September 12, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1832-P 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 [RIN 0938-AV50]

Dear Administrator Oz:

The below associations representing Advanced Practice Registered Nurses (APRNs) and advanced practice nursing education appreciate the opportunity to provide comments on the proposed rule: *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*.

The APRN Workgroup represents all four APRN roles: Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), and Clinical Nurse Specialist (CNS), as well as advanced nursing education. APRNs are prepared at the master's or doctoral level to provide primary, acute, chronic and specialty care to patients in all settings across all ages and backgrounds. APRNs are a growing, critical, and highly educated part of the healthcare workforce. APRNs advance healthcare access, improve quality of care, and provide cost-effective healthcare delivery, particularly in rural and underserved communities. Despite their importance to the healthcare ecosystem, many outdated policies hamper APRNs from serving to the full extent of their license and serve to exacerbate healthcare access gaps.

Proposed CY 2026 Qualifying APM and Non-Qualifying APM Conversion Factor Structure

***APRN Workgroup Comment**: Ensure that all APRNs have maximal access to meaningfully participate in Alternative Payment Models (APMs) to ensure adequate reimbursement under the new Medicare PFS conversion factor structure that CMS proposes for CY 2026.*

We understand that the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) requires CMS to implement two separate conversion factors – the qualifying APM conversion factor and the non-qualifying APM conversion factor – for services paid under the Medicare Part B Physician Fee Schedule (PFS) beginning in CY 2026. Given this incentive structure, it is critical that CMS support Medicare Part B providers, including APRNs, in facilitating participation in APMs to maintain adequate reimbursement.

Limitations of the Relative-Value Scale Update Committee (RUC) Survey Data and Process

***APRN Workgroup Comment**: Agreement with CMS' recognition of the inherent flaws associated with the American Medical Association (AMA) Relative-Value Scale Update Committee (RUC) survey process and supports the use of electronic health record data to supplement RUC survey data.*

CMS notes in the preamble of the proposed rule on page 32400 that, "longstanding concerns about the use of surveys that have low response rates, low total number of responses, and a large range in responses, all of which may undermine the accuracy of recommendations relying on survey data", and that, "those practitioners who respond to the RUC surveys may be fundamentally different than those clinicians who do not respond to the surveys."

We agree that the RUC survey response rates and types of respondents create gaps in the information collected through the RUC process. Specifically, the valuations established by this process should represent the valuation of services for all providers who bill Medicare, not just physicians. However, the RUC places all allied health practitioners within the RUC Health Care Professionals Advisory Committee (HCPAC), which is comprised of 13 organizations. These 13 organizations, which represent millions of providers who use CPT codes to report the services they provide to Medicare patients and who are paid for these services based on the Medicare PFS, only receive one vote on issues that come before the full RUC through representation by the one HCPAC seat.

As such, allied health practitioners' input is often undervalued or not collected at all through the RUC survey process. We support CMS' openness to using empirical data, including electronic health record data, to supplement the RUC survey data in determining

code valuation on the Medicare PFS. We would encourage CMS when using such empirical data to examine data for all types of providers who perform a given service, including APRNs, and would appreciate the opportunity to partner with CMS to develop empirical data standards.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

***APRN Workgroup Comment**: Adopt policies that are consistent with the MedPAC recommendation to eliminate 'incident-to' billing for APRNs and avoid the use of wasteful services in the name of telehealth that would increase costs without improving healthcare access or quality.*

CMS is proposing to make permanent the definition of "direct supervision" that includes immediate availability through a virtual presence using two-way, real-time audio/visual technology. While this has increased access to care and recognize the value of telehealth as a modality to supervise care delivery, we do not believe this direct-supervision flexibility policy should be extended to services performed by APRNs and other advanced practice providers who are able to directly bill Medicare for services, Furthermore, we remain concerned that adopting this policy as proposed will lead to an increase in 'incident to' services billed under a physician's NPI when those services are performed by an APRN. We recommend that CMS adopt a policy expressed by MedPAC in their June 2019 report[1] which recommended "eliminating incident to billing for APRNs", to "update Medicare's payment policies to better reflect current clinical practice."[2]

<u>Policies to Improve Care for Chronic Illness and Behavioral Health Needs</u>

Comment Solicitation on Payment Policy for Software as a Service (SaaS)

***APRN Workgroup Comment**: Ensure that APRNs and their patients are involved in the development and optimization of SaaS policy as CMS continues to evaluate ways to cover these services.*

In this section, CMS has requested feedback on developing a consistent payment policy for SaaS tools and how the costs of these tools can be incorporated into evolving models of care delivery. SaaS tools as a complement to a clinician-patient relationship may prove impactful as a strategy to improve health, and clinicians and patients should remain at the forefront of developing and optimizing these policies. We urge CMS to adopt principles that

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[1] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*. June 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf

[2] Ibid.

ensure clinician expertise is protected in order to support clinical decision-making and improve patient care. AI should assist - but never replace – APRN clinical judgment that is based on extensive education and experience.

As CMS continues to explore ways to cover SaaS, it is critical that APRNs and their patients are involved in these conversations as they are the end users of the product, most impacted by their utilization.

Prevention and Management of Chronic Disease—Request for Information

***APRN Workgroup Comment**: APRNs are critical to preventing and managing chronic disease across all patient populations and CMS should ensure that regulatory barriers are removed which limit the ability of APRNs to practice to the full extent of their education and clinical training.*

The APRN workgroup greatly appreciates the focus of CMS on addressing the root causes of chronic disease and improving interventions and treatments that support whole-patient centered care. APRNs are critical to preventing and managing chronic disease, and we look forward to working with the Administration on this important initiative. There is substantial evidence that APRNs effectively deliver care to patients with diabetes, both in terms of quality of care and cost effectiveness.

Despite the importance of APRNs to the Medicare and Medicaid programs, they continue to encounter barriers to referring for or providing preventative services to their Medicare and Medicaid patients that help prevent and manage chronic conditions due to outdated regulatory barriers. We have appreciated that the Trump Administration has recognized the importance of increasing access to these services, and the value in removing these barriers for APRNs and their patients. We continue to encourage the Administration to utilize all available regulatory pathways, including through the adoption of waivers in the MSSP and Innovation Center models, to expand access to these critical services. This is consistent with Section 5 of Executive Order 13890 on *Protecting and Improving Medicare for Our Nation's Seniors* which called for removing burdensome requirements in the Medicare program that are "more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession."[3]

Ambulatory Specialty Model

[3] Executive Order on Protecting and Improving Medicare for Our Nation's Seniors – The White House

***APRN Workgroup Comment**: Revise the proposed regulatory language at 42 CFR § 512.710(b) and 42 CFR § 512.710(d) to include all APRNs as participants in the ASM Low Back Pain and Heart Failure cohorts*.

We are very concerned that CMS proposes to arbitrarily exclude APRNs from participation in the proposed implementation and testing of the new Ambulatory Specialty Model (ASM). CMS proposes that participants in the ASM would treat one of two ASM targeted chronic conditions: heart failure or low back pain. CMS also proposes to define an "ASM cohort" as, "a group of ASM participants who treat the same targeted chronic condition." CMS further goes on to state that, "the proposed ASM cohorts would not include nonphysician practitioners (NPP) because NPPs would not meet the ASM participant eligibility criteria as proposed at § 512.710(b), which states that only clinicians assigned one of the specialty codes at § 512.710(d) may be ASM participants. Medicare does not currently assign specialty codes to NPPs; therefore, NPPs would not satisfy this criterion."

We would highlight that the regulatory language at 42 CFR § 512.710(b) and 42 CFR § 512.710(d)) is novel and that CMS has the regulatory authority under Section 1115A(b) of the Social Security Act to include all APRNs as participants in the ASM; conversely, nothing in Section 1115A(b) of the Social Security Act precludes CMS from doing so.[4] Doing so in this proposed rule creates a precedent for excluding APRNs from future ASM or similar models.

Excluding APRNs from ASM models would put Medicare beneficiaries at a disadvantage by disincentivizing APRNs from providing these types of services, particularly in rural and underserved areas where APRNs are the predominant providers. It would also put APRNs at a disadvantage at a time when the MACRA-required changes to the Medicare PFS conversion factor incentivizes participation in APMs starting in CY 2026. As noted previously, CMS should ensure that Medicare Part B providers have ample opportunity to participate in APMs rather than arbitrarily excluding them from doing so.

Conclusion

We appreciate the opportunity to provide input to the proposed policies in the proposed rule *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*.

[4] 42 U.S.C. § 1315a – Center for Medicare and Medicaid Innovation.

For any questions, please do not hesitate to reach out to Romy Gelb-Zimmer, Director of Regulatory Affairs, at rgelb-zimmer@aana.com.

Sincerely,

American Academy of Nursing
American Association of Colleges of Nursing
American Association of Nurse Anesthesiology
American Association of Nurse Practitioners
American College of Nurse-Midwives
American Organization for Nursing Leadership
Gerontological Advanced Practice Nurses Association
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Organization of Nurse Practitioner Faculties