American Society of Anesthesiologists®

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January 14, 2021

RE: MIPS Value Pathway (MVP) Town Hall Comments
Submitted electronically via CMSMVPFeedback@ketchum.com

To Whom It May Concern,

On behalf of the more than 54,000 members of the American Society of Anesthesiologists (ASA), I thank CMS for this opportunity to provide comment following the MIPS Value Pathways Town Hall. We are optimistic that the prudent development of the MIPS Value Pathway (MVP) option for reporting MIPS will allow our members greater opportunities to meaningfully participate in the Quality Payment Program (QPP). Our responses correspond with the questions posed to attendees and, where relevant, we have added additional detail and comment.

ASA submitted comments to CMS in both the 2020 and 2021 QPP rulemaking period. We appreciate that CMS reviewed and, in many cases, implemented our policy objectives in its recent final rule. We thank CMS for providing clarity on the continuation of the non-patient facing status for those clinicians participating in an MVP. This clarification allows anesthesiologists to participate in MVPs without the risk of being scored on a performance category that does not apply to them.

Additionally, we thank you for encouraging collaboration across other specialties. Anesthesiologists participate in wide variety of surgical procedures and across multiple care settings. The ability for our members to be included within other MVPs is essential. With this in mind, we have already reached out to several specialties and expect that the MVP we submit to CMS later this year will reflect this multispecialty approach.

We also thank CMS for making participation in MVPs voluntary. For the program to succeed, it is imperative to allow for physicians to make informed decisions on their participation and be held harmless in the first few years of the MVP rollout. We agree with the use of APM measures as a part of an MVP and believe this further supports a vision of better alignment with APMs and bridging the gap between MIPS and APMs. We would support greater flexibility to allow appropriate anesthesiology measures to be used within APMs. Last, we have appreciated our discussions with you on anesthesiology-related MVPs and look forward to future discussions with CMS and other stakeholders.

We offer the following comments based upon the Town Hall discussion.

Subgroup reporting
We urge CMS to reconsider the subgroup reporting mechanism and develop a process that both encourages MVP reporting and reduces group reporting burden. We originally supported this option because of the benefit we saw for members working in mid-sized and larger groups. However, with additional CMS guidance via the 2021 final rule and discussion during the Town Hall, we believe that CMS policy will unfortunately increase burden on practices, especially since CMS has proposed that part

of a group would be able to report an MVP but that the rest of the group would still need to report traditional MIPS. We believe this would increase the burden on that group and discourage the use of MVPs. Furthermore, this may disincentivize Eligible Clinicians (ECs) and groups to participate in a pathway meaningful to them because their larger group may not have the resources to report both traditional MIPS and an MVP. Conversely, splitting TINs into different TINs may fracture a common purpose for groups to focus on improving care for a specific patient population. A practice that reports as a subgroup as well as through traditional MIPS will be burdened by cost and time resource allocation.

The finalization of subgroup reporting as written would not only increase the burden for practices, but it also increases the burden for third-party intermediaries to accept and report data to CMS. We are concerned that the subgroups policy as written, as well as the lack of knowledge about the process of reporting by groups wishing to report MVPs, will present challenges for third-party intermediaries to accurately verify TIN/NPIs reporting MVPs versus those in the group reporting traditional MIPS. The added technical requirements and verification needed to ensure accuracy will require additional staff and time to implement. We urge CMS to not finalize the subgroup reporting mechanism unless these issues of burden are addressed.

MVP Alignment with APMs

We appreciate CMS clarity on, and encouragement for, developers to include APM measures within MVPs. Although anesthesiologists rarely report measures found in an APM, this policy will encourage our members to better understand how their role contributes to measured outcomes and patient-centered measures. MVPs present an opportunity for specialists to use their measures that reflect their quality of care and at the same time contribute to the features and outcomes measures by an APM. We continue to have concerns with the lack of specialty-specific measures within APMs. Regardless, we support the first group of MVPs be prioritized to align with APMs or episode-specific cost measures.

MVP Participation

CMS should not discontinue the availability of the traditional MIPS program for ECs and groups. The majority of our members, especially those in small and mid-sized groups, have sufficient resources to report traditional MIPS but not MVPs (as currently described). CMS should always allow options that meet the statutory requirements without penalizing those groups with limited resources. Discontinuing the traditional MIPS pathway without evidence of groups or individuals transitioning to MVPs or APMs will be detrimental to many anesthesiology groups.

Clinician Choice of MVPs

We agree with CMS policy to allow voluntary MVP reporting and believe the policy will promote MVP uptake in future years. We also support and encourage CMS to consider incentives such as awarding additional MIPS points and/or preferential scoring to encourage MVP use by practices. However, CMS should test and publish different scoring methods to ensure a sense of fairness and accuracy in how ECs and groups are assessed. The awarding of additional points to individuals and groups should only be applied when ECs and groups have sufficient opportunities to report an MVP that reflects their practice and patient populations.

MVP Reporting Requirements

MVP reporting requirements should not be more burdensome than current regulatory requirements. We appreciated the Town Hall example on the number of quality measures and improvement activities that could be proposed for each MVP. We likewise appreciated CMS clarity that non-patient facing physicians will have their special status applied to the promoting interoperability performance category within an MVP. This policy clarification has assuaged our fears that anesthesiologists and other non-patient facing physicians would be excluded from MVPs.

We recognize that CMS has concerns about whether the MVP will include a sufficient number of quality measures and improvement activities for individuals and groups to report. However, we have confidence that the vetting and rulemaking process will ensure that CMS has enough information to propose MVPs that meet participant needs. MVPs may need to be enhanced or improved over time, but the process should protect against approving incomplete or unnecessary MVPs.

Measure Objectives

CMS should promote equity across all MVPs and set a standard or minimum number of quality measures for ECs and groups to report when participating in an MVP. We also support ECs and groups being allowed to report more measures than necessary without penalty. As MVPs mature, CMS should monitor and receive feedback from specialties on their ability to report and/or be assessed by public health measures, population health measures, and other foundational elements of the MVP. We believe that CMS should find other solutions for participants to receive credit for the foundational layer (via administrative claims, exemptions, etc.) when data is not available or easily collected by individuals or the group.

In recent years, CMS has limited the approval of new MIPS measures and constrained the pipeline of new measures for inclusion in the MIPS program. For the MVP policy to be successful, the MVP process should incorporate new and innovative measures. We urge CMS to reverse its policy of reducing measures within the MIPS program and focus instead on encouraging and approving measures that fill gaps within MVPs and measures that lead to a greater understanding of patient outcomes. The current policy of reducing measures has and will continue to undermine the MVP process. Reducing measures in the program and discouraging the submission of measures for MIPS inclusion has increased barriers for individuals and groups to demonstrate their value to payers, patients, and APM entities.

We appreciate CMS finalizing and supporting the use of Qualified Clinical Data Registry (QCDR) measures within the MVP program. Because the period for MVP nomination and maintenance does not align with the QCDR Self-Nomination period, it is imperative for CMS to approve QCDR measures for a minimum of two years. The barriers for ECs and groups to report MVPs will be greatly reduced by CMS establishing a two-year approval process for QCDR measures. Continuity on available quality measures from year to year reduces reporting burden on individuals and groups.

MVP Scoring

We support and encourage CMS considering incentives such as awarding additional MIPS points and/or preferential scoring to encourage MVP use by practices. However, CMS should test and publish different

scoring methods to ensure a sense of fairness and accuracy in how ECs and groups are assessed. We understand CMS's concern with assigning too many bonus points as it may mask poor performers, however, ECs and groups must be encouraged to test their performance in MVPs. Few will participate in MVPs if there is no clear advantage or incentive to transition from traditional MIPS to MVPs. The awarding of additional points to individuals and groups should only be applied when ECs and groups have sufficient opportunities to report an MVP that reflects their practice and patient populations.

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Thank you for the opportunity to provide comments following the MIPS Value Pathways Town Hall and we look forward to continued work and collaboration in developing meaningful MVPs. Please contact Matthew T. Popovich, ASA Director of Quality and Regulatory Affairs (m.popovich@asahq.org), or Claire Ostarello, ASA Quality Associate (c.ostarello@asahq.org), for further discussion.

Sincerely,

Beverly Philip, MD, FACA, FASA
President
American Society of Anesthesiologists