American Nurses Association

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

July 8, 2025

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

Dear Secretary Kennedy,

The American Nurses Association (ANA) is pleased to submit the following response to the United States Department of Health and Human Services' (HHS') and the Food and Drug Administration's (FDA's) Request for Information (RFI) on eliminating outdated or unnecessary regulations to lower costs and empower providers in the nation's healthcare delivery system.

ANA knows that the nursing profession has been constricted by undue regulations. We have long identified rules and regulations that both hinder the nursing profession and create unnecessary barriers for nurses and patients across healthcare settings. As part of the federal government-wide deregulatory efforts, we appreciate the opportunity to detail the concerns of both registered nurses (RNs) and advanced practice registered nurses (APRNs) to HHS and FDA and seek ways for us to work together to remove these barriers.

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 healthcare issues that affect nurses and the public. ANA members also include the four 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, administrative, and 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 delivery system. Nurses meet the needs of all patients and provide quality care that leads to better health outcomes. Moreover, nurses are critical to coordinated care approaches for patients in all care 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.

As we detail below, there are persistent regulatory barriers that constrain RN and APRN nursing practice. While ANA understands that HHS can remove many of these regulatory barriers, we acknowledge that additional barriers to nursing fall under the scope of other federal agencies; we

encourage HHS to work with and encourage the other applicable federal agencies to remove these barriers.

1) **HHS Must Allow APRNs to Practice at the Top of Their License.**

APRNs are highly trained medical practitioners, but there are many states that still do not allow them to practice medicine to the full extent of their license. Full Practice Authority (FPA) allows APRNs to practice at the top of their license, but only 24 to 28 states (depending on the APRN practice area) provide FPA currently. ANA agrees that APRNs and physicians are trained in different ways, and as a result, have different roles in treating patients. FPA does not change APRN scope of practice (SOP) in any way, rather it simply allows these clinicians to practice advanced practice nursing in the way that they are educated and trained.

Due to regulatory barriers, APRNs, including NPs, CNSs, CNMs, and CRNAs, face real barriers to practicing medicine at the top of their license due to outdated regulations. HHS has the authority to provide FPA to patients who receive healthcare through federal programs, such as Medicare, by creating a program similar to the Veteran Affairs' (VA's) National Standards of Practice—which defines a consistent scope of practice and responsibilities across all VA facilities—but the HHS program should include both RNs and CRNAs, who are not yet included in the VA's National Standards of Practice. Requiring national standards in other care settings, such as facilities that accept Medicare or Medicaid, would allow APRNs to practice at the top of their license while seeing patients covered by federal insurance programs. These standards would only cover patients covered by federal insurance programs and would not require other payers to follow federal rules. The care provided by APRNs to Medicare beneficiaries is comparable to the care provided by physicians.[1] There is also legislation introduced in Congress that would remove many of these barriers, but ANA would strongly encourage HHS and its subagencies, such as Centers for Medicare & Medicaid Services (CMS), to remove these barriers on its own, instead of waiting for Congressional action.[2]

Physician organizations oppose many of these changes, as they view the practice of medicine as their exclusive domain. However, modern medicine is built on interprofessional healthcare delivery, and patients should be able to choose which type of healthcare provider they want to see. Recognizing the important role that non-physician providers play in our healthcare system is becoming increasingly important, as our healthcare delivery system faces real shortages in clinicians, particularly in primary care, mental and behavioral health, and in rural/underserved areas. The physician shortage is only expected to grow, and APRNs are trained and ready to fill care delivery gaps to ensure patients have access to the care they need. However, outdated SOP laws do not allow APRNs to practice in the settings and manners in which they are needed the most. Realizing that there is a shortage of physicians, physician groups have informally ceded full practice authority to APRNs and other non-physician providers, but there is pushback whenever this is

[1] American Association of Nurse Practitioners. (d.). Quality of nurse practitioner practice. https://www.aanp.org/advocacy/advocacy-resource/position-statements/quality-of-nurse-practitioner-practice

[2] U.S. Congress. (2025, February 13). S.575 - I CAN Act: A bill to amend titles XVIII and XIX of the Social Security Act to increase access to services provided by advanced practice registered nurses under the Medicare and Medicaid programs, and for other purposes. https://www.congress.gov/bill/119th-congress/senate-bill/575

formalized by either states or the federal government. It is past time for APRNs to have the needed regulations that definitively allow them to practice at the top of their license, which they are trained and highly qualified to do.

Allowing APRNs to practice at the top of their license is particularly needed in rural areas. People who live in rural areas face greater barriers accessing care, leading to delayed care, which allow diseases to progress and become more expensive to treat. Removing APRN practice barriers will help make timely care more accessible in rural areas and help address the chronic disease epidemic, which is in alignment with the priorities outlined in the Executive Order Establishing the President's Make America Healthy Again Commission.[3]

Providing full practice authority to APRNs is an excellent way to ensure that APRNs can practice at the top of their license. **ANA urges HHS to remove all barriers that prevent nurses from practicing at the top of their license and ensure that patients have access to care from trusted nurse clinicians in their communities.**

2) HHS Must End Collaborative Agreements.

Collaborative agreements fulfill a regulatory requirement placed by many states on APRN practice, which require an agreement between a physician and an APRN for either a limited period (transition to practice) or granting permission to practice. Many of these requirements were relaxed during the COVID-19 public health emergency (PHE) with no negative effect on patient care.[4] **ANA believes that the flexibilities provided during the pandemic should be made permanent.**

These collaborative agreements do not relate to the APRNs' SOP, and there is no evidence to suggest that these collaborative agreements protect patients. Additionally, these transition-to-practice requirements are becoming increasingly difficult to initiate and maintain as primary care physicians and psychiatrists increasingly decline to offer them. Mergers and acquisitions also prevent physicians from signing agreements with APRNs who are not employed by the parent organization, creating additional barriers to practice. Physicians and APRNs collaborate to meet patient and community needs without the need for collaborative agreements. **As such, ANA urges HHS to end unnecessary and overly burdensome collaborative agreements.**

3) HHS Must End Unnecessary Supervision Requirements.

Supervision requirements, which are very similar to collaborative agreements, generally require that a physician sign off on an APRN's work. Many states allow APRN practice without unnecessary supervision requirements.[5] During the COVID-19 PHE, the Trump Administration rightfully relaxed these supervision requirements without any difference in patient care. Part of the

---

[3] The White House. (2025, February 13). *Establishing the President's Make America Healthy Again Commission*. The United States Government. https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/

[4] Martin, B., Buck, M., & Zhong, E. (2023). *Evaluating the impact of executive orders lifting restrictions on advanced practice registered nurses during the COVID-19 pandemic*. National Council of State Boards of Nursing. https://www.ncsbn.org/public-files/evaluating_impact_of_eo_lifting_restrictions_on_aprns_during_covid.pdf

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

reasoning behind supervision requirements is to prevent APRNs from exceeding their scope of practice. Moreover, supervision requirements pose an increased burden on practitioners and facilities in rural areas due to unique challenges. Often APRNs and other clinicians must travel to where patients are, and direct supervision requirements only add to the already-lengthy time and distance needed to provide prompt, appropriate care to patients. APRNs wish to practice at the top of their license within their education, training and expertise—they are not interested in providing services that they have not been trained to do. **ANA maintains that these reconfigured supervision requirements should become permanent and urges HHS to formally remove them.**

a) HHS Must Remove Overly Burdensome Supervision Requirements for CRNAs.

Federal requirements regarding supervision requirements for CRNAs continue to be overly burdensome. While there is no federal statutory language requiring supervision requirements, currently states must individually request permission from CMS to remove supervision requirements. Previously, the federal government was right to rescind supervision requirements in a final rule in 2001.[6] However, that final rule was withdrawn and replaced with the current bureaucratic opt-out process. This process places an extra burden on states.[7] Now, only 25 states and one territory have completed the opt-out process of federal supervision requirements for CRNAs. These overly burdensome requirements can be easily removed by amending 42 CFR § 482.52(a)(4), 485.639 (c)(2), 416.42 (b)(2), and 485.524 (d)(3)(ii) and eliminating 42 CFR § 482.52(c), 485.639 (e), 416.42 (c), and 485.524 (d)(5). **HHS should rescind physician supervision requirements from the conditions for coverage for ambulatory surgical centers and the conditions of participation for hospitals, rural emergency hospitals, and critical access hospitals**.

4) HHS Must Remove "Incident to" Billing from Medicare Reimbursement.

"Incident to" billing occurs when an APRN bills payors under a physician or provider National Provider Identifier (NPI) and is then reimbursed at 100 percent of Medicare rate instead of at 85 percent. This is a massive roadblock for APRNs looking to start their own business, as they would be reimbursed less for the same work. This is another reason why Section 2706 nondiscrimination regulations are essential for APRNs. Currently, private payers set their rates and can choose to reimburse APRNs at a lower rate than physicians.

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.

---

[6] Centers for Medicare & Medicaid Services. (2001, January 18). *Medicare and Medicaid programs; Hospital conditions of participation: Anesthesia services*. *Federal Register*, *66*(12), 4674–4682. https://www.govinfo.gov/content/pkg/FR-2001-01-18/pdf/01-1388.pdf

[7] Centers for Medicare & Medicaid Services. (2001, November 13). *Medicare and Medicaid programs; Hospital conditions of participation: Anesthesia services*. *Federal Register*, *66*(219), 56762–56769. https://www.govinfo.gov/content/pkg/FR-2001-11-13/pdf/01-28439.pdf

"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.

Medicare beneficiaries have become increasingly reliant on APRNs, leading the Medicare Payment Advisory Commission (MedPAC) to recommend eliminating "incident to" billing.[8] MedPAC has verified that eliminating "incident to" billing will not change the quality of care or how it is delivered.[9] Additionally, "incident to" billing creates inflated claims, crediting physicians in instances when APRNs have often conducted the bulk of the work. Ending "incident to" billing will, therefore, help CMS' reach its goal[10] of eliminating waste, fraud, and abuse in the Medicare program. **Due to all the aforementioned reasons, ANA strongly opposes the use of "incident to" billing and believes it should be removed from the Code of Federal Regulations (CFR)[11] to create an equal playing field among all practitioners.**

5) **HHS Must Standardize Terms in Regulations.**

The CFR refers to medical practitioners by different terms depending on where the service is provided and under which federal program the patient is receiving healthcare coverage. This leads to confusion for both practitioners and administrative staff as it forces practitioners to know not only where the patient is located, but also which program is providing coverage, before they can provide treatment.

In the calendar year 2024 Physician Fee Schedule proposed rule, the Centers for Medicare & Medicaid Services (CMS) declared that it would use the term "practitioner" for anyone who provides care to patients, instead of using different terms for physicians or APRNs.[12] ANA strongly supports this proposal and was pleased to see it incorporated into the final rule. Yet, at this time, this change has only been accepted by CMS and is not standard practice across all HHS agencies or the larger federal government. As a result, there are different rules and regulations depending on which federal department is funding or regulating care. These variations in terms cause confusion and make it more difficult for practitioners to know what regulations apply before they can administer care to patients. Standardizing terms would remove unnecessary regulatory barriers and allow practitioners to practice medicine without worrying about what program the patient is covered by and what federal regulations apply. **ANA supports the standardization of terms across the federal government, and the term "practitioner" should be used for all healthcare providers.**

---

[8] 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/

[9] *Ibid.,*

[10] Centers for Medicare & Medicaid Services. (n.d.). *Fraud*. U.S. Department of Health & Human Services. https://www.cms.gov/fraud

[11] 42 CFR §410.26

[12] The term *physician* may still exist in CMS regulations, but CMS stated that anywhere the term "physician" is used, it includes all practitioners.

6) HHS Must Allow Continued Use of Telehealth.

Prior to the COVID-19 PHE, telehealth was a very small part of Medicare and was only used in very specific situations. One of the few upsides from the COVID-19 PHE was allowing for the expanded use of telehealth which led to greater access to care. This was shown to be a safe, efficient, cost-effective way to treat patients for many chronic conditions[13,14] and for carrying out varying forms of healthcare visits, such as primary care screenings[15], postoperative visits[16], and acute stroke care.[17,18] Telehealth use during the COVID-19 PHE was found to be associated with fewer emergency department visits, reduced inpatient admissions, and lower overall medical costs.[19] Additionally, if beneficiaries do not have access to telehealth, they will often be forced to use the emergency room, which is the most expensive point of care.

The end of the COVID-19 PHE returned some of the telehealth rules to their pre-pandemic status, but Congress has fortunately continued to extend telehealth flexibilities through the end of this year. **ANA has long advocated for HHS' subagency, CMS, to take the position that they have the regulatory authority to make some flexibilities permanent, but CMS has continued to maintain that only Congress has that authority.** 42 CFR §410.78(b) provides practitioners with the general rules for telehealth, and while there are limitations, there are many services that can be provided on a permanent basis without waiting for Congressional action. Relying on this section of the law would reduce the need for waivers and provide practitioners with more tools that they can use to treat their patients on a permanent basis.

Making the flexibilities permanent would permit many patients in rural areas to visit the practitioner of their choice. Currently, many rural areas have a shortage of nurses and other healthcare professionals, which telehealth would help improve. Additionally, many patients who benefit from

---

[13] Gupta, S., Askenazi, D., Fonacier, L., Greenhawt, M., Kalangara, J. P., Lanser, B. J., ... & Shaker, M. S. (2023). Rapid implementation and evaluation of virtual health training in allergy/immunology during COVID-19. *The Journal of Allergy and Clinical Immunology: In Practice, 11*(2), 426–437. https://doi.org/10.1016/j.jaip.2022.08.019

[14] Keszler, P., Maloni, H., Miles, Z., Jin, S., & Wallin, M. T. (2022). Telemedicine and multiple sclerosis: A survey of health care providers before and during the COVID-19 pandemic. *International Journal of MS Care, 24*(6), 266–270. https://pmc.ncbi.nlm.nih.gov/articles/PMC9749831/

[15] E De Guzman, K., Snoswell, C., Caffery, L. J., & Smith, A. C. (2021). Is telehealth in primary care cost-effective? A systematic review. *Value in Health, 24*(Supplement 1), S188. https://doi.org/10.1016/j.jval.2021.04.935 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8913160/

[16] Kantor, O., Silverman, R. S., Colavita, P. D., Tsikitis, V. L., & Ricciardi, R. (2022). Telemedicine versus in-person postoperative visits following colorectal surgery: A randomized trial of patient satisfaction and clinical outcomes. *Annals of Surgery Open, 3*(4), e217. https://doi.org/10.1097/AS9.0000000000000217 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9659327/

[17] Lee, J. S., Bhatt, A., Pollack, L. M., Jackson, S. L., Chang, J. E., Tong, X., & Luo, F. (2024). Telehealth use during the early COVID-19 public health emergency and subsequent health care costs and utilization. *Health Affairs Scholar, 2*(1), qxae001. https://doi.org/10.1093/haschl/qxae001

[18] Al Kasab, S., Almallouhi, E., & Holmstedt, C. A. (2022). Telestroke through the COVID-19 pandemic—A systematic review and current perspectives. *Current Treatment Options in Neurology, 24*(10), 429–444. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9388966/

[19] Lee, J. S., Bhatt, A., Pollack, L. M., Jackson, S. L., Chang, J. E., Tong, X., & Luo, F. (2024). Telehealth use during the early COVID-19 public health emergency and subsequent health care costs and utilization. *Health Affairs Scholar, 2*(1), qxae001. https://doi.org/10.1093/haschl/qxae001

telehealth would not otherwise be able to see their practitioner or would rather be forced to seek care through more costly emergency services. This may be because they have limited mobility, cannot afford transportation, or do not have paid time off from their jobs. Telehealth has allowed many patients to see their practitioners from locations other than the practitioner's office, resulting in better health maintenance and follow-up, which can ultimately lead to a healthier public. Additionally, there are shortages of physicians, and other healthcare practitioners in many rural areas and APRNs are critical to ensure patients do not face gaps in needed care.

Continuing to allow telehealth access will make Americans healthier by allowing patients to receive more timely care, have needed follow up visits, and obtain preventative care, especially in rural communities or areas with provider shortages—therefore, aligning with the Administration's vision to Make America Healthy Again.[20] **As such, ANA urges HHS to make telehealth flexibilities permanent.**

7) HHS Must Interpret the Rural Emergency Hospital Provisions Correctly.

Congress recently created a new class of hospital called the "rural emergency hospital" (REH). REHs were created as a way for rural hospitals to survive in a time when hospitals are closing at alarmingly high rates in rural areas nationwide. REHs receive a higher Medicare reimbursement rate under federal regulations than non-REHs, but an ambiguity in the authorizing statute has been an obstacle to many hospitals that requested REH designation.

HHS has interpreted the REH authorizing statute as forbidding REHs from receiving Medicaid payments in most cases. This becomes an issue because while REHs do receive a higher Medicare reimbursement rate, many of these hospitals are in regions where a large percentage of the patient population also receives health insurance coverage through the Medicaid program. The loss of Medicaid reimbursement would be a death knell for these hospitals, and, as a result, they are not seeking to change their status to an REH. However, this only serves to compound existing financial challenges faced by these hospitals as they struggle to remain open.[21] This interpretation is likely not Congress' intent, as Congress would not have intentionally put hospitals in this impossible position of having to choose between Medicare or Medicaid payments. Having the ability to accept beneficiaries covered by Medicaid and Medicare is crucial, as the nurses in these hospitals know the impact on patients when they do not have access to care. In line with the Executive Order to Make America Healthy Again, ensuring access to healthcare services in rural areas is paramount to keeping communities healthy.[22] **HHS must clarify that REHs may participate in the Medicaid program without unnecessary limitations, as it would allow hospitals to fulfill Congressional intent and become REHs.**

---

[20] The White House. (2025, February 13). *Establishing the President's Make America Healthy Again Commission*. The United States Government. https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/

[21] 146 rural hospitals have closed in the last twenty years. (2025, February 18). 146 rural hospitals closed or stopped providing inpatient services from 2005 to 2023 in the United States. Retrieved April 15, 2025, from https://www.ers.usda.gov/data-products/charts-of-note/chart-detail?chartId=110927

[22] The White House. (2025, February 13). *Establishing the President's Make America Healthy Again Commission*. The United States Government. https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/

8) **HHS Must Work with the VA to Finalize the VA National Standards of Practice for All RNs.**

ANA encourages HHS to work with the VA to finalize their National Standards of Practice for VA employees, specifically for RNs and CRNAs. The VA has been slowly creating national standards for years, but they have yet to propose or promulgate national standards for RNs. These standards are not an overreach, as they do not override state law and would only apply to nurses while they are working at VA facilities as the existing standards for other professionals do now. The VA, like other hospitals across the country, is faced with a shortage of nurses, which hinders the ability of patients to receive needed care. A lack of a national standard hinders the ability of nurses to easily transfer to VA facilities to address nursing shortages in states where they are not licensed to practice medicine.

Like RNs, CRNAs face similar barriers at the VA. While the three other APRN specialties (CNSs, CNMS, and NPs) received national standards of practice in 2016, CRNAs were not granted the same privileges that other APRNs receive.[23] The lack of a CRNA national standard is especially egregious; in some states, CRNAs are the only providers for anesthesia services in nearly all rural hospitals.[24] As many anesthesiologists refuse to leave their urban hospitals, CRNAs—like many other APRNs—have been ready and willing to move to areas with shortages. Again, without a national standard of practice it would be extremely time consuming for CRNAs to receive the state licensing necessary when switching facilities to address anesthesiology shortages at VA facilities in other states.

These national standards are long overdue to address this burdensome regulatory barrier that only serves to hinder veterans' access to care. **ANA strongly supports the implementation of national standards for all nurses in VA facilities so that these clinicians are able to practice where they are needed without unnecessary barriers. Although these National Standards of Practice fall under VA jurisdiction, HHS must use its influence to encourage the VA to finalize them.**

9) **HHS Should Work with Drug Enforcement Administration (DEA) to Repromulgate Proposed Rules on Special Registration.**

In the final week of the Biden Administration, DEA released a long overdue proposed rule on special registration for telehealth prescribers of certain controlled substances. While ANA appreciated that DEA issued this statutory mandated rule, the proposal contains many provisions that create new regulatory barriers for nurses and patients.

One example of where the proposed rule may have unintended consequences is requiring at least 50 percent of prescriptions in a calendar month not to be Schedule II narcotics. DEA does not offer any reason for this number, and it is illogical. Prescribers may have a different patient mix in a given month, or they may have other reasons for not issuing specific prescriptions which could cause them to run afoul of the regulations.

---

[23] 38 CFR §17.415

[24] American Association of Nurse Anesthesiology. (2023). *CRNAs address the unique challenges of rural healthcare, support quality care and access for rural communities*. https://www.aana.com/news/crnas-address-the-unique-challenges-of-rural-healthcare-support-quality-care-and-access-for-rural-communities/

Another proposal that creates an unnecessary burden to practice is requiring that patients and practitioners be physically located within the same state. While we understand the intention of this provision, we recognize that there are areas of the country where it is very common for residents to cross state lines for work, healthcare, and other daily activities due to geographic proximity. Often, in these cases, a patient would be unnecessarily barred from continuing to receive care from their established and trusted provider simply because their residence is over the state line. Moreover, the rule allows for no exception, even when the provider is licensed in both the state where they are physically located and the state where the patient is located. ANA urges HHS to work with DEA to explicitly allow for telehealth prescribing across state lines, provided that the practitioner is licensed to practice in both states where the practitioner and the patient are physically located.

Although these rules fall under DEA's and the United States Department of Justice's jurisdictions, both HHS and FDA have vast expertise and sway in the fields of healthcare access and drug regulation—two barriers posed by these proposed rules. Telehealth prescribers are already operating under a waiver that allows patient access; therefore, it would not be detrimental to telehealth prescribers or consumers to continue operating under the current waiver until a revised proposed rule can be published. **ANA believes that HHS and FDA must use their influence and work with the DEA to get rulemaking that does not create new and unnecessary regulatory barriers or burdens.**

10) HHS Must Direct CMS to Reform the CPT/RUC Process.

Reimbursement for all practitioners is determined through the Current Procedural Terminology (CPT) and the Relative Value Scale Update Committee (RUC) systems. These were created, and are still run, by the American Medical Association (AMA). The AMA has a contract with CMS to determine Medicare payments, and most, if not all, private payers use the CPT system as well to set reimbursement rates. ANA is proud to be the only nursing organization that has advisors representing nursing in both the CPT code development and RUC code valuation processes. While nursing is represented in this process, they are not heard equally. Since CPT and RUC are driven by the AMA, often non-physician provider perspectives are overlooked. This results in a general perception that the payment system is biased towards physicians.

As such, CMS has sought comment on rulemaking on the CPT/RUC process and whether it should be replaced with a different payment system. While ANA does not believe that the CPT/RUC process should be replaced with a different payment system, reform is needed. A complete overhaul may create havoc in the healthcare delivery system since the current reimbursement determinations are ingrained into both public and private payment systems.

ANA believes that the current system must be reformed to better reflect the critical role of non-physicians in the healthcare delivery system in payment decision-making**.** CMS should reconsider the current contract with AMA and demand that changes be made to make the CPT and RUC systems more inclusive of non-physicians such as through having a better balance of physicians to non-physicians on each of the RUC and CPT panels. As a result, ANA believes that CMS should use its regulatory authority and **require** that the AMA provide more seats and input into the process for non-physicians. This is particularly important as nurse practitioners continue to meet more and more of the nation's primary care needs. The elevation of non-physician perspectives in this process is critical to creating more transparency in how payments are determined and ensuring

payment rates appropriately reflect how care is provided to patients. **In light of this, ANA urges HHS to direct CMS to institute real reforms to the CPT/RUC process to better reflect the provision of healthcare by all clinicians.**

11) HHS Must End Outside Regulation of Nursing.

Healthcare, and non-healthcare, professions generally regulate themselves—however, there is one glaring example where this is not true, nursing. Nurses are the only healthcare professionals who do not regulate their own profession, as there are states that require physician representation on nursing boards. This is patently unfair and is not a matter of education—generally the reasoning is to give objectivity to the nursing board.

Nurse licensure must be run by nurses as they are the only ones who understand the education and training needed to become a nurse. ANA firmly believes that healthcare professions should regulate their respective professions, and that other healthcare professions must not be primary in regulating the nursing profession. This should not require any additional regulations. Removing requirements to have physicians sit on nursing boards is simply a common-sense reform that would put nursing on par with other healthcare professionals. **ANA strongly urges HHS to end all outside regulation of nursing practice.**

12) HHS Must Ban the Use of Non-Compete Agreements for Nurses in Medicare and Medicaid Facilities.

ANA strongly believes that non-compete agreements are harmful to frontline nurses. ANA understands that non-compete agreements may have some utility in business and finance, especially among management and design personnel as they have access to corporate secrets. Nurses, especially frontline nurses, do not have access to corporate secrets. Therefore, the only reason for nurses to sign non-compete agreements would be to force them to stay in their current job and limit their employment opportunities. This takes nurses out of the free market and artificially caps salaries. Banning non-compete agreements for nurses would raise salaries by increasing competition for nurses who are in demand without decreasing the supply of nurses in the marketplace. Higher salaried and greater employment opportunities would likely draw more people into the profession and could help alleviate the current nursing shortage. Unlike non-compete agreements, a combination of Health Insurance Portability and Accountability Act and non-disclosure agreements can protect patient and business information without imposing additional restrictions on job mobility.

Some of the non-compete agreements that ANA is aware of are extreme. One member mentioned that their office had a non-compete that forbade them from working as a nurse for a specified period of time within 7,500 miles of their current workplace. That covered the nurse's employment not only in New York state, but also the entirety of the contiguous 48 states, Alaska, Hawaii, Puerto Rico, and Guam. Such agreements are not intended to protect business interests other than tethering nurses to specific roles, reducing their employment prospects and exacerbating workforce shortages.

Distance is not the only unfair element in non-compete agreements. Sometimes these restrictive agreements can last for years, leading nurses to feel that they are either stuck in their current position or they must be retrained in another nursing specialty in order to seek other employment—

which takes both time and money. **As such, ANA urges HHS to ban non-compete agreements in facilities that accept Medicare and Medicaid.**

ANA appreciates the opportunity to have this discussion and looks forward to continued engagement with HHS and FDA 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