October 2, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8013
Baltimore, MD 21244-1850

RE: Request for Information for the Development of a CMS Action Plan to Prevent Opioid Addiction and Enhance Access to Medication-Assisted Treatment

Dear Ms. Verma:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to submit comments to the Centers of Medicare and Medicaid Services (CMS) regarding the Request for Information (RFI) for the Development of a CMS Action Plan to Prevent Opioid Addiction and Enhance Access to Medication-Assisted Treatment (Action Plan). Our comments reflect how Certified Registered Nurse Anesthetists’ (CRNAs) multimodal anesthesia services can help reduce reliance on opioids to treat pain, the importance of provider training and patient education efforts regarding opioid use disorder (OUD) and how CRNAs can contribute toward the treatment of OUD with MAT. The AANA makes the following comments and recommendations:

I. Who CRNAs Are

II. Questions on Acute and Chronic Pain: 1. What actions can CMS take to enhance access to appropriate care for acute and/or chronic pain in Medicare and Medicaid, including:
   b. Through remote patient monitoring, telehealth, and other telecommunications technologies?

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

   B. Emphasize the Use of Cost-Effective Anesthesia Care Provided by CRNAs in Advancing Interoperability of Health Information

   C. For Anesthesia, Interoperability of Health Information Should Communicate Across the Continuum of Patient Care and EHRs Should Use Standardized Taxonomies Across Technology Platforms
III. Questions on Acute and Chronic Pain: 5. What payment and service delivery models, such as those that utilize multimodal and multi-disciplinary approaches to effectively manage acute and chronic pain and minimize the risk of opioid misuse and OUD, could be tested by the Center for Medicare and Medicaid Innovation or through other federal demonstration projects?

A. CRNAs Use a Multi-Modal Pain Management Approach, which may Reduce Patient Need for and Reliance on Opioids

B. Acute and Chronic Pain Management Education Should Utilize a Multimodal, Patient Focused Multidisciplinary Team Approach

IV. Questions on Acute and Chronic Pain: 8. What other issues should CMS consider to improve coverage and payment policies in Medicare and Medicaid to enhance access to and effective management of beneficiaries with acute and/or chronic pain?

A. Invite the AANA to Collaborate in the Development of Education Recommendations for Pain Management and Safe Use of Opioid Analgesics

B. Ensure that Prescriber Education and Training Efforts Extend to All Members of the Multidisciplinary Team

C. Patient Education for Engagement in their Plan of Care should be a Central Component of Acute and Chronic Pain Management

D. Ensure That Educational Efforts Are Harmonized Across all Specialty and Care Settings to Minimize Variation in Care Across the Patient’s Healthcare Experience

V. Questions on Substance Use Disorders, including Opioid Use Disorders: 9. What other issues should CMS consider to improve coverage and payment policies in Medicare and Medicaid to enhance the identification of, treatment access by, and the treatment of beneficiaries with SUDs, including OUD?

A. Support Increased Patient Access to Safe, Responsible use of Medication Assisted Treatment (MAT) for the Comprehensive Treatment of Substance and Opioid Use Disorder

B. Include Information on Anesthesia Care Considerations for Patients with Substance Use Disorder

C. Recognize the Role of CRNAs in Opioid Treatment Programs and Clarify Payment for MAT
I. **Who CRNAs Are**

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes nearly 54,000 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 more than 49 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 assuring 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

\(^1\) Paul F. Hogan et al., “Cost Effectiveness Analysis of Anesthesia Providers.” *Nursing Economic*$, 2010; 28:159-169. 
[http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf)
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

II. **Questions on Acute and Chronic Pain**: 1. What actions can CMS take to enhance access to appropriate care for acute and/or chronic pain in Medicare and Medicaid, including:
   b. Through remote patient monitoring, telehealth, and other telecommunications technologies?

A. **AANA Recommendation: Prohibit the Use of Wasteful Tele-Supervision of CRNA Services**

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. The AANA is supportive of telehealth and remote monitoring technology that improves the quality of care provided for all patients. However, we caution the Caucus against crafting legislation that includes the use of wasteful telehealth services that increase costs without improving healthcare access or quality. 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.⁵ Therefore, we ask that the use

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wasteful anesthesiologist tele-supervision of CRNA services is prohibited in future telehealth policies contained in CMS’ Action Plan to help increase access to patient-centered care.

B. **AANA Recommendation: Emphasize the Use of Cost-Effective Anesthesia Care Provided by CRNAs in Advancing Interoperability of Health Information**

The AANA supports the agency’s goal of developing and implementing telehealth policies to encourage providers to routinely exchange health information through interoperable systems in support and higher quality and more coordinated care. The AANA believes the use of telehealth as a care delivery option can improve access to and timeliness of needed care, increase convenience for patients, increase communication between providers and patients, enhance care coordination, improve quality, and reduce costs related to in person care. As many alternative payment models (APMs) would involve anesthesia delivery, and as CRNAs are an eligible clinician under the MIPS program, we believe the Caucus should have an interest in creating legislation that increases access to and promotes high-quality, cost-effective anesthesia care. As the Caucus contemplates next steps regarding interoperability, you should consider how best to ensure that you are capturing cost effective anesthesia care. Anesthesia professionals work as members of the patient’s interprofessional team in all practice settings and all staffing models of anesthesia delivery are equally safe according to extensive published research as noted above. The most cost-effective safe anesthesia care delivery model is the CRNA non-medically directed model, and we recommend that any future telehealth legislation should promote high quality, affordable care models.

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

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and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, $170,000 for the CRNA and $540,314 for the anesthesiologist. 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 to staff the 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>
</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>
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With CRNAs providing over 45 million anesthetics in the U.S., and a considerable fraction of them being “medically directed,” the additional costs of 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 if anesthesiologists submit claims to Medicare or Medicaid for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread Medicare and Medicaid 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.

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6 AANA member survey, 2014
We believe the agency has an interest in increasing access to and promoting high-quality, cost-effective anesthesia care. Anesthesiologist medical direction reimbursement models contribute to increased healthcare system costs without improving access or quality when medical direction requirements are not met by the anesthesiologist submitting a claim for such services. Therefore, the agency should favor reimbursement systems that support the most cost-effective and safe anesthesia delivery models such as for nonmedically directed CRNA services. All staffing models of anesthesia delivery are equally safe according to extensive published research as noted above, but the most cost-effective safe anesthesia care delivery model is the CRNA non-medically directed model, and we recommend the agency promote its use in advancing interoperability of health information.

C. **AANA Recommendation: For Anesthesia, Interoperability of Health Information Should Communicate Across the Continuum of Patient Care and EHRs Should Use Standardized Taxonomies Across Technology Platforms**

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 Electronic Health Records (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.

III. **Questions on Acute and Chronic Pain: 5. What payment and service delivery models, such as those that utilize multimodal and multi-disciplinary approaches to effectively manage acute and chronic pain and minimize the risk of opioid misuse and OUD, could be tested by the Center for Medicare and Medicaid Innovation or through other federal demonstration projects?**
A. CRNAs Use a Multi-Modal Pain Management Approach, which may Reduce Patient Need for and Reliance on Opioids

The AANA shares the agency’s concern about the increase in opioid drug use, abuse and deaths and is committed to working collaboratively toward comprehensive solutions to 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 across the pain continuum in all clinical settings. 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.

Suffering from acute and chronic 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. The Centers for Disease Control and Prevention reports that the problem with misuse of prescription drugs is related to high levels of prescribing of such medications – for example, in 2016 prescribers wrote 66.5 opioid and 25.2 sedative prescriptions for every 100 Americans. Acute and chronic pain are 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 anesthesia professionals, CRNAs help work to decrease or eliminate the need for opioids by collaborating with the patient and the interdisciplinary team on a comprehensive plan for pain relief known as enhanced recovery after surgery (ERAS®). 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 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.”

Using specific protocol-driven enhanced recovery after surgery (ERAS®) pathways improves patient outcomes by reducing the patient’s stress response to surgery, shortening the overall hospital length of stay, and accelerating the return to normal daily function. The patient’s pain management plan of care begins pre-procedure and continues through post-discharge using opioid-sparing techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures. The evidence is quite clear that careful assessment, evaluation, and treatment of acute pain, with appropriate prescribing of an opioid, may prevent access to unused opioids and development of opioid dependency and abuse. CRNAs play a critical role by ensuring proper anesthesia services management which can make a tremendous difference in terms of improving patient flow, patient safety, and cost savings.

Many patients rely on CRNAs as their primary pain care specialist. CRNAs manage chronic pain in a compassionate, patient-centered, holistic manner, using a variety of therapeutic, physiological, pharmacological, and interventional modalities. The purpose behind this approach is to reduce the reliance on opioids as a primary pain management modality, thus aiding in the reduction of potential adverse drug events related to opioids, including addiction. In developing a plan of care for the patient, CRNAs, evaluate the patient, obtain a complete patient history, 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 techniques may not be

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sufficient when used alone but have significant benefit when they are used in a complementary manner with other therapies.

**B. Acute and Chronic Pain Management Education Should Utilize a Multimodal, Patient Focused Multidisciplinary Team Approach**

The AANA supports healthcare provider and patient education regarding alternative non-pharmacologic and pharmacologic modalities for pain management that minimize the use of opioids. Many clinicians across numerous disciplines and specialties, such as primary care, anesthesia, addiction, pain, emergency, and palliative care are involved in the management of acute and chronic pain. Promotion of collaborative, multidisciplinary clinician and patient education, research, and practice will have a positive impact on patients who seek and increasingly rely on acute and chronic pain management services.

Any national education framework should be in the form of recommendations that are adaptable to profession- and practice-specific requirements. Interprofessional education should also cover topics such as identification of individuals at risk of opioid abuse, signs of drug seeking behavior, acute and chronic pain management options for patients with substance use disorder or in recovery, criteria for referral to medication assisted treatment and for transfer of the patient to a specialty pain care provider. Patient education recommendation regarding multimodal pain management alternatives and related therapy should be developed to increase patient awareness for make best decisions for their plan of care for safe or no opioid use.

Education should be evidence-based and align with national guidelines, such as the Centers for Disease Control and Prevention (CDC) *Guideline for Prescribing Opioids for Chronic Pain*. The AANA has many resources related to acute and chronic pain management and substance use disorder which can be applied to patient care settings, such as [Analgesia and Anesthesia for the Substance Use Disorder Patient Practice Considerations](https://www.aana.com/education-and-resources/practice-guidelines) and [Chronic Pain Management Guidelines](https://www.aana.com/education-and-resources/practice-guidelines).

Many nursing and medical organizations, patient advocacy groups, and governmental agencies share the common concern of increased opioid use, abuse, and deaths in the United States. The AANA encourages the use of federal and non-federal partnerships, including nursing and medical professional organizations, including the AANA, the CDC, the Food and Drug Administration, the American Nurses Association, the Substance Abuse and Mental Health Services Administration, and SmartTots, to support a collaborative, multidisciplinary effort in the refinement of healthcare provider education models surrounding pain...
management and safe opioid use. The AANA welcomes the opportunity to serve as member of a multidisciplinary collaborative.

IV. Questions on Acute and Chronic Pain: 8. What other issues should CMS consider to improve coverage and payment policies in Medicare and Medicaid to enhance access to and effective management of beneficiaries with acute and/or chronic pain?

   A. Invite the AANA to Collaborate in the Development of Education Recommendations for Pain Management and Safe Use of Opioid Analgesics

CRNAs provide holistic anesthesia and pain related care for patients of all ages in all communities across the U.S. From entry into practice education and certification through ongoing education and skills acquisition throughout their career, CRNAs provide robust, patient centered acute and chronic pain management services. Prescriber education is also essential to curbing the opioid epidemic, and CRNAs are also well-positioned to educate clinicians and patients alike on the minimization or elimination of prescribed opioids for both acute and chronic pain management. The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) offers a voluntary nonsurgical pain management (NSPM) subspecialty certification for CRNAs. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) requires acute and chronic pain management content in the curriculum of the 120-accredited nurse anesthesia educational programs, and for continued learning, the AANA offers CRNAs a continuum of educational resources for pain management practice. These resources include advanced acute and chronic pain management workshops for CRNAs to enhance their skills to improve quality of life and to mitigate complications associated with opioid use and misuse. The AANA, State Nurse Anesthetist Associations, universities and other stakeholders play an active role in CRNA education and professional development, reinforcing how to safely integrate and, when appropriate, eliminate opioids in acute and chronic pain management. In addition, Texas Christian University, the University of South Florida, and Middle Tennessee School of Anesthesia offer fellowships to CRNAs seeking to further specialize in this growing field. The AANA also offers an Online Continuing Education pain management educational series that includes a lecture on non-opioid anesthesia for substance use disorder (SUD) patients, to increase understanding of the acute and recovery phases of SUD with knowledge of how to create an anesthesia care plan that supports the patient's recovery efforts.

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In addition to the education efforts by the AANA, the agency could also leverage efforts developed by the greater APRN community. The AANA, along with the American Association of Colleges of Nursing and other APRN organizations, developed a joint online educational series that serves as a resource for practicing nurses, faculty, and students on the current need to address opioid use disorder and overdose, integration of timely content into education program curricula, and the CDC’s opioid prescribing guidelines.

B. Ensure that Prescriber Education and Training Efforts Extend to All Members of the Multidisciplinary Team

The AANA recognizes that acute and chronic pain management involves a multidisciplinary approach, and we believe that HHS’s efforts should extend to all members of the multidisciplinary team and be aligned with national guidelines. Because patients see many qualified healthcare professionals, all healthcare education programs for professional disciplines of nursing, medicine, and other healthcare professions are needed to prepare pain management experts and leaders. Therefore, we ask that HHS ensure that efforts do not preclude clinicians, such as CRNAs, from educational opportunities. One potential issue that could arise without proper provider education would be clinicians who are not appropriately educated or have misinterpreted chronic pain guidelines. For example, if they have taken the guidelines “too far”, are not appropriately tapering medications or managing patients, or are not prescribing opioids when it is clinically appropriate to do so.

We also ask that prescribing education be comprehensive and provider neutral. As is recognized in the National Academies 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. However, leading physician subspecialty organizations in pain management research, practice guideline development, and education have used economic and advocacy measures to exclude other clinical providers from contributing to the pain management team. Patient access to care, diagnosis, treatment, and quality of life may be impacted when CRNA scope of practice is limited by physician societies through constrained scope of practice statute, facility privileges, or educational and training opportunities.

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13 National Academies of Medicine, op cit. p. 9
In many rural and frontier areas, CRNAs often are the only health care professionals trained in pain management in these communities. Without CRNAs to provide chronic pain management services, patients in vast rural and frontier areas would lose access to vital treatment, which could result in poor healthcare outcomes, lower quality of life, and unnecessary costs to patients and the healthcare system. According to a 2012 analysis by the Lewin Group of four case studies based on the real life situations of four individuals living in rural communities representing different geographic locations throughout the U.S., the direct medical costs of alternatives such as surgery or nursing home care range between 2.3 times to more than 150 times the cost of a CRNA providing these services in the community.14

Furthermore, 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.”15 Therefore, we recommend that the HHS ensure that educational and training opportunities are inclusive of all clinicians. We request that the agency engage with the FTC to prevent efforts to block access to prescriber education. 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.

C. **Patient Education for Engagement in their Plan of Care should be a Central Component of Acute and Chronic Pain Management**

Patient-centered care offers the patient greater transparency, understanding, and engagement in their care for desired outcome. Using a shared decision-making model facilitates collaborative care through planning and discussion of risks and benefits of the pain management plan, encourages the patient to express his or her preferences and values, and jointly establishes realistic goals for the patient’s well-being and quality of life. In the treatment of pain, patients and their caregivers should understand the etiology of pain, treatment plans and goals, treatment options and alternatives, as well as consequence to non-adherence to the pain management plan. For chronic pain management, particularly if opioids are prescribed in the treatment, the clinician

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should discuss the risk of dependence and opioid use disorder, as well as enter into a pain management treatment agreement with the patient.

D. **Ensure That Educational Efforts Are Harmonized Across all Specialty and Care Settings to Minimize Variation in Care Across the Patient’s Healthcare Experience**

As CMS develops and implements an action plan to prevent opioid addiction and enhance access to MAT, we recommend this plan include programs for prescriber education and training that is inclusive of all specialties across all types of healthcare settings to optimize safe and appropriate use of opioids for chronic pain. As there is no bright line between acute and chronic pain, opioid use disorder may originate or become evident in many care settings. We believe that being provider and prescriber?-inclusive will minimize variation in care across the patient’s healthcare experience.

The AANA stands ready to work with the agency to support its efforts. Please consider the valuable contribution that APRNs and specifically CRNAs will offer the interprofessional teams who create policy and resources necessary to make this guideline the standard for pain management. As APRNs, CRNAs are uniquely skilled to deliver pain treatment in a compassionate and holistic manner. By virtue of education and individual clinical experience and competency, a CRNA may practice chronic pain management utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain. The AANA has many evidence based resources related to acute and chronic pain management considerations and guidelines which can guide patient care settings, such as *Chronic Pain Management Guidelines* and *Regional Anesthesia for Surgical Procedures and Acute Pain Management, Practice Considerations*. CRNA knowledge and practice experience will prove invaluable as the agency works to develop and implement provider education and training programs.

V. **Questions on Substance Use Disorders, including Opioid Use Disorders: 9. What other issues should CMS consider to improve coverage and payment policies in Medicare and Medicaid to**

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enhance the identification of, treatment access by, and the treatment of beneficiaries with SUDs, including OUD?

A. Support Increased Patient Access to Safe, Responsible use of Medication Assisted Treatment (MAT) for the Comprehensive Treatment of Substance and Opioid Use Disorder

The AANA supports increased patient access to safe, responsible use of MAT for the comprehensive treatment of substance and opioid use disorder. The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was enacted into law on October 24, 2018. This new law represents a major bipartisan victory and the strongest response yet to the opioid crisis. One of the major provisions of the bill is a section that would allow CRNAs and other advanced practice registered nurses (APRNs) to obtain a waiver from the Drug Enforcement Agency (DEA) to prescribe medication-assisted treatments (MATs), such as buprenorphine, to individuals suffering from opioid use disorder (OUD). The law allows for a five-year pilot program for most APRNs, including CRNAs. This continues to allow CRNAs to contribute toward eradicating the opioid epidemic that is tearing at the fabric of our nation.

The AANA recognizes that CRNAs have an ethical obligation and professional responsibility for self-assessment of their knowledge and skills related to the comprehensive treatment of substance use disorders (SUD) and related somatic and/or mental health conditions; developing and maintaining clinical competencies related to the care of individuals receiving MAT; obtaining any necessary continuing education beyond the required 24 hours of training necessary in order to provide safe behavioral healthcare involving MAT. CRNAs may prescribe MAT in states where they have prescriptive authority, consistent with state law. The CRNA must provide MAT in accordance with their professional state specific scope of practice, state and federal laws and regulations, and their respective facility’s institutional policies.

Anesthesia professionals may encounter more patients with substance use disorder, on medication-assisted treatment or in abstinent recovery who require surgery and procedures that involve analgesia and anesthesia. Considerations include preanesthesia assessment and evaluation, developing a plan of care in collaboration with the patient and the interdisciplinary healthcare team, deploying an opioid-sparing multimodal approach to managing pain, and responsible oversight that includes safe prescribing practices and discharge planning to provide a patient-centered approach to care.

B. Include Information on Anesthesia Care Considerations for Patients with Substance Use Disorder

The AANA advocates for increased understanding by anesthesia professionals to address substance use disorder, which is often stigmatized, when creating an anesthesia and analgesia care plan which support the patient in either active or remission stages of the disease while managing pain and maintaining sobriety. Anesthesia professionals may encounter more patients with substance use disorder, on MAT or in abstinent recovery who require surgery and procedures that involve analgesia and anesthesia. With the epidemic of opioid use disorder and the growth in availability of MAT, it’s expected more patients will need these care considerations, which include non-judgemental preanesthesia assessment and evaluation, development of a plan of care in collaboration with the patient as well as their addiction professional if applicable, and the interdisciplinary healthcare team, deploying an opioid-sparing multimodal approach to managing pain, and responsible oversight through safe prescribing practices and discharge planning to provide a patient-centered approach to care. Therefore, we request that any future action plan on preventing opioid addiction and enhancing access to MAT should include this type of information.


C. Recognize the Role of CRNAs in Opioid Treatment Programs and Clarify Payment for MAT

The AANA commends the bipartisan efforts of Congress and the administration for enacting the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (the SUPPORT Act) (Pub. L. 115–271, October 24, 2018), and we appreciate CMS’s efforts to implement it. We also appreciate that Section 3201 allows for CRNAs to apply for MAT-waivers and recommend that Congress should make permanent access to these waivers for most APRNs, including CRNAs.

While the AANA appreciate CMS’s proposals coverage of Opioid Treatment Programs, it is not clear what happens for reimbursement for MAT services for providers who are not part of Opioid Treatment Program. CRNAs that provide pain services have training in managing opioid use disorders. CRNAs are currently treating Medicare patients with opioid use with opioid abuse deterrent drug formulations. As a main provider of pain management services, CRNAs are qualified pain practitioners who provide access to excellent care and counsel in many practice settings to treat patients suffering from a wide range of acute and chronic pain conditions. Many patients rely on CRNAs as their primary pain specialist. CRNA chronic pain management practitioners address chronic pain through the use of a multimodal approach that includes opioid sparing or no opioid pharmacologic and non-pharmacologic pain mitigation strategies. This is shown in a recent study which calls for an increased number of nursing pain specialists “to not only implement aggressive acute pain care to prevent chronic pain but also to effectively treat chronic pain with evidence-based integrative therapies that include multimodal analgesia, interventional techniques, and complementary and alternative approaches to pain management.”\(^\text{26}\)

The AANA supports increased patient access to safe, responsible use of MAT for the comprehensive treatment of substance and opioid use disorder. The AANA recognizes that the CRNA has an ethical obligation and professional responsibility for self-assessment of their knowledge and skills related to the comprehensive treatment of substance use disorders (SUD) and related somatic and/or mental health conditions; developing and maintaining clinical competencies related to the care of individuals receiving MAT; and obtaining any necessary continuing education beyond the required 24 hours of training necessary

in order to provide safe behavioral healthcare involving MAT. CRNAs may prescribe MAT in states where they have prescriptive authority, consistent with state law. The CRNA must provide MAT in accordance with their professional state specific scope of practice, state and federal laws and regulations, and their respective facility’s institutional policies.

The AANA appreciates this opportunity to comment on this request for information. We look forward to working with the agency on development of an action plan to prevent opioid addiction and enhance access to MAT. CRNAs are essential to helping resolve the widespread opioid drug crisis, a huge challenge facing our nation’s healthcare system, by providing services that eliminate or decrease the use of opioids to address pain, contributing toward the treatment of OUD with MAT and with supporting patient recovery efforts with anesthesia considerations to avoid relapse. 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 rkohl@aanadc.com.

Sincerely,

[Signature]

Kathryn Jansky, MHS, CRNA, APRN, USA LTC (ret)
AANA President

cc: Randall D. Moore, DNP, MBA, CRNA, AANA Chief Executive Officer
Ralph Kohl, AANA Senior Director of Federal Government Affairs
Randi Gold, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy

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