American Nurses Association

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

August 25, 2026

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 Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities to Apply for Available Slots

Dear Administrator Oz,

The American Nurses Association (ANA) appreciates the opportunity to comment on the calendar year 2027 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. Several proposed provisions impact how nurses provide care and ANA urges the Centers for Medicare & Medicaid Services (CMS) to account for nurses as the agency works to finalize the proposed provisions. ANA appreciates thoughtful consideration of our comment and encourages CMS to:

- promote nurse inclusion in procedure panels;
- support adequate reimbursement for ancillary goods and services;
- ensure that products are included in the proper Ambulatory Payment Classification (APC);
- advance appropriate reimbursement for mental health services;
- software as a medical service;
- maintain the cost-of-living allowance for Alaska and Hawaii;
- maintain payment adjustments for domestically produced personal protective equipment; and
- continue moving forward on price transparency initiatives.

ANA represents the interests of the nation's over 5 million registered nurses (RNs) through its constituent and state nursing associations, organizational affiliates, and individual members. ANA advances the nursing profession by championing nurses, fostering rigorous standards of nursing practice, promoting safe and ethical work environments, bolstering nurses' health and wellness, and advocating on the healthcare issues that impact both nurses and their patients. ANA seeks to ensure that nurses' voices, interests, and perspectives are represented and heard in all

policymaking discussions. Our membership consists of both RNs and Advanced Practice Registered Nurses (APRNs)—nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs).

Nursing is a profession grounded in critical thinking, scientific rigor, and evidence-based practice. Nurses are central to the delivery of high-quality care across many settings and serve in essential direct care, research, and administrative leadership roles. Nurses form the backbone of the American health care system, applying their clinical expertise and training to provide and coordinate care, educate patients and the public, and counsel and support patients and their families. As the most trusted profession, nurses play a critical role in treating patients, advancing health outcomes, and helping create healthier communities.[1]

1. **CMS must require that nurses are included on the Advisory Panel on Hospital Outpatient Payment.**

CMS is statutorily required to create an advisory panel on hospital outpatient payment. Per the proposed rule, this panel must consist of "appropriate representatives of providers." Nurses are the largest and most trusted segment of the health care workforce and are involved in every part of the care continuum, including hospital outpatient services and therefore are appropriate providers. To guarantee their critical perspective is reflected in these panels, CMS must require that, at minimum, a **nurse be included as members of the Advisory Panel on Hospital Outpatient Payment.**

Nurses are vastly underrepresented across both federal agencies and advisory panels; as a result, the practice of nursing has not been adequately considered in recommendations that arise from many federal panels. Nurses understand what is included within their scope of practice and while they are not performing the procedures that this panel oversees, nurses complete a significant percentage of the work included in the surgical reimbursement bundle.[2] This includes work done not only during the procedure itself, but pre-operative and post-operative work as well. This perspective is missing from most federal panels, and therefore, ANA implores CMS to ensure that nurses are included as panel members.

2. **CMS must ensure adequate reimbursement for packaged items and services.**

CMS proposes continuing its current policy of packaging, or bundling, new ancillary services into payment for a primary service. While ANA does not disagree with the policy of using bundled payments, we remain concerned that this payment strategy further exacerbates the lower reimbursement rates APRNs receive than their physician colleagues. APRNs are reimbursed for these packaged items at a rate 15% lower than what physicians receive, while not only being fundamentally unfair, but this inequity also forces APRNs to receive reimbursement for the bundled payments that are often lower than the cost of the service. The practice expense portion of the RVU

[1] American Nurses Association. (2026, January 12). *Nurses ranked most trusted profession for 24th consecutive year* [Press release]. https://www.nursingworld.org/news/news-releases/2025/nurses-ranked-most-trusted-professionals-for-24th-consecutive-year/

[2] This work is captured in practice expense.

costs the same whether they are being procured by a physician or by an APRN[3] and therefore APRNs must receive the same reimbursement for these goods as their physician colleagues. This persistent payment differential only serves to undervalue the clinical expertise of and services provided by APRNs, who are increasingly relied on to provide primary care services to Medicare beneficiaries.

Another byproduct of APRNs receiving improper reimbursement is that the important healthcare services provided by APRNs is often hidden. Facilities understand the importance of APRNs, but as they want to receive higher reimbursement rates, services facilitated by APRNs are often reimbursed under the facility's, or physician's NPI and not the APRN's NPI. Frankly, this makes it impossible to fully understand the true percentage of the work being done by APRNs and having needed data to inform policymaking. The result of this is that while APRNs are providing a large percentage of services to beneficiaries, they are not credited with that work.

ANA has long advocated for all practitioners to receive the same reimbursement for the same work and recognizes that CMS does not have the authority to unilaterally raise reimbursement rates for APRNs. It is long overdue for Congress to rectify this reimbursement inequity and ANA continues to work with lawmakers towards that change. **ANA urges CMS to also work with Congress to ensure that APRNs receive the same reimbursement for these packaged items that physicians receive, that better reflects the vital healthcare services APRNs provide in the nation's healthcare delivery system.**[4]

3. **CMS must keep Continuous Glucose Monitoring in a New Technology APC.**

CMS proposes keeping items with fewer than ten claims in the 4-year lookback period within the same APC— including continuous glucose monitoring under APC 1563—a service that NPs provide for their patients. Currently, continuous glucose monitoring is represented in the CPT code set as a category III code, and these codes are not reimbursed by Medicare. As a result, category III codes are chronically underreported within Medicare. Additionally, while there were fewer than 10 continuous glucose monitoring claims within the hospital outpatient facility, there were 304 claims for continuous glucose monitoring in the non-facility setting.[5]

Continuous glucose monitoring is also being presented before the CPT Editorial Panel for a possible category I code.[6] Making a category adjustment will allow the code to be valued by the RUC process and, therefore, will allow Medicare providers to receive reimbursement for this service.

Keeping continuous glucose monitoring in the same APC will allow the CPT coding and reimbursement process to play out and give time for practitioners to understand the proper

[3] An example is rent does not change if the space is leased to an MD or APRN.
[4] An example of a bundle is Esketamine which is discussed further on in these comments.
[5] American Medical Association. (2026). *Version 2.1*. Continuous Glucose Monitoring Codes. RUC Database. https://rucapp.ama-assn.org/#/ruc-home
[6] American Medical Association (2026, July 10). *Proposed Panel Agenda September 2026 CPT® Editorial Panel Meeting*. Retrieved July 21, 2026, from https://www.ama-assn.org/system/files/cpt-panel-september-2026-agenda.pdf

reimbursement for this service. Therefore, **ANA supports keeping continuous glucose monitoring within the same APC.**

4. **CMS must finalize its proposal to increase reimbursement for esketamine treatment.**

CMS proposes to increase reimbursement for esketamine treatment for CY 2027 and to place esketamine treatment into APCs 1513 and 1518. This follows CMS' previous rulemaking that placed the reimbursement for this treatment into APCs 1512 and 1517, effectively raising payments for providers for the provision of this emerging therapy. This evolution in the agency's rulemaking is critical for APRNs. The Food and Drug Administration (FDA) approved the use of esketamine therapy for treatment-resistant depression in March 2019. Initially, Medicare placed two new payment codes in the OPPS for esketamine administration (G2082 and G2083) into bundled payments of $789.89 for G2082 and $1,117.23 for G2083 in the non-facility setting for physicians. Under Medicare statute, APRNs (including NPs) receive 15% less reimbursement than their physician colleagues. The resulting, reduced amount that NPs were reimbursed for the treatment bundles was $671.32 for G2082 and $949.65 for G2083—**which rendered reimbursement less than the cost of the esketamine treatment**. As such, NPs and other APRNS had unreimbursed costs if they administered esketamine to their patients, effectively creating a barrier to access for patients in need of this therapy. In the calendar year 2026 OPPS rule, CMS placed esketamine into APCs 1512 and 1517. The increase to the reimbursement rates allowed APRNs to prescribe esketamine without facing reductions for providing this treatment for their patients. Reclassifying the APC again this year will continue to allow APRNs to prescribe esketamine as part of treatment plans for their patients.

ANA appreciates CMS for its thoughtful approach to appropriately and adequately resourcing esketamine treatment since FDA approval and strongly supports the related provisions in the above-captioned proposed rule. Placing esketamine into higher APCs safeguards the adequate reimbursement for this necessary treatment, therefore allowing APRNs to prescribe it to their patients. **CMS is right to propose a reimbursement increase for esketamine treatment, and ANA urges the agency to finalize the proposed provisions.**

5. **CMS must finalize its proposal to use a consolidated list of codes**

CMS, in the proposed rule, believes that utilizing a consolidated list of healthcare common procedure coding system (HCPCS) codes related to mental health services to identify services for benefits under both the partial hospitalization program (PHP) and the intensive outpatient program (IOP) benefits beneficiaries and supports a smooth transition between the programs when a beneficiary's needs change.[7] ANA agrees with CMS that using a consolidated list is valuable for the care management of Medicare beneficiaries. Furthermore, ANA believes that this proposal will allow nurses to provide better care management for their patients as they will not have to translate the different HCPCS codes based on site of service. **As such, ANA urges CMS to finalize using a consolidated list of HCPCS codes for mental health services.**

[7] APCs 5851-54 and 5861-64

6. **CMS Must Continue Innovating with Software as a Medical Service**

CMS is seeking comment on changes that make use of software easier to understand. **ANA supports changing the name from software as a service to software as a medical service (SaMS).** "Software as a service" is very vague and many people may not understand that the service is medical in nature and removes any ambiguity as the term is common in general, non-medical cloud-based computing services.[8]

ANA understands the reimbursement difficulties inherent in artificial intelligence (AI) technology and usage and looks forward to working with the agency on a path forward.[9] **While stakeholders work on reimbursement pathways, ANA supports CMS' proposal to place SaMS applications into new technology APCs**. Placing SaMS applications into these APCs will allow for provider reimbursement and, therefore, allow medical practices to invest in and utilize this software. SaMS will never replace either human ingenuity or the human brain, but ANA recognizes it can support practitioners and provide treatment options on effective ways to diagnosis and treat patients.

ANA also supports creating the new status indicator for SaMS technology. This indicator will allow CMS to track SaMS use and aid in the creation of appropriate future HCPCS codes and reimbursement. Placing SaMS applications into new technology APCs will also allow practitioners, and developers, access to more data as these applications become more common. The data gathered can then be used to make more informed decisions about how the various applications are used in healthcare delivery, and this in turn may allow practitioners to purchase applications that they have both used and believe will benefit their practices. All of this use will then allow for more investments in emerging technology that will benefit both practitioners and patients. Importantly, tracking and collecting better claims data allow policymakers to make informed decisions on how to best create reimbursement frameworks that appropriately value emerging technologies.

ANA strongly supports the use of AI in a medical context, but ANA also believes that AI analysis must be reviewed by a licensed medical practitioner. AI algorithms provide AI with the ability to review large amounts of data in a short period of time, but data is only one element that is used by practitioners in their clinical practice. Practitioners still must take time to review and validate information provided by AI technology. Human review by practitioners is critical as AI technology may not capture nuances and other considerations and the clinical human element is key to guard against costly errors and impact on patient outcomes. **The last step in any use of SaMS must be a final review by a qualified human to ensure that SaMS is not making unintended errors.**

7. **CMS must maintain the adjustment for cost of living in Alaska and Hawaii.**

Under Section 1886(d)(5)(H) of the Social Security Act, the Secretary of HHS has discretionary authority to make necessary adjustments for hospitals in Alaska and Hawaii due to their unique geographic and workforce circumstances and CMS proposes to maintain the cost-of-living adjustments for practitioners living in these states. Practitioners working in Alaska and Hawaii face

[8] That is an accepted definition for software as a service.
[9] Examples are monthly, per patient, or per click.

unique challenges often due to distance, rural characteristics, and cost of living among other factors. Additionally, there is frequently a shortage of practitioners in these locations due to these aforementioned factors. APRNs have been moving to these areas to help alleviate the practitioner shortage, but providing care can still be difficult. ANA has heard from members in Hawaii that if a patient requires a hospital, or specialized care, obtaining that care would require the use of either a boat or airplane, as there are islands that do not have these facilities available.

Under OPPS, the Secretary of HHS has authority to raise reimbursement rates to Alaska and Hawaii due to their distinct geography, and in past years there has been a location adjustment for Alaska and Hawaii. **ANA strongly supports CMS' proposal to continue to provide this necessary cost of living adjustment for both Alaska and Hawaii.**

8. **CMS must continue to provide incentives for use of domestically produced personal protective equipment (PPE) and medicine.**

CMS is seeking comment on policy approaches for payment adjustments that provide incentives for use of domestically produced PPE and medicine. **ANA has long supported these payment adjustments**, especially for PPE. ANA knows that nurses require PPE in a greater scale than many other practitioners as they spend more time with patients than most other medical practitioners.[10] As a result, they need the most protections against communicable diseases, and any shortage of PPE will have a calamitous effect on nurses' ability to provide care to patients, especially during disease outbreaks.

ANA also strongly encourages CMS to ensure that these payment adjustments account not only for a wide range of PPE and medications, but also for variations within the same category of equipment or medication. Facilities may use different versions of the same product depending on the needs of specific patient populations. In addition, practitioners and patients may have sensitivities to certain materials or formulations. For example, some latex gloves may cause reactions, while gloves from other manufacturers may use non-latex materials. Respirators provide another important example, as a poorly fitting respirator does not offer adequate protection. This is why nurses undergo annual respirator fit testing to ensure proper protection. ANA does not offer comment on the general definition of "domestically produced" but would support the exception for nitrile gloves for the CMS proffered reason of lack of domestic nitrile butadiene rubber. ANA would also support federal government intervention in creating a domestic producer of nitrile butadiene rubber, as this would protect from any possible future disruptions in the supply chain.

ANA understands that it is sometimes financially more feasible to procure non-domestically produced PPE and medication and does not oppose these procurements. ANA would only strongly encourage the federal government to ensure that there is domestic production available if the need arises. **Therefore, ANA urges CMS to continue providing appropriate payment adjustments that**

[10] 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

provide incentives for domestic PPE and safeguard nurses and all healthcare personnel caring for patients.

9. **CMS must continue putting patients first in their price transparency initiatives.**

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

ANA supports efforts by CMS to require consistency across settings. Health literacy is generally challenging and much of the information released by facilities often does not make it easier for patients to fully comprehend and make informed decisions. This defeats the intent of CMS' price transparency initiatives and protections for patients to understand the cost of needed care. **ANA supports efforts to increase price transparency in simple formats for patients receiving care across settings and urges CMS to continue to refine its rulemaking and implement requirements that further enhance price transparency in patient care.**

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

Sincerely,

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

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