June 25, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1694-P  
P.O. Box 8011  
7500 Security Boulevard  
Baltimore, MD  21244

RE: CMS-1694-P – Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims; Proposed Rule (83 Fed.Reg. 20164 May 7, 2018)

Dear Ms. Verma:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on this proposed rule; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospital and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims (83 Fed.Reg. 20164, May 7, 2018). The AANA makes the following comments and requests of CMS:

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

- Recommend Enhancing the Safe Surgery Checklist Measure to Incorporate Demonstration of Improved Communication, Education, and Competency
• Modify Language of Proposed Hospital Harm-Opioid Related Adverse Events Electronic Clinical Quality Measure

**PROPOSED CHANGES TO THE PROMOTING INTEROPERABILITY PROGRAMS**

• Support Inclusion of Query of PDPM and Verify Opioid Treatment Agreement as New Measures for the e-Prescribing Objective of the Medicare and Medicaid Promoting Interoperability Programs

**REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES VIA THE INTERNET**

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

• CMS Can Work with Stakeholders in Developing Guidance to Educate Consumers on Questions to Ask Their Insurance Companies

**REQUEST FOR INFORMATION ON PROMOTING INTEROPERABILITY AND ELECTRONIC HEALTHCARE INFORMATION EXCHANGE**

• CMS Should Apply Provisions Set Forth in the Quality Payment Program for Special Status Clinicians to the Development of Any New Medicare Condition of Participation

**Background of the AANA and CRNAs**

The AANA is the professional association for CRNAs and student nurse anesthetists, and AANA membership includes more than 52,000 CRNAs and student nurse anesthetists (SRNAs) 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 provide every aspect of the delivery of anesthesia services including 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, 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 play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures. The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic

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\(^1\) Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economic$. 2010; 28:159-169.


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.\(^6\)

**HOSPITAL INPATIENT QUALITY REPORTING PROGRAM**

**AANA Comment: Recommend Enhancing the Safe Surgery Checklist Measure to Incorporate Demonstration of Improved Communication, Education, and Competency**

The AANA supports the removal of the current Safe Surgery Checklist Use measure from the Inpatient Quality Reporting program and recommends revisiting the measure criteria. The AANA believes that the Safe Surgery Checklist Use measure as written does not reflect whether communication among team members was effective in translating anticipated critical events. Moreover, there is limited indication of increased administrative burden in submitting a binary response to whether the facility uses a checklist.

While we agree with the agency that the safe surgical checklist has been widely adopted and used by hospitals, we caution the agency from presuming that the measure is widely used based on the original intent of the measure, which is meant to enhance perioperative communication prior procedure. Further, there is little evidence that this measure provides educational opportunities for improving ongoing competency of the surgical team with regards to preventing patient harm. Even though facilities have created processes to assure documentation, compliance for reporting, wrong body part, wrong patient surgeries continue as reported by Agency for Healthcare Research and Quality (AHRQ) and The Joint Commission. Studies show that education aimed at reducing near miss events is effective. For instance, a pre-post intervention


\(^6\) Liao, op cit.
study that integrated surgeon education to reduce near-miss events related to incorrectly sided surgical bookings and incorrectly performed preoperative time-out procedures helped reduce these events. Through education, incorrectly booked cases decreased from 0.75 percent to 0.41 percent and improperly performed time-out procedures decreased from 18.7 percent to 5.9 percent. For these reasons, we recommend that the Centers for Medicare & Medicaid Services (CMS) revisit the measure criteria to ensure that education is provided and to demonstrate improved communication and ongoing all surgical team competency.

AANA Request: Modify Language of Proposed Hospital Harm-Opioid Related Adverse Events Electronic Clinical Quality Measure

The AANA appreciates CMS’s dedication to combating the opioid epidemic and its focus on developing metrics aimed at reducing opioid related adverse events. Naloxone is used for opioid recuse from deep sedation or anesthesia. In facility quality improvement programs, identifying the use of naloxone by non-anesthesia professionals for procedural sedation or acute pain management rescue has the potential to be a valuable metric to assess educational needs and opportunity for improvement. Regarding the agency’s consideration of including Hospital Harm—Opioid-Related Adverse Events electronic clinical quality measure in future years in the Hospital Inpatient Reporting Quality program, we have issues with the proposed construct of this measure. We note that CMS is proposing to narrow cases in the numerator to exclude naloxone use in the operating room where it could be a part of the sedation plan as administered by an anesthesiologist. Recognizing that CRNAs also are anesthesia professionals responsible for administering sedation and anesthesia plans that take place in the operating room, the measure should narrow cases for exclusion by all anesthesia professionals, such as CRNAs, and not just anesthesiologists. Should CMS include this measure in the Hospital Inpatient Reporting Quality program, we recommend that CMS modify this construct to narrow cases to exclude naloxone when administered by an anesthesia professional.


8 Ibid.
PROPOSED CHANGES TO THE PROMOTING INTEROPERABILITY PROGRAMS

AANA Comment: Support Inclusion of Query of PDPM and Verify Opioid Treatment Agreement as New Measures for the e-Prescribing Objective of the Medicare and Medicaid Promoting Interoperability Programs

The AANA shares the agency’s concern about the increase in opioid drug use, abuse and deaths and is committed to working collaboratively toward comprehensive solutions to curb the opioid epidemic in the United States. The AANA supports the use of a patient-centered, multidisciplinary, multimodal treatment approach to pain management as a primary pain management modality, thus helping to curb the opioid epidemic. The AANA also believes that the additions of two proposed measures, Query of Prescription Drug Monitoring Program (PDPM) and Verify Opioid Treatment Agreement, to the e-Prescribing objective to the Medicare and Medicaid Promoting Interoperability Programs are steps in the right direction. We believe these additions will help reduce inappropriate opioid prescriptions, improve patient outcomes, and promote more informed opioid prescribing practices.

REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES VIA THE INTERNET

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

The AANA appreciates the agency’s concern regarding the issues with insufficient price transparency, particularly with regards to patients being surprised by out-of-network bills. The economic burden of receiving care out-of-network can be substantial for patients. Furthermore, knowing which providers and services are in-network and out-of-network is a huge burden for the patient as well as the provider and the facility. CMS can address this issue best by addressing the underlying causes, such as inadequate networks offered by insurance plans and plans engaging in discrimination against providers based on their licensure or certification. While this is not an issue under Medicare Part B, as Medicare recognizes CRNAs as qualified
providers and CRNAs must accept assignment as a condition for payment,\(^9\) this is an issue with private health plans, thus potentially affecting the private payer market and Medicare Advantage plans.

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

We recommend that CMS use its authority to further implement the federal provider nondiscrimination law by issuing a proposed rule on it. In 2010, Congress passed this provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), “Non-Discrimination in Health Care, 42 USC §300gg-5),\(^{10}\) which prohibits health plans from discriminating against qualified licensed healthcare professionals, such as CRNAs, solely on the basis of their licensure. This law promotes access to healthcare and consumer choice of healthcare professionals and helps reduce healthcare costs through competition. It prohibits discrimination based on provider licensure that keeps patients from getting the care they need.

To promote patient access to high quality healthcare, market competition and cost efficiency, all qualified health plans must all avoid discrimination against qualified, licensed healthcare

\(^9\) See 42 §414.60 (c).

\(^{10}\) 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.”
professionals, such as CRNAs, solely on the basis of licensure or certification. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs of their enrollees. However, when health plans organize their healthcare delivery in such a way that discriminate against whole classes of qualified licensed healthcare professionals by licensure or certification, for example, by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition. Additionally, such discrimination provides incentives for the use of higher-cost providers without improving quality or access to care. Promoting nondiscrimination encourages the use of qualified, licensed, and certified healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers.

While we recognize that CMS has developed network adequacy standards in Medicare Advantage plans and in the Marketplace, CMS must do more to ensure that health carriers maintain networks that are sufficient in numbers and types of providers to assure that all services to covered persons will be accessible to them without unreasonable delay. The AANA believes that patients benefit the greatest from a healthcare system where they receive easily accessible care from an appropriate choice of safe, high quality and cost-effective providers, such as CRNAs. Therefore, we request that CRNAs be included in all health carrier network plans, which will help ensure network adequacy, access and affordability to consumers.

**AANA Comment: CMS Can Work with Stakeholders in Developing Guidance to Educate Consumers on Questions to Ask Their Insurance Companies**

We also recommend that CMS work with healthcare stakeholders, such as CRNAs, in developing consumer guidance documents on surprise billing and out-of-network coverage and resources for assistance. For instance, this guidance could provide consumers with the education needed to know what questions to ask their insurance plans prior to procedures and where to go for help. We are happy to assist in the development of these patient tools.
REQUEST FOR INFORMATION ON PROMOTING INTEROPERABILITY AND ELECTRONIC HEALTHCARE INFORMATION EXCHANGE

AANA Comment: CMS Should Apply Provisions Set Forth in the Quality Payment Program for Special Status Clinicians to the Development of Any New Medicare Condition of Participation

The AANA recognizes that health information exchange has the potential to improve the healthcare system in numerous ways by advancing interoperability and that health information exchange between patients, providers and health care settings is an important step toward realizing this potential. Furthermore, the AANA is a determined advocate for policy development that results in a connected, patient-centered healthcare system where health information is routinely shared across providers and settings of care to encourage the consistent provision of high-quality, safe, and affordable care. Most anesthesia professionals, such as CRNAs, lack the “face-to-face” interaction according to billing codes and have difficulty influencing the availability of anesthesia EHR technology in facilities due to cost and limited anesthesia certified EHR technology (CEHRTs) to choose from. According to our analysis of the 2014 Medicare Provider Utilization and Payment data, 98.7% of CRNAs billed for anesthesia services CPT codes 0100-0199, which CMS determined to be non-patient-facing codes for 2016.

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

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

Sincerely,

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

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cc: Randall D. Moore, DNP, MBA, CRNA, AANA Chief Executive Officer
    Ralph Kohl, AANA Senior Director of Federal Government Affairs
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