



October 31, 2022

The Honorable Ami Bera, MD
U.S. House of Representatives
172 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, M.D.
United States House of Representatives
1123 Longworth House Office Building
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The Honorable Michael C. Burgess, M.D.
United States House of Representatives
2161 Rayburn House Office Building
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The Honorable Earl Blumenauer
United States House of Representatives
1111 Longworth House Office Building
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The Honorable Brad R. Wenstrup, D.P.M.
United States House of Representatives
2419 Rayburn House Office Building
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The Honorable Bradley Schneider
United States House of Representatives
300 Cannon House Office Building
Washington, DC 20515

The Honorable Mariannette Miller-Meeks
United States House of Representatives
1716 Longworth House Office Building
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Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

The American Society of Anesthesiologists[®] (ASA) is pleased to provide comments on the Medicare Access and CHIP Reauthorization Act (MACRA) to members of the House of Representatives on behalf of our over 55,000 members. We welcome the opportunity to work with Congress to ensure that anesthesiologists and other clinicians can be successful in Medicare quality programs as well as be paid fairly for the care they provide to their patients. We encourage Congress to consider legislation aimed at supporting those anesthesiologists and physician groups who are making good-faith efforts to participate in MACRA, improve patient care, and reduce costs.

In the years since MACRA became law in 2015, the Centers for Medicare & Medicaid Services (CMS) has taken steps to develop value-based payments that reward high-performing quality of care, but the goals of the Quality Payment Program (QPP) will remain unfulfilled until the underlying issue of establishing appropriate incentives that compare favorably to the burden and the cost of performance is addressed. Adequate incentives for the Merit-based Incentive Payment System (MIPS), MIPS Value Pathways (MVPs), and Advanced Alternative Payment Models (APMs) are needed and were anticipated when MACRA was passed. Yet, as currently structured, the budget neutrality features of MIPS and

MVPs make it extremely hard or nearly impossible for performers exceeding the performance threshold to receive any sort of meaningful incentive payment, or even break even, due to the costs and burdens of the programs.

For MACRA to be successful, Congress must also act on fixing a broken Medicare physician payment system. Beyond the merits of value-based care and the intricacies of current quality reporting structures, an inherent flaw lies with CMS's insufficient payment for physician services. Because the QPP builds off the underlying Medicare fee-for-service payment, additional MIPS and MVP incentives will only drive change and improvements in care if the combination of the underlying payment and the quality reporting programs offer sufficient incentives. For anesthesiologists, the Medicare physician payment system is especially burdensome, as current Medicare payment rates for our specialty are less than one-third of commercial rates. Any incentive that the QPP provides, whether through MIPS, MVPs, or APMs, will be modest or completely negated so long as these low Medicare payment rates exist for anesthesiologists.

Annual statutory payment reductions outside of the QPP further exacerbate this disparity in payment between Medicare and commercial rates. Medicare physician payment is based on the application of a dollar-based conversion factor (CF) to work, practice expense (PE), and malpractice relative value units (RVUs), which are then geographically adjusted. The CMS-proposed 2023 Anesthesia CF was \$20.7191, compared with the 2022 Anesthesia CF of \$21.5623. This \$0.84 reduction represents a -3.91% payment adjustment. The 2023 proposed resource-based relative value scale (RBRVS) CF is \$33.0775 and represents a decrease of \$1.53 or -4.42% from the 2022 RBRVS CF of \$34.6062. CMS believes the resulting specialty level impact on Anesthesia, Interventional Pain Management, and Nurse Anesthetists will be -1% in 2023 with greater negative impacts on non-facility practices than facility practices.

The magnitude of the proposed cuts to the Anesthesia and RBRVS CFs is significant and will potentially have a devastating impact on anesthesiologists' practices while the country continues to struggle with the COVID-19 pandemic, evolving variants, rising inflation, health care worker burnout, staffing shortages, and regulatory requirements that increase administrative burden on practices. Absent Congressional action, physicians are facing a combined 10% payment cut in calendar year (CY) 2023 when you consider the negative update to the Anesthesia and RBRVS CFs (3.91% and 4.42% respectively), Medicare Sequestration (2%), and PAYGO Sequestration (4%). In addition, physician payment is not increasing in concordance with inflationary pressures. This uncertain financial environment ultimately impacts the ability of our physicians to focus on improving their quality of care and expending additional resources to participate in the QPP. We therefore urge Congress to recognize how these Medicare cuts jeopardize the ultimate success of MACRA.

Lastly, the COVID-19 pandemic distorted the timeline and several of the goals for MACRA that Congress initially envisioned back in 2015. Congress and CMS should now take the opportunity to revisit long-term objectives for the QPP. The pandemic disruption effectively eliminated the expected payment incentives that physicians were seeking to earn and reduced opportunities for physicians to move into APMs. Effective participation in the QPP, both before and during the pandemic, has resulted in real and significant costs for anesthesiologists, their groups, and third-party intermediaries like the Anesthesia Quality Institute National Anesthesia Clinical Outcomes Registry (AQI NACOR). Congress should take

this opportunity to rethink how the program is structured in a post-pandemic environment and identify program objectives that reflect our new healthcare realities and priorities.

To increase physician participation in value-based models and to stabilize the QPP, we recommend the following:

Address Current Payment Cuts

- Patch the proposed 2023 cut to the Anesthesia Conversion Factor.
- Provide inflationary support to physician practices.
- Waive the 4% PAYGO sequester.

Stabilize MIPS Participation and Encourage Pathways to APMs

- Continue the exceptional performance bonus for MIPS beyond the 2022 performance year.
- Reward MIPS participants who exceed the performance threshold but fall short of the exceptional performance bonus.
- Incentivize pathways to APMs by allowing groups participating in delivery-of-care models, like the ASA Perioperative Surgical Home (as a designated Improvement Activity), to receive 50% of their MIPS bonus points based upon their successful participation in those models.
- Provide grant funding or financial assistance to develop cross-specialty measures that are developed, stewarded, tested, and maintained by CMS and/or its contractors.
- Fund measure testing processes that encourage collaboration between specialty societies, CMS, and its contractors.
- Ensure Qualified Clinical Data Registry (QCDR) measures are approved for at least three performance years to promote stability.
- Fund MVP development and testing that targets multispecialty episodes of care.
- Incentivize MVP participation with financial rewards or bonus points.
- Fund grant opportunities or direct financial assistance to medical specialty society registries affected by the COVID-19 pandemic.
- Allocate funds for CMS to either conduct audits or contract with third parties to implement audits more effectively.
- Commission a study on whether negative payment adjustments improve performance, quality of care, or costs.

Make Participation in APMs More Equitable

- Continue the 5% bonus for APM participation past the 2022 performance year.
- Fund a study on how groups can transition from MIPS to APMs.
- Ensure APM incentives are equitably divided among members of the patient's care team.
- Direct CMS to work with medical specialty societies to expand the use of current APMs and develop APMs that reflect surgical episodes of care.
- Consider allotting a percentage of APM savings to all contributing clinicians or provide some upfront and direct payments to those clinicians.

- Ensure APMs, including Accountable Care Organizations (ACOs), employ specialists either through structural requirements or a score multiplier.
- Delay any implementation of mandatory APM models until value-based payment systems are proven to be viable and sustainable, or allow mandatory models to include an opt-out for physicians and their groups.

Below, we provide comments on the specified areas of feedback included in the Request for Information:

1. **The Effectiveness of MACRA**

Areas of success where MACRA could continue to drive quality improvements

ASA recognizes that the QPP, in its first five years, has demonstrated several proven benefits for physicians and patients. One early success is that QPP programs have increased participants' reporting and tracking of quality data. At the practice level, this influx of data allows physicians to more effectively identify areas for quality improvement and patient-centered care and subsequently develop better workflows and processes. Prior to the beginning of the COVID-19 pandemic, the growth in data reporting also increased participation in clinical data registries operated by medical specialty societies. These registries have established processes and dashboards to help groups identify gaps in patient care and implement quality improvement projects. Groups that report to registries have tracked their progress throughout a performance year, allowing for more immediate quality improvement processes to occur. The speed of these processes was also supported by the initial MIPS policy that allowed QCDR measures to be implemented and reported on, even in their first year of performance.

QPP initiatives, like MVPs, have encouraged groups to link their quality measures and improvement activity to their facility's goals, bringing a more cohesive approach to quality improvement within hospitals and other facilities. Many hospital-based anesthesiologists have also found facility-based scoring and the prospect of episode-based MVPs to be effective in capturing an anesthesiologist's contributions to patient care. ASA appreciates the inclusion of the "Patient Safety and Support of Positive Experiences with Anesthesia MVP" within the 2023 MIPS performance year program, and we believe it will reduce the reporting burden for anesthesia groups as they seek to join value-based payment models. We believe that CMS can further advance the access and efficacy of this program by more clearly defining a policy around multispecialty episodes of care and attribution of physician services. Such an initiative could incorporate anesthesia care within existing surgical MVPs and encourage specialties to develop multispecialty surgical episode MVPs.

Incentivizing participation and the movement to value

Despite the benefits presented by the QPP, there are significant challenges that continue to limit the program's effectiveness. **Most pressing, many physicians are beginning to question whether participation in the QPP will lead them away from the fee-for-service model and towards value-based care.** CMS has failed to widely articulate a clear narrative of how a group can move from MIPS to MVPs and onto APMs or other value-based payment systems, and MACRA has not offered a compelling

financial incentive to do so. While CMS has shared some aspects of this transition, it could be more proactive and transparent with the agency's vision for the QPP. For example, over several years, CMS laid a foundation for the rollout of MVPs and communicated how the agency plans to sunset the traditional MIPS program. We recommend that CMS provide a more concrete vision with details on how the transition for eligible clinicians to MVPs and APMs will be handled. To earn physician buy-in (particularly among those not currently participating in the QPP), CMS should circulate proven pathways groups have taken to provide better quality of care, reduce costs, and increase physician payment.

Importantly, many physicians and groups participating in MIPS are frustrated that the initial projection of positive payment adjustments for the highest-performing participants has not been realized. Since positive payment adjustments are capped by a scaling factor of 3x the negative adjustments, the incentives have unfortunately been quite low. The highest existing positive adjustments have fallen short of 2%. This is exceptionally disappointing for groups, as these positive adjustments often fail to cover the costs of implementing and maintaining MIPS reporting locally. In short, there simply isn't a financial return on investment for groups to participate in MIPS and oftentimes successful participation in the program can still result in overall negative costs. This is causing groups, including many small groups and private practices, to become less engaged or leave the MIPS program altogether.

At the same time, there is no public evidence that negative payment adjustments have improved care or group performance. In theory, MIPS creates a system of "winners and losers" in which negative payment adjustments for poorly performing groups fund the positive adjustments for the high-performing groups. This flawed approach pits physician groups against one another rather than fostering collaboration among physicians, nurses, and other health care professionals. The system requires "poor performance" for the QPP to operate. In practice, CMS has mitigated downside risk and limited the number of poor performers by using COVID-19 exceptions in recent years to accomplish this task. Only 1.88% of MIPS participants received a negative adjustment in 2020 and less than 0.31% received a negative adjustment in 2019. This strategy from CMS predates the COVID-19 Public Health Emergency (PHE), but since 2020 the agency's Extreme and Uncontrollable Circumstances exemption (EUC) has removed many groups from the program altogether, including those that would have scored poorly.

With the majority of participant scores clustered near the mean or median performance threshold and few funds saved from negative adjustments, the ability to award positive payment adjustments is severely limited. The anesthesia groups most hurt by these policies are those that exceeded the performance threshold but received a payment bonus significantly less than the cost of participating in the program. **In 2020, those scoring between 45.01 and 84.99 points (exceeding the performance threshold of 45 points but not earning the exceptional performance bonus) received a maximum payment bonus of just 0.01%.** Such an outcome was not only demoralizing for the groups but failed to justify the costs for the group to participate in the program. In that one year, thousands of groups spent time and money on administrative costs to implement the program, technological costs to engage vendors, and clinical costs where physicians were spending time optimizing their participation in MIPS when they could have been spending time delivering patient care. The most equitable and quality-centered solution is not to fully enable the "winners and losers" model with +9/-9% payment adjustments as initially envisioned. Rather, Congress should fully fund MIPS and other QPP programs to financially incentivize those required to

participate who strive to deliver a high quality of care. Funding a minimum positive payment adjustment within MIPS charts a more secure path to greater MIPS participation.

Unfortunately, the MIPS structure encourages competition between specialties rather than collaboration. Beyond the issues of financial incentives, the QPP has not been as effective for hospital-based specialties like anesthesiology as it has been for primary care physicians. Primary care physicians often have more APMs and quality measures to choose from and are attributed to more cost measures than other specialists. This allows for some physicians to diversify their scores and further hone their measure choices to meet the needs of their patient populations. Anesthesiology, as an episode-driven specialty, requires process and intermediate outcome measures to perform well. Cost measures are difficult to attribute solely to anesthesiologists since our members work in a team-based environment and have limited access to outcomes data. Competition to do well in MIPS has a chilling effect on sharing measures; developing quality measures or improvement activities that span multiple specialties; or even in creating multispecialty MVPs.

Effect on measure development and retention

MIPS has been successful in driving improved performance among specialty-specific measures, meeting the goal of supporting better quality of care. However, we are concerned about CMS's intention to retire measures based primarily on a measure's "topped out" status. When a measure's performance reaches a sufficiently high threshold where it can no longer appear to differentiate the care between physicians, the measure is considered "topped out" by CMS, with its available points reduced, and the measure is eventually removed from the program. There is a persistent fear among anesthesiologists that excellent performance on a measure will therefore result in lower performance scores and fewer measures to use in the future. Such a policy contradicts an original feature of MACRA that encouraged patient safety, high quality care, and transparency. Topped out measures demonstrate and ensure continued high performance.

Instead of removing measures, CMS should acknowledge that measure stewards and developers are nearing the end of a measure development cycle based upon clinical practice guidelines and literature. In some ways, this is a success of the MACRA legislation – it jumpstarted a dormant measure development process and encouraged specialties to explore and develop new measures. Since 2017, a significant number of measure gaps have been filled or assessed for feasibility by many specialties. Because of this, the program would benefit from an increased emphasis on using measures that clearly demonstrate aspects of patient safety, infection control, and patient outcomes instead of focusing on whether measures with high performance rates should be discontinued based upon a statistical algorithm.

Impact on registries

The EUC exemption has been valuable for groups experiencing workflow and workforce challenges brought upon by the uncertainty of the COVID-19 pandemic. But this exemption has come with negative financial effects on clinical data registries like AQI NACOR. With significantly fewer groups reporting MIPS, registries have lost a large fraction of their participants who, when not required to collect and report

quality data, opt not to. This has resulted in increased financial strain on our registry and resulted in a lack of data needed to provide definitive analysis of performance, benchmarking, and measure testing. **To ensure that registries can continue serving their specialties and assisting groups to report on quality measures, Congress and CMS should encourage registry participation outside of payment programs and find ways to support the financial standing of these registries.**

Participation in APMs

The lack of participation in APMs from specialties like anesthesiology demonstrates that one of MACRA's goals has not been fully realized. Although some anesthesiologists have participated in APMs, the vast majority of anesthesiologists find themselves left out of APMs, including those APMs designed to include surgical episodes. For those sufficiently fortunate to join APMs, anesthesiologists have limited opportunities to demonstrate their care since there are no anesthesia-specific quality measures available to report. At the same time, anesthesiologists often miss out on payment bonuses because the savings disbursements are often controlled by hospitals with little regard for how the disbursements should be equitably distributed.

We recognize the challenges that CMS has faced with approving APMs, especially since it is unclear if APMs have decreased overall costs of care. CMS should, in addition to continuing its work on APMs, embrace service delivery care models that align physician and hospital goals like the ASA's Perioperative Surgical Home (PSH). Delivery-of-care models are designed to help facilitate clinical actions, standardization of care, care coordination activities, and other patient-focused features that contribute to a group achieving the goals of an APM. Facilities that have implemented PSH programs have improved the cost curve (saving millions) through the standardization of processes and management of patients. For example, if the average facility saved \$3 million by implementing such delivery-of-care models, then with 5,000 facilities, the US could save \$15 billion in healthcare dollars. Such initiatives would align stakeholders and create a virtual gain-sharing pool without the need to differentiate so-called winners and losers.

2. Regulatory, Statutory, and Implementation Barriers that Need to be Addressed for MACRA to Fulfill its Purpose of Increasing Value in the U.S. Health Care System

Lack of appropriate incentives and a clear pathway to advance through the QPP

The cost to participate in either MIPS or APMs currently outweighs any potential positive payment adjustment, even for the highest performing groups. Costs to participate include the installation and maintenance of IT infrastructure to report necessary measures, staff time and resources needed to manage the data reporting process, and clinician education on quality measures and improvement activities. These costs were not fully considered in the development of the QPP. As the positive payment adjustments have not reached 2% for even the highest performers, groups cannot even break even on their investment, making it unlikely that groups not already participating in the QPP will choose to join in future reporting years.

As mentioned above, the path to move from MIPS to more advanced stages of the QPP is unclear. Congress should revisit whether the improvement activities performance category can be reweighted to encourage participation in delivery-of-care models. As currently structured, CMS lacks the ability to increase the amount of MIPS points available in the improvement activities performance category. Congress has set that category to constitute just 15% of the total MIPS score, regardless of the type of improvement activity that a group chooses to perform. **For groups that attest to and demonstrate performance in a delivery-of-care improvement activity, like IA_CC_15: PSH Care Coordination, we believe Congress should allow CMS to reweight the improvement activity category up to 50% of the group's total MIPS score.** By encouraging pathways to APMs through improvement activities credit, Congress and CMS can more readily convince groups to take a lower-risk action on the pathway toward joining an APM.

Recognize and support the value of registries

Many of the barriers to entry surrounding the processing and submission of quality measures are successfully addressed with the involvement of medical specialty society clinical data registries. Specialists look first to their medical specialty societies to develop measures and facilitate their participation in the QPP. ASA is the leader in developing anesthesia quality measures and our AQI NACOR has been recognized as a Qualified Registry and QCDR for nearly a decade. Measure development often takes more than 18 months to complete and costs hundreds of thousands of dollars over the course of several years. With increased administrative burden to meet an extremely high standard for measure testing, new QCDR measures are not easily included for MIPS reporting. At the same time, having to submit and defend the use of a QCDR measure annually promotes instability in the program and discourages MIPS participants from reporting on those measures. **We ask that Congress authorize CMS to approve QCDR measures for a minimum of three performance years, creating more stability for physicians and measure developers.**

As the EUC exemption indefinitely drives down quality reporting participation for MIPS, the ability of our registry to benchmark and test measures becomes more difficult. Moreover, reductions in QPP participation have resulted in registries losing their once-stable primary revenue stream. Although CMS can reverse some of these trends by scrutinizing its EUC exemption policies, we also support Congress and CMS encouraging registry participation outside of participation in the QPP. Moreover, CMS has applied burdensome regulations that have increased our costs to test measures, audit groups, and operate a registry. To maintain a specialty society registry's support of QPP participants, Congress and CMS should consider ways to ensure these registries are not overly burdened by regulation and provide assistance to facilitate continued participation by a registry's members and QPP participants.

Address regulatory timelines and the current audit process

Third-party intermediaries, like AQI NACOR, and groups participating in the QPP are burdened by reporting timelines that may not be realistic or easily implemented. ASA's member physicians often cite not having enough time at the beginning of the reporting year to manage workflow changes related to implementing MIPS updates alongside their responsibilities to submit data from the previous reporting

year. The time that physicians and other clinicians must spend on these tasks is time that could be spent directly providing care to patients. Exacerbating this workflow crunch, MIPS participants are currently expected to be ready to implement rule changes in January, less than two months after those changes are published in the final rule. Measure specifications are provided to groups even later, often published by CMS in late December for immediate implementation in January. The time and resources needed to meet these tight deadlines drive up the cost of implementation.

Likewise, registries must complete significant tasks from each of the two reporting years, with differing requirements, within a small window of time. CMS requires that registries make all measures reportable for their participants on January 1 of the reporting year. This requires the registry to work with its vendors and data warehouse to update their measure specifications within just a few weeks. In addition, CMS requires that data from the previous year, including audits, be completed by March 31. With more than 12,000 anesthesia professionals reporting to AQI NACOR each year, the turnaround time for new measure implementation, audits, and validation processes is a significant cost and regulatory burden.

We see a possible solution for sharing the auditing burden of registries. Congress and CMS have underestimated the time and resources necessary for a registry to perform CMS-standardized audits. Anesthesiologists, like other hospital-based groups, have difficulty collecting original source materials from a patient's medical record to demonstrate compliance with a measure. In some cases, hospitals are reluctant to share data or patient information with a group as part of an audit. This may result in an error in the auditing process. Since CMS does not allow for any errors or delays, it has become a burden for registries to collect and submit the data required for auditing on time. **Congress should encourage CMS to take on additional auditing responsibilities for those participants reporting to a third-party intermediary. We also encourage CMS to provide guidance on auditing requirements rather than continuing to use the restrictive one-size-fits-all auditing process.**

Lastly, but perhaps most importantly, developing a substantial financial value proposition is crucial to achieving physician buy-in for the QPP. By necessity, anesthesiologists and other physicians are especially attuned to how CMS policy changes will affect the financial standing of their practices, especially the impact of yearly Medicare payment cuts. Congress can ease the significant financial pressure physicians face by allotting funds to prevent future Medicare payment cuts. **Within the context of less financial pressure, it would be easier for CMS to convince physician practices to explore value-based care models.** We also recommend that Congress provide grant opportunities for specialty society registries to maintain and expand their QPP reporting offerings.

3. How to Increase Provider Participation in Value-based Payment Models

Moving eligible clinicians and their groups from MIPS into value-based payment models will require Congress to encourage physicians to take on additional risk and explore their participation in those models. As currently funded, low Medicare payment rates ensure that anesthesiologists take a more conservative approach to QPP participation. With adequate funding for MIPS, additional incentives for those reporting an MVP, and robust development of episode-based APMs, Congress will see an increased movement away from fee-for-service payments.

As previously stated, for MACRA to be successful, Congress must act on fixing a broken Medicare physician payment system. To move physicians and their groups toward value-based payment models, physicians should not be focused on impending Medicare payment cuts, but rather on providing optimal care to patients. **Congress should patch the proposed 2023 cut to the anesthesia conversion factor, waive the 2023 4% PAYGO Sequester as well as any future PAYGO sequesters, and provide inflationary support for practices regardless of their participation in the QPP.** Strategic and meaningful financial support for groups participating in the QPP will incentivize the adoption of value-based payment models.

At the same time, Congress must understand and address the effects that the COVID-19 pandemic has had on QPP participation. ASA supports the continued availability of the EUC exemption for the duration of the COVID-19 PHE, but we recognize that this exemption has been reducing physician participation. Congress must consider how to incentivize groups to return to reporting measures and fully participating in the QPP. **Congress should fund greater financial incentives for QPP participants, including those who exceed the performance threshold but fail to earn an exceptional bonus, which would encourage groups to continue participating or rejoin the QPP.**

Congress should immediately stabilize MIPS and APM participation by extending existing financial incentives. Most anesthesiologists participate in the MIPS program, but only those groups that have performed exceptionally well have seen even modest positive payment adjustments. Congress should encourage those groups to continue performing well by rewarding them with adequate financial incentives. At the same time, Congress must incentivize the continued participation of groups in APMs. ASA is concerned that ending the 5% APM bonus will incentivize groups to backslide into the MIPS program. Considering the health care system is just emerging from the COVID-19 pandemic, now is not the time to reduce payments to front-line physicians and their groups. As the financial value proposition for QPP participation has shown mixed results, Congress should not risk further eroding program enthusiasm among physicians and groups.

Our letter has also touched on the lack of clarity regarding how CMS envisions a group transitioning from MIPS to APMs. **We support Congressional funding of studies aimed at providing a pathway for groups to move from MIPS to APMs (with or without the adoption of MVPs) and how CMS can adjust its policies to best facilitate these transitions.** With research-backed recommendations, it would be easier for physicians and groups to understand their risks, chart a plan for joining a value-based payment system, and understand the financial benefits such a move would generate.

To increase anesthesiologist participation within value-based payment models, **Congress should emphasize episode-based models and encourage CMS to holistically rethink how anesthesiology and other specialties fit within those models.** Because anesthesia care is episode-based and requires collaboration with other specialties, distinguishing anesthesia's role in patient care from that of the other specialties is not always straightforward. If CMS can ensure that anesthesiologists are properly attributed across value-based payment systems, this would be a strong selling point for our members and specialty.

To that end, CMS could encourage participation in value-based models through MVPs. We are proud that our members will be able to report the anesthesia-specific MVP in 2023. However, we believe anesthesiologists should not be siloed within the MVP framework. **CMS should take a prudent next step and develop multispecialty MVPs to ensure that the full perioperative team has a common interest to perform well as a group.** Developing MVPs specifically designed to capture the individual members of a multispecialty case would help clear up existing ambiguities in attribution and strengthen the relationship between specialties in delivering patient-centered care. Working through these attribution issues in MVPs may also help CMS identify additional delivery-of-care models and future APMs.

Participation in an APM or other value-based payment model requires data transparency between the hospital and individual physicians providing patient care. **Congress could advance interoperability and data transparency by creating financial incentives for purchasing technology that facilitates information sharing across specialties and facilities.** Deploying these solutions allows all stakeholders access to actionable data that will improve quality and support improvement activities. Financial incentives for the installation of interoperability software would help remove a financial barrier that physicians and groups, especially small practices, have when seeking to join an APM.

Congress should encourage multispecialty participation in APMs through quality reporting requirements and financial incentives. For physicians within the APM, CMS should emphasize the use of specialty-specific measures that reflect the care each specialist provides. We also recommend adjusting the alignment of incentives to more accurately represent the totality of a patient's care journey. For anesthesiologists, APM incentives could highlight the perioperative role anesthesiologists play in delivering patient-centered care. Anesthesiologists practice perioperative medicine and their many roles, including prehabilitating patients and coordinating care, serve as a significant cost-saver for facilities and payers. Unfortunately, such activities are not recognized in APM payments. A better accounting of multispecialty cases and perioperative care will enable greater incentives for anesthesiologists both to provide cost-saving care and to join APMs.

ASA recommends that Congress and CMS consider allotting a percentage of the APM savings to all contributing clinicians or provide some upfront direct payment to those clinicians (this latter approach is used by some ACOs). The Medicare Shared Savings Program has unfortunately resulted in some primary care physicians excluding specialists from ACOs. To address attrition, Congress could incentivize ACOs to include specialists through statutory requirements or through a score multiplier within the QPP.

ASA believes these proposed actions will increase physician participation in CMS's value-based payment models. However, even if CMS encourages physician participation in APMs on a widespread basis, value-based payment models may not be the optimal system for every physician or group. Particularly for small groups and private practice groups, the fee-for-service model could be more financially feasible without sacrificing quality of care. For this reason, we caution against the adoption of mandatory models. **We believe that any mandatory model must demonstrate financial stability and practicality for widespread adoption before becoming mandatory.** If higher participation is needed to produce the data that would prove the models' viability, then this participation should be incentivized on a voluntary

basis. If CMS reaches the point at which the models are proven viable and the agency wishes to make them mandatory, it would be appropriate to offer an opt-out for those groups that benefit the most from maintaining their existing payment models without sacrificing patient care or safety.

4. **Recommendations to Improve MIPS and APM Programs**

The COVID-19 pandemic distorted the timeline for MACRA that Congress initially envisioned. Congress and CMS should now take the opportunity to revisit long-term plans for the program, particularly as they pertain to the QPP. We offer the following recommendations both to stabilize the current program and to envision a program that rewards high quality care instead of a program that emphasizes unnecessary competition between health care professionals.

Congress should provide sufficient funding for positive payment adjustments for those exceeding the performance threshold. We recommend that Congress approve the funds necessary to award the positive adjustments CMS initially projected without requiring a larger volume of negative adjustments as a counterbalance. This proposed increase in funds would create a substantial financial incentive for groups to participate in MIPS while keeping with CMS's current practice of maintaining a low number of groups receiving negative adjustments. ASA believes that if MIPS participants are meeting CMS's QPP expectations, as indicated by the minimal negative adjustments, then these groups should be rewarded for satisfying those objectives. For those practices, the cost of participation far exceeds the financial benefits of performing well in the program. Without such action, Congress may risk a significant contingent of MIPS participants leaving the program. Ensuring that these groups are properly compensated for satisfactory performance will strengthen the stability and sustained participation of MIPS.

We believe that the negative adjustments have not validated the original intent of the legislation.

Congress should commission studies to determine if negative payment adjustments result in higher scores in future performance years. The studies should determine if a -9% adjustment has negatively affected group finances and whether or not those negative adjustments actually led to administrative and clinical changes that resulted in a better quality of care. Additionally, keeping negative adjustments to a minimum number of groups will prevent additional groups from questioning whether their voluntary reporting to MIPS is worthwhile.

ASA also supports financial incentives (or bonus points that may result in more positive adjustments) for groups participating in MVPs. There are currently few, if any, incentives for groups to move from MIPS to MVPs. CMS has often commented that MVPs should be similarly scored as traditional MIPS. As CMS has indicated its intention to phase out traditional MIPS and transition eligible clinicians and their groups to MVPs by the end of the decade, it would be appropriate for CMS to reward the early MVP adopters. These groups will help provide test cases and valuable data for further development of the MVP initiative. Congress should allow CMS to modify MVP scoring to encourage the use of MVPs as well.

Congress should fund cross-specialty quality measure development and MVPs. Funding this initiative would help assuage the unnecessary competition between specialties encouraged by the current

structure of the QPP. CMS can help facilitate this by providing grant funding, financial assistance, or expertise to measure stewards working on cross-specialty measures. Such a process would bring relevant specialty societies and stakeholders together with experts and agencies that have the data and tools necessary to appropriately develop, steward, test, and maintain future measures. Such funding could further advance CMS's goals by aligning measures for hospital-based specialties around larger hospital, facility, or patient population goals.

ASA requests that Congress intervene to limit the onerous regulatory burdens associated with "full measure" testing. ASA tests our measures based upon available data that we have access to as well as on-the-ground analysis of the measure's validity. Recent requirements on validity testing have increased measure steward costs and reduced our ability to develop and implement new measures. **Measure development and testing could be expedited if CMS is empowered to fund measure testing processes among both measure stewards and CMS contractors.**

As mentioned throughout this letter, CMS's response to the COVID-19 pandemic has undermined many specialty society registries. These registries have experienced a significant decline in enrollment based upon the implementation and extension of the EUC exemption. As we move out of the pandemic, Congress must ensure that health care professionals have sufficient options to report data. **Congress should fund grant opportunities or provide direct financial assistance to medical specialty society registries affected by the COVID-19 pandemic and its residual effect on participation rates.** Health care professionals need to be encouraged to report their data to a registry that meets their professional needs. By supporting clinical data registries, Congress will be supporting long-term investments in health outcomes, patient safety, and surveillance.

Congress can also reduce programmatic burden by encouraging CMS to directly audit practices reporting data to a clinical data registry or other third-party intermediaries. Currently, CMS dictates a registry's obligations when conducting an audit, even though registries have other methods for auditing and assessing the data submitted by an individual or group. Such auditing requirements have burdened registries and have been unclear, resulting in an incomplete understanding of CMS's expectations of a registry or an individual reporting to a registry. **Congress should allocate funds for CMS to either conduct audits directly or provide funding for third party intermediaries to implement audits more effectively.** Either solution would improve workflows for registries to process QPP data more efficiently while also allowing for a more efficient and targeted auditing process.

As stated in Section 3, **ASA supports Congress extending the exceptional performance bonus for MIPS and the 5% bonus for participating in an APM. ASA also supports the creation of physician-designed APMs or a more collaborative process between CMS and medical specialty societies to develop new APMs or make recommended changes to existing APMs.** This effort would serve to remove barriers to specialty involvement in APMs, while advancing broad APM goals of health savings and improved patient outcomes. In addition, CMS should ensure there are measures for specialists to report or by which to be directly assessed within an APM. We recognize that a standard set of measures for some APM participants to report may be necessary, including certain screening processes (blood pressure, glucose, congestive heart failure, obesity, anemia), management or limitation of costly

procedures, or complication rate from procedures. Avoidance of unnecessary services or tests should also be considered. Measures could span the care of a patient and all physicians could participate in the success of meeting national benchmarks. To truly increase adoption of APMs by all clinicians that are part of a patient's care journey, incentives must reward every member of the care team.

Thank you for your consideration of our comments. We welcome the opportunity to speak with you further about our feedback. Please contact Manuel Bonilla, ASA Chief Advocacy Officer at (202) 289-7045 or Nora Matus, ASA Director of Congressional Political Affairs at (202) 591-3708 for questions or further information.

Sincerely,

A handwritten signature in cursive script that reads "Michael Champeau MD".

Michael Champeau, MD, FASA
President
American Society of Anesthesiologists