September 10, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1693-P  
P.O. Box 8016  
7500 Security Boulevard  
Baltimore, MD  21244

RE: CMS-1693-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program; Proposed Rule (83 Fed.Reg. 35704 July 27, 2018)

Dear Ms. Verma:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on this proposed rule; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (83 Fed.Reg. 35704, July 27, 2018). The AANA makes the following comments and requests of CMS:

MODERNIZING MEDICARE PHYSICIAN PAYMENT BY RECOGNIZING COMMUNICATION TECHNOLOGY-BASED SERVICES

- Ensure that New Communication Technology-Based Services Are Not Used for Tele-supervision of CRNA Services
- Allow Virtual Check-Ins for Acute and Chronic Pain Services Provided by CRNAs

COMMENT SOLICITATION ON CREATING A BUNDLED EPISODE OF CARE FOR MANAGEMENT AND COUNSELING TREATMENT FOR SUBSTANCE USE DISORDERS
• In the Context of Managing Chronic Pain Patients, CRNAs who Provide Chronic Pain Care Services Also May Be Addressing Substance Use Disorders

• Medicare Should Promote CRNA Services Regarding Multimodal Pain Management and Enhanced Recovery After Surgery and the Use of Other Opioid Sparing Techniques in an Effort to Reduce the Need for and Reliance on Opioids

• Ensure that Medicare Carriers Do Not Limit Medically Necessary CRNA Pain Management Services

POTENTIALLY MISVALUED SERVICES UNDER THE PFS

• Support Proposal to Maintain Work RVU for CPT Code 64405

E&M CHANGES

• Streamlining of E & M Services Could Result in Unintended Consequences on Patient Care

• Assure that CRNAs and Other APRNs Are Not Precluded from Reimbursement for All Levels of the Revised Office and Outpatient E&M Visits and That Visit Complexity Add-On Codes for Interventional Pain Management Apply to CRNAs

QUALITY PAYMENT PROGRAM

• Support Proposal to Allow Clinicians Who Meet One of the Low-Volume Threshold Criteria to Opt-In To MIPS

• Allow for Clinicians Who Have Switched TINs During the MIPS Determination Period to Opt-In

• Shorten the Minimum Reporting Period for the Quality Performance Category to Continuous 90 Day Period in Line with the Promoting Interoperability and Improvement Activities Performance Categories

• Change CMS Definitions to Better Reflect Quality Measure Types, Submission Method and Submitting Entity

• Do Not Require Individual Eligible Clinicians and Groups to Have to Submit Six Measures within a Measure Set Unless it is Applicable to Their Practice

• Reduce the Data Completeness Requirement for Quality Performance Category to 50 Percent for Clinicians with Two or More Special Status Categories

• Support the Application of Facility-Based Measures to All Eligible MIPS Clinicians such as CRNAs for the Quality Performance Scoring and Assure that Provider Facility Attribution is Clearly Highlighted in the QPP Lookup Tool

• Do Not Remove Topped Out Measures Predominately Relevant to Non-Patient Facing Clinicians Such as MIPS CQM 426 and 427
• Assure that CRNAs are Represented in the CMS Study on Factors Associated with Reporting Quality Measures
• Do Not Support Proposal to Change Quality Scoring Points from 1 to 0 Based on Data Completeness for Non-Small Groups
• Do not Transition the Small Practice Bonus to the Quality Performance Category and Maintain the High-Priority Measure Incentive
• Maintain Performance Threshold at 15 Points
• Indicate a Disclaimer on the Clinician’s Profile on Physician Compare That They are Exempt from Participating in the Promoting Interoperability Performance Category
• Support and Adopt Continuity of Pharmacotherapy for Opioid Use Disorder Measure, Proposal for Patient Medication Risk Education Improvement Activity, and Proposal for Use of Patient Safety Tools Improvement Activity
• Assure that CRNAs in Multispecialty Groups Have Access to Cost Reports that Provide Detailed Anesthesia Cost for Clinician that Contributes to the Overall Cost of an Episode
• Set the Starting CEHRT Use Criterion to 50 Percent for Advanced APMs with an Annual Incremental Increase of 5 Percentage Points

REQUEST FOR INFORMATION ON PRICE TRANSPARENCY: IMPROVING BENEFICIAIRY ACCESS TO PROVIDER AND SUPPLIER CHARGE INFORMATION

• CMS Can Address Underlying Causes of Surprise Billing by Issuing a Proposed Rule on Provider Non-Discrimination Provision and by Promoting Adequate Provider Networks in Medicare Advantage Plans and Health Plans Inside the Marketplace
• CMS Can Work with Stakeholders in Developing Guidance to Educate Consumers on Questions to Ask Their Insurance Companies

REQUEST FOR INFORMATION ON PROMOTING INTEROPERABILITY AND ELECTRONIC HEALTHCARE INFORMATION EXCHANGE

• CMS Should Apply Provisions Set Forth in the Quality Payment Program for Special Status Clinicians to the Development of Any New Medicare Condition of Participation

Background of the AANA and CRNAs
The AANA is the professional association for 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

1 Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economic$. 2010; 28:159-169.


4 Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. Medical Care June
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 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.\(^6\)

MODERNIZING MEDICARE PHYSICIAN PAYMENT BY RECOGNIZING COMMUNICATION TECHNOLOGY-BASED SERVICES

**AANA Request: Ensure that New Communication Technology-Based Services Are Not Used for Tele-Supervision of CRNA Services**

The AANA is supportive of telehealth and the Centers for Medicare & Medicaid Services’ (CMS) efforts to modernize payment for communication technology-based services, especially as it improves the quality of care provided for all patients. However, the AANA cautions against the use of wasteful services in the name of telehealth that would increase costs without improving healthcare access or quality. As CMS is considering making separate payment for such services as internet consultation and chronic care remote physiologic monitoring, we stress that one wasteful payment policy to avoid would be covering anesthesiologists that are not providing actual anesthesia care, through billing for remote so-called “supervision” services. This type of remote supervision would not improve access to healthcare for patients and would

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\(^6\) Liao, op cit.
instead reward providers not actually furnishing healthcare services. Furthermore, as there is no evidence of the efficacy and cost-effectiveness of in-person physician supervision requirements, there also is no evidence regarding the benefit for the use of supervision of anesthesia via telehealth. In these instances, anesthesiologist tele-supervision of CRNA services would not meet CMS’s criteria for Medicare telehealth services of providing a clinical benefit to the patient. Therefore, we ask in this and future rules that CMS prohibit wasteful anesthesiologist tele-supervision of anesthesia delivery from being included among these telehealth services.

**AANA Request: Allow Virtual Check-ins for Acute and Chronic Pain Services Provided by CRNAs**

The AANA supports the creation of G-code CVCI1 and encourages CMS to ensure that this could be used for checking in provided by CRNAs for the management of both chronic pain services and acute pain services following discharge from the outpatient setting. As a main provider of pain management services and as APRNs, CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient centered, compassionate and holistic manner in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics). For patients who are in rural areas or who have difficulty traveling for an office visit, this virtual service allows the CRNA to collaborate with the patient to optimize management without having to schedule unnecessary office visits. CRNAs who provide chronic pain management services are currently using telehealth tools to manage patients. For instance, CRNAs may provide teleconference evaluations and follow up on patient with chronic pain who are unable to drive in for a visit.

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7 See B. Dulisse and J. Cromwell op cit. and Paul F. Hogan et. al, op cit.


We also recommend that virtual check-ins be used for acute pain following patient discharge from the outpatient setting. In these instances, CRNAs are uniquely skilled to provide acute pain management and do so by employing opioid-sparing techniques that may require assessment of the patient’s unique pain experience to bridge to non-opioids for the transitions from a regional or block technique. Research suggests that postoperative pain continues to be undertreated. To help manage acute pain after discharge and to reduce the instances of undertreatment or over treatment with an opioid, we suggest that this check in could be used by CRNAs to ensure that patients with acute pain after discharge is appropriately managed and addressed or whether a follow up visit is needed.

COMMENT SOLICITATION ON CREATING A BUNDLED EPISODE OF CARE FOR MANAGEMENT AND COUNSELING TREATMENT FOR SUBSTANCE USE DISORDERS

AANA Comment: In the Context of Managing Chronic Pain Patients, CRNAs who Provide Chronic Pain Care Services Also May Be Addressing Substance Use Disorders

We appreciate that CMS is considering options for the treatment of substance use disorders (SUD). As CMS considers options such as a separate payment for a bundled episode of care, we want to highlight that CRNAs providing chronic pain are part of the new paradigm to promote compassionate and effective pain care and simultaneously act as practitioners to decrease abuse, addition, and diversion of opioid prescriptions. CRNAs do address psychological and associated substance abuse potential of patients experiencing chronic pain disorders. CRNAs also act as educators who help other practitioners and patients effectively manage pain using opioid sparing techniques to decrease the risk of opioid misuse and addiction.

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The AANA appreciates the opportunity to comment on strategies to improve existing requirements in order to more effectively address the opioid epidemic. The AANA is concerned in the increase in opioid drug use, abuse and deaths and is committed to collaboratively working toward a common solution to help curb the opioid epidemic in the United States. As the risk of opioid dependence and addiction begins with the first exposure, we recommend that CMS promote comprehensive multimodal pain management in all clinical settings. As a positive step, we recommend that CMS create a reimbursement model that provides a reimbursement incentive for comprehensive multimodal pain management with access to opioid rescue available in all settings from offices to healthcare facilities and for the treatment of acute and chronic pain.

As a main provider of pain management services and as APRNs, CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient-centered, compassionate and holistic manner in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics). Furthermore, the holistic approach that CRNA pain management practitioners employ when treating their chronic pain patients may reduce the reliance on opioids as a primary pain management modality, thus aiding in the reduction of potential adverse drug events related to opioids.

In developing the plan of care for the management of chronic pain for the patient, CRNAs obtain patient history, evaluate the patient, order and review necessary diagnostic testing, and assess the patient’s psychological and emotional state. Non-pharmacologic pain mitigation techniques are often employed in the treatment of chronic pain and considered as part of the care plan. These techniques may include patient education regarding behavioral changes that can decrease pain, such as weight loss, smoking cessation, daily exercise, stretching, and physical or chiropractic therapy. Such therapies may not be sufficient when used alone, but they have significant benefit when they are used in a complementary manner with other therapies.
As anesthesia professionals, CRNAs also help to decrease or eliminate the need for opioids by collaborating with the patient and the interdisciplinary team on a comprehensive plan for pain relief known as enhanced recovery after surgery, or ERAS.\textsuperscript{11} Using specific protocol-driven ERAS pathways improves patient outcomes by reducing the patient’s stress response to surgery, shortening the overall hospital length of stay, and accelerating the return to normal daily function. The patient’s pain management plan of care begins pre-procedure and continues through post-discharge using opioid-sparing techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures. The evidence is quite clear that careful assessment, evaluation, and treatment of acute pain, with appropriate prescribing of an opioid, may prevent access to unused opioids and development of opioid dependency and abuse. CRNAs play a critical role by ensuring proper anesthesia services management which can make a tremendous difference in terms of improving patient flow, patient safety, and cost savings.

**AANA Comment: Ensure that Medicare Carriers Do Not Limit Medically Necessary CRNA Pain Management Services**

The AANA recommends that CMS should ensure that Medicare carriers do not limit patient access to the use of medically necessary CRNA pain management. Leading physician subspecialty organizations in pain management research, practice guideline development, and education are known to use economic and advocacy means to exclude other members of the pain management team, such as CRNAs, from educational and practice opportunities, thereby limiting patient access to care, diagnosis, treatment, and ultimately improved patient quality of life. A report issued in April 2015 by the FTC, “Competition and the Regulation of Advanced Practice Registered Nurses,” underscores the point that for CRNAs and other APRNs, “even well intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition.”\textsuperscript{12} Therefore, we recommend that CMS be cognizant of these barriers and require


Medicare contractors to follow Medicare regulations and policy and to not impose barriers that limit a CRNA’s ability to provide comprehensive pain management care. Limitations to patient access to these services are also counterproductive in the fight against the opioid epidemic and contradict the agency’s opioid road map. In the interest of patients and the public, the education, regulation, and reimbursement of each member of the pain management team should allow the team to practice to the full extent of their education and training.

POTENTIALLY MISVALUED SERVICES UNDER THE PFS

AANA Request: Support Proposal to Maintain Work RVU for CPT Code 64405

The AANA supports and appreciates that CMS is maintaining the work RVU for CPT code 64405 (Injection, anesthetic agent; greater occipital nerve), which is a common injection performed by CRNAs for occipital neuralgia, a very common disorder. The greater occipital nerve, a branch of the second cranial nerve and fibers of the third cervical nerve, exits the fascia covering the skull at the same location as the occipital artery. Injection to this nerve requires palpating the nuchal ridge and palpating the occipital artery to avoid accidental injection into the artery. The correct needle insertion is just medial to the occipital artery, advancing the needle to meet the periosteum of the occipital bone, which may result in a paresthesia. Medication is injected in a fanlike fashion with care that the needle not go too medial. The block can be used as a therapeutic injection in addition to acting as a diagnostic block. Because of the importance of this service in managing pain, we recommend that CMS not devalue the work RVU associated with this procedure.

E&M CHANGES

AANA Comment: Streamlining of E & M Services Could Result in Unintended Consequences on Patient Care

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While we appreciate the agency’s efforts to reduce clinician burden and confusion as it relates to evaluation and management (E & M) payment, we are concerned that this streamlined payment could lead to a harmful “race to the bottom,” which could have an effect on patient care. Implementing a single payment rate for E & M visit levels two through five could adversely disincentivize practitioners who used to provide care at E&M levels three and higher to do the bare minimum for reimbursement. We caution CMS about this unintended consequence.

**AANA Request: Assure that CRNAs and Other APRNs Are Not Precluded from Reimbursement for All Levels of the Revised Office and Outpatient E&M Visits and That Visit Complexity Add-On Codes for Interventional Pain Management Apply to CRNAs**

CMS should ensure that CRNAs are not precluded from furnishing and being reimbursed for all levels of E&M visits and from using the add-on code for interventional pain management as long as these services are medically necessary and within state scope of practice. We ask CMS to ensure that these services and the add-on code both apply to CRNA specialty code 43 under the Healthcare Provider Taxonomy Code Set. As noted earlier, CRNAs are the main provider of pain management services and are uniquely skilled to provide interventional pain management in a patient centered, compassionate and holistic manner in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics). Furthermore, as Medicare covers medically necessary CRNA services within state scope of practice according to 42 CFR §410.69(b), we request that CMS ensure that CRNAs are reimbursed for these services and can use the add-on code for interventional pain management.

**QUALITY PAYMENT PROGRAM**

**AANA Request: Support Proposal to Allow Clinicians Who Meet One of the Low-Volume Threshold Criteria to Opt-In To MIPS**

The AANA applauds CMS for continuing to address the issues and challenges faced by individuals, small groups, rural health providers, and non-patient facing clinicians as they engage in the Merit-Based Incentive Payment System (MIPS) program. More specifically, we support

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CMS’s effort to make MIPS reporting accessible to more clinicians through options such as allowing clinicians who meet one of the low-volume threshold criteria to opt-in and to provide clinicians the opportunity to voluntarily report without holding them subject to the payment adjustment. Providing more providers the opportunity to opt-in enables individual and small groups the flexibility needed to transition into MIPS and allows these clinicians to determine feasibility.

**AANA Request: Allow for Clinicians Who Have Switched TINs During the MIPS Determination Period to Opt-In**

We appreciate that CMS recognizes that if a clinician who joins a new or existing TIN during the last 90 days of the performance period will have difficulty participating in MIPS. It is not uncommon for CRNAs to be associated with 2, 3, or 4 TINs and potentially move to a new TIN during a performance period. While we agree with aligning and streamlining the MIPS determination periods for determining eligibility of multiple status determinations for the payment adjustment, we do have some concerns with determining MIPS eligibility in the second segment recognizing that the payment adjustment is based on participation within the performance period. This is especially concerning since CMS describes a scenario where a clinician initially exceeded the low-volume threshold criteria under one TIN, then switched practices under a new TIN and undergo a second determination analysis during the determination period. In this scenario, CMS states that “the eligible clinician may not find their TIN or TIN/NPI in the Quality Payment Program lookup tool but may still be eligible if they exceed the low-volume threshold in the second segment.” We note that the second segment will determine eligibility while the provider is currently in the performance period affecting the payment year. Moreover, this determination may occur mid-performance period making participation nearly impossible for many CRNAs based on MIPS performance category participation requirements.

We recommend that a first quarterly snap shot for the second segment determination period be mandatorily accessible to providers in the look up tool no later than January 1, 2019, the first day of the performance period. We also recommend that if the provider does not exceed the low volume threshold then they should be automatically excluded from MIPS unless further snap shots allow for an opt-in in accordance to the proposed low-volume threshold opt-in provision.
Further, if a provider exceeds the low-volume threshold during the second segment of MIPS eligibility determination period, the clinician should remain excluded unless the clinician opts-in. While we understand that CMS places importance on capturing as many eligible clinicians in the program, it is equally important to recognize the burden placed on clinicians who are transitioning between group practice TINs and practice environments. Recognizing that CRNAs may not have a full year to meet participation requirements, our recommendation will allow clinicians to determine if they are prepared to participate and opt-in during the new TIN transition period.

**AANA Request: Shorten the Minimum Reporting Period for the Quality Performance Category to Continuous 90 Day Period in Line with the Promoting Interoperability and Improvement Activities Performance Categories**

While the AANA supports that the MIPS performance period remain over an entire calendar year, we do not support requiring the submission of quality measures for an entire calendar year as the minimum reporting period. However, we continue to support CMS’ proposal to allow a minimum continuous 90-day reporting period for the promoting interoperability and improvement activities performance categories and recommend that the same minimum continuous 90-day reporting period apply for the quality measures performance category. CRNAs continue to face burdens with identifying appropriate measures applicable to their place of service, implementing measures into practice to meet specification criteria, adapting new qualified clinical data registry (QCDR) measures into practice, and identifying a third-party vendor for registry or QCDR to appropriately submit data on their behalf. Like the minimum continuous 90-day period within the calendar year for promoting interoperability and improvement activities performance categories, this allows CRNAs to adequately prepare for the program changes in program requirements. Because there is a lack of consistency in quality measures from year-to-year, adequate time within the performance year is needed to prepare and modify internal processes which does not lend well to a full calendar year. Without altering the lead time for registry and QCDR measure release and adoption, reporting for a full calendar year is an impossible task. Therefore, we recommend that quality measures also have the same minimum continuous 90-day reporting period as the promoting interoperability and improvement activities.
AANA Request: Change CMS Definitions to Better Reflect Quality Measure Types, Submission Method and Submitting Entity

While we appreciate CMS’ acknowledgment that the terms that they have developed both previously and in this proposed rule do not reflect user experiences, the AANA believes the definition of terms relative to the wireframe examples for collection type, submission type, and submitter type do not adequately reflect the clinician’s role and do not account for the relationships and interactions between the clinicians and third-party intermediaries that submit data on the clinician’s behalf. For example, based on the proposed definitions, it is unclear how an individual clinician (submitter type) would identify which platform directly submits (submission type) a QCDR measure (collection type) or what mechanism a group practice (submitter type) should use to log in and upload (submission type) an improvement category. Without further delineation of the roles and responsibilities of third party intermediaries, clinicians are left with the burden of deciphering what submission mechanism to use and what information is being submitted on their behalf. This alone is a major burden and hurdle for clinicians who want to successfully participate in MIPS. Since it is the eligible clinician who is subject to the payment adjustment, we recommend that more clarity be placed on guiding clinicians as to what submission mechanisms support the data requirements requested by third parties and/or what performance categories third parties support.

The AANA recommends changing the term “submission type” to “submission method” and to define the mechanisms by which CMS means by “direct,” “log in,” “upload,” and “attest.” We also recommend that CMS change “submitter type” to “submitting entity” and define this as the entity who will be submitting the eligible clinician’s data. If the “collection type” definition only refers to quality measures, we recommend changing “collection type” to “quality measure type” and request that CMS provide a definition for data collection recognizing that all performance categories collect data. The fact that clinicians require more descriptive and in-depth definitions exemplifies the complexity of the program and the burden clinicians face in trying to decipher participation requirements.
**AANA Request: Do Not Require Individual Eligible Clinicians and Groups to Have to Submit Six Measures within a Measure Set Unless it is Applicable to Their Practice**

We do not understand the purpose behind CMS’s proposal for individual eligible clinicians or groups to have to “submit data on at least six measures within [a] set, provided the set contain at least six measures.” The concept that an EC or group must submit at least six measures within a measure set harkens back to the Measure Applicability Validation (MAV) process under PQRS, which was historically problematic for CRNAs due to the constraints stemming from the anesthesia measure specifications. Given that individual eligible clinicians and groups should only submit data that applies to their practice and not a fixed number of measures within a measure set, this proposed language should not be included in the final rule.

It would be impossible to meet the measures requirement if CRNAs had to rely on the proposed six measures in the MIPS Anesthesiology Set as not all the measures in the set apply to all types of anesthesia services and settings. Should CMS adopt this proposal in the final rule, we request that CMS clarify how the requirement applies when clinicians submit both MIPS clinical quality measures (CQMs) and QCDR measures to meet the quality performance category requirements recognizing that few anesthesia professionals will meet this requirement.

**AANA Request: Reduce the Data Completeness Requirement for Quality Performance Category to 50 Percent for Clinicians with Two or More Special Status Categories**

We continue to have concerns with the 60 percent data completeness requirement for CRNAs. Participation in MIPS is challenging as CRNAs typically meet multiple special status categories as non-patient facing ASC-based or hospital-based clinicians. Participation is further compounded for CRNAs who practice in health professional shortage areas (HPSAs) or in small groups. Because many anesthesia measures apply to CRNAs at each encounter, this suggests that CRNAs must be fully prepared to participate in MIPS by the fifth month of the performance period to meet the requirements. Further, to assure that CRNAs have at least six or more measures to obtain enough points, CRNAs must defer to a QCDR to select additional measures due to the limited number of applicable measures in the MIPS Anesthesiology measure set. Given the evolving nature of measure specifications from year to year and the limited lead time
needed to implement these measures, we recommend that individual MIPS eligible clinicians or
groups with two or more special status determinations have their data completeness requirement
reduced to 50 percent for patients across all payers in the performance. We recommend that this
data completeness criteria apply to CRNAs if facility-based measures are not attributed to the
clinician.

**AANA Request: Support the Application of Facility-Based Measures to All Eligible MIPS
Clinicians such as CRNAs for the Quality Performance Scoring and Assure that Provider Facility Attribution is Clearly Highlighted in the QPP Lookup Tool**

The AANA supports the use of facility-based measures through the Hospital Value-Based Purchasing (VBP) Program as a means of reducing burden among providers who are MIPS eligible. We also support extending this option to on-campus outpatient hospital POS code (POS code 22). Like anesthesiologists, a significant portion of CRNAs are non-patient facing, hospital-based clinicians who provide services in the emergency department, inpatient and outpatient hospital settings. This feature will ease the quality reporting burden on CRNAs who are attributed to the facility.

We agree with the proposal to automatically apply the facility-based measurement to MIPS CRNAs or group only if they would benefit from a higher combined quality and cost performance category score, which would be similar to CRNAs choosing a mixed-specialty group reporting option. We strongly encourage CMS to ensure that facility attribution is readily accessible on the QPP look up tool for the MIPS 2019 performance period to assist CRNAs in recognizing when they are covered under the VBP or not.

**AANA Request: Do Not Remove Topped Out Measures Predominately Relevant to Non-Patient Facing Clinicians Such as MIPS CQM 426 and 427**

While we agree that topped out measures may be a data collection burden without noticeable added value to the clinician or group, the AANA is very concerned by the number of applicable MIPS CQMs available to CRNAs. Without a concerted effort to expand measure specifications to include non-patient facing CPT codes, we recommend that measures attributed to non-patient facing providers be excluded from the removal process to assure that CRNAs do not face
additional MIPS participation burden. More specifically, we urge CMS to retain measures 426 (Post-Anesthetic Transfer of Care: Procedure Room to a Post Anesthesia Care Unit) and 427 (Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direction Transfer of Care from Procedure Room to Intensive Care Unit) given the current challenges CRNAs face with identifying applicable measures to practice are addressed.

**AANA Request: Assure that CRNAs are Represented in the CMS Study on Factors Associated with Reporting Quality Measures**

We appreciate CMS’s dedication and interest in getting at the crux of clinicians’ burden with respect to performance measure data collection and submission as well as challenges that hinder accurate and timely quality measurement activities. We anticipate that there are sufficient numbers of clinicians that meet the CMS special status requirements in the six specialty groups. While many clinicians may be categorized as either hospital based or non-patient facing in the sample, we request that CMS also ascertain the burden placed on special status clinicians in outpatient and ASC facilities. For this reason, we believe that the quality reporting burden study must include a sample of clinicians with multiple special status categories, such as CRNAs.

**AANA Request: Do Not Support Proposal to Change Quality Scoring Points from 1 to 0 Based on Data Completeness for Non-Small Groups**

We request that whole special status groups, like CRNAs, receive at least three points for attempting to participate when they submit quality data. Anesthesia services are not a one size fits all service in terms of the anesthesia care plan, anesthesia technique, modality, and setting. Given the continued administrative burden CRNAs face in finding vendors with adequate anesthesia measures that apply to outpatient facilities like ASC or clinic settings, we believe it is unfair to penalize providers with zero points when they are spending significant time and resources trying to participate.

**AANA Request: Do not Transition the Small Practice Bonus to the Quality Performance Category and Maintain the High-Priority Measure Incentive**
We urge CMS not to transition the small practice bonus from the final score calculation to the quality performance category. We also recommend that CMS maintain the high-priority measure incentive points for anesthesia measures since these bonus points do not inflate CRNA total scores. CRNAs in small groups have few MIPS CQMs to choose from forcing them to participate in costly QCDRs. Currently, many anesthesia specific QCDR measures have minimal variation lending to insufficient higher deciles needed to achieve higher points for any given anesthesia measure. We estimate that CRNAs in small groups who maximally participate in the quality MIPs category even with the category reweights will achieve approximately 35 points \((18 + 3 \text{ bonus}/60 \times 85\% \times 100 = 35)\). This maximum effort in the quality category, in addition to the significant administrative time and cost it requires to participate via a QCDR is almost a 1 measure difference from being assessed a penalty, especially if the composite score point threshold is raised to 30 points. This is further exacerbated if the incentives to report high-priority anesthesia measures are eliminated. In cases where providers meet multiple special status categories, like non-patient facing and small group status with limited MIPS CQMs, we recommend that these providers continue to receive a 5-point bonus to the total MIPS score to recognize significant participation.

**AANA Request: Maintain Performance Threshold at 15 Points**

We recommend that CMS maintain the performance threshold at 15 points instead of increasing it to 30 points. We are concerned that as CMS continues to increase its performance threshold points, more and more CRNAs will be subject to unfair penalties under a program that is not conducive to assessing high-performing CRNAs given the lack of anesthesia-related measures, low achievable points due to quality measure benchmarking, cost measures that are not applicable to anesthesia, and a CRNA’s inability to participate in the promoting interoperability category. Anesthesia is applauded for its safety record. According to a study looking at anesthesia related complications, only 8 in every 10,000 anesthesia-related procedures resulted in complications for all settings, and complications were less likely in outpatient settings where
only 4 per 10,000 were found.\textsuperscript{15} While category reweighting helps CRNAs focus their efforts in the program, the AANA estimates that CRNAs will likely only achieve 40.5 points with full participation using a QCDR, excluding bonus points. This is primarily due to quality performance decile benchmarking. Therefore, CRNAs are placing a significant amount of time, money, and resources in achieving performance scores to meet the minimum performance threshold. To relieve this burden, we recommend keeping the minimum performance threshold at 15 points.

**AANA Request: Indicate a Disclaimer on the Clinician’s Profile on Physician Compare That They are Exempt from Participating in the Promoting Interoperability Performance Category**

As CMS proposes to maintain an indicator for “successful” performance for the Promoting Interoperability category on Physician Compare for MIPS eligible clinician, we ask that the agency note that a clinician is exempt from a performance category. For example, the agency could use the disclaimer “NOTE: CRNAs are Exempt from Participating in the Promoting Interoperability Performance Category.” Doing so will help ensure that the public has accurate information, and will not mislead the public or leave any impression that such MIPS eligible clinicians are somehow poor performers on the Promoting Interoperability performance category.

**AANA Request: Support and Adopt Continuity of Pharmacotherapy for Opioid Use Disorder Measure, Proposal for Patient Medication Risk Education Improvement Activity, and Proposal for Use of Patient Safety Tools Improvement Activity**

We applaud the agency’s dedication to promoting the measurement of opioid use and overuse, risk, monitoring, and education through quality reporting and for developing new and revising existing improvement activities to incorporate the use of patient medication risk education and opiate risk tools. The AANA is concerned in the increase in opioid drug use, abuse and deaths and is committed to collaboratively working toward a common solution to help curb the opioid

\textsuperscript{15} Negrusa Op cit.
epidemic in the United States. As such, we support the agency’s proposal to redefine the definition of high priority measures to include opioid-related quality measures. Furthermore, we support CMS’s proposal to include “Continuity of Pharmacotherapy for Opioid Use Disorder” as a MIPS Quality Measure.

We also applaud the agency’s inclusion of “Patient Medication Risk Education” as a new improvement activity. CRNAs have in-depth pharmacology background in anesthesia and analgesia drugs and are well positioned to provide written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients. We support this new proposed improvement activity and the agency’s proposal to weigh this as a high activity.

Finally, the AANA supports CMS’s proposal to add the use of the opiate risk tool into the existing improvement activity of “Use of Patient Safety Tools.” We agree with the agency that the inclusion of the use of this tool can be undertaken to meet the requirements of this activity.

**AANA Request: Assure that CRNAs in Multispecialty Groups Have Access to Cost Reports that Provide Detailed Anesthesia Cost for Clinician that Contributes to the Overall Cost of an Episode**

The AANA believes that it is essential for individual clinicians to know and understand how their costs contribute to an overall cost in an episode. Our review of the trigger codes for the eight episode cost measures indicates that no anesthesia-related HCPCS/CPT codes are listed as episode trigger codes. Although there are no anesthesia trigger codes, seven of the eight proposed episode cost measures will include costs related to anesthesia services. Based on this information, a CRNA who participates in MIPS episode cost measures as an individual may not be attributed any cost episodes measures and will be subject to the performance category reweight. CRNAs who are a part of a mixed specialty group practice and who participate in MIPS using the group reporting option will be given a cost score if the group meets the case minimums for the episode cost measures, which will count towards their MIPS composite score.
The AANA requests that CMS provide CRNAs access to clearly delineated cost reports to better illustrate anesthesia’s value within the episode and in order affect meaningful change in cost relative to other providers in the group TIN/NPI. For CRNAs who have a cost score based on group reporting, we recommend that CMS add cost measure scores such as dollar amounts to the average share of cost per episode for each clinician in the attributed group TIN. This will accurately reflect the portion of the episode that each clinician is responsible for in terms of cost. We also recommend that CMS provide clinical quality and utilization costs for each clinician, including anesthesia professionals. Finally, we recommend that these cost reports include site of service information as costs may vary widely between inpatient and outpatient surgical locations.

**AANA Recommendation: Set the Starting CEHRT Use Criterion to 50 Percent for Advanced APMs with an Annual Incremental Increase of 5 Percentage Points**

The AANA is concerned that the proposal to set the Advanced APM (AAPM) minimum CEHRT use threshold at 75 percent for CY 2019 is too drastic an increase to implement and will cause major disruption and low adoption into the program. Given how complicated it has been for providers to adopt CERHT as demonstrated by the previous Meaningful Use Program, we believe a minimum CEHRT use threshold at 75 percent would be onerous. Instead, we recommend that the agency set the starting CEHRT use criterion at 50 percent for provider groups and APM entities that are new to the AAPM with an annual incremental percentage increase of approximately 5 percent for existing entities. We believe this gradual percentage increase will allow provider groups and APM entities time to adapt to these new levels over an appropriate amount of time. Furthermore, by adopting this approach, we believe CMS will encourage more providers to participate in an Advanced APM.

**REQUEST FOR INFORMATION ON PRICE TRANSPARENCY: IMPROVING BENEFICIARY ACCESS TO PROVIDER AND SUPPLIER CHARGE INFORMATION**

**AANA Comment: CMS Can Address Underlying Causes of Surprise Billing by Issuing a Proposed Rule on Provider Non-Discrimination Provision and by Promoting Adequate Provider Networks in Medicare Advantage Plans and Health Plans Inside the Marketplace**
The AANA appreciates the agency’s concern regarding the issues with insufficient price transparency, particularly with regards to patients being surprised by out-of-network bills. The economic burden of receiving care out-of-network can be substantial for patients. Furthermore, knowing which providers and services are in-network and out-of-network is a huge burden for the patient as well as the provider and the facility. CMS can address this issue best by addressing the underlying causes, such as inadequate networks offered by insurance plans and plans engaging in discrimination against providers based on their licensure or certification. While this is not an issue under Medicare Part B, as Medicare recognizes CRNAs as qualified providers and CRNAs must accept assignment as a condition for payment,\textsuperscript{16} this is an issue with private health plans, thus potentially affecting the private payer market and Medicare Advantage plans.

Therefore, it is important to highlight the harms of discrimination CRNAs currently face in the selection criteria that certain health plans develop, which determines the selection of providers that participate in their networks. CRNAs, acting within the scope of their license or certification under applicable state law or regulation, have experienced discrimination with respect to participation in qualified health plans, thus forcing them to become an out-of-network provider. Such discrimination may exacerbate surprise billing, impair consumer choice, reduce competition, and affect healthcare costs.

We recommend that CMS use its authority to further implement the federal provider nondiscrimination law by issuing a proposed rule. In 2010, Congress passed this 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 Healthcare, 42 USC §300gg-5”),\textsuperscript{17} which

\textsuperscript{16}See 42 §414.60 (c).

\textsuperscript{17}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
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. It prohibits discrimination based on provider licensure that keeps patients from getting the care they need.

To promote patient access to high quality healthcare, market competition and cost efficiency, all qualified health plans must all avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure or certification. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs of their enrollees. However, when health plans organize their healthcare delivery in such a way that discriminate against whole classes of qualified licensed healthcare professionals by licensure or certification, 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 the use of qualified, licensed, and certified healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers.

While we recognize that CMS has developed network adequacy standards in Medicare Advantage plans and in the Marketplace, CMS must do more to ensure that health carriers maintain networks that are sufficient in numbers and types of providers to assure that all services to covered persons will be accessible to them without unreasonable delay. The AANA believes that patients benefit the greatest from a healthcare system where they receive easily accessible care from an appropriate choice of safe, high quality and cost-effective providers, such as CRNAs. Therefore, we request that CRNAs be included in all health carrier network plans, which will help ensure network adequacy, access and affordability to consumers.

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.”
AANA Comment: CMS Can Work with Stakeholders in Developing Guidance to Educate Consumers on Questions to Ask Their Insurance Companies

We also recommend that CMS work with healthcare stakeholders, such as CRNAs, in developing consumer guidance documents on surprise billing, out-of-network coverage, and resources for assistance. For instance, this guidance could provide consumers with the education on questions to ask their insurance plans prior to procedures and where to go for help. We are happy to assist in the development of these patient tools.

REQUEST FOR INFORMATION ON PROMOTING INTEROPERABILITY AND ELECTRONIC HEALTHCARE INFORMATION EXCHANGE

AANA Request: CMS Should Apply Provisions Set Forth in the Quality Payment Program for Special Status Clinicians to the Development of Any New Medicare Condition of Participation

The AANA recognizes that health information exchange has the potential to improve the healthcare system in numerous ways by advancing interoperability and that health information exchange between patients, providers and health care settings is an important step toward realizing this potential. Furthermore, the AANA is a determined advocate for policy development that results in a connected, patient-centered healthcare system where health information is routinely shared across providers and settings of care to encourage the consistent provision of high-quality, safe, and affordable care. Most anesthesia professionals, such as CRNAs, lack the “face-to-face” interaction according to billing codes and have difficulty influencing the availability of anesthesia EHR technology in facilities due to cost and limited anesthesia certified EHR technology (CEHRTs) to choose from. According to our analysis of the 2014 Medicare Provider Utilization and Payment data, 98.7% of CRNAs billed for anesthesia services CPT codes 0100-0199, which CMS determined to be non-patient-facing codes for 2016.

In addition, issues around interoperability and electronic clinical quality measures that apply to anesthesia continue to be a challenge. Such difficulties were the impetus for CMS to provide Special Status to non-patient facing clinicians and hospital-based or ASC-based clinicians, such as many, if not most anesthesia professions. While CRNAs are not required to participate in the
MIPS Promoting Interoperability performance category, all anesthesia professionals should be granted similar exceptions in terms of CEHRT adoption similar to that under the Medicare Quality Payment Program. The evidence shows that adoption of specific anesthesia information management systems (AIMS) lags behind other segments in the healthcare industry and has low implementation rates in anesthesia departments. According to an August 2012 KLAS Performance Report, which reports on vendor performance data, fewer than 300 organizations nationwide are using or implementing AIMS. Low adoption of AIMS means that the surgical patient experience remains a black hole in the center of the grand plan for health information exchange. Furthermore, even with a robust certified AIMS system, it continues to be a challenge to meet some of the former meaningful use measures, some of which are now Promoting Interoperability measures. Due to few, if any comprehensive CEHRT anesthesia EHRs, clinicians must relay on modular AIMS, which may or may not be CEHRT, and have extensive technical experts on hand. Therefore, we request that CMS apply similar exceptions when considering changes to health information exchange requirements in CMS Conditions of Participation, Conditions for Coverage, or any CMS requests for proposals.

We thank you for the opportunity to comment on this proposed rule. 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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