

September 6, 2023

Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-1850

Submitted electronically at www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program [CMS-1784-P]

Dear Administrator Brooks-LaSure:

The American Nurses Association (ANA) appreciates the opportunity to comment on the fiscal year 2024 Physician Fee Schedule (PFS) proposed rule. ANA applauds the continued commitment to health equity and expanding access to quality health care from the Center for Medicare & Medicaid Services (CMS) in the PFS. To achieve these goals, it is critical that CMS and the PFS recognize the value of nurses and nursing practice. ANA therefore offers these comments urging the following:

- 1. Continue using language that includes all healthcare practitioners;**
- 2. Institute proposed codes;**
- 3. Continue reliance on the RUC process while advancing methods of properly valuing services of all qualified healthcare professionals (QHPs);**
- 4. Finalize E/M proposals;**
- 5. Continue expanding access to telehealth;**
- 6. Expand access to APRN care;**
- 7. Work closely with nurses to advance health equity goals throughout the Medicare program,**
- 8. Continue promoting access to in-home vaccination; and**
- 9. Work with nurses to strengthen the Medicare Diabetes Prevention Program and expand its impact.**

ANA is the premier organization representing the interests of the nation's over 5 million registered nurses (RNs) through its state and constituent member associations, organizational affiliates, and the individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of health care settings.

RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four Advanced Practice Registered Nurse (APRN) roles: nurse practitioner, certified nurse midwife, clinical nurse specialist, and certified registered nurse anesthetist. ANA is dedicated to partnering with health care consumers to improve practice, policies, delivery models, outcomes, and access across the health care continuum.

1. ANA strongly supports the use of “practitioner” terminology.

ANA would like to thank CMS for including terminology recognizing all medical practitioners and not just physicians in this year’s Medicare Physician Fee Schedule proposed rule. Changing the language from “physician” to “practitioner” signals to stakeholders that APRNs, including nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives, are valued for their contributions to health and patient care, and encourages entry of healthcare professionals into APRN ranks.

2. CMS should finalize the following codes as proposed:

99484

This is a PE only code. The RUC recommended a PE value of .61 which CMS disagreed with and recommends a value of .93. ANA agrees PE should be higher and supports CMS’ recommendation for a PE value of .93.

99497, 99498

The RUC recommended work values of 1.50 for CPT code 99497 and 1.40 for CPT code 99498. CMS proposes to accept these valuations and ANA thanks CMS for accepting the RUC recommendations.

9X036

The CPT Editorial Panel created this new code as a PE only code. This code is designed to capture the PE expenses where a pelvic exam is performed in a non-facility setting. CMS proposed to accept the RUC’s PE recommendations for this code and ANA thanks CMS for accepting the RUC recommendations.

3. CMS should continue relying on the RUC process while advancing methods of valuing services of all qualified healthcare professionals (QHPs).

CMS asked whether the RVU Update Committee (RUC) is the appropriate way to value codes in the future. The RUC has been valuing codes since 1991 and ever since then, they have been proposing CPT code values to CMS. RUC members have diligently worked to provide fair valuations of new and revised codes, and CMS has accepted many of the RUC’s proposed values. While CMS frequently accepts RUC recommendations, there is no requirement to do so, and CMS does propose alternative values where there is disagreement. Additionally, if any new valuation process were proposed, it would take a number of years to create a viable system and may result in chaos throughout the healthcare system. The CPT and RUC processes are widely accepted, and while Medicare is the only payer that ties reimbursement to the RUC directly, many other payers look to the RUC valuations when they negotiate reimbursement rates with other practices and practitioners. The RUC process helps ensure that new and existing codes are evaluated on a system of relative value that helps provide stability to code valuations.

ANA believes the RUC valuation process can always be improved, particularly in how non-physician QHPs such as nurses are represented, and how their services are valued. ANA would support keeping

the current system in place with the RUC recommending code values, but urges CMS to encourage the RUC to improve valuation of non-physician practitioners, and expand the main RUC panel to include more non-physicians.

4. CMS must finalize the E/M Proposals.

a. ANA supports activation of HCPCS code G2211.

ANA strongly urges CMS to finalize the proposal to activate HCPCS code G2211. In some parts of the country, nurse practitioners conduct a significant percentage of primary care visits, many of which are reimbursed under E/M codes. CMS, by their own estimate, believes that this code will be billed as roughly 38 percent of all E/M visits. This increase in reimbursement will encourage more practitioners, including nurse practitioners, to provide primary care as the reimbursement gap between primary and specialty care continues to narrow. Ensuring access to primary care in Medicare must be a top federal priority.

Additionally, ANA agrees that G2211 should not be reportable when the provider reports an E/M code along with payment modifier 25. Modifier 25 signifies that additional, specifically non-E/M services were provided during the encounter. If these services were not E/M services, then there should be no reimbursement adjustment for services that are reimbursed under a different CPT code. G2211 is only for E/M services and the resulting higher reimbursement should be based on E/M services only and not other services that are reimbursed concurrently for other CPT codes.

b. CMS should delay the implementation of the substantive portion of split E/Ms.

APRNs often provide valuable care during E/M visits, and their work should not be discounted simply because a physician has spent time reviewing the work that has already been done. CMS must develop E/M policy that avoids inappropriate and unfair incentives for a physician to do slightly more than half of the work and therefore be reimbursed at a higher rate than the equally qualified APRN working within their established scope of practice.

ANA appreciates the ongoing consideration CMS has given to stakeholder concerns about defining and documenting facility-based E/M services when performed by non-physician QHPs and physicians. We recognize there are certain challenges under the current system in appropriately reimbursing team-based care when more than one team member is providing care associated with one code. Nonetheless, we believe CMS must develop policy that recognizes the various ways team-based care is provided, and does not unnecessarily or inequitably incentivize one approach over another that may reduce provider efficiency and ultimately patient access to care.

ANA supports CMS' proposal to delay the implementation of the split E/M proposal through the end of calendar year 2024. We would also support a delay beyond the additional one year proposed, not only to analyze claims experience sufficiently, but also for policymakers to engage stakeholders to fully understand variations in practices and staffing approaches for these codes.

5. CMS must continue to expand access to telehealth.

ANA strongly supports the continuation of the telehealth flexibilities that have been in place since the start of the COVID-19 public health emergency (PHE). These flexibilities greatly expanded the range of services available to the many beneficiaries who do not live within a reasonable distance of the

practitioner they need to see for their medical needs. Medicare beneficiaries in health professional shortage areas (HPSAs) with complex medical conditions have not always been able to travel and see their practitioner, but expanding telehealth has greatly increased the ability of these beneficiaries to receive the care they require. While many people may assume that HPSAs are a rural issue, there are many inner city HPSAs as well. Many Medicare beneficiaries have limited mobility along with complex and chronic conditions that require significant amounts of care. Telehealth allows these patients to receive high quality care from the comfort of their own home thereby improving access to care and improving the health of the population.

a. Items on the Telehealth List.

CMS is proposing changes in how services will be added to the telehealth list. The five-step process looks at whether items are separately reimbursable under the PFS and whether the service contains an inherent face-to-face element. The steps required are reasonable and ANA supports these requirements for the telehealth list. Items that have a face-to-face element cannot be done remotely. ANA would support any efforts that would simplify the list while at the same time ensuring that telehealth services can be done safely and effectively. ANA understands that CMS must exercise due diligence in ensuring that all telehealth services comply with current law and that is the reason for some of the current steps. CMS cannot remove the steps, but they may be able to combine some of the steps and therefore simplify the administrative burden. This would have the double benefit of saving money and providing high quality care to patients who otherwise would not have access to care.

b. Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM).

CMS proposes to allow RPM reimbursement within a global period of other procedures. ANA supports this proposal as chronic conditions monitored by RPM are not necessarily related to follow-up visits from the underlying procedure.

CMS also clarifies that RPM and RTM cannot be billed together. ANA opposes this policy as the work, and devices, are different for the two types of monitoring. CMS, in the proposed rule, admits this stating that multiple devices may be used for monitoring, but at the same time requires that there be 16 days of independent data to bill for either service. Clearly this is impossible as there are no months with 32 days, but the monitoring work for the two differing services still must be done by the practitioners. ANA understands that there is the potential for fraud if these two services are billed together, but if practitioners provide proper documentation they should be billable at the same time when both are delivered to the patient.

c. Non-Facility Rate Reimbursement.

CMS proposes to reimburse telehealth visits at the non-facility rate for at home visits (POS 10). CMS further proposes an expansive definition of home to include almost any place where a person would be living including hotels and homeless shelters. ANA strongly supports these definitions as it will allow more practitioners to see patients remotely.

ANA agrees that labeling an appointment telehealth should not necessarily mean that it is paid at the non-facility rate. Practitioners should not be able to have patients be seen in other exam rooms and be reimbursed at the telehealth rates. The requirement that patients be seen in the expansive definition of home is reasonable and ANA supports finalizing the proposal as written.

d. Requirement for In Person Mental Health Appointments.

CMS proposes to delay the requirement that initial mental health appointments be in person until January 1, 2025. Behavioral health is a difficult field and many patients in this field may be justifiably afraid of contracting various contagious diseases, including COVID-19 and MPOX, that are constantly spreading. Delaying the in-person visit requirement for an additional year allows the CDC, and other government agencies, time to find additional effective treatments and these could give peace of mind to these patients. As a result, ANA strongly supports the proposal to delay the in-person behavioral health requirements until January 1, 2025.

e. Audio Only Visits for Opioid Treatment.

CMS proposes to extend flexibilities put in place during the COVID-19 PHE through the end of 2024 to better align opioid treatments with other telehealth legislation included in the Consolidated Appropriations Act. These flexibilities are only allowed where they also align with DEA and SAMHSA requirements and laws. ANA agrees with CMS' assessment that continuing these flexibilities will promote access to treatments that may not be available if video were required as part of the appointment. The additional year will also give both practitioners and patients the time they need to adjust how they conduct appointments in preparation for 2025 when audio and video requirements will revert to pre-pandemic rules.

f. Removing Telehealth Frequency Limitations.

During the PHE, CMS removed telehealth frequency limitations. These limited how often one could have telehealth visits. In previous rulemaking, CMS extended the flexibility through the end of calendar year 2023. While CMS is not proposing to fully re-instate these limitations, they are proposing to only allow them for a specific list of codes mentioned in the proposed rule. ANA supports the removal of the frequency limitations for these codes and would support a system similar to how codes are included in the telehealth list for placing codes on this list in future years.

6. ANA Applauds CMS' work to expand access to care provided by APRNs.

ANA has long advocated for policy improvements to expand access to care provided by APRNs, including removal of unnecessary federal barriers to APRN practice. Such policy improvements have been indicated by the National Academy of Medicine (NAM) at least since its 2011 Future of Nursing report¹; and again in NAM's 2021 report.² Federal experts are unequivocal that APRNs should be able to practice to the full extent of their education and training. State law determines provider scope of practice and as with other providers, CMS should allow APRNs the ability to practice within their fully authorized state scope of practice.

ANA supports federal action to promote APRN practice across the health care system, and particularly in programs and efforts to ensure equitable access to care for patient groups that experience disparities in

¹ National Academy of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. 2011. Available at <https://nap.nationalacademies.org/catalog/12956/the-future-of-nursing-leading-change-advancing-health>.

² National Academy of Medicine. *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. 2021. Available at: <https://nam.edu/publications/the-future-of-nursing-2020-2030/>.

access and outcomes. We thank CMS for its steady progress in removing regulatory barriers to APRN practice and expanding patient choice of practitioner.

a. ANA supports proposed methods of ACO/MSSP assignment that recognize primary care provided by APRNs.

ANA supports the proposal to modify its existing method of assigning beneficiaries to Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP). We agree with CMS' assessment that its current method overlooks many beneficiaries who rely on APRNs for their primary care. ANA has long advocated for legislative and regulatory reforms to extend value-centered delivery models to patients of APRNs. While NPs specifically are considered ACO/MSSP professionals and their patients can opt into assignment, the current claims-based assignment method identifies only patients whose primary care provider is a physician.

ANA appreciates CMS' proposal, working within statutory limitations, to identify Medicare beneficiaries who have received primary care from a CNS or NP during the previous year, if a primary care claim from a physician has been received in the previous two years. We urge CMS to finalize this proposal, which we believe will result in more beneficiaries assigned to ACOs, particularly those who live in underserved areas where many people rely on non-physician practitioners to meet their primary care and other healthcare needs. We applaud this effort to align ACO incentives with CMS health equity goals, which ANA and our members fully support. Ultimately, patients seen by APRNs should be included without limitation but the proposal represents a positive step forward for nurses, patients and ACOs/MSSPs

b. ANA supports CMS' proposed changes related to APRNs in RHCs and FQHCs.

The proposed rule takes several steps to amend regulations related to care that APRNs provide in rural health centers (RHCs) and federally qualified health centers (FQHCs).

We agree that the current definition of NP should be updated, to remove the requirement that NPs must be certified in primary care. This change will allow more flexibility for RHCs and FQHCs to recruit QHPs whose skills and experience match patient needs in a given area, including needs for behavioral health. CMS appropriately cites the APRN Consensus Model for guidance in drafting the proposed rule. Regardless of setting, APRNs should be nationally board certified in at least one recognized role and population.

We encourage CMS to continue updating Medicare regulations to align with the Consensus Model, which represents broad professional agreement on APRN roles and patient populations. Accordingly, we support elimination of all supervision requirements applied to APRNs who are practicing to the extent authorized by state law. We also urge CMS to work with Congress to remove barriers that cannot be addressed through the rulemaking process, including codifications of the flexibilities that CMS allowed during the COVID-19 public health emergency.

c. ANA supports CMS implementing provisions allowing APRNs to supervise cardiac and pulmonary rehabilitation.

ANA thanks CMS for implementing the Balanced Budget Act of 2018 (BBA) requiring the removal of APRN practice barriers which take effect January 1, 2024. Specifically, the proposed rule implements provisions allowing APRNs to supervise cardiac and pulmonary rehabilitation services. We believe that

this positive change should be implemented as proposed in order to expand access to these important services, particularly in rural areas where APRNs play such an important role in ensuring access to care.

ANA thanks CMS for recognizing the work being done by APRNs. The supervision of diagnostic test requirements specifically mentions that physicians and other practitioners (including APRNs) can supervise cardiac and pulmonary rehabilitation which is a positive change from requiring that supervision be done only by a physician. APRNs are highly trained individuals and the education and licensure requirements more than prepare them to supervise cardiac and pulmonary rehabilitation.

d. CMS must ensure all four APRN roles are included in Principal Illness Navigation and Community Health Integration services.

We appreciate that CMS is better identifying and value practitioners' work in helping patients navigating the healthcare system by proposing payment for Principal Illness Navigation (PIN) Services. We request that CMS require as condition of paying for services as part of the PIN Services (CPT codes GXXX3 and GXXX4), that the individual billing for these services ensure that all applicable APRN roles are identified and included in the services that are recommended for the patient and caregiver. As more than 40 percent of Medicare beneficiaries receive their care from APRNs, we believe it is crucial that the billing practitioner include all appropriate types of APRNs and to fully recognize and account for all the care that each type of APRN provides as part of this service. Including all APRNs as part of this service is in line with CMS's strategic plan to advance health equity as it helps ensure access to needed healthcare services. Expanding access is crucial as more than 57 million Americans live in rural areas, and many APRNs treat patients in rural and medically underserved areas where there are no or limited physician counterparts available.

Additionally, CMS proposes to create two new G codes for community health integration services performed by "auxiliary personnel", including community health workers, under the general supervision of the billing practitioners, including APRNs. We request that CMS recognize all four types of APRNs as the billing practitioners in this role. The goal of these codes is to provide increased recognition of the impact of social needs on patients' health. Addressing SDOH and providing whole-person centered care is a core component of APRN practice and we support this proposal which will help support clinicians to address SDOH in their patients' plans of care.

7. ANA continues to support CMS' focus on advancing health equity throughout the Medicare program.

ANA remains focused on the prominent issue of advancing health equity in our nation's health care delivery system. Providing culturally appropriate care to patients has long been an ethical imperative for the nursing profession. Nurses embrace diversity and engage in culturally appropriate care, while working to remove unconscious biases to effectively promote meaningful patient outcomes. ANA applauds CMS for its continued focus on health equity, which is reflected in this and other rulemaking. ANA supports the agency's efforts around increased alignment across all programs—such as in the Advanced Payment Models and Merit-based Incentive Payment System (MIPS)—to advance health equity priorities. The association remains steadfast in urging the agency to turn to our nurses to address health equity barriers and identify real solutions. Specifically, ANA appreciates consideration of the following comments related to proposed provisions in the above-captioned rule.

a. ANA supports the advancement of the Quality Payment Program (QPP) but urges CMS to properly account for the impact of nurses and nursing practice.

In the proposed rule, CMS has advanced the QPP toward MIPS Value Pathways (MVPs). ANA supports the overall move toward CMS' Universal Foundation which will result in better care for patients and reduced administrative burden for clinicians. However, current payment policy still does not account for the value of RNs and their impact on patient outcomes. For example, ANA supports the addition of the Patient Activation Measure (PAM) as a tool to address chronic conditions, ensure care is patient-centered, and reduce costs for the Medicare program.³ Nurses are critical to the success and administration of this measure due to their expertise in patient education and care coordination. Nurses help patients and their families navigate the healthcare system and gain more independence. ANA encourages CMS to continue to look for ways to ensure the value of nurses, both RN and APRN, are recognized and captured within the QPP and value-based care more broadly.

Coaching patients on their health is a core tenant of nursing practice, as is caregiver training. This work, often done by RNs in their regular practice, should be counted and rewarded through quality initiatives. ANA strongly supports CMS' proposal in the rule to reimburse clinicians for caregiver training via CPT codes 96202 and 96203 as well as CPT codes 9X015, 9X016, and 9X017. However, there remain many more opportunities to recognize and reimburse the work of nurses. For instance, the patient reported Feeling Heard and Understood measure will likely be led by nurses due to their focus on patient understanding and creating meaningful communication. Nurses advocate for their patients at and beyond the bedside, ensuring patients and their caregivers receive high-quality compassionate care. ANA urges CMS to accurately account for the impact nurses have on care delivery and patient outcomes.

b. CMS must finalize health equity focused measures in the QPP.

ANA strongly supports CMS' proposal to align health equity focused measures across the QPP. As CMS notes in the proposed rule, health disparities persist in the U.S. causing worse health outcomes for marginalized communities, especially communities of color. Providing equitable care to patients has long been an ethical imperative for the nursing profession and again, it will be RNs implementing CMS' important health equity measures. For example, nurses are critical for CMS' proposal to encourage partnerships with local Community-Based Organizations (CBOs) in order to follow up on Social Determinants of Health risk assessments. As nurses coordinate care and coach their patients, they are best positioned to identify appropriate services and CBOs as well as the most common socioeconomic and sociodemographic barriers their patients face. Nurses are key partners in CMS' effort to ensure that health equity focused measures truly capture the needs of patients, the impact of nursing care on patients, reflect the role of the nurse in identifying and addressing health disparities, all while balancing administrative burden.

As mentioned above, ANA encourages CMS to examine recommendations contained in NAM's report *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*.⁴ Some of the recommendations in the report call on government agencies and other stakeholders to take action that

³ Ann Lindsay, MD., et al., *Patient Activation Changes as a Potential Signal for Changes in Health Care Costs: Cohort Study of US High-Cost Patients*. *Journal of General Internal Medicine*. October 5, 2018. Available at: <https://link.springer.com/article/10.1007/s11606-018-4657-6>.

⁴ National Academy of Medicine. *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. 2021. Available at: <https://nam.edu/publications/the-future-of-nursing-2020-2030/>.

allow nurses to comprehensively address social determinants of health across care settings, allow nurses to practice to the top of their license, support the mental well-being of nurses and ensure a robust and diverse workforce ready for future challenges, and implement payment strategies that support addressing patients' social needs and health equity challenges. The report also specifically calls on CMS, with other federal agencies, to convene nurses and other key stakeholders to work together to identify research areas and other evidence-based approaches that examine the impact of nursing services on patients' health and nurses' well-being.

c. CMS must implement the new MVP on Women's Health.

ANA applauds CMS' proposed new MVP on Women's Health. Access to basic reproductive and preventive care is critical for healthy communities but data shows many women are still delaying this care.⁵ It is imperative to ensure evidence-based preventive services recommendations and access to this care is strengthened. APRNs are highly qualified clinicians that work to fill provider deserts and practice patient-centered primary and specialized care. NPs and CNMs are especially important for the appropriate breadth of the new MVP. These clinicians have the expertise to not only conduct the appropriate screening measure but also create the provider-patient dialogue required for improvement activities, such as discussions on postpartum depression and connecting patients with quality referrals.

d. CMS should work closely with nurses to determine the best approach to integrating a Social Determinants of Health (SDOH) risk assessment to Annual Wellness Visits (AWVs).

CMS proposes to allow an optional SDOH risk assessment as part of Medicare's AWVs, paid at 100 percent of the fee schedule amount of the assessment with no beneficiary cost sharing, using a standardized, evidence-based tool that is culturally and linguistically appropriate for each patient. ANA agrees with CMS' reasoning for proposing the inclusion of such an assessment as we understand that health outcomes are inextricably tied to SDOH. We also support the agency's desire to incorporate this assessment with resources for the provider, while shielding patients from additional cost-sharing.

CMS proposes to allow clinicians to choose screening instruments that are standardized and evidence-based to conduct the Risk Assessment. ANA strongly urges CMS to work closely with nurses to further refine the tools available to clinicians for this Risk Assessment. As noted above, nurses are key partners for CMS' efforts around health equity and their knowledge of their patients is key, especially when conducting nuanced assessments to determine a patient's SDOH challenges and barriers. Nurses are positioned, given their roles in the health care delivery system, to understand the approaches that are culturally and linguistically appropriate for the patients in their care. As such, ANA encourages CMS to finalize its proposal to include a SDOH Risk Assessment and to work closely with nurses to identify the best approach to integrate this assessment in the AWV.

8. CMS must retain the COVID-19 in-home vaccination administration add on payment.

⁵ Michelle Long, et al., *Many Women Use Preventive Services, but Gaps in Awareness of Insurance Coverage Requirements Persist: Findings from the 2022 KFF Women's Health Survey*. Kaiser Family Foundation. February 22, 2023. Available at: <https://www.kff.org/womens-health-policy/issue-brief/many-women-use-preventive-services-but-gaps-awareness-insurance-coverage-requirements-persist-findings-from-2022-kff-womens-health-survey/>.

ANA continues to support COVID-19 vaccination access as immunizations for preventable diseases protects the public health and follows nursing professional and ethical obligations.⁶ Consistent vaccination access and data tracking are important to respond to current and future infectious threats. ANA agrees with CMS' proposal to permanently keep the COVID-19 vaccine administration add on payment for in-home administration. As the proposed rule states, this policy increases access to patients with incredible barriers who rely on in-home care. The proposal from CMS streamlines the process for administering all four Part B preventive vaccines and ensures equitable access to a critical public health service.

9. CMS should finalize proposals to strengthen the Medicare Diabetes Prevention Program (MDPP) and look to nurses for the demonstration's success.

CMS proposes several changes to the MDPP aimed at strengthening the program. Specifically, CMS proposes to modify the payment from attendance to fee-for-service to better reflect how services are provided within the program. The agency proposes to extend COVID-19 flexibilities for another four years, largely to allow for check-ins and other resources of the program provided to beneficiaries through virtual modalities. CMS also proposes modifications to the payment program—from performance-based to fee-for-service payments—to better align with the structure and implementation of the program. The agency is right to do this to ensure providers receive compensation as they execute the program and have the resources to continue to work with program participants.

ANA supports the agency's desire to strengthen this program, which is an evidence-based behavioral intervention as part of the preventative services available to Medicare beneficiaries with no additional cost sharing. The intervention utilizes coaches who work with Medicare beneficiaries diagnosed with prediabetes to prevent or delay the onset of Type 2 diabetes.

ANA encourages CMS to continue to work closely with nurses as they look at continued refinements to and the expansion of the MDPP. Nurses are natural coaches and program leads as nurses work closely with and advocate for the patients in their care. As CMS works to strengthen the MDPP, ANA urges the agency to finalize its proposals and work closely with nurses to further implement this program.

Thank you for the opportunity to submit comments on this proposed rule. If you have any questions, please contact Tim Nanof, Vice President, Policy and Government Affairs, at tim.nanof@ana.org or (301) 628-5166.

Sincerely,



Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer / EVP

cc: Jennifer Mensik Kennedy, PhD, RN, NEA-BC, FAAN, ANA President
Loressa Cole, DNP, MBA, RN, NEA-BC, FAAN, ANA Chief Executive Officer

⁶ American Nurses Association. *Position Statement: Immunizations*. Updated November 23, 2021. Available at: <https://www.nursingworld.org/~4afdf9/globalassets/docs/ana/practice/official-position-statements/immunizations-position-statement-nov-2021.pdf>.