



American Association of
NURSE ANESTHESIOLOGY

August 24, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
PO Box 8013
Baltimore, MD 21244-8013

RE: Request for Information on Medicare

Dear Ms. Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to submit comments to the Request for Information on Medicare. We are firmly committed to working with the agency and other healthcare stakeholders to help achieve our common goals of increasing access to healthcare, advancing health equity, increasing innovative healthcare models, reducing regulatory burdens on stakeholders, empowering consumers and making healthcare more affordable for all Americans. The AANA makes the following comments and recommendations:

- I. Support Advancement of Health Equity for all Medicare Advantage Enrollees**
- II. Reduce Regulatory Barriers for CRNAs to Increase Access to Anesthesia Care in Rural Communities**
- III. Promulgation of a Meaningful Regulation on the Issue of Provider Nondiscrimination will Ensure Patient Access to the Highest Quality Cost Effective Care**
- IV. Support Expanding Access and Coverage to Medicare Advantage Beneficiaries**
- V. Ensure that Interactive Telecommunications Technology Are Not Used for Anesthesiologist TeleSupervision of Anesthesia Services or For Meeting Anesthesiologist Medical Direction Requirements**
- VI. Require CRNAs to be Included in Qualified Health Plan Networks that Participate in Medicare Advantage**

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- VII. For Anesthesia, Interoperability of Health Information Should Communicate Across the Continuum of Patient Care and EHRs Should Use Standardized Taxonomies Across Technology Platforms**
- VIII. Permanently Remove Unnecessary Regulatory Burdens That Limit Medicare Beneficiaries' Access to Care**
- IX. The Focus of Measurement of Interoperability Should Not Be Limited to Only Use of Certified EHR Technology**
- X. Additional Anesthesia Data Sources Should be Used to Evaluate Interoperability**
- XI. Partner with the AANA and CRNAs in MA Policy Development**

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 59,000 CRNAs and SRNAs, representing about 90 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 and are among the nation's most trusted professions according to Gallup¹. 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 also 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.

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 and recovery. 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

¹ Gallup "U.S. Ethics Ratings Rise for Medical Workers and Teachers (December 22, 2020), <https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx>

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.² 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.³ 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.⁴ In addition, a study published in *Medical Care* found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.⁵

The importance of CRNA services in rural areas was highlighted in a study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.⁶ 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

² Paul F. Hogan et al., "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic*. 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

³ B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs*. 2010; 29: 1469-1475. <http://content.healthaffairs.org/content/29/8/1469.full.pdf>

⁴ Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database of Systematic Reviews* 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract>

⁵ Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. *Medical Care* June 2016, http://journals.lww.com/ww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

⁶ Liao CJ, Qurashi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. *Nurs Econ*. 2015;33(5):263-270. <http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx>

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.⁷ This information highlights the importance of CRNAs who provide high-quality, evidence-based care to millions of Americans living and working in rural and underserved areas. Allowing them to participate in rural emergency hospitals will increase needed access to care for patients who live in these areas.

A. ADVANCE HEALTH EQUITY

QUESTION: 1. What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following: • Enrollees from racial and ethnic minority groups. • Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation. • Enrollees who identify as transgender, nonbinary, or another gender identity. • Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life. • Enrollees with diverse cultural or religious beliefs and practices. • Enrollees of disadvantaged socioeconomic status. • Enrollees with limited English proficiency or other communication needs. • Enrollees who live in rural or other underserved communities.

AANA Request: Support Advancement of Health Equity for all Medicare Advantage Enrollees

The AANA supports that the agency is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all people served by their programs. We are happy to see the agency is creating policies that continue to work towards these goals. CRNAs provide holistic, patient-centered anesthesia, analgesia and pain management services for patients from diverse backgrounds in a variety of practice settings across the United States in all Medicare programs including Medicare Advantage (MA). The AANA has been accomplishing important work on health equity and completed a Diversity, Inclusion and Equity Vision and Position Statement. It details how nurse anesthetists provide excellent care by advocating for cultural awareness, promoting civility, and eliminate health disparities to enhance health outcomes for individuals, families and communities and also outlines how the AANA continues to mentor and educate future generations of nurse anesthetists and conduct research to advance knowledge and understanding of issues related to diversity, inclusion and equity.⁸ Enhancing and

⁷ Liao, op cit.

⁸ AANA Diversity, Inclusion and Equity Vision and Position Statement, [https://www.aana.com/docs/default-source/practice-aana-com-web-documents-\(all\)/professional-practice-manual/diversity-inclusion-and-equity120128731dff6dddb37cff0000940c19.pdf?sfvrsn=eefe45b1_14](https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/diversity-inclusion-and-equity120128731dff6dddb37cff0000940c19.pdf?sfvrsn=eefe45b1_14)

advancing health equity for all enrollees, eliminating avoidable differences in health outcomes, and providing the care and support that our enrollees need to thrive through all programs, including Medicare Advantage is an important factor in our work and the AANA continues to embrace the rich diversity of patients, the nurse anesthesia profession and communities to achieve new standards of excellence in anesthesia care, education and research.

AANA Request: Reduce Regulatory Barriers for CRNAs to Increase Access to Anesthesia Care in Rural Communities

As 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, it vital that the agency should promote access to the use of CRNA anesthesia services in rural America. Furthermore, the agency should ensure that future policy does not create unintended barriers to the use of CRNA services and that CRNA are practicing at their full professional education, skills, and scope of practice. Nurse anesthetists are experienced and highly trained anesthesia professionals who provide high-quality patient care, which has been proven through decades of scientific research.

Rural hospitals are vital to providing health care to their communities and the increasing closure of rural hospitals limits access to care, produces long trips for emergency care and causes an increase in negative health outcomes for patients living in rural areas.⁹ According to the Center for Healthcare Quality and Payment Reform, over 150 rural hospitals across the country closed between 2005 and 2019 and an additional 19 rural hospitals closed their doors in 2020¹⁰. In addition, more than 600 rural hospitals, which is about 30% of all rural hospitals in the United States, are at risk of closing in the near future¹¹.

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 obstetrical, surgical, trauma stabilization, and pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and can provide every aspect of the delivery of anesthesia services, from pre-

⁹ "The Health 202: Congress is throwing a lifeline to struggling rural hospitals." The Washington Post, June 29, 2021.

¹⁰ Center for Healthcare Quality and Payment Reform, "Rural Hospitals at Risk of Closing." (July 2022)
https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

¹¹ Center for Healthcare Quality and Payment Reform, op cit.

anesthesia patient assessment, to administering the anesthetic, and monitoring and interpreting the patient's vital signs and managing the patient throughout the surgery.

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 which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.¹² 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.¹³ This information highlights the importance of CRNAs who provide high-quality, evidence-based care to millions of Americans living and working in rural and underserved areas. In addition, a 2007 Government Accountability Office (GAO) study found that Medicare paid 67 percent of what private insurers paid for anesthesia services.¹⁴ Furthermore, the study also reported that CRNAs are the predominant anesthesia professional where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less, indicating that CRNAs are providing services in areas in which there is a greater proportion of Medicare beneficiaries compared to private payor payment, and there is less private payment to make up for the lower payment by Medicare. Such a disproportion in payment places a financial strain on healthcare professionals and facilities, shifts Medicare costs onto others, and can threaten beneficiary access to care.

Research evaluating type of facility, size, and anesthesia staffing by rural location shows that 55.5% of small rural hospitals and 61.2% of rural ambulatory surgery centers were predominately staffed by CRNAs.¹⁵ Further research has shown that there is significant geographic variation in anesthesia provider

¹² Liao CJ, Qurashi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. *Nurs Econ*. 2015;33(5):263-270. <http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx>

¹³ Liao, op cit.

¹⁴ U.S. Government Accountability Office (GAO). Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Services. Report to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. GAO-07-463. July 2007;15. <http://www.gao.gov/new.items/d07463.pdf>.

¹⁵ Coomer N. et al. (2019). Anesthesia staffing models and geographic prevalence post-Medicare CRNA/physician exemption policy. *Nursing Economic\$, 37*(2), 86-91. <https://search.proquest.com/openview/3f55b0d94533f910b7c0c1dc5d7202bc/1?pq-origsite=gscholar&cbl=30765>

supply and lower supply in rural communities raises concerns about access to procedures that require anesthesia in rural areas.¹⁶ The study found that enforcing state policies related to CRNA practice, such as less restrictive scope of practice regulations, were consistently correlated with a greater supply of CRNAs, especially in rural counties.¹⁷

QUESTION: 2. What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

AANA Request: Promulgation of a Meaningful Regulation on the Issue of Provider Nondiscrimination will Ensure Patient Access to the Highest Quality Cost Effective Care

We stand ready to work with you as the agency works to promulgate a rule implementing the provider nondiscrimination provision in the bipartisan enacted Consolidated Appropriations Act of 2021. Meaningful implementation of this provision is important to protect CRNAs and other advanced practice providers (APPs) from discriminatory practices in the private insurance market. CRNAs, and other advanced APPs acting within the scope of their license or certification under applicable state law or regulation, have experienced discrimination with respect to participation in and coverage of procedures that are clearly included in their state scope of practice. Such discrimination impairs access to needed healthcare services, consumer choice and competition, and impairs efforts to control healthcare cost growth. Further, this discrimination violates the federal provider nondiscrimination provision.

The federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), “Non-Discrimination in Health Care, 42 USC §300gg-5),¹⁸ which took effect January 1, 2014, and prohibits health plans from

¹⁶ Martsolf, G et. Al. (2019) Relationship Between State Policy and Anesthesia Provider Supply in Rural Communities. *Medical Care*, 57(5):341:347. <https://www.ncbi.nlm.nih.gov/pubmed/30870391>

¹⁷ Martsolf, op cit.

¹⁸ 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.”

discriminating against qualified licensed healthcare professionals, such as CRNAs, solely on the basis of their licensure. However, no regulation has been issued since this law took effect and there is no real way to enforce it, allowing health plans to issue discriminatory policies against CRNAs and other APPs. In order to promote access to healthcare, consumer choice of safe and high-quality healthcare professionals, reduce healthcare costs through competition, and allow providers to practice to the full extent of their education, training, and certification we urge HHS to promulgate a regulation that will end this problematic practice.

Nurse anesthetists are experienced and highly trained anesthesia professionals who provide high-quality patient care, demonstrated through evidence in decades of scientific research and practice to the full extent of their education, training, and certification. This law promotes competition and consumer choice by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote patient access to care, health insurers and health plans must all avoid discrimination against qualified, licensed healthcare professionals solely on the basis of licensure. The provider nondiscrimination provision also respects local control of healthcare systems and local autonomy in the organization of health plans and benefits. It does not impose “any willing provider” requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures. Ensuring that qualified health plans adhere to this nondiscrimination law would promote patient access to a range of beneficial, safe and cost-efficient healthcare professionals, consistent with public interests in quality, access and cost-effectiveness.

The AANA believes it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types while achieving the same high-quality outcomes. While health plans might believe this is a cost-effective way to save money and lower health care costs, this would direct cases to more expensive providers, such as anesthesiologists, leading to impaired access, increased costs and lower quality of care. Paying one qualified provider type a higher rate than another for providing the same high-quality service offers a powerful incentive to increase healthcare costs without improving healthcare quality or access, by helping to steer healthcare delivery to more expensive providers. For example, in the delivery of anesthesia services, the labor costs of anesthesiologists are approximately three times higher than those of CRNAs.¹⁹ Quality of care is high and continually

¹⁹ Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012.

improving, and patient outcomes by provider type are similarly excellent as measured by the published research we have already shown. The choice of discriminating in coverage or reimbursement against qualified licensed providers solely on the basis of licensure therefore leads to impaired access, increased costs and lower quality of care. Ensuring that qualified health plans adhere to this nondiscrimination law would promote patient access to a range of beneficial, safe and cost-efficient healthcare professionals, consistent with public interests in quality, access and cost-effectiveness.

The AANA also interprets the provider nondiscrimination provision to mean that if a health plan or health insurer network offers a specific covered service, they should include in their network all types of providers who can safely provide that service and should not refuse to contract based on licensure alone. For example, if a health plan offers coverage for anesthesia services, they should allow both CRNAs and anesthesiologists full participation in their networks. Medicare reimburses CRNAs directly for their services and does so at 100 percent of the physician fee schedule amount for services, the same rate as physicians for the same services. The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorized direct reimbursement of CRNA services under Medicare Part B beginning in 1989.^[1] The Medicare regulation implementing the OBRA law, updated as part of a November 2012 final rule further clarifying the authorization of direct reimbursement of nurse anesthesia services within the provider’s state scope of practice,^[2] states, “Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist who is legally authorized to perform the services by the State in which the services are furnished.”^[3] The final rule also states, “Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished.” The agency also said in the rule’s preamble, “In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states.”^[4] Therefore, the Medicare agency stands on solid ground in clarifying that the nondiscrimination provision should apply to private plans in a way that is consistent with Medicare direct reimbursement of CRNA services where they are allowed to furnish those services under state law. We encourage all private health insurance plans (and Medicaid) to model reimbursement in the Medicare program.

^[1] Pub.L. 99-509 (42 U.S.C. § 1395 l(a)(1)(H), 42 U.S.C. § 1395 x(s)(11)).

^[2] 77 Fed. Reg. 68892 (November 16, 2013).

^[3] 42 C.F.R. § 410.69(a).

^[4] *Ibid.*

Proper implementation of the provider nondiscrimination law is crucial because health plans have latitude to determine the quantity, type, and geographic location of healthcare professionals they need to ensure availability of healthcare benefits to their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure, 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 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 consumers to be able to choose anesthesia care from qualified, licensed healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers. Moreover, promulgation of a regulation on provider nondiscrimination would allow CRNAs to fully utilize their education and training to enhance the patient care team model and work collaboratively with anesthesiologists as equal partners in anesthesia delivery for surgery, labor and delivery, trauma stabilization, and chronic pain management.

Issuing a regulation on provider nondiscrimination will help dissipate any unintended barriers to the use of CRNA services and ensure that CRNA are practicing at their full professional education, skills, and scope of practice. It will also help the advancement of health equity in all plans, including Medicare Advantage.

B. EXPAND ACCESS: COVERAGE AND CARE

AANA Recommendation: Support Expanding Access and Coverage to Medicare Advantage Beneficiaries

The AANA supports expanding access to care and coverage and providing adorable quality health care to Medicare beneficiaries under MA. Our members provide essential care and pain management to veterans, aging Americans and Americans in rural communities, among others. We recognize the importance of access to MA to these patient groups which is why we support expansion of access to MA care and

coverage. In the last decade, MA enrollment has doubled, and, in the coming years, MA is projected to be the dominant choice for Medicare beneficiaries.²⁰

Additionally, it is important to note that MA provides greater access and additional benefits not available in Medicare Fee-for-Service (FFS) plans.²¹ For example:

- 89% of MA plans offered include prescription drug coverage.
- More than 90% of MA plans provide some combination of dental, vision, hearing, or fitness and wellness benefit, which are not offered in FFS Medicare.
- Over 95% of MA plans offer additional telehealth benefits not offered in FFS Medicare.

QUESTION 5) What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS’ statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity’s telehealth services?

AANA Request: Ensure that Interactive Telecommunications Technology Are Not Used for Anesthesiologist TeleSupervision of Anesthesia Services or For Meeting Anesthesiologist Medical Direction Requirements

As CMS seeks comment on strengthening beneficiary access to health services to support the goal of expanding access to telehealth coverage and care in Medicare Advantage, the AANA cautions 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. Furthermore, as there is no evidence of the efficacy and cost-effectiveness of in-person physician supervision requirements²², there also

²⁰ 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (Table IV.C1), June 2022. Available at: <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>; J. Michael McWilliams, Don’t Look Up? Medicare Advantage’s Trajectory and the Future of Medicare, Health Affairs, March 24, 2022. Available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20220323.773602>

²¹ Kaiser Family Foundation, Medicare Advantage 2022 Spotlight: First Look, November 2, 2021. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/>

²² See B. Dulisse and J. Cromwell op cit. and Paul F. Hogan et. al, op cit.

is no evidence regarding the benefit for the use of supervision of anesthesia via telehealth.²³ 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. In these instances, anesthesiologist telesupervision of anesthesia provider services would not meet CMS's current Category 2 criteria for Medicare telehealth services of providing a clinical benefit to the patient. As CMS has noted that Medicare Part B anesthesiologist medical direction is a condition for payment of anesthesiologist services²⁴ and not quality standards,²⁵ we also would urge the agency against using interactive telecommunications technology as a way to fulfill any of the seven required steps for payment. We stress that the use of telehealth for these purposes would be wasteful and would constitute inappropriate use. As CMS continues to consider guiderails of the use of telehealth 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.

QUESTION 6) What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

AANA Request: Require CRNAs to be Included in Qualified Health Plan Networks that Participate in Medicare Advantage

The AANA agrees with the agency that strong network adequacy standards are necessary to achieve greater equity in health care and enhance consumer access to quality, affordable care in Medicare Advantage. The AANA supports the agency's long-standing requirement that qualified health plans (QHPs) that participate

²³ 3 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.

²⁴ 4 42 CFR §415.110 Conditions for payment: Medically directed anesthesia services.

²⁵ 63 FR 58813, November 2, 1998

in health plans must 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.

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, as the agency proposes to evaluate the adequacy of provider networks of QHPs offered through Medicare Advantage we request that CRNAs be included in all health carrier network plans that participate in these plans. Doing so would help establish appropriate minimum standards for ensuring sufficient choice of providers within health carrier networks and will help ensure network adequacy, access and affordability to consumers. This would help ensure patient access to a range of beneficial, safe and cost-efficient healthcare professionals and allow CRNAs to practice to full extent of their scope of practice.

CRNAs are an important type of provider with an integral role in providing anesthesia and analgesia-related care, and pain management services. They provide safe, high-quality and cost-effective anesthesia care and are advanced practice registered nurses who personally administer more than 50 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. Their presence enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who might otherwise be forced to travel long distances for this essential care. Without strong patient access safeguards in place, we are concerned that lax network adequacy standards could limit the number of providers or the types of providers on their panels, which could severely limit patient access to needed care. Consistent with the goals and policies of the Affordable Care Act in establishing strong provider networks that ensure extensive access to care, we encourage health carriers to include CRNAs in their networks by expressly recognizing CRNAs as eligible professionals in all health plan networks, including Medicare Advantage.

C. DRIVE INNOVATION TO PROMOTE PERSON-CENTERED CARE

QUESTION 7. What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? How could CMS better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data? What approaches could CMS pursue to advance the interoperability of health information across MA plans and other stakeholders? What opportunities are there for the recently released Trusted Exchange Framework

and Common Agreement 3 to support improved health information exchange for use cases relevant to MA plans and providers?

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

The AANA supports the agency's strategic goal of promoting interoperability and data sharing through widely accepting standards to ensure health information is freely available across care settings for patient care, public health, research and emergency and disaster preparedness, response and recovery. The AANA believes the use of health information technology as a care delivery option can improve access to and timeliness of needed care, increase convenience for patients, increase communication between providers and patients, enhance care coordination, improve quality, and reduce costs related to in person care. The use of telemedicine has expanded during the COVID-19 pandemic and anesthesia professionals have been able to monitor patients in their homes remotely or perform telemonitoring in electronic ICU delivery models. Telehealth is also indicated in alternative settings such as post-anesthesia care units (PACU), as extensions of COVID-19 or critical care locations. Benefits of telemedicine in these areas include increased compliance with clinical guidelines and protocols, rapid responses to medical alerts and the ability of facilities to expand capacity for intensive care.

We offer the following recommendations regarding interoperability and communication of patient information across technology platforms in the realm of anesthesia to help advance interoperability of health information across Medicare Advantage plans and other stakeholders. For anesthesia measures, we recommend that interoperability of electronic health records (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 Request: 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 health information technology 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 Request: Additional Anesthesia Data Sources Should be Used to Evaluate Interoperability

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 in Medicare Advantage plans, 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, ambulatory surgical centers, clinics, and office practice locations.

D. SUPPORT AFFORDABILITY AND SUSTAINABILITY

QUESTION 1: What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

AANA Request: Permanently Remove Unnecessary Regulatory Burdens That Limit Medicare Beneficiaries' Access to Care

The AANA supports the agency's commitment to ensure that Medicare beneficiaries have access to affordable, high value and high quality healthcare. We request feedback on how we can improve the MA market and support effective competition. We ask that as the agency continue to explore policies in Medicare Advantage plans, do not impose any barriers to those providers participating in those plans. The current Public Health Emergency (PHE) has shown the important need for health care professionals to work to the top of their scope to care for patients and highlights the important role that CRNAs play in our healthcare system, especially when workforce barriers to practice are eliminated.

In their roles as Advanced Practice Registered Nurses (APRNs), many CRNAs have assisted on the frontlines of the pandemic to provide expert care to the sickest patients. We have seen barriers to CRNA practice removed at both the state and federal levels, allowing CRNAs to provide critical, lifesaving care to patients. CRNAs are practicing independently, providing invaluable support by using their expertise in rapid systems assessment, airway management, managing ventilators, vascular volume resuscitation, placing of invasive lines and monitors, overseeing complex hemodynamic monitoring, emergency preparedness, and resource management. Data from CMS showed that CRNAs are one of the top specialties serving the most Medicare beneficiaries during the first three months of the pandemic (March – June) in 2020²⁶.

Permanently removing barriers to care will benefit patients and the larger healthcare system. Given the important role that CRNAs are playing in providing care during the pandemic through the removal of unnecessary rules, the AANA supports a thorough and evidence-based approach to ensure that any rules that have been suspended during the PHE are only re-enacted if they serve a meaningful purpose in healthcare delivery.

E. ENGAGE PARTNERS

QUESTION 3: What steps could CMS take to enhance the voice of MA enrollees to inform policy development?

²⁶ CMS Report January 2021 "Putting Patients First: The Center for Medicare and Medicaid Services Record of Accomplishment from 2017-2020."

AANA Request: Partner with the AANA and CRNAs in MA Policy Development

We agree that the goals of Medicare can be achieved through partnerships and an ongoing dialogue between the program and enrollees and other key stakeholders. CRNAs play an essential role in ensuring that rural America has access to critical anesthesia services, including critical obstetrical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures. As CRNAs have expertise in anesthesia and pain management services that may be provided to Medicare Advantage beneficiaries, CRNAs should be allowed to provide advice on written policies affecting the provision of these and related services. As the agency looks to create future policies in order to continuously improve MA, we request that CRNAs be used as a resource in policy development for MA plans.

The AANA appreciates the opportunity to comment on this RFI regarding the Medicare Advantage program. Should you have any questions regarding our comments, please feel free to contact AANA Senior Associate Director Randi Gold at rgold@aana.com.

Sincerely,



Angela Mund, DNP, CRNA
AANA President

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