



July 1, 2026

**Submitted electronically via [REPORTSCLEARANCEOFFICER@ahrq.hhs.gov](mailto:REPORTSCLEARANCEOFFICER@ahrq.hhs.gov)**

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

**RE: 4160-90-P – HHS Request for Information on Chronic Disease of Addiction**

Dear Secretary Kennedy:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to respond to the Request for Information (RFI) on Chronic Disease of Addiction. AANA's comments address two complementary priorities: (1) leveraging CRNAs and multimodal, opioid-sparing pain management to prevent new opioid use disorders arising from the perioperative setting; and (2) expanding the role of CRNAs in treating and supporting recovery for patients already living with opioid use disorder (OUD). Together, these recommendations advance the Great American Recovery Initiative's goals across the full prevention–treatment–recovery continuum.

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 approximately 88 percent of the nurse anesthetist workforce in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 58.5 million anesthetics to patients each year. Since 1989, CRNAs have been Medicare Part B providers, billing at 100% of the Physician Fee Schedule. CRNAs must be board certified and complete continuing education and recertification every four years to practice. As independently licensed professionals, CRNAs are responsible and accountable for making judgments and taking actions in their professional healthcare practice.<sup>1</sup>

**RFI Question: What are programs or interventions that have rigorous, empirical evidence of effectiveness in improving outcomes for substance use prevention, treatment, and recovery?**

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<sup>1</sup> AANA Code of Ethics for the Certified Registered Nurse Anesthetist. July 2018. Available at: [https://issuu.com/aanapublishing/docs/code\\_of\\_ethics\\_for\\_the\\_certified\\_registered\\_nurse](https://issuu.com/aanapublishing/docs/code_of_ethics_for_the_certified_registered_nurse)

## **PRIORITY 1: Leveraging CRNAs and Multimodal Pain Management to Prevent New Opioid Use Disorder**

### **Surgery as a Sentinel Exposure for Opioid Use Disorder**

Surgery represents a critical and underrecognized exposure point for opioid-naive individuals. Each year, tens of millions of Americans undergo inpatient surgical procedures, and for approximately 60 percent of them, the perioperative period is their first prolonged exposure to prescription opioids.<sup>2</sup> A 2024 systematic review of 22 studies found that among opioid-naive surgical patients, the incidence of new persistent opioid use ranged from 3.9% to 14.0% in adults, representing hundreds of thousands of new cases annually attributable to the surgical care setting.<sup>3</sup> The same literature identifies prior history of substance use disorder, spinal surgery, and prolonged hospitalization as significant risk factors for progression to persistent opioid use,<sup>4</sup> underscoring the need for perioperative teams to actively mitigate opioid exposure in vulnerable populations.

Evidence from the University of Michigan's Opioid Prescribing Engagement Network confirms that surgery remains one of the primary pathways through which patients transition from opioid-naive status to new persistent opioid use and, in some cases, frank OUD.<sup>5</sup> Most patients undergoing even low-risk procedures receive opioid prescriptions, most commonly oxycodone or hydrocodone, medications also frequently implicated in overdose deaths. This makes the perioperative encounter both a high-risk exposure event and a strategic intervention opportunity.

### **Multimodal Analgesia: Evidence-Based Opioid Sparing**

Multimodal analgesia (MMA) is the evidence-based standard for perioperative pain management and a cornerstone of Enhanced Recovery After Surgery (ERAS) protocols. MMA targets multiple pain pathways simultaneously through combinations of regional anesthesia and neuraxial techniques, local anesthetics, nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, N-methyl-D-aspartate (NMDA) antagonists such as ketamine, alpha-2 agonists such as dexmedetomidine, and other adjuncts reducing reliance on opioids without sacrificing analgesic efficacy.<sup>6</sup>

The body of evidence supporting MMA is robust. A 2025 instrumental variable analysis by Graham and colleagues demonstrated that specific multimodal combinations, particularly NSAIDs combined with dexamethasone and regional anesthesia, delivered the most clinically

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<sup>2</sup> Hah JM, Bateman BT, Ratliff J, Curtin C, Sun E. Chronic opioid use after surgery: implications for perioperative management in the face of the opioid epidemic. *Anesth Analg*. 2017;125(5):1733–1740. <https://doi.org/10.1213/ANE.0000000000002458>

<sup>3</sup> Gong J, Jones P, Chan AHY. Incidence and risk factors of new persistent opioid use after surgery and trauma: a systematic review. *BMC Surg*. 2024;24(1):226. <https://doi.org/10.1186/s12893-024-02494-0>,

<sup>4</sup> Bologheanu R, et al. New persistent opioid use after surgery. *JAMA Netw Open*. 2025;8(2). <https://doi.org/10.1001/jamanetworkopen.2024.58867>

<sup>5</sup> Brummett CM, et al. New persistent opioid use after surgery: a risk factor for opioid use disorder? *Ann Surg*. 2022;275(2):e288–e289. <https://doi.org/10.1097/SLA.0000000000005297>

<sup>6</sup> Ghai B, Jafra A, Bhatia N, Chanana N, Bansal D, Mehta V. Opioid sparing strategies for perioperative pain management other than regional anaesthesia: a narrative review. *J Anaesthesiol Clin Pharmacol*. 2022;38(1):3–10. [https://doi.org/10.4103/joacp.JOACP\\_362\\_19](https://doi.org/10.4103/joacp.JOACP_362_19)

meaningful reductions in postoperative opioid use following non-cardiac surgery.<sup>7</sup> A network meta-analysis of 37 randomized controlled trials found that dexmedetomidine, ketamine, intravenous lidocaine, magnesium, and gabapentin each independently and significantly reduced postoperative opioid consumption compared to placebo or standard care.<sup>8</sup> A 2025 in-depth analysis by Kincaid and colleagues confirmed that MMA protocols incorporating peripheral nerve blocks, including adductor canal, transversus abdominis plane (TAP), and erector spinae plane (ESP) blocks, produce significantly lower pain scores and reduced opioid consumption compared to opioid-centric regimens across major surgical populations.<sup>9</sup>

Critically, these opioid-sparing benefits extend beyond the immediate postoperative period. By reducing total opioid exposure during and after surgery, MMA strategies directly address one of the most modifiable upstream drivers of new persistent opioid use and OUD—the perioperative opioid burden.

## **PRIORITY 2: CRNAs in Treatment and Recovery for Patients with Existing OUD**

### **Perioperative Care for Patients on Medications for Opioid Use Disorder (MOUD)**

The Department of Health and Human Services (HHS) rightly frames addiction as a chronic disease requiring sustained medical management. A growing population of Americans with OUD is maintained on medications for opioid use disorder (MOUD), including buprenorphine and methadone, and many of these patients present for surgical and procedural care. Managing acute pain in this population while protecting their recovery is a complex clinical challenge that falls squarely within CRNA expertise.

Contemporary evidence and multi-society consensus, including guidance from the American Society of Regional Anesthesia and Pain Medicine, now recommend that buprenorphine be continued throughout the perioperative period rather than discontinued, as the historical practice of holding buprenorphine to "open receptors" for full agonists has been shown to increase withdrawal risk and, in some cases, to be fatal.<sup>10</sup> For patients maintained on buprenorphine or methadone, individualized multimodal strategies that include regional anesthesia, non-opioid adjuncts, and close coordination with outpatient MOUD prescribers are associated with decreased opioid requirements and lower risk of return to illicit use.<sup>11</sup>

CRNAs are uniquely trained to implement these nuanced perioperative protocols. Their doctoral-level education encompasses pharmacology of MOUD agents, regional anesthesia techniques, and the physiologic considerations specific to patients with OUD. In the surgical setting, CRNAs often serve as the primary clinician managing both anesthetic care and acute pain, making their

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<sup>7</sup> Graham LA, Illarmino S, Wren SM, Mudumbai SC, Odden MC. Optimal multimodal analgesia combinations to reduce pain and opioid use following non-cardiac surgery: an instrumental variable analysis. *Reg Anesth Pain Med*. 2025. <https://doi.org/10.1136/rapm-2025-106720>

<sup>8</sup> Shoar S, et al. Efficacy of nonopioid analgesics and adjuvants in multimodal analgesia for reducing postoperative opioid consumption and complications in obesity: a systematic review and network meta-analysis. *Br J Anaesth*. 2024. <https://doi.org/10.1016/j.bja.2024.07.023>

<sup>9</sup> Kincaid S, How J, Agrawal DK. Multimodal analgesia in the perioperative period of major surgeries: an in-depth analysis. *Anesthesia and Critical Care*. 2025;7(3):68–76. <https://pmc.ncbi.nlm.nih.gov/articles/PMC12463453/>

<sup>10</sup> Selvamani BJ, Kral L, Swaran Singh T. Perioperative management of patients on buprenorphine for opioid use disorder. *ASRA Pain Medicine News*. 2023;47. <https://doi.org/10.52211/asra020123.010>

<sup>11</sup> Kohan L, et al. Narrative review: managing buprenorphine and opioid use disorder in the perioperative setting. *Pain Pract*. 2025;25:e13427. <https://doi.org/10.1111/papr.13427>

role in protecting the recovery of patients on MOUD both clinically central and systemically important.

### **Ketamine Infusion Therapy: An Emerging CRNA Contribution at the Addiction–Mental Health Interface**

The RFI specifically references mental illness alongside addiction, recognizing their frequent co-occurrence. An estimated two-thirds of individuals with OUD meet criteria for a co-occurring mental health disorder, most commonly major depressive disorder (MDD) and post-traumatic stress disorder. Addressing comorbid mental illness is essential to durable recovery.

Ketamine and its S-enantiomer esketamine (Food and Drug Administration (FDA)-approved for treatment-resistant depression) represent a clinical bridge between anesthesia expertise and addiction–mental health care. A 2025 systematic review of randomized controlled trials found evidence supporting ketamine's efficacy across cocaine, alcohol, and opioid use disorders, with effects particularly pronounced when combined with psychotherapy.<sup>12</sup> The AANA Board of Directors has recognized this emerging clinical domain, adopting updated guidance on Ketamine Therapy for Psychiatric Disorders and Chronic Pain Management in April 2024.<sup>13</sup>

CRNAs are among the most qualified clinicians to administer ketamine infusion therapy safely, given their training in pharmacokinetics, hemodynamic monitoring, and airway management. In rural and underserved areas where psychiatrists and anesthesiologists are scarce, CRNAs may represent the only available providers with the clinical competencies to offer this therapy.

### **The Rural Workforce Imperative**

Opioid use disorder disproportionately burdens rural America, yet rural communities face the most acute shortages of addiction medicine specialists, pain management providers, and surgical anesthesiologists. CRNAs provide more than 80 percent of anesthesia services in rural counties and serve as the primary or sole anesthesia provider in the majority of critical access hospitals.<sup>14</sup> A 2025 workforce analysis projects a shortage of approximately 8,450 anesthesiologists nationally by 2037, with rural communities absorbing the greatest impact.<sup>15</sup> As of late 2022, 78 percent of healthcare facilities reported anesthesia staffing shortages, a rate more than double pre-pandemic levels.<sup>16</sup>

In this context, CRNAs are not an alternative to evidence-based substance use disorder (SUD) care, they are frequently the only available clinicians with the training to provide it. Enabling

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<sup>12</sup> Thomas A, Chambers RA. Ketamine's therapeutic role in substance use disorders: a narrative review. *Neurosci*. 2025;6(3):83. <https://doi.org/10.3390/neurosci6030083>

<sup>13</sup> American Association of Nurse Anesthesiology. Ketamine Therapy for Psychiatric Disorders and Chronic Pain Management. Revised April 2024.

<sup>14</sup> American Association of Nurse Anesthesiology. Access to Care: CRNAs and Rural Healthcare. Available at: [https://www.anesthesiafacts.com/wp-content/uploads/2022/10/Get-the-Facts-Access\\_General.pdf](https://www.anesthesiafacts.com/wp-content/uploads/2022/10/Get-the-Facts-Access_General.pdf)

<sup>15</sup> Health Resources & Services Administration (HRSA). National and State-Level Projections of Dentists and Oral Health Workforce, 2016–2025 [series]. HRSA projects shortage of approximately 8,450 anesthesiologists by 2037. Cited in: Rebuilding the Anesthesia Workforce from Within. Texas Hospital Association. March 2026.

<sup>16</sup> Manella J, et al. The anesthesia workforce shortage demystified. *Becker's ASC Review*. February 3, 2026. Available at: <https://www.beckersasc.com/anesthesia/the-anesthesia-workforce-shortage-demystified/>

CRNAs to practice to the full extent of their education in rural communities is a direct mechanism for closing the geographic inequity in addiction prevention and treatment access.

### **Policy Recommendations to Advance CRNA Contributions to SUD Prevention, Treatment, and Recovery**

To maximize the clinical contributions described above, AANA urges HHS to pursue the following targeted policy actions:

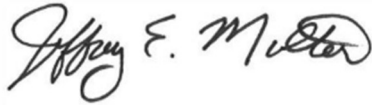
- **Remove federal barriers to autonomous CRNA practice in addiction-relevant settings.** Outdated physician supervision requirements under 42 C.F.R. § 482.52 and 42 C.F.R. § 485.639 restrict CRNA practice in hospital settings, particularly in rural and critical access hospitals where physician availability is limited. These requirements create administrative bottlenecks that reduce access to opioid-sparing pain management services and perioperative MOUD management. In line with Executive Orders 13890 and 14219,<sup>17</sup> HHS should remove these unnecessary requirements.
- **Ensure comprehensive Medicare and Medicaid coverage and appropriate reimbursement for CRNA-delivered pain management and MOUD-related perioperative services.** Payment parity between CRNA and physician-delivered services is essential to sustaining access to opioid-sparing multimodal analgesia, regional anesthesia, and perioperative MOUD management in underserved communities. Coverage policies should explicitly include evidence-based MMA procedures when furnished by CRNAs.
- **Integrate CRNAs into federally supported MOUD access and perioperative OUD care initiatives.** HHS and CMS should include CRNAs as eligible providers in programs designed to expand MOUD access, including perioperative buprenorphine continuity protocols and opioid stewardship initiatives in critical access and rural hospitals.
- **Support the evaluation and adoption of emerging evidence-based therapies for co-occurring SUD and mental health disorders, and establish timely reimbursement pathways as treatments receive FDA approval;** this includes CRNA-administered ketamine infusion therapy for treatment-resistant depression comorbid with SUD. HHS should proactively develop and update coverage and reimbursement policies consistent with AANA's 2024 clinical guidance to ensure that reimbursement policies do not create unnecessary barriers to patient access to safe, effective, and clinically appropriate treatments.
- **Promote interdisciplinary, team-based care models that integrate CRNAs into SUD prevention and recovery infrastructure.** CRNA expertise in pain management, opioid stewardship, and perioperative pharmacology should be explicitly recognized within federally supported integrated care models, including opioid treatment programs operating in surgical and procedure-based settings.

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<sup>17</sup> See: 84 FR 53573, October 3, 2019. <https://www.federalregister.gov/documents/2019/10/08/2019-22073/protectingand-improving-medicare-for-our-nations-seniors> and 90 FR 9065, January 21, 2025. <https://www.federalregister.gov/documents/2025/02/06/2025-02345/unleashingprosperity-through-deregulation>.

Thank you for the opportunity to comment on this important request. AANA stands ready to assist in advancing the goals of the Great American Recovery Initiative and welcomes the opportunity to meet with you to discuss these recommendations further. Should you have questions or wish to schedule a meeting, please contact AANA Director of Regulatory Affairs, Romy Gelb-Zimmer, at 202-484-8400 or [rgelb-zimmer@aana.com](mailto:rgelb-zimmer@aana.com).

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