Issue Briefs on Reimbursement and Nurse Anesthesia – 10th Edition

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AANA Division of Federal Government Affairs

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TABLE OF CONTENTS

OVERVIEW/EXECUTIVE SUMMARY

We are pleased to provide AANA board members, AANA staff and AANA membership with Edition 10 of AANA Issue Briefs on Reimbursement and Nurse Anesthesia. CRNA reimbursement parity has long been a priority of the AANA and the AANA has consistently advocated for this, publicizing CRNAs' safe, high quality and cost-effective anesthesia and pain management services. In response to member interest, the AANA Anesthesia Reimbursement Summit was held in May 2011 to discuss economic issues shaping CRNA practice and to help develop a more robust system for advocating for the reimbursement policy interests of CRNAs within a state. Involving AANA staff, CRNA reimbursement thought leaders, anesthesia practice managers and businesspeople, and leaders in associations for health professionals and health plans, the summit gave participants a snapshot of the current and anticipated future state of various issues shaping CRNA reimbursement.

To further support CRNA reimbursement interests, in 2012, the AANA Board of Directors approved the development of the State Reimbursement Specialist (SRS) Program, which establishes reimbursement issues monitoring and advocacy programs in all 50 states. The Pain Reimbursement Specialist (PRS) program was added in 2017. We are implementing these programs in a manner that best reflects the needs of each state.

The main objective of this reimbursement primer is to give an overview of the complex and dynamic changes in the reimbursement landscape in the public and private payor markets and how these changes have affected CRNA practice and reimbursement. It also highlights the strong and continued advocacy, practice and research efforts the AANA has accomplished in each reimbursement-related subject area in recent years. The briefs give a history of numerous reimbursement related issues, the current state of these issues and the anticipated future state of the issues. A second objective of these issue briefs is to help provide background information necessary to build productive, engaging professional relationships with reimbursement decision makers including federal agencies, health plans, organizations and people who impact the reimbursement of CRNA services nationally, in each state and in each practice. The objective of the relationship-building is to educate and inform major influencers of nurse anesthetist reimbursement, and in doing so to help improve the healthcare system by expanding patient access to the safe, high-quality, and cost-effective anesthesia and pain care services of CRNAs

The landscape in the public and private payor reimbursement markets has changed significantly in recent years. The Affordable Care Act was enacted 2010 intending to reform the current healthcare system, expanding access to healthcare while improving the quality and reducing future cost growth. In April 2015, as a result of AANA and APRN advocacy, the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) was passed, which replaced the SGR formula and permanently ended the threat of annual 21% Part B payment cuts to CRNAs. This is also referred to as the CMS Quality Payment Program (QPP) and has two tracks: The Merit-based Incentive Payments System (MIPS) and the Advanced Alternative Payment System (APMs).

Former U.S. Department of Health and Human Services (HHS) Secretary Alex Azar has identified using the value-based transformation the healthcare system as one of the top priorities for the agency and for future years. The agency has promoted value based transformation including giving consumers greater control over health information through interoperable and accessible health information technology; encouraging price transparency from providers and payers; using experimental models in Medicare and Medicaid to drive value and quality throughout the entire system; and removing government burdens that impede value-based transformation. Medicare is making major investments in alternative payment systems, including bundled payment, episode-of-care payments, pay-for-quality, and capitated payment and the eventual elimination of traditional fee for service payment. Current models emphasize primary care services and providers will continue to be highly valued while specialties like anesthesia, labor will have to find their niche to be recognized in APM models. In March 2021, Xavier Becerra was confirmed as the latest Secretary of Health and Human Services under President Joe Biden.

Beyond traditional fee-for service Medicare, objections to Medicare fee-for-service reimbursement have policymakers and plans making major investments in alternative payment systems, including bundled payment, episode-of-care payments, pay for outcomes or pay for quality, and capitated payment per covered population. Reimbursement decisions will be data-driven – with the plans holding the data. Health plans will continue shifting out-of-pocket costs onto employees to mitigate premium growth.

Even with these advancements, there are areas of concern for reimbursement for CRNAs. Current quality payment programs are not designed for anesthesia. About 25% of AANA membership practices pain management in addition to their anesthesia services. CRNAs will continue to practice chronic pain management utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain. In spite of this, organized medicine will continue resisting CRNA services in this practice marketplace, whose growth is driven by demographics, public health trends, and the absence of effective alternative therapies.

In the rural arena, CRNAs play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures. Research evaluating type of facility, size, and anesthesia staffing by rural location shows that 55.5% of small rural hospitals and 61.2% of rural ambulatory surgery centers were predominately staffed by CRNAs. However, since 2010, 136 rural hospitals have closed, with more than 180 and counting closed since 2005, and this trend will continue.

In Medicaid, outlay demands will continue outstripping available revenue. Cash-strapped states will increasingly replace fee-for-service Medicaid with managed care or capitated payment schemes, with the goals of improving care coordination and saving money. Many state Medicaid plans will continue to make cuts to CRNA services.

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Issue Brief: [Medicare in General]

History in Brief

Enacted in 1965, the Medicare program providing health coverage to seniors and qualifying persons with disabilities was for a long time the largest public benefit health program in the U.S., only recently falling behind the faster-growing Medicaid program. In 2016, Medicare spending was 15 percent of total federal spending. Medicare Part A provides hospital coverage, governing conditions of participation and interpretive guidelines that shape CRNA practice environments in hospitals and ASCs, and the rural reasonable-cost pass-through program for the services of a CRNA. Medicare Part B provides physician services, including CRNA anesthesia services and medical and surgical services a CRNA is authorized in a state to furnish. Medicare Part C includes Medicare Advantage plans which are private Medicare plans offered by private insurance companies that contract with Medicare and provide Part A and Part B benefits. Created by Congress as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108-173), these plans became known as Medicare Advantage Plans. Also created by Congress in 2003, Created by Congress in 2003, Part D is the Medicare drug benefit.

With respect to CRNAs, Congress authorized Medicare direct reimbursement of CRNA "anesthesia and related services" as part of the Omnibus Reconciliation Act of 1986, Pub. L. 99-509. The Tax Equity and Fiscal Responsibility Act of 1986 (TEFRA), which with its enabling regulations formalized anesthesiologist medical direction payment and the Medicare rural reasonable-cost pass-through program. (TEFRA is addressed in a separate document). A GAO report (2007) finding CRNAs predominate where there are more Medicare beneficiaries, and where the gap between Medicare and private payment is less, spurred substantial increases in the Medicare valuation of anesthesia work, and thus the anesthesia conversion factor, the following year. Congress enacted legislation amending anesthesia payment teaching rules in 2008, enabled by regulation effective January 2010. In addition to the teaching rules, Medicare has on several occasions amended regulations and interpretive guidelines affecting CRNA services, including the adjustments to who may provide the pre- and post-anesthesia evaluation in ambulatory surgical centers, survey procedures for ambulatory surgical center infection prevention, and the anesthesia hospital conditions of participation interpretive guidelines five times. Notably in 2020, at the request of the AANA, Medicare amended Part A regulations to allow CRNAs to provide the pre-anesthetic evaluation in ASCs. In 2012, Medicare finalized a final regulation approving coverage of all Medicare CRNA services within their state scope of practice, including chronic pain management services.

On April 16, 2015, President Obama signed into law the historic Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA), which replaced the Medicare sustainable growth rate (SGR) formula with statutorily prescribed physician payment updates and provisions. This Public Law 114-10 permanently stopped the Medicare SGR cuts.

Furthermore, in January 2015, the Department of Health and Human Services (HHS) announced that it is testing and expanding new healthcare payment models intended to improve healthcare quality and reduce costs. To help drive the healthcare system towards greater value-based purchasing – rather than continuing to reward volume regardless of quality of care delivered, former HHS Secretary Sylvia M. Burwell announced an initiative to move the Medicare program from paying for volume to paying for value. As part of this initiative, HHS' goal was to have 85 percent of Medicare payments tied to quality or value by 2016 and 90 percent by 2018. Burwell said this goal could be achieved through investment in alternative payment models such as Accountable Care Organizations (ACOs), advanced primary care medical home models, new models of bundling payments for episodes of care, and integrated care demonstrations for beneficiaries that are Medicare-Medicaid enrollees. To support these efforts, HHS launched the Health Care Payment Learning and Action Network (LAN) in March 2015 to help increase the adoption of value-based payments and alternative payment models. Since its inception, the AANA has become a stakeholder in the LAN as part of the agency's initiative to transform payment from volume to value and has participated in all its meetings and commented, with other APRN organizations, on its white paper covering alternative payment model framework.

Current State of the Issue

Over the past year, the mean anesthesia CF for CY22 increased $21.56 per unit for services effective Jan. 1, 2021, over the originally Centers for Medicare & Medicaid Services (CMS)-proposed $20.93 per unit thanks to enactment of AANA-backed provision in the *Protecting Medicare and American Farmers from Sequester Cuts Act* that mitigated cuts in the Physician Fee Schedule. CMS's temporary waiver suspending Part A physician supervision requirement for Certified Registered Nurse Anesthetists (CRNAs), a critical step for CRNAs to serve the U.S. healthcare system more effectively during the COVID-19 pandemic, remains in effect. However, the Medicare agency has not yet made this waiver permanent.

In March 2021, Xavier Becerra was confirmed as the new Secretary of the Department of Health and Human Services (HHS) and Chiquita Brooks-LaSure was confirmed as the new Administrator for the Centers for Medicare & Medicaid Services (CMS) in May 2021.. Under Becerra's leadership, HHS released its Strategic Plan for 2022-2026 where

its five strategic goals are (1) Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, (2) Safeguard and Improve National and Global Health Conditions and Outcomes, (3) Strengthen Social Well-being, Equity, and Economic Resilience, (4) Restore Trust and Accelerate Advancements in Science and Research for All, and (5) Advance Strategic Management to Build Trust, Transparency, and Accountability. Each goal is supported by objectives and strategies. Furthermore, the administration continues to drive alternative payment models in the Medicare program. CMS has set "Driving Accountable Care" as one of the five objectives in the CMS Innovation Center's Strategic Objectives. As part of this objective, CMS plans to have all Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

Practicing nurse anesthetists continue to face current illegitimate characterization of TEFRA conditions as a "standard of care."

Furthermore, CRNAs continue face issues with anesthesiologist's attestation of fulfilling the seven medical direction steps, especially given the development of electronic medical records. CRNAs also face barriers with respect to inequities in the teaching rules and respect to Part A hospital Conditions of Participation requirements, particularly with respect to the requirement that anesthesia be directed by a MD or a DO.

Anticipated Future State

- Medicare is making major investments in alternative payment systems, including bundled payment, episode-of-care payments, pay-for-quality, and capitated payment and we expect the gradual elimination of traditional fee for service payment.
- Medicare will continue to expand telehealth operational and payment policy.

- The AANA will continue to ask for the temporary regulatory changes instituted during the COVID Public Health Emergency to become permanent.

For More Information

- CMS March 30, 2020 Press Release on Temporary Regulatory Changes, https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19
- AANA March 30, 2020 Press Release on Temporary Removal of Physician Supervision, https://www.aana.com/news/press-releases/2020/03/31/cms-suspends-supervision-requirements-for-crnas
- CMS' compendium of anesthesia matters, https://www.cms.gov/center/anesth.asp
- TEFRA medical direction rules, 42 CFR §415.110, http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec415-110.pdf

- Primer on Medicare Advantage plans from CMS, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx?AspxAutoDetectCookieSupport=1
- AANA website on Quality and Reimbursement, http://www.aana.com/resources2/quality-reimbursement/Pages/default.aspx (requires AANA member login and password)
- AANA website on Practice Management, http://www.aana.com/resources2/practicemanagement/Pages/default.aspx
- HHS fact sheet on rewarding providers for value and not volume, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html
- HHS web site on the Health Care Payment Learning and Action Network, http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/
- Public Law 114-10, the Medicare Access and CHIP Reauthorization Act of 2015, https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf
- AANA Anesthesia Conversion Factor list for CY 2020, https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/20191120-anesthesia-conversion-factor-list.pdf?sfvrsn=42b4d502_0 (requires AANA member login and password—note CY 2021 was not final as of publication of this brief)
- AANA News Bulletin (May 2015): "Congress Permanently Repeals Medicare SGR Cuts – But the Rest of the Bill Means More for CRNAs," (Page 1 and 6), http://www.aana.com/myaana/Publications/aananewsbulletin/Documents/05nb15.pdf (requires AANA member login and password)
- AANA News Bulletin (November 2015): "AANA Protects and Advances CRNA Reimbursement and Practice as Medicare Proposes Major Changes," (Page 28-29), http://www.aana.com/myaana/Publications/aananewsbulletin/Documents/11NB15.pdf (requires AANA member login and password)

Issue Brief: [Quality Incentives in Healthcare and the Medicare Quality Payment Program]

History in Brief

The U.S. healthcare system reimburses and rewards providers and practitioners based on the volume of healthcare services generated, regardless of whether these services improve care. The traditional fee-for-service payment system provides incentives when it pays more in the long run for a service that results in poor-quality care and complications than for the same service provided at high-quality care. Therefore, under the fee-for-service system, a provider has little financial incentive to improve quality while reducing costs to the healthcare system.

To help align payment policies with quality, the Affordable Care Act (ACA) introduced various provisions, predominately centered on the Medicare and Medicaid programs, that created innovative payment and delivery models, value-based purchasing programs for hospitals, quality reporting, and established the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models. In addition, Section 3022 of the Affordable Care Act also established the accountable care organization (ACO) program for Medicare (also known as the Medicare Shared Savings Program) in which participating ACOs are eligible to receive payments for shared savings if they meet performance standards established by the HHS Secretary.

In January 2015, the Department of Health and Human Services (HHS) announced that it was testing and expanding new healthcare payment models intended to improve healthcare quality and reduce costs. To help drive the healthcare system towards greater value-based purchasing, rather than continuing to reward volume regardless of quality of care delivered, former HHS Secretary Sylvia M. Burwell announced an initiative to move the Medicare program from paying for volume to paying for value. Burwell stated this would be achieved through investment in alternative payment models (APMs) such as Accountable Care Organizations (ACOs), advanced primary care medical home models, new models of bundling payments for episodes of care, and integrated care demonstrations for beneficiaries that are Medicare-Medicaid enrollees.

Physician and APRN Medicare Part B payment also underwent transition as well. In April 2015, as a result of AANA and APRN advocacy, the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) was passed, which replaced the SGR formula and permanently ended the threat of annual 21% Part B payment cuts to

CRNAs. This new payment program, also referred to as the CMS Quality Payment Program (QPP), impacts the nation's frontline healthcare providers, including 340,000 APRNs and helps move Medicare away from a volume-based payment system toward a more patient-centered focus of rewarding healthcare providers for the value and quality of services rendered. The QPP has two tracks: The Merit-based Incentive Payments System (MIPS) and the Advanced Alternative Payment System (APMs). Beginning in 2019, "eligible clinicians" that participated in MIPS received a positive, downward, or neutral payment for performance on certain quality metrics under the Merit-Based Incentive Payment System (MIPS) based on 2017 performance or an automatic 5 percent bonus for participation in an Advanced Alternative Payment Model (APM).

Under MIPS, payments to eligible clinicians are adjusted based on performance under a set of measures designed to consolidate the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier, and the Electronic Health Records Meaningful Use incentive programs. The law removed the existing reporting requirements and payment penalties required under PQRS to be replaced by four performance categories are used to establish a MIPS composite performance score (0-100) used to determine physician payment: Quality, Cost, Advancing Care Information (now Promoting Interoperability) and Improvement Activities. Eligible clinicians under MIPS include: CRNAs, NPs, CNSs, physicians, dental surgeons, podiatrists, optometric physicians, chiropractors and PAs. By 2022, , CMS expanded the list of eligible clinicians in MIPS to include individual clinicians, groups or virtual groups of clinical psychologists, physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, and registered dietitians or nutrition professionals, clinical social workers and certified nurse midwives.

The Bipartisan Budget Act of 2018 made changes to the MACRA law by extending the transition years for MIPS through 2021. The extension allows for a gradual increase in the performance threshold for avoiding MIPS payment penalty, and the weighting of Cost performance category in the MIPS final score.

The Act mandated that MIPS payment adjustments are only applied to Medicare Part B covered professional services rather than items, such as drugs. It increased the weight of the Cost performance category to 30 by 2022, which is the terminal weight according to the rule. . The changes made by the law did not impact the maximum penalties for low performance or non-participation (without an exclusion), so they remain the same.

Another provision in the new law was the addition of a criterion for the low-volume threshold exclusion from MIPS reporting. An eligible clinician (EC) who provides less than 200 Medicare Part B covered professional services during a performance year will be exempt (not required to participate).

Current State of the Issue

AANA continues to be engaged in the development of the MIPS and APM programs and in alternative payment programs in general. In 2016, former AANA President Juan Quintana, DNP, MHS, CRNA, was appointed to serve on the Episode-Based Cost Measures Technical Experts Panel, which is responsible for developing care episode and patient condition groups for use in cost measures to meet the requirements for MIPS. Subsequently, AANA members Juan Quintana, DNP, MHS, CRNA, Jack Hitchens, CRNA, Michael MacKinnon MSN, FNP-C, CRNA, and Robert Gauvin, MS, CRNA, were appointed to clinical subcommittees assigned to the development of episode-based cost measures for use in the cost category of MIPS.

Examples of current Advanced APMs (AAPM) under the Medicare program eligible for automatic bonuses include: the Direct Contracting Model, the Medicare Shared Savings Program Accountable Care Organization (ACO) (Tracks 2 and 3, Level E of the BASIC track, the ENHANCED track all involved two-sided financial risk), the Medicare Next Generation ACO Model, and Comprehensive Care for Joint Replacement Payment Model (Track 1-CEHRT). For participation in AAPMs organized by other payers to count under the Medicare program, they must have quality measures comparable to Medicare quality measures, require the use of certified EHR technology, and include downside financial risk for participants.

Professional organizations and medical societies whose members participate in the QPP are pushing the Trump Administration and Congress to reform the program to make it less burdensome. CMS Administrator Seema Verma has created Patients Over Paperwork Initiative to reduce regulatory burden in Medicare. Congress passed the Bipartisan Budget Act (BBA) of 2018 (H.R. 1892), which along with a Continuing Resolution (CR), to temporarily fund the government, made modest technical changes to the MIPS program, so that clinicians are assessed on performance relative to their peers from 2018 through 2021 instead of improvement. The law also established more incremental changes to the performance threshold for program years two through five. Congress scheduled hearings on the Quality Payment Program and MedPAC, the nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program, has pushed for major reforms, but it is unlikely that there will be any substantial changes to the program. Further, the push for mandatory episode payment model programs have stalled, specifically, CMS finalized its plans to cancel the Episode Payment Models and the Cardiac Rehabilitation Incentive Payment Model, which were scheduled to begin on Jan. 1, 2018. CMS also cut down the number of providers required to participate in the Comprehensive Care for Joint Replacement Model (CJR).

CRNAs are subject to automatic re-weights of the Promoting Interoperability and Cost performance categories, so they would only be required to report data on the Quality

and Improvement Activities categories. (CMS, 2020) However, the availability of relevant quality measures for anesthesia professionals continues to present a challenge, because some measures that were used in the first few years of the Quality Payment Program (QPP) have topped-out, and there is little opportunity to improve in certain areas. CMS also wants to focus on outcomes, but anesthesia services are process oriented. The limited number of anesthesia-related quality measures (six in the 2022 MIPS Anesthesia Measure Set), and the automatic re-weight that CRNAs are subject to for the Promoting Interoperability and Cost Performance Measures, presents a challenge to CRNAs who need to obtain the highest measure achievement points possible to meet the performance threshold, which is 75 points for the 2022 performance year, and avoid a negative payment adjustment capped at -9%.

The trend in value-based measures continues to emphasize population health and chronic care, rather than specialties like anesthesia/surgical services.

CMS announced plans to reduce the MIPS reporting burden and incorporate more meaningful measures using a new framework called MIPS Value Pathways (MVP), which is described in the 2020 Quality Payment Program Final Rule. MVPs were initially scheduled for implementation for the 2021 Performance Year, but was changed in response to the COVID-19 pandemic shifting priorities, according to the 2021 CMS Quality Payment Program Proposed Rule. (HHS, 2020)

The CY2022 Final Rule established 7 MVPs that will be implemented in 2023:

- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Improving Care for Lower Extremity Joint Repair
- Support of Positive Experiences with Anesthesia

Anesthesia providers, including CRNAs have the opportunity to participate in The Improving Care for Lower Extremity Joint Repair and Support of Positive Experiences with Anesthesia MVPs because they include measures from the MIPS Anesthesia Quality Measure set.

CMS plans to advance the Meaningful Measure framework, designed to reduce administrative burden and align measures across the Agency (CMS), federal programs and private payers. The objectives include modernizing value-based programs by providing more timely results and feedback to help create learning systems that support ongoing performance improvement. Another goal is to leverage quality measures to

promote equity and close gaps in health care. The measures prioritize patient reported outcomes and those that incorporate the patient voice.

The model was developed in response to the challenges communicated to CMS about the current MIPS structure. Many participants commented about the high administrative burden, there were too many MIPS measures to choose from, and that the measures are not meaningfully aligned. The objective of the MVP framework is to combine performance categories around specific conditions or specialties, while requiring less measures. The MVPs will include promoting interoperability and claims-based measures that focus on population health, promote care coordination, patient engagement and team-based care.

In QPP Performance Year (PY) 2022, as the country continues to deal with the public health emergency (PHE) of COVID-19, CMS eased many of the QPP participation requirements. Under CMS' Extreme and Uncontrollable Circumstances policy, allowing individual clinicians, groups and virtual groups to submit an application requesting reweighting of one or more MIPS performance categories due to the pandemic. CMS also maintains awarding up to 10 bonus points for the Complex Patient Bonus to be added to one's 2022 MIPS final score and expanding the use of telehealth codes in Medicare patient assignments for CMS Web Interface for Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey. For PY 2020, all ACOs were considered affected by the COVID-19 pandemic PHE, and therefore the Shared Savings Program's Extreme and Uncontrollable Circumstances (EUC) policy would apply. CMS waived the requirement for ACOs to field a CAHPS for ACOs survey, which resulted in all ACOs receiving full credit for the patient experience measures.

CMS finalized updating the EUC policy under the Shared Savings Program, which will freeze the quality performance standards for Shared Savings ACOs at the 30th percentile for performance year 2023.

Anticipated Future State

- An increase in eligible clinicians that qualify for an exception to reporting MIPS data for 2020 and 2021 due to the COVID-19 pandemic, leading to more providers receiving a neutral payment adjustment for 2022 and 2023
- Modification of MIPS Value Pathways finalized in the 2022 PFS Final Rule to expand the use of relevant measures for specialties, including anesthesia.
- Implementation of the CMS Action Plan, which will support public reporting and promote patient-directed measures
- Increased emphasis by CMS on value-based quality measures will focus on chronic conditions and population health
- Primary care services and providers will continue to be highly valued while specialties like anesthesia, labor to be recognized in APM models.

- The metrics and outcome measures used to assess quality will matter more.
- Specialty societies will work to develop physician focused payment models in efforts to get them accepted as APMs.
- For the time being, bundled payment models will remain voluntary.
- Private payers will continue to develop and implement APMs faster than CMS.
- Telehealth acceptance and usage will continue expanding to better serve rural and underserved communities.

For More Information

- CMS web site and the Quality Payment Program, https://qpp.cms.gov/
- Extreme and Uncontrollable Circumstances Exception, https://qpp.cms.gov/mips/exception-applications#extremeCircumstancesException-2021
- Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, https://www.federalregister.gov/public-inspection/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part
- Quality Payment Program Policies in CY 2022 PFS Final Rule: MIPS Value Pathway Policies
- Meaningful Measures Framework: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy
- AANA letter on MACRA Implementation, https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/comment-letters/20151116---aprn-comment-cms-rfi-macra.pdf?sfvrsn=d17c45b1_2(requires AANA member login and password)
- AANA letter on Quality Payment Program Proposed Rule, https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/comment-letters/20150904---pfs-cy-2016-proposed-rule-aana-comment.pdf?sfvrsn=e77c45b1_2
- AANA letter on Quality Payment Program Final Rule with Comment, https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/20161216-aana-comment-on-cms-qpp-final-rule-final5b5529731dff6ddbb37cff0000940c19.pdf?sfvrsn=b7aa44b1_0
- AANA MACRA FAQ available at: https://www.aana.com/advocacy/quality-reimbursement/2020-quality-payment-program
- CMS information what providers need to know regarding ACOs, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/for-providers
- Health Affairs policy brief on ACOs (Updated), available at: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=23

- Information on ACOs from the CMS website, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/
- CMS Fast Facts on ACOs, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf
- CMS web site on ACOs, https://innovation.cms.gov/initiatives/aco/
- CMS Quality Payment Program, https://qpp.cms.gov/
- CMS web site on ACOs, https://innovation.cms.gov/initiatives/aco/
- Health Care Payment Learning and Action Network website, https://hcp-lan.org/
- IOM Quality Chasm Research brief: https://www.ncbi.nlm.nih.gov/books/NBK2677/#ch4.s6
- AANA web site on Quality and Reimbursement, https://www.aana.com/advocacy/quality-reimbursement HHS fact sheet on rewarding providers for value and not volume , http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html
- HHS web site on the Health Care Payment Learning and Action Network, http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/
- AANA and APRN letter on LAN White Paper covering the alternative payment model framework, https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/comment-letters/20151120---apm-draft-framework-aprn-comment-final.pdf?sfvrsn=d87c45b1_2 (requires AANA member login and password
- Public Law 114-10, the Medicare Access and CHIP Reauthorization Act of 2015, https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf
- Quality Payment Program's COVID-19 Response, https://qpp.cms.gov/about/resource-library
- Quality Payment Program Resource Library, https://qpp.cms.gov/about/resource-library

Issue Brief: [Merit-based Incentive Payment Program]

History in Brief

The Merit Based Incentive Payment Program (MIPS) is a budget-neutral program so participating clinicians with higher composite scores will be eligible for a positive payment adjustment up to three times the baseline positive payment adjustment for a given year. For example, the higher performers will be eligible for a positive payment adjustment of up to 9% for the 2020 performance year. This scaling process will only apply to positive adjustments, not negative ones. An additional positive payment adjustment will be available to "exceptional" performers. Under MIPS, the following four new performance categories are used to establish a MIPS composite performance score (0-100) used to determine physician payment: Quality, Cost, Promoting Interoperability and Improvement Activities.

The Bipartisan Budget Act of 2018 made changes to the MACRA law by extending the transition years for MIPS through 2021. The extension allows for a gradual increase in the performance threshold for avoiding MIPS payment penalty, and the weighting of Cost performance category in the MIPS final score. It mandated that MIPS payment adjustments are only applied to Medicare Part B covered professional services rather than items, such as drugs. It increased the weight of the Cost performance category to 30%. The changes made by the law did not impact the maximum penalties for low performance or non-participation (without an exclusion), so they remain the same.

Another provision in the law was the addition of a criterion for the low-volume threshold exclusion from MIPS reporting. An eligible clinician (EC) who provides less than 200 Medicare Part B covered professional services during a performance year will be exempt (not required to participate).

Current State of the Issue

CRNAs are designated as eligible clinicians (ECs) under MIPS, so they are required participate in MIPS unless they meet all three of the following exclusion criteria:

- Bill less than $90,000 for Medicare Part B covered professional services in a performance year; and
- See less than 200 Part B patients; and
- Provide less than 200 covered professional services to Part B patients

However, CRNAs are subject to automatic re-weights of the Promoting Interoperability and Cost performance categories, so they would only be required to report data on the Quality and Improvement Activities categories.

The availability of relevant quality measures for anesthesia professionals continues to present a challenge, because some measures that were used in the first few years of the Quality Payment Program (QPP) have topped-out and there is little opportunity to improve in certain areas. CMS also wants to focus on outcomes, but anesthesia services are process oriented. The limited number of anesthesia-related quality measures (seven in the MIPS Anesthesia Measure Set), and the automatic re-weight that CRNAs are subject to for the Promoting Interoperability and Cost Performance Measures, presents a challenge to CRNAs who need to obtain the highest measure achievement points possible to meet the performance threshold, which is 75 points for the 2022 performance year, and avoid a negative payment adjustment capped at -9%.

The trend in value-based measures continues to emphasize population health and chronic care, rather than specialties like anesthesia/surgical services, although MIPS Cost Measures include some anesthesia costs in surgical services. CMS made provisions to include telehealth visits in relevant cost measures for 2021, in response to expanded use during the COVID-9 pandemic. CMS has proposed MIPS Value Pathways (MVPs) and Alternative Payment Pathways (APPs) to enable providers to identify and use more relevant measures and payment models to demonstrate achieve a higher level of care at lower cost.

APPs were implemented in 2021 as an optional approach to participation in an Alternative Payment Model (APM). The objectives of APPs are to reduce reporting burden, create new scoring opportunities for MIPS APM participants and encourage participation in APMs. Clinicians report Quality measures through a single, predetermined measure set, along with Improvement Activities and Promoting Interoperability measures.

CMS announced plans to reduce the MIPS reporting burden and incorporate more meaningful measures using a new framework called MIPS Value Pathways (MVP), which is described in the 2020 Quality Payment Program Final Rule. MVPs were initially scheduled for implementation for the 2021 Performance Year, but that could be changed in response the COVID-19 pandemic shifting priorities, according to the 2021 CMS Quality Payment Program Proposed Rule.

The model was developed in response to the challenges communicated to CMS about the current MIPS structure. Many participants commented about the high administrative burden, there were too many MIPS measures to choose from, and that

the measures are not meaningfully aligned. The objective of the MVP framework is to combine performance categories around specific conditions or specialties, while requiring less measures. The MVPs will include promoting interoperability and claims-based measures that focus on population health, promote care coordination, patient engagement and team-based care.

CMS responded to the COVID-19 pandemic by implementing flexibilities for eligible clinicians who encounter challenges in collecting and reporting MIPS data. Providers can submit an Extreme and Uncontrollable Circumstances exception application to receive a reweight for the performance categories they were unable to report in 2020. This provision enables clinicians to avoid negative payment adjustments for the 2022 payment year. A new high-weighted activity related to the treatment of COVID-19 patients was added to the Improvement Activities category. Also, the Complex Patient Bonus for 2020 was revised so that clinicians could earn up to 10 bonus points for treating COVID-19 patients There was also an expansion of the use of telehealth codes in Medicare patient assignments for CMS Web Interface for Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey.

Anticipated Future State

- Increase in MIPS performance threshold required to avoid negative payment adjustment
- Extension of MIPS participation flexibilities due to the ongoing COVID-19 public health emergency into 2022.
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- CMS encouraging measure developers and specialty societies to develop additional MIPS Value Pathways to include relevant measures for specialties, including anesthesia.
- CMS plans to retire the traditional MIPS programs as eligible clinicians are steered into MVPs, then APMs.
- CMS emphasizing the use of digital quality measures (dQMs) that can be captured from multiple sources and transmitted through interoperable information systems.
- Trends in value-based quality measures will focus on chronic conditions and population health

For More Information:

- APM Performance Pathways, https://qpp.cms.gov/mips/exception-applications#extremeCircumstancesException-2021
- 2022 Physician Fee Schedule Final Rule, https://www.federalregister.gov/public-inspection/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

- 2019 MIPS Extreme and Uncontrollable Circumstances Policy (Updated), https://qpp-cm-prod-content.s3.amazonaws.com/uploads/749/2019%20MIPS%20Automatic%20EUC%20Fact%20Sheet.pdf
- 2021 Quality Payment Program Proposed Rule, https://www.federalregister.gov/documents/2020/08/17/2020-17127/medicare-program-cy-2021-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other
- MIPS Value Pathways (MVPs) Overview: https://youtu.be/ZhM3KiojPjY
- Quality Payment Program—COVID-19 Response: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/966/QPP%20COVID-19%20Response%20Fact%20Sheet.pdf

Issue Brief: [Medicare - Supervision]

History in Brief

Medicare long required physician supervision of the administration of CRNA anesthesia services as a Part A hospital and critical access hospital condition of participation (CoP) and an ambulatory surgical center Condition for Coverage (CfC) in the program. The supervision requirement drives surgeons concerned with unfounded vicarious liability for CRNA anesthesia services to seek anesthesiologists to either provide or supervise anesthesia care. This impetus increases healthcare costs and reduces patient access to care though inefficient healthcare workforce utilization. In the early 1990s, AANA asked the Medicare agency to repeal the requirement, citing an absence of evidence linking the requirement to quality. The agency proposed repeal in 1997, setting off a tidal wave of public comments into Medicare and triggering attention to supportive and oppositional legislation in Congress. The ASA backed a study in *Anesthesiology* claiming to link an absence of anesthesiologist involvement in cases to "excess deaths," an assertion contested by AANA via Pine and ultimately by the Medicare agency itself in the preamble to its January 2001 final rule repealing supervision. President Clinton's action on the eve of the inauguration of his successor allowed President George W. Bush, who suspended all final rules that had not yet taken effect, to suspend the effective date of the final rule repealing supervision. Rather than eliminating repeal, President Bush yielded a second final rule in November 2001 establishing a process by which states could opt-out of the requirement. To date, 19 states and Guam have opted-out, most recently in Arizona and Oklahoma.

The Administration's development of a regulatory reform agenda during the summer of 2011 acknowledged AANA's advocacy for repealing supervision. In April 2013, in response to a proposed rule from the Center for Medicare and Medicaid Services (CMS) on reducing regulatory burden in the Medicare and Medicaid programs, the AANA urged the agency to reform the Medicare Conditions for Coverage (CfCs) and the Medicare Conditions of Participation (CoPs) to eliminate the costly and unnecessary requirement for physician supervision of CRNA anesthesia services. This would allow for states and healthcare facilities nationwide to make their own decisions about the delivery of healthcare based on state laws and patient needs, thereby controlling cost and ensuring access to quality care.

Furthermore, a 2012 study published in the journal *Anesthesiology*, the professional journal of the American Society of Anesthesiologists, showed that lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs. The authors reviewed over 15,000 anesthesia records in one leading U.S. hospital, and found supervision lapses in 50 percent of the cases involving anesthesiologist supervision of two concurrent CRNA cases, and in more than

90 percent of cases involving anesthesiologist supervision of three concurrent CRNA cases. In addition, researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration. Most recently, a study published in Medical Care June 2016 found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.

Moreover, the American Society of Anesthesiologists *ASA Relative Value Guide 2013* newly suggests loosening further the requirements that anesthesiologists must meet to be "immediately available," stating that it is "impossible to define a specific time or distance for physical proximity." This *ASA Relative Value Guide* definition marginalizes any relationship that the "supervisor" has with the patient and is inconsistent with the Medicare CoPs and CfCs, and with the Medicare interpretive guidelines for those conditions which require anesthesiologists claiming to fulfill the role of "supervising" CRNA services be physically present in the operating room or suite.

The AANA secured publication of a landmark study in *Health Affairs* headlined "No Harm When CRNAs Provide Care Without Physician Supervision," and participated in the development and distribution of an National Academy of Medicine publication whose first recommendation was to permit advanced practice registered nurses to practice to the full extent of their education and skill. In 2016, a study published in *Medical Care* found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions. This evidence suggests that there is no empirical evidence for SOP laws that restrict CRNAs from practicing at levels that are below their education and training based on differences in anesthesia complication risk.

Current State of the Issue

The AANA continues to advocate for full federal repeal of supervision. Several recent CMS and U.S. Department of Health and Human Services' (HHS) efforts aimed at reducing regulatory burden and improving access to care have created opportunities to push for supervision removal. This included the creation of CMS's Patients of Over Paperwork initiative focused on removing unnecessary regulatory barriers and CMS's Rural Health Strategy in 2018, which includes maximizing scope of practice for providers such as CRNAs as a key supporting activity to improve access to care. Furthermore, HHS recommended to broaden scope of practice in its report entitled, "Reforming America's Healthcare System through Choice and Competition" and Executive Order (#13890) on Protecting and Improving Medicare for Our Nation's Seniors, which included Section 5(a) called for eliminating supervision requirements. Similarly, Congress has developed

efforts, such as the House Ways and Means' program entitled, "The Provider Relief and Regulatory Relief Initiative that began in 2017. Throughout all of these efforts, the AANA, either as part of a coalition or alone, has advocated both in meetings with agency officials, Congress, and through comment letters.

CMS has removed certain regulatory barriers in response to the COVID-19 pandemic, which began in early 2020, including temporary removal of supervision. In March 2020, CMS issued numerous temporary waivers and rules to allow for providers to quickly respond to the pandemic and care for the influx of patients infected with the virus. Included in these temporary waivers was the suspension of Part A physician supervision requirement for CRNAs. This is a crucial step for CRNAs to serve the U.S. healthcare system more effectively during the COVID-19 pandemic, as CRNAs are expert in providing critical, lifesaving care to COVID-19 patients, including managing ventilators, placing of invasive lines and monitors, and overseeing complex hemodynamic monitoring. However, to date, the Medicare agency has not acted in 2021 to permanently repeal the supervision requirement for CRNAs or make these temporary waivers permanent. In November 2020 HHS did publish a request for information on waivers, which sought comments on permanently removing all waivers, including the one for supervision. Yet, no further action has taken place. During this time, the Medicare agency appointed an anesthesiologist as the Chief Medical Officer, which may complicate AANA's efforts in getting a proposed rule published to repeal supervision. The AANA continues to advocate for a proposed rule to remove physician supervision of CRNAs through advocacy efforts, such as: including developing comment letters, working alongside various coalition partners, and by holding numerous meetings with high level staff at the Medicare agency, HHS, other federal agencies, members of Congress, other key healthcare stakeholders as well as the current Administration.

Anticipated Future State

- With healthcare industry leaders focused on quality, access and cost of care, an increase in the drumbeat of support for supervision repeal continues.

- Opportunities will continue to arise as the push increases for APRNs to operate at the top of their license and to reduce unnecessary regulatory burden.

- Opt-outs will continue to be promoted state-by-state by nurse anesthetist state associations and by hospitals and opposed by state anesthesiologist and medical societies.

For More Information

- AANA Information on state opt outs, https://www.aana.com/advocacy/state-government-affairs/federal-supervision-rule-opt-out-information and fact sheet on

state opt outs, https://www.aana.com/advocacy/state-government-affairs/federal-supervision-rule-opt-out-information/fact-sheet-concerning-state-opt-outs

- Letter from Bipartisan group of lawmakers to HHS Secretary asking for removal of supervision, https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/9-25-20-crna-supervision-removal-letter.pdf?sfvrsn=e627be79_0
- AANA and APRN letter to CMS on removing supervision, https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/aprn-workgroup-letter--scope-of-practice-request-for-feedback.pdf?sfvrsn=21f5d93b_0
- AANA Letter on Reducing Regulatory Burden (2013): http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20130408%20AANA_Cmt-CoP-PropRule.pdf (requires AANA member login and password)
- Medicare hospital conditions of participation for anesthesia services http://edocket.access.gpo.gov/cfr_2002/octqtr/42cfr482.52.htm and hospital manual including interpretive guidelines for anesthesia services at tag A-1001 https://www.cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf
- History of establishment of opt-out process by Downey CRNA et al, from AANA Journal 2010 http://www.aana.com/newsandjournal/Documents/imagining_0410_p96-100.pdf (requires AANA member login and password),
- Health Affairs paper on opt-outs and patient safety (2010), http://www.aana.com/newsandjournal/News/Pages/080310-Study-in-Health-Affairs-Confirms-Quality-Safety-of-Nurse-Anesthetist-Care.aspx (requires AANA member login and password)
- National Academy of Medicine "The Future of Nursing: Leading Change, Advancing Health" summary recommendations, http://www.thefutureofnursing.org/recommendations, and access to the full report by PDF http://www.thefutureofnursing.org/IOM-Report
- AANA monograph "Quality of Care in Anesthesia" summarizing evidence supporting CRNA practice and critiquing the *Anesthesiology* study mentioned above, http://www.aana.com/resources2/professionalpractice/Documents/Quality%20of%20Care%20in%20Anesthesia%2012102009.pdf (requires AANA member login and password)
- Cochrane Anesthesia Groups Report "Physician anesthetists versus non-physician providers of anesthesia for surgical patients" (2014) http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false

Issue Brief: [Pain Management/Non-Opioid Alternatives to Treat Pain/ERAS]

History in Brief

The National Academy of Medicine report, *Relieving Pain in America* (2011) estimated approximately 100 million people in the United States live with chronic intractable pain, and that an insufficient supply of healthcare professionals is available to diagnose, treat and prevent pain. CRNA pain management services are vital to patient care and have long been part of the body of services that CRNAs provide patients, especially to patients in rural areas. The alternatives for these patients in rural communities are often more expensive, inconvenient, and sometimes significantly affect the quality of the patients' life. Based on discussions with CRNAs engaged in interventional pain management services, their reimbursement is practice- and plan-specific, and developed according to local trial-and-error experiments, plan consultations, and other techniques for maximizing payment. Following a nearly two-year campaign by the AANA and its allies, Medicare authorized coverage of all Medicare services that CRNAs provide within their scope of practice, including chronic pain management services, acting through a final rule published November 2012 and effective January 2013. The final rule states, "anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished. In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states." The final rule was effective on Jan. 1, 2013. The agency applied the new rule to services reimbursed through the Medicare Part A reasonable cost pass-through program for rural CRNA services but did not apply this new rule to Part A or Part B claims retroactively.

Medicare outlays for pain management services have been climbing because of service volume, prompting the agency Office of Inspector General to yield two reports documenting common improper claims for such services (2008 and 2010, linked below).

Of those CRNA members of the AANA who work full-time approximately 25 percent also practice pain management in addition to other clinical practice areas, according to member surveys. Pain management services by CRNAs have been targeted state by state by organized medicine; litigation in Louisiana ruled it "the practice of medicine"; legislation enacted in Oklahoma imposed constraints on CRNA pain practice; various attempts have long been under way in Iowa (unsuccessfully) and other states to limit or eliminate CRNA pain practice. The Federal Trade Commission intervened against an Alabama Board of Medicine proposal limiting CRNA pain practice, citing harm to competition, patient access and choice.

The pain care provisions as part of the Affordable Care Act of 2010 sought to address the treatment of chronic pain in America. As a result of recommendations from this report, HHS and its family of agencies has taken further action to address the treatment of chronic pain. In the CY 2015 Physician Fee Schedule rule, CMS announced that it would bundle imaging services with the procedures for certain types of epidural steroid injections. The National Institutes of Health in early April 2015 published a draft National Pain Strategy, intended to guide public policy and payment for pain care, and invited public comments. The AANA provided comments that addressed removal of barriers to CRNA pain management practice and education. At the request of HHS, The AANA participated in an HHS stakeholder strategy session on implementation of finalized National Pain Strategy in 2017.

Also in 2017, the Department of Health and Human Services issued nominations for a newly formed Pain Management Best Practice Inter-Agency Task Force which was charged with identifying, reviewing and determining gaps between best practices for pain management developed or adopted by federal agencies, propose updates to best practices and recommendations on addressing any gaps or inconsistencies in pain management and develop a strategy for disseminating such best practices to relevant Federal agencies and the general public. The AANA was excited that Bruce A. Schoneboom, PhD, CRNA, FAAN was appointed to this task force and was able to give a CRNA/APRN perspective on addressing gaps in this realm. The Task Force met several times over the course of a year and during this time the AANA submit comments for each of their public meetings. The Task Force's Final Report on Best Practices: Updates, Gaps, Inconsistencies and Recommendations report was issued in May 2019, and the following gap was identified: "Multimodal, non-opioid therapies are underutilized in the perioperative, inflammatory, musculoskeletal, and neuropathic injury settings." The report recommended that to close this gap, use of procedure-specific, multimodal regimens and therapies when indicated in the perioperative period, including various non-opioid medications, ultrasound-guided nerve blocks, analgesia techniques (e.g., lidocaine, ketamine infusions), and psychological and integrative therapies should be used to mitigate opioid exposure. The report also recommended use of multidisciplinary and multimodal approaches for perioperative pain control in selected patients at higher risk for opioid use disorder such as joint camps and Enhanced Recovery After Surgery [ERAS].

Current State of the Issue

CRNAs provide holistic anesthesia and pain related care for patients of all ages in all communities across the US. From entry into practice education and certification through

ongoing education and skills acquisition throughout their career, CRNAs provide robust, patient-centered acute, chronic and interventional pain management services. In recent years, certain Medicare Administrative Contractors (MACs) have issued local coverage determinations (LCDs) or have denied claims that limit Medicare coverage of services CRNAs can perform and bring a higher scrutiny with respect to provider qualifications. A March 2014 Government Accountability Office (GAO) report investigated found that that MACs are inconsistently implementing Medicare coverage of CRNA chronic pain management services. By issuing LCDs that refuse to cover medically necessary services, such as chronic pain treatment provided CRNAs, MACs are exceeding their authority and are effectively creating their own rules that often contradict existing CMS regulations and policy as well as scope of practice under state law. Patients are being denied services that are medically necessary and vital to patient access.

Since these policies and denials had started, the AANA began communicating and educating these MACs and the Medicare agency that pain management services are well within a CRNA's state scope of practice and shouldn't be denied. The AANA began commenting on draft LCDs and also scheduled meetings with MACs to discuss these policies. As a result of this advocacy work, in 2014, the MAC National Government Services (NGS), who was previously denying CRNA reimbursement for evaluation and management services, reversed their policy and announced that they will reimburse CRNAs for "anesthesia and related care services allowed by the state scope of practice which could include E&Ms provided for pain management." The AANA was also successful in ensuring that three problematic Novitas draft LCDs were never finalized in 2016 and in 2017. The AANA has also been successful in working with the Medicare agency in 2019 to get Novitas to place a hold on an additional LCD on facet joint injections. The AANA also continues to work with the Medicare agency regarding denials of pain management by the MAC Palmetto, and has been successful in resolving issues in Tennessee, South Carolina, and Alabama. Current issues remain with private health insurers, mainly around credentialing CRNAs for pain management in networks.

The AANA has also taken action to prevent the future development of these policies and denials in the Medicare program. The AANA had worked alongside other APRNs to get CMS to change its policy regarding Contractor Advisory Committees (CACs) to solely be represented by physicians. These CACs advise the MACs on the development of LCDs. In 2018, CMS changed its policy manual to allow practitioners who were not physicians to serve on these CACs and also increased the transparency of the development of LCDs. Furthermore, the AANA is working on introducing a bill in Congress that would address barriers to practice including enforcing existing law to ensure that LCDs do not contain any language or provision that limits or denies the free choice of a patient to obtain health services from any institution, agency, or person; develop a process by which a Medicare beneficiary or an adversely affected health care provider, has recourse for filing a claim prior to the finalization of a LCD; require each MAC to provide free of charge to a Medicare beneficiary or to an adversely affected health care provider, any

internal rule, guideline, protocol, or other criterion which was relied upon in making its LCD; and levy penalties when necessary**.** The AANA has also created the voluntary Pain Reimbursement Specialist program for state associations alongside the State Reimbursement Specialist program.

Due to advocacy efforts on part of the AANA with the Medicare agency, CMS has pushed the MACs to work together to come up with standardized policies and has encouraged the MACs to include the AANA as a major stakeholder in its development. In late May 2019, CGS Medicare hosted a Multijurisdictional Contractor Advisory meeting to discuss facet joint injections. CGS Medicare invited the AANA to nominate a CRNA to serve as a subject matter expert for this group alongside with pain physicians, and Keith Barnhill, PhD, CRNA, ARNP served on this group. The first standard draft policy on facet joint interventions was issued by multiple MACs in the Fall of 2020. In February 2021, Novitas hosted a Multijurisdictional Contractor Advisory meeting on epidural injections, and Keith Barnhill, PhD, CRNA, ARNP served as a subject matter expert for this group on behalf of the AANA. The AANA is awaiting issuance of a draft policy on epidural injections and anticipates more policies on chronic pain to be developed in this manner. The MACS have issued a policy on epidural injections, and the AANA anticipates development of a policy on sacroiliac joint injections to be developed in this manner.

In addition, the AANA has increased its advocacy work with coalition partners in the area of pain. For the last few years, the AANA has been an active participant with the Alliance to Advance Integrative Pain Management (AAIPM), a multi-stakeholder collaborative, comprised of people living with pain, public and private insurers, government agencies, patient and caregiver advocates, researchers, purchasers of healthcare, policy experts, and the spectrum of healthcare providers involved in the delivery of comprehensive integrative pain management. AAIPM seeks to advance access to comprehensive integrated pain management for patients living with pain. The AANA has participated in past workgroups creating white papers and in AAIPM's Policy Congress in past years. The AANA has also been asked to join the writing group within AAPIM that will allow us to work closely with this group to help advance our advocacy interests.

The increasing opioid and substance use disorder crises created a new focus on finding alternatives to the reliance on opioids to treat pain, and reducing adverse drug events related to opioids, including addiction. As a main provider of pain management services, CRNAs are well-qualified pain practitioners who provide access to patient centered, compassionate and holistic care in many practice settings to treat patients suffering from a wide range of acute and chronic pain conditions. As such, many patients rely on CRNAs as their primary pain care specialist, especially in rural and underserved areas. CRNAs manage chronic pain in a compassionate, patient-centered, multimodal, holistic manner, using a variety of therapeutic, physiological, pharmacological, and interventional modalities. This also includes opioid sparing or no opioid pharmacologic and non-pharmacologic pain mitigation strategies. The approach that CRNA pain

management practitioners employ when treating their chronic pain patients may reduce the reliance on opioids as a primary pain management modality, thus aiding in the reduction of potential adverse drug events related to opioids.

One example of CRNAs using non-opioid treatments for pain includes their increasing collaboration with patients and the interdisciplinary team on a comprehensive plan for pain relief known as enhanced recovery after surgery (ERAS®). This refers to patient-centered, evidence-based, multidisciplinary team developed pathways for a surgical specialty and facility culture to reduce the patient's surgical stress response, optimize their physiologic function, and facilitate recovery. These care pathways form an integrated continuum, as the patient moves from home through the pre-hospital / preadmission, preoperative, intraoperative, and postoperative phases of surgery and home again. Using specific protocol-driven ERAS® pathways improves patient outcomes by reducing the patient's stress response to surgery, shortening the overall hospital length of stay, and accelerating the return to normal daily function. The patient's pain management plan of care begins pre-procedure and continues through post-discharge using opioid-sparing techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures. The evidence is quite clear that careful assessment, evaluation, and treatment of acute pain, with appropriate prescribing of an opioid, may prevent access to unused opioids and development of opioid dependency and abuse. CRNAs play a critical role by ensuring proper anesthesia services management which can make a tremendous difference in terms of improving patient flow, patient safety, and cost savings. However, currently CMS does not have separate reimbursement for ERAS.

The AANA shares the increasing concern about the escalation in opioid drug use, abuse and deaths and is committed to working collaboratively to achieve comprehensive solutions to curb the opioid crisis in the United States. The AANA supports increased patient access to safe, responsible use of medication-assisted treatment (MAT) for the comprehensive treatment of substance and opioid use disorder. There are more than 53,000 CRNAs who can now treat opioid addictions with medications such as buprenorphine. These medications ease withdrawal symptoms and improve treatment outcomes. Many of these CRNAs are practicing in rural and underserved communities where access to these services is limited—there are either no qualified providers currently working in the area or they're overwhelmed by the large number of patients, which results in extended wait times. Under current Medicare payment policy, CRNAs cannot get reimbursed just for providing MAT. Instead, these services would be bundled as part of an opioid treatment program.

In October 2018, HR 6, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was enacted into law. This Act expands earlier legislation in the 2016 Comprehensive Addiction and Recovery Act (CARA) to include CRNAs among providers able to prescribe MAT to

individuals suffering from opioid addiction. The AANA worked with members of both parties and in both chambers of Congress to help ensure that provisions allowing CRNAs and other advanced practice registered nurses the ability to prescribe MATs were a part of the final bill, an effort to increase the availability of these lifesaving treatments, especially in rural and underserved communities. The AANA also supported many important components of the final bill that would encourage the reduced use of opioids in emergency rooms and in pain management throughout the healthcare system. Nurse anesthesia's support of this law continues to put the patients first in our efforts to decrease the reliance on opioids by offering interventional pain management that is opioid-free or opioid-sparing.

In the non-opioid treatment for pain realm, the AANA has partnered with Voices for Non-Opioid Choices, as part of the coalition group who advocates for increasing patient access to non-opioid therapies and approaches to managing acute pain. The AANA had important participation at their Solutions Summit in 2019 by having a CRNA as a speaker and having a large role in creation of the policy document from that meeting. In February 2020, former AANA President Kate Jansky also co-write an opinion piece with Voices in Modern Healthcare about the importance of increased access to non-opioid treatments for pain. In 2021 the AANA joined their Steering Committee to help this coalition with introduction of the NOPAIN Act, which seeks to promoteg access to non-opioid treatments in the hospital outpatient setting. AANA staff and CRNA members participate in numerous round tables with members of Congress to help urge passage of this important legislation.

In addition, the AANA has recently become an affiliate member of the Mental Health Liaison Group, a coalition of national organizations representing providers, consumers, family members, advocates, payors and other stakeholders committed to strengthening access to mental health and addiction care. As part of the coalition work, the AANA has signed on to letters of support for legislation that supports both providers and patients with mental health and substance use needs.

Anticipated Future State

- The AANA will work to introduce legislation on Capitol Hill to ensure that MACs do not surpass their authority by refusing to cover medically necessary services provided by certain health professions.

- MACs will continue to develop at a multijurisdictional level policies related to pain management.

- Medicare will continue cracking down on improper claims that fail to document medical necessity for the pain service; private plans can be expected to do likewise.

- Organized medicine will continue resisting CRNA services in this practice marketplace, whose growth is driven by demography, public health trends, and the absence of effective alternative therapies.

- CRNAs will continue to practice chronic pain management utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain.

- Increased focus on combating the opioid abuse/substance use disorder crises will continue to increase the demand for non-opioid treatments for pain, including ERAS, non-surgical interventions and ketamine therapies, and other medications and procedures, all of which are performed by CRNAs.

- There is currently not a reimbursement method for ERAS and the AANA will continue to advocate reimbursement for these services.

For More Information

- HHS Best Practices Pain Management Inter-Agency Task Force final report from May 2019, https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf
- AANA Enhanced Recovery after Surgery Protocols, https://www.aana.com/practice/clinical-practice-resources/enhanced-recovery-after-surgery
- Federal regulatory recognition for CRNA services, 42 CFR §410.69, https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-69.pdf and and Sec. 140.4.3 of the Medicare carrier manual Chapter 12, https://www.cms.gov/manuals/downloads/clm104c12.pdf
- Medicare Program Integrity Manual Chapter 13—Local Coverage Determinations, https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/Downloads/pim83c13.pdf
- Medicare benefit policy for services "incident to" the services of a physician, Chapter 15 Medicare benefits manual, Sec. 60, https://www.cms.gov/manuals/Downloads/bp102c15.pdf
- HHS Office of Inspector General reports on improper billing of facet joint injections (2008) http://oig.hhs.gov/oei/reports/oei-05-07-00200.pdf, and for transforaminal epidural injection services (2010), http://oig.hhs.gov/oei/reports/oei-05-09-00030.pdf
- AANA letter on chronic pain management services, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20120904_PhysicianFeeSchedule-CY2013_ProposedRuleCRNA-ChronicPainManagementAANAComment-FINAL.pdf (requires AANA member login and password)

- Final pain rule, 77 Fed. Reg. 68892, 69005 et seq., Nov. 16, 2012, amending 42 CFR §410.69(b). Certified Registered Nurse Anesthetists scope of benefit. http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf
- AANA Fact Sheet on Medicare Coverage of Chronic Pain Management Provided by CRNAs, http://www.aana.com/myaana/Advocacy/stategovtaffairs/Documents/Fact%20Sheet%20on%20Medicare%20CRNA%20Pain%20Mgt%20Final%20Rule.pdf (requires AANA member login and password)
- AANA letter on NIH draft National Pain Strategy, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150519%20AANA%20Comment%20on%20draft%20National%20Pain%20Strategy%20-%20FINAL.pdf (requires AANA member login and password)
- NIH draft National Pain Strategy, http://iprcc.nih.gov/docs/DraftHHSNationalPainStrategy.pdf
- AANA Chronic Pain Management Guidelines, http://www.aana.com/resources2/professionalpractice/Documents/PPM%20Chronic%20Pain%20Management%20Guidelines.pdf (requires AANA member login and password)
- National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA) Nonsurgical Pain Management Subspeciality Certification Overview, http://www.nbcrna.com/NSPM/Pages/NSPM.aspx
- Text of HR 6, the SUPPORT Act, https://www.congress.gov/bill/115th-congress/house-bill/6/text
- Text of the NOPAIN Act (HR 5172), https://www.congress.gov/bill/116th-congress/house-bill/5172/text and (S 3067), https://www.congress.gov/bill/116th-congress/senate-bill/3067/text

Issue Brief: [Rural Healthcare (CAHs/Rural Pass-through)]

History in Brief

Before 1983, a lump payment was given to hospitals by Medicare based on the diagnosis-related groups (DRGs) for all services provided to Medicare beneficiaries at the hospital. The hospital would receive the DRG payment through Medicare Part A; meanwhile, anesthesiologists could bill Medicare Part B individually for the anesthesia services. CRNA anesthesia services, however, were grouped into the DRG payment such that the payment for CRNA services came out of the total DRG payment provided to the hospital. Therefore, hospitals would receive less in DRG payments if they used CRNAs for anesthesia services. To resolve this inequity, Congress allowed facilities to be reimbursed for CRNA expenses from the Medicare program over and above the DRG payment, an initiative that persisted for qualifying rural hospitals after Congress enacted direct reimbursement for CRNAs in 1986.

If the hospital chooses to participate in the rural pass-through program, the CRNA and the hospital agree not to bill Medicare Part B for CRNA anesthesia services, and instead include the costs of these CRNA services as they relate to the treatment of Medicare patients in the annual Medicare Cost Report. Medicare then pays the hospital a lump sum for the CRNAs' services and related expenses during the next calendar year. The hospital includes provider salaries, facility and equipment costs incurred in serving Medicare beneficiaries as a part of their Medicare Cost Report. The funding that the pass-through hospitals receive in reimbursement is calculated according to the total costs for the hospital which are included in the Medicare Cost Report. Pass-through hospitals receive additional funding beyond their total costs as an incentive to continue to serve the Medicare population in rural areas. The hospitals can choose to use that funding in a variety of ways from increasing salaries to keep providers at the hospital, to facility/equipment improvements etc.

For CRNAs, in addition to the lump payment from Medicare Part A, pass-through hospitals are also paid an additional amount specifically for the cost of CRNA services. The cost is calculated according to the Physician Fee Schedule. Rather than being paid for CRNA services through Part B, the CRNA services are paid for through Part A pass-through funding. The hospital then pays to the CRNA a salary (if the CRNA is a hospital employee) or the appropriate contracted amount for anesthesia services provided.

Rural hospitals must meet several requirements to be eligible for the program, including providing 800 or fewer cases in a year.

Current State of the Issue

In 2009, acting CMS administrators twice overruled the agency's Provider Reimbursement Review Board (PRRB) and wrongly denied rural hospitals pass-through payment for CRNAs' standby and on-call services even though such payments are clearly permissible and necessary to rural hospitals' emergency care and trauma stabilization capabilities. These CMS rulings have denied rural hospitals' claims for tens of thousands of dollars each in annual Medicare funding that they had come to rely upon to serve their communities. The AANA has worked to restore CRNA on-call payments in the rural pass-through program. In past Congresses, legislation was introduced to clarify reasonable costs for critical access hospital payments under the Medicare program. The legislation, titled the Critical Access and Rural Equity (CARE) Act, would resume passthrough payments for CRNA "on call" services.

Services of anesthesiologists remain ineligible for pass-through funding. Therefore, they or the hospital must bill Medicare Part B for anesthesiologists' anesthesia services. In past years, Members of Congress introduced the ASA supported "Medicare Access to Rural Anesthesiology Act", making anesthesiologists eligible to participate in the pass-through program. The AANA expressed opposition to this legislation because if it is signed into law, it will increase costs to the Medicare Part A program and promote remote "supervision" instead of rural anesthesia professionals on site. Anesthesiologists' participation in the rural pass-through program would increase cost to Medicare at a time when Medicare dollars are tight. However, this bill never moved in Congress and has not been reintroduced in three years.

In addition, at the time of this writing, 138 rural hospitals have closed since 2010, with more than 181 hospitals have closed since 2005. Currently, 673 additional facilities are vulnerable and could close, representing more than one-third of rural hospitals in the U.S. The rate of closure has steadily increased since sequestration began, and bad debt cuts began to hit rural hospitals, resulting in a rate six times higher in 2015 compared to 2010.

Since 2010, 135 rural hospitals have closed, and an additional 450 facilities are vulnerable to closure. This represents more than one-third of rural hospitals in the U.S. The rate of closure has steadily increased since sequestration began, and bad debt cuts began to hit rural hospitals, resulting in a rate six times higher in 2015 compared to 2010. In 2022, Representatives Sam Graves (R-MO) and Jared Huffman (D-CA) introduced the "Save America's Rural Hospitals Act (HR 6400)." This legislation will permanently suspend Medicare sequestration for rural hospitals, eliminate regulations for rural hospitals such as the 96-hour Physician Certification Requirement, and offer new payments for rural hospitals. Additionally, Representatives Terri Sewell (D-AL) and Tom Reed (R-NY) introduced the "Save Rural Hospitals Act," HR 4066. This legislation would establish an appropriate national minimum (0.85) for the Medicare Area Wage Index to ensure that rural hospitals receive their payment for the care they provide, while preserving the existing reimbursements for urban hospitals. Companion legislation, S. 999, was introduced in the Senate by Mark Warner (D-VA). Both bills were introduced in 2021.

Anticipated Future State

- It will be important to continue to seek support from Congress to restore on-call payments to CRNAs. ASA has continued to support rural pass-through legislation for anesthesiologists. The AANA will monitor the status of critical access hospital and rural health legislation introduced in the current Congress.

- The AANA will continue to partner with the National Rural Health Association to form a coalition of healthcare groups and interested parties, called the "Rural Health Action Alliance," which focuses on rural health. The mission statement is that the Rural Health Action Alliance is committed to delivering high-quality, cost-effective healthcare to patients in rural areas. Through advocacy and education, the Rural Health Action Alliance seeks to improve federal policy related to rural healthcare. Most recently, the RHAA sent a letter to Congress, outlining the coalition's priorities in any future legislation to address the COVID-19 pandemic.

- Potential greater scrutiny over CAH cost reports and CRNA compensation.

For More Information

- Reasonable cost pass-through program described on AANA Federal FAQ's page, http://www.aana.com/advocacy/federalgovernmentaffairs/Pages/Rural-Anesthesia-Access.aspx (requires AANA member login and password)
- CMS brief on critical access hospitals and rural pass through https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsht.pdf
- Federal Definition of urban vs. rural (42 CFR §412.62 – Federal rates for inpatient operating costs, http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr412_main_02.tpl); and (42 CFR §414.605 – Definitions, http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=3a02ef78e6457cee45c557470be21788&rgn=div8&view=text&node=42:3.0.1.1.1.8.1.2&idno=42)
- The Code of Federal Regulations (CFR) lists the requirements a hospital or Critical Access Hospital (CAH) must fulfill to receive rural pass-through funding from Medicare Part A for CRNA anesthesia services. (42 CFR 412.113 – Other Payments), http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=3a02ef78e6457cee45c557470be21788&rgn=div5&view=text&node=42:2.0.1.2.12&idno=42#42:2.0.1.2.12.8.47.3
- Medicare Provider Reimbursement Manual, Part 1, Chapter 21 , Section 2103 available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929

- Text of HR 2666, https://www.congress.gov/bill/116th-congress/house-bill/2666?q=%7B%22search%22%3A%5B%22HR+2666%22%5D%7D&s=1&r=1
- Text of HR 1887, https://www.congress.gov/bill/117th-congress/house-bill/1887?q=%7B%22search%22%3A%5B%22reed%22%5D%7D&s=4&r=1
- UNC Shep Center on Rural Hospital Closures, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

Issue Brief: [Medicare - TEFRA]

History in Brief

Authorized through the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1986 and its enabling regulations, the TEFRA medical direction payment rules specify what an anesthesiologist must do to claim 50 percent of a Medicare fee in each of up to four concurrent anesthesia cases administered by a CRNA (or AA where permitted). Though the TEFRA rules are not required except for anesthesiologists making these claims, anesthesiologists and their allies frequently promote anesthesiologist medical direction as a standard of care, contributing to healthcare cost growth and impairments to access. Private plans paying for medical direction services commonly abide by the TEFRA rules, though sometimes they weight the 50/50 payment scheme used by Medicare more heavily towards anesthesiologists.

The TEFRA rules were amended in 1998 following discussions with AANA and ASA. Substantial changes in the rules proposed by Medicare with AANA's backing were rejected by state anesthesiologist societies, yielding one significant beneficial change for CRNAs: that the anesthesiologist bears sole responsibility for testifying that he or she has completed the seven medical direction tasks required to complete a claim. Anesthesiologists sought in the early 2000s to be reimbursed 50 percent of a fee for "broken medical direction," when the anesthesiologist fulfills less than the seven required steps; AANA rejected that proposal, and it died. Such cases may be billed CRNA-nonmedically directed at 100 percent of a fee.

An important study reported in *Anesthesiology*, a journal published by the American Society of Anesthesiologists, found that medical direction responsibilities are not fulfilled in every case where that service is billed. Reviewing over 15,000 anesthesia records in one leading U.S. hospital, the study raises critical issues about propriety and compliance in the most common and costly model of anesthesia delivery at a time when quality and cost-effectiveness are important healthcare issues at every level. The study states that "(e)ven at a ratio of 1:2, there would have been at least one such lapse in supervision for 35% of days. At a ratio of 1:3, there would be supervision lapses on 99% of days." The researchers define a "supervision lapse" as an instance when there is an "inability to supervise all critical portions" of a case. Without personally performing such supervision, the seven medical direction tasks that an anesthesiologist must complete for billing Medicare for medical direction are not fulfilled, and a medical direction claim is not permitted.

Current State of the Issue

About 82 percent of CRNAs operate in the medically directed environment, according to AANA member surveys. The same member surveys indicate all seven TEFRA requirements are frequently *not* met by the medically directing anesthesiologist.

Medical direction contributes to healthcare cost growth as identified in *Nursing Economic$* (2010). However, CRNAs do not have to use medical direction and can use the QZ modifier in all 50 states, whether or not that state has opted out of the physician supervision requirement. Furthermore, surgeons erroneously concerned with vicarious liability of supervising CRNAs may support anesthesiologist medical direction as a way of alleviating that unfounded fear.

During the period 2000-2014, significant redistribution of Medicare billed cases was occurring according to an analysis of trends in modifier shares. QK, the primary modifier for directed cases declined slightly from 34.8 to 31.8 percent of Medicare cases while AA or anesthesiologist alone cases declined from 48.6 to 36.7 percent. Undirected CRNA (QZ) cases increased from 16.0 to 30.9% suggesting that there has been a substantial shift toward billing QZ.

Medicare recently clarified anesthesiologist assistants (AA) may not bill QZ (CRNA nonmedically directed services), limiting medically directing anesthesiologist flexibility to fail to perform all the medical direction tasks when AAs are involved. In 2020, the AANA learned that two Medicare Administrative Contractors (MACs) had issued private email communications indicating that AAs could use the QZ modifier and that one MAC had issued a FAQ on its website indicating that AAs could use the QZ modifier. The AANA contacted all three MACs and successfully confirmed that they had issued misleading statements about AAs using the QZ modifier. These MAC have now verified with us that AAs cannot bill QZ. In 2020, CMS incorporated AANA's suggestions for changes to their Revised Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet to further clarify that AAs cannot use the QZ modifier. the MACs that we've heard had issued misleading statements about AAs using the QZ modifier have now verified with us that AAs cannot bill QZ.

Anticipated Future State

- Bundled, episode-of-care, and capitated payment structures will drive facilities and surgeons to consider the value of anesthesia delivery models in relation to their costs.

For More Information

- Medicare Claims Manual Chapter 12, Sec. 50, describes general payment for anesthesiologist services, and Sec. 140 CRNA services. Medical direction rules lie at Sec. 50.C. https://www.cms.gov/manuals/downloads/clm104c12.pdf

- March 2012 *Anesthesiology* article, "Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics", http://journals.lww.com/anesthesiology/Fulltext/2012/03000/Influence_of_SupervisionRatiosby.28.aspx
- Letter from AANA President to membership on *Anesthesiology* study, http://www.aana.com/myaana/Publications/membernews/Pages/031512-Journal-Anesthesiology-Confirms-that-Anesthesiologist-Supervision-Often-Lapses.aspx (requires AANA member login and password)
- The TEFRA rules, http://law.justia.com/cfr/title42/42-2.0.1.2.15.3.51.4.html
- Nursing Economic$ cost-effectiveness analysis of anesthesia professionals (2010), (requires AANA member login and password) http://www.aana.com/newsandjournal/News/Pages/062110-Study-Shows-CRNA-Only-Anesthesia-Delivery-Most-Cost-Effective-.aspx
- Health Affairs article indicating anesthesia medical direction claims declined 1999-2005 (2010), (requires AANA member login and password) http://www.aana.com/newsandjournal/News/Pages/08310-Study-in-Health-Affairs-Confirms-Quality,-Safety-of-Nurse-Anesthetist-Care.aspx
- CMS Transmittal on AAs not billing QZ (May 30, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2716CP.pdf
- CMS APRN booklet, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf
- QZ trends 2000-2014, https://www.aana.com/docs/default-source/aana-journal-web-documents-1/anesthesia-medicare-trend-analysis-shows-increased-utilization-of-crna-services-october-2017.pdf

Issue Brief: [Medicare Advantage (Medicare Part C)]

History in Brief

Medicare Advantage (MA), also known as Medicare Part C, was started by the federal government in 1995 to give Medicare beneficiaries other insurance coverage choices beyond traditional Medicare. MAs are insurance plans regulated by the federal government and funded by CMS, however, they are administered by private insurance companies that offer their own plans. MA plans are required to cover all services furnished under traditional Medicare Part A and Part B, however, they often include additional services to attract Medicare beneficiaries away from traditional Medicare. There are several different types of MA plans: (1) health maintenance organizations (HMOs); (2) preferred provider organizations (PPOs); (3) private fee-for-service (PFFs); (4) special needs plans (SNPs); and (5) medical savings accounts (MSAs). Medicare advantage plans have leeway as to how they recognize and reimburse CRNAs.

According to Kaiser Family Foundation (KFF) there will be 3,834 MA plans available nationwide for individual enrollment in 2022 – a 8 percent increase (284 more plans) from 2021 and the largest number of plans ever available. These numbers exclude employer or union-sponsored group plans and special needs plans, which are only available to select populations. The vast majority of (89%) of all Medicare Advantage plans offered include prescription drug coverage in 2022. Similar to prior years, HMOs continue to account for about two-thirds (59%) of all plans offered in 2022. Between 2021 and 2022 the number of regional PPOs has remained constant, while the number of private fee-for-service plans has continued to decline.

The growth in number of plans varies across states and counties, with the preponderance of the growth in plans occurring in Texas and Florida (41 more and 32 more plans, respectively). Changes in the states include: Alaska now offering two plans; Arkansas losing 8 plans, Kentucky losing 6 plans and Washington and Ohio losing 3 plans and Tennessee lost 2 plans. While many employers and unions also offer MA plans to their retirees, no information about these 2022 plans is made available by CMS to the public during the Medicare open enrollment period because these plans are not available to the general Medicare population.

One important development in 2021 is that enrollees with end stage renal disease (ESRD) are now able to enroll in Medicare Advantage plans. Previously, beneficiaries with ESRD were not eligible to enroll in many Medicare Advantage plans unless they were covered by an exception. Approximately 4,800 Medicare Advantage enrollees were in a plan for people with ESRD in 2021.

The table below compares traditional Medicare vs Medicare Advantage.

	Original Medicare	**MA**

Coverage	Covers hospital and medical costs related to Part A and Part B. Optional to add Part D.	Generally, covers all hospital and medical services under Part A and Part B when you go to the providers in the plans network and service area. Commercials payers may add services such as vision, dental, hearing and prescription drug benefits (Part D) to attract enrollees.
Cost	Monthly premium for Part B. No yearly limits on out of pocket expenses, (e.g. beneficiary pays 20% of all total costs) unless you have supplemental coverage like Medicare Supplement Insurance (Medigap). Limited coverage – the number of days covered for stays in hospitals or nursing homes is capped.	Monthly premium for Part B but some plans offer $0 premiums to help with all or some of Part B. Many plans include Part D premium drug coverage (MA-PDs). Co-payments on common health services with financial liability is limited to co-payment amount. Annual out-of-pocket maximum limits. Cannot purchase and do not need Medigap.
Travel	Generally, no coverage for medical care during international travel, including emergency situations.	May cover emergency care during international travel, with limits determined by the policy.
Network of providers	Can visit any doctor or facility that accepts Medicare.	Plan determines fixed network of providers and hospitals that enrollees can utilize.

Current State of the Issue

MA enrollment has grown rapidly over the past decade, and MA plans have taken on a larger role in the Medicare program. Enrollment in MA has nearly doubled over the past decade, in 1999 MA plans had 6.9 million enrollees which grew to 24.1 million enrollees in 2020. The Congressional Budget Office (CBO) projects that the share of beneficiaries enrolled in MA plans will rise to about 47 percent by 2029. Two health plans dominate the national Medicare Advantage market, UnitedHealthcare and Humana offer plans in 74 percent and 85 percent of U.S. counties respectively. These insurance companies

offer MA plans in the following number of counties: Blue Cross Blue Shield = 2,190; CVS Health = 1,840; Centene = 1,525; Cigna = 477; and Kaiser = 116. Medicare Advantage plans are a lucrative market for insurers with 20 new firms entering the market for the first time in 2022.

Between 2012 and 2015, the MA population grew younger and included greater proportions of racial and ethnic minorities. There were also more low-income enrollees, more living in poor neighborhoods, and more living in neighborhoods where few residents have college degrees. While chronic conditions had not become more prevalent by 2015, a greater proportion of enrollees had complex medical needs. Hospitalization rates were stable, but lengths of hospital stays increased as did use of observation stays and emergency department visits. Spending was 13 percent higher in 2015, largely because of spending on prescription drugs. Performance on several measures of health care quality improved, but medication adherence declined slightly. MA plans will need to develop targeted interventions to address enrollees' social risks, avoid medical complications, and increase medication adherence. Plans also need to reduce spending on post-acute care, for example, by expanding use of services provided in enrollees' homes.

MA plans set their provider rates based on CMS' traditional Medicare rates. MA plans set their provider rates based on CMS' traditional Medicare rates, but they are not bound by these rates. These agreements vary widely, including in the amounts they pay contracted providers compared to Medicare fee-for-service rates. Federal law requires the MAO to provide at least the same set of benefits to individuals enrolled in its Medicare Advantage plan as those that are available in the Medicare fee-for-service program. MAOs assemble provider networks to deliver these services and there are a number of complex regulatory requirements the MAO must meet when setting up their network, including adhering to network adequacy and provider non-discrimination requirements.

A study published by the Better Medicare Alliance found the Medicare Advantage quality of care exceed traditional Medicare, particularly in the area of preventative care. The study compared six categories of traditional Medicare and Medicare beneficiaries: those with chronic conditions, the frail elderly, those under 65 with disabilities including end-stage-renal disease, those with minor complex conditions, those with simple chronic conditions, and those who are healthy. The research found that that Medicare Advantage's key program components – risk-adjusted capitated payments, strong value-based performance incentives, and flexibility in benefit design, allowed plans to offer care management interventions that meet the complex care needs of vulnerable beneficiaries in ways that produce robust positive outcomes and greater value for high need, high cost, beneficiaries.

To offset these low rates, MA plans succeed at negotiating lower prices for healthcare services for which traditional Medicare overpays such as lab services and durable

medical equipment. According to UnitedHealthcare its anesthesia reimbursement policy was developed in part using the ASA's Relative Value Guide (RVG®), the ASA's CROSSWALK®, and CMS' CMS methodology. For anesthesia and procedural bundled services, UnitedHealthcare's MA plan uses the CMS National Correct Coding Initiative (NCCI) Policy Manual, CMS NCCI edits and the CMS' National Physician Fee Schedule when considering procedural or pain management services that are an integral part of anesthesia services, and anesthesia services that are an integral part of procedural or pain management services, which are not separately reimbursable when performed by the same individual physician or other qualified health care professional on the same date of service. UnitedHealthcare instructs CRNAs to report their services using the appropriate anesthesia modifier QX or QZ. CRNA services must also be reported under the supervising physician's name or the employer or entity under which the CRNA is contracted. In cases where the CRNA is credentialed and/or individually contracted by the UnitedHealthcare company, the CRNA reports one's services under his or her name.

CMS calculates risk scores using diagnoses submitted by MA organizations and from Medicare fee-for-service (FFS) claims. CMS has used diagnoses submitted into CMS' Risk Adjustment Processing System (RAPS) by MA organizations for the purpose of calculating risk scores for payment. In the past few years, CMS started collecting encounter data from MA organizations, that also included diagnostic information. CMS is working to complete its phase-in of the 2022 CMS-Hierarchical Condition Categories (HCC) Medicare Part C (Medicare Advantage) payment model that was first implemented in CY 2020 as mandated by the 21st Century Cures Act. The Cures Act specifically requires this risk adjustment model to include variables that count the number of conditions a beneficiary has among the risk adjusted model and additional conditions for mental health, substance use disorder and chronic kidney disease. This is a change from the 2021 calculations that used a blend of 75 percent of the risk score calculation from the 2020 CMS-HCC model and 25 percent of the risk score using the 2017 CMS-HCC model.

Anticipated Future State

- MA plans will continue enrolling beneficiaries at a high rate as more Americans turn 65 and qualify for Medicare health insurance.

- MA plans will seek to enroll beneficiaries in rural and underserved areas, places where healthcare insurers have previously overlooked.

- MA providers will have to furnish high quality of care while decreasing the overall costs as value-based care becomes the norm.

- CMS will require MA plans to offer more supplemental benefits.

- MA plans will be a cost-saving alternative to traditional Medicare, recent statistics indicate that MA costs 40 percent less than fee-for-service Medicare**.**

For More Information

- Understanding MA Plans, CMS, https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf
- Kaiser Family Foundation, MA Spotlight, 2022 First Look https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/
- UnitedHealtcare, Anesthesia Services Policy, Professional
- **https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Anesthesia-Policy.pdf**
- Positive Outcomes for High Need, High Cost Beneficiaries in Medicare Advantage Compared to Traditional Fee-for-Service Medicare https://www.bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf
- 2022 Medicare Advantage and Part D Rate Announcement Fact Sheet , https://www.cms.gov/newsroom/fact-sheets/2022-medicare-advantage-and-part-d-rate-announcement-fact-sheet
- As it Grows, Medicare Advantage is Enrolling More Low-Income and Medically Complex Beneficiaries https://www.commonwealthfund.org/publications/issue-briefs/2020/may/medicare-advantage-enrolling-low-income-medically-complex

Issue Brief: [Alternative Payment Models]

History in Brief

The Affordable Care Act (ACA) (P.L. 111-148) created numerous initiatives that change how healthcare is delivered and experienced. Created by the ACA, the Center for Medicare and Medicaid Innovation (CMMI) is tasked with identifying, testing, and expanding new systems for delivering and paying for care. Under CMMI's guidance, alternative payment models such as accountable care organizations (ACOs) and bundled payments are demonstrating that quality and coordinated care can obtain improved healthcare outcomes at lower costs. An alternative payment model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Healthcare payers agree that that the current fee-for service (FFS) system is expensive and inefficient and that value-based care is the future. In March 2015, former Health and Human Services' (HHS) Secretary Sylvia M. Burwell announced that HHS' "goal is to have 85 percent of all Medicare FFS payment tied to quality or value by 2016 and 90 percent by 2018." She also noted that "more importantly, our target is to have 30 percent of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50 percent of payments by the end of 2018." Recognizing that changing the federal government's healthcare reimbursement polices requires bringing together public and private stakeholders, Burwell announced the creation of the *Health Care Payment Learning and Action Network*. The network serves as a forum where payers, providers, and all other stakeholders can discuss, track, and share best practices on transitioning towards alternative payment models that emphasize value. While Burwell's 2015 announcement included no implementation requirements for the new payment models, it provided a framework that categorizes payment to providers and explains how healthcare payments move from FFS to a variety of alternative payment models. Importantly, clinicians and organizations are increasingly accountable for quality and care, and there is a greater focus on population health management instead of paying for specific services. Accountable care organizations (ACOs) and bundled payment initiatives are the most widely recognized alternative payment models. Both models have been used by public and private payers to implement value-based care in addition to lowering costs.

Current State of the Issue

Driven by Medicare's push towards value-based care and away from fee-for-service (FFS) which emphasizes volume, healthcare is changing. It's unclear whether CMS' goal of having 100 percent of providers take on downside risk by 2025 will be reached. Currently only 20 percent of Medicare spending is value-based. This means in the next few years, the federal government will be pushing financial risk on to hospitals, health systems and providers. Given that Medicare is the largest payer in healthcare and has

enormous influence on provider reimbursements and what innovations in healthcare will be implemented, it is important to understand the two most important types APMs.

Accountable Care Organizations: ACOs are the largest kind of APM used by providers. As Medicare moves away from FFS and towards value-based care, payers will transfer more financial risk away from themselves and more towards clinicians including CRNAs. According to the HCPLAN by 2025, it anticipates that the reported share of payments in APMs will be distributed as follows: 50% Medicaid/Commercial; 100% Medicare Advantage/FFS Medicare.

To advance quality, an ACO coordinates care, focuses on the chronically ill, provides the right care at the right time, avoids duplicative services, and prevents medical errors. A Medicare ACO is an individual or group of primary care providers or provider organizations, identifiable by a single Medicare tax identification number (TIN), that voluntarily comes together to be accountable for the quality, cost, and overall care of the Medicare FFS beneficiaries assigned to it. An ACO's billing TIN will be used to establish its eligibility, assignment of beneficiaries, financial benchmarks, and quality assessments. Financial benchmarks and quality assessments would be based on a defined set of resource and quality or outcome measures under a defined period of time (e.g., one-year performance period).

Although ACOs focus on primary care, because ACOs are a total cost of care model, all conditions/procedures for ACO aligned beneficiaries will be included in the model, which will include anesthesia services. Currently, Medicare has the Medicare Shared Savings Program (MSSP). MSSP ACOs are characterized by: (1) the number of beneficiaries aligned to it; (2) its relationships with providers and suppliers; (3) the payment model that includes shared savings and shared risk requirements for the ACO; and (3) spending benchmarks in relation to Medicare Part A and Part B services. In January 2022, Medicare had 483 MSSP ACOs with 11 million assigned beneficiaries. Approximately 41 percent of ACO has one-sided risk and 59 percent of ACOs have two-sided risk. There are also hundreds more commercial ACOs and Medicaid ACOs serving millions of more patients.

Under the Biden Administration, in February 2022 the Center for Medicare and Medicaid Innovation (CMMI) released a Request for Applications (RFA) to solicit a cohort of participants for the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. CMS redesigned the Global and Professional Direct Contracting Model (GPDC) Model in response to the Administration's priorities, including advancing health equity, stakeholder feedback, and participant experience. CMS is renaming the model the ACO REACH Model to better align the name with the purpose of the model: to improve the quality of care for people with Medicare through better care coordination, reaching and connecting health care providers and beneficiaries, including those beneficiaries who are underserved. The new cohort will begin participation in the ACO REACH Model on January 1, 2023. Current GPDC Model participants must maintain a strong compliance record and agree to meet all the ACO

REACH Model requirements by January 1, 2023 to continue participating in the ACO REACH Model as ACOs.

Bundled Payments: A bundled payment is a single payment given to a provider organization or hospital that is intended to cover all services for a given condition or an episode of care. The provider organization or hospital that receives the bundled payment assumes all financial risk for providing the care and all costs associated with preventable complications. Bundle payments are best suited for episodes of care that have a definite start and end period, such as a surgical procedure or a specific medical condition. The goal of the bundled payment is higher quality and coordinated care at a lower cost.

The Rand Corporation's study, "*Increase the Use of "Bundled" Payment Approaches*," found that bundled payments that involve multiple payers may reduce spending by eliminating unnecessary services and costs. Bundled payments are intended to generate savings through several mechanisms: reducing unnecessary physician services during a hospitalization, more judicious use of healthcare resources during the hospital stay, and a reduction in post-discharge costs, including unnecessary post-acute care services and avoidable readmissions. The Rand study noted that bundled payments could improve care coordination and lead to improved health outcomes and patient experiences.

In a CMS bundled payment, CMS reimburses participants on a FFS basis with retrospective reconciliation as episode spending is measured against a target price. Note: that even though CMS refers to this as a "bundled payment," CMS does not make a single payment for all services included in the bundle. All providers will continue to receive FFS payments and spending is then compared to a target price. To determine the bundled payment CMS undertakes three steps: (1) CMS sets the target price - based on baseline episode costs for each selected episode at the MS-DRG level, than a discount is applied; (2) CMS pays standard FFS rates – Medicare will pay all Part A and Part B providers who furnish care to patients identified as participating in the initiative using the current FFS payment systems; and (3) CMS determines bonus/penalty based on bundled performance – actual spending is compared to a target price where if spending exceeds the target price, the participant pays the difference or if the spending is less than the target price, Medicare will pay the difference/participant gets to keep the saved amount. Current examples of CMS bundled payment programs include the Bundled Payments for Care Improvement Advanced (BPCI Advanced) and the Comprehensive Care for Joint Replacement (CJR) Initiative.

Quality Payment Program: CMS began the Quality Payment Program (QPP) on January 1, 2017. Prior to the QPP, payment increases for Medicare services were set by the Sustainable Growth Rate (SGR) law. This capped spending increases according to the growth in the Medicare population, and a modest allowance for inflation. However, as clinicians increased their utilization of services, the reimbursement for each unit of service had to be adjusted downward to hold costs constant. In practice, the SGR would have resulted in large decreases in the Physician Fee Schedule, which was not

sustainable. To avoid these decreases in reimbursement, Congress had to pass a new law (every year) authorizing the current fee schedule and a small increase for inflation.

CMS eliminated the SGR with passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS intends to reward high-value, high-quality Medicare clinicians with payment increases - while at the same time reducing payments to those clinicians who aren't meeting performance standards. CMS also seeks to improve Medicare by helping clinicians focus on caring for their patients rather than filling out paperwork. The goal being for CMS listen to and take steps towards reducing burdens for clinicians and improving health outcomes for Medicare patients. To participate in the QPP clinicians choose from two tracks based on their practice size, specialty, location, or patient population: Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models.

Advanced alternative payment models (AAPMs) are a subset of APMs that let group practices and clinicians earn more for taking on some risk related to their patients' outcomes. Eligible clinicians (ECs) may earn an incentive payment by going further in improving patient care and taking on risk through an Advanced APM. ECs determined to be Qualified Participants (QPs) in an Advanced APM may earn a 5 percent incentive bonus until the end of their 2022 performance period which will be paid in 2024 payment period according to MACRA.

QP status means an EC (e.g. CRNA) is determined to have met or exceeded relevant QP payment or patient threshold levels for a participation year in an APM entity that is also participating in an Advanced APM. To become a QP, you must receive at least 50 percent of your Medicare Part B payments or see at least 35 percent of Medicare patients through an Advanced APM entity during the QP performance period (January 1 - August 31). In addition, 75 percent of practices need to be using certified EHR Technology within the Advanced APM entity. QP status allows CRNAs with a signed Participation Agreement with the Advanced APM to qualify for the 5 percent bonus. CRNAs in Advanced APMs that do not meet the QP patient or payment thresholds may qualify for Partial QP status. To become a Partial QP, you must receive at least 40 percent of your Medicare Part B payments or see at least 25 percent of Medicare patients through an Advanced APM entity during the QP performance period (January 1 - August 31). Partial QPs in an Advanced APM may elect to participate in MIPS and will have their score calculated through the APM Scoring Standard.

To be considered an Advanced APM an APM must meet the following criteria: (1) Requires 75% of eligible clinicians in each APM entity to use certified electronic health record technology (CEHRT); (2) Provides payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment Systems (MIPS) Program; and (3) Participates in either a Medical Home Model expanded under CMS Innovation Center authority; or an APM entity that bears financial risk based on total Medicare expenditures or the Medicare revenue-based nominal standard amount of 8 percent.

For a current list of ACO please visit the Quality Payment Program webpage at qqp.cms.gov.

Policy Considerations: As CMS continues to propose and implement APMs to shift away from FFS and towards value-based care, a critical question is whether CMS should engage providers on a voluntary or a mandatory basis. Clinicians and policy makers may view the benefits and drawbacks of these two modes of participation differently. Comparisons must be made between the benefits and drawbacks of mandatory and voluntary participation, based on clinical versus policy perspectives. There is an argument that both modes are necessary for APMs to achieve the goal of improving value. Policy makers need to match the mode of participation and related financial incentives to each clinical scenario in which an APM is implemented. Importantly, U.S. healthcare spending grew in 2020 by 9.7 percent, approximately $4.1 trillion, while the nation's Gross Domestic Product fell 2.2 percent in 2020. Successful change requires strong leadership from all stakeholders. Care and payment systems must consider local, social and technical needs among different care settings. As ACOs and bundled payments continue to evolve, CRNAs should be aware of how their services may be incorporated into an APM and build the necessary relationships to improve care coordination.

Anticipated Future State

- CMS will likely move into more mandatory bundled payments to encourage participation from providers who are unable/unwilling to participate in an APM
- ACOs will encourage primary care providers to engage specialty care providers in finding alignment on measures common to all specialties to increase quality reporting and strategic pathways
- APMS will share data to determine efficiencies in care coordination and cost containment to maximize shared savings
- APMs will look to beneficiary attribution with capitation payments (e.g. PBPM payments) to provide a stable financial base for their organizations

For More Information

- The Affordable Care Act https://www.hhs.gov/healthcare/about-the-aca/index.html
- Quality Payment Program Overview https://qpp.cms.gov/about/qpp-overview
- Alternative Payment Models (APMs) Overview QPP https://qpp.cms.gov/apms/overview
- Burwell SM. Setting value-based payment goals—HHS efforts to improve U.S. health care. N Engl J Med. Mar 5 2015;372(10):897-899.
- Health Care Payment Learning and Action Network - https://hcp-lan.org/

- Bertko J, Effros R. Increase the Use of “Bundled” Payment Approaches, Santa Monica, Calif.: RAND Corporation, TR-562/20-HLTH, 2010. https://www.rand.org/pubs/technical_reports/TR562z20.html
- National Association of ACOs. https://www.naacos.com/
- Medicare Shared Savings ACOs 2022 Fast Facts. https://www.cms.gov/files/document/2022-shared-savings-program-fast-facts.pdf
- ACO REACH https://innovation.cms.gov/innovation-models/aco-reach

Issue Brief: [Incident-To Billing]

History in Brief

Medicare Part B pays for services and supplies "incident to" the service of a physician or non-physician practitioner (NPP), including a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or clinical psychologist, for which payment is not made under a separate benefit category under Sec. 1861(s) of the Social Security Act. According to Medicare, to be covered "incident to" such a service under Part B it must be: a) furnished in a non-institutional setting to non-institutional patients, where the "non-institutional" setting is defined as all settings other than a hospital (not including outpatient departments) or skilled nursing facility; b) "an integral, although incidental," part of the physician or NPP's professional service. "Incidental" is not defined in Medicare policy. The service may be furnished at any time "during a course of treatment where the physician [or NPP] performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment;" c) commonly provided without charge or included in the physician's or NPP's bill; d) of a type that commonly is furnished in a physician's office or clinic; and e) furnished under the physician's or NPP's "direct supervision."

A healthcare professional does not use his or her own National Provider Identifier (NPI) number to bill for services furnished "incident to" those of a physician or NPP, nor does the healthcare professional receive direct reimbursement from the Medicare program in this case. Rather, the services are billed under the physician's or NPP's NPI, or that of the entity with whom the physician or NPP has a legal relationship, such as a group practice. Under an "incident to" arrangement, the physician, NPP, or practice will receive the amount that they are entitled to under the Physician Fee Schedule as if they had furnished the services themselves (so long as all conditions are met). Total reimbursement will differ if services are billed by an NPP, such as an NP, PA, or CNS, instead of a physician, as reimbursement rates are lower for these healthcare professionals than for physicians. If a service is provided incident to an NPP, that service is paid at 85 percent of the Medicare fee schedule amount; services provided incident to a physician are paid at 100 percent of the fee schedule amount.

In 2011, the bulletins from WPS Medicare and Noridian stated that CRNAs may be reimbursed for chronic pain management services on an "incident to" basis only, and these MACs will no longer reimburse CRNAs directly for furnishing chronic pain management services to Medicare patients. In 2013, Medicare authorized reimbursement of all Medicare services that CRNAs provide within their scope of

practice and use of incident to became unnecessary if state law supported CRNAs to provide chronic pain management services.

Current State of the Issue

APRNs and other NPPs who are reimbursed directly by Medicare at 85% of the fee schedule amount and bill "incident to" are looking to reform "incident to" billing by stating that it obscures the provider who is actually accountable for services delivered to patients. In its August 2009 report, "Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services" (OEI-09-06-00430), the HHS Office of Inspector General recommended that CMS "require physicians who bill services to Medicare that they do not personally perform to identify the services on their Medicare claims by using a service code modifier." Recently, members of the Medicare Payment Advisory Commission (MedPAC) have also recognized the inherent problems with "incident to" billing. In MedPAC's June 2019 report to Congress the Commission formerly requested that Congress act to retire incident to billing practices. Commissioners recognized the same inequities and confusion that our organizations

Anticipated Future State

- "Incident to" billing will become obsolete.

For More Information

- AANA brief on incident-to billing in Medicare, available at: https://www.aana.com/docs/default-source/fga-my-aana-web-documents-(members-only)/20120102-crna-_incident-to_-billing-final.pdf?sfvrsn=cd4849b1_4 (requires AANA password and login)
- MedPAC June 2019 report, available at: http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf
- Medicare Benefits Policy Manual, Pub. 100-02, Ch. 15, § 60, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- OIG report August 2009, available at: https://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf

Issue Brief: [Commercial Health Plans in States]

History in Brief

Instituted so that employers could compete for labor during World War II-era wage controls, today about half of U.S. healthcare is delivered through employer benefit private health plans, the remainder through public benefits like Medicare, Medicaid and CHIP. Not all plans are insurance governed by state insurance commissioners; many plans instead administer group health benefits governed by the federal Employee Retirement Income Security Act (ERISA). The largest 125 U.S. health insurers collected about $816 billion in premiums in 2020 and the top 25 companies accounted for nearly two-thirds of the total.

Markets for health coverage are undergoing substantial change, shaped by healthcare cost growth, economic constraints, consolidation of health plans and of hospital systems, and comprehensive health reform implementation. Health plans now take several forms, including fee-for-service, preferred provider organization, health maintenance organization, high-deductible plan, and combinations of the above.

AANA has intervened on certain occasions with members addressing issues in private health plan anesthesia reimbursement:

- In 2008, Aetna (the fifth largest plan in the U.S., primarily a benefits administrator) proposed all but eliminating reimbursement for anesthesia services associated with gastrointestinal endoscopic procedures; Aetna reversed its decision following AANA intervention.
- In 2008, an effort was undertaken to urge the Blue Cross Blue Shield of Alabama's Federal Employee Health Benefits Program (FEHBP) to directly reimburse CRNAs. The FEHBP allows for beneficiary but not provider appeals; the state association was counseled to develop support among patient groups.
- In 2009, Wellmark (Iowa), ruled similarly as Aetna, but its decision was not reversed notwithstanding AANA intervention.
- In 2011, the Alabama Association of Nurse Anesthetists sought AANA's assistance in securing direct reimbursement for CRNAs by Blue Cross Blue Shield of Alabama. On Oct. 1, 2013, Blue Cross Blue Shield of Alabama announced that it would initiate a CRNA network in the fall of 2013 with a Jan. 1, 2014, effective date. The plan created separate networks for CRNAs and anesthesiologist assistants, and the CRNA network allows direct reimbursement of CRNAs across all Blue Cross Blue Shield plans and self-insured plans.
- In 2012, Blue Shield of California (BSC) decreased its reimbursement rates for CRNAs from 80% to 65% of the rate provided to physicians performing

anesthesia services. Following advocacy work of CRNAs in California and the state association, in June 2014, BSC began reimbursing CRNAs for 100% of the physician fee schedule.

Established seven years ago by the AANA Board of Directors, the goals of the State Reimbursement Specialist (SRS)/Pain Reimbursement Specialist (PRS) Program is to establish representation from all 50 state nurse anesthesia associations for effective reimbursement advocacy in each state. The SRS/PRS will be the point person for reimbursement knowledge and advocacy in each individual state. The SRS in each state will most likely coordinate the monitoring and advocacy work of the program through a team of involved and engaged individuals.

Current State of the Issue

President Barack Obama signed into law the Affordable Care Act (ACA) in 2010 which made major changes to rules governing private health insurance in order to promote broader pooling of risk, prohibit discrimination on the basis of health status and pre-existing conditions, foster competition to enhance insurance market efficiency and affordability, promote prevention and wellness, and institute greater consumer protections. Some changes included insurance mandates on individuals and employers, expansion of Medicaid to cover more adults, creation of state based insurance exchanges where people can buy coverage, imposing new insurance market regulations, requiring plans in the individual and small group market to cover ten essential health benefits, provide refundable premium tax credits, and require that regulated plans pay out benefits as a fixed percentage of claim revenue (referred to as minimum loss ratio or MLR). This ratio is 85% for large group plans and 80% for small group and individual plans. Because an insurer's profits are now tied directly to the overall amount of revenue taken in, the MLR is thought to contribute to premium growth and reduced efforts to curtail increases in reimbursements.

A provider nondiscrimination clause was also included in the ACA to prevent discrimination against providers based on licensure, however this provision is still awaiting rulemaking and remains unenforced. Below is an overview of various types of insurance markets and CRNA credentialing and reimbursement.

Large group plans are those with more than 100 members and this market covers somewhere around 145 million people. Most of these are included in self-insured plans, where the employer covers the costs of the medical care and pays the insurer an administrative fee for use of the network and claims processing. These plans are covered by ERISA and exempt from state regulation. In addition, there are about 42 million people in fully insured policies subject to state regulation. Under the ACA, these

plans are subject to an MLR of 85% and some additional taxes. In recent years there has been an increasing trend toward self-insured plans due to these additional taxes as well the availability of stop-loss or reinsurance to mitigate the risk of high cost claims resulting in greater feasibility for smaller companies self-insure.

A subset of the large group market represents what the industry refers to as national accounts. These employers typically have over 5,000 enrollees across multiple states or geographic markets. Their expanded geographic presence requires that they seek coverage from one of the four carriers able to sustain a national provider network: Blue Cross Blue Shield, United Healthcare, Aetna, or Cigna.

The small group and individual insurance markets cover 13 million and 14 million Americans respectively. These policies are subject to an 80% MLR, which is lower than large group plans due their greater per enrollee costs associated with selling and administering the plans.

Credentialing implies that a provider can be directly reimbursed by the payer. While many payers do credential CRNAs, often they are exempt as employees of a hospital or medical group. This may reflect a state's supervision policy, where a payer may limit reimbursement to the supervising physician or employing facility. Once credentialed, a CRNA may establish a contractual rate for reimbursement. This rate is the conversion factor used in the standard formula for fee for service anesthesia payment that also incorporates base units determined by HCPCS code and time units. ASA conducts a survey annually to assess trends in commercial anesthesia reimbursement rates. The 2021 ASA study reports a national average conversion factor of $ 85.23. Anecdotal reports suggest that independent CRNAs and CRNA owned practices contracting with commercial payers receive much lower reimbursement rates. While stated reimbursement policies often mirror that of Medicare using a similar modifier-based structure for MDA provided, MDA directed, and CRNA undirected services, exceptions are common. A modifier may be excluded or reimbursed at a different rate than the Medicare standard. Also, TEFRA rules governing Medicare reimbursement for medical direction are often not referenced in the policy leaving medical direction defined solely by the number of concurrent procedures.

In the last few years multiple proposals to repeal and replace the ACA were released culminating with the passage of the Tax Cuts and Jobs Act which repeals the ACA's individual mandate by revoking the tax penalty. No other legislation repealing the ACA has been passed thus far but we expect that opponents will continue to try to weaken this law in the future.

Anticipated Future State

- Objections to Medicare fee-for-service reimbursement have policymakers and plans making major investments in alternative payment systems, including bundled payment, episode-of-care payments, pay for outcomes or pay for quality, and capitated payment per covered population. Reimbursement decisions will be data-driven – with the plans holding the data.

- Health plans will continue shifting out-of-pocket costs onto employees to mitigate premium growth. Health reform implementation will reduce the tax boons associated with employer-provided health benefits. Demography dictates that over time more Americans will have government rather than private health plans.

- Commercial health plans will continue to attempt to become certified to participate in state health insurance marketplaces and CRNAs should continue to try to become part of these health plan networks in marketplaces.

- The AANA will continuously monitor all legislation introduced to replace the Affordable Care Act to see how they would affect CRNA practice.

- The AANA will continue to educate reimbursement decision makers at health plans about CRNA anesthesia and pain management services to urge them to rescind discriminatory reimbursement policies.

- Consolidation among hospitals, provider groups (anesthesia groups included), as well as insurers has been a major trend over the past several years. Increased EMR requirements or other technology needs that smaller organizations are unable to support, increased patient volumes needed to support population health initiatives, as well as the general desire to increase market power are all drivers of these changes. One provision in Joe Biden's healthcare plan proposes greater use of anti-trust enforcement to control healthcare costs, which could mean less consolidation in the future.

- Value-based care is here, and the use of alternative payment models continues to grow. Cigna, one of the largest commercial insurers, recently reported that over half of all revenue is being generated through value-based care arrangements in both Medicare and commercial lines of business in top markets.

- With more than 100 million Americans covered by employer self-insured plans, there is some evidence that large employers are having greater influence over provider networks and reimbursement contracting decisions including greater

scrutiny of reimbursements and openness to narrower networks in exchange for lower rates.

For More Information

- Patient Protection and Affordable Care Act, http://housedocs.house.gov/energycommerce/ppacacon.pdf
- Tax Cuts and Jobs Act, https://www.congress.gov/bill/115th-congress/house-bill/1
- Kaiser Family Foundation Summary of Coverage Provisions in the Affordable Care Act (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8023-r.pdf
- Commission on Anesthesia Economics and Reimbursement report (2008), http://www.ilcrna.com/Portals/74/Documents/Continuing%20Education/S09/CAER_Report.pdf
- U.S. Department of Labor summary of its role with respect to health plans and benefits, http://www.dol.gov/dol/topic/health-plans/index.htm
- U.S. News and Work Report Top Health Insurance Companies, http://health.usnews.com/health-news/health-insurance/articles/2013/12/16/top-health-insurance-companies
- Kaiser Family Foundation 2015 Employer Benefits Survey, http://kff.org/health-costs/report/2015-employer-health-benefits-survey/
- Major associations involving health plans, www.naic.org, www.ahip.org, www.bcbs.com, major health plans, www.uhc.com, www.aetna.com
- AANA Comments on CMS Notice of Benefit and Payment Parameters in Federally Facilitated Marketplaces, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20151218-aana-comment-on-hhs-notice-of-benefit-and-payment-parameters-for-2017-proposed-rule-final.pdf
- AANA comments on Medicaid Managed Care Rule, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150727%20AANA%20Comment%20on%20Medicaid%20managed%20care%20proposed%20rule%20FINAL.pdf
- AANA comments on the NAIC's updates to the Health Benefit Plan Network Access and Adequacy Model Act, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150109%20AANA%20Comment%20on%20NAIC%20Network%20Adequacy%20Model%20Act%20Final.pdf (requires AANA member login and password)
- NAIC Final Health Benefit Plan Network Access and Adequacy Model Act, http://www.naic.org/documents/committees_b_exposure_draft_proposed_revisions_mcpnama74.pdf
- Healthcare Pricing Project paper, http://www.healthcarepricingproject.org/papers/paper-1
- Market structure of health insurance industry, https://www.ncsl.org/documents/health/MrktStrOfHlthIns.pdf

- Commercial insurer market share, https://www.kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/
- ASA Commercial reimbursement survey https://pubs.asahq.org/monitor/article/84/10/1/110713/ASA-Survey-Results-Commercial-Fees-Paid-for
- Self-insured market impact, https://www.modernhealthcare.com/article/20150103/MAGAZINE/301039980/self-service-insurance-insurers-forced-to-compete-harder-for-self-insured-customers

Issue Brief: [Medicaid and CHIP]

History in Brief

Established in 1965 as a modest federal-state initiative to provide basic health coverage for indigent mothers and their children, the Medicaid program has grown into the largest of all public health benefit programs in the United States, surpassing the Medicare program in 2010 in excess of $550 billion in total outlays. Over 68 million beneficiaries use Medicaid for services such as acute care, long term care and managed care. The Children's Health Insurance Program (CHIP), by comparison, is much smaller than Medicaid, covering about 6.5 million children from lower-income families and spending $15 billion per year chiefly on primary care.

Medicaid's unique federal-state financing and structural characteristics make CRNA reimbursement under such a program difficult to consistently assess and shape. With the federal government paying 50 percent of Medicaid costs in wealthier states and greater shares in less wealthy states, states themselves increasingly protest Medicaid cost growth impositions on strapped state budgets. Moreover, the Affordable Care Act enacted in 2010 expanded Medicaid eligibility to up to 6 million more beneficiaries and provides states 100 percent of the funding required to cover their benefits from 2014-2016 and reduces that share to 90 percent by 2020 and years following.

CRNA services are covered inconsistently by Medicaid state by state and are customarily reimbursed at a level 10-15 percent below Medicare rates. Information provided by AANA member experts to the Commission on Anesthesia Economics and Reimbursement pegged Medicaid at an average 10 percent of CRNA caseload and 4-5 percent of CRNA claims with wide variation.

Current State of the Issue

A 2008 Alston & Bird survey of state Medicaid directors (unpublished) found 33 states directly reimburse CRNAs for their services, 31 states reimbursed hospitals for CRNA services, and 15 reported some type of anesthesiologist medical direction requirement (although some respondents interpreted this as the administrative requirement for a physician to oversee anesthesia services).

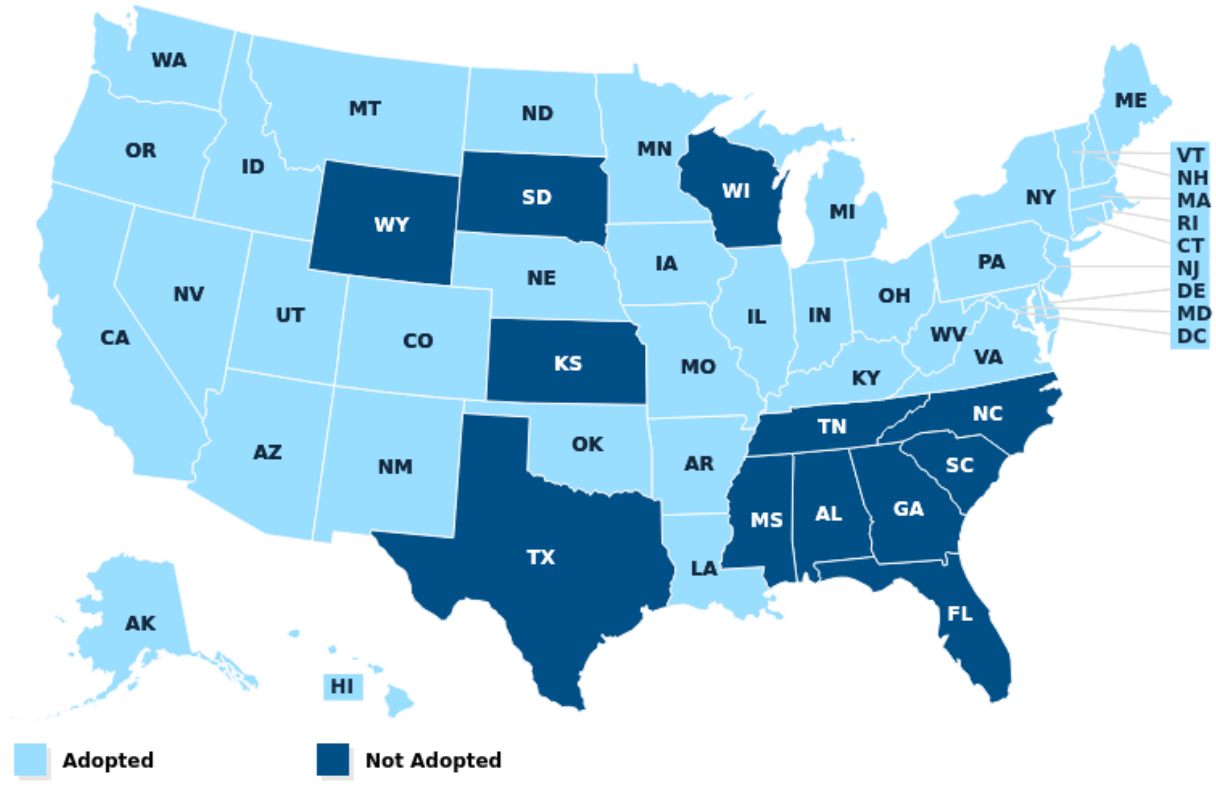
Securing direct reimbursement of CRNA services, which is most cost-effective for the healthcare system, proves challenging because some strategies to save healthcare system resources may not save Medicaid system resources directly. Why should a strapped state Medicaid take it on except to save money for Medicaid? Yet if a Medicaid program is getting solo-CRNA anesthesia services for free, its outlays will increase if an anesthesiologist medical direction requirement is eliminated. Other than

the 2008 survey, AANA has little information on characteristics and value of CRNA reimbursement under the Medicaid and CHIP programs.

With passage of the Affordable Care Act, beginning in January 2014, individuals under age 65 with incomes up to 138% of the Federal poverty level (FPL) were eligible for Medicaid in those states that implement the Medicaid expansion. This expansion creates a new minimum Medicaid eligibility level for adults and eliminates a limitation of the program that prohibits most adults without dependent children from enrolling in the program. Eligibility for Medicaid and CHIP for children with family incomes above 138% of the poverty level will continue at their current eligibility levels until 2019.

While the expansion was intended to be implemented in all states, the 2012 Supreme Court ruling on the Affordable Care Act limited the ability of the Department of Health and Human Services to enforce the Medicaid expansion. Now it is effectively a state choice, and states are divided about implementing the Medicaid expansion. The chart below explains current state action on Medicaid expansion. As of February 2022, 39 states (including DC) adopted Medicaid expansion and 12 states were not expanding their programs.

Status of State Action on the Medicaid Expansion Decision: Status of Medicaid Expansion Decision, February 24, 2



SOURCE: Kaiser Family Foundation's State Health Facts.

The COVID -19 pandemic has had a major impact on state budgets and their Medicaid programs. As states face economic downturns, Medicaid enrollment is up about 5 percent since February 2020 for 22 states, with ranges from less than 3 percent in some states to nearly 9 percent in other according to the Georgetown Center for Children and Families. As many states face increased Medicaid enrollment, state governments are making difficult decisions to cut Medicaid rates in order to balance the shortfalls in the state's budget. For example, Nevada Medicaid is moving forward with a planned 6 percent across-the-board rate reduction approved by lawmakers during a special session in 2020. This cut saved the state about $53 million. Similarly, Governor DeWine of Ohio announced that fiscal year 2020 revenues to be down by $775 million or more and as a result would be making an equivalent reduction in General Fund expenses, including a reduction of $210 million to the state's Medicaid program.

In order to help advance advocacy in the Medicaid realm, the AANA joined the Modern Medicaid Alliance, a partnership between consumers who use Medicaid and leading advocacy organizations. The mission is to educate policymakers and the public about the benefits of Medicaid to the American people in terms of cost savings, health outcomes and social impact, and to highlight how Medicaid is innovating in the delivery of care – especially for America's most vulnerable citizens – and accountability of the program.

Anticipated Future State

- Medicaid outlay demands will continue outstripping available revenue. Cash-strapped states will increasingly replace fee-for-service Medicaid with managed care or capitated payment schemes, with the goals of improving care coordination and saving money. These state-based initiatives will be augmented by the Centers for Medicare & Medicaid Innovation initiatives to improve care coordination and control costs for "dual eligible" beneficiaries -- indigent elderly persons whose conditions render them eligible for both Medicaid and Medicare.

- Expansion of Medicaid could increase the case mix for CRNAs to care for new patients who may have not received coverage in the past.

- The AANA will continuously monitor all plans introduced to replace the Affordable Care Act to see how they would affect CRNA practice.

- The AANA will also continue to advocate against discriminatory CRNA reimbursement policies from Medicaid or Medicaid managed care plans. The AANA will continue to educate reimbursement decision makers at health plans about CRNA anesthesia and pain management services to urge them to rescind discriminatory reimbursement policies.

For More Information

- Kaiser Family Foundation March 2020 brief on The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review, https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/
- Summaries of Medicare and Medicaid from CMS, http://www.cms.gov/MedicareProgramRatesStats/02_SummaryMedicareMedicaid.asp
- Kaiser Family Foundation information on Medicaid spending, https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D and https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
- Medicaid and CHIP state health facts, http://www.statehealthfacts.org/comparecat.jsp?cat=4
- CMMI dual eligibles program, http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/state-demonstrations-to-integrate-care-for-dual-eligible-individuals/
- Dr. Atul Gawande's *New Yorker* article (January 2011) noting gains to be made from coordinating care of the poorest, sickest dual-eligible beneficiaries, http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande
- Kaiser Family Foundation brief on the impact of state Medicaid expansion decisions (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8458-analyzing-the-impact-of-state-medicaid-expansion-decisions2.pdf
- Kaiser Family Foundation brief on the role of Medicaid and state economies and the ACA (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf
- Kaiser Family Foundation brief on Medicaid enrollment under the ACA (2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8548-medicaid-enrollment-under-the-affordable-care-act-understanding-the-numbers2.pdf
- Kaiser Family Foundation brief on the Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid (2016), https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8659-04-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid.pdf
- AANA comments on Medicaid Managed Care Rule, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150727%20AANA%20Comment%20on%20Medicaid%20managed%20care%20proposed%20rule%20FINAL.pdf (requires AANA member login and password)

Issue Brief: [CRNAs and the Veterans Health Administration System]

History in Brief

The Veterans Health Administration (VHA) is an integrated health system that provides care to those military personnel who have served our country in the Armed Forces. It is not an insurance plan but is a health system. Department of Veterans Affairs facilities employ CRNAs and contract with CRNAs outside of the system to ensure our veterans have the care they need and deserve. In 2010, the AANA secured enactment of legislation to lift a statutory cap on CRNA pay in the VA, following a GAO report circumscribing difficulties in VA access to anesthesia services. (GAO-08-647T April 9, 2008).

This GAO report revealed that the recruitment and retention of CRNAs was challenged by a statutory pay cap for CRNAs well below the commercial market, particularly in locations such as New York and Minnesota. This pay cap has been removed as of 2010, allowing a facility to lift the salary level of a CRNA. It does not mean that reimbursement levels to CRNAs have increased; the VA system is a health system and not an insurance payer.

In 2007, the VA authorized AAs to practice in the VA. The pay rate is considerably lower than market rates for AAs. It is tied to the Civil Service pay scale, which puts pay for AAs at about $50,000 per year rather than the typical pay of an AA of $125,000 per year.

Current State of the Issue

In an effort to improve Veterans access to high quality healthcare and align with recommendation from the National Academy of Medicine on the Future of Nursing, the Veterans Health Administration (VHA) has been working for several years to improve Veterans access to quality care through recognition of the full practice authority of all advanced practice registered nurses including CRNAs.

In December 2016, the Department of Veterans Affairs (VA) released a final rule, with a 30-day comment period, which established full practice authority in VHA facilities for nurse midwives, clinical nurse specialists and nurse practitioners, but not CRNAs. The final rule stated that the agency was not going to grant full practice authority to CRNAs at that time and requested comment on this decision. In our response, the AANA and other APRN organizations expressed extreme disappointment with the VA's irresponsible and biased decision to not grant CRNAs full practice authority in the advanced practice registered nurses (APRN) final rule and called for permitting full

practice authority for CRNAs to ensure Veterans receive the full scope of timely, high-quality anesthesia and pain management care they so rightfully deserve. The final rule also stated that if the agency learned of access problems in anesthesia care that could be solved by granting full practice authority to CRNAs, now or in the future, or if other relevant circumstances change, the agency will consider follow-up rulemaking to address granting full practice authority to CRNAs.

Comments from the AANA and other APRN groups provided a strong assessment of current and future anesthesia access to care issues, namely: how the VA's own studies and data confirm an anesthesia access issue; how unrequired, unnecessary CRNA supervision reduces access to care in VHA facilities; and how CRNAs are held to a different set of rules than other APRNs regarding recruitment and retention information. The AANA's letter also described how full practice authority for CRNAs is a solution to current and future access to anesthesia care issues, including how CRNA full practice authority increases Veterans' access to care and promotes safe, efficient healthcare delivery. The AANA's comment letter also focused on how CRNAs provide multi-modal pain management which may reduce Veterans' need for and reliance on opioids to help combat the increasing dependency Veterans have on opioids to help reduce pain. Finally, the AANA's letter ended with information on the widespread support for CRNA full practice authority among Veterans groups, members of Congress, the media, healthcare organizations and the broader APRN community. The APRN coalition comments supported recognizing CRNA full practice authority because it ensures increased access to safe and high-quality care for Veterans and recommended that CRNA full practice authority is a solution to VA anesthesia provider recruitment and retention difficulties.

Recognizing FPA for all APRNs will improve access to care for Veterans throughout the country and aligns with the evidence-based recommendations from a congressionally-mandated Independent Assessment of the health care delivery system and management processes of the Department of Veterans Affairs, the National Academy of Medicine, and current APRN policy in the Army, Navy, Air Force, Combat Support Hospitals and Indian and Public Health services. The VHA proposal is supported by the AANA, the Association of Veterans Affairs Nurse Anesthetists (AVANA), 53 national nursing organizations, the Military Officers Association of America and the AARP. However, this effort has come under attack by the American Society of Anesthesiologists (ASA), which has made inaccurate statements about the excellent care CRNAs provide our veterans. Meanwhile, the AANA has been advocating on Capitol Hill and at VA to support all four APRN roles practicing in the VHA to their full practice authority.

The AANA continues to highlight examples of a lack of anesthesia care in the VHA. In its 2016 final rule granting full practice authority to three of the four APRN roles, the VA's basis for excluding CRNAs was access, stating "VA's position to not include the CRNAs in

this final rule does not stem from the CRNAs' inability to practice to the full extent of their professional competence, but rather from VA's lack of access problems in the area of anesthesiology."[1] However, reports continuously show a lack of access to anesthesia in the VHA. In August, it was reported that 65 to 90 surgeries were canceled or postponed at the Denver Veterans Affairs Medical Center due to a lack of anesthesia providers.[2] Further, The VHA currently has 38 contracts with outside anesthesia providers, costing over $100 million, and indicating a lack of internal resources to meet the growing healthcare demands of our nation's veterans.

Finally, the AANA is working with the Veterans Affairs Committees in the House and Senate on a study to look at supervision models utilized in the VHA. 1:2 supervisions models lead to increased costs and reduced access – not to timely care. 1:1 and 1:2 ratios are not generally found in the commercial healthcare delivery marketplace. The Denver VA Medical Center operates at a 1:2 ratio, preventing CRNAs from serving patients

The AANA continues to strongly support the VHA's efforts to grant CRNAs and other APRNs full practice authority, consistent with the recommendations of the recently completed VA independent assessment and the National Academy of Medicine report *The Future of Nursing: Leading Change, Advancing Health.* Thousands of AANA members have already contacted the VHA in support of this work.

In the summer of 2018, the VHA made unreasonable and unsubstantiated revisions to the anesthesia handbook via VHA Directive 1123. The AANA met with VHA leadership and members of Congress to discuss how we believed these edits to the handbook were irresponsible, demonstrate bias against CRNAs, and will lead to reduced access, higher costs and less efficiency in anesthesia care for our nation's veterans. The VHA released the final version of this directive in 2019 and made many of the changes the AANA requested.

During the COVID-19 public health emergency, in April 2020, the Veterans' Health Administration (VHA) released Directive 1899 and an accompanying memo, which called on VHA facilities to allow practitioners, including CRNAs, to be able to practice to the top of their scope of practice and also temporarily suspended certain licensure limitations during the health crisis. The VHA's decision to allow CRNAs to practice to the top of their scope without unnecessary supervision during the public health emergency has allowed VHA facilities to respond more quickly to the ongoing pandemic, allowing CRNAs to provide critical, lifesaving care to COVID-19 patients, including managing ventilators, placing of invasive lines and monitors, and overseeing complex hemodynamic monitoring. It has also shown the important role that CRNAs

[1] https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-29950.pdf

[2] http://kdvr.com/2017/10/11/va-surgeries-postponed-because-there-arent-enough-anesthesiologists/

play in the healthcare system, especially when workforce barriers to practice are eliminated.

While the AANA supports the temporary removal of workforce barriers during this emergency, the AANA continues to advocate for full practice authority for CRNAs working within the VA to be made permanent. The AANA continues to request meetings with leadership in the VHA, members of Congress, members of the current administration and other healthcare stakeholders pushing for permanent full practice authority as our nation's veterans deserve access to timely, cost effective and high-quality care within the VA health system at all times.

In March 2020, the AANA partnered with the VA's Travel Nurse Corps program, the AANA and its contacts at the VA have created an opportunity for CRNAs at 157 facilities across the Veterans Health Administration (VHA) in support of COVID-19 operations to meet the needs of our nation's veterans during the COVID-19 pandemic. In the fall of 2020, the VA issued an interim final rule confirming that VA healthcare professionals, including CRNAs, may practice their profession consistent with the scope and requirements of their VA employment, notwithstanding any state license, registration, certification, or other requirements that unduly interfere with their practice. The rulemaking also confirms the VA's authority to establish national standards of practice for healthcare professionals, which will standardize a healthcare professional's practice in all VA medical facilities.

On another issue, relating to VHA compensation of CRNAs to ensure a sufficient supply of anesthesia services, the agency's previous pay cap has been lifted since 2010. However, each individual VA facility can determine how it pays its CRNAs, and the Association of Veterans Administration Nurse Anesthetists (AVANA) reports that the change is slowly being implemented in VHA facilities. As of February 2016, anesthesia departments in multiple VHA facilities across the country are staffed solely by CRNAs. A CRNA needs only to have a license and be credentialed in a state. The state where the CRNA is licensed and credentialed does not have to be the same state where the facility is located.

Two reimbursement issues worth noting is that pursuant to the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146) ("Choice Act") the VA will still be able to refer Veterans to community providers under other non-VA care authorities including Department of Defense and Indian Health facilities. Also, at some point the VHA may bill Medicare to reimburse for services provided to veterans who are Medicare eligible and who have non-service related injuries or illnesses. The VHA has not determined how to accurately bill Medicare for these cases, so the agency typically absorbs the cost rather than billing Medicare. These costs get folded into the funding for the VHA provided by the federal government through the annual appropriations process.

In November 2020, the VA published an interim final rule reiterating their federal supremacy and notifying of their intent to develop National Standards of Practice for healthcare providers working within the VA. The VA stated this development was "crucial for VA to be able to determine the location and practice of its VA health care professionals to carry out its mission without any unduly burdensome restrictions imposed by State licensure, registration, certification, or other requirement." These standards will help address issues including: • Nearly one third of all VA medical facilities have one or more sites of care in another state • 14 percent of licensed health care professionals employed by VA have a state license, registration, or certification in another state than their main VA medical facility • Sending providers across state lines where there are shortages • Utilizing providers in rural and smaller facilities or in mobile care units that may cross state lines.

The AANA and other healthcare organizations have weighed in with the VA in support of development of national standards that allow all providers to work to the top of their scope. It's critical that providers not be limited to the most restrictive scope possible, which would be detrimental to veterans by decreasing access, limiting choice, and increases costs.

Anticipated Future State

- The VHA anticipates many CRNA retirements within the next 10 years, further exemplifying the need for stronger recruitment and retention efforts of CRNAs.

- The recognition of the full practice authority of all APRNs, including CRNAs, would support patient access to cost-effective care in the VA, but will likely continue being opposed by organized medicine.

- The AANA will continue to advocate for CRNA full practice authority with the Department of Veterans Affairs, Congress and healthcare stakeholders.

- The AANA will continue to weigh in as the VA develops its National Standards of Practice

For More Information

- AANA Full Practice Authority brief 2020, https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/va-issue-brief-final.pdf?sfvrsn=54bf563b_0

- APRN Final Rule (December 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf and VA Press Release, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847
- The Association of Veterans Affairs Nurse Anesthetists (AVANA) website, http://www.vacrna.org/
- VHA handbook outlining anesthesia services, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1548
- VHA Health Care: Recruitment and Retention Challenges and Efforts to Make Salaries Competitive for Nurse Anesthetists, http://www.gao.gov/products/GAO-08-647T
- The AANA-AVANA joint VHA letter of fall 2013**,** http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20130830-AANA_AVANA-ltr_VHA-anes_care.pdf (requires AANA member login and password)
- AARP Letter of Support to Secretary of the Department of Veterans Affairs Eric Shinseki Department of Veterans Affairs, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20131212_AARP--Ltr_VA-re-Nursing_full_practice.pdf (requires AANA member login and password)
- APRN Nursing Groups Letter of Support to Secretary of the Department of Veterans Affairs, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/NC_Ltr-Sec_Shinseki-VA.pdf (requires AANA member login and password)
- Bill text of S 297, https://www.congress.gov/bill/114th-congress/senate-bill/297/text?q=%7B%22search%22%3A%5B%22%5C%22s297%5C%22%22%5D%7D&resultIndex=1
- AANA letter expressing concern about S 297, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150209%20FINAL%20AANA%20ltr%20to%20SVAC%20re%20S%20297%20Sec%204.pdf (requires AANA member login and password)
- Bill text of HR 1247, https://www.congress.gov/bill/114th-congress/house-bill/1247/text?q=%7B%22search%22%3A%5B%22%5C%22hr1247%5C%22%22%5D%7D&resultIndex=1
- Nursing Community support letter for HR 1247, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150304%20Nursing%20Organizations'%20Letter%20to%20Reps.%20Graves%20and%20Schakowsky.pdf (requires AANA member login and password)
- APRN Coalition support letter for HR 1247, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150304%20APRN%20Letter%20for%20Graves-Schakowsky%20IVAQCA%20Final.pdf (requires AANA member login and password)

- Bill text of S 2279, https://www.congress.gov/bill/114th-congress/senate-bill/2279/text?q=%7B%22search%22%3A%5B%22%5C%22s2279%5C%22%22%5D%7D&resultIndex=1
- Bill text of HR 4134, https://www.congress.gov/bill/114th-congress/house-bill/4134/text?q=%7B%22search%22%3A%5B%22%5C%22hr4134%5C%22%22%5D%7D&resultIndex=1
- The Association of Veterans Affairs Nurse Anesthetists (AVANA) testimony to the House Veterans' Affairs Subcommittee on Health (May 2015), http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150515%20Testimony%20HVAC-H%20AVANA%20Pres%20Peterson%20on%20VA%20Staffing%20-%20FINAL.pdf (requires AANA member login and password)
- AANA and APRN organizations submit testimony to the Senate Veterans' Affairs Committee on S 297 (June 2015), http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150603%20Testimony%20SVAC%20-%20AANA%20Pres%20Pearce%20on%20S%20297%20-%20FINAL.pdf and http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20150603%20Testimony%20SVAC%20-%20APRNs%20on%20S%20297%20-FINAL.pdf (requires AANA member login and password)
- AANA and APRN organizations letter on supporting VHA independent assessment recommendation of APRN full practice authority, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/VA%20FINAL%20Letter%20HVAC%20Chair%20and%20RM%20on%20VA%20Independent%20Assessment%20v2.pdf (requires AANA member login and password)
- The VA Final APRN rule with comments, https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf
- AANA and APRN comments on VA APRN final rule with comments, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20170112-aana-comments-on-vha-fpa-final-rule-with-comments-final.pdf and http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20170112-aprn-coalition-letter-on-va-aprn-final-rule-with-comments-final.pdf (requires AANA member login and password)
- VA Directive 1899, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=8794
- VA Interim Final Rule on Authority of VA Professionals to Practice Health Care, https://public-inspection.federalregister.gov/2020-24817.pdf

Issue Brief: [CRNAs and TRICARE]

History in Brief

TRICARE® is the health plan for military personnel and their dependents. It is administered by the Department of Defense (DoD) and pays CRNAs and anesthesiologists at the same rate for the care they provide. In 2004, TRICARE recognized Anesthesiologist Assistants (AAs) as qualified providers under TRICARE (32 CFR Part 199.6). At that time, the AANA successfully negotiated that AAs be medically directed by an anesthesiologist if AAs are authorized to provide services in the state in which the care is provided.

Current State of the Issue

Since the AANA negotiated with the Department of Defense to ensure that AAs are medically directed if providing care in the DoD, AANA has not received many inquiries regarding payment of CRNAs in the TRICARE program, though we have had an issue with CRNAs being recognized as pain providers in one TRICARE region. This issue has been resolved. Reimbursement for this insurance program is calculated similarly to Medicare reimbursement: (Base Units + Time Units) x Conversion Factor. Pending cuts to the Medicare Part B sustainable growth rate (SGR) payment formula will directly affect reimbursement rates for TRICARE; both federal insurance programs are tied to SGR.

Anticipated Future State

- TRICARE beneficiaries will likely see an increase in premiums over the coming years. As costs for the program increase, the Administration and Congress will likely require beneficiaries to pay higher premiums. This could affect utilization of healthcare in the Tricare program.

- The TRICARE system will be subject to the same payment reform pressures that Medicare and Medicaid experience (i.e. pressures for more managed care, bundled and capitated payments, etc.)

For More Information

- TRICARE website, http://www.tricare.mil/
- Anesthesia Procedure Pricer in Tricare, http://www.tricare.mil/anesthesia/RateSearch.aspx
- Final Rule indicating that AAs need to be Medically Directed in the TRICARE program: Fed Register 2004 May 21;69(99):29226-30, http://edocket.access.gpo.gov/2004/04-11464.htm

Issue Brief: [Federal Employee Health Benefits Program]

History in Brief

The Federal Employee Health Benefits Program (FEHBP), operated by the Office of Personnel Management (OPM), was created in 1959 and is a health plan for federal employees, their dependents, and retirees from the federal government. It is the largest employer-sponsored health benefits plan in the country. The federal government contracts with private insurers across the country to offer a variety of health insurance plans to its employees. Those participants of the FEHBP can choose from catastrophic plans to more comprehensive plans, and the federal government pays a share of the plan's premium.

Current State of the Issue

The program includes several private payers participating where they compete for federal employees' business and participation in their plans. AANA D.C. does not currently have information regarding CRNA participation in the FEHBP health plans nor has AANA D.C. been alerted of specific problems with CRNAs providing care to federal employees participating in the FEHBP, except for in one state in 2009. Having found one particular FEHBP participating plan initially unresponsive to the CRNAs' concerns, the CRNAs reached out to patient advocacy groups in the state to express their concerns to the plan, because under the FEHBP patients have more opportunity for recourse than provider groups. The issue has since been resolved.

The Affordable Care Act requires members of Congress and their staff to get coverage through plans participating in Affordable Care Act marketplaces, rather than through the FEHBP.

Anticipated Future State

- AANA anticipates that federal employees' premium cost sharing will continue to rise as healthcare costs rise.

For More Information

- U.S. Office of Personnel Management administers the FEHBP, http://www.opm.gov/insure/health/
- Is the FEHBP a Good Model of Health Care Reform for all Americans?, http://www.myfederalretirement.com/public/479.cfm

Issue Brief: [Overall Impact of Health Reform]

History in Brief

The Patient Protection and Affordable Care Act of 2010 (ACA) (P. L. 111-148), was enacted intending to reform the current healthcare system, expanding access to healthcare while improving the quality and reducing future cost growth. National health expenditures in the U.S. exceed $3.1 trillion annually, continue growing faster than the economy and the population, remain double the per-capita health spending levels of the next most costly industrialized competitor, and fail by many measures to yield healthcare quality outcomes comparable to rest of the industrialized world. The current system rewards the volume of procedures, regardless of whether they improve patient outcomes, and discourages care coordination that might improve care and save money.

During congressional consideration of the ACA, the AANA engaged in the legislative process, securing provisions in the ACA for provider nondiscrimination, graduate nursing education, and Title 8 reauthorization, and forestalling several anti-CRNA provisions such as an attempt to restrict interventional pain management reimbursement to physicians operating in accredited facilities. The AANA expressed conditional support for the ACA, citing these provisions and consistent with an interest to maximize CRNA influence in health reform implementation processes; the ASA opposed it, prominently citing the AANA-backed nondiscrimination provision. Fourteen months into his term, in March 2010, President Obama signed the ACA into law.

Litigation challenging the constitutionality of the ACA was taken up by the U.S. Supreme Court, which ruled 5-4 in June 2012 the ACA was constitutional, including its individual mandate requiring virtually all Americans to enroll in health insurance coverage. The Court deemed the expansion of Medicaid under the ACA as constitutional except for the provision that threatened loss of existing Medicaid funds for states that do not participate in the expansion.

In 2017, through Executive Order 13813, the President directed the Administration to facilitate the development and operation of a health care system that provides high-quality care at affordable prices for the American people by promoting choice and competition. As a result in 2018, the Department of Health and Human Services (HHS) in collaboration with the Departments of the Treasury and Labor, the Federal Trade Commission, and several offices within the White House issued a report titled "Reforming America's Healthcare System through Choice and Competition". While this report was being developed, the AANA continued to advocate about the need to fully utilize all healthcare professionals to ensure patient access to the widest possible spectrum of high quality, safe and affordable healthcare options. Among the report's final recommendations included: encourage state governments to remove barriers to practice and allow all healthcare providers to practice to the top of their license and skill

set, states should consider loosening network adequacy standards and avoid stringent requirements and the administration should continue to work with Congress to enact legislation that remedies key problems resulting from the ACA, that promotes greater choice and competition in healthcare markets, and that produces a sustainable government healthcare financing structure.

Current State of the Issue

The previous Trump administration tried to repeal the ACA in a repeal and replace strategy which ultimately failed. The action on attempting to repeal and replace the ACA was a significant issue in the midterm elections in 2018, which saw the election of a Democratic House majority and defeat of several of the bill's supporters for re-election.

The 115th Congress did not pass an ACA repeal bill, though it did pass the Tax Cuts and Jobs Act of 2017, which repealed the individual mandate by revoking the tax penalty. No other legislation repealing the ACA has been passed. The action on attempting to repeal and replace the ACA was a significant issue in the midterm elections in 2018, which saw the election of a Democratic House majority and defeat of several of the bill's supporters for re-election. The Trump administration ultimately passed efforts to make cuts to various aspects of the ACA.

The delivery system reforms focus on paying for quality outcomes by promoting payment innovations – namely, accountable care organizations and the Center for Medicare and Medicaid Innovation (CMMI) where new payment and service delivery models can be tested. In January 2015, the Department of Health and Human Services (HHS) announced that it is testing and expanding new healthcare payment models intended to improve healthcare quality and reduce costs. To help drive the healthcare system towards greater value-based purchasing – rather than continuing to reward volume regardless of quality of care delivered- former HHS Secretary Sylvia M. Burwell announced an initiative to move the Medicare program from paying for volume to paying for value. As part of this initiative, HHS wanted to have 85 percent of Medicare payments tied to quality or value by 2016 and 90 percent by 2018. She said that this will be achieved through investment in alternative payment models such as Accountable Care Organizations (ACOs), advanced primary care medical home models, new models of bundling payments for episodes of care, and integrated care demonstrations for beneficiaries that are Medicare-Medicaid enrollees. To support these efforts, HHS launched the Health Care Payment Learning and Action Network (LAN) in March 2015 to help increase the adoption of value-based payments and alternative payment models. Since its inception, the AANA has become a stakeholder in the LAN as part of the agency's initiative to transform payment from volume to value and has participated in all of its meetings and commented, with other APRN organizations, on its white paper covering alternative payment model framework.

Joseph R. Biden was elected President and took office on January 20, 2021 and his healthcare platform included building on the ACA by increasing access to care for patients, creating a less complex health care system for patients, increasing health equity and reducing the prices of prescription drugs. In his first year as President, Joe Biden reopened and extended a special ACA open enrollment period because of the coronavirus pandemic and changes made to the ACA in the Covid-19 relief package. The changes include temporarily expanding subsidies and ending an income cap that limited eligibility. It also provides financial incentives for states to expand Medicaid. The Biden Administration indicated the President's priorities for Fiscal Year 2022 include public health preparedness, health equity, biomedical research, reducing maternal mortality and morbidity, and ending the opioid crisis.

In March 2021, Xavier Becerra was confirmed as the latest Secretary of the Department of Health and Human Services (HHS). Response to the coronavirus pandemic has overshadowed and dominated Biden and Becerra's first years in office. HHS did release their Strategic Plans for 2022-2026 that includes the following goals: (1) Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, (2) Safeguard and Improve National and Global Health Conditions and Outcomes, (3) Strengthen Social Well-being, Equity, and Economic Resilience, (4) Restore Trust and Accelerate Advancements in Science and Research for All, and (5) Advance Strategic Management to Build Trust, Transparency, and Accountability. Each goal is supported by objectives and strategies. In addition, both the Biden administration and HHS have recently announced collaborative initiatives to help tackle the opioid/substance use disorder and mental health crises.

Anticipated Future State

- With a current Democratic President, a Democratic controlled House of Representatives and an even party split in the Senate, there is not a current demand to repeal the ACA. The future of ACA-related litigation is uncertain.

- Health reform will be implemented differently in each state. Implementation of state-based insurance marketplaces will continue to migrate health reform initiatives from the federal to the state and local levels.

- Healthcare reimbursement is moving away from fee-for-service to alternative payment systems such as bundled and capitated payment that reward improvements in quality, access and cost-effectiveness, and promote preventative care and care coordination, as demonstrated by evidence and data reporting.

- Services whose outlays are climbing will be subject to additional scrutiny.

- The AANA will continuously monitor all plans introduced to replace or change the Affordable Care Act to see how they would affect CRNA practice.

For More Information

- HHS Draft Strategic Plan for 2022-2026, https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21939.pdf
- AANA resources on health reform including the initial guide on health reform for CRNAs, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20100326_initial_guide_on_major_health_reform_for_crnas.pdf, section-by-section analysis of the health reform law, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20100326%20AB%20Side%20by%20Side%20Reform%203_25_2010.pdf (requires AANA member login and password)
- Kaiser Family Foundation summary of the health reform law http://www.kff.org/healthreform/upload/8061.pdf, timeline for health reform implementation http://spannj.org/healthcarematerials/Health%20Reform%20Implementation%20Timeline.pdf
- Kaiser Family Foundation Summary of the Affordable Care Act, http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/
- Kaiser Family Foundation Summary of health coverage provisions in the ACA, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8023-r.pdf The U.S. Supreme Court 2012 decision on the case: National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al, http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf
- Kaiser Family Foundation Health Reform FAQs (2013), http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/
- Commonwealth Fund Brief on state action on health reforms (2013), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/1662_Keith_implementing_ACA_state_action_2014_reform_brief_v2.pdf
- The 2014 Provider Nondiscrimination RFI, http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05348.pdf
- AANA web site on Quality and Reimbursement, http://www.aana.com/resources2/quality-reimbursement/Pages/default.aspx
- HHS fact sheet on rewarding providers for value and not volume , http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html
- HHS web site on the Health Care Payment Learning and Action Network, http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/

- Transcript of King v. Burwell oral arguments, http://www.supremecourt.gov/oral_arguments/argument_transcripts/14-114_lkhn.pdf
- King v. Burwell final opinion, http://www.supremecourt.gov/opinions/14pdf/14-114_qol1.pdf
- The Departments of Labor, Health and Human Services and Treasury May 2015 Frequently Asked Questions document, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part-XXVII-MOOP-2706-FINAL.pdf

Issue Brief: [Provider Non-Discrimination]

History in Brief

The Affordable Care Act (ACA) was signed into law by President Barack Obama on March 23, 2010 and it contains the largest overhaul and expansion of healthcare since the 1960s. The federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5), which took effect January 1, 2014, prohibits health plans from discriminating against qualified licensed healthcare professionals, such as CRNAs, solely on the basis of their licensure. This law promotes access to healthcare and consumer choice of healthcare professionals and helps reduce healthcare costs through competition. The AANA worked with its healthcare stakeholder partners to ensure this provision was enacted.

The primary sponsor and supporter of Section 2706 was former Senator Tom Harkin (D-Iowa). The ACA nondiscrimination provision states: "A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

This law promotes competition and consumer choice by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote patient access to care, health insurers and health plans must all avoid discrimination against qualified, licensed healthcare professionals solely on the basis of licensure. The provider nondiscrimination provision also respects local control of healthcare systems and local autonomy in the organization of health plans and benefits. It does not impose "any willing provider" requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.

The AANA interprets Section 2706 to protect patient choice and access to a range of beneficial providers and prevent discrimination by health insurance plans against an entire class of health professionals, such as CRNAs. We believe it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure. While health plans might believe this is a cost-effective way to save money and lower health care costs, this would direct cases to more expensive providers, such as anesthesiologists, leading to impaired access, increased costs and lower quality of care. The AANA also interprets the provider nondiscrimination provision to mean that if a health plan or health insurer network offers a specific covered service, they should include in their network all types of providers who can offer that service. For example, if a health plan offers coverage for anesthesia services, they should allow all anesthesia providers to participate in their networks and they cannot refuse to contract with CRNAs just based on their licensure alone.

The AANA has continuously worked to ensure this provision is properly implemented even though this provision has is detractors. In 2013, Representative Andy Harris introduced HR 2817 to repeal the provider nondiscrimination provision. The AANA advocated to oppose it and the bill did not pass. Furthermore, in 2013, the Departments of Labor, Health and Human Services (HHS), and the Treasury released a flawed frequently asked questions document (FAQ). The FAQ stated that the statutory language of PHS Act section 2706(a) is self-implementing and the three Departments do not expect to issue regulations in the near future. It also stated that until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of Section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. However, the FAQ contained two policy areas in the FAQ that were concerning to us which were:

- The statement that the provider nondiscrimination provision in the Affordable Care Act "does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations."
- And the language that the provider nondiscrimination provision "does not require plans or issuers to accept all types of providers into a network."

The AANA held a meeting with the three agencies regarding the FAQ. Our message to them regarding the reimbursement issue was that the provider nondiscrimination

provision in the Affordable Care Act says that health plans cannot discriminate with respect to coverage under the plan against any provider who is acting within the scope of their license under applicable state law. Thus, it is discrimination if health plans are reimbursing providers at different rates for the same covered service solely on account of their licensure. Regarding the network issue, the AANA told the agencies that the provider nondiscrimination provision means if a health plan offers a specific covered service, they should include in their network all types of providers who can offer that service, such as anesthesia and CRNAs. At the end of the meeting, the agencies said that they most likely will not regulate on provider nondiscrimination until after the January 1, 2014, implementation deadline. In 2015, the three agencies withdrew the original FAQ and replaced it with an updated FAQ contained a more realistic approach to the issue and more reasonable standard for enforcement that is more in line with the AANA's interpretation of the issue.

In March 2014, the three agencies issued a request for information (RFI) seeking stakeholder comments on all aspects of the interpretation of section 2706(a) of the PHS Act. This includes but is not limited to comments on access, costs, other federal and state laws, and feasibility. The AANA and its coalition partners wrote letters saying that to promote patient access to high quality healthcare, market competition and cost efficiency, health insurance marketplaces, health insurers and health plans must all avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure. The AANA also conducted a grassroots effort asking individual AANA members, State Reimbursement Specialists, Federal Political Directors, and State Associations of Nurse Anesthetists to write and submit their own comments on the RFI to CMS. The agencies have not taken further action on the RFI.

Current State of the Issue

Over the last few years, there have been attempts to dismantle all or parts of the Affordable Care Act under a repeal and replace strategy. The most critical insurance reform for CRNAs is the provider nondiscrimination provision and the AANA has worked tirelessly to ensure this provision is maintained and also to make sure it is subject to a notice and comment rulemaking process.

The provider nondiscrimination provision has not yet gone through a formal notice and comment rulemaking process and the AANA continues to advocate for proper implementation of this provision before Congress, federal agencies and various healthcare stakeholders. Even though no formal rule has been published, there has been recent action on federal guidance regarding the provider nondiscrimination provision. In May 2015, the Departments of Labor, Health and Human Services and Treasury issued a new Frequently Asked Questions (FAQ) document changing their

current enforcement approach to the important provider nondiscrimination law. Replacing the problematic FAQ guidance published in 2013, the new guidance now states, "until further guidance is issued, the Departments will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision."

The 116th Congress was focused on the issue of surprise billing, where an insured patient receives care from a provider that is out of the individual's insurance network, and the AANA advocated for provider nondiscrimination during this process. There were four bills that were main contenders for lawmakers to begin negotiations on: The House Energy and Commerce Committee's No Surprises Act (HR 3630), the House Education and Labor Committee's Ban Surprise Billing Act (HR 5800), the House Ways and Means Committee's Consumer Protections Against Surprise Medical Bills Act (HR 5826), and the Senate Health, Education, Labor and Pensions Committee's Lower Health Care Costs Act (S 1895). Three of the four major bills, with the exception of HR 5826, included provisions strengthening existing provider nondiscrimination law. Despite Congressional efforts to resolve the issue, progress on the legislation has stalled because they couldn't agree on whether to use benchmark payment rates or arbitration for out-of-network billing.

During this process, the AANA advocated for CRNAs and worked with Congress and all invested parties to address surprise medical billing and to remove patients from disputes between providers and insurers. The AANA advocated that Congress should keep in mind that any legislation developed to address surprise billing should hold the patient harmless financially in surprise medical billing situations; should offer a fair process for provider reimbursement; and address one of the underlying causes of surprise medical bills by enforcing provider nondiscrimination.

The Supreme Court heard oral arguments in November 2020 for a case challenging the individual mandate in the Affordable Care Act and ultimately dismantling it, while stakeholders are examining parts of the Affordable Care Act that they wish to retain and strengthen legislatively. During oral arguments, a majority of the justices seemed to agree that even if the law's individual insurance mandate is unconstitutional, the rest of the ACA could still survive. In February 2021, the Biden administration told the Supreme Court that it should uphold the entire law. A decision by the Supreme Court is expected by summer 2021. The AANA is working to ensure that provider nondiscrimination is part of these efforts.

In December 2020, Congress passed the the 2021 Consolidated Appropriations Act, which included a provision that requires the Departments of Health and Human Services, Labor and Treasury to issue a proposed rule implementing the protections of provider

nondiscrimination [section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg-5(a))] by January 1, 2022. This was a huge win for the AANA and the FGA team who lobbied Congress, federal agencies and healthcare stakeholders for a year to make sure this provision was included in this legislation.

Since the No Surprises Act was passed, the AANA has been hard at work to ensure a rule is promulgated. This includes holding numerous meetings with the three agencies tasked with drafting the rule, members of Congress and many healthcare stakeholders. The AANA drafted regulatory language along with help from reimbursement experts among AANA staff, membership and healthcare stakeholders to send to the agencies to make them aware of robust language that should be included in the rule. In addition, the AANA worked with legislative champions in Congress to secure letters of intent that help ensure the agencies promulgate the rule.

As of publication of this primer, the federal agencies in charge of promulgating a rule have not released a provider nondiscrimination regulation. While the deadline to draft a rule has passed, the agencies in charge of crafting the rule are still hard at work to create this rule. As we await release of the regulation, the AANA has been close contact with HHS, DOL and Treasury to ensure our recommendations are included in the regulation.

Anticipated Future State

- The AANA will continue to advocate for and push for a regulation to be issued on the provider nondiscrimination provision.
- The AANA will introduce federal legislation implementing protections of provider nondiscrimination.
- The AANA will advocate for Congressional champions to make this provision stronger.
- The AANA will continue to advocate against discriminatory CRNA reimbursement policies from all private health plans, Medicaid and Medicaid managed care plans.
- The AANA will continue to educate reimbursement decision makers at health plans about CRNA anesthesia and pain management services to urge them to rescind discriminatory reimbursement policies.

For More Information

- No Surprises Act of the 2021 Consolidated Appropriations Act, https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf

- 42 U.S. Code § 300gg–5 - Non-discrimination in health care**,** https://www.law.cornell.edu/uscode/text/42/300gg-5

- 2015 Department of Health and Human Services, Department of Labor, Department of Treasury FAQ, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part-XXVII-MOOP-2706-FINAL.pdf

- No Surprises Act of 2020, https://www.congress.gov/bill/116th-congress/house-bill/133/text?q=%7B%22search%22%3A%5B%22hr133%22%5D%7D&r=1&s=3

Issue Brief: [State Health Insurance Marketplaces]

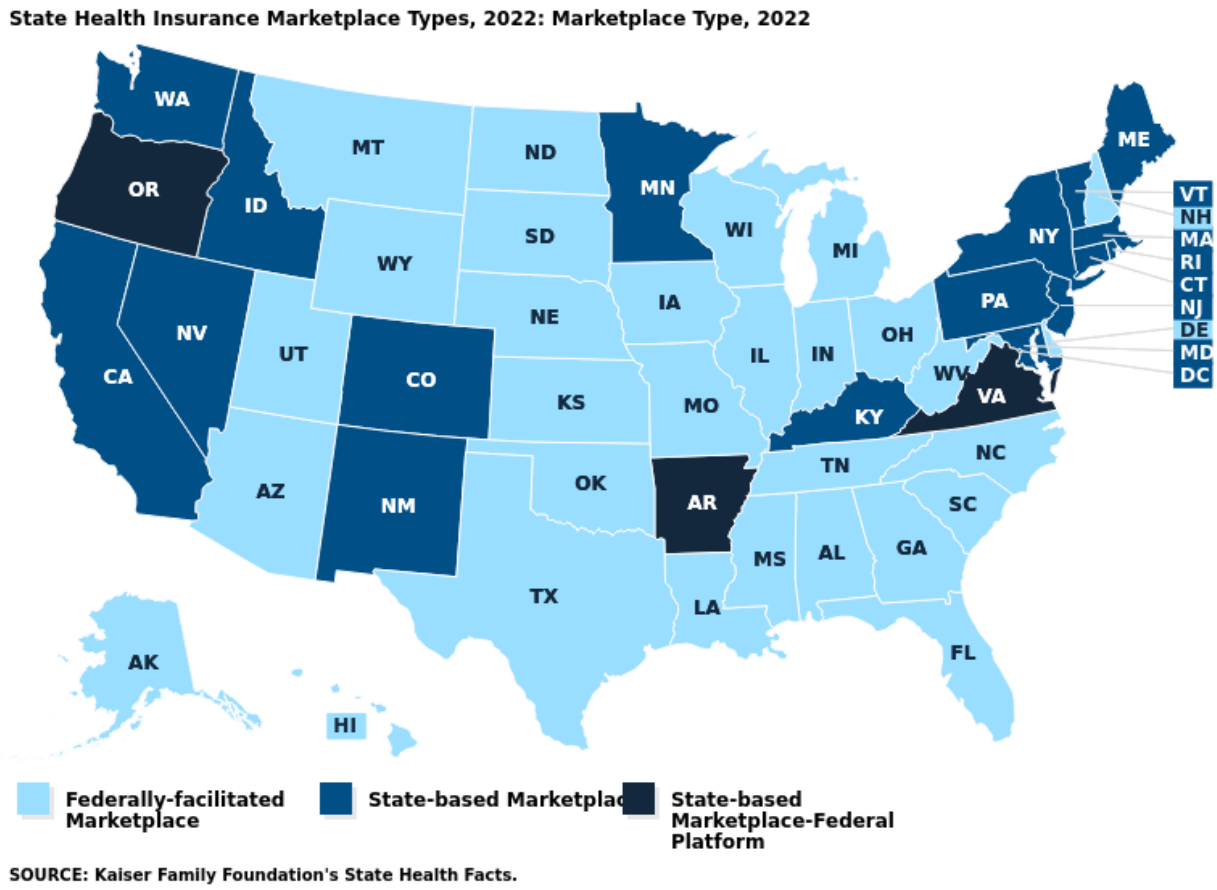
History in Brief

State health insurance marketplaces (formerly exchanges) were created as part of health reforms aiming to expand the number of people insured and to promote universal access to affordable healthcare coverage. Their history began with the passage of comprehensive health reform at the state level, starting in Massachusetts in 2006 and in Utah in 2009.

Current State of the Issue

Following the provisions of the Affordable Care Act, some states have established their own marketplaces for coverage, while most have elected to have the federal government operate their marketplaces. The marketplaces continue to play an important role in fulfilling one of the Affordable Care Act's core goals: reducing the number of uninsured Americans by providing affordable, high-quality health insurance to enrollees. Plans began marketing coverage through the marketplaces on Oct. 1, 2013, via the website www.healthcare.gov, for the first open enrollment session that concluded Mar. 31, 2014. Since then there have been three open enrollment periods for marketplace coverage. According to a report released in January 2016, the Department of Health and Human Services (HHS) announced that about 11.3 million consumers selected or were automatically re-enrolled in health insurance marketplaces, which is a slight decrease from the year before. Approximately 35 percent of consumers who selected or were automatically re-enrolled in health insurance marketplaces were under the age of 35. Currently, more than 8.5 million consumers are enrolled in states with federally facilitated marketplaces and more than 2.7 million enrollees are in the 13 states (including Washington, D.C.) with state-run marketplaces.

Plans in the marketplaces are required to offer benefits that meet a minimum set of standards, offering four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required, plus a catastrophic coverage plan. Marketplaces may also include expanded Medicaid coverage for all individuals and families whose incomes are up to 138 percent of the federal poverty level, but only in those states that accept the ACA's Medicaid expansion funds (see separate section in this document on Medicaid). See the chart below for state decisions on marketplaces for 2022.



Throughout the process for implementing the ACA's marketplaces, the AANA has engaged in regulatory advocacy in support of CRNA practice, noting the high quality and cost effectiveness of CRNA services, and promoting the implementation of the ACA provider nondiscrimination provision. The final rule on the multi-state plan program stated that the federal nondiscrimination standards "adequately prohibit discrimination against specific provider types. OPM (Office of Personnel Management) will reinforce these protections through its contract negotiations with MSPP (Multi-State Plan Program) issuers."

Anticipated Future State

- Effective implementation of health coverage marketplaces depends on how many people sign up for coverage.

- The AANA will continue to monitor final and future proposed rules regarding state health insurance marketplaces to further outline our interests.

- The AANA will continue to educate federal agencies and members of Congress on the value of CRNA services within state health insurance marketplaces and that

health plans participating in marketplaces should adhere to the provider nondiscrimination provision.

- The AANA will also continue to advocate against discriminatory CRNA reimbursement policies from Medicaid or Medicaid managed care plans. tele

- The AANA will continue to monitor any new changes regarding health insurance marketplaces in Affordable Care Act repeal and replace legislation.

For More Information

- Kaiser Family Foundation overview of state insurance marketplaces , https://www.kff.org/state-category/affordable-care-act/
- Healthinsurance.org list of marketplaces by state: https://www.healthinsurance.org/health-insurance-marketplaces/
- Kaiser Family Foundation list of state decisions for creating marketplaces, http://kff.org/health-reform/state-indicator/health-insurance-exchanges/
- CMS marketplace website, http://marketplace.cms.gov/
- Center for Consumer Information and Insurance Oversight marketplace implementation information site, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/index.html
- CMS list of state marketplaces, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html
- Provider nondiscrimination FAQ, http://www.dol.gov/ebsa/faqs/faq-aca15.html
- HHS February 2016 Marketplace enrollment update, http://www.hhs.gov/about/leadership/secretary/speeches/2016/success-by-the-numbers-2016-open-enrollment.html
- Kaiser Family Foundation Brief of Analysis of Insurer Participation in 2016 Marketplaces, http://kff.org/health-reform/issue-brief/analysis-of-insurer-participation-in-2016-marketplaces/
- AANA Comments on CMS Notice of Benefit and Payment Parameters in Federally Facilitated Marketplaces, http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20151218-aana-comment-on-hhs-notice-of-benefit-and-payment-parameters-for-2017-proposed-rule-final.pdf (requires AANA member login and password)

Issue Brief: [Telehealth/Telemedicine]

History in Brief

Telehealth is the use of audio/video technology to remotely provide care, monitor patient health status and educate patients. Telemedicine is the use of audio/visual technology to diagnose or treat patients. CRNAs utilize telehealth, for conducting presurgical and postoperative evaluations in non-emergent situations and for monitoring patients perioperatively and after discharge.

The delivery of anesthesia services using telecommunication (audio and visual) has been available since the early 2000's and offers benefits such as the ability to conduct preoperative evaluations on patients before coming to a facility and identifying potential risks in patients. However, telehealth is not as widely used for post-operative monitoring in part because there are information technology limitations to accessing relevant patient data and completing the feedback loop. Studies on the use of telehealth for postsurgical visits are effective for wound and drain assessments and demonstrated improved access to care and convenience for patients.

Medicare statute defines Medicare telehealth services to include consultations, office visits, office psychiatry services, and any additional service specified by the Secretary, when furnished via a telecommunications system. Regarding payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner is equal to what would have been paid without the use of telemedicine. CRNAs were added to the list of distant site practitioners eligible for Medicare reimbursement in 2015. Telehealth services eligible for Medicare payment are added yearly in the Physician Fee Schedule. Those services that are beyond the existing professional consultations, office visits, and office psychiatry services must meet specific criteria including showing that there is a clinical benefit before being added as a covered service on the Medicare telehealth list. The use of Telehealth under Medicare has been historically low because it was limited to rural areas. Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established Medicare payment for telehealth services. Section 190 of Chapter 12 of the Medicare Claims Processing Manual provides information on Medicare payment policy for telehealth health services.

Current State of the Issue

The use of telemedicine has expanded during the COVID-19 pandemic. Anesthesia professionals have been able to monitor patients in their homes remotely or perform

telemonitoring in electronic ICU delivery models. Telehealth is also indicated in alternative settings such as post-anesthesia care units (PACU), as extensions of COVID-19 or critical care locations. Benefits of telemedicine in these areas include increased compliance with clinical guidelines and protocols, rapid responses to medical alerts and the ability of facilities to expand capacity for intensive care.

During the COVID-19 PHE, CMS issued waivers lifting restrictions on the use of telehealth services. CMS is expanding this benefit on a temporary and emergency basis under the Section 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act (HR 6704). Before this waiver, Medicare would only pay for telehealth on a limited basis such as when the person receiving the service lives in a rural area and then they leave their home to go to a clinic, hospital or certain other types of medical facilities for that service. Under the waiver, Medicare can pay for office, hospital and other visits furnished via telehealth across the US and including patient's homes as of March 6, 2020, CRNAs have been eligible to be telehealth providers prior to this expansion, but this wavier expands the circumstances for CRNAs to provide telehealth. Reimbursement is dependent on the CRNA's Medicare Administrative Contactor (MAC) and their Local Coverage Determinations (LCDs), on state scope of practice laws, and existing Medicare policy.

Under the waiver, Medicare can pay for office, hospital and other visits furnished via telehealth across the US and including patient's homes as of March 6, 2020. These waivers will expire when the public health emergency is lifted. Furthermore, during the PHE, CMS added 135 services such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services, that could be paid when delivered by telehealth. Telehealth services can be provided to both new and existing beneficiaries in any location, in both urban and rural areas, including a private home. This applies to all existing Medicare telehealth services. The visits can be via telephone call and do not have to contain both an audio and a visual component as was previously required. CMS proposed to permanently allow some of those services to be done by telehealth in the Physician Fee Schedule proposed rule. In the CY 2022 Physician Fee Schedule Final Rule, CMS recommended "to retain all services added to the Medicare telehealth services list on a Category 3 [temporary] basis until the end of CY 2023. This provision would enable CMS to collect more information regarding the use of telehealth services during the pandemic and provide stakeholders the opportunity to continue developing support for the permanent addition of appropriate services to the telehealth list through the notice and comment rulemaking process."

Most recently, in the CMS Physician Fee Schedule proposed rule for FY 2021, CMS proposed to change the definition of direct supervision to allow the supervising physician, or other practitioner, to be remote and use real-time, interactive audio-video

technology. Under current regulations, direct supervision requires the physician, or other practitioner, to be physically present in the office suite and immediately available to furnish assistance. CMS proposed this change to be effect through December 31, 2021 or the end of the PHE, whichever is later. The physician, or other practitioner, would provide direct supervision for "auxiliary" staff performing the service. CMS does state that they are concerned that virtual presence would not be sufficient "…in complex, high-risk, surgical, interventional, or endoscopic procedures, or anesthesia procedures…such services to be furnished or supervised in person to allow for rapid on-site decision-making in the event of an adverse clinical situation." What does this mean for CRNAs? Under Medicare regulations §410.78(b)(2), CRNAs are distant site practitioners who can furnish and get paid for covered telehealth services. CMS does not currently have any regulation or policy that allows for the payment of anesthesiologist telesupervision, despite the direction the agency is going with respect to telehealth.

Telehealth services were incorporated into electronic Clinical Quality Measures (eCQMs) for CY2020, so that clinicians reporting them under MIPS or APMS could include them in their reporting populations. An activity was added to the Expanded Practice subcategory of the Improvement Activities Performance Category in 2021 related to the use and analysis of data related to telehealth services, for the purpose of improving the quality of care to patients.

The AANA opposes any payment policy reimbursing for anesthesiologists that are not providing actual anesthesia care, through billing for remote so-called "supervision" services. This type of remote supervision would not improve quality or access to healthcare for patients and would instead reward providers not actually furnishing healthcare services. Furthermore, as there is no evidence of the efficacy and cost-effectiveness of in-person physician supervision requirements, there also is no evidence regarding the benefit for the use of supervision of anesthesia via telehealth. In these instances, anesthesiologist tele-supervision of CRNA services would not meet CMS's current criteria for Medicare telehealth services of providing a clinical benefit to the patient.

In the last few years, the AANA has written over 20 letters that have included the issue of telehealth to federal agencies including: the FCC, HHS Office of the National Coordinator for Health Information Technology (ONC), CMS and HHS. The AANA has also written letters to members of Congress including the Congressional Telehealth Caucus and the House Healthcare Innovation Caucus. Some of the issues the AANA submit comments on include:

- ensuring CRNAs ability to participate in telehealth services
- promoting telehealth in rural America
- prohibiting wasteful telesupervision of CRNA services
- creation of the ONC Trusted Exchange network
- 21st Century Cures Act Electronic Health Record reporting program

- technical changes to federal health programs such as Medicare, Medicaid, Medicare Advantage, managed care plans
- technologies needed to support innovative payment models
- Federal Health IT Strategic Plan 2020-2025

Remote patient monitoring (RPM) is gaining in popularity because of applications are available on smart phones, which can be attached to equipment such as spirometry devices or heart monitors. Despite the availability of apps, many are currently unable to integrate with EHR systems. There is a need to address jurisdiction limitations, as telehealth would enable a provider in one state to communicate with a patient in another state. Telehealth guidelines differ from state to state, and to date, only 19 states have implemented the Interstate Medical Licensure Compact, which provides an expedited licensure process for physicians who seek to practice across state lines.

Anticipated Future State

- Telehealth services will be added to MIPS measures in the Quality, Cost and Improvement Activity Performance Categories.
- Potential for continued expanded use of telehealth in anesthesia after the COVID-19 public health emergency ends.
- The AANA will continue to advocate for ensuring CRNAs ability to participate in telehealth services and prohibiting wasteful telesupervision of CRNA services
- Patient care delivery models will adjust to incorporate telemedicine technology and telehealth services, such as remote patient monitoring (RPM)
- Increased challenges in aligning telehealth utilization with reimbursement for CRNAs.
- Expanded scope of practice for anesthesia professionals using electronic ICU delivery models and applications to monitor critical care patients.

For More Information:

- News Release: Calendar Year 2022 Medicare Physician Fee Schedule Final Rule, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule
- Patrick, L. (2020, September 1). CMS Identifies Telemedicine Quality Tracking Measures. Retrieved from Relias Media : https://www.reliasmedia.com/articles/146690-cms-identifies-telemedicine-quality-tracking-measures
- Medicare Program: CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, https://www.federalregister.gov/public-inspection/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

- Coronavirus Preparedness and Response Supplemental Appropriations Act (HR 6704), https://www.congress.gov/bill/116th-congress/house-bill/6074
- CMS Section 1135 Telehealth Benefits Waiver Expansion, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Telehealth-Services-Text-Only.pdf
- AANA Resources: Telehealth Services and how they Impact CRNA Services, https://www.aana.com/aana-covid-19-resources/covid-19-medicare-resources
- Section 190 of Chapter 12 of the Medicare Claims Processing Manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf).
- CMS Provider Telehealth and Telemedicine Toolkit 2020, https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf
- CMS Press Releases on Expansion of Telehealth 2020, https://www.cms.gov/newsroom/press-releases/trump-administration-drives-telehealth-services-medicaid-and-medicare
- AANA Comments on the Physician Fee Schedule Proposed Rule for FY 2021, which includes comments on the telehealth provisions, see: https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/20201005-aana-comments-on-cy-2021-physician-fee-schedule-proposed-rule---final.pdf?sfvrsn=e80f074e_0
- Medicare Telehealth Frequently Asked Questions: https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
- Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
- Teleheatlth Services – CMS: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/telehealth-services-text-only.pdf

FOR MORE INFORMATION

For questions regarding federal reimbursement-related requirements, please contact the AANA Federal Government Affairs division at info@aanadc.com. For questions regarding state laws and regulations, please contact the State Government Affairs division at sga@aana.com. For questions regarding research and quality, please contact research@aana.com.