AANA
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NURSE ANESTHESIOLOGY

On July 14, the Centers for Medicare & Medicaid Services (CMS) released the CY 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule. The PFS is significant because it includes payment updates for CRNAs and other clinicians billing Medicare Part B and influences private payer fee schedules.

The CY 2027 Medicare PFS proposed rule contains several major policy proposals that could impact CRNA practice and reimbursement. The following summary offers a high-level overview of the major, relevant policy proposals and requests for information contained in the CY 2027 PFS proposed rule. AANA continues to analyze this proposed rule and will submit comments ahead of the September 14, 2026, comment submission deadline.

Calendar Year 2027 Medicare Conversion Factor

Beginning with the CY 2026, the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) required CMS to implement two separate conversion factors:

- One conversion factor for items and services furnished by a qualifying Alternative Payment Models (APM) participant (referred to as the *qualifying APM conversion factor*).
- One conversion factor for other items and services (referred to as the *non-qualifying APM conversion factor*).

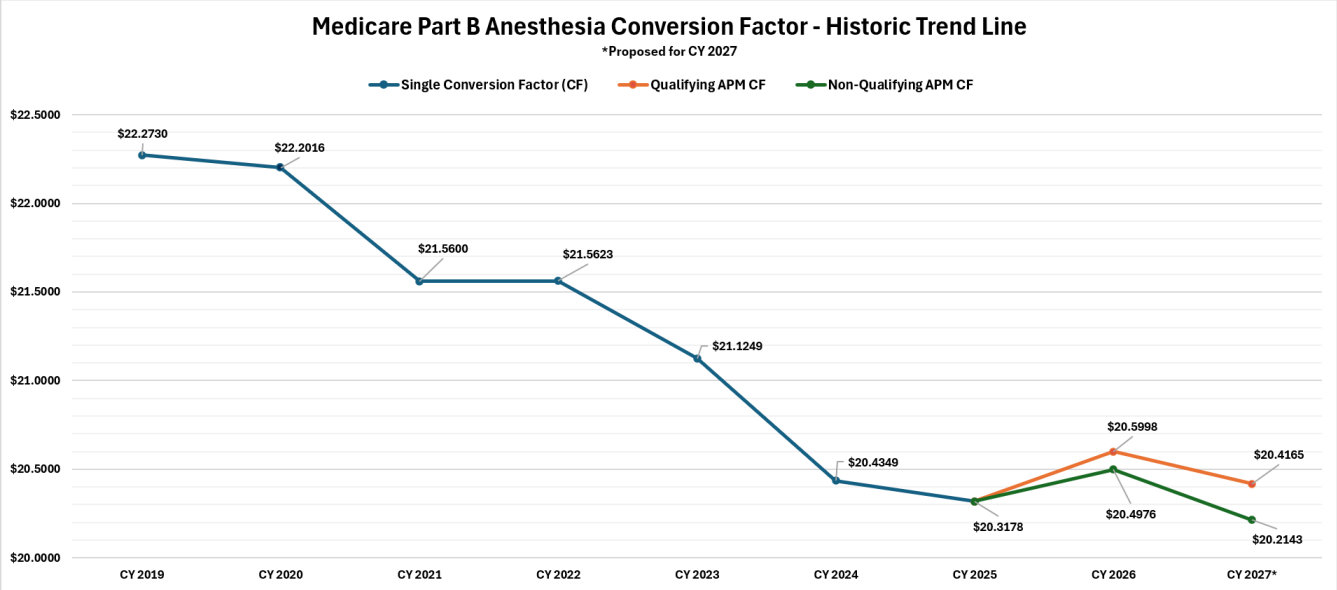
For CY 2027, CMS proposes the following average national anesthesia conversion factors:

- **Qualifying APM Anesthesia Conversion Factor**: **$20.4165** (a **0.89% decrease** compared to the CY 2026 Qualifying APM anesthesia conversion factor).

- **Non-Qualifying APM Anesthesia Conversion Factor**: **$20.2143** (a **1.38% decrease** compared to the CY 2026 Non-Qualifying APM anesthesia conversion factor).

The proposed decreases to the average national anesthesia conversion factors are due to proposed positive adjustments to anesthesia practice expense and malpractice RVUs and the expiration of the 2.5 percent increase in the conversion factor for CY 2026 from the Working Families Tax Cut. These proposed decreases are smaller than the decreases to the general conversion factors, which are -1.19% and -1.68% for the general Qualifying APM and general Non-Qualifying APM conversion factors, respectively, for CY 2027.

CMS also factored in the MACRA mandated annual updates of +0.75% to the Qualifying APM conversion factors and 0.25% to the Non-Qualifying APM conversion factors. As illustrated in the chart below, these differential increases are leading to a growing divergence between Medicare payment for providers based on whether they are a Qualifying APM Participant.



PFS Proposed Policies Would Increase Overall Medicare Part B CRNA Payment by One Percent

According to Table D-B5 (*CY 2027 PFS Estimated Impact on Total Allowed Charges by Specialty*) in the CY 2-27 PFS proposed rule, CY 2027 allowed charges for Nurse Anesthetist/Anesthesiology Assistant services are $1,130M, a 1 percent increase in the combined impact on total allowed charges of all proposed RVU and policy changes**.** The allowed charges for Anesthesiology services are $1,656M, a net 0 percent change in the combined impact on total allowed charges of all proposed RVU and policy changes.

CY 2027 PFS Proposed Rule – Table D-B5 Proposed Policy Impacts					
Total/Non-Facility/Facility*	**Allowed Charges (mil)**	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of MP RVU Changes**	**Combined Impact**
Total	**$1,130**	**0%**	**1%**	**0%**	**1%**
Non-Facility	$19	0%	10%	0%	10%
Facility	$1,111	0%	1%	0%	1%

*CMS refers to non-facility services as services that can be furnished in a physician's office. CMS refers to facility services as services performed in a facility (e.g., an ASC or a hospital outpatient department) setting.

Request for Information on Global Period Assignment for CPT Codes 01953, 01968, and 01969
CMS seeks comments from interested parties regarding the global period assignment for CPT codes 01953, 01968, and 01969. CMS notes that the American Medical Association (AMA) Relative-Value Update Committee (RUC) requested assigning the ZZZ global period to these codes. CMS pointed out that all anesthesia codes currently use the XXX global period and that it is unclear whether the concept of an add-on global period would apply to anesthesia codes given that they are uniquely valued using base units and time units.

A global surgical package for major surgical procedures refers to a payment policy of bundling payment for the various services associated with an operation into a single payment covering the operation and these other services, such as postoperative hospital visits.

- Codes assigned a ZZZ global period are related to another service and are always included in the global period of another service.
- Codes assigned an XXX global period are codes to which the global concept does not apply.

Current Procedural Terminology (CPT) Request for Information
CMS seeks comments on the influence of the Current Procedural Terminology (CPT) coding system and the AMA process on physician payment policy (i.e., the RUC). CMS cites longstanding concern expressed over the Federal reliance on a private organization with an obvious conflict of interest providing time and resource requirements to conduct healthcare services while noting that there is no statutory requirement for CMS to utilize CPT codes in Federal policymaking. Combined with CMS' criticism of the RUC process and RUC data in the CY 2026 PFS proposed and final rules, this RFI signals a continued skepticism of the current CPT/RUC paradigm and potential shift away from reliance on the CPT/RUC process for coding updates and valuation in the Medicare program.

CY 2026 Efficiency Adjustment

CMS confirmed in the CY 2027 PFS proposed rule that it will apply an efficiency adjustment to non-time-based codes every 3 years. This efficiency adjustment did not apply to anesthesia codes in CY 2026 but did apply to non-time-based pain management codes. For CY 2026, CMS finalized a proposal to apply **a negative 2.5 percent efficiency update** to the work RVU and corresponding intra-service time portion of certain non-time-based services paid under the PFS. The list of finalized codes can be accessed here.

In finalizing the efficiency adjustment, CMS also called into question the AMA RUC process. CMS cited potential downsides of the RUC process, including low survey response rates, subjective information, inherent conflicts of interest, and extensive periods of time between code re-evaluations. CMS noted that, in the future, they may give

preference to empiric studies of time to incorporate into service valuation over RUC survey data.

Ambulatory Specialty Model (ASM)

For CY 2027, CMS proposes several changes to the Ambulatory Surgical Model (ASM). However, CMS states that they are not proposing any adjustments to the specialty types included in each AMS cohort for low back pain and heart failure, respectively as finalized at § 512.710(d) in the CY 2026 PFS final rule. In our comments in response to the CY 2026 PFS proposed rule, AANA urged CMS to expand the low back pain cohort to include CRNAs and to make ASM a voluntary model; CMS responded in the CY 2026 PFS final rule that they would not expand this cohort to include CRNAs.

CMS had finalized the implementation and testing of the Ambulatory Specialty Model (ASM), a mandatory alternative payment model with 5 performance years that began January 1, 2027as part of the CY 2026 final rule. ASM tests whether adjusting payment for specialists based on their performance on targeted measures of quality, cost, care coordination, and meaningful use of certified electronic health record (EHR) technology (CEHRT) results in enhanced quality of care and reduced costs through more effective upstream chronic condition management for heart failure and low back pain.

Medicare Quality Payment Program

CMS proposes several policy changes to the Medicare Quality Payment Program in the CY 2027 PFS proposed rule. These policy changes include:

Mandatory Transition to MVP Reporting

- CMS proposes to phase out the traditional Merit-based Incentive Payment System (MIPS) reporting for MIPS-eligible clinicians not participating in the Advanced Payment Program (APP), beginning with the CY 2029 performance period/2031 MIPS payment year.
    - CMS proposes to modify the existing "Patient Safety and Support of Positive Experiences with Anesthesia" MIPS Value Pathway (MVP) (one of the 27 previously finalized MVPs) along with all other MVPs to incorporate the new MIPS core measure requirement.
    - CMS proposes to include virtual groups in MVP reporting beginning in the CY 2029 performance period/2031 MIPS payment year, revising the definition of "MVP participant" at § 414.1305 to add virtual groups.

New and Removed MIPS Measures for CY 2027/PY 2029

- CMS proposes adding the following MIPS measures for CY 2027/PY 2029:
    - **AQI48**: Patient-Reported Experience with Anesthesia
    - **ePreop31**: Intraoperative Hypotension Among Non-Emergent Noncardiac Surgical Cases

- CMS proposes removing the following MIPS measures:
    - **QID 430**: Prevention of Post-Operative Nausea and Vomiting – Combination Therapy from MIPS and the Anesthesiology Specialty Measure Set
    - **QID 463**: Prevention of Post-Operative Vomiting – Combination Therapy (Pediatrics) from MIPS and the Anesthesiology Specialty Measure Set

New and Removed Patient Safety and Support of Positive Experiences with Anesthesia MVP Measures for CY 2027/PY 2029

- CMS proposes the following MIPS core measures for CY 2027/PY 2029:
    - **Q404**: Anesthesiology Smoking Abstinence
    - **Q477**: Multimodal Pain Management
    - Intraoperative Hypotension (IOH) among Non-Emergent Noncardiac Surgical Cases

- CMS proposes adding the following MVP measures for CY 2027/PY 2029:
    - Intraoperative Hypotension Among Non-Emergent Noncardiac Surgical Cases (**designated as an MVP core measure**)
    - Patient-Reported Experience with Anesthesia
    - **AQI65**: Avoidance of Cerebral Hyperthermia for Procedures Involving Cardiopulmonary Bypass (QCDR measure)
    - **AQI71**: Ambulatory Glucose Management (QCDR measure)

- CMS proposes removing the following MVP measures for CY 2027/PY 2029:
    - **QID 430**: Prevention of Post-Operative Nausea and Vomiting – Combination Therapy
    - **QID 463**: Prevention of Post-Operative Vomiting – Combination Therapy (Pediatrics)

MIPS Core Measure Requirements

- CMS proposes to replace the outcome/high-priority measure requirement with a MIPS core measure requirement (minimum of one core measure among six required quality measures in traditional MIPS, or four in MVP reporting), beginning CY 2027/ PY 2029 MIPS payment year.

- CMS proposes a self-attestation process for clinicians lacking an applicable/available core measure, allowing them to substitute another measure without penalty.

- Small practices (TINs of 15 or fewer eligible clinicians) would be exempted from this core measure requirement.

Topped-Out Anesthesia-Relevant Quality Measures

- CMS proposes to apply the "defined topped-out benchmark" (removing the standard 7-point scoring cap, scoring instead from 1–10 points) to several measures directly relevant to anesthesia practice, including:

    - **Measure 430**: Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy
    - **Measure 463**: Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)
    - **Measure 477**: Multimodal Pain Management

Quality Payment Program Proposals to Reduce Administrative Burden

- CMS proposes removing the Security Risk Analysis measure from the Promoting Interoperability performance category beginning CY 2027/2029 MIPS payment year, reducing one attestation requirement for CRNAs using Certified Electronic Health Record Technology (CEHRT).

- CMS proposes removing the ONC Direct Review and ONC-ACB Surveillance attestations beginning CY 2026/2028 MIPS payment year, eliminating another PI reporting step.

- CMS proposes removing the high-priority measure designation from the quality measure inventory entirely, simplifying measure selection logic (replaced by the core measure framework above).

- CMS proposes modifying the CEHRT definition to drop several ONC certification criteria requirements (e.g., "family health history," "patient health information capture," automated numerator/measure calculation criteria), which may reduce technical certification burden on CRNAs' EHR systems.

Quality Payment Program Proposals that Could Increase Administrative Burden

- CMS proposes a new Electronic Prior Authorization for Prescription Drugs measure (attestation-based, unscored) beginning CY 2028 performance period/2030 MIPS payment year, an added reporting element, though not scored.

- CMS proposes to make the existing Electronic Prior Authorization measure optional (bonus-eligible) for CY 2027/PY2029, then required again (but unscored) beginning CY 2028/PY2030 with an expanded measure description requiring use of three separate ONC-certified health IT modules for full compliance, which could require CRNA practices to adopt or verify new EHR/health IT capabilities.

- CMS proposes new/modified Improvement Activities relevant to clinical workflows, including modification of IA_PSPA_16 to explicitly incorporate AI-enabled clinical decision support tools with added oversight/monitoring requirements.

Limitations on Program Inclusion and Structural Changes

- CMS proposes exempting small practices from the MIPS core measure reporting requirement.

- CMS proposes applying Qualifying APM Participant (QP) and Partial Qualifying APM Participant status at the TIN/NPI level rather than across all of a clinician's billing arrangements, beginning with future QP performance periods.

- CMS proposes extending the APM Incentive Payment for payment year 2028 at 3.1 percent.

- CMS proposes updates to the QP and Partial QP payment amount/patient count thresholds for 2027–2029 and later.

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