AANA
American Association of
NURSE ANESTHESIOLOGY

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Electronic Submission via: macra.rfi@mail.house.gov

The Honorable Ami Bera, MD
United States House of Representatives
172 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Buschon, MD
United States House of Representatives
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, MD
United States House of Representatives
1123 Longworth House Office Building
Washington, DC 20515

The Honorable Michael Burgess, MD
United States House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
United States House of Representatives
1111 Longworth House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup, DPM
United States House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

RE: MACRA RFI

Dear Representatives:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on the MACRA RFI. We appreciate your dedication to finding solutions to stabilize the Medicare payment system while ensuring that successful value-based care incentives are in place. The AANA makes the following comments and requests:

- Alleviate the Reimbursement Cuts to Providers, Such as CRNAs
- Maintain Existing Anesthesia Quality Measures and Allow for the Use of Surgical Measures
- Incentivize the Development of CEHRT Measures and Adoption of Systems
- Account for the Use of ERAS Pathways in Value-Based Programs

- Provide New Incentives Given the Loss of the 5 Percent Bonus in AAPMs

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 included among the nation's most trusted professions according to Gallup[1]. 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 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.

[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.

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] 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.[5]

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.[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 programs in the U.S., the study

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[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/lww-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

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]

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

The AANA appreciates Congressional efforts in fixing payment cuts in the Physician Fee Schedule in recent years. We were disappointed to see a proposed decrease of nearly 4 percent in the anesthesia conversion factor (CF) in this year's Medicare Physician Fee Schedule proposed rule. Because CRNAs are not the predominate provider of evaluation and management (E&M) services, they have been subject to significant cuts in the Physician Fee Schedule in recent years. We understand that the Centers for Medicare & Medicaid Services (CMS) is bound by budget neutrality requirements, and that any changes to these requirements would necessitate future Congressional action. However, anesthesia services are currently underfunded, and this disproportionate pay affects patient access to anesthesia care, especially in rural and underserved areas where CRNAs predominate. A study of CRNAs in rural areas that correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations, showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[8]

In addition, this year's Physician Fee Schedule proposed payment policy changes will have a negative 1 percent impact on anesthesia payment rates. This cut is especially challenging to providers given inflation is recently at historically high levels.[9] We ask for continued assistance in lessening the impact of this decrease in the anesthesia CF. We appreciate the continued dedication by Congress to resolve these issues.

[7] Liao, op cit.

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

[9]" U.S. Consumer Spending Inched Forward in July, With Inflation Historically High," Wall Street Journal, August 26, 2022.

AANA Request: Maintain Existing Anesthesia Quality Measures and Allow for the Use of Surgical Measures

The AANA wanted to alert Congress to some of the challenges that anesthesia providers, such as CRNAs, face in participating in CMS' Quality Payment Program (QPP). Specific to the Merit-based Incentive Payment Program (MIPS), anesthesia has few quality measures. Anesthesia is a service that is incidental to another service, making it more process-based. Anesthesia providers have found it challenging to have a lack of outcomes-based quality measures that meet CMS criteria. This is due partially to anesthesia services typically being non-patient facing, and the relationship and services furnished to a patient in the perioperative setting is usually limited to the time period around the surgery and the inpatient hospital stay. Moreover, some of the measures used in the past have topped-out with no further improvement possible, and CMS continues to propose to remove additional measures that have been topped out. For instance, in this year's Physician Fee Schedule proposed rule, CMS is proposing to remove #076 Prevention of Central Venous Catheter (CVC) – Related Blood Stream Infections from the Anesthesiology Measure Set. While this measure and others have topped out, we still believe that these measures are appropriate for inclusion in the anesthesiology measure set as they are still useful for monitoring patient safety and the impact of patient outcomes. Therefore, we request that Congress instruct CMS to retain the existing quality measures for anesthesia in the MIPS program. Furthermore, we request that CRNAs not be left out of measures that pertain to them. We also request that Congress allow CMS to accept measures that are vetted by CRNAs and the AANA that are surgical or anesthesia process measures.

AANA Request: Incentivize the Development of CEHRT Measures and Adoption of Systems

We ask Congress to incentivize the development of certified EHR technology (CEHRT) measures and systems for anesthesia providers as well as the adoption of or encouraged use of measures or AIMS data from modules and software. We note that CRNAs were never incentivized to adopt or implement meaningful use, including under the Health Information

Technology for Economic and Clinical Health (HITECH) Act.[10] The HITECH Act provided incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology, however, CRNAs were never included as eligible professionals under these definitions. In addition to CRNAs being ineligible for incentive programs, whole categories of healthcare facilities such as ambulatory surgical centers (ASCs) were also ineligible for EHR incentive programs. Many of our members work in the outpatient and ASC settings. These multiple levels of ineligibility caused an additional burden for CRNAs to have access to this technology in order to report quality measures electronically. Furthermore, CMS proposed in the 2023 Medicare Physician Fee Schedule proposed rule to no longer reweight to zero the Promoting Interoperability category for CRNAs. This has a direct negative effect on our members as they will no longer be recognized as a clinician type that is exempted from mandatory participation.

Since CRNAs were never eligible for incentive payments, there is a major gap in the adoption of electronic medical records in the operating room environment. Our members inform us that in many facilities, they do not have access to or control over the availability of the Health IT infrastructure that other types of providers who are eligible for incentive payments may access. Additionally, quality measures for specialty services continue to lag because CEHRT and quality reporting initiatives focus on primary care services. 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 their facilities due to the high cost and limited anesthesia CEHRTs to choose from. 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.[11] Low adoption of AIMS means that the surgical patient experience has a huge black hole centered around the lack of anesthesia-related data in CMS' grand plan for health information exchange. Moreover, even with a robust certified AIMS system, it continues to be a challenge to meet Promoting

[10] Section 4101 of the American Recovery and Reinvestment Act of 2009, Pub.L. No. 110-275.

[11] Peterson, Jessica et al. Anesthesia Information Management Systems: Imperatives for Nurse Anesthetists. *AANA Journal* 82:5 (October 2014), *available at* http://www.aana.com/newsandjournal/20102019/1014anesinfomanagsystems.pdf.

Interoperability measures. According to data from the 2020 QPP Experience report, about 20-30 percent of anesthesia provider participate in the Promoting Interoperability performance category. Due to few, if any comprehensive CEHRT anesthesia EHRs, clinicians must rely on modular AIMS, which may or may not be CEHRT, and must have extensive technical experts on hand.[12] Quality measures for specialty services continue to lag because CEHRT and quality reporting initiatives focus on primary care services. In light of these obstacles, we implore Congress to incentivize the development of certified EHR technology (CEHRT) measures and systems for anesthesia providers.

AANA Recommendation: Account for the Use of ERAS Pathways in Value-Based Programs

We believe it is critical that CRNAs should not be responsible for overall surgical complications or outcomes that are unrelated to anesthesia given that anesthesia services are typically non-patient-facing and the services furnished to a patient in the perioperative setting is usually limited to the time period around the surgery and any hospital stay. Typically, complications around anesthesia happen within 24 to 48 hours after surgery. Anesthesia represents a very small percentage of an episode's total cost of care and does not drive up the costs of a surgical procedure.

One area of service that may be reasonably influenced by the clinician providing the anesthesia services rather than the surgeon is the use of techniques such as anesthesia enhanced recovery after surgery (ERAS®) pathways. ERAS® is a patient-centered, evidence-based, pain management strategy employed by CRNAs to reduce the need for opioids, improve patient outcomes and reduce costs.[13] Using specific protocol-driven enhanced recovery after surgery 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. For example, the enhanced recovery pathway for total hip arthroplasty engages the entire perioperative team with the patient to limit care variation that improves outcomes and

[12] Galvez, Jorge et al. A Narrative Review of Meaningful Use and Anesthesia Information Management Systems. Anesthesia & Analgesia 121(3):693-706, September 2015.

[13] AANA Enhanced Recovery After Surgery, https://www.aana.com/practice/clinical-practice-resources/enhanced-recovery-after-surgery.

patient satisfaction. A total hip arthroplasty that includes minimally invasive surgical techniques and multimodal pain management with motor sparing regional anesthesia allows the patient to eat, drink and walk/exercise soon after recovery from anesthesia. The patient's pain management plan of care begins pre-procedure and continues through post-discharge using techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures.

As ERAS® pathways have been implemented, patient engagement in their own plan of care has improved return to preprocedural health on the day of surgery. CRNAs play an integral role in these episodes of care, in both inpatient and outpatient settings, as proper anesthesia services management can make a tremendous difference in terms of improving patient flow, patient safety, and ultimately in cost savings.[14] Conversely, research shows that suboptimal care in the preoperative, intraoperative, or postoperative phases of surgery may compromise care, resulting in poor patient outcomes and unnecessarily higher healthcare costs.[15] Facility and population specific ERAS® protocols engages the patient and the multidisciplinary team in the plan of care and continued assessment of patient status to optimize care, decrease complications, decrease time to discharge, improve outcomes and lower cost of care by limiting variation in care. CRNAs provide many ERAS® elements of care to optimize the patient to return to normal activity and diet, including minimally invasive surgical techniques, giving the patient a carbohydrate beverage at least two hours before surgery, maintaining patient warmth during the procedure and also providing multimodal pain management services to minimize or eliminate use of opioids. We ask that Congress consider this use of ERAS® pathways in value-based programs.

AANA Request: Provide New Incentives Given the Loss of the 5 Percent Bonus in AAPMs

[14] See for example Rice AN, Muckler VC, Miller WR, Vacchiano CA. Fast-tracking ambulatory surgery patients following anesthesia. J Perianesth Nurs. Apr 2015;30(2):124-133. Also see Kimbrough CW et al. Improved Operating Room Efficiency via Constraint Management: Experience of a Tertiary-Care Academic Medical Center. Journal of the American College of Surgeons 2015; 221: 154-162.

[15] Miller TE, Roche AM, Mythen M. Fluid Management and Goal-Directed Therapy as an Adjunct to Enhanced Recovery After Surgery (ERAS). Canadian Journal of Anesthesia 2015; 62 (2)" 158-168.

There is little return on investment currently to participate in the advanced alternative payment program (AAPM) with the loss of the 5 percent bonus, especially since MIPS has the potential for a positive payment adjustment of up to nine percent. The next performance year's bonus is less than one percent, which does not account for the administrative costs involved in participating in the program. Therefore, extending the 5 percent bonus is a critical incentive for eligible clinicians to stay in AAPMs.

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

Sincerely,

Angela R. Mund, DNP, CRNA
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Lorraine Jordan, PhD, CRNA, CAE, FAAN, AANA Chief Advocacy Officer and AANA Foundation CEO
Romy Gelb-Zimmer, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy