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Submitted via email at DPC@cms.hhs.gov

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Dear Mr. Boehler:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on this Request for Information on Direct Provider Contracting Models. The AANA is submitting comments in the following areas asked for review:

- What features should CMS require practices to demonstrate in order for practices to be able to participate in a DPC model (e.g., use of certified EHR technology, certain organizational structure requirements, certain safeguards to ensure beneficiaries receive high quality and necessary care, minimum percent of revenue in similar arrangements, experience with patient enrollment, staffing and staff competencies, level of risk assumption, repayment/reserve requirements)? Should these features or requirements vary for those practices that are already part of similar arrangements with other payers versus those that are new to such arrangements? If so, please provide specific examples of features or requirements CMS should include in a DPC model and, if applicable, for which practice types.

I. DPC Models Should Be Designed to Ensure Equal Treatment of CRNAs and APRNs

II. A DPC Model Should be Designed to Incentivize the Strategic Use of Anesthesia Services and Opioid Sparing Techniques When Anesthesia is Involved

III. CMS Should Require that DPC Models Promote Full Scope of Practice and Remove Barriers to Care
Background of the AANA and CRNAs

The AANA is the professional association for CRNAs and student nurse anesthetists, and AANA membership includes more than 52,000 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.\(^3\) 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.\(^4\)

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.\(^5\) 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.\(^6\)

- **What features should CMS require practices to demonstrate in order for practices to be able to participate in a DPC model (e.g., use of certified EHR technology, certain organizational structure requirements, certain safeguards to ensure beneficiaries receive high quality and necessary care, minimum percent of revenue in similar arrangements, experience with patient enrollment, staffing and staff competencies, level of risk assumption, repayment/reserve requirement(s))? Should these features or requirements vary for those practices that are already part of similar arrangements with other payers versus those that are new to such arrangements? If so, please provide specific examples of features or requirements CMS should include in a DPC model and, if applicable, for which practice types.**

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\(^6\) Liao, op cit.
I. **DPC Models Should Be Designed to Ensure Equal Treatment of CRNAs and APRNs**

The AANA urges the Centers for Medicare & Medicaid Services (CMS) to ensure that CRNAs and other APRNs are treated equally with physicians in Direct Provider Contracting (DPC) models. These healthcare providers are core to improved access to high quality, cost-effective care. Furthermore, the National Academy of Medicine (NAM) recommends that government policy expand opportunities for nurses to lead collaborative healthcare improvement efforts, and prepare and enable nurses to lead changes that advance health.\(^7\) Increasingly, the healthcare industry is recognizing APRNs for their leadership role in clinical, educational and academic, executive, board, legislative, and regulatory domains. In addition to their roles as expert healthcare professionals, APRNs are CEOs of hospitals and health systems, chief nursing officers, chairs of regulatory bodies and advisory committees, and have taken many other positions with wide spans of responsibility. Ensuring equal treatment of APRNs and physicians with a DPC will also help achieve our common goals of promoting choice and competition, increasing access to the highest quality healthcare, reducing regulatory burdens on providers, and making healthcare more affordable for all Americans.

II. **A DPC Model Should be Designed to Incentivize the Strategic Use of Anesthesia Services and Opioid Sparing Techniques When Anesthesia is Involved**

CRNAs personally administer more than 43 million anesthetics to patients each year in the United States, and anesthesia has a critical role in outcome on optimization for population health. Because of this, we believe the CMS Innovation Center should design DPC models to incentivize the strategic use of anesthesia services when anesthesia is involved. CRNAs play an integral role in care that involve anesthesia as proper anesthesia services management can

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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. Furthermore, the AANA is aware of the increasing opioid drug crisis and believes that CRNAs can play a key role in the process of working toward solutions to curb this epidemic. Use of techniques such as Enhanced Recovery After Surgery (ERAS) programs that decrease or eliminate the need for opioids have been shown to help reduce costs and improve patients outcomes. For example, for surgical pain, using specific protocol-driven ERAS pathways improves patient outcomes by reducing the patient’s stress response to surgery, shortening the overall hospital length of stay, and accelerating the return to normal daily function. The patient’s pain management plan of care begins pre-procedure and continues through post-discharge using opioid-sparing techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures.

III. CMS Should Require that DPC Models Promote Full Scope of Practice and Removes Barriers to Care

CMS should require that DPC models encourage APRNs, including CRNAs, to practice to their full professional education, skills, and scope of practice. Our policy recommendation

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corresponds with a recommendation from the NAM’s report titled *The Future of Nursing: Leading Change, Advancing Health*, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs, including CRNAs. The NAM report specifically recommends that, “advanced practice registered nurses should be able to practice to the full extent of their education and training.”

Furthermore, DPC models should encourage, and not limit, the use of these medically necessary CRNA pain management services. Leading physician subspecialty organizations in pain management research, practice guideline development, and education are known to use economic and advocacy means to exclude other members of the pain management team, such as CRNAs, from educational and practice opportunities, thereby limiting patient access to care, diagnosis, treatment, and ultimately improved patient quality of life. A report issued in April 2015 by the Federal Trade Commission (FTC), “Competition and the Regulation of Advanced Practice Registered Nurses,” underscores the point that for CRNAs and other APRNs, “even well intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition.” Therefore, we recommend that the Innovation Center be cognizant of these barriers and require that future DPC models do not limit a CRNA’s ability to provide comprehensive pain management care. In the interest of patients and the public, the education, regulation, and reimbursement of each member of the pain management team should allow the team to practice to the full extent of their education and training.

We also recommend that CMS ensure that DPC models not impose unnecessary physician supervision requirements. Removing unnecessary supervision requirements is consistent with

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12 NAM op. cit. p. 69.
13 NAM op. cit. p. 7-8.
15 See 42 CFR §§ 482.52, 485.639, 416.42.
Medicare policy reimbursing CRNA services in alignment with their state scope of practice,\textsuperscript{16} and with NAM’s recommendation, “Advanced practice registered nurses should be able to practice to the full extent of their education and training.”\textsuperscript{17}

There is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality, and may restrict access and increase cost. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a 2010 study published in \textit{Health Affairs}\textsuperscript{18} led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 17 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. In reviewing the study, the \textit{New York Times} stated, “In the long run, there could also be savings to the health care system if nurses delivered more of the care.”\textsuperscript{19} 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{20}

CRNA safety in anesthesia is further evidenced by the significant decrease in liability premiums witnessed in recent decades. In 2015, self-employed CRNAs paid 33 percent less for malpractice premiums nationwide when compared to the average cost in 1988. When adjusted for inflation through 2015, the reduction in CRNA liability premiums is an astounding 65 percent less than approximately 25 years ago according to Anesthesia Insurance Services, Inc. According to a May/June 2010 study published in the journal of \textit{Nursing Economic$}, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery

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\textsuperscript{17} NAM op. cit. 3-13 (pdf 108).
\textsuperscript{18} Dulisse, op. cit.
\textsuperscript{20} Negrusa B et al. op. cit.
\end{flushright}
without any measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.\textsuperscript{21}

The evidence also demonstrates that the supervision requirement is costly. Though Medicare requires supervision of CRNAs (except in opt-out states) by an operating practitioner or by an anesthesiologist who is immediately available if needed, hospitals and healthcare facilities often misinterpret this requirement to be a quality standard rather than a condition of participation. The AANA receives reports from the field that anesthesiologists suggest erroneously that supervision is some type of quality standard, an assertion bearing potential financial benefit for anesthesiologists marketing their medical direction services as a way to comply with the supervision condition of participation. When this ideology is established, anesthesiologist supervision adds substantial costs to healthcare by requiring duplication of services where none is necessary. Further, the Medicare agency has clearly stated that medical direction is a condition for payment of anesthesiologist services and not a quality standard.\textsuperscript{22} But there are even bigger costs involved if the hospital administrator believes that CRNAs are required to have anesthesiologist supervision.

According to a nationwide survey of anesthesiology group subsidies,\textsuperscript{23} 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 hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

There is strong evidence in the literature that anesthesiologist supervision fails to comply with federal requirements, either the Part A conditions of participation or Part B conditions for

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  \item Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” \textit{Nursing Economics}. 2010; 28:159-169.
  \item 63 FR 58813, November 2, 1998.
\end{itemize}
coverage. 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*,24 the professional journal of the American Society of Anesthesiologists. This is consistent with over ten years of AANA membership survey data. Moreover, the American Society of Anesthesiologists ASA *Relative Value Guide 2013* newly suggests loosening further the requirements that anesthesiologists must meet to be “immediately available,” stating that it is “impossible to define a specific time or distance for physical proximity.” This newer ASA *Relative Value Guide* definition marginalizes any relationship that the “supervisor” has with the patient and is inconsistent with the Medicare CoPs and CfCs, and with the Medicare interpretive guidelines for those conditions, which require anesthesiologists claiming to fulfill the role of “supervising” CRNA services be physically present in the operating room or suite.

If a regulatory requirement is meaningless in practice, contributes to greater healthcare costs, and is contrary to existing evidence regarding patient safety and access to care, it should not be included. Therefore, we recommend that CMS ensure that DPC models not impose unnecessary physician supervision requirements.

We thank you for the opportunity to comment on this request for information. We would be happy to serve as a resource to the CMS Innovation Center on further development of these models. 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,

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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 Senior Associate Director Federal Regulatory and Payment Policy