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Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically to www.regulations.gov

RE: Medicare and Medicaid Programs: CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

The American Nurses Association (ANA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2027 Physician Fee Schedule (PFS) proposed rule. ANA looks forward to working with CMS on its proposals to ensure 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:

- **finalize RUC recommendations for new and potentially misvalued codes and encourage refinements to the CPT and RUC processes to better reflect how care is delivered;**
- **continue thoughtful implementation and reimbursement of artificial intelligence (AI), integration of telehealth into Medicare, and optimization of interoperability;**
- **ensure APRNs are recognized and appropriately reimbursed in all areas of patient care;**
- **support practitioners and adopt thoughtful reforms to shared savings programs and care models;**
- **integrate nursing expertise in the Quality Payment Program, further implement refinements to quality measure reporting, and streamline the transition of digital quality reporting; and**
- **give thoughtful consideration of the association's feedback on program improvements.**

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 finalize proposals for new or potentially misvalued codes.**

ANA appreciates the opportunity to comment on CMS's proposals regarding new and potentially misvalued codes under the Medicare PFS. Accurate valuation of services is essential to ensuring that Medicare payment rates appropriately reflect the resources, time, clinical complexity, and expertise required to provide high-quality care. CMS must incorporate the perspectives and expertise of nurses and other non-physician practitioners into the valuation process to help ensure that payment policies accurately reflect the services they provide and the resources required to deliver them.

A. *Maternity Care Services (CPT codes 59320, 59325, 59412, 59871, 59XX1, 59XX2, 59XX3, 59XX4, 59030, 59051, 59XX5, 59XX6, 59414, 59300, 59XX7, 59XX8, 59XX9, 59X10, 59X11, 59X12, and 59160)*

At the January 2026 AMA RUC meeting, the maternity global codes were revised to delete 17 legacy CPT codes, create 12 new CPT codes, and revise 9 CPT codes used to describe maternity care services. CMS proposes the RUC-recommended values for the new and revised maternity care family of codes without modification to time or work RVUs. **ANA supports the RUC recommendations and urges CMS to accept them as they finalize the above-captioned rule.** CMS also issues several queries for comment, including whether they should establish a family of G-codes to maintain the prior maternity care coding structure and valuation. This query is based on CMS' concerns that adoption of the new codes would be disruptive based on how the longstanding existing code structure is currently accounted for in clinical practice patterns.

ANA appreciates CMS' thoughtful approach to this transition and supports the creation of the G-codes for CY 2027. This approach will help ease the transition from the current code set to the new CPT codes, as any confusion in reimbursement affects all practitioners. New coding structures take time to be understood, and the new maternity codes are no different. The proposed G-codes will allow time for practices to understand how the new codes should be used before they are required to be fully implemented.

[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/

B. Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211)

CMS began reimbursing G2211 as an add on code for E/M services in the CY 2026 PFS, but now CMS is looking to change how this code is reimbursed. In the CY 2027 PFS proposed rule, CMS proposes changing how this code is billed from an add-on code to a modifier. ANA is concerned about the possible unintended consequences of changing the reimbursement model for G2211. This change would undo most of the work that practitioners have done to define the value of this code in the past year. In the CY 2026 PFS final rule, CMS finalized a proposal that expanded the definition of the setting where a practitioner could be reimbursed for G2211 and the updated regulations permitted telehealth encounters.[2] ANA is concerned about how a modifier would affect this change and asks CMS to study the issue before finalizing any proposals.

If G2211 transitions from a billable service to a modifier, many providers may lose RVU credit for complex longitudinal care management despite continuing to perform the same work. While healthcare systems may still receive reimbursement, providers compensated under RVU-based models could see reduced productivity credit and potentially lower incentive compensation. This risks undervaluing the comprehensive care that primary care clinicians provide. CMS proposes to reimburse providers at 16% of the base E/M code for the modifier, but that does not solve the RVU-based model problem. Modifiers do not contain their own RVUs and as a result, practitioners who are reimbursed under an RVU based model will not benefit from the modifier even though the facility that is employing them will receive higher reimbursement. **ANA urges CMS to utilize code G2211 as it is currently reimbursed and not finalize its proposal to change the code from an add-on code to a modifier to ensure that practitioners are reimbursed appropriately for covered services.**

C. Ultrasonic Wound Assessment (CPT code 97610)

CMS notes that they received a request from a public nominator to review this CPT code, which is the billing code for low-frequency, noncontact, nonthermal ultrasound wound therapy. The requestor feels this code as potentially misvalued due to an inflated supply costs direct practice expense (PE) input. The nominator stated that this inflation causes a site of service disparity where CMS pays significantly more for the non-facility practice expense (PE) compared to the hospital outpatient (OPPS) payment rate. The CY 2026 non-facility PE RVU of 11.51 for CPT code 97610 results in a payment of $384, compared to an OPPS payment rate of $205, representing a payment differential of $179.

The nominator stated that this disparity is primarily driven by the $320 direct PE input, SA119 (kit, low frequency ultrasound wound therapy (MIST)). The nominator provided a hyperlink to the UltraMIST® system manufacturer's Investor Presentation from December 2025 which states that "consumable costs = ~$100/procedure (list price)." On slide 13 of the presentation, it states that the single use applicators are $100 and that the pricing reflects manufacturer's suggested retail price (MSRP). The nominator also estimated an implied sales price of $86 per disposable kit on average using publicly available manufacturer disclosures and Medicare claims data. The

[2] Centers for Medicare & Medicaid Services. (2025, November 5). *Medicare program; Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program*. *Federal Register, 90*(212), 49462–49464. https://www.federalregister.gov/

nominator stated that the manufacturer reported $21.0 million in U.S. consumable and parts net revenue for CY 2024. The nominator was able to estimate the total volume of kits sold by the manufacturer by assuming each of the 745 unique billing NPIs in Medicare claims have approximately one of the ~1,000 UltraMist® systems in the field, such that the 181,851 Medicare claim lines account for 74.5 percent of total volume ($21.0 million / [181,851/{745/1,000}] = $86), noting that actual sales price would vary due to volume-based or other supplier discounts, commercial utilization, and other factors.

CMS agrees with the nominator and is proposing CPT code 97610 as potentially misvalued. Additionally, they are proposing to change the cost of supply code SA119 to $100 in the direct PE database. CMS seeks comment on this proposal and invites interested parties to submit paid invoices for supply code SA119 (kit, low frequency ultrasound wound therapy (MIST)). CMS notes that physician time may be currently overstated for CPT code 97610, as the December 2025 Investor Presentation asserts that the procedure takes about 3 to 20 minutes, with an average of 6 minutes. The current total physician time is nearly 26 minutes, with a work RVU of 0.39. Because the current intraservice time is over double the time asserted by the supply manufacturer in the Investor Presentation, CMS seeks comment on whether the typical physician time to perform this service is closer to the manufacturer's assertion of 6 minutes or the current intraservice time of nearly 15 minutes.

ANA thanks CMS for this additional information and context related to this CPT code. It is our understanding that based on the proposed rule language that this code will appear on a future RUC level of interest form, at which time ANA will be prepared to indicate interest and participate in future valuation discussions.

D. Injection Anesthetic Agent (CPT Codes 64400, 64405)

The codes related to injection anesthetic agent, specific somatic peripheral nerve blocks, were flagged by the Relativity Assessment Workgroup as codes designated "Do not use to validate physician work." These codes were then resurveyed for the September 2025 RUC meeting by ANA and other specialties. In the above-captioned rule, CMS proposes the RUC-recommended values for the resurveyed injection anesthetic agent family of codes without modification to time or work RVUs. **ANA supports CMS' recommended work and practice expense values for this family of codes and requests that the agency finalize its proposal.**

E. Vaccine Adverse Effects Management (HCPCS Code GADV1)

CMS is proposing an add-on code for vaccine adverse effects management to better track, reimburse, and expand access to care for patients experiencing significant reactions following vaccinations. While ANA does not dispute that there are small segments of the population who have adverse reactions to vaccinations, the association is concerned that creating a new add-on code for adverse effects management may incentivize some providers to link unrelated symptoms to vaccine administration. ANA is also concerned that the vaccine adverse effects reporting system (VAERS) may be misused under this proposed add-on code. This system relies on practitioners to honestly report when there are adverse effects to vaccinations, and a new add-on code may result in clinical staff reporting adverse effects when there is no discernible link between symptoms and vaccines.

CMS proposes to minimize concerns about misattribution by requiring a practitioner to perform a medically appropriate assessment to rule out alternative causes. However, that may not be enough to safeguard some practitioners from attributing a condition to vaccination if they are predisposed to view vaccines as the sole cause of adverse outcomes.[3] It is imperative that CMS review and study the associated data from this add-on code to ensure proper use.

These concerns, however, do not outweigh the potential benefit of an add-on code for patients who are experiencing legitimate, vaccine-associated adverse effects. **As such, ANA supports the creation of an add-on code for vaccine adverse effects management, provided that CMS finalize this creation coupled with stringent safeguards and ongoing oversight to ensure appropriate use of the code.**

ANA is also concerned that the vaccine adverse effects reporting system (VAERS) may be misused under this proposed add-on code. This system relies on practitioners to honestly report when there are adverse effects to vaccinations, and a new add-on code may result in clinical staff reporting adverse effects when there is no discernible link between symptoms and vaccines.

F. Health Coaching (CPT codes 0591T, 0592T, and 0593T)

Health coaching helps advance the Administration's goal to Make America Healthy Again (MAHA) initiative, as it can support patients with chronic health conditions to make lifestyle changes. In the CY 2027 PFS, CMS proposes to reimburse providers for the three category III health coaching CPT codes, adopting the CPT prefatory language for these codes.

Furthermore, CMS proposes to require that healthcare personnel be certified to perform these services. In the past, ANA has opposed many health coaching proposals as they have not included a certification requirement, and ANA was concerned about the lack of standards over who could be reimbursed for health coaching services. Requiring certification assuages these concerns, and ANA appreciates CMS for refining the certification standards in the above-captioned rule. ANA also appreciates CMS's recognition that RNs are well-positioned to provide these services, as health coaching is a natural extension of nursing practice, which includes patient education, behavior-change support, and care coordination. Additional certification provides a valuable opportunity for nurses to further develop and formally demonstrate these skills. Notably, one of the certifications recognized by CMS is offered by the American Holistic Nurses Association, an organizational affiliate of ANA, which employs rigorous certification standards. **ANA supports reimbursement for certified professionals providing health coaching, lauds CMS for specifically including RNs as certified professionals, and urges the agency to finalize its proposal as written.**

G. Remote Monitoring (CPT Codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470)

CMS began payment of CPT codes for remote physiologic monitoring (RPM) in 2019. Codes for remote therapy monitoring (RTM) followed, as well as expansion of coding for RPM. CMS has required that RPM services be furnished only to established patients since 2021. For CY 2027, CMS proposes that RTM services also be furnished only to established patients. Clinicians reporting RPM

[3] Physician Fee Schedule Proposed Rule, 91 Fed. Reg. 43905 (July 16, 2026).

or RTM services must furnish a separately reportable initiating visit in association with the onset of RPM or RTM services. For 2027, CMS is proposing to only allow payment for RPM or RTM services when performed by clinical staff employed by the practice and not when those services are delivered by contractors.

CMS cites that they believe that a lack of data regarding the typical device used in the provision of RPM and RTM services has led to possible overpayment. Therefore, CMS proposes to decrease the PE RVUs for several of these services using crosswalks to other services and by eliminating all direct practice costs for the treatment management codes. These changes will result in significant payment reductions in RPM and RTM services in 2027. CMS also proposes bundling the RPM and RTM CPT codes and creating four new HCPCS G-Codes in 2027 to describe remote monitoring services, which would lead to immediate implementation of significant cuts to the monthly supply codes.

As CMS is making this proposal due to a lack of current data on the typical devices and other resources being used in the provision of RPM and RTM services, **ANA believes it would be far better to collect the needed data than to arbitrarily reduce payments for the services without any data to serve as a foundation for revised RVUs. As such, ANA recommends that CMS refrain from implementing any changes the RPM and RTM direct practice expenses or creating G-codes until specialty societies and the RUC have the opportunity to review these services in January 2027.**

H. Smoking and Tobacco Use Cessation (CPT codes 99406, 99407)

ANA has long supported efforts to encourage tobacco use cessation and NPs are among the top users of these codes. However, a combination of the limited reimbursement available under these codes and the 15% reduction in reimbursement received by NPs often limit their use. For CY 2027, CMS proposes a 19.1% payment increase in the work RVUs for time-based tobacco use cessation psychotherapy codes to be implemented in a four-year transition period. This increase aligns with the Administration's goals to Make America Healthy Again and reduce chronic disease, as the health impacts caused tobacco usage is one of the largest preventable public health challenges today.[4] CMS is right to increase the payment rate for these services, providing an incentive for NPs and other practitioners to provide targeted care to help that aim. **ANA strongly supports this payment adjustment and urges CMS to finalize its proposed payment increase for tobacco use cessation care.**

2. CMS must identify and pursue approaches to refine the RUC and CPT process.

ANA proudly represents the nation's nurses as it is the only nursing specialty to have advisors at the CPT Editorial Panel meetings and at RUC meetings. At the same time, ANA recognizes that the current CPT and RUC processes can be improved. Physicians make up an overwhelming majority on the CPT panel and as non-physician providers make up a growing, and much larger, percentage of the health workforce, ANA believes that non-physician providers should have more

[4] U.S. Department of Health and Human Services. (2024). *Eliminating tobacco-related disease and death: Addressing disparities: A report of the Surgeon General: Executive summary*. U.S. Department of Health and Human Services. Retrieved August 17, 2026, from https://www.hhs.gov/sites/default/files/2024-sgr-tobacco-related-health-disparities-exec-summary.pdf

representation on both the CPT Editorial Panel and at the RUC. However, ANA is hesitant to support a complete overhaul of the CPT system, as it is ingrained into the American healthcare system—removing it would create havoc among all payors, public and private. All payors currently use the CPT system, and there is currently no alternative reimbursement system that can seamlessly replace CPT.

CMS discusses the history and evolution of the American Medical Association's CPT and RUC processes to develop and subsequently value CPT codes. CMS notes that there have been longstanding concerns expressed over federal reliance on a private organization with an obvious conflict of interest as providing information on the time and resource requirements to conduct physician services when this information may influence their own payment. For nearly 20 years, MedPAC has expressed concern over the influence of the AMA RUC to value services, specifically noting that CMS has "*over-relied on specialty societies with a financial stake in the process*" and has recommended that CMS establish a separate group of experts to make payment recommendations.[5] Further, MedPAC questions whether the historic reliance on the CPT and RUC process has been a potential contributor to the development of US health care as a 'sick care' system with limited emphasis on prevention and lifestyle modifications, which may inhibit progress on the Administration's priority to Make America Healthy Again.

ANA holds that the current system can be better structured to more accurately capture the way healthcare is delivered across the country. **ANA strongly believes that non-physician providers should have more representation on both the CPT Editorial Panel and at the RUC.** CMS should encourage AMA to strengthen the clinical diversity of the CPT and RUC processes to ensure coding and payment recommendations appropriately account for the full range of providers delivering care to patients and the evolving realities of our nation's healthcare delivery system.

Another area for improvement in the CPT and RUC processes is in the creation of new codes for groundbreaking devices and procedures. While reimbursement is available temporarily under 99 codes, these codes are not permanent and often include fraudulent claims, which can make payors, including Medicare, hesitant to reimburse practitioners using these codes without significant burdensome documentation. Additionally, new codes require a number of studies showing that use is widespread, but it is very difficult to show use if there is no reimbursement for these devices. Shortening the time frame from when the Food and Drug Administration (FDA) approves items and when CPT provides codes for them could foster innovation since designers have a general understanding of how long it might take for their products to come to market. ANA also supports the use of HCPCS codes created by CMS, which fill holes for services that either do not have a CPT code or the code does not allow for proper reimbursement. CMS' use of HCPCS codes bridge gaps while codes undergo the lengthy CPT and RUC processes. These approaches are critical to reimbursing practitioners adoption of emerging technologies and clinical practices.

3. **CMS must continue thoughtful implementation and application of Artificial Intelligence.**

[5] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2006, Chapter 3, Recommendation 3-1, "Reviewing the work relative values of physician fee schedule services.

Innovation plays a key role in healthcare, and artificial intelligence (AI) is a driving force shaping how care is delivered today. As the Administration looks to integrate AI use in healthcare, ANA supports approaches that advance safe, ethical, transparent, and equitable AI adoption while ensuring that the clinical expertise of human practitioners remains central to all determinations about diagnosis, treatment, and care. This approach aligns with ANA priorities to guide responsible AI use in nursing practice and ensure technology strengthens, rather than replaces clinical judgment.

A. Software as a Medical Service

CMS is seeking comment on changes that make use of software easier to understand. CMS proposes changing the name of "software as a service" to "software as a medical service" (SaMS). **ANA supports this change, as "software as a service" is very vague and is not indicative that the service is medical in nature.** Changing the name to "software as a medical service" clears up this ambiguity and removes general cloud-based computing services from any possible definition.[6] Although ANA strongly supports the use of AI in a medical context, we firmly believe that AI analysis must be reviewed by a licensed medical practitioner. AI algorithms aid practitioners in reviewing large amounts of data in a short period of time, but AI does not always understand nuances and other considerations that could lead to costly errors without human intervention. As such, **ANA strongly believes that the last step in any use of SaMS must be final review by a human practitioner to ensure the validity of SaMS tools.**

B. AI-assisted Laboratory Tests

CMS proposes contractor pricing for a number of AI-assisted laboratory tests that do not fall under the clinical laboratory fee schedule (CLFS). Like many other industries, CMS is trying to understand how artificial intelligence (AI) is used in healthcare delivery and the best method of reimbursement. Using contractor pricing for laboratory tests that are not covered by the CLFS allows the agency to provide reimbursement while gathering claims data to inform how these services are utilized and to inform future payment adjustments. **CMS is right to take this approach, and ANA supports contractor pricing for these AI-assisted laboratory tests as a temporary placeholder while CMS reviews and analyzes claims data to determine future approaches to reimbursement that foster innovation.**

C. Technology Use in Primary Care

CMS seeks comment on how technology is used in primary care and how AI is affecting primary and preventative care. **ANA does not believe changing reimbursement for E/M encounters where AI software or services are used to analyze tests is warranted**. While AI driven analysis does save the practitioner some time, the overwhelming majority of the work associated with the any diagnostic testing must still be carried out by a human practitioner. Practitioners must continue to exercise clinical judgment in reviewing AI-generated outputs to ensure that results are accurate, valid, and clinically appropriate. Although the AI-generated results may offer some time efficiency, the medical decision-making elements do not change, and therefore the reimbursement offered for the encounter also should not change.

[6] That is an accepted definition for software as a service.

As part of examining how AI and technology affect care delivery, CMS is also considering an approach that would base reimbursement on clinical outcomes. ANA has long supported value-based care models, and this approach appears to mirror elements of those models. CMS does not detail how this would be accomplished, but **ANA encourages CMS to include nurses and other practitioners in the development of any new models that would base reimbursement on clinical outcomes.**

4. CMS must continue integrating telehealth across the Medicare program.

ANA has long been a proponent of expanding telehealth services, and the COVID-19 public health emergency (PHE) provided the impetus for Medicare to greatly expand coverage of services provided remotely. Telehealth increasingly is an essential part of care for many Americans, especially those with limited mobility or those in rural areas. Many rural areas have few—if any—practitioners within a reasonable driving distance, and allowing practitioners to treat patients anywhere in their state has greatly improved care for those rural patients. Despite the end of the PHE, telehealth has remained commonplace, with NPs among its most extensive users.[7, 8] Accordingly, **ANA strongly urges CMS to finalize the COVID-19 telehealth flexibility extensions but further encourages telehealth flexibility permanency. ANA implores CMS to use their authority where possible to either extend or make the COVID-19 PHE telehealth flexibilities permanent. CMS also must work with Congress on permanency for provisions that are beyond its rulemaking authority.**

A. CMS Must Maintain Payment for Telehealth Services.

CMS proposes to maintain their policies from CY 2026, which generally increased flexibility for providers to render services via telehealth. CMS further notes that Section 6209(a) and (b) of the Consolidated Appropriations Act, 2026 (CAA, 2026) (Pub. L. 119-75, February 3, 2026) expands access to telehealth in Medicare in the following methods: extending the flexibilities for Medicare telehealth services to remove the geographic restrictions; growing the list of acceptable originating sites; and expanding the array of practitioners eligible to furnish telehealth services from January 30, 2026 to the extended date of December 31, 2027. Section 6209(d) of the CAA, 2026 delays the in-person visit requirements for mental health services furnished through telehealth from January 30, 2026 to the extended date of January 1, 2028. Section 6209(e) of the CAA, 2026 extends the flexibilities to allow audio-only Medicare telehealth services from January 30, 2026 to the extended date of January 1, 2028. Additionally, section 6209(g) of the CAA, 2026, requires CMS to establish modifiers for telehealth services in certain instances, effective January 1, 2027. CMS states that they anticipate these provisions will result in continued utilization of services furnished as

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

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

Medicare telehealth services during CY 2027 at levels comparable to observed utilization of these services during CY 2026.

ANA continues to support policies which increase the flexibility of telehealth which increases access to medically necessary services across the United States. We urge CMS to continue to refine their policies in this space such that Medicare beneficiaries receive vital healthcare services, particularly in rural and underserved areas.

B. CMS Must Finalize its Conforming Regulatory Text Amendment to Reflect the Statutory Extension of Telehealth Flexibilities for Mental Health Visits in Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

In February 2026, Congress extended Medicare telehealth flexibilities, including the suspension of an in-person requirement for telehealth services, through December 31, 2027.[9] Consequently, CMS proposes a conforming regulatory amendment to CMS' telehealth regulations under §§ 405.2463(b)(3) and 405.2469(d) to reflect the statutory extension of Medicare telehealth mental health flexibilities. These proposed changes would require that in-person visit requirements would not apply to any services furnished through December 31, 2027. **ANA strongly supports this proposal, as telehealth access is pivotal to ensuring mental health access to Americans, particularly those in rural areas or care deserts, and urges CMS to finalize these provisions as proposed.**

5. CMS must ensure that APRNs are accounted for and included in all elements of care delivery.

CMS includes a number of proposals in the CY 2027 PFS that impact how the healthcare services provided by APRNs and the patients they serve are accounted for that impact reimbursement and other critical programmatic elements. APRNs increasingly are relied on for primary and specialty care services critical for Medicare beneficiaries, and CMS must engage in policymaking that reflects their vital role.

A. Accounting for Care Delivered by NPs in the Medicare Shared Savings Program (MSSP).

CMS solicits information on how it can account for care delivered by NPs in assignment methodologies and on the role of NP-led care in supporting beneficiary attribution under the MSSP. ANA applauds CMS' efforts to make sure that the high-quality care delivered by NPs is better accounted for in beneficiary attribution. Even though CMS continues to increasingly recognize that primary care is delivered by interdisciplinary teams and that NPs often serve as beneficiaries' main source of primary care, many APRNs still struggle with accurate attribution. **As CMS considers future reforms to beneficiary assignment, ANA holds that assignment methodologies should more consistently attribute beneficiaries based on whichever clinician provides the plurality of primary care services, regardless of their provider type.**

[9] Consolidated Appropriations Act, 2026, Pub. L. No. 119-75, § 6209, *Extension of Certain Telehealth Flexibilities*, 140 Stat. 476 (2026). https://www.congress.gov/119/plaws/publ75/PLAW-119publ75.pdf

In order to better determine when an NP is the main provider delivering the plurality of care, CMS must work with Congress to eliminate "incident to" billing, as it obscures the amount of care provided. "Incident to" billing occurs when an APRN bills payors under a physician or provider National Provider Identifier and is then reimbursed at 100 percent of the Medicare rate, rather than the statutorily required 85 percent. The current "incident to" billing system reflects an earlier era, before APRNs received the advanced training and clinical experience they have today, and the system places the physician at the forefront of the medical team. The physician is no longer always the center of the medical team, as care coordination and other interdisciplinary care models are becoming increasingly commonplace, and APRNs are often leading these efforts within their scope of practice.

In fact, the MedPAC recommended eliminating "incident to" billing, as Medicare beneficiaries have become increasingly reliant on APRNs, and they determined that eliminating "incident to" billing would not change the quality of care or how it is delivered.[10] Michigan and North Carolina health plans have taken steps to eliminate "incident to" billing in their states.[11] Furthermore, "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, additionally help CMS' reach its goal[12] of eliminating waste, fraud, and abuse in the Medicare program and will further clarify the amount of primary care services being furnished by NPs. **As such, CMS must work with Congress to remove "incident to" billing from the Code of Federal Regulations[13] to create an equal playing field among all practitioners and allow CMS to better attribute beneficiaries based on NP-led care.**

Additionally, CMS must also acknowledge and properly account for both specialty care and primary care administered by APRNs, as some APRNs can serve as both primary care and specialist providers. For example, CNMs not only provide specialty obstetrics care, they also provide a level of primary care services to expectant or postpartum mothers and to infants. **Therefore, CMS must also account for the ability of certain APRNs to provide both specialty and primary care services when attributing beneficiaries to ACOs.**

B. CMS Must Include APRNs in its Ambulatory Specialty Models.

In the above captioned rule, CMS further builds upon the proposal in CY 2026 PFS to create two new Ambulatory Specialty Models (ASMs)—one for heart failure and one for lower back pain. While certain physicians will participate in these ASMs under mandatory participation rules, APRNs

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[10] Medicare Payment Advisory Commission. (2019, February 19). *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/

[11] BCBS Michigan (2026, June 1). *Changes are coming to incident-to billing policy for Blue Cross, BCN commercial*. Blue Cross Blue Shield Blue Care Network. Retrieved August 17, 2026, from https://www.bcbsm.com/content/dam/microsites/corpcomm/provider/the_record/2026/jun/Record_0626a.html. *See also* BCBS North Carolina (2026, May 15). *Reimbursement policy update: Bundling guidelines of "Incident To" services*. Retrieved August 17, 2026, from https://www.bcbsnc.com/providers/provider-news/2026/reimbursement-policy-update-bundling-guidelines-incident-to-services.

[12] Centers for Medicare & Medicaid Services. (n.d.). *Fraud*. U.S. Department of Health & Human Services. Retrieved August 5, 2026, from https://www.cms.gov/fraud

[13] 42 CFR §410.26

continue to be excluded from participation. Yet, despite their exclusion, CRNAs provide chronic pain management services, including those for lower back pain, such as interventional procedures.

CMS previously noted that the exclusion of APRNs is due to existing regulatory language. However, the agency created new regulatory language to implement this model. Therefore, CMS likely has the authority to amend its own regulatory language to include APRNs, even though it does not plan on changing membership at this moment. By continuing to exclude a whole class of providers from participating in these ASMs, CMS continues to put APRNs at a disadvantage, hurting reimbursement for APRNs from a conversion factor perspective. Last year, ANA advocated for APRN inclusion in this model,[14] and even though CMS says in the proposed rule that it does not plan to change model membership, **ANA continues to urge CMS to expand this program so that APRNs who specialize in any of the required fields of medicine can participate.**

6. **CMS should finalize its proposal to increase rural access to diabetes self-management training and medical nutrition therapy services.**

CMS proposes to amend § 405.2463(a) and (b)(2) to recognize Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services as qualified preventive services to be eligible for coverage and paid the all-inclusive rate as stand-alone reimbursable visits under the rural health clinic (RHC) benefit. In order to qualify as a reimbursable RHC visit, under this proposal, DSMT or MNT services must be furnished by a certified provider under the direct supervision of RHC professional staff, which rightly includes nurses. ANA agrees with CMS that, when appropriate, aligning payment policies in RHCs with those in other settings, such as physician offices or federally qualified health centers (FQHCs), will help expand access to care for Medicare beneficiaries in rural areas. It is imperative that rural Medicare beneficiaries have access to high-quality diabetes treatment, and the visit payment methodology for DSMT and MNT in RHCs should align with those in non-rural, other settings. **Therefore, ANA believes that CMS should finalize its proposal to recognize DMT and MNT as qualified preventative services and stand-alone reimbursable visits under the RHC benefit.**

7. **Medicare must continue thoughtful reforms of Accountable Care Organizations and the Medicare Shared Savings Program.**

The MSSP allows groups of providers to create collaborative Accountable Care Organizations (ACOs) to deliver high-quality care to Medicare patients and enable healthcare savings for Medicare. By coordinating care to create these savings, ACOs who meet certain criteria may be eligible to partake in and share a portion of these savings. In the CY 2027 PFS, CMS proposes many reforms to the MSSP and the ACOs who participate in the program, including changes to beneficiary assignment, growth adjustments, reporting requirements, and cost sharing components.

[14] American Nurses Association. (2025, September 3). *RE: Medicare and Medicaid programs; calendar year (CY) 2026 payment policies under the physician fee schedule and other changes to Part B payment and coverage policies; Medicare Shared Savings Program requirements; and Medicare Prescription Drug Inflation Rebate Program* [Comment letter]. https://www.nursingworld.org/globalassets/docs/ana/comment-letters/anapol_fy26-pfs-2025.08.25.pdf

A. *CMS should amend the proposed addition of primary care services to the definition of "primary care services" as used in shared savings program beneficiary assignment.*

CMS proposes to revise the definition of "primary care services" used for beneficiary assignment purposes under the MSSP to include six new HCPCS codes, spanning substance abuse screening, vaccine adverse effects management, and advance care planning. **While ANA supports the addition G2011, G0396, GADV1, GACP1, and GACP2, we oppose the addition of G0397**.

a. *Screening Brief Intervention, and Referral to Treatment (SBIRT): G2011, G0396, and G0397.*

HCPCS codes G2011, G0396, and G0397 all encompass structured misuse assessments for alcohol and/or substances other than tobacco—such as the Alcohol Use Disorders Identification Test (AUDIT) or the Drug Abuse Screening Test (DAST)—alongside referral to treatment and brief intervention lasting 5-14 minutes, 15-30 minutes, or over 30 minutes, respectively. ANA fully supports adding SBIRT measures to the definition of primary care, as substance use treatment and evaluation is increasingly expanding into primary care practice. However, we believe that G0397 does not typically fall under the typical scope of primary care visits, as substance misuse screening services do not typically extend beyond 30 minutes in a traditional primary care visit.

Most primary care settings focus on brief screening and intervention using validated tools—such as AUDIT or DAST—followed by referral to psychiatry, behavioral health, addiction medicine, or other specialized services when additional treatment is needed. The need for referral is often because time constraints within primary care visits often limit the provider's ability to provide prolonged substance abuse counseling. Thus, with the exception of the occasional primary care practices that directly manage medication-assisted treatment programs—such as buprenorphine/Suboxone—counseling sessions greater than 30 minutes will usually qualify as specialty care. **Therefore, while ANA strongly supports the addition of G2011 and G0396 to the definition of primary care, we believe that G0397 currently remains more closely aligned with specialty care and should not currently be added to the definition of primary care. Since MSSP assignment is intended to identify the provider most responsible for a beneficiary's longitudinal primary care, inclusion of G0397 could result in beneficiaries being attributed to an ACO because of a specialist visit rather than a primary care provider (PCP) visit.**

b. *Vaccine Adverse Effects Management (GADV1)*

ANA supports the inclusion of GADV1 as part of the definition of "primary care services" for MSSP beneficiary assignment. While PCPs frequently provide counseling related to vaccine concerns and adverse events, it is not routinely reimbursed as a separate service despite the significant time involved. Historically, many practices have not utilized the existing vaccination counseling codes because reimbursement for them has been inadequate or inconsistent. Yet, primary care is the principal setting for most of the care required when rare immunization-related adverse events arise, since the provider must manage symptoms and engage in conversations that address patient concerns, review risks and benefits, discuss appropriate evaluation follow up, and help patients navigate future immunizations decisions. Even though allergy/immunology specialists and certain subspecialists may also provide services regarding the treatment of these adverse events depending on the clinical scenario, primary care would generally remain the first and most

consistent point of contact for most patients. Although ANA is concerned about the proposal of GADV1 as a new HCPCS code, holding similar concerns we outline above, we fully believe that GADV1 falls under the definition of primary care and that **CMS should finalize its proposal to add GADV1 to the definition of primary care under the MSSP.**

c. *Advance Care Planning (GACP1, and GACP2).*

CMS proposes the creation of two new HCPCS codes, GACP1 and GACP2, and adding them to the definition of "primary care services" for MSSP beneficiary assignment. GACP1 and GACP2 would both include advance care planning services such as the explanation and discussion of advanced directives and standard forms. GACP1 would cover the first 20 minutes of clinical staff time with the patient or family member, while GACP2 would cover each additional 20 minutes. Even though advance care planning discussions occur across many specialties, they are particularly common and appropriate in the field of primary care, since these conversations frequently take place during annual physical examinations, annual wellness visits, chronic disease management visits, and transitional care discussions.

Nurses and APRNs play a key role in advance care planning, whether it be contacting the appropriate specialist, documenting updated advanced directives, connecting patients to relevant at-home health supports, ensuring patients are informed of their rights, guaranteeing that patients' decisions are respected, or engaging in frequent conversations with patients and their families.[15,16] Primary care providers spend considerable time helping patients and their families understand the goals of care, advanced directives, end-of-life preferences, and surrogate decision-making. **Thus, ANA urges CMS to proceed with its proposal to create and add GACP1 and GACP2 to the MSSP definition for "primary care services" for the purpose of beneficiary assignment.**

B. CMS should finalize more flexible electronic reporting requirements under the MSSP.

In response to CMS' proposal to sunset the requirement to report all merit-based incentive payment system (MIPS) Promoting Interoperability performance category measures and requirements, CMS proposes changes to the current Certified Electronic Health Record Technology (CEHRT) use requirements with more flexible reporting options tied to electronic Clinical Quality Measures (eCQM) reporting, Fast Healthcare Interoperability Resources-enabled quality measurement, or through interoperability attestations.

More specifically, CMS proposes replacing the MIPS, which we comment on in subsequent sections, measures for ACOs with different options and measures to meet CEHRT use requirements in the future. Under this new proposal ACOs must choose one of the following reporting methods:

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[15] 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://onlinelibrary.wiley.com/doi/10.1111/jocn.12853?msockid=115e86913ec46a3d13bd93ff3f966bd6

[16] 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/

- using CEHRT to report at least 1 of 5 ACO-reported measures in the Alternative Payment Model Performance Pathways Plus (APP plus) quality measure set through eCQM collection type,
- using CEHRT to attest to the ACO's use of FHIR capability to support reporting of at least 1 of the 5 ACO-reported measures in the APP Plus Quality Measure Set, or
- selecting and attesting to one of the proposed MSSP CEHRT use metrics, which may be updated annually and are based on a subset of the MIPS Promoting Interoperability performance category measures.

ANA believes this proposal could reduce administrative burden on providers by simplifying ACO electronic reporting, especially at a time when MIPS faces a likely transition. We support the intention of making electronic reporting more easily adoptable for providers and giving providers more options for how to meet quality reporting requirements. This availability of choice in reporting methods should help providers meet reporting requirements, no matter what kind of technological tools or resources their practice or ACO can access, but this proposal must be implemented in such a way that reporting flexibility will not impact quality reporting data or consistency. Therefore, **ANA supports this proposal to make it easier to comply with electronic record reporting requirements, as long as it will not weaken quality reporting data quality.**

Relatedly, while CMS proposes to stop requiring ACOs to use the MIPS Promoting Interoperability measure set to demonstrate CEHRT requirements, they propose several policies that will complement one another during CMS' quality reporting framework transition. For example, CMS plans to extend MIPS collection requirements for ACOs in the meantime before sunsetting the requirements in 2030 as currently intended. The agency also intends to continue aligning the reporting incentive with the MIPS CQM collection type, and they additionally propose extending the scoring of shared savings program ACO CQM proposals with flat benchmarks. Overall, these proposals may work in concert to reduce administrative burden, help ensure continuity during transition, and facilitate the adoption of new electronic reporting processes. As such, **CMS should finalize these policies that complement the proposed CEHRT flexibility by providing predictability and operational stability for providers and ACOs while CMS continues to modernize quality measurement and reporting infrastructure**.

C. *CMS should finalize its proposal to allow ACOs to reduce or eliminate Medicare Part B cost sharing.*

CMS proposes allowing ACOs who obtain approval to reduce or eliminate Medicare Part B cost sharing for certain beneficiaries. CMS states that its goal is to improve access, care coordination, and beneficiary engagement in ACO arrangements while advancing value-based care. CMS' rationale for this change is that Part B cost sharing can sometimes discourage beneficiaries from obtaining necessary preventative care, mental health services, or chronic disease management support, because they ultimately reduce utilization and spending. Reducing or eliminating beneficiary cost sharing for evidence-based, high value preventative care or condition management will improve uptake and access of preventative services among beneficiaries. CMS is well aware of the benefits of preventative care in addressing health risks early on to help people have longer,

healthier lives and avoid costly treatments.[17] Further, research has shown that chronic care management services reduce expensive downstream utilization, such as emergency department visits, especially in Medicare patient populations.[18] As such, **CMS should finalize its proposal to allow ACOs to reduce Part B cost sharing, as long as CMS works to guarantee that these changes will not negatively impact reimbursement for APRNs working under the applicable ACOs.**

D. CMS should encourage ACOs to utilize APRNs for specialty referrals.

High-revenue ACOs, when compared to low-revenue ACOs, generally underperform in generating cost savings and are more likely to be hospital based and have a high proportion of high-cost specialists participating.[19] In order to better support the cost-savings performance of high-revenue ACOs, CMS seeks feedback on how to improve specialty care data to better support referrals to specialists based on proven outcomes, low complications, and efficient use of resources. In order to improve efficient, high-quality specialty care referrals, ANA recommends that CMS encourage primary care providers to refer patients to specialist APRNs, when an APRN is the best-suited specialist to treat the patient.

Specialist APRNs provide high-quality, efficient care and have comparable, or often better, outcomes than specialist physicians do. For example, CNMs often have better outcomes, fewer complications, and use resources more efficiently than physicians, while serving as a maternal health specialist. In the Military Health System, where CNMs have full practice authority, low-risk women whose births are attended by CNMs have lower odds of birth complications, induction/augmentation of labor, cesarean births, endometritis, preterm birth, and postpartum hemorrhage than low-risk women attended by physicians.[20]

Additionally, specialized APRNs are often more likely than physicians to practice in rural and underserved areas, helping to address provider shortages and improve access to specialty care. This is particularly evident among psychiatric mental health nurse practitioners (PMHNPs), who deliver a significant amount of mental health services for Medicare beneficiaries in rural communities, and, in states with full practice authority, account for half of all rural mental health prescriber visits.[21] Utilizing PMHNPs referrals for rural psychiatric care in the Medicare program is particularly necessary, as PMHNPs are more likely than psychiatrists to accept Medicare.[22] **As such, ANA recommends that CMS encourage its participating primary care providers to refer**

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[17] Centers for Medicare & Medicaid Services. (2025, June 2). *Preventive care*. Retrieved August 5, 2026, from https://www.cms.gov/priorities/innovation/key-concepts/preventive-care

[18] Avalere Health. (2025, June 18). *Chronic care management in Medicare: Optimizing utilization*. https://advisory.avalerehealth.com/insights/chronic-care-management-in-medicare-optimizing-utilization

[19] 91 FR 44129

[20] Hamlin, L., Grunwald, L., Sturdivant, R. X., & Koehlmoos, T. P. (2021). *Comparison of nurse-midwife and physician birth outcomes in the Military Health System*. *Policy, Politics, & Nursing Practice, 22*(2), 105-113. https://doi.org/10.1177/1527154421994071

[21] Cai, A., Mehrotra, A., Germack, H. D., Busch, A. B., Huskamp, H. A., & Barnett, M. L. (2022). Trends in mental health care delivery by psychiatrists and nurse practitioners in Medicare, 2011-19. *Health Affairs, 41*(9), 1222-1230. https://doi.org/10.1377/hlthaff.2022.00289

[22] Oh, S., McDowell, A., Benson, N. M., Cook, B. L., & Fung, V. (2022). Trends in participation in Medicare among psychiatrists and psychiatric mental health nurse practitioners, 2013-2019. *JAMA Network Open, 5*(7), e2224368. https://doi.org/10.1001/jamanetworkopen.2022.24368

patients to APRNs with specialty training, when appropriate, as APRNs deliver high-quality, efficient, and geographically available care. Furthermore, CMS must continue to work with and incentivize the states to permit full practice authority for APRNs in each state where it is not currently legal, in order to expand access to this high-quality and efficient care.

E. CMS must continue to adopt waivers and regulatory flexibilities for the MSSP.

CMS seeks feedback on how waivers and regulatory flexibility can better support specialist engagement and participation in the MSSP. In the request for information (RFI), CMS draws on the extension of COVID-19 telehealth flexibilities as an example of beneficial regulatory flexibilities to support specialty care. **While ANA firmly believes the extension to be highly beneficial and appreciates the formal regulatory text proposed in the CY 2027 PFS to extend COVID-19 telehealth flexibilities, we hold that the flexibilities should be made permanent across the Medicare Program.** Telehealth waivers help connect patients in rural and underserved areas to both primary and specialty care, so allowing practitioners to treat patients anywhere in their state has greatly improved care for rural patients. **As such, CMS should work with Congress on codifying telehealth flexibility permanency in areas where CMS does not have the authority to do so on their own.**

While highly beneficial, telehealth waivers are not the only kind of regulatory change CMS must make in order to support specialist participation in MSSP. There are substantial regulatory barriers and attribution challenges that make it difficult for APRNs to participate in ACOs and the MSSP. In particular, statue requires that APRNs receive 15% less reimbursement for the exact same care when furnished by physicians.[23] Thus, lower reimbursement rates make it more difficult for independent APRN providers or small practices to join ACOs due to the high costs associated with joining an ACO, such as ACO participation fees, financial risk exposure, necessary technology costs, and care coordination expenses. **As such, ANA believes that CMS must work with Congress to get rid of the 15% differential in Medicare reimbursement for APRNs under 42 C.F.R. § 414.56, in order to give more APRNs the opportunities and financial security to be able to participate in ACOs and the MSSP**.

8. CMS must integrate nursing expertise into Medicare Quality Payment Program, interoperability, and AI initiatives.

ANA supports CMS's efforts to advance value-based care by reducing administrative burden, strengthening quality measurement, improving interoperability, and promoting prevention and wellness across Medicare. These priorities align with nursing's longstanding commitment to improving outcomes, expanding access, and delivering high-value, person-centered care. As CMS modernizes payment and quality programs, ANA encourages the agency to ensure RNs and APRNs are meaningfully integrated into value-based payment and care delivery models through measurement, reporting, and governance structures that recognize the contributions of the entire healthcare team.

Nurses bring essential expertise in care delivery, workflow design, data stewardship, and implementation science that is critical to ensuring these policies improve outcomes and support clinicians. **Accordingly, CMS should incorporate nursing and nursing informatics expertise**

[23] 42 C.F.R. § 414.56

throughout the development, implementation, and evaluation of Medicare quality, interoperability, and AI initiatives to ensure these policies improve outcomes while supporting clinicians and reducing burden.

A. CMS should align MAHA goals with the Medicare Quality Payment Program (QPP).

CMS is aligning policies in the MIPS and APMs within the QPP with the foundational pillars of the MAHA initiative. This approach emphasizes prevention, wellness, and addressing the root causes of chronic disease. Consistent with these goals, CMS proposes expanding the MIPS Value Pathways (MVP) portfolio to include Diabetic Disease and Hypertension MVPs, as well as a new Advancing Health and Wellness Improvement Activities subcategory. CMS states that Disease-specific MVPs allow for more targeted interventions, improved measurement accuracy, and support clinicians in delivering evidence-based care for high-risk populations.

ANA supports CMS's efforts to advance MAHA-related chronic disease initiatives through the QPP, including the proposed Diabetic Disease and Hypertension MVPs. ANA also supports simplifying MIPS, aligning measures and activities, rewarding high-value care, and using data to strengthen care delivery and patient engagement. As CMS advances these initiatives, quality and payment policies should continue to emphasize prevention, early intervention, chronic disease management, and longitudinal care relationships that improve outcomes over time. These policies should also recognize nursing clinical care and judgment in measuring, assessing, and reporting outcomes.

B. CMS should continue transitioning from traditional MIPS to MVPs and adopt more flexible Electronic Reporting Requirements under the MSSP accordingly.

CMS continues to phase out of traditional MIPS reporting, making MVPs the sole MIPS reporting option beginning with the CY 2029 performance period and the 2031 MIPS payment year. Traditional MIPS would remain available through the CY 2028 performance period. Beginning with the CY 2029 performance period, MIPS-eligible clinicians who do not report through the APM Performance Pathway (APP) would be required to report the measures and activities included in a selected MVP. **ANA supports CMS's transition from traditional MIPS reporting to MVPs and agrees that MVPs offer an opportunity to create more meaningful, clinically relevant reporting pathways while reducing measure proliferation.**

As CMS expands MVPs, nursing stakeholders should be represented in pathway development, testing, governance, and evaluation. MVPs should include measures that reflect how care is actually delivered and recognize the contributions of nurses, APRNs, and interdisciplinary care teams. As such, CMS should emphasize measures addressing:

- care coordination and care transitions,
- patient and caregiver education,
- prevention and health promotion,
- chronic disease management,
- medication management,
- continuity of care,
- patient engagement and shared decision-making, and
- team-based care delivery.

Outcomes associated with prevention, care management, chronic disease management, and care transitions are frequently achieved through coordinated team-based care and should be measured accordingly.

CMS should also ensure that the transition to MVPs does not create unintended barriers for APRNs, rural providers, small practices, safety-net organizations, and nurse-led practices. Technical assistance, implementation flexibility, and appropriate hardship accommodations will be important to maintaining participation during the transition. ANA also recommends establishing a formal nursing advisory process to provide ongoing input into MVP design, implementation, measure selection, and evaluation.

While CMS transitions away from MIPS, it has proposed changes to the MSSP accordingly, like proposed changes to Certified Electronic Health Record Technology (CEHRT) use requirements with more flexible options tied to electronic Clinical Quality Measures (eCQM) reporting for participating ACOs. More specifically, CMS proposes replacing the MIPS measures for ACOs with different options and measures to meet CEHRT use requirements for the MSSP in the future. Under this new proposal ACOs must choose one of the following reporting methods:

- using CEHRT to report at least 1 of 5 ACO-reported measures in the APP plus quality measure set through eCQM collection type,
- using CEHRT to attest to the ACO's use of FHIR capability to support reporting of at least 1 of the 5 ACO-reported measures in the APP Plus Quality Measure Set, or
- selecting and attesting to one of the proposed MSSP CEHRT use metrics, which may be updated annually and are based on a subset of the MIPS Promoting Interoperability performance category measures.

ANA believes that a proposal to adopt more flexible reporting requirements for measures that are currently related to MIPS could reduce administrative burden on providers by simplifying ACO electronic reporting. We support the intention of making electronic reporting more easily adoptable for providers and giving providers more options for how to meet quality reporting requirements, especially in a time of change while MIPS transitions over to MVPs. This availability of choice in reporting methods should help providers meet reporting requirements, no matter what kind of technological tools or resources their practice or ACO can access, but this proposal must be implemented in such a way that reporting flexibility will not impact quality reporting data or consistency.

Similarly, while CMS proposes to stop requiring ACOs to use the MIPS Promoting Interoperability measure set to demonstrate CEHRT requirements, they propose several policies that will complement one another during CMS' quality reporting framework transition. The agency intends to continue aligning the reporting incentive with the MIPS CQM collection type, and they additionally propose extending the scoring of shared savings program ACO CQM proposals with flat benchmarks. Overall, these proposals may work in concert to reduce administrative burden and help ensure continuity during this period of transition, as well as facilitate the adoption of new electronic reporting processes. As such, **CMS should finalize policies regarding quality reporting for ACOs that will assist in the MIPS transition and complement proposed CEHRT flexibilities to modernize quality measurement and reporting infrastructure**.

C. CMS Should Support Virtual Group Participation in MVP Reporting

ANA supports CMS's proposal to permit virtual group participation in MVP reporting. Virtual groups may expand participation opportunities for independent clinicians, APRNs, rural providers, and small practices by allowing organizations to share reporting infrastructure and administrative resources. CMS should provide clear guidance regarding attribution, reporting responsibilities, and performance assessment requirements to ensure successful implementation. Virtual group participation has the potential to increase access to value-based care programs while reducing administrative burden.

D. CMS Should Ensure MVP Attribution Reflects Team-Based Care

As CMS continues to expand MVP participation, attribution methodologies should reflect how care is delivered across interdisciplinary healthcare teams. Many quality outcomes result from coordinated care provided by physicians, APRNs, registered nurses, pharmacists, and other healthcare professionals working together. CMS should ensure attribution policies appropriately recognize team-based care, accurately identify the clinicians responsible for delivering services, and avoid unintended exclusions or duplicative attribution. Transparent and reliable attribution methodologies will improve the fairness and accuracy of quality measurement programs.

E. CMS Should Minimize Administrative Burden for Clinicians Practicing Across Multiple Organizations

Many APRNs furnish services across multiple practice settings, healthcare organizations, and billing arrangements. As CMS refines MVP and Advanced APM participation requirements, the agency should ensure that reporting obligations and eligibility determinations do not create unnecessary administrative complexity for clinicians practicing under multiple Taxpayer Identification Numbers (TINs). Clear guidance and appropriate operational flexibilities will support continued participation in value-based care programs while reducing reporting burden.

F. CMS Should Maintain Appropriate Flexibilities for Small Practices During the MVP Transition

ANA supports CMS's transition from traditional MIPS reporting to MVPs and recognizes the potential of MVPs to create more meaningful and clinically relevant reporting pathways. As CMS implements this transition, the agency should continue to provide flexibility, technical assistance, and appropriate hardship protections for small practices, rural providers, safety-net organizations, and nurse-led practices. CMS should also provide timely implementation guidance to support participation and reduce administrative burden during the transition. These safeguards will help promote equitable participation in value-based care programs across diverse practice settings.

G. CMS should continue updating Alternative Payment Model Performance Pathways (APP).

CMS is proposing several updates to the APP and APP Plus quality measure sets to support measure refinement and maintain a stable transition to digital quality measurement.

Specifically, CMS proposes revising the specifications for three measures in the APP and APP Plus measure sets: Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID 001) for the

eCQM collection type; Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID 134); and Hospital-Wide, 30-Day, All-Cause Unplanned Readmission Rate for MIPS Eligible Clinician Groups (Quality ID 479). These updates are intended to keep the measures relevant and support the continued implementation of digital quality reporting.

CMS is also proposing to remove two measures that were previously scheduled to be added to the APP Plus quality measure set in future performance periods: the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure (Quality ID 305) and the Adult Immunization Status measure (Quality ID 493). CMS states that these measures are being removed because of operational challenges affecting the development of the necessary collection types finalized in the CY 2025 PFS final rule. The proposal also reflects stakeholder concerns about continued expansion of the APP Plus measure set during the transition to digital quality measurement. In previous PFS rulemaking, ACOs emphasized the importance of maintaining a stable measure portfolio while organizations build the infrastructure and capabilities needed to support digital quality reporting. Similarly, commenters responding to CMS's CY 2026 digital quality measurement Request for Information (RFI) urged CMS to prioritize stability within the APP Plus measure set and account for the operational challenges associated with data aggregation and reporting across eCQM, MIPS CQM, and Medicare CQM reporting frameworks.[24]

ANA supports the three measures being included and supports CMS's efforts to maintain a stable, feasible, and meaningful quality measure set during the transition to digital quality measurement. Maintaining consistency in measuring requirements can help reduce administrative burden and allow clinicians, ACOs, and healthcare organizations to focus resources on implementing interoperable digital reporting capabilities.

However, **ANA opposes the removal of Adult Immunization Status (Quality ID 493) from the APP Plus quality measure set.** Adult immunization is one of the most effective preventive services available and tracking serves as an important indicator of whether providers are engaging patients in preventive care and long-term health maintenance, rather than focusing solely on the treatment of acute illness and symptoms. Retaining this measure aligns with CMS's broader emphasis on prevention, wellness, and reducing the burden of chronic disease.

Immunization assessment and counseling often require substantial clinical time and patient engagement. This is particularly true as vaccine recommendations continue to evolve and some immunizations shift from universally recommended approaches to shared clinical decision-making models. These conversations frequently involve discussing risks, benefits, patient concerns, and individual clinical circumstances to support informed decision-making.
Nurses and APRNs play a critical role in these efforts. As the most trusted healthcare professionals, they are often responsible for educating patients, addressing vaccine hesitancy, evaluating

[24] Centers for Medicare & Medicaid Services. (2024). *Medicare and Medicaid programs; CY 2025 payment policies under the physician fee schedule and other changes to Part B payment and coverage policies; Medicare Shared Savings Program requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare overpayments* (CMS-1807-F; CMS-4201-F5). *Federal Register*. https://www.federalregister.gov/d/2024-25382

immunization needs, and facilitating preventive care discussions.[25] Patients may be more likely to engage in these conversations with their primary care NP or other trusted members of their care team, making immunization measures an important reflection of the person-centered, relationship-based care that supports prevention and population health. **Accordingly, ANA encourages CMS to retain Adult Immunization Status within the APP Plus quality measure set and to continue recognizing preventive care activities that improve long-term health outcomes.**

Additionally, ANA opposes the removal of Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Quality ID 305) measure. Capturing the initiation of substance treatment aligns behavioral, mental, and physical care. This measure is particularly important to primary care as many times conversations regarding addiction first happen with the patient's primary care; given that addiction is a lifelong disease, substance usage may need to be brought up at every primary care appointment for the rest of a patient's life. Furthermore, the removal of this measure is contrary to the Administration's goal and efforts of addressing addiction and substance abuse.[26]

As CMS considers future measure additions and revisions, ANA urges the agency to prioritize feasible measures that improve prevention, chronic disease management, care coordination, and person-centered outcomes across diverse practice settings and care delivery models.

H. ANA supports CMS's ongoing efforts to update the MIPS Improvement Activities Performance Category.

CMS proposes several updates to the MIPS Improvement Activities performance category aimed at streamlining the inventory of activities, promoting care quality and patient outcomes, and expanding MIPS Value Pathways (MVPs). Specifically, CMS proposes adding six new improvement activities within the Care Coordination and newly established Advancing Health and Wellness subcategories, modifying five existing improvement activities to better align with current practice and program priorities, removing 11 activities considered outdated or duplicative, and implementing 10 new MIPS quality measures. CMS also proposes adding three new MVPs beginning with the CY 2027 performance period.

a. ANA supports the expansion of MIPS Value Pathways

ANA commends the agency's continued efforts to expand the MVP portfolio with pathways that promote evidence-based, high-quality care and improve outcomes for patients with chronic conditions.

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[25] 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/

[26] The White House. (2026, January 29). *Addressing addiction through the Great American Recovery Initiative*. https://www.whitehouse.gov/presidential-actions/2026/01/addressing-addiction-through-the-great-american-recovery-initiative

ANA supports the proposed Diabetic Disease MVP and Hypertension: Adopting Best Practices MVP. These pathways have the potential to advance evidence-based care, improve chronic disease management, and encourage greater accountability for outcomes that matter to patients and families.

However, ANA opposes limiting participation in the Hypertension: Adopting Best Practices MVP through the Hospitalist MVP pathway. While ANA appreciates the important role hospitalists play in monitoring and coordinating care for patients with hypertension, narrowing recognition to hospital-based physicians fails to reflect how hypertension care is actually delivered. Effective hypertension management depends on interdisciplinary teams that include registered nurses, advanced practice registered nurses (APRNs), primary care clinicians, care coordinators, pharmacists, and other professionals who contribute to patient education, medication management, care coordination, and ongoing monitoring across settings.

Restricting attribution to hospital-based physicians risks overlooking the contributions of the broader clinical team that is responsible for achieving and sustaining improvements in hypertension outcomes. Accordingly, CMS should revise the Hypertension: Adopting Best Practices MVP to better recognize and incentivize the interdisciplinary care teams, including nurses, that coordinate and deliver high-quality hypertension care.

b. Strengthening Future MVPs Through Team-Based and Longitudinal Care Measures

As CMS continues to refine MVPs, ANA encourages the agency to further advance measures that reflect how care is delivered across settings and through interdisciplinary teams. Domains such as access to care, care coordination, continuity of care, care transitions, chronic disease management, patient and caregiver engagement, and team-based care are critical drivers of quality, health equity, and value.

ANA also encourages CMS to strengthen the Value in Primary Care MVP by incorporating measures that better reflect Advanced Primary Care Management (APCM) and longitudinal, team-based care delivery. These measures should recognize the contributions of nurses, APRNs, and other members of the interdisciplinary care team in coordinating care, managing complex conditions, improving outcomes, and supporting chronic disease prevention and management.

Future MVPs should increasingly evaluate whether interdisciplinary teams effectively deliver comprehensive care management functions, including:

- Comprehensive assessment of clinical, functional, behavioral, social, and caregiver needs;
- Continuity with a designated care team member;
- Interoperable care planning;
- Symptom monitoring and escalation pathways;
- Medication management and reconciliation;
- Timely follow-up after care transitions;
- Patient and caregiver engagement;
- Integration of patient-generated health data and digital health tools; and
- Outcomes meaningful to patients and families, including functional status, symptom burden, caregiver experience, and goal-concordant care.

Future measurement should increasingly focus on whether patients receive coordinated, proactive, person-centered care from the right team members at the right time, rather than relying primarily on individual encounters or billing activity as proxies for quality. Accordingly, CMS should continue to expand MVPs and quality measures that assess interdisciplinary care delivery, longitudinal care management, and meaningful patient outcomes.

I. ANA supports Clinician Use of Artificial Intelligence (AI) to Improve Patient Care Improvement Activity if it appropriately shifts the focus from AI adoption to responsible AI use.

CMS proposes a new improvement activity, *Clinician Use of Artificial Intelligence (AI) to Improve Patient Care* (ID: IA_AHW_XX). The proposed activity would recognize clinicians who establish policies for evaluating and monitoring AI tools used in clinical practice, participate in the development and refinement of AI-enabled resources, and apply AI technologies in ways that improve patient outcomes, care efficiency, and safety.

ANA supports this proposal because it appropriately emphasizes responsible use, governance, evaluation, and oversight of AI-enabled technologies rather than simply encouraging adoption. As AI tools become increasingly integrated into clinical care, robust governance processes are essential to ensure patient safety, transparency, fairness, reliability, and alignment with evidence-based practice.

AI-enabled clinical decision support tools should be subject to ongoing monitoring, evaluation, and risk mitigation. Importantly, AI-generated recommendations and outputs should not replace clinical judgment and should always be reviewed by a qualified healthcare professional. **Human oversight remains essential to ensuring safe, high-quality, patient-centered care.**

ANA encourages CMS to further strengthen the improvement activity by explicitly evaluating the impact of AI-enabled tools on clinical workflows, cognitive workload, documentation burden, and communication among members of the healthcare team. Understanding how these technologies affect frontline clinicians will be critical to ensure that AI enhances, rather than disrupts, care delivery and patient outcomes.

Accordingly, CMS should finalize the proposed improvement activity and strengthen it by incorporating additional evaluation criteria related to clinician workflow, team communication, workload, and patient safety.

J. ANA opposes the removal of the Behavioral Health Information Exchange Improvement Activity

ANA is concerned about and opposes CMS's proposal to remove Improvement Activity Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients (ID: IA_CC_16). CMS states that the activity is no longer sufficiently relevant and may be considered obsolete under the agency's improvement activity removal criteria.

Despite ongoing efforts to improve interoperability, information exchange between primary care and behavioral health providers remains inconsistent and often inadequate. Effective coordination

between these settings is essential to delivering high-quality behavioral healthcare, yet providers continue to face barriers to timely access to diagnoses, medication information, treatment plans, and other clinical information necessary to coordinate care. Information silos can undermine care continuity, increase the risk of adverse events, and negatively affect patient outcomes.

In addition, providers frequently receive limited reimbursement for the time and resources required to obtain records, communicate across care settings, and perform the documentation necessary to support care coordination activities. Maintaining incentives that encourage meaningful information exchange remains important as healthcare organizations continue to address interoperability challenges. If CMS believes the measure is not having the intended impact, the measure should be revised not eliminated.

Retaining this improvement activity would continue to promote effective communication, strengthen care coordination, and improve continuity of care for patients receiving services across primary care and behavioral health settings. **As such, CMS should not finalize its proposal to remove Improvement Activity IA_CC_16, Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients.**

K. CMS should continue core measure alignment.

CMS is advancing its Digital Quality Measurement (dQM) strategy to modernize quality reporting, aiming to transition all CMS quality measures—such as those in the Alternative Payment Model (APM) Performance Pathway (APP Plus)—to digital quality measures (dQMs). dQMs are designed to reduce administrative burden and costs, reduce the likelihood of manual data entry and interpretation errors, and provide more timely quality assessments by enabling automated, standardized data analysis directly from electronic data sources.[27] **ANA supports CMS's efforts to digitally streamline the APP Plus quality measure set and prioritize measures that are feasible, interoperable, and capable of being captured through digital quality measurement approaches.**

Additionally, **ANA supports CMS's efforts to streamline quality reporting through greater measure alignment and the implementation of MIPS core measures**. Core measures should remain clinically relevant, feasible to report, and applicable across diverse practice settings. APRNs practice across numerous specialties and care environments, and CMS should ensure clinicians have access to meaningful core measure options that reflect the care they provide. CMS should also maintain flexibilities when no applicable core measure exists and periodically evaluates whether designated core measures continue to reflect evolving clinical practice. These steps will help reduce reporting burden while supporting meaningful quality improvement.

ANA also supports policies that encourage clinician participation in Advanced Alternative Payment Models and other value-based care arrangements. Continued incentives for Advanced APM participation help support care coordination, improve patient outcomes, and encourage clinician engagement in innovative payment and delivery models. As CMS advances its value-

[27] Centers for Medicare & Medicaid Services. (2022). *Digital quality measurement strategic roadmap*. https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdf

based care goals, the agency should continue supporting pathways that encourage participation by APRNs and other members of interdisciplinary care teams.

As CMS evaluates future measures, the agency should continue prioritizing the transition of measures that reflect:

- prevention and wellness,
- chronic disease management,
- care coordination,
- health equity,
- team-based care, and
- longitudinal patient-centered outcomes.

Maintaining a stable and aligned measure portfolio will reduce reporting burden while supporting meaningful quality measurement and improvement.

9. **CMS should thoughtfully review implementation of dQM and Fast Healthcare Interoperability Resources® (FHIR®)-Based reporting.**

CMS is advancing digital quality measurement by transitioning existing measures and reporting processes to approaches based on Fast Healthcare Interoperability Resources® (FHIR®). As the agency continues to refine this approach, CMS seeks feedback through an RFI on:

- a proposed two-year phased transition beginning with the 2028 performance period;
- factors that may affect readiness for FHIR-based reporting; and
- other issues, opportunities, or considerations related to the transition.

ANA supports CMS's transition to digital quality measurement and FHIR-based reporting and recognizes the significant potential of interoperability and automation to improve quality measurement while reducing burden. However, successful implementation will require attention to workflow integration, workforce impacts, and data standardization. Important nursing-generated information—including assessments, care plans, functional status evaluations, care coordination activities, and social needs assessments—is frequently not captured in structured and computable formats suitable for digital measurement.

Standardized nursing terminologies (the specialized language nurses use in electronic health records, charting systems, and telehealth platform), also provide an important foundation for digital quality measurement. The evidence base demonstrates that structured nursing data can support quality measurement, workload assessment, continuity of care, and secondary data use for quality improvement and outcomes evaluation. As CMS advances digital quality measurement and FHIR-based reporting, ensuring that nursing assessments, interventions, and outcomes are captured using standardized and interoperable approaches will be critical to accurately representing the contributions of nursing care within quality reporting programs.[28]
ANA recommends that CMS:

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[28] Tastan, S., Linch, G. C. F., Keenan, G. M., Stifter, J., McKinney, D., Fahey, L., Dunn Lopez, K., Yao, Y., & Wilkie, D. J. (2014). *Evidence for the existing American Nurses Association-recognized standardized nursing terminologies: A systematic review*. *International Journal of Nursing Studies, 51*(8), 1160-1170. https://doi.org/10.1016/j.ijnurstu.2013.12.004

- promote standardized nursing terminologies and interoperable clinical data standards that support the statured capture and exchange of nursing data;
- include nurses, APRNs, and nursing informatics professionals in implementation planning;
- conduct ongoing burden analyses focused on nursing workflows and workforce capacity;
- ensure digital measures reduce rather than increase documentation burden;
- provide technical assistance tailored to smaller and resource-constrained organizations (e.g., safety net and essential hospitals, providers in rural areas); and
- implement phased transition timelines that account for variation in technology readiness and infrastructure.

CMS must ensure that any approach to modernize quality measurement and digital reporting infrastructure advances interoperability while reducing burden, strengthens the nurse-informed approach to digital quality measurement, and supports equitable implementation across all healthcare settings.

10. **CMS must continue promoting interoperability across the healthcare continuum and use of standardized clinical documentation that can be consistently interpreted across healthcare settings, systems, and providers.**

The CY 2027 MIPS performance improvement updates mark a shift toward specialized, digital-first, interoperability-driven quality reporting, with a clear roadmap to MVPs and FHIR-based measures, requiring providers to modernize EHR use, data collection, and interoperability practices now to avoid disruption in 2029. Superficially, CMS is advancing two major initiatives in its CY 2027 rulemaking, modifications to the existing electronic prior authorization (EPA) measure, a new EPA requirement for prescription drugs. ANA is supportive of both these measures. Effective interoperability is essential to improving care coordination, enhancing patient safety, reducing duplicative services, and supporting value-based care. Nurses and APRNs rely on timely access to accurate and comprehensive patient information across care settings to make informed clinical decisions, facilitate care transitions, and ensure continuity of care. Continued progress toward interoperable health information exchange is therefore critical to achieving CMS's goals of improving quality, efficiency, and patient outcomes. **To achieve meaningful interoperability, ANA asks CMS to include nursing documentation and nursing-generated data must be fully incorporated into interoperability standards and exchange framework.**

Nurses document a substantial portion of the clinical information contained in the health record, including patient assessments, histories, care plans, interventions, care coordination activities, patient education, discharge planning, functional status evaluations, and social needs assessments. However, these data elements are often inconsistently captured, stored, or exchanged across health information systems, limiting their usefulness for care coordination, quality improvement, and population health management. Failure to adequately incorporate nursing documentation into interoperability efforts risks creating an incomplete picture of patient care and overlooking information that influences clinical decision-making and patient outcomes.

Meaningful interoperability depends not only on the technical ability to exchange data, but also on the use of standardized clinical documentation that can be consistently interpreted across healthcare settings, systems, and providers. Nursing documentation is frequently captured through local terminology, non-standardized fields, or free-text entries that are difficult to exchange, aggregate, or analyze electronically. As a result, nursing contributions to patient outcomes often

remain underrepresented in quality measurement programs, value-based payment models, and health system analytics. Standardized, structured nursing data improve care coordination, support continuity of care, facilitate quality measurement, and enable a more accurate representation of team-based care delivery.

ANA recommends CMS:

- encourage broader adoption of recognized nursing terminologies and documentation standards that support the structured capture and exchange of nursing data;
- support interoperable electronic care plans that facilitate communication across primary care, specialty care, hospitals, post-acute care providers, home health agencies, community-based organizations, and caregivers, as appropriate;
- improve integration of nursing assessments, care coordination activities, and patient-generated health data into longitudinal health records and clinical decision-making processes;
- evaluate interoperability initiatives based on workflow usability and clinician experience, in addition to technical performance;
- include nursing informatics experts in the design, implementation, testing, and evaluation of interoperability initiatives to ensure nursing workflows and nursing-generated data are fully represented;

Recent advances in standardized clinical terminology, including improved representation of nursing concepts within SNOMED CT (the world's most comprehensive multilingual clinical terminology, providing standardized, computer-processable medical codes, terms, synonyms, and definitions to support clinical documentation, reporting, and interoperability), present opportunities to strengthen the visibility of nursing assessments, interventions, and outcomes within longitudinal health records and better align clinical documentation, quality measurement, and payment models.[29] Structured nursing data also supports CMS's transition to value-based care by enabling the measurement of nursing's impact on quality, utilization, patient experience, and population health outcomes. Over time, they can reduce administrative burden by supporting automated quality reporting, reducing manual chart abstraction, minimizing duplicate documentation, and streamlining regulatory reporting requirements.

Digital measurement systems should support clinical workflows and accurately capture the contributions of interdisciplinary teams. Technology should enhance care delivery without creating new administrative burdens for clinicians. **ANA encourages CMS to support the adoption of standardized nursing terminologies and interoperable nursing data standards**. A systematic review of 312 studies found that standardized nursing terminologies improve documentation consistency, facilitate communication across care teams, support integration into electronic health records, and provide the foundation for interoperable nursing data capable of supporting quality measurement and outcomes evaluation.[30]

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[29] National Library of Medicine. (n.d.). *SNOMED CT*. U.S. National Library of Medicine. https://www.nlm.nih.gov/healthit/snomedct/index.html

[30] Tastan, S., Linch, G. C. F., Keenan, G. M., Stifter, J., McKinney, D., Fahey, L., Dunn Lopez, K., Yao, Y., & Wilkie, D. J. (2014). *Evidence for the existing American Nurses Association-recognized standardized nursing terminologies: A systematic review*. *International Journal of Nursing Studies, 51*(8), 1160-1170. https://doi.org/10.1016/j.ijnurstu.2013.12.004

Structured nursing data also provides a foundation for future digital health technologies, including clinical decision support, predictive analytics, AI-enabled applications, and automated quality reporting. ANA notes that interoperable health information exchange is increasingly becoming the infrastructure through which these technologies are deployed. As interoperability expands and more standardized clinical data become available across systems, those data will increasingly be used to support automated decision-making, workflow optimization, population health management, and care coordination activities. While CMS is not specifically seeking comments on AI governance in this section, ANA's 2026 AI in Nursing Think Tank highlighted the increased reliance of AI-enabled healthcare technologies on interoperable, high-quality, standardized health data. Because effective and trustworthy AI systems depend on the seamless exchange of accurate clinical information across healthcare settings, interoperability policies will play a critical role in shaping the safe, equitable, and effective use of AI in healthcare. Accordingly, CMS should consider the implications of interoperability initiatives for AI-enabled care delivery and ensure nursing expertise informs both areas.[31]

To support the responsible use of these technologies, CMS should consider how future interoperability initiatives can promote transparency, accountability, human oversight, and appropriate validation of AI-enabled tools that rely on interoperable clinical data. Clinicians and healthcare organizations should have clear information regarding how AI-generated outputs are developed, integrated into workflows, and used to inform clinical or administrative decisions. Interoperability policies should also help ensure that nursing documentation, patient-generated data, and information reflecting the full continuum of care are appropriately represented within the datasets that inform AI-enabled technologies.

As CMS continues to advance interoperability and digital health infrastructure, ANA encourages the agency to consider not only whether information can be exchanged across systems, but also how interoperable data are subsequently used within technology-enabled workflows. Establishing expectations for transparency, human oversight, and equitable data representation will help ensure that future AI-enabled innovations support patient safety, care quality, clinician trust, and access to high-quality care for all patients, while complementing, rather than replacing, clinical judgment.

Finally, ANA encourages CMS to place greater emphasis on the usability of electronic health record (EHR) systems and interoperability-related workflows. While expanded information exchange offers substantial benefits, poorly designed interfaces and workflow requirements can contribute to documentation inefficiencies, clinician frustration, and administrative burden. CMS should routinely assess the impact of interoperability requirements on clinician workload and incorporate workforce usability metrics into future interoperability evaluations. By recognizing the essential role of nursing documentation, supporting structured and interoperable data, prioritizing workforce usability, and establishing a foundation for responsible AI-enabled innovation, CMS can strengthen interoperability, improve patient outcomes, and ensure nursing contributions are appropriately reflected throughout the nation's evolving digital health infrastructure.

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[31] American Nurses Association, "*American Nurses Association Calls for Nurse-Led Guardrails on Artificial Intelligence in Healthcare*," May 5, 2026, https://www.nursingworld.org/news/news-releases/2026-news-releases/american-nurses-association-calls-for-nurse-led-guardrails-on-artificial-intelligence-in-healthcare/.

11. **CMS must pursue efforts to redesign the provision and reimbursement of primary care services.**

The Administration seeks comment on a RFI on how primary care services are managed and reimbursed. Primary care is the cornerstone of the health system and is a key component in the Administration's MAHA goals. Primary care is a key component of preventative care, which can help reduce the effects of chronic diseases and can also detect health conditions before patients are aware of them and before they become more difficult and costly to treat. This care is a guaranteed essential health benefit, and the Administration should continue to promote preventative care to improve the health of the American public. **ANA strongly supports a comprehensive primary care system and looks forward to working with CMS and the Administration on ways to implement a more modern system that better reflects how primary care is provided by trusted practitioners.**

While ANA strongly supports the proposal to redesign primary care as a whole, CMS should continue to explore ways to better align reimbursement and RVUs with the time and effort required during preventive visits. Annual wellness visits and preventive examinations often involve extensive counseling, screening, care coordination, and chronic disease discussions. In many cases, these visits require more provider time and clinical judgment than traditional E/M encounters, yet providers receive less RVU credit for preventative visits (99214 is wRVU 1.92 vs physical on a 30-year-old 99395 is wRVU 1.50). **Improved reimbursement for preventive care services would better support the clinical work and time necessary to achieve the population health goals CMS is promoting.**

CMS also asks stakeholders about enhanced reimbursement for G2211 and consultative services that are not reimbursed by Medicare. ANA believes that G2211 is effective as written; ANA holds that no changes should be made to the add-on code, as detailed in preceding sections. CMS does not currently reimburse practitioners for consultative services, but the proposed rule states that there are private payers who reimburse these services. A**NA believes that CMS should reimburse practitioners for consultative services, as practitioners are already providing consultative services to their patients, and providing reimbursement will allow for more accurate CPT codes.** Many practitioners do not understand the differences between what CPT codes are reimbursed by different payors, and CMS could help simplify this differentiation by providing reimbursement for these consultation codes. Proper reimbursement will incentivize the delivery or more effective and less costly preventative care and improve patient outcomes while reducing overall system costs.

12. **CMS must thoughtfully consider data gathered on duplicate laboratory testing, imaging, and result sharing and interoperability before implementing any payment adjustments.**

CMS seeks feedback regarding duplicate laboratory testing, imaging, result sharing, and interoperability. In particular, CMS is exploring the use of payment integrity levers to recoup payments from health care providers and suppliers who performed duplicate laboratory or imaging tests, and/or local Medicare Administrative Contractor edits that would result in nonpayment or reductions in payment for duplicate laboratory or imaging tests. However, there are many reasons in clinical care for repeat care, labs, and imaging that go far beyond accidental duplication.

Retesting in quick succession is often essential to both the diagnostic process and the provision of care. The need to order imaging or lab results in quick succession could be due to a sudden change in symptoms or new information reported by the patient. Patients do not engage in perfect behaviors, so a provider should not be penalized for retesting a patient to gain better clinical information, such as if a patient were unknowingly dehydrated at the time of blood draw, impacting and potentially introducing bias in the resulting laboratory analysis. Similarly, patients may be exposed to multiple consecutive risks in a short period of time, or potential infectious disease exposures that require retesting in a timespan that could be deemed duplicative without the known context. Additionally, patients are not perfect historians and typically do not have an advanced clinical education, so when a patient is experiencing clinically severe symptoms, their provider might not have time to get in contact with another provider who may have ordered similar tests to verify which tests have previously been ordered and what the recent results were.

Lab results and imaging also are often very time sensitive and situation dependent. Some test results may differ or be influenced by time of day, diet, or unrelated infection. Similarly, alarming findings or suspected incorrect lab results require retesting. Additionally, if CMS were to penalize providers for ordering duplicate tests, there is a risk that any repeat test ordered by a specialist after a PCP's initial evaluation could be deemed a duplicate, despite the fact that results or the clinical picture could change in the amount of time passing between the PCP appointment and when they can be seen by a specialist. Moreover, frequent or repeat testing is central to the clinical diagnostic and monitoring processes for many conditions. As such, there would be large room for error if CMS were to determine based on test order records alone that could result in practitioners being unnecessarily penalized for providing the highest quality of care as they apply their clinical expertise and judgement in assessing, diagnosing, and determining care treatment for patients.

There is no perfect list of diagnostic testing that *should* or *should not* be duplicated; clinical context and clinical judgement matter when ordering any test or imaging. Setting a list of procedures that can or cannot be duplicated limits the clinical judgement of practitioners. By unnecessarily penalizing providers, CMS could unintentionally discourage providers from sending their patients for a needed retest, if that test is what the provider needs to ascertain the patient's condition. **As such, CMS should work with practitioners, including APRNs, to get a better understanding of why there is duplication and identify ways to get more information about perceived unnecessary diagnostics, rather than proceeding with penalizing providers for duplicate lab tests and imaging orders.**

13. **CMS must recognize the critical role of nurses in the care management of seriously ill Medicare beneficiaries.**

CMS seeks comment on how best to differentiate between seriously ill and other Medicare beneficiaries and what essential services should be provided for beneficiaries deemed to be seriously ill patients. Seriously ill Medicare beneficiaries require a differentiated approach to care management because their needs extend beyond routine chronic disease management and require a higher intensity, proactive, and longitudinal model of care.

Serious illness is not defined solely by diagnosis. Rather, it is characterized by the interaction of clinical complexity, functional needs, symptom burden, caregiver responsibilities, and social circumstances. Individuals living with serious illness often experience multiple chronic conditions,

progressive functional decline, complex medication regimens, frequent care transitions, and increased reliance on caregivers and interdisciplinary healthcare teams.

Seriously ill beneficiaries must have access to a designated member of the care team who understands their clinical history, goals, preferences, functional status, and care priorities. **As nurses are the most trusted healthcare professionals and are the members of the care team that spend the most time with their patients, ANA holds that nurses are the ideal members of the care team to fulfill care management roles for patients.**[32]

Access to timely clinical support is crucial for care management. This support that nurses provide can identify and respond to changes in health status before they result in preventable emergency department visits, hospitalizations, or functional decline. Timely follow-up visits are also an important element of care management. These can include medication reconciliation, communication of treatment plans, coordination with treating clinicians, and follow-up on unresolved clinical needs. Moreover, nurses must be included in the design and endorsement, and use of rigorously tested care coordination measures for any subset of Medicare beneficiaries. The contributions of nurses performing care coordination services must be defined, measured, and reported to inform and ensure appropriate financial incentives that support the scope of services needed for high-value care coordination. **As CMS seeks to improve the care coordination of seriously ill Medicare beneficiaries, it is imperative that the agency recognize the distinct and critical role nurses play in coordinating care for these patients and that this role is appropriately accounted for, supported, and resourced.**

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, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, ANA Chief Executive Office

[32] American Nurses Association. *The Essential Role of Registered Nurses in Care Coordination [Position statement].* February 2021. https://www.nursingworld.org/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements-secure/carecoordinationpositionupdatefeb2021_final.pdf