

January 26, 2018

Marlene Dortch
Secretary
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

RE: WC Docket No17-310 – Promoting Telehealth in Rural America

Dear Ms. Dortch:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to submit comments to the proposed rule WC Docket No17-310 – Promoting Telehealth in Rural America. We are firmly committed to ensure that rural healthcare providers get the support they need while guarding against waste, fraud, and abuse. The AANA makes the following comments and recommendations:

- I. CRNAs Provide Safe, High Quality and Cost Effective Healthcare**
- II. Prohibit the Use of Wasteful Tele-Supervision of CRNA Services**
- III. Reducing Regulatory Barriers for CRNAs Increases Access to Anesthesia Care in Rural Communities**
- IV. Emphasize the Use of Cost-Effective Anesthesia Care Provided by CRNAs in Advancing Interoperability of Health Information**
- V. For Anesthesia, Interoperability of Health Information Should Communicate Across the Continuum of Patient Care and EHRs Should Use Standardized Taxonomies Across Technology Platforms**
- VI. The Focus of Measurement of Interoperability Should Not Be Limited to Only Use of Certified EHR Technology**
- VII. Additional Anesthesia Data Sources Should be Used to Evaluate Interoperability**
- I. CRNAs Provide Safe, High Quality and Cost Effective Healthcare**

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and

student registered nurse anesthetists (SRNAs). AANA membership includes more than 52,000 CRNAs and SRNAs, representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer approximately 43 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services are in high demand. CRNAs are Medicare Part B providers and since 1989 have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNAs are involved in every aspect of anesthesia services including a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute, chronic, and interventional pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons. CRNAs play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals and affording these facilities the capability to provide many necessary procedures.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal *Nursing Economic\$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.¹ An August 2010 study published in *Health Affairs* showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.² Researchers studying anesthesia safety found no differences in care

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

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.pdf>

between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration, the internationally recognized authority on evidence-based practice in healthcare.³ Most recently, a study published in *Medical Care* (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.⁴

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

The AANA is supportive of telehealth and remote monitoring technology that improves the quality of care provided for all patients. We caution the agency against the use of wasteful telehealth services that increase costs without improving healthcare access or quality. Specifically, we oppose policies that allow anesthesiologists to be reimbursed without providing actual anesthesia care, through billing for remote supervision services. This type of remote supervision would not improve access to healthcare for patients with chronic conditions and would instead reward providers not actually furnishing healthcare services. Furthermore, there is no evidence of a benefit for the use of supervision of anesthesia via telehealth.⁵ Therefore, we ask that the use wasteful anesthesiologist tele-supervision of CRNA services is prohibited in the future strategies the agency plans to help reform, strengthen, and modernize the Nation's health care system.

AANA Recommendation: Reducing Regulatory Barriers for CRNAs Increases Access to Anesthesia Care in Rural Communities

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, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities, it vital that the agency should promote access to the use of CRNA anesthesia services in rural America. Furthermore, the

³ Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database of Systematic Reviews* 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract>

⁴ Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. *Medical Care* June 2016, http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

⁵ See: Applegate RL, 2nd, Gildea B, Patchin R, et al. Telemedicine pre-anesthesia evaluation: a randomized pilot trial. *Telemed J E H ealth*. 2013;19:211-6; Cone SW, Gehr L, Hummel R, Merrell RC. Remote anesthetic monitoring using satellite telecommunications and the Internet. *Anesthesia and analgesia*. 2006;102(5):1463-1467; Dilisio RP, Dilisio AJ, Weiner MM. Preoperative virtual screening examination of the airway. *J Clin Anesth*. 2014;26:315-7; and Galvez JA, Rehman MA. Telemedicine in anesthesia: an update. *Curr Opin Anaesthesiol*. 2011;24:459-62.

agency should ensure that future policy does 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. Nurse anesthetists are experienced and highly trained anesthesia professionals who provide high-quality patient care, which has been proven through decades of scientific research. CRNAs play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures.

The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.⁶ The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.⁷ CRNAs play an essential role in assuring that rural America has access to critical anesthesia services and by removing regulatory barriers to CRNA practice and allowing CRNAs to practice to the full extent of their scope, licensure and training, patients in rural areas will receive consistently safe and high quality care delivery.

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

As many APMs would involve anesthesia delivery, and as CRNAs are an eligible clinician under the MIPS program, we believe that ONC has an interest in increasing access to and promoting high-quality, cost-effective anesthesia care. As the agency contemplates next steps regarding interoperability, the agency should consider how best to ensure that they are capturing cost effective anesthesia care. Anesthesia professionals work as members of the patient's interprofessional team in all practice settings and all staffing models of anesthesia delivery are equally safe according to extensive published research as noted above. The most cost-effective safe anesthesia care delivery model is the CRNA non-medically directed model, and we recommend that the agency arrange the components within the MIPS system and APMs to promote high quality, affordable care models.

⁶ Liao CJ, Quraishi JA, Jordan, LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270.

<http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx>

⁷ Liao, op cit.

In demonstrating the costs of various modes of anesthesia delivery, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by an anesthesia care team where a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia delivered by an anesthesia care team where CRNA medically directed at a 2:1 ratio; and (d) has anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, \$170,000 for the CRNA⁸ and \$540,314 for the anesthesiologist⁹. Under the Medicare program, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable.

However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost to staff the practice modality (a) equals \$170,000 per year. For case (b), it is (\$170,000 + (0.25 x \$540,314) or \$305,079 per year. For case (c) it is (\$170,000 + (0.50 x \$540,314) or \$440,157 per year. Finally, for case (d), the annualized cost equals \$540,314 per year.

Anesthesia Payment Model	FTEs / Case	Clinician costs per year / FTE
(a) CRNA Nonmedically Directed	1.00	\$170,000
(b) Medical Direction 1:4	1.25	\$305,079
(c) Medical Direction 1:2	1.50	\$440,157
(d) Anesthesiologist Only	1.00	\$540,314
<i>Anesthesiologist mean annual pay</i>	<i>\$540,314</i>	<i>MGMA, 2014</i>
<i>CRNA mean annual pay</i>	<i>\$170,000</i>	<i>AANA, 2014</i>

With CRNAs providing over 40 million anesthetics in the U.S., and a considerable fraction of them being “medically directed,” the additional costs of this medical direction service are substantial. In addition, the most recent peer-reviewed literature makes clear that the requirements of anesthesiologist medical direction are often not met in practice— and if anesthesiologists submit claims to Medicare or Medicaid for medical direction but did not perform all of the required services in each instance, then

⁸ AANA member survey, 2014

⁹ MGMA Physician Compensation and Production Survey, 2014. www.mgma.com

the likelihood of widespread Medicare and Medicaid fraud in this area is high. Lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs, according to a 2012 study published in the journal *Anesthesiology*,¹⁰ the professional journal of the American Society of Anesthesiologists. The authors reviewed over 15,000 anesthesia records in one leading U.S. hospital, and found supervision lapses in 50 percent of the cases involving anesthesiologist supervision of two concurrent CRNA cases, and in more than 90 percent of cases involving anesthesiologist supervision of three concurrent CRNA cases.

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

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

We offer the following recommendations regarding interoperability and communication of patient information across technology platforms in the realm of anesthesia. For anesthesia measures, we recommend that interoperability of EHRs and other information systems should communicate across the continuum of patient care. Disparate information systems should interface between offices, clinics, hospitals, and pharmacy platforms to communicate across the patient's experience to increase patient safety, improve outcomes and decrease cost of care.

We also recommend that EHR systems should include standardized taxonomy and fields and require providers to use these across various platforms to optimize communication of care and interoperability. In the major anesthesia information management systems, some standardized taxonomies are present; however, valuable patient specific information is entered as free text or in unstructured data hindering

¹⁰ 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.

data sharing and communication, in addition to making this information difficult to extract for quality reporting without manually reading the fields.

AANA Recommendation: The Focus of Measurement of Exchange and Use of Interoperability Should Not Be Limited to Only Use of Certified EHR Technology

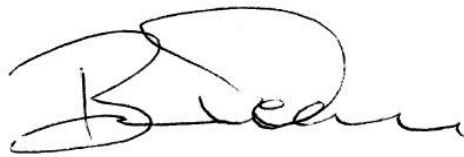
In order to establish metrics that will assess the extent to which widespread exchange of health information through interoperable certified EHR technology nationwide has occurred, FCC needs to first define the scope of measurement. The AANA believes that the measurement of EHR interoperability is limited if the focus of this measurement is restricted only to use of certified EHR technology. Smaller facilities and anesthesia groups may not have the funds and resources necessary to participate in use of a certified, comprehensive EHR, but may purchase a standalone AIMS that is added to the facility EHR. If the agency's goal is to measure true interoperability, and if smaller EHR companies can construct an AIMS that is affordable for use by smaller provider groups, then these groups should be included in this measurement. Furthermore, use of non-certified EHRs in measurement of interoperable EHR technology will also encourage innovation in this field because having to get certified first will limit many programmers who are experimenting with novel methods of handling and accessing EHR data.

AANA Recommendation: Additional Anesthesia Data Sources Should be Used to Evaluate Interoperability

As stated above, CRNAs in some settings have continued to document on paper or used paper/EHR to document care because they have not been eligible for incentive payments for the adoption and meaningful use of certified EHR technology. As a result, electronic capture of point of care patient information is very difficult to collect. The AANA supports collection of meaningful data through interoperability across all patient care experiences to provide access to a complete and comprehensive healthcare record to improve patient satisfaction, outcomes and affordability of care. Not only would this data be used to provide care, but also to analyze care processes to continually improve outcomes. In evaluating the interoperability of systems across the patient care experience, we recommend development and participation in team and composite measures such as sharing patient health and medication history, communication of encounter information, and decrease in repeat diagnostic testing. Though we only have anecdotal information, sharing of information across platforms is currently very limited and hybrid paper and electronic records are used in many rural, ASC, clinic, and office practice locations.

The AANA appreciates this opportunity to comment on this proposed rule. CRNAs are vital to resolving the challenges facing our nation's healthcare system and we look forward to partnering with the agency to show the important role CRNAs can have in achieving the main goals of meaningful reform, reducing health care costs, and improving access to the highest quality healthcare. Should you have any questions, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202-741-9080 or rkohl@aanadc.com.

Sincerely,

A handwritten signature in black ink, appearing to read "B. Weiner", with a large, stylized initial "B" and a long, sweeping underline.

Bruce A. Weiner, DNP, MSNA, CRNA
AANA President

Cc: Randall Moore II, DNP, MBA, CRNA, AANA CEO
Ralph Kohl, AANA Senior Director of Federal Government Affairs
Randi Gold, MPP, AANA Associate Director Federal Regulatory and Payment Policy