Ms. Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
CMS-1695-P  
PO Box 8013  
Baltimore, MD 21244-1850

RE: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologics for a Potential CMS Innovation Center Model (83 Fed. Reg. 37046, July 31, 2018)

Dear Ms. Verma:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the proposed rule Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologics for a Potential CMS Innovation Center Model (83 Fed. Reg. 37046, July 31, 2018). The issues addressed in our comment are outlined as follows:

I. **CRNAs Provide Safe, High Quality and Cost-Effective Care**

II. **Proposed CY 2019 ASC Packing Policy for Non-Opioid Pain Management Treatments**

- Use of Non-Opioid Alternatives, Such as Multi-Modal Pain Management and Enhanced Recovery After Surgery (ERAS) Protocols, Do Lead to a Decrease in Prescription Opioid Use and Addiction
- Ensure that Medicare Carriers Do Not Limit Medically Necessary CRNA Pain Management Services
III. **Hospital OQR Program Measures and Topics for Future Consideration**

- Do Not Use Outcome Measures as a Replacement for Clinical Process Measures Without Stakeholder Input for Future Measure Topics in the OQR Program

IV. **ASCQR Program Measures and Topics for Future Consideration: Possible Future Validation of ASCQR Program Measures**

- Support Use of Normothermia Measure to Validate Chart-Abstracted Measures in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program Prior to Expanding to More Measures and Request to Keep the Definition of Normothermia Consistent through all Quality Reporting Programs

V. **Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and other Medicare-and Medicaid-Participating Providers and Suppliers**

- CMS Should Apply Provisions Set Forth in the Quality Payment Program for Special Status Clinicians to the Development of Any New Medicare Condition of Participation
- Prohibit the Use of Wasteful Tele-Supervision of CRNA Services
- Emphasize the Use of Cost-Effective Anesthesia Care Provided by CRNAs in Advancing Interoperability of Health Information
- For Anesthesia, Interoperability of Health Information Should Communicate Across the Continuum of Patient Care and EHRs Should Use Standardized Taxonomies Across Technology Platforms
- The Focus of Measurement of Interoperability Should Not Be Limited to Only Use of Certified EHR Technology
- Additional Anesthesia Data Sources Should be Used to Evaluate Interoperability

VI. **Request for Information on Price Transparency: Improving Beneficiary Access to Providers and Supplier Charge Information**

- CMS Can Address Underlying Causes of Surprise Billing by Issuing a Proposed Rule on Provider Non-Discrimination Provision and by Promoting Adequate Provider Networks in Medicare Advantage Plans and Health Plans Inside the Marketplace
- CMS Can Work with Health Care Stakeholders in Developing Guidance to Educate Consumers on Questions to Ask Their Insurance Companies to Help Avoid Surprise Billing

VII. **Proposed Updates to the HCAHPS Survey Measure (NQF #0166) for the FY 2024 Payment Determination and Subsequent Years**
• Support Removal of Communication about Pain Questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey in the Hospital IQR Program in Exchange for Meaningful High-Priority Pain Measures that Can Improve Functional Assessment Scores with Reduced Opioid Use

I. CRNAS PROVIDE SAFE, HIGH QUALITY AND COST-EFFECTIVE HEALTHCARE

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 50,000 CRNAs and SRNAs, representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer approximately 43 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services are in high demand. CRNAs are Medicare Part B providers and since 1989 have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNAs are involved in every aspect of anesthesia services including a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute, chronic, and interventional pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal Nursing Economic$, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery
model. An August 2010 study published in *Health Affairs* showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians. 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, the internationally recognized authority on evidence-based practice in healthcare. 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.

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. The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type. The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also 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.

**II. Proposed CY 2019 ASC Packing Policy for Non-Opioid Pain Management Treatments**

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1. Paul F. Hogan et al., “Cost Effectiveness Analysis of Anesthesia Providers.” *Nursing Economic*s. 2010; 28:159-169. [http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf)


AANA Comment: Use of Non-Opioid Alternatives, Such as Multi-Modal Pain Management and Enhanced Recovery After Surgery (ERAS) Protocols, Do Lead to a Decrease in Prescription Opioid Use and Addiction

The AANA appreciates the opportunity to comment on strategies to improve existing requirements in order to more effectively address the opioid epidemic. We support the agency’s interest in reviewing peer-reviewed evidence that demonstrates that use of non-opioid alternatives in the outpatient setting and contend that these alternatives do lead to a decrease in prescription opioid use and addiction. As the risk of opioid dependence and addiction begins with the first exposure, we recommend that CMS promote comprehensive multimodal pain management and enhanced recovery after surgery (ERAS) protocols as a non-opioid alternative to treat pain in all clinical settings. 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. 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 (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics). 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 mitigating the risk of dependency and aiding in the reduction of potential adverse drug events related to opioids.

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. A multimodal, instead of the traditional unimodal opioid approach involves the administration of several analgesics with separate mechanisms of action across the perioperative period and/or concurrent field block using local anesthetic, regional or neuraxial analgesia (e.g., paravertebral block with non-opioid analgesia). 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

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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.\textsuperscript{10}

Non-opioid medications include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), systemic lidocaine or ketamine infusion, long-acting local anesthetics, and gabapentinoids (gabapentin/pregabalin).\textsuperscript{11} 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.\textsuperscript{12} 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.\textsuperscript{13,14}

Regarding the treatment of acute and chronic pain, the AANA believes it’s best treated and managed by an interdisciplinary team that actively engages the patient to diagnose and manage their pain for improved well-being, functionality, and quality of life. As anesthesia professionals, CRNAs also help to decrease or eliminate the need for opioids by collaborating with the patient and the interdisciplinary team on a comprehensive plan for pain relief known as ERAS.\textsuperscript{15} According to a recent AANA position statement titled, \textit{A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment}, “CRNAs integrate multimodal pain management as an element of enhanced recovery after surgery (ERAS) protocols to manage pain. 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

\textsuperscript{10} Miller ET, Gan TJ, Thacker JK. Enhanced Recovery pathways for major abdominal surgery \textit{Anesthesiology News} 2014.


\textsuperscript{13} Tan M, Law LS, Gan TJ, op cit.

\textsuperscript{14} Montgomery R, McNamara SA, op cit

begins pre-procedure and continues after discharge by using opioid sparing techniques such as regional anesthesia, peripheral nerve blocks, non-pharmacological approaches, and non-opioid based pharmacologic measures. The evidence is quite clear that careful assessment and treatment of acute pain can decrease the risk of acute pain transitioning to chronic pain or the development of opioid dependency and abuse. CRNAs play a vital role by ensuring proper anesthesia services management which can make a tremendous difference in terms of improving patient flow, patient safety, and cost savings.

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. 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. Collaboration with the patient's advanced pain management team and utilizing multi-modal pain management strategies can improve outcomes, especially for patients with difficult to control pain (e.g., chronic pain patient, substance use disorder). The evidence is quite clear that

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careful assessment, evaluation, and treatment of acute pain 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.

**AANA Comment: Ensure that Medicare Carriers Do Not Limit Medically Necessary CRNA Pain Management Services**

The AANA recommends that CMS should ensure that Medicare carriers do not limit patient access to the use of medically necessary CRNA pain management. Leading physician subspecialty organizations in pain management research, practice guideline development, and education are known to use economic and advocacy means to exclude other members of the pain management team, such as CRNAs, from educational and practice opportunities, thereby limiting patient access to care, diagnosis, treatment, and ultimately improved patient quality of life. A report issued in April 2015 by the FTC, “Competition and the Regulation of Advanced Practice Registered Nurses,” underscores the point that for CRNAs and other APRNs, “even well intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition.”22 Therefore, we recommend that CMS be cognizant of these barriers and require Medicare contractors to follow Medicare regulations and policy and to not impose barriers that limit a CRNA’s ability to provide comprehensive pain management care. Limitations to patient access to these services are also counterproductive in the fight against the opioid epidemic and contradict the agency’s opioid road map. In the interest of patients and the public, the education, regulation, and reimbursement of each member of the pain management team should allow the team to practice to the full extent of their education and training.

**III. HOSPITAL OQR PROGRAM MEASURES AND TOPICS FOR FUTURE CONSIDERATION**

**AANA Comment: Do Not Use Outcome Measures as a Replacement for Clinical Process Measures Without Stakeholder Input for Future Measure Topics in the OQR Program**

The AANA supports the agency’s goal of developing a comprehensive set of quality measures to be available for widespread use for informed decision-making and quality improvement in the hospital outpatient setting. We agree that this will help further the agency’s goal of achieving better health care and improved health for Medicare beneficiaries who receive health care in hospital outpatient settings, while aligning quality measures across the Medicare program. The AANA supports the use of quality measures that are transparent, actionable, evidence-based, patient-centered and consensus-driven. However, while the use of outcome measures are necessary for ascertaining the impact of care processes, caution should be used with using outcome measures alone for interpreting quality. Dependence on outcome measures that only rely on patient feedback or responses may not be as reliable as data from more objective measures. Outcome measures should also be statistically adjusted for the outpatient setting. In addition, using outcome measures without stratification for social and patient risk factors make interpreting their use in Medicare value-purchasing and quality programs problematic. Therefore, for future planning of measure topics in the OQR program, we recommend the agency not use outcome measures as a as a replacement for clinical process measures without stakeholder input. Quality measures pertaining to anesthesia services should take into account all appropriate stakeholders, including CRNA input, regarding their professional role in the spectrum of anesthesia services and pain management.

IV. ASCQR PROGRAM MEASURES AND TOPICS FOR FUTURE CONSIDERATION: POSSIBLE FUTURE VALIDATION OF ASCQR PROGRAM MEASURES

AANA Comment: Support Use of Normothermia Measure to Validate Chart-Abstracted Measures in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program Prior to Expanding to More Measures and Request to Keep the Definition of Normothermia Consistent through all Quality Reporting Programs

We applaud the agency’s interest in using ASC- 13: Noromothermia Outcome as the measure to validate chart-abstracted measures in the ASCQR program. The addition of this quality measure will help further the goal of achieving better healthcare and improved health for Medicare beneficiaries who receive healthcare in ASC settings, including facilities where CRNAs provide each patient’s anesthetic and perioperative care. As determined advocates for patient safety and access to quality healthcare, CRNAs have been providing safe and high-quality anesthesia care in the United States for 150 years and provide anesthesia services in a wide variety of settings including ASCs.
Specifically, we believe that using the ASC-13 normothermia measure as a test measure for the validation process will be informative. While we continue to support the agency’s use of the normothermia measure in the ASCQR program, (which assesses the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration) we note that there is an incongruent definition of normothermia from other federal quality reporting programs. The AANA has previously voiced concern with adopting this measure in the ASCQR program due to the inconsistency, which could impact quality scores. Particularly, ASC-13 continues to apply the older definition of normothermia as 36 degrees Celsius/96.8 degrees Fahrenheit. This definition is included in the measure specifications used by facilities reporting this measure through the ASC Quality Collaboration. On the other hand, the Merit-based Incentive Payment System (MIPS) measure # 424 uses 35.5 degrees Celsius/95.9 degrees Fahrenheit for its definition of normothermia and has been incorporated into the MIPS anesthesiology measure set. Since both measures are nearly identical in measure specification, eligible MIPS anesthesiology professionals will likely adhere to the MIPS measure definition since their professional services are subject to a 7% financial penalty under MACRA in the 2019 performance period. As a result, any documented temperature between 95.9 F – 96.7 F will be compliant with MIPS measure # 424 but not with ASC-13. We believe that using the more current definition for normothermia (i.e., 35.5 degrees Celsius/95.9 degrees Fahrenheit) is a non-substantive change to the ASC measure specification, as it is an acceptable definition for normothermia by anesthesia professionals. Therefore, we recommend that this definition be adopted to remain consistent with the agency’s Blueprint measure evaluation criteria for harmonized measures, maintain uniformity in anesthesia quality improvement, improve the validation process, and reduce confusion among anesthesia professionals.

If the definition of normothermia does not change in the ASC measure specification, and discrepancies are found during the validation process, then the AANA urges that all anesthesia professionals are held harmless for complying with MIPS measure #424, and ASC facilities should be notified of the conflicting measure specifications imposed on anesthesia professionals.

V. REQUEST FOR INFORMATION ON PROMOTING INTEROPERABILITY AND ELECTRONIC HEALTHCARE INFORMATION EXCHANGE THROUGH POSSIBLE REVISIONS TO THE CMS PATIENT HEALTH AND SAFETY REQUIREMENTS FOR HOSPITALS AND OTHER MEDICARE-AND MEDICAID-PARTICIPATING PROVIDERS AND SUPPLIERS
AANA Comment: CMS Should Apply Provisions Set Forth in the Quality Payment Program for Special Status Clinicians to the Development of Any New Medicare Condition of Participation

The AANA recognizes that health information exchange has the potential to improve the healthcare system in numerous ways by advancing interoperability and that health information exchange between patients, providers and health care settings is an important step toward realizing this potential. Furthermore, the AANA is a determined advocate for policy development that results in a connected, patient-centered healthcare system where health information is routinely shared across providers and settings of care to encourage the consistent provision of high-quality, safe, and affordable care. Most anesthesia professionals, such as CRNAs, lack the “face-to-face” interaction according to billing codes and have difficulty influencing the availability of anesthesia EHR technology in facilities due to cost and limited anesthesia certified EHR technology (CEHRTs) to choose from. According to our analysis of the 2014 Medicare Provider Utilization and Payment data, 98.7% of CRNAs billed for anesthesia services CPT codes 00100-01999, which CMS determined to be non-patient-facing codes for 2016.

In addition, issues around interoperability and electronic clinical quality measures that apply to anesthesia continue to be a challenge. Such difficulties were the impetus for CMS to provide Special Status to non-patient facing clinicians and hospital-based or ASC-based clinicians, such as many, if not most anesthesia professions. While CRNAs are not required to participate in the Merit-based Incentive Payment System (MIPS) Promoting Interoperability performance category, all anesthesia professionals should be granted similar exceptions in terms of CEHRT adoption similar to that under the Medicare Quality Payment Program. The evidence shows that adoption of specific anesthesia information management systems (AIMS) lags behind other segments in the healthcare industry and has low implementation rates in anesthesia departments.\(^{23}\) According to an August 2012 KLAS Performance Report,\(^ {24}\) which reports on vendor performance data, fewer than 300 organizations nationwide are using or implementing AIMS. Low adoption of AIMS means that the surgical patient experience remains a black hole in the center of the grand plan for health information exchange. Furthermore, even with a robust certified AIMS system, it continues to be a challenge to meet some of the former meaningful use measures, some of which are now Promoting Interoperability measures. Due to few, if any comprehensive CEHRT anesthesia EHRs,


clinicians must relay on modular AIMS, which may or may not be CEHRT, and have extensive technical experts on hand. Therefore, we request that CMS apply similar exceptions when considering changes to health information exchange requirements in CMS Conditions of Participation, Conditions for Coverage, or any CMS requests for proposals.

**AANA Comment: Prohibit the Use of Wasteful Tele-Supervision of CRNA Services**

The AANA is supportive of telehealth and remote monitoring technology that improves the quality of care provided for all patients. However, the AANA cautions against the use of wasteful technology services that exchanges electronic healthcare information in the name of telehealth that would increase costs without improving healthcare access or quality. Specifically, we oppose policies that allow anesthesiologists to be reimbursed without providing actual anesthesia care, through billing for remote supervision services. This type of remote supervision would not improve access to healthcare for patients with chronic conditions and would instead reward providers not actually furnishing healthcare services. Furthermore, there is no evidence of a benefit for the use of supervision of anesthesia via telehealth. In these instances, anesthesiologist tele-supervision of CRNA services would not meet CMS’s criteria for Medicare telehealth services of providing a clinical benefit to the patient. Therefore, we ask in this and future rules that CMS prohibit wasteful anesthesiologist tele-supervision of CRNA services from being included among these telehealth services.

**AANA Comment: Emphasize the Use of Cost-Effective Anesthesia Care Provided by CRNAs in Advancing Interoperability of Health Information**

The AANA supports agency’s goal of developing and implementing EHR interoperability policies to encourage Medicare and Medicaid providers to routinely exchange health information through interoperable systems in support of higher quality and more coordinated care. As many APMs, which require the use of certified EHR technology (CEHRTs) and involve anesthesia delivery, and as CRNAs are an eligible clinician under the Quality Payment Program (QPP), we believe the agency has an interest

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in increasing access to and promoting high-quality, cost-effective anesthesia care. As the agency contemplates next steps regarding interoperability, CMS should consider how best to ensure that they are capturing cost effective anesthesia care. Anesthesia professionals work as members of the patient’s interprofessional team in all practice settings and all staffing models of anesthesia delivery are equally safe according to extensive published research as noted above. The most cost-effective safe anesthesia care delivery model is the CRNA non-medically directed model, and we recommend that the agency arrange the components within the QPP to promote high quality, affordable care models.

In demonstrating the costs of various modes of anesthesia delivery, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by an anesthesia care team where a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia delivered by an anesthesia care team where CRNA medically directed at a 2:1 ratio; and (d) has anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, $170,000 for the CRNA and $540,314 for the anesthesiologist. Under the Medicare program, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable.

However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost to staff the practice modality (a) equals $170,000 per year. For case (b), it is ($170,000 +(0.25 x $540,314) or $305,079 per year. For case (c) it is ($170,000 + (0.50 x $540,314) or $440,157 per year. Finally, for case (d), the annualized cost equals $540,314 per year.

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<th>Anesthesia Payment Model</th>
<th>FTEs / Case</th>
<th>Clinician costs per year / FTE</th>
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<tr>
<td>(a) CRNA Nonmedically Directed</td>
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<td>$170,000</td>
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<tr>
<td>(b) Medical Direction 1:4</td>
<td>1.25</td>
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27 AANA member survey, 2014
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<th>Anesthesiologist mean annual pay</th>
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<td>CRNA mean annual pay</td>
<td>$170,000</td>
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With CRNAs providing over 43 million anesthetics in the U.S., and a considerable fraction of them being “medically directed,” the additional costs of this medical direction service are substantial. In addition, the most recent peer-reviewed literature makes clear that the requirements of anesthesiologist medical direction are often not met in practice— and if anesthesiologists submit claims to Medicare or Medicaid for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread Medicare and Medicaid fraud in this area is high. Lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs, according to a 2012 study published in the journal *Anesthesiology,* the professional journal of the American Society of Anesthesiologists. 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.

We believe the agency has an interest in increasing access to and promoting high-quality, cost-effective anesthesia care. Anesthesiologist medical direction reimbursement models contribute to increased healthcare system costs without improving access or quality when medical direction requirements are not met by the anesthesiologist submitting a claim for such services. Therefore, the agency should favor reimbursement systems that support the most cost-effective and safe anesthesia delivery models such as for nonmedically directed CRNA services. All staffing models of anesthesia delivery are equally safe according to extensive published research as noted above, but the most cost-effective safe anesthesia care delivery model is the CRNA non-medically directed model, and we recommend the agency promote its use in advancing interoperability of health information.

**AANA Comment: For Anesthesia, Interoperability of Health Information Should Communicate Across the Continuum of Patient Care and EHRs Should Use Standardized Taxonomies Across Technology Platforms**

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We offer the following recommendations regarding interoperability and communication of patient information across technology platforms in the realm of anesthesia. For anesthesia measures, we recommend that interoperability of EHRs and other information systems should communicate across the continuum of patient care. Disparate information systems should interface between offices, clinics, hospitals, and pharmacy platforms to communicate across the patient’s experience to increase patient safety, improve outcomes and decrease cost of care.

We also recommend that EHR systems should include standardized taxonomy and fields and require providers to use these across various platforms to optimize communication of care and interoperability. In the major anesthesia information management systems, some standardized taxonomies are present; however, valuable patient specific information is entered as free text or in unstructured data hindering data sharing and communication, in addition to making this information difficult to extract for quality reporting without manually reading the fields.

**AANA Recommendation: The Focus of Measurement of Exchange and Use of Interoperability Should Not Be Limited to Only Use of Certified EHR Technology**

In order to establish metrics that will assess the extent to which widespread exchange of health information through interoperable certified EHR technology nationwide has occurred, the agency needs to first define the scope of measurement. The AANA believes that the measurement of EHR interoperability is limited if the focus of this measurement is restricted only to use of certified EHR technology. Smaller facilities and anesthesia groups may not have the funds and resources necessary to participate in use of a certified, comprehensive EHR, but may purchase a standalone AIMS that is added to the facility EHR. If the agency’s goal is to measure true interoperability, and if smaller EHR companies can construct an AIMS that is affordable for use by smaller provider groups, then these groups should be included in this measurement. Furthermore, use of non-certified EHRs in measurement of interoperable EHR technology will also encourage innovation in this field because having to get certified first will limit many programmers who are experimenting with novel methods of handling and accessing EHR data.

**AANA Recommendation: Additional Anesthesia Data Sources Should be Used to Evaluate Interoperability**
As stated above, CRNAs in some settings have continued to document on paper or used paper/EHR to document care because they have not been eligible for incentive payments for the adoption and meaningful use of certified EHR technology. As a result, electronic capture of point of care patient information is very difficult to collect. The AANA supports collection of meaningful data through interoperability across all patient care experiences to provide access to a complete and comprehensive healthcare record to improve patient satisfaction, outcomes and affordability of care. Not only would this data be used to provide care, but also to analyze care processes to continually improve outcomes. In evaluating the interoperability of systems across the patient care experience, we recommend development and participation in team and composite measures such as sharing patient health and medication history, communication of encounter information, and decrease in repeat diagnostic testing. Though we only have anecdotal information, sharing of information across platforms is currently very limited and hybrid paper and electronic records are used in many rural, ASC, clinic, and office practice locations.

VI. REQUEST FOR INFORMATION ON PRICE TRANSPARENCY: IMPROVING BENEFICIARY ACCESS TO PROVIDERS AND SUPPLIER CHARGE INFORMATION

AANA Comment: CMS Can Address Underlying Causes of Surprise Billing by Issuing a Proposed Rule on Provider Non-Discrimination Provision and by Promoting Adequate Provider Networks in Medicare Advantage Plans and Health Plans Inside the Marketplace

The AANA shares the agency’s concern regarding the issues with insufficient price transparency, particularly with regards to patients being surprised by out-of-network bills and extra facility fees. The economic burden of receiving care out-of-network can be substantial for patients. Furthermore, knowing which providers and services are in-network and out-of-network is a huge burden for the patient as well as the provider and the facility. CMS can address this issue best by helping to resolve the underlying causes of surprise billing, such as addressing inadequate networks offered by insurance plans and addressing health insurance plans engaging in discrimination against providers based on their licensure or certification. While this is not an issue under Medicare Part B, as Medicare recognizes CRNAs as qualified providers and CRNAs must accept assignment as a condition for payment, this is an issue with private health plans, thus potentially affecting the private payer market and Medicare Advantage plans.

30 See 42 §414.60 (c).
Therefore, it is important to highlight the harms of discrimination CRNAs currently face in the selection criteria that certain health plans develop, which determines the selection of providers that participate in their networks. CRNAs, acting within the scope of their license or certification under applicable state law or regulation, have experienced discrimination with respect to participation in qualified health plans, thus forcing them to become an out-of-network provider. Such discrimination may exacerbate surprise billing, impair consumer choice, reduce competition, and affect healthcare costs.

We recommend that CMS use its authority to further implement the federal provider nondiscrimination law by issuing a proposed rule. In 2010, Congress passed this 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 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. It prohibits discrimination based on provider licensure that keeps patients from getting the care they need.

To promote patient access to high quality healthcare, market competition and cost efficiency, all qualified health plans must all avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure or certification. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs of their enrollees. However, when health plans organize their healthcare delivery in such a way that discriminate against whole classes of qualified licensed healthcare professionals by licensure or certification, for example, by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, patient access to care is impaired, consumer choice suffers, and healthcare costs

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31 Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §300gg-5). The statutory provision reads as follows: “(a) Providers.—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 healthcare 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 healthcare 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.”
climb for lack of competition. Additionally, such discrimination provides incentives for the use of higher-cost providers without improving quality or access to care. Promoting nondiscrimination encourages the use of qualified, licensed, and certified healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers.

Furthermore, while we recognize that CMS has developed network adequacy standards in Medicare Advantage plans and in the Marketplace, CMS must do more to ensure that health carriers maintain networks that are sufficient in numbers and types of providers to assure that all services to covered persons will be accessible to them without unreasonable delay. CRNAs are an important type of provider with an integral role in providing anesthesia and analgesia-related care, including pain management services. They provide safe, high-quality and cost-effective anesthesia care and are advanced practice registered nurses who personally administer more than 43 million anesthetics to patients each year. Furthermore, in rural communities and other medically underserved areas of the United States, CRNAs can be the sole anesthesia professionals. The AANA believes that patients benefit the greatest from a healthcare system where they receive easily accessible care from an appropriate choice of safe, high quality and cost-effective providers, such as CRNAs. Therefore, we request that CRNAs be included in all health carrier network plans, which will help ensure network adequacy, access and affordability to consumers. Doing so would help establish appropriate minimum standards for ensuring sufficient choice of providers within health carrier networks.

AANA Comment: CMS Can Work with Health Care Stakeholders in Developing Guidance to Educate Consumers on Questions to Ask Their Insurance Companies to Help Avoid Surprise Billing

The AANA supports the agency’s goal that providers and suppliers of health care service should undertake efforts to engage in consumer-friendly communication of their charges to help patients what their potential financial liability might be for services they obtain and to enable patients to compare charges for similar services. We recommend that CMS work with healthcare stakeholders, such as CRNAs, in developing consumer guidance documents on surprise billing and out-of-network coverage and resources for assistance. For instance, this guidance could provide consumers with the education needed to know what questions to ask their insurance plans prior to procedures and where to go for help. We are happy to assist in the development of these patient tools.
VII. PROPOSED UPDATES TO THE HCAHPS SURVEY MEASURE (NQF #0166) FOR THE FY 2024 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

AANA Comment: Support Removal of Communication about Pain Questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey in the Hospital IQR Program in Exchange for Meaningful High-Priority Pain Measures that Can Improve Functional Assessment Scores with Reduced Opioid Use

The proposed rule states that CMS is proposing to remove the pain management dimension of HCAHPS survey for purposes of the Hospital IQR Program, beginning with the FY 2024 payment determination, due to stakeholder concern that these particular questions focus on communication with patients about their pain and treatment of that pain, rather than how well their pain was controlled. The proposed rule further states that stakeholders are concerned that the questions still could potentially impose pressure on hospital staff to prescribe more opioids in order to achieve higher scores on the HCAHPS Survey. As CRNAs administer more than 43 million anesthetics to patients each year in the United States, as well as acute, chronic, and interventional pain management services, the AANA agrees with the unintended consequences that may result based on these questions and supports removal of the current pain management questions in the HCAHPS survey. Removal of the questions is a positive step toward improving patient safety and changing staff, patient and family perception about appropriate pain management and outcomes. Furthermore, the AANA is concerned in the increase in opioid drug use, abuse and deaths and is committed to working toward a common solution to help curb the opioid epidemic in the United States.

CRNAs are involved in every aspect of a patient’s anesthesia and analgesia care including the pre-anesthesia patient assessment, obtaining informed consent for anesthesia, developing the anesthesia and acute pain plan of care, administering the anesthetic, monitoring and addressing the patient’s response to anesthesia, providing emergency services as needed, and managing the patient’s anesthesia and pain related needs following the procedure. As stated above, CRNAs are a main provider of pain management services and are exceptionally skilled to provide both acute and chronic pain management in all clinical settings and are also well-positioned to educate clinicians and patients alike on the minimization or elimination of prescribed opioids for both acute and chronic pain management. Furthermore, the holistic, multi-modal 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.
CRNAs provide safe and highly-effective pain management services that would contribute to better patient satisfaction with pain levels. Useful and meaningful HCAHPS measures may need to focus on pain management processes and evidence-based standards of care rather than patient-reported outcomes, which are more subjective. Further, as HCAHPS is a global survey about patient experience, assessment of the communication of pain are likely better addressed for specific care episodes where there are targeted modalities available to achieve better outcomes. CMS should put their focus on developing high-priority pain measures that can improve functional assessment scores with reduced opioid use.

The AANA appreciates the opportunity to comment on this proposed rule. Should you have any questions regarding this matter, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202-741-9080 or rkoohl@aanadc.com.

Sincerely,

Bruce A. Weiner, DNP, MSNA, CRNA
AANA President

cc: Randall D. Moore, DNP, MBA, CRNA, AANA Chief Executive Officer
Ralph Kohl, AANA Senior Director of Federal Government Affairs
Randi Gold, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy