June 9, 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 Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz,

The American Nurses Association (ANA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) IPPS proposed rule. ANA looks forward to working with CMS on its proposals and ensuring that nurses are accounted for in all aspects of the proposed rule. As the agency works to finalize the proposed provisions, ANA urges CMS to:

- ensure nurses are included in procedure panels;
- work with nurses to maintain targeted education programs;
- maintain severity levels for social determinants of health measures; and
- maintain the hospital readmission reduction program.

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 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, care coordination, research, and administrative leadership roles. Nurses form the backbone of the American health care system, providing and coordinating care, educating patients and the public, and offering counsel and emotional support to patients and their families. As the most trusted profession, nurses play a critical role in treating patients and influencing health behaviors.[1]

1) **CMS must include nurses on the Operating Room procedure panels.**

In the proposed rule, CMS discusses the physician panels that determine whether procedures must take place in an operating room (OR) or if they can be performed in other facilities. **ANA does not object to the work of the panels on where the procedures should be performed, but we object to the composition of the panels themselves. RNs must have seats on these panels.** CMS continues to conduct a systematic, comprehensive review of whether procedures require an OR or non-OR setting, and nurses must be part of the determination process. RNs perform critical roles in the OR, that includes monitoring, assessing, documenting and rapid responses in case of emergency or the need for lifesaving measures. Due to their critical roles, they must be considered and included in OR procedure panels. Moreover, nurses and physicians have different roles as part of the care team and offer different, but equally important, perspectives on how procedures are performed. Omitting nurses from the panels obscures their critical role, perspectives and expertise, and does not fully capture the necessary hospital resources used in all the procedures. As the agency examines procedure panels focused on determining OR and non-OR procedures, it is vital that surgical nurses are mandatory participants on these panels.

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

2) **CMS must use the most recent date for reasonable cost payments for nursing and allied health education programs.**

Medicare has historically paid hospitals for its own share of the costs that providers incur in connection with approved educational activities. These costs are separately identified and "passed through," that is, paid separately on a reasonable cost basis. Data from the Calendar Year (CY) 2023 were used to calculate the previous year's payment. This year, CMS proposes to base the CY 2027 payments on data from CY 2025, which is the most recent data available. ANA thanks CMS for

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[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/

continuing and utilizing the most up to date data available to determine these payments. **As such, ANA recommends that CMS finalize its proposal to use the most recent data available to calculate the most accurate payments.**

3) **CMS must maintain current social determinants of health (SDoH) quality measures and not lower their severity levels.**

SDoH screenings—such as assessments for housing instability, food insecurity, economic stability, lack of transportation, economic hardship, and utility needs—are vital tools for identifying non-medical factors that directly affect health outcomes, readmissions, and care quality. In fact, up to 80 percent of an individual's health is influenced by social, behavioral, and environmental factors, far outweighing the impact of clinical care alone.[2] Unmet social needs can lead to downstream effects such as delayed care, poor chronic disease management, difficulty affording or adhering to medications, missed follow-up appointments, and increased financial strain. When practitioners have a full picture of a patient's circumstances, they can proactively assess these risks and intervene earlier to improve outcomes.[3] Thus, collecting and acting on this data is critical for improving patient centered care quality, reducing healthcare costs and utilization, addressing differences in patient outcomes, and driving cost-effective care delivery.[4,5]

Nurses are uniquely positioned to lead this effort, as they are often the first point of contact for patients. Incorporating social needs into care is both a professional responsibility and an ethical imperative, as outlined in the Nursing Code of Ethics.[6,7] 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.[8] When nurses screen for and respond to social needs, patients receive more personalized care, improved discharge planning, and enhanced connections to community resources.

Moreover, research shows that more than one-third of Medicare and Medicaid beneficiaries have at least one social need, and aligning social needs data with care delivery can reduce per-patient

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

costs by at least $1,400.[9] Integrating SDoH into care improves outcomes and offers a compelling return on investment, both clinically and financially.[10] Moreover, meaningful clinical improvements and cost savings from screening and referral of social needs have led to better medication adherence, blood pressure control, and diabetes management and significantly less readmissions.[11,12] The two severity levels of complication or comorbidity(CC) and nonCC require different levels of resources as CC represent secondary conditions that can increase diagnosis difficulty or facility length of stay. On the other hand, nonCC are clinically insignificant such as minor chronic issues.[13]

Rather than lowering the severity SDoH-related measures, CMS should consider incentivizing hospitals and health systems to fully implement them—transforming data into actionable care interventions and catalyzing healthcare innovation that integrate social service partners. Doing so aligns with the Administration's commitment to drive industry level progress, efficiency, prevention, and patient-centered care, including priorities outlined in the Executive Order to Make America Healthy Again (MAHA), and the Center for Medicare and Medicaid Innovation center vision to test care models that leverage prevention.[14]

Lowering the severity level of the SDoH quality measures will disincentivize providers from fully implementing the measures and using them to improve patient care. The SDOH measures work hand-in-hand with other diagnostic procedures to determine the best care for patients. A patient's background tells a story that is an integral part of their care. Additionally, there are some medical conditions that affect certain parts of the population more than others, and having this information will allow practitioners to better target diagnostics and interventions to ensure the delivery of quality, efficient care for their patients.

a. CMS Must Maintain the Current Severity Measure Homelessness, Inadequate Housing, and Housing Instability

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

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

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

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

[13] Agency for Healthcare Research and Quality (n.d.). *Overview of Disease Severity Measures*. Retrieved May 21, 2026, from https://hcup-us.ahrq.gov/db/nation/nis/severity_overview.jsp

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

In previous rules, CMS has proposed eliminating the severity measure entirely which would make it extremely difficult to obtain patient housing information, but that position has changed. In the calendar year 2027 proposed rule, CMS proposes to lower the severity level of the Social Determinant of Health (SDOH) quality measure from complication or comorbidity (CC) to nonCC. ANA is pleased that CMS has changed its position and plans on keeping SDOH quality measure for calendar year 2027, but **ANA opposes CMS' proposal to lower the severity level of the measure and urges CMS to maintain the measure as CC.** Nurses spend more time with their patients than any other practitioner, and their knowledge of a patient's background can be instrumental in determining the best course of treatment. Lowering the severity level of the measure would be a disincentive in the program and would discourage nurses, and other practitioners, from conducting screenings and obtaining this vital information which can result in incorrect diagnoses.

b. CMS must maintain the current severity level of the malnutrition quality measure.

Similar to SDoH measures, CMS proposes lowering the severity level of the malnutrition quality measure from CC to non-CC, but unlike the SDOH measure CMS has never proposed eliminating it. **ANA opposes CMS' proposal to lower the severity level of the measure and urges CMS to maintain the measure as CC.**

A person's nutrition status can be a key part of their diagnosis; lowering the severity level of the quality measure may disincentivize its use as it may lower the reimbursement and therefore the practitioner might not have the time to ask about diet. Knowing a person's diet can help a practitioner diagnose their patient and, at the least, remove possible diagnoses and tests from the equation as malnutrition is related to many medical conditions including vitamin deficiencies, scurvy, and osteoporosis. Additionally, malnutrition does not affect the American population equally and knowing where malnutrition is more prevalent can help providers provide resources where they are needed.

4) CMS should include the sepsis measure to the Hospital Readmission Reduction Program.

CMS proposes adding a sepsis measure to the hospital readmission reduction program. This measure would weigh certain factors to determine if their patient is at risk of sepsis prior to discharging the patient from the hospital. Adding this measure will require facilities take accountability for their patients and not discharge them from hospitals before they are ready. **ANA supports the addition of a sepsis measure to the program and urges CMS to finalize its proposal**. Finalizing this proposal would require more care coordination in the facility and ANA supports this additional coordination.

Care coordination is an important element of discharge. Nurses are very active in care coordination and responsible for carrying out discharge; they need to be consulted before patients are discharged. If nurses were active members of the discharge team, hospital readmissions could be reduced, especially since nurses are the healthcare practitioners who spend the most time with

patients. Additionally, nursing remains the most trusted profession,[15] and therefore patients share information with nurses that they might not share with other practitioners. Care coordination is a key element of the hospital readmission reduction program and nurses have information vital to these reductions.

5) CMS must finalize the Advanced Care Planning Electronic Critical Quality Measure.

CMS is proposing a quality measure for advanced care planning which will measure the percentage of Medicare patients who have advanced care plans. These care plans will then be documented in electronic patient records. Effective advanced care planning is a longitudinal process that focuses on preparing patients and their surrogate decision makers for healthcare decision making across the illness, treatment, and recovery trajectory, rather than a one-time event or decision at admission or at end-of-life.[16] The measure is intended to promote discussions between patients and providers about advanced care plans. Even though additional professionals engage in advanced care planning conversations, nurses spend more time with patients and often find themselves in the ideal position to lead these conversations.[17,18]

Nurses already play a key role in advanced care planning, whether it be contacting the appropriate specialist, documenting updated advanced directives, connecting patients to relevant at-home health supports for after discharge, ensuring patients are informed of their rights, guaranteeing that patients' decisions are respected, or even engaging in frequent conversations with patients and families.[19,20] Any sort of advanced care planning quality measures should measure or track these conversations, steps, and actions carried out by nurses to ensure that the work of the nurses is seen. Facilities frequently see RNs as a cost as they are not reimbursed directly and therefore facilities try to keep as few nurses on shift as possible. **ANA strongly supports quality measures for advanced care planning, as nurse-led advanced care planning is both a crucial and an incredibly involved portion of patient care, and urges CMS to finalize inclusion of the advanced care planning.**

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[15] 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/

[16] McMahan, R. D., Hickman, S. E., & Sudore, R. L. (2024). *What clinicians and researchers should know about the evolving field of advance care planning: A narrative review*. Journal of General Internal Medicine, 39(4), 652–660. https://doi.org/10.1007/s11606-023-08579-5

[17] Ke, L.-S., Huang, X., O'Connor, M., & Lee, S. (2015). Nurses' views regarding implementing advance care planning for older people: A systematic review and synthesis of qualitative studies. *Journal of Clinical Nursing, 24*(15–16), 2057–2073. https://pubmed.ncbi.nlm.nih.gov/25940451/

[18] Resendes, J. (2024, March 1). *The nurse's role in advance care planning*. American Nurse Journal. https://www.myamericannurse.com/the-nurses-role-in-advance-care-planning/

[19] Ke, L.-S., Huang, X., O'Connor, M., & Lee, S. (2015). Nurses' views regarding implementing advance care planning for older people: A systematic review and synthesis of qualitative studies. *Journal of Clinical Nursing, 24*(15–16), 2057–2073. https://pubmed.ncbi.nlm.nih.gov/25940451/

[20] Resendes, J. (2024, March 1). *The nurse's role in advance care planning*. **American Nurse Journal**. https://www.myamericannurse.com/the-nurses-role-in-advance-care-planning/

6) CMS must consider midwifery in any birthing-friendly hospital designation.

The above captioned proposed rule seeks feedback on a RFI on birthing-friendly designations in hospitals. ANA supports efforts to create a designation that allows patients to make informed choices when choosing practitioners and facilities as they prepare their birthing care plans. However, CMS must include patient access to CNMs and certified midwives (CMs) **as part of considerations and criterion to confer this designation for hospitals.** Besides labor and delivery, midwives provide primary care for the first month of a baby's life, prescribe medications, admit, manage, and discharge patients, and order and interpret laboratory and diagnostic tests.[21]

ANA believes that there are a few essential items for CMS to consider when hospitals are applying for this designation. Hospitals designated as birthing-friendly must employ and contract with advanced practice certified nurse-midwives or certified midwives. As of 2022, midwives assisted in about 11% of births[22] and that rate has likely risen in the last few years—especially in rural and underserved areas. Moreover, birthing-friendly designation must reflect that advanced practice certified nurse-midwives and certified midwives are able to practice to the full extent of their education, clinical training, and national certification and allow these practitioners to be included in the same voting medical staff categories as physicians, rather than being relegated to "Allied Health" or "Associate" categories. Hospitals designated as birthing-friendly must safeguard patient access to midwifery-led care models; integrate certified nurse-midwives and certified midwives into inpatient labor and delivery teams and maternal safety initiatives; and include them in hospital quality improvement and perinatal collaborative efforts.

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

Sincerely,

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Chief Nursing Officer

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

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[21] American College of Nurse Midwives (n.d.). *DEFINITION OF MIDWIFERY AND SCOPE OF PRACTICE OF CERTIFIED NURSE-MIDWIVES AND CERTIFIED MIDWIVES*. Retrieved May 21, 2026, from https://midwife.org/wp-content/uploads/2024/09/Definition-Midwifery-Scope-of-Practice_2021.pdf
[22] American College of Nurse Midwives (n.d.). *Essential Facts About Midwives*. Retrieved May 20, 2026, from https://midwife.org/wp-content/uploads/2024/10/Essential-Facts-about-Midwives.pdf