Electronic submission via: https://www.surveymonkey.com/r/macra-cost-measures-field-testing

Acumen, LLC

To Whom It May Concern:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the MACRA Episode-Based Cost Measures field test feedback survey. Due to the continued interest the AANA has in episode based-cost measures, we are providing comments based on the mock report and the additional documents that were distributed. We recognize that as more episode based-cost measures are developed, CRNAs may have an opportunity to review future field testing results based on the trigger event and methodology. The AANA recognizes the challenge the Centers for Medicare & Medicaid Services (CMS) and Acumen face in developing an actionable and meaningful cost report; therefore, we have identified some general concerns with the mock report and provide these comments in an effort to offer support from a clinician perspective. The comments below pertain to all episodes unless otherwise noted. The AANA makes the following comments and requests in the following areas:

**GENERAL ISSUES**

- Ensure that episode-based cost measures and feedback reports are understandable and actionable by all stakeholders and provide sufficient time to allow stakeholders the opportunity to properly assess, evaluate, and develop substantive comments.

- Provide episode-based cost measures reports to all NPIs under the TIN.

**HIGH LEVEL SUMMARY RESULTS FOR ALL EIGHT EPISODES**

- Provide further interpretation of the average episode risk score percentile for providers and consider the inclusion of a high-level summary tab of TIN and national patient severity risk scores, complexity scores, and demographics at the episode level.

**SUMMARY RESULTS FOR ALL EIGHT EPISODES**
• Recommend adding cost measures scores, such as dollar amounts, to the average share of cost per episode for providers in attributed clinician’s TIN and providers in different TINs.

• Describe the purpose of the clinical theme and define it in terms of clinical quality and utilization costs for providers and provide clarification on the risk bracket and its relationship to the episode risk score percentile for clinicians.

APPENDIX A: BREAKDOWN OF UTILIZATION AND COST BY MEDICARE SETTING AND SERVICE CATEGORY

• Provide clarification on how anesthesia services are incorporated into the cost measures.

EPISODE-BASED COST MEASURES FIELD TEST ZIP FILES

• Consider including Medicare “QY” billing modifier (anesthesiologist medical direction of 1 CRNA) under the “Attribution” tab for procedural episode based-cost measures.

• Narrow the definitions for the anesthesia CPT codes used in the “Post-Trigger Services Assigned to the Episode Group” tab for the five procedural episode based-cost measures.

Background of the AANA and CRNAS

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

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services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.\textsuperscript{6}

GENERAL ISSUES

**AANA Comment: Ensure that Episode-Based Cost Measures Reports are Understandable by All Stakeholders and Provide Sufficient Time to Allow Stakeholders the Opportunity to Properly Assess, Evaluate, and Develop Substantive Comments**

The AANA appreciates and acknowledges the arduous task that CMS, Acumen, and the members of the Clinical Subcommittees and members of the Technical Expert Panels (TEP) undertook in creating the eight Episode Based-Cost Measures. While we appreciate that Acumen and CMS have extended the comment period for the feedback survey and is open to receiving feedback on other aspects of the measure specifications, such as assigned services and risk adjustment variables, as well as the format of the field test reports and supplemental documentation after the conclusion of the comment period, we urge CMS and Acumen not to rush finalizing these eight measures or the corresponding reports. Instead, we recommend that CMS take the time to separately discuss each of the eight proposed episode based-cost measures to thoroughly explain each measure and its corresponding feedback report during webinar offerings and other avenues in order to receive substantive feedback. As Episode Based-Cost Measures will affect clinician reimbursement under the MIPS Program for the next five years, we urge that the Medicare agency take the time to make sure that it is developing clinically relevant cost measures and providing actionable and meaningful cost reports. We stand ready to continue to work with the CMS and Acumen on these efforts.

**AANA Comment: Provide Episode-Cost Based Measures Reports to All NPIs Under the TIN**

\textsuperscript{6}Liao, op cit.
Given that the cost data contained in these reports may potentially affect resource allocation and staffing decisions in the years to come, we recommend that CMS make these reports available to all National Provider Identifiers (NPIs) under the Tax Identification Number (TIN) and ensure the information be understandable by all. We note that it is possible that these reports will be read and interpreted by a wide audience such as small rural health care facilities or large multihospital healthcare systems whose clinicians are employed by the hospitals and whose NPIs are included under the hospitals’ TIN. We also request clarification regarding terminology used in Appendix B: Episode-Level Table for All Episodes Attributed to Your TIN under the section entitled “Other Providers Rendering Care Within the Episode”. Appendix B contains the terms “# of TIN-NPIs within your TIN” and “# of TIN-NPIs Outside of Your TINs, but these terms are not defined or explained.

HIGH LEVEL SUMMARY RESULTS FOR ALL EIGHT EPISODES

AANA Comment: Provide Further Interpretation of the Average Episode Risk Score Percentile for Clinicians and Consider the Inclusion of a High-Level Summary Tab of TIN and National Patient Severity Risk Scores, Complexity Scores, and Demographics at the Episode-Level

We have concerns about the usefulness of the average episode risk score percentile in the High Level Summary Results of the mock report. Because the percentile is based on the distribution of average risk scores taken across all TINs and is not a ratio of the expected versus observed episode cost (risk score) for all of the episodes for the measure, it very difficult to interpret the percentile as illustrated in the mock report. In general, the average episode cost risk score may be more appropriate. Furthermore, the term “episode risk” is not explicitly referenced to cost and may be inappropriately interpreted as patient risk (complexity) within the episode or even across different episodes. If left in the high level summary, we recommend that a distribution illustration with explanation and interpretation of the average episode risk score percentile be included on the tab and further expounded upon in Appendix C. An additional legend showing risk level may assist with interpretation. Lastly, we recommend considering the inclusion of a high level summary tab of TIN and national patient severity risk scores, complexity scores, and demographics at the episode-level.
SUMMARY RESULTS FOR ALL EIGHT EPISODES

AANA Comment: Recommend Adding Cost Measures Scores, Such as Dollar Amounts, to the Average Share of Cost Per Episode for Clinicians in Attributed Clinician’s TIN and Clinicians in Different TINs

The section entitled “Breakdown of Part B Physician/Supplier Episode Cost by Your TIN vs. Other TINs” within the Summary Results of mock report for all episode measures provides some insight with regards to costs within the clinician’s TIN versus providers in a different TIN, but we have concerns that this information is not actionable to clinicians. We recommend adding cost measure score in terms of dollar amounts to average share of cost per episode for providers in attributed clinician’s TIN and providers in different TINs. While many clinicians do not have much control over the cost of providers in a different TIN, this section does provide some insight of share of cost per episode based on physician/supplier cost during an episode within the TIN and the providers in a different TIN. Clinicians need specific cost information that is actionable, within their ability to control and allows them an opportunity to lower the cost of care they provide during an entire episode. Key information could include cost information for the drugs or implantable medical devices used during a procedure. The cost information for these items indicates cost variability that clinicians may be able to influence, such as switching to lower cost drugs or medical devices. This may also illuminate readers about where cost issues may be present; however, information in this section as currently presented does not constitute information that is actionable.

AANA Comment: Describe the Purpose of the Clinical Theme and Define it in Terms of Clinical Quality and Utilization Costs for Clinicians and Provide Clarification on the Risk Bracket and its Relationship to the Episode Risk Score Percentile for Clinicians

The section titled “Breakdown of Utilization and Cost by Selected Clinical Theme” within the Summary Results does not provide the detail needed to interpret what is meant by risk bracket and clinical theme. While it makes sense that episode costs should be compared to other TINs with similar patient complexity, it is not clear what “risk bracket” the TIN or TIN-NPI falls into and how this relates to the episode risk score percentile highlighted in the High Level Summary. Clinicians are sensitive to patient case mix and need clarity around patient severity. Therefore,
we recommend that CMS and Acumen include an episode HCC score for the attributed TIN and its risk bracket, including the HCC national average for the episode measure.

Furthermore, we have questions regarding the development of the clinical themes. Ideally the goal of clinical themes is to identify utilization costs around issues relevant to poor clinical outcomes that may increase cost such as complications, adverse events, and readmissions. In other words, by providing a clinical theme it presumes that insight can be gleaned about the cost of care for potentially avoidable events. However, some clinical themes are based on utilization of services that may not be related to a clinically relevant outcomes, but rather misuse or overuse of services. We note the development of clinical themes was not well delineated in the Draft Measures Methodology documents. In order to provide greater clarity around clinical theme, clinicians will need more detail to describe the purpose of the clinical theme in the actual report. While percent difference in average cost is helpful, the information is not actionable without further clarification of whether the cost difference is due to quality of care, such as complications, or inappropriate use of services. We stress that it is not meaningful to simply cut costs without also improving quality and outcomes.

APPENDIX A: BREAKDOWN OF UTILIZATION AND COST BY MEDICARE SETTING AND SERVICE CATEGORY

AANA Comment: Provide Clarification on How Anesthesia Services are Incorporated into the Cost Measures

Appendix A of the mock report provides some information about services that are higher than average cost and may help clinicians focus on areas that need to be addressed, but it does not help the clinician identify where those services fall in terms of the selected clinical theme. Of particular interest to anesthesia professionals are the clinician service assignments used to generate the share of episode costs in Appendix A.

While we understand that anesthesia professionals are not the attributing clinician in any of the eight cost measures, we note that anesthesia HCPCS/CPT codes are identified as a clinician service assignment in the Draft Measures Code List for determining episode costs. In particular, five episodes, Knee Arthroplasty, Routine Cataract Removal with Intraocular Lens (IOL)
Implantation, Screening/Surveillance Colonoscopy, Intracranial Hemorrhage or Cerebral Infarction, and Simple Pneumonia with Hospitalization, included anesthesia HCPCS/CPT codes which are mostly post trigger service for clinician service assignment, while three episodes, elective outpatient PCI, Revascularization for Lower Extremity Chronic Critical Limb Ischemia, and STEMI with PCI, did not. Given that anesthesia service codes were found in five out of eight cost measures, it is somewhat concerning that Appendix A in the mock reports included a line item for anesthesia services under “All Other Services” that provided figures with national average share of episode for all eight episodes. We would appreciate further clarification for how anesthesia services were incorporated into the three of the cost measures as noted above due to the lack of apparent clinician service assignments in Draft Measures Code List.

EPISODE-BASED COST MEASURES FIELD TEST ZIP FILES

AANA Comment: Consider Including Medicare “QY” Billing Modifier (Anesthesiologist Medical Direction of 1 CRNA) under the “Attribution” Tab for Procedural Episode Based-Cost Measures

We reviewed the “Episode-based Cost Measures Field Test Zip Files” attribution tab for “Routine Cataract Removal with Intraocular Lens (IOL) Implantation; Knee Arthroplasty; Revascularization for Lower Extremity Chronic Critical Limb Ischemia; Elective Outpatient Percutaneous Coronary Intervention (PCI), and Screening/Surveillance Colonoscopy, and noticed that the Medicare “QY” billing modifier (anesthesiologist medical direction of one CRNA) was missing either inadvertently or was omitted from all these procedures. We request that this issue be corrected so that the billing modifiers accurately identify the clinician that provided the anesthesia for an episode of care.

AANA Comment: Narrow the Definitions for the Anesthesia CPT Codes Used in the “Post-Trigger Services Assigned to the Episode Group” Tab for the Five Procedural Episode Based-Cost Measures

We are concerned that the anesthesia CPT codes used in the “Post-Trigger Services Assigned to the Episode Group” tab for the five procedural Episode Based-Cost Measures noted above may be too broadly defined to present accurate cost information. For example under “Post-Trigger Services Assigned to the Episode Group” for “Knee Arthroplasty” anesthesia CPT 00400 may be
assigned to an episode 17 different times. Accuracy is vital since clinicians will be assessed a Cost performance score under the MIPS Program that could cost them hundreds or thousands of dollars in Medicare reimbursements.

We thank you for the opportunity to comment on this survey. 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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