



February 16, 2015

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. P13-1207**

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. Attachments are provided separately.

The AANA provides statements in the following areas:

- I. Background of the AANA and Certified Registered Nurse Anesthetists (CRNAs)**
- II. Alternatives to Traditional Fee-for-Service Payment Models**
- III. Provider Network and Benefit Design**

**I. BACKGROUND OF THE AANA AND CRNAs**

The AANA is the professional association for CRNAs and student nurse anesthetists. AANA membership includes more than 48,000 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.<sup>1</sup> 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.<sup>2</sup> Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of

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<sup>1</sup> 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](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf)

<sup>2</sup> 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>

research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.<sup>3</sup>

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.<sup>4</sup> 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.<sup>5</sup>

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.<sup>6</sup>

## II. ALTERNATIVES TO TRADITIONAL FEE-FOR-SERVICE PAYMENT MODEL

The AANA supports the FTC's efforts to better understand the potential benefits of alternative payment models and whether they can offer significant cost savings while maintaining, or

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<sup>3</sup> 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.

<sup>4</sup> 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>

<sup>5</sup> 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](http://practice.sph.umich.edu/practice/files/cephw/PDFs/Cromwell_1991.pdf) .

<sup>6</sup> Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. [http://books.nap.edu/openbook.php?record\\_id=12956&page=R1](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> .

helping to improve, quality of care. The information in this section will address the Federal Trade Commission's (FTC) questions regarding alternatives to traditional fee-for-service payment models.

Under the current fee-for-service model, there are instances where the current model contributes to high costs without improving quality. 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. It also includes a system for "anesthesiologist medical direction"<sup>7</sup> 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.<sup>8</sup> Furthermore, 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.<sup>9</sup>

In demonstrating the increased costs, 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 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

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<sup>7</sup> 42 CFR §415.110. <http://www.gpo.gov/fdsys/pkg/CFR-2003-title42-vol2/pdf/CFR-2003-title42-vol2-sec415-130.pdf>

<sup>8</sup> 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](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf)

<sup>9</sup> 63 FR 58813, November 2, 1998, <http://www.gpo.gov/fdsys/pkg/FR-1998-11-02/pdf/98-29181.pdf>.

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 CRNA<sup>10</sup> and \$540,314 for the anesthesiologist<sup>11</sup>. 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 \$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.

<b>Anesthesia Payment Model</b>	<b>FTEs / Case</b>	<b>Clinician costs per year / FTE</b>
(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>

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 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

<sup>10</sup> AANA member survey, 2014

<sup>11</sup> MGMA Physician Compensation and Production Survey, 2014. [www.mgma.com](http://www.mgma.com)

makes clear that the requirements of anesthesiologist medical direction are often not met in practice— 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*.<sup>12</sup>

Another factor driving up the cost of healthcare under the current fee-for-service model 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,<sup>13</sup> 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 pays an average of \$3.2 million in anesthesiology subsidy. Such payments from hospitals to anesthesiology groups do not appear on hospitals' Medicare cost reports or their billings to health plans, making information about them hard to come by except from survey information. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing. Without question, such subsidy payments to anesthesiology groups represent cost-shifting away from other critical services within the healthcare delivery system.

As the FTC examines the merits of alternative payment systems, we recommend ensuring that these alternatives are in the best interests of the patients receiving care, that they encourage improvements in patient care quality and efficiency, and that the alternative payment systems have been developed and deployed in a manner that healthcare professionals deem as valid.

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<sup>12</sup> 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](http://journals.lww.com/anesthesiology/Fulltext/2012/03000/Influence_of_Supervision_Ratios_by.29.aspx)

<sup>13</sup> Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012. <http://drivinghp.com/consulting/2012-anesthesia-subsidy-survey-report-now-available/>

Alternative payment systems should recognize and reward all qualified healthcare providers, not just physicians, for ensuring patient access to safe, cost-effective healthcare services. Bundled payment systems can reward care coordination and cost-efficiency, but without an equal and crucial focus on quality such systems can lead to a harmful “race to the bottom” when incentives to cut costs are not balanced with quality standards – an outcome that must be avoided. Bundled payment systems should recognize the full range of qualified healthcare providers delivering care, including CRNAs and other APRNs, and avoid physician-centricity that increases costs without improving quality or access.

Alternative payment models, such as bundled payment, have the potential to drive value-based healthcare delivery, particularly in anesthesia care and related services, and meet the triple health care aims of improving patient experience of care, improving population health and reducing health care costs. But certain alternative payment models do not follow these goals and instead lead to higher healthcare costs and decreased access to safe, high quality anesthesia providers such as CRNAs. One type of payment model that does not drive value-based healthcare delivery can be found in large group practices composed solely of anesthesiologists. Holding substantial market power, these large anesthesiologist-only group practices enter into exclusive single source contract service agreements with health systems, facilities and surgeons where the group practice’s market power increases costs, limits choice of anesthesia provider, and imposes opportunity costs that deprive resources from delivery of other critical healthcare services. Such enterprises may use their market power to maximize their income without relation to the actual costs of performing the procedure.<sup>14</sup> For example, according to the New York Times, a patient was billed \$8,675 for anesthesia during cardiac surgery. The anesthesia group accepted \$6,970 from United Healthcare, \$5,208.01 from Blue Cross and Blue Shield, \$1,605.29 from Medicare

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<sup>14</sup> 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](http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html?_r=0)

and \$797.50 from Medicaid.<sup>15</sup> This type of model drives up healthcare costs and puts additional economic strain on consumers and the country.

### **III. PROVIDER NETWORK AND BENEFIT DESIGN**

The AANA thanks the Federal Trade Commission (FTC) for requesting comments on recent developments in health plan provider networks which limit the number of providers in a network. The information in this section will address the FTC's questions regarding this issue as well as questions regarding the types of provider-payer contracting practices that may limit the implementation of different types of network design strategies. We have found that in some states, health plan networks operating in exchanges and in the private market conduct discriminatory behaviors based on provider licensure which violates the provider nondiscrimination provision in the Affordable Care Act and inhibits CRNAs' ability to practice to full extent of their scope of practice. The end result of these practices is increased healthcare costs, diminished competition and reduced patient choice for safe, high quality and cost-effective anesthesia and related services.

The federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5),<sup>16</sup> which took effect January 1, 2014, states 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

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<sup>15</sup> Ibid.

<sup>16</sup> Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.--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 healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law." It also states that "nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

Section 2706 is an important law because it promotes competition, consumer choice and high quality healthcare by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote patient access to high quality healthcare, market competition and cost efficiency, health insurance exchanges, health insurers and health plans must avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure -- by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, for example -- patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition.

The provider nondiscrimination provision also respects local control and autonomy in the organization of healthcare delivery systems, health plans and benefits. It does not impose "any willing provider" requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.

#### *Types and Examples of Provider Discrimination*

**The AANA believes it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure.** Medicare reimburses CRNAs directly for their services and does so

at 100 percent of the physician fee schedule amount for services, the same rate as physicians for the same services. The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorized direct reimbursement of CRNA services under Medicare Part B beginning in 1989.<sup>17</sup> The Medicare regulation implementing the OBRA law, updated as part of a November 2012 final rule further clarifying the authorization of direct reimbursement of nurse anesthesia services within the provider's state scope of practice,<sup>18</sup> states, "Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist who is legally authorized to perform the services by the State in which the services are furnished."<sup>19</sup> The final rule also states, "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." The agency also said in the rule's preamble, "In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states."<sup>20</sup> Therefore, the Medicare agency stands on solid ground in clarifying that the nondiscrimination provision should apply to private plans in a way that is consistent with Medicare direct reimbursement of CRNA services where they are allowed to furnish those services under state law.

Unfortunately, we have heard from our members who state that certain health plans and insurers across the United States have policies that discriminate against CRNAs. In many of these cases, health plans or insurers either do not reimburse CRNAs at all for anesthesia services that are fully reimbursed when performed by anesthesiologists, or they reimburse CRNAs at a lower rate than anesthesiologists for performing the same services. For example, effective November 1, 2013, Regence Blue Shield of Idaho lowered CRNA reimbursement by 15 percent for anesthesia services. Its new policy states, "Physician conversion factor is \$55.10. Certified Registered Nurse Anesthetist conversion factor is \$46.84."<sup>21</sup> When justifying its rationale for setting the reimbursement rates for all non-physician healthcare providers, including CRNAs, at 85 percent

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<sup>17</sup> Pub.L. 99-509 (42 U.S.C. § 1395 l(a)(1)(H), 42 U.S.C. § 1395 x(s)(11)).

<sup>18</sup> 77 Fed. Reg. 68892 (November 16, 2013).

<sup>19</sup> 42 C.F.R. § 410.69(a).

<sup>20</sup> *Ibid.*

<sup>21</sup> Regence Blue Shield of Idaho Professional Fee Schedule 2013 Supplemental Information:  
<http://www.assets.regence.com/idreg/library/docs/2013-11-01/supplemental-information.pdf>

of the physician rate, Regence stated in a letter to a CRNA that the decision was in part “based on the difference in education, training and scope of practice” between physician and non-physician providers. Regence did not identify any differences in “quality or performance measures” to explain the reimbursement differential. As we have shown above, the literature is clear in showing that no quality outcomes difference can be found between the models of CRNA anesthesia care, anesthesiologist services, or both professionals providing anesthesia care together.

We believe that this is an example of clearly prohibited provider discrimination, because the coverage differentials are so evidently based on the difference in licensure between CRNAs and anesthesiologists and have no relation to “quality or performance measures.” As recognized by the Institute of Medicine, studies reflect that there is no quality or performance difference between anesthesia services provided by CRNAs or anesthesiologists. Paying one qualified provider type a higher rate than another for providing the same high quality service creates a significant risk of unnecessarily increasing healthcare costs without improving healthcare quality or access. Quality of anesthesia care is high and continually improving, and patient outcomes by provider type are similarly excellent as measured by the published research we have already shown. The choice of discriminating in coverage or reimbursement against qualified licensed providers solely on the basis of licensure therefore leads to impaired access, increased costs and lower quality of care.

**If a health plan or health insurer network offers a specific covered service, Section 2706 requires that the health insurer or health plan network include all types of qualified licensed providers who can offer that service.** If a health plan offers coverage for anesthesia services, it should allow all anesthesia provider types to participate in their networks and should not refuse to contract with CRNAs just based on their licensure alone. For example, as of April 2012, Blue Cross Blue Shield of South Carolina states in its anesthesia guidelines policy manual that it will not reimburse CRNAs for monitored anesthesia care (MAC), but it will pay

anesthesiologists for these same services.<sup>22</sup> Specifically the policy states, “BlueCross may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. BlueCross will not reimburse CRNAs for MAC.”<sup>23</sup>

The AANA views all of these policies outlined above as examples of discrimination against CRNAs based on their licensure and not based on CRNA quality and performance, and such discrimination clearly is prohibited by Section 2706. These policies impair patient access to care provided by CRNAs, and they expressly impair competition and choice, and contribute to unjustifiably higher healthcare costs without improving quality or access to care. The negative impacts of provider discrimination can 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 otherwise might be forced to travel long distances for these essential care. As stated above, CRNAs have been providing safe and high-quality anesthesia care in the United States for 150 years and the AANA is a determined advocate for patients and CRNAs concerning issues such as access to quality healthcare services and patient safety.

We believe proper implementation of the provider nondiscrimination provision by preventing health plans and health insurers from discriminating against specific types of health providers, such as CRNAs, will ensure full access to anesthesia services and to the procedures and services that they make possible, efficient delivery and local management and optimization of these services, and equitable reimbursement for CRNA services based on quality and performance, rather than licensure. This is consistent with the FTC’s and the public’s interests in quality, access and cost-effectiveness. Ensuring that health plans and health insurers adhere to the provider nondiscrimination law will protect competition and patient choice and promote patient

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<sup>22</sup> Blue Cross Blue Shield of South Carolina Anesthesia Guidelines:  
[http://web.southcarolinablues.com/UserFiles/scblues/Documents/Providers/Anesthesia%20Guidelines\\_2012.pdf](http://web.southcarolinablues.com/UserFiles/scblues/Documents/Providers/Anesthesia%20Guidelines_2012.pdf)

<sup>23</sup> Ibid.

access to a range of beneficial, safe, and cost-efficient healthcare services, such as those provided by CRNAs.

We thank you for the opportunity to comment on this proposed notice of public workshop. 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](mailto:fpurcell@aanadc.com).

Sincerely,



Sharon P. Pearce, CRNA, MSN  
AANA President

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. Cochrane Review executive summary: “Physician anaesthetists versus nurse anaesthetists for surgical patients”
5. Institute of Medicine summary: The Future of Nursing – Leading Change, Advancing Health
6. Institute of Medicine summary: Relieving Pain in America
7. 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  
Romy Gelb- Zimmer, MPP, AANA Associate Director Federal Regulatory and Payment Policy