

June 27, 2016

Acting Administrator Andrew Slavitt  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5517-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: CMS-5517-P Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Proposed Rule

[Submitted via <http://www.regulations.gov>]

Dear Acting Administrator Slavitt:

The American Society of Anesthesiologists® (ASA), on behalf of our over 52,000 members, appreciates the opportunity to comment on several of the issues in the above-captioned Proposed Rule. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Sustainable Growth Rate (SGR) and established two pathways for clinicians in the Medicare Part B program: the Merit-Based Incentive Payment System (MIPS) and incentives for participation in Advanced Alternative Payment Models (APMs). In the MACRA Proposed Rule, the Centers for Medicare and Medicaid Services (CMS) established the Quality Payment Program (QPP) which encompasses both MIPS and Advanced APM initiatives. The proposed rule implementing this new payment program is extremely complex and, if finalized, will prove challenging for physicians to successfully navigate. ASA welcomes the opportunity to work with you to ensure that our members can successfully participate in this new program and continue to provide Medicare beneficiaries high quality and high value healthcare.

ASA has invested heavily in initiatives aimed at improving the safety, quality and efficiency of care for the surgical patient. We have developed a clinical registry, operated by the Anesthesia Quality Institute (AQI) that contains detailed files on millions of anesthetic administrations by thousands of physician anesthesiologists in hundreds of care settings. These data have led to dozens of published reviews to inform the safe practice of anesthesia.

We have sponsored the Perioperative Surgical Home (PSH) Collaboratives in almost 60 large and small health care institutions. PSH is a patient-centered delivery system that aligns with the National Quality Strategy (NQS) to achieve the triple aim of improving health, improving the delivery of healthcare and reducing costs. These goals are met through shared decision-making and seamless continuity of care for the surgical patient, from the moment surgery is made, all the

way through recovery, discharge and beyond. In these collaboratives, care redesign exercises have improved outcomes and reduced cost. We are about to launch an expanded series of demonstrations for physician anesthesiologists to further develop the key concepts of care coordination for the surgical patient and maximize the benefits to be derived from these opportunities. Physician anesthesiologists represent the common pathway for nearly all surgical and procedural care patients and can contribute to improved quality and more cost effective care.

In these efforts and others, ASA has embraced the underlying goals of MACRA. The comments that follow are focused on finding ways to support such ongoing efforts through the provisions of the law and the related regulations.

### **Executive Summary of Recommendations:**

Appendix A of this letter provides a complete listing of all our recommendations. Below are our key recommendations.

- **Non-Patient-Facing MIPS Eligible Clinicians:** ASA urges CMS to modify the proposal to identify non-patient-facing groups. Instead of using a single threshold of patient-facing encounters for the entire group, CMS should apply that criterion to individual members of the group. If 51 percent or more members of the group individually meet the criterion of 50 or fewer patient-facing encounters, then the group should be considered non-patient-facing. **The coding criteria used to measure encounters should appropriately identify most anesthesiologists as non-patient facing.**
- **Hospital-Based MIPS Eligible Clinicians:** ASA urges CMS to revise the criteria to designate clinicians as hospital-based to include care provided in hospital outpatient departments (22) and ASCs (24) – excluding E/M services. ASA also recommends that CMS describe this group of MIPS eligible clinicians as facility-based rather than hospital-based.
- **Payment Adjustments Distorting Resource Use Measurement:** ASA urges CMS to make an adjustment to remove positive and negative MIPS payment adjustments along with geographic and other adjustments that do not reflect the utilization and intensity of services when calculating Resource Use for a Performance Period (beginning with the 2019 Performance Year).
- **MIPS Implementation Timeline:** ASA recommends (1) a delayed start date for the initial Performance Year to at least July 1, 2017 and (2) initial Performance Year in 2017 running through December 31, 2017 (for the first MIPS Payment Year of 2019).
- **Virtual Groups:** ASA supports the creation of these virtual groups and encourages CMS to allow for maximum flexibility in this new option. In order to enhance their potential, we recommend that virtual groups not be restricted by specialty, size or geographic region.

- **Reweighting of MIPS Score to Eliminate Bias:** For clinicians for whom there are no Resource Use measures reported, ASA recommends that CMS reweight the Resource Use performance category to all available MIPS performance categories rather than just to Quality. This will mitigate the distortion in the distribution produced by the distribution of “topped-out” quality measures. ASA recommends that for clinicians who do not have Advancing Care Information (ACI) scores, CMS substitute a score with a 50 percent base and with the clinician’s Quality score substituting for the ACI score. This approach aligns with the CMS stated goal of allowing the Quality score to carry additional weight when an ACI score is unavailable, while correcting the fundamental bias against these MIPS eligible clinicians present in the current proposal.
- **Quality Performance Category:** ASA requests that prior to removing “topped-out” measures from the MIPS program, that CMS provide at least a year’s notice through the rule-making process of the measures removal.
- **Advancing Care Information Performance Category:** ASA welcomes the opportunity to collaborate with CMS and the Office of the National Coordinator for Health IT to develop standards and meaningful objectives for physician anesthesiologists so that our members can report on ACI with new measures in 2018.
- **Clinical Practice Improvement Activities Performance Category:** ASA requests that CMS assign high weights to Clinical Practice Improvement Activities (CPIA) that include QCDR and qualified registry participation. Participation in an ABMS Maintenance of Certification program should be recognized as fully satisfying the CPIA score in MIPS.
- **Registry Reporting:** ASA opposes CMS proposals to gather non-Medicare data through non-QCDR reporting mechanisms.
- **APMs:** CMS should implement a process to review proposed Advanced and non-Advanced APMs in a transparent and expeditious manner that includes input and feedback from all physicians and other healthcare professionals involved in the model under review. CMS should take steps to ensure that specialists and primary care have equal opportunities to participate in Advanced APMs.

### **Merit-Based Incentive Payment System (MIPS)**

Under MIPS, eligible clinicians will be measured in four performance categories: Quality, Advancing Care Information (ACI) (previously referred to as Meaningful Use), Clinical Practice Improvement Activities (CPIAs) and Resource Use. A Composite Performance Score (CPS) will be calculated based on a weighted score in these four performance categories, which will determine if a positive or negative payment adjustment is received.

### **Overarching Issues**

ASA has a few overarching concerns with the proposals presented in the Proposed Rule. Some of the issues discussed below are applicable to all healthcare professionals but may have a unique

impact on physician anesthesiologists. Therefore, there may be specialty specific solutions to common challenges within the Proposed Rule.

#### Non-Patient-Facing MIPS Eligible Clinicians

CMS introduces the term “non-patient facing” to apply to MIPS eligible clinicians “who typically furnish services that do not involve face-to-face interaction with a patient.” CMS indicates in the Proposed Rule that this typically includes anesthesiologists, pathologists, and radiologists.<sup>1</sup> Because certain proposed MIPS measures and activities may not apply, CMS proposed special accommodations for measure reporting and scoring for non-patient-facing MIPS eligible clinicians. We applaud the Agency’s recognition that implementation of MIPS will not succeed with a “one-size fits all” approach.

#### *Non-patient-facing MIPS eligible clinician definition and criteria*

The term “non-patient-facing MIPS eligible clinician,” is not defined in statute. In the Proposed Rule, CMS defines this term as an individual or group that bills 25 or fewer patient-facing encounters during a performance period (one calendar year). CMS estimates that 25 percent of all MIPS eligible clinicians will qualify as non-patient-facing MIPS eligible clinicians.

Additionally, CMS estimates that a majority of anesthesiologists will qualify as non-patient-facing. ASA is unclear how CMS derived this estimate. The coding criteria for determination of non-patient facing status should be carefully examined to insure that its application designates most anesthesiologists, as CMS projects, as non-patient facing clinicians.

We raise this issue because even though the list of patient-facing services is not currently available, we assume it will be substantially similar to the list of patient-facing services under the Physician Quality Reporting System’s (PQRS) list of patient-facing services. Using the PQRS patient-facing code list, it appears likely that many physician anesthesiologists would be categorized as patient-facing. Although anesthesia services (CPT<sup>®</sup> codes 00100-01999) are non-patient-facing under PQRS, physician anesthesiologists also typically perform other services that are included among patient-facing services under PQRS. Examples of typical patient-facing services performed by physician anesthesiologists are insertion of invasive hemodynamic monitoring lines and post-operative pain procedures. These services are provided, when indicated, by physician anesthesiologists during a surgical procedure separate and apart from the anesthesia care they provide related to the surgical procedure.

ASA supports the stated intention of CMS to make accommodations for physician anesthesiologists with respect to certain quality reporting and resource use measurements provisions of MIPS. In particular, lifting the requirement to report cross-cutting quality measures is a welcome improvement. Given the nature of anesthesia practice, such accommodations are warranted and appropriate. The formulaic determination of patient-facing status should not serve as a barrier to implementing these considerations.

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<sup>1</sup> In the sections of our comments addressing non-patient-facing clinicians and Resource Use, we refer to “anesthesiologists” as those clinicians who are designated with the anesthesiology specialty code (05) We do not include anesthesiologists who are designated with the pain management (72) or interventional pain management (09) codes because these physicians are typically patient facing and are much more likely to have some patients attributed to them for the Resource Use component.

**ASA urges CMS to post the list of patient-facing services as quickly as possible to allow individual MIPS eligible clinicians to determine if they will be considered patient-facing or non-patient-facing clinicians under MIPS. We also ask CMS to provide details on how they estimated that a majority of anesthesiologists would likely qualify as non-patient-facing.**

CMS proposes a threshold of 25 or fewer patient-facing encounters during a performance period (one calendar year) as the threshold for identifying non-patient-facing MIPS eligible clinicians at both the individual as well as group practice level. A threshold of 25 patient encounters is much different at the individual or small group levels from that of a large group—*e.g.*, a single or small number of National Provider Identifiers (NPIs) versus hundreds of NPIs in large groups. ASA does not understand the rationale for using the same threshold for large groups and individual MIPS eligible clinicians and believes that the threshold of 25 encounters for groups or for individual MIPS eligible clinicians is too low.

We propose an alternative methodology to more accurately identify non-patient-facing practice groups, regardless of group size. Rather than applying the same criterion to individuals and groups, ASA recommends a two-step process to identify non-patient-facing groups. First, CMS should apply a criterion of 50 patient encounters to individual members of a group practice. We believe that 50 encounters is a more reasonable threshold. As a second step, if a majority (51 percent or more) of the individual members of the group practice meet the individual non-patient-facing threshold of 50 or fewer patient-facing encounters, then the entire group would be considered non-patient-facing.

**ASA urges CMS to modify the proposal to identify non-patient-facing groups. Instead of using a single threshold of 50 or fewer patient-facing encounters for the entire group, CMS should apply that criterion to individual members of the group. If 51 percent or more members of the group individually meet the criterion of 50 or fewer patient-facing encounters, then the group should be considered non-patient-facing.**

Lastly, ASA requests that the Agency consider different terminology for the MIPS eligible clinicians that would be included in the proposed “non-patient-facing” category. We believe this term is an inaccurate representation of the role that physician anesthesiologists play and diminishes the important direct clinical care that physician anesthesiologists provide as well as the leadership role they play as a member of a surgical team. We are very concerned that this term will be confusing to patients if it is used in public spaces, such as the Physician Compare website.

**ASA recommends that CMS consider alternative language to the term “non-patient-facing” as it applies to physician anesthesiologists.**

#### Hospital-Based MIPS Eligible Clinicians

MACRA authorized the Secretary to use measures from other payment systems (*e.g.*, inpatient hospitals) for the Quality and Resource Use performance categories for “hospital-based” MIPS eligible clinicians but excluded measures from hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and

anesthesiologists. However, the MACRA legislation did not define the term “hospital-based” clinicians. The Proposed Rule defines a hospital-based MIPS eligible clinician as one who furnishes 90 percent or more of his or her covered professional services with a Place of Service Code indicating the inpatient hospital (21) or emergency room (23) setting.

*Definition of hospital-based MIPS eligible clinicians*

Similar to the discussion of non-patient-facing clinicians, Congress and CMS identified hospital-based MIPS eligible clinicians as ones for whom some measures may not easily fit for reporting and scoring under MIPS. At the same time, given the alignment of performance and incentives among facilities and clinicians who provide services in those facilities, Congress and CMS recognized that facility-based (*i.e.*, hospital-based) clinicians may more efficiently report under MIPS and reduce redundancies with reporting under facility reporting systems if measures designed for the outpatient or inpatient hospitals can be used by hospital-based clinicians or if hospitals’ quality scores can be used as proxy quality scores for individual MIPS eligible clinicians.<sup>2</sup>

ASA believes it is unlikely that many physician anesthesiologists will be considered hospital-based using the narrow definition proposed by CMS because the inpatient and emergency department settings are no longer the dominant sites of service for anesthesia services (as is also common among many surgical specialties). Although the site of service has changed from principally inpatient to outpatient (hospital outpatient and ambulatory surgical center (ASC) settings), facility-based clinicians face many of the same realities and limitations in reporting measures irrespective of whether the site of service is inpatient, hospital outpatient or the ASC. The criterion proposed to define hospital-based physicians is outdated and does not reflect modern settings of care for those who perform services primarily in a facility setting.

Our members provide care to patients in a variety of facilities and care settings that include inpatient hospital settings, outpatient hospital departments, ASCs and office-based locations. CMS’s proposed criterion for determining hospital-based status is flawed in that it fails to recognize the care provided in the hospital outpatient department (outpatient surgery) or ASC settings involve the same incentives and limitations in terms of the four MIPS performance categories, as does care provided in the inpatient setting. The rationale for making the distinction for hospital-based clinicians is to recognize the integration of clinicians with the facility on both a clinical and administrative level. This relationship between the clinician and facility exists not just on the inpatient-side but also with outpatient services. For example, the challenges facing MIPS eligible clinicians related to insufficient control over Electronic Health Record (EHR) resources are at least as relevant in outpatient hospital and ASC settings as they are in the inpatient hospital setting.

In making a recommendation to modify the criteria for hospital-based MIPS eligible clinicians, we propose CMS should exclude evaluation and management (E/M) services from the calculation of sites of services. This would help separate the truly facility-based MIPS eligible clinicians from specialists that perform E/M services in the hospital outpatient setting. E/M

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<sup>2</sup> ASA understands that CMS is not proposing to adopt this for the 2017 Performance Year but is seeking comments on these options.

services performed in the hospital outpatient department by medical specialists who are not necessarily otherwise facility-based are quite common in academic medical centers.

**ASA urges CMS to revise the criteria to designate clinicians as hospital-based to include care provided in hospital outpatient departments (22) and ASCs (24) – excluding E/M services. ASA also recommends that CMS describe this group of MIPS eligible clinicians as facility-based rather than hospital-based.**

*Use of measures from other payment systems and facility quality scores as a proxy for facility-based MIPS eligible clinicians*

ASA supports efforts to make the MIPS program more efficient and reduce the reporting burden on MIPS eligible clinicians. Measures that reflect the performance of both the facility and the MIPS eligible clinicians should be integrated into MIPS, where appropriate. ASA also supports the concept of using a hospital's quality score as a proxy for an individual physician. We believe that this shared accountability can incentivize collaboration among physicians and the facilities in which they provide services.

Although we support these concepts, more work is needed on both options (use of facility measures and use of facility scores) before they can be implemented. With respect to the use of facility measures by hospital-based clinicians, we believe some modifications to the measures may be necessary to facilitate dual reporting by the facility and the clinician. Recognizing that the Agency's strategy for quality measure development resides in your *Quality Measure Development Plan*, which is separate from this Proposed Rule, we believe consideration should be given in that plan to the identification and adaptation of appropriate measures that reflect performance for both the facility and the clinician. With respect to the use of facility quality scores as a proxy for individual clinicians, we believe more details are needed as to how this would work in practice—especially considering that many physicians perform services in multiple facilities.

**ASA believes there is merit to CMS's proposal that hospital-based MIPS eligible clinicians may use facility quality reporting measures and/or apply facility scores as proxies for the quality reporting component. We encourage CMS to work with stakeholders to develop these proposals in more detail.**

*Impact on MIPS scoring*

CMS proposes automatically to reweight the ACI performance category to zero for a MIPS eligible clinician who is classified as hospital-based. Although ASA applauds CMS for trying to accommodate hospital-based clinicians by exempting them from requirements to report under the ACI category, we are concerned that the proposal to weight this category to zero is not a neutral scoring proposal. ASA conducted an analysis on the impact of this proposed policy on the MIPS CPS, and concluded that clinicians unable to report under ACI are systematically put at a disadvantage under this CMS proposal. Our analysis is presented in the Resource Use section of this letter, and we are recommending an alternative policy to address the concern about the systematic bias introduced by the zero reweighting of the ACI for hospital-based clinicians and other MIPS eligible clinicians who may not have an ACI score.

### Payment Adjustments Distorting Resource Use Measurement

Under the MIPS program, Medicare Part B payments for MIPS eligible clinicians in a Payment Year will be adjusted either positively or negatively based upon the MIPS eligible clinicians' MIPS CPS in the Performance Year, which occurs two years prior.

For example, for the 2021 MIPS payment adjustment, CMS will use 2019 performance data. ASA is concerned that CMS has not addressed how the payment adjustments applicable in a payment year will be accounted for when that same year is used to measure the MIPS eligible clinician's Resource Use for that year as the Performance Year. Carrying forward the example above, how will Resource Use be measured for physicians who receive positive adjustments in 2019 when their CPS is calculated using 2019 performance data to establish payment adjustments for 2021? Without properly accounting for the performance-based payment adjustments, ASA is concerned that MIPS eligible clinicians who receive positive adjustments could potentially be disadvantaged in future years because they would have relatively higher Medicare payments than those who receive a negative adjustment for an equivalent set of services. This would paradoxically favor poorer performers relative to top performers.

In addition to the MIPS adjustment, geographic and other adjustments that do not reflect the utilization and intensity of services must also be considered.

We appreciate that, given the complexity of the MIPS program, CMS may not have considered this issue when drafting the Proposed Rule. We are confident that CMS does not intend to penalize high performing MIPS eligible clinicians who earn positive MIPS adjustments for the high quality and effective care that they provide.

**ASA urges CMS to make an adjustment to remove positive and negative MIPS payment adjustments along with geographic and other adjustments that do not reflect the utilization and intensity of services when calculating Resource Use for a Performance Period (beginning with the 2019 Performance Year).**

### MIPS Implementation Timeline

MACRA requires that MIPS eligible clinicians receive Medicare payment adjustments of zero up to plus or minus 4-percent beginning in 2019 and gradually increasing to up to plus or minus 9 percent for 2022<sup>3</sup>. CMS is proposing that for 2019, the first year of the payment adjustments under MIPS, the Performance Year will be CY 2017. CMS believes this time frame is needed for submission of data and claims for a full year's performance and for subsequent data analysis to calculate a CPS.

The proposed timeline does not provide sufficient time for MIPS eligible clinicians and facilities that may employ clinicians to establish necessary procedures and systems to be able to begin MIPS performance data collection as of January 1, 2017. The MACRA Final Rule is scheduled to be released in the fall of 2016. This leaves only a short time—perhaps as little as two months—to review the Final Rule, evaluate the applicability of various reporting options based

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<sup>3</sup> ASA recognizes that the positive adjustment can be increased up to 3-fold and that there is an additional bonus for top performing clinicians in the initial reporting years.

upon decisions announced in the Final Rule, and prepare internal systems, hire vendors and train staff before the beginning of the Performance Year.

CMS officials have indicated that, although the Performance Year starts on January 1, 2017, for most submission options, measures and other data will not have to be submitted until the beginning of 2018. However, it is not the time of reporting that is critical—it is the Performance Year that is key, and it takes time to adopt the procedures and systems necessary to collect data during the 2017 Performance Year.

Although on an ongoing basis, collecting performance data for a complete year may be preferable, a shorter period of data collection can be robust and should be considered for the first Performance Year to allow MIPS eligible clinicians adequate time to set up for the new program. The current timeline does not provide adequate time for MIPS eligible clinicians to prepare for participation in this very complex program—a program that will directly impact their payment and have implications on their publically available performance-related data posted on the Physician Compare website.

CMS should not sacrifice the care necessary in developing a smart and defensible payment program under MACRA for an aggressive implementation timeline.

**ASA recommends (1) a delayed start date for the initial Performance Year to at least July 1, 2017 and (2) initial Performance Year in 2017 running through December 31, 2017 (for the first MIPS Payment Year of 2019).**

#### MIPS Eligible Clinicians – Certified Anesthesiologist Assistants

In the Proposed Rule, CMS identifies MIPS eligible clinicians as including physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists (CRNAs) and groups that include such clinicians. In the Proposed Rule, CMS notes that the term “CRNA” would be defined as found in section 1861(bb)(2) of the Act, which states, “*The term “certified registered nurse anesthetist” means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.*”<sup>4</sup> (emphasis added).

**ASA urges CMS to confirm that certified anesthesiologist assistants are included in the definition of MIPS eligible clinicians starting in year 1 of the MIPS program.**

#### Virtual Groups

CMS offers the option for groups of 10 or fewer MIPS eligible clinicians to form virtual groups with other groups of 10 or fewer MIPS eligible clinicians, but technical concerns prevent the use of this option in the first year of the program. We believe that this option will be of great interest and potential benefit to smaller practices that face unique challenges under MIPS. Further, creation of virtual groups may support inter-specialty collaborations and care redesign, such as

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<sup>4</sup> 42 U.S.C. 1395x(bb)(2).

the work we have seen in our Perioperative Surgical Home (PSH) collaboratives, by providing an administrative framework to enhance and facilitate multi-specialty collaboration and the sharing of best practices.

**ASA supports the creation of these virtual groups and encourages CMS to allow for maximum flexibility in this new option. In order to enhance their potential, we recommend that virtual groups not be restricted by specialty, size or geographic region.**

### **MIPS Performance Categories**

#### Resource Use Performance Category

The Resource Use performance category will compare resources used to treat similar care episodes and clinical condition groups across practices. For the 2017 Performance Year, Resource Use accounts for 10 percent of the total MIPS score.

#### *Implications of Resource Use proposed policies on physician anesthesiologists*

Physician anesthesiologists are unlikely to meet the required criteria to be scored in the Resource Use performance category of MIPS based upon our review and analysis of the criteria CMS set forth for patient attribution in the determination of the Resource Use performance category using claims data.

The Total Per Capita Cost (TPCC) measure, which was included in the Value Based Modifier Program (VBM Program), attributes patients only to clinicians providing the plurality of “primary care services.” Few physician anesthesiologists were eligible to participate in the TPCC under the VBM. The minor changes to this measure proposed for the new MIPS program will not improve their ability to participate in this measure. Similarly, the Medicare Spending Per Beneficiary (MSPB) measure, which also was included in the VBM Program, attributes patients to clinicians who are responsible for the plurality of Part B allowed charges during an inpatient hospital episode. Physician anesthesiologists are unlikely to provide the plurality of care (as measured by allowed charges) for enough patients to generate a Resource Use score on this measure.

The episode-based measures (Method A and Method B) that have been proposed for the MIPS Resource Use performance category have the same attribution problem as the MSPB measure. Acute condition episodes are attributed to the physician who bills at least 30 percent of inpatient evaluation and management services, which is not likely to be the physician anesthesiologist. Procedural episodes are attributed to the physicians billing the trigger codes, which typically will be reported by surgeons—not physician anesthesiologists.

Therefore, as currently designed, most physician anesthesiologists will not be scored on the Resource Use performance category of MIPS. We believe it is important for CMS to work with ASA and other specialties whose members are likely to have little to no Resource Use attribution to develop ways to allow these specialties to fully participate in MIPS, including the Resource Use performance category. Redesign of the episode based measures offers the greatest potential to open the door to Resource Use attribution by physician anesthesiologists.

We note that the measures of Resource Use, both under MIPS and APM provisions, are based on allowed charges under Medicare Parts A and B. Our experience with our Perioperative Surgical Home (PSH) and other care redesign work suggests that many of our interventions manifest their cost savings through decreased length of stay and other improvements not evident in measures based on allowed charges. It is unfortunate that such genuine improvements in resource use are “invisible” to the programs as currently designed. Future APM opportunities should be designed to recognize and reward such impacts, as gainsharing bundles have done in the past.

Below we discuss specific issues raised in the Proposed Rule about the Resource Use performance category that apply with particularity to physician anesthesiologists.

#### *Facility measures applied to clinicians*

In the Proposed Rule, CMS requested comment on whether the Agency should consider applying measures designed for outpatient or inpatient hospitals to clinicians who work in those settings. ASA appreciates CMS’s recognition of the difficulties certain specialties may face in reporting under MIPS—especially the Resource Use performance category—and looks forward to working with CMS to identify and adapt established facility measures that may apply and to develop new measures where gaps remain. However, our review of the existing outpatient and inpatient hospital measures suggests that few, if any, of the current measures designed for hospitals would apply to physician anesthesiologists.

**ASA recommends that CMS make additional information available regarding its thinking around the option for use of facility measures for the Resource Use performance category and publish information about the extent to which this option may improve participation by physicians who are predicted to be ineligible to participate in the Resource Use performance category of MIPS. ASA is prepared to work with CMS and other similarly situated stakeholders to identify a process to identify and adopt such measures or develop new facility measures that could be used by facility-based clinicians to allow a greater proportion of physicians to be scored in the Resource Use performance category of MIPS.**

#### *Facility-based physicians replacing their score with facility score*

In the Proposed Rule, CMS requested comment on whether the Agency should consider applying measures at the facility level to facility-based physicians. Here too, ASA supports efforts to increase reporting under MIPS by specialties like anesthesiology. However, we are not clear how this approach would apply. Which measures would apply and how would the scores apply to the construct CMS has proposed for the Resource Use performance category? If a physician performs services in multiple facilities, how would the Resource Use score be calculated?

In addition, ASA is concerned that individual physicians may have little influence over resource use at the level of the facility in which they perform services. Any measure score selected to serve as a proxy for individual clinician performance would need to be filtered to assure that the measure reflects closely aligned incentives and control by both the facility and clinician over resource use. Measures of resource use in an episode of care for a surgical procedure or condition have the greatest potential to advance this concept, especially if the episodes of care counted in the measure could be limited only to those in which the clinician provided professional services.

Therefore, ASA believes there is insufficient information in the Proposed Rule to comment meaningfully at this time.

*Reweighting MIPS performance categories when physicians have insufficient numbers of patients to report Resource Use and/or ACI*

CMS's proposal to load Resource Use and ACI performance category weights onto the Quality performance category of MIPS means that the quality metrics (values and distribution) have a disproportionate impact on specialties that are unlikely to participate in the other performance categories. Physician anesthesiologists are particularly likely to fall into this group due to the Resource Use attribution methodology and the multiple barriers they face in reporting ACI measures.

The distribution of Quality scores is not likely to mirror the distribution of scores for the Resource Use or ACI performance categories of MIPS. As CMS acknowledged in the Proposed Rule, the distribution of the Quality scores may fall within a narrow band—especially considering measures that are expected to be “topped-out.” For these measures, clinicians may have relatively minor differences in quality but result in dramatically different Quality scores. As shown in the Proposed Rule, for a topped-out measure, the potential difference in a Quality measure score for a 99.9 percent performance and a 100 percent performance can be great. Assigning the Resource Use performance category (and ACI) weight to the Quality performance category will magnify this distortion for those specialties whose members are not eligible to report Resource Use (or ACI) compared to specialties whose members are eligible to report these measures.

**For clinicians for whom there are no Resource Use measures reported, ASA recommends that CMS reweight the Resource Use performance category to all available MIPS performance categories rather than just to Quality. This will mitigate the distortion in the distribution produced by the distribution of “topped-out” Quality measures.**

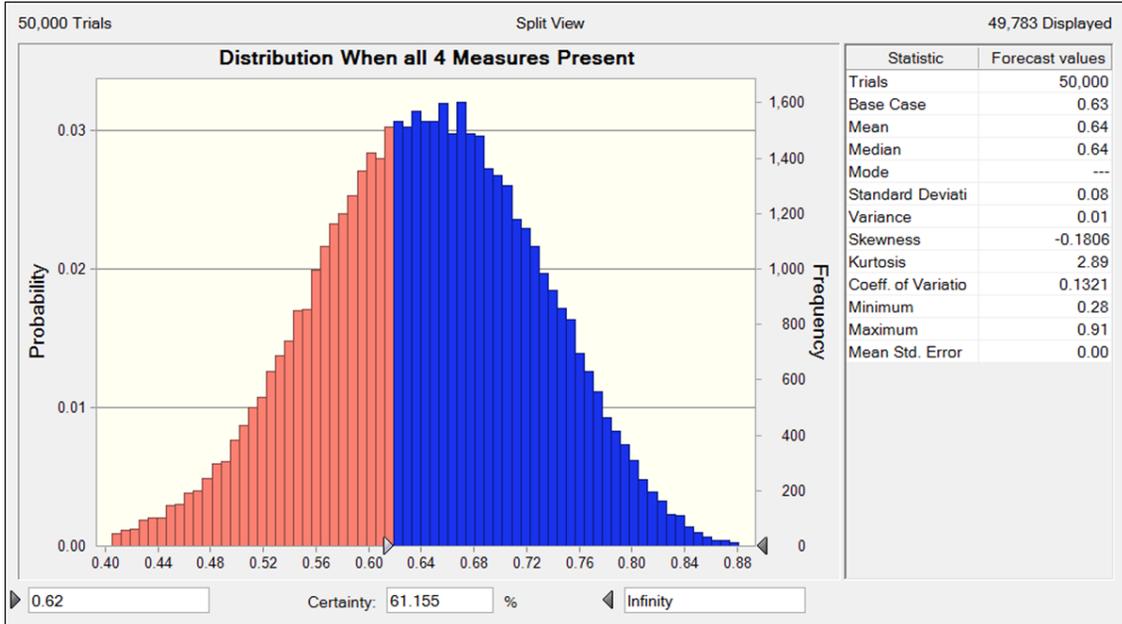
Because nearly all users of EHR technology will qualify for the ACI “base score” of 50 percent, non-EHR users reweighting this category to the Quality performance category will sacrifice this favorable scoring feature and be systematically disadvantaged. The Quality score can range from 0 percent to 100 percent of the denominator for Quality. By contrast, assuming the MIPS eligible clinician meets the minimum reporting and data protection thresholds, the ACI score effectively has a more constricted range from 50 percent to 100 percent. Since CMS has proposed a single overall MIPS performance threshold, physicians without the ability to be scored under the ACI component will be at a significant disadvantage relative to other MIPS participants.

ASA conducted a simulation model to test the expected distribution of MIPS scores for physicians participating in all four MIPS performance categories and compared these physicians to physicians who are unable to participate in the Resource Use and ACI performance categories (*i.e.*, non-patient-facing physicians). Figures 1 and 2 below demonstrate the magnitude of the distortion created by reweighting these performance categories to Quality, which has a different range from ACI.

This distortion with respect to reweighting of ACI to Quality can be mitigated in large part by maintaining the 50 percent “floor” for ACI for physicians who are not eligible to report ACI and then replacing the *performance* portion of the ACI score (the additional 80 points) with a function of the Quality score. The Quality score can be scaled to the 0-80 range of possible values for the ACI performance score to ensure that clinicians are not incentivized to avoid reporting ACI.

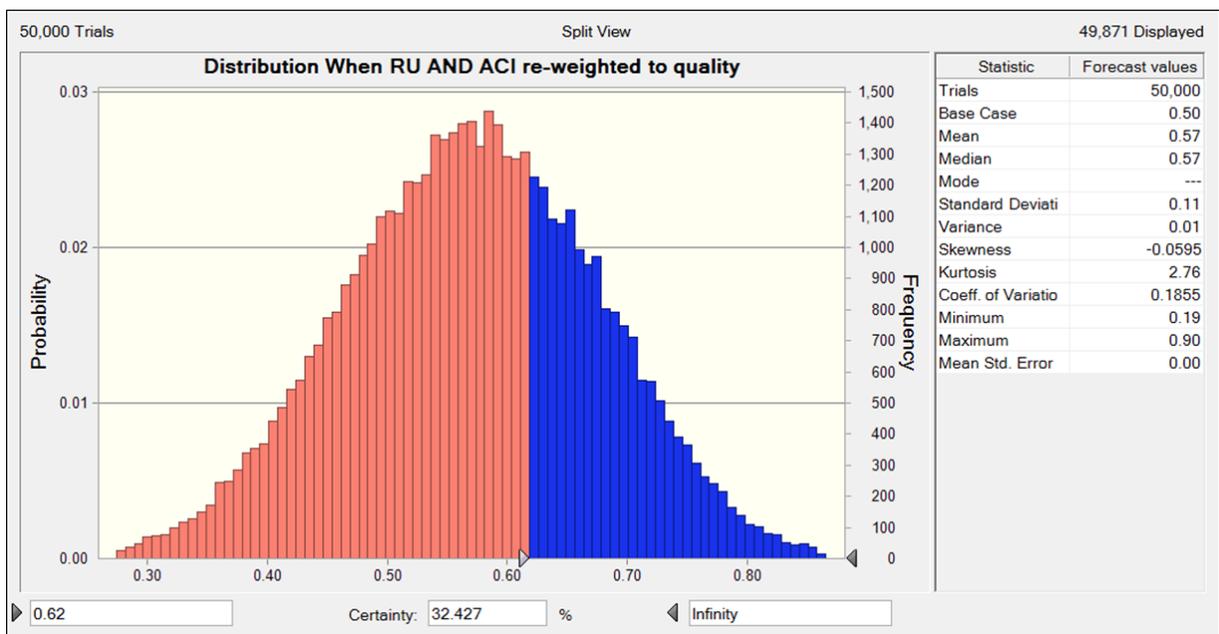
**ASA recommends that for clinicians who do not have ACI scores, CMS substitute a score with a 50 percent base and with the clinician’s Quality score substituting for the ACI performance score. This approach aligns with the CMS stated goal of allowing the Quality score to carry additional weight when an ACI score is unavailable, while correcting the fundamental bias against these MIPS eligible clinicians present in the current proposal.**

**Figure 1. Expected distribution of MIPS scores for physicians with 4 performance category scores**



61 percent of MIPS physicians with 4 performance category scores are projected to receive a positive adjustment.

**Figure 2. Expected distribution of MIPS scores for physicians who cannot participate under Resource Use and ACI**



Only 32 percent of MIPS eligible clinicians without Resource Use and ACI scores (i.e., non-patient-facing) are expected to have a positive MIPS adjustment

### Quality Performance Category

ASA appreciates CMS' movement toward streamlining and improving the quality reporting process under MIPS. We recognize the value of aligning reporting requirements across quality programs and know in many cases this action will ease the reporting burden of our members. We support opportunities to ensure our members can adequately meet MIPS criteria through any and all reporting mechanisms already approved by the Physician Quality Reporting System (PQRS). Given that CMS proposes to reweight other MIPS categories, with the exception of Quality, it is imperative for CMS to ensure that requirements under the Quality performance category are clear and transparent.

**ASA urges CMS to ensure that their reweighting policy to the Quality performance category is accurate, fair and reasonable so that providers have the best chance to be successful under this category and the MIPS program overall.**

We agree with the CMS proposal to reduce the reporting requirements from nine to six measures and to remove the requirement to report across three NQS Domains. Under PQRS, many of our members have been challenged to report on nine measures that are applicable and meaningful, and the requirement to report measures across the three NQS domains added another level of complexity. We support any effort to reduce the reporting burden for our members and health care providers in general.

We agree with CMS that providers should be given credit for measures they successfully report, rather than instituting an "all or nothing" approach to scoring. The scoring methodology proposed for the Quality performance category appears to be fair and equitable and provides the opportunity for eligible clinicians to receive credit for the measures they successfully report. We support provisions to hold harmless physicians who choose to report new measures or measures that do not meet the minimum case threshold.

Scoring for non-MIPS Qualified Clinical Data Registry (QCDR) measures was not directly addressed in the Proposed Rule. As CMS has virtually eliminated the ability of physician anesthesiologists to report via the claims-based mechanism, the Agency should foster a smooth transition toward registry-based reporting. QCDRs allow eligible clinicians to report specialty-specific measures that are meaningful to their practice and physician anesthesiologists should continue to receive fair recognition for reporting such measures. We oppose the requirement that eligible clinicians using the QCDR reporting option must report a cross-cutting measure.

**ASA urges CMS to establish scoring methodology that gives reporters of MIPS measures and non-MIPS QCDR measures equal opportunity to be successful in the Quality performance category.**

### *Group practice reporting*

We strongly support the Group Practice Reporting Option (GPRO) for eligible clinicians to satisfactorily participate in MIPS. The availability of this option continues to be beneficial to ASA members and will reduce the reporting burden of certain group practices. The ASA strongly endorses making CAHPS for MIPS reporting a voluntary option for groups of 100+ eligible clinicians. While CAHPS reporting may be meaningful to some providers, the content of

these surveys does not allow for physician anesthesiologists to make effective improvements to the quality of anesthesiology care they provide. In addition, CAHPS reporting adds yet additional burden and expense for our members to meet program requirements

#### *Reporting criteria/threshold*

ASA opposes CMS's proposal to increase the reporting thresholds from 50 percent to 90 percent for MIPS eligible clinicians reporting via QCDR and qualified registry mechanisms. We also oppose the increased reporting requirements for those eligible clinicians using the claims-based mechanism. A significant increase in the reporting rate threshold would undermine the desire of CMS to give as many eligible clinicians as possible the ability to report and be scored in the Quality performance category. The rather abrupt disappearance of nearly all claims-based measures for physician anesthesiologists in 2016 has been disruptive for these practices and they are not positioned to escalate their rate of reporting at this time. Although we anticipate ongoing transition from claims-based reporting to electronic reporting via registries among our members, a significant number of practices, especially smaller and resource-limited practices continue to operate in a paper-based environment for many of the reasons CMS cited in its discussion of hospital-based clinicians and ACI reporting.

We anticipate significant barriers for clinicians to meet these new requirements. Anesthesia data may be captured by a billing system, an Anesthesia Information Management System (AIMS), a hospital Electronic Health Record, on paper and any combination of these systems. Oftentimes, physician anesthesiologist access to clinical data is dependent on a facility's commitment to collecting and sharing quality data. Each year, practices must work with their internal quality processes, billing companies, facilities and a registry to ensure their data is accurately sent and received. CMS should retain a 50 percent threshold for 2017 and then increase that threshold each year beginning in 2018. We feel that a 5 percent increase in the threshold each year is more reasonable and manageable, and will allow providers to more effectively adapt to the changing requirements while still creating incentives for improving reporting performance.

**ASA recommends that CMS take a more phased approach and incrementally increase the reporting threshold over the next several years. We also request that CMS release data demonstrating that raising the reporting rate is feasible for all MIPS eligible clinicians.**

In addition, the CMS timeline for approving QCDR measures remains a significant barrier that limits a MIPS eligible clinician's ability to meet the 90 percent threshold. QCDR measures are not typically approved until the end of the first quarter, which means eligible clinicians have already "lost" a quarter of the year to collect and submit data. Thus, they are expected to retrospectively audit their medical charts and submit data on patients seen during the January – March timeline in order to achieve the 90 percent threshold. Furthermore, the delay approving measures also means that practices aren't able to effectively establish and implement their quality capture processes (*i.e.*, development of quality capture forms, establishment of protocol for collecting the appropriate data) causing practices to scramble to complete this process. The delay in operationalizing and reporting measures also has a detrimental effect on a MIPS eligible clinician's performance rate for each measure. Additional time is needed for practices to learn how to correctly and reliably report each non-MIPS QCDR measure. By approving measures earlier, MIPS eligible clinicians and practices will have more time to improve and hone their

processes, potentially improving care quality for more patients by implementing data-informed corrective actions earlier in the reporting year.

Regardless of whether CMS implements a phased approach or not, ASA embraces CMS attempts to approve QCDR measures earlier in the reporting year and, in future years, prior to January 1. This will allow both QCDR vendors and health care providers to better operationalize new requirements and updated measure specifications.

#### *Scoring measures under MIPS*

In general, we support the proposal to group MIPS measures by specialty as we believe this will provide some clarity for those who are unsure of which measures may apply to them. We also see value in maintaining the non-MIPS QCDR measures in the program, as these measures reflect the needs of physician anesthesiologists who practice in a variety of clinical environments and encounter a diverse patient population. This option allows our members the flexibility to select and report on measures that are most meaningful to them. CMS should award bonus points to MIPS eligible clinicians who report to a QCDR regardless of whether they use Certified Electronic Health Record Technology (CEHRT) or not.

ASA requests CMS recognize PQRS (now MIPS) #424: Perioperative Temperature Management as an intermediate outcome, just as it is recognized by the National Quality Forum. The measure fits the CMS criteria to be an intermediate outcome measure. As defined by CMS, “an intermediate outcome is a (measured) change in physiologic state that leads to a longer-term health outcome.” The desired outcome for Perioperative Temperature Management is a reduction in adverse surgical effects due to perioperative hypothermia. Physician anesthesiologists must appropriately monitor and maintain core temperature levels of the patient. A drop in core temperature during surgery can result in numerous adverse effects, which can include adverse cardiac events, peripheral vasoconstriction with hypertension, delayed drug metabolism, altered blood coagulation, increased incidence of surgical site infection, and impaired healing of wounds. MIPS #424 identifies a patient outcome (core temperature) and contributes to a desired longer-term health outcome.

#### **ASA recommends that CMS recognize MIPS #424 as an intermediate outcome measure under MIPS.**

We are pleased that CMS intends on giving credit to physicians who report on measures that CMS considers to be “topped-out.” CMS identifies that about 50 percent of the current measures are topped-out and has indicated a desire to remove those measures over time.

#### **ASA requests that prior to removing “topped-out” measures from the MIPS program, that CMS provide at least a year’s notice through the rule-making process of the measures removal.**

We are also concerned about the specialty measure set and its application to physician anesthesiologists who may not have the opportunity to report all measures under the specialty set. In 2016, CMS developed the registry anesthesia cluster that many of our members working in office-based or certain outpatient environments could not use. Such anesthesiologists included

those who rarely gave general anesthesia (PQRS #424, PQRS #430) or would never directly transfer a patient to the Intensive Care Unit (PQRS #427). Additionally, not every anesthesiologist places central venous catheter lines, limiting their ability to also report on PQRS #76.

**ASA requests CMS develop and publish FAQs, explanations or scenarios specific to anesthesiology describing which measures certain physician anesthesiologists may need to report in 2017.**

We are concerned with the lack of details offered on the MIPS equivalent of the PQRS Measure Applicability Validation (MAV) process. Under the current MAV process, clinicians are given very little detail as to why they failed to meet PQRS reporting requirements. Clinicians who wish to appeal the penalty face several challenges in the process as they can neither verify the accuracy of CMS's decision nor challenge its findings. We are eager that this process will be improved under MIPS, especially with respect to clear communication with MIPS eligible clinicians about the application of reporting standards.

**We strongly urge CMS to establish more transparency with its new validation strategy, including the evidence or methodology used to determine if a physician anesthesiologist should have reported a specific measure.**

ASA is also concerned about the inclusion of cross-cutting requirements for “patient-facing” providers. A majority of physician anesthesiologists rarely have the opportunity to report a cross-cutting measure as defined by CMS. We seek assurances from CMS that those who report a patient-facing encounter code but not a sufficient number of encounter codes found in a cross-cutting measure denominator are not penalized for not meeting the cross-cutting requirement.

Reporting of new, potentially poorly understood measures by a wider variety of MIPS eligible clinicians who may be unaware of certain, specific reporting standards may unfairly skew first year scoring. Because of this, we recommend that MIPS eligible clinicians who may not meet the threshold in the first year be held harmless on that measure.

**ASA recommends that CMS safeguard against unintended consequences of scoring newly introduced Quality measures.**

CMS proposes to score three population-based measures that have rarely been, or ever, reported by physician anesthesiologists. The three measures – Acute Conditions Composite (Bacterial Pneumonia, Urinary Tract Infection and Dehydration), Chronic Conditions Composite (Diabetes, Chronic Obstructive Pulmonary Disease or Asthma, Heart Failure) and All-cause Hospital Readmission Measure are measures that the physician anesthesiologist will have little control over, especially since CMS will calculate these measures. The use of these measures will place anesthesiology at a disadvantage to other MIPS eligible clinicians. We fear that attribution of these measures to individual physician anesthesiologists may prove to be equally or less transparent than current measures within the VBM Program.

**ASA urges CMS to recognize that the three proposed population health measures for the Quality performance category are generally inappropriate and offer little value to physician anesthesiologists and should not be required.**

We support the concept of awarding bonus points to clinicians who report high-priority and outcome measures. However, we foresee limitations with this approach as some clinicians may have a limited number of high-priority measures available to report. This scenario would put them at a disadvantage when calculating their composite score. We ask CMS to monitor and release detailed reports on measure use among eligible clinicians and their specialties.

Although ASA and our members have invested significant time and energy in developing measures that apply to a large percentage of our physicians, we recognize that measure gaps remain especially in the high-priority areas. ASA is focused on addressing measure gaps that include, but are not limited to, ambulatory care, pain medicine, critical care and pediatric measures.

**We urge CMS to recognize that measure development in anesthesiology is a priority and partner with ASA, CMS contractors and other measure developers to develop high-priority and outcome measures that fill gaps so that our members can fully participate in the Quality performance category under MACRA. Allocation of measure development resources provided for in the MACRA toward this goal is warranted and appropriate.**

#### Advancing Care Information Performance Category

The ACI performance category replaces the current Meaningful Use program. ACI accounts for 25 percent of the total MIPS score.

ASA was encouraged by recent statements by CMS that suggested a willingness to re-engineer the EHR Incentive Program into a system that would recognize the unique role that different specialties play in using Health IT beyond the stated objectives and measures in Meaningful Use Stage 2 and Stage 3. In our response to the Request for Information in November and in our December 2015 comments on Stage 3, ASA provided a number of examples of how our members could demonstrate effective use of electronic health records. Regrettably, we are disappointed that ACI for 2017 performance lacks relevant EHR measures for even our members who regularly use EHR technology, and that the obligation to report is dependent on unclear definitions of patient-facing and hospital-based provider status.

In our previous comments on Meaningful Use, we noted our concern with the proposed implementation timelines as many of our members operate in practices that still use paper, have limited financial resources and require additional time to plan for large expenditures. Implementing and updating software to the required CEHRT, whether within their AIMS or in their facility EHRs, is an incredibly costly and time-consuming endeavor. We believe the aggressive timeline will have a substantial impact on anesthesia practices. Most practices will struggle to access the necessary technology to comply with these proposed requirements.

CMS has correctly recognized the fact that many of our facility-based members have little control on the availability of EHR technology, its functionality or its capacity to integrate with

other hospital systems. On this basis, making available the option of omitting ACI reporting is entirely appropriate for individuals and groups who find themselves, on this basis, unable to effectively use or report use of an EHR. This is the basis for the existing automatic hardship exemption that was put in place through calendar year 2017 and remains appropriate for a significant number of physician anesthesiologists.

On the other hand, there is a growing portion of our specialty who have access to EHR systems and effectively use them to deliver improved care with seamless integration with other components of the patient's medical record. The ability to share information with other clinicians, access diagnostic studies in real time and provide a flow of information across care settings represents the goal of EHR that CMS promotes. The ways in which physician anesthesiologists effectively use EHRs differs substantially from those in office-based practices.

We appreciate that CMS can recognize that some measures may be applicable to a physician anesthesiologist in one setting (perhaps a pre-op clinic) but that same measure may not apply to that same physician anesthesiologist practicing in a different setting (operating room) the next day. This is an important consideration in developing a relevant and valuable set of ACI measures for physician anesthesiologists.

We also thank CMS for recognizing that hospital-based MIPS eligible clinicians may not have control over the decisions regarding the use of Health IT and CEHRT. We thank CMS for outlining these exclusionary categories in the Proposed Rule and how they will apply to a subset of our members. However, we reiterate that just because eligible clinicians in a large group practice may have the resources to acquire CEHRT, it does not ensure interoperability with the hospital systems without a significant commitment of IT resources made at the discretion of the facility. Thus, when facing these barriers we urge that even physician anesthesiologists who may have limited EHR use have the option of being exempt from ACI reporting and reweighting the category as discussed earlier.

#### *ACI scoring methodology*

The majority of objectives and measures have been continued from the Meaningful Use program and have been repackaged with an updated scoring system. We noted in our comments for Modified MU Stage 2 and Stage 3 that we saw the potential for development of anesthesia-focused measures within the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives. These objectives are still available in the alternative base score but will be phased out in the future. We feel that these objectives provide value for our members and are highly relevant to measuring use of EHR technology in anesthesiology.

We remain skeptical of the applicability of other proposed higher-impact objectives and measures to anesthesia. We are concerned about the ability of our members to attest to the three high-impact objectives that make up the Performance Score scoring methodology: **Patient Electronic Access, Coordination of Care Through Patient Engagement and Health Information Exchange**. We believe that there is great potential to develop equally valuable substitute metrics to assess the key features of meaningful use of EHR technology in anesthesiology, a clinical setting dramatically different from the office-based practice.

ASA believes there are ways to structure the ACI performance category of MIPS to be more applicable to anesthesia documentation. For example, automated population of data from physiologic devices (*e.g.*, vital signs, anesthesia machine parameters) is critically important. Consistently completing this process is an important AIMS feature that reflects its intrinsic quality. Additionally, transfers of care from anesthesia professionals to other providers that occur when patients are moved from anesthesia care to a post-anesthesia care unit are important processes that can be supported and improved by transfer of information with robust electronic tools. Minimal requirements or features of high-quality transfer of care documentation can be established for anesthesia care. Interoperability with facility laboratories can provide real-time access to perioperative laboratory testing and speed medical decision making for the surgical patient.

Some of the functionality important in assessing EHR use in anesthesiology is outlined here:

- Inclusion of intraoperative medications in the patient's global Medication Administration Record
- Real-time read/write access to the facility's allergy data repository
- Real time access to diagnostic images, laboratory data, consultant and office notes
- Real-time read/write access to the patient's global problem list
- Read/write access to vital sign history database
- Summary of intraoperative medications, fluids, blood and physiology at each transfer of care
- Decision support for antibiotic prophylaxis, DVT prophylaxis and beta blocker administration
- Data extraction capacity for registry reporting and outcomes analysis

**ASA welcomes the opportunity to collaborate with CMS and the Office of the National Coordinator for Health IT to develop standards and meaningful objectives for physician anesthesiologists so that our members can report on ACI with new measures in 2018.**

#### *Group practice reporting option*

ASA is pleased that CMS is proposing the GPRO mechanism for individual MIPS eligible clinicians. This proposal would alleviate the burden for our members to attest individually. In particular, we have a population of office-based members who would be able to take advantage of group reporting. However, we note that the process for GPRO ACI reporting was not included in the Proposed Rule.

**ASA requests CMS release regulatory guidance on the GPRO ACI process as soon as possible.**

#### *Clinical quality measures*

ASA supports the CMS proposal to no longer require the reporting of electronic Clinical Quality Measures. We thank CMS for recognizing the limitations of this previous requirement and the additional burden it placed on practices to report.

#### *Interoperability between CEHRT and AIMS*

Anesthesia professionals provide intensive care and perform invasive procedures in challenging,

rapidly-changing conditions while documenting complex care in real-time. In such circumstances, any potential for distraction due to a cumbersome documentation system would be detrimental to patient safety. EHR documentation tools must be tailored to suit this unique care setting. In addition, consistent population of data from physiologic monitors and anesthesia devices is a fundamental requirement for a minimally functional electronic anesthesia record system. Failure of such data to populate reliably in every case equates to a failed system that cannot be used without distracting from care.

CMS seeks comment on the concept of a holistic approach to Health IT. It is clear that CMS thoughtfully constructed the new scoring framework for the use of EHRs with a focus on patient engagement and interoperability. ASA believes Health IT has the potential to improve the safety, quality and efficiency of anesthesia. But for physician anesthesiologists to use CEHRT in the most productive way, interoperability between AIMS and EHRs is necessary. AIMS must be integrated into CEHRT in a way that allows the AIMS data to update the EHR but also allows the EHR to update the AIMS with relevant and necessary clinical data.

**ASA requests CMS recognize and give credit to eligible clinicians who use Health IT tools and methods that fall outside of the traditional Meaningful Use criteria.**

Physician anesthesiologists use Health IT through multiple systems and products to deliver optimal care and protect patient safety. ASA continues to recommend that AIMS be integrated into CEHRT so physician anesthesiologists may receive credit for their use of AIMS without increasing their reporting burden. AIMS improves efficiency in the operating room (often enhancing patient satisfaction with timeliness and improving efficiency) and allow physician anesthesiologists to receive real-time, critical information. Such information supplements physician anesthesiologists' knowledge and serves not just to improve quality and reduce resource costs but to ensure patient safety as well.

**Our members should have the opportunity to participate and succeed in MIPS based upon their optimal use of AIMS and other electronic tools.**

*Registry reporting*

While we recognize reporting to a public health immunization registry contributes to population health, few physician anesthesiologists who will be included in this program will find that category meaningful to their practice. The awarding of points to that registry while decreasing the emphasis on specialty registries (by awarding just one point), undermines specialty registry reporting and increases reporting burden among physicians outside of primary care or intimately involved in population health.

We believe that the Anesthesia Quality Institute (AQI), with clear guidance from the Office of the National Coordinator for Health IT (ONC) has the potential to become a clinical data registry (CDR) under this Proposed Rule. In addition to being a CMS-approved QCDR, ASA and AQI are uniquely positioned to assist eligible clinicians with receiving a bonus point under the proposed scoring system by reporting to CDRs. As a registry and Patient Safety Organization (PSO), AQI has improved the care physician anesthesiologists provide to patients, has aided practices in improving their responses to critical incidents and has assisted in the reduction of

anesthesia-related morbidity and mortality. The AQI National Anesthesia Clinical Outcomes Registry (NACOR) has safely and securely captured data on millions of procedures from physician anesthesiologists and the facilities in which they practice.

#### Clinical Practice Improvement Activities Performance Category

The CPIA performance category recognizes activities that improve clinical practice or care delivery and that when effectively executed are likely to result in improved outcomes. CPIA accounts for 15 percent of the total MIPS score.

ASA appreciates the expansive set of more than 90 CPIA options in the proposed rule and have identified below several that we believe many of our members will find the most applicable and meaningful. We request that CMS provide guidance as soon as possible for MIPS eligible clinicians to report CPIA and how QCDRs and qualified registries are to collect attestations and measurements.

We view CPIA as becoming more precise over time. In the interim, we request additional guidance from CMS on the degree to which the QCDR must define certain programs and/or activities for participants or if attestations to such activities will suffice. For instance, one CPIA activity includes “Participation in a QCDR that promotes collaborative learning network opportunities that are interactive.” Within this one activity, the terms “promote” “collaborative” and “interactive” may have different meanings for different QCDRs.

**ASA requests that CMS assign high weights to CPIA that include QCDR and qualified registry participation. Participation in an ABMS Maintenance of Certification program should be recognized as fully satisfying the CPIA score in MIPS.**

We believe that the optimal CPIAs will vary based on practice setting and CMS should be flexible in allowing clinicians to choose the activities of the greatest value to their practices and patients. Some of the CPIAs described that will be valuable in many, but not all, anesthesiology practices, include:

- Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.
- Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (*e.g.*, comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).
- Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.
- Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.
- Use of QCDR data, for ongoing practice assessment and improvements in patient safety.
- Participation in Maintenance of Certification Part IV for improving professional practice including participation in a local, regional or national outcome registry or quality assessment program. Performance of activities across practice to regularly assess

performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.

- Participation in a QCDR, demonstrating performance of activities for promoting use of patient-reported outcome (PRO) tools and corresponding collection of PRO data (*e.g.*, use of PHQ-2 or PHQ-9 and PROMIS instruments).
- Participation in an AHRQ-listed patient safety organization.
- Implementation of regular care coordination training.
- Implementation of practices/processes that document care coordination activities.
- Implementation of practices/process for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient centered action plan for first 30 days following a discharge.
- Establish standard operations to manage transitions of care.

We request that CMS explicitly recognize qualifying continuing medical education (CME) as a CPIA. CME has long been recognized as an effective means by which physicians demonstrate engagement in continued professional development. Consistent with the intent of MACRA, and with focus on the “three aims,” the NQS and the CMS Quality Strategy, CME encourages physicians to develop and maintain the knowledge, skills, and practice performance that leads to improved performance with optimal patient outcomes.

Simply put, without translating the new payment system into meaningful actions for physicians, the promise of MACRA will never be fully achieved. Because they have the ability to make a measurable difference in the way physicians practice, accredited CME activities that are designed to further the objectives of MACRA, the “three aims,” and the NQS should result in credit for the CPIA performance category.

*Background on the role of CME in driving quality and its relevance to MIPS*

Lifelong learning, assessment, and improvement are integrally related. Practice improvement multi-dimensional interventions, including participation in professional development activities, like CME is a necessary component of the change process that results in meaningful, sustained clinical performance improvement. Without this professional development, the measurement of adherence to quality metrics and use of health information technology are insufficient to produce clinical performance improvement. Patients will continue to need health care professionals that engage in lifelong learning, assessment, and improvement in practice, so it is important these activities be recognized and rewarded in value-based payment programs promulgated by CMS and private payers.

CMS and private payers can also reduce burdens on physicians by counting CME and continuing education as progress toward program goals. Eligible clinicians should be credited for their effort to stay current with clinical practice and quality measures by utilizing CME. The inclusion of CME as a clinical practice improvement activity, with integration of CME into the planning and implementation of improvement activities, will help these professionals obtain credit for the time they invest in learning about practice improvement and implementing that learning into their practices.

Additionally, the sources of information on quality improvement requirements for professionals are limited and participation can only be increased with education. Failure to learn about the major changes in healthcare reform places health care professionals at risk financially, operationally, and clinically. Fortunately, accredited education is an understandable and predefined measure to help avoid these concerns.

Physicians have a professional responsibility to keep up-to-date through CME and there is a preexisting infrastructure to record participation in CME activities. Currently 45 states plus the District of Columbia require participation in CME to maintain licensure. CME is a familiar activity for physicians and giving CMA credit for participation in CME will help to align the interests of physicians with the value being driven by the QPP. The mechanisms already in place ensure that accredited/certified CME activities are designed to address clinicians' practice-relevant learning needs and practice gaps. The programs are also measured to evaluate the educational and clinical impact of the activity.

*ACCME's PARS reporting can be easily integrated into the MIPS reporting platform*

The Accreditation Council for Continuing Medical Education's (ACCME's) Program and Activity Reporting System (PARS) is a web-based portal designed to streamline and support the collection of ACCME program and activity data from accredited continuing medical education (CME) providers. The ACCME uses the information collected in PARS to support the performance-in-practice reviews that are part of the process for initial accreditation, reaccreditation, and progress report reviews. In addition, the ACCME uses data from PARS to produce annual reports as a service to accredited CME providers and other stakeholders.

As CMS looks to develop ways to track and confirm MIPS eligible clinician participation in approved CPIAs, we believe that the ACCME's PARS system provides an important tool. Having already been developed for the purpose of tracking learner participation at accredited CME activities, PARS, along with specialty board MOC portals and clinical registries, can be fairly easily enhanced and integrated into MIPS so as to ensure true, consistent reporting in the CPIA performance category.

*Proposed guidance on CME*

ASA recommends that CMS explicitly acknowledge and provide credit for certain CME activities, provided by a nationally-recognized accreditor, as clinical practice improvement activities within MIPS. Specifically, we seek explicit credit for certain defined CME activities in two of the CMS designated CPIAs, namely:

- Accredited CME activities that involve assessment and improvement of patient outcomes or care quality, as demonstrated by clinical data or patient experience of care data, such as Performance Improvement CME, Quality Improvement CME.
- Accredited CME that teaches the principles of quality improvement and the basic tenets of MACRA implementation, including application of the "three aims," the NQS, and the CMS Quality Strategy, with these goals being incorporated into practice.

We suggest that approved CME activities that incorporate a 90-day survey or evaluation period into the program should be considered to have met the proposed rule's 90-day activity threshold.

The ASA has been working with a variety of health systems and other specialties within a PSH collaborative. These efforts have demonstrated how this team-based approach to perioperative care can increase the quality and value of the care provided to patients. ASA recommends that CMS explicitly recognize participation in a PSH pilot as a CPIA activity as it is a physician-led, patient-centric, team-based system of coordinated care that guides patients through the entire surgical experience, from the decision to undergo surgery to discharge and beyond, with the goal of providing cost-effective, high quality perioperative care and exceptional patient experiences. The work of our PSH groups is analogous to the work done in the Patient Centered Medical Home and should be recognized in a similar fashion under MIPS. We acknowledge that several components of the PSH model are recognized in the current list of CPIA activities, but note that the proposed CPIA activities do not adequately represent the PSH model in its entirety.

**ASA urges CMS to recognize the existing clinical practice improvement programs in which MIPS eligible clinicians currently participate and make every effort to harmonize MIPS CPIA requirements and avoid duplicating the reporting of these activities.**

#### Registry Provisions

We are excited about the prospects of members using QCDRs and qualified registries to participate in MACRA. The Anesthesia Quality Institute (AQI) National Anesthesia Clinical Outcomes Registry (NACOR) has been in existence for more than five years and has been a QCDR since 2014. We welcome the opportunity for physician anesthesiologists to have the option to report three of their four performance categories through one mechanism. CMS should encourage eligible clinicians to report via one mechanism but should not require, at this time, that eligible clinicians report by using just one mechanism. We support many of the established provisions of the self-nomination process for QCDR and request further guidance on how QCDRs can be used for the ACI and CPIA performance categories.

Multiple QCDRs function within the anesthesia space and the variety has produced mixed results. We are concerned that billing companies and those QCDRs established solely for reporting quality measures without collecting substantial data for local quality improvement purposes do not fully live up to CMS's original intent.

**ASA asks that CMS reinforce its definition of a QCDR as one that “collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality care provided to patients.”**

We also ask that CMS foster harmonization among measures that are nearly identical. In the two years that ASA has published our measures, measures (or their general concepts) within the ASA QCDR have appeared in some form or another in subsequent non-ASA QCDRs without our knowledge or ability to ensure the measures are being reported in the same way. We are concerned that a variety of measures that address the same topic may skew patient understanding and physician assessments under MACRA. Consistency in measurement should be a primary goal of CMS.

CMS should continue to embrace processes for QCDRs to appropriately license and report on other QCDR measures. ASA has offered to license our measures without cost to several QCDRs. We have appreciated working with other QCDRs in this manner as it increases the ability for specialists to be assessed fairly across multiple QCDRs. Moreover, licensing of measures encourages trust and collaboration among QCDRs.

**We request that when a QCDR measure steward licenses a measure to another QCDR, the licensed measure does not count toward the 30 non-MIPS QCDR measure limit of the licensee.**

CMS must consider the time and resources needed to educate MIPS eligible clinicians on how to report MIPS performance categories via a registry. ASA published a number of materials on our website, hosted webinars, held virtual office hours and answered hundreds of phone calls and e-mails in 2015. From our experience, we know there will be a number of practices who will struggle to operationalize reporting across three MIPS categories.

We also have concerns about the time needed for our registry to operationalize the ACI and CPIA reporting mechanisms as well as the GPRO mechanism in these components.

**These concerns further reinforce our recommendations for (1) a delayed start date for the initial Performance Year to at least July 1, 2017 and (2) initial Performance Year in 2017 running through December 31, 2017 (for the first MIPS Payment Year of 2019).**

#### *QCDR and qualified registry self-nomination process*

ASA agrees with CMS that self-nominations for the QCDR and qualified registry be submitted earlier in the year and that the measures in future years (beginning in 2018 performance year) will be finalized by January 1. ASA has the mechanisms in place to meet these requirements while developing measures and performing routine maintenance of measures currently available in our QCDR. Although QCDR self-nomination requirements are relatively consistent, we oppose the proposed requirement that eligible clinicians using the QCDR report a cross-cutting measure.

ASA recommends that efforts to procure and track signed documentation of each NPI holder whose data are submitted to the QCDR and has authorized the QCDR to submit data for MIPS be captured at the practice level by the practice. We have, in the past, collaborated with practices to track their rosters and individual providers. Because it not uncommon for anesthesia groups to include greater than one thousand eligible clinicians, it is a burden for ASA to maintain such records as well as track down individual eligible clinicians for final sign-off.

ASA opposes the inclusion of “notations on [a] qualified QCDR [qualified registry] posting of low data quality” or publication of probationary status on a public website. We understand that submitting data is very important not just to CMS but also to registry participants. However, the QCDR and qualified registry, in general, should collect more information than what is submitted to CMS. Identifying poor quality submission may undermine other positive and meaningful uses of a registry beyond participation in MACRA. In addition, we believe it is incumbent upon the participant to conduct their due diligence in selecting a QCDR.

We also note that the collection of sociodemographic data is often outside of the scope and resources of clinical registries. Certain demographic data such as ethnicity, race and income are rarely collected by registries. Other terms such as vulnerable populations need further explanation. Any emphasis on risk stratification or adjustment with sociodemographic data must take into consideration the ability to capture accurate and reliable data points.

Risk-adjustment strategies and models take a significant amount of expertise and financial resources to develop and test. Although process and intermediate outcome measures are relatively easy to understand and replicate, risk-adjustment strategies evolve and must incorporate sound and relevant factors over time. Although we understand that certain variables of risk adjustment should be published to notify the public and stakeholders on certain criteria of risk-adjustments, we request that only the minimum necessary related to risk-adjustment strategies and methodology be published as required under QCDR self-nomination requirements.

**ASA requests that CMS provide adequate protections to safeguard any intellectual property associated with a measure steward’s risk adjustment methodology, especially in regard to posting non-MIPS QCDR measure specifications.**

ASA requests reconsideration of “mandatory participation in ongoing support conference calls, including an in-person QCDR kick-off meeting.” ASA staff has always participated in these succinct, informative and effective calls. However, we are unclear what constitutes an “excused absence” and fear that an inadvertently missed meeting (e.g., miscommunication) could result in a technical disqualification of the QCDR by CMS.

**ASA asks that CMS identify “topped out” non-MIPS QCDR measures more than one year prior to retiring such measures. We also request that CMS notify QCDRs as soon as possible if a non-MIPS QCDR measure will not be renewed in future years for other reasons.**

#### *Registries and the Quality performance category*

Scoring for non-MIPS QCDR measures was not directly addressed in the proposed rule. As CMS has virtually eliminated the ability of physician anesthesiologists to report via the claims-based mechanism, the Agency should foster a smooth transition toward registry-based reporting. QCDRs allow eligible clinicians to report specialty-specific measures that are meaningful to their practice and physician anesthesiologists should continue to receive fair recognition for reporting such measures.

**ASA urges CMS to establish scoring methodology that gives reporters of MIPS measures and non-MIPS QCDR measures equal opportunity to be successful in the Quality performance category.**

Similar to our concerns stated in the Quality performance category section of this letter, ASA opposes CMS’s proposal to increase the reporting thresholds from 50 percent to 90 percent for MIPS eligible clinicians reporting via the Qualified Clinical Data Registry (QCDR) and qualified registry mechanisms. A significant increase in the reporting rate threshold would undermine the

desire of CMS to give as many MIPS eligible clinicians as possible the ability to report and be scored in the quality component.

We anticipate significant barriers for MIPS eligible clinicians to meet these new requirements. Anesthesia data may be captured by a billing system, AIMS, a hospital EHR, on paper and any combination of these systems. Oftentimes, access to clinical data is dependent on a facility's commitment to collecting and sharing quality data. Each year, practices must work with their internal quality processes, billing companies, facilities and a registry to ensure their data is accurately sent and received. CMS should retain a 50 percent threshold for 2017 and then increase that threshold each year beginning in 2018. We feel that a 5 percent increase in the threshold each year is more reasonable and manageable, and will allow providers to more effectively adapt to the changing requirements.

**ASA recommends that CMS take a more phased approach and incrementally increase the reporting threshold over the next several years. We also request that CMS release data demonstrating that raising the reporting rate is feasible for all eligible clinicians.**

The ASA supports making CAHPS for MIPS reporting a voluntary option for group practices of 100+ eligible clinicians reporting under GPRO. The CAHPS requirement for these practices has limited their full participation in PQRS. The content of the CAHPS program, in its current form, offers little information useful to improve anesthesiology practice. CAHPS reporting adds another level of complexity for our members to meet program requirements as well as increased financial and human resources requirements at the QCDR level to work with CAHPS vendors.

CMS has proposed that MIPS eligible clinicians reporting through other quality mechanisms than the QCDR begin to report data on all payers. Throughout the Proposed Rule, CMS identifies certain case minimums or thresholds that must be met to make a measure valid and reliable. The additional data burden on providers to submit data on non-Medicare patients does not balance with how a measure would be statistically valid or reliable. Instead, the collection of such data would increase the burden among registries, clinicians and practices to quickly scale their operations to collect and submit three to four times more data than in current regulations.

**ASA opposes CMS proposals to gather non-Medicare data through non-QCDR reporting mechanisms.**

#### *Registries and the ACI performance category*

Our experience in maintaining a QCDR for PQRS provides us with the background to developing solutions for members in the ACI and CPIA components. We know the most challenging aspect for physician anesthesiologists seeking electronic reporting solutions revolve around the burden of data collection from multiple sources. Administrative, clinical and billing data are often housed in multiple locations in each of the facilities in which a physician anesthesiologist may provide care. In particular, those providing preoperative, intraoperative and postoperative care routinely encounter fragmented records that frustrate practices, their administrators and the best efforts of CMS and ONC to decrease reporting burdens.

Part of the solution to data fragmentation among our members has been the use of data management tools and apps. Our QCDR interacts with a number of software and EHR providers who collect disparate information from multiple sources, clean, merge and format the data, and then report this information as a bundled package to our data warehouse. This multi-step process is rarely completed by one “certified” electronic device. CMS and ONC should recognize and provide credit to certain electronic tools that, although they may not fulfill a strict definition of CEHRT, contribute to data submission and encourage full participation in MACRA.

As with many medical specialty registries, we are concerned with the proposed timeline to support the ACI QCDR reporting mechanism. CMS even noted that the Agency expects some QCDRs to struggle in upgrading their processes to include ACI reporting. In addition to delaying the implementation of these regulations, one solution may be for CMS to provide enhanced technical support and training to established QCDRs that wish to expand their reporting options to include reporting the ACI category.

#### *Registries and CPIAs*

ASA is grateful for the emphasis that CMS has put in developing a wide variety of CPIAs that award credit for participation in a QCDR. No other section in the Proposed Rule reinforces the intent of the MACRA legislation to leverage QCDRs in quality improvement at the local practice and facility. We support CMS weighting the use of a QCDR that summarizes local practice patterns and treatment outcomes as a high weight activity.

**Because some participants may find qualified registries to fulfill their quality and ACI needs, we support extending the “high weight” CPIA *“Use of a QCDR that summarizes local practice patterns and treatment outcomes”* to participation in a qualified registry. ASA supports all registry and QCDR CPIA to be considered and scored as “high weight”.**

ASA appreciates the flexibility that CMS has incorporated into many CPIA, balancing attestations with demonstrable action on the part of eligible clinicians. However, we seek additional information on how CMS expects a QCDR or qualified registry to collect and report CPIA. ASA requests additional information on how CMS intends for the QCDR to track 90-day performance for several categories that appear to be either attestations or intermittent activities. We support QCDRs having the ability to pick and choose which CPIA to collect and report.

As with the previous roll out of QCDRs in 2014 and 2015, we view CPIAs as becoming more precise over time. In the interim, we request additional guidance from CMS on the degree to which the QCDR must define certain programs and/or activities for participants or if attestations to such activities will suffice. For instance, one CPIA activity includes “Participation in a QCDR that promotes collaborative learning network opportunities that are interactive.” Within this one activity, the terms “promote” “collaborative” and “interactive” may have different meanings for different QCDRs. Our QCDR would be able to promote such activities through the PSH and other learning networks of registry participants, however, we want to make sure that this matches CMS intent. We ask CMS to provide guidance on defining CPIA in a way that is both flexible (allowing for attestation) yet understandable and comparable across multiple QCDRs.

We support CMS proposals to use similar processes for proposing and maintaining CPIA as CMS and their contractors have for quality measures. This process allows for open, informal communication that ASA staff has found constructive and helpful. We only recommend that CMS explore options for moving CPIA proposals faster through the approval process than their measure peers.

### **Alternative Payment Models**

ASA recognizes that the majority of providers will enter into the QPP through the MIPS pathway. We look forward to the development of APMs that will provide means for our members to provide care in these arrangements.

In the Proposed Rule, CMS indicates that in order for a provider to receive enhanced payment through a qualified Advanced APM, the Advanced APM must not only meet one of the following MACRA criteria to be an APM:

- A CMMI model;
- A MSSP;
- A demonstration under section 1866C, the Medicare Health Quality Demonstration Program; or
- A demonstration required by federal law

but also all of the following criteria:

- Base payment on quality measures;
- Require the use of certified EHR technology; and
- Either bear more than nominal financial risk for monetary losses or be a medical home model expanded under CMMI authority

CMS should strive towards consistency between APMs that focus on population health and those that are episode-based. One way to promote inclusion of episode-based APMs as Advanced APMs is to adjust the required revenue thresholds.

**Advanced APM revenue thresholds start at 25 percent for 2019 payments and increase to 75 percent for 2023. CMS should finalize its flexible alternative approach to qualify for the bonus payments by having 20 percent of patients receiving care through the APM for 2019, increasing to 50 percent by 2023.**

At this time given these requirements, we perceive that the PSH model does not currently qualify as an Advanced APM. However, we understand that CMS will be continuing to assess Advanced APM criteria and will be expanding its list of such APMs over time. We believe that the PSH embodies the key objectives of APMs by focusing on multi-professional collaboration to improve the entire continuum of the patient's perioperative experience with higher quality and reduced costs.

**We are eager to find ways in which the Advanced APM provisions of MACRA can promote and accelerate the dispersion of the PSH innovations.**

We will continue to monitor these activities and have them inform our strategic planning. ASA encourages the Agency as it reviews proposed Advanced APMs and bundles to consider all of the specialties and providers that are represented within these proposals. ASA requests that all specialties within a proposed bundle are contacted by CMS or the Advanced APM developer and asked to review the proposal to ensure the accuracy of what is being proposed.

**CMS should implement a process to review proposed Advanced and non-Advanced APMs in a transparent and expeditious manner that includes input and feedback from all physicians and other healthcare professionals involved in the model under review. CMS should take steps to ensure that specialists and primary care have equal opportunities to participate in Advanced APMs.**

This proposed rule presents a large amount of complex information and we offer many comments in response. Appendix A provides a summary of these recommendations. Appendix B provides technical details of our analysis on the implications of the proposed reweighting of the MIPS CPS for those MIPS eligible clinicians without an ACI component.

Thank you for your consideration of our comments, We would be very glad to follow up with you as necessary on any issues on which you need additional information or would like further discussion. Please contact Sharon Merrick, M.S. CCS-P, ASA Director of Payment and Practice Management or Matthew Popovich, Ph.D., ASA Director of Quality and Regulatory Affairs at 202-289-2222.

Sincerely,

A handwritten signature in black ink that reads "Daniel J. Cole". The signature is written in a cursive, flowing style.

Daniel J. Cole, M.D.  
President  
American Society of Anesthesiologists

# **APPENDIX A – SUMMARY OF RECOMMENDATIONS**

## **Merit-Based Incentive Payment System (MIPS)**

### **Overarching Issues**

#### **Non-Patient-Facing MIPS Eligible Clinicians**

- ASA urges CMS to post the list of patient-facing services as quickly as possible to allow individual MIPS eligible clinicians to determine if they will be considered patient-facing or non-patient-facing clinicians under MIPS. We also ask CMS to provide details on how they estimated that a majority of anesthesiologists would likely qualify as non-patient-facing. (see page 5)
- ASA urges CMS to modify the proposal to identify non-patient-facing groups. Instead of using a single threshold of 50 or fewer patient-facing encounters for the entire group, CMS should apply that criterion to individual members of the group. If 51 percent or more members of the group individually meet the criterion of 50 or fewer patient-facing encounters, then the group should be considered non-patient-facing. (see page 5)
- ASA recommends that CMS consider alternative language to the term “non-patient-facing” as it applies to physician anesthesiologists. (see page 5)

#### **Hospital-Based MIPS Eligible Clinicians**

- ASA urges CMS to revise the criteria to designate clinicians as hospital-based to include care provided in hospital outpatient departments (22) and ASCs (24) – excluding E/M services. ASA also recommends that CMS describe this group of MIPS eligible clinicians as facility-based rather than hospital-based. (see page 7)
- ASA believes there is merit to CMS’s proposal that hospital-based MIPS eligible clinicians may use facility quality reporting measures and/or apply facility scores as proxies for the quality reporting component. We encourage CMS to work with stakeholders to develop these proposals in more detail. (see page 7)

#### **Payment Adjustments Distorting Resource Use Measurement**

- ASA urges CMS to make an adjustment to remove positive and negative MIPS payment adjustments along with geographic and other adjustments that do not reflect the utilization and intensity of services when calculating Resource Use for a Performance Period (beginning with the 2019 Performance Year). (see page 8)

#### **MIPS Implementation Timeline**

- ASA recommends (1) a delayed start date for the initial Performance Year to at least July 1, 2017 and (2) initial Performance Year in 2017 running through December 31, 2017 (for the first MIPS Payment Year of 2019). (see page 9)

### MIPS Eligible Clinicians – Certified Anesthesiologist Assistants

- ASA urges CMS to confirm that Certified Anesthesiologist Assistants are included in the definition of MIPS eligible clinicians starting in year 1 of the MIPS program. (see page 9)

### Virtual Groups

- ASA supports the creation of these virtual groups and encourages CMS to allow for maximum flexibility in this new option. In order to enhance their potential, we recommend that virtual groups not be restricted by specialty, size or geographic region. (see page 10)

## **MIPS Performance Categories**

### Resource Use Performance Category

- ASA recommends that CMS make additional information available regarding its thinking around the option for use of facility measures for the Resource Use performance category and publish information about the extent to which this option may improve participation by physicians who are predicted to be ineligible to participate in the Resource Use performance category of MIPS. ASA is prepared to work with CMS and other similarly situated stakeholders to identify a process to identify and adopt such measures or develop new facility measures that could be used by facility-based clinicians to allow a greater proportion of physicians to be scored in the Resource Use performance category of MIPS. (see page 11)
- For clinicians for whom there are no Resource Use measures reported, ASA recommends that CMS reweight the Resource Use performance category to all available MIPS performance categories rather than just to Quality. This will mitigate the distortion in the distribution produced by the distribution of “topped-out” Quality measures. (see page 12)
- ASA recommends that for clinicians who do not have ACI scores, CMS substitute a score with a 50 percent base and with the clinician’s Quality score substituting for the ACI performance score. This approach aligns with the CMS stated goal of allowing the Quality score to carry additional weight when an ACI score is unavailable, while correcting the fundamental bias against these MIPS eligible clinicians present in the current proposal. (see page 13)

### Quality Performance Category

- ASA urges CMS to ensure that their reweighting policy to the Quality performance category is accurate, fair and reasonable so that providers have the best chance to be successful under this category and the MIPS program overall. (see page 15)
- ASA urges CMS to establish a scoring methodology that gives reporters of MIPS measures and non-MIPS QCDR measures equal opportunity to be successful in the Quality performance category. (see page 15)
- ASA recommends that CMS take a more phased approach and incrementally increase the reporting threshold over the next several years. We also request that CMS release data

demonstrating that raising the reporting rate is feasible for all MIPS eligible clinicians. (see page 16)

- ASA recommends that CMS recognize MIPS #424 as an intermediate outcome measure under MIPS. (see page 17)
- ASA requests that prior to removing “topped-out” measures from the MIPS program, that CMS provide at least a year’s notice through the rule-making process of the measures removal. (see page 17)
- ASA requests CMS develop and publish FAQs, explanations or scenarios specific to anesthesiology describing which measures certain physician anesthesiologists may need to report in 2017. (see page 18)
- We strongly urge CMS to establish more transparency with its new validation strategy, including the evidence or methodology used to determine if a physician anesthesiologist should have reported a specific measure. (see page 18)
- ASA recommends that CMS safeguard against unintended consequences of scoring newly introduced Quality measures. (see page 18)
- ASA urges CMS to recognize that the three proposed population health measures for the Quality performance category are generally inappropriate and offer little value to physician anesthesiologists and should not be required. (see page 19)
- We urge CMS to recognize that measure development in anesthesiology is a priority and partner with ASA, CMS contractors and other measure developers to develop high-priority and outcome measures that fill gaps so that our members can fully participate in the Quality performance category under MACRA. Allocation of measure development resources provided for in the MACRA toward this goal is warranted and appropriate. (see page 19)

#### Advancing Care Information Performance Category

- ASA welcomes the opportunity to collaborate with CMS and the Office of the National Coordinator for Health IT to develop standards and meaningful objectives for physician anesthesiologists so that our members can report on ACI with new measures in 2018. (see page 21)
- ASA requests CMS release regulatory guidance on the GPRO ACI process as soon as possible. (see page 21)
- ASA requests CMS recognize and give credit to eligible clinicians who use Health IT tools and methods that fall outside of the traditional Meaningful Use criteria. (see page 22)

- Our members should have the opportunity to participate and succeed in MIPS based upon their optimal use of AIMS and other electronic tools. (see page 22)

#### Clinical Practice Improvement Activities Performance Category

- ASA requests that CMS assign high weights to CPIA that include QCDR and qualified registry participation. Participation in an ABMS Maintenance of Certification program should be recognized as fully satisfying the CPIA score in MIPS. (see page 23)
- ASA urges CMS to recognize the existing clinical practice improvement programs in which MIPS eligible clinicians currently participate and make every effort to harmonize MIPS CPIA requirements and avoid duplicating the reporting of these activities. (see page 26)

#### Registry Provisions

- ASA asks that CMS reinforce its definition of a QCDR as one that “collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality care provided to patients.” (see page 26)
- We request that when a QCDR measure steward licenses a measure to another QCDR, the licensed measure does not count toward the 30 non-MIPS QCDR measure limit of the licensee. (see page 27)
- ASA recommends (1) a delayed start date for the initial Performance Year to at least July 1, 2017 and (2) initial Performance Year in 2017 running through December 31, 2017 (for the first MIPS Payment Year of 2019). (see page 27)
- ASA requests that CMS provide adequate protections to safeguard any intellectual property associated with a measure steward’s risk adjustment methodology, especially in regard to posting non-MIPS QCDR measure specifications. (see page 28)
- ASA asks that CMS identify “topped out” non-MIPS QCDR measures more than one year prior to retiring such measures. We also request that CMS notify QCDRs as soon as possible if a non-MIPS QCDR measure will not be renewed in future years for other reasons. (see page 28)
- ASA urges CMS to establish scoring methodology that gives reporters of MIPS measures and non-MIPS QCDR measures equal opportunity to be successful in the Quality performance category. (see page 28)
- ASA recommends that CMS take a more phased approach and incrementally increase the reporting threshold over the next several years. We also request that CMS release data demonstrating that raising the reporting rate is feasible for all MIPS eligible clinicians. (see page 29)
- ASA opposes CMS proposals to gather non-Medicare data through non-QCDR reporting mechanisms. (see page 29)

- Because some participants may find qualified registries to fulfill their quality and ACI needs, we support extending the “high weight” CPIA “*Use of a QCDR that summarizes local practice patterns and treatment outcomes*” to participation in a qualified registry. ASA supports all registry and QCDR CPIA to be considered and scored as “high”. (see page 30)

### **Alternative Payment Models**

- Advanced APM revenue thresholds start at 25 percent for 2019 payments and increase to 75 percent for 2023. CMS should finalize its flexible alternative approach to qualify for the bonus payments by having 20 percent of patients receiving care through the APM for 2019, increasing to 50 percent by 2023. (see page 31)
- We are eager to find ways in which the Advanced APM provisions of MACRA can promote and accelerate the dispersion of the PSH innovations. (see page 31)
- CMS should implement a process to review proposed Advanced and non-Advanced APMs in a transparent and expeditious manner that includes input and feedback from all physicians and other healthcare professionals involved in the model under review. CMS should take steps to ensure that specialists and primary care have equal opportunities to participate in Advanced APMs. (see page 32)

## **APPENDIX B – TECHNICAL REPORT**

### **MIPS Scoring Simulation**

In order to examine how sensitive the MIPS Composite Score is to diverse options for weighting individual performance categories when specific categories are not applicable, ASA constructed a Monte Carlo simulation model. This model enabled a simulated universe of MIPS scores to be built up from assumed distributions of the four MIPS performance categories. Once the distributions of the underlying performance categories were defined, 50,000 trials were run and the resultant distributions of MIPS scores were analyzed to determine the performance threshold for receiving a positive versus negative payment adjustment (median) and the performance of certain sub-populations versus the overall model performance threshold.

#### **Defining the Assumed Distributions of MIPS Performance Categories**

Quality - The Quality performance category scores were built from six measure distributions. Three measures were defined to have uniform score distributions from 0 to 10. This is the defined distribution of a typical Quality measure. The final three modeled measures were assumed to be “Topped-out” measures. For these measures, we assumed a uniform distribution from 0 to 5 for 50 percent of clinicians and a score of 8.5 for the remaining 50 percent of clinicians. This scoring distribution was taken directly from Table 18 of the Proposed Rule. The overall Quality score was then taken against a denominator of 60 possible points.

Resource Use – Resource Use, as defined in the Proposed Rule, is always built up from uniformly distributed measures under the decile system. CMS proposed two carry-over measures from the VBM program and 41 episode based measures. For this model, we included six measures for the total Resource Use score. Since the denominator for the Resource Use score is equal to the number of measures times 10, it was not necessary to test further numbers of measures to determine the shape of the overall Resource Use curve. Since it is likely that efficient providers will perform well on all measures (and inefficient providers will perform poorly on all RU measures), we assumed a positive correlation between all RU measures when calculating the overall RU score.

Clinical Practice Improvement Activities – Since CPIA is a new concept, there is no available information on the likely distribution of scores. Since CPIA scores are “points for reporting” during the 2017 performance period, we modeled scores presuming the majority of clinicians would achieve a high score in the first year. We set the median score at 90 percent of available points with a maximum of 100 percent and a left-skew down to 0 percent.

Advancing Care Information – ACI scores begin with a base score of 50 percent for the vast majority of clinicians. In the absence of other information, we assumed that 95 percent of clinicians would achieve at least the base score. The ACI performance score was presumed to range from 0-80 in a triangular distribution centered around 40 (above the base score). When compared to the overall 100 point ACI cap, this meant that 28 percent of clinicians were assumed to achieve the maximum score.

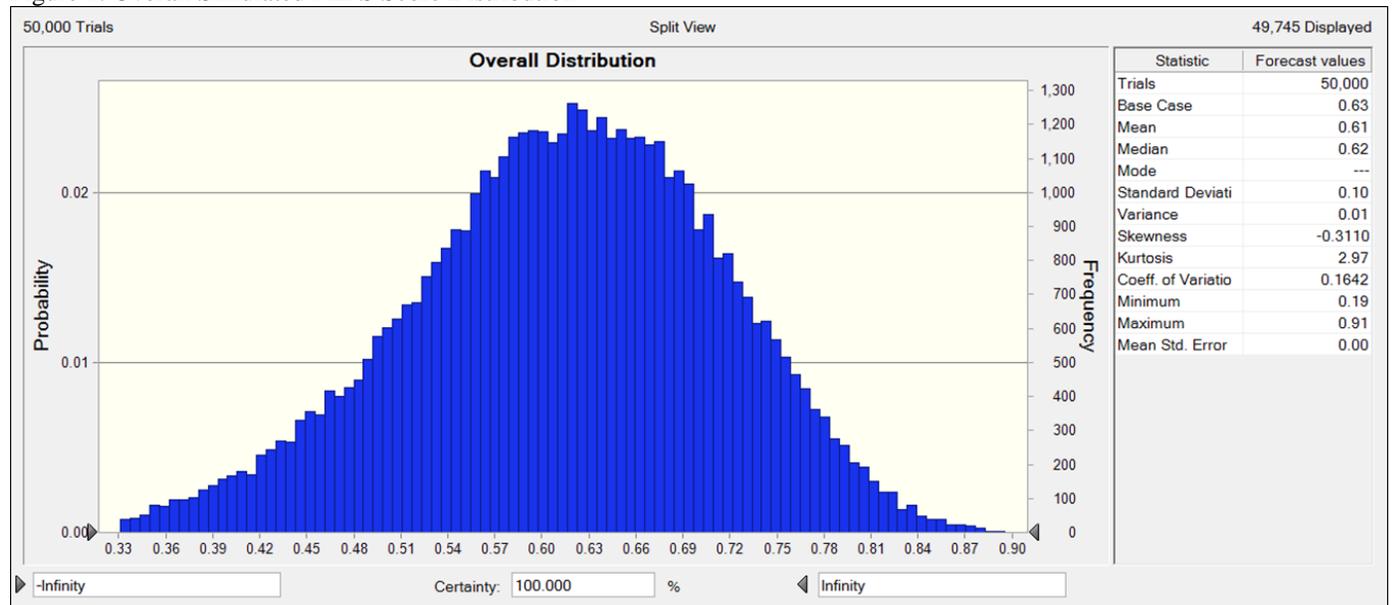
## Constructing the MIPS Score Universe

Once these initial assumptions were defined, a Monte Carlo simulation was performed for 50,000 trials (using Oracle Crystal Ball). Each of the 4 performance categories was assumed to be an independent event. The model assumed that 60 percent of clinicians would report and obtain a score in all 4 MIPS performance categories. A further 25 percent were presumed to be non-patient-facing or hospital-based clinicians who would not be able to report under either ACI or RU. The final 15 percent of clinicians were assumed to fail to meet the RU patient thresholds. Whenever a clinician was assumed to lack a given performance category score, that performance category was re-weighted to the Quality score consistent with the Proposed Rule. In all cases, the 2021 weights were used so as to test the MIPS methodology once it reaches its final weighting condition in 2021.

## Results

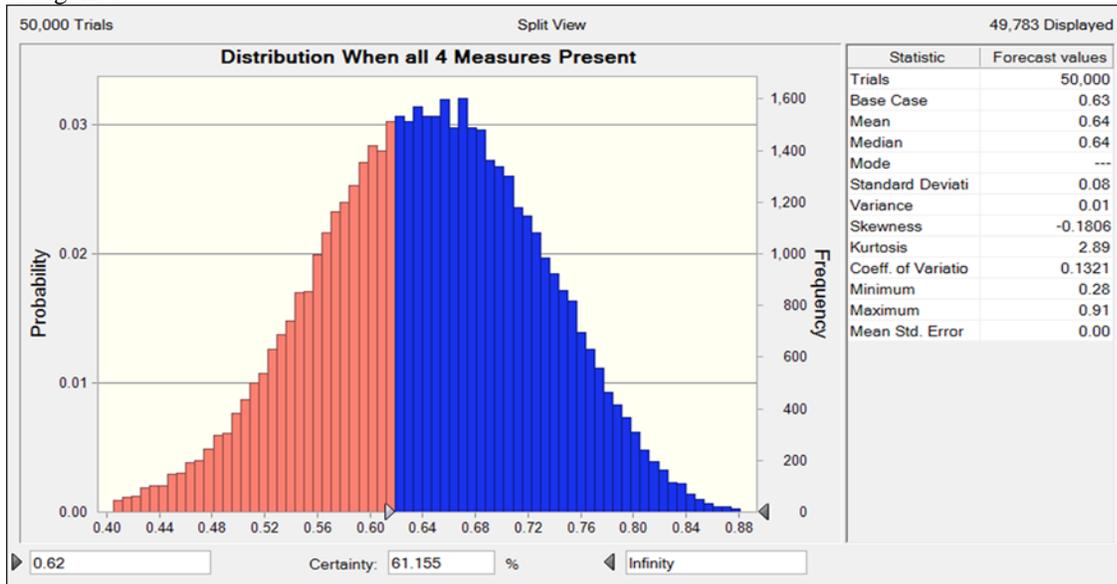
After 50,000 simulations, the overall MIPS score distribution was estimated to be 0.62 = 62% of the available points.

Figure 1. Overall Simulated MIPS Score Distribution



For the subgroup of clinicians estimated to report all 4 MIPS performance categories, the simulation estimated that 61% of these clinicians would receive a positive adjustment under MIPS.

Figure 2. Simulated MIPS Score Distribution of MIPS Eligible Clinicians Reporting all 4 MIPS Performance Categories



The subgroup of MIPS clinicians who were unable to report ACI and RU scores (*i.e.*, non-patient-facing or hospital-based clinicians) was significantly disadvantaged relative to the overall distribution. The simulation estimated that only 32 percent of these clinicians would receive a positive adjustment under MIPS. Because ACI has a “base score” of 50 percent, re-weighting the ACI category to Quality disadvantages clinicians unable to report under ACI (including all non-patient-facing or hospital-based clinicians). In particular, the Quality score can range from 0 percent to 100 percent of the denominator for the Quality Performance Category. By contrast, assuming the physician meets the minimum reporting and data protection thresholds, the ACI score has a more constricted range from 50 percent to 100 percent. Since CMS has proposed a single overall MIPS performance threshold, clinicians without the ability to be scored under the ACI performance category will be at a significant disadvantage relative to other clinicians.

Figure 3. Simulated Distribution of MIPS Scores for Non-patient-facing MIPS Eligible Clinicians

