American Society of Anesthesiologists™

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VIA Electronic Submission to http://www.regulations.gov

September 13, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services, Department of Health and Human Services
Attn: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: **[CMS-1751-P]** Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements

Dear Administrator Brooks-LaSure:

The American Society of Anesthesiologists® (ASA), on behalf of our more than 53,000 members, appreciates the opportunity to comment on the above-captioned Proposed Rule. Medicare is an essential program that currently provides health care benefits to 58 million Americans. ASA is committed to working with the Centers for Medicare and Medicaid Services (CMS) to promote policies that support high quality care in a fiscally sustainable manner. We are pleased to work with the agency to create a health care system that reduces administrative burden on practicing physicians; supports the provision of high-quality, cost-effective care; and is forward-thinking in the development of innovative solutions to overcome the challenges facing clinicians, patients, and the Medicare system overall. As the medical specialty representing the recognized leaders in patient safety and quality, ASA welcomes the opportunity to work with you to ensure high-quality and high-value care for our Medicare patients.

In this letter, ASA provides comments on the following issues:

- Calculation of the CY 2022 PFS RBRVS and Anesthesia Conversion Factors (CFs)

- Valuation of Specific Codes
  - Anesthesia Services for Image Guided Spinal Procedures (CPT® Codes 01XX2, 01XX3, 01XX4, 01XX5, 01XX6, and 01XX7)
  - Anesthesia for Cardiac Electrophysiologic Procedures (CPT Code 00537)
  - Destruction by Neurolytic Agent (CPT Codes 64633, 64634, 64635, and 64636)

- Resource Costs for Services Involving the Use of Innovative Technologies, Including but not Limited to Software Algorithms and Artificial Intelligence

- Separate Coding and Payment for Chronic Pain Management
- Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests
- Telehealth and Other Services Involving Communications Technology
  - Extension of Coverage to Category 3 Services Through the End of CY 2023
  - Additions to Category 3 List of Services
  - Permanent Adoption of Virtual Check-in Code G2252
- Critical Care Services – Split Billing
- Quality Payment Program Proposals

A summary of our recommendations can be found in Appendix A.

Calculation of the CY 2022 PFS RBRVS and Anesthesia Conversion Factors (CFs) (Section VII.)

ASA has concerns about continued Medicare payment cuts in CY 2022 for anesthesiologists and other physician services. We recognize the limited authority CMS has to modify statutorily mandated budget neutrality adjustments when calculating updates to the conversion factors, however, we are alarmed at the potential cascading impacts on both physician practices and clinical patient outcomes. Resolution of this issue will require action by Congress and others outside of CMS. ASA urges CMS to coordinate with these entities on the updates to the fee schedule and processing claims.

Medicare physician payment is based on the application of a dollar-based conversion factor to work, practice expense (PE) and malpractice relative value units (RVUs), which are then geographically adjusted. Anesthesia services also have their own dollar-based CF referred to as the anesthesia CF. The payment formula for anesthesia services is: Payment = (Base Units + Time) * Anesthesia CF. The proposed 2022 Anesthesia CF is $21.0442, in comparison to the 2021 Anesthesia CF of $21.5600. This represents a 2.39 percent reduction. The 2022 proposed RBRVS CF is $33.5848. This represents a 3.75 percent reduction from the 2021 RBRVS CF of $34.8931. The proposed reduction is based on two factors: there is a 0% update scheduled for the PFS in CY 2022 and an expiration of a funding patch to avoid a negative update, which passed by Congress at the end of CY 2020 that is only funded through the end of CY 2021. Congress will need to act in order to extend it through CY 2022 and beyond.

Absent Congressional action, CY 2022 will be the second year in a row that physicians will be facing Medicare payment cuts. In 2021, the Anesthesia CF was reduced by 2.89 percent and the RBRVS CF was reduced by 3.32 percent. In recent years, since the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), Medicare physician payment has

remained essentially flat. We would note that the budget neutrality threshold of $20 million has not been updated for inflation since it was enacted by the Omnibus Budget Reconciliation Act 1989. We believe this is too low and like other components of the fee schedule, it should be updated to reflect current costs. Updating the $20 million budget neutrality threshold from December of 1989 to July of 2021 to account for inflation would lead to a more reasonable budget neutrality threshold of $43.3 million.[1]

In addition to the reduction in the CF, physicians are also facing other looming payment cuts that require Congressional action in order to be averted. These payment reductions include expiration of the moratorium on the 2 percent Medicare sequestration at the end of CY 2021 and statutory sequestration cuts of 4 percent required by Pay-As-You-Go or PAYGO legislation, which were triggered by the significant additional spending in the American Rescue Plan enacted in March 2021.

Taken together, physicians are facing across the board cuts in the range of 8.39 to 9.75 percent. These payment reductions come at a time when physician practices are facing uncertainty about the future of the pandemic recovery, telehealth services, and regulatory burdens.

ASA is also concerned that these payment cuts will undermine the government's significant efforts to support health care practices during the pandemic. ASA thanks the Administration and Congress for recognizing the financial stress of the COVID-19 pandemic on physicians and practices, and for allocating resources to critical relief efforts. The COVID-19 pandemic continues to cause significant economic challenges that threaten the viability of medical practices throughout the country. We ask CMS to take measures to protect our nation's medical providers and the patients we serve.

Valuation of Specific Codes (Section II.E)

In this rule, CMS is proposing valuation for several anesthesia and RBRVS codes reported by physician anesthesiologists. Unlike other codes on the PFS which are assigned relative value units (RVUs), anesthesia services are assigned anesthesia base units which capture the intensity and complexity of a service and time is reported separately.

After conducting a multi-year review process where CMS officials were engaged observers, the RVS Update Committee (RUC) recently approved criteria for reviewing anesthesia base units. Anesthesia services in this rule are the first set of codes to be reviewed through this new process. Similar to RBRVS codes, the RUC determined that base unit recommendations for anesthesia codes shall be based on established RUC methodology (e.g., RUC survey). As such, base unit recommendations for anesthesia service recommendations rely on the same foundational analysis of RUC survey data as RBRVS codes, including the evaluation of time, recommended base unit value, and comparison with key reference service codes.

[1] CPI Inflation Calculator, Bureau of Labor Statistics. Accessed Aug 31st 2021, https://www.bls.gov/data/inflation_calculator.htm

As part of this process, the RUC identified 14 appropriately valued codes for the Anesthesia Reference Service List (RSL). A regression line resulting from the 14 codes from the RSL was established as a reference to compare relativity of base units among anesthesia services. Using the RUC Building Block Methodology, the surveyed code is plotted on the regression line. The closer a point is to the regression line, the more it conforms to the relative valuation of the codes on the Anesthesia RSL. The Building Block Methodology and the regression line are used to validate recommendations based on survey data.

In this section, ASA provides recommendations on CMS proposed values for both anesthesia and RBRVS codes.

Anesthesia Services for Image Guided Spinal Procedures (CPT Codes 01XX2, 01XX3, 01XX4, 01XX5, 01XX6, and 01XX7)

ASA urges CMS to accept the RUC recommendation of 6 base units for CPT codes 01XX6 and 01XX7.

In October 2019, the RUC reviewed codes 01935 and 01936 and recommended that they be referred to the CPT Editorial Panel to create more granular codes. In October 2020, the CPT Editorial Panel created six new codes to report percutaneous image-guided spine and spinal cord anesthesia procedures. These codes were surveyed and reviewed for the January 2021 RUC meeting. The RUC recommended 4 base units for codes 01XX2-01XX5 and 6 base units for 01XX6-01XX7. CMS accepted the RUC recommendations for codes 01XX2-01XX5. ASA appreciates CMS's confirmation of the RUC recommendations for these four codes and encourages CMS to finalize the proposed base units for these codes in the Final Rule. However, the agency declined to accept the RUC recommendations for 01XX6 and 01XX7, and CMS is proposing 5 base units for both of these codes. ASA respectfully disagrees with this proposal and encourages CMS to establish 6 base units for these two codes.

In crafting the new codes, the specialty determined that categorization by anatomical location in the spine was appropriate and consistent with current CPT nomenclature of other CPT codes related to the spine. It was also noted that anesthetic care for pain procedures will depend on the needs of the patient. There are certain services that typically do not require anesthesia, but it may be needed for certain patients in certain circumstances (e.g., uncontrolled essential hypertension). There are other procedures for which anesthesia may be used to address extreme patient anxiety or to help a patient remain motionless for prolonged periods of time and/or remain in a painful position. Finally, there are complex pain procedures on the spine that more commonly require the use of anesthesia, which would likely be reported by CPT codes 01XX6 and 01XX7.

ASA reviewed Medicare claims data to estimate the utilization from prior CPT codes 01935 and 01936 to the new CPT codes 01XX2-01XX7. As the table below illustrates, it is projected that the bulk of the utilization of CPT codes 01935 and 01936 will now be reported by CPT codes 01XX2-01XX5.

	Projected % of Total Utilization From Prior Codes 01935 and 01936		
New Code	**Code Descriptor**	**Code 01935** Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	**Code 01936** Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic
01XX2	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic	7%	6%
01XX3	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	84%	20%
01XX4	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	1%	13%
01XX5	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	4%	31%
01XX6	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	2%	15%
01XX7	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	2%	15%
Total		**100%**	**100%**

Valuation Methodology

The RUC base unit recommendation of 6 for codes 01XX6 and 01XX7 is based on a crosswalk to CPT code 00732 (*Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)*). This value falls between the survey's 25th percentile and median.

While CMS indicated in the proposed rule text that they agreed with the RUC that 01XX6 and 01XX7 should be valued higher than the other codes in the family, they concluded that a value of 6 was too high. CMS proposed a value of 5 base units which is based on a crosswalk to CPT

code 00813 (*Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum).*

Code	Survey 25th Percentile Jan. 2021 Survey	Survey Median Jan. 2021 Survey	RUC Recommendation	CMS Proposed Value
01XX2	4	5	4	4
01XX3	4	5	4	4
01XX4	5	5	4	4
01XX5	4	5	4	4
01XX6	5	7	6	5
01XX7	5	7	6	5

The agency indicated that the disparity in time between the surveyed code and the crosswalk selected by the RUC was too great. As a result, the agency selected a crosswalk with time closer to the surveyed codes.

Code	Post-Induction Intra-Operative Anesthesia Time	Total Time
00732 (RUC crosswalk)	65	100
00813 (CMS crosswalk)	40	70
01XX6	20	58
01XX7	20	58

ASA recognizes this time disparity but reminds the agency that valuation of services and selection of crosswalks is not driven solely by post-induction intra-operative anesthesia time or total time, but also clinical similarity. Anesthesia base units capture the intensity and complexity of a service. Crosswalk codes should align with surveyed codes on intensity and complexity, not just time. ASA finds the crosswalk selected by CMS lacks clinical similarity to CPT codes 01XX6 and 01XX7.

CMS Crosswalk to 00813 Lacks Clinical Similarity to 01XX6, 01XX7

ASA strongly believes that from a clinical perspective, codes 01XX6 and 01XX7 are much more aligned with CPT code 00732 than code 00813. Code 00732 describes anesthesia for ERCP while 00813 describes anesthesia for upper and lower endoscopic procedures. Both of these codes have recent and robust survey data having both been reviewed by the RUC in 2017. From the perspective of clinical complexity and intensity, 00732 is a better comparison for the newly surveyed codes. The typical patient undergoing 00813 will have limited comorbid conditions and will present electively for their procedure. By contrast, similar to 01XX6 and

01XX7, the typical patient undergoing 00732 will have multiple medical conditions and an acute deterioration in their overall health status leading to the need for the procedure. This complexity is apparent when comparing vignettes. In terms of patient complexity, 01XX6 and 01XX7 are much more aligned with CPT code 00732.

Code	Descriptor	Vignette
00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)	A 68-year-old patient presents with abdominal pain and abnormal laboratory tests (aspartate aminotransferase, alanine aminotransferase, alkaline phosphatase, total bilirubin, amylase). Imaging studies show an apparent retained common bile duct stone. Therapeutic endoscopic retrograde cholangiopancreatography with stone removal is performed.
00813	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum	A 68-year-old patient with persistent abdominal pain, positive fecal blood tests, and mild anemia on laboratory exam presents for upper and lower GI endoscopic procedures to determine cause of occult bleeding.
01XX6	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	A 75-year-old female develops sudden, severe mid-back pain after lifting her grandchild. Plain radiographs reveal an acute compression fracture with severe anterior wedging involving T10 and consequent new kyphosis. Pain persists despite a period of conservative care. After referral, percutaneous thoracic vertebral augmentation (and bone biopsy, if indicated) is performed.
01XX7	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	A 75-year-old female presents with severe, persistent low back pain and progressive spinal deformity secondary to osteoporotic vertebral collapse. Plain radiographs reveal an acute compression fracture of L3. Despite conservative medical management, pain persists. Percutaneous lumbar vertebral augmentation (and bone biopsy, if indicated) is performed.

The greater complexity of 00732 is also apparent when comparing the different techniques for the procedure. Patients undergoing 00813 typically require general anesthesia but not endotracheal intubation, and are in the lateral position, not in a prone position. In contrast, but similar to 01XX6 and 01XX7, 00732 requires intubation, paralysis, and prone positioning. Intubation and positive pressure ventilation in debilitated medically complex patients necessarily invites elevated risk of cardiopulmonary complications. Positioning any anesthetized and paralyzed patient in a prone position increases the technical difficulty of the procedure and increases the risk of patient injury. Both technical procedural success and patient safety are

critically dependent on proper patient positioning and immobility for 00732 as well as 01XX6 and 01XX7. In contrast, frequent minor patient movements are expected and generally of little consequence during 00813.

This analysis clearly demonstrates that the RUC recommendation represents a more robust and accurate valuation of the intensity and complexity of the anesthesia services required for 01XX6 and 01XX7 than the CMS proposed value. **Therefore, ASA urges CMS to accept the RUC recommendation of 6 base units for CPT codes 01XX6 and 01XX7.**

Anesthesia for Cardiac Electrophysiologic Procedures (CPT Code 00537)

ASA urges CMS to accept the RUC recommendation of 12 base units for CPT code 00537.

CPT code 00537 is used to report anesthesia for more complex electrophysiologic procedures. The code was originally surveyed in 2000. More recently, CPT code 00537 was identified by the Relativity Assessment Workgroup of the RUC for increased utilization and the code was surveyed for the October 2020 RUC meeting. The code is currently valued at 7 base units. The RUC recommended a value of 12 base units for CPT code 00537. CMS declined to accept the RUC's recommendation and has proposed a value of 10 base units.

Code	Descriptor	Current Base Units	RUC Recommended Base Units	CMS Proposed Base Units
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	7	12	10

The RUC-recommended value for CPT code 00537 is an increase from its current value. This increase in valuation reflects the change in population for code 00537 in the 20 years since its last survey. The current patient population for CPT code 00537 is older, more complex and with more comorbidities than in 2000. There was also a change in technique with the anesthetic care required for the typical patient in the 2020 survey than in previous survey.

The pulmonary vein isolation (PVI) technique included in the vignette for the October 2020 survey typically requires general anesthesia with endotracheal intubation. The patient is undergoing an electrophysiological procedure requiring complex mapping, extensive intracardiac interventions, and as a result more invasive and advanced anesthetic techniques. Close coordination between the anesthesiologist and electrophysiologist throughout these procedures is necessary to minimize movement of the cardiac structures, to identify and immediately address cardiovascular and respiratory compromise, and to avoid major complications. The increased complexity in the typical patient population and anesthetic technique provided compelling evidence for the increase in valuation.

Vignette for October 2000 Survey	Vignette for October 2020 Survey
A 32-year-old male in good general health complains of palpitations and occasional shortness of breath, not associated with activity. Evaluation includes ECG, which reveals findings consistent with the Wolff-Parkinson-White Syndrome (WPW). Given that patients with WPW are at increased risk for fatal rhythm disturbances, he is scheduled for cardiac electrophysiologic studies and possible ablation of the aberrant pathways.	A 62-year-old man with recurrent atrial fibrillation having electrophysiologic studies with induction or attempted induction of atrial fibrillation and then intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation (PVI).

Valuation Methodology

The RUC used the RUC-approved criteria for developing a base unit recommendation for CPT code 00537. The RUC recommendation was based on a RUC survey which was then validated by the RUC Building Block Methodology and regression line analysis.

The agency's proposed value for CPT code 00537 was based on a crosswalk to CPT code 00620 (*Anesthesia for procedures on the thoracic spine and cord, not otherwise specified)* and CPT code 00600 (*Anesthesia for procedures on cervical spine and cord; not otherwise specified),* which both have a valuation of 10 base units and were selected based on having similar time to CPT code 00537.

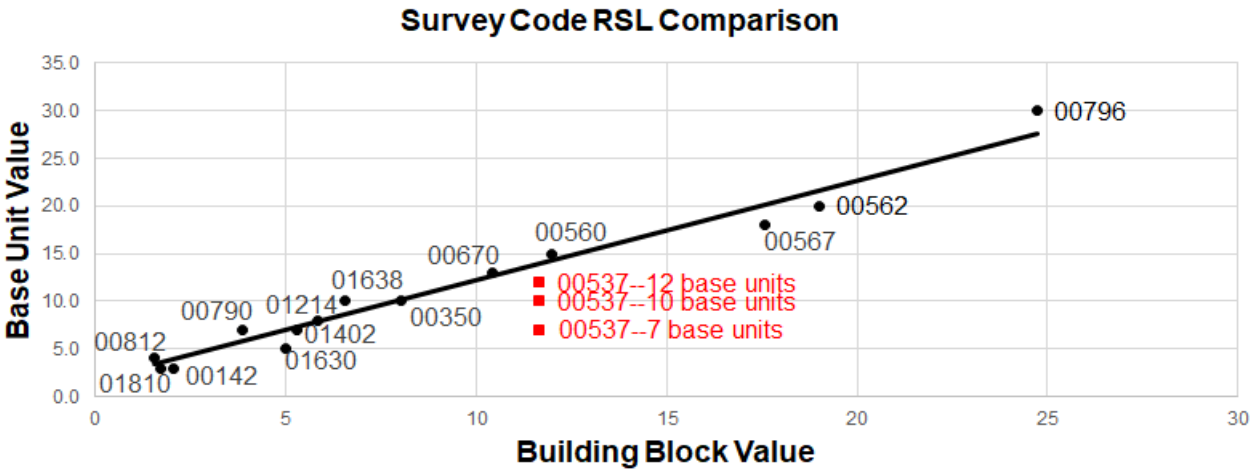
ASA has significant concerns with the methodology employed by CMS. The crosswalks are not comparable in terms of intensity or complexity, resulting in rank order problems with clinically similar anesthesia services. Also, the agency appeared not to consider the validation of the survey results provided by the Building Block Methodology and the regression line analysis.

RUC Recommendation

The RUC recommendation is based on robust survey results validated by the RUC Building Block Methodology. The RUC compared the surveyed code to other codes on the Anesthesia RSL. Based on the RUC approved methodology for reviewing anesthesia services, codes on the RSL, whose values have been validated, are the most appropriate codes to use as comparisons.

The median base unit value from the survey was 12 and the 25th percentile was 10. After considering a number of factors, the RUC agreed that the median value of 12 base units was the more appropriate value.

- RUC Building Block Methodology: The RUC found that the RUC Building Block Methodology validated the median value of 12 base units. The survey median and 25th percentile were plotted on the graph. The closer a point is to the regression line, the more it conforms to the relative valuation of the codes on the Anesthesia RSL. As the graph below illustrates, the median value is closest to the regression line.



- Key reference services: The RUC also concluded that the top two key reference services appropriately bracketed the recommended value of 12 base units. The majority of survey respondents indicated that the intensity and complexity measures for 00537 are identical to slightly more to somewhat more intense than top key reference service 00560 (*Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator* [base unit = 15]) and identical to slightly more intense than the second top key reference service 00350 (*Anesthesia for procedures on major vessels of neck; not otherwise specified* [base unit = 10]). The RUC noted that the surveyed code requires 180 minutes post-induction intra-operative anesthesia time, where 00560 requires 152 minutes and 00350 requires 120 minutes.

- Intensity levels: Post-Induction Period Procedure Anesthesia (PIPPA) is a relative intensity methodology used to support the validation of base unit values. Survey respondents were asked to allocate the post induction period to five different intensity levels. CPT code 00537 had a greater overall amount of time spent in the higher PIPPA levels in comparison to the top key reference services.

- Other anesthesia services: The RUC also compared 00537 to other services on the anesthesia RSL with a base unit of 10. The RUC found that the post-induction intra-operative anesthesia and total time is much lower for these services with a base unit of 10 compared to CPT code 00537. Based on the complexity and intensity of these services, ASA believes it is appropriate for code 00537 to be valued higher.

Code	Descriptor	Base Unit	Post-Induction Intra-Operative Anesthesia Time	Total Time
00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	12	180	238
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10	120	177
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10	120	180

CMS Proposed Value

CMS is basing its proposed valuation for code 00537 on crosswalks to codes 00600 (*Anesthesia for procedures on cervical spine and cord; not otherwise specified*) and 00620 (*Anesthesia for procedures on thoracic spine and cord, not otherwise specified*), both of which are valued at 10 base units. ASA finds the selection of these codes for crosswalks problematic.

Neither code has been surveyed or reviewed by the RUC. CMS should not compare the unvalidated times of 00600 and 00620 to the surveyed code 00537 to arrive at a lower base unit. CMS indicates in the proposed rule that these codes have similar times to 00537. Yet, since these codes have not been surveyed, we cannot know if the associated times are accurate.

ASA also believes these crosswalks are a clinically inappropriate comparison. Code 00537 describes a much more clinically complex and intense anesthetic than codes 00600 and 00620. The clinical complexity of the patient and the technique for code 00537 was previously described. The typical approach for code 00537 requires general anesthesia with tracheal intubation. General anesthesia is chosen to provide better patient comfort, immobility throughout the catheterization of the pulmonary vein and during the ablation, tight control and ongoing modification of ventilation patterns (which can affect electrophysiological mapping), rapid response to hemodynamic abnormalities, and better overall outcomes for ablation of the arrhythmogenic foci. Ongoing communication and close coordination between the anesthesiologist and cardiologist are required throughout the duration of the procedure in order to provide optimal conditions for the ablation technique and to avoid or permit the early detection of major cardiovascular complications including malignant arrhythmias, myocardial depression, intravascular volume overload, and pericardial tamponade.

In contrast, codes 00600 and 00620 describe anesthesiology procedures that are clearly not as clinically complex as 00537. Codes 00600 and 00620 do not involve the heart or great vessels and as a result have less significant hemodynamic changes and do not require minute to minute intervention by the anesthesiologist throughout the procedure. In contrast, as the vignette

indicates, the patient population for code 00537 has recurrent rhythm abnormalities for which the anesthesiologist must monitor closely and intervene emergently should they recur.

This analysis demonstrates that the RUC recommendation is more robust and accurate than the CMS proposed value. ASA urges CMS to accept the RUC recommendation of 12 base units for CPT code 00537.

Destruction by Neurolytic Agent (CPT Codes 64633, 64634, 64635, and 64636)

ASA urges CMS to accept the RUC recommendation of 3.42 work RVUs for codes 64633 and 64635.

CPT codes 64633 and 64635 represent invasive procedures used in the treatment of chronic back pain and describe destruction by a neurolytic agent with imaging guidance. The services are typically performed when a facet joint's degeneration has been determined to be the source of a patient's chronic back pain, and the patient has failed conservative measures. CPT code 64633 represents treatment of a facet joint in the cervical or thoracic region and CPT code 64635 represents treatment of a facet joint in the lumbar or sacral region. They are paired with add-on codes 64634 and 64636 for the treatment of an additional facet joint.

The codes were originally surveyed in 2011 and CMS established work RVUs for the CY 2012 fee schedule: 64633 (3.84 wRVUs), 64634 (1.32 wRVUs), 64635 (3.78 wRVUs) and 64635 (1.16 wRVUs). After being identified in a high volume screen in 2019, the codes were resurveyed at the October 2020 RUC meeting. In the CY 2022 PFS Proposed Rule, CMS accepted RUC recommendations for CPT codes 64634 and 64636 but declined to accept RUC recommendations for CPT codes 64633 and 64635.

Code	Descriptor	Current work RVU	RUC Recommended work RVU	CMS Proposed work RVU
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	3.84	3.42	3.31
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	1.32	1.32	1.32
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	3.78	3.42	3.32
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	1.16	1.16	1.16

Valuation Methodology
RUC work RVU recommendations are based on survey data (generally the 25th percentile or median value) or to a direct crosswalk to a clinically similar code with similar physician time. When making these recommendations, maintaining appropriate relativity to other codes in the family is a significant consideration. When reviewing RUC recommendations, the agency generally uses these criteria when determining the appropriateness of the RUC's recommendations.

In this instance the RUC concluded and ASA agrees that the 25th percentile for code 64633 (25th percentile = 3.36 wRVUs) and code 64635 (25th percentile = 3.00 wRVUs) was too low and would create rank order anomalies with the key reference code of 64625 *(Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance*). Therefore, the median value of 64635 of 3.42 work RVUs was much more appropriate for both codes.

ASA has significant concerns with the methodology CMS used to propose values for CPT codes 64633 and 64635. We believe the methodology employed by the RUC is based on a sound and proven method while the methodology proposed by CMS is severely flawed. These flaws undercut the appropriateness of the CMS proposed values.

RUC Recommendation
In collaboration with other medical specialty societies, ASA surveyed physician anesthesiologists across the country, and the RUC recommendations are based on the robust results of this survey. The work RVU recommendations for CPT codes 64633 and 64635 are based on the survey median for code 64635. In reaching their recommended values, the RUC considered additional factors such as the reduction in intra-service time for 64633 and 64635, as well as rank order relative to other similar services.

- Reduction in intra-time: As is often the case with resurveyed codes, the intra-time for these codes decreased with the current survey. To account for the reduced intra-time, the RUC recommended a reduced work RVU from the current value.

- Rank order: The RUC agreed that CPT codes 64633 and 64635 are slightly more intense and complex than the top key reference code 64625 *(Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance*) and therefore they should be valued higher. CPT code 64625 is valued at 3.39 work RVUs. While code 64625 requires more injections, CPT codes 64633 and 64635 are much more clinically complex.

CMS Proposed Value
While the RUC did agree that the value of the code should be reduced because of the reduction in intra-time with the new survey, ASA believes that CMS has set the value too low. ASA found the methodology used by CMS to propose a value to be flawed.

CMS is using a total-time ratio methodology to propose work RVUs of 3.31 for CPT code 64633 and 3.32 for CPT code 64635. These values fall between codes 54164 (*Frenulotomy of penis*

[work RVU = 2.82]) and code 68371 (*Harvesting conjunctival allograft, living donor* [work RVU = 5.09]). ASA notes that the CMS rationale is atypical since it is based neither on the survey value nor a direct crosswalk.

ASA has significant concerns with this approach. We believe the CMS proposed values create a rank order anomaly and are based on flawed crosswalk selections.

- Rank order anomaly: As previously noted, the RUC determined that due to their complexity, CPT codes 64633 and 64635 should be valued higher than their key reference CPT code 64625. The CMS proposed values for 64633 and 64635 sets their work RVU value below code 64625.

- Flawed crosswalks: Most significantly for ASA, there is a lack of any clinical relationship between codes 64633 and 64635 and the CMS proposed reference codes. The only point of similarity between the four codes is the intra-service time. In selecting crosswalks, time cannot be the only criteria. There must be some alignment in clinical similarity, intensity or other related factors between a surveyed code and its crosswalk. If intra-service time alone was a valid and reliable predictor of total physician work effort, codes 54164 and 68371 would be expected to have the same valuation, rather than an 80% discrepancy in work RVUs. Beyond issues of a lack of clinical similarity, the society finds the crosswalks problematic because they are based on survey data that are 18 and 20 years old. There are reasonable grounds on which to expect that these values may no longer represent the true value of the services used as references by CMS. RUC data demonstrates a predictable pattern of reduced times as codes are resurveyed over years. Significantly different physician time for CMS reference CPT codes 54164 and 68371 would undermine the validity of the proposed CMS total-time ratio methodology and as a result the validity of the CMS proposed values for codes 64633 and 64635.

This analysis clearly demonstrates that the RUC recommendation is more robust and accurate than the CMS proposed values. ASA urges CMS to accept the RUC recommendation of 3.42 work RVUs for CPT codes 64633 and 64635.

CMS is proposing the RUC recommended direct PE inputs without refinement for these codes. ASA appreciates the agency's support of these inputs and asks CMS to finalize this proposal.

Resource Costs for Services Involving the Use of Innovative Technologies, Including but not Limited to Software Algorithms and Artificial Intelligence (Section II.B.)

ASA urges CMS to take a broad and flexible approach to setting policy on the pricing for innovative technology such as artificial intelligence (AI). These technologies are still very much in development and evolving in anesthesia care as well as other clinical areas. Because of the critical role AI will play in anesthesiology, ASA very much would like to work collaboratively with the agency in the development of policy around these issues.

Practice expense (PE) inputs for equipment, supplies, and clinical labor (called "direct" practice expense inputs) are used as the first step in a multi-step calculation to generate PE RVUs. Direct PE inputs account for approximately 12 percent of PFS payments.

In this proposed rule, CMS is soliciting comments on the pricing of innovative technologies such as AI. The agency is increasingly encountering new services that have artificial/augmented intelligence or software algorithms incorporated. This technology does not fit well into the current standard methodology for pricing resource costs in the development of PE RVUs and the agency is seeking guidance from stakeholders. Specifically, the agency is soliciting comment regarding the use of innovative technologies, including but not limited to software algorithms and AI, and their effects on physician work intensity, cost structures and resource costs, quality of care, and equity.

While still very much in development for anesthesiology, there are six main clinical applications of AI research within the specialty: (1) depth of anesthesia monitoring, (2) control of anesthesia, (3) event and risk prediction, (4) ultrasound guidance, (5) pain management, and (6) operating room logistics. In anesthesiology the focus has mainly been on how to augment physician skills and judgement.[2] We anticipate that AI will have a significant impact on perioperative care, risk stratification, and the utilization of anesthesia services.

Because AI is very much in its infancy and as of yet it is unclear the overall impact this technology will have on physician work and practice costs, it is critical that the agency take a broad and flexible approach at this stage. The challenge will be to provide a means for practices that provide services that incorporate AI to appropriately capture these costs. Policy should balance allowing for innovation and development while providing the agency a means to measure costs in a fair and reasonable manner.

Because of the range of areas where AI will impact anesthesiology and to allow the specialty to benefit from it, ASA is well-positioned to collaborate with the agency. We can provide both valuable clinical insight as well as expertise on how to modify current methodologies to help capture the costs of innovative technologies.

Separate Coding and Payment for Chronic Pain Management (Section II.E)

ASA is a leader in the advancement of acute and chronic pain management best practices. ASA is very pleased that the agency is exploring how to more appropriately pay for chronic pain management services. Currently, the payment for these services is inadequate. ASA urges CMS to work collaboratively with ASA and other experts in the field to develop appropriate coding and payment for these services.

[2] Daniel A. Hashimoto, Elan Witkowski, Lei Gao, Ozanan Meireles, Guy Rosman; Artificial Intelligence in Anesthesiology: Current Techniques, Clinical Applications, and Limitations. Anesthesiology 2020; 132:379–394 doi: https://doi.org/10.1097/ALN.0000000000002960

CMS is soliciting comments on the establishment of a separate code and payment mechanism for chronic pain management services. This proposal is aligned with numerous efforts by the Department of Health and Human Services (HHS) to address access to adequate treatment of pain. The agency indicates in the rule that pain is a "significant public health challenge" with the Centers for Disease Control and Prevention (CDC) estimating 50 million adults in the United States have chronic daily pain, with nearly 20 million experiencing high impact pain that interferes with daily life or work. Pain is also associated with substantial economic costs for medical costs and lost productivity. In soliciting comments, the agency is interested in whether these services are currently being provided, and if adequately paid when provided. The agency also seeks feedback on appropriate valuation of these services and the type of clinicians providing these services.

Anesthesiologists play a unique role in acute and chronic pain management and it is a priority issue for ASA. Pain management is complex and can cause more harm than good if not provided by a physician with specific training in pain management. Pain medicine specialists are certified in a pain medicine subspecialty. In addition to the training of individual ASA members, as a society, ASA has also done significant work in developing guidelines and best practices, particularly in the area of opioid treatment alternatives. In 2019, ASA commended the HHS Pain Task Force on their recommendations to address safe opioid use and multimodal approaches to control pain. Many of the best practice recommendations aligned with solutions advocated by ASA.

ASA recognizes that the *2016 CDC Guideline for Prescribing Opioids for Chronic Pain* was an important step for safe pain care, but it has had unintended consequences. This includes an increasingly cumbersome process for clinicians who care for patients with pain that require pain medication for relief. The pressure and demands on workflow, as well as heightened clinical oversight by entities such as state licensing boards, have led to many physicians being unable or unwilling to provide pain management in the wake of the 2016 Guideline. Payment currently does not recognize the increased effort and demand required of physicians.

ASA is eager to collaborate with the agency on the development of coding and payment mechanisms for chronic pain management. While these services are currently provided by some physicians, they are not being paid at an adequate level. Improving coding and payment in this area could also increase beneficiary access to these important services. ASA would be a critical partner for CMS in the area of chronic pain management. Many of our members are specially trained in chronic pain management, receiving years of training to obtain subspecialty certification. Over the years, the society has done significant work in the advancement of high quality chronic pain management. For these reasons, we believe we are uniquely positioned to collaborate with the agency in this area. We look forward to working with CMS on this important initiative.

Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests (Section II.I.)

ASA urges CMS to finalize its proposal to eliminate patient responsibility for co-insurance for screening colonoscopies that turn therapeutic. ASA reminds CMS that these policies must also be extended to the associated anesthesia services.

Under Medicare, beneficiaries do not need to meet a deductible or pay the standard Part B coinsurance amount for a screening colonoscopy or sigmoidoscopy. Yet, in the past, if a polyp was detected on a screening evaluation and removed, the procedure was not to be reported as a screening but instead as a diagnostic procedure and while the deductible was waived, it was still subject to standard co-insurance requirements.

Following a statutory change in the Consolidated Appropriations Act (CAA) of 2021, CMS is making two regulatory changes that will reduce the financial burden of colorectal cancer (CRC) screening to beneficiaries. The first change is that screening colonoscopies and sigmoidoscopies that detect a lesion and lead to tissue removal, will be treated as screening rather than diagnostic procedures and subject to special screening payment provisions. Additionally, CMS will phase in a reduction in beneficiary co-insurance requirements between 2022 and 2030, at which point beneficiary co-insurance will be zero.

ASA welcomes the agency's proposal to implement a provision in the CAA of 2021 to eliminate the financial burden of coinsurance when a screening turns therapeutic. CRC is the second most common cause of cancer-related deaths for men and women in the US.[3] Screening may prevent CRC death and is recommended for people ages 50 – 75 years by the US Preventive Services Task Force. Studies have found that out-of-pocket cost is an important barrier for utilization of health services and a contributor to health disparities.[4] This proposal will have a meaningful impact at eliminating out-of-pocket costs for this important screening service and has the potential of improving CRC screening rates overall as well as addressing disparities in screening. ASA urges CMS to finalize this proposal.

ASA reminds CMS that this policy to reduce patient financial burdens must also be extended to the associated anesthesia services provided with the colonoscopy. Medicare coverage policies indicate that anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 (*Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy*). When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported

[3] American Cancer Society. (2021). Colorectal Cancer Statistics | How Common Is Colorectal Cancer? https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html#:%7E:text=Deaths%20from%20colorectal%20cancer,men%20and%20women%20are%20combined.

[4] Peterse, E., Meester, R., Gini, A., Doubeni, C. A., Anderson, D. S., Berger, F. G., Zauber, A. G., & Lansdorp-Vogelaar, I. (2017). Value Of Waiving Coinsurance For Colorectal Cancer Screening In Medicare Beneficiaries. Health affairs (Project Hope), 36(12), 2151–2159. https://doi.org/10.1377/hlthaff.2017.0228

with CPT code 00811 along with the PT modifier.[5] When coverage policies and other guidance is updated to implement the elimination of the co-insurance for screening colonoscopies that turn therapeutic, updated guidance should also address the associated anesthesia services.

Telehealth and Other Services Involving Communications Technology (Section II.D.)

During the COVID-19 public health emergency (PHE), HHS issued several waivers that made it easier to provide telehealth services to Medicare beneficiaries. These waivers—that are tied to the PHE—provide flexibility related to where telehealth can be provided (e.g., at home), which services can be provided (e.g., expanded list of covered services), what type of technology can be used (e.g., enforcement discretion around HIPAA rules), and the level of payment for these services (e.g., allowing the higher nonfacility rate for office-based physicians).

Extension of Coverage to Category 3 Services Through the End of CY 2023
In the CY 2021 Final Rule CMS provided coverage through the end of the PHE for over 100 services that had been added to the Medicare Telehealth List on an interim basis. These services were given Category 3 status (Categories 1 and 2 represent the long-term criteria for additions to the telehealth list; Category 3 was created to allow additions not clearly fitting under Categories 1 and 2). In this rule, CMS is proposing to extend coverage to these services through the end of CY 2023.

ASA strongly supports the proposed coverage extension for Category 3 telehealth services through CY 2023. We remain concerned, however, that statutory site-of-service restrictions and other restrictions will prevent Medicare beneficiaries from meaningfully accessing these needed telehealth services. We will continue to urge Congress to remove all telehealth originating site and geographic restrictions, and we urge CMS to interpret statutory language in a manner that provides Medicare beneficiaries with the broadest possible access to telehealth services.

At this time, there is great uncertainty on how the pandemic will evolve over the next few months. In 2020, telehealth utilization increased dramatically and it was generally believed to be an effective means to access health care safely during the pandemic. Clinicians need to maintain access to these services until the pandemic is under control. We appreciate the agency extending coverage for these services and urge CMS to continue approaching telehealth policies broadly and with flexibilities.

Additions to Category 3 List of Services
CMS also proposes to add services that were added to the Medicare telehealth services list on an interim basis but were not extended on a temporary Category 3 basis in the CY 2021 PFS Final Rule. These services are listed in Table 11 of the proposed rule. Under current policy,

[5] Centers for Medicare and Medicaid Services (CMS). (2015, October 1). Billing and Coding: Colorectal Cancer Screening – Medical Policy Article (A52378). Medicare Coverage Database. https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52378&DocID=A52378

these services would be removed from the Medicare telehealth services list as of the date the PHE ends.

ASA supports the addition of services from Table 11 to the Medicare telehealth services list on a Category 3 basis. We urge CMS to finalize this proposal.

Permanent Adoption of Virtual Check-in Code G2252
In the CY 2021 PFS Final Rule, CMS established code G2252 on an interim basis for an extended virtual check-in. This code allows health care providers to check in with an established patient using any form of synchronous communication technology, including audio-only communication. In the proposed rule, CMS plans to adopt coding and payment for code G2252 on a permanent basis.

ASA supports the proposal to permanently adopt the extended virtual check-in code, as it facilitates continued access to care for established patients and we urge CMS to finalize this proposal.

Critical Care Services—Split Billing (Section II.F.)
In this proposed rule CMS is making several proposals related to the reporting of critical care visits and split billing of these services. ASA would like to address some of these proposals in our comments.

CMS is proposing to prohibit practitioners from reporting critical care visits during the same time-period as a procedure with a global surgical period. CMS indicates that they are clarifying current policy in light of the recent withdrawal of the guidance in the *Medicare Claims Processing Manual*.

ASA requests that CMS confirm that the critical care split billing proposal would maintain the current reporting policy which prohibits the surgeon that performs the procedure from reporting a critical care service but that a separate critical care provider can bill for critical care services.

CMS is proposing to adopt CPT's listing of bundled services that are part of critical care visits to improve transparency and clarity of CMS policy for this service.

ASA supports the proposal to adopt CPT's listing of bundled services that are part of critical care visits and urges CMS to finalize it.

CMS is also making proposals related to split visits. CMS is proposing that the total critical care service time provided by a physician and nonphysician practitioner in the same group on a given calendar date to a patient would be summed, and the practitioner who furnishes the substantive portion of the cumulative critical care time would report the critical care service(s). This would be consistent with current policy.

ASA supports this proposal and urges CMS to finalize it.

CMS is proposing that no other E/M visit can be reported for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty in the same group. This would be inconsistent with current CPT policy.

ASA does not support this proposal and urges CMS not to finalize it. There are scenarios where such billing would be clinically appropriate. The agency should maintain enough flexibility around these services to allow practitioners to bill an E/M on the same date as a critical care service in those instances when it is clinically appropriate and for which there is documentation of the specific services provided by each practitioner.

For example, a physician could see a patient in the morning with that care being described with an E/M service as the patient is not critically ill at that time. However, later in the day, the patient's condition could deteriorate to the point that the patient does meet criteria to be critically ill. That subsequent care is separate from the morning visit and should be separately reported as critical care.

CY 2022 Updates to the Quality Payment Program (Section IV)

Advancing to Digital Quality Measurement of the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs — Request for Information

We hope this RFI on "Advancing to Digital Quality Measurement" will allow CMS to design a strategy and timeline to garner additional stakeholder perspective, feedback, and buy-in. ASA feels that CMS's five-year timeline for moving to full digital quality measurement is too aggressive given the level of national data integration required, as well as the cost for measure stewards like the ASA to revise and update their measures. Establishing pilot programs at certain facilities may be useful to evaluate the feasibility and resource requirements for converting clinical quality measures to digital quality measures (dQMs). We recommend CMS work in a comprehensive fashion with hospital systems and other facilities, physicians and their group practices, and medical specialty associations to evaluate their level of readiness for any transition to dQMs. Without physician buy-in, we fear that the transition to dQMs will be partially fulfilled and will not take advantage of available data generated in the delivery of patient care. We look forward to working with CMS, hospitals, payers, and other stakeholders on transitioning current clinical quality measure sets found in various CMS programs to dQMs.

ASA is optimistic about the promise of digital quality measures, especially since digitization of quality measures has the potential to provide physician anesthesiologists, surgeons, and other members of the surgical care team with actionable information, and in some cases, risk-adjusted outcome information. These data could be used to promote patient-centered care and achieve better outcomes at lower cost. In addition, the promise of digital measures will foster additional opportunities to assess the contributions anesthesiologists make to patient outcomes and experience of care. We believe automation of the measure data collection process through

FHIR-based quality reporting could decrease provider burden and improve patient outcomes. However, the process will take time and **CMS must move prudently in assessing which measures should be prioritized for digitization, while at the same time, understanding that not every provider will have an opportunity or the resources to use digital measures.**

We remind CMS that collecting data on anesthesia care is not always a straight-forward endeavor. Many anesthesiologists work in facilities that continue to use paper charting for the anesthesia record. Anesthesia records are complicated, include multiple clinical data points and free text that are not always easily translatable to Electronic Health Records (EHRs). Moreover, anesthesiologists provide care to patients in a variety of facilities and care settings that include hospitals, ambulatory surgery centers, and office-based locations where an anesthesiologist does not control or own the EHR. This is especially true in ambulatory surgery centers and office-based environments where most anesthesiologists continue to work with paper charting and medical records. As CMS allows additional procedures to occur at these facilities, the agency should be mindful of the technological and resource challenges anesthesiologists and others will face in reporting digital quality measures. Anesthesiologists interact with a variety of technology, facility administrations, and patient populations that carry their own facility-specific workflow challenges. To an individual or group, the burden of understanding differences between systems in multiple locations, including how data is gathered, pulled, and submitted for reporting purposes can be overwhelming.

Clinical data registries, like the Anesthesia Quality Institute National Anesthesia Clinical Outcomes Registry (AQI NACOR), must be a central feature during and after the transition to dQMs. We urge CMS to rely on its relationships with medical specialty society clinical data registries throughout the digital quality measure transition. As proposed by this RFI, CMS envisions that quality data will be automatically captured at the point of care and sent directly to CMS for scoring. Although that process may seem rather straightforward and idealistic, it nonetheless does not capture the relationships registries have built with their groups as well as the feedback loops that registries nurture among users of their measures. Registries, along with the physicians and staff who operate them, are able to identify gaps in measurement, learn about feasibility issues from groups, and educate groups on appropriate ways to implement quality measures. Without registries, the digital quality measure initiative would be more focused on efficiency rather than innovation and patient-centered care.

- *Do you have feedback on the dQM definition? Does this approach to defining and deploying dQMs to interface with FHIR-based APIs seem promising? We also welcome more specific comments on the attributes or functions to support such an approach of deploying dQMs.*

ASA agrees with the general definition of digital quality measures, including the addition of "a software that processes digital data to produce a measure score or measure scores." ASA also agrees with the delineation of individual data sources such as "administrative systems, electronically submitted clinical assessment data, case management systems, EHRs" and other sources as it gives a more comprehensive assessment of the complexity for digitizing measures.

CMS and the Office of the National Coordinator for Health Information Technology (ONC) should work collaboratively with data registries and vendors to ensure that common definitions are used. For example, AQI NACOR uses a standardized data dictionary that was created with input from multiple stakeholders and culled from nationally recognized standard setting organizations. AQI NACOR and our physician leaders hope to work with EHR vendors to incorporate these as structural data elements and create a data standard for perioperative data collection. Based on our prior experience working with vendors, we believe that those vendors will be receptive to this approach.

- *Would access to near real-time quality measure scores benefit your practice? How so? In what ways could a CMS FHIR Reporting IG be crafted to reduce burden on providers and vendors?*

Near real-time quality measure scoring, based upon best practices of perhaps 7-day, 30-day, or quarterly data availability, would be beneficial to anesthesiologists. Our registry, AQI NACOR, offers participants the ability to review their quality scores and benchmarks at any time during the reporting year. But to truly understand the totality of care a patient received, anesthesiologists should also have meaningful access to hospital performance data as well as performance data from other physicians and clinicians who participated in the episode of care. Quality measure data from hospitals, available in near real-time, can help clinicians optimize their performance and it has the potential to identify hospitals and other health care workers within the hospitals that do considerably better or worse than others. For them, near real-time data could, in a timely manner, help to improve the care those physicians and clinicians provide to patients. ASA welcomes efforts by CMS to create dQMs that have near real-time scores as the means to improve outcomes, increase accountability, and reduce health care costs.

Successful merging of patient and electronic health record (EHR) data has tremendous potential to improve the analysis and utility of quality data. Although we agree in principle with the digitization of MIPS measures, we encourage greater transparency in data that individual physicians can use to improve individual patient care. Currently, ASA struggles to develop risk-adjusted outcome measures because we lack the necessary outcomes data that hospitals, payers, and other large systems can readily acquire from patients. Anesthesiologists have limited access to and control over the aggregated data stored in hospital and facility EHRs. Our ability as a specialty to create digital quality measures and have near real-time access to that data crucially depends on our ability to access and work with the patient-level databases that are created during clinical encounters.

CMS should also consider instances where non-primary care physicians are treating and collecting data on patients. If the anesthesiologist is “invisible” to the FHIR API because their recordkeeping is in a separate system (or on paper), their efforts on the patient’s behalf may not be counted for the purposes of quality measurement. ASA expects that hospitals and academic medical centers who have already implemented major integrated EHR platforms are well-positioned to move to digital quality measurement. We anticipate, however, that our members

working in community hospitals and private practices will encounter significant obstacles in deploying fully integrated EHRs to meet the FHIR standard by 2025.

Our members may face challenges if the deployed EHR system does not have specific support for sharing information in a standardized format from the Anesthesia Information Management System (AIMS). EHR vendors have been slow to develop interoperable AIMS connections because no standard has been published by HL7, the parent organization of FHIR. Even anesthesiologists working in well-resourced settings at times experience difficulties accessing patient health information because of this particular health IT challenge. Such a disruption has real world implications for patient care. For example, the importance of incorporating all known health evaluations into a pre-anesthesia evaluation is frequently underestimated by developers and non-anesthesiologists. The lack of reliable electronic data transfers between primary care and specialty offices (like cardiology) and the anesthesia EHR inhibits the ability to share data and improve care coordination efforts. These interoperability issues must be addressed to take full advantage of FHIR standards for digital quality measurement.

At the same time, information generated by anesthesiologists oftentimes is siloed from other specialists. Sharing of anesthesiologist-generated information during the perioperative period would enhance health care delivery and help surgeons, primary care physicians, and others to better manage patients after surgeries and procedures. Ideally, better access to this data could create the framework for a collaborative and transparent process, including access to real-time quality measure scores and predictive analytics, would provide actionable feedback for anesthesiologists and our colleagues to drive local quality improvement efforts, improve clinical decision-making, and enhance patient outcomes and experiences.

- *Do you agree with the goal of aligning data needed for quality measurement with interoperability requirements? What are the strengths and limitations of this approach? Are there specific FHIR Implementation Guides suggested for consideration?*

ASA understands and recognizes that recently adopted rules are powerful drivers guiding CMS's vision of transitioning fully to digital quality measurement by 2025. However, the CMS Interoperability and Patient Access Final Rule and the ONC 21st Century Act Final Rule were published amid the COVID-19 pandemic and the timing has imposed implementation delays for physicians, hospitals, health IT developers, and payers. For anesthesiologists and other clinicians, the pandemic has further limited the available resources to upgrade local systems and to prioritize EHR and AIMS updates.

At this time, ASA believes that digitization of our current measure set would not be dependent upon the rollout of interoperability initiatives or actions. Anesthesia records are complicated and generate large amounts of clinical data points—even for short cases. Anesthesia records include a number of physiological measures that include vital signs (often captured every three minutes or more frequently), physiological values pertaining to ventilation, neuromuscular activity, temperature, and other features. All this is in addition to pharmacological episodes and free text fields that are not easily translatable to EHRs. Challenges like this make our specialty unique in regard to the application of federal interoperability policy and local EHR and health IT

implementation. Our quality measures take into account multiple data points during the patient's episode of care but the measures are more focused on the care an anesthesiologist provided than how that information is collected, stored, and transferred to other physicians and clinicians.

Although we have been working with ONC on identifying potential anesthesia data elements that could be included in United States Core Data for Interoperability (USCDI), we nonetheless are far from aligning our quality measures with interoperability goals. CMS should encourage stakeholders to expand the use of common FHIR standards, implementation guidelines, and reference implementation. For anesthesiologists, the HL7 organization has developed and published a domain analysis model and implementation guide for preprocedural anesthesia, and a domain analysis model for intraprocedural anesthesia, but not an implementation guide. At present, there is no formal HL7 standard for anesthesiology data—and we do not expect anesthesiology-specific data in HL7 to be included in future versions of the USCDI for some time. It is our hope that there will be anesthesia-specific FHIR resources specified by HL7 in the future.

Despite reservations about cost, implementation, and realistic timelines, we believe the implementation of the FHIR standard would eventually facilitate data transmission across health care entities and make it possible to measure outcomes longitudinally across various care settings (e.g., outpatient, inpatient, post-acute care, nursing home settings). Most quality measures only measure quality while a patient is cared for in a single setting, such as a hospital setting. Improving population health requires that we measure and understand patient outcomes across multiple patient settings. Anesthesiologists could participate in and benefit from such data exchanges. For example, if a patient is admitted to a hospital with an acute myocardial infarction (AMI), CMS's goal should not only be to measure 30-day mortality, readmissions, and hospital-free days but also to measure short-term and long-term complications, which requires access to data from other health care entities (outpatient, post-acute care, etc.). For anesthesiologists contributing to the care of the AMI patient, patient-reported satisfaction data may, for instance, be linked with pain scores and use of anti-nausea drugs. The improved data sharing of quality measures, both at the patient and facility levels, would significantly enhance our anesthesiologists' abilities to provide more personalized patient-centered care.

- *What functionalities, described in Section (4)(b) or others, should quality measure tools ideally have in the context of the pending availability of standardized and interoperable data (for example, standardized EHR data available via FHIR-based APIs)? How would this more open, agile strategy for end-to-end measure calculation facilitate broader engagement in quality measure development, the use of tools developed for measurement for local quality improvement, and/or the application of quality tools for related purposes such as public health or research?*

ASA believes quality measure tool functionalities must be advanced to expand the availability of standardized and interoperable data (standardized EHR data available via FHIR-based APIs). For example, tools must have the capacity to build custom and batch searches. Cross-discipline search functionality is a critical interoperable feature to allow clinicians to view, for example,

when patients have undergone cardiac catheterization or had a stroke code called within seven days of surgery.

Data inputs must be defined and standardized to ensure optimal functionality of quality measure tools. For instance, there are inherent challenges in aggregating data for measurement when combining data from multiple sources and the extent of these challenges will stem from how well the data quality can be managed. If data quality is low and there is a large amount of data missing, combining data from multiple sources has the potential to create misleading representations and could lead to inaccurate scoring. Unfortunately, even the most basic information has proven to be challenging to standardize, including patient height and weight. With CMS focus put on data infrastructure and data measurement tool improvement, the quality of data mapping to clinical diagnoses could greatly improve.

- *What are key policy considerations for aggregation of data from multiple sources being used to inform measurement? What role can or should data aggregators play in CMS quality measure reporting in collaboration with providers? How can CMS best facilitate and enable aggregation?*

ASA (through our AQI NACOR registry) acts as a data aggregator for many anesthesiologists, nurse anesthetists, and certified anesthesiologist assistants. Operating the registry is a phenomenally difficult task to undertake. First, legal agreements are required between the AQI and the parties holding physician and patient-level data. Second, there are significant technical challenges of getting data from electronic systems designed foremost for billing. Third, if any change is made from the sender or receiver, staff from the registry must fix the interface. This amounts to a significant expense for the registry and is often accomplished by external vendors or consultants. Although AQI NACOR Quality Concierge has established some adapters to streamline data collection, most physicians and groups have incomplete or non-existent access to their EHR data.

An alternative to this labor-intensive work could be that CMS mandate tightly specified interfaces for pulling the quality information that registries need. CMS can best facilitate aggregation not only be defining these interfaces but by encouraging stakeholders to validate that the interfaces work using a CMS-sanctioned testbed. Data validation should be required in order for a healthcare organization to receive any quality-related bonuses. Without some kind of enforcement, groups will claim to support CMS APIs without actually doing so. We believe CMS has set precedent for this kind of validation via its Strategic National Implementation Process of the Workgroup for Electronic Data Interchange which defines seven levels of validation. Many data aggregators have the capacity to assist in developing specialty-specific tooling to enable more streamlined workflows for data mapping and validation. The vast majority of the effort required to provide quality measure data is in the identification of the appropriate data fields (mapping), as well as the process of reviewing extracted data and comparing it to the source system to ensure the extraction was done correctly (validation). Our specialty has experience in mapping and validating extracts with the AIMS systems we use. This process has collectively taken hundreds of hours per participating site with contributions from data analysts and anesthesiologists. Should data not be resourced aggressively at a local level, then the data

quality for the extract would be poor. If mapping is done incorrectly, this could easily result in clinicians erroneously failing to meet dQM reporting standards or receiving measurement data from hospitals and health systems. We recommend CMS create a task force or working group comprised of EHR vendors, hospital administrators, and physicians to explore potential solutions for improving data aggregation.

- *What are initial priority areas for the dQM portfolio given evolving interoperability requirements (for example, measurement areas, measure requirements, tools)?*

CMS should work with individual specialties and registries to identify which measures should be prioritized for digitization. Additionally, CMS should, and ASA would support, provide funding for third-party entities to assist specialty societies in digitizing and testing their measures. ASA wants anesthesiologists and other members of the anesthesia care team to have every opportunity to participate in the Quality Payment Program and have a sufficient number of measures available to report. We remain concerned that a significant number of anesthesia groups still rely on using paper records and may be at a disadvantage when implementing digital measure initiatives. At this time, our society is developing future plans for measure development that will take into account CMS priorities and initiatives like digital quality measures and health equity. We expect to have additional conversations with CMS about the role anesthesia quality measures will play in MIPS Value Pathways, care coordination efforts, and the future of quality measurement. Regardless, we wish to spend our limited resources on measures that will have the most impact on patient care, grow opportunities for anesthesiologists to participate in MVPs, and align with future CMS priorities.

<u>Closing the Health Equity Gap in CMS Clinician Quality Programs — Request for Information (RFI)</u>
This RFI is an important step in creating a better understanding among health care professionals, including anesthesiologists, on how quality measures can better capture health disparities, clinical outcomes, and quality of life measures for patients. Anesthesiologists have and will continue to play a significant role in addressing health care disparities. ASA believes that recent literature and studies have allowed the health care community to better understand their potential role in reducing disparities, improving access to care, and ultimately improving health outcomes. For anesthesiologists, this has implications for nearly every surgical, therapeutic, and diagnostic procedure.

We appreciate the opportunity to contribute to the U.S. Department of Health and Human Service's mission to make health care more equitable by using the best possible research and evidence available. We look forward to collaborating with CMS and other agencies to address health disparities.

- *What are current collection practices by hospitals to capture demographic data elements (such as race, ethnicity, sex, sexual orientation and gender identity (SOGI), language preference, tribal membership, and disability status)?*

Anesthesiologists often receive patient demographic information that is self-reported by the patient at the hospital level. Race, ethnicity, sex, and language preference are commonly collected demographic data elements. However, SOGI, tribal membership, and disability status may not be collected as often. The CDC Race & Ethnicity code set may be available via multiple EHRs, but it is unclear to us how often anesthesiologists or their hospitals have used that code set.

- *What are the potential challenges facing clinicians collecting a minimum set of demographic data elements in alignment with national data collection standards?*

Anesthesiologists oftentimes rely on their hospital systems or patient intake procedures for a patient to report their demographic information. Although self-reported race, ethnicity, and other demographic data is the recognized standard for collecting such data, each hospital or facility may have different ways of identifying patients based on race and ethnicity. We also recognize that patients may not understand how their race and ethnicity data may be used to measure quality, patient safety, and access to care. It is understandable that patients may hesitate to respond to questions of race and ethnicity, especially if they believe that the collection of this data may be to render inferior care. By creating a more transparent process, including patient education on why race and demographic data is being collected, hospitals and clinicians may be able to improve trust between the patient and their care team.

CMS should also assess how often this data is collected by hospitals and how that data is shared with individual clinicians. We suspect that demographic data may be more readily available for anesthesia groups that work within larger hospital systems, especially those hospitals that may have extensive measurement and quality improvement activities. On the flip side, we also suspect that anesthesiologists working in smaller groups, in community hospitals, or those without extensive EHR systems, may not have access to race and ethnicity data.

- *Should health equity measures be developed in a manner to be broadly applicable to the various specialties and subspecialties that participate in MIPS?*

ASA supports the development of health equity measures that are broadly applicable to various specialties at the facility-level and also at the clinician level. For hospitals, measures that capture health equity features within patient satisfaction and experience of care surveys would be valuable. We also support measures that may look at the care a patient received from multiple vantage points. For example, CMS has rightfully focused greater scrutiny on maternal mortality — an important and urgent topic that would include the care provided by multiple specialties, including anesthesiology.

Although hospital- and clinician-level data may suffer from small sample sizes, we nonetheless support, when data is available, the stratification of measures by race and ethnicity. As ASA explores how best to approach stratification and its applicability to our current measure set, we believe that CMS should issue some guidance on current measures that should be prioritized to assess health equity. Likewise, we expect to build questions of health equity into our measure

development process. We welcome collaboration with CMS and in the piloting of quality measures at the clinician-level related to health equity.

- *Is there value in the development of more specialty specific health equity measures?*

As perioperative physicians, anesthesiologists can best assist in the development of health equity measures by focusing on care coordination, surgical care, patient safety, and shared accountability measures. Many examples exist related to how anesthesia measures are carried out on a daily basis. However, our members also deliver care to patients in acute need and those who may encounter significant barriers to care.

For example, more can be done to understand the role anesthesiologists and other specialists can play when encountering people who receive routine primary care and are having elective or urgent surgeries versus those who may have an acute surgical event without prior contact with health care personnel. In both situations, anesthesiologists can be partners with patients, their caregivers, and their health care teams to improve the patient's health, outcomes, and well-being. The anesthesiologist may encounter a patient with previously undiagnosed conditions that may have resulted from health care disparities. More explicitly, the case of a homeless patient receiving care in an ambulatory surgery center is instructive since that patient's care may result in an increased likelihood of a surgical site infection. Knowing this piece of information may encourage anesthesiologists to work with their surgical and facility colleagues to create a system of shared accountability for that patient's outcome. As a group, they may consult with social workers as soon as the patient is scheduled for surgery or perhaps the surgeon and anesthesiologist may schedule the patient as an inpatient.

Another example that affects patient care is the reluctance among patients who do not speak English to be offered or ask for regional anesthesia. This common language or cultural competency barrier could perhaps be eliminated with a focused educational campaign among physicians but also at the patient population level. Having specialty specific health equity measures complement hospital-level measures would be just one effective way to decrease health disparities.

- *Considering MIPS and MVPs includes several specialties and subspecialties, what factors should be considered when developing a health equity measure?*

CMS has already established standard criteria for accepting measures in the Quality Payment Program. These standards require that measures are based on clinical practice guidelines or literature. We believe that sufficient evidence exists for health equity measures to be developed that are supported by a practice parameter. For health equity measures not supported by clinical practice guidelines, CMS can rely on emerging literature that looks at access to care, timeliness of care, delays in care, and referrals as well as outcome measures such as complication rates, readmissions, reoperations, and mortality. Literature oftentimes can support these measures by their analysis of socioeconomic status, race, and other criteria for analysis.

- *Should we include a health equity measure in the foundational layer of all MVPs, as a required measure, in the future? If not, why not?*

We agree that a health equity measure should be included as a foundational layer of all MVPs so long as the measure moves through the established measure development and approval process. Measures are a base element toward achieving health equity, but at this time, no measures are readily available or vetted for widespread use. ASA wants to make sure that physicians, health care administrators, policymakers, and others work together to address this multifaceted health care issue. As CMS develops these measures, careful attention should be paid to ensure all specialties and MVP participants can be appropriately assessed. Disparity reduction cannot be addressed without first promoting transparency and accountability, and, from there, incentivizing healthcare systems on effective ways to reduce inequity.

MIPS Value Pathways

ASA supports the finalization of the Patient Safety and Support of Positive Experiences with Anesthesia MVP as proposed by CMS. The ASA proposed this MVP to CMS with the intention that it could be reported by a broad scope of anesthesiologists and members of the anesthesia care team, including nurse anesthetists and certified anesthesiologist assistants. Physician anesthesiologists represent the common pathway for nearly all surgical and procedural care patients and contribute to improved quality and more cost-effective care. The ability for our members to be included within surgical MVPs is also essential. As the MVP framework matures, we hope that CMS will explore how this anesthesia MVP can be coupled with or incorporated into surgical MVPs and episodes of care. We thank CMS for the opportunity to meet with them to discuss the merits and promise of this MVP.

ASA also took the opportunity this year to nominate a cross-specialty, shared-accountability MVP that was based upon a surgical episode of care. In February 2021, ASA submitted the Total Joint Replacement of the Lower Extremity as a cross specialty collaboration with the American Academy of Orthopedic Surgeons (AAOS), American Geriatric Society (AGS), and American Academy of Physical Medicine and Rehabilitation (AAPM&R). The intent of that MVP was to provide high quality health care at the lowest cost for the patient. The MVP was written to align all stakeholders (surgeons, anesthesiologists, primary care physicians, and rehabilitation professionals) to improve patient outcomes and satisfaction and decrease cost in total joint replacement procedures. Our proposed MVP included quality measures from multiple specialties, cross-cutting measures, and common improvement activities that each specialty could report. The episode of care would begin from the decision to have surgery until 30 days post-discharge and required all MVP participants to work with the patient on expectations, optimize the patient for surgery and recovery, and find the optimal destination for post-acute care.

We appreciate that several of our ideas found in each of these MVPs found their way into this proposed rule. CMS feedback on our proposals were transparent and straight-forward. The feedback loop will be used to further hone how we consider MVPs in the future and where our measure development priorities should be placed. We were disappointed that CMS did not propose our cross-specialty MVP on total joint replacement of the lower extremity, but we look

forward to the continued collaboration and conversation with CMS to develop MVPs that foster team-based care.

MVP Implementation Timeline

ASA was hoping our MVP could be implemented in 2022, but we understand the reasons why CMS delayed its implementation until the 2023 Performance Year. CMS is taking a prudent approach to rolling out MVPs and the designated timeline for transitioning to MVPs will allow eligible clinicians (ECs) and groups to adopt and prepare for reporting to an MVP. We were also surprised that CMS anticipates that just 10% of ECs will choose to report MVPs in their first few years. Based upon the reduced burden of reporting quality measures and improvement activities, we are optimistic that anesthesiologists will report the anesthesia-specific MVP in greater numbers than those predicted.

MVP Transition

ASA supports the CMS proposal to allow voluntary reporting of MVPs. Allowing for voluntary reporting will allow clinicians to familiarize themselves with the structure and scoring of MVPs. In webinars and discussions hosted by CMS, we have learned that the agency does not have the capacity to incentivize participation in MVPs by awarding bonus points. ECs nonetheless will be faced with a decision to continue in traditional MIPS or to move toward MVPs. CMS should consider alternative mechanisms to incentivize the adoption of MVPs that encourage early adoption of the MVP program. One proposed mechanism would be for CMS to hold harmless those groups reporting the MVP. This action may assign a neutral payment adjustment to those groups who choose to report to the MVP but fall below the minimum threshold to avoid a penalty.

Further, to encourage physicians to adopt MVPs, CMS should find ways to encourage boards and licensing agents to award CME or MOC credit opportunities for physicians. This action could be a way to reduce burden for physicians already required to report future MVPs. Although ASA does not see this incentive as a driver for groups to report MVPs, it could ease existing groups into making the transition to MVPs. In addition, CMS should continue to assess subgroup scoring from 2023-2027 to ensure that the scoring of multiple subgroups within a TIN is appropriate and fair.

Implementing the MVP Guiding principles

1. MVPs should consist of limited, connected complementary sets of measures and activities that are meaningful to clinicians. This will reduce clinician burden, align scoring, and lead to sufficient comparative data.

ASA supports a smooth transition from MIPS to MVPs and, to encourage uptake of MVPs, CMS should be more creative in their approach to measure choice and to scoring in future years. We agree that there should be a limited number of quality measures and improvement activities within an MVP. However, for anesthesiology, this may become an issue if anesthesiologists are

siloed within just one MVP. Our MIPS measures are generally applicable to many procedures. However, our QCDR measures today, and those developed in the future, will need to address subspecialty priorities and different patient populations. For instance, we know we have gaps in pain management, regional anesthesia, ambulatory care, care coordination, and patient-reported outcomes. Our QCDR has measures that address each of these areas and we hope that MVPs will be developed where these measures can be used.

2. MVPs should include measures and activities that result in providing comparative performance data, which is valuable to patients and caregivers in evaluating clinician performance and making choices about their care. MVPs will enhance this comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups.

We are concerned that CMS emphasis on "comparative performance data" is based far too often at the clinician level and not at the episode of care. Within MIPS, anesthesiologists and their groups are scored against other physicians and clinicians participating in the program, regardless of whether they report the same measures or not. We question why CMS is intent on siloing specialties within MVPs instead of assessing individual physicians based upon the totality of care provided to the patient. While ASA agrees with the option for subgroup reporting, we believe there could be unintended consequences of creating a pool of too many subgroups that could dilute the number of physicians reporting certain measures or episodes of care.

3. MVPs should include measures selected using the Meaningful Measures approach and, wherever possible, the patient voice must be included, to encourage performance improvements in high priority areas.

We agree that the patient voice is a key component to have in measure development as well as in MVPs. We currently have the patient voice represented through our patient experience and engagement with anesthesia care QCDR measure. For our MVP submissions, ASA reached out to a patient organization for input to ensure that our proposals were meaningful and patient-centered. We are grateful to have these relationships with patient organizations, but the process could be improved by CMS providing a set of questions or actions that patient organizations can complete to ensure we are fulfilling the vision of MVPs as embracing patient-centered care. In the future, we expect and welcome patients and their advocates to be further engaged in patient-reported outcome measures, care coordination efforts, and other activities that enhance their understanding of their care and expectations for recovery.

4. MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.

CMS should identify the methodology that specialties can use to achieve APP or APM status. We agree that MVPs can be used as a bridge to move ECs and groups from the MIPS program into an APM. However, the current set of APM measures is limited in scope as there are many more measures and options available for primary care physicians than specialists.

These primary care measures make it unclear what long-term outcomes our members should target when working across specialties. CMS has indicated their belief that a combination of factors including quality of care and patient experience, cost, continuous improvement, and innovation, as well as efficient management of resources and transfers of information, will help remove barriers to APM participation. To the average anesthesiologist or group, this list detailing qualities of a MIPS APM can be daunting. CMS should publish guidance or case studies on how individuals or groups have leveraged their MIPS participation into APM agreements. Such a blueprint will help specialties better engage their members.

Because cost is a significant feature of APMs, CMS should strive to work with specialties on identifying applicable cost measures for the MVP. Anesthesiologists rarely receive attribution in the cost performance category. Therefore, the linkage to cost measures within an MVP is concerning to us. We request CMS be transparent in their cost attribution methodology and provide information to groups regarding how their cost scores are calculated. As discussed below, we encourage CMS to explore innovative approaches to have MVP cost measures apply to all groups reporting a particular MVP. Anesthesiologists should be able to share in the cost measure by demonstrating participation in any shared or cross-specialty MVP. With this transparency, the inclusion of relevant cost measures in MVPs would be more meaningful and understandable to clinicians.

5. MVPs should support the transition to digital quality measures.

As previously mentioned, ASA is optimistic about the promise of digital quality measures, especially since digitization of quality measures has the potential to provide physician anesthesiologists, surgeons, and other members of the surgical care team with actionable information. These data could be used to promote patient-centered care and achieve better outcomes at lower cost. In addition, the promise of digital measures will foster additional opportunities to assess the contributions anesthesiologists make to patient outcomes and experience of care. By leveraging advances in technology to access and electronically submit interoperable data, we believe automation of the measure data collection process through FHIR-based quality reporting could decrease provider burden and improve patient outcomes. For MVPs, CMS should provide clear priorities on which measures should be digitized. The process will take time and CMS must move prudently in assessing which measures should be prioritized for digitization while at the same time, understanding that not every provider will have an opportunity or the resources to use digital measures. **Clinical data registries, like the Anesthesia Quality Institute National Anesthesia Clinical Outcomes Registry (AQI NACOR), must be a central feature during and after the transition to dQMs.**

Subgroup reporting

Although a minority of anesthesiologists practice within a multispecialty group, we nonetheless urge CMS to further assess the burdens that multiple MVPs may place on multispecialty groups. After 2025, the requirement for multispecialty groups to divide into subgroups based upon their clinical specialization may increase their reporting burden and disincentivize their wider participation in team-based care. One of the many reasons ASA was excited about MVPs

rested with CMS's intention to allow for cross specialty collaboration. We hope that CMS will reexplore how MVPs are structured in a way that would allow multiple specialties to report to the same MVP. This reporting can be accomplished through allowing each specialty to report relevant measures within the given MVP. **Allowing for multispecialty groups to report to the same MVP would open the door to the use of cross-cutting measures that can be directly linked to MVP relevant conditions and care coordination.** It will reduce the burden on groups as they can focus on the measures and improvement activities that will improve patient care, better coordinate care, and effectively manage patients during the broadly defined episode.

Until such policies are in place, ASA supports the subgroup reporting mechanism which encourages representation of various specialties in a multispecialty group. In past years, many anesthesia groups in large ACOs have been frustrated that anesthesia measures are not incorporated into their measure set. Subgroup reporting for MVPs will ensure that multispecialty groups have options that reflect their local practice needs. We had this in mind when we proposed our total joint replacement of the lower extremity MVP. On one hand, a large multispecialty group with anesthesiologists and orthopedic surgeons might wish to report a cross-specialty MVP as one TIN. On the other hand, if that group believed their interests are specialty-specific, they should have the option to split their TIN and form subgroups. However, the implementation of subgroups may place an undue burden on clinicians, especially in the early years of implementation where there are a limited number of MVPs available.

We support CMS's proposal for the Patient Safety and Support of Positive Experiences with Anesthesia MVP to be used as an option for anesthesiologists working within a multispecialty group. Within anesthesia, there may be instances where an anesthesia group may be made up of anesthesiologists and pain medicine physicians. Some anesthesiologists in such a group may choose to form a subgroup to report to an anesthesia MVP while the pain medicine physicians may be left without relevant measures to report. In this scenario, regulation may have created an undue burden on those physicians left without measures to report. But for the other subgroups of anesthesiologists, the burden may shift to the registry. CMS should allow sufficient time for and describe in detail the requirements on third-party vendors to validate participants in the subgroups and their MVP selection. Regardless, CMS should continue to assess subgroup scoring from 2023-2027 to ensure that the scoring of multiple subgroups within a TIN is appropriate and fair.

Request for Information on the Future Vision of Subgroup Reporting:

- *Additional approaches we should consider to incentivize team-based care as we move towards MVP and subgroup implementation.*

ASA understands CMS's current approach to MVPs but we feel that the creation of subgroup reporting, in the long run, does not incentive team-based care. The inclusion of measures and improvement activities that are linked in a complimentary way that assesses different dimensions of care, different places of service, and different levels of care coordination through improvement process management could be an avenue to incentivize such a model for

development of MVPs. For example, performance measures aimed at preventing postoperative nausea and vomiting, and those measures encouraging postoperative ambulation, can easily be supported and improved upon by a practice using the improvement activity for decision support and use of treatment protocols. We also know that care coordination is a significant driver of patient satisfaction. But, as currently structured by CMS, the anesthesiologist in an anesthesia-specific MVP might report on the prevention of post-operative nausea, postoperative ambulation might be captured by surgeons in their MVP, and treatment protocols might be captured by an acute care setting clinician. **CMS should, in the next few years, develop methods for shared, team-based MVPs that span multiple physicians and other clinicians.**

- *If individual clinicians or groups should attest to their specialty during MVP and subgroup registration.*

Although anesthesiologists have multiple subspecialties, such as cardiovascular, pain, and critical care, we do not believe that subspecialization needs to be captured at this time. Instead, we would embrace MVPs based upon episodes of surgical care where anesthesiologists can contribute their measures and receive credit for participating in the MVP regardless of subspecialization.

- *If there may be ways to group clinicians in like specialties who may provide similar care and would be interested in reporting the same measures and activities under a given MVP.*

ASA agrees with the approach to allow like specialties to report the same measures and activities within an MVP. We also agree that cross-cutting measures can allow ECs across specialties to report on similar measures. We disagree with the description of TABLE 33 where CMS describes anesthesiologists and nurse anesthetists as reporting different anesthesia measures or that Qualified Clinical Data Registry (QCDR) measures do not apply to nurse anesthetists. In addition to physician anesthesiologists, AQI NACOR reports MIPS data for thousands of nurse anesthetists each year. Working as part of the physician-led anesthesia care team, both the physician anesthesiologist and the nurse anesthetist can, in most cases, report the same quality measures. Additionally, ASA licenses several of our QCDR measures to entities who report MIPS for their nurse anesthetist clients. ASA supports physician-led care and we encourage anesthesia groups to have their anesthesiologists, nurse anesthetists, and certified anesthesiologist assistants report the same measures and improvement activities.

Sunsetting Traditional MIPS

ASA encourages CMS to assess the success of MVPs before they determine a set year to sunset the traditional MIPS program. The current consideration for the sunsetting of traditional MIPS in five years is a prudent step to ensure that the MVP policy is appropriate and implementable. The deadline serves as a reminder to practices to join and/or try MVPs. We believe there are several benchmarks that CMS can use to evaluate when the optimal time for the transition to occur. First, requiring multispecialty groups to identify subgroups and require subgroup reporting by 2025 will allow CMS to use the information to assess subgroup reporting

success and any resulting burdens on groups. Second, CMS can monitor the number of groups that matriculate from MIPS to MVPs over the course of the next five or six years. Last, CMS must assess whether the MVPs reflect EC and group needs. We recommend that CMS ensure there are a sufficient number of MVPs available for practices to succeed via the MVP pathway before sunsetting traditional MIPS. Limiting the availability of unique specialties to report to only a small number of subgroups could disincentivize clinicians to want to report MVPs.

Maintenance Process for MVPs

ASA agrees with the proposed maintenance process as it would allow CMS to maintain an objective stewardship over all MVPs. For us and the anesthesiology MVP, we would welcome the opportunity to work with CMS to respond to MVP participant questions, refine, and modify our proposed anesthesiology MVP over time. We likewise believe that CMS will provide an objective space for specialty societies and other stakeholders to recommend appropriate modifications to MVPs. This process would be a departure from how measures are developed but one that will make the process more transparent and nimbler. The process will also ensure that owners do not unnecessarily prevent appropriate modifications of the MVP from taking place.

We ask that CMS consider aligning multiple timelines to improve the process for MVP maintenance. The requirement to review an existing MVP in January preceding the performance year may lead to an unintended burden placed on the MVP developer to submit updates to quality measures. Measure owners are required to submit MIPS changes in December two years prior to the reporting year and QCDR self-nomination data and measures are submitted in the September prior to the reporting year. Better alignment of these processes, or a two-year approval of QCDR measures, would assuage this burden.

Reporting Requirements

We understand why CMS has proposed a specific timeframe for ECs and groups to identify the MVP they wish to report, however placing this responsibility on the group could lead to a burden for third-party intermediaries. AQI NACOR has a robust communication strategy with ECs and their groups. Each month, AQI NACOR staff host an office hours session, send multiple notices for groups to check their MIPS participation status and issue regulatory guidance. We ask that CMS partner with registries on participant communications to ensure groups know when and how to identify the MVP they wish to report.

CMS should finalize its MVP reporting requirements proposal. MVP participants will benefit from having to report just four quality measures and one high-weighted improvement activity. This meaningful policy proposal will reduce the burden on groups to report MIPS. We encourage CMS to also allow groups to submit additional measures that are either outcome measures or high priority status and to receive any bonus points, as included in the traditional MIPS program. We feel that overall, the requirement for MVP participants to report on fewer measures and improvement activities as a way to obtain individualized results,

would allow for a more cohesive participation experience. ASA is optimistic about the implementation of MVPs and we look forward to the continued collaboration with CMS.

Use of Clinical Data Registries and Third-Party Intermediaries.

ASA recommends that CMS allow Qualified Registries, QCDRs, and other third-party intermediaries to choose which MVPs they wish to support. We agree with CMS that third-party intermediaries should only report the MVPs that reflect their participant needs. However, we do not believe that CMS should arbitrarily assign MVPs to QCDRs, Qualified Registries, or other Third-Party Intermediaries. As previously mentioned, anesthesiologists practice in a number of settings, can be subspecialized, and may report, in some cases, cross-cutting measures. We do not want CMS to inadvertently limit the MVPs that an anesthesiologist may report via a QCDR. As MVPs mature and more are developed, CMS should assess whether the limit on the number of QCDR measures available (30 measures) should be revised.

MIPS Performance Category Measures and Activities

Physician anesthesiologists have participated in the Quality Payment Program (QPP) and the Merit-based Incentive Payment System (MIPS) in significant numbers for the first five years of the program. During this period, our registry, the Anesthesia Quality Institute (AQI) National Anesthesia Clinical Outcomes Registry (NACOR) has supported the reporting of MIPS data to CMS for tens of thousands of physician anesthesiologists, nurse anesthetists, and certified anesthesiologist assistants. Just as CMS has used the program's first few years to understand how ECs and their groups have participated, ASA and AQI NACOR have gathered a significant amount of information from our members and participants on their understanding of MIPS requirements, the burdens they face, and how data is collected and reported by individuals and their groups.

Quality Performance Category

In general, ASA supports the inclusion of administrative claims measures, as described in the proposed rule, that may be applied to non-small group practices and to groups reporting MVPs. But the benefits that other groups have had with regard to diversifying their scores with these administrative claims measures have not always been available to anesthesiologists. We request that CMS consider additional measures or amendments to the proposed measures that would be applicable and meaningfully attributed to anesthesiologists. As CMS continues to frame MVPs, we expect that CMS would identify gaps in measures as they pertain to individual specialties.

With this in mind, we want to make sure that anesthesia groups elect to have the appropriate administrative claims measures reported for their MVP. The proposed rule describes how groups would need to select up to four administrative claims measures to be scored via the MVP reporting option. CMS would make historical data available on those measures so that the individual group could choose the appropriate measures reflective of their group's work. We are concerned about the burden placed on registries, specialty societies, and others to educate participants into making an appropriate decision. This proposed action by CMS may lead to

groups scrambling to choose measures late in the reporting year. We are unclear why CMS would not assess each individual group on every available administrative claims measure and use the highest scores of all measure data for the year to produce the best possible score. In short, the burden of selecting administrative claims measures should not fall on individuals, groups, or registries.

ASA opposes the increase to the data completeness threshold from 70% to 80% by 2023. According to data gathered by our registry, a significant majority of groups within our registry fall within the 70% to 80% threshold for data and have done so for several years. These groups, however, may have reached their ceiling with regard to data completeness. The problem lies less with the groups and more with the timing of when the quality measures are released. In 2019 and again in 2020, MIPS measures and QCDR measure specifications were made available in late December of the year prior to the performance year. The delay in publication by CMS delayed implementation by individuals and their groups, sometimes as late as April or May of the reporting year. In short, *timing*, and not effort, is the barrier to achieving an 80% reporting threshold.

ASA worked with the Anesthesia Business Group (ABG) on harmonizing two QCDR measures, AQI56: Use of Neuraxial Techniques Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA) and ABG41: Upper Extremity Nerve Blockade in Shoulder Surgery. Although CMS hoped for having one comprehensive measure concerning the overall concept of appropriate use of regional anesthesia for extremity surgery, we do not believe that the two measures should be merged. ASA noted that the evidence for each measure, the population that the measure seeks to measure, and how the measures are collected do not support merging the two measures. Regardless, ASA worked with ABG to harmonize terminology and other features of those measures. The final decision by CMS for measure harmonization efforts should not result in any adverse actions on either measure, especially when the measure stewards worked in good faith with one another and CMS. CMS should approve both AQI56 and ABG41 for use in performance year 2022.

ASA supports the inclusion and approval of the SARS-CoV-2 Vaccination by Clinicians measure for reporting by MIPS ECs and their groups. ASA believes that this measure is an important measure for clinicians to report and the measure will encourage clinicians to discuss the benefits of the vaccine to those vaccine-hesitant patients. Widespread vaccination is the most effective path to reduce illness and death, and to ameliorate the impact of the pandemic.

Having a sufficient number of quality measures available for anesthesiologists and members of the anesthesia care team is the priority of our measure development experts. For us, this means developing and then moving QCDR measures through the Measures Under Consideration (MUC) process and into MIPS. In addition, we understand CMS's desire to have the right balance of MIPS measures and QCDR measures when approving MVPs. Therefore, it is important for CMS to return to a more open MUC process that was in place prior to 2017. Over the course of the last four years, the number of measures approved via the MUC has declined precipitously from several dozen measures to only four quality measures last year. Combined with measure attrition, the availability of quality measures for groups to report has become more

limited. **CMS should rebuild the library of MIPS measures available for reporting by encouraging the submission of QCDR measures through an open MUC process**.

Yet rebuilding a library of quality measures will be challenged by regulations finalized by CMS last year. We are very concerned about CMS's policy on measure testing for 2023 and beyond. In the 2021 quality payment program, CMS finalized a proposal to require face validity testing for measures in 2022 and then "full testing" for measures submitted as part of the QCDR in 2023. Because data to fully test an anesthesia quality measure for validity is difficult to capture, we cannot support requirements that each measure be tested for validity beyond face validity. Our physician leaders in quality, our research and analytics team and other subject matter experts in anesthesia quality measures have determined that few, if any, anesthesia measures would meet CMS expectations for validity testing as described by that rule. The implications of this for anesthesia quality measures could be profoundly devastating.

We recognize that CMS will attempt to implement these testing requirements over the next year. Even with this time lag, we believe that fully testing more than a dozen measures on data that is not readily accessible will not be feasible. In 2020 and again in 2021, CMS rightly allowed groups that were disrupted by the COVID-19 pandemic to apply for and receive a hardship exemption. That policy, however, reduced the amount of data available in our QCDR for measure testing. **Because the extreme and uncontrollable circumstances policy decreased the number of groups reporting to MIPS via our QCDR, we ask that measure testing requirements (not including face validity testing) be delayed until two years after the end of the public health emergency (PHE).**

CMS currently has a number of meaningful proposals that will fundamentally reshape measure development and testing in the next five to ten years. The agency has an opportunity to align measure testing with its larger priorities of digital quality measures, health equity, and the implementation of MVPs. ASA believes that CMS can gradually implement this policy over a two-to-three-year period and work with individual measure stewards on prioritizing measures and identifying the appropriate measure testing method to use for each measure. Most important, CMS's desire to move to digital quality measures and for measures to be stratified based upon socioeconomic, race, and ethnicity features may complicate measure testing. In short, we are concerned that measure testing in 2023 may not live up to the expectations of CMS in future years.

We offer several solutions, in addition to CMS delaying measure testing beyond the PHE by two years, that would ensure CMS and measure stewards are traveling in the same policy direction. First, before commencing measure testing, medical society measure stewards should be able to proactively share our testing plans with CMS for review, feedback, and approval. ASA believes this policy would ensure that testing will meet CMS expectations. Second, we believe that measures should only need to be tested once. More testing could be required if there are substantial changes to the measure. Third, we ask that CMS develop a consistent evaluation method of measure testing data. This evaluation would include the persons responsible for reviewing the methods and results, how insufficient data is determined, and whether or not an appeals process will be available. Anesthesiologists are not alone among specialties in

expressing our concern with measure availability and testing. We hope that CMS will work constructively with measure stewards on a reasonable process to meet these challenges ahead.

ASA also believes that quality measures can benefit from strong relationships with CMS and its measure contractors. Although we are concerned about the timeline for digitizing our measures as well as meeting testing requirements, we know that partnerships between ASA and CMS can help us meet upcoming deadlines. We would be supportive of assistance and efforts to fund the digitization and testing high-priority measures as determined by specialty needs. In recent years, we have worked constructively with Mathematica, with CMS approval, to e-specify one of our QCDR measures. Although the collaboration has taken several years, we felt the process was transparent, professional, and the outcome of the effort will lead to a better measure and understanding of the care patients receive and the outcomes they experience.

Cost Performance Category

In recent years, CMS has reached out to the ASA and other specialties for additional considerations for developing cost measures. ASA recognizes the importance of having cost measures attributable to the individual or group, especially since it allows for the diversification of MIPS scores. In future years, especially as MVPs become more prominent, we expect that anesthesiologists will need ample opportunities to demonstrate their value in the cost performance category.

Until CMS can develop anesthesia-specific cost measures, we see that there are three pathways that CMS can take to improve anesthesiology participation in MIPS. First, we are supportive of the continued use of facility-based scoring and expect that CMS will continue to use that proxy scoring throughout the public health emergency. The second pathway has already been taken by CMS — to limit the ways in which non-patient facing clinicians like anesthesiologists are attributed to the Medicare Spending Per Beneficiary (MSPB) measure. For those groups who receive an MSPB score, we once again ask that CMS provide more detailed information on individual cases that were scored by CMS.

The third pathway CMS could take to expand the use of cost measures is via the MVP reporting option. ASA worked with our colleagues in orthopedics to develop and submit an MVP related to lower extremity procedures. We included the use of the Knee Arthroplasty as a cost measure. In our submission, we recommended that CMS explore applying the facility-based score on that measure to all participants within the MVP. In a way, our recommendation acts very similar to the facility-based scoring option where anesthesiologists would be scored based upon that cost measure's performance at the facility where the procedure occurred. We hope that CMS will consider that option in future years.

We appreciate CMS opening up avenues for specialty societies and third parties to develop and nominate cost measures. The structure that CMS proposes for cost measure development is fairly straightforward and mirrors that of the quality performance category. In the past, ASA has welcomed opportunities to nominate physician anesthesiologists to serve on cost measure

technical expert panels. We hope that CMS will encourage, if not require, cost measure developers to provide for open technical expert panel opportunities and comment periods.

Improvement Activities

ASA applauds CMS for proposing several improvement activities that reflect priorities within health care. We believe that each new improvement activity proposed should be finalized and made available for ECs and their groups to report. These activities span multiple initiatives and can be used by groups that wish to create and implement an anti-racism plan, promote clinician well-being, and implement a personal protective equipment (PPE) plan. We appreciated working with CMS in 2020 on this last improvement activity. With regard to IA modifications, we agree with the enhancements and further clarifications to several IAs within the achieving health equity subcategory. Likewise, the consolidation of multiple patient experience and satisfaction improvement activities will serve to help practices meet a broader definition of survey activities rather than the narrower descriptions used in previous years.

ASA thanks CMS for proposing, and we strongly support, increasing the IA_CC_15 PSH Care Coordination Improvement Activity from a medium-weighted activity to a high weighted activity. Over 125 hospitals and their anesthesiologists, their surgical colleagues, and postoperative care clinicians participate in perioperative surgical home activities throughout the United States. CMS succinctly captured the intent of this improvement activity by stating, "the level of effort to complete this activity [reflects] high intensity activities, requiring significant investment of time and resources. This activity requires team-based, interdisciplinary care coordinated across multiple care settings and requires efforts to both plan for and implement the selected care coordination actions." We couldn't agree more and recommend CMS finalize its proposal for IA_CC_15.

CMS should approve an improvement activity for groups that assist measure stewards with measure development and testing efforts. At ASA, measure development oftentimes relies on volunteers to see if a proposed measure can be captured and, if so, the amount of burden that measure may place on the individual or group practice. In addition, as described in our quality measures response, measure testing requires a significant amount of time, money, and analysis to complete in the next few years. Offering MIPS ECs and groups opportunities to earn improvement activities credit for helping improve the measures offered in MIPS is a worthwhile and meaningful action CMS can immediately take.

Promoting Interoperability

Most physician anesthesiologists and their groups are considered non-patient facing and do not need to report promoting interoperability measures. ASA affirms our support for the special status designations that CMS has implemented and its policy to provide non-patient facing clinicians with an exception for reporting the promoting interoperability measures. We likewise support the continued use of the special status designation and its exemptions within the MIPS Value Pathway reporting option.

MIPS Final Score Methodology

In recent years, CMS has been careful to set the minimum threshold for receiving a neutral or positive payment at an achievable level. This resulted in a number of groups focusing first on building their capacity to report measures and improvement activities. The policy, coupled with the extreme and uncontrollable circumstances option, resulted in few groups receiving a negative adjustment and many more practices receiving a neutral or modest positive payment adjustment. Combined with revisions to scoring policies in the 2022 proposed rule, we believe that setting the minimum threshold at 75 points, as required by statute, will result in a number of anesthesiology groups receiving negative payment adjustments in 2022 and beyond.

Because CMS must place the minimum threshold at 75 points, we believe that it is important for CMS to maintain current regulations for scoring for at least one additional year. Despite the PHE, many anesthesiologists and their groups continued to report MIPS quality measures and perform improvement activities. Many of those same groups lamented how they received a 0% payment adjustment because of CMS's PHE policies. On the other hand, some anesthesia groups received less than a 2% payment increase based upon their exceptional performance in 2019 and again in 2020. The higher performance threshold, coupled with the removal of quality measure scoring floors and bonus point opportunities, will disproportionately affect those groups who have earnestly participated in MIPS throughout the pandemic and, most likely, since its first year.

ASA supports CMS policies that are consistent and acknowledge the limitations that the public health emergency, including the recent spike in COVID-19 cases, have placed on individuals and their groups. We support these policy positions:

- CMS should maintain the bonus point scoring structure for groups reporting high priority and outcome measures beyond the minimum requirement.
- We support CMS in their codification of how facility-based scoring is carried out. MIPS participants across the board have benefited from this facility-based scoring method where CMS will take the higher of the two scores generated either by quality measure submissions (and cost measure calculations) or the facility-based score.
- ASA agrees with CMS in maintaining the complex patient bonus at 10 points.
- **We support the introduction of the "New Measures: Class 4" policy where MIPS participants will receive at least five achievement points out of 10 for reporting new measures within the MIPS program.** We believe that a five-point floor for the first two years of an approved measure will encourage individuals and groups to report new measures in sufficient numbers for measure testing and benchmarking purposes.

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Third Party Intermediaries — Qualified Clinical Data Registries and Qualified Registries

The Anesthesia Quality Institute, an affiliate of the ASA, and its registry, the National Anesthesia

Clinical Outcomes Registry (AQI NACOR), have submitted MIPS data for thousands of anesthesia providers in each of the last five years. Our participants rely on AQI NACOR for their MIPS reporting and we strive to ensure that their participation is not burdensome, their data correctly captures their performance and that data can be used for both quality reporting and local quality improvement purposes. In 2020, AQI submitted data for over 12,000 anesthesiologists, nurse anesthetists, and certified anesthesiologist assistants and their groups. We know that AQI NACOR is a central component in moving anesthesiologists from MIPS to MVPs and into Alternative Payment Models.

CMS should work closely with third-party registries and medical specialty societies to transition current registry measures into digital quality measures. AQI NACOR serves a variety of anesthesia groups who rely not just on our registry but on dozens of vendors for the collection of and reporting of quality measure data to our registry. The groups are not homogenous and oftentimes there is a significant gap in the use of technology and digital resources between large groups reporting to our registry and small and medium-sized groups. As CMS prepares for the transition to digital measures, the agency should consult with registries to understand the resource needs among groups to update their systems and to collect data digitally.

The uniqueness of anesthesiology data capture at the point of care or facility is oftentimes quite different than other specialties. Many of our quality measures are derived from multiple sources. For example, data to report a measure may reside in the preoperative assessment form, the anesthesia record, the surgeon's report, and/or the post-anesthesia care unit notes. Data from multiple sources is a burden for practices to initially collect and burdensome to provide in support of audit requirements. This is especially true for practices who are collecting quality data on paper or practicing in numerous locations—a very common occurrence for anesthesia practices that is reflected in the types of anesthesia groups that report to AQI NACOR.

Regulatory Burdens for Registries and Registry Participants

CMS should revisit its auditing requirements for third-party intermediaries. In addition to the public health emergency, our registry and the groups reporting to the registry experienced significant burdens to reporting in 2020. We were disappointed that our concerns regarding the auditing regulations were not accepted by CMS, resulting in audits being immediately required for all submitter types. Because of the low number of participants reporting via the Qualified Registry as individuals, the randomized auditing resulted in an unintended consequence of increasing the burden on small and mid-sized group practices. CMS should view the burden of auditing not just on registries but on participants within registries.

AQI NACOR is acutely aware of the significant auditing burden that is placed on individual ECs and their groups. During the public health emergency, we have conducted dozens of audits and have encountered practices struggling to collect and report data while a majority of their time and effort has been spent on responding to the COVID-19 pandemic. Our members, especially those in small and mid-sized groups, have often been challenged by large hospital systems that may restrict their access to data files that would support their response to our auditing requests. We request that CMS reassess the goals of its auditing requirements—not to reduce the

importance of those audits. CMS should explore, for instance, ways for Quality Improvement Organizations to assist small and mid-sized groups in best practices to prepare for potential data audits.

CMS must get the auditing requirements right before announcing any proposals for auditing MVP participants. We are concerned that CMS may layer another auditing requirement on when MVPs are finalized. As currently written, CMS requires data validation audits on data for each submitter type, including individual groups, subgroups, voluntary, etc. For MVPs, especially once subgroups are established, this could increase regulatory complexity and result in added work and burden without making a significant difference in the quality of data submitted. We ask CMS to describe in more detail future requirements for third-party intermediaries to validate data submitted by MVP participants. Early knowledge of any additional auditing burden, especially with regard to subgroup reporting, will allow our registry to plan for future requirements.

CMS estimates of the auditing responsibilities underrepresented the time commitment of registry staff. In addition, the burden estimate does not fully capture the time a group or individual may spend to comply with registry and CMS auditing requirements. Based upon our 2020 experience, our staff time allocation for QCDR auditing was two-to-three times more burdensome than the estimates that CMS provided. A significant amount of time was spent on participant service calls to groups to understand their burdens related to auditing. As mentioned previously, CMS should empower groups to work with QIOs on best practices for auditing requirements and documentation needs.

Clinical Data Registries and MIPS Value Pathways

As mentioned in our MVP discussion, we are concerned about the burden placed on registries for educating MVP participants on the administrative claims measures they should report as well as their responsibility to identify which MVP they seek to report. We understand why CMS has proposed a specific timeframe for ECs and groups to identify the MVP they wish to report, however placing this responsibility on the group could lead to a burden for third-party intermediaries. As mentioned before, AQI NACOR has a robust communication strategy with ECs and their groups. Each month, AQI NACOR staff host an office hours session, send multiple notices for groups to check their MIPS participation, and issue regulatory guidance. We ask that CMS partner with registries on participant communications to ensure groups know when and how to identify the MVP they wish to report.

AQI NACOR sees additional burdens placed on the registry to identify and validate MVP subgroup reporting. As currently proposed, a majority of anesthesiologists may only need to report a single MVP. However, should CMS decide to expand MVPs to offer team-based or shared accountability MVPs as well as MVPs related to an anesthesiology subspecialty (such as pain medicine or critical care), AQI NACOR will need to develop systems to manage and validate the participants in a subgroup. Although most anesthesiologists do not belong to multispecialty groups, we nonetheless are concerned about the burden subgroups may place upon registries, including how we validate NPIs for an MVP.

ASA recommends that CMS allow Qualified Registries, QCDRs, and other third-party intermediaries to choose which MVPs they wish to support. We agree with CMS that third-party intermediaries should only report the MVPs that reflect their participant needs. However, we do not believe that CMS should arbitrarily assign MVPs to QCDRs, Qualified Registries, or other Third-Party Intermediaries. As previously mentioned, anesthesiologists practice in a number of settings, can be subspecialized, and may report, in some cases, cross-cutting measures. We do not want CMS to inadvertently limit the MVPs that an anesthesiologist may report via a QCDR. As MVPs mature and more are developed, CMS should assess whether the limit on the number of QCDR measures available (30 measures) should be revised.

QCDR and Qualified Registry Self-Nomination Process

ASA and AQI NACOR appreciate the updates that CMS has made to the QCDR and Qualified Registry self-nomination process, including the development of the measure submission portal. The portal has also made it easier for our QCDR partners and measure licensees to upload our agreements. The portal could benefit from additional quality assurance as we noticed that a small portion of the information from our previous submissions was not accurately carried over to the new platform. We also note that the portal does not allow an option for composite measures. Last, we recommend that the portal be reordered to align with the criteria CMS requires for measures (measure title, measure description, NQF status, etc.)

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

Sincerely,

Beverly K. Philip, MD, FACA, FASA
President

APPENDIX

Calculation of the CY 2022 PFS RBRVS and Anesthesia Conversion Factors (CFs)

- ASA has concerns about continued Medicare payment cuts in CY 2022 for anesthesiologists and other physician services. We recognize the limited authority CMS has to modify statutorily mandated budget neutrality adjustments when calculating updates to the conversion factors, however, we are alarmed at the potential cascading impacts on both physician practices and clinical patient outcomes. Resolution of this issue will require action by Congress and others outside of CMS. ASA urges CMS to coordinate with these entities on the updates to the fee schedule and processing claims.

Valuation of Specific Codes

- ASA urges CMS to accept the RUC recommendation of 6 base units for CPT codes 01XX6 and 01XX7.

- ASA urges CMS to accept the RUC recommendation of 12 base units for CPT code 00537.

- ASA urges CMS to accept the RUC recommendation of 3.42 work RVUs for codes 64633 and 64635.

Resource Costs for Services Involving the Use of Innovative Technologies, Including but not Limited to Software Algorithms and Artificial Intelligence

- ASA urges CMS to take a broad and flexible approach to setting policy on the pricing for innovative technology such as artificial intelligence (AI). These technologies are still very much in development and evolving in anesthesia care as well as other clinical areas. Because of the critical role AI will play in anesthesiology, ASA very much would like to work collaboratively with the agency in the development of policy around these issues.

Separate Coding and Payment for Chronic Pain Management

- ASA is a leader in the advancement of acute and chronic pain management best practices. ASA is very pleased that the agency is exploring how to more appropriately pay for chronic pain management services. Currently, the payment for these services is inadequate. ASA urges CMS to work collaboratively with ASA and other experts in the field to develop appropriate coding and payment for these services.

Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests (Section II.I.)

- ASA urges CMS to finalize its proposal to eliminate patient responsibility for co-insurance for screening colonoscopies that turn therapeutic. ASA reminds CMS that these policies must also be extended to the associated anesthesia services.

Telehealth and Other Services Involving Communications Technology

- ASA strongly supports the proposed coverage extension for Category 3 telehealth services through CY 2023. We remain concerned however, that statutory site-of-service restrictions and other restrictions will prevent Medicare beneficiaries from meaningfully accessing these needed telehealth services. We will continue to urge Congress to remove all telehealth originating site and geographic restrictions, and we urge CMS to interpret statutory language in a manner that provides Medicare beneficiaries with the broadest possible access to telehealth services.

- ASA supports the addition of services from Table 11 to the Medicare telehealth services list on a Category 3 basis. We urge CMS to finalize this proposal.

- ASA supports the proposal to permanently adopt the extended virtual check-in code, as it facilitates continued access to care for established patients and we urge CMS to finalize this proposal.

Critical Care Services—Split Billing

- ASA requests that CMS confirm that the critical care split billing proposal would maintain the current reporting policy which prohibits the surgeon that performs the procedure from reporting a critical care service but that a separate critical care provider can bill for critical care services.

- ASA supports the proposal to adopt CPT's listing of bundled services that are part of critical care visits and urges CMS to finalize it.

- CMS is proposing that the total critical care service time provided by a physician and nonphysician practitioner in the same group on a given calendar date to a patient would be summed, and the practitioner who furnishes the substantive portion of the cumulative critical care time would report the critical care service(s). This would be consistent with current policy. ASA supports this proposal and urges CMS to finalize it.

Quality Payment Program

- CMS must move prudently in assessing which measures should be prioritized for digitization while at the same time, understanding that not every provider will have an opportunity or the resources to use digital measures.

- Clinical data registries, like the Anesthesia Quality Institute National Anesthesia Clinical Outcomes Registry (AQI NACOR), must be a central feature during and after the transition to dQMs.

- CMS should work with individual specialties and registries to identify which measures should be prioritized for digitization.

- ASA supports the development of health equity measures that are broadly applicable to various specialties at the facility-level and also at the clinician level.
- We agree that a health equity measure should be included as a foundational layer of all MVPs so long as the measure moves through the established measure development and approval process.
- ASA supports the finalization of the Patient Safety and Support of Positive Experiences with Anesthesia MVP as proposed by CMS.
- ASA was hoping our MVP could be implemented in 2022, but we understand the reasons why CMS delayed its implementation until the 2023 Performance Year.
- ASA supports the CMS proposal to allow voluntary reporting of MVPs.
- We are concerned that CMS emphasis on "comparative performance data" is based far too often at the clinician level and not at the episode of care.
- CMS should identify the methodology that specialties can use to achieve APP or APM status.
- Because cost is a significant feature of APMs, CMS should strive to work with specialties on identifying applicable cost measures for the MVP.
- Allowing for multispecialty groups to report to the same MVP would open the door to the use of cross-cutting measures that can be directly linked to MVP relevant conditions and care coordination.
- CMS should develop methods for shared, team-based MVPs that span multiple physicians and other clinicians.
- CMS should finalize its MVP reporting requirements proposal. MVP participants will benefit from having to report just four quality measures and one high-weighted improvement activity.
- ASA recommends that CMS allow Qualified Registries, QCDRs, and other third-party intermediaries to choose which MVPs they wish to support.
- ASA opposes the increase to the data completeness threshold from 70% to 80% by 2023.
- CMS should rebuild the library of MIPS measures available for reporting by encouraging the submission of QCDR measures through the MUC process.

- Because the extreme and uncontrollable circumstances policy decreased the number of groups reporting to MIPS via our QCDR, we ask that measure testing requirements (not including face validity testing) be delayed until two years after the end of the public health emergency (PHE).

- ASA thanks CMS for proposing, and we strongly support, increasing the IA_CC_15 PSH Care Coordination Improvement Activity from a medium-weighted activity to a high weighted activity.

- CMS should approve an improvement activity for groups that assist measure stewards with measure development and testing efforts.

- Because CMS must place the minimum threshold at 75 points, we believe that it is important for CMS to maintain current regulations for scoring for at least one additional year.

- We support the introduction of the "New Measures: Class 4" policy where MIPS participants will receive at least five achievement points out of 10 for reporting new measures within the MIPS program.

- CMS should revisit its auditing requirements for third-party intermediaries.

- CMS should reverse its policy decision on the auditing requirements based on each submitter type.

- CMS should clarify that access to a live or continuous dashboard qualifies as providing feedback reports at least four times a year. CMS should also clarify that access to feedback reports four times a year is dependent upon the registry participant submitting timely data.