



March 10, 2014

Mr. Donald S. Clark
Secretary
Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

RE: FTC Health Care Workshop, Project No. P131207

Dear Mr. Clark:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the notice of public workshop on “Examining Health Care Competition,” and opportunity for comment. The letter is composed so that each section can be read and considered independently by each workshop panel. Therefore, some material is repeated throughout the letter. Attachments are provided separately.

The AANA provides statements in the following areas:

- I. Background of the AANA and Certified Registered Nurse Anesthetists (CRNAs)**
- II. Professional regulation of healthcare providers**
- III. Innovations in healthcare delivery**
- IV. Measuring and assessing quality of care**
- V. Price transparency of healthcare services.**

I. BACKGROUND OF THE AANA AND CRNAs

The AANA is the professional association for CRNAs and student nurse anesthetists. AANA membership includes nearly 47,000 CRNAs and student registered nurse anesthetists

representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) and anesthesia professionals who safely administer more than 34 million anesthetics to patients each year in the United States, according to the 2012 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia care to patients in the U.S. for over 150 years, and high quality, cost effective and safe 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.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities. CRNA services include providing a pre-anesthetic 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 are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. 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

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

patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.²

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.³ Nurse anesthesia predominates in Veterans Hospitals, the U.S. Armed Forces and Public Health Service. 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. As colleagues and competitors in the provision of anesthesia and pain management services, CRNAs and anesthesiologists have long been considered substitutes in the delivery of surgeries.⁴

In its landmark publication *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made its first recommendation that advanced practice registered nurses (APRNs) such as CRNAs be authorized to practice to their full scope, in the interest of patient access to quality care, and in the interest of competition to help promote innovation and control healthcare price growth.⁵

² B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs*. 2010; 29: 1469-1475.

<http://content.healthaffairs.org/content/29/8/1469.full?ijkey=ezh7UYKltCyLY&keytype=ref&siteid=healthaff>

³ U.S. Government Accountability Office (GAO). Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Services. Report to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. GAO-07-463. July 2007;15. <http://www.gao.gov/new.items/d07463.pdf>

⁴ Cromwell, J. et al. CRNA manpower forecasts, 1990-2010. *Medical Care* 29:7(1991).

http://practice.sph.umich.edu/practice/files/cephw/PDFs/Cromwell_1991.pdf .

⁵ Institute of Medicine. (2010). The future of nursing: Leading change, advancing health.

http://books.nap.edu/openbook.php?record_id=12956&page=R1 . Report recommendations in summary at <http://www.iom.edu/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Recommendations.pdf> .

II. PROFESSIONAL REGULATION OF HEALTHCARE PROVIDERS

The scope of practice for CRNAs is first determined by the profession⁶, and is subject to state legislation and regulation through nurse practice acts and regulations, and through state healthcare facility licensing statutes and regulations. At the federal level, CRNA practice is circumscribed by federal regulations governing Medicare healthcare facilities, chiefly hospital conditions of participation (CoPs) and ambulatory surgery center conditions for coverage (CfCs).⁷ At both the state and federal levels, however, recognition of CRNA services to the full extent of the profession's practice authority is commonly constrained through the highly organized and well-funded policy advocacy efforts of marketplace competitors from the community of organized medicine.^{8, 9, 10}

⁶ American Association of Nurse Anesthetists. "Scope of nurse anesthesia practice." AANA, Park Ridge, IL, 2013. <http://www.aana.com/resources2/professionalpractice/Pages/Scope-of-Nurse-Anesthesia-Practice.aspx>.

⁷ For example, Medicare hospital conditions of participation require CRNA anesthesia services to be subject to supervision by the operating practitioner or by an anesthesiologist who is immediately available, unless the state in which the service is provided has opted-out from this supervision requirement. See 42 CFR §482.52 at <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-52.pdf> and Medicare hospital interpretive guidelines at the Medicare state operations manual Appendix A, tag #A-1000, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.

⁸ See Federal Trade Commission. "Improving Health Care: A Dose of Competition." Washington, DC, 2004. P. <http://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf>. P. 22, "Providers that obtain countervailing market power also likely will cause competitive harm to other market participants that do not possess monopsony power. One panelist suggested, for example, that physicians may use their countervailing market power to disadvantage non-physician competitors, such as nurse midwives and nurse anesthetists..."

⁹ Neeld, J. "Winning the War," Emery A. Rovenstine Memorial Lecture. American Society of Anesthesiologists annual meeting, Oct. 14, 2013, San Francisco, Calif. <http://education.asahq.org/2013/Rovenstine>. Astoundingly, the "war" Dr. Neeld proposes to "win" is not a war on pain or suffering or unmet medical needs, but a war on CRNAs. From the abstract, "Responding to the economic reality that our nation cannot sustain ever-increasing health care costs and the need to provide best quality anesthesia care to an aging and growing population in an era of a continuing shortage of anesthesiologists, ASA has promoted the anesthesiologist-led anesthesia care team as the best model for 21st century care."

¹⁰ Safriet, B. "Federal options for maximizing the value of advanced practice nurses in providing quality, cost-effective health care." Appendix H to *The Future of Nursing: Leading Change, Advancing Health*. National Academy of Sciences (2010). <http://www.iom.edu/~media/Files/Activity%20Files/Workforce/Nursing/Federal%20Options%20for%20Maximizing%20the%20Value%20of%20Advanced%20Practice%20Nurses.pdf>. See p. 444, 454-460. At 458, Safriet quotes a 2004 American Society of Anesthesiologists policy as follows: "ASA opposes the independent practice of nurse anesthetists and views legislation and regulations designed to grant independent practice authority—mostly regulations promulgated by state nursing boards without concurrence by state medical boards—as efforts to confer a medical degree by political means rather than by educational means."

The information in this section will address the Federal Trade Commission's (FTC) questions regarding recent developments in the regulation of healthcare professionals and the consequences of these regulations as well as a description of how the regulations affect reimbursement for healthcare services. Several constraints in the legislative, regulatory, and practice arenas inhibit CRNAs' ability to practice to full extent of their scope, reducing competition and choice and increasing healthcare costs.

Current reimbursement structures in Medicare, which are also used in most private health insurance, also impede full practice by CRNAs. CRNA reimbursement is defined in Medicare Part B conditions for payment. Appropriately, Medicare reimburses CRNAs and anesthesiologists at the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. Medicare also operates a payment system for "anesthesiologist medical direction"¹¹ that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are capable of and are already directly providing patient access to high quality anesthesia care themselves as part of the surgical team caring for the patient. The Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.¹² An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases that the physician "medically directs", totaling 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.¹³

CRNAs' ability to practice to their full scope is also affected by Medicare regulations associated with Medicare Part A Conditions of Participation and Conditions for Coverage (CoPs and CfCs).

¹¹ 42 CFR §415.110. <http://www.ecfr.gov/cgi-bin/text-idx?SID=5ce8cb6375c7d5c22c454c7ec1fe07de&node=42:3.0.1.1.2&rgn=div5#42:3.0.1.1.2.3.1.4>

¹² 63 FR 58813, November 2, 1998, <http://www.gpo.gov/fdsys/pkg/FR-1998-11-02/pdf/98-29181.pdf> .

¹³ P. 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

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. In particular, the requirement for physician supervision of CRNA services is costly and unnecessary.¹⁴ This requirement is more restrictive than the majority of state laws and impedes local communities from implementing the most innovative and competitive model of providing quality care. Reforming the CfCs and the CoPs to eliminate the costly and unnecessary requirement for physician supervision of CRNA anesthesia services supports delivery of 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*¹⁵ 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.”¹⁶

¹⁴ 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>, 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>, 416.42, <http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.3.1.3>.

¹⁵ B. Dulisse and J. Cromwell, “No Harm Found When Nurse Anesthetists Work Without Physician Supervision.” *Health Affairs*. 2010; 29: 1469-1475. <http://content.healthaffairs.org/content/29/8/1469.full?ijkey=ezh7UYKltCyLY&keytype=ref&siteid=healthaff>

¹⁶ Who should provide anesthesia care? (Editorial) *New York Times*, Sept. 6, 2010, http://www.nytimes.com/2010/09/07/opinion/07tue3.html?_r=0.

Permitting states to decide this issue according to their own laws is consistent with Medicare policy reimbursing CRNA services in alignment with their state scope of practice,¹⁷ and with the Institute of Medicine's recommendation, "Advanced practice registered nurses should be able to practice to the full extent of their education and training."¹⁸ Unfortunately, the opt-out process is not the same as allowing states to decide this issue themselves like any other issue, through statutory or regulatory action. The opt-out process introduces unique, political barriers to the optimal utilization of CRNAs to ensure access to high-quality cost-effective care. Given the clear evidence of CRNA safety, CMS should eliminate the requirement that governor's request additional permission to implement their own statutes and policies in this area. Nor should a state's statutes regarding an existing opt-out be reversible by the unilateral decision of the governor, since the possibility that each incoming governor could summarily re-write the law creates the potential for disruption and confusion regarding the federal physician supervision of the CRNA requirement.

Evidence demonstrates that the supervision requirement is costly. Though CMS 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 as 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 Medicare 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, as stated earlier, the Medicare agency has clearly noted that medical direction is a condition for payment of anesthesiologist services and not a

¹⁷ 42 CFR §410.69(b), <http://www.ecfr.gov/cgi-bin/text-idx?SID=5ce8cb6375c7d5c22c454c7ec1fe07de&node=42:2.0.1.2.10&rgn=div5#42:2.0.1.2.10.2.35.52>

77 Fed. Reg. 68892, November 16, 2012, <http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf>.

¹⁸ Institute of Medicine (IOM). *The future of nursing: leading change, advancing health*. Washington, DC: The National Academies Press, p. 3-13 (pdf p. 108) 2011. http://books.nap.edu/openbook.php?record_id=12956

quality standard.¹⁹ But there are even bigger costs involved if the hospital administrator believes that CRNAs are required to have anesthesiologist supervision.

Another restriction in the Part A CfC regulations impairs CRNAs' ability to evaluate the risk of anesthesia in ambulatory surgical centers (ASCs), which again constrains competition and choice and increases healthcare costs without improving quality. Performing the comprehensive preanesthetic assessment and evaluation of the risk of anesthesia is within the scope of practice of a CRNA.²⁰ We have asked that CMS recognize CRNAs as authorized to evaluate the risk of anesthesia immediately before a surgical procedure performed in an 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. 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.²¹ 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.

Yet another restrictive regulation in the CoPs is the requirement that a physician serve as the director of anesthesia services. This requirement places regulatory burdens on hospitals where they need to pay a stipend for a physician "in name only" to serve as director of the anesthesia department instead of allowing the hospital to 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

¹⁹ 63 FR 58813, November 2, 1998, <http://www.gpo.gov/fdsys/pkg/FR-1998-11-02/pdf/98-29181.pdf> .

²⁰ American Association of Nurse Anesthetists Scope of Nurse Anesthesia Practice 2013, <http://www.aana.com/resources2/professionalpractice/Documents/PPM%20Scope%20of%20Nurse%20Anesthesia%20Practice.pdf>

²¹ American Association of Nurse Anesthetists. Standards for Nurse Anesthesia Practice. Adopted 1974, Revised 2013. <http://www.aana.com/resources2/professionalpractice/Documents/PPM%20Standards%20for%20Nurse%20Anesthesia%20Practice.pdf> .

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. Again, such a regulation impairs choice and competition, and increases healthcare costs without improving quality.

CRNAs are highly educated anesthesia experts and are fully qualified to serve in the role of director of anesthesia services. In many hospitals the CRNA may be the only healthcare 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. 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. Allowing CRNAs to serve as the director of anesthesia services 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 Medicare agency has been responsive in other areas to eliminate barriers to competition and choice, most notably and recently under the Part B program. One barrier that previously existed in Medicare was denial of coverage of CRNA services including pain management services within their state scope of practice. In 2011, two Medicare Administrative Contractors issued policies stating that chronic pain was not within a CRNA's scope of practice and denied reimbursement for these services. This previous policy impaired consumer choice and raised healthcare costs without improving patient safety. Following a notice-and-comment rulemaking process, CMS decided in a 2013 final rule that Medicare would reimburse for all services

provided by CRNAs within their state scope of practice²², ultimately deferring to states on the issue of what services are within that scope. The preamble to that final rule states in part:

We believe that using state scope of practice law as a proxy for services encompassed in the statutory benefit language “anesthesia and related care” is preferable to choosing among individual interpretations of whether particular services fall within the scope of “anesthesia and related care.” Moreover, we believe states are in an ideal position to gauge the status of, and respond to changes in, CRNA training and practice over time that might warrant changes in the definition of the scope of “anesthesia services and related care” for purposes of the Medicare program. As such, we believe it is appropriate to look to state scope of practice law as a proxy for the scope of the CRNA benefit.²³

This proposal is consistent with the Institute of Medicine’s report on advanced practice nursing, which recommends that Medicare should “include coverage of advanced practice registered nurse services that are within the scope of practice under applicable state law, just as physicians’ services are covered.”²⁴

The agency’s final rule concluded, “Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to provide in the state in which the services are furnished.”²⁵

Competitors to CRNAs, including anesthesiologists and pain physicians, have objected to this final ruling by CMS, even though such an august authority as the Institute of Medicine concludes that there is a shortage of providers in this field. In many rural and frontier areas, Medicare beneficiaries must travel hundreds of miles to access alternative care, and CRNAs often are the only health care professionals trained in pain management in these communities. As the Institute of Medicine (IOM) report entitled “Relieving Pain in America” states, many more health care professionals are needed to assess and treat pain.²⁶ The IOM report estimates that the total

²² 77 Fed. Reg. 68892, 69005 et seq., Nov. 16, 2012, amending 42 CFR §410.69(b). Certified Registered Nurse Anesthetists scope of benefit. <http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf> .

²³ Ibid, 69007.

²⁴ Ibid, 69008.

²⁵ Ibid, 69009.

²⁶ IOM (Institute of Medicine). Relieving Pain in America: A Blueprint for Transforming Prevention Care, Education, and Research (Washington, DC: The National Academies Press, 2011). http://books.nap.edu/openbook.php?record_id=13172 .

number of certified currently practicing physician pain specialists to be 3,000-4,000.²⁷ The report also states that 100 million Americans suffer from chronic intractable pain that costs \$635 billion each year in medical treatment and lost productivity.²⁸

Beyond the ordinary purview of the Medicare program, but implemented by the Medicare agency, are the provisions of the Affordable Care Act of 2010. To promote competition, patient access to care, consumer choice, patient safety and lower healthcare costs, Congress enacted the federal provider nondiscrimination provision as part of the Patient Protection and Affordable Care Act²⁹ which took effect January 1, 2014. Though the provision is beneficial to competition, ineffective implementation as well as legislation pending in Congress threaten to present constraints to competition and to CRNA services. As the Federal Trade Commission (FTC) is aware, the federal nondiscrimination provision indicates that “a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.” We interpret this provision to protect patient choice and access to a range of beneficial providers and prevent discrimination by health insurance plans against an entire class of health professionals, such as CRNAs.

Provider nondiscrimination laws help to protect competition, patient choice and access to a range of beneficial providers, and also prevent plans from discriminating against specific types of health providers, such as CRNAs. Ensuring that all health plans adhere to these nondiscrimination laws would promote patient access to a range of beneficial, safe and cost-efficient healthcare professionals, consistent with public interests in quality, access and cost-effectiveness.

Proper implementation of the ACA provider nondiscrimination provision is crucial because

²⁷ IOM (Institute of Medicine).Op. cit., p. 198.

²⁸ IOM (Institute of Medicine).Op. cit., p. 1.

²⁹ Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706, “Non-Discrimination in Health Care, 42 USC §300gg-5.

health plans today may discriminate against whole classes of healthcare professionals based solely on their licensure or certification, limiting or denying patient choice and access to beneficial, safe and cost-efficient healthcare professionals, impairing competition, patient access to care, and optimal healthcare delivery. For example, a commercial carrier in South Carolina stated in its policy manual that it will not reimburse CRNAs for monitored anesthesia care (MAC), but that it will pay anesthesiologists for these same services. Not only does such a policy impair patient access to care provided by CRNAs; it expressly impairs competition and choice and contributes to unjustifiably higher healthcare costs without improving quality or access to care. Its negative impacts hit rural communities hardest, where CRNAs are the primary anesthesia professionals and often the sole anesthesia providers. The availability of CRNAs in rural America enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who might otherwise be forced to travel long distances for these essential care. Ensuring that providers are not discriminated against based on their licensure or certification would also help encourage the placement of skilled healthcare professionals in rural areas.

A recent legislative attempt to reverse provider nondiscrimination occurred in 2013 with the introduction of HR 2817, legislation to repeal federal healthcare provider nondiscrimination provisions, by Rep. Andy Harris (R-MD), who is an anesthesiologist. This bill, which was referred to the House Energy and Commerce Committee, would reverse market-oriented, pro-competitive, pro-consumer choice policy that respects state scope of practice laws. By overturning provider nondiscrimination, HR 2817 would expressly reauthorize policy favoring discrimination against qualified licensed healthcare providers, such as CRNAs, solely on the basis of their licensure. The AANA has acted to oppose this legislation because provider discrimination would promote anticompetitive practices that deny patient access to safe and high quality providers, and increase healthcare costs by impairing competition and rewarding provider guild collusion with plans.

Finally, other federal regulations governing CRNAs remain a target for competitors to constrain CRNA services more narrowly than their scope of practice. The recent experience of the U.S. Department of Veterans Affairs provides one further example where organized medical

community advocacy seeks to impair patient access to care provided by CRNAs and other APRNs. In the summer of 2013, the Veterans Health Administration (VHA) made known it would seek to update its longstanding Nursing Handbook governing nursing services in Veterans healthcare facilities. Among the updates was to recognize APRNs including CRNAs to their full scope of practice, as full practice providers. In letters to the VHA and comments to legislators on Capitol Hill, the American Society of Anesthesiologists (ASA) variously claimed³⁰ that the plan would put Veterans health and healthcare at risk, override and invalidate the VHA Anesthesia Handbook³¹ governing anesthesia services, demand CRNAs provide services they were unwilling or unable to perform, and prohibit VHA from directing physicians and nurses or APRNs from working together in the best interests of the patient³². As of March 2014, the proposal remains in a draft stage at the U.S. Department of Veterans Affairs.

Constraints in the legislative, regulatory, and practice arena can ultimately result in anticompetitive practices and collusion, increasing healthcare costs and diminishing quality of care and patient choice. In the early 2000s, the FTC and DOJ conducted two years of hearings on healthcare and antitrust, yielding a landmark joint report entitled *Improving Health Care: A Dose of Competition*.³³ More recently, the Institute of Medicine (IOM) report entitled *The Future of Nursing: Leading Change, Advancing Health*³⁴ specifically recommended that the FTC examine how anticompetitive acts, such as limiting APRNs like CRNAs from providing care to the fullest extent of their education and skill, reduce patient choice and increase healthcare costs without improving quality.

³⁰ American Society of Anesthesiologists. Reports to ASA membership Nov. 1, 2013, <http://www.asahq.org/For-Members/Advocacy/Washington-Alerts/Ask-Your-Lawmaker-to-Stop-VA-ONS-Initiative-Mandating-Independent-Practice-for-Nurses.aspx>, Dec. 9, 2013, <http://www.asahq.org/For-Members/Advocacy/Washington-Alerts/ASA-President-Meets-with-Senior-VA-Officials-Voices-Concerns-about-Proposed-VA-Nursing-Handbook.aspx>, Feb. 11, 2014, <http://www.asahq.org/For-Members/Advocacy/Washington-Alerts/A-Message-from-ASA-President-Jane-Fitch-regarding-the-VA-APRN-Independent-Practice-Initiative.aspx>.

³¹ U.S. Department of Veterans Affairs. VHA Handbook 1123, Anesthesia Service. March 7, 2007. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1548.

³² Beck, M. "At VHA, Doctors, Nurses Clash on Oversight." Wall Street Journal, Jan. 26, 2014. <http://online.wsj.com/news/articles/SB10001424052702304856504579340603947983912>.

³³ Department of Justice and Federal Trade Commission op. cit..

³⁴ Institute of Medicine op. cit.

More specifically:

- According to the FTC and DOJ, "...anticompetitive conduct that raises prices, even if it is done in the name of improving 'quality,' is likely to have a systemic adverse effect on the quality of care actually provided to the population as a whole. In a competitive market, consumers consider various dimensions of quality and price. Competition law exists to promote and enhance consumer choice along all of these dimensions."³⁵
- According to one of the supplementary papers in the IOM report, "The Federal Trade Commission should be charged with actively monitoring proposed state laws and regulations specifically applicable to retail or convenient care clinics (or other innovative delivery mechanisms utilizing APNs) to assure that impermissible anti-competitive measures are not enacted. The need for such monitoring is confirmed by the recent FTC evaluations of proposals in Massachusetts and Illinois and Kentucky, which revealed that several such provisions (including limitations on advertising, differential cost-sharing, more stringent physician supervision requirements, restrictions on clinic locations and physical configurations or proximity to other commercial ventures, and limitations on the scope of professional services that can be provided which do not apply to the same credentialed professionals in comparable limited care settings) could be considered anti-competitive."³⁶

On the state level, the staff of the FTC's Office of Policy Planning, Bureau of Economics, and Bureau of Competition has submitted comment letters in response to proposed bills and a proposed rule that, if adopted, would impact the scope of practice of CRNAs and advanced practice nurses. In these letters, the FTC discouraged unnecessary restrictions on CRNA

³⁵ Department of Justice and Federal Trade Commission. Improving Health Care: A Dose of Healthy Competition, July 2004, Chapter 1, p. 30. <http://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf> .

³⁶ Barbara J. Safriet, "Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost Effective Health Care," in Institute of Medicine. The Further of Nursing: Leading Change, Advancing Health (Washington, DC: The National Academies Press, 2011) p. 470. <http://www.iom.edu/~media/Files/Activity%20Files/Workforce/Nursing/Federal%20Options%20for%20Maximizing%20the%20Value%20of%20Advanced%20Practice%20Nurses.pdf> .

practice³⁷ and supported eliminating requirements that advanced practice nurses collaborate with, or be supervised by, physicians.³⁸

The FTC has warned that unnecessary legislative or regulatory restrictions on CRNA pain management practice, if adopted, could reduce competition, raise the prices of pain management services, reduce the availability of these services, especially for the most vulnerable patients, and discourage healthcare innovation in this area.³⁹ Allowing CRNAs to practice to the full scope of their training and expertise in all areas of their practice will increase competition in the healthcare marketplace, as reflected by the FTC's own assessment of the competitive impact of various bills and proposed rules relating to regulatory restrictions on advanced practice nurses.

After receiving a letter of concern from the FTC, in November 2010, Alabama's medical board postponed indefinitely consideration of a proposed rule (i.e., the rule was neither withdrawn nor adopted) that, if adopted, would likely have prohibited CRNA interventional pain management practice.⁴⁰ This reaffirms the public policy wisdom of avoiding unnecessary restrictions on CRNA pain management practice.

The FTC submitted letters commenting on restrictive pain management bills in Tennessee (2011), Missouri (2012) and Illinois (2013) respectively, expressing significant concern about overbroad state proposals that would prohibit or unduly restrict CRNA pain management

³⁷ See FTC November 3, 2010 letter to the Alabama State Board of Medical Examiners at <http://www.ftc.gov/opa/2010/11/alabamarule.shtm> .

³⁸ See FTC March 19, 2013 letter to Connecticut State Representative Theresa W. Conroy at <http://www.ftc.gov/news-events/press-releases/2013/03/ftc-staff-connecticut-should-consider-expanding-advance-practice> and FTC January 23, 2014 letter to Massachusetts State Representative Kay Khan at <http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician>.

³⁹ See FTC November 3, 2010 letter to the Alabama State Board of Medical Examiners at <http://www.ftc.gov/opa/2010/11/alabamarule.shtm> , FTC September 28, 2011 letter to Tennessee Representative Gary Odom at <http://www.ftc.gov/opa/2011/10/nursestennessee.shtm> , FTC March 27, 2012 letter to Missouri Representative Jeanne Kirkton at <http://www.ftc.gov/opa/2012/03/missouripain.shtm> , and FTC April 19, 2013 letter to Illinois Senator Heather Steans at <http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against> .

⁴⁰ See FTC April 19, 2013 letter to Illinois Senator Heather Steans at <http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against>.

practice, thereby raising prices and reducing availability of CRNA services.⁴¹ In Tennessee and Missouri, the bills ultimately passed; however, the FTC comment letters generated discussion amongst the legislators and were cited during hearings. CRNAs utilized these letters as educational tools with legislators and as references during negotiations for more acceptable and less restrictive bill language. In Illinois, a restrictive pain management bill stalled at the committee level in 2013; a similar, revised restrictive pain management bill was introduced in Illinois in 2014 and is currently pending.⁴² The CRNAs are using the FTC's 2013 comment letter on the previous Illinois pain management bill in their efforts to educate legislators on the anti-competitive impacts of the bill.

In addition, the FTC commented favorably on bills in Connecticut (2013) and Massachusetts (2014) that proposed eliminating unnecessary restrictions on advanced practice registered nurses (APRNs).⁴³ The FTC stated that eliminating the requirement that APRNs have collaborative agreements with physicians in order to practice independently could benefit Connecticut health care consumers by expanding choices for patients, containing costs, and improving access to primary health care services (note that this collaborative agreement requirement does not apply to CRNAs). Further, the FTC stated that as proposed in a 2013 Massachusetts bill, the elimination of certain supervision requirements for nurse practitioners and nurse anesthetists would likely benefit consumers and competition in Massachusetts. Ultimately, the Connecticut bill did not pass out of committee and the Massachusetts bill is currently pending.

⁴¹ See FTC September 28, 2011 letter to Tennessee Representative Gary Odom at <http://www.ftc.gov/opa/2011/10/nursestennessee.shtm> , FTC March 27, 2012 letter to Missouri Representative Jeanne Kirkton at <http://www.ftc.gov/opa/2012/03/missouripain.shtm> , and FTC April 19, 2013 letter to Illinois Senator Heather Steans at <http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against> .

⁴² See FTC April 19, 2013 letter to Illinois Senator Heather Steans at <http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against> .

⁴³ See FTC March 19, 2013 letter to Connecticut State Representative Theresa W. Conroy at <http://www.ftc.gov/news-events/press-releases/2013/03/ftc-staff-connecticut-should-consider-expanding-advance-practice> and FTC January 23, 2014 letter to Massachusetts State Representative Kay Khan at <http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician> .

III. INNOVATIONS IN HEALTHCARE DELIVERY

The AANA supports the FTC's effort to better understand the potential benefits of new healthcare delivery models that have emerged in recent years which can offer significant cost savings while maintaining, or even improving, quality of care. These models may also increase the supply of health care services, which may expand consumer access to care. In this section, the AANA will share information on the prevalent and emerging forms of healthcare delivery in the anesthesia and pain management arena. One innovative model the agency should study as a cost-efficient model in healthcare delivery is non-medically directed anesthesia services performed by a CRNA.

Similar to general physician payment, Medicare reimburses CRNAs and anesthesiologists the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. Medicare also authorizes coverage of "anesthesiologist medical direction"⁴⁴ that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are capable of and are often providing patient access to high quality anesthesia care unassisted. An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases, a total of 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.⁴⁵

The cost-effectiveness promoted by non-medically directed CRNA anesthesia care can be established through a straightforward case analysis. Suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia

⁴⁴ 42 CFR §415.110. <http://www.gpo.gov/fdsys/pkg/CFR-2003-title42-vol2/pdf/CFR-2003-title42-vol2-sec415-130.pdf>

⁴⁵ P. 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

delivered by a 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, \$145,000 for the CRNA⁴⁶ and \$380,000 for the anesthesiologist⁴⁷. Under the Medicare program and most private payment systems, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable. However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost of practice modality (a) equals \$145,000 per year. For case (b), it is (\$145,000 + (0.25 x \$380,000)) or \$240,000 per year. For case (c) it is (\$145,000 + (0.50 x \$380,000)) or \$335,000 per year. Finally, for case (d), the annualized cost equals \$380,000 per year.

Anesthesia Payment Model	FTEs / Case	Clinician costs per year / FTE
(a) CRNA Nonmedically Directed	1.00	\$145,000
(b) Medical Direction 1:4	1.25	\$240,000
(c) Medical Direction 1:2	1.50	\$335,000
(d) Anesthesiologist Only	1.00	\$380,000
<i>Anesthesiologist mean annual pay</i>	<i>\$380,000</i>	<i>ASA, 2007</i>
<i>CRNA mean annual pay</i>	<i>\$145,000</i>	<i>AANA, 2007</i>

If Medicare and private plans pay the same rate whether the care is delivered according to modalities (a), (b), (c) or (d), someone in the health system is bearing the additional cost of the

⁴⁶ AANA member survey, 2007

⁴⁷ American Society of Anesthesiologists Newsletter, April 2007.
<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCYQFjAA&url=https%3A%2F%2Fwww.asahq.org%2FFor-Members%2FPractice-Management%2F~%2Fmedia%2FFor%2520Members%2FPractice%2520Management%2FPracticeManagementNewsletterArticles%2F2007%2Fpm0407.ashx&ei=lOcYU9nMDlyxrgHZpIG4Aw&usq=AFQjCNFN5GaGV0MIThjxSPYtoCnwSTSYuw&bvm=bv.62577051,d.aWWM>

medical direction service authorized under the Medicare regulations at 42 CFR §415.110. This additional cost is shifted onto hospitals and other healthcare facilities, and ultimately to patients, premium payers and taxpayers. With CRNAs providing over 34 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 frequently not met – and if anesthesiologists submit claims to Medicare for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread Medicare fraud in this area is high. Lapses in anesthesiologist supervision of CRNAs are common even when an anesthesiologist is medically directing as few as two CRNAs, according to an important new study published in the journal *Anesthesiology*.⁴⁸

Reviewing over 15,000 anesthesia records in one leading U.S. hospital, this study raises critical issues about Medicare claims compliance in a common and costly model of anesthesia delivery at a time when quality, cost-effectiveness, and best use of Medicare resources are the focus of healthcare reform. In the interest of patient safety and access to care, these additional costs imposed by medical direction modalities more than justify the public interest in recognizing and reimbursing fully for non-medically directed CRNA services within Medicare, Medicaid and private plans in the same manner that physician services are reimbursed. Sometimes non-Medicare plans, particularly Medicaid plans, fail to directly reimburse non-medically directed CRNA services, and thus drive healthcare facilities to adopt higher-cost anesthesia services delivery systems that do not improve quality or access and divert healthcare resources from other needed areas. The Pennsylvania Medicaid system, for example, reimburses CRNA services only when they are medically directed by an anesthesiologist, imposing unnecessary additional costs upon the healthcare system. Pennsylvania Medicaid direct reimbursement of non-medically directed CRNA services would help reduce healthcare system costs and ensure that CRNA services are valued appropriately.

⁴⁸ Epstein R, Dexter F. Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics. *Anesth.* 2012;116(3): 683-691.
http://journals.lww.com/anesthesiology/Fulltext/2012/03000/Influence_of_Supervision_Ratios_by.29.aspx

A second innovation in healthcare delivery the FTC should consider is the benefit of CRNA pain management services. CRNA provision of pain management service increases the availability and ease of obtaining of pain management services, expanding consumer access to high quality, safe and cost-effective health care. Chronic pain management is an evolving field relating to the treatment of persistent intractable pain. The Institute of Medicine (IOM) reported in *Relieving Pain in America* (2011) that 100 million Americans suffer from chronic intractable pain at an annual cost exceeding \$600 billion from healthcare expenditures and lost productivity.⁴⁹ The IOM also reported an insufficient supply of healthcare professionals treating pain patients, and concluded that more professionals and more training are needed to meet the needs of a growing population of U.S. retirees. Providing acute and chronic pain management and treatment is within the professional scope of practice of CRNAs. CRNA employment of pain management techniques is neither new nor unusual and has long been a part of CRNA practice. By virtue of education and individual clinical experience, a CRNA possesses the necessary knowledge and skills to employ therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of acute and chronic pain.

Already, CRNAs provide access to vital chronic pain management services, especially in rural and frontier areas with few viable alternatives. In many rural and frontier areas, Medicare beneficiaries must travel hundreds of miles to access alternative care, and CRNAs often are the only health care professionals trained in pain management in these communities. In these cases, referring practitioners choose to refer their patients to CRNAs for high-quality pain care, and patients choose to receive their care from a CRNA in their local community rather than travelling long distances. Without CRNAs to administer chronic pain management services, Medicare beneficiaries 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, Medicare, and the healthcare system.⁵⁰

⁴⁹ IOM (Institute of Medicine). *Relieving Pain in America: A Blueprint for Transforming Prevention Care, Education, and Research* (Washington, DC: The National Academies Press, 2011).

http://www.nap.edu/openbook.php?record_id=13172

⁵⁰ The Lewin Group. *Cases: Costs of Alternative Pain Management Paths* (August 14, 2012).

http://www.lewin.com/~media/Lewin/Site_Sections/Publications/CRNAPainMgtCaseStudies.pdf

When analyzing innovative models of healthcare delivery, it must be noted that some models have hidden costs and may work to reduce competition by reinforcing current staffing models.. Consideration should be given to the cost impact of innovative models of care, which may be premised on protecting the interests of a particular profession, instead of offering additional options that serve legitimate patient needs or improve the cost efficiency of health care.

IV. PRICE TRANSPARENCY OF HEALTHCARE SERVICES

The FTC asked for factors to be considered when analyzing the competitive implications of price transparency in the healthcare industry. Anesthesia pricing is among the most opaque in all of healthcare, impairing competition and innovation. The medical direction payment model, in which an anesthesiologist performs seven specific tasks in each of up to four concurrent cases in exchange for 50 percent of a Medicare anesthesia fee, the CRNA providing the anesthesia service claiming the other 50 percent⁵¹, is unique in healthcare, fails to fairly or accurately reflect the services provided to patients by each professional, and contributes significantly to healthcare cost growth. When a hospital employs CRNAs, and contracts with an anesthesiology group to provide anesthesiologist services, it is not uncommon for patients and plans to receive two bills for anesthesia services – or to learn, unpleasantly, that the anesthesiologist group is outside of the plan’s network and demands full payment directly. The medical direction payment model introduces high costs of additional personnel that are not required to deliver an anesthesia service safely and effectively.

On account of the medical direction payment model, it is increasingly common that billings for anesthesia services do not represent all anesthesia costs in the system. One factor driving up the cost of healthcare is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,⁵² 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.

⁵¹ 42 CFR §415.110. <http://www.gpo.gov/fdsys/pkg/CFR-2003-title42-vol2/pdf/CFR-2003-title42-vol2-sec415-130.pdf>

⁵² Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012. <http://drivinghp.com/consulting/2012-anesthesia-subsidy-survey-report-now-available/>

Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

The agency also asked for examples where price transparency might facilitate price coordination among healthcare providers thereby damaging competition. Some anesthesia groups establish single source contracts with hospitals and healthcare facilities and the anesthesiology group does not negotiate with health plans. The group bills the patient directly for specific procedures, resulting in high out of pocket costs for the patient and curbing competition that could give patients more choices that may be less expensive.⁵³ This type of model uses economic incentives and to drive up healthcare costs, while putting economic strains on consumers.

⁵³ Rosenthal, E.. (2013, June 1). The \$2.7 Trillion Medical Bill. *The New York Times*, pp. A1, A4.
http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html?_r=0

V. MEASURING AND ASSESSING QUALITY OF HEALTH CARE

The FTC asked for a description of how healthcare quality is measured and evaluated. We will outline the quality of CRNA services, describe how Medicare billing modalities impair data collections on the services of APRNs (especially with respect to “incident-to” services) and inadequately account for their contributions to healthcare delivery, and note how registries developed and operated by medical societies present risk to competition.

As we have stated previously, peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. 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.⁵⁴ 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.⁵⁵

In three significant aspects, Medicare billing modalities tend to significantly underrepresent the contributions that CRNAs and other APRNs make to healthcare delivery. In the field of anesthesia, billing services as “medically directed” suggests that in such cases anesthesiologists have performed each of the seven medical direction steps for which medical direction reimbursement is claimed. According to AANA member surveys and more importantly the American Society of Anesthesiologists journal *Anesthesiology*, medical direction frequently lapses⁵⁶ and one or more of the “medical direction” services are actually performed by the CRNA, just as they are performed when a service is billed nonmedically directed. Second, in

⁵⁴ 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

⁵⁵ B. Dulisse and J. Cromwell, “No Harm Found When Nurse Anesthetists Work Without Physician Supervision.” *Health Affairs*. 2010; 29: 1469-1475. <http://content.healthaffairs.org/content/29/8/1469.full?ikey=ezh7UYKltCyLY&keytype=ref&siteid=healthaff>

⁵⁶ Epstein R, Dexter F. Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics. *Anesth*. 2012;116(3): 683-691. http://journals.lww.com/anesthesiology/Fulltext/2012/03000/Influence_of_Supervision_Ratios_by.29.aspx

many fields, the services of CRNAs, APRNs and other healthcare providers are frequently billed “incident-to” the services of a physician. Under “incident-to,” the claim is paid at 100 percent, and the claim indicates that the service was provided by the physician not the CRNA or other APRN, without providing any modifier indicating who actually performed the service.

“Incident-to” drives substantial underrepresentation of APRN services when claims data undergo examination. Last, not all Medicare Part B services provided by CRNAs are billed through Medicare Part B. In qualifying rural hospitals, Medicare Part A reimburses for the “reasonable cost” of CRNA services through a pass-through payment to the hospital. The CRNA may not bill Part B for services that the hospital bills Medicare through Part A. With CRNA services predominating in rural America, and many CRNA services noted not in Part B claims but embedded in Part A cost reports, ordinary Part B claims data underrepresents the anesthesia and pain management services CRNAs provide, particularly in rural and frontier parts of the United States.

With respect to registries, we strongly recommend that the infrastructure for quality reporting be accessible and transparent, particularly when it drives incentive payments from public benefit programs. Current registry procedures raise serious concerns about their accuracy and reliability with respect to reporting CRNA service provision. Under many registry practice rules the services that CRNAs and APRNs provide are often kept from being reported to registries organized and managed by medical specialty societies. When APRN services and data are reportable, the terms for participation and data submission are different from those that medical specialty society registries extend to physicians. In some cases physician organizations charge exorbitant fees for non-guild members to enroll in a registry, which is prohibitive to advanced practice nursing groups’ participation. In this way, registries developed in response to public policy promoting healthcare quality may instead be used to justify illegitimate protection of guilds, higher healthcare costs, less competition and reduced access to care.

The FTC asked for a description of any challenges that are encountered when measuring quality. The AANA remains concerned over the use of EHR reporting, especially when CRNAs and other APRNs are ineligible for EHR incentives, and note that this is a barrier to reporting of

quality measures. We understand that the HITECH Act⁵⁷ did not include CRNAs as an “Eligible Professional,” thus making them ineligible for incentive payments. However, CRNAs are “eligible professionals” under the Physician Quality Reporting System (PQRS) who regularly report quality measures and are eligible for incentive payments under that program. The AANA remains concerned that CRNAs must not be penalized in Medicare payment or in eligibility for PQRS incentives simply because they are currently ineligible for the EHR incentive program. We note that CMS seems to assume that CRNAs and other healthcare professionals will rely on the facilities where they work in order to adopt this technology. However, whole categories of healthcare facilities, such as ambulatory surgical centers (ASCs), are also ineligible for EHR incentive programs. Multiple levels of ineligibility cause an additional obstacle for providers, such as CRNAs, to have access to this technology in order to report quality measures electronically. Furthermore, the AANA is concerned that as CMS moves from claims based reporting to solely reporting through EHR-based reporting systems and through clinical registries, information on CRNAs will be underreported. As CMS expands the quality measures that can be reported through an EHR and ultimately ends the way that CRNAs predominately report measures, healthcare professionals such as CRNAs are at risk for being penalized and being placed at a disadvantage if they do not have access to report through a qualified EHR.

We thank you for the opportunity to comment on this proposed notice. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Dennis C. Bless, CRNA, MS
AANA President

⁵⁷ American Recovery and Reinvestment Act of 2009. Pub. L. No. 110-275. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ309/html/PLAW-111publ309.htm>

Attachments:

1. Health Affairs study: “No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians”
2. Nursing Economics study: “Cost Effectiveness Analysis of Anesthesia Providers”
3. Journal of Anesthesiology article: “Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics”
4. Institute of Medicine summary: The Future of Nursing – Leading Change, Advancing Health
5. Institute of Medicine summary: Relieving Pain in America
6. Institute of Medicine: The Future of Nursing appendix by Barbara Safriet, JD

cc: Wanda O. Wilson, CRNA, PhD, AANA Executive Director
Frank J. Purcell, AANA Senior Director of Federal Government Affairs
Anna Polyak, RN, JD, AANA Senior Director of State Government Affairs
Randi Gold, MPP, AANA Associate Director Federal Regulatory and Payment Policy
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