



American Association of
NURSE ANESTHESIOLOGY

March 25, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

RE: CMS-6098-NC–Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare

Dear Secretary Kennedy and Administrator Oz:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on the Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare. AANA's comments recommend the following:

- Remove Physician Supervision Requirements for CRNAs
- Investigate Anticompetitive and Discriminatory Commercial Payer Anesthesia Policies and Enforce Provider Nondiscrimination Statute.

AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 69,000 CRNAs and SRNAs, representing about 88 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 58.5 million anesthetics to patients each year in the United States. Since 1989, CRNAs have been Medicare Part B providers, billing Medicare directly at 100% of the Physician Fee Schedule (PFS). CRNAs must be board certified and must participate in continuing education and recertification every 4 years to practice.

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As independently licensed professionals, CRNAs are responsible and accountable for making judgments and taking actions in their professional healthcare practice.¹ CRNAs provide expert anesthesia and pain management care across diverse clinical settings and are trained and licensed to care for all patients, including those with complex medical conditions. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.²

RFI Question: Are there existing requirements or policies, including those issued through regulations, memoranda, administrative orders, subregulatory guidance documents, or policy statements that could be altered to increase CMS' ability to promote payment accuracy and efficiency to protect the integrity of Medicare, Medicaid, CHIP, and the Health Insurance Marketplace?

AANA Comment: Unnecessary Medicare physician supervision requirements and anticompetitive commercial payer reimbursement policies perpetuate the use of inefficient and wasteful medical direction payment models.

- **AANA Request: CMS should remove physician supervision requirements for CRNAs.**

The Centers for Medicare & Medicaid Services (CMS) should remove onerous and unnecessary physician supervision requirements on CRNAs in Medicare Part A as part of the Hospital, Critical Access Hospital, and Rural Emergency Hospital Conditions of Participation (CoPs) and the Ambulatory Surgical Center Conditions for Coverage (CfCs).³ These requirements result in operational inefficiencies and waste in the Medicare program and increase financial costs, particularly for rural facilities that rely upon CRNAs for anesthesia services. Physician supervision requirements, which are not required as a Condition of Payment for CRNAs under Medicare Part B, incentivize the use of inefficient Medicare Part B anesthesiologist medical direction payment models.

Medically directed anesthesia payment models contribute nothing to care quality or patient safety. In fact, the Health Care Finance Administration (HCFA) stated in 1998 that, “[t]he medical direction requirements are not quality of care standards”.⁴ These models allow physician anesthesiologists to spuriously collect 50% of the fee per case for up to four concurrent cases performed by CRNAs, while consistently failing to meet Medicare regulatory requirements. This has resulted in significant lapses as made evident by a 2012 study in *Anesthesiology*, the official journal of the American Society of Anesthesiologists,⁵ that found that lapses occurred on 35 percent of days even under a 1:2 anesthesiologist to CRNA ratio. One of the more common iterations is the medically directed anesthesia payment model with a 1:4 ratio, where a single physician anesthesiologist medically directs four CRNAs. Under this model, the CRNAs bill for their

¹ AANA Code of Ethics for the Certified Registered Nurse Anesthetists, July 18, available at: https://issuu.com/aanapublishing/docs/code_of_ethics_for_the_certified_registered_nurse_?fr=sZGY1YTU2NDAxMjU.

² For further information see: <https://www.aana.com/about-us>.

³ 42 CFR §482.52(a)(4) and (c), §485.639(c)(2) and (e), §416.42 (b)(2) and (c), and § 485.524 (d)(3)(ii) and (d)(5).

⁴ 63 FR 58843, November 2, 1998, available at: <https://www.govinfo.gov/content/pkg/FR-1998-11-02/pdf/98-29181.pdf>.

⁵ Epstein RH, Dexter F. Influence of supervision ratios by anesthesiologists on first-case starts and critical portions of anesthetics. *Anesthesiology*. 2012 Mar;116(3):683-91. doi: 10.1097/ALN.0b013e318246ec24. PMID: 22297567.

services but the physician anesthesiologist will as well, concurrently billing a combined 200% of the PFS, without even providing direct patient care, creating unnecessary payments at the expense of American taxpayers. This is one of the most expensive models possible, but every iteration of the care team model is necessarily less efficient and more expensive than a model that allows for autonomous practice of CRNAs.

In contrast, study after study has concluded that, “the strong safety record of anesthesia in general and CRNAs in particular suggest that *politics and professional interests* are the main drivers of supervision policy in anesthesia delivery.”⁶ Research also shows that hospitals have higher revenue when CRNAs are able to practice without supervision.⁷ These supervision requirements are also unnecessary as they are more stringent than most state laws. To date, half of all states have opted out of the CMS requirement for physician supervision of CRNAs. Furthermore, 45 states do not have any requirements for physician supervision of CRNAs in their nursing/medicine laws or rules. Physician supervision of CRNAs under the Medicare program remains in place only due to political pressure from a small number of providers who have successfully lobbied for wasteful spending that benefits their own special interests and wastes taxpayer dollars. Furthermore, no other health care provider is required to lobby their state governors to opt-out of federal regulations for the purposes of meeting CoP or CfC requirements. Rescinding these requirements would align Medicare policy with clinical evidence and would allow facilities the flexibility to choose the anesthesia delivery model that meets their needs, thus reducing operating costs coming and improving operational efficiency.

CMS has the regulatory authority to rescind physician supervision requirements. While the CoPs and the CfCs themselves have a statutory basis, there is no enabling statute regarding physician supervision for anesthesia services provided by CRNAs. The first explicit mention of physician supervision of CRNAs was in the then-HCFA 1980 proposed rule that was never finalized (though a subsequent version of it was finalized in 1986 after a regulatory review and re-issuance). These requirements were originally rescinded in a final rule on January 18, 2001,⁸ but this final rule was withdrawn and replaced with a bureaucratic opt-out process for states to individually remove their physician supervision requirements.⁹ These requirements are clear regulatory overreach; there exists no enabling statute mandating CMS to implement physician supervision requirements of CRNAs or for the state supervision opt-out process. **HHS/CMS should remove these requirements to allow states and facilities to more efficiently manage their anesthesia care models.**

- **AANA Request: HHS and CMS should investigate these anticompetitive and discriminatory commercial payer anesthesia policies and enforce federal provider nondiscrimination statute.**

Recent commercial payer reimbursement policies also perpetuate the use of inefficient anesthesiologist medical direction payment models. Since 2023, numerous commercial payers issued anticompetitive and

⁶ Hoyem RL, Quraishi JA, Jordan L, Wiltse Nicely KL. Advocacy, Research, and Anesthesia Practice Models: Key Studies of Safety and Cost-Effectiveness. *Policy Polit Nurs Pract.* 2019 Nov;20(4):193-204. doi: 10.1177/1527154419874410. Epub 2019 Sep 11. PMID: 31510877.

⁷ Cintina I., et al., Cost Effectiveness of Anesthesia Providers and Implications of Scope of Practice in a Medicare Population, *Nursing Economic\$,* March-April 2018.

⁸ 66 Fed. Reg.4674, January 18, 2001.

⁹ 66 Fed. Reg. 56762, November 13, 2001.

discriminatory anesthesia reimbursement policies against CRNAs that have reduced reimbursement by 15 percent for non-medically directed CRNA services. These policies include:

- Cigna (nationwide) reduced reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e., claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, in March 2023.¹⁰
- Anthem Blue Cross Blue Shield of California, Connecticut, Maine, Missouri, Nevada, New York, Ohio, and Virginia reduced reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e., claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, in November 2024.¹¹
- Kaiser Foundation Health Plan of Washington (WA) reduced reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e., claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, in December 2024 (*policy later rescinded*).¹²
- Medical Mutual of Ohio (OH) reduced reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e., claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, in January 2025.¹³
- UnitedHealthcare (nationwide) reduced reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e., claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, in October 2025.¹⁴
- Blue Cross Blue Shield of Tennessee (TN) reduced reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e., claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, in October 2025.¹⁵
- Independence Blue Cross (PA) reduced reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e.,

¹⁰ Cigna Healthcare. (2023, March 12). Reimbursement Policy Commercial: Anesthesia Professional Services. https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/R39_Anesthesia_Professional_Services.pdf

¹¹ Anthem Blue Cross and Blue Shield. (2024, November 1). Commercial Reimbursement Policy: Anesthesia Services – Professional. <https://files.providernews.anthem.com/5106/ME-Anesthesia-Services-policy-06122024.pdf>

¹² Kaiser Foundation Health Plan of Washington. (2024, July 25). Modifiers. <https://wa-provider.kaiserpermanente.org/static/pdf/provider/communications/letters/20240725-modifier-policy.pdf>

¹³ Medical Mutual of Ohio. (2025, January 24). Reimbursement Policy: Anesthesia. https://www.medmutual.com/-/media/MedMutual/Files/Providers/CorporateReimbursementPolicies/Anesthesia_Reimbursement_Policy.pdf

¹⁴ United Healthcare. (2025, July 1). Anesthesia Policy, Professional.

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Anesthesia-Policy.pdf>

¹⁵ Blue Cross Blue Shield of Tennessee. (2025, September 1). Anesthesia Billing and Reimbursement Guidelines.

https://www.bcbst.com/providers/manuals/bcbst-preview-pam.pdf?_gl=1*19ufy8q*_gcl_au*MTQ2NDc5NzAwMS4xNzUzODk0OTey

claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, in December 2025.¹⁶

- Premera (WA, AK) proposed reducing reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e., claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, effective March 2026.¹⁷
- Highmark (PA, DE, NY) proposed reducing reimbursement for anesthesia services rendered by a Certified Registered Nurse Anesthetist (CRNA) without medical direction (i.e., claims submitted using the QZ modifier), by 15 percent, to 85 percent of the physician fee schedule amount, effective March 2026.¹⁸

These commercial payers have not issued policies to reduce reimbursement for any other anesthesia provider type. Because of this, these policies are inherently anticompetitive and push facilities to use more expensive medical direction payment models to maximize reimbursement revenue from commercial payers. These policies lead to inefficient care and create barriers to care, especially in rural areas where facilities already operate on razor thin margins or at a loss.

Given that these policies only apply to non-medically directed CRNA care, these policies are also blatantly discriminatory against CRNAs and violate provider nondiscrimination law under Section 2706(a) of the Public Health Service Act. Section 2706(a) of the Public Health Service Act prohibits health insurance plans and issuers from discriminating against providers based on their licensure when practicing within the legal scope of their license. While the statute makes clear that it does not prohibit "...establishing varying reimbursement rates based on quality or performance measures," none of these payers have provided evidence to support that these policies are due to any such measures.

As stated previously, peer-reviewed evidence shows the safety and effectiveness of CRNA-only care. HHS and CMS, specifically the Center for Consumer Information and Insurance Oversight (CCIIO), have the regulatory authority to intervene and enforce Section 2706(a) of the Public Health Service Act, **and we urge them to intervene, investigate, and address these policies.** Doing so will not only help protect patients and program integrity in the Health Insurance Marketplace® but will also have downstream benefits and savings for Medicare and Medicaid.

Conclusion

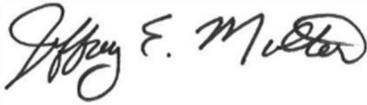
Thank you for the opportunity to comment on this request for information. AANA stands ready to assist you in efforts to combat waste and inefficiencies in the healthcare system, and we would be honored to meet with you in the coming months to further discuss recommended remedies. Should you have any questions regarding these matters and to schedule a meeting, please contact AANA Director of Regulatory Affairs, Romy Gelb-Zimmer at 202-484-8400, rgelb-zimmer@aana.com.

¹⁶ Independence Blue Cross. (2025, August 29). 00.01.14t: Reporting and Documentation Requirements for Anesthesia Services. <https://provcomm.ibx.com/pnc-ibc/news/Pages/Update-to-reporting-and-documentation-requirements-for-anesthesia-services.aspx>

¹⁷ Premera Blue Cross. (2025, December 4). Anesthesia Guidelines. https://www.premera.com/paymentpolicies/cmi_051695.pdf

¹⁸ Highmark Health. (2025, November 24). Mid-Level Practitioner and Advanced Practice Providers. <https://providers.highmark.com/content/dam/highmark/en/providerresourcecenter/rp-drafts/rp-068-030226.pdf>

Sincerely,

A handwritten signature in black ink that reads "Jeff E. Molter". The signature is written in a cursive style with a large, stylized "J" and "M".

Jeff Molter, MBA, MSN, CRNA
President, AANA

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer