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Electronic Submission via HealthyChildrenandYouth@cms.hhs.gov

Patrick Conway, MD, MSc
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

RE: Request for Information on Pediatric Alternative Payment Model Concepts

Dear Dr. Conway:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the Request for Information on Pediatric Alternative Payment Model Concepts. The issues addressed in our comment are outlined as follows:

I. Background of the AANA and CRNAs

II. CMS Should Support Innovative Cost-Effective Models in Healthcare Delivery such as Non-medically Directed Anesthesia Services Performed by CRNAs

III. Encourage the Strategic Use of Anesthesia Services in the Development of New Pediatric Healthcare Payment Models

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

V. The Focus of Measurement of Interoperability Should Not Be Limited to Only Use of Certified EHR Technology

I. Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 50,000 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.

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*,$^1$ 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

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](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf)
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 prepared by the Cochrane Collaboration, the internationally recognized authority on evidence-based practice in healthcare. 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.

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. 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. 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 United States, 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.

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6 Liao, op cit.
AANA Comment: CMS Should Support Innovative Cost-Effective Models in Healthcare Delivery such as Non-medically Directed Anesthesia Services Performed by CRNAs

The AANA supports the aim of this alternative payment model which is to facilitate strategies for timely and appropriate delivery of family-centered, community-based, linguistically and culturally appropriate, cost-effective, and integrated services to all children and youth covered by Medicaid and CHIP. Alternative payment models have the potential to drive value-based healthcare delivery, particularly in anesthesia care and related services, and meet the triple healthcare aims of improving patient experience of care, improving population health and reducing health care costs. In the anesthesia and pain management arena, one innovative model that the agency should study as a cost-efficient model in healthcare delivery is non-medically directed CRNA anesthesia services.

In most respects, 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. However, Medicare Part B also authorizes payment for “anesthesiologist medical direction”\(^7\) 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. While this RFI does not cover the Medicare program, many Medicaid policies use these anesthesia payment models. 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.\(^8\) The CMS has also stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.\(^9\)

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8 Hogan, op cit.
In demonstrating the increased costs associated with anesthesiologist medical direction, 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 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\(^{10}\) and $540,314 for the anesthesiologist\(^{11}\). 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.

<table>
<thead>
<tr>
<th>Anesthesia Payment Model</th>
<th>FTEs / Case</th>
<th>Clinician costs per year / FTE</th>
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</thead>
<tbody>
<tr>
<td>(a) CRNA Non-medically Directed</td>
<td>1.00</td>
<td>$170,000</td>
</tr>
<tr>
<td>(b) Medical Direction 1:4</td>
<td>1.25</td>
<td>$305,079</td>
</tr>
<tr>
<td>(c) Medical Direction 1:2</td>
<td>1.50</td>
<td>$440,157</td>
</tr>
<tr>
<td>(d) Anesthesiologist Only</td>
<td>1.00</td>
<td>$540,314</td>
</tr>
</tbody>
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Anesthesiologist mean annual pay $540,314 MGMA, 2014

CRNA mean annual pay $170,000 AANA, 2014

\(^{10}\) AANA member survey, 2014

\(^{11}\) MGMA Physician Compensation and Production Survey, 2014. [www.mgma.com](http://www.mgma.com)
If 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. Pertinent to Medicaid, if a state Medicaid program reimburses for CRNA anesthesia services only to the extent that they are medically directed by an anesthesiologist (as is the case in Pennsylvania, for example), that policy is driving additional healthcare costs and waste without improving healthcare quality or access to care. This additional cost is shifted onto hospitals and other healthcare facilities, and ultimately to patients, premium payers and taxpayers. With CRNAs providing over 38 million anesthetics in the U.S., and a considerable fraction of them being “medically directed,” the additional healthcare costs driven by 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 Medicaid for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread 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, 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. This study raises critical issues about Medicare claims compliance in a common and costly model of anesthesia delivery at a time when quality, cost-effectiveness, and best use of Medicare resources are the focus of healthcare reform. In the interest of patient safety and access to care, these additional costs imposed by medical direction modalities more than justify the public interest in recognizing and reimbursing fully for non-medically directed CRNA services within Medicare, Medicaid and private plans in the same manner that physician services are reimbursed.

In conclusion, anesthesiologist medical direction reimbursement models contribute to increased healthcare system costs without improving access or quality, and also present fraud risk when medical direction requirements are not met by the anesthesiologist submitting a claim for such services. Therefore, CMS should consider such costs when developing and carrying out new systems for anesthesia reimbursement in new healthcare delivery models, and to favor reimbursement systems that support the most cost-effective and safe anesthesia delivery models such as for non-medically directed CRNA services.

**AANA Comment: Encourage the Strategic Use of Anesthesia Services in the Development of New Pediatric Healthcare Payment Models**

The AANA asks the agency to encourage the strategic use of anesthesia services in the development of new pediatric healthcare payment and service delivery models. Anesthesia professionals, such as CRNAs, play an integral role in these procedures as proper anesthesia services management can make a tremendous difference in terms of improving patient flow, patient safety, and ultimately in 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 and unnecessarily higher healthcare costs. Anesthesia is a small portion of the variable costs associated with procedures involving pediatrics. We urge that any new pediatric payment models developed should emphasize the strategic consideration of the role of anesthesia delivery that is safe and cost-efficient and include the use of techniques such as Enhanced Recovery After Surgery (ERAS) programs, which help reduce costs and improve patient outcomes.

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

As the agency is interested in comments related to infrastructure development, we offer the following recommendations regarding interoperability and communication of patient information across technology platforms when it comes to the realm of anesthesia. For anesthesia measures, we recommend that interoperability of electronic health records (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 data sharing and communication, in addition to making this information difficult to extract for quality reporting without manually reading the fields.

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

The AANA believes that a pediatric APM should not be 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.

We thank you for the opportunity to comment on this RFI. 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, rkoehl@aanadc.com.

Sincerely,

Cheryl L. Nimmo, DNP, MSHSA, CRNA
AANA President

cc: Wanda O. Wilson, PhD, CRNA, AANA Executive Director
Ralph Kohl, AANA Senior Director of Federal Government Affairs
Randi Gold, MPP, AANA Associate Director Federal Regulatory and Payment Policy