American Association of
NURSE ANESTHESIOLOGY

January 22, 2026

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

Re: CMS-4212-P Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program [RIN 0938–AV63]

Submitted electronically via: Regulations.gov (Docket CMS-4212-P)

Dear Administrator Oz:

On behalf of the 69,000 members of the American Association of Nurse Anesthesiology (AANA), I am respectfully submitting comments in response to the proposed rule: *Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program*.

Certified Registered Nurse Anesthetist Background

Certified Registered Nurse Anesthetists (CRNAs) are Advanced Practice Registered Nurses (APRNs) who are autonomous anesthesia providers through their extensive training and preparation. CRNAs must be board certified and must participate in continuing education and recertification every 4 years to practice. CRNAs have four years of education to get their Bachelor of Science in Nursing (BSN). They are required to practice for a minimum of one year as critical care nurses, with most CRNAs averaging three years practicing as critical care nurses. Additionally, all CRNAs have completed either a Masters or Doctoral program in nurse anesthesia and average just under 10,000 clinical hours before practicing as a CRNA.

As independently licensed professionals, CRNAs are responsible and accountable for making judgments and taking actions in their professional healthcare practice.[1] CRNAs are doctorally prepared and extensively trained to practice independently. CRNAs take the lead in anesthesia before, during, and after surgery and are leaders within the surgical care team.

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. CRNAs provide over 50 million anesthetics annually across the United States. 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.

Future Direction of the Medicare Advantage Program and Star Ratings

As CMS continues to make improvements to the Medicare Advantage program and considers changes to the Medicare Star Ratings program, AANA would urge CMS to ensure that Medicare Advantage plans align their plan policies to comply with Medicare statute. Specifically, AANA would urge CMS to hold Medicare Advantage plans accountable for reimbursing CRNAs for the provision of anesthesia services in accordance with Medicare statutory language. 42 U.S.C. § 1395*l* states that:

> ***(a) Amounts*** *Except as provided in section 1395mm of this title, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to— […]* ***(1)(H)*** *with respect to services of a* ***certified registered nurse anesthetist*** *under section 1395x(s)(11) of this title, the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (****or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title****) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l).*

As this statutory language is applicable to Medicare Parts B and C, Medicare Advantage plans must reimburse CRNAs at 100 percent of the Medicare Part B Physician Fee

[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.

Schedule amount for the provision of anesthesia services; this statute has been in effect since 1989.

This statutory requirement, however, does not seem to have prevented some Medicare Advantage plans from proposing policy changes that would unlawfully reduce CRNA reimbursement across-the-board for the provision of anesthesia services simply based on licensure. For example, Independence Blue Cross (IBX) of Pennsylvania recently proposed a policy that would squarely contradict the Medicare statute. This policy would reduce reimbursement from 100 percent to 85 percent of Medicare's fee schedule used by IBX for services billed with the Healthcare Common Procedure Coding System (HCPCS) modifier "QZ", denoting anesthesia services provided by a CRNA without medical direction by a physician.

This policy also violates the federal provider non-discrimination provision at 42 USC §300gg-5,[2,3] which took effect on January 1, 2014, and prohibits health plans from discriminating against qualified licensed healthcare professionals, such as CRNAs, solely based on their licensure. Given that the QZ modifier applies only to CRNA services provided without medical direction by a physician, does not impact reimbursement for other anesthesia providers, and IBX did not implement similar policies with respect to other anesthesia providers, it stands to reason that this IBX policy effectively discriminates against CRNAs based on their licensure.

Given Medicare Advantage's increasing role in providing healthcare services to older Americans, it is imperative that CMS consider adherence to Medicare statute in rating Medicare Advantage plans. Discrimination against whole classes of provider groups, as described above, suppresses competition, inflates costs, and denies patients the ability to receive anesthesia care from qualified anesthesia providers. It also directly impairs small, independent CRNA businesses by limiting fair access to networks and contracts. Such impacts would be particularly harmful to Medicare Advantage beneficiaries in rural and underserved areas in which CRNAs are often the sole anesthesia providers.

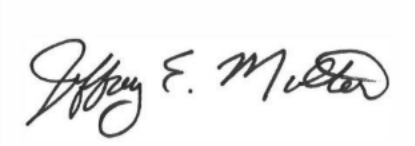
[2] Patient Protection and Affordable Care Act. Sec. 1201, Subpart 1.

[3] The statutory provision 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."

Conclusion

We appreciate the opportunity to provide input to the proposed policies in the proposed rule *Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program*. We would welcome the opportunity to meet with you in the coming months to further discuss these issues. 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.

Sincerely,



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