June 13, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1716-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD  21244

RE: CMS-1716-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 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Rule (84 Fed.Reg. 19158 May 3, 2019)

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 Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals (84 Fed.Reg. 19158, May 3, 2018).  The AANA makes the following comments and requests of CMS:

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

- Thank Agency for Modifying Language of Proposed Hospital Harm-Opioid Related Adverse Events Electronic Clinical Quality Measure

PPS-EXEMPT CANCER HOSPITAL QUALITY REPORTING
• Support Removal of Communication about Pain Questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey in the PCHQR in Exchange for Meaningful High-Priority Pain Measures that Can Improve Functional Assessment Scores with Reduced Opioid Use

Background of the AANA and CRNAs

The AANA is the professional association for CRNAs and student nurse anesthetists, and AANA membership includes more than 53,000 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 45 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.

CRNAs 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...

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

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 factors related to geography and insurance type and the distribution of anesthesia provider type. 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.

### HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

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6 Liao, op cit.
AANA Comment: Thank Agency for Modifying Language of Proposed Hospital Harm-Opioid Related Adverse Events Electronic Clinical Quality Measure

The AANA appreciates the Centers for Medicare & Medicaid Services’ (CMS) dedication to combating the opioid epidemic and its focus on developing metrics aimed at reducing opioid related adverse events. Naloxone is used for opioid rescue 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 appreciate that the agency has modified the construct of the measure so that it has narrowed 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 all anesthesia professionals, such as CRNAs, and not just anesthesiologists. We thank the agency for recognizing that CRNAs in addition to anesthesiologists are anesthesia professionals responsible for administering sedation and anesthesia plans that take place in the operating room.

PPS-EXEMPT CANCER HOSPITAL QUALITY REPORTING

AANA Comment: Support Removal of Pain Questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey in the PCHQR in Exchange for Meaningful High-Priority Pain Measures that Can Improve Functional Assessment Scores with Reduced Opioid Use

The proposed rule states that CMS is proposing to remove the pain management dimension of HCAHPS survey for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) program, beginning with October 1, 2019 discharges, due to stakeholder concern that these particular questions focus on communication with patients about their pain and treatment of that pain, rather than how well their pain was controlled. The proposed rule further states that stakeholders are concerned that the questions as they are presently written still could potentially impose pressure on hospital staff to prescribe more opioids in order to achieve higher scores on the HCAHPS Survey. As CRNAs administer more than 45 million anesthetics to patients each year
in the United States, as well as acute, chronic, and interventional pain management services, the AANA agrees with the unintended consequences that may result based on these questions remaining in the survey and supports removal of the current pain management questions in the HCAHPS survey. Removal of the questions is a positive step toward improving patient safety and changing staff, patient and family perception about appropriate pain management and outcomes. Furthermore, the AANA is concerned in the increase in opioid drug use, abuse and deaths and is committed to working toward a common solution to help curb the opioid epidemic in the United States.

CRNAs are involved in every aspect of a patient’s anesthesia and analgesia care including the pre-anesthesia patient assessment, obtaining informed consent for anesthesia, developing the anesthesia and acute pain plan of care, administering the anesthetic, monitoring and addressing the patient’s response to anesthesia, providing emergency services as needed, and managing the patient’s anesthesia and pain related needs following the procedure. As stated above, CRNAs are a main provider of pain management services and are exceptionally skilled to provide both acute and chronic pain management in all clinical settings and are also well-positioned to educate clinicians and patients alike on the minimization or elimination of prescribed opioids for both acute and chronic pain management. Furthermore, the holistic, multi-modal approach that CRNA pain management practitioners employ when treating their chronic pain patients may reduce the reliance on opioids as a primary pain management modality, thus aiding in the reduction of potential adverse drug events related to opioids.

CRNAs provide safe and highly-effective pain management services that would contribute to better patient satisfaction with pain levels. Useful and meaningful HCAHPS measures may need to focus on pain management processes and evidence-based standards of care rather than patient-reported outcomes, which are more subjective. Further, as HCAHPS is a global survey about patient experience, assessment of the communication of pain are likely better addressed for specific care episodes where there are targeted modalities available to achieve better outcomes. CMS should put their focus on developing high-priority pain measures that can improve functional assessment scores with reduced opioid use.
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,

Garry Brydges, PhD, DNP, MBA, ACNP-BC, CRNA, FAAN
AANA President

cc: Randall D. Moore, DNP, MBA, CRNA, AANA Chief Executive Officer
    Ralph Kohl, AANA Senior Director of Federal Government Affairs
    Romy Gelb-Zimmer, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy