July 10, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-9928-NC
PO Box 8016
Baltimore, MD 21244-8016


Dear Ms. Verma,

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the proposed request for information (RFI), CMS-9928-NC– Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients. In this communication, the AANA highlights specific ways CRNAs can help achieve the main goals of reducing regulatory burdens and achieving meaningful reform to reduce healthcare costs, while improving access to the highest quality healthcare. The AANA makes the following comments and requests:

I. CRNAs Provide Safe, High Quality and Cost Effective Healthcare

II. Empowering Patients and Promoting Consumer Choice

- The Costly and Unnecessary Requirements Relating to Physician Supervision of CRNA Anesthesia Services Should be Removed

- Implementing CRNA Full Practice Authority Increases Veterans Access to Care and Promotes Safe, Efficient Healthcare Delivery

- Appropriate Enforcement of the Provider Nondiscrimination Law Promotes Consumer Choice and Market Competition, Advancing Patient Safety Innovations and Cost-Efficiency in the Public Interest
• Cost-Effective Models in Healthcare Delivery such as Non-medically Directed Anesthesia Services Performed by CRNAs Can Help Consumers Choose Health Plans that Best Meets Their Needs

• Include Strategic Consideration of the Role of Anesthesia in Enhanced Recovery after Surgery Protocol as an Innovative Healthcare Delivery Model

• Use a Multi-Modal Pain Management Approach which may Reduce Patient Need for and Reliance on Opioids

I. CRNAs Provide Safe, High Quality and Cost Effective Healthcare

The AANA is the professional association for CRNAs and 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$, 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 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

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

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
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.

II. EMPOWERING PATIENTS AND PROMOTING CONSUMER CHOICE

QUESTION: WHAT ACTIVITIES WOULD BEST INFORM CONSUMERS AND HELP THEM CHOOSE A PLAN THAT BEST MEETS THEIR NEEDS? WHICH REGULATIONS CURRENTLY REDUCE CONSUMER CHOICES OF HOW TO FINANCE THEIR HEALTH CARE AND HEALTH INSURANCE NEEDS?

The AANA supports the agency’s commitment towards reducing regulatory burden under Title I of the Patient Protection and Affordable Care Act to help create a more patient centered system that adheres to the key principles of affordability, accessibility, quality, innovation and empowerment. We also stress the importance of reducing regulatory burdens to achieve these principles in the Medicare and Medicaid programs as well. We recommend removing administrative and regulatory barriers to the use of CRNA services, which will help promote competition and choice while reducing costs in the healthcare system. Before outlining these proposals, we wanted to provide an overview of the professional regulation of CRNAs. The scope of practice for CRNAs is first determined by the profession, and is subject to state legislation and regulation through nurse practice acts and regulations, and through state healthcare facility licensing statutes and regulations. At the federal level, CRNA practice is circumscribed by federal regulations governing Medicare healthcare facilities, chiefly hospital conditions of participation (CoPs) and ambulatory surgery center conditions for coverage.


6 Liao, op cit.

At both the state and federal levels, however, recognition of CRNA services to the full extent of the profession’s practice authority is commonly constrained through the highly organized and well-funded policy advocacy efforts of marketplace competitors from the community of organized medicine.9,10,11

**AANA Request: The Costly and Unnecessary Requirements Relating to Physician Supervision of CRNA Anesthesia Services Should be Removed**

As stated in the agency’s RFI, consumer choice includes the freedom to choose how to finance one’s healthcare, which insurer to use, and which provider to use. The current regulations in some cases encourage wasteful and ineffective care and reduce consumer choices of safe, high quality and cost effective anesthesia providers. We have suggested regulatory reform related to the delivery of anesthesia services that will promote competitiveness and economic growth through reduction of waste and innovation at the local level. As part of this effort, the AANA recommends that CMS remove costly and unnecessary requirements relating to physician supervision of CRNA anesthesia services.9 These requirements are more restrictive than the majority of states and impede local communities from implementing the most innovative and competitive model of providing quality care. Reforming the Conditions of Coverage (CfCs) and the Conditions of Participation (CoPs) to eliminate the costly and unnecessary requirement for physician supervision of CRNA anesthesia services supports delivery of population and community health care in a manner allowing states and healthcare facilities nationwide to make their own decisions based on state laws and patient needs, controlling cost, providing access and delivering quality care.

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9 See 42 CFR §§ 482.52, [http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1.1.4.4.2&rgn=div5#42:5.0.1.1.1.1.4.4.2](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1.1.4.4.2&rgn=div5#42:5.0.1.1.1.1.4.4.2), 482.639 [http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1.4&rgn=div5#42:5.0.1.1.1.4.7.16](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1.4&rgn=div5#42:5.0.1.1.1.4.7.16), and 416.42, [http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.3.3.1.3](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.3.3.1.3).
CRNAs’ ability to practice to their full scope is affected by Medicare regulations associated with Medicare Part A Conditions of Participation and Conditions for Coverage (CoPs and CfCs). The Medicare CoPs and CfCs are federal regulations with which particular healthcare facilities must comply in order to participate in the Medicare program. While these regulations directly apply to facilities, they affect CRNA practice and impair competition and choice. Regulatory reforms that reduce barriers to CRNA practice can help improve healthcare quality, reduce healthcare expenditures and increase access for patients. Among these reforms is a recommendation to eliminate the Medicare requirement for physician supervision of CRNA anesthesia services.  

The requirement for physician supervision of CRNA anesthesia services is costly and unnecessary, driving healthcare expenditures higher without improving patient safety. Eliminating the requirement supports delivery of healthcare in a manner allowing states and healthcare facilities to make their own decisions based on state laws and patient needs, thus controlling cost, providing access and delivering quality care. There is strong and compelling evidence 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 Health Affairs 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 New York Times stated, “In the long run, there could also be savings to the healthcare system if nurses

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10 See 42 CFR §§ 482.52, [http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1.1.4.4.2](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1.1.4.4.2), 482.639 [http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1.4.4.7.16](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1.4.4.7.16), and 416.42, [http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.3.1.3](http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.3.1.3).

11 Dulisse, op cit.
delivered more of the care.”

Most recently, a peer-reviewed study published in Medical Care (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.

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 Nursing Economic$, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery without any measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.

The evidence also demonstrates that the supervision requirement is costly. Though Medicare requires supervision of CRNAs (except in opt-out states) by a physician, 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. But there are even bigger

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13 Negusa, op cit.
14 Hogan, op cit.
15 63 FR 58813, November 2, 1998.
costs involved if the hospital administrator believes that CRNAs are required to have anesthesiologist supervision (which they are not).

According to a nationwide survey of anesthesiology group subsidies, 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 on average a $3.2 million anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

There is also 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 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*, 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 is consistent with more than 10 years of AANA membership survey data.

Since this regulatory requirement is meaningless in practice, contributes to greater healthcare costs, and is contrary to existing evidence regarding patient safety and access to care, we recommend CMS eliminate the regulatory barrier of physician supervision of CRNAs in the Medicare program. Removing this barrier is also consistent with the findings and recommendations of the National Academy of Medicine, whose landmark publication titled *The Future of Nursing: Leading Change, Advancing Health* calls for removing barriers so that

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APRNs, including CRNAs, can practice to the full extent of their education and training, indicating that APRNs play a critical role in the future of healthcare.\textsuperscript{18}

**AANA Request: Implementing CRNA Full Practice Authority Increases Veterans Access to Care and Promotes Safe, Efficient Healthcare Delivery**

The Department of Veterans Affairs (VA) proposed a regulation amending medical regulations to grant Full Practice Authority to all APRNs, including CRNAs, when they are acting within the scope of their employment within the Veterans Health Administration (VHA) system.\textsuperscript{19} In the interest of expanding Veterans’ access to quality healthcare, we express strong support for the VHA recognizing all APRNs, including CRNAs, to practice to the full extent of their education, training, and certification without the clinical supervision of physicians. Nurse anesthetists are experienced, highly educated anesthesia professionals who provide quality patient care confirmed by decades of scientific research. Peer-reviewed research and authoritative policy documents have illustrated how CRNAs consistently deliver safe, high-quality, cost-effective anesthesia care in today’s ever-changing healthcare environment. By standardizing care delivery models across the country via Full Practice Authority for APRNs, including CRNAs, Veterans can be assured consistently safe and high quality care delivery in any VHA healthcare facility. Nearly 900 CRNAs provide every type of anesthesia care, as well as chronic pain management services, for our Veterans in the VHA. The safety of CRNA services has long been recognized by the VHA and underscored by peer-reviewed scientific studies.

Permitting Full Practice Authority for CRNAs will ensure Veterans receive the full scope of high-quality anesthesia and pain management care they so rightfully deserve. An Independent Assessment of the VA’s healthcare delivery system and management processes as required by the Veterans Choice Access and Accountability Act of 2014, recommended formalizing Full Nursing Practice Authority for all APRNs, including CRNAs, throughout the VHA.\textsuperscript{20} In


\textsuperscript{20} U.S. Department of Veterans Affairs Assessment B - Health Care Capabilities (September 1, 2015), \url{http://www.va.gov/opa/choiceact/documents/assessments/Assessment_B_Health_Care_Capabilities.pdf}
addition, in June 2016 following an exhaustive 10-month assessment of the VHA, the independent federal Commission on Care reported that 23 percent of healthcare professionals in the VHA are not working to the top of their licensure, identifying this underuse of available resources as a major barrier to effective healthcare provision. One solution recommended by the Commission is implementation of policy that allows full practice authority for APRNs, which adds further data to the increasing amount of evidence in support of allowing CRNAs and other APRNs to practice to the full scope of their education, training, and abilities in the VHA, without physician supervision. This policy would not only help address the increasing healthcare demands of our nation’s Veterans, but would also improve healthcare efficiency in the VHA system by reducing wait times and increasing cost-effective care. The common sense solution to avoid further interruption in Veterans’ care is to immediately implement the new Full Practice Authority policy for all CRNAs and APRNs working in the VHA system.

**AANA Request: Appropriate Enforcement of the Provider Nondiscrimination Law**

**Promotes Consumer Choice and Market Competition, Advancing Patient Safety Innovations and Cost-Efficiency in the Public Interest**

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), which took effect January 1, 2014, prohibits health plans from discriminating against qualified licensed healthcare professionals, such as CRNAs, solely on the basis of their licensure. This law promotes access to healthcare and consumer choice of healthcare professionals, and helps reduce healthcare costs through competition.

21 The Commission on Care, Final Report on the Commission on Care (June 30, 2016),

22 The Commission on Care, op cit.

23 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.”
This law promotes competition and consumer choice by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote patient access to care, health insurers and health plans must all avoid discrimination against qualified, licensed healthcare professionals solely on the basis of licensure. The Provider Nondiscrimination provision also respects local control of healthcare systems and local autonomy in the organization of 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.

The AANA interprets Section 2706 to protect patient choice and access to a range of beneficial providers and prevent discrimination by health insurance plans against an entire class of health professionals, such as CRNAs. We believe 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. While health plans might believe this is a cost-effective way to save money and lower health care costs, this would direct cases to more expensive providers, such as anesthesiologists, leading to impaired access, increased costs and lower quality of care. The AANA also interprets the Provider Nondiscrimination provision to mean that if a health plan or health insurer network offers a specific covered service, they should include in their network all types of providers who can offer that service. For example, if a health plan offers coverage for anesthesia services, they should allow all anesthesia providers to participate in their networks and they cannot refuse to contract with CRNAs just based on their licensure alone.

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.[1] 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,[2] 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.”[3] 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.”[4] 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. Therefore, we recommend removal of any barriers to reimbursement for plans in the exchange (related to cost effective models). For example, currently in Massachusetts health plans in the exchange are mirroring Medicaid reimbursement policy for CRNAs and will begin to directly reimburse for CRNA anesthesia services in Massachusetts. We encourage all private health insurance plans (and Medicaid) to model reimbursement in the Medicare program.

Proper implementation of the Provider Nondiscrimination law is crucial because health plans have latitude to determine the quantity, type, and geographic location of healthcare professionals they need to ensure availability of healthcare benefits to 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, for example, by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition. Additionally, such discrimination provides incentives for the use of higher-cost providers without improving quality or access to care. Promoting nondiscrimination encourages consumers to be able to choose anesthesia care from qualified, licensed healthcare professionals such as

[4] Ibid.
CRNAs who perform the same services to the same high level of quality as other qualified providers.

**AANA Request: Cost-Effective Models in Healthcare Delivery such as Non-Medically Directed Anesthesia Services Performed by CRNAs Can Help Consumers Choose Health Plans that Best Meet Their Needs**

The AANA supports efforts to better understand the potential benefits of new healthcare delivery models that have emerged in recent years which can offer significant cost savings while maintaining, or even improving, quality of care. These models may also increase the supply of healthcare services, which can expand consumer access to care. We recommend that the agency include innovative, cost-effective models in anesthesia delivery such as non-medically directed anesthesia services performed by a CRNA.

In most respects, Medicare reimburses CRNAs and anesthesiologists at 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”\(^{24}\) that provides a financial incentive for anesthesiologists to “medically direct” CRNAs who are capable of and often provide 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, and 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 Safety.\(^{25}\) The CMS has also stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.\(^{26}\)

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\(^{25}\) Hogan, op cit.

In demonstrating the increased costs associated with anesthesiologist medical direction, suppose there are four identical cases: (a) anesthesia delivered by a non-medically directed CRNA; (b) 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) anesthesia delivered by a CRNA medically directed at a 2:1 ratio; and (d) 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\textsuperscript{27} and $540,314 for the anesthesiologist\textsuperscript{28}. 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 $305,079 per year ($170,000 + (0.25 \times 540,314)). For case (c) it is $440,157 per year ($170,000 + (0.50 \times 540,314)). Finally, for case (d), the annualized cost equals $540,314 per year.

<table>
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<th>Anesthesia Payment Model</th>
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<th>Clinician costs per year / FTE</th>
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<td>(a) CRNA Non-medically Directed</td>
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<tr>
<td>(b) Medical Direction 1:4</td>
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\textsuperscript{27}\textsuperscript{ }AANA member survey, 2014

\textsuperscript{28}\textsuperscript{ }MGMA Physician Compensation and Production Survey, 2014. [www.mgma.com](http://www.mgma.com)
If Medicare, Medicaid, 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 43 million anesthetics each year in the United States, 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 that 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 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.

services. Therefore, such costs should be considered when developing and carrying out new systems for anesthesia reimbursement in 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 Request: Include Strategic Consideration of the Role of Anesthesia in Enhanced Recovery after Surgery Protocol as an Innovative Healthcare Delivery Model**

Because CRNAs personally administer more than 43 million anesthetics to patients each year in the United States, their services are crucial to the successful development and implementation of techniques such as anesthesia enhanced recovery after surgery (ERAS) programs. CRNAs and other anesthesia professionals play an integral role in these episodes of care as proper anesthesia services management can make a tremendous difference in terms of improving patient flow, patient safety, and cost savings.\(^\text{30}\) 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.\(^\text{31}\) As the agency increases its ongoing efforts to create a more patient-centered health care system that adheres to the key principles of affordability, accessibility, quality, innovation, and empowerment, we urge that the agency emphasize the strategic consideration of the role of anesthesia delivery that is safe and cost-efficient and include the use of techniques such as ERAS programs, which help reduce costs and improve patient outcomes.\(^\text{32}\)

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AANA Request: Use of a Multi-Modal Pain Management Approach May Reduce Patient Need for and Reliance on Opioids

The AANA recognizes that solving the opioid drug epidemic is an integral part of healthcare reform, and we are committed to collaboratively working toward a common solution to this issue. Pain is a personal experience that, if left undertreated or mismanaged, can radically change an individual’s quality of life and impact important relationships. Utilizing a patient-centered, multidisciplinary, multimodal treatment approach to pain management may reduce the reliance on opioids as a primary pain management modality, thus helping curb the prescribed opioid epidemic. Acute and chronic pain is best treated and managed by an interdisciplinary team that actively engages the patient to diagnose and manage their pain for improved well-being, functionality, and quality of life. As members of the interdisciplinary team, CRNAs are well positioned to provide holistic, patient-centered, multimodal pain treatment and management across the continuum of pain and in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics).33

According to a recent AANA position statement titled, A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment, “CRNAs integrate multimodal pain management as an element of enhanced recovery after surgery (ERAS) protocols to manage pain. Management begins pre-procedure and continues after discharge by using opioid sparing techniques such as regional anesthesia, peripheral nerve blocks, non-pharmacological approaches, and non-opioid based pharmacologic measures. Careful assessment and treatment of acute pain, which may include appropriate opioid prescribing, can decrease the risk of acute pain transitioning to chronic pain or the development of opioid dependency and abuse.”34

Prescriber education is also essential to curbing the opioid epidemic, and CRNAs are well-positioned to provide education related to minimization or elimination of prescribed opioids through pharmacologic and non-pharmacologic multi-modal pain management strategies. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) already requires acute and chronic pain management content in the curriculum of the 115 accredited nurse anesthesia programs, and the AANA provides advanced workshops to CRNAs specifically on pain management, including acute and chronic pain, to enhance their skills and increase their awareness of the complications associated with opioid use and misuse.

Consistent with the recommendation to increase access to pain management services in the National Academies of Medicine report “Relieving Pain in America,” the AANA has partnered with academia to develop an Advanced Chronic Pain Management Fellowship that is accredited by the COA to enter the field as advanced, subspecialty practitioners beyond that which is required for initial certification of nurse anesthetists. The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) offers a voluntary nonsurgical pain management (NSPM) subspecialty certification for CRNAs.

CRNAs are safe, high-quality and cost-effective anesthesia professionals who will stand with your new Administration and the new Congress as we all work together to meet your health reform goals and policies. We look forward to our future work to help generate reforms to our healthcare system that strengthen care for all Americans. 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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Cheryl L. Nimmo, DNP, MSHSA, CRNA
AANA President

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