July 19, 2018

Submitted via email at InnovationCaucus@mail.house.gov

Dear Co-chairs Representative Kelly, Kind, Mullin, and Bera:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on this request for information on value-based provider payment reform, value-based arrangements, and technology integration. In particular, we make the following comments and requests:

VALUE-BASED PROVIDER PAYMENT REFORM

**WHAT BARRIERS IN EACH OF THE FOLLOWING AREAS LIMIT THE FULL POTENTIAL OF INNOVATION IN MEDICARE AND MEDICAID?**

- **PAYMENT AND REIMBURSEMENT**
- **POLICY AND REGULATION**

- The requirement for physician supervision of CRNA anesthesia services is a regulatory barrier that is unnecessary, costly, and there is no credible peer-reviewed evidence that shows improved patient safety or quality of care
- Policy and reimbursement barriers exist for the use of medically necessary, opioid sparring CRNA pain care

VALUE-BASED ARRANGEMENTS

**WHAT ROLE SHOULD MEDICARE PLAY IN CREATING VALUE-BASED ARRANGEMENTS AND ENCOURAGING MANUFACTURESRES, PAYERS, AND PROVIDERS TO TAKE ON RISK?**

- Medicare should ensure equal treatment of CRNAs and APRNs in value-based payment models and arrangements
- Medicare should ensure that value-based payment models and arrangements require the strategic use of anesthesia services when anesthesia is involved
• Medicare should ensure that value-based payment models and arrangements promote full scope of practice and remove barriers to care
• Medicare should allow facilities to waive Medicare Part A Physician Anesthesia Supervision requirements for CRNAs to encourage participation in value-based payment models and arrangements
• Medicare should prohibit the use of wasteful tele-supervision of CRNA services in models
• Medicare should promote access to anesthesia care in rural areas
• Medicare should promote CRNA services regarding multimodal pain management in an effort to reduce the need for and reliance on opioids

TECHNOLOGY AND HEALTH IT

WHAT IMPACT DOES HEALTH IT AND DATA INTEROPERABILITY HAVE ON SUCCESSFULLY RUNNING VALUE-BASED PAYMENT MODELS AND CONTRACTING? WHAT ARE SOME WAYS TO IMPROVE INTEROPERABILITY AND THE SHARING OF DATA?
• Allow for an advanced APM waiver for the requirement of a Certified Electronic Health Record Technology (CEHRT) for hospital-based and non-patient facing clinicians

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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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.

VALUE-BASED PROVIDER PAYMENT REFORM

WHAT BARRIERS IN EACH OF THE FOLLOWING AREAS LIMIT THE FULL POTENTIAL OF INNOVATION IN MEDICARE AND MEDICAID?

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- POLICY AND REGULATION

The Requirement for Physician Supervision of CRNA Anesthesia Services is a Regulatory Barrier that is Unnecessary, Costly, and There is No Credible Peer-Reviewed Evidence that Shows Improved Patient Safety or Quality of Care

One regulatory barrier that could limit the full potential of innovation in Medicare and Medicaid is the Medicare Condition of Participation (CoP) and Condition for Coverage (CfC) requirements for physician supervision of CRNA anesthesia services. 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. This requirement is more restrictive than a majority of state laws and impede local communities from implementing the most innovative and competitive model of providing quality care. Reforming the CfCs and the CoPs to eliminate the

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6 Liao, op cit.

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#42:5.0.1.1.1.4.4.2](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1&rgn=div5#42:5.0.1.1.1.4.4.2), 482.639 [http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.4&rgn=div5#42:5.0.1.1.4.4.7.16](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.4&rgn=div5#42:5.0.1.1.4.4.7.16), 416.42, [http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.1.3](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.1.3).
costly and unnecessary requirement for physician supervision of CRNA anesthesia services supports the delivery of population and community health care in a manner allowing states and healthcare facilities nationwide to make their own decisions based on state laws and patient needs, thus controlling cost, providing access and delivering quality care.

Though one common argument for additional regulation is to protect public safety, 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* 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 health care system if nurses delivered more of the care.” 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.

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

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10 Negrusa B et al. op. cit.
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.\textsuperscript{11}

The evidence also demonstrates that the supervision requirement is costly. Though Medicare requires supervision of CRNAs (except in opt-out states) by an operating practitioner or by an anesthesiologist who is immediately available if needed, 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 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.\textsuperscript{12} But there are even bigger costs involved if the hospital administrator believes that CRNAs are required to have anesthesiologist supervision.

According to a nationwide survey of anesthesia group subsidies,\textsuperscript{13} hospitals pay an average of $160,096 per anesthetizing location to anesthesia 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 anesthesia group subsidy. Translated into concrete terms, a hospital with 20 operating rooms hospital pays an average of $3.2 million in anesthesia subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

\textsuperscript{11} Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” \textit{Nursing Economic}s. 2010; 28:159-169.

\textsuperscript{12} 63 FR 58813, November 2, 1998.

\textsuperscript{13} Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012.
As independently licensed professionals, CRNAs are responsible and accountable for judgments made and actions taken in his or her professional practice.\textsuperscript{14} The scope of practice of the CRNA addresses the responsibilities associated with anesthesia practice and pain management that are performed by the nurse anesthetist as a member of inter-professional teams. The same principles are used to determine liability for surgeons for negligence of anesthesiologists or nurse anesthetists. The laws’ tradition of basing surgeon liability on control predates the discovery of anesthesia and continues today regardless of whether the surgeon is working with an anesthesiologist or a nurse anesthetist.\textsuperscript{15}

There is 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 \textit{Anesthesiology},\textsuperscript{16} 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 over ten years of AANA membership survey data. Moreover, the American Society of Anesthesiologists ASA \textit{Relative Value Guide 2013} newly suggests loosening further the requirements that anesthesiologists must meet to be “immediately available,” stating that it is “impossible to define a specific time or distance for physical proximity.” This newer ASA \textit{Relative Value Guide} definition marginalizes any relationship that the “supervisor” has with the patient and is inconsistent with the Medicare CoPs and CfCs, and with the Medicare interpretive guidelines for those conditions, which require anesthesiologists claiming to fulfill the role of “supervising” CRNA services be physically present in the operating room or suite.


\textsuperscript{15} Blumenreich, G. Another article on the surgeon’s liability for anesthesia negligence. \textit{AANA Journal}. April 2007.

Policy and Reimbursement Barriers Exist for the Use of Medically Necessary, Opioid Sparring CRNA Pain Care

There are policy and reimbursement barriers to the use of medically necessary CRNA pain care that could potentially limit the full potential of innovation in Medicare and Medicaid. As anesthesia professionals and APRNs, CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient centered, compassionate and holistic manner in collaboration with other healthcare professionals, as appropriate for the patient’s plan of care. As is recognized in the National Academy of Medicine’s report entitled The Future of Nursing: Leading Change, Advancing Health, APRNs, including CRNAs, should practice to the full extent of their education and training. Furthermore, CRNAs are vital to helping resolve the widespread opioid drug crisis, which is a huge challenge facing our nation’s healthcare system and requires the engagement of all healthcare providers in practices that eliminate or decrease the use of opioids to address pain through multimodal pain management techniques.

However, leading physician subspecialty organizations in pain management research, practice guideline development, and education are known to use economic and advocacy means to exclude other members of the pain management team, such as CRNAs, from educational and practice opportunities, thereby limiting patient access to care, diagnosis, treatment, and ultimately improved patient quality of life. A report issued in April 2015 by the Federal Trade Commission (FTC), “Competition and the Regulation of Advanced Practice Registered Nurses,” underscores the point that for CRNAs and other APRNs, “even well intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition.” As multimodal pain management can be used in value-based payment models to help curb the

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opioid crisis, it is important that models do not limit the use of medically necessary pain management services. To meet the increasing need for pain management services, there must be a comprehensive effort to remove artificial, unnecessary barriers to practice and reimbursement at the practice, state, and federal levels.

VALUE-BASED ARRANGEMENTS

WHAT ROLE SHOULD MEDICARE PLAY IN CREATING VALUE-BASED ARRANGEMENTS AND ENCOURAGING MANUFACTURESRES, PAYERS, AND PROVIDERS TO TAKE ON RISK?

Medicare Should Ensure Equal Treatment of CRNAs and APRNs in Value-Based Payment Models and Arrangements

The AANA recommends that the Centers for Medicare & Medicaid Services (CMS) should ensure that CRNAs and other APRNs are treated on par with physicians in models, including physician specialty models and 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. We recommend that Congress urge CMS to ensure that CRNAs will not face professional discrimination based solely on licensure in these efforts.

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Medicare Should Ensure that Value-Based Payment Models and Arrangements Require the Strategic Use of Anesthesia Services When Anesthesia is Involved

CMS also should ensure that value-based arrangements encourage the strategic use of anesthesia services when anesthesia is involved. Anesthesia professionals, such as CRNAs, can play an integral role in episodes of care that involve anesthesia as proper anesthesia services management can improve patient flow, advance patient safety, and ultimately yield 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 that increase healthcare costs. We recommend that Congress urge CMS to include as part of value-based arrangements the strategic consideration of the role of anesthesia delivery that is safe and cost-efficient in itself and encourages the use of techniques such as Enhanced Recovery After Surgery (ERAS) programs, which help reduce costs and improve patient outcomes.

Furthermore, we recommend that Congress direct CMS to promote cost-efficient anesthesia delivery models. All models of anesthesia delivery being equally safe according to extensive published research, the most cost-effective safe anesthesia care delivery model is the CRNA non-medically directed model, and we recommend that CMS promote its use in this regard.

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In demonstrating the costs of various modes of anesthesia delivery, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by an anesthesia care team where 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) has anesthesia delivered by an anesthesia care team where CRNA medically directed at a 2:1 ratio; and (d) has 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{25} and $540,314 for the anesthesiologist\textsuperscript{26}. Under the Medicare program, 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 ($170,000 + (0.25 x $540,314) or $305,079 per year. For case (c) it is ($170,000 + (0.50 x $540,314) or $440,157 per year. 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 Nonmedically 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>
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<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>
</table>

\textsuperscript{25} AANA member survey, 2014

\textsuperscript{26} MGMA Physician Compensation and Production Survey, 2014. www.mgma.com
Under the more costly anesthesia models, hospitals and other facilities – not to mention patients and employers paying for commercial health plan coverage – are bearing the additional costs. Therefore, CMS should include as a part of value-based arrangements incentives for high value care that includes the use of cost-effective anesthesia care.

**Medicare Should Ensure that Value-Based Payment Models and Arrangements Promote Full Scope of Practice and Remove Barriers to Care**

CMS should require that value-based arrangements support and encourage APRNs, including CRNAs, to practice to their full professional education, skills, and scope of practice. As part of the application process, CMS should require model sponsors to document how they will include high-quality, cost-effect CRNA and APRN services, and how they will use CRNAs and other APRNs to the fullest extent of their education, licensure, and certification. Our policy recommendation corresponds with a recommendation from the NAM’s report titled *The Future of Nursing: Leading Change, Advancing Health*, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs, including CRNAs. The NAM report specifically recommends that, “advanced practice registered nurses should be able to practice to the full extent of their education and training.” Moreover, the NAM states with regard to one type of APM, the accountable care organizations (ACOs), that “ACOs that use APRNs and other nurses to the full extent of their education and training in such roles as health coaching, chronic disease management, transitional care, prevention activities, and quality improvement will most likely benefit from providing high-value and more accessible care that patients will find to be in their best interest.”

We also recommend that CMS ensure that value-based arrangements do not impose unnecessary physician supervision requirements. Removing unnecessary supervision requirements is

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27 NAM op. cit. p. 69.
28 NAM op. cit. p. 7-8.
29 NAM op. cit. p. 3-41.
30 See 42 CFR §§ 482.52, 485.639, 416.42.
consistent with Medicare policy reimbursing CRNA services in alignment with their state scope of practice, and with NAM’s recommendation, “Advanced practice registered nurses should be able to practice to the full extent of their education and training.”

As outlined above, there is no evidence that physician supervision of CRNAs improves patient safety or quality of care and there is strong and compelling data showing that physician supervision does not have any impact on quality, and may restrict access and increase cost. If a 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 that Congress direct CMS to ensure that value-based arrangements do not impose unnecessary supervision requirements.

**Medicare Should Allow Facilities to Waive Medicare Part A Physician Anesthesia Supervision Requirements for CRNAs to Encourage Participation in Value-Based Payment Models and Arrangements**

In addition to ensuring that models do not impose unnecessary supervision requirements, we also request that facilities be given the opportunity to waive requirements for physician supervision of CRNAs under the umbrella of value-based payment models in states that have not opted out of this requirement. Facilities could request this waiver during a participation agreement with CMS, and, in return, the value-based payment model entity would need to assure that this is being done in accordance with state law. Providing facilities the opportunity to waive this requirement will allow for the most cost-effective anesthesia delivery while providing the capital needed to enhance local level innovation to adopt care coordination.

**Medicare Should Prohibit the Use of Wasteful Tele-Supervision of CRNA Services in Models**

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32 NAM op. cit. 3-13 (pdf 108).
33 See 42 CFR §§ 482.52, 485.639, 416.42
The AANA is supportive of telehealth and remote monitoring technology that improves the quality of care provided for all patients. We caution CMS against the use of wasteful telehealth services that increase costs without improving healthcare access or quality as part of value-based arrangements. 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 Congress direct CMS prohibit the use wasteful anesthesiologist tele-supervision of CRNA services in any value-based arrangements.

**Medicare Should Promote Access to Anesthesia Care in Rural Areas**

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 CMS promote access to the use of CRNA anesthesia services in rural America in value-based arrangements. Furthermore, Congress should direct CMS to ensure that models do 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. 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

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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.  

**Medicare Should Promote CRNA Services Regarding Multimodal Pain Management in an Effort to Reduce the Need for and Reliance on Opioids**

The AANA recommends that Congress direct CMS to promote multimodal pain management in models to help curb the opioid epidemic and should ensure that models do not limit the use of medically necessary CRNA pain management services. The AANA is concerned in the increase in opioid drug use, abuse and deaths and is committed to collaboratively working toward a common solution to help curb the opioid epidemic in the United States. As a main provider of pain management services and as APRNs, CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient centered, compassionate and holistic manner in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics). Furthermore, the holistic 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. According to a recent AANA position statement, *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 an 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

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36 Liao, op cit.

decrease the risk of acute pain transitioning to chronic pain or the development of opioid dependency and abuse.”

In developing the plan of care for the patient, CRNAs obtain patient history, evaluate the patient, order and review necessary diagnostic testing, and assess the patient’s psychological and emotional state. Non-pharmacologic pain mitigation techniques are often employed in the treatment of chronic pain and considered as part of the care plan. These techniques may include patient education regarding behavioral changes that can decrease pain, such as weight loss, smoking cessation, daily exercise, stretching, and physical or chiropractic therapy. Such therapies may not be sufficient when used alone, but they have significant benefit when they are used in a complementary manner with other therapies.

Furthermore, we recommend that Congress direct CMS to ensure that models do not limit the use of these medically necessary CRNA pain management services. As outlined above, leading physician subspecialty organizations in pain management research, practice guideline development, and education are known to use economic and advocacy means to exclude other members of the pain management team, such as CRNAs, from educational and practice opportunities, thereby limiting patient access to care, diagnosis, treatment, and ultimately improved patient quality of life. A report issued in April 2015 by the FTC, “Competition and the Regulation of Advanced Practice Registered Nurses,” underscores the point that for CRNAs and other APRNs, “even well intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition.”

Therefore, we recommend that CMS be cognizant of these barriers and require that value-based arrangements do not impose barriers that limit a CRNA’s ability to provide comprehensive pain management care. In the interest of patients and the public, the education, regulation, and reimbursement of each member of the pain management team should allow the team to practice to the full extent of their education and training.

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TECHNOLOGY AND HEALTH IT

WHAT IMPACT DOES HEALTH IT AND DATA INTEOPERABILITY HAVE ON SUCCESSFULLY RUNNING VALUE-BASED PAYMENT MODELS AND CONTRACTING? WHAT ARE SOME WAYS TO IMPROVE INTEROPERABILITY AND THE SHARING OF DATA?

Allow for an Advanced APM Waiver for the Requirement of a Certified Electronic Health Record Technology (CEHRT) for Hospital-Based and Non-Patient Facing Clinicians

Health information exchange has the potential to improve the healthcare system in numerous ways by advancing interoperability and health information exchange between patients, providers and health care settings is an important step toward realizing this potential. As the Innovation Caucus is looking to advance successful payment models as well as technologies needed to support these models, we recommend that Congress direct CMS to allow for waivers of the requirement of a Certified Electronic Health Record Technology (CEHRT) for hospital-based and non-patient facing clinicians in value-based payment models, including advanced alternative payment models (APM). Anesthesia professionals 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 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 00100-01999, 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) Advancing Care Information performance category, all anesthesia professionals should be granted similar exceptions in terms of CEHRT adoption similar to that under the Medicare Quality Payment Program. These hurdles make it difficult for many CRNAs to participate in an Advanced APM because the anesthesia
information that is meaningful to perioperative care is simply not available via an anesthesia CEHRT. 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 departments.\(^{40}\) According to an August 2012 KLAS Performance Report,\(^ {41}\) 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 Advancing Care Information or Promoting Interoperability Measures. Due to few, if any comprehensive CEHRT anesthesia EHRs, clinicians must rely on modular AIMS, which may or may not be CEHRT, and have extensive technical experts on hand.\(^ {42}\) This hurdle will be exacerbated when more Advanced APMs are developed that affect procedural episodes of care incorporating anesthesia services in outpatient and ambulatory places of service. Therefore, anesthesia providers, such as CRNAs, should be able to apply for a waiver under the Advanced APM criteria to expedite the ability to participate in an Advanced APM. Such a waiver will improve participation amongst providers committed to providing high quality value-based care.

We thank you for the opportunity to comment on this request for information. 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, rkoohl@aanadc.com.

Sincerely,

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Bruce A. Weiner, DNP, MSNA, CRNA
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