



May 15, 2009

Sen. Max Baucus
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20500

Sen. Charles Grassley
Ranking Minority Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20500

VIA EMAIL:
Health_Reform@finance-dem.senate.gov

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the 40,000 members of the American Association of Nurse Anesthetists (AANA), I am pleased to present our statement in response to the Senate Finance Committee's April 29, 2009, paper titled "Description of Policy Options: Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs" (the "Health Care Delivery System Policy Paper,"

<http://www.finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf>).

We appreciate your circulating the Health Care Delivery System Policy Paper for review and public comment prior to the Committee's full consideration of a comprehensive health reform measure. We continue to extend you our support for the development of comprehensive health reform legislation. Our comments as a professional organization address the general principles that we consider to be critical to promoting health reform (some of which will also be applicable to the Committee's policy options for the expansion of healthcare coverage issued on May 11, 2009), and speak to the specific proposals outlined by the Committee in the order in which they appear.

I. INTRODUCTION

The AANA is the professional association representing over 90 percent of the Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists in the United States. CRNAs are prepared to the master's or doctoral level, and must be certified by the autonomous National Board for Certification and Recertification of Nurse Anesthetists in order to practice, and must be recertified every two years. As advanced practice nurses, CRNAs administer about 30 million anesthetics given to patients each year in the United States. Our services include administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery, as well as managing acute and chronic pain.

Nurse anesthetists have provided anesthesia in the United States for nearly 150 years, and high quality, cost effective 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 their services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

According to a 2007 Government Accountability Office (GAO) study, CRNAs predominate where there are more Medicare patients than average. CRNAs also predominate where private payment is lower than average, which is also where the gap between Medicare and private payment is less. Where anesthesiologists predominate, private payments are higher than average and the gap between Medicare and private payment is greater. (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.)

Nurse anesthesia predominates in Veterans' Hospitals and in the U.S. Armed Forces. Indeed, CRNAs work in every setting in which anesthesia is delivered, including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management centers and the offices of dentists, podiatrists, and all varieties of specialty surgeons.

II. AANA'S GENERAL HEALTH REFORM PRINCIPLES

As we stated in a letter to President Obama, we want you to know that the nurse anesthesia profession is at the forefront of healthcare reform. Americans deserve access to high-quality healthcare services that individuals and our country can afford. However, as so many experts have written and so many households tragically know, healthcare in this great country falls short of our needs and aspirations, while costing too much. We can and should work together now to make the American system better. To expand patients' access to high-quality healthcare services, and to control healthcare costs, CRNAs are ready and able to contribute toward improving healthcare in every community. To this end, we believe that Congress and the Administration should:

- **Lower federal barriers to patients' use of qualified licensed healthcare providers who are not physicians.** Notwithstanding that anesthesia is 50 times safer today than in the early 1980s, and that nurse anesthesia care specifically is of very high quality, numerous outdated federal policies limit patients' access to CRNA care and hinder physicians and facilities from using CRNAs to our fullest scope and training. The cost of these barriers is large, and borne by taxpayers, employers, and patients, both financially and in impeded access to healthcare.
- **Ensure that health plans incorporate a policy of nondiscrimination among qualified licensed providers.** When plans limit patients' access to whole categories

of healthcare professionals such as CRNAs by licensure, costs rise, and patients' choices and access to care are limited. Health insurance market reforms should support patients' interests and incorporate nondiscrimination policies among qualified licensed providers.

- **Adopt Medicare payment reforms that promote high quality care and cost-efficient healthcare delivery.** Currently, the Medicare system provides incentives to deliver anesthesia services by the most costly and inefficient means, without regard to quality of care, and without sufficient regard to patients' needs. Payment incentives that reward inefficiency and high cost without public benefit should be replaced by incentives that reward the efficient delivery of high-quality care that meets patients' needs.
- **Invest in the development of the nursing and nurse anesthesia workforce we know we need.** Insurance coverage reforms alone are insufficient to ensure that people get the care they need from professionals who are educated and available to provide that care. Many studies have long pointed to the value that increasing our investment in nursing and nurse anesthesia education provides to expand healthcare access and improve healthcare quality while securing cost savings.

Expanding on these efforts, AANA supports the following key principles for accomplishing health reform.

A. AANA SUPPORTS PROVIDER NONDISCRIMINATION LANGUAGE

With more than 45 million Americans lacking health insurance, expanding coverage must come with the assurance that patients have access to the quality healthcare services they need. We believe that health reform legislation should promote consumer choice and provider competition, while reducing costs, by including "nondiscrimination" language.

Adopted as part of the 1997 Balanced Budget Act (BBA) for federal health insurance programs, and separately as part of House- and Senate-passed “Patients’ Bills of Rights” legislation that were never enacted into law, such “nondiscrimination” language would prohibit plans from discriminating with respect to the reimbursement of qualified licensed healthcare providers.

Congress should include the “nondiscrimination” language below in any health reform legislation, and closely examine the nondiscrimination issue to ensure that such plans truly make quality healthcare more affordable and accessible.

SEC. __. PROHIBITION ON DISCRIMINATION AGAINST HEALTH CARE PROVIDERS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), a health insurance issuer to which this Act (or amendment) applies shall not discriminate with respect to participation, reimbursement, covered services or indemnification under a health plan or other health insurance coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

B. AANA SUPPORTS MEDICARE PAYMENT REFORMS AND REVERSING SEVERE AND UNSUSTAINABLE MEDICARE CUTS

We appreciate Congress taking action in July 2008, and in previous years, to reverse the Medicare “sustainable growth rate” (SGR) formula cuts facing anesthesia and other providers. Unfortunately, beginning January 1, 2010, Medicare will cut payments for Medicare Part B provider services by approximately 20 percent and another 5 percent for each of many subsequent years, unless Congress acts to reverse these cuts. In fact, unless Congress fixes the Medicare SGR formula, AANA anticipates Medicare anesthesia payment cuts amounting to a 35 percent to 40 percent gross reduction by 2014. Such cuts can be anticipated to have far-reaching effects on seniors’ access to anesthesia services. CRNAs, like anesthesiologists and other physicians, have been authorized for 20 years to

bill Medicare Part B directly for services provided to Medicare beneficiaries. Thus, cuts to the Medicare physician fee schedule affect reimbursements to CRNAs the same as they do physicians. According to the Medicare Payment Advisory Commission (MedPAC), continued cuts to Medicare Part B providers are not sustainable and could cause a decrease in Medicare beneficiary access to healthcare provider services.

C. AANA SUPPORTS HEALTHCARE WORKFORCE DEVELOPMENT

AANA recognizes that Congress must act to expand patients' access to affordable, high-quality healthcare coverage. But with expanded coverage comes an equally robust commitment to strengthening the healthcare workforce available to provide needed care. Within our field of anesthesia services, the CRNA vacancy rate is above 12 percent in both clinical and educational settings, a rate that is higher than the national shortage of registered nurses. In 2007, the AANA conducted a nurse anesthesia workforce study that found a 12.6 percent vacancy rate in hospitals for CRNAs, and a 12.5 percent faculty vacancy rate. (Merwin E, Stern S, et al. New Estimates for CRNA Vacancies. *J AANA* 77:2, 121-129.) Though the number of nurse anesthesia educational program graduates doubled from 2000 - 2008, the nurse anesthetist vacancy rate remained steady at around 12 percent, due to increased demand for anesthesia services in the aging population, growth in the number of clinical sites requiring anesthesia services, and CRNA retirements. In rural and medically underserved America, particularly, the availability of CRNA care represents the difference between availability and absence of surgical care, trauma stabilization, invasive diagnostic procedures, labor and obstetrical care, and pain management services. The availability of CRNA services may also mean the difference between the existence and the absence of a hospital in a rural community.

AANA is committed to working with the Senate Finance Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee to ensure this nation has a strong healthcare workforce. Though a great deal of deserved attention has been focused

on primary care, Congress should also strengthen the healthcare workforce needed in rural and medically underserved America, and include investments in CRNAs and other advanced practice registered nurses (APRNs).

III. AANA'S COMMENTS TO THE HEALTH CARE DELIVERY SYSTEM POLICY PAPER

Turning now to the policy options proposed in the Committee's Health Care Delivery System Policy Paper, we have provided our comments below with respect to the Committee's specific proposals.

A. PAGE 5: PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) IMPROVEMENTS AND REQUIREMENT

We appreciate your focus on improving the Physician Quality Reporting Initiative (PQRI). As you know, the AANA worked with Congress in support of value-based purchasing systems such as PQRI at their inception, and has vigorously participated in many professional, governmental, and clinical forums to help develop, execute and report quality measures pertinent to nurse anesthesia practice and patients. Healthcare quality being a universal public interest, we continue to believe and request that quality measures development, execution, reporting, incentives and evaluation must apply equitably to all healthcare provider types, including CRNAs and other advanced practice nurses, in the same manner as physicians.

We note with particular interest your proposal authorizing PQRI incentive payments to certain physicians participating in a qualified American Board of Medical Specialties Maintenance of Certification system. As presented, the proposal restricts participation to medical doctors, and seems to exclude CRNAs, advanced practice nurses, and any

qualified providers who are not medical doctors or doctors of osteopathy. We would be deeply concerned about current or proposed PQRI measures that discriminate on the basis of licensure in this way; such discrimination is unsupported by evidence and inconsistent with established Medicare policy paying qualified providers the same fee for the same anesthesia service.

However, we find meritorious the notion that healthcare professionals demonstrate continuous professional excellence in practice. It is unacceptable that in the 21st century it can take upwards of 17 years for research evidence to reach daily clinical practice (Balas EA, Boren SA. *Managing Clinical Knowledge for Health Care Improvement*. Yearbook of Medical Informatics 2000: Patient-centered Systems. Stuttgart, Germany: Schattauer, 2000:65–70 as cited in Balas EA. Information Systems Can Prevent Errors and Improve Quality. *J Am Med Inform Assoc*. 2001 Jul–Aug; 8(4): 398–399 and available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=130085>). For more than half of a century, our profession of nurse anesthesia has developed for itself, met, and continued to improve methods of professional certification and recertification, via the autonomous National Board for Certification and Recertification of Nurse Anesthetists (NBCRNA, www.nbcrna.com) and its predecessor councils. These methods are regarded as the most rigorous and effective in our field, and have yielded continued improvements in anesthesia patient safety. We are proud of this record, but never satisfied. Healthcare facilities, nongovernmental standard-setting bodies (e.g., The Joint Commission), and professional certification organizations are increasingly linking clinician privileging and credentialing to three factors: (1) verification of professional practice; (2) demonstration of continuing professional education; and (3) professional assessment. The public interest demands even greater rigor in developing, assessing and assuring a high degree of competency among healthcare professionals. Our professional direction is buttressed by an extensive report commissioned by the NBCRNA and other organizations (Henderson J PhD, “Practices and Requirements of Renewal Programs in Professional Licensure and Certification,” National Organization for Competency Assurance, Nov. 11, 2009, www.noca.org) which states, “The data indicate that more

needs to be done to ensure the continuing competence of licensed and certified professionals in virtually every field.”

Rather than to specify in a health reform statute a particular professional competency program, we recommend the statute authorize the Secretary of Health and Human Services to develop a process by which the Secretary takes counsel from organizations such as the AANA and the NBCRNA to establish criteria for recognizing certifications appropriate to the policy objectives of the Medicare Part B PQRI program. The opportunity to develop, execute, report, benefit from and evaluate measures and incentives of the PQRI program must be equally available to all qualified licensed healthcare providers including CRNAs.

B. PAGE 10: PRIMARY CARE AND GENERAL SURGERY BONUS

We support provisions rendering an additional bonus payment for rural general surgeons under the Medicare program. As the predominant anesthesia provider in rural and medically underserved America, CRNAs are acutely aware that the scarcity of surgeons in rural America challenges millions of Americans’ access to care, a concern shared by the American College of Surgeons. A bonus payment system would provide general surgeons a greater incentive to choose and maintain rural practice.

Currently, the Medicare program provides a 10 percent bonus to physicians serving in health professional shortage areas (HPSAs), but is constrained by statute from paying the HPSA physician bonus to advanced practice nurses such as CRNAs who likewise are in great need in rural America. (Merwin E, Stern S, et al. New Estimates for CRNA Vacancies. J AANA 77:2, 121-129. The national CRNA vacancy rate exceeds 12 percent notwithstanding substantial growth in new graduates. In the southeast, central, and west regions of the United States, CRNA vacancies per 1,000 surgeries in rural America are twice that of metropolitan areas.) We urge the Committee to include provisions

extending the rural physician or general surgeon bonus to CRNAs who bill the Medicare Part B program for services delivered in rural areas.

C. PAGE 13: HOSPITAL READMISSIONS AND BUNDLING

We observe your proposal to bundle certain hospital payments with payments for post-acute services, such as home health and nursing home care. While your proposal does not expressly include language authorizing bundling Medicare Part A and Part B payments in any way, we understand that the Centers for Medicare & Medicaid Services (CMS) is in the early stages of determining whether the bundling of services including Medicare Part B services could yield savings for the Medicare program.

On January 1, 2009, CMS began the Medicare Acute Care Episode (ACE) demonstration program that attempts to align incentives among various providers and provide flexibility to hospitals and practitioners by bundling all related services, such as surgical services, into an “episode of care” and paying a single, global payment that the hospital or other provider can distribute and use as they deem appropriate. The demonstration is taking place in hospitals located in Colorado, New Mexico, Oklahoma and Texas.

We are concerned that a move toward the bundling of practitioner services may result in the loss of professional and financial recognition of the services practitioners such as CRNAs provide. Continued and increased access to cost-efficient, quality anesthesia services is dependent in part on the individual recognition and reimbursement of CRNA services.

D. PAGE 16: SUSTAINABLE GROWTH RATE (SGR)

We echo the comments we have made previously to Congress and the CMS, and those comments by medical and other professional societies, in regard to establishing a better methodology for calculating the SGR. We appreciate that the intent of the Balanced Budget Act (BBA) in replacing the Medicare Volume Performance Standard (MVPS) calculation with the SGR methodology was to curb Medicare expenditures.

Unfortunately, the SGR as it is today does not accurately reflect the cost or quality of healthcare services. We understand that Section 1848(f)(2) of the Social Security Act specifies the formula for establishing yearly SGR targets for physicians' services under Medicare and, therefore, any fix to the SGR formula requires congressional action. If the deeply flawed SGR funding formula is not substantially reformed by Congress, increasing cuts could cause providers not to participate in the Medicare program thereby reducing access to healthcare services for all patients.

The Medicare Payment Advisory Commission (MedPAC) has proposed and Congress is considering establishing separate geographically specific SGRs as one alternative to the current SGR. Our concern with this proposal is that it is a short-term resolution that could result in the same problem we have today: that Medicare payments would not accurately account for the real cost of healthcare services delivered to Medicare beneficiaries. With annual payment cuts looming, Congress would then continue to be in the position of having to override not one, but multiple geographic SGRs to account for payment changes year after year. Additionally, geographic SGRs would penalize cost-effective providers who happen to practice in high-cost-growth regions. The AANA is committed to working with Congress and others to establish a permanent SGR fix.

E. PAGE 19: ENCOURAGING HEALTH INFORMATION TECHNOLOGY USE AND ADOPTION IN SUPPORT OF DELIVERY SYSTEM REFORM GOALS

We commend Congress for investing approximately \$20 billion into Health Information Technology (HIT) through the recently enacted American Recovery and Reinvestment

Act (ARRA, Title XIII of Pub. L. No. 111-5). However, we are concerned that the incentives, while commendable, nonetheless exclude CRNAs and other Medicare Part B providers from participation. Further, the Committee's document on healthcare delivery systems is unclear on whether clinicians ineligible for the HIT program incentives are nonetheless vulnerable to future Medicare payment cuts.

We request that CRNAs be added to the list of clinicians eligible for federal HIT program benefits. For most CRNAs, HIT and electronic health records (EHR) systems are provided by the healthcare facility in which the CRNA practices. These CRNAs use the facility's EHR systems as part of their clinical practice. Thus, these CRNAs do not necessarily require specific eligibility for the federal HIT initiatives, because the facilities where they work should be eligible. There are, however, a number of CRNAs around the country who provide pain management services in small clinic settings, chiefly located in deeply rural and medically underserved communities, who would certainly benefit from having access to federal HIT and EHR systems benefits, and whose access to these programs would serve the public good.

Second, we would caution the Committee against adopting provisions penalizing the Medicare payments of Medicare providers that have not implemented an HIT program for which they were ineligible in the first place.

F. PAGE 21: IMPROVING QUALITY MEASUREMENT

The AANA appreciates and supports that Congress is focused on improving healthcare quality measurement and reporting. CRNAs are committed to patient safety, developing and reporting quality measures, improving quality, and helping to find efficiencies in the provision of healthcare services that enhance healthcare quality while controlling costs. To the extent that Congress provides additional resources and empowers advisory bodies to offer additional counsel toward this purpose, the views and participation of CRNAs

should continue to be taken into account. At present, the AANA and CRNAs have been involved in the development, vetting, approval and evaluation of quality measures, through our involvement in multiple measure development forums and in the National Quality Forum. AANA encourages the Committee to continue to include AANA and CRNAs in these valuable discussions.

G. PAGE 24: COMPARATIVE EFFECTIVENESS RESEARCH

We appreciate the interest Congress has in promoting comparative effectiveness research. CRNAs have a long-standing record of providing safe, high-quality, cost-effective anesthesia services. Nurse anesthetists welcome the opportunity to contribute our expertise to the research and ongoing dialogue in this area by providing recommendations and participating on expert panels.

H. PAGE 25: PHYSICIAN PAYMENT SUNSHINE

We support the physician payment sunshine proposal described in the Health Care Delivery System Policy Paper. Given the great responsibility healthcare professionals have over people's health, payments from manufacturers of covered drugs, devices, and biological or medical supplies to physicians and other clinicians should be disclosed to the public.

I. PAGE 33: REDISTRIBUTION OF UNUSED GME SLOTS TO INCREASE ACCESS TO PRIMARY CARE AND GENERALIST PHYSICIANS

We note the provisions in support of redistributing unused Graduate Medical Education (GME) slots to increase training in areas of primary care and general surgery, and request

that the Committee consider a proposal authorizing the establishment of a Graduate Nursing Education (GNE) initiative supported by several leading nursing organizations.

As you know, CRNAs predominate in rural and medically underserved areas, with 38 percent of 2006 graduates at work in medically underserved areas or among medically underserved populations. In addition, as noted above, the GAO reported that CRNAs predominate where more Medicare patients reside. Furthermore, as we have previously discussed, the vacancy rate for CRNAs is above 12 percent.

To ensure that rural and medically underserved America has access to needed surgical, labor and obstetrical, invasive diagnostic, and pain management services, healthcare workforce programs should focus on increasing the supply of CRNAs. We recommend a two-fold strategy to ensure a strong nurse anesthesia workforce in rural and medically underserved America.

The first is to reauthorize and strengthen the Public Health Service Act Title VIII nurse workforce development programs to help produce more CRNAs, nurse practitioners, certified nurse midwives, and clinical nurse specialists to comprehensively, cost-effectively and safely fill the healthcare workforce vacancies that exist among Advanced Practice Registered Nurses (APRNs). Title VIII Advanced Education Nursing programs have helped double the supply of nurse anesthesia graduates in the last eight years, enabling the CRNA vacancy rate to remain the same instead of worsening. The reauthorization should be coupled with additional funding for Title VIII Advanced Education Nursing programs. From this modest pool of funds, the infrastructure of advanced practice nursing education can be strengthened to produce a deeper reservoir of APRNs and faculty needed to serve America's rural and medically underserved communities.

In addition to reauthorizing Title VIII nurse workforce development programs, the AANA and several APRN groups urge Congress to establish a new and promising

healthcare workforce development initiative. Graduate Nursing Education (GNE) would help to support an APRN workforce struggling with shortages, and would increase the supply of providers in key areas across the country. Because no federal program exists to address the clinical education costs of these professionals, a proposal currently under development by the APRN community would provide payments to hospitals and community-based care facilities in coordination with accredited advanced practice nurse educational programs in schools of nursing as defined in Sec. 801 of the Public Health Service Act (42 USC §296(2) and (3)). Such payments would help reimburse both direct and indirect costs of clinical education for advanced practice nursing students. With more than 30,000 advanced practice nursing students currently in educational programs across the country today, and more APRNs needed to address current healthcare demand and ensure care is available for the newly insured, new resources should be dedicated to APRNs' clinical education costs.

We also take note of the paper's proposal to promote physician training in outpatient settings and to ensure the availability of residency programs in rural and underserved areas. The Committee proposes several changes, including "removing current disincentives placed on training programs that rely on volunteer supervisory physicians to provide training in outpatient settings." It is important for us to advise the Committee that student registered nurse anesthetists very commonly receive their clinical education from volunteer supervisory CRNAs, and yet there is no federal funding available to support this necessary activity important to our healthcare system. However, our GNE proposal is structured with the goal of funding the support of clinical educators. We would welcome the opportunity to discuss this GNE proposal more fully with the Committee in the near future.

**J. PAGE 36: PROPOSAL ON DEVELOPMENT OF A NATIONAL
WORKFORCE STRATEGY**

AANA supports the Committee's commitment to developing a strong health workforce to meet the needs of an aging nation. Our workforce development interests are described at length earlier in our comments. However, to the extent that Congress authorizes a system to draw external stakeholders into a panel for developing a national healthcare workforce strategy, AANA recommends that such advisory bodies include equal representation from both physician and non-physician providers, such as CRNAs.

K. PAGE 42: PUBLIC PROGRAM INTEGRITY – OPTIONS TO COMBAT WASTE, FRAUD AND ABUSE

Given the fraud and abuse that exists under the Medicare and Medicaid programs, which is costing taxpayers billions of dollars per year and impacting patients' access to the high quality of care that they need and deserve, we support provisions intended to combat waste, fraud, and abuse to ensure the integrity of public healthcare programs and to combat waste, fraud and abuse. Healthcare professionals such as CRNAs hold positions of great public and private trust, and are responsible for completing the jobs for which they submit claims to public benefit programs.

Medicare fraud impacts CRNAs directly. When a physician submits a claim for medical direction without having completed all seven medical direction steps in each case as required by Medicare regulations (42 CFR §415.110), the Medicare reimbursement to the CRNA providing anesthesia services (or whomever he or she has assigned billing rights) is cut by 50 percent. This type of fraud is a source of great concern in the nurse anesthesia profession because it imposes unnecessary costs on hospitals, ASCs, patients and public benefit health programs for the expense of physicians who document and submit claims for work that they have not done.

IV. CONCLUSION

We thank you for the opportunity to comment on the policy options for transforming the healthcare delivery system, and we welcome the challenge of actively working with Congress, the Administration and all stakeholders on this tremendously critical task. Should you have any questions regarding these matters, please contact our AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202-484-8400, fpurcell@aanadc.com .

Sincerely,

A handwritten signature in black ink that reads "Jackie S Rowles". The signature is written in a cursive style with a large, prominent "J" and "R".

Jackie S. Rowles, CRNA, MBA, MA, FAAPM
President