September 27, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1715-P
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1715-P – Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations; Proposed Rule (84 Fed. Reg. 40482 August 14, 2019)

Dear Ms. Verma:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the Proposed Rule; Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations (84 Fed. Reg. 40482 August 14, 2019). The AANA makes the following comments and requests:

Ambulatory Surgical Centers Page 40724

- Finalize Proposal that Allows CRNAs to Evaluate the Risk of Anesthesia Immediately Before a Surgical Procedure Performed in an ASC
Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs) Pages 40518-40546

- Recognize the Role of CRNAs in Opioid Treatment Programs and Clarify Payment for MAT Services

Proposed Valuation of Specific Codes for CY 2020—Somatic Nerve Injection Pages 40579-40583

- Maintain Current Work RVUs for Somatic Nerve Injections

QUALITY PAYMENT PROGRAM

MIPS Value Pathways Request for Information

- Anesthesia-Related MVPs Should Take Into Account All Appropriate Stakeholders, Including CRNAs
- Change the Number of QCDR Measures a QCDR can House to As Many as Necessary
- Provide Scoring Options for Single-Specialty Groups if an MVP is not Available to Them
- Ensure Use of Value Indicator is Meaningful and Does Not Disadvantage Eligible Clinicians with No Performance Score

Quality Performance Category

- Maintain the Data Completeness Requirement for Quality Performance Category at 60 Percent for Clinicians

Cost Performance Category—Episode-Based Performance Measures

- Consider Anesthesia-Specific Cost Measures for Future Rulemaking Continually Providing Opportunities for Engaging the AANA in Development of These Measures

Promoting Interoperability Performance Category

- Finalize Proposal to Maintain the Scoring Methodology the Promoting Interoperability Performance Score for the 2020 Performance Year and the Policy for Reweighting the Category to the Quality Performance Category

MIPS Payment Adjustments
• Maintain Performance Threshold at 30 Points

Advanced Alternative Payment Models

• Do Not Automatically Eliminate Partial Qualified Provider Status Across An Eligible Clinician’s TIN/NPI Combinations; Instead, Provide an Election OPT-out for Eligible Clinicians

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 nearly 54,000 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 49 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,

1 Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economic$. 2010; 28:159-169.
an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.\(^2\) Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.\(^3\) Most recently, a study published in *Medical Care* June 2016 found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.\(^4\)

CRNAs play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures. The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.\(^5\) The study correlated CRNAs with lower-income populations and correlated anesthesiologist 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.\(^6\)

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\(^6\) Liao, op cit.
AANA Request: Finalize Proposal that Allows CRNAs to Evaluate the Risk of Anesthesia Immediately Before a Surgical Procedure Performed in an ASC

We are grateful and strongly support the Centers for Medicare & Medicaid Services’ (CMS) proposal to recognize CRNAs as authorized to evaluate the risk of anesthesia immediately before a surgical procedure performed in an ASC. This is the same manner that the agency recognizes both CRNAs and physicians conducting the final pre-anesthetic assessment of risk for a patient in the hospital. Modification of this regulation to promote efficiency will reduce administrative burden associated with unnecessary delays and also will make the ASC conditions for Coverage (CfCs) consistent with the CfCs for anesthesia for patient discharge. In actual practice, CRNAs evaluate patients preoperatively for anesthesia risk in the ASC environment, consistent with Standard 2 of the Standards for Nurse Anesthesia Practice. Furthermore, the current ASC rule on pre-anesthesia examination is inconsistent with ASC rules regarding patient discharge, and with Medicare hospital Conditions of Participation (CoPs) in this same area. Under the hospital CoPs for anesthesia services (42 CFR§ 482.52 (b) (1)), CRNAs are recognized to perform the pre-anesthesia evaluation for hospital patients presenting with a greater range of complexity and multiple chronic conditions than ASC patients. Under 42 CFR § 416.42 (a) (2), a CRNA is recognized to evaluate the patient prior to discharge. CRNAs perform anesthesia risk assessment routinely in hospitals across America.

We recommend for CMS’s consideration two technical regulatory changes to the agency’s proposal. First, we recommend separating the language referring to the assessment for anesthesia risk from the language describing the surgeon’s immediate assessment of the risk of the procedure. The current language combines the assessment of surgical risk with the assessment of anesthetic risk in one sentence, when in reality these activities are most frequently performed by two different members of the team, the surgeon and the anesthesia professional. The CfCs for ASC surgical services at 42 CFR§ 416.42 (a) (1) state that a “physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be

performed.” (Italics added.) By combining the two functions into a single sentence, in an ASC, a physician must evaluate the risk of anesthesia, precluding a CRNA from being recognized for performing an essential function within the CRNA’s scope of practice and may place the surgeon in the position of evaluating an aspect of care outside his field of expertise. Our recommendation limits the direction under “Standard: Anesthetic risk and evaluation” solely to those matters relating to anesthesia, and places language related to the surgical risk evaluation within the “Standard: Admission and pre-surgical assessment.” Second, we recommend clarifying that this change applies to “certified registered nurse anesthetists.” We note that anesthesiologist’s assistants must work under medical direction of an anesthesiologist under federal law, and the anesthesiologist must perform the pre-anesthetic examination as a condition for payment for medically directed anesthesia services.

Therefore, the AANA recommends the language at 42 CFR§ 416.42 (a) (1) be revised to read (relative to the existing rule, additional language is underlined and language is stricken):

(a) Standard: Anesthetic risk and evaluation. (1) A physician or certified registered nurse anesthetist, as defined in 42 C.F.R. § 410.69(b) must examine the patient immediately before surgery the procedure to evaluate the risk of anesthesia and of the procedure to be performed.

Further, the AANA recommends the language at 42 CFR§ 416.52(a) (2) be revised to read (relative to the existing rule, additional language is underlined):

§ 416.52 Conditions for coverage—Patient admission, assessment and discharge.

(2) Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination immediately prior to surgery for any changes in the patient’s condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals.

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8 42 CFR§410.69(b)(2).
9 42 CFR §415.110(a)(1)(i).
AANA Request: Recognize the Role of CRNAs in Opioid Treatment Programs and Clarify Payment for MAT Services

The AANA commends the bipartisan efforts of Congress and the administration for enacting the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (the SUPPORT Act) (Pub. L. 115–271, October 24, 2018), and we appreciate CMS’s efforts to implement it. We also appreciate that Section 3201 allows for CRNAs to apply for medication-assisted treatment (MAT) waivers and recommend that Congress should make permanent access to these waivers for most APRNs, including CRNAs.

While the AANA appreciate CMS’s proposals for Medicare coverage of Opioid Treatment Programs (OTPs), it is not clear what happens regarding Medicare reimbursement for MAT services for providers who are not part of an OTP. CRNAs are currently treating Medicare patients with opioid use disorders with opioid abuse deterrent drug formulations to address concerns of opioid abuse, and these CRNAs have training in managing opioid use disorders. As a main provider of pain management services, CRNAs are qualified pain practitioners who provide access to excellent care and counsel in many practice settings to treat patients suffering from a wide range of acute and chronic pain conditions. Many patients rely on CRNAs as their primary pain specialist, especially in rural communities. CRNA chronic pain management practitioners address chronic pain through the use of a multimodal approach that includes opioid sparing or no opioid pharmacologic and non-pharmacologic pain mitigation strategies. This is shown in a recent study which calls for an increased number of nursing pain specialists “to not only implement aggressive acute pain care to prevent chronic pain but also to effectively treat chronic pain with evidence-based integrative therapies that include multimodal analgesia, interventional techniques, and complementary and alternative approaches to pain management.”

The AANA supports increased patient access to safe, responsible use of MAT for the comprehensive treatment of substance and opioid use disorder. The AANA recognizes that the CRNA has an ethical obligation and professional responsibility for self-assessment of their knowledge and skills related to the comprehensive treatment of substance use disorders (SUD) and related somatic and/or mental health conditions; developing and maintaining clinical competencies related to the care of individuals receiving MAT; and obtaining any necessary continuing education beyond the required 24 hours of training necessary in order to provide safe behavioral healthcare involving MAT. CRNAs may prescribe MAT in states where they have prescriptive authority, consistent with state law. The CRNA must provide MAT in accordance with their professional state specific scope of practice, state and federal laws and regulations, and their respective facility’s institutional policies.

Proposed Valuation of Specific Codes for CY 2020—Somatic Nerve Injection Pages 40579-40583

AANA Request: Maintain Current Work RVUs for Somatic Nerve Injections

We request maintaining the current work RVUs for somatic nerve injections (CPT codes 64400, 64408, 64415, 64416, 64417, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, and 64450). Given the efforts to combat the opioid epidemic and the need to tackle and prevent opioid use disorders, procedures that employ safe, non-opioid pain management alternatives, such these somatic nerve injections, should be incentivized and not discouraged. Our members report that a drop in these values will put a burden on practices and will particularly hurt practitioners and the ability of rural hospitals to provide these services. As opioid epidemic is tearing at the fabric of our nation and because of the importance of these services in managing pain, we recommend that CMS not devalue the work RVU associated with these procedures.

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QUALITY PAYMENT PROGRAM

MIPS Value Pathways Request for Information

**AANA Overarching Request on MVPs: Anesthesia-Related MVPs Should Take Into Account All Appropriate Stakeholders, Including CRNAs**

We appreciate that CMS is considering a pathway to simplifying and streamlining the Merit-Based Incentive Payment System (MIPS) through its MIPS Value Pathways (MVPs) and trying to accomplish this in a way that is meaningful for all providers. We recognize the obstacles and challenges CMS will face in developing an MVP relevant to anesthesia providers, such as CRNAs, given constraints in participation under the current MIPS program. The constraints under the MIPS program include few quality measures that are currently available and applicable to CRNAs, cost measures that are not applicable to anesthesia, and a CRNA’s inability to participate in the Promoting Interoperability category in the current MIPS program.

Furthermore, as CMS is proposing to use a hybrid approach where clinicians are measured on a unified set of measures and activities around a clinician condition or specialty, layered on top of a base of population health measures, we recognize that single-specialty groups made up of anesthesia providers, such as CRNAs, who can only report on anesthesia-specific measures may be at a disadvantage using such an approach. Moreover, anesthesia providers, such as CRNAs, lack face-to-face interaction and tend to use CPT codes that are considered non-patient facing. Anesthesia services are not significantly represented in population health data or in patient-reported outcome measures.

Construction and assignment of MVPs can be challenging as well. As CMS states that the agency envisions the Promoting Interoperability performance categories to be the key structural part of any MVP (p. 40734), we note application of this will be problematic for clinicians, such as CRNAs, who currently do not participate in the Promoting Interoperability category.

Scoring also will be a challenge for anesthesia providers because they are eligible for the automatic re-weight of the Promoting Interoperability and Cost measures categories to the Quality category. Therefore, anesthesia providers achieve most performance points in the
Quality category. However, the total achievable score in this category will be affected because of the small variation in benchmarking, making it difficult to meet the performance threshold.

Furthermore, CMS’s proposed timeline for transition to MVPs beginning with the 2021 MIPS performance period seems very ambitious, especially given these challenges and the fact that identifying or developing additional measures can take more than a year to accomplish. We recommend that CMS delay the timeline for transition to MVPs and not force any anesthesia provider into an MVP or require them to use any specific set of measures. Instead, we ask that CMS work with the AANA and CRNAs about the feasibility for participation. We support engaging in further discussions with CMS to discuss these challenges and stand ready to work with CMS in finding innovative solutions to these challenges.

**AANA Request: Change the Number of QCDR Measures a QCDR can House to As Many as Necessary**

If qualified clinical data registry (QCDR) measures are going to be integrated into MVPs, CMS should ensure that there are not barriers to use of measures and that CMS supports the adoption of measures. We note that CMS changed the definition of a QCDR in the Physician Fee Schedule final rule of 2019, and this has could lead to fewer QCDRs being available for specialties like anesthesia to use. Therefore, these CRNAs have potentially fewer QCDR measures available to them due to fewer QCDR options available in CY 2020. We ask that CMS change the current requirement that QCDRs can house from 30 measures to an unlimited amount of measures. An increased number of clinicians would be able to adopt the measures, providing enough volume so that more specific and meaningful comparisons can be made to other clinicians, because the benchmarks may include more variations. QCDRs that can provide multiple types of measures for group practices can include performance feedback that is more relevant to the care team and more specific to particular patient populations.

**AANA Request: Provide Scoring Options for Single-Specialty Groups if an MVP is not Available to Them**
We also recommend that CMS provide scoring options that will enable single-specialty groups to meet the performance threshold if they are unable to participate in an MVP or do not have one available to them for the 2022 payment year. We are concerned that if not properly worked out, scoring for practices that use more than one MVP may be put at an advantage over those just using one, especially if they are awarded an aggregate score. Anesthesia providers achieve most performance points in the Quality category, and have limited ability to attain the performance threshold, which would continue to occur in an MVP. We request additional information from CMS about how single-specialty groups would be able to meet scoring requirements when not all performance categories apply to clinicians. CRNAs in individual, small, and rural practices have few MIPS eCQMs to choose from, given that current eCQMs do not pertain to anesthesia services, forcing them to participate in costly QCDRs. Furthermore, use of eCQMs requires the use of EHR systems and, in many instances, third-party vendors, which are not always available to solo practitioners and providers in small groups or rural practices. As noted above, CRNAs potentially will have fewer QCDR measures available to them due to fewer QCDR options available in CY 2020.

AANA Request: Ensure Use of Value Indicator is Meaningful and Does Not Disadvantage Eligible Clinicians with No Performance Score

We appreciate CMS’s dedication to empowering patients to make well-informed decisions about their care by providing information that is useful and important. As CMS is considering use of a single “value indicator” for the MVP on Physician Compare (p. 40734, 40744-5), we remain concerned that this term will be misleading and not meaningful for patients, especially as it relates to anesthesia providers. The streamlining of the MIPS program into an MVP could affect the total score for an overall value indicator on Physician Compare if a given performance category cannot be assessed. For specialties, such as anesthesia, the absence of a performance score in a given category could give the appearance of a low value score to the value indicator, if that is not considered in the development of the “value indicator.” We request that the “value indicator” does not disadvantage clinicians whose performance category cannot be assessed and that CMS work with the AANA in the development of this indicator.
Quality Performance Category

AANA Request: Maintain the Data Completeness Requirement for Quality Performance Category at 60 Percent for Clinicians

We have concerns with the 70 percent data completeness requirement for CRNAs (p. 40747-8). 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. A decrease in the weight for the quality performance category to 40 percent in 2020 to 35 percent in 2021 affects the possible measure achievements points and final scores possible for CRNAs, especially those in single specialty groups. 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 have their data completeness requirement maintained at 60 percent for patients across all payers in the performance.

Cost Performance Category—Episode-Based Performance Measures

AANA Request: Consider Anesthesia-Specific Cost Measures for Future Rulemaking Continually Providing Opportunities for Engaging the AANA in Development of These Measures

The AANA is an interested stakeholder in the development of episode-based cost measures and continues to appreciate CMS’s support of our membership’s participation in Technical Expert Panels and Clinical Subcommittees in development of these measures. We request that CMS consider anesthesia-specific cost measures in future rulemaking and that CMS continue to provide opportunities for engagement with the AANA in the development of these measures. In reviewing the documentation related to the existing episode-based cost measures, although
anesthesia providers such as CRNAs are included in the “Attribution Tab” and anesthesia care services are included under the “Service Assignment Tab,” CRNAs and other anesthesia providers will not be attributed any of these episode measures. This is because for the procedural episode groups, the attributed clinician is the clinician who renders the trigger service (as defined by CPT/HCPCS) and is identified by the Taxpayer Identification Number and National Provider Identifier (TIN/NPI) on the Medicare Part B claim. As described in CMS’s measure specifications, none of the trigger service codes listed in the Trigger Tab include anesthesia CPT codes as a trigger service.

We stand ready to work with CMS in the development of anesthesia-specific cost measures. Creation of anesthesia specific cost measures would allow anesthesia providers such as CRNAs and anesthesiologists to fully participate in the MIPS programs since most current episode-based cost measures include anesthesia care services but are not attributed to anesthesia providers. The development of episode-based measures that include anesthesia services will continue to be challenging given that the utilization of anesthesia services and the cost of providing them may vary by episode and these differences may be ascribed to factors such as place of service, patient risk factors, physician preferences, regulations and payment policies.12

Promoting Interoperability Performance Category

AANA Request: Finalize Proposal to Maintain the Scoring Methodology the Promoting Interoperability Performance Score for the 2020 Performance Year and the Policy for Reweighting the Category to the Quality Performance Category

The AANA appreciates CMS’s proposal to continue the existing policy of assigning a weight of zero to the Promoting Interoperability performance category in the MIPS final score and to reweigh the Promoting Interoperability performance category to the Quality performance category for the 2020 performance year for CRNAs and other clinicians who are not physicians. We believe this is a wise policy as approximately four percent of CRNAs submitted data for the

Interoperability performance category. This policy will continue help CRNAs and other clinicians successfully participate in the MIPS program.

**MIPS Payment Adjustments**

**AANA Request: Maintain Performance Threshold at 30 Points**

We recommend that CMS maintain the performance threshold at 30 points instead of increasing it to 45 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 performance 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. 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 30 points.

**Advanced Alternative Payment Models**

**AANA Request: Do Not Automatically Eliminate Partial Qualified Provider Status Across An Eligible Clinician’s TIN/NPI Combinations; Instead, Provide an Election OPT-out for Eligible Clinicians**

13 Negrusa Op cit.
We have concerns with CMS’s proposal to automatically eliminate the Partial Qualified Provider (QP) status across a clinician’s TIN/NPI combinations. We believe this proposal increases a clinician’s administrative burden and creates barriers to participating in the Advanced APM Program (AAPM). An eligible clinician will have to track each TIN/NPI combination to ensure he or she has enough participation in each of his or her AAPMs and prepare a back-up plan to participate in MIPS should he or she fail to attain QP or Partial QP status. The requirement that eligible clinicians expressly elect to participate in MIPS or automatically be excluded from MIPS provides a security guarantee for most eligible clinicians participating in AAPMs.

Furthermore, there is substantial value in keeping the option of having Partial QP status apply across all of a clinician’s TIN/NPI combinations. Since the beginning of performance year 2019, CMS included the new All-Payer Combination Option as another opportunity to help eligible clinicians reach QP or Partial QP status. The All-Payer Combination Option provides several more opportunities for clinicians to participate in AAPMs since prior to the All-Payer Combination Option, there were a very limited number of AAPMs clinicians who could participate in to achieve QP or Partial QP status.

Instead of automatically eliminating Partial QP status across all eligible clinicians’ TIN/NPI combinations, CMS should consider allowing clinicians to opt-out of having Partial QP status and then opt-in to MIPS. This opt-out and opt-in approach allows those clinicians who want to participate in MIPS the ability to do so. It also preserves the Partial QP status for those that need and want to have Partial QP status applied across all of one’s TIN/NPI combinations while easing their administrative burden. As CMS has stated that it will become increasing difficult for clinicians to attain QP and Partial QP status in the coming years, we believe this approach will make it easier for clinicians to participate in AAPMs and move out of the MIPS program consistent with CMS goal of putting patients over paperwork.

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,

Kathryn Jansky, MHS, CRNA, APRN, USA LTC (ret)
AANA President

cc:  Randall D. Moore, DNP, MBA, CRNA, AANA Chief Executive Officer
     Ralph Kohl, AANA Senior Director of Federal Government Affairs
     Romy Gelb-Zimmer, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy