August 25, 2016

Electronic Submission via episodegroups@cms.hhs.gov

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-8016

RE: CMS Episode Groups

Dear Mr. Slavitt:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the Centers for Medicare and Medicaid (CMS) posting on episode groups. The AANA makes the following comments and requests of CMS:

- Develop an anesthesia care episode measure to ensure anesthesia care services and resource use costs are appropriately attributed to the clinician that furnished the service.
- Do not attribute anesthesia services for procedural treatment episodes as currently outlined in Method A and B without clarifying how CMS will determine anesthesia costs.
- Do not attribute anesthesia services for acute condition episode noting that anesthesia service costs and beneficiaries are not appropriately reflected in the acute condition episode.
- Add sixth Patient Relationship Category that specifically recognizes non-patient facing providers and couple that with an episode group measure that specifically recognizes anesthesia care services.
- For CRNAs without a resource use category score, the agency should redistribute weights into the Clinical Practice Improvement Activities Performance Category.

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 49,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer
more than 40 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 services include providing 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 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

¹ Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economic$. 2010; 28:159-169.
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 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. The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.\(^5\) The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.\(^6\)

**AANA Request: Develop an Anesthesia Care Episode Measure to Ensure Anesthesia Care Services and Resource Use Costs are Appropriately Attributed to the Clinician That Furnished the Service**

CMS has provided no information regarding the basis for the difference between Method A and Method B’s classification of anesthesia care services under an episode group measure, and we request that the agency be more transparent regarding how episode group measures are developed. We request detailed definitions as they relate to anesthesia providers CRNAs, as listed as 43 under the Healthcare Provider Taxonomy Code Set, and anesthesiologists, as listed as 05 under the Healthcare Provider Taxonomy Code Set; and traditional anesthesia services

---


\(^6\) Liao, op cit.
(CPTs 00100-01999) for the terms *ancillary services* under Method A and *treatment services* and *clinically associated services* under Method B. Knee Arthroplasty, for example, is listed as an episode group under both Method A and Method B and both share the episode trigger code CPT 27440 (Arthroplasty, knee, tibial plateau). Under Method A, anesthesia services are identified as relevant services represented by CPT codes 01320, 01392, 01400 and 01402. In contrast, there are no explicit anesthesia CPT codes identified for Knee Arthroplasty under Method B. We are unclear how anesthesia services are attributed to Method A and Method B for acute care episode measures and procedural treatment episode measures. Method A states anesthesia is an ancillary service, therefore we assume that anesthesia under Method B would be a clinically associated service. It is crucial that CMS provide definitions to explain the differences between these various terms in order to provide clarity, avoid confusion and allow anesthesia providers the ability to verify how their services will be defined.

Given the lack of clarity associated with Method A and B’s classification of anesthesia care services for procedure treatment episode and acute care episode measures, we propose that CMS develop an episode measure that is specific to anesthesia care services. Anesthesia care services necessitates its own distinct episode group that is currently not reflected in the clinical acute care or procedural treatment episode-based measures under either Method A or Method B. The AANA recommends that CMS work collaboratively with the AANA for guidance on how specialty services like anesthesia should be grouped to ensure that anesthesia care services are properly attributed to the specific anesthesia provider who furnished the service. The AANA stands ready to work with the agency.

**AANA Request: Do Not Attribute Anesthesia Services for Procedural Treatment Episodes as Currently Outlined in Method A and B without Clarifying how CMS Will Determine Anesthesia Costs**

MIPS eligible clinicians, such as CRNAs, will be attributed procedural treatment measures and acute care measures and Medicare beneficiaries under the Resource Use performance category. The attribution of procedural treatment measures and beneficiaries is significant to CRNAs since resource use is a key factor in assessing a clinician’s performance based on cost. The episode
group measures under Method A and Method B do no accurately account for the true cost of providing anesthesia care services nor do they accurately attribute anesthesia care services to the proper clinician. CRNAs may be at financial risk under the Resource Use category if the total cost for all services in the episode is determined to be “high cost.” This designation may have an unjustified negative impact on a CRNA’s overall composite performance score. The AANA requests that CMS provide clarity regarding how it would determine anesthesia costs for a given episode measure and provide a definition for “anesthesia cost” given that anesthesia cost is not defined in any of the episodes under Method A or Method B, and is driven chiefly by case complexity and intensity (measured in base units) and by the length of the procedure (measured in time units). We request that CMS define its attribution methodology and the other cost measures that clearly reflects the anesthesia care services provided by CRNAs. As stated previously, we also recommend that CMS develop an anesthesia care services measure to ensure that anesthesia services are appropriately attributed to the provider that furnished the service.

**AANA Request: Do Not Attribute Anesthesia Services for Acute Condition Episode**
**Nothing that Anesthesia Service Costs and Beneficiaries are not Appropriately Reflected in the Acute Condition Episode**

We are concerned that anesthesia services are included as relevant services for a handful of acute care episode measures under Method A. We understand that CMS is proposing to attribute acute condition episodes to all MIPS eligible clinicians that bill at least 30 percent of inpatient evaluation and management (IP E&M) visits during the initial treatment, or triggering event, that opened the episode. A review of the acute condition episode measures shows that although anesthesia services may be included as relevant service for measures under Method A, CRNAs who practice traditional anesthesia many not provide any inpatient E&M visits that would count towards attribution of this measure. As non-patient facing providers, the vast majority of CRNAs provide traditional anesthesia services under CPTs 00100 to 01999 and are unlikely to bill for at least 30 percent of IP E&M visits during the initial treatment. Furthermore, we are unclear as to CMS’s rationale for including anesthesia services as relevant services in acute condition episodes given that CRNAs are unlikely to be responsible for the oversight of care for the acute condition during an episode.
An illustrative example is the acute care measure for Parkinson’s Disease, which includes the anesthesia CPTs 00196, 00210, 00214, 00300, 00400, 00532, 01922 under relevant services. Six of the seven CPTs are related to anesthesia procedures and the last CPT is anesthesia for non-invasive imaging or radiation therapy. As the anesthesia CPT codes for Parkinson’s Disease suggest, anesthesia care services are related to procedural treatment episodes and not acute conditions as identified by the measure. Anesthesia services included in existing acute condition episodes do not make sense and may leave CRNAs subject to measures under the Resource Use performance category that do not reflect actual anesthesia care service costs or resource use for the anesthesia services they provide. Therefore, we recommend that the agency not attribute anesthesia services to acute care episode measures.

AANA Request: Add Sixth Patient Relationship Category that Specifically Recognizes Non-Patient Facing Providers And Couple that with an Episode Group Measure that Specifically Recognizes Anesthesia Care Services

As stated in our comments on CMS’s Proposed Patient Relationship Categories, we request the addition of a patient relationship category that recognizes non-patient facing providers and an episode group that accounts for the true cost of furnishing anesthesia service. Doing so will ensure that resource use spending is only attributed to the clinician that provided those services. As CMS recognizes that specialties such as anesthesia are considered non-patient facing clinicians, we urge the agency to develop episode group with an episode duration that accounts for the true cost of furnishing anesthesia care services for a particular group of anesthesia procedures. In creating patient relationship categories, we urge CMS to distinguish between providers that make the medical decisions that dictate how patient care is to be provided and non-patient facing provider specialties like anesthesia whose contact, relationship and services furnished to a patient is usually limited to the time period around the surgery and the inpatient hospital stay. CRNAs do not select their patients or the surgical procedures. This generally falls on the surgeons who will determine the surgical procedure or diagnosis codes that will be billed and which may trigger an episode measure. Instead, anesthesia professionals determine the anesthesia procedure that best suits the patient needs for the perioperative event, including acute
pain management, and we believe that it would be appropriate to attribute the costs of these services to these anesthesia professionals.

**AANA Request: For CRNAs Without a Resource Use Category Score, Redistribute Weights into the Clinical Practice Improvement Activities Performance Category**

Under CMS’s current proposal, some CRNAs may not have any episode care measures attributed to them under the Resource Use category, in which they would not have a resource use performance category score. CMS stated its willingness to reweigh the Resource Use performance category and suggested that the performance score for Resource Use may be added to the Quality category. This reweighting may not benefit CRNAs because many CRNAs will find it difficult to report the minimum number of three measures under the Quality category. Further, some existing quality measures used by CRNAs may be “topped out” and unavailable in the future. This reweighting also places too much emphasis on Quality scoring. Having one performance category determine 65 percent of a provider’s total composite performance score does not accurately represent a clinician’s overall performance.

We, therefore, propose that CMS incorporate the weighted performance for Resource Use and Advancing Care Information (ACI) performance categories into the Clinical Practice Improvement Activities (CPIA) performance category so that these three categories may balance out the Quality performance category. Specifically, we recommend that instead of reweighting Resource Use to the Quality category, CMS add Resource Use’s weight of 10 percent and ACI’s weight of 25 percent, as CRNAs are exempt from the ACI performance category in the first year of MIPS, to CPIA’s weight of 15 percent so that the weight of the CPIA and quality performance categories are scored equally at 50 percent each.

The CPIA performance category focuses on a patient-centered approach and emphasizes activities that have a proven association with improved outcomes. Using the CPIA performance category offers CRNAs certain benefits. First, during the initial year of MIPS, the CPIA category is allowed to have a differentially weighted scoring model with two categories – medium and high activities; which include a wide range of activities under six categories that give CRNAs a variety of activities to choose from. By allowing performance categories to be
equally (50/50) split between the CPIA and Quality performance categories mitigates any potential disadvantage CRNAs may incur that are outside their control for their total composite performance score; and avoids overreliance on the Quality category and quality scoring. Doing so will allow CRNAs the opportunity to be competitive participants in the MIPS program.

We thank you for the opportunity to comment on the CMS Episode Groups. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

[Signature]

Juan F. Quintana, DNP, MHS, CRNA
AANA President

cc: Wanda O. Wilson, CRNA, PhD, AANA Executive Director
Frank J. Purcell, AANA Senior Director of Federal Government Affairs
Romy Gelb-Zimmer, MPP, AANA Associate Director Federal Regulatory and Payment Policy