September 6, 2024

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1807-P –Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments; Proposed Rule (89 Fed.Reg. 61596, July 31, 2024)

Dear Administrator Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on this Proposed Rule: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (89 Fed.Reg. 61596, July 31, 2023). AANA makes the following comments and requests:

Changes in Relative Value Unit (RVU) Impact

- Alleviate the Reimbursement Cuts to Providers, Such as CRNAs

Proposal to Extend Direct Supervision to Include Audio-Video Communication Technology Through 2025

- Ensure that Interactive Telecommunications Technology are not Used for Anesthesiologist Telesupervision of Anesthesia Services

Expand Colorectal Cancer Screening

- Support Expansion of Medicare Coverage for Colorectal Cancer Screenings Including Anesthesia Services Provided by CRNAs

UPDATES TO THE QUALITY PAYMENT PROGRAM

Request for Information: Building upon the MIPS Value Pathways—Framework to Improve Ambulatory Specialty Care Updates to the Quality Payment Program

- Ensure That Participation is Voluntary and Use Regulatory Flexibilities that Remove Barriers to Scope of Practice

MVP Adoption and Subgroup Participation Request for Information

- Provide Publicly Available Data on MVP Performance and Uptake to Help Identify Barriers to Participation

Codification of Improvement Activity Removal Factors

Ensure that Removal Factors for Improvement Activities Take into Account APRN Guidelines and Practice

Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice

- Provide Affected Clinicians Further Guidance on Alternative Measures and Relevant MVPs to Meet Participation Requirements

Surgical Care MVPs

- Surgical Care MVP Not Very Relevant to CRNAs as Proposed

AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 65,000 CRNAs and SRNAs, representing about 88 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. For further information, see: https://www.aana.com/about-us.

Changes in Relative Value Unit (RVU) Impact

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

While we do appreciate that the Centers for Medicare & Medicaid Services (CMS) has proposed payment policy changes in this proposed rule that will have a positive impact on CRNA payment, we were disappointed to see a proposed 2.1 percent decrease over last year's anesthesia conversion factor (CF) in this proposed rule. The positive impact on payment is not enough to make up for this cut to the anesthesia CF, as these constant cuts in reimbursement have not kept with inflation. These effects are compounded by the fact that private payers are cutting rates for CRNA anesthesia services. This disproportionate pay affects patient access to anesthesia care, especially in rural and underserved areas where CRNAs predominate, and is particularly troubling in light of current and future anesthesia workforce shortages.[1] 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.[2] We understand that CMS is bound by budget neutrality requirements, and that any changes to these requirements would necessitate future Congressional action. To the extent that CMS does have the ability to alter payment rates, we ask that CMS help lessen the impact of this decrease in the anesthesia CF and to work with Congress to establish an answer. AANA would be happy to work with the agency in these efforts.

Proposal to Extend Direct Supervision to Include Audio-Video Communication Technology Through 2025

AANA Request: Ensure that Interactive Telecommunications Technology are not Used for Anesthesiologist Telesupervision of Anesthesia Services

As CMS considers flexibilities in telehealth, especially with respect to audio-video communication technology, AANA cautions CMS against the use of wasteful services in the name of telehealth that would increase costs without improving healthcare access or quality. We stress that one wasteful payment policy to avoid would be reimbursing anesthesiologists that are not providing actual anesthesia care, through billing for remote so-called "supervision" services. This type of remote supervision would not improve access to healthcare for patients and would instead reward providers not actually furnishing healthcare services. CMS also states in the preamble in this proposed rule and in the 2021 Physician Fee Schedule final rule that they are concerned that virtual presence would not be sufficient "…in complex, high-risk, surgical,

[1] Negrusa et al 2021., Anesthesia Services: A Workforce Model and Projections of Demand and Supply. Nursing Economic$, 39(6), 275–284

[2] 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.

interventional, or endoscopic procedures, or anesthesia procedures…such services to be furnished or supervised in person to allow for rapid on-site decision-making in the event of an adverse clinical situation.”[3] We also have concerns that this proposal could lead to virtual supervision in other instances. While we understand that supervision of residents in teaching situations is a slightly different situation, we note that there is no evidence of the efficacy and cost-effectiveness of in-person physician supervision requirements,[4] there also is no evidence regarding the benefit for the use of supervision of anesthesia via telehealth.[5] As evidence shows that in-person supervision by physicians does not improve anesthesia outcomes, while it does significantly increase costs; thus it stands to reason that remote supervision would not improve outcomes, while also substantially increasing costs. As CMS continues to consider this matter and any potential use in anesthesia, we also urge that any CMS policy or direction recognize AANA as a major stakeholder in its formulation and that future AANA developed guidelines should be integrated in the determination into Medicare payment policy.

Expand Colorectal Cancer Screening

<u>AANA Request: Support Expansion of Medicare Coverage for Colorectal Cancer Screenings including Anesthesia Services Provided by CRNAs</u>

AANA supports the agency's proposal to expand the definition of "complete colorectal screening" to include a follow-on screening colonoscopies after a Medicare covered blood-based biomarker CRC screening test. We agree with CMS that this proposal will directly advance health equity by promoting access and removing barriers to cancer prevention and early detection. We also ask that CMS continue to cover anesthesia services associated with follow-on screening colonoscopies furnished by anesthesia providers, such as CRNAs. 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 recover more quickly from Monitored Anesthesia Care than from other sedation, enabling GI endoscopy proceduralists to provide a dramatically greater number of higher quality procedures than those using alternative forms of sedation.

UPDATES TO THE QUALITY PAYMENT PROGRAM

[3] 85 FR 84539, December 28, 2020 and 89 FR 61533, 61534.

[4] See B. Dulisse and J. Cromwell op cit. and Paul F. Hogan et. al, op cit.

[5] See: Applegate RL, 2nd, Gildea B, Patchin R, et al. Telemedicine pre-anesthesia evaluation: a randomized pilot trial. Telemed J E H ealth. 2013;19:211-6; Cone SW, Gehr L, Hummel R, Merrell RC. Remote anesthetic monitoring using satellite telecommunications and the Internet. Anesthesia and analgesia. 2006;102(5):1463-1467; Dilisio RP, Dilisio AJ, Weiner MM. Preoperative virtual screening examination of the airway. J Clin Anesth. 2014;26:315-7; and Galvez JA, Rehman MA. Telemedicine in anesthesia: an update. Curr Opin Anaesthesiol. 2011;24:459-62.

Request for Information: Building upon the MIPS Value Pathways—Framework to Improve Ambulatory Specialty Care

AANA Request: Ensure That Participation is Voluntary and Use Regulatory Flexibilities that Remove Barriers to Scope of Practice

As CMS is seeking to encourage specialty care provider engagement in ambulatory settings, we request that CMS ensure that models designed for the ambulatory surgery center are voluntary and that they include policy flexibilities that allow advanced practice providers, including CRNAs, to practice at the top of their scope. CRNAs practice in all types of healthcare settings including in ambulatory surgical centers. CRNAs are licensed as independent practitioners who plan and deliver anesthesia, pain management, and related care to patients of all health complexities across the lifespan. As autonomous healthcare professionals, CRNAs collaborate with the patient and a variety of healthcare professionals in order to provide patient-centered high-quality, holistic, evidence-based and cost-effective care.

In order to allow CRNAs to practice at the top of their scope, we recommend that CMS permanently waive unnecessary physician supervision requirements as part of the Medicare Conditions for Coverage in ASCs[6] and other facilities. In May 2020, CMS had issued a blanket waiver to remove requirement in ASCs and other facilities as part of the COVID-19 public health emergency (PHE), but had ended this waiver in May 2023.[7]

Permanently removing unnecessary supervision requirements is consistent with Medicare policy reimbursing CRNA services in alignment with their state scope of practice (see: 42 CFR §410.69(b), 77 Fed. Reg. 68892, November 16, 2012). Currently, 43 states do not have a physician supervision requirement for CRNAs in their nursing or medical laws or regulations.

There is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality and may restrict access and increase cost. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a 2010 study published in *Health Affairs*[8] led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 25 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. Furthermore, a study published in *Medical Care* June 2016 found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[9]

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[6] 42 CFR § 416.42

[7] See https://www.cms.gov/newsroom/fact-sheets/cms-waivers-flexibilities-and-transition-forward-covid-19-public-health-emergency.

[8] Dulisse, op. cit.

[9] Negrusa B et al. op. cit.

CRNA safety in anesthesia is further evidenced by the significant decrease in liability premiums witnessed in recent decades. n 2022, self-employed CRNAs paid 36.17 percent less for malpractice premiums nationwide when compared to the average cost in 1988. When adjusted for inflation through 2022, the reduction in CRNA liability premiums is an astounding 74.5 percent less than approximately 34 years ago according to Anesthesia Insurance Services, Inc. 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 without any measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[10]

Permanently removing supervision will also help improve health equity and access to care in ambulatory surgery centers, which is crucial given the current anesthesia labor shortage. According to a 2021 study by Negrusa, a baseline trend using data from 2017 shows that there is an estimated 10.7% excess demand for anesthesia services, meaning that the labor market for anesthesia providers is short by over 9,000 providers.[11] According to this same analysis, shortfalls are to continue to 2027, though at a slower rate of decline. Removing supervision will offer flexibilities that ease the impact of these shortages and thereby increase access to care, particularly in underserved areas. In light of all this evidence, we strongly urge CMS to permanently remove supervision restrictions.

MVP Adoption and Subgroup Participation Request for Information

AANA Request: Provide Publicly Available Data on MVP Performance and Uptake to Help Identify Barriers to Participation

We appreciate the opportunity to comment on this request for information. In order to prepare for the full transition to MVPs, we recommend that CMS provide publicly available data about MVP performance and uptake. This information may be helpful in identifying barriers to participating in MVPs. Furthermore, as many eligible clinicians may still not be aware of MVPs as a reporting option, it will offer the opportunity for further education and awareness.

Codification of Improvement Activity Removal Factors

AANA Request: Ensure that Removal Factors for Improvement Activities Take into Account APRN Guidelines and Practice

Within the process for identifying improvement activities for potential removal, we request that CMS ensure that it is not discriminating on the basis of licensure and is looking at all current clinical guidelines and practice, including those for APRNs and CRNAs. Practitioners who are

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[10] Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” *Nursing Economic$.* 2010; 28:159-169.

[11] Negrusa et al 2021., Anesthesia Services: A Workforce Model and Projections of Demand and Supply. Nursing Economic$, 39(6), 275–284.

not physicians, such as CRNAs and other types of APRNs, should have equal opportunities to participate. This is especially important as CMS is looking to also streamline the inventory of improvement activities as stated on page 62059 of the preamble of this proposed rule.

Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice

AANA Request: Provide Affected Clinicians Further Guidance on Alternative Measures and Relevant MVPs to Meet Participation Requirements

We appreciate that CMS acknowledges that anesthesia is among of the list of specialty sets that are impacted by limited measure choice, and that CMS notes that as performance thresholds increase, it will be more difficult for these eligible clinicians, like CRNAs, to maximize their MIPS performance score. We do agree with CMS's approach to identifying topped out measure benchmarks so that MIPS-eligible clinicians, such as CRNAs, can prepare for the changes. We also do request that CMS provide further guidance for these affected clinicians on how to identify alternative measures or use relevant MVPs to meet participation and performance criteria.

Surgical Care MVPs

AANA Comment: Surgical Care MVP Not Very Relevant to CRNAs as Proposed

CMS has identified CRNAs as a type of clinician that the Surgical Care MVP would be appropriate for. While we appreciate opportunities to participate in different MVPs, we note that only one of the quality measures, Coronary Artery Bypass Graft: Prolonged Intubation (Q164), is directly attributable to CRNAs. Furthermore, IA-CC_15: PSH Care Coordination is listed as the high priority measure for this MVP, which is not multidisciplinary and does not necessarily involve CRNAs. If CMS intends for CRNAs to participate in this MVP, we would ask that CMS provide refinements to it in order to make it more accessible to CRNAs or to encourage subgroup participation.

Thank you for the opportunity to comment on this proposed rule. Should you have any questions regarding these matters, please contact AANA Director of Regulatory Affairs, Romy Gelb-Zimmer at 202-484-8400, rgelb-zimmer@aana.com.

Sincerely,

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