AANA
American Association of
NURSE ANESTHESIOLOGY

October 5, 2021

The Honorable Joseph R. Biden
President of the United States of America
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear President Biden:

On behalf of the American Association of Nurse Anesthesiology (AANA), I am writing to you today in support of your Administration's recent Executive Order on Promoting Competition in the American Economy and the subsequent work of the White House Competition Council. The healthcare sector could benefit from improved competition to help increase access to care and drive down the costs of healthcare for consumers. To that end, there are several policies specific to the healthcare industry that we believe would help to promote competition, including the development of robust provider nondiscrimination rules, the removal of unnecessary regulatory barriers such as Medicare's physician supervision requirement for Certified Registered Nurse Anesthetists (CRNA) services, and the implementation of full practice authority for CRNAs working in the Veterans Health Administration (VHA). We would welcome the opportunity to work with your Administration and the White House Competition Council on these important ideas.

The AANA is the professional association for Certified Registered Nurse Anesthetists and student registered nurse anesthetists (SRNAs). AANA membership includes more than 59,000 CRNAs and SRNAs, representing almost 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year in the United States and are among the nation's most trusted professions, according to Gallup[1]. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services are in high demand. Today, more than 1,000 CRNAs serve in the Veterans Health Administration (VHA), providing the highest quality care to our nation's veterans and practice in every setting and with every patient population. CRNAs have historically provided much of the anesthesia to our active-duty military in combat arenas since World War I and predominate in veterans' hospitals and the U.S. Armed Services, where they enjoy full practice authority in every branch of the military. CRNAs also

[1] Gallup "U.S. Ethics Ratings Rise for Medical Workers and Teachers (December 22, 2020), https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx

predominate in rural and underserved areas of the United States, offering critical, lifesaving care and obstetrical care to patients who might otherwise not have access.

Developing Robust Provider Nondiscrimination Rules to Protect Patient Access to Care

To improve upon the Affordable Care Act and healthcare delivery, we suggest the promulgation of a robust and enforceable regulation on the issue of provider nondiscrimination. Congress passed the *Consolidated Appropriations Act of 2021,* which seeks implementation of the provider nondiscrimination provision in the *Patient Protection and Affordable Care Act*. Meaningful implementation of this provision is important to protect patient access to critical services provided by CRNAs and other advanced practice providers (APPs) from discriminatory practices in the private insurance market. CRNAs, and other APPs acting within the scope of their license or certification under applicable state law or regulation, have experienced discrimination with respect to participation in and coverage of procedures that are clearly included in their state scope of practice. Such discrimination impairs access to needed healthcare services, consumer choice and competition, and impairs efforts to control healthcare cost growth. Further, this discrimination violates the federal provider nondiscrimination provision.

The federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Nondiscrimination in Health Care, 42 USC §300gg-5), took effect on January 1, 2014, and prohibits health plans from discriminating against qualified licensed healthcare professionals, such as CRNAs, solely based on their licensure. However, no regulation has been issued since this law took effect and there is not a specific enforcement mechanism, allowing health plans to issue discriminatory policies against CRNAs and other APPs. To promote access to healthcare, consumer choice of safe and high-quality healthcare professionals, reduce healthcare costs through competition, and allow providers to practice to the full extent of their education, training, and certification, we urge the Centers for Medicare & Medicaid Services (CMS) to work with the other required agencies to help promulgate a regulation that will end this problematic practice.

Proper implementation of the provider nondiscrimination law is crucial because health plans have latitude to determine the quantity, type, and geographic location of healthcare professionals they need to ensure availability of healthcare benefits to their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure, for example, by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition. Additionally, such discrimination provides incentives for the use of higher-cost providers without improving quality or access to care. Discouraging health plans or health insurers discriminatory reimbursement practices encourages consumers to choose anesthesia care from qualified, licensed healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers. Moreover, promulgating regulations on provider nondiscrimination would allow CRNAs to fully utilize their education and training to enhance the patient care team model and work collaboratively with anesthesiologists as equal partners in anesthesia delivery for surgery, labor and delivery, trauma stabilization, and chronic pain management.

Removing Unnecessary Regulatory Burdens That Limit Medicare Beneficiaries' Access to Care

The AANA was encouraged to see CMS temporarily waive Medicare's physician supervision requirement for CRNA anesthesia services as a Condition of Participation during the Public Health Emergency (PHE), and we believe that making this waiver permanent will benefit consumers, especially in rural and underserved areas. The COVID-19 PHE has shown the important need for health care professionals to work to the top of their scope to care for patients and highlights the important role that CRNAs play in our healthcare system, especially when workforce barriers to practice are eliminated. In their roles as APRNs, many CRNAs have stepped up in these challenging times by assisting on the frontlines of the pandemic to provide expert care to the sickest patients. During this pandemic, we have seen barriers to CRNA practice removed at both the state and federal levels, allowing CRNAs to provide critical, lifesaving care to patients. CRNAs are practicing independently during this crisis, working under stressful conditions in facilities across America, providing invaluable support by using their expertise in rapid systems assessment, airway management, managing ventilators, vascular volume resuscitation, placing of invasive lines and monitors, overseeing complex hemodynamic monitoring, emergency preparedness, and resource management.

Medicare's physician supervision requirement for CRNAs is an unnecessary requirement that does not improve safety and only serves to increase costs and decrease access to care. This outdated and superfluous regulation adds an extra burden on states by overriding state laws to add unnecessary supervision requirements. Currently, only seven states require supervision of CRNA services according to state nursing laws. There is no evidence that physician supervision of CRNAs improves patient safety or quality of care. There is strong and compelling data showing that physician supervision does not have any impact on quality and may restrict access and increase healthcare costs. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a gold standard study published in Health Affairs[2] 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. 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."[3]

Letting states have the final decision on this issue according to their own laws is consistent with Medicare policy reimbursing CRNA services in alignment with their state scope of practice[4], and with the National Academy of Medicine's recommendation, "Advanced practice registered nurses should be able to practice to the full extent of their education and training."[5] The opt-out process introduces unique, political barriers to the optimal utilization of CRNAs to ensure access to high-quality cost effective care. With the evidence for

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[2] Dulisse, op. cit
[3] Who should provide anesthesia care? (Editorial) New York Times, Sept. 6, 2010
[4] 42 CFR §410.69(b), 77 Fed. Reg. 68892, November 16, 2012
[5] National Academy of Medicine. The future of nursing: leading change, advancing health. Washington, DC: The National Academies Press, p. 3-13 (pdf p. 108) 2011.

CRNA patient safety so clear, the Agency should eliminate the requirement for governors to request additional permission to implement their own statutes and policies in this area. Nor should a state's statutes in this area be reversed by the sole decision of the governor in reversing an opt-out resulting in potential confusion regarding federal supervision. We believe permanently eliminating this barrier will increase patient access, lower costs, and maintain the highest safety standards for patients.

CRNAs Working in the VHA Should Be Allowed to Work at the Top of Their Scope

Allowing providers, including CRNAs, to work to the top of their scope, without unnecessary supervision requirements or added artificial barriers, will increase veterans access to the care that they deserve, and help lower costs within the VHA. Allowing CRNAs to work to the top of their scope in the VHA is a position supported by the Federal Trade Commission, in a letter from July 25, 2016[6] in which the FTC commented, "If APRNs are better able to practice to the full extent of their education, training, and abilities, and if institutional health care providers are better able to deploy APRNs as needed, health care consumers—including VA patients—are likely to benefit from improved access to health care, lower costs, and additional innovation." We have seen firsthand how the successful implementation of full practice authority for Nurse Practitioners (NPs), Nurse-Midwives and Clinical Nurse Specialists has improved care within the VHA. Allowing CRNAs to work to the top of their scope also provides inherent cost savings. A study in Health Affairs using VA data found that "when we controlled for important patient- and facility-level factors, we found greater rates of hospitalizations and ED visits and higher health care expenditures among primary care patients of physicians compared to those of NPs or PAs. These findings are notable particularly because we studied NPs and PAs in relatively expansive primary care provider roles analogous to those of physicians in the same system and because we analyzed the total cost of care over a one-year period."[7]

As the VA works to develop national standards of practice, the AANA urges the VA to consider prevailing practices, and resist efforts to develop standards that are overly restrictive and default to the lowest possible scope for providers. We strongly agree with the testimony of AMVETs in front of the House Veterans Affairs Committee this June that national standards or practice must allow providers to work to the top of their scope to better serve veterans. As stated in their testimony, "AMVETS supports the creation of these new national practice standards to aid in the implementation of the new joint VA-DOD EHR system. AMVETS agrees with VA that basing these practice standards on the most restrictive state scope of practice for its health care professionals is not a viable option, as it would lead to decreased access to needed care and reduced health outcomes for our nation's Veterans. AMVETS urges VA to continue working toward utilizing its health care professionals to the full scope of their license, registration, or certification. As such, AMVETS believes these new national practice standards must be inclusive of all health care services that its health care professionals are authorized to provide in any state. Anything short of fully comprehensive

[6] https://www.ftc.gov/system/files/documents/advocacy_documents/comment-staff-ftc-office-policy-planning-bureau-competition-bureau-economics-department-veterans/v160013_staff_comment_department_of_veterans_affairs.pdf

[7] Berkowirz, T., Edelmen, D., Everett, C., Henxrix, C., Jackson, G., Morgan, P., Smith, V., Van Houtven, C., White, B., Woolson, S. (2019) Impact of Physician, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients. Health Affairs. No.6 p1028-1036. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00014

practice standards will unnecessarily limit Veteran access to care and negatively impact Veteran access and health outcomes."[8]

Additionally, the AANA believes that allowing one group of providers to define the scope of practice for another is inherently anticompetitive, as many MD health professionals have an intrinsic incentive to minimize scope for other providers, regardless of the data or what is best for veterans. The recent letter by the American Medical Association (AMA) shows their willingness to make inaccurate claims about non-MD safety, without providing any evidence to back up those claims, despite multiple studies showing that CRNAs working independently are just as safe as our physician colleagues[9][10][11][12][13][14][15]. It is exactly because of the record of safety and quality care that CRNAs provide that groups including the Bipartisan Commission on Care[16] and the VA's own Independent Assessment[17] support implementing full practice authority for CRNAs in the VA, while groups such as the New England Journal of Medicine[18]and the Bipartisan Policy Center[19] support full practice authority for CRNAs and other APRNs more broadly.

The AANA appreciates the efforts of your Administration to increase competition across the economy, including in the healthcare sector, to help benefit consumers and patients. We hope that you'll consider the suggestions laid out here and hope that we can be constructive partners in your efforts. Should you or your Administration wish to meet to discuss these ideas, you can reach out to Ralph Kohl, Senior Director of Federal Government Affairs for the AANA at rkohl@aana.com or 202-484-8400. Thank you for your consideration.

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[8] https://amvets.org/wp-content/uploads/2021/06/06082021AMVETSTESTIMONYFINAL-1.pdf
[9] https://journals.lww.com/lww-medicalcare/Abstract/2016/10000/Scope_of_Practice_Laws_and_Anesthesia.4.aspx
[10] https://pubmed.ncbi.nlm.nih.gov/28288089/
[11] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010357.pub2/full
[12] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff
[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2677049/
[14] https://journals.lww.com/nursingresearchonline/Abstract/2007/01000/Anesthesia_Staffing_and_Anesthetic_Complications.2.aspx
[15] https://www.aana.com/docs/default-source/aana-journal-web-documents-1/109-116.pdf?sfvrsn=28cc55b1_8
[16] https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf
[17] https://www.rand.org/content/dam/rand/pubs/research_reports/RR1100/RR1165z2/RAND_RR1165z2.pdf
[18] https://www.nejm.org/doi/full/10.1056/NEJMp1911077
[19] https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2020/04/WEB_BPC_Rural-Health-Care-Report.pdf

Sincerely,

Dina Velocci, DNP, CRNA, APRN
President
American Association of Nurse Anesthesiology

Cc: Brian Deese, Chair
The Honorable Janet Yellen, Secretary of the Treasury
The Honorable Marty Walsh, Secretary of Labor
The Honorable Xavier Becerra, Secretary of Health and Human Services
The Honorable Lina Khan, Chair of the Federal Trade Commission,
The Honorable Susan Rice, Assistant to the President for Domestic Policy and Director of the Domestic Policy Council
The Honorable Louisa Terrell, Assistant to the President and Director of the Office of Legislative Affairs