October 16, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-5524-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD  21244

RE: CMS-5524-P – Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model; Proposed Rule (82 Fed.Reg. 39310, August 17, 2017)

Dear Ms. Verma:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on this proposed rule; Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model; (82 Fed.Reg. 39310, August 17, 2017). The AANA makes the following comments and requests of CMS:

- CMS Should Advise and Recommend that Hospitals Treat APRNs, Such as CRNAs, and Physicians Equally When Participating in the CJR Program
- Conditions and Restrictions Under the CJR Program Should Encourage the Strategic Use of Anesthesia Services
- Ensure that CJR Collaborator Participation in a CJR Sharing Arrangement Remain Voluntary and Without Penalty for Nonparticipation
- Preclude Instituting Risky Policies that Drive Up Healthcare Costs
- Prohibit Wasteful Tele-Supervision of CRNA Services in the CJR Program
Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, and AANA membership includes more than 50,000 CRNAs and student nurse anesthetists (SRNAs) representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 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 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.

CRNA provide every aspect of the delivery of anesthesia services including 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 and chronic 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. 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 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 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

1 Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economic$. 2010; 28:159-169.
prepared by the Cochrane Collaboration.\textsuperscript{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.\textsuperscript{4}

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.\textsuperscript{5} 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.\textsuperscript{6}

**AANA Request: CMS Should Advise and Recommend that Hospitals Treat APRNs, Such as CRNAs, and Physicians Equally when Participating in the CJR Program**

We appreciate that the Centers for Medicare & Medicaid Services’ (CMS) existing regulation for the Comprehensive Care for Joint Replacement (CJR) model acknowledges the role of all providers, including APRNs such as CRNAs, as CJR collaborators. CRNAs play an important role in cases involving hip and knee procedures in the delivery of anesthesia and post-operative pain management services. Furthermore, CRNAs practice with a high degree of autonomy and

\begin{itemize}
  \item \textsuperscript{4} Negusa 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, \url{http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx}.
  \item \textsuperscript{5} 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. \url{http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx}
  \item \textsuperscript{6} Liao, op cit.
\end{itemize}
provide approximately 43 million anesthetics per year. Since anesthesia care and related services have the potential to drive value-based healthcare delivery, we recognize that CRNA services used within the CJR model can meet the triple aims of improving patient experience of care, improving population health and reducing healthcare costs.

Given that joint replacements incorporate anesthesia services, the AANA encourages that the CJR payment model continue to 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. Payment should recognize and account for the qualified healthcare professionals who delivered care to the patient, in part so that the healthcare professionals themselves can be held accountable.

Therefore, we request that CMS advise hospitals participating in this payment model to treat physicians and APRNs equally. Moreover, we also request that this same equality be extended to groups made up solely of practitioners other than physicians. As CMS requires the CJR program collaborator agreements to be in compliance with all Medicare provider enrollment requirements including having an active NPI and TIN, we remind CMS that groups made up solely of practitioners other than physicians, including those made up entirely of CRNAs, would meet this requirement as these groups would be defined as group practices under a TIN.

Furthermore, we request that CMS monitor all collaborator agreements so that participant hospitals and their CJR collaborators, such as physician group practices, do not limit or restrict access to CRNA services through hospital bylaws and credentialing committees by discriminating against one provider type in preference for another. Discriminatory practices embedded in hospital bylaws and credentialing processes may limit patient choice and healthy competition and increase healthcare costs without improving quality, to the detriment of patients and the Medicare program, and should be discouraged by CMS.

**AANA Request: Conditions and Restrictions Under the CJR Program Should Encourage the Strategic Use of Anesthesia Services**

As CRNAs personally administer more than 43 million anesthetics to patients each year in the United States, including anesthesia for hip and knee procedures, the AANA understands that
CRNA services would have a major role in the CJR payment model. Anesthesia professionals, such as CRNAs, can play an integral role in these episodes of care as proper anesthesia services management can improve patient flow, advance patient safety, and ultimately yield cost savings. Conversely, research shows that suboptimal care in the preoperative, intraoperative, or postoperative phases of surgery may compromise care, resulting in poor patient outcomes that increase healthcare costs. Though anesthesia is a relatively small portion of the variable costs associated with procedures covered by the CJR program, we urge that the program emphasize the strategic consideration of the role of anesthesia delivery that is safe and cost-efficient in itself and encourages the use of techniques such as Enhanced Recovery After Surgery (ERAS) programs, which help reduce costs and improve patients outcomes.

Furthermore, we recommend that CMS promote cost-efficient anesthesia delivery models in the CJR program. CMS should not institute any policy or requirement in this payment model that would result in different payment for the anesthesia service when furnished by a CRNA, an anesthesiologist, or both working together, except in the instance of medical necessity for more than one anesthesia professional in a case. In order to promote patient access to safe and cost-efficient healthcare delivery, CMS should prohibit any signed participation agreement for a CJR sharing arrangement from requiring anesthesiologist medical direction of CRNA anesthesia services, or requiring physician supervision of CRNAs.

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AANA Request: Ensure that CJR Collaborator Participation in a CJR Sharing Arrangement Remain Voluntary and Without Penalty for Nonparticipation

As CMS is proposing to reduce mandatory participation to 34 metropolitan statistical areas (MSAs) for the CJR model, we urge that sharing arrangements continue to remain voluntary and without penalty for nonparticipation. Anesthesia professionals, such as CRNAs, can play an integral role in these episodes of care as proper anesthesia services management can improve patient flow, advance patient safety, and ultimately yield cost savings. Yet, anesthesia professionals are considered a non-patient facing provider specialty whose contact, relationship and services furnished to a patient is usually limited to the perioperative window including the inpatient stay. Furthermore, CRNAs do not select their patients or the surgical procedures. Therefore, we recommend that anesthesia groups and anesthesia providers should continue to have their CJR sharing arrangements voluntary and without penalty for nonparticipation.

AANA Request: Preclude Instituting Risky Policies that Drive Up Healthcare Costs

While the AANA emphasizes the important role of anesthesia in the CJR program, CMS would be wise to preclude instituting risky policies that may drive up healthcare costs to a facility and to patients while also decreasing access to safe, high-quality anesthesia providers, such as CRNAs. For instance, the use of certain large group practices, such as those comprised solely of anesthesiologists, promotes higher cost models of anesthesia delivery and may not demonstrate sufficient patient-centeredness. Furthermore, evidence indicates that such large group practices have engaged in anticompetitive practices. Holding substantial market power, large anesthesiologist-only group practices have entered 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. 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 and $797.50 from Medicaid. Providing large anesthesiologist-only single-source anesthesia services groups with too much leverage drives up healthcare costs and puts additional economic strain on consumers without improving healthcare quality. Such arrangements should be discouraged by CMS in this program.

**AANA Request: Prohibit Wasteful Tele-Supervision of CRNA Services in the CJR Program**

The AANA is supportive of telehealth and remote monitoring technology that improves the quality of care provided for all patients. As CMS proposes to make adjustments to the pricing calculation for the CJR telehealth HCPCS codes, we caution CMS 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. Therefore, we ask that CMS prohibit wasteful anesthesiologist tele-supervision of CRNA services in the CJR program.

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12 Ibid.

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

Sincerely,

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

cc: Randall D. Moore, DNP, MBA, CRNA, AANA Chief Executive Officer
Ralph Kohl, AANA Senior Director of Federal Government Affairs
Romy Gelb-Zimmer, MPP, AANA Associate Director Federal Regulatory and Payment Policy