AANA
American Association of
NURSE ANESTHESIOLOGY

September 3, 2025

Dr. Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services (CMS)
7500 Security Blvd
Baltimore, MD 21244

Submitted electronically at https://www.regulations.gov/commenton/CMS-2025-0306-0002

Dear Administrator Oz:

On behalf of the more than 65,000 members of the American Association of Nurse Anesthesiology (AANA), I submit these comments in response to the Calendar Year 2026 Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule (hereafter OPPS). 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 are autonomous anesthesia providers with extensive education and clinical training. AANA welcomes the opportunity to provide feedback on policies in the OPPS that impact CRNAs and the patients and facilities they serve.

We comment on and recommend the following:

1. The phase out of the IPO list could have unintended consequences for patient safety and outpatient facilities.
2. CMS should continue additional payments for non-opioid pain management and include payments under the Medicare Physician Fee Schedule.
3. Esketamine therapy must be adequately reimbursed.
4. Payment methodologies for Software as a Service must incorporate principles that protect the essential clinical decision-making of CRNAs.
5. If finalized, the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery quality measure should consider patient access and specialty specific questions.

1. **The phase out of the IPO list could have unintended consequences for patient safety and outpatient facilities.**

In the proposed rule, CMS reintroduces a proposal from the CY 2021 OPPS rule to phase out the inpatient-only (IPO) list over the course of three years. AANA appreciates CMS' reasoning that there should be deference to clinician decision making about the appropriateness of site of service. We agree that outpatient and ASC settings are important because they provide cost-effective access to much needed care, especially for rural communities. Additionally, we agree that advancements in surgical care, specifically perioperative anesthesia techniques, have led to shorter rehabilitation time and better outcomes. Indeed, CRNAs are leaders in the advancement of acute and chronic pain management techniques that are integral to reducing lengths of stay and improving patients' quality of life.

However, while CMS argues on page 33667 of the proposed rule, that there are patient safety protections in place due to "accreditation requirements, hospital conditions of participation (CoPs), medical malpractice laws, and CMS quality and monitoring initiatives and programs," AANA advises caution in the unintended consequences of eliminating the IPO list as proposed. We are concerned that there is no evidence-based review process for the removal of all procedures on the IPO list. The current utilization of the Advisory Panel on Hospital Outpatient Payment and internal CMS review provides a rigorous evidence-based review process for removal, but we understand that with advancements in care this process could be outdated. Appropriate site of service must depend on patient selection criteria that determines risk based on patient comorbidities as this is the critical factor in determining suitability in the outpatient setting. While being cognizant of not imposing arduous barriers to care, we urge CMS to establish an approach that ensures the necessary evidence review of patient selection criteria for IPO list procedures before their transition to the outpatient setting.

Finally, we are concerned with the process of moving all IPO list procedures over to the OPPS where they will have to be assigned APCs and payment rates. As these are APCs that would be subject to budget neutrality requirements, it could be burdening facilities with inadequate reimbursement. This would fall hardest on rural facilities which already run on very tight margins and are closing at an alarming rate.

2. **CMS should continue additional payments for non-opioid pain management and include payments under the Physician Fee Schedule.**

Advancements in non-opioid pain management are critical to the future of anesthesia care. AANA strongly supports CMS continuing additional payments for these methods in hospital outpatient and ASC settings. CRNAs are especially important in this regard as they provide most of the anesthesia care in rural communities which suffer the highest opioid-

related hospital admissions and deaths.[1] Chronic opioid use after surgery is a contributing factor of the opioid crisis and CRNAs are already leading the practice of opioid sparing techniques informed by risk factors identified in their practice.[2]

CRNAs are instrumental in the development of policies to provide effective pain management alternatives to opioids such as through the use of Enhanced Recovery After Surgery (ERAS) pathways.[3] ERAS is a patient-centered, evidence-based, pain management strategy employed by CRNAs to reduce the need for opioids, improve patient outcomes, and reduce costs.[4] Whereas the outdated method of pain management included simply a patient assessment followed by either opioid or non-opioid medication, ERAS is a pathway of six holistic steps. Starting with preadmission patient and caregiver education and pain management planning and ending in a quality assessment to improve outcomes, ERAS is a comprehensive tactic that emphasizes collaboration with patients. This strategy employs techniques such as multimodal medication in the postoperative stage which uses more than one pharmacological class of analgesic medication. AANA practice standards explain that patients with current or a history of substance use disorder deserve high-quality pain management care and multimodal anesthesia can be tailored to this population.[5] ERAS reduces patient stays by an average of 3-4 days and produces average savings of $880 to $5,560 per patient.[6]

AANA applauds the reimbursement policy contained in the Consolidated Appropriations Act of 2023 that instituted these additional payments. Importantly, CMS must include separate clinician payments under the Physician Fee Schedule to ensure the continued advancement of these safer and more effective techniques. By limiting additional investments to only facilities and not extending to clinicians directly, it suppresses further innovation by CRNAs who are leading the actual implementation of these techniques in the rural communities that need them the most.

---

[1] Mary-Bailey White, et al., *Chronic Opioid Use After Surgery: An Exploratory Study Examining Rural Certified Registered Nurse Anesthetist Strategies to Mitigate Chronic Opioid Use and Their View of Their Role in the Opioid Crisis*, AANA Journal, December 2022, available at: https://pubmed.ncbi.nlm.nih.gov/36413186/.
[2] Mary-Bailey White, et al., *Chronic Opioid Use After Surgery: An Exploratory Study Examining Rural Certified Registered Nurse Anesthetist Strategies to Mitigate Chronic Opioid Use and Their View of Their Role in the Opioid Crisis*, AANA Journal, December 2022, available at: https://pubmed.ncbi.nlm.nih.gov/36413186/.
[3] American Association of Nurse Anesthesiology, *Enhanced Recovery After Surgery Overview*, available at: https://www.aana.com/practice/clinical-practice/clinical-practice-resources/enhanced-recovery-after-surgery/.
[4] American Association of Nurse Anesthesiology, *Enhanced Recovery After Surgery: How CRNAs are reducing opioid use, improving outcomes, and lowering costs*, December 2020, available at: https://www.anesthesiafacts.com/wp-content/uploads/2020/12/AANA_ERAS_OneSheet_Final.pdf
[5] American Association of Nurse Anesthesiology, *Analgesia and Anesthesia for the Substance Use Disorder Patient: Practice Considerations*, October 2023, available at: https://issuu.com/aanapublishing/docs/2_-_analgesia_and_anesthesia_for_the_substance_use?fr=sMzA1MDU2NDAxMjU.
[6] American Association of Nurse Anesthesiology, *Enhanced Recovery After Surgery: How CRNAs are reducing opioid use, improving outcomes, and lowering costs*, December 2020, available at: https://www.anesthesiafacts.com/wp-content/uploads/2020/12/AANA_ERAS_OneSheet_Final.pdf

3. **Esketamine therapy must be adequately reimbursed.**

Ketamine is an anesthetic commonly used in surgery and other procedures for acute pain. CRNAs, and other anesthesia providers, have extensive experience providing it. CRNAs also provide ketamine therapy for mental health treatments within an interdisciplinary team alongside psychiatric clinicians such as psychiatric-mental health nurses.[7] CRNAs are a growing workforce in this area that provide all methods of ketamine administration, including Esketamine. AANA agrees with CMS that access to this live-saving treatment must be prompt and urges adequate reimbursement. There must be suitable payment rates as facilities face the costs of the product itself to staff time required for treatment and REMS compliance. As CMS continues to analyze claims over the next year, we caution undervaluing the complexity of these services.

4. **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), in order to support clinical decision-making and improve patient care, we urge the adoption of principles that ensure clinician expertise is protected. AI should assist and never replace CRNA clinical judgment that encompasses 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 on their Request for Information on the Development of an Artificial Intelligence (AI) Action Plan.[8]

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

---

[7] American Association of Nurse Anesthesiology, *Ketamine Therapy for Psychiatric Disorders and Chronic Pain Management: Practice Considerations*, May 2024, available at: https://issuu.com/aanapublishing/docs/7_-_ketamine_infusion_therapy_for_psychiatric_diso?fr=sNTFhMjU2NDAxMjU.

[8] American Association of Nurse Anesthesiology, *Request for Information on the Development of an Artificial Intelligence (AI) Action Plan Comments*, February 27, 2025, available at: https://www.aana.com/wp-content/uploads/2025/03/AANA-comments-on-RFI-Development-of-an-AI-Action-Plan.pdf

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.

5. **If finalized, the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery quality measure should consider patient access and specialty specific questions.**

AANA appreciates CMS' efforts to strengthen the ASCQR Program measure set by adopting the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO–PM). We support the inclusion of patient-reported outcome measures, much like the theory behind ERAS, they provide valuable insights into the effectiveness of communication with patients and patient satisfaction and can help identify opportunities for improvement in perioperative care. However, we have concern with balancing survey fatigue, patient access to survey instruments, and administrative burden to facilities as this measure has not been tested in the ASC setting.

We note that CMS proposes to calculate the Information Transfer PRO–PM using data collected via a nonproprietary, free survey instrument administered electronically (through email or text). While we appreciate CMS' goal of reducing burden, if finalizing this measure, we urge consideration of whether limiting data collection to electronic methods could affect response quality and representativeness, particularly among patients with limited digital access or literacy. Allowing flexibility to administer the survey through alternative modalities, such as telephone calls or mailed paper forms, would help ensure that patient voices are captured more equitably across diverse populations.

Additionally, if finalizing this measure, we recommend CMS consider incorporating specialty-specific questions within the measure set. For example, asking patients about their experience with anesthesia or pain medications, including issues such as numbness or increased pain would provide actionable feedback for CRNAs and support follow-up care after outpatient procedures. These refinements would help ensure that the measure not only supports cross-setting comparisons but also provides clinically relevant data that can directly improve patient outcomes.

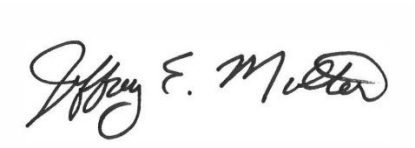
Conclusion

Finally, we applaud CMS for their separate Request for Information (RFI) "Unleashing Prosperity Through Deregulation of the Medicare Program" referenced in the proposed rule

and released earlier this year. AANA submitted comments to this RFI on June 3, 2025[9], and looks forward to working with CMS to streamline and strengthen Medicare programs.

Thank you for your time and attention to the critical role of CRNAs in our nation's healthcare workforce and the Medicare program. Should you have any questions or need to request a meeting please contact Romy Gelb-Zimmer, Director of Regulatory Affairs, at rgelb-zimmer@aana.com.

Sincerely,



Jeffrey E. Molter CRNA, MSN, MBA
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Ingrida Lusis, AANA Chief Advocacy Officer
Emily Champlin, JD, AANA Associate Director of Regulatory Affairs

[9] American Association of Nurse Anesthesiology, *Request for Information Unleashing Prosperity Through Deregulation of the Medicare Program Comments*, June 3, 2025, available at: https://www.aana.com/wp-content/uploads/2025/06/AANA-Comment-Letter_CMS-Deregulatory-RFI-06.03.2025.pdf.