American Society of Anesthesiologists®

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Pierre Yong, MD
Director
Quality Measurement and Value-Based Incentives Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Yong:

The American Society of Anesthesiologists® (ASA), on behalf of our over 52,000 members, appreciated the opportunity to meet with members of your team on February 20, 2018, to discuss a select number of issues related to the Merit-based Incentive Payment System (MIPS). In response to some of the questions raised during our discussion, we are providing additional feedback and analysis on the Advancing Care Information (ACI) exemption for ASC-based clinicians; requesting increasing access to timely data to better understand our members' experience with the Quality Payment Program (QPP); and providing guidance on the development of the facility-based scoring option. ASA welcomes the opportunity to work with you to ensure that our members can successfully participate in MIPS and continue to provide Medicare beneficiaries high quality and high value healthcare.

MIPS is one of the two pathways established through the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. MACRA also established incentives for participation in Advanced Alternative Payment Models (APMs). The implementation of MIPS will have a significant impact on physician anesthesiologists and the patients they serve. ASA has demonstrated a commitment to supporting our members with their MIPS participation through our membership education efforts as well as our active participation in the public comment process on proposed regulations and sub-regulations. Multiple ASA members also served on the first wave of clinical subcommittees to develop episode-based cost measures established by a CMS contractor, Acumen.

ASA commends the agency for your continued responsiveness to stakeholders' comments and finalized policies that reflect flexibility in the implementation of the program and a continued commitment to a gradual transition to MIPS. Our comments submitted today are made in the same collaborative spirit of a continued dialogue and exchange to support the development of the maturing MIPS program.

<u>Advancing Care Information (ACI) exemption for ASC-based clinicians</u>
In early March CMS indicated that in the near future they will be announcing an overhaul of the ACI performance category with a focus on interoperability and streamlining of the program to reduce time and costs associated with participation. We look forward to learning more about this initiative.

ASA reaches out to you today to urge CMS to revise its approach to identifying eligible clinicians for exemption from payment adjustments under the Merit-based Incentive Payment System ("MIPS") Advancing Care Information ("ACI") performance category. CMS's current policy has created a gap that the Congress intended CMS to fill. While hospital-based and ambulatory surgical center ("ASC") based eligible clinicians are exempt from the ACI performance category, clinicians who furnish "substantially all" of their services in hospitals and ASCs collectively, but who do not meet the "substantially all" threshold for either setting alone are not exempt. CMS may and should use existing statutory authority to correct this gap.

Section 1848(a)(7)(D) of the Social Security Act (the "Act"), as amended by MACRA, exempts hospital-based eligible professionals from meaningful use payment adjustments. The 21st Century Cures Act further amended this provision to exempt ASC-based eligible professionals from meaningful use payment adjustments.[1] The 21st Century Cures Act also extended these exemptions to the assessment of MIPS eligible clinicians under the ACI performance category—so long as the eligible clinician spends substantially all (which CMS interpreted to mean, at least 75 percent) of their time in *either* the hospital *or* ASC setting.[2] In exempting these eligible clinicians from the ACI performance category, the Congress and CMS recognized that clinicians practicing in a facility environment lack control over their administrative environment and may not have access to the appropriate electronic health record ("EHR") systems or the ability to use them in a meaningful way.[3] Thus, the purpose of these ACI exemptions is to avoid penalizing eligible clinicians who lack access to a certified EHR system or control over their EHR system's functionality.[4]

Separately, section 1848(q)(5)(F) of the Act commands CMS to reweight an eligible clinician's score under the four MIPs performance categories "if there are not sufficient measures and activities … applicable and available to each type of eligible [clinician] involved." Prior to the passage of the 21st Century Cures Act, CMS used this authority to exempt hospital-based eligible clinicians from the MIPS ACI performance category.[5] Absent CMS's action, hospital-based eligible clinicians would have been subject to negative payment adjustments under the ACI performance category. After the passage of the 21st Century Cures Act, CMS no longer relied on this reweighting authority to exempt hospital-based eligible clinicians. Instead, as noted

[1] *See* § 16003 of the 21st Century Cures Act (amending § 1848(a)(7)(D) of the Act).
[2] *See* § 4002(b)(1)(B) of the 21st Century Cures Act (amending § 1848(o)(2)(d) of the Act); *see also* Medicare Program; CY 2018 Updates to the Quality Payment Program, 82 Fed. Reg. 30010, 30077 (June 30, 2017).
[3] *See* § 1848(a)(7)(D)(iv) of the Act (providing a sunset to the ACI exemption for ASC-based clinicians after "the Secretary determines … that certified EHR technology applicable to the [ASC] setting is available"); *see also* Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53568, 53684 (November 11, 2017)(supporting the continued exemption of hospital-based clinicians because "[CMS] continue[s] to believe that hospital-based MIPS eligible clinicians may not have control over the decisions that the hospital makes regarding the use of health IT and CEHRT").
[4] *See id*. For both hospital-based eligible clinicians and ASC-based eligible clinicians, CMS and the Congress, respectively, appear to have provided exemptions from the ACI performance measure due to a determination of lack of control over or access to certified EHR technology.
[5] *See* 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, 81 Fed. Reg. 77008, 77238–39 (November 4, 2016) ("Hospital-based MIPS eligible clinicians may not have control over the decisions that the hospital makes regarding the use of health IT and CEHRT").

above, hospital-based and ASC-based MIPS eligible clinicians were directly exempted by statute.[6]

Many eligible clinicians split their time between ASCs and the inpatient or outpatient hospital setting and therefore cannot meet the 75 percent threshold under either the ACI ASC-based clinician exemption or the hospital-based clinician exemption. Physician anesthesiologists disproportionately find themselves in this position because, unlike their surgical colleagues who also practice in ASCs, they do not perform and report E/M visits in the office setting where a certified EHR system may be available. As these do not meet either exemption, they are subject to a negative payment adjustment due to circumstances beyond their control. They may, however, meet a threshold of providing 75 percent of their services in the ASC ***and*** hospital settings combined.

CMS may use its statutory authority under section 1848(q)(5)(F) of the Act to reweight the MIPS performance categories for clinicians who meet the 75 percent threshold when their ASC, inpatient and outpatient services are pooled. CMS has already determined that hospital-based eligible clinicians "do not have sufficient advancing care information measures applicable to them…."[7] The Congress has similarly determined that ASC-based eligible clinicians lack the ability to report "sufficient measures and activities" through its creation of a statutory exemption for such clinicians in the 21st Century Cures Act. Indeed, there is currently no certified EHR system available for the ASC setting.[8] Surely, if CMS determined that hospital-based eligible clinicians lack sufficient ACI measures, and Congress similarly determined that ASC-based eligible clinicians lack the ability to report sufficient ACI measures, then it stands to reason that eligible clinicians who furnish substantially all of their services in a combination of these settings also lack adequate ACI measures, and therefore they should be exempt from the ACI performance category. It would be illogical and inequitable to penalize an eligible clinician who provides services predominantly in two exempt settings simply because the clinician does not achieve the threshold in a single exempt setting. Therefore, CMS should exercise the authority it clearly has under section 1848(q)(5)(F) of the Act to extend the ACI exemption to these clinicians by summing time spent cumulatively to determine which eligible clinicians meet the exemption threshold. As this exemption would provide relief to eligible clinicians who cannot meet the ACI measure due to circumstances beyond their control, the policy would be consistent with the intent of both the existing ACI exemptions at section 1848(a)(7)(D) of the Act and CMS's reweighting authority at section 1848(q)(5)(F) of the Act.

That the Congress provided a statutory exemption from the ACI performance category for hospital-based clinicians and ASC-based clinicians but not for clinicians who meet the threshold when these sites of services are pooled in order to meet the 75 percent threshold does not preclude CMS from expanding the ACI exemption to include these clinicians. Indeed, CMS may in fact be *required* by section 1848(q)(5)(F) of the Act to exempt them. CMS is not precluded by section 1848(a)(7)(D) of the Act from exempting these clinicians as the Congress did not

[6] *See* § 1848(o)(2)(d) of the Act; *see also* 82 Fed. Reg. at 30077.
[7] 81 Fed. Reg. at 77238–39.
[8] *See, e.g.*, Ambulatory Surgery Center Association, Electronic Health Records, available at http://www.ascassociation.org/govtadvocacy/legislativepriorities/electronichealthfairnessactof2015 (last visited March 19, 2018).

specifically speak on this issue. Section 1848(a)(7)(D) of the Act addresses only clinicians who spend a substantially all of their time in the hospital and ASC settings, not clinicians who spend substantially all of their time in neither setting individually, but in both settings combined. Indeed, CMS has interpreted the exemptions for hospital-based clinicians and the exemption for ASC-based clinicians at 1848(a)(7)(D) of the Act as "separate[]" and not covering clinicians who meet the 75 percent threshold when their ASC, inpatient and outpatient services are pooled because the statute "distinguishes" between ASC-based and hospital-based clinicians.[9]

Even though section 1848(a)(7)(d) of the Act does not provide an exemption for these clinicians, CMS may still be required to provide such an exemption. CMS's authority to reweight the MIPS performance categories under section 1848(q)(5)(F) of the Act provides that the Secretary "shall" assign different weights "if there are not sufficient measures and activities" applicable to a type of eligible clinician. CMS and the Congress have already determined that hospital-based and ASC-based eligible clinicians lack sufficient measures for the ACI performance category. As this clinician is simply a clinician who spends substantially all of his or her time in the combination of these exempt settings, it must logically follow that they lack sufficient measures in the ACI category, and therefore section 1848(q)(5)(F) of the Act may be read to require the exemption from the ACI performance category of clinicians who meet the 75 percent threshold when their ASC, inpatient and outpatient services are pooled.

ASA urges that when determining if an eligible clinician is exempt from the ACI performance category, CMS should cumulatively calculate a clinician's utilization of services provided in following the inpatient settings: (POS 21), on-campus outpatient (POS 22), off-campus outpatient (POS 19), emergency room (POS 23), and ASC (POS 24).

<u>Increasing access to timely data to better understand our members' experience with the MIPS program</u>

CMS has taken an incremental approach with the implementation of MIPS. ASA believes that there is great value in this approach that has benefitted providers, patients and the agency. Yet, this more deliberate approach does not diminish the need for stakeholders to have a clear and comprehensive understanding of the program. As MIPS is a large and inherently complex program, this becomes information becomes even more critical. We have two requests related to increasing timely access to relevant data that follow.

<u>1. Specialty Specific Aggregate Data</u>: Despite our best efforts, ASA has found that the available data provides us with a limited understanding of members' participation in the QPP. For example, in the 2018 QPP Final Rule CMS estimated that MIPS would only apply to 40% of eligible clinicians. While this information was useful, what we did not know was how many anesthesiologists were exempt. A breakdown by specialty of MIPS exempted clinicians would have been very helpful.

An individual clinician can find out their MIPS status by using a look-up tool on the CMS website, but specialty-specific aggregate data is currently not available. This limitation in our understanding of the application of MIPS to anesthesiologists has created roadblocks in our ability to support our members, prioritize our work in this area, and provide CMS robust

[9] *See* 82 Fed. Reg. at 53685.

feedback. Accurate, timely data that is accessible and easily understandable will allow ASA and other stakeholders to provide CMS meaningful feedback on MIPS and support our members' participation in this important initiative.

ASA requests that CMS make additional data available to help providers understand and assess the impact of MIPS reporting requirements. In the 2018 QPP Final Rule, CMS published a table titled "Projected Number of Clinicians Ineligible for or Excluded from MIPS in CY 2018, by Reason," but the data in that table are at the aggregate level and did not provide specialty-specific data. ***ASA recommends that CMS release a specialty-specific breakout of clinicians of a number of relevant data points that we are confident will have broad interest and contribute to a better understanding of MIPS for all stakeholders. Specifically, ASA recommends that CMS release specialty-specific data on clinicians who are:***

- ***Exempt from MIPS because they have not exceeded the low volume threshold***
- ***Exempt from MIPS because they are newly enrolled in Medicare***
- ***Exempt from MIPS because they are Qualified Participants (QPs) or Partial QPs in Advanced APMs***
- ***Assigned to certain special categories (e.g. non-patient facing, hospital-based, facility-based, and ASC-based for the purposes of the ACI exemption)***

ASA also recommends CMS release data broken down by specialty on the various performance categories. Specifically, ASA recommends CMS release aggregate data broken down by specialty of:

- ***Data on reporting and performance rates on quality measures (similar to what was released for PQRS)***
- ***Statistics on clinical improvement activities reported***
- ***Statistics on clinician attribution to cost measures and performance on cost measures***

2. Indicator for Group Reporting versus Individual Reporting: In order to estimate the impact by specialty, ASA conducted an analysis of various data sources (including the Medicare Provider Utilization and Payment Data and Carrier Files). In conducting the analysis, we encountered a number of challenges associated with identifying providers that bill as part of a group practice. The publicly available data files we used for the analyses do not contain information on whether or not a provider is part of a group practice and, if so, which group practice. We are not aware of a separate data file that contains a crosswalk of individual NPIs to TINs.

ASA requests that CMS make available a crosswalk of NPIs to TINs. We understand that such a data file exists in order for CMS to make payment adjustments in other payment programs. We request that the crosswalk file include the following data elements for each individual NPI: (1) A Yes/No field for whether or not an individual provider belongs to a group practice, and (2) Group TINs. We understand that an individual NPI may be associated with multiple group TINs. In those instances, we ask that all associated TINs are listed. Also, if CMS is not able to release data on TINs, we would ask that CMS provide a crosswalk of individual NPIs to billing NPIs instead.

Facility-based scoring option

MACRA authorized CMS to use measures from other payment systems (e.g., inpatient hospitals) for the Quality and Cost 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. ASA is pleased that CMS is planning on implementing facility-based measurement for 2019 Performance Year/2021 Payment Year.

ASA believes facility-based measures can have several benefits: aligning interests between eligible clinicians and the facility at which they work (i.e., joint accountability), reducing the reporting burden and providing a pathway towards more meaningful reporting of outcomes of team-based care for which there is shared accountability. In the current system, CMS is receiving data on the care of the same patient and episodes of care from two sources: the facility and the clinician. Through the implementation of facility-based measures, CMS will only receive this data once through a single source thereby providing data to the agency in a streamlined and efficient manner and reducing the reporting burden on clinicians as well as reducing the administrative burden on the agency to analyze potentially redundant data.

CMS indicated that they will use 2018 to ensure that clinicians better understand the opportunity and ensure operational readiness to offer facility-based measurement. ASA urges CMS to consider the following principles as they develop the facility-based scoring option.

- *Participation election*: One participation election option discussed in the 2018 QPP Final Rule was that the facility-based scoring option would automatically apply, and the eligible clinician would need to opt out. ASA believes an option that would require action by the clinician to opt-out is problematic. This is a new program that even with a strong marketing effort, could be unknown to many eligible clinicians in its first year of implementation. ***ASA recommends that eligible clinicians should have to elect to participate in the program.***

- *Timing of decision to participate*: Prior to making a decision to participate a clinician should be informed of the mechanics of the program, how they will be evaluated via the facility-based option versus the traditional MIPS options and a general sense of the risks and rewards of the two participation options. ***One of the significant benefits of this initiative is to reduce the reporting burden on the clinician, therefore ASA recommends CMS make this information available prior to the clinician making a significant investment in resources and time with MIPS quality reporting.***

- *Measures:* While not finalized, CMS proposed to score using all 12 measures of the hospital value-based program. ***ASA agrees that this is a fair and reasonable approach and recommends CMS base the scoring on all 12 measures.*** While the statute allows CMS to consider hospital outpatient quality measures for emergency physicians, radiologists, and anesthesiologists, for 2019, CMS is limiting the initiative to the hospital inpatient value-based program. CMS indicated that they believe the inpatient hospital value-based program is the most mature and robust of their facility-based quality programs. ***ASA agrees that in this first year it is appropriate to limit the program to the inpatient hospital valued-based program, but in future years we urge CMS to explore the appropriateness of the hospital outpatient program as well.*** In reviewing the

measures of the hospital outpatient program, we noted that they tend to be more narrow in scope and more specialty specific relative to the measures in the hospital value-based program. Therefore, the same approach of applying all measures in the scoring may not necessarily be appropriate since they cannot be so universally applied as the inpatient measures. Even if a different approach is required for the scoring of hospital outpatient measures, ASA does not believe it would necessarily be incompatible to use measures from both programs.

- *Scoring*: In the 2018 QPP Final Rule CMS proposed that scoring would be reached by determining the percentile performance of the facility in the value-based program and award a score associated with that same percentile performed in the MIPS Quality and Cost Performance Categories. Thus if a hospital achieved a score in the 75th percentile in the hospital value based program, the clinician would receive equivalent 75th percentile Quality and Cost performance category scores for the MIPS program. ***ASA believes that this is a reasonable approach. If implemented for 2019, we urge CMS to closely evaluate it and its impact and fairness on not just hospital-based clinicians but also non-hospital-based clinicians participating in MIPS.***

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,

Alexander Hannenberg, MD
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