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January 23, 2025

The Honorable Dorothy Fink
Acting Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically to www.regulations.gov

RE: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Acting Secretary Fink,

The American Nurses Association (ANA) is pleased to submit the following comments in response to the above-captioned rule. ANA supports the Center for Medicare & Medicaid Services' (CMS') goals for increasing access to care and ensuring network adequacy by ensuring patients can see the practitioner of their choice.

While we appreciate CMS' thoughtful proposals, ANA urges the agency to incorporate the following as it finalizes this rulemaking:

- providing Medicare and Medicaid coverage of obesity medications,
- ensure equitable access to behavioral health,
- safeguard network adequacy, including access to Advanced Practice Registered Nurses (APRNs), and
- guarantee the proper use of Artificial Intelligence (AI) in health care.

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 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. ANA members also include the four APRN roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). 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.

Nurses are critical to a robust health care system. Nurses meet the needs of patients and provide quality care that leads to better health outcomes for all patients. Moreover, nurses are critical to coordinated care approaches for Medicare beneficiaries in all settings, including hospital outpatient settings. Patient-centered care coordination is a core professional standard for all RNs and is central to nurses' longtime practice of providing holistic care to patients.

We appreciate the agency's thoughtful consideration of our comments.

1. **CMS must provide Medicare coverage of obesity medications.**

CMS proposed to change their interpretation of current law. This new interpretation would allow CMS to cover obesity medications, which until now have not been a covered service under Medicare. ANA published, with the Nurses Obesity Network (NON),[1] a May 2023 position statement[2] calling for obesity to be treated with the full continuum of care—including the use of medication. The statement outlined recommendations for CMS, including the agency's current proposal to cover anti-obesity medication (AOM). CMS is right to propose this to ensure patients have access to the care they need to address this critical health condition.

Since 2013, obesity has been classified as a chronic disease and coverage of medication, and other treatment, will allow patients to receive the care they need and can improve their health significantly. Obesity has been shown to be a root cause of other chronic diseases, such as diabetes. Treating the root cause of these diseases is critical to reducing chronic conditions and a healthier population nationwide. The obesity epidemic is worsening and it is estimated that nearly half of American adults will be obese by 2030.[3] The National Institutes of Health (NIH) has reported that being obese or overweight are now the second leading cause of death nationally, with an estimated 300,000 deaths a year attributed to the epidemic.[4] Obesity is also not a disease that affects all populations equally. African Americans have the highest prevalence of obesity at close to 50% of the population.[5]

ANA believes that all clinicians should have access to all available treatment tools for their patients. Evidence-based medication treatments targeting obesity allow clinicians an additional approach to address patient's health needs. Clinicians must be able to prescribe medication they deem appropriate without patients facing additional barriers due to lack of coverage. **As such, ANA urges CMS to finalize its proposal for Medicare to cover obesity medication.**

Obesity also has a significant cost to the health care delivery system and, more specifically, the Medicare and Medicaid programs. Treatment of obesity represents nearly half of all the costs

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[1] ANA is a member of the NON.

[2] https://www.nursingworld.org/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/social-causes-and-health-care/nurses_obesity_network-position_statement-final_5-24-23.pdf

[3] Ward, Z et al. Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity. N Engl J Med (2019); 381:2440-2450.

[4] West Virginia Health Statistics Center. (n.d.) Obesity: Facts, Figures, Guidelines. https://www.wvdhhr.org/bph/oehp/obesity/mortality.htm

[5] Centers for Disease Control and Prevention. (2022, May 17). Adult obesity facts. Centers for Disease Control and Prevention. https://www.cdc.gov/obesity/adult-obesity-facts/index.html

associated with treating chronic disease in the US.[6] This leads to significant federal outlays, with Medicare and Medicaid estimated to spend over $90 billion a year due to obesity.[7]

ANA further agrees with CMS that this interpretation should take effect 60 days after finalization instead of waiting for the next calendar year. Effective treatments should be available as soon as possible and should not have to wait for artificial timelines. This is especially true in this case as obesity medications have proven efficacy and practitioners are already prescribing them.

CMS is also proposing that Medicaid plans make the same changes that would be required under Medicare. ANA strongly supports these proposals and urges CMS to work with the states and cover AOM.

2. **CMS must ensure equitable access to behavioral health.**

CMS proposes that in-network cost sharing for substance abuse disorder services and mental health services, referred to as behavioral health services, under Medicare Advantage (MA) plans be no greater than traditional Medicare fee-for-service beginning January 1, 2026. Many beneficiaries choose coverage by MA plans for a variety of reasons, and limiting cost sharing for services under these plans allows patients more comprehensive coverage and limits barriers to needed care. CMS is also seeking comment on whether this proposal should take effect in calendar year 2026 or 2027. ANA believes that this change should be made as soon as possible, and therefore it should take effect in 2026. This still gives MA plans ample time to adjust their plans and be in compliance with the new cost sharing requirements. **ANA strongly supports the agency's proposal and urges CMS to finalize limiting MA plan cost-sharing for behavioral health services.**

3. **ANA urges CMS to ensure MA plan beneficiaries have access to all providers, including APRNs.**

MA plans are allowed to choose providers for their enrollees provided that there is enough access to maintain continuity of care. CMS has long maintained that network adequacy is assessed at the county level. ANA remains concerned that network adequacy requirements for MA plans do not adequately and explicitly ensure access to the health care services provided by APRNs. **ANA urges CMS to ensure that plans offer enrollees robust choice of provider type, including APRNs.**

APRNs provide safe and cost-effective care and are often the providers preferred by patients—but all too often find themselves excluded from health plan provider networks. That exclusion only further compounds access barriers for patients in states with outdated licensing rules that unnecessarily restrict APRN practice. However, even in states that grant full practice authority for APRNs, patient access can be hampered. Unfortunately, ANA can share numerous accounts from our APRN members with firsthand experience of how plans discriminate against them, and the adverse impacts that discrimination has on patients. Excluding these clinicians from plans has led to delayed care, inaccurate patient follow-up, and dissatisfaction. We also know that patients often must pay out of pocket when APRN claims are denied, which could lead them to look for

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[6] Hammond R, Levine. The economic impact of obesity in the United States. Diabetes Metab Syndr Obes. 2010;3:285-295 https://doi.org/10.2147/DMSO.S7384

[7] Benjamin, H., & Harris, AW. (2014, December 12). Obesity costs evident at the state level https://www.brookings.edu/articles/obesity-costs-evident-at-the-state-level/.

another clinician who will be covered. This creates unnecessary barriers to access to care for patients, especially the most vulnerable. Moreover, a physician may not be available or accessible, especially in rural and underserved areas. Patients are left without meaningful choices, even though APRNs stand ready to provide primary care and other services as within their scope of practice. ANA believes CMS must exercise its oversight authority to ensure APRN inclusion in MA plan networks.

Ensuring the inclusion of APRNs, allowed to practice at the top of their license, is imperative to addressing barriers to care faced by patients. As such, CMS must ensure APRNs are considered when determining MA plan network adequacy requirements across all settings and geographic areas.

4. **ANA supports appropriate use of AI in the health care delivery system.**

CMS would like to ensure that AI is used equitably in healthcare. ANA does not object to the continued use of AI in healthcare but wants to ensure that it is being used in a proper fashion. As outlined in a recent position statement, ANA calls for AI to be used ethically in all health care settings.[8] This works in tandem with CMS' proposal in this rule ensuring AI is used equitably and that programming algorithms do not discriminate against any patients. CMS is concerned that the algorithm will discriminate against certain patient populations not out of malice, but out of programming algorithms that look for patterns. An example could be missed appointments. Many Medicare patients live on fixed incomes and there might be times where they cannot afford transportation to see their practitioners. CMS wants to ensure that these patterns are not programmed into the AI thereby ensuring that all patients have the same access to care. ANA strongly supports this principle and looks forward to working with the Administration on ways to ensure that the application and use of AI in health care settings is done in an ethical and appropriate manner.

ANA appreciates the opportunity to submit these comments and looks forward to continued engagement with CMS. Please contact ANA's Executive Vice President, Policy & Government Affairs at (301) 628-5166 or tim.nanof@ana.org with any questions.

Sincerely,

Jennifer Mensik Kennedy PhD, MBA, RN, NEA-BC, FAAN
President

cc: Angela Beddoe, ANA Chief Executive Officer

[8] The ethical use of Artificial Intelligence in Nursing Practice. https://www.nursingworld.org/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/the-ethical-use-of-artificial-intelligence-in-nursing-practice_bod-approved-12_20_22.pdf. Last Accessed January 22, 2025.