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An Evaluation of Commercial Payer Reimbursement and Contracting Factors for Physician Anesthesiologists and Certified Registered Nurse Anesthetists for Services Performed in 2019

Jean Covillo, DNAP, MA, CRNA
Maria Sallie Poepsel, PhD, CRNA, APRN, FAANA
Jeanie Skibiski, DNAP, MHA, CRNA, CPPS, FAANA

We sought to establish commercial rate benchmarks specific to certified registered nurse anesthetist (CRNA) anesthesia delivery models (QZ), quantify any payer disparities discovered between CRNAs and anesthesiologists, and determine payer alignment with nondiscrimination provisions of the Affordable Care Act (ACA). The Lewin Group administered the exploratory, descriptive study of QZ billing practices by surveying a targeted cross-section of 345 CRNAs known for QZ billing. Forty-one respondents reported information from 1,089 CRNAs and 351,920 cases with 127,888 commercial claims billed under 144 unique commercial contracts as performed in 2019. There was a 24% payer disparity in rates negotiated reported between anesthesia providers: CRNAs overall average of $58.62; $55.33-$64.57, compared with anesthesiologist average of $77.01 overall; $73.79-$80.76. Other findings included QZ payment adjustments, denials for reimbursement, and exclusion from plan participation. The study found disparities in rate and discriminatory payer practices specific to CRNA contracting and reimbursement, which suggests payer misalignment with nondiscrimination provisions of the ACA.

Keywords: anesthesia, commercial payers, CRNAs, QZ, reimbursement

This study evaluates how commercial insurer (payer) reimbursement practices and other contracting factors align with the Affordable Care Act's nondiscrimination provision (ACA-NDP). Distinct commercial rate benchmarks are established for services rendered by nonmedically directed certified registered nurse anesthetists (CRNAs) in 2019. These benchmarks are then compared with rates publicly disclosed by physician anesthesiologists to assess whether payers uphold equitable reimbursement practices for identical services across providers as performed in 2019.

The ACA-NDP aims to promote cost-efficient healthcare delivery by prioritizing quality and performance over licensure when reimbursing different types of providers for the same services.[1] Payers are expected to use good faith when interpreting the ACA requirements.[2] However, in the absence of regulations or consequences for noncompliant payers, this report finds that many payers persist in applying negative payment adjustments for CRNA services, excluding CRNAs from plan participation, and denying reimbursement for procedures authorized within CRNAs' state scope of practice.

The Centers for Medicare & Medicaid Services (CMS) adhere to a universal fee schedule in which both anesthesiologists and CRNAs receive the same reimbursement rates.[3] However, commercial insurers (payers) independently negotiate rates with each contracted provider. Given that these negotiations often occur confidentially and are safeguarded by nondisclosure agreements, it becomes challenging to ascertain whether equitable and unbiased policies are being upheld. The American Society of Anesthesiologists (ASA) conducts yearly reimbursement rate surveys but does not differentiate between physician anesthesiologists and CRNAs

Anesthesia Delivery Model	Descriptor	Physician Code and % of Payment	CRNA Code and % of Payment
Physician Personally Performed	The physician personally performs the procedure.	AA 100%	None 0%
Medical Direction	The physician medically directs qualified providers in 2-4 concurrent anesthesia procedures. The medically directing "physician" must satisfy all seven TEFRA steps as a condition of payment.[a]	QK/QY 50%	QX 50%
CRNA Personally Performed	Services provided without medical direction by a "physician."	None 0%	QZ 100%
Medical Supervision	Used when the medical direction requirements are not met or when supervising more than four CRNAs at one time.	AD 3 BU + 1 TU added if present on induction.	QX 50%

Table 1. Anesthesia Delivery Models and Modifier Codes for Reimbursement

Abbreviations: CRNA, certified registered nurse anesthetist; QK, QY, QX, QZ, AD are code modifiers; BU, base units; TU, time units..
Source: Compilation of information published by CMS available online in Medicare Claims Processing Manual chapter 12–Physicians/ Nonphysician Practitioners; see section 50 (p. 82) for anesthesiologists and section 140 (p. 128) for CRNA services.
[a]The seven TEFRA steps refer to tasks that must be completed by the physician to meet CMS conditions of reimbursement for medical direction. These steps are as follows: 1) perform a preanesthetic examination and evaluation, 2) prescribe the anesthesia plan, 3) personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence if applicable, 4) ensure that any procedures that he/she does not perform are performed by a qualified individual, 5) monitor the course of anesthesia administration at frequent intervals, 6) remain physically present and available for immediate diagnosis and treatment of emergencies, and 7) provide postanesthesia care.

or delivery models when setting benchmarks.[4]

When CRNAS bill for anesthesia services, they do so under the QZ modifier which is the only modifier available and specific to CRNAs when providing nonmedically directed services.[5] To establish reimbursement comparisons between anesthesiologists and CRNAs, this study used the QZ modifier for benchmark development. The Anesthesia Commercial Payer Report (referred to as the Payer Report or Report) presents the findings from the 2019 CRNA Commercial Reimbursement Survey (the survey). The survey was administered and conducted by the Lewin Group (Lewin), who analyzed the data, ensuring adherence to the regulations set forth by the Department of Justice (DOJ) and the Federal Trade Commission (FTC).[6] The survey gathered specific commercial contracting data for QZ services and sought information about particular contracting factors that have the potential to constrain competition or limit scope of practice. Respondents contributed data on contracted rates associated with their top five commercial payers.

This report presents the survey findings, accompanied by analysis and discourse to explore the question of whether regulations are needed to guarantee payer adherence to the ACA-NDP.

BACKGROUND

CRNAs were the first nursing specialty to gain the right to bill Medicare Part B under the Omnibus Reconciliation Act of 1989.[7] They receive direct reimbursement at 100% of the physician fee schedule, unlike other nursing specialties.[8] When CRNAs provide nonmedically directed anesthesia services, they are reimbursed by Medicare at the same rate as physicians.[8-10] This recognition is a result of the unique ability of CRNAs to provide comprehensive care comparable with primary providers.[11]

Both anesthesiologists and CRNAs possess the qualifications and licenses to deliver similar anesthesia services with equivalent quality and safety outcomes, adhering to the same standards of care.[12-14]

Anesthesia billing involves specific modifiers for CRNAs and anesthesiologists when submitting claims. While anesthesiologists use various modifier codes, CRNAs only have the QZ modifier code for nonmedically directed claims.[5] Anesthesia reimbursement is calculated differently from other specialties. Anesthesia fees are calculated by taking the sum of the total units (base units + modifier units + time units) and multiplying the value by the rate established per unit.[15] Both CRNAs and anesthesiologists are reimbursed by CMS at the same rate per unit established through its universal conversion factor.

Anesthesia services are reimbursed according to conditions established by CMS in four delivery models, each with specific modifier codes: physician personally performed (AA), CRNA personally performed without medical direction (QZ), medical direction (QK), and medical supervision (AD).[15] When anesthesiologists medically direct CRNAs, the CMS payment is divided equally provided that the anesthesiologist meets the specific conditions required for their portion of the charge. These conditions, known as the seven TEFRA steps, ensure compliance with the Tax Equity and Fiscal Responsibility Act of 1982.[16] These steps are not necessary when services are provided under the other three delivery models and are not to be confused with the standard of care.

Table 1 summarizes the delivery models, modifier codes, CMS payment allocation, conditions for payment,

and the seven TEFRA steps. It is important to note that regardless of the delivery model or the number of providers involved, usually only one payment is allowed per procedure. CRNAs are always reimbursed for half of the shared units when working under medical direction or supervision. The anesthesiologist reimbursement portion depends on meeting conditions specific to the selected delivery model. In cases where anesthesiologists cannot fulfill the seven TEFRA steps, medical direction criteria are not met, and the model is reclassified to medical supervision or nonmedically directed QZ. The QZ modifier is often billed as a "workaround" when medical direction criteria are not met because all units can be captured for billing whereas the supervision model restricts the total units an anesthesiologist is eligible to bill.[15] This "workaround" is believed to be a large contributor to the nationwide increase (11%) in QZ claim submissions from 2000 to 2014.[17-19] Anesthesia departments nationwide increasingly depend on CRNAs to reduce operating expenses and enhance savings through cost-effective workforce strategies that allow providers to work more flexibly without loss in revenue.[20-22] Regardless, any savings associated with these strategies may be offset by payer rate reductions specific to the CRNA QZ modifier.[23] The importance of this study is highlighted by results published in 2021 by Duffy and associates, which found a 30% disparity in commercial reimbursement between CRNAs and anesthesiologists after analyzing more than 3 million claims.[24]

Payment disparities have been further exacerbated by the No Surprises Act,[25] which called for the establishment of rules to standardize the methodology for determining the qualified payment amount (QPA) for out-of-network services.[26] The methodology outlined in the interim final rule inadvertently reinforces those payment disparities. The median payment rate, which plays a key role in calculating the QPA, is determined based on the average rate or median payment associated with the *service provider modifier code*.[27]

The modifier codes are primarily tied to the provider's licensure rather than considering the performance or outcome of the procedure. Consequently, this approach tends to result in higher median payments for services billed under physician modifier codes (i.e., AA, QK, or AD) in comparison with nonmedically directed CRNA services billed under the QZ modifier code.

METHODS AND MATERIALS

This was an exploratory, descriptive study of CRNAs who billed QZ to commercial payers in 2019. The survey sample included a cross-section of 345 CRNA responses specific to QZ commercial claims (FFS Database). The FFS Database was developed in January of 2021 in an earlier pilot study. The database was designed specifically for use in the Commercial Reimbursement Survey and is solely comprised of CRNAs who provide QZ-billed services. The Lewin Group used the FFS Database as the sampling framework for the QZ Survey.[28] The FFS Database Study may be accessed at https://www.eakc.net/wp-content/uploads/2021/11/CRNA-FEE-for-Service-Posted-Content-1.pdf.

The Survey tool was divided into two sections: 1) commercial QZ reimbursement rates and 2) factors contributing to CRNA contract negotiations. The reimbursement section was designed to closely match variables and methodologies established in previous ASA reimbursement surveys for comparison purposes.[4] Participants were provided a worksheet with instructions to assist in preparation for survey reimbursement questions.[29] The Lewin Group launched the 2019 survey on July 7, 2021, via direct email invitation. Access to the online Commercial Reimbursement Survey was available through August 8, 2021.

The first section of the survey asked respondents to provide information relative to the top five commercial contracts contributing the greatest percentage of managed care business. Of 81 consented respondents, 41 (51%) provided data used in analyses. Respondents who did not fully complete all survey questions were excluded from rate analysis in some calculations but allowed for inclusion in others.

The study complied with the policies established by the DOJ and FTC.[6] Data provided were at least 3 months old, and all information included in the reported analysis complied with three conditions as required by these policies:

- There are at least five providers reporting data upon which each disseminated statistic is based.
- No individual provider's data represent more than 25% on a weighted basis of that statistic.
- Any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any specific provider.

Because data collected included three separate measurements defining a single unit, adjustments were applied to normalize all units to each represent 15 minutes. Units were expressed in 10-, 12-, and 15-minute measures. The adjustment factors applied were derived from the 2019 ASA survey report, where claims data from the CMS Physician/Supplier Procedure Summary datasets were used to normalize units.[4] Adjustment factors were multiplied by the rate per unit reported by each respondent to calculate the normalized rate per unit. Adjustments varied depending on the number of minutes each unit represented: 15-minute time units (TUs), 1.000; 12-minute TUs, 1.117; and 10-minute TUs, 1.235. Average rates are calculated using the "weighted mean," where *weights* reflect the *share of normalized unit volume* that a given contract represents of the total contracts reported.

Cases	Totals	M	SD	Minimum	Maximum
All Payers	351,920	8,583	16,453	29	92,400
Commercial Payers	127,888	3,119	5,742	7	34,300
Units					
All Payers	3,010,569	73,429	153,731	315	891,000
Commercial Payers	1,070,652	26,113	54,419	13	330,600

Table 2. Payer Distribution of Cases and Units

Abbreviation: CRNA, certified registered nurse anesthetist; M, mean; SD, standard deviation.

Source: The Lewin Group administered and analyzed response data from the 2019 CRNA Commercial Reimbursement Survey.

RESULTS

Forty-one respondents provided case data for more than 1,089 CRNAs and 144 unique commercial contracts. Most submitted information for five commercial contracts. Of the 144 contracts eligible for analysis, one respondent submitted data spanning two regions; 70% of cases occurred in the Southern Region and 30% in the Western Region. Allocation adjustments were made according to the percentages reported to represent data spanning both regions. These adjustments only appear in regional tables.

The contracts eligible for inclusion in each calculation vary because eligibility specific to rate is subject to DOJ conditions. One contract was excluded from all rate analyses because it represented more than 25% of all data reported. Additionally, there were five contracts excluded as outliers (i.e., rates were reported as $1, $2, $3, etc.). Although those five contracts were removed from rate analyses, they were eligible for other reporting. References are provided in summary tables with details specific to each calculation. The survey returned responses associated with 351,920 cases, with 127,888 from commercial contracts. Statistical analyses of cases and units are shown in Table 2.

Commercial cases represented 36.34% of all claims when including obstetric (OB) cases and 35.33% when OB cases were excluded. OB cases accounted for a small percentage of the commercial payer data and did not impact the overall percentage of payer distribution or subsequent rate calculations.

Overall Survey results were reported nationally with additional analysis by region. Regions were allocated by states as defined by the Medical Group Management Association, where several *central* states (i.e., KS, MO, and OK) are assigned to the Southern Region.[30] The regions are as follows:

- Eastern: CT, DE, DC, ME, MD, MA, NH, NJ, NY, NC, PA, RI, VT, VA, WV
- Midwestern: IL, IN, IA, MI, MN, NE, ND, OH, SD, WI
- Southern: AL, AR, FL, GA, KS, KY, LA, MS, MO, OK, SC, TN, TX
- Western: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

Data were distributed by geographical region, with most respondents (85%) reporting on behalf of multiple CRNAs. More than half (615 out of 1,089 CRNAs) worked in mixed practice settings. Mixed practice settings reported that most claims (68%) submitted were billed under the QZ modifier for nonmedically directed CRNA services. The Southern Region contributed the highest number of QZ claim data on behalf of 479 CRNAs (Table 3).

The commercial payers' summary by region shown in Table 4 provides additional information relative to contracts, CRNAs, cases, units, and percentage of managed care. Nearly 50% of all cases were distributed in the Southern Region, followed by the Midwestern, Western, and Eastern Regions.

- *Rate Analysis.* The first section of the survey requests information relative to contract rates. Eligibility for inclusion in rate analysis was subject to DOJ conditions. Results are reported nationally by each contract separately, whereas overall regional results are reported in the aggregate, (all contracts combined) which reduced exclusions related to DOJ policies. References are provided under each table for additional details. A significant number of claims reported (> 25% from one respondent) were excluded from the overall rate analyses in compliance with DOJ policies. Had these data been included, it is estimated that the national rate/unit may have been lowered by as much as $5/unit, reducing the overall mean to $53.62/unit.

Respondents ranked their top five commercial contracts by their contribution to managed care business. Contract 1 had the highest business share, and its rate was reported first, followed by contracts 2 through 5 in descending order of business share(s). Table 5 shows calculated weighted means which are the national average rates for each contract category. The weighted mean considers each contract's normalized unit volume share when calculating the average. Additionally, Table 5 presents the overall average of each separate contract (contracts 1-5) using the same weighted mean calculation. The national unit rate across all commercial contracts ranged from $55.33 to $64.57, with an overall average of $58.62. Unlike the national rate calculations in Table 5, where averages were calculated for each contract separately (up to five), Table 6 combines all five contracts by region in the aggregate when performing analyses. The Eastern Region reported the highest rate ($63.97) and

Region[a]	N	CRNAs Individual	Mixed Practice	Sum of CRNAS	% Mixed Practice
Eastern	5[c]	40	42	82	51
Midwestern	14	267	73	340	21.4
Southern[b]	13	108	371	479	77.4
Western[b]	8[b]	59	129	188	68.6
Grand Total	40	474	615	1,089	56.4

Table 3. Regional Distribution of CRNAs Providing QZ Services by Practice Setting
Abbreviation: CRNA, certified registered nurse anesthetist.
Source: The Lewin Group administered and analyzed response data reported from the 2019 CRNA Commercial Reimbursement Survey.
[a]One respondent did not provide regional information.
[b]For one respondent, 70% of cases occurred in the Southern region and 30% in the Western Region. The number of CRNAs for each region was distributed according to the percentages reported, and the respondent was counted twice under the N column.
[c]One respondent in the Eastern Region was excluded from the N column because no information was provided relative to the number of CRNAs.

Region[a]	N[b]	Contracts	CRNAs	Cases	Units	Mean Units/Case Weighted	% Managed Care
Eastern	6	12	82	7,940	33,543	6.1	25.00
Midwestern	14	58	340	24,881	186,942	8.4	44.52
Southern	13	46	479	62,898	572,916	9.2	38.31
Western	8	30	188	22,419	189,501	8.7	26.74
Grand Total	41	146	1,089	118,138	982,902	8.9	35.19

Table 4. Regional Distribution by Contracts, CRNAs, Cases, and Units
Abbreviation: CRNA, certified registered nurse anesthetist.
Source: The Lewin Group administered and analyzed response data reported from the 2019 CRNA Commercial Reimbursement Survey.
Note: Adjustments increased the initial 144 contracts reported to 147. Of these 147 contracts, 146 were eligible for inclusion.
[a]One respondent and one contract were excluded because no regional information was provided.
[b]One respondent's total contract numbers were increased by three through adjustments to represent reporting that spanned two regions; 70% of cases occurred in the Southern Region and 30% in the Western Region. This respondent was also counted twice under the N column to represent the added contracts specific to the two regions. This respondent's percentages of services reported per region were allocated accordingly in the distribution of cases, units, and CRNAs.
[c]One respondent in the Eastern Region was excluded from the N column because no information was provided relative to the number of CRNAs.

Item	Contract 1[c]	Contract 2[c]	Contract 3	Contract 4[c]	Contract 5	Mean[a] of All Contracts
Mean/Contract[a]	55.33	63.08	63.61	64.57	59.28	58.62
Minimum[b]	36.00	22.68	37.42	37.42	37.42	--
25th Percentile[b]	51.00	45.61	54.00	52.00	52.00	--
Median[b]	60.72	59.00	60.00	60.00	60.00	--
75th Percentile[b]	61.20	73.69	65.43	67.73	67.73	--
Maximum[b]	135.00	135.00	125.00	101.27	101.27	--
Contracts[b]	37	31	27	21	19	--
Percentage of Managed Care Business[d]	25%	9%	2.70%	1.60%	0.73%	--

Table 5. National Commercial Rate per Unit ($/Unit)
Source: The Lewin Group administered and analyzed response data reported from the 2019 CRNA Commercial Reimbursement Survey.
[a]The overall mean (weighted) of all contracts relies on 137 eligible contracts from the original 144: five were excluded as outliers, one was excluded due to missing information for contract rates, and one contract was suppressed in compliance with Department of Justice regulations in Contract 1 calculations.
[b]The values associated with the minimum 25th percentile, median, 75th percentile, and maximum percentile is based on 135 eligible contracts of the original 144 reported as follows: five were excluded as outliers, one was excluded due to missing contract rates, and three were suppressed under Contracts 1, 2, and 4 in compliance with Department of Justice regulations.
[c]Data were suppressed in the results.
[d]Percentage of managed care business represents the contribution each contract represents of the overall commercial business reported and does not reflect the percentage of total billing.

Region[a]	Contracts	Mean Weighted	Minimum	25th Percentile	Median	75th Percentile	Maximum
Eastern[c]	11	63.97	38.10	55.00	61.27	74.46	80.00
Midwestern	53	57.55	22.68	48.00	54.00	60.72	78.00
Southernb,c	45	59.42	36.00	52.00	61.00	77.50	135.00
Western[b]	30	56.36	37.00	52.25	60.00	69.43	90.00

Table 6. Regional Rate per Unit ($/Unit) All contracts Combined in the Aggregate

Source: The Lewin Group administered and analyzed response data reported from the 2019 CRNA Commercial Reimbursement Survey. Of the initial 144 contracts reported, 139 met eligibility criteria for inclusion; three contracts were added to represent the respondent data that spanned two regions, one contract was removed due to lack of regional responses, five contracts were excluded as outliers, and two contracts were suppressed in compliance with Department of Justice regulations. All contracts eligible for inclusion were averaged by region in the aggregate.

[a]One respondent did not provide regional information.

[b]For one respondent, 70% of cases occurred in the Southern Region and 30% in the Western Region. When calculating statistics, this respondent's services per region were allocated to contracts, cases, and units by percentages reported.

[c]Data from one contract each were suppressed in the Eastern and Southern Regions in compliance with Department of Justice regulations.

the Western Region ($56.30) reported the lowest. Rate variations of 13% ($7.61/unit) are present across regions.

- *Factors Contributing to CRNA Commercial Contract Negotiation.* The second section of the Commercial Reimbursement Survey focused on the factors contributing to CRNA contract negotiations. It provides an overview of responses reported by 40 out of 41 respondents (98%). Of the 40 participant responses, 62% reported negative payment adjustments based solely on the provider's licensure or the QZ modifier, 25% were denied plan participation due to services deemed outside the CRNA scope of practice, and 20% reported denials in reimbursement for pain management services due to inaccurate payer interpretation of the CRNA scope of practice. Furthermore, 27% were denied participation in state-authorized plans, with most denials reported in the Western Region. Finally, more than 25% of participants experienced payer delays due to timely renewal and renegotiation of CRNA contracts.

DISCUSSION

This report reveals a 24% decrease in commercial reimbursement rates when CRNAs provide identical services as their anesthesiologist counterparts. The average CRNA payer rates were $58.62 overall, ranging from $55.33 to $64.57, compared with anesthesiologist rates of $77.01, ranging from $73.79 to $80.76, reported in the same year. The average rates derived from the small sample in this report align closely with the findings of the study by Duffy and colleagues, which analyzed over 3 million commercial claims and reported a 30% disparity.[24]

While Duffy and associates presented the results as an opportunity for payers to benefit from increased savings, this report underscores the financial impact to the healthcare economy when payers, rather than providers, benefit directly from savings associated with discriminative policies. The financial impact the policies present extends well beyond individual practicing CRNAs because most anesthesia groups, hospitals, and other out-patient facilities depend on a balanced and cost-effective blend of providers. Studies show that nonmedically directed CRNA services is increasing nationwide, and mixed practice settings are responsible for more than half of the commercial cases in this report (56%).[17–19] Hospital subsidies for anesthesia departments could be eliminated or substantially reduced if payers reimbursed providers equitably.[31,32] Hoyem and associates noted in their review of anesthesia delivery models utilizing Medicare Part B reimbursement that a healthcare system which is driven by market forces should aim for policies that promote fair competition among providers offering equivalent services of high quality.[33]

The Commercial Payer Reimbursement Report also reveals other contracting factors that restrict the CRNA scope of practice and limit competition. These factors include payer denials due to lack of recognition of CRNA licensure and misinterpretation of scope of practice, CRNA exclusion from network participation in both major commercial and state-authorized government plans, and barriers to timely contract renewal.

CMS reimburses both CRNAs and anesthesiologists equally at 100% of the physician fee schedule. The ACA-NDP establishes a framework structure that requires commercial payers to negotiate varying rates based on quality and performance rather than the licensure of the provider. This framework incentivizes cost-efficient strategies. Achieving commercial payer parity among providers performing the same services is a crucial element within approaches designed to curtail healthcare expenses. Ideally, acknowledging both providers as primary caregivers facilitates adaptable staffing, optimizes workflow, and trims overhead expenses without compromising revenue.[17,20,21,22]

CONCLUSION

The findings of this report suggest that payers base provider reimbursement rates on "licensure" rather than the "quality" of service resulting in disparities. These dis-

parities are further compounded in the interim final rule of the No Surprises Act where payments for out-of-network providers are based on the average rate associated with the *service provider modifier code rather than the performance or outcome of the procedure*. Consequently, this approach tends to result in higher median payments for services billed under physician modifiers (i.e., AA, QK, or AD) in comparison with nonmedically directed CRNA services billed under the QZ modifier.

While payers are expected to make "good faith efforts in complying with the law," the report's findings indicate that more than good faith is necessary to ensure payer compliance. Payer discriminatory practices hamper consumer choice and competition, reduce quality and access to care, and undermine efforts to contain healthcare costs. Moreover, it disincentivizes efficiencies by encouraging the use of higher cost providers without any substantiated enhancement in the quality of care. Given hospitals' reliance on anesthesia services, it is crucial to adopt cost-effective strategies and ensure reimbursement parity between anesthesiologists and CRNAs when they perform equivalent services. With increasing costs and declining revenues in almost all surgical areas, optimizing operating expenses and eliminating or reducing anesthesia subsidies are becoming essential objectives.

This research underscores the importance of addressing reimbursement disparities and contracting factors between anesthesiologists and CRNAs within the context of the ACA-NDP and the interim final rule of the No Surprises Act. The findings highlight the need for payers to align their practices with the nondiscrimination provision, ensuring equitable reimbursement for anesthesia services provided by CRNAs. By placing emphasis on "quality" and "performance" in valuation, healthcare systems can foster the development of cost-effective strategies, benefiting both providers and patients.

RECOMMENDATIONS

This report emphasizes the urgency to address reimbursement disparities by enacting rules that enforce compliance with the nondiscrimination provision of the ACA. Additionally, it highlights the need to rectify the discriminatory methodology present in the interim final rule of the No Surprises Act.

The Merit-Based Incentive Payment System (MIPS) is already established within the Medicare payment program and is widely utilized by various commercial payers to incentivize quality performance.[34] An equitable reimbursement methodology for all providers can be achieved by calculating the median payment amount across all service provider codes, collectively forming the QPA. Subsequent adjustments to this amount can be made based on the performance scores of each group or provider, as determined by MIPS. These performance scores, based on procedure outcomes, are impartial and do not consider provider type or service code. This approach ensures that payment rates are contingent on performance and outcomes rather than the provider's licensure.

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AUTHORS

Jean M. Covillo, DNAP, CRNA, APRN, is a practicing CRNA and the owner of Excel Anesthesia, LLC, operating in multiple facilities across Kansas and Missouri, Shawnee, Kansas. Email: jcovillo@eakc.net

Maria Sallie Poepsel, PhD, CRNA, APRN, FAANA, is a practicing CRNA and owner of MSMP Anesthesia Services, LLC, Columbia, Missouri. Email: msmpanesthesia@gmail.com

B. Jeanie Skibiski, DNAP, MHA, CRNA, CPPS, FAANA, is an Associate Professor at the Missouri State University School of Anesthesia, Springfield, Missouri. Email: jskibiski@missouristate.edu

DISCLOSURES

Name: Jean M. Covillo, DNAP, CRNA, APRN
Contribution: This author made significant contributions to the conception, synthesis, writing, and final editing and approval of the manuscript to justify inclusion as an author.
Disclosures: None.
Name: Maria Sallie Poepsel, PhD, CRNA, APRN, FAANA
Contribution: This author made significant contributions to the conception, synthesis, writing, and final editing and approval of the manuscript to justify inclusion as an author.
Disclosures: None.
Name: B. Jeanie Skibiski, DNAP, MHA, CRNA, CPPS, FAANA
Contribution: This author made significant contributions to the conception, synthesis, writing, and final editing and approval of the manuscript to justify inclusion as an author. She is the corresponding author of this article.
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