September 6, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1654-P  
P.O. Box 8013  
7500 Security Boulevard  
Baltimore, MD  21244-8013


Dear Mr. Slavitt:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on this proposed rule, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model (81 Fed.Reg. 46162, July 15, 2016). The AANA makes the following comments and requests in the following areas:

- Thank the agency for its role in permanently reversing harmful cuts.
- Convene CRNAs and other qualified professionals to develop recommendations on valuations for anesthesia codes associated with colorectal cancer screening tests.
- Convene CRNAs and other qualified professionals to develop recommendations for the valuation of moderate sedation services.
- Ensure that CDSMs are provider neutral.
Support CMS’s proposed policies that modify a TIN’s quality and cost composites when they are affected by a value-based modifier (VM) informal review determination or when there are widespread quality and cost data issues.

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, and AANA membership includes more than 50,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 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 continue to be 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.

CRNA services include providing 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 and chronic 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. According to a May/June 2010 study published in the journal of 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.1 Furthermore, an August 2010 study published in Health Affairs shows no differences in patient outcomes when anesthesia services are provided by CRNAs,

1 Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economic$. 2010; 28:159-169.
physicians, or CRNAs supervised by physicians.\(^2\) 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.\(^3\) 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.\(^4\)

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. 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.\(^5\) 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.\(^6\)


\(^6\) Liao, op cit.
PHYSICIAN FEE SCHEDULE UPDATE FOR CY 2017

AANA Request: Thank the Agency for its Role in Permanently Reversing Harmful Cuts

We thank the agency for its proposed 0.5 percent increase in the anesthesia conversion factor for calendar year 2017 (p.46459). We also recognize that the flawed “sustainable growth rate” (SGR) funding formula had threatened substantial cuts in anesthesia and physician payment, and we thank the Centers for Medicare and Medicaid Services (CMS) for its role in finding a long-term solution to the SGR. A dramatic and unjustified cut, if allowed to take effect, would have devastated patient access to healthcare and deeply impaired the Medicare program from its objectives as a public benefit.

AANA Request: Convene CRNAs and Other Qualified Professionals to Develop Recommendations on Anesthesia Codes Associated with Colorectal Cancer Screening Tests

We appreciate the opportunity to provide public comments in this rule and in future proposed rules regarding valuations of services. We applaud CMS for acknowledging that anesthesia furnished as part of screening colonoscopies is the standard of care, and for finalizing the proposal to include anesthesia as part of colorectal cancer screening tests in the 2015 Physician Fee Schedule rule. We also note that the agency continues to believe that CPT codes 00740 and 00810 are potentially misvalued and is looking to receive input on valuation of these services from interested parties and specialty societies for consideration during future notice and comment rulemaking (p.46240).

The AANA has an interest in improving patient outcomes by delivering colonoscopies safely, comfortably and efficiently, and we caution the agency not to devalue these codes. Patients undergoing these procedures recover more quickly from CRNA-delivered anesthesia than from other sedation, enabling GI endoscopy proceduralists to provide a dramatically patient focused, higher quality procedure than those using alternative forms of sedation. Furthermore, as the AANA is excluded from the AMA Relative Value Update Committee (AMA-RUC) process, and CRNA contributions to understanding about these codes is so critical given the large volume of
these services that CRNAs provide, we strongly urge that CMS convene CRNAs and other qualified professionals to examine the issue more closely and develop a recommendation. We stand ready to work with the agency and would be happy to answer any questions to help with this process.

**AANA Request: Convene CRNAs and Other Qualified Professionals to Develop Recommendations for the Valuation of Moderate Sedation Services**

We thank the agency for its work regarding issues related to the valuation of moderate sedation (46259-46260). In terms of appropriately valuing these services, we recommend that the CMS convene CRNAs and other qualified professionals to develop a recommendation for the valuation of the share of procedural sedation when the separate anesthesia service is provided and billed to Medicare. As we have stated previously, the AANA is excluded from the AMA Relative Value Update Committee (AMA-RUC) process. The AMA-RUC advisory body for organized medicine cannot and will not take into account the specific contributions that CRNAs make to anesthesia services, or the background and skills of CRNAs in the administration, economics and staffing of such services. When provided as part of the surgical service, sedation services are usually delivered by registered nurses in the form of narcotics and other relatively inexpensive medications -- but the patient characteristically experiences more side effects and recovers from the procedure and the sedation much more slowly than from sedation provided separately by a CRNA. These side effects and slower recovery period effectively increase costs and reduce the number of life-saving colonoscopy services that can be provided in a given facility in comparison with services that a facility can safely and excellently provide using CRNA sedation. Appropriate valuation of the sedation service should take into account the expenses associated with the registered nurse, the medications and their side effects, their delivery systems and patient monitoring equipment, and the lengthened postoperative recovery period.

**AANA Request: Ensure that CDSMs Are Provider Neutral**

As CMS develops its requirements for clinical decision support mechanisms (CDSM) under the Medicare Appropriate Use Criteria (AUC) program, we request that the agency ensure that
CDSMs are provider neutral so that APRNs, such as CRNAs, can consult them. Furthermore, we reiterate the importance of ensuring that the agency builds in safeguards to ensure that the AUC program and associated processes are not used as a means to restrict scope of practice and limit a CRNA’s ability to provide comprehensive pain management care. As part of treatment for chronic pain, CRNAs order diagnostic tests as part of the initial evaluation and treatment planning process. Our members report that as part of generalized evidence-based practice they may order plain films, computerized tomography (CT) scans, magnetic resonance imaging (MRIs), electromyograms, and nuclear bone scans. Additionally, most spinal interventions require an MRI or CT scan with myelogram prior to administering the injection.

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 Federal Trade Commission (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.” In the interest of protecting patients and the public, AUC program and associated processes should not prohibit practice to the full extent of a provider’s education and training, and should not institute differential reimbursement for the same service by qualified providers of differing licensure.

**AANA Request: Support CMS’s Proposed Policies that Modify a TIN’s Quality and Cost Composites When They are Affected by a Value-based Modifier (VM) Informal Review Determination or When There are Widespread Quality and Cost Data Issues**

The AANA supports CMS’s proposed policies that modify a TIN’s quality and cost composites when the quality or cost composites are affected by a Value-based Modifier (VM) Informal Review determination or when there are widespread quality and cost data issues for the CY 2017 payment adjustment period and the CY 2018 payment adjustment period (pages 46442-46446).

We agree with CMS that in four specific situations, classifying a TIN as having “average quality” is an adequate remedy to correct an error made by either CMS or a third-party vendor in the calculation of a TIN’s quality composite. Classifying providers as having “average quality” provides them with a neutral score and does not unfairly penalize them in these four specific situations. Limiting the potential movement between the VM quality tiers based on an informal review determination results in a fairer adjustment factor calculation and greater predictability.

We thank you for the opportunity to comment on the proposed rule. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Juan F. Quintana, DNP, MHS, CRNA
AANA President

cc: Wanda O. Wilson, CRNA, PhD, AANA Executive Director
Frank J. Purcell, AANA Senior Director of Federal Government Affairs
Romy Gelb-Zimmer, MPP, AANA Associate Director Federal Regulatory and Payment Policy