American Association of
NURSE ANESTHESIOLOGY

September 1, 2026

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

Re: CMS-1848-P Medicare and Medicaid Programs; CY 2027 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-AV82]
Dear Administrator Oz:

On behalf of the more than 71,000 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 2027 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:

- Work with Congress and other stakeholders to implement Medicare payment reform to ensure long-term, appropriate reimbursement for anesthesia services.
- Ensure access for all Medicare Part B providers to meaningfully participate in Alternative Payment Models.
- Maintain an XXX global period for CPT codes 01953, 01968, and 01969.
- Support a fairer and more transparent process related to coding and valuation determinations with respect to the CPT® Editorial Panel and RUC processes.
- 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

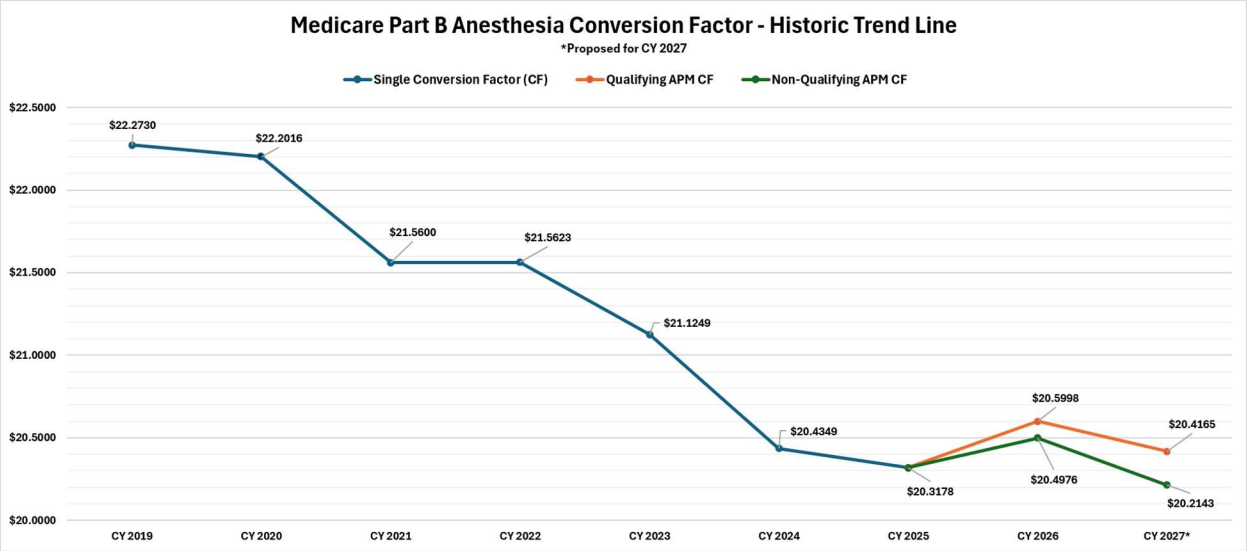
Continuing Medicare Anesthesia Reimbursement Reductions and Harmful Commercial Payer Policies

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

AANA is concerned and disappointed that CMS' proposed CY 2027 Medicare Part B anesthesia conversion factors will result in decreases in reimbursement for anesthesia services paid for under the Medicare PFS:

- **Proposed CY 2027 Qualifying APM Anesthesia Conversion Factor**: **$20.4165** (a **0.89% decrease** compared to the CY 2026 Qualifying APM anesthesia conversion factor).
- **Proposed CY 2027 Non-Qualifying APM Anesthesia Conversion Factor**: **$20.2143** (a **1.38% decrease** compared to the CY 2026 Non-Qualifying APM anesthesia conversion factor).

These proposed decreases in boAANAth Medicare Part B anesthesia conversion factors represent a return to consistently declining anesthesia reimbursement rates in Medicare Part B as shown in the chart below.



The proposed CY 2027 Qualifying APM conversion factor ($20.4165), has **decreased by 8.3%** since 2019, when it was $22.2730; the proposed CY 2027 Non-Qualifying APM conversion factor ($20.2143) has **decreased by 9.2%** since 2019. Meanwhile, the Medicare Economic Index (MEI) from 2020 through CY 2027 (estimated) has **increased by a cumulative 22.50%**.

The trend of declining anesthesia reimbursement will continue to grow more acute for CRNAs who do not have adequate opportunities to participate as Qualifying APM Participants (QPs), as MACRA mandates an annual 0.75% increase for the Qualifying APM conversion factor but only an annual 0.25% increase for the Non-Qualifying APM conversion factor. This differential is already evident after only year one of implementation and will continue to diverge by 0.50% each calendar year:

- *CY 2026 Qualifying APM vs. Non-Qualifying APM Conversion Factor Differential*: **0.50%**
- *CY 2027 (Proposed) Qualifying APM vs. Non-Qualifying APM Conversion Factor Differential*: **1.00%**

In addition to declining Medicare reimbursement, commercial payers have increasingly issued policies since 2023 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]

For example, UnitedHealth Group implemented a policy change on October 1, 2025, that reduced anesthesia claims appended with the QZ modifier by 15%, effectively lowering payment to 85% of the UnitedHealth Group fee schedule for anesthesia services rendered by a CRNA without medical direction.[2]

Taken together, the increase in costs and erosion in Medicare and commercial reimbursement has created an unsustainable trend in which facilities – particularly ambulatory surgical centers (ASCs) and rural hospitals with smaller operating margins – 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.

A 2025 study[3] examined California hospitals between 2002 and 2021 and found that the share of facilities paying anesthesiology stipends increased from 35.5% to 57.4% over that period. Among hospitals paying an anesthesia stipend, the average annual payment rose from $648,000 in 2002 to $2.89 million in 2021. A 2025 study[4] reported that the percentage of ASCs paying an anesthesia stipend increased from 28% in 2024 to 44% in 2025.

Anesthesia services are critical to chronic disease prevention, ensuring access to preventative screenings like colonoscopies, and key in providing non-opioid pain management services that provide an effective alternative to opioid-based pain

---

[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 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

[3] Duffy, Erin, et al. *Stipends from Hospitals to Emergency Medicine and Anesthesiology Clinicians Increased in California, 2002-21*. Health Affairs 44. No. 6 (2025): 754-760. DOI: 10.1377/hlthaff.2024.01220

[4] VMG Health. *ASC Leader Expectations for 2026*. VMG Holdings, LLC. 2025. Online: https://1863187.fs1.hubspotusercontent-na1.net/hubfs/1863187/VMG%20Health%20ASC%20Leader%20Expectations%20for%202026%20Survey.pdf

management. 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 – such as the 2.5% conversion factor increase for CY 2026 included in the *Working Families Tax Cut Act*. However, these anesthesia reimbursement trends are not sustainable. 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 long-term solution to support sustainable anesthesia reimbursement.

Proposed CY 2027 Qualifying APM and Non-Qualifying APM Conversion Factors and Qualifying APM Participant Opportunities

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 Qualifying APM/Non-Qualifying APM conversion factor structure.

As noted in the preceding section, AANA understands that since January 1, 2026, the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) has required 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 PFS. We also understand that 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.[5]

Given this incentive structure, it is critical that CMS support Medicare Part B providers, including CRNAs, in facilitating QP status to maintain adequate reimbursement. For instance, AANA appreciates the opportunity for greater participation through the Comprehensive Joint Replacement (CJR) model to the nationwide CJR-X model in the *FY 2027 Inpatient Prospective Payment System and Long-Term Care Hospital (LTCH)*

[5] In addition to other annual anesthesia conversion factor adjustments (e.g., budget neutrality adjustments); the MACRA conversion factor increases **do not** mean that the anesthesia conversion factor will increase year over year.

Prospective Payment System final rule. Such models provide CRNAs with greater opportunities to achieve QP status.

While we are disappointed that CMS in this proposed rule has chosen not to revisit the specialty types that can participate in the Ambulatory Specialty Model (ASM) Low Back Pain cohort as noted on Federal Register page 43966 of the proposed rule, and maintain that CRNAs should be considered a Low Back Pain specialty as we did in our comments on the CY 2026 PFS proposed rule, we are encouraged by some of CMS' other proposals related to the Quality Payment Program as discussed in later sections of this comment letter. We believe that these proposals will support CRNAs in achieving and maintaining QP participation status.

We encourage CMS to establish additional, voluntary APMs specifically related to anesthesia and pain management services to ensure meaningful CRNA QP participation. AANA stands ready to partner with CMS to develop such models and to establish other methods by which to ensure meaningful CRNA QP participation.

Global Period Assignment for Anesthesia CPT Codes 01953, 01968, and 01969

AANA does not support assigning a ZZZ global period to CPT codes 01953, 01968, and 01969 and questions the necessity and negative consequences of doing so.

On Federal Register page 43859 of the proposed rule, CMS solicits comments from interested parties regarding a potential future ZZZ global period assignment for the following three anesthesia CPT codes:

- CPT 01953 *Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; each additional 9% total body surface area or part thereof (List separately in addition to code for primary procedure)*
- CPT 01968 *Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)*
- CPT 01969 *Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)*

CMS notes that the RUC requested assigning a ZZZ global period to these anesthesia codes, while pointing out that currently all anesthesia codes use the XXX global period, and

that it is unclear whether the concept of an add-on global period would apply to anesthesia coding given that they are valued using base units and time units, unlike all other PFS services. These global periods are defined as follows:

- **XXX Global Period**: Global concept does not apply.
- **ZZZ Global Period**: Code related to another service and is always included in the global period of the other service.

These three codes are unique among the anesthesia CPT code set. *CPT® 2025 Professional Edition*[6] defines these three as add-on codes, as their own long descriptors make clear: CPT 01953 is only used in conjunction with 01952, while CPT 01968 and CPT 01969 are each only used in conjunction with CPT 01967. These are the only three add-on codes in the entire anesthesia code set.

The June 2011 edition of *CPT Assistant* further notes that, "Generally, a single code is reported for anesthesia administration, whether the operating physician performs one or multiple procedures. When multiple procedures are performed during a single anesthetic administration, usually only the procedure code for the most complex service and the total time for all procedures are reported. Anesthesia add-on codes are an exception. Codes 01953, 01968, and 01969 describe anesthesia add-on procedures, which are reported in addition to the primary anesthesia codes."[7]

The December 2001 edition of *CPT Assistant*[8] also describes base unit and time unit reporting for CPT codes 01968 and 01969:

"Base and time would be reported as:

- 01967 with 5 base units. Time reported per local standard for labor analgesia. 01968 with 3 base units. Time reported as for all surgical procedures. The total base unit value is 8 **or;**
- 01967 with 5 base units. Time reported per local standard for labor analgesia. 01969 with 5 base units. Time reported as for all surgical procedures. The total base unit value is 10."

[6] American Medical Association. *CPT 2026 Professional Edition*. 2026.
[7] American Medical Association. *CPT Assistant*. June 11:13. Accessed via the CPT QuickRef application.
[8] American Medical Association. *CPT Assistant*. December 01: 3. Accessed via the CPT QuickRef application.

While we understand the RUC's rationale for requesting a ZZZ global period assignment for CPT codes 01953, 01968, and 01969, **we believe this would be an inappropriate policy change that could have unintended negative consequences**. Taken together, there is no practical difference between these add-on codes and a typical anesthesia code with an XXX global period assignment (i.e., the global period concept does not apply), specifically when it comes to base unit and time unit reporting and reimbursement.

The anesthesia code set does not currently utilize global periods beyond the perceived global period defined by the anesthesia start and stop times of an anesthesia service. Establishing any structure that would appear to assign an anesthesia global period – as the assignment of a ZZZ global period to these codes would – could lay the groundwork to establishing a defined generic or average global period that could impact the unique recognition and utilization of an actual case's unique start and stop times.

Each anesthesia service is inherently unique and is bound by its own duration (i.e., time unit); anesthesia time is a vital, case-specific identifying variable in determining the reimbursement for each unique anesthesia professional service. Moving toward a global period paradigm for anesthesia services like that of surgical services would remove the recognition the reimbursement system has for the delivery of each unique individual anesthesia service based on base units and time units.

CMS should also carefully consider any administrative or reporting consequences associated with potentially assigning these codes a ZZZ global period. Such a change could create ambiguity for Medicare Administrative Contractor edits, Medicare Advantage plan edits, billing system edits, modifier logic, audits and denials, and future policy development.

CMS would also need to clearly state that such a change would be administrative and not impact policies including anesthesia base-unit valuation, time unit reporting, existing payment methodologies, the anesthesia conversion factor calculation, separately billable anesthesia-related services otherwise permitted under Medicare policy, or the application of E/M or global-surgery edits simply because an anesthesia codes is now assigned a ZZZ global period.

The administrative burden of ensuring that these downstream impacts would not occur would far outweigh any perceived benefit of unnecessarily assigning a ZZZ global period to these codes.

Current Procedural Terminology Request for Information

AANA appreciates and agrees with CMS' recognition of the inherent flaws associated with the American Medical Association (AMA) Current Procedural Terminology® (CPT®) system and Relative-Value Scale Update Committee (RUC) process and supports CMS efforts to move to a more objective and transparent process.

On Federal Register pages 43951-43953 of the proposed rule, CMS discusses the CPT® Editorial Panel process and the Relative-Value Scale Update Committee (RUC) process, both administered by the American Medical Association (AMA). CMS specifically requests information on several questions related to CPT® codes and the CPT® Editorial Panel process in relation to AMA's monopoly over most of the procedural codes that CMS and other payers use for billing and coding. AANA provides input on the following questions:

CMS Question 1*: What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA's monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure*.

AANA Response 1: We note that according to recent reporting by *Becker's Hospital Review*, the AMA reported $296.4 million in revenue from "Books and Digital Content" in 2025, netting $267.5 million, while AMA's annual CPT code royalties generate more than $300 million a year.[9] These essentially amount to a tax in the hundreds of millions of dollars by a private lobbying organization on legally required information. This is an enormous opportunity cost to the healthcare system that could otherwise be spent on patient care, healthcare innovation, combating fraud, waste, and abuse, or myriad other uses.

CMS Question 4: *What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?*

AANA Response 4: AANA would highlight that CMS already maintains established processes for HCPCS Level II codes and for ICD-10-PCS codes. CMS could model alternative, objective processes on these existing processes to leverage institutional knowledge and experience and to provide transparent decision-making with greater public

[9] Twenter, Paige. *AMA Sued Over CPT Billing Code Copyright: 8 Things to Know*. Becker's Hospital Review. August 13, 2026. Online: https://www.beckershospitalreview.com/legal-regulatory-issues/ama-sued-over-cpt-billing-code-copyright-8-things-to-know/

scrutiny and accountability. **We would emphasize, however, that any supplemental or replacement processes should explicitly utilize the input of all providers who perform a specific service, including non-physician practitioners such as CRNAs.** Provider voices should still be important parts of any coding and valuation decision making process alongside empirical data and real-world inputs.

CMS also notes in reference to the RUC process that, "There has also been longstanding concern expressed over Federal reliance on a private organization with such an obvious conflict of interest as providing information on the time and resource requirements to conduct physician services when this information may influence their own payment."

AANA agrees with this assessment. We also noted in our comments to CMS in response to the CY 2026 PFS proposed rule, and reiterate here, 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 the RUC 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 re-evaluating the CPT® and RUC processes using objective, transparent, and empirical processes. We would encourage CMS to consider all provider types – and not overly relying on physician input – and to emphasize transparency and patient access to care when determining the optimal process for creating and revising new codes and assigning or revising their values. We stand ready to assist CMS in this venture.

Updates to the Quality Payment Program

Ensure a Smooth Transition to MVP Reporting with Appropriate Support and Small Practice Protections

AANA supports CMS' goal of transitioning the Quality Payment Program toward more clinically cohesive and specialty-relevant reporting by phasing out traditional MIPS for clinicians not participating in the APM Performance Pathway (APP) and requiring

participation through MIPS Value Pathways (MVPs). We urge CMS to provide sufficient technical assistance well in advance of the PY 2029 transition to support clinicians, groups, and qualified registries in adopting MVP reporting. Since small practices are already eligible for automatic Promoting Interoperability (PI) category reweighting under current policy, CMS should clarify that PI reweighting applies consistently to small-practice CRNAs reporting individually, as part of a group, or, where applicable, as part of a subgroup. This information should be made available before the applicable MVP registration period so small-practice CRNAs can make informed reporting decisions without unnecessary administrative burden.

Strengthen CRNA Access and Attribution Within the Anesthesiology MVP

AANA appreciates and supports CMS's proposal to add four new quality measures to the Anesthesiology MIPS Value Pathway (MVP) and to establish a core measure set. These proposed additions reflect clinically meaningful, evidence-based priorities in anesthesia care and would improve the specificity and relevance of the Anesthesiology MVP for the anesthesia workforce, including CRNAs. We also support establishing the proposed core measures within the Anesthesiology MVP. Establishing a consistent and clinically relevant core measure set would promote greater measurement stability, reduce unnecessary reporting complexity, and improve comparability across the anesthesia specialty.

While we support these additions, CMS should take affirmative steps to ensure that qualifying CRNAs can fully participate in and report on all four new measures and the proposed core measure set. CMS should identify and remove technical, administrative, and attribution-related barriers that could prevent or disadvantage CRNA participation. CMS should also ensure that the QCDR measures developed through the Anesthesia Quality Institute are fully accessible to CRNAs through participating registries and do not include data-sharing or attribution restrictions that disadvantage CRNA reporting relative to other anesthesia professionals.

CMS should further clarify attribution methodologies for team-based anesthesia care, including cases involving both a CRNA and a supervising or medically directing physician. Clear attribution rules are necessary to ensure that patient-reported experience and intraoperative hypotension measures accurately reflect the care delivered and do not inappropriately exclude or double-count CRNA-delivered services. CMS should verify that the electronic health record (EHR), anesthesia information management system (AIMS), and registry infrastructure used by CRNAs, including those in rural, small, and facility-embedded settings can capture and transmit required data elements without costly system upgrades. Finally, CMS should also provide specialty-specific implementation guidance and detailed measure specifications sufficiently in advance of the applicable

performance period, including clear requirements for reporting through EHRs or third-party vendors. These steps will help ensure CRNAs have equitable access to reporting infrastructure, clear eligibility requirements, and appropriate attribution within the Anesthesiology MVP.

Ensure Core Measure Requirements Are Meaningful and Applicable to CRNA Practice

AANA supports CMS' proposal to modify the Patient Safety and Support of Positive Experiences with Anesthesia MVP to incorporate the new MIPS core measure requirement, and we commend CMS' broader efforts to streamline MIPS quality reporting through the proposed MIPS core measure requirement. As implemented, CRNAs participating in the Patient Safety and Support of Positive Experiences with Anesthesia MVP would be required to report a designated core measure specific to that MVP or attest that no applicable core measure is available, while exempting small practices from the requirement. This approach appropriately recognizes the unique challenges faced by small and independent anesthesia practices and helps reduce unnecessary reporting burden.

For CRNAs subject to this requirement, CMS should ensure that the designated core measure options are clinically relevant to anesthesia practice, feasible to report across diverse practice settings, and reflective of the services CRNAs provide. Providing multiple applicable core measure options within the MVP will allow CRNAs to select the measure that best aligns with their scope of practice while minimizing unnecessary reporting burden and preserving meaningful quality measurement.

To strengthen this policy over time, CMS should continue to evaluate whether the available core measures adequately capture the value of anesthesia care and expand the measure set over time as additional anesthesia-specific quality measures become available. AANA also requests clarification on whether proposed or newly developed anesthesia-specific quality measures may be eligible for designation as core measures in future rulemaking. Expanding the availability of anesthesia-specific core measures will improve the clinical relevance of MIPS reporting while reducing reliance on attestation when no applicable measure exists.

Support Inclusion of Virtual Groups in MVP Reporting While Preserving Flexibility for CRNAs

AANA supports CMS's proposal to allow virtual groups to participate in MIPS Value Pathways (MVPs) beginning with the CY 2029 performance period. This change has the potential to increase MVP participation among CRNAs who practice across multiple Taxpayer Identification Numbers (TINs) or in independent and collaborative practice arrangements by providing greater flexibility in how they meet MIPS reporting requirements. As CMS implements this policy, CMS should ensure that participation requirements are

operationally feasible for clinicians practicing across multiple settings and that guidance clearly addresses attribution, data aggregation, and reporting responsibilities for virtual group participants. These considerations will help maximize participation while minimizing administrative burden for CRNAs.

Support Flexible Scoring for Topped-Out Anesthesia Measures to Promote Meaningful Quality Reporting

AANA supports CMS' proposal to apply the defined topped-out benchmark methodology to anesthesia-relevant quality measures, including Measure 430: Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy, Measure 463: Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics), and Measure 477: Multimodal Pain Management. This approach appropriately recognizes that CRNAs and other anesthesia clinicians often have limited availability of specialty-specific quality measures and should not be disadvantaged by standard topped-out scoring limitations. Allowing these measures to be scored on a 1–10 point scale will provide anesthesia clinicians with a fairer opportunity to achieve the MIPS performance threshold and avoid negative payment adjustments while continuing to report clinically meaningful measures.

AANA supports this transition as CMS continues to evolve the anesthesia quality measure portfolio. As these measures reach the end of their topped-out lifecycle, CMS should ensure that replacement measures, including Patient-Reported Experience with Anesthesia and Intraoperative Hypotension Among Non-Emergent Noncardiac Surgical Cases, are implemented thoughtfully and provide anesthesia clinicians with meaningful, specialty-relevant options for quality reporting.

Safeguard Responsible Integration of AI-Enabled Clinical Decision Support Tools in Anesthesia Care

AANA recognizes CMS' proposal to modify IA_PSPA_16 to distinguish the use of AI-enabled clinical decision support tools with appropriate oversight and monitoring requirements. AI-enabled tools may support anesthesia care teams by enhancing clinical workflows related to medication safety, hemodynamic and ventilatory monitoring, environmental sustainability, and postoperative recovery. However, CMS must emphasize that these technologies are intended to augment, not replace the clinical judgment, expertise, and decision-making of anesthesia clinicians.

As CMS develops implementation guidance, we urge clarification on how appropriate oversight and monitoring of AI-enabled clinical decision support tools will be evaluated. Monitoring requirements should focus on ensuring tool performance, reliability, transparency, and alignment with clinician decision-making while avoiding administrative

burdens that discourage responsible adoption. CMS should also recognize that final clinical decisions remain with the treating anesthesia professional, who must be able to appropriately assess, interpret, and act on patient-specific information.

Maintain Flexibility for Small Independent CRNA Practices Under MIPS Core Measure Requirements

AANA supports CMS' proposal to exempt small practices from the MIPS core measure reporting requirement. This exemption appropriately acknowledges the operational and administrative challenges faced by small independent anesthesia practices and provides CRNAs with greater flexibility in meeting MIPS reporting requirements. Allowing small practices to continue reporting the standard six quality measures under traditional MIPS or four quality measures under MVP reporting, without the additional core measure selection or attestation requirement, will reduce unnecessary administrative burden while preserving meaningful quality reporting. CMS should continue to consider the unique circumstances of small and rural anesthesia practices when implementing future MIPS requirements to ensure that quality programs remain accessible and achievable for all clinicians.

Ensure QP Determinations Account for CRNAs Practicing Across Multiple Billing Arrangements

AANA recognizes CMS' proposal to apply Qualifying APM Participant (QP) and Partial QP status at the TIN/NPI level rather than across all of a clinician's billing arrangements. However, CMS should carefully consider the impact this change may have on CRNAs who practice across multiple groups or billing arrangements. Under the proposed approach, CRNAs who split their time between an Advanced APM-participating TIN and a non-participating TIN may only receive QP status for the participating TIN, potentially requiring additional MIPS reporting obligations for services provided under non-participating arrangements.

CMS should provide clear guidance and consider appropriate flexibilities to minimize administrative burden for clinicians who participate in multiple practice settings. CRNAs often provide care across diverse practice arrangements, including independent and rural settings, and should not be unintentionally disadvantaged due to the structure of their professional affiliations. CMS should ensure that implementation of this policy maintains access to Advanced APM incentives while avoiding unnecessary complexity for clinicians engaged in multiple billing arrangements.

Support Extension of the APM Incentive Payment to Encourage Advanced APM Participation

AANA supports CMS' proposal to extend the APM Incentive Payment for the 2028 payment year at 3.1 percent. Extending this incentive provides continued support for CRNAs

practicing through Advanced APM entities that achieve Qualifying APM Participant (QP) status and helps sustain clinician participation in value-based care models. This extension is particularly important as CMS continues the transition toward broader MVP adoption and encourages clinicians to engage in alternative payment arrangements that promote quality, cost efficiency, and improved patient outcomes. CMS should continue to provide incentives that recognize the contributions of anesthesia clinicians participating in Advanced APMs and support their ongoing transition to value-based care.

Provide Clear QP Threshold Guidance to Support CRNA Participation in Advanced APMs

AANA appreciates CMS' notice to update the QP and Partial QP payment amount and patient count thresholds for future performance years. These thresholds are critical for determining whether CRNAs participating in Advanced APMs qualify for QP status and receive associated benefits, including MIPS exemption and payment incentives. CMS should provide timely, clear, and accessible information regarding applicable thresholds to allow CRNAs and Advanced APM entities to accurately assess participation status and plan accordingly. Transparent threshold requirements will support clinician engagement in Advanced APMs and promote continued participation in value-based care models.

Conclusion

We appreciate the opportunity to provide input to the proposed policies in the proposed rule *Medicare and Medicaid Programs; CY 2027 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,

Tracy P. Young, MSNA, MBA, CRNA
AANA President

CC: William Bruce, AANA Chief Executive Officer