September 8, 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:

On behalf of the more than 69,000 members of the American Association of Nurse Anesthesiology (AANA), I wish to submit comments and recommendations in response to 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*.

AANA's comments and recommendations make the following recommendations to CMS:

- Ensure access for all Medicare Part B providers to meaningfully participate in Alternative Payment Models.
- Work with Congress and other stakeholders to implement Medicare payment reform to ensure long-term, appropriate reimbursement for anesthesia services.
- Utilize empirical data to support RUC survey data in the valuation of services paid under the Medicare PFS.
- Implement payment methodologies for Software as a Service that incorporate principles that protect CRNAs' essential clinical decision-making.
- Avoid developing or implementing policies allowing for remote supervision of anesthesia services.
- Include CRNAs as participants in the Low Back Pain cohort for the Ambulatory Specialty Model and make participation voluntary.
- Ensure meaningful CRNA participation in the Medicare Quality Payment Program and maintain the use of clinically relevant anesthesia measures.

AANA is the professional association representing Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs) nationwide. CRNAs are Advanced Practice Registered Nurses (APRNs) who have been Medicare Part B providers since 1989, billing Medicare directly at 100% of the Physician Fee Schedule (PFS). CRNAs are autonomous anesthesia providers through their training and preparation and must be board certified and participate in continuing education and recertification every 4 years to practice. 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. For further information see: https://www.aana.com/about-us/

Medicare Part B Anesthesia Conversion Factor and Anesthesia Reimbursement

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

AANA urges CMS to ensure that all Medicare Part B providers, including CRNAs, 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.

AANA understands 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. Beginning in CY 2026, providers who participate in a qualifying APM will receive a 0.75% increase in reimbursement each year, while providers who do not participate in a qualifying APM will receive a 0.25% increase in reimbursement each year.

Given this incentive structure, it is critical that CMS support Medicare Part B providers, including CRNAs, in facilitating participation in APMs to maintain adequate reimbursement. We provide detailed proposals on how to facilitate CRNA participation in APMs in the sections of this comment letter on the *Ambulatory Specialty Model* and *Updates to the Quality Payment Program*. AANA stands ready to partner with CMS to develop these and other methods by which to ensure meaningful CRNA access to these models.

Anesthesia Reimbursement Reductions by Medicare and Commercial Payers

AANA urges CMS to work with Congress and other stakeholders to implement Medicare payment reform to ensure long-term, appropriate reimbursement for anesthesia services.

Participation in the proposed APM conversion factor structure is particularly crucial given the declining trendlines for anesthesia reimbursement over the last several years. AANA appreciates that CMS' Medicare PFS conversion factor proposals will result in slight increases to anesthesia services paid for under the Medicare PFS:

- **Qualifying APM Conversion Factor**: **$20.6754** (a **+1.76% increase** compared to the CY 2025 average national anesthesia conversion factor).

- **Non-Qualifying APM Conversion Factor**: **$20.5728** (a **+1.30% increase** compared to the CY 2025 average national anesthesia conversion factor).

However, this positive increase is not enough to make up for the erosion of reimbursement for anesthesia services over the last several years. If not for the one-time 2.5% increase in the conversion factor required under the *One Big Beautiful Bill Act,* CRNAs would once again be facing a **reduction** in reimbursement for services paid for under the Medicare PFS. The national anesthesia conversion factor, compared to the proposed CY 2026 Qualifying APM conversion factor ($20.6754), has **decreased by 7.2%** since 2019, when it was $22.2730. Meanwhile, the Medicare Economic Index (MEI) from 2020 through CY 2026 (estimated) has **increased by a cumulative 20.06%**.

In addition to declining Medicare reimbursement, commercial payers have issued policies that reimburse CRNAs at a lower rate than that of physician anesthesiologists for providing anesthesia services without medical direction; such services are identified using the QZ HCPCS modifier. This disparity persists even though CMS recognizes CRNAs as qualified Medicare Part B providers and reimburses CRNAs at 100 percent of the Medicare PFS amount. These policies blatantly violate the federal provider non-discrimination requirements at 42 U.S.C. §300gg-5.[1]

[1] Section 2706(a) of the Public Health Service Act, which reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by

The most recent example of this trend among commercial payers occurred in July 2025 with UnitedHealth Group's announced policy changes[2] to its anesthesia calculations, effective October 1, 2025. These changes include a 15% reduction in reimbursement to claims submitted using the QZ modifier, effectively lowering payment to 85% of the UnitedHealth Group fee schedule for anesthesia services rendered by a CRNA without medical direction.

Declining reimbursement for anesthesia services ultimately stands to negatively impact patient access to care across the country, particularly in rural and underserved areas. Hospitals and ambulatory surgery centers (ASCs) nationwide are forced to absorb the financial shortfall created by declining reimbursement from Medicare, Medicaid, and commercial insurers. As external reimbursement rates continue to fall, hospitals and ASCs are forced to cover a growing share of anesthesia department costs, frequently subsidizing more than 50% of the total expenses necessary to maintain operating room availability and clinical coverage. This often requires facilities to divert resources from other departments or service lines.

For institutions already operating on narrow margins, especially those serving underserved populations, these subsidies are not sustainable. Without policy or payment reform, hospitals and ASCs may be forced to scale back surgical capacity or eliminate certain services altogether, reducing patient access to timely, high-quality surgical care.

AANA understands that CMS must adhere to statutory budget neutrality requirements and that any changes to these requirements would necessitate future Congressional action. However, these anesthesia reimbursement trends are not sustainable. Without policy or payment reform, hospitals and ASCs may be forced to scale back surgical capacity or eliminate certain services altogether, reducing patient access to timely, high-quality surgical care. To the extent that CMS does have the ability to alter Medicare reimbursement rates, we ask that CMS work to mitigate the impact of declining anesthesia reimbursement rates and to work with Congress to establish a long-term solution. AANA stands ready to work with CMS to develop a solution to this issue.

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the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

[2] UnitedHealthcare Commercial. *Reimbursement Policy Update Bulletin: July 2025*. July 2025. https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/rpub/UHC-COMM-RPUB-July-2025.pdf

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

Payment methodologies for Software as a Service must incorporate principles that protect the essential clinical decision-making of CRNAs.

AANA agrees that Software as a Service (SaaS) is a rapidly growing and changing issue for Medicare programs. As CMS creates a payment system for innovative technologies, such as Artificial Intelligence (AI), we urge the adoption of principles that ensure clinician expertise is protected in order to support clinical decision-making and improve patient care. AI should assist - but never replace – CRNA clinical judgment that is based on extensive education and experience.

The opportunities to enhance patient safety and decrease the administrative burden on clinicians must be paired with proper oversight process for review. For more details on AANA's recommendations for utilizing AI see our comments to the National Science Foundation in response to their Request for Information on the Development of an Artificial Intelligence (AI) Action Plan.[3]

As CMS develops new processes and payment methodologies for SaaS, we urge the inclusion of CRNAs in any stakeholder roundtables or advisory committees as their clinical expertise will be invaluable. The scope of nurse anesthesia practice includes responsibilities for administration and management, quality assessment, interdepartmental liaising, and clinical as well as administrative oversight of other departments. As CRNAs possess a strong foundation in nursing, critical care, anesthesia, and pain management, they are frequently called upon to assume administrative and executive positions. CRNAs are regularly selected to function as anesthesia and surgery department administrators, chief nurse executives, chief operating officers and chief executive officers of hospitals. They are innovative leaders who are adept at recommending policy informed by high-quality innovative practice.

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

[3] American Association of Nurse Anesthesiology. *Comment Letter in Response to the National Science Foundation Request for Information on the Development of an Artificial Intelligence Action Plan*. February 27, 2025. https://www.aana.com/wp-content/uploads/2025/03/AANA-comments-on-RFI-Development-of-an-AI-Action-Plan.pdf

AANA appreciates and agrees 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. AANA supports 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 CRNAs, and would appreciate the opportunity to partner with CMS to develop empirical data standards.

Telehealth Supervision Requirements

AANA cautions CMS against the use of wasteful services in the name of telehealth that would increase costs without improving healthcare access or quality.

We would specifically caution CMS against any future proposals to reimburse physician anesthesiologists who are not providing actual anesthesia care through billing for so-called "remote supervision" services.

CMS notes in the preamble of the proposed rule on pages 32394-32395 – in justifying the exclusion of services that have a global surgery indicator of 010 or 090 from the definition of "direct supervision" that allows immediate availability of the supervising practitioner using audio/video real-time communications technology (excluding audio-only) for all services described under 42 CFR § 410.26 – that:

"The purpose of excluding these services is to ensure the quality of care and patient safety, and in particular, the ability of the supervising practitioner to intervene if complications arise, particularly in complex, high-risk instances where unexpected or adverse events may occur or for procedures that may be riskier or more intense where a patient's clinical status can quickly change. For such services, in-person supervision would be necessary to allow for rapid on-site decision-making in the event of an adverse clinical situation."

Anesthesia services are inherently complex and high-risk; the nature of providing anesthesia services does not lend itself to any form of remote supervision and would fall under the guidelines for exclusion that CMS describes in the preamble. There also exists no evidence that remote supervision for anesthesia services provides any tangible benefit.[4,5,6,7]

As CMS continues to consider revisions to its telehealth policies and any potential application in the provision of anesthesia services, we urge CMS to recognize AANA as a major stakeholder in policy formulation and to incorporate future AANA-developed guidelines around telehealth into the determination of Medicare payment policy.

Ambulatory Specialty Model

AANA urges CMS to revise the proposed regulatory language at 42 CFR § 512.710(b) and 42 CFR § 512.710(d) to include CRNAs as participants in the ASM Low Back Pain cohort.

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[4] Applegate II, Richad L., Gildea, Brett, et al. *Telemedicine pre-anesthesia evaluation: a randomized pilot trial*. Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association. E-Publication: February 5, 2013. doi: 10.1089/tmj.2012.0132. https://pubmed.ncbi.nlm.nih.gov/23384334/

[5] Dilisio Ralph P., Dilisio, Abra J., Weiner, Menachem M. *Preoperative virtual screening examination of the airway*. Journal of Clinical Anesthesiology. E-Publication: June 8, 2014. doi: 10.1016/j.jclinane.2013.12.010. https://pubmed.ncbi.nlm.nih.gov/24916897/

[6] Galvez, Jorge A. and Rehman, Mohamed A. *Telemedicine in anesthesia: an update*. Current Opinion in Anesthesiology. August 2011; 24(4):459-62. doi: 10.1097/ACO.0b013e328348717b. https://pubmed.ncbi.nlm.nih.gov/21659874/

[7] Cone, Stephen W., Gehr, Lynne, Hummel, Russell, and Merrell, Ronald C. *Remote anesthetic monitoring using satellite telecommunications and the Internet*. Anesthesia and Analgesia. May 2006;102(5):1463-1467. doi: 10.1213/01.ane.0000204303.21165.a4. https://pubmed.ncbi.nlm.nih.gov/16632827/

We are very concerned that CMS proposes to arbitrarily exclude CRNAs from participation in the proposed implementation and testing of the new Ambulatory Specialty Model (ASM). This is especially the case given the instrumental role that CRNAs play in the treatment of chronic pain, including low back pain. 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."

AANA 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 CRNAs as participants in the Low Back Pain cohort in the ASM; conversely, nothing in Section 1115A(b) of the Social Security Act precludes CMS from doing so.[8] CMS seems to have simply chosen to arbitrarily exclude CRNAs from participating in the ASM Low Back Pain cohort in its creation of the regulatory language at 42 CFR § 512.710(b) and 42 CFR § 512.710(d).

AANA would also respectfully point out that, contrary to CMS' statement that, "Medicare does not currently assign specialty codes to NPPs; therefore, NPPs would not satisfy that criterion", **Medicare does, in fact, assign specialty codes to APRNs, including CRNAs**. Chapter 12 of the Medicare Claims Processing Manual (revised December 19, 2024), states that, "A CRNA is identified on the provider file by specialty code 43."[9] Therefore, CRNAs do satisfy the specific criterion for participation that CMS cites as reason for CRNAs' exclusion from participation.

CRNAs are critical providers of pain management services and frequently treat low back pain. CRNAs practice in accordance with their professional scope of practice, federal, state, and local law, facility accreditation standards, and healthcare organization policy to

[8] 42 U.S.C. § 1315a – Center for Medicare and Medicaid Innovation.
[9] Centers for Medicare & Medicaid Services. *Medicare Claims Processing Manual*. Chapter 12 – Physicians/Nonphysician Practitioners (Rev. 13012; Issued: 12-19-24). Transmittal 140.3.4 – Anesthesia Fee Schedule Payment for Qualified Nonphysician Anesthetists – General Billing Instructions. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104C12.pdf

provide chronic pain management services, including treatment for low back pain.[10] The National Board of Certification & Recertification for Nurse Anesthetists (NBCRNA) has offered a subspecialty certification for CRNAs in Nonsurgical Pain Management (NSPM-C) since 2015,[11] while multiple institutions offer fellowships in advanced pain management.[12] Furthermore, federal regulations state that Medicare will pay for services furnished by CRNAs if they are legally authorized to perform these services in the State in which the services are furnished.[13,14]

As APRNs, CRNAs are uniquely skilled to deliver pain management in a compassionate and holistic manner. CRNAs provide chronic pain management services in various settings, such as hospitals, ambulatory surgical centers, offices, and pain management clinics. By virtue of education and individual clinical experience and competency, a CRNA may practice chronic pain management utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain.[15]

Excluding CRNAs from the ASM Low Back Pain cohort would put Medicare beneficiaries experiencing chronic low back pain at a disadvantage by disincentivizing CRNAs from providing these types of services, particularly in rural and underserved areas where CRNAs are the predominant providers of anesthesia services. It would also put CRNAs who provide pain management services 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. CMS should ensure that Medicare Part B providers have ample opportunity to participate in APMs rather than arbitrarily excluding them from doing so. AANA would appreciate the opportunity to meet with CMS to further discuss this proposal.

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[10] American Association of Nurse Anesthesiology. *Chronic Pain Management Guidelines*. Pg. 3. September 2014; revised November 2021. https://issuu.com/aanapublishing/docs/2_-_chronic_pain_management_guidelines?fr=sZDgxODU2NDAxMjU

[11] National Board of Certification & Recertification for Nurse Anesthetists. *Nonsurgical Pain Management*. https://www.nbcrna.com/certification-programs/nspm

[12] Council on Accreditation of Nurse Anesthesia Educational Programs. *List of Accredited Fellowships*. December 19, 2024. https://www.coacrna.org/programs-fellowships/list-of-accredited-fellowships/

[13] 42 CFR § 410.69(b).

[14] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule. 77 Fed. Reg. No. 222. 68892, 69005, et seq. November 16, 2012. https://www.govinfo.gov/content/pkg/FR-2012-11-16/pdf/2012-26900.pdf

[15] American Association of Nurse Anesthesiology. *Chronic Pain Management Guidelines*. Pg. 3. September 2014; revised November 2021. https://issuu.com/aanapublishing/docs/2_-_chronic_pain_management_guidelines?fr=sZDgxODU2NDAxMjU

AANA recommends that CMS revise the proposed ASM language at 42 CFR § 512.710(a) to make participation voluntary rather than mandatory.

CMS notes in the preamble of the proposed rule on page 32562 that, "we propose at § 512.710(a)(1) that participation in ASM would be mandatory for all clinicians who meet the eligibility criteria at § 512.710(b)." AANA urges CMS to make participation in this ASM model voluntary rather than mandatory. While AANA understands CMS' rationale for proposing to make the ASM model mandatory, we believe that providers should retain the right to choose whether to participate in any APM. This is particularly important in an era of ever-increasing administrative burdens and for providers in rural and underserved areas who might not have access to the same resources to facilitate participation.

Updates to the Quality Payment Program

AANA Urges CMS to Maintain Flexible MVP Group Reporting to Reduce Burden on Small Multispecialty Practices, Including CRNAs

AANA appreciates and thanks CMS for proposing to maintain flexible MIPS Value Pathway (MVP) group reporting options for small multispecialty practices. Allowing these practices to report as a single group rather than dividing into subgroups will meaningfully reduce administrative and operational burden. For CRNAs in small practices, subgroup reporting would create unrealistic requirements for additional staffing, data infrastructure, and preparation, diverting time and resources away from patient care. By preserving a streamlined reporting pathway, CMS will help ensure that these providers can fully participate in relevant MVPs, maintain compliance, and focus on delivering high-quality care. This flexibility is especially critical for small and rural practices that often operate with limited administrative capacity yet play a vital role in serving patients in underserved areas. AANA looks forward to working with CMS to ensure this flexibility and would be happy to meet to discuss strategies to do so.

AANA Urges CMS to Preserve Critical Improvement Activities Supporting Communication and Patient Safety in Anesthesia Care

AANA commends CMS' continued efforts to refine the "Patient Safety and Support of Positive Experiences with Anesthesia" MVP to ensure measures remain meaningful and aligned with clinical practice. While we understand that the Perioperative Temperature Management measure (Q424) has reached topped-out status, we urge CMS to replace it with another relevant process or outcome measure supported by anesthesia clinical data and/or qualified clinical data registries. The current Anesthesia Quality Measure set is

small; without sufficient replacement measures that are applicable to all anesthesia providers, eligible clinicians, particularly those in multispecialty group reporting arrangements, may have limited opportunities to demonstrate quality improvement or to meaningfully impact their total scores. This could inadvertently weaken the value of MVP participation for anesthesia professionals and reduce the utility of the MVP in driving improvements in perioperative care. We recommend that CMS consider adding a patient-focused or patient-reported outcome measure, such as postoperative pain levels, or incorporating the Bauer Patient Satisfaction Questionnaire as an option for an Improvement Activity, to better capture patient experience and outcomes.

We also request additional detail on CMS' rationale for removing the improvement activity "Implementation of improvements that contribute to more timely communication of test results" (IA_CC_2). This activity can serve as a valuable mechanism for enhancing the timeliness and accuracy of communication within health information technology systems, particularly when leveraging FHIR standards. Such improvements can directly benefit the preoperative assessment process, streamline care coordination, and positively influence patient satisfaction. Removing this activity could reduce opportunities for anesthesia providers to receive credit for meaningful, technology-enabled care improvements that support patient safety and experience. We encourage CMS to reconsider the removal of this activity or to identify a comparable replacement that similarly promotes effective communication and patient-centered care. In doing so, CMS might consider using a more specific outcome such as the timely communication of a critical value test result or other finding that could directly impact the patient's physical status, plan of care, or risk, to better capture its relevance to clinical decision-making and patient outcomes.

AANA looks forward to discussing these recommendations further and to meeting with CMS on how to implement critical improvement activities.

AANA Urges CMS to Ensure that Performance Thresholds Reflect Current Anesthesia Provider Participation and Maintain Clinically Relevant Measures

AANA is concerned that the proposed performance threshold of 75 points for the CY 2026 performance period/2028 MIPS payment year through the CY 2028 performance period/2030 MIPS payment year is too high and is based on mean final scores from the CY 2017 performance period/2019 payment year. AANA recognizes and values CMS' commitment to establishing performance thresholds that are intended to drive meaningful quality improvement while maintaining fairness across specialties. However, MIPS participation in 2017 was significantly lower than it is today, and anesthesia providers were

generally not reporting MIPS data at that time, since they were not required to do so. We question whether it is appropriate to set thresholds using nearly decade-old data that may not reflect current program participation, measure availability, or specialty-specific performance trends. We request that CMS account for these differences by providing scoring adjustments to ensure that CRNAs, especially those in small or resource-limited practices, can reasonably meet this threshold without being disadvantaged by historical baselines.

We also note CMS' proposal to apply topped-out measure benchmarks to certain measures in Table 66 for the CY 2026 performance period/2028 MIPS payment year, including MIPS #477 (Multimodal Pain Management), MIPS #463 (Prevention of Post-Operative Vomiting – Combination Therapy, Pediatrics), and MIPS #430 (Prevention of Post-Operative Nausea and Vomiting – Combination Therapy). These measures remain clinically relevant for CRNAs, as they support internal quality initiatives, inform perioperative best practices, and serve as the foundation for other improvement activities tied to patient-reported outcomes and patient satisfaction. We encourage CMS to maintain these measures within MVP and specialty sets, even under topped-out benchmarks, so CRNAs can continue to use them in ways that directly advance patient care quality and safety. We look forward to discussing these performance thresholds and clinically relevant anesthesia measures through an in-person meeting.

Core Elements Request for Information (RFI)

AANA appreciates CMS' continued efforts to strengthen the MIPS Value Pathways (MVP) framework and explore opportunities for more meaningful, comparable performance data through the introduction of Core Elements. We agree that requiring at least one standardized, clinically meaningful quality measure within each MVP could help patients and other stakeholders better interpret provider performance. However, for specialties such as anesthesia, many measures within the Adult Universal Foundation or Advancing Health and Wellness subcategories may have limited applicability. We recommend that CMS consider identifying multiple Core Elements that reflect key aspects of care for specific patient populations, surgical procedures, or chronic care episodes in which CRNAs play a central role. This would preserve the intent of standardization while ensuring that Core Elements remain relevant, clinically actionable, and representative of the quality of care provided across diverse specialties. Importantly, Core Elements for specialty providers should also account for their role in communicating and coordinating care with primary care providers. CMS should consider developing Core Elements that are triggered by a surgical episode or by a condition requiring pain management, paired with measures

that assess communication between anesthesia or other specialties and primary providers, as well as timely follow-up with patients, including patient-reported outcomes. We stand ready to assist further in development of these core elements. We look forward to discussing these Core Elements proposals through an in-person meeting and stand ready to assist CMS in implementation.

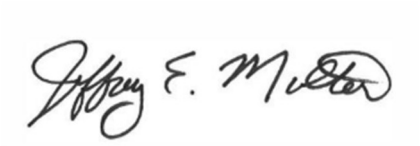
Medicare Procedural Codes Request for Information (RFI)

AANA finally appreciates CMS' request for feedback on using procedural billing codes to assign or suggest MVPs for clinicians. While we understand the potential for aligning measure selection more closely with services provided, CRNAs present a unique challenge in this approach because they bill services separately from other clinicians, such as surgeons or attending physicians, and their procedural codes often do not fully capture the context of the patient's care episode. We request clarification on whether this assignment would be mandatory or elective, and if elective, how CMS would structure the opt-in process to ensure fairness and accuracy. Without careful design, automatic MVP assignment based solely on procedural codes risks misalignment with the actual scope of anesthesia practice and could inadvertently limit clinician flexibility in selecting measures most relevant to their patient populations and care settings. We look forward to discussing these Medicare Procedural Codes proposals through an in-person meeting and stand ready to assist CMS in implementation.

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*. We would welcome the opportunity to meet with you in the coming months to further discuss these issues and AANA's recommendations. For any questions or comments, and to schedule a meeting, please do not hesitate to reach out to Romy Gelb-Zimmer, Director of Regulatory Affairs, at rgelb-zimmer@aana.com or Gregory Craig, Senior Associate Director of Regulatory Affairs, at gcraig@aana.com.

Sincerely,



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