomes.

Such care includes primary care throughout the reproductive life span, as well as preconception care, pregnancy care, contraception care, and postpartum and inter-conception care. While there are examples of nurse-led programs that are promising cost-effective maternal care models, these models are not sustainable or scalable unless the Medicare program adequately pays nurses for services provided.[2] ANA encourages CMS to examine and develop payment models that target women's and maternal health and ensure nursing services are measured and accounted for. These models should be scalable and integrate the critical role of nurses in addressing access to women's and maternal health care services.

Moreover, CMS must provide reimbursement for telehealth services in maternal and childcare. Telehealth is a tool for providers and beneficiaries to ensure early and timely access to prenatal and postnatal care, eliminating barriers that can be created by provider shortages, transportation issues, and employment schedules. This is especially critical for patients needing critical maternal health services in rural and underserved geographic regions. Currently, only a handful of states specifically address obstetric care in reimbursement. CMS should research and evaluate which services provide the greatest value to beneficiaries including but not limited to tobacco cessation, remote monitoring of high-risk comorbidities, postpartum care, and lactation support.

As CMS continues to propose and implement approaches to addressing maternal health challenges, ANA urges the agency to ensure access to APRNs and payment parity are central to those approaches. Our nurses are too critical to the health care delivery system, especially in providing maternal health services, to be overlooked.

c) CMS must recognize and support the nurse through any obstetric-specific conditions of participation (CoP) requirements.

[2] American Academy of Nursing. Edge Runners: Transforming America's Health System Through Nursing Solutions. https://www.aannet.org/initiatives/edge-runners. Accessed August 2024.

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CMS must also ensure that facilities subject to the obstetric CoP staff adequately and appropriately to allow their nurses to provide high quality, patient centered care. CMS must structure the obstetric CoP requirements related to staffing in a way that guarantees appropriate staffing levels. Appropriate staffing is a dynamic process that aligns the number of nurses, their workload, expertise, and resources with patient needs in order to achieve quality patient outcomes within a healthy work environment. ANA supports many approaches to achieving appropriate staffing, including the use of enforceable minimum nurse staffing ratios as an approach to reduce patient harm and improve quality outcomes and to ensure the creation of an optimal work environment that supports the recruitment and retention of nurses.

Insufficient nurse staffing jeopardizes patient safety and quality outcomes and negatively affects nurse retention and the overall work environment. Nurses are professionals providing critical health care services to patients—they should not have to fight for allotted breaks and other challenges created by antiquated views of the profession and payment policies that disincentivize adequate nurse staffing. All too often, we hear of staffing plans not being enforced, resulting in long shifts and strains on bedside nurses providing care. Nurses know best the provisions that they and their team need. Moreover, we also know nurses understand and value appropriate, evidence-based nurse staffing approaches driven by patient complexity, layout of the nursing unit, patient census, and other key factors. For example, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) issued several reports detailing research findings that support recommended, evidence-based nurse-to-patient ratios for perinatal units that aim to support high quality nursing care.[3] Recommendations such as those suggested by AWHONN strive to ensure the nurse has the resources and support they need and demonstrate that nurses have solutions to staffing challenges. This only underscores the need for nurses to be involved in staffing determinations and the importance to fully consider their needs in any staffing standards.

As CMS structures an obstetric CoP, ANA urges the agency to recognize and support the nurse in all requirements. This is just another instance where health care delivery and outcomes would be improved by greater nurse involvement. It is crucial for nurses to take on leadership roles, in all settings, to meet the demands of our ever-changing health care system, including being permitted to practice to the full extent of their education, training and licensure. The agency must ensure patient access to APRNs and payment parity for nurses. **CMS also must use its oversight authority to ensure adequate and appropriate staffing levels in all facilities that allow for work environments that support the nurse in the provision of high-quality care. ANA and its members stand ready to work with federal policymakers on continued approaches to ensuring patient access to obstetric care.**

4) CMS Must Continue the Payment Adjustment for Domestically Produced Personal Protective Equipment (PPE)

CMS proposes to continue the payment adjustments for domestically produced PPE and also requests comments on how to reduce the reporting burden while ensuring that domestic production continues to ensure an adequate supply when the PPE is required. ANA strongly supports continuing the payment

[3] Association of Women's Health, Obstetric and Neonatal Nurses. Standards for Professional Registered Nurse Staffing for Perinatal Units. 2022. https://www.awhonn.org/education/staffing-standards/. Accessed August 2024.

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adjustments for PPE. In most cases, nurses are the front-line providers who spend the most time with patients. As a result, they need the most protections against communicable diseases and any shortage of PPE will have a calamitous effect on nursing care which will exacerbate the current nursing shortage.

ANA does not have any specific comments on how to reduce the reporting requirements, but would emphasize that any reductions not have any effect on the PPE available to nurses.

CMS also has a list of questions that are mainly for hospitals on the payment adjustments for PPE. Some of these questions look at whether hospitals require more information on what PPE is eligible for the adjustments. ANA believes that more information is always valuable that CMS should provide whatever information they have available to hospitals to better inform their decisions and ensure that their staff, especially nurses, have access to PPE.

CMS is also considering whether to include all NIOSH approved N95 respirators (both surgical and non-surgical) in the payment adjustments. ANA supports this change as the different respirators have different uses. Only having payment adjustments for one kind of respirator does not teach best practices to hospitals or clinicians. For example, reusable respirators are proven to be more effective for protecting healthcare workers and reduce costs in the long term.[4] ANA urges CMS to include domestically produced reusable respirators as well. Expanding the payment adjustments could not only save money but would ensure that all clinicians are trained and using the best possible respirator for their specific situation.

a) Nitrile Gloves

CMS is studying whether to include nitrile gloves in PPE payment adjustments. There are very few manufacturers of nitrile gloves in the US, and they provide a miniscule percentage of the required number of gloves. If there were another public health emergency, American hospitals would by necessity be required to buy these gloves from foreign manufacturers and some of these gloves would be of dubious quality. **ANA would encourage CMS to include nitrile gloves in the payment adjustments for PPE as the barrier they provide practitioners is necessary to protect the practitioner from diseases being carried by their patients.**

Having access to domestically produced nitrile gloves would not only protect practitioners in the event of another PHE, but would also ensure that hospitals could spend resources where it is most necessary to protect the public. If nitrile gloves were not included in the payment adjustment and produced domestically, hospitals, and other facilities, would spend valuable time and resources looking for nitrile gloves instead of caring for their patients. This would also dramatically affect patient care as the lack of nitrile gloves would not allow nurses to give proper care to their patients as they would be hesitant to be near or touch patients as they would be rightfully scared of contracting whatever disease they are trying to protect themselves, and the general public, from contracting.

[4] Eric Toner, MD, et al., *The Major Role of Reusable Respirators in Increasing Respiratory Protection for Future Infectious Disease Emergencies: A Stakeholder Discussion*, Johns Hopkins Bloomberg School of Public Health: Center for Health Security, April 25, 2024, available at: https://www.centerforhealthsecurity.org/sites/default/files/2024-07/2024-07-reusablerespirators.pdf

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5) CMS should finalize proposed Health Equity Quality Measures

CMS has quality measure that are across payment systems regarding their commitment to advancing health equity. ANA continues to support these measures and agrees with CMS that they can close gaps in care.

One measure is the Hospital Commitment to Health Equity (HCHE) Measure. This takes a top-down approach and looks to hospital leadership to reduce health disparities and increase health equity. The Agency for Healthcare Research and Quality (AHRQ) and The Joint Commission identified leadership as playing an important role in reducing disparities. ANA agrees with this assessment and believes that when leadership sets the proper tone of a facility, and welcomes all individuals requiring care, it allows for the best care to be given to all patients regardless of ability to pay.

Similarly, CMS proposed to adopt the Screening for Social Drivers of Health (SDOH) and the Screen Positive Rate for Social Drivers of Health (SDOH) Measures. These measures would screen a number of social drivers that affect patient health. CMS recognizes that many patients do not want to answer questions about the social drivers of health and that may skew the results. **ANA thanks CMS for this understanding and believes that these proposals should be adopted.**

Currently, there are SDOH Z codes, but they are not reimbursed by CMS. **In order to ensure that the practitioners take the proper amount of time with these measures, there should be some reimbursement for the time spent with patients.** Sometimes, patients are uncomfortable when meeting new practitioners, but over time they build a relationship, most likely with a nurse, and they are more likely to answer questions. The lack of reimbursement incentivizes practitioners to ask questions once and then move on to other priorities. Even small reimbursements are strong incentives for returning to previous questions and possibly having better data for future care.

6) CMS should shorten the Timeframe for Prior Authorization Approval

CMS requires that in order to receive reimbursement under Medicare for certain procedures, the patient receive authorization that the service is required. Services that require prior authorization have both cosmetic and health purposes and CMS reasons that there are times where the service is being done for cosmetic purposes, which is not a covered Medicare service. Currently, services that require prior authorization have up to ten business days to receive approval for Medicare reimbursement. This extremely long period of time is bad for patient care and requires nurses to spend their valuable time with patients who should already have received care.

ANA supports CMS' proposal to lower the maximum amount of time before authorization to seven calendar days. This cuts the allowable time frame for authorization in half and is a positive change for practitioners and their patients. Nurses will be able to treat healthier patients as their conditions will not have as much time to worsen and patients will receive the quality care they deserve in a faster time period which will not give them more time for their conditions to worsen and will therefore likely result in more positive outcomes.

7) CMS should finalize the proposed Payment for HIV Pre-Exposure Prophylaxis (PrEP) in Hospital Outpatient Departments

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CMS proposes to pay for these services as preventative services and outlines how payment will be determined under various scenarios. **ANA strongly supports access to PrEP as prevention for individuals at risk of acquiring HIV and as strategy to end HIV transmission.**[5] Clarifying payment for PrEP administration in outpatient settings has the potential to improve access to the service.

CMS also proposes to pay for counseling services. Nurses frequently provide this service and it is uncompensated care. **Nurses deserve reimbursement for the work they are doing and providing, and then reimbursing, a new j code for the work being done by nurses is a good way to show the great work being done by our nation's nurses.**

8) CMS should finalize proposed changes to Medicaid Policy to expand needed access to care.

a) Continuous Eligibility for Medicaid

The Consolidated Appropriations Act of 2023 required states to provide 12 months of continuous eligibility for children under Medicaid and the Children's Health Insurance Program (CHIP). **ANA thanks CMS for ensuring our nation's children have insurance coverage available which will provide more access to care.** The access provided by insurance helps maintain our nation's overall health and this will ensure that there is access to preventative care which both maintains a child's health and is also the most cost-effective form of care.

NPs and other APRNs provide a large percentage of primary care nationwide and many of their patients receive coverage through either the Medicaid or CHIP programs. Ensuring that children maintain their access to coverage and care is essential to their continued health and success.

b) Medicaid Clinic Four Walls Exception

Generally, clinics that participate in the Medicaid program must treat their patients within the clinic, with limited exceptions for unhoused individuals. CMS does not disagree with the statutory language but is proposing to add a number of exceptions to the rule for individuals who have similar situations to unhoused individuals, but do not fit the current definition of unhoused. CMS believes that Congressional intent does allow for these exceptions and therefore they are proposing to add exceptions based on four criteria that mirror many unhoused individuals: behavioral health diagnoses or difficulty accessing behavioral health care, lack of transportation, mistrust of the healthcare system, and high rates of poor outcomes.

ANA supports these additional exceptions and believes that it will allow clinics to connect with and provide care to these individuals that better meets their challenges and needs, hopefully leading to better health outcomes.

CMS understands that state Medicaid plans generally pay providers less in clinics than in facilities. CMS implores states to raise the reimbursement rates for these clinics. This would incentivize more practitioners to practice at these clinics and would therefore provide better care for the individuals receiving care. ANA echoes CMS' comments and encourages the agency to work closely with states to

[5] ANA. Prevention and Care for HIV and Related Conditions. 2019. Position Statement. Accessed at https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/prevention-and-care-for-hiv-and-related-conditions/

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raise reimbursement rates for these clinics. NPs and other APRNs are reimbursed at fifteen percent less than physicians are reimbursed for the same care. Continued low reimbursement rates for services provided by these clinics threaten the ability of NPs and other APRNs to afford to practice in underserved areas—which, in turn, threatens patient access to needed care.

9) ANA supports Formerly Incarcerated Individuals' Access to Medicare Benefits

CMS proposes to narrow the definition of "custody" for incarcerated individuals to exclude those under supervised release or in home detention. Currently, the definition bars them from access to Medicare benefits and this proposal allows these individuals to enroll in Medicare and receive care from Medicare providers. CMS recognizes the need for this change to rectify a coverage gap—as those that are incarcerated within a facility receive care in that facility, but those in home detention or supervised release do not have a facility or provider to seek care. Therefore, this highly necessary change in definitions is being made to ensure that persons who are no longer actively detained have access to Medicare benefits and, thus, coverage for needed health services.

ANA supports this change and believes that all Americans should have access to high quality care. This change provides the option for these individuals to receive coverage and likely access to practitioners for the care they deserve.

Conclusion

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 on health care issues that affect nurses and the public. ANA members also include the four advanced practice registered nurse roles (APRNs): 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 health care 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 leads to better health outcomes for all patients. Moreover, nurses are critical to coordinated care approaches for Medicare beneficiaries in all settings, including hospital outpatient settings. Patient-centered care coordination is a core professional standard for all RNs and is central to nurses' longtime practice of providing holistic care to patients.

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ANA appreciates the opportunity to submit these comments and looks forward to continued engagement with HHS. Please contact Tim Nanof, Vice President, Policy and Government Affairs, at (301) 628-5166 or Tim.Nanof@ana.org , with any questions.

Sincerely,

Debbie Hatmaker

Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer/EVP

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

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