August 21, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-5522-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244


Dear Ms. Verma:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on this proposed rule; Medicare Program; CY 2018 Updates to the Quality Payment Program (82 Fed.Reg. 30010, June 30, 2017). The AANA makes the following comments and requests of CMS:

A. MIPS Eligible Clinicians and Low-Volume Threshold Pgs. 30019-30026

- Support MIPS Clinician Participation Proposals and Provide Clinicians with Further Details in MIPS Participation Status Tool.
- Reduce the Burden on Clinicians Who Have NPIs Associated with More than One TIN by Accepting One Quality Measure or One Improvement Activity.

B. Virtual Groups Pgs. 30027-30034

- Allow Transitional Period for Virtual Group Reporting Option and Recommend that Participation in Groups Have Similar Patient Populations

C. Data Completeness Criteria Pgs. 30041-30043

- Maintain Current 50 Percent Denominator Data Submission Criteria for Registry Reporting and Shorten Reporting Period to a Minimum of Any Continuous 90-Day Period.

- Anesthesia Related Measures Require Substantive Changes and Proposed Measure Specifications Should Be Open to Public Comment Prior to Finalization into the MIPS Program

E. Application of Facility-Based Measures Pgs. 30043; 30123-30131

- Support the Expansion of Facility-Based Measurement via VBP Programs and Include Measures Associated with Future VBPs for the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

F. Topped Out Quality Measures Pgs. 30045-30047

- Topped Out MIPS Measures that are Removed Should Still be Made Available Via a QCDR

G. Cost Performance Category Pgs. 30047-30051

- Do Not Use the Episode-Based Cost Measures in the Weight of the Cost Performance Category Until CMS Can Ensure that Measures are Meaningful and Accurately Reflect the Care that is Influenced or Directly Managed by All Eligible Clinician Types.

H. 21st Century Cures Act Pgs. 30078-30079

- Support the Exclusion of Ambulatory Surgery Center Clinicians from the ACI Performance Category

I. Proposed Improvement Activities P. 30479-30500

- Activity Entitled “Completion of an Accredited Safety or Quality Improvement Program” Should Recognize and Include all Advanced Practice Nursing Accredited Continuing Education Programs
- Change Proposed PSH Care Coordination Activity to Perioperative Care Coordination
- Prohibit Wasteful Tele-Supervision of CRNA Services From Being Included as part of Improvement Activities
- Count Other Organizations’ Continuing Education Programs as Part of Activity on CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain.

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O. Data Validation and Auditing Pgs. 30157-30158
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• Shorten Look-Back Period for Recoupment of Payment to Three Years

P. QCDR Measure Specifications Criteria Pgs. 30160
• Allow QCDR Vendors to Seek Permission to Use Another QCDR’s Measure with the Caveat that the QCDR Refrain from Using Measures with Intentionally Biased Language

Q. Public Reporting on Physician Compare Pgs. 30163-30170
• Stratify Scores for Public Reporting So That Non-Patient Facing, Small Group, or Rural Providers are Benchmarked Against One Another and Use Caution in Reporting Group-Level QCDRs
• Indicate a Disclaimer on the Clinician’s Profile That They are Exempt from Participating in the Advancing Care Information Performance Category
• Include Board Certification Relevant for all Eligible Clinicians Including CRNAs on the Physician Compare Website
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 (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* $^1$, 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.

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

published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration. 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.

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. 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.

A. MIPS Eligible Clinicians and Low-Volume Threshold Pgs. 30019-30026

**AANA Request: Support MIPS Clinician Participation Proposals and Provide Clinicians with Further Details in MIPS Participation Status Tool**

The AANA applauds the Centers for Medicare & Medicaid Services (CMS) for continuing to address the issues and challenges faced by small groups, rural health providers, and non-patient facing clinicians as they engage in the Merit-Based Incentive Payment System (MIPS) program. We agree with CMS’ recommendation to increase the low-volume threshold, in addition to

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6 Liao, op cit.
allowing providers formerly deemed ineligible with the opportunity to opt-in to participate in the MIPS Program. Furthermore, we would like to thank CMS for providing clinicians the ability to use their National Provider Identifier (NPI) to determine their MIPS eligibility through the use of the “MIPS Participation Status Tool,” which has been helpful in determining a clinician’s low-volume threshold eligibility. However, some of our members reported confusion with how to participate in the program during the 2017 performance period given multiple definitions and classifications used throughout the Quality Payment Program (QPP).

We would like to offer our recommendations to improve the utility of the “MIPS Participation Status Tool,” which will help CRNAs and other clinicians better understand their responsibilities for participation. As requirements for participating in the QPP differ depending on all these classifications, CRNAs and other clinicians need to know if they meet these classifications. First, we suggest that CMS include whether or not a clinician is patient-facing or non-patient facing under the Clinician Details section. Second, we suggest that under the Practice Details section, CMS include whether the practice is a) a small group provider, b) a rural and health professional shortage area practice, and c) the type of entity, such as an alternative payment model (APM) participant, Next Generation ACO, or a Medicare Shared Savings Program ACO Participant along with the track.

AANA Request: Reduce the Burden on Clinicians Who Have NPIs Associated with More than One TIN by Accepting One Quality Measure or One Improvement Activity

It is pretty common for CRNAs to be associated with 2, 3, or 4 Tax Identification Numbers (TINS), and our members report the various challenges that they face when they are associated with more than one TIN. As a result, participation becomes more challenging, especially as it pertains to identifying measures and improvement activities for specific sub-populations. A reporting mechanism that works for one TIN may not be appropriate for another, placing undue financial and administrative burden on eligible clinicians to figure out multiple pathways for participation. To reduce this burden, we recommend that CMS accept one quality measure or one improvement activity for an NPI associated with multiple TINs.

B. Virtual Groups Pgs. 30027-30034
AANA Request: Allow Transitional Period for Virtual Group Reporting Option and Recommend that Participation in Groups Have Similar Patient Populations

We commend the agency for its proposals regarding virtual groups, and acknowledge that virtual group reporting can be beneficial for small groups and providers, particularly for those in rural areas. To assist in greater participation in virtual groups and to gain optimal utility from them, we offer the following comments regarding the agency’s proposals regarding reporting requirements, the election process, virtual group identifier, and virtual group agreements:

- As a new reporting option, we recommend that the virtual group reporting option should be a transition year for CY 2018 and CY 2019 performance periods so that individuals and groups can become familiar with the option along with the agreements and election process necessary to participate. Similar to CMS’s Pick-Your-Pace program offered for the 2017 performance period, we recommend that virtual groups have the option to test whereby the virtual group need only report one quality measure or one improvement activity to avoid a negative payment adjustment. We also recommend that virtual groups have the option to submit 90 continuous days of performance data any time during the performance period to earn a partial or full positive payment adjustment.

- We also recommend that participants in a virtual group share a similar patient population.

- While we understand that CMS is bound by MACRA statute to limit participation in a virtual group to not more than 10 MIPS eligible clinicians, we ask that CMS consider possible ways to increase this number to 15 to be in line with the MIPS program definition for a small group.

- To be consistent with the MACRA statute, we recommend that MIPS eligible clinicians and groups should elect to participate in a virtual group no later than December 31st to allow more eligible participants to consider this option as stage 1. Stage 1 of the election process should include intent to submit formal agreements.

- We recommend that the stage 2 final registration and election, which includes final documentation and confirmation of agreements for the virtual group, should occur no
later than June 30th to be consistent with the CMS Web Interface group reporting option deadline.

• We recommend that those NPI/TINs assigned a Virtual Group TIN who have not submitted a virtual group agreement in writing for stage 2 confirmation to CMS through the portal by June 30th shall not be held liable for the virtual group reporting option and members will default to reporting to MIPS as an individual clinician or other group reporting option.

• Finally, we recommend that the agency assure that feedback reports for virtual groups have understandable performance data that address how the Virtual Group TIN is affected relative to individual TINs. Information should consist of completeness of performance data on each performance category relative to sub scores and final score.

C. Data Completeness Criteria Pgs. 30041-30043

AANA Request: Maintain Current 50 Percent Denominator Data Submission Criteria for Registry Reporting and Shorten Reporting Period to a Minimum of Any Continuous 90-Day Period

Under this proposed rule, we are pleased to see that CMS is maintaining its data completeness criteria of 50 percent for the 2020 payment year. However, we have concerns with requiring a full calendar year reporting period. While we appreciate that CMS is allowing different submission mechanisms that may assist in increasing participation, we do not believe this will ease burden on clinicians. CRNAs have little option than to use a qualified clinical data registry (QCDR) because of too few applicable measures that can be reported via claims or qualified registry. We note that the final list for CMS-approved QCDRs with accompanying QCDR measures for the 2017 reporting period was not released until six months after the start of the performance period. Furthermore, individual clinicians and groups need at least 90 days to review applicable QCDRs, identify applicable QCDR measures, register, and make appropriate changes to workflow for measure documentation. More importantly, because there is a lack of consistency in QCDR measures from year-to-year, eligible clinicians need more lead time to
adopt measures in practice. Without altering the lead time for QCDR measure release and adoption, reporting for a full calendar year is an impossible task.

We, therefore, request that CMS shorten the reporting period to a minimum of any continuous 90-day period to be eligible for a small positive payment adjustment for those eligible clinicians who need to use a QCDR in order to participate in MIPS. We support the 90-day period because it is in line with CMS’s performance period proposals for the Advancing Care Information (ACI) and Improvement Activities categories. We also request that eligible clinicians who use a QCDR and submit some data short of the continuous 90-day period, should be eligible to remain neutral and avoid a payment adjustment.


AANA Comments: Anesthesia Related Measures Require Substantive Changes and Proposed Measure Specifications Should Be Open to Public Comment Prior to Finalization into the MIPS Program

We are concerned that CMS has carried over measures from the existing 2016 Physician Quality Reporting System (PQRS) anesthesia measure set that were not vetted by the AANA. Four of these measures were transferred without any regard as to how they would affect registry reporting for other anesthesia professionals besides anesthesiologists. The AANA supports the use of quality measures that are transparent, actionable, evidence-based, patient-centered and consensus-driven. Quality measures pertaining to anesthesia services should take into account all appropriate stakeholders, including CRNA input, regarding their professional role in the spectrum of anesthesia services and pain management. For this reason, the AANA supports measures that are subject to a legitimate stakeholder consensus development process, such as one as demonstrated by the National Quality Forum (NQF) consensus process, which includes a wide variety of healthcare stakeholders and employs a rigorous process of accountability to assure validity and reliability.

We oppose the agency propagating quality measures that have not met such a standard. The AANA maintains that a legitimate stakeholder consensus development process is one that
follows NQF’s “Candidate Consensus Standard Review,” which allows for public and member comment period. Furthermore, any anesthesia measure that has not undergone a consensus development process involving full disclosure of the measure, CRNA input, and vote, should put into question the integrity of that measure. Therefore, the AANA urges CMS not to allow the use of any anesthesia specific measure where a CRNA was not involved in the development of the measure when applied as CRNAs as MIPS eligible clinicians. While we are in support of the rationale of the proposed measure Prevention of Post-Operative Vomiting (POV)- Combination Therapy (Pediatrics) (p. 30265) for the 2018 performance period, we note that the AANA was not involved in the development nor was able to comment on this measure and potential specifications. We would ask that the agency include the AANA in the development of future measures.

We do thank the agency for making some modifications to measure specifications for the anesthesiology measure set that we recommended in our comments for the CY 2017 Quality Payment proposed rule. However, we continue to concerns with measure #404 Anesthesiology Smoking Abstinence. We want to highlight that the measure owner has not made any modifications to the specifications. Given its potential impact as an applicable measure for CRNAs, we would like to reiterate our concerns and recommendations for modifications:

- **Measure #404: Anesthesiology Smoking Abstinence**
  - The CPT codes included in the measure specifications do not include those primarily used by all anesthesia providers, such as CRNAs, thereby limiting the number of CRNAs who can report this measure.
  - The title and language used throughout the measure specification references “anesthesiologists” without regarding to any other anesthesia provider. Billers, managers, and administrative staff responsible for submitting quality actions codes on behalf of CRNAs assume that this measure only applies to anesthesiologists. CRNAs personally administer more than 43 million anesthetics to patients each year in the United States and in some states are the sole owners of anesthesia services.

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anesthesia providers in nearly 100 percent of rural hospitals. Nationally, CRNAs provide the same anesthesia services and patient assessments as anesthesiologists. The measure specifications should be changed to be inclusive of all anesthesia professionals, including CRNAs.

- The term “routine screening” used in the denominator is vague and requires clarification.
- The phrase “anesthesiologist or proxy” in the denominator criteria requires clarification as well. In particular, the phrase raises concern because proxy is not defined. If the proxy is not a qualified anesthesia provider, then a definition of what provider type may serve as a proxy, such as a registered nurse, non-anesthesia physician, or nurse practitioner, is required to assure maximal participation in this measure. Again, because this measure is intended to be used by CRNAs, this measure requires that the word “anesthesiologist” be replaced by a provider neutral phrase such as “anesthesia professional”, “anesthesia practitioner”, or “anesthesia provider”.

We would welcome the opportunity to further clarify our comments in light of the several issues that we have noted.

E. Application of Facility-Based Measures Pgs. 30043; 30123-30131

**AANA Request: Support the Expansion of Facility-Based Measurement via VBP programs and Include Measures Associated with Future VBPs for the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs**

We support CMS’s proposal for clinicians to voluntarily opt-in as facility-based clinicians under the Hospital Value-Based Purchasing (VBP) program for the purposes of the quality and cost performance categories under MIPS. We recognize that this option may assist hospital-based CRNAs engaged in anesthesia services within perioperative, critical care, and the emergency room environments more flexibility with MIPS participation. Because CRNAs continue to face challenges with MIPS participation, we recommend that CMS expand the VBP programs to include measures associated with place of service (POS) codes used under the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Quality
Reporting Programs. As with the Hospital VBP facility based clinicians, expanding the VBP programs will allow eligible clinicians in outpatient and ASC facilities greater flexibility with participation.

While we support the concept of creating a new special status for facility-based clinicians using the VBP programs to improve MIPS participation, we request on clarification how this will affect performance category reweighting for non-patient facing clinicians such as CRNAs. We agree that CRNAs should not have the advancing care information performance category assessed under this election because of limited control or lack of EHR technology. Additionally, we take note of CMS’s proposal to use the Hospital VBP program Medicare Spending Per Beneficiary (MSPB) methodology for attributing cost to non-patient facing individual clinicians like CRNAs. While each MSPB episode, from which the cost performance category will be assessed, will be attributed to a TIN that provides the plurality of Part B carrier services, we believe that anesthesia services will likely have limited impact on the MSPB relative to other services. Furthermore, while CRNAs may positively influence the clinical and patient safety domain measures, use of the domains does not offer a complete reflection of anesthesia services provided by anesthesia providers.

As this reporting option has the potential to increase MIPS participation for clinicians that are facing participation barriers, we agree that CMS should release and assure that all eligible clinicians have access to VBP program reports prior to opting into this special status to make an informed decision prior to opting in. We recommend that CMS provide clinicians with an estimated MIPS score based on the proposed facility based scoring methodology using the previous performance period data.

F. Topped Out Quality Measures Pgs. 30045-30047

AANA Request: Topped Out MIPS Measures that are Removed Should Still be Made Available Via a QCDR

As CMS is proposing to identify topped out MIPS quality measures and remove them from program after three years, we request that CMS continue to make these measures available via a
QCDR. Furthermore, as more anesthesia professionals transition to the MIPS program using a registry or QCDR, these topped out measures still have merit.

G. Cost Performance Category Pgs. 30047-30051

AANA Request: Do Not Use the Episode-Based Cost Measures in the Weight of the Cost Performance Category Until CMS Can Ensure that Measures are Meaningful and Accurately Reflect the Care that is Influenced or Directly Managed by All Eligible Clinician Types

We share the agency’s concerns about allowing enough time for a smooth transition before increasing the weight of the cost performance category to 30 percent in 2021 as per the statutory requirement. While we understand that CMS is bound by Statute to increase the cost performance category weight to 30 percent, we have concerns regarding this significant increase. We believe this increase will negatively affect CRNAs total performance scores since CRNAs do not have control over choosing their patient population or over the procedures for which CRNAs provide anesthesia services. Furthermore, while we appreciate that some of our members have been appointed to Technical Expert Panels, CMS has not publicly released any information on episode-based measures in this proposed rule. CRNAs need to know if new episode-based measures will include anesthesia or pain management services. Until CMS can ensure through an extensive stakeholder vetting process that episode-based measures are meaningful and accurately reflect the care that is influenced or directly managed by all eligible clinician types, we request that CMS not include episode-based measures in the weight of the cost performance category. Finally, we suggest that CMS include a transition year when implementing new episode-based measures.

H. 21st Century Cures Act Pgs. 30078-30079

AANA Request: Support the Exclusion of Ambulatory Surgery Center Clinicians from the ACI Performance Category
We welcome and support the agency’s proposal to exclude ambulatory surgery center clinicians from the ACI performance category per section 16003 of the 21st Century Cures Act.\textsuperscript{8} We recognize that doing so will better align with hospital-based MIPS eligible clinician policy and not disadvantage clinicians who work in facilities that lack EHR technology.

I. Proposed Improvement Activities P. 30479-30500

The AANA is pleased to see that a number of the proposed improvement activities could apply to anesthesia, and that some of the improvement activities recommendations that we provided to the Agency are included in this proposed rule. However, we note that some of the proposed activities exclude clinicians who are not physicians from participation, and we note some examples in the subsequent comments. We ask that the agency treat processes used by APRNs the same as the processes taken by physician colleagues. In previous Physician Fee Schedule rules and in the Affordable Care Act,\textsuperscript{9} physicians who are governed by medical specialty boards could report quality measures through a medical Maintenance of Certification Program and receive an incentive payment for doing so, but such incentive payment programs were denied to CRNAs and other APRNs engaged in analogous professional recertification. We request that the agency afford CRNAs and other APRNs the same opportunities as physicians in the development, implementation, and evaluation of improvement activities, and that any certification processes so recognized include those used by CRNAs and APRNs as well as physicians.

AANA Comment: Activity Entitled “Completion of an Accredited Safety or Quality Improvement Program” Should Recognize and Include all Advanced Practice Nursing Accredited Continuing Education Programs

The AANA strongly supports the promotion of the integration of quality improvement and continuing education for health professionals with the goal of improving patient care. However, we are concerned about the exclusionary nature of the activity entitled “Completion of an Accredited Safety or Quality Improvement Program.” MIPS eligible clinicians who are not

\textsuperscript{8} Pub. L. 114–255.

\textsuperscript{9} The Patient Protection and Affordable Care Act of 2010, Pub.L. No. 111-148
physicians would not be credited for their commitment to continued professional development. Improvement in professional practice and educational standards and expectations cannot adequately be accomplished without the ongoing involvement of knowledgeable and skillful nursing professionals who are engaged in lifelong learning and professional growth processes. The rapidly changing character and increasing complexity of nurse anesthesia practice demands continuous updating of the practitioner’s knowledge, skills, and understanding. The AANA believes that nursing is accountable to the public for promulgating standards of nursing practice that improve the delivery of services and promote quality patient care. As the national professional association for nurses specializing in anesthesia, the AANA holds itself responsible for providing continuing education (CE) activities that help members maintain excellence in practice. It further meets this commitment to society and the profession by establishing standards that foster quality CE activities offered by other providers.

**AANA Comment: Change Proposed PSH Care Coordination Activity to Perioperative Care Coordination**

We are very concerned that participation in the Perioperative Surgical Home (PSH) has been isolated as a separate improvement activity relative to other perioperative care programs that require the same level of coordination yet are a component of improvement activity. In particular, we note that the activity entitled “Use of Patient Safety Tools” proposes to include Enhanced Recovery After Surgery (ERAS) as a component. The PSH and ERAS require the same level of coordination, yet the proposal to include ERAS as a component of an activity suggests that the PSH and ERAS are different and that ERAS is not a meaningful activity. The use of ERAS programs can play a large role in reducing costs and improving patient outcomes in these episodes.  

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To assure that all perioperative team members can participate in perioperative care program activities, we request that the activity entitled “PSH Care Coordination” be changed to be entitled “Perioperative Care Coordination” and change the activity description to be inclusive of elements attributed to ERAS without being associated to any particular model. Specifically, we request that CMS to replace the existing activity description to the following proposed language (relative to the existing activity description, additional language is underlined and language is stricken):

Participation in perioperative care pathways in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities:

- Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care;

AANA Request: Prohibit Wasteful Tele-Supervision of CRNA Services From Being Included as part of Improvement Activities

We recognize that telehealth is included among various practice improvement activities. The AANA is supportive of telehealth and remote monitoring technology that improves the quality of care provided for all patients and especially those with chronic conditions, but cautions against the use of wasteful services in the name of telehealth that would increase costs without improving healthcare access or quality. One wasteful policy would be to reimburse anesthesiologists through billing for remote so-called “supervision” services even though they are not providing actual anesthesia care. This type of remote supervision would not improve access to healthcare for patients with chronic conditions and would instead reward providers not actually furnishing healthcare services. Furthermore, there is no evidence regarding the benefit for the use of supervision of anesthesia via telehealth.11 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 that CMS prohibit wasteful anesthesiologist tele-supervision of CRNA services from being included in as a practice improvement activity and as part of the MIPS and Advanced Alternative Payment Programs.

AANA Request: Count Other Organizations’ Continuing Education Programs as Part of Activity on CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain

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We applaud the agency for proposing to include CDC’s Training on CDC’s Guideline for Prescribing Opioids for Chronic Pain as an improvement activity, and we request that other organizations’ continuing education programs on this topic also be counted as part of this activity. The AANA is committed to working toward a solution to help curb the opioid epidemic in the U.S. and to support and include efforts regarding opioid analgesic prescriber education. The AANA along with the American Association of Colleges of Nursing and other APRN organizations have developed a joint online educational series that serve as a resource for practicing nurses, faculty, and students on opioid topics. As part of this initiative, these organizations have developed four webinars to provide an overview of the current need to address opioid use disorder and overdose; integration of timely content into education program curricula; and the Centers for Disease Control and Prevention’s (CDC) new prescribing guideline. We believe these webinar programs fit in with this particular activity.

J. Complex Patient Bonus Pgs. 30135-30139

AANA Request: Employ Risk Adjustment Accordingly to Properly Account for Complex Patients

We accept and agree with many of the proposals associated with the complex patient bonus. We do request, however, that CMS employ risk adjustment accordingly, including sociodemographic adjustment where appropriate, to ensure providers do not perform poorly in the MIPS program simply because the types of patients they care for.

K. Small Practice Bonus for the 2020 MIPS Payment Year Pgs. 30139-30140

AANA Request: Support Proposal to Award Bonuses to Small Practices

We support and thank CMS for its proposal to award bonuses to small practices. We do agree that this proposal will incentivize MIPS eligible clinicians in small practices to participate in the QPP and is a positive step in addressing performance discrepancy due to practice size.

L. Redistributing Performance Category Weights P. 30144-30146
AANA Request: Support CMS’s Proposal for Reweighting Scenario If No Advancing Care Information Performance Category Score

The AANA supports CMS’s proposal for its reweighting scenario in instances where eligible clinicians have no advancing care performance for the 2020 performance period (see Table 38 p. 30145). While CMS states in the preamble to the proposed rule that some commenters suggested redistributing the weight of the performance the advancing care information performance category to the improvement activities performance category, we would not support such approach for the 2020 performance period because improvement activities are still new and eligible clinicians have more familiarity with the quality performance category.

M. Establishing Performance Threshold P. 30147-30148

AANA Request: Support CMS’s Alternative of Setting a Performance Threshold of Six Points

We recommend that CMS use an alternative of setting a performance threshold of six points instead of its proposal of 15 points. In the preamble to the proposed rule, CMS states that this alternative “could be met by submitting two quality measures with required data completeness or one high-weighted improvement activity” (p.30148). Under the PQRS program, anesthesia professionals often only had one or two PQRS measures to report using the claims or qualified registry reporting mechanism. Likewise, under the MIPS program, many CRNAs may only have 1 or 2 MIPS measures that they can use if reporting through a qualified registry reporting system. Furthermore, a lower threshold will allow CRNAs and other eligible clinicians greater familiarity with QCDR measure reporting and improvement activities.

N. Review and Correction of MIPS Final Score: Feedback and Information to Improve Performance Pgs. 30154-30157

AANA Request: Support CMS Providing Quarterly Reports on Performance
The AANA welcomes opportunities to allow MIPS eligible clinicians to review their performance status on a quarterly basis. To encourage participation and help clinicians identify success, we recommend that feedback reports be clinician-friendly while identifying the key aspects of the MIPS program and scoring methodology. In particular, CRNAs need detailed information on quality and improvement activities and whether they qualify for special scoring considerations. In addition, because CRNAs will likely be using QCDRs with varying measures and benchmarks, detailed information pertaining to measures and benchmarks are essential.

We recommend that feedback reports contain detailed information regarding performance in each performance category in addition to providing an overall scoring table. We recommend that the following data elements be included in reports:

- Indications for individual or group classification for non-patient facing, small group practice, and rural area and health professional shortage area.

- Indications for performance category reweighting and special scoring considerations.

- For the Quality Performance Category, include the title of the quality measure submitted, measure type, the total points that can be achieved based on the benchmark; whether data completeness has been met for the quality measure; decile level achieved; measure achievement points; bonus points awarded; and performance score.

- For the Improvement Activities Category, include the title of the improvement activity submitted; weighting of the improvement activity; total points that can be earned; special scoring applied; and points earned for the measure performance score.

We also support CMS’s proposal for eligible clinicians who participate in MIPS APMs to receive feedback reports and strongly request that CMS provide these reports on a quarterly basis beginning in 2018 and for future years. According to the rules and regulations of the QPP, eligible clinicians who are participating in MIPS APMs, who do not have a signed Participation Agreement, must submit performance data according to regular MIPS reporting requirements. These feedback reports are critical so that these eligible clinicians who need to report regular MIPS can make changes in the performance areas where they need improvement to positively affect their MIPS total composite score. Having feedback reports available on a quarterly basis
would enable CRNAs to implement changes immediately once weaknesses are identified so that improvement is continuous throughout the performance year.

O. Data Validation and Auditing Pgs. 30157-30158

AANA Request: Prior to Performing Any Audits for Data Validation, CMS Should Provide to MIPS Eligible Clinicians, Facilities, and Medicare Administrative Contractors with Guidance on How Eligible Clinicians and Facilities Should Document Clinicians’ Performance in Source Documents

The AANA applauds CMS’s dedication to the issue of program integrity, and takes this issue very seriously. If CMS chooses to monitor MIPS eligible clinicians for non-compliance with MIPS requirements for the purpose of auditing and data validation, CMS should clearly define how MIPS eligible clinicians and their facilities should document performance in their source documents, such as medical records and progress notes. We request that CMS provides guidance on what data should be documented for each MIPS category to inform MIPS clinicians and their billers and administrators how validation will be conducted. Without further guidance, it is impossible to retrospectively identify where measures, such as QCDR measures, and improvement activities were accurately performed as many individuals may be involved in submitting MIPS measures and attesting to improvement activities.

In the interest of preserving patient access and enabling clinicians to dedicate their time to caring for their patients instead of fulfilling extensive documentation requests, we strongly urge CMS to ensure that it not create a process that is excessively burdensome and frivolous. We request that CMS establish an ombudsmen within its headquarters for the sole purpose of monitoring and responding to eligible clinicians’ complaints and concerns regarding audits that become excessively burdensome.

AANA Request: Shorten Look-Back Period for Recoupment of Payments to Three Years

We also request that CMS shorten the proposed ten-year look back period for recoupment of payments to no more than three years. CMS’s proposal to implement a ten-year requirement for clinicians to retain data and information related to a MIPS payment determination for a
performance period is excessive and will create an undue financial and time burden on eligible clinicians. We believe it is unrealistic to expect practices to keep these records for longer than records are retained for tax purposes. Furthermore, reducing the look back period to no more than three years is in line with similar rules implemented for the CMS’s Recovery Audit Contractors. We also request that CMS provide detailed guidance on the specific data and information that must be retained along with who is assigned responsibility for keeping the data. CMS should also develop a process to protect clinicians’ rights and offer recourse for clinicians in instances where there are problems and issues with third party intermediaries.

P. QCDR Measure Specifications Criteria Pgs. 30160

AANA Request: Allow QCDR Vendors to Seek Permission to Use Another QCDR’s Measure with the Caveat that the QCDR Refrain from Using Measures with Intentionally Biased Language

The AANA agrees with CMS’s proposal for QCDR vendors to seek permission from another QCDR to use an existing measure with the caveat that the QCDR refrains from using measures with intentionally biased language that prohibits the use of the measure by the intended audience. An example of such a measure is MIPS measure #404 Anesthesiology Smoking Abstinence. We oppose the propagation of anesthesia measures that have not been properly vetted by all stakeholders as we believe that outreach by measure stewards is essential to get buy-in from CRNAs and to assure its validity and reliability. Because it is presumed that anesthesia measures are intended for the use by all anesthesia professionals regardless of provider type, we caution CMS approving any measure that does not use provider neutral language such as “anesthesia provider”, “anesthesia professional” or “anesthesia practitioner”. While we believe that harmonization of proprietary measures within multiple QCDRs is essential for promoting overall quality, we believe that QCDRs should adhere to provider neutral language.

Q. Public Reporting on Physician Compare Pgs. 30163-30170
AANA Request: Stratify Scores for Public Reporting So That Non-Patient Facing, Small Group, or Rural Providers are Benchmarked Against One Another and Use Caution in Reporting Group-Level QCDRs

We request that CMS stratify aggregate scores for public reporting so that non-patient facing, small group, or rural providers are benchmarked against one another. The AANA has significant concerns with public reporting of MIPS eligible clinician’s final score, performance scores under each category, and reporting out on group-level QCDR measures even if the aggregate information is posted along with a range of final scores. Many CRNAs will be considered non-patient facing clinicians and some of these eligible clinicians will face hardships as clinicians in small group practices or as rural providers. All these aspects make participation in MIPS more challenging and publicly reporting final scores and performance under each performance category in an “easily understandable format” requires that consumers are educated on the alternative scoring methods, achievable quality benchmark points, and reweighting schemes.

We also request that CMS use caution with the reporting of group-level QCDR measures. Among anesthesia in particular, many QCDRs have emerged catering to anesthesia professionals creating a variety of disparate QCDR measures, making the creation of a benchmark extremely difficult.

AANA Request: Indicate a Disclaimer on the Clinician’s Profile That They are Exempt from Participating in the Advancing Care Information Performance Category

As CMS proposes to post publicly on Physician Compare the composite score for each MIPS eligible clinician and performance of each performance category for each 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 Advancing Care Information 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 ACI Performance Category.
AANA Request: Include Board Certification Relevant for all Eligible Clinicians Including CRNAs on the Physician Compare Website

As CMS is proposing to include additional Board Certification information on the Physician Compare Website, it is imperative that CMS include all Board Certification relevant for all eligible clinicians, including CRNA board certification on the Physician Compare Website. We would like to note that 100 percent of CRNAs are board-certified. As a condition for Medicare payment under §410.69, a CRNA must have passed a certification exam. To have physicians indicate this information and to not have it indicated for CRNAs is unfair and misleading to patients and to CRNAs. Public websites, such as Physician Compare, must allow for consumers to easily compare a variety of providers on the same scale in order to provide clear and appropriate information for healthcare providers and their patients. Therefore, we request that CMS indicate CRNAs’ Board Certification status on the Physician Compare website, as it does for physicians.

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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AANA President

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