American Association of
NURSE ANESTHESIOLOGY

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Administrator Oz:

On behalf of the more than 69,000 members of the American Association of Nurse Anesthesiology (AANA) I submit these comments in response to the Calendar Year 2027 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 doctorally prepared autonomous anesthesia providers through their training and preparation. 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. 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.

AANA welcomes the opportunity to provide feedback on policies in the OPPS that impact CRNAs and the patients and facilities they serve. In these comments we address:

1. **CMS must remove the physician supervision requirements for CRNAs, address anesthesia reimbursement, and ensure Ambulatory Surgery Centers are properly reimbursed.**
2. **CMS' phase out of the IPO list should be led by a specified evidence-based review.**
3. **CMS's continued investment in non-opioid treatments for pain relief is vital, but CMS must include direct clinician reimbursement.**

4. **AANA applauds CMS's continued support of access to Esketamine treatment.**
5. **Software as a Medical Service payment policy must support requirements that include clinician decision-making protections.**
6. **CMS must ensure payment policy for domestic Personal Protective Equipment and essential medicines considers the needs of anesthesia care.**
7. **If finalized, CMS should modify the Advance Care Planning eCQM for the hospital outpatient setting and provide implementation guidance that reflects the roles of outpatient specialists and procedural providers.**
8. **If finalized, CMS should ensure phase-of-care stratification of the All-Cause Transfer/Admission measure improves attribution, incorporates appropriate safeguards, and avoids unintended consequences for anesthesia providers.**

1. **CMS must remove the physician supervision requirements for CRNAs, address anesthesia reimbursement, and ensure Ambulatory Surgery Centers are properly reimbursed.**

AANA urges CMS to stabilize anesthesia care delivery by eliminating the wasteful physician supervision requirements and ensuring anesthesia and outpatient facility reimbursement responds to the realities of care delivery. AANA is deeply concerned with the mounting anesthesia crisis in the Medicare program. The demand for anesthesia care is rising while the country continues to face provider shortages. The impact of years of a declining anesthesia reimbursement rate, undervaluing of chronic pain management care, and continuation of the burdensome physician supervision requirement for CRNAs as part of the Hospital, Critical Access Hospital, and Rural Emergency Hospital Conditions of Participation (CoPs), and the Ambulatory Surgical Center Conditions for Coverage (CfCs) is contributing to facility closures and growing anesthesia access care gaps.

Additionally, outpatient facilities, especially ambulatory surgery centers (ASCs) and those in rural communities, are vital for care access yet also bear the brunt of the under payment for anesthesia care. It is predicted that outpatient volumes will grow 20 percent over the next 10 years with a large shift toward more efficient ambulatory settings.[1] ASCs and CRNAs represent efficient, effective, and safe care delivery. ASCs are proven cost savers for Medicare programs.[2] CRNAs are not only essential care providers for rural areas as 80 percent of rural counties rely on CRNAs as their primary

[1] Vizient, *2026 Impact of Change Forecast,* June 2026, available at: https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/d68f76ac86a74bc286889f37eba3d3fb.
[2] KNG Health Consulting, *Medicare Savings from Use of Ambulatory Surgery Centers, 2019-2024*, May 6, 2026, available at: https://www.ascassociation.org/asca/about-ascs/savings/medicare-savings-from-use-of-ambulatory-surgery-centers.

anesthesia care providers, but ASCs overwhelmingly utilize CRNA led care teams due to the efficiency of CRNA-only anesthesia models.[3] However, many ASCs are prevented from using the CRNA only model if they reside in a state that has not yet gone through the onerous process to opt-out of the physician supervision requirements. To date, 27 states have opted out of these policies while the majority of states, 45, do not have any physician supervision requirements of CRNAs in their nursing/medicine laws or rules. Evidence continues to overwhelmingly show that autonomously practicing CRNAs are safe and effective clinicians with no increase in negative patient outcomes.[4] Research also shows that when CRNAs are able to practice to the full extent of their education and training without physician supervision requirements, this expands access to anesthesia care.[5]

We therefore strongly recommend CMS remove the wasteful and burdensome physician supervision requirements for CRNAs. They are not based on any evidence and only contribute waste to the Medicare program. Removal of these policies will also boost the capabilities of ASCs which are vital to the future of outpatient care, but CMS must ensure ASC payment policies also support their growth and sustainability. We strongly support the continuation of applying the hospital market basket update to ASC rates for an additional year and urge CMS to make this policy permanent.

2. **CMS' phase out of the IPO list should be led by a specified evidence-based review.**

In the proposed rule, CMS continues its second year of the three-year phase out of the inpatient only (IPO) list. AANA remains concerned with CMS' process to eliminate the IPO list as it does not rely on an individualized evidence-based review. While we do support the transfer of appropriate services to outpatient settings and the reliance on clinician decision making for proper site of service, we still caution that the current process could have unintended consequences. This is especially important as CMS notes in this year's proposed rule that the remaining procedures on the IPO list set to be removed in CY 2028 are complex procedures requiring extra review. Appropriate site of service must depend on patient selection criteria that determines risk based on

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[3] American Association of Nurse Anesthesiology, *CRNAs are the Most Versatile and Cost-Effective Anesthesia Providers*, Updated January 2025, available at: https://www.aana.com/wp-content/uploads/2023/02/CRNA-Cost-Effective-General-AANA-2025.pdf.

[4] Negrusa B., et al., *Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications*, Medical Care, June 2016, available at http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx; Dulisse B., et al., *No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians*, Health Affairs, August 2010, available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2008.0966; Lewis SR, et al., *Physician anesthetists versus non-physician providers of anesthesia for surgical patients*, Cochrane Database of Systematic Reviews, July 2014, available at: https://pubmed.ncbi.nlm.nih.gov/25019298/.

[5] Ghosh, PP, et al., *Impact of Scope of Practice Laws for Certified Registered Nurse Anesthetists on the Utilization of Anesthesia Services*, Health Services Research, October 2025, available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12857518/.

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.

3. **CMS's continued investment in non-opioid treatments for pain relief is vital, but CMS must include direct clinician reimbursement.**

AANA remains committed to opioid-sparing techniques which are critical to the future of anesthesia care. CRNAs are important leaders in this area due to being the primary providers in rural communities that remain at the highest risk of opioid-use disorders, often evolving from chronic use after surgery.[6] CRNAs are highly skilled in chronic pain management utilizing holistic methods such as Enhanced Recovery After Surgery (ERAS) pathways.[7] 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.

CMS' continuing additional payments is a critical investment in these life-saving advancements. AANA agrees with the proposal that a more often quarterly review of non-opioid treatments will ensure timely advancements. 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.

4. **AANA applauds CMS's continued support of access to Esketamine treatment.**

AANA supports CMS' proposal to increase Esketamine payments reflecting most recent available utilization data. As stated in our comments on last year's proposed rule, Esketamine treatment is a critical service for treatment resistant major depressive disorder and other mental health conditions. CRNAs provide ketamine therapy for mental health treatments within an interdisciplinary team alongside psychiatric clinicians such as psychiatric-mental health nurses.[8] CRNAs are a growing

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[6] 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/.

[7] 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

[8] American Association of Nurse Anesthesiology, *Ketamine Therapy for Psychiatric Disorders and Chronic Pain Management: Practice Considerations*, May 2024, available

workforce in this area that provide all methods of ketamine administration, including Esketamine. AANA supports CMS' increase based on analysis of most recent available claims data that led to updating for CY 2027 HCPCS code G2082 being assigned to APC 1513 (New Technology—Level 13) with a payment rate of $1,150.50 and HCPCS code G2083 being assigned to APC 1518 (New Technology—Level 18) with a payment rate of $1,650.50. AANA urges CMS to ensure the continued proper reimbursement for this service as a critical investment in mental health care.

5. **Software as a Medical Service payment policy must support requirements that include clinician decision-making protections.**

CMS's approach to standardizing Software as a Medical Service (SaMS) payments by testing them for CY 2027 as New Technology APCs with status indicator "01" will be a beneficial to expand access to efficient evolving technologies. Applicable HCPCS codes designated as SaMS for CY 2027 in Table 61 include important clinician review and interpretation requirements, as well as inclusive provider type language, which must remain central factors for clinical and payment policy. Especially as CMS and the entire Department of Health and Human Services (HHS) investigate best pathways to incorporate rapidly evolving Artificial Intelligence (AI) technologies, we urge that there be careful attention to these tools supporting but never replacing CRNA clinical decision-making and expertise.[9]

6. **CMS must ensure payment policy for domestic Personal Protective Equipment and essential medicines considers the needs of anesthesia care.**

AANA appreciates the request for information on domestic Personal Protective Equipment (PPE) and essential medicines and strongly supports separate payment for these supplies. Supply chain shortages and rising costs of medicines and supplies fall especially on small hospitals, rural hospitals, and ASCs as they all run extremely tight margins. Recent shortages of IV fluids were deeply felt in these facilities and communities. We therefore stress that anesthesia drugs must be included on any lists of essential medicines.

While AANA wholly supports the domestic production and supply of PPE and medicines, anesthesia drugs required across the perioperative continuum require flexibilities for emergencies. In previous circumstances the Food and Drug Administration (FDA) has conducted emergency inspections of foreign facilities to

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at: https://issuu.com/aanapublishing/docs/7_-_ketamine_infusion_therapy_for_psychiatric_diso?fr=sNTFhMjU2NDAxMjU.

[9] For more on this topic see *AANA Comments on HHS Request for Information: Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care [RIN 0955-AA13]*, February 18, 2026, available at: https://www.aana.com/wp-content/uploads/2026/02/AANA-Comment-Letter-responding-to-the-Department-of-Health-Human-Services-Request-for-Information.pdf.

allow temporary importation of foreign drugs in critical shortages such as Propoven, the European version of Propofol. Additionally, payment structure must match clinical realities such as correct vial sizes of Propofol, which is single use but 100mL vials do not match every case, such as pediatric cases, and therefore creates unnecessary waste. We propose CMS continue to conduct stakeholder input events to gather more specialty specific information and strongly recommend utilizing CRNA expertise to ensure anesthesia care is fully incorporated in PPE and essential medicine supply chain planning.

7. **If finalized, CMS should modify the Advance Care Planning eCQM for the hospital outpatient setting and provide implementation guidance that reflects the roles of outpatient specialists and procedural providers.**

AANA applauds CMS' efforts to advance person-centered care by exploring the inclusion of an Advance Care Planning (ACP) eCQM within the Hospital OQR Program. Advance care planning is an important component of high-quality care, particularly for patients with serious illness or those undergoing high-risk procedures. However, we encourage CMS to carefully consider how responsibility for this measure is attributed within the hospital outpatient setting. Advance care planning is typically initiated and maintained by primary care providers or attending physicians who have an ongoing longitudinal relationship with the patient. By contrast, hospital outpatient clinicians such as surgeons, certified registered nurse anesthetists, and other specialists often have limited encounters that are focused on a specific procedure or episode of care. If the measure is attributed to outpatient procedural providers or specialists, we believe the current measure specifications would require modification to reflect their role in the continuum of care.

Specifically, CMS should clarify whether the expectation is for outpatient providers to initiate new advance care planning discussions, verify the presence of existing documentation, update existing documents, or simply document that advance care planning was addressed. Without clearly defining provider responsibilities, implementation may create duplicative documentation requirements and administrative burden without meaningfully improving patient-centered care.

We also note that the proposed measure includes no exclusions and applies to all adults aged 18 years and older. While advance care planning is beneficial for all adults, implementation may present unique challenges among younger populations, particularly patients aged 18 to 35 years, where advance directives and related documentation are less common. We implore CMS to provide additional information on strategies that facilities could use to increase advance care planning engagement among younger adults and whether alternative implementation approaches or risk-adjusted benchmarks should be considered for this population.

We encourage CMS to work closely with stakeholders, including CRNAs, during measure development to ensure that any future outpatient ACP measure is feasible to implement, appropriately attributed, and designed to improve meaningful patient engagement rather than solely increasing documentation.

8. **If finalized, CMS should ensure phase-of-care stratification of the All-Cause Transfer/Admission measure improves attribution, incorporates appropriate safeguards, and avoids unintended consequences for anesthesia providers.**

AANA supports CMS' efforts to improve the usefulness and interpretation of the All-Cause Transfer/Admission measure through potential phase-of-care stratification. Stratifying transfers into pre-procedure, intra-procedure, and post-procedure categories has the potential to provide a more accurate understanding of when and why transfers occur and improve attribution of quality outcomes across the ASC setting. A phase-of-care approach could help distinguish transfers identified during pre-procedure evaluation from those related to intraoperative or postoperative events. This distinction is particularly important for recognizing the role of CRNAs, in identifying high-risk patients and facilitating appropriate escalation of care before a procedure begins. Transfers resulting from anesthesia-led preoperative assessments may represent effective patient safety practices rather than adverse outcomes associated with anesthesia care.

However, CMS should ensure that any future stratification methodology includes appropriate definitions, risk adjustment, and safeguards to prevent unintended consequences. Without careful measure design, more granular reporting could lead to misattribution of transfers to anesthesia providers or anesthesia services, particularly for events driven by patient complexity, underlying medical conditions, or appropriate clinical decision-making.

Additionally, phase-specific transfer data may eventually be considered by payers, facilities, or policymakers in quality evaluations, value-based arrangements, or contracting decisions. CMS should ensure that such data are not used to compare anesthesia providers or anesthesia delivery models without accounting for important differences, including:

- Patient acuity and complexity.
- Case mix and procedure types.
- Facility resources and capabilities.
- Availability of emergency support and hospital resources.
- Differences in populations served, including rural and underserved communities.

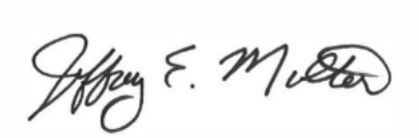
We also recommend that CMS carefully consider the data sources used to identify and attribute transfers. If claims-based methodologies are used, CMS should ensure accurate attribution through appropriate diagnosis codes, CPT codes, and modifiers, including those associated with anesthesia services, to avoid inaccurate assignment of outcomes to providers.

Finally, CMS should carefully define the time anchors used for stratification. We recommend using procedure start and stop times, rather than anesthesia start and stop times, as the primary reference point for categorizing transfers. While many ASC procedures involve anesthesia services, not all procedures require anesthesia. Some procedures may be performed under local anesthesia or with sedation administered by other qualified clinical staff. Using anesthesia start and stop times could exclude certain ASC procedures and limit the completeness and comparability of the measure. We further request that CMS clarify that procedure start and stop times are intended solely for measure calculation and should not be used as a basis for determining anesthesia coverage, payment, or reimbursement. This clarification is particularly important given that some insurers have attempted to impose arbitrary time limits on anesthesia coverage and payment based on procedure times, which may not accurately reflect the time or resources required to provide anesthesia services.

Overall, we agree that the All-Cause Transfer/Admission measure is an important quality and patient safety measure, and additional stratification may improve its clinical relevance. However, successful implementation will require clear definitions, appropriate risk adjustment, accurate attribution, and consideration of the diverse clinical settings and anesthesia delivery models represented within ASCs.

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 or Emily Champlin, Associate Director of Regulatory Affairs at echamplin@aana.com.

Sincerely,



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