March 8, 2017

Submitted electronically via PTAC@hhs.gov

Physician Focused Payment Model Technical Advisory Committee
c/o United States Department of Health and Human Services
Assistant Secretary of Planning and Development Office of Health Policy
200 Independence Ave S.W.
Washington, DC 20201

RE: American College of Surgeons (ACS)–Brandeis Advanced Alternative Payment Model

Dear Committee Members:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the proposed American College of Surgeons (ACS)–Brandeis advanced alternative payment model (APM). The AANA appreciates the shared accountability team-based model approach proposed by the ACS model. As the role of anesthesia and Certified Registered Nurse Anesthetists (CRNAs) are directly mentioned in the proposal, we seek further clarification about how CRNAs will be incorporated into this model. Specifically, the AANA makes the following comments and requests:

- Ensure equal treatment of CRNAs and anesthesiologists in the model and clarify that CRNAs are included in all three levels of aggregation.
- Confirm whether the application and meaning of the terms nesting and clustering and bundles of bundles provide flexibility whereby they do not reduce a CRNA’s ability to participate at the same level as an anesthesiologist
- Clarify the patient relationship categories and their corresponding levels of financial risk attribution
- Identity the 54 proposed procedural episode groups used in this model
- Proposal makes mention of rural and small practices ability to participate but does not address barriers for participation

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 50,000 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 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.

AANA Request: Ensure Equal Treatment of CRNAs and Anesthesiologists in the Model and Clarify that CRNAs are Included in All Three Levels of Aggregation

As the role of anesthesia and CRNAs are directly mentioned in the proposal, the AANA appreciates further clarification on how CRNAs will be incorporated into the model. CRNAs play an important role in the delivery of anesthesia care and post-operative pain management services and are critical in improving access to safe, cost-effective anesthesia care for all Americans. Furthermore, as CRNAs provide 43 million anesthetics per year, CRNAs practice with a high degree of autonomy. We also recognize that this model has the potential to drive value-based healthcare delivery, particularly in anesthesia care and related services, and meet the triple aims of improving patient experience of care, improving population health and reducing healthcare costs. The AANA expects that based on an anesthesia provider’s clinical roles defined for each episode of care, CRNAs should automatically be included when anesthesiologists are mentioned. We urge the PTAC to ensure that CRNAs will not face professional discrimination based solely on licensure under the proposed APM.

The ACS-Brandeis model proposed three levels of aggregation above patient, episodes and clinicians, and our interpretation is that CRNAs are included in all three levels of aggregation. Specifically, the proposal uses the term “clinical teams” to mean individual clinicians will comprise a clinical team that furnishes care to a patient during a procedural episode. Clinicians in the team will have distinct roles and will share accountability for the cost and quality of that episode for an individual patient. The proposal also uses the term “Clinical Affinity Groups (CAG),” which is defined as a set of clinicians who participate together in episode groups to form the standards of care for the episode groups and who will be responsible for care redesign and improvement. Finally, the proposal uses the term “Advanced APM Entity,” which is defined as organizations that enter into risk-based contracts with Medicare and other payers for the quality and cost of its contributions to episodes of care defined by the Episode Grouper for Medicare (EGM). If it is not the case that CRNAs are included among these three levels, we request clarification on how CRNAs will be incorporated into these three levels. We also request that the ACS-Brandeis model provide instruction regarding how an APM entity such as a medical home or ACO may participate in this proposed APM.

AANA Request: Confirm Whether the Application and Meaning of the Terms “Nesting,” “Clustering,” and “Bundles of Bundles” Provide Flexibility Whereby They do not Reduce a CRNA’s Ability to Participate at the Same Level of an Anesthesiologist

We assume that the model is designed to be flexible whereby it does not reduce a CRNA’s ability to participate at the same level of an anesthesiologist. We note that CRNAs and anesthesiologists both provide the same anesthesia services and use the same anesthesia CPT codes and HCPCs billing codes and are reimbursed 100 percent by Medicare, and therefore, should not be treated differently in this model. The proposal states the model was designed to be a “bundle of bundles” and “clusters” in a subspecialty with the
potential for procedural episode groups being “nested” in condition groups whereby grouper logic may accommodate “nested” episodes. Although these are interesting concepts, they are vague and do not provide detailed information and guidance on the group logic and their practical application and attribution to clinical practice by CRNAs and other members of the perioperative team. The ACS-Brandeis model acknowledges nurse anesthesia as one of the surgical subspecialties in procedural episodes, and we request confirmation as to whether the application and meaning of these terms provide flexibility whereby they do not reduce a CRNA’s ability to participate at the same level as that of an anesthesiologist.

**AANA Request: Clarify the Patient Relationship Categories and their Corresponding Levels of Financial Risk Attribution**

We request clarification of the patient relationship categories and their corresponding levels of financial risk attribution. We note that in the model, a clinician’s patient relationship category changes for each episode of care he or she furnishes as does his or her corresponding level of financial risk attribution. The *ACS-Brandeis* model classifies an anesthesia provider (e.g., anesthesiologist) as a *Supporting Provider* with financial risk at 30 percent for a procedural episode, but the methodology did not explain how they determined that this percentage was an appropriate level of risk. Furthermore, there is no data provided to substantiate these cost distributions relative to the clinical role. Given that resource use is a key factor in assessing a clinician’s performance in this model and is used in determining shared shavings or shared risk, the AANA requests that ACS explain their attribution methodology so that it clearly reflects the cost of anesthesia care services provided by CRNAs and other anesthesia care providers. It is critical that the *ACS-Brandeis* model does not unfairly burden anesthesia care providers for costs that are unrelated to the services they provide particularly when it comes to issues such as readmissions and complications.

**AANA Request: Identity the 54 Proposed Procedural Episode Groups used in this Model**

We request that the proposal identify the 54 proposed procedural episode groups that are included in this model. It is critical that prior to implementation of this model, CRNAs are able to examine what procedures will be included so that they are aware of the level of services (i.e. simple or complex) they may be expected to provide as well as the potential costs associated these procedures. The current CMS bundled payment initiatives such as the Bundled Payments for Care Improvement (BPCI) and the Comprehensive Joint Replacement (CJR) programs list the procedures that are being tested and their respective diagnosis related groups (DRGs). The AANA requests that the *ACS Brandeis* model publish its list of procedural episodes, codes, grouper logic, and any corresponding documentation before PTAC makes any determinations.

**AANA Comment: Proposal makes Mention of Rural and Small Practices’ Ability to Participate but Does Not Address Barriers for Participation**
The ACS-Brandeis model makes mention of the ability of rural and small practices to participate in this model, but the proposal does not do enough to address barriers of participation for these practices. The ACS-Brandeis model recommends that small and rural providers consolidate their practices or convene as a group in order to be able to participate. This suggestion, however, does not deal with the challenges and barriers faced by small group practices. One challenge is the difficulty of implementing electronic health records (EHRs) into a solo or small surgical or anesthesia group practice. Using EHRs is a fundamental requirement for an advanced APM but many small and rural providers lack access to the capital and infrastructure needed. There is also a shortage of qualified personnel available to implement and maintain a practice’s EHR system. If the intent of the model is to allow rural and small practices to participate, we request that the proposal address the barriers that these practices face.

The AANA appreciates this opportunity to comment and requests for additional occasions in which we may participate and provide input regarding the proposed ACS-Brandeis APM. Should you have any questions regarding this matter, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202 741 9080 or rko@aanadc.com.

Sincerely,

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

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