



1501 M Street, N.W. • Suite 300 • Washington, D.C. 20005 • (202) 289-2222 • Fax: (202) 371-0384 • www.asahq.org

Donald S. Clark, Secretary
Federal Trade Commission
Office of the Secretary
600 Pennsylvania Avenue NW
Suite CC-5610 (Annex X)
Washington, D.C. 20580

[Submitted online at: <https://ftcpublic.commentworks.com/ftc/examhealthcareworkshop>]

Re: Health Care Workshop, Project No. P131207

Dear Mr. Clark:

The American Society of Anesthesiologists (ASA) appreciates this opportunity to comment on the Federal Trade Commission's (FTC) Public Workshop, "Examining Health Care Competition."¹ The ASA is a more than 53,000 member educational, research and advocacy organization dedicated to improving the medical care of anesthesiology patients and raising the standards for anesthesia medicine. Since its founding in 1905, the ASA has been at the forefront of patient safety in the perioperative environment and in the field of pain medicine.

ASA commends the FTC for its continued dedication to studying how the changes in the health care system affect competition and consumer protection. Our comments will focus on the importance of physician-led teams in ensuring safety, quality of care, and consumer protection in the development of provider networks, benefit design, and alternative payment models.

ASA has been a leader in patient safety and in the science and practice of anesthesiology since its founding, and our leadership has not gone unnoticed. In its 2000 report, *To Err is Human*, the Institute of Medicine listed anesthesiology and its professional organizations as systematically contributing to improvements in patient safety and quality of care in anesthesiology.² These results, which have made the administration of anesthesia safe, along with continuing research, and public opinion surveys, all show that physician anesthesiologists have been the driving force in ensuring patient safety and quality. The special nature, intensity and longer hours of physician anesthesiologists' education and training reinforce that maintaining physician anesthesiologists as leaders of the anesthesia care team is the optimal

¹ 80 Fed. Reg. 5,533 (Feb. 2, 2015).

² United States Inst. of Med., *To Err is Human: Building a Safer Health System*, (2000).

approach for improving patient safety, quality of care and innovation in the provision of anesthesia services.

1. Provider network and benefit design must allow for distinctions between provider types where necessary to promote patient safety and quality of care

ASA supports a health care model of physician-led patient care teams that may include non-physician provider types. However, provider network and benefit design must account for distinctions between physicians and non-physicians based on education, hours of training, clinical skills, independent research and public opinion surveys.

a) Education and training

Physician anesthesiologists receive substantially more years of education and more patient care hours as part of their training than nurse anesthetists. Physician anesthesiologists must complete a four-year bachelor's degree followed by four years of medical school, a one-year postdoctoral internship, and a three-year postdoctoral residency, for a total of twelve years of education.³ Board-certified physicians often receive an additional one to two years of subspecialty training after their postdoctoral residency, for a total of thirteen to fourteen years of education.⁴ During the course of their education, physician anesthesiologists receive a total of 12,000 to 16,000 hours of clinical training, including many hours of face time with patients.⁵ This education and training focuses on the entire human life cycle, diagnosis, treatment, comprehensive medical care, and pain medicine.⁶

In contrast, nurse anesthetists receive a bachelor's degree in nursing and a master's degree from a graduate school of nursing for a total of five to seven years of education covering only 1,651 hours of clinical training.⁷ The scope of a nurse anesthetist's nursing education and training is also much more limited, focusing on basic anatomy, physiology, pharmacology, and nurse anesthesia.⁸ This difference in education and training translates into a difference in the ability to comprehensively perform more complex pain medicine procedures, such as neurodestruction, and limits the ability of a nurse anesthetist to comprehensively assess and manage a patient's pain. Accordingly, distinctions among provider types must be an essential component of network and benefit design to ensure that the appropriate providers are supplying the correct level of services based on their education and training. Such distinctions are critical to protecting patient safety and ensuring high quality care.

³ American Society of Anesthesiologists, *When Seconds Count . . . Physician Anesthesiologists Save Lives: Education and Training Can Mean the Difference Between Life and Death*, (2013).

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

b) Independent research on quality of care, patient outcomes, and cost

Independent research suggests that physician anesthesiologist involvement as the leader of the patient care team results in fewer deaths and fewer unexpected dispositions when patients are discharged. For example, a 2000 study by Jeffery H. Silber et al. (the Silber study) found that there were 2.5 excess deaths per thousand cases within 30 days of admission to the hospital when a physician anesthesiologist was not involved in the patient's care.⁹ A 2012 study by Stavros G. Memtsoudis et al. (the Memtsoudis study) found that the chances of an "unexpected disposition after ambulatory surgery, defined as any outcome after surgery other than being discharged home, were 80 percent higher when a nurse anesthetist rather than a physician anesthesiologist provided anesthesia care.¹⁰ The sum of this research clearly indicates that physician anesthesiologist-led care reduces the number of perioperative-related deaths and unexpected dispositions.

Independent research also suggests that physician anesthesiologist supervision of anesthesiology services can lead to lower health care costs by reducing the number of medical consultations, cancellations, additional laboratory tests, and unexpected dispositions when discharged. For example, a literature review in the *New England Journal of Medicine* concluded that physician anesthesiologist-led care results in a 75 percent reduction in medical consultation requests, a 59 percent reduction in the cost of laboratory tests because fewer tests are ordered, and an 88 percent reduction in the cancellation of operations for medical reasons.¹¹ In addition, with fewer unexpected dispositions (see the Memtsoudis study), patients will need fewer follow-up services after surgery, also reducing costs.¹² Clearly, the practice of medicine is essential to the safe conduct of an anesthetic.

c) Public opinion surveys

Finally, public opinion surveys also make clear that patients prefer services from physician-led provider teams. According to an American Medical Association (AMA) survey, "[e]ighty-four percent of respondents said that they prefer a physician to have primary responsibility for the diagnosis and management of their health care."¹³ The AMA also asked whether only physicians (defined as a medical doctor or doctor of osteopathic medicine) should be allowed to perform certain activities, including "[a]dminister[ing] and monitor[ing] anesthesia levels and

⁹ Jeffery H. Silber, et al., *Anesthesiologist Direction and Patient Outcomes*, 93 ANESTHESIOLOGY 153 (2003).

¹⁰ Stavros G. Memtsoudis, et al, *Anesthesiology Direction and Patient Outcomes*, 12 J. AMBULATORY SURGERY 67 (2005).

¹¹ RA Wiklund et al., *Anesthesiology*, 337 New England J. Med. 1132 (1997).

¹² Stavros G. Memtsoudis, et al, *Anesthesiology Direction and Patient Outcomes*, 12 J. AMBULATORY SURGERY 67 (2005).

¹³ AMA's Global Strategy Group Survey, *Truth in Advertising Survey Results*, (2008).

patient condition before and during surgery.”¹⁴ Seventy-seven percent of respondents in 2012 indicated that only a physician should be allowed to perform these procedures.¹⁵

Differences in education and training, differences in patient outcomes, quality of care, and costs, and differences in public opinion are all legitimate bases for distinguishing among provider types as part of provider network and benefit design. Payers must be allowed to structure their networks to account for patient safety and quality of care, which may in some cases include more physician-anesthesiologists, as opposed to nurse anesthetists, and may further include differential reimbursement between these two provider types. Payers must also be allowed and even encouraged to account for market considerations in making these decisions, particularly to avoid unnecessary testing, rescheduling and follow-up services after surgery.

2. Allowing payers to make some distinctions among provider types is consistent with federal provider nondiscrimination laws and federal agencies’ interpretation of them

Section 2706(a) of the Patient Protection and Affordable Care Act (ACA) and §§ 1852(b)(2) and 1932(b)(7) of the Social Security Act (SSA) prevent health insurers, Medicare Advantage plans, and Medicaid managed care respectively from discriminating among provider types when a provider is acting with the scope of her state license or certification.¹⁶ ACA § 2706(a) also states: “[t]his section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer” and that payers may vary payment “based on quality or performance measures.”¹⁷ Sections 1852(b)(2) and 1932(b)(7) contain similar provisions.¹⁸ The plain language of these laws contemplates (a) that payers may make distinctions among provider types consistent with variations in scope of practice, (b) that these non-discrimination provisions do not require payers to include any willing provider in their networks, and (c) that payers may take into account market considerations, as a measure of quality and performance, in setting payment levels for different provider types.¹⁹

This interpretation of ACA § 2706(a) and SSA §§ 1852(b)(2) and 1932(b)(7) is consistent with those of Health and Human Services (HHS) and its sub-agency, the Centers for Medicare and Medicaid Services (CMS), as well as other federal agencies. In an FAQ jointly issued by HHS and the Departments of Treasury and Labor (collectively “the Departments”), the

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ ACA, § 2706(a) (codified at 42 U.S.C. § 300gg-5(a)); SSA § 1852(b)(2) (codified at 42 U.S.C. § 1295w-22(b)(2)); SSA § 1932(b)(7) (codified at 42 U.S.C. § 1396u-2(b)(7)).

¹⁷ ACA, § 2706(a).

¹⁸ SSA § 1852(b)(2); SSA § 1932(b)(7).

¹⁹ For a more in depth analysis of § 2706(a), please see the ASA’s comments to CMS on this issue. Comments from the American Society of Anesthesiologists, et al., to Marilyn Tavenner, Administrator, Ctrs for Medicare & Medicaid Servs., (June 10, 2014) (regarding CMS 09942-NC).

Departments concluded that under § 2706(a) payers may not discriminate on the basis of a provider's license or certification, but this should not be read as an "any willing provider" provision.²⁰ CMS has also stated in the preamble to regulations interpreting SSA §§ 1852(b)(2) that "[i]f a[] [Medicare Choice] organization can provide all physicians' services through a doctor of medicine, it may not 'need' to contract with another practitioner who can only provide a discrete subset of physicians' services (such as a podiatrist or chiropractor . . .)" as long as "all Medicare-covered services are available in the plan."²¹ Similarly, a payer may not need to contract with all provider types and should not be required to do so if there is no added benefit to patients in terms of quality or cost of care.

The Departments also concluded in the FAQ that reimbursement rates "may be subject to quality, performance or *market standards and consideration*."²² Likewise, CMS stated in the preamble to regulations interpreting SSA § 1852(b)(7) that because this statute does not contain an any willing provider provision, Medicaid managed care organizations would not be "handicap[ped]" in selecting their networks "on the basis of quality and market need."²³ Payers may need to offer different payment to different provider types to protect patient safety and quality of care, including by compensating physicians at a level commensurate with their education and training to ensure an adequate supply of physicians in network.

3. ASA supports alternative payment models that promote safe, cost-effective care provided through physician or physician anesthesiologist-led teams

ASA supports the physician-led Perioperative Surgical Home (PSH) model as a safe, cost-effective pathway to provide perioperative services. A PSH is "a patient-centered, physician-led interdisciplinary[] and team-based system of coordinated care" that "spans the entire experience from decision of the need for any invasive procedure—surgical, diagnostic, or therapeutic—to discharge from the acute-care facility and beyond."²⁴ The primary goal of a PSH is to achieve the triple aim of better patient experience, better health care, and reduced costs for patients undergoing surgical procedures. A PSH offers physician anesthesiologists early access to patients for preoperative counseling, increased communication with patients, more involvement in protocol development, and the opportunity to better coordinate postoperative care.²⁵

²⁰ Health and Human Servs., Dept. of Labor, and Dept. of Treasury, FAQs About Affordable Care Act Implementation (Part XV), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html (last accessed April 21, 2015).

²¹ 65 Fed. Reg. 40,170, 40,237 (June 29, 2000). *See also* 42 CFR § 422.205 (2014).

²² FAQs About Affordable Care Act Implementation (XV).

²³ 67 Fed. Reg. 40,989, 41,019 (June 14, 2002). *See also* 42 CFR § 438.12 (2014).

²⁴ Presentation by the ASA on the Perioperative Surgical Home: An Introduction (April 20, 2015).

²⁵ Mark Warner, *The Surgical Home*, 76 ASA NEWSLETTER: ACADEMIC ANESTHESIA 30 (2012).

According to a comprehensive literature review, the PSH introduces significant efficiencies into the surgical system that ultimately save costs, without sacrificing quality of care.²⁶ As part of the PSH model, physicians who medically optimize patients early in the surgical process can help those patients better prepare for surgery, which can reduce the overall cost of care.²⁷ Early patient engagement can also reduce post-surgery recovery time, complications, and readmissions.²⁸ The PSH model has also been associated with a reduction in the number of preoperative tests and the additional costs that come with them,²⁹ without a corresponding increase in adverse events.³⁰

Physician anesthesiologists are important members of the PSH team. For example, selective ordering of preoperative tests by physician anesthesiologists reduces the number of overall tests conducted when compared to those ordered by non-physicians and reduces the corresponding cost.³¹ Physician anesthesiologists' unique positioning in the operating room can also help improve efficiency and communication and reduce morbidity or mortality that results from errors and lack of communication.³² The literature review identifies many more articles outlining the benefits of the PSH and the role of anesthesiologists in this model, which are beyond the scope of this comment letter.

Because of these efficiencies and cost savings, the ASA believes that the PSH should be considered an alternative form of payment. Beyond these efficiencies, however, there are at least six different payment methods for PSHs, ranging from FFS to bundled payments to bonuses for quality and cost-saving metrics. As discussed above, a PSH should result in reduced patient care costs due to fewer cancellations, early entry into the operating room, reduced post-surgery recovery time, fewer complications and re-admissions, and appropriately reduced preoperative tests. Payment for a PSH should nevertheless compensate providers fairly for their services,

²⁶ Bitka Kash et. al., *The Perioperative Surgical Home (PSH): A Comprehensive Literature Review for the American Society of Anesthesiologists*, (June 12, 2014).

²⁷ *Id.* at 11–12 (citing Darin J. Correll et al, *Value of Perioperative Clinic Visits in Identifying Issues with Potential Impact on Operating Room Efficiency*, 105 ANESTHESIOLOGY 1254 (2006); Marla B. Ferschl et al., *Perioperative Clinic Visits Reduce Operating Room Cancellations and Delays*, 103 ANESTHESIOLOGY 855 (2005); M. Knox et al., *The Impact of Pre-Operative Assessment Clinics on Elective Surgical Case Cancellations*, 7 THE SURGEON 76 (2009)).

²⁸ *Id.* (citing Samantha Jones, *Pre-Operative Patient Education Reduces Length of Stay After Knee Joint Arthroplasty*, 93 ANNALS OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND 71 (2011)).

²⁹ *Id.* at 13.

³⁰ *Id.* (citing Frances Chung et al., *Elimination of Preoperative Testing in Ambulatory Surgery*, 108 ANESTHESIA & ANALGESIA 467 (2009)).

³¹ *Id.* (citing Barry A. Finegan et al., *Selective Ordering of Preoperative Investigations By Anesthesiologists Reduces the Number and Cost of Tests*, 52 CANADIAN JOURNAL OF ANESTHESIA 575 (2005)).

³² *Id.* (citing Mark Warner, *The Perioperative or Surgical Home: An Emerging Draft Proposal for Pilot Innovation Demonstration Projects*, Draft (2011)).

particularly if the PSH is going to result in more savings to the health system. The type of payment that is appropriate may ultimately vary based on the nature and type of PSH.³³

The PSH provides acute episode management that will contribute to overall population health management—an important goal of Accountable Care Organizations (ACOs)—and could help contribute to the cost savings and improved quality of care potentially generated by these organizations. Like an ACO, a PSH is designed to bring multiple providers together to share accountability for a patient’s care in the surgical context. For physician anesthesiologists, the PSH, like the patient centered medical home (PCMH), presents an opportunity to contribute to the ACO model by helping hospitals better coordinate patient care, improve quality, and reduce costs.

4. In the context of alternative payment models, the ASA would like to clarify some issues about how anesthesiologists are paid that have been misrepresented in other comments submitted to the FTC

On February 16, 2015, the American Association of Nurse Anesthetists (AANA) submitted a comment on FTC Health Care Workshop, Project No. P131207 addressing alternative payment models and provider network benefit and design. In its comments, the AANA used self-funded literature to support its view that there were no differences between physician anesthesiologists and nurses. Each of the following assertions is misleading and/or misrepresents the facts.

Misstatement #1: Physician anesthesiologists and nurse anesthetists provide the same quality of care and achieve the same patient outcomes

In contrast to the Silber and Memtsoudis research previously discussed in § 1(b), the AANA claims that there is no difference in the quality of care and patient outcomes between physician anesthesiologist supervised services and those provided by nurse anesthetists alone. The Brian Dulisse and Jerry Cromwell *Health Affairs* study cited for this point—and funded—by the AANA, however, is methodologically flawed.³⁴ The study, which concludes that there is no difference in quality of care when a nurse anesthetist works with or without physician supervision, identified nurse anesthetist-only staffing using a Medicare billing code modifier, QZ, that is not used exclusively for nurse anesthetist-only cases; instead, physicians are often supervising nurse anesthetists when this modifier is used. The study also relies on “all-cause mortality” as a measure of surgical mortality, whereas anesthesia-related mortality is only a

³³ For more information about payment models and the PSH, please see Marc L. Leib and Peter J. Dunbar, *Payment Models for the Perioperative Surgical Home*, 79 AME. SOCIETY OF ANESTHESIOLOGISTS NEWSLETTER 30 (April 2015).

³⁴ See Brian Dulisse and Jerry Cromwell, *No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians*, 29 HEALTH AFFAIRS 1469 (2010).

small portion of deaths following surgery.³⁵ It further did not adequately account for differences in the health status of patients treated by nurse anesthetists alone or nurse anesthetists under the supervision of a physician anesthesiologist.³⁶

In addition, the Cochrane Collaboration literature review, also cited by the AANA, far from indicating that there is no difference between the quality of care provided by physician anesthesiologists and nurse anesthetists, concludes that “no definitive statement” can be made about the relative quality of different types of anesthesia care.³⁷ In addition, the Cochrane Collaboration authors evaluated the *Health Affairs* study as being at “high risk” for bias because it was funded by the AANA.

The Wiklund Rosenbaum *New England Journal of Medicine* and Memtsoudis research discussed above in § 1(b) indicates that physician anesthesiologist-supervised services can introduce efficiencies by reducing the number of cancellations, laboratory tests, consultations and adverse outcomes. In contrast, the AANA claims that care provided by nurse anesthetists is the most cost-effective model for delivering anesthesia services. The *Nursing Economic\$* study cited—and, again, funded by—the AANA for this point does not present any original data or measure differences in cost-effectiveness between nurse anesthetists and physician anesthesiologists and does not account for different rates of productivity between nurse anesthetists and physician anesthesiologists. It also relies in part on other AANA-funded research that uses the modifier QZ to identify nurse anesthetist-solo cases, among other issues.³⁸ As discussed above, physician-led anesthesia services results in better quality of care, improved patient outcomes, and cost-saving efficiencies.

Misstatement #2: The costs of services provided by or supervised by physician anesthesiologists is substantially greater than services provided by nurse anesthetists alone

Using a table to compare the costs of different models of providing anesthesia services, the AANA argues that anesthesia provided by physician anesthesiologists is substantially more costly than services provided by nurse anesthetists alone. First, the AANA’s estimate of physician anesthesiologists pay at \$540,314 per year grossly exaggerates compensation and is inconsistent with other surveys. The Medical Group Management Association publishes an annual survey of all physicians and non-physician private practice providers with a large sample. The 2014 MGMA survey (most recent) lists the average private practice nurse anesthetist salary

³⁵ *Id.*

³⁶ *Id.*

³⁷ S.R. Lewis et al., *Physician Anesthetists versus Non—Physician Providers of Anesthesia for Surgical Patients*, CD010357 Cochrane Database of Systematic Reviews (July 2014).

³⁸ American Society of Anesthesiologists, *Summary of Research Studies Comparing Anesthesia Professionals*, HEALTH POLICY RESEARCH (March 2015).

at \$168,319 and physician anesthesiologists at \$439,509.³⁹ Medscape's 2014 Anesthesiologists Compensation Report lists a combination of academic and private practice physician anesthesiologists mean compensation at \$338,000. According to the Medscape survey, compensation for physician anesthesiologists varies nationwide ranging from \$296,000 per year in the Northwest (including Alaska and Hawaii) to \$365,000 in the North Central region.⁴⁰

What is less obvious is that the average salaries do not compensate for the same quantity of work. Putting aside the issue of whether nurse anesthetists' and physician anesthesiologists' clinical care is comparable, a \$168,319 average salary for nurse anesthetists reflects payment for 40 daytime hours worked per week. The salary for a nurse anesthetist that worked more than 40 hours per week or covers premium shifts (on evenings, nights or weekends) presumably would increase significantly. In contrast, the same Medscape 2014 Compensation Report for anesthesiologists is based on an average 55-hour workweek, which includes call hours (evenings, nights and weekends). A significant part of the difference between physician anesthesiologist compensation and nurse anesthetist compensation is due to the additional fifteen hours worked per week on average by physician anesthesiologists when compared to nurse anesthetists. If a nurse anesthetist worked 55 hours per week, with 40 hours of regular time and 15 hours of overtime, he or she presumably would be paid \$262,998. Essentially, nurse anesthetists have priced their services to nearly equal that of physician anesthesiologists, and their salaries exceed those of many physicians.

Third, the remaining differences in compensation between physician anesthesiologists and nurse anesthetists are a consequence of the more extensive training, education and skill of physician anesthesiologists when compared to nurse anesthetists. As discussed in § 1(a), physician anesthesiologists have a total of twelve to fourteen years of education and training post-high school compared to only five to seven years for nurse anesthetists. In addition, physician anesthesiologists undergo 12,000 to 16,000 hours of training compared to 1,651 for nurse anesthetists. As noted in § 1(b), research also indicates that the involvement of a physician anesthesiologist in providing anesthesia services leads to better patient outcomes and cost-savings.

Misstatement #3: Hospitals offer subsidization of physician anesthesiology group practices to counterbalance decreased reimbursement to these groups

The AANA claims that hospitals offer subsidization to physician anesthesiologist practices to counterbalance decreased reimbursement to these groups and that these payments represent cost-shifting away from other critical services. The AANA offers absolutely no support for the

³⁹ Medical Group Management Ass'n Physician Compensation Survey (2014), *available for purchase at* <http://www.mgma.com/industry-data/survey-reports/physician-compensation-and-production-survey>

⁴⁰ Medscape Physician Compensation Report (2014), *available at* <http://www.medscape.com/features/slideshow/compensation/2014/public/overview>

statement that these payments are intended to counterbalance shortfalls in payments to physician anesthesiologist practice groups. Hospitals in some cases may offer additional payment to physician anesthesiologist groups because physician anesthesiologists have more years of training and education, provide services that result in fewer deaths and unexpected dispositions, introduce cost-savings into the hospital setting, and work more hours per clinical work week than nurse anesthetists. These payments also may be intended to incentivize physician anesthesiologists to help introduce perioperative efficiencies into the hospital system, as through the PSH model discussed above.

Misstatement #4: Lapses in supervision on the part of physician anesthesiologists are common in practice and as a result “the likelihood of widespread Medicare fraud in this area is high”

The AANA asserts that lapses in physician anesthesiologist supervision of nurse anesthetists are common, and that if physician anesthesiologists submit claims for payment to Medicare based on these lapses, “the likelihood of widespread Medicare fraud . . . is high.” The *Anesthesiology* article that the AANA cites as the basis for these statements, however, does not conclude that lapses in physician anesthesiologist supervision are common. Instead, the article suggests that the more operating rooms a physician is responsible for supervising, the more likely lapses in supervision are to occur.⁴¹ But, the article suggests that to address these lapses would require the services of *more* physician anesthesiologists, not less.⁴²

In any case, the *Anesthesiology* article does not examine the implications for physician anesthesiologist supervision of anesthesia services and Medicare fraud. The AANA’s claim that the likelihood of widespread fraud is high due to an alleged lack of supervision on the part of physician anesthesiologists is purely speculative and irresponsible and is in no way supported by the study it cites.

Misstatement #5: Physician anesthesiologist-only group practices use their substantial market power to enter exclusive agreement with hospitals, other facilities and surgeons that increase costs, limit choice of provider and create lost opportunity costs from the diversion of funding from other resources.

Relying heavily on a *New York Times* article, the AANA also alleges that physician anesthesiologist-only group practices leverage significant market power to enter into exclusive agreements with health systems, facilities, and surgeons that prevent other provider types from entering the market and increase costs. While physician anesthesiologist practice group consolidation is increasingly common, thus far the research does not show that larger

⁴¹ RH Epstein and F. Dexter, *Influence of Supervision Ratios by Anesthesiologists on First-Case Starts and Critical Portions of Anesthetics*, 116 ANESTHESIOLOGY 683 (2012).

⁴² *Id.*

Donald S. Clark, Secretary
Federal Trade Commission
April 30, 2015
Page 11

anesthesiology practices receive “significantly higher payments” from commercial payers across United States markets.⁴³ Nor did the *New York Times* conduct a survey of physician anesthesiologist group practice consolidation. Rather, the article simply reviewed the provision of anesthesiology services during colonoscopies and focused on no more than a few physician anesthesiologist group practices. The AANA’s conclusion that the case studies in the *New York Times* piece are evidence of widespread physician anesthesiologist practices with too much market power and that these practices negotiate exclusive arrangements with hospitals that drive up prices and limit provider choice is unsupported by any concrete evidence.

Conclusion

ASA is dedicated to ensuring patient safety and improving quality of care while introducing efficiencies into the health system that can ultimately reduce costs. We support inclusive provider networks and alternative payment models where these models continue to put patient safety and welfare first. It is wholly appropriate for payers to distinguish among provider types as to network and benefit design when doing so is justified based on differences in education, training, patient outcomes, and cost-saving efficiencies. Alternative payment models, such as the physician-led Perioperative Surgical Home, can also introduce systemic efficiencies, while still promoting high quality care.

Thank you again for the opportunity to provide comments on these important issues and for the opportunity to address some of the misstatements that have been made about physician anesthesiologists and physician-led anesthesia services. If you have any questions or need additional information, please contact Nora Matus, Director of Congressional and Political Affairs at: n.matus@asahq.org, or by phone at: 202-289-2222.

Respectfully yours,



J.P. Abenstein, M.S.E.E., M.D.
President

⁴³ Eric Sun. et. al., *Lack of Significant Influence of Anesthesiology Group Consolidation on Private-Payer Payment in the USA*, ASA Abstracts (Oct. 13, 2013).