American Association of
NURSE ANESTHESIOLOGY

November, 22 2022

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-0058-NC
P.O. Box 8013
7500 Security Blvd.
Baltimore, MD 21244

**RE: CMS-0058-NC – Request for Information; National Directory of Healthcare Providers & Services (87 Fed.Reg. 61018, October 7, 2022)**

Dear Administrator Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on this request for information; National Directory of Healthcare Providers & Services (87 Fed.Reg. 61018, October 7, 2022). The AANA makes the following comments and requests of CMS:

**Interactions With Current CMS Data Systems and Impacts to Business Processes**

- Include CRNAs and Account for All CRNA Sub-Specialties and Dual Degrees
- Challenges in Design, Development, and Implementation Can Be Addressed by Allowing Providers to Make Edits for Accuracy

**Phased Approach to Implementation**

- Ensure that the AANA and CRNAs are Included in the Development of Directories

**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.

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

[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.

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 also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with

---

[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

lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[7]

**Interactions With Current CMS Data Systems and Impacts to Business Processes**

**AANA Request: Include CRNAs and Account for All CRNA Sub-Specialties and Dual Degrees**

While we appreciate that CMS would use this directory to help patients find providers, facilitate interoperable provider data exchange, and help payers improve the accuracy of their own directories, this seems like a very ambitious goal to satisfy all three objectives. These distinct audiences have different needs and different interests. At the very least, we believe it is imperative that CMS ensure that this directory does not inadvertently treat CRNAs and APRNs differently from physicians. In doing so, CMS should ensure that they are not discriminating against provider types based on licensure[8] and should ensure that patients can find and locate an APRN just as easily as they can to find a physician. Furthermore, since payers will be using the directory in updating networks, not upholding these principles could lead payors to discriminate through no fault of their own.

The AANA was disappointed to see that CRNAs were not included among the list of allied health professionals included in CMS's example on page 61026 of the preamble. We urge CMS to include CRNAs in this directory. We believe it is critical to do so because CRNAs, who are a type of APRN, are Medicare Part B providers and since 1989 have billed Medicare directly and are in the CMS systems. Furthermore, CRNAs personally administer more than 50 million anesthetics to patients each year in the United States and provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospital. CRNAs are the predominant anesthesia providers in underserved areas and are more likely to work in areas with lower median incomes and larger populations of citizens who are

[7] Liao, op cit.

[8] 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) and Consolidation Appropriations Act, DIVISION BB—PRIVATE HEALTH INSURANCE AND PUBLIC HEALTH PROVISIONS, Sec. 108.

unemployed, uninsured, and/or Medicaid beneficiaries when compared with physician counterparts.[9]

We also ask that CMS also ensure that CRNA services and subspecialties also be included in the directories, and that CMS ensure that CRNAs are readily and easily locatable in the directory for these services. In addition to providing anesthesia services, CRNAs also provide acute, chronic, and interventional pain management services. We note that patients will not have complete, accurate, and up-to-date information if CRNAs are not listed and recognized for all the services they provide a directory despite those services being within their scope of practice in a given state. If a particular subspecialty or service is not listed for CRNAs, it could open up commercial payors to use this as a reason for not including CRNAs in their networks or not reimbursing for particular services. Moreover, including CRNA sub-specializations in the directory reinforces and help promotes CMS's strategic plan to advance health equity as it helps identify providers ensuring access to the closest available healthcare services. Should CRNAs not be included, patients will get an incomplete and inaccurate list of providers available for services, which hampers improving access to medically necessary anesthesia and pain management services, especially in rural and underserved areas. The directory should also account for CRNAs who hold dual degrees as well. For instance, a CRNA who also is certified as a Nurse Practitioner should be able to have both designations accounted for. Furthermore, the information displayed for CRNAs should be equivalent to that displayed for physicians including recognizing CRNA board certifications if they include medical board certifications.

**AANA Comment: Challenges in Design, Development, and Implementation Can Be Addressed by Allowing Providers to Make Edits for Accuracy**

The AANA recognizes the many challenges that CMS may encounter during the design, development, and implementation and we would like to flag two challenges that may be unique to CRNAs. If CMS is relying on NPPES/Healthcare Provider Taxonomy Code Set, there is only a primary code where CRNAs are just named as "Nurse Anesthetist, Certified Registered." This might negate qualified CRNAs from being listed for services outside of anesthesia. The current

[9] Liao, op cit.

taxonomy code does not account for the various subspecialty designations that CRNAs may pursue and have expertise in and for which may be part of a CRNA's scope of practice in a state. Another challenge is accurately identifying in a national directory the services of those providers who practice in multiple states. For example, a CRNA who is licensed in more than one state, such as Virginia and Maryland, may have different services listed based on the scope of practice for which they are allowed for each state. That could make it difficult for patients to discern what services the provider can offer, even if the practices are essentially the same in each location. For these reasons, we recommend that clinicians have access to making edits to ensure its accuracy in the directory. We believe it is critically important to allow providers to have input if they note discrepancies in the directory.

**Phased Approach to Implementation**

**AANA Request: Ensure that the AANA and CRNAs are Included in the Development of Directories**

Given the unique aforementioned challenges that we have flagged, we believe it is important that professional associations, like the AANA, and CRNAs be included in the development of an NDH and have input in the development of these directories. CRNAs can help provide needed input in development of these directories, especially when it comes to providing information about anesthesia and pain management services. We ask that the AANA and CRNAs be consulted on and involved in providing input on such factors as data fields are going to be presented, how data from various other datasets be verified and consolidated, and how competencies are going to be accounted for. These are areas where the AANA stands ready to help CMS.

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