American Hospital Association

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March 18, 2009

Ms. Charlene Frizzera
Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 38,000 individual members, the American Hospital Association (AHA) urges you to affirm the decision of the Provider Reimbursement Review Board (the Board) in the case of *St. Luke Community Healthcare v. BlueCross BlueShield Association/Noridian Administrative Services*.[i]

In this decision, the Board found that standby costs for certified registered nurse anesthetists (CRNA) at critical access hospitals (CAH) are allowable costs under Medicare. CRNAs have provided anesthesia care to patients in all parts of the U.S. for more than 125 years. In rural parts of the country, they often are the primary providers of anesthesia, which enables health care facilities in these medically underserved areas to offer surgical services. As a result, CRNAs greatly improve patient access in rural areas where physician shortages are particularly problematic. Disallowing their standby costs would threaten this access by forcing hospitals to inappropriately absorb these costs.

Although there is no statute, regulation or guideline that specifically allows standby costs for CRNAs, there is no statute, regulation or guideline that specifically *disallows* these costs either. In the absence of such definitive sources, the Board ruled that there are several authorities that, when taken together, provide for allowing these costs by defining them as reasonable and, therefore, allowable by Medicare.[ii] Further, the *Medicare Provider Reimbursement Manual* explicitly states that "ordinarily, costs for standby services will be recognized if reasonable in amount and related to patient care."[iii]

The Centers for Medicare & Medicaid Services (CMS) does place limits on CAH reimbursement for the standby costs of emergency department providers. However, the Board found that less than 1 percent of CRNA services are performed in the emergency department; therefore, these limits do not apply to CRNAs. Further, it has been longstanding CMS policy to allow standby costs for CRNAs, as well as other types of employees and contractors, such as laboratory staff, insofar as they are reasonable and necessary.

The issue of allowing CRNA standby costs previously has come before the Board. Specifically, in a case decided last year, the Board also ruled that CRNA standby costs were Medicare allowable costs for CAHs.[iv] However, the CMS administrator subsequently reversed this decision. Rather than adopting the position of the previous administrator, we again urge you to review and affirm the current Board decision and adopt a policy that CRNA standby costs are allowable for CAHs. The availability of these services in rural areas is critical to preserving patient access to necessary services.

If you have any questions, please feel free to contact me or Joanna Hiatt, senior associate director for policy, at (202) 626-2340 or jhiatt@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

cc: Jonathan Blum, Director, Center for Medicare Management

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[i] Provider Reimbursement Review Board Dec. No. 2009-D9, February 25, 2009.
[ii] The Provider Reimbursement Review Board cited 42 U.S.C. §1395x(v)(1)(A), 42 C.F.R. §413.9(c)(3), and CMS Pub. 15-1 §2102.1. See Provider Reimbursement Review Board Dec. No. 2009-D9, February 25, 2009.
[iii] CMS Pub. 15-1 §2135.3(D)(2)
[iv] See Marias Medical Center v. BlueCross BlueShield Association/Blue Cross and Blue Shield of Montana, Provider Reimbursement Review Board Dec. No. 2008-D40, September 29, 2008.