

November 20, 2019

The Honorable Richard Neal
Chairman
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

RE: Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal and Ranking Member Brady:

The American Association of Nurse Anesthetists (AANA), representing the nation's 53,000 Certified Registered Nurse Anesthetists (CRNAs) and Student Registered Nurse Anesthetists (SRNAs) welcomes the opportunity to comment on the task force's request for information (RFI) to discuss the delivery and financing of healthcare and related social determinants in rural and underserved communities and help identify strategies to address the challenges that contribute to health inequalities. Our comments outline our firm commitment to working with the task force and other healthcare stakeholders to explore policy options to improving outcomes and care in rural communities.

Question 2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

As CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, it vital that Congress ensure CMS promote access to the use of CRNA anesthesia services in rural America in payment models. Furthermore, Congress should direct CMS to ensure that these models do not create unintended barriers to the use of CRNA services and that CRNAs are practicing at their full professional education, skills, and scope of practice.

The current Medicare requirements for physician supervision of CRNA anesthesia services do not have any impact on quality of care, restricts patient access and increases healthcare costs. Removal of these requirements would allow states and healthcare facilities to make their own decisions based on state laws and patient needs, thus controlling cost, providing access and delivering quality care.

There is no evidence that physician supervision of CRNAs improves patient safety or quality of care. CRNA safety in anesthesia is further evidenced by the significant decrease in liability premiums witnessed in recent decades.

The supervision requirement is also costly. Though Medicare requires supervision of CRNAs by an operating practitioner or by an anesthesiologist who is immediately available if needed, hospitals and

healthcare facilities often misinterpret this requirement to be a quality standard rather than a condition of participation. When this happens, anesthesiologist supervision adds substantial costs to healthcare by requiring duplication of services where none is necessary.

Question 7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

The AANA commends the bipartisan efforts of Congress and the administration for enacting the SUPPORT Act, particularly Section 3201, which allows CRNAs 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. The law allows for a five-year pilot program.

We request that any future Congressional action on preventing opioid addiction and enhancing access to MAT make the waiver for CRNAs permanent. Furthermore, it is critical to promote patient access to counseling by CRNAs on non-opioid alternatives to pain management. We suggest that Congress direct the Secretary of Health and Human Services to establish and cover a distinct, separately-coded and separately-reimbursed service under Medicare's Part B physician fee schedule for healthcare professionals to educate, counsel, and discuss the full range of pain management options, including the potential use of medical devices and other non-opioid options, with their patients suffering from acute, chronic, or surgical pain.

Question 10: Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

The Medicare Part A reasonable cost-based pass-through program ensures that rural hospitals have access to anesthesia services at a level that is economically sustainable for facilities and providers, so that the qualifying facility may provide the full range of surgical, interventional and labor and delivery care that anesthesia services afford. The program's payment to qualifying hospitals for CRNA services helps ensure the availability of safe and cost-effective anesthesia care in these facilities. With that in mind, we ask Congress to restore nurse anesthetist stand by and on-call payment eligibility to the Part A reasonable cost-based pass-through program and ensure rural access to critical healthcare services.

Congress should also direct CMS to provide equitable reimbursement in anesthesia educational settings. For an anesthesiologist to be reimbursed only 50 percent for each of two cases involving SRNAs is not consistent with Medicare's equitable payment policies for CRNAs and anesthesiologists, nor does it comply with the intent of Congress that directed the teaching rules for CRNAs be "consistent" with the rules for anesthesiologists.

Finally, Congress should recommend that CMS clarify in its educational materials that CRNAs can order and refer medically necessary Medicare services and also include CRNAs among the order and referring data file as long as CRNAs are legally authorized to perform these services in the state in which the services are furnished. CRNAs are not expressly prohibited from ordering and referring Medicare services by legislation or by regulation. In fact, Medicare in November 2012 published a rule indicating Medicare coverage of all Medicare CRNA services within their state scope of practice. However, our membership has informed us that the services that CRNAs order and specialists they refer to are not being reimbursed because CRNAs are not included among the type or specialty to be on the CMS ordering and referring file.

The AANA appreciates this opportunity to comment. CRNAs are crucial to the health and well-being of patients in rural communities and it is ever more important that Congress reduces the barriers in access to their care. The AANA and its members look forward to collaborating with the Task Force on this very important issue. 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.