Statement for the Record
to the
House Committee on Ways and Means
Rural and Underserved Communities Health Task Force

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Introduction

Representatives Davis, Sewell, Wenstrup, and Arrington, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthetists (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 53,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 45 million anesthetics to patients each year in the United States. CRNAs provide acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Promote Full Scope of Practice and Remove Barriers to Care in Rural America

We appreciate the Task Force’s commitment to exploring policy options to improving outcomes and care in rural communities. 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.1 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.2 Because all APRNs, including CRNAs, are crucial to the health and well-being of patients in rural communities, we recommend that the Task Force focus on removing barriers to their access by ensuring that all APRNs, including CRNAs, practice to their full professional education, skills, and scope of practice.

This policy recommendation aligns with the Centers for Medicare & Medicaid (CMS) Rural Health Strategy, which includes maximizing scope of practice for providers such as CRNAs as a key supporting activity to improve access to care3 and the U.S. Department of Health and Human

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2 Liao, op cit.

Services’ recommendation to broaden scope of practice in its report entitled, “Reforming America’s Healthcare System through Choice and Competition.”

This policy recommendation also corresponds with a recommendation from the National Academy of Medicine’s (NAM) 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.”

We also recommend that Task Force remove unnecessary physician supervision requirements as part of the Medicare Conditions of Participation (CoPs). Removing unnecessary supervision requirements is 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.”

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 Economics, CRNAs

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6 NAM op. cit. p. 7-8.
7 See 42 CFR §§ 482.52, 485.639, 416.42.
9 NAM op. cit. 3-13 (pdf 108).
10 Dulisse, op. cit.
12 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{13}

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 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.\textsuperscript{14} 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 anesthesiology group subsidies,\textsuperscript{15} 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 hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

As independently licensed professionals, CRNAs are responsible and accountable for judgments made and actions taken in his or her professional practice.\textsuperscript{16} 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{17}

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

\begin{itemize}
\item \textsuperscript{13} Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” \textit{Nursing Economics}. 2010; 28:159-169.
\item \textsuperscript{14} 63 FR 58813, November 2, 1998.
\item \textsuperscript{15} Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012.
\item \textsuperscript{17} Blumenreich, G. Another article on the surgeon’s liability for anesthesia negligence. \textit{AANA Journal}. April 2007.
\end{itemize}
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 over ten years of AANA membership survey data. Moreover, the American Society of Anesthesiologists ASA 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 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.

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 the Task Force remove unnecessary supervision requirements in the Medicare CoPs.

Promote Efficiency in Rural America by Amending the Ambulatory Surgical Center Conditions for Coverage (CfCs) by Recognizing CRNAs to Evaluate the Risk of Anesthesia Immediately Before Surgery

Performing the comprehensive preanesthetic assessment and evaluation of the risk of anesthesia is within the scope of practice of a CRNA. We ask that the Task Force direct CMS to recognize CRNAs as authorized to evaluate the risk of anesthesia immediately before a surgical procedure performed in an ambulatory surgery center (ASC) in the same manner that the agency recognizes both CRNAs and physicians conducting the final pre-anesthetic assessment of risk for a patient in the hospital. Accordingly, the AANA requests revision of the ASC Conditions of Coverage (CfC) at 42 CFR § 416.42 (a) (1).

We recommend amending the ambulatory surgical center CfCs so that CRNAs are authorized to evaluate the risk of anesthesia immediately before surgery. The AANA continues to receive examples of inefficiency and operational waste due to this regulation, and this is especially problematic in ASCs in rural and underserved communities. In actual practice, CRNAs evaluate patients preoperatively for anesthesia risk in the ASC environment. The CRNA has a duty to do so, consistent with Standard 1 of the Standards for Nurse Anesthesia Practice. The current ASC rule on preanesthesia examination is inconsistent with ASC rules regarding patient discharge, and with Medicare hospital CoPs in this same area. Under the hospital CoPs for anesthesia services (42 CFR§ 482.52 (b) (1)), CRNAs are recognized to perform the pre-anesthesia evaluation for hospital patients presenting with a greater range of complexity and multiple chronic conditions than ASC patients.

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The problem appears to be that the current language combines the assessment of surgical risk with the assessment of anesthetic risk in one sentence, when in reality these activities are most frequently performed by two different members of the team, the surgeon and the anesthesia professional. The CfCs for ASC surgical services at 42 CFR § 416.42 (a) (1) state that a “physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.” (Italics added.) By combining the two functions into a single sentence, in an ASC, a physician must evaluate the risk of anesthesia, precluding a CRNA from being recognized for performing an essential function within the CRNA’s scope of practice and may place the surgeon in the position of evaluating an aspect of care outside his field of expertise. Yet, under 42 CFR § 416.42 (a) (2), a CRNA is recognized to evaluate the patient prior to discharge. CRNAs perform anesthesia risk assessment routinely in hospitals across America. Modification of this regulation to promote efficiency will reduce administrative burden associated with unnecessary delays, particularly in rural and underserved areas.

Encourage Flexibility By Amending the Hospital Conditions of Participation so that Anesthesia Services (42 CFR § 482.52) Can Be Under the Direction of Either a CRNA or a Physician

To promote cost effective and innovative approaches to the delivery of quality anesthesia services in rural America, the Task Force should direct CMS to allow hospitals to determine the administrative structure that best meets the needs of their patients and surgeons by revising 42 CFR § 482.52 to include CRNAs among the healthcare professionals who may direct the provision of anesthesia services in hospitals.

When anesthesia services are under the direction of a CRNA, each Medicare beneficiary patient remains under the overall care of a physician, consistent with the statutes and regulations governing the Medicare program in general and the hospital CoPs in particular. The change we recommend would relieve hospital regulatory burden associated with operating the Medicare program, reduce healthcare costs, and enable the organization of anesthesia services tailor-made to ensure patient safety and meet community needs.

The change reduces regulatory burdens on hospitals by eliminating the need to pay a stipend for a physician “in name only” to serve as director of the anesthesia department while the hospital would have the flexibility to retain those services if they so desired. In some cases, the existing regulation leads to confusion by placing into the hands of persons inexpert in anesthesia care a federal regulatory responsibility for directing the unified anesthesia service of a hospital solely because he or she is a doctor of medicine or of osteopathy. In other cases, the hospital may contract with and pay a stipend to an anesthesiologist for department administration only, solely because there is a federal regulation. There is no evidence supporting the requirement for a physician or osteopathic doctor to direct anesthesia services. More importantly, rural hospitals often struggle with this requirement as they may lack financial resources to pay a stipend for this physician.
CRNAs are highly educated anesthesia experts and are fully qualified to serve in this role. In many hospitals the CRNA may be the only health care professional possessing expertise and training in the anesthesia specialty. The scope of nurse anesthesia practice includes responsibilities for administration and management, quality assessment, interdepartmental liaison and clinical/administrative oversight of other departments.

Because CRNAs possess a strong foundation in nursing, critical care and anesthesia and pain management, CRNAs are frequently called upon to assume administrative and executive positions. With their specialty background as well as the CRNA educational preparation at the master’s and doctoral level, CRNA are being selected to function as anesthesia and surgery department administrators, chief nurse executives, chief operating officers and chief executive officers of hospitals. To achieve a more effective regulatory framework, we propose maximizing flexibility and innovation at the local level by encouraging facilities to structure their anesthesia departments efficiently and effectively. Rural hospitals should be able to select the very best anesthesia leader for the job at a cost they can afford.

**Promote Parity in Anesthesia Education By Amending Anesthesia Payment Rules to Allow 100 Percent Payment for One Anesthesiologist Teaching Two SRNA**

In order to make health care more accessible and reduce barriers to educational opportunities for anesthesia professionals, the AANA recommends that the Task Force direct CMS to provide equitable reimbursement in anesthesia educational settings. For an anesthesiologist to be reimbursed only 50 percent for each of two cases involving SRNAs is not consistent with Medicare’s equitable payment policies for CRNAs and anesthesiologists, nor does it comply with the intent of Congress that directed the teaching rules for CRNAs be “consistent” with the rules for anesthesiologists.\(^{20}\) In fact, CMS stated that it agreed that an anesthesiologist who is concurrently teaching two SRNAs to be able to bill for 100 percent of the anesthesia fee schedule for each case involving a SRNA “would establish parity of payment…” for anesthesia services.\(^{21}\) CMS also stated in the proposed rule and in the final rule that, “There currently are no substantive differences in payment between teaching anesthesiologists and teaching CRNAs, and there would continue to be no such differences under our proposed policies.”\(^{22}\)

We appreciate that the Medicare agency recognizes there are no substantive differences in payment between CRNAs and anesthesiologists. However, by allowing an anesthesiologist to bill for only 50 percent of the fee for each of two cases involving SRNAs, when an anesthesiologist can bill for 100 percent for the fee for each of two cases involving residents and CRNAs can bill for 100 percent of the fee for each of two cases involving SRNA, this creates a substantive difference between its payments for teaching anesthesiologists and teaching CRNAs. Regardless of whether a teaching CRNA or teaching anesthesiologist is involved in the cases with SRNAs, the teacher is providing 100 percent of an anesthesia service to each patient and should be able to bill for 100 percent of the fee for each case.

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\(^{20}\) P.L.110-275, MIPPA, Sec. 139.


In addition, to reimburse an anesthesiologist only 50 percent when teaching SRNAs erroneously implies that services provided by a teaching anesthesiologist and SRNA are less valuable than anesthesia service provided by a teaching CRNA and SRNA or a teaching anesthesiologist and anesthesiology resident. This lower reimbursement is discriminatory by devaluing the anesthesia services provided by a teaching anesthesiologist and SRNA.

**Direct the Medicare Agency to Amend Medicare Guidance to Clarify that CRNAs can Order and Refer Services if Allowed under State Law**

In the interest of improving access to care, especially for Medicare beneficiaries living in rural and underserved areas, the AANA requests that CMS clarify in its educational materials that CRNAs can order and refer medically necessary Medicare services and also include CRNAs among the order and referring data file as long as CRNAs are legally authorized to perform these services in the state in which the services are furnished. CRNAs are not expressly prohibited from ordering and referring Medicare services by legislation or by regulation. In fact, Medicare in November 2012 published a rule indicating Medicare coverage of all Medicare CRNA services within their state scope of practice. However, our membership has informed us that the services that CRNAs order and specialists they refer to are not being reimbursed because CRNAs are not included among the type or specialty to be on the CMS ordering and referring file. Furthermore, a Medicare Learning Network article revised in October 2015 does not list CRNAs among the specialists that can order and refer. These denials are affecting patient access to needed services as laboratory services and physical therapy related to chronic pain management services, especially in rural areas.

**Direct the Medicare Agency to Update Medicare Policy to include CRNAs Among the List of Providers that Can Provide E&M Services**

In the interest of improving access to care in rural America, the AANA requests that the Task Force direct CMS to include CRNAs among the list of providers that can provide Evaluation and Management Services (E&M) in the Medicare Claims Processing Manual. This section of the manual has not been updated since January 2010, and does not take into account the language

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23 See https://data.coms.gov/
from the CY 2013 Physician Fee Schedule final rule\textsuperscript{27} and from Section 140.4.3 of the Medicare Claims Processing Manual, clarifying that Medicare covers all medically necessary Medicare services provided by CRNAs within their state scope of practice. Access to E&M services is essential for the proper management of pain and in the reduction of reliance on opioid drugs, and this is especially important in rural areas of the country hit hard by the opioid epidemic. As a main provider of pain management services, especially in rural communities, 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).\textsuperscript{28} Prior to performing a pain management technique, CRNAs conduct a comprehensive patient evaluation to confirm the necessity of the planned technique. These E&M services may include conducting a history and physical examination, ordering and reviewing diagnostic tests including imaging studies, and performing the indicated diagnostic and therapeutic pain management techniques. Conducting a history and physical examination and reviewing diagnostic studies is a well established and essential component of patient evaluation. In some cases, the referring physician conducts the comprehensive patient evaluation and in other practices, the CRNA may be responsible to obtaining the patient history, physical examination, psychosocial evaluation, and numerous studies associated with the pain condition.

Conclusion

In conclusion, because all APRNs, including CRNAs, are crucial to the health and well-being of patients in rural communities, it is ever more important that Congress reduces the barriers in access to their care. 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 AANA and its members look forward to collaborating with the Task Force on this very important issue.


\textsuperscript{28} AANA Chronic Pain Management Guidelines, September 2014, available at: \url{http://www.aana.com/resources2/professionalpractice/Pages/Chronic-Pain-Management-Guidelines.aspx}. 