American Association of
NURSE ANESTHESIOLOGY

September 7, 2023

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1784-P –Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies, and Basic Health Program; Proposed Rule (88 Fed.Reg. 52262, August 7, 2023)

Dear Administrator Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on this Propose Rule: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies, and Basic Health Program; (88 Fed.Reg. 52262, August 7, 2023). The AANA makes the following comments and requests:

Changes in Relative Value Unit (RVU) Impact Pages 52678-52686

- Alleviate the Reimbursement Cuts to Providers, Such as CRNAs

Supervision of Residents in Teaching Settings

- Ensure that Interactive Telecommunications Technology are not Used for Anesthesiologist Telesupervision of Anesthesia Services

Request for Comment about Evaluating E/M Services More Regularly and Comprehensively

- Support the Creation of Additional Coding and Payment to Address Acute Pain
- Develop an Equitable Valuation Process that Allows Full Participation by APRNs, Including CRNAs

Social Determinants of Health (SDOH) –Proposal to Establish a Stand-Alone G Code

- Allow CRNAs to Use Stand Alone G Code for Preanesthesia Patient Assessment and Evaluation and as Part of Evaluation and Management for Pain Management Practices

Comment Solicitation on Expanding Access to Behavioral Health Services

- CRNAs Play a Role in Behavioral Health Services

Principal Illness Navigation (PIN) Services

- As a Condition of Payment for Principal Navigation Services, Ensure that CRNAs and Their Services Are Identified and Included in Referrals

Medicare Provider Enrollment Provisions—"Pattern or Practice'' Page 52522

- Protect Providers in Program Integrity Efforts in Instances When MAC s Incorrectly Deny Services

Updates to the Quality Payment Program

- Clarify Data Completeness Criteria for Quality Measures for Clinicians with Special Statues
- Encourage Measures that Best Reflect Clinician Practice and Workforce
- Do Not Finalize Proposal to Establish Performance Threshold at 82 Percent

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 61,000 CRNAs and SRNAs, representing about 86 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year in the United States. For further information, see: https://www.aana.com/about-us.

Changes in Relative Value Unit (RVU) Impact Pages 52678-52686

AANA Request: Alleviate the Reimbursement Cuts to Providers, Such as CRNAs

We were disappointed to see a proposed 3.26 percent decrease over last year's anesthesia conversion factor (CF) in this proposed rule. We understand that the Centers for Medicare & Medicaid Services (CMS) is bound by budget neutrality requirements, and that any changes to these requirements would necessitate future Congressional action. However, anesthesia services are currently underfunded, and this disproportionate pay affects patient access to anesthesia care, especially in rural and underserved areas where CRNAs predominate. A study of CRNAs in rural areas that correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations, showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[1] In addition, the proposed payment policy changes in this proposed rule will have a negative 2 percent impact on anesthesia payment rates. As CMS notes that changes are due to policy changes, we would ask that CMS minimize effects to practitioners. This cut is especially challenging to providers given current inflation rates. To the extent that CMS does have the ability to alter payment rates, we ask that CMS help lessen the impact of this decrease in the anesthesia CF and to work with Congress to establish an answer. The AANA would be happy to work with the agency in these efforts.

Supervision of Residents in Teaching Settings

AANA Request: Ensure that Interactive Telecommunications Technology are not Used for Anesthesiologist Telesupervision of Anesthesia Services

As CMS is considering how telehealth services can be furnished in all residency training locations beyond December 31, 2024 (page 52303), the AANA cautions CMS against the use of wasteful services in the name of telehealth that would increase costs without improving healthcare access or quality. We stress that one wasteful payment policy to avoid would be reimbursing anesthesiologists that are not providing actual anesthesia care, through billing for remote so-called "supervision" services. This type of remote supervision would not improve access to healthcare for patients and would instead reward providers not actually furnishing healthcare services. CMS also states in the preamble of the 2021 Physician Fee Schedule final rule 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."[2] We also have concerns that this proposal could lead to virtual supervision in other instances. While we understand that supervision of residents in teaching

[1] Liao CJ, Quraishi JA, Jordan, LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270.

[2] 85 FR 84539, December 28, 2020.

situations is a slightly different situation, we note that there is no evidence of the efficacy and cost-effectiveness of in-person physician supervision requirements,[3] there also is no evidence regarding the benefit for the use of supervision of anesthesia via telehealth.[4] As evidence shows that in-person supervision by physicians does not improve anesthesia outcomes, while it does significantly increase costs; thus it stands to reason that remote supervision would not improve outcomes, while also substantially increasing costs. As CMS continues to consider this matter and any potential use in anesthesia, we also urge that any CMS policy or direction recognize AANA as a major stakeholder in its formulation and that future AANA developed guidelines should be integrated in the determination into Medicare payment policy.

Request for Comment about Evaluating E/M Services More Regularly and Comprehensively

AANA Comment: Support the Creation of Additional Coding and Payment to Address Acute Pain

We appreciate CMS's consideration of how they can potentially move forward with reforms to the way they establish values for E/M and other services (page 52354). One area that we recommend CMS explore further is payment for opioid free techniques for anesthesia. We note that CMS was considering the creation of additional coding and payment to address acute pain in the FY 2023 Physician Fee Schedule proposed rule, and we had previously recommended that CMS include separate coding and payment that supports the use of opioid free techniques and ERAS® pathways available in all settings from offices to healthcare facilities. We continue to recommend this. We also recommend that these be made available for use for direct reimbursement by providers, such as CRNAs. The AANA believes that the use of opioid sparing techniques and ERAS® pathways are essential since the risk of opioid dependence and addiction begins with the first exposure. As any E&M associated with the primary anesthetic is already bundled into the reimbursement for the anesthetic provided, and opioid free techniques and ERAS® pathways are not currently reimbursed. Therefore, we recommend that coding be developed and used as a stand-alone or a single unit specialty service in addition to the primary anesthetic.

Multimodal analgesia describes the use of more than one modality or techniques to achieve effective pain control from the preoperative period through initial recovery and return home.[5] A multimodal treatment, instead of the traditional unimodal opioid approach involves the administration of several analgesics with separate mechanisms of action across the perioperative

[3] See B. Dulisse and J. Cromwell op cit. and Paul F. Hogan et. al, op cit.

[4] See: Applegate RL, 2nd, Gildea B, Patchin R, et al. Telemedicine pre-anesthesia evaluation: a randomized pilot trial. Telemed J E H ealth. 2013;19:211-6; Cone SW, Gehr L, Hummel R, Merrell RC. Remote anesthetic monitoring using satellite telecommunications and the Internet. Anesthesia and analgesia. 2006;102(5):1463-1467; Dilisio RP, Dilisio AJ, Weiner MM. Preoperative virtual screening examination of the airway. J Clin Anesth. 2014;26:315-7; and Galvez JA, Rehman MA. Telemedicine in anesthesia: an update. Curr Opin Anaesthesiol. 2011;24:459-62.

[5] Tan M, Law LS, Gan TJ, Optimizing pain management to facilitate Enhanced Recovery After Surgery pathways. Can J Anaesth. Feb 2015;62(2):203-218.

period and/or concurrent field block using local anesthetic, regional or neuraxial analgesia (e.g., paravertebral block with non-opioid analgesia).[6] It is important to take into consideration the complexity of the surgical procedure, patient pain experience history and preferences, anticipated level of postoperative pain, and duration of action of analgesics and local anesthetics when deciding on pain management options for pathway development and for individual patients. Multimodal analgesia may eliminate or significantly reduce the use of opioids and adverse side effects such as respiratory depression, postoperative nausea and vomiting (PONV), and delayed return of gastrointestinal function.[7]

Non-opioid medications include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), systemic lidocaine or ketamine infusion, long-acting local anesthetics, and gabapentinoids (gabapentin/pregabalin).[8] Other modalities using local anesthetics of varying durations of action include surgical site local anesthetic infiltration, field blocks (e.g., transversus abdominis plane (TAP) block), central neuraxial techniques (e.g., epidural and spinal analgesia), and regional blocks.[9] Non-pharmacological analgesia (e.g., acupuncture, music therapy) as well as cognitive-behavioral techniques (e.g., guided imagery, relaxation), may be used as an adjunct to pharmacological methods to support the patient to reduce postoperative pain, anxiety, and use of pain medication.[10]

Using a multimodal approach and 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 anesthesia professional plays a pivotal role in patient/family education by engaging the patient as an active participant in his or her care and the recovery process.[11] Anesthesia professionals continue to build on these activities throughout the Prehospital/Preadmission Phase through patient assessment and evaluation to identify unique elements of the patient's health, pain and anesthesia history that may require modification of the ERAS® pathway to coordinate development of the plan of care with the patient and their primary care and specialty team, as appropriate. 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. Careful assessment and treatment of acute pain, which may include appropriate opioid prescribing, can decrease the risk of acute pain transitioning to chronic pain or

[6] Tan M, Law LS, Gan TJ, op cit.

[7] Miller ET, Gan TJ, Thacker JK. Enhanced Recovery pathways for major abdominal surgery Anesthesiology News 2014.

[8] Siu-Chun Law L, Ah-Gi Lo E, Gan TJ. Preoperative Antiemetic and Analgesic Management In: Gan TJ, Thacker JK, Miller TE, Scott MJ, Holubar SD, eds. Enhanced Recovery for Major Abdominopelvic Surgery. West Islip, NY: Professional Communications, Inc; 2016:105-120.

[9] Montgomery R, McNamara SA. Multimodal Pain Management for Enhanced Recovery: Reinforcing the Shift From Traditional Pathways Through Nurse-Led Interventions. AORN J. Dec 2016;104(6S): S9-S16.

[10] See: Tan M, Law LS, Gan TJ, op cit. and Montgomery R, McNamara SA, op cit.

[11] Brady KM, Keller DS, Delaney CP. Successful Implementation of an Enhanced Recovery Pathway: The Nurse's Role. AORN J. Nov 2015;102(5):469-481.

the development of opioid dependency and abuse.[12] We stand ready to further support CMS in the development of additional coding and payment to address acute pain.

AANA Request: Develop an Equitable Valuation Process that Allows Full Participation by APRNs, Including CRNAs

We appreciate that CMS is requesting comments for exploring alternatives to the AMA RUC (page 52354). We do not believe that the AMA RUC is the entity best positioned to provide recommendations to CMS on resource inputs for work and PE valuations, as well as how to establish values for E/M and other physicians' services. We believe that healthcare equity must also include equitable representation of APRNs, including CRNAs in the valuation process. Since the AMA RUC was established in 1991, there has been a significant increase in Medicare patients who receive treatment from APRNs. The valuations established by this process no longer represent the valuation of services for just physicians, but all providers who bill Medicare. Despite this, the RUC does not allow for full APRN participation in the valuation process, instead relegating the interests to be represented by the Health Care Professionals Advisory Committee (HCPAC), which only has one seat on the RUC.

Outstanding recommendations issued by both the United States Government Accountability Office (GAO)[13] and the Medicare Payment Advisory Commission (MedPAC)[14], call for better data and transparency to improve accuracy within the valuation process. Therefore, we request that CMS develop an equitable valuation process which allows full participation by APRNs to better reflect the clinicians providing care to Medicare beneficiaries. This change would align the valuation process with CMS' strategic pillars of advancing health care equity, engaging partners, and driving innovation.[15]

Social Determinants of Health (SDOH) –Proposal to Establish a Stand-Alone G Code

AANA Request: Allow CRNAs to Use Stand Alone G Code for Preanesthesia Patient Assessment and Evaluation and as Part of Evaluation and Management for Pain Management Practices

[12] See AANA Position Statement, "A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment, July 2016, available at: www.aana.com/HolisticPainMgmt.

[13] GAO-15-434, Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy

[14] jun18_ch3_medpacreport_sec.pdf

[15] CMS Strategic Plan | CMS

Should CMS finalize its proposal to establish a stand-alone G code for social determinants of health (SDOH) (page 52330), we recommend that this code be used for CRNAs as part of the preanesthesia patient assessment and evaluation and as part of the evaluation and management for pain management practices. As CMS is proposing to include Q487: Screening for Social Drivers of Health in the anesthesia MVP, it seems appropriate that CRNAs be recognized for providing this service in practice. SDOH's may affect a patient's condition and their pain experience. The preanesthesia assessment and evaluation provides vital information about the patient, and the associated record documents patient demographics, height and weight, vital signs, allergies and medication history, health history and review of systems, physical examination, relevant diagnostic test results, physical status designation, and anesthesia plan of care.[16] Furthermore, the experience of chronic pain is unique to each patient and involves complex biological (e.g., age, gender), psychological (e.g., childhood trauma), and social (e.g., social and economic disadvantages) factors.[17] Social and economic disadvantages correlate with chronic pain. For instance, low socioeconomic status, being a racial/ethnic minority, poverty, unemployment, geographic isolation, and inadequate insurance coverage are associated with higher prevalence and intensity of chronic pain compared to people without these characteristics.[18]

Comment Solicitation on Expanding Access to Behavioral Health Services

AANA Comment: CRNAs Play a Role in Behavioral Health Services

We appreciate CMS's dedication to expanding access to behavioral health services and for including pain treatment and management in the agency's Behavioral Health strategy (page 52369). Pain management is central to the scope and practice of a CRNA, and CRNAs play a vital role by providing patient focused, comprehensive pain care in communities throughout the United States. As a main provider of pain management services and as APRNs, CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient-centered, compassionate and holistic manner in all clinical settings. [19] Furthermore, the holistic 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.[20]

---

[16] AANA Practice and Policy Considerations, Documenting Anesthesia Care, February 2014, available at: https://issuu.com/aanapublishing/docs/4_-_documenting_anesthesia_care?fr=sNDZlYTU2NDAxMjU.

[17] AANA Chronic Pain Management Guidelines, November 2021, available at: https://issuu.com/aanapublishing/docs/2_-_chronic_pain_management_guidelines?fr=sZDgxODU2NDAxMjU.

[18] Ibid.

[19] AANA Chronic Pain Management Guidelines, op cit and AANA, Regional Anesthesia and Analgesia Techniques - An Element of Multimodal Pain Management. Guidelines, https://issuu.com/aanapublishing/docs/15_-_regional_anesthesia_and_analgesia_techniques_ and AANA Guidelines on A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment, https://issuu.com/aanapublishing/docs/1_-_a_holistic_approach_to_pain_management-_integr.

[20] Ibid.

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. CRNAs are involved in every aspect of anesthesia services and work in many types of facilities and provide acute, chronic, and interventional pain management services. In some states they are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. CRNAs have been on the front lines of developing novel non-opioid based treatments for both chronic and acute pain and the AANA supports maximum flexibility in allowing pain treatment plans that rely on the clinical judgment of the practitioner directing care.

Also related to behavioral health, CRNAs are educated and trained to administer ketamine both for sedation and general anesthesia, chronic pain management and ketamine infusion therapy and related modalities for psychiatric disorders and chronic pain. Ketamine infusion clinics are becoming more available, and this therapy has been shown to have antidepressive properties and is increasingly becoming used to treat psychiatric disorders, including major depressive disorder (MDD), bipolar disorder, treatment-resistant depression, and post-traumatic stress disorder (PTSD). The AANA supports a patient-centered, interdisciplinary approach to managing patients who suffer from psychiatric disorders and may benefit from ketamine infusion therapy. As with all clinical practice, CRNAs practice in accordance with professional ethics, scope and standards of practice, sound professional judgment, available evidence, interests of the patient, and applicable law. When administering ketamine for the treatment of psychiatric disorders, CRNAs collaborate with healthcare professionals whose practice includes focusing on and diagnosing psychiatric disorders within their professional and state scope of practice.[21] We request that CMS examine CRNA reimbursement for their work associated with collaborating with psychiatric-mental health providers.

Principal Illness Navigation (PIN) Services

AANA Request: As a Condition of Payment for Principal Navigation Services, Ensure that CRNAs and Their Services Are Identified and Included in Referrals

We appreciate that CMS is better identifying and value practitioners' work in helping patients navigating the healthcare system by proposing payment for Principal Illness Navigation (PIN) Services. We believe it is imperative that CMS ensure that the individual billing for these services does not inadvertently leave out CRNAs and APRNs as part of referral services. We request that CMS require as condition of paying for services as part of the PIN Services (CPT codes GXXX3 and GXXX4) that the individual billing for these services ensure that all applicable services of CRNAs are identified and included in the services that are recommended for the patient and caregiver. CRNAs personally administer more than 50 million anesthetics to patients each year in the United States and provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospital.

[21] AANA and APNA Joint Position Statement on Ketamine Infusion Therapy for Psychiatric Disorders (2019), https://issuu.com/aanapublishing/docs/apna-aana-joint-statement-on-ketamine?fr=sY2VlZjU2NDAxMjU

CRNAs are the predominant anesthesia providers in underserved areas and are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries when compared with physician counterparts.[22] In addition to providing anesthesia services, CRNAs also provide acute, chronic, and interventional pain management services. Therefore, it is also important that referral services for CRNAs include their subspecialties as well. Failure to do so will hamper efforts to improving access to medically necessary anesthesia and pain management services, especially in rural and underserved areas.

Medicare Provider Enrollment Provisions—"Pattern or Practice'' Page 52522

AANA Request: Protect Providers in Program Integrity Efforts in Instances When MAC s Incorrectly Deny Services

AANA takes seriously the improper or abusive billing to the Medicare and Medicaid programs and believes that these practices can have negative and detrimental consequences for patients. While we appreciate the efforts that CMS is taking to improve program integrity in the Medicare and Medicaid programs in establishing changes in the definition of ''pattern or practice'' at § 424.502, we have concerns that the proposal does not include protections against actions taken against providers due to improper claims denials made by Medicare Administrative Contractors (MACs). As new CPT codes are introduced or existing CPT codes are revised, CRNAs may be inadvertently left off as the type of provider that can bill for services or be incorrectly denied due to failure to recognize scope of practice in a particular state. In such instances, it is not clear whether three denials would result in "non-compliant claims." Furthermore, as CRNA payment may be made to an entity, such as a hospital, critical access hospital, physician, group practice, or ambulatory surgical center, with which the CRNA or has an employment or contractor relationship, CRNAs may not be made aware of denials long after three claims have been issued and denied. In addition, as part of their pain practices, CRNA may order services, such as MRIs and refer for services. CRNAs are not expressly prohibited from ordering and referring Medicare services by legislation or by regulation. In fact, Medicare in November 2012 published a rule indicating Medicare coverage of all Medicare CRNA services within their state scope of practice.[23] Improper denials for services that our members order and refer go to the patient and the facility/practitioner that carries out the order. The facility/practitioner may not share a denial with the CRNA. Revocation of billing rights in the instances outlined above can harm patient access to medically necessary care and services. Therefore, we request that protections be added for providers in both the final regulation and in subregulatory documents. We stand ready to work with the agency in these efforts.

Updates to the Quality Payment Program

[22] Liao, op cit.

[23] 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 Request: Clarify Data Completeness Criteria for Quality Measures for Clinicians with Special Statues

As CMS is proposing to increase the data completeness criteria threshold from 75 percent to 80 percent for the CY 2027 performance period/2029 MIPS payment year (page 52566), we would request that CMS clarify how this proposed data completeness criteria will affect eligible clinicians with special statuses, such as small practice or non-patient facing, or who qualify for hardship exemptions would not report the PI category. We do not recall seeing how this will affect CRNAs in resources provided by the agency, and we respectfully request that this information be included in the agency's resources.

AANA Request: Encourage Measures that Best Reflect Clinician Practice and Workforce

We appreciate that CMS is looking at ways to encourage clinicians who have consistently been high performers in MIPS to continuously improve various areas of their clinical practice (page 52557). We wish to highlight that the emphasis on the use of outcome measures in the MIPS program presents a challenge to some specialty clinicians, such as CRNAs. Few outcome measures apply to anesthesia. Anesthesia is a specialty area where it has been difficult to identify or develop outcomes-based measures, as opposed to process-based, that meet CMS criteria or that have not been topped out where no further improvement is possible. Therefore, we request that CMS encourage measures that best reflect clinician practice and workflow over insisting on the use of outcome measures meaningful. For example, CRNAs use specific processes to ensure patient safety during the perioperative and postoperative periods, so a combination of process and measures may provide more value than outcomes measures alone. Furthermore, we would also encourage CMS to mitigate unintended consequences by promoting the use of Improvement Activities that are related to quality measures. This recommendation could help eligible clinicians to align their activities with quality objectives and goals without the need for separate data collection and reporting.

AANA Comment: Do Not Finalize Proposal to Establish Performance Threshold at 82 Percent

AANA has concerns with CMS's proposal to establish the performance threshold at 82 points for the CY 2024 performance period/2026 MIPS payment year (page 52554). The limited number of MIPS anesthesia measures coupled with the fact that CRNAs and other anesthesia providers are newer to the Promoting Interoperative performance category make it difficult for eligible clinicians, such as CRNAs, to meet the 82-point threshold.

Thank you for the opportunity to comment on this proposed rule. Should you have any questions regarding these matters, please contact AANA Senior Associate Director, Federal Regulatory and Payment Policy, Romy Gelb-Zimmer at 202-484-8400, rgelb-zimmer@aana.com.

Sincerely,

Dru Riddle, PhD, CRNA, FAAN
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Ingrid Lusis, AANA Chief Advocacy Officer
Romy Gelb-Zimmer, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy