American Association of
NURSE ANESTHESIOLOGY

June 2, 2026

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

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes [CMS-1849-P]

Dear Administrator Oz:

On behalf of the more than 69,000 members of the American Association of Nurse Anesthesiology (AANA), I wish to submit comments and recommendations in response to the proposed rule: *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes [RIN 0938-AV79]*. AANA's comments and recommendations focus on the following:

- Comments Related to the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model
- Clarification on Whether Enrollment Modifications to MORT–30–CABG Measure in the Hospital Inpatient Quality Reporting Program Apply to Other Medicare Populations
- Support for Updates to the Risk Adjustment Methodology for the MORT–30–CABG Measure in the Hospital Inpatient Quality Reporting and Value-based Purchasing Programs
- Recognition of CRNAs as Key Stakeholders in Implementation of the Hospital Harm—Postoperative Venous Thromboembolism Electronic Clinical Quality Measure

- Assurance that the Birthing-Friendly Hospital Designation Reflects the Role of CRNAs in Obstetric Anesthesia and Maternal Safety

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.

Comments on Comprehensive Care for Joint Replacement Expanded (CJR-X) Model

Appreciate the Opportunity for CRNAs to Serve as Qualifying APM Participants through the Expansion of Comprehensive Care for Joint Replacement (CJR) Model to CJR-X

AANA believes the proposed expansion of the Comprehensive Care for Joint Replacement (CJR) Model to the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model will meaningfully increase the opportunities for CRNAs nationwide to participate in a Qualifying Alternative Payment Model (APM) in line with MACRA statutory requirements and Medicare Part B payment incentives.

CMS proposes at 42 CFR § 512.615(a) that a CJR-X participant may select the Advanced APM (AAPM) option for their mandatory participation in the CJR-X Model (assuming meaningful certified electronic health record technology (CEHRT) adoption). CMS notes in the preamble of this proposed rule that, "We seek to align the design of CJR-X with the Advanced APM criteria in the Quality Payment Program and enable CMS to have the necessary information on eligible clinicians to make the requisite Qualifying APM Participant (QP) determinations."

CMS further notes in the proposed rule that, "We propose that the CJR-X participant would be considered the APM entity, as defined at 42 CFR § 414.1305, and that the CJR-X participant's affiliated practitioners, as defined at 42 § CFR 414.1305, may be assessed for QP determinations depending on whether the CEHRT criteria are met, as established at 42 CFR § 414.1425(b)(2)."

CMS finally notes in the proposed rule that, "We propose that each CJR–X participant would be required to submit information about the eligible clinicians or MIPS eligible

clinicians who enter into financial arrangements with the CJR–X participant for purposes of supporting the CJR–X participants' cost or quality goals as discussed in section X.C.2.i. of this proposed rule. This information would enable CMS to make determinations as to eligible clinicians who could be considered for QP determinations based on the services furnished under CJR–X (to the extent the model is determined to be an AAPM) and would be necessary for APP reporting and scoring for MIPS eligible clinicians (to the extent the model is determined to be a MIPS APM)."

AANA takes the proposed regulatory text and preamble discussions to mean that CJR-X collaborators, including CRNAs and CRNA group practices, would be considered QPs under the CJR-X Model (assuming the CJR-X participant meets CEHRT criteria and assuming they furnish services under the CJR-X Model during the performance period).

AANA supports the inclusion of CRNAs and CRNA group practices as QPs under the CJR-X Model. As we noted in our September 8, 2025, comment letter to CMS[1] in response to the proposed rule *Medicare and Medicaid Programs; CY 2026 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*, it is critical that CMS support Medicare providers, including CRNAs, in facilitating participation in APMs to maintain adequate reimbursement in the face of consistently declining anesthesia reimbursement rates, especially given the Qualifying APM/Non-Qualifying APM Medicare Part B conversion factor structure.

We thank CMS for providing an opportunity for CRNAs and CRNA group practices to participate as QPs in the nationwide CJR-X Model. AANA stands ready to partner with CMS to refine the CJR-X Model and to develop other models and methods to ensure meaningful CRNA QP participation.

Support the Inclusion of CRNAs as Collaborators Under CJR-X and Prohibition on Collaborator Fees

AANA appreciates CMS' inclusion of nonphysician practitioners (including CRNAs) and non-physician provider group practices (NPPGPs) as **CJR-X collaborators**, defined at 42 CFR § 512.605 as, "an ACO or [...] Medicare-enrolled individuals or entities that enters into a sharing arrangement", and in the preamble of this proposed rule as, "individuals and entities that have a role in the CJR-X participant's performance in the model." Including

[1] American Association of Nurse Anesthesiology. *Comment Letter Re: Medicare and Medicaid Programs; CY 2026 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*. September 8, 2025. https://www.aana.com/wp-content/uploads/2025/09/AANA-CY-2026-PFS-Comment-Letter-Final.pdf

CRNAs and CRNA group practices will allow CRNAs an expanded opportunity to participate in a Qualifying APM (as discussed in the previous section) and to engage in gainsharing payments as described at 42 CFR § 512.670, 42 CFR § 512.675, and 42 CFR § 512.680.

AANA further appreciates CMS' clarification in the preamble of this proposed rule that, "CJR-X participants may not charge any CJR-X collaborator a fee to be included on any list of preferred providers or suppliers, nor may the hospital accept such payments, which would be considered to be outside the realm of risk-sharing agreements." Such prohibition will further facilitate the inclusion of CRNAs and CRNA group practices as collaborators with CJR-X participants.

Clarification on the Status of Locum Tenens Practitioners

AANA seeks clarification from CMS that the clinician engagement list, defined at 42 CFR § 512.605 and discussed in the preamble of this proposed rule, would include clinicians, including CRNAs, who perform CJR-X activities under a CJR-X participant through a 1099 independent contractor *locum tenens* arrangement.

CMS defines the clinician engagement list as, "the list of eligible clinicians or MIPS eligible clinicians that participate in CJR-X activities, have a contractual relationship with the CJR-X participant, and who are not listed on the financial arrangements list."

AANA takes the proposed regulatory text and preamble discussions with respect to the financial arrangements list and the clinician engagement list to be inclusive of all contractual relationship types to facilitate inclusion of all clinicians participating in CJR-X activities as QPs.

Modification to the Proposed CJR-X Collaborator Notice Requirement

AANA opposes the proposed requirement at 42 CFR § 512.622(b) that requires every CJR-X collaborator that furnishes an item or service to a CJR-X beneficiary during an episode to provide written notice, to be developed by CMS, to the CJR-X beneficiary that describes general information on the quality and payment incentives under CJR-X, and existence of the CJR-X collaborator's sharing arrangement.

We believe that this requirement represents unnecessary administrative burden with little to no value to the CJR-X beneficiary. This proposed requirement is duplicative of the proposed CJR-X participant beneficiary notification requirement at 42 CFR § 512.622(a), specifically the requirement at 42 CFR § 512.622(a)(vi) that requires the CJR-X participant notice to include a list of the CJR-X collaborators with which the CJR-X has a sharing arrangement. Furthermore, it is impractical to require CRNAs to provide a CJR-X collaborator notice at the time of service given the nature of anesthesia services.

We urge CMS not to finalize this proposed requirement. Removing it would streamline the notification process and reduce administrative burden. We alternatively recommend that CMS develop a web-based, searchable portal – utilizing the financial arrangements lists that CMS proposes to require CJR-X participants to submit at 42 CFR § 512.615(b) – to allow CJR-X beneficiaries to identify CJR-X collaborators based on the CJR-X participant at which they initiate the episode of care.

Clarification on Whether Enrollment Modifications to MORT–30–CABG Measure in the Hospital Inpatient Quality Reporting Program Apply to Other Medicare Populations

CMS proposes to reintroduce with modification the "Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery (MORT-30-CABG)" measure to the Hospital IQR Program beginning with the FY 2028 payment determination, despite previously removing the measure under Removal Factor 8 because the reporting burden outweighed the benefit in a pay-for-reporting program.

AANA appreciates CMS' rationale that the measure continues to provide meaningful information on hospital quality and value and remains used in the Hospital VBP Program. AANA also supports CMS' proposed modifications to expand the measure cohort to include Medicare Advantage beneficiaries and shorten the reporting period from 3 years to 2 years, as these changes have the potential to improve data reliability, increase hospital participation, enhance detection of quality differences among low-volume hospitals, and provide more actionable insights.

AANA seeks clarification on whether similar enrollment requirements or cohort expansions would also apply to other Medicare populations, such as beneficiaries with End-Stage Renal Disease or individuals eligible for Medicare due to long-term disabilities, given the potential for higher clinical complexity, greater comorbidity burden, and elevated baseline mortality risk that could influence observed mortality rates following CABG surgery.

Support Updates to the Risk Adjustment Methodology for the MORT–30–CABG Measure in the Hospital Inpatient Quality Reporting and Value-based Purchasing Programs

AANA appreciates that CMS is updating the risk adjustment methodology for the MORT–30–CABG measure to use individual International Classification of Diseases, Tenth Revision (ICD-10) codes in place of Hierarchical Condition Categories (HCCs).

As in the FY 26 IPPS proposed rule, AANA agrees with CMS' assessment that updating the risk adjustment methodology will enhance the specificity and clinical relevance of the model. This improved specificity can strengthen the accuracy of risk adjustment by better accounting for the diverse clinical factors that influence patient outcomes following CABG

surgery. Additionally, greater diagnostic specificity may support providers like CRNAs in performing comprehensive preoperative evaluations and tailoring perioperative anesthesia care plans and postoperative monitoring, particularly for patients with complex comorbidities undergoing CABG surgery.

AANA supports this methodological advancement and encourages CMS to continue collaborating with stakeholders to monitor the impact of the change and ensure continued transparency and validity in the implementation process.

Recognition of CRNAs as Key Stakeholders in Implementation of the Hospital Harm—Postoperative Venous Thromboembolism Electronic Clinical Quality Measure

AANA recognizes CMS' efforts to strengthen the Inpatient Quality Reporting Program Hospital Harm measure set through adoption of the Postoperative Venous Thromboembolism (VTE) Electronic Clinical Quality Measure and removal of the VTE-1 and VTE-2 eCQMs. AANA supports this transition given the significant morbidity, recurrence risk, readmissions, mortality, and costs associated with postoperative VTE, as well as evidence that timely, evidence-based prophylaxis including combined mechanical and pharmacologic strategies can reduce VTE incidence.

CRNAs as anesthesia providers play an important role in perioperative VTE prevention through risk assessment, coordination of prophylaxis timing, adherence to protocols, and accurate documentation. As hospitals respond to increased accountability for postoperative VTE outcomes, anesthesia providers will likely see greater emphasis on standardized perioperative workflows and documentation practices. Accordingly, if finalized, CMS should ensure implementation guidance reflects the collaborative, team-based nature of perioperative VTE prevention and avoids undue administrative burden or inappropriate attribution of hospital-level outcomes to individual anesthesia providers.

The Pre-rulemaking Measure Review Hospital Committee has appropriately identified concerns related to the measure, including potential unintended consequences such as overtreatment and unnecessary anticoagulation, the need for clearer diagnostic criteria to reduce misclassification, and the importance of continued evaluation of additional risk factors affecting post-discharge VTE outcomes, including social determinants of health.

In addition, given the likelihood that hospitals will also implement enhanced quality improvement activities, workflow standardization, and increased monitoring and documentation in response to the measure, AANA recommends that CMS engage stakeholders, including CRNAs, in ongoing implementation, maintenance, and quality improvement efforts for this measure. Anesthesia expertise should be incorporated into perioperative workflow design, risk adjustment refinement, and clinical guidance to

support effective VTE prevention while ensuring appropriate, collaborative implementation across the care team.

Assurance that the Birthing-Friendly Hospital Designation Reflects the Role of CRNAs in Obstetric Anesthesia and Maternal Safety When Anesthesia and Pain Management are Involved.

AANA appreciates CMS' Request for Information (RFI) regarding the future direction of the Birthing-Friendly Hospital Designation, including potential expansion of designation criteria through the incorporation of outcome measures such as the Cesarean Birth eCQM and the Severe Obstetric Complications eCQM, revised eligibility requirements, and development of a composite scoring methodology. As proposed, we recognize that the current specifications for the outcome measures do not provide a way to meaningfully attribute outcomes to anesthesia other than the presence of diagnosis codes for anesthetic complications.

As CMS considers refinements to the designation methodology and to the extent that they appropriately involve anesthesia and pain management, we urge CMS to recognize the role CRNAs play in ensuring safe, timely, and equitable maternal care across hospital settings. This is particularly important as CMS evaluates measures related to cesarean births, severe maternal morbidity, and obstetric complications, all of which are influenced by access to high-quality obstetric anesthesia, pain management, and rapid response capabilities. We urge CMS to include AANA and CRNAs as stakeholders as CMS continues to consider the future direction of measures in this designation.

CRNAs are essential members of the maternal care team and, in many rural and underserved communities, are the primary or sole anesthesia professionals furnishing obstetric anesthesia services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, enabling these facilities to maintain obstetrical, surgical, trauma stabilization, and pain management services. Without access to CRNA services, many hospitals would face substantial barriers to sustaining labor and delivery units and providing emergency obstetric interventions.

CRNAs support safe labor and delivery through the administration of neuraxial analgesia and anesthesia techniques, including epidurals and spinal anesthesia, and play a critical role in emergency obstetric response and the management of severe maternal complications such as obstetric hemorrhage, hemodynamic instability, and sepsis. CRNAs have also contributed to national maternal safety and quality improvement initiatives, including AANA's participation in the American College of Obstetricians and Gynecologists (ACOG) Council on Patient Safety in Women's Healthcare and development of evidence-

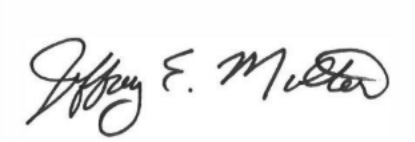
based maternal safety bundles addressing obstetric hemorrhage, hypertension in pregnancy, reduction of primary cesarean birth, venous thromboembolism, and support following severe maternal events.[2]

As CMS considers future modifications to the Birthing-Friendly Hospital Designation, we encourage the agency to ensure the framework captures the workforce and clinical infrastructure necessary to support high-quality maternal care, including access to qualified anesthesia professionals capable of furnishing obstetric anesthesia, neuraxial analgesia, emergency cesarean anesthesia, and rapid response services on a 24/7 basis. Recognizing the role of CRNAs as essential obstetric anesthesia providers would strengthen the designation's ability to identify hospitals equipped to provide safe, equitable, and comprehensive maternity care. We stand ready to work with CMS on this important initiative.

Conclusion

We appreciate the opportunity to provide input to the proposed policies in the proposed rule *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes*. 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,



Jeff Molter, MBA, MSN, CRNA
AANA President

CC: William Bruce, AANA Chief Executive Officer

[2] See: www.safehealthcareforeverywoman.org