October 26, 2017

John Graham
Acting Assistant Secretary and Principal Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Avenue, SW, Room 415F
Washington, DC 20201

RE: Draft HHS Strategic Plan, FY 2018 –2022 (September 2017)

Dear Mr. Graham:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to provide written comments on this draft Strategic Health Plan. We are firmly committed to working with the agency and other healthcare stakeholders to help achieve our common goals of increasing access to healthcare, making healthcare more affordable and improving the quality of the care available for all Americans. Specifically, the AANA makes the following comments and recommendations:

I. **CRNAs Provide Safe, High Quality and Cost Effective Healthcare**

II. **Our Proposals for Incentivizing Safe, High Quality Care**

   A. The Costly and Unnecessary Requirements Relating to Physician Supervision of CRNA Anesthesia Services should be Removed

   B. Cost-Effective Models in Healthcare Delivery such as Non-medically Directed Anesthesia Services Performed by CRNAs Should be Included as Part of Healthcare Reform

   C. Implementing CRNA Full Practice Authority Increases Veterans Access to Care and Promotes Safe, Efficient Healthcare Delivery

   D. Appropriate Enforcement of the Provider Nondiscrimination Law Promotes Consumer Choice and Market Competition, Advancing Patient Safety Innovations and Cost-Efficiency in the Public Interest

   E. Ensure Equal Treatment of CRNAs and APRNS in Physician Specialty Models and Advanced
Alternative Payment Models

III. Our Proposals to Leverage Technology Solutions to Support Safe, High Quality Care

A. For Anesthesia, Interoperability of Health Information Should Communicate Across the Continuum of Patient Care and EHRs Should Use Standardized Taxonomies Across Technology Platforms

B. The Focus of Measurement of Interoperability Should Not Be Limited to Only Use of Certified EHR Technology

C. Additional Anesthesia Data Sources Should be Used to Evaluate Interoperability

D. Measures Assessing Interoperability Across the Care Continuum Should be Considered

E. Prohibit the Use of Wasteful Tele-Supervision of CRNA Services

IV. Our Proposals to Implement Coordinated, Team-Based Approaches to Care

A. Include Strategic Consideration of the Role of Anesthesia in Enhanced Recovery after Surgery Protocol as an Innovative Healthcare Delivery Model

B. Use of a Multi-Modal Pain Management Approach which may Reduce Patient Need for and Reliance on Opioids

V. Our Proposals to Reduce Provider Shortages in Underserved and Rural Communities

A. Reducing Regulatory Barriers for CRNAs Increases Access to Anesthesia Care in Rural Communities

CRNAs Provide Safe, High Quality and Cost Effective Healthcare

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 52,000 CRNAs and SRNAs, representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer approximately 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 are 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 are involved in every aspect of anesthesia services including 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, chronic, and interventional
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. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons. CRNAs play an essential role in ensuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals and affording these facilities the capability to provide many necessary procedures.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal 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.\(^1\) An August 2010 study published in Health Affairs showed 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, the internationally recognized authority on evidence-based practice in healthcare.\(^3\) 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.\(^4\)

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I. OBJECTIVE 1.2: EXPAND SAFE, HIGH QUALITY HEALTHCARE OPTIONS AND ENCOURAGE INNOVATION AND COMPETITION

A. Our Proposals for Incentivizing Safe, High Quality Care

We recommend removing administrative and regulatory barriers to the use of CRNA services, which will help promote competition and choice while reducing costs in the healthcare system. Before outlining these proposals, we wanted to provide an overview of the professional regulation of CRNAs. The scope of practice for CRNAs is first determined by the profession, and is subject to state legislation and regulation through nurse practice acts and regulations, and through state healthcare facility licensing statutes and regulations. At the federal level, CRNA practice is circumscribed by federal regulations governing Medicare healthcare facilities, chiefly hospital conditions of participation (CoPs) and ambulatory surgery center conditions for coverage (CfCs). At both the state and federal levels, however, recognition of CRNA services to the full extent of the profession’s practice authority is commonly constrained through the highly organized and well-funded policy advocacy efforts of marketplace competitors from the community of organized medicine.

1. The Costly and Unnecessary Requirements Relating to Physician Supervision of CRNA Anesthesia Services Should be Removed

CRNAs’ ability to practice to their full scope is affected by Medicare regulations associated with Medicare Part A Conditions of Participation and Conditions for Coverage (CoPs and CfCs). The Medicare CoPs and CfCs are federal regulations with which particular healthcare facilities must comply in order to participate in the Medicare program. While these regulations directly apply to facilities, they affect CRNA practice and impair competition and choice. Regulatory reforms that reduce barriers to CRNA practice can help improve healthcare quality, reduce healthcare expenditures and increase access for patients. Among these reforms is a recommendation to eliminate the Medicare requirement for physician supervision of CRNA anesthesia services.

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6 For example, Medicare hospital conditions of participation require CRNA anesthesia services to be subject to supervision by the operating practitioner or by an anesthesiologist who is immediately available, unless the state in which the service is provided has opted-out from this supervision requirement. See 42 CFR §482.52 at http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-52.pdf and Medicare hospital interpretive guidelines at the Medicare state operations manual Appendix A, tag #A-1000, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.

7 See 42 CFR §§ 482.52, http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1&rgn=div5#42:5.0.1.1.4.4.2, 482.639 http://www.ecfr.gov/cgi-bin/text-
The requirement for physician supervision of CRNA anesthesia services is costly and unnecessary, driving healthcare expenditures higher without improving patient safety. Eliminating the requirement supports delivery of healthcare in a manner allowing states and healthcare facilities to make their own decisions based on state laws and patient needs, thus controlling cost, providing access and delivering quality care. There is strong and compelling evidence 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* 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, 17 states have opted out.) The researchers found that anesthesia has continued to become safer in opt-out and non opt-out states alike. In reviewing the study, the *New York Times* stated, “In the long run, there could also be savings to the healthcare system if nurses delivered more of the care.” Most recently, a peer-reviewed study published in *Medical Care* (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.

CRNA safety in anesthesia is further evidenced by the significant decrease in liability premiums witnessed in recent decades. In 2015, self-employed CRNAs paid 33 percent less for malpractice premiums nationwide when compared to the average cost in 1988. When adjusted for inflation through 2015, the reduction in CRNA liability premiums is an astounding 65 percent less than approximately 25 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.

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8 Dulisse, op cit.


10 Negusa, op cit.

11 Hogan, op cit.
The evidence also demonstrates that the supervision requirement is costly. Though Medicare requires supervision of CRNAs (except in opt-out states) by a physician, hospitals and healthcare facilities often misinterpret this requirement to be a quality standard rather than a condition of participation.

The AANA receives reports from the field that anesthesiologists suggest erroneously that supervision is some type of quality standard, an assertion bearing potential financial benefit for anesthesiologists marketing their medical direction services as a way to comply with the supervision condition of participation. When this ideology is established, anesthesiologist supervision adds substantial costs to healthcare by requiring duplication of services where none is necessary. Further, the Medicare agency has clearly stated that medical direction is a condition for payment of anesthesiologist services and not a quality standard. But there are even bigger costs involved if the hospital administrator believes that CRNAs are required to have anesthesiologist supervision (which they are not).

According to a nationwide survey of anesthesia group subsidies, hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms pays on average a $3.2 million anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

There is also strong evidence in the literature that anesthesiologist supervision fails to comply with federal requirements, either the Part A conditions of participation or Part B conditions for coverage. Lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs, according to a 2012 study published in the journal *Anesthesiology*, the professional journal of the American Society of Anesthesiologists. The authors reviewed over 15,000 anesthesia records in one leading U.S. hospital, and found supervision lapses in 50 percent of the cases involving anesthesiologist supervision of two concurrent CRNA cases, and in more than 90 percent of cases involving anesthesiologist supervision of three concurrent CRNA cases. This is consistent with more than 10 years of AANA membership survey data.

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12 63 FR 58813, November 2, 1998.
Since this regulatory requirement is meaningless in practice, contributes to greater healthcare costs, and is contrary to existing evidence regarding patient safety and access to care, we recommend CMS eliminate the regulatory barrier of physician supervision of CRNAs in the Medicare program. Removing this barrier is also consistent with the findings and recommendations of the National Academy of Medicine, whose landmark publication titled *The Future of Nursing: Leading Change, Advancing Health* calls for removing barriers so that APRNs, including CRNAs, can practice to the full extent of their education and training, indicating that APRNs play a critical role in the future of healthcare.\(^\text{15}\)

2. **Cost-Effective Models in Healthcare Delivery such as Non-Medically Directed Anesthesia Services Performed by CRNAs should be Included as Part of Healthcare Reform**

The AANA supports efforts to better understand the potential benefits of new healthcare delivery models that have emerged in recent years which can offer significant cost savings while maintaining, or even improving, quality of care. These models may also increase the supply of healthcare services, which can expand consumer access to care. We recommend that innovative, cost-effective models in anesthesia delivery such as *non-medically directed* anesthesia services performed by a CRNA be included in the agency’s strategic plan to help reform, strengthen and modernize our nation’s healthcare system.

In most respects, Medicare reimburses CRNAs and anesthesiologists at the same rate for the same high-quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. However, Medicare Part B also authorizes payment for “anesthesiologist medical direction”\(^\text{16}\) that provides a financial incentive for anesthesiologists to “medically direct” CRNAs who are capable of and often provide patient access to high-quality anesthesia care unassisted. An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases, a total of 200 percent over a given period of time, and twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare


costs without improving Safety.\textsuperscript{17} The CMS has also stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.\textsuperscript{18}

In demonstrating the increased costs associated with anesthesiologist medical direction, suppose there are four identical cases: (a) anesthesia delivered by a non-medically directed CRNA; (b) anesthesia delivered by a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) anesthesia delivered by a CRNA medically directed at a 2:1 ratio; and (d) anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, $170,000 for the CRNA\textsuperscript{19} and $540,314 for the anesthesiologist\textsuperscript{20}. Under the Medicare program and most private payment systems, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable. However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost of practice modality (a) equals $170,000 per year. For case (b), it is $305,079 per year ($170,000 + (0.25 x $540,314). For case (c) it is $440,157 per year ($170,000 + (0.50 x $540,314). Finally, for case (d), the annualized cost equals $540,314 per year.

<table>
<thead>
<tr>
<th>Anesthesia Payment Model</th>
<th>FTEs / Case</th>
<th>Clinician costs per year / FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) CRNA Non-medically Directed</td>
<td>1.00</td>
<td>$170,000</td>
</tr>
<tr>
<td>(b) Medical Direction 1:4</td>
<td>1.25</td>
<td>$305,079</td>
</tr>
<tr>
<td>(c) Medical Direction 1:2</td>
<td>1.50</td>
<td>$440,157</td>
</tr>
<tr>
<td>(d) Anesthesiologist Only</td>
<td>1.00</td>
<td>$540,314</td>
</tr>
<tr>
<td>Anesthesiologist mean annual pay</td>
<td>$540,314</td>
<td>MGMA, 2014</td>
</tr>
<tr>
<td>CRNA mean annual pay</td>
<td>$170,000</td>
<td>AANA, 2014</td>
</tr>
</tbody>
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If Medicare, Medicaid, and private plans pay the same rate whether the care is delivered according to modalities (a), (b), (c) or (d), someone in the health system is bearing the additional cost of the medical

\textsuperscript{17} Hogan, op cit.
\textsuperscript{19} AANA member survey, 2014
\textsuperscript{20} MGMA Physician Compensation and Production Survey, 2014. www.mgma.com
direction service authorized under the Medicare regulations at 42 CFR §415.110. This additional cost is shifted onto hospitals and other healthcare facilities, and ultimately to patients, premium payers and taxpayers. With CRNAs providing over 43 million anesthetics each year in the United States, and a considerable fraction of them being “medically directed,” the additional healthcare costs driven by this medical direction service are substantial.

In addition, the most recent peer-reviewed literature makes clear that the requirements of anesthesiologist medical direction are often not met in practice, and that if anesthesiologists submit claims to Medicaid for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread fraud in this area is high. Lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs, according to a 2012 study published in the journal *Anesthesiology*; the professional journal of the American Society of Anesthesiologists. The authors reviewed over 15,000 anesthesia records in one leading U.S. hospital, and found supervision lapses in 50 percent of the cases involving anesthesiologist supervision of two concurrent CRNA cases, and in more than 90 percent of cases involving anesthesiologist supervision of three concurrent CRNA cases. This study raises critical issues about Medicare claims compliance in a common and costly model of anesthesia delivery at a time when quality, cost-effectiveness, and best use of Medicare resources are the focus of healthcare reform. In the interest of patient safety and access to care, these additional costs imposed by medical direction modalities more than justify the public interest in recognizing and reimbursing fully for non-medically directed CRNA services within Medicare, Medicaid and private plans in the same manner that physician services are reimbursed.

In conclusion, anesthesiologist medical direction reimbursement models contribute to increased healthcare system costs without improving access or quality, and also present fraud risk when medical direction requirements are not met by the anesthesiologist submitting a claim for such services. Therefore, such costs should be considered when developing and carrying out new systems for anesthesia reimbursement in healthcare delivery models, and to favor reimbursement systems that support the most cost-effective and safe anesthesia delivery models such as for non-medically directed CRNA services.

3. **Implementing CRNA Full Practice Authority Increases Veterans Access to Care and Promotes Safe, Efficient Healthcare Delivery**

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The AANA advocates on numerous issues to help improve healthcare, patient safety and practice excellence by working to increase access to healthcare, make healthcare more affordable, and improve the quality of the care available to all patients, including our nation’s veterans. On December 14, 2016, the Department of Veterans Affairs (VA) published its final rule granting full practice authority to three of the four APRN specialties, illogically excluding CRNAs from the rule “due to VA’s lack of access problems in the area of anesthesiology.”22 This is a dangerously inaccurate statement that is clearly refuted by evidence. The most recent evidence was shown in a news story from Denver highlighting the lack of access to anesthesia services at Veterans Health Administration (VHA) facilities and the ensuing delays for critical surgeries for our veterans.23 Due to anesthesia delays, veterans are indeed waiting for care they deserve and have earned. The decision to exclude CRNAs will cause veterans to continue to endure dangerously long wait times for anesthesia and other healthcare services due to the ongoing underutilization of CRNAs currently working in VHA facilities.

In the interest of expanding Veterans’ access to quality healthcare, we express strong support for the VHA recognizing all APRNs, including CRNAs, to practice to the full extent of their education, training, and certification without the clinical supervision of physicians. Nurse anesthetists are experienced, highly educated anesthesia professionals who provide quality patient care confirmed by decades of scientific research. Peer-reviewed research and authoritative policy documents have illustrated how CRNAs consistently deliver safe, high-quality, cost-effective anesthesia care in today’s ever-changing healthcare environment and this has long been recognized by the VHA. By standardizing care delivery models across the country via full practice authority for APRNs, including CRNAs, Veterans can be assured consistently safe and high quality care delivery in any VHA healthcare facility. More than 900 CRNAs provide every type of anesthesia care, as well as chronic pain management services, for our Veterans in the VHA.

Permitting full practice authority for CRNAs will ensure veterans receive the full scope of high-quality anesthesia and pain management care they so rightfully deserve. An Independent Assessment of the VA’s healthcare delivery system and management processes as required by the Veterans Choice Access and Accountability Act of 2014, recommended formalizing Full Nursing Practice Authority for


all APRNs, including CRNAs, throughout the VHA. In addition, in June 2016 following an exhaustive 10-month assessment of the VHA, the independent federal Commission on Care reported that 23 percent of healthcare professionals in the VHA are not working to the top of their licensure, identifying this underuse of available resources as a major barrier to effective healthcare provision. One solution recommended by the Commission is implementation of policy that allows full practice authority for APRNs, which adds further data to the increasing amount of evidence in support of allowing CRNAs and other APRNs to practice to the full scope of their education, training, and abilities in the VHA, without physician supervision. This policy would not only help address the increasing healthcare demands of our nation’s veterans, but would also improve healthcare efficiency in the VHA system by reducing wait times and increasing cost-effective care. The common sense solution to avoid further interruption in veterans’ care is to immediately implement full practice authority for all CRNAs and APRNs working in the VHA system.

The landmark National Academy of Medicine (formerly the Institute of Medicine) report *To Err is Human* found in 2000 that anesthesia was 50 times safer than in the 1980s. Though many studies have demonstrated the high quality of nurse anesthesia care, the results of a 2010 study published in *Health Affairs* 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, 17 states have opted-out). The researchers found that anesthesia has continued to grow more safe in opt-out and non-opt-out states alike. A June 2016 study published in the independent scientific journal *Medical Care* found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions. The study, which is the first to focus on the effects of state scope of practice laws and anesthesia delivery models on patient safety, also concluded that limitations on CRNA practice such as state scope of practice restrictions and physician supervision reduce patient access to quality care and increase costs of healthcare.

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26 The Commission on Care, op cit.

services. Furthermore, a 2014 Cochrane Collaboration publication found no differences in care between nurse anesthetists and physician anesthesiologists.

In the interest of improving Veterans’ access to quality healthcare, we express strong support for the VA recognizing CRNAs to practice to the full extent of their education, training, and licensure without the clinical supervision of physicians. Permitting full practice authority for CRNAs will ensure Veterans receive the full scope of high-quality anesthesia and pain management care they so rightfully deserve. The Independent Assessment of the healthcare delivery system and management processes of the VA recommended formalizing full practice authority for all APRNs, including CRNAs, throughout the VHA. In addition, in June 2016, following an exhaustive 10-month assessment of the VHA, the independent federal Commission on Care reported that 23 percent of healthcare professionals in the VHA are not working to the top of their licensure, identifying this underuse of available resources as a major barrier to effective healthcare provision. One solution recommended by the Commission is implementation of policy that allows full practice authority for APRNs, which adds further data to the increasing amount of evidence in support of allowing CRNAs to practice to the full scope of their education, training, and licensure in the VHA, without physician supervision. This policy would not only help address the increasing healthcare demands of our nation’s Veterans, but would also improve healthcare efficiency in the VHA system by reducing wait times and thereby increasing cost-effective care. Moreover, granting full practice authority to CRNAs would allow CRNAs to fully utilize their education and training to enhance the patient care team model and work collaboratively with anesthesiologists as equal partners in anesthesia delivery for surgery, labor and delivery, trauma stabilization, and chronic pain management.

Recognizing CRNAs to their full practice authority corresponds with the first policy recommendation from the National Academy of Medicine report titled The Future of Nursing: Leading Change, Advancing Health. This report outlines several paths by which patient access to care may be

28 Negrusa op cit.
31 The Commission on Care, op cit.
expanded, quality preserved or improved, and costs controlled through greater use of APRNs.\textsuperscript{32} The National Academy of Medicine report specifically recommends that, “advanced practice registered nurses should be able to practice to the full extent of their education and training.”\textsuperscript{33}

Access to care should be measured by whether veterans are getting the services they need. Notwithstanding the VA’s efforts to reform access issues, veterans are still experiencing long wait times for care, which has been identified in numerous instances by published government reports, the VHA Independent Assessment, and observations within the VHA. Such delays justify prompt implementation of full practice authority for VHA CRNAs. Thus, we urge the VA to allow full practice authority for CRNAs to continue improving healthcare for our veterans throughout the country.


The federal provider nondiscrimination 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),\textsuperscript{34} which took effect January 1, 2014, 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.

This law promotes competition and consumer choice by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote patient access to care, health

\begin{itemize}
  \item \textsuperscript{33} National Academy of Medicine op cit., p. 9.
  \item \textsuperscript{34} 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.”
\end{itemize}
insurers and health plans must all avoid discrimination against qualified, licensed healthcare professionals solely on the basis of licensure. The Provider Nondiscrimination provision also respects local control of healthcare systems and local autonomy in the organization of health plans and benefits. It does not impose “any willing provider” requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.

The AANA interprets Section 2706 to protect patient choice and access to a range of beneficial providers and prevent discrimination by health insurance plans against an entire class of health professionals, such as CRNAs. We believe it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure. While health plans might believe this is a cost-effective way to save money and lower health care costs, this would direct cases to more expensive providers, such as anesthesiologists, leading to impaired access, increased costs and lower quality of care. The AANA also interprets the Provider Nondiscrimination provision to mean that if a health plan or health insurer network offers a specific covered service, they should include in their network all types of providers who can offer that service. For example, if a health plan offers coverage for anesthesia services, they should allow all anesthesia providers to participate in their networks and they cannot refuse to contract with CRNAs just based on their licensure alone.

Proper implementation of the Provider Nondiscrimination law is crucial because health plans have latitude to determine the quantity, type, and geographic location of healthcare professionals they need to ensure availability of healthcare benefits to their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure, 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 healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers.

5. Ensure Equal Treatment of CRNAs and APRNS in Physician Specialty Models and Advanced Alternative Payment Models
The AANA urges the agency to ensure that CRNAs and other APRNs are treated on par with physicians in physician specialty models and other advanced alternative payment models. These healthcare providers are core to improved access to high quality, cost-effective care. Furthermore, the National Academy of Medicine (NAM) recommends that government policy expand opportunities for nurses to lead collaborative healthcare improvement efforts, and prepare and enable nurses to lead changes that advance health. Increasingly, the healthcare industry is recognizing APRNs for their leadership role in clinical, educational and academic, executive, board, legislative, and regulatory domains. In addition to their roles as expert healthcare professionals, APRNs are CEOs of hospitals and health systems, chief nursing officers, chairs of regulatory bodies and advisory committees, and have taken many other positions with wide spans of responsibility.

In particular, the AANA expects that CRNAs should automatically be included in models when anesthesiologists are mentioned. As CMS develops the new direction of the Innovation Center, we urge CMS ensure that CRNAs will not face professional discrimination based solely on licensure in these efforts.

B. Our Proposals to Leverage Technology Solutions to Support Safe, High Quality Care

1. For Anesthesia, Interoperability of Health Information Should Communicate Across the Continuum of Patient Care and EHRs Should Use Standardized Taxonomies Across Technology Platforms

As the agency contemplates next steps regarding interoperability, the agency should consider how best to ensure that they are capturing cost effective anesthesia care. We offer the following recommendations regarding interoperability and communication of patient information across technology platforms in the realm of anesthesia. For anesthesia measures, we recommend that interoperability of EHRs and other information systems should communicate across the continuum of patient care. Disparate information systems should interface between offices, clinics, hospitals, and pharmacy platforms to communicate across the patient’s experience to increase patient safety, improve outcomes and decrease cost of care.

We also recommend that EHR systems should include standardized taxonomy and fields and require providers to use these across various platforms to optimize communication of care and interoperability. In the major anesthesia information management systems, some standardized taxonomies are present; however, valuable patient specific information is entered as free text or in unstructured data hindering data sharing and communication, in addition to making this information difficult to extract for quality reporting without manually reading the fields.

2. The Focus of Measurement of Exchange and Use of Interoperability Should Not Be Limited to Only Use of Certified EHR Technology

In order to establish metrics that will assess the extent to which widespread exchange of health information through interoperable certified EHR technology nationwide has occurred, the agency needs to first define the scope of measurement. The AANA believes that the measurement of EHR interoperability is limited if the focus of this measurement is restricted only to use of certified EHR technology. Smaller facilities and anesthesia groups may not have the funds and resources necessary to participate in use of a certified, comprehensive EHR, but may purchase a standalone AIMS that is added to the facility EHR. If the agency’s goal is to measure true interoperability, and if smaller EHR companies can construct an AIMS that is affordable for use by smaller provider groups, then these groups should be included in this measurement. Furthermore, use of non-certified EHRs in measurement of interoperable EHR technology will also encourage innovation in this field because having to get certified first will limit many programmers who are experimenting with novel methods of handling and accessing EHR data.

3. Additional Anesthesia Data Sources Should be Used to Evaluate Interoperability

CRNAs play an essential role in assuring that rural America has access to critical anesthesia services. As stated above, CRNAs in some settings have continued to document on paper or used paper/EHR to document care because they have not been eligible for incentive payments for the adoption and meaningful use of certified EHR technology. In addition, EHR utilization and governmental support in rural health care is virtually non-existent. As a result, electronic capture of point of care patient information is very difficult to collect. The AANA supports collection of meaningful data through interoperability across all patient care experiences to provide access to a complete and comprehensive healthcare record to improve patient satisfaction, outcomes and affordability of care. Not only would this data be used to provide care, but also to analyze care processes to continually improve outcomes.
In evaluating the interoperability of systems across the patient care experience, we recommend development and participation in team and composite measures such as sharing patient health and medication history, communication of encounter information, and decrease in repeat diagnostic testing. Though we only have anecdotal information, sharing of information across platforms is currently very limited and hybrid paper and electronic records are used in many rural, ASC, clinic, and office practice locations.

4. Measures Assessing Interoperability Across the Care Continuum Should be Considered When Evaluating Interoperability

The AANA supports the interoperability of EHRs for collection of meaningful data to improve communication across all patient care experiences to provide access to a complete and comprehensive healthcare record to improve patient satisfaction, outcomes and affordability of care. Development of measures in a manner that improves measure quality and outcomes and increases clinical data availability has the potential to improve the healthcare system in numerous ways. We recommend the agency include a process measure or composite set of measures that can be used to assess interoperability across the entire care continuum, which can be reported as a score or percentage of compliance. Doing so will allow CRNAs to be participants in the measurement of EHR interoperability and help federal agencies reach their goal of widespread exchange of health information by December 31, 2018.

5. Prohibit the Use of Wasteful Tele-Supervision of CRNA Services

The AANA is supportive of telehealth and remote monitoring technology that improves the quality of care provided for all patients. We caution the agency against the use of wasteful telehealth services that increase costs without improving healthcare access or quality as part of the Strategic Plan for 2018-2022. Specifically, we oppose policies that allow anesthesiologists to be reimbursed without providing actual anesthesia care, through billing for remote supervision services. This type of remote supervision would not improve access to healthcare for patients with chronic conditions and would instead reward providers not actually furnishing healthcare services. Furthermore, there is no evidence of a benefit for the use of supervision of anesthesia via telehealth. Therefore, we ask that the use

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wasteful anesthesiologist tele-supervision of CRNA services is prohibited in the future strategies the agency plans to help reform, strengthen, and modernize the Nation’s health care system.

C. **Our Proposals to Implement Coordinated, Team-Based Approaches to Care**

1. **Include Strategic Consideration of the Role of Anesthesia in Enhanced Recovery after Surgery Protocol as an Innovative Healthcare Delivery Model**

Because CRNAs personally administer more than 43 million anesthetics to patients each year in the United States, their services are crucial to the successful development and implementation of techniques such as anesthesia enhanced recovery after surgery (ERAS) programs. CRNAs and other anesthesia professionals play an integral role in these episodes of care as proper anesthesia services management can make a tremendous difference in terms of improving patient flow, patient safety, and cost savings. Conversely, research shows that suboptimal care in the preoperative, intraoperative, or postoperative phases of surgery may compromise care, resulting in poor patient outcomes and unnecessarily higher healthcare costs. We urge that the agency emphasize the strategic consideration of the role of anesthesia delivery that is safe and cost-efficient and include the use of techniques such as ERAS programs, which help reduce costs and improve patient outcomes.

2. **Use of a Multi-Modal Pain Management Approach May Reduce Patient Need for and Reliance on Opioids**

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The AANA recognizes that solving the opioid drug epidemic is an integral part of healthcare reform, and we are committed to collaboratively working toward a common solution to this issue. Pain is a personal experience that, if left undertreated or mismanaged, can radically change an individual’s quality of life and impact important relationships. Utilizing a patient-centered, multidisciplinary, multimodal treatment approach to pain management may reduce the reliance on opioids as a primary pain management modality, thus helping curb the prescribed opioid epidemic. Acute and chronic pain is best treated and managed by an interdisciplinary team that actively engages the patient to diagnose and manage their pain for improved well-being, functionality, and quality of life. As members of the interdisciplinary team, CRNAs are well positioned to provide holistic, patient-centered, multimodal pain treatment and management across the continuum of pain and in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics). 

According to a recent AANA position statement titled, A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment, “CRNAs integrate multimodal pain management as an element of enhanced recovery after surgery (ERAS) protocols to manage pain. Management begins pre-procedure and continues after discharge by using opioid sparing techniques such as regional anesthesia, peripheral nerve blocks, non-pharmacological approaches, and non-opioid based pharmacologic measures. Careful assessment and treatment of acute pain, which may include appropriate opioid prescribing, can decrease the risk of acute pain transitioning to chronic pain or the development of opioid dependency and abuse.”

Prescriber education is also essential to curbing the opioid epidemic, and CRNAs are well-positioned to provide education related to minimization or elimination of prescribed opioids through pharmacologic and non-pharmacologic multi-modal pain management strategies. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) already requires acute and chronic pain management content in the curriculum of the 115 accredited nurse anesthesia programs, and the AANA provides advanced workshops to CRNAs specifically on pain management, including acute

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and chronic pain, to enhance their skills and increase their awareness of the complications associated with opioid use and misuse.

Consistent with the recommendation to increase access to pain management services in the National Academies of Medicine report “Relieving Pain in America,” the AANA has partnered with academia to develop an Advanced Chronic Pain Management Fellowship that is accredited by the COA to enter the field as advanced, subspecialty practitioners beyond that which is required for initial certification of nurse anesthetists. The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) offers a voluntary nonsurgical pain management (NSPM) subspecialty certification for CRNAs.

D. Our Proposals to Reduce Provider Shortages in Underserved and Rural Communities

1. Reducing Regulatory Barriers for CRNAs Increases Access to Anesthesia Care in Rural Communities

As 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, it vital that the agency should promote access to the use of CRNA anesthesia services in rural America. Furthermore, the agency should ensure that the Strategic Plan for 2018-2022 does not create unintended barriers to the use of CRNA services and that CRNA are practicing at their full professional education, skills, and scope of practice. Nurse anesthetists are experienced and highly trained anesthesia professionals who provide high-quality patient care, which has been proven through decades of scientific research. 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

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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.

CRNAs play an essential role in assuring that rural America has access to critical anesthesia services and by removing regulatory barriers to CRNA practice and allowing CRNAs to practice to the full extent of their scope, licensure and training, patients in rural areas will receive consistently safe and high quality care delivery.

The AANA appreciates this opportunity to comment on this draft strategic report. CRNAs are vital to resolving the challenges facing our nation’s healthcare system and we look forward to partnering with the agency to show the important role CRNAs can have in achieving the main goals of meaningful reform, reducing health care costs, and improving access to the highest quality healthcare. Should you have any questions, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202-741-9080 or rkoahl@aanadc.com.

Sincerely,

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AANA President

Cc: Randall Moore II, DNP, MBA, CRNA, AANA CEO
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47 Liao, op cit.