September 6, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services
Attn: CMS-1770-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted Electronically at www.regulations.gov

Re: [CMS-1770-P] Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts.

Dear Administrator Brooks-LaSure:

The American Society of Anesthesiologists® (ASA), on behalf of our more than 55,000 members, appreciates the opportunity to comment on several of the issues in the above-captioned Proposed Rule. Medicare is an essential program that currently provides healthcare benefits to over 63 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 both high quality and 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 2023 Anesthesia and RBRVS Conversion Factors (CFs)
- Valuation of Specific Codes
  - Somatic Nerve Injection Codes (64415-64417; 64445-64448)
Chronic Pain Management Services (GYYY1, GYYY2)

- Indirect Practice Expense Methodology
- Rebasing and Revising the Medicare Economic Index (MEI)
- Expansion of Medicare Coverage Policies for Colorectal Cancer Screening
- Proposed Delay of New Split (Shared) E/M Visit Policy
- Medicare Part A and B Dental Services
- Proposed Payment Adjustments for NIOSH-Approved Domestic Surgical N95 Respirators
- Medicare Shared Savings Program
- Updates to the Quality Payment Program

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

**Calculation of the CY 2023 PFS RBRVS and Anesthesia Conversion Factors (CFs)**

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. The proposed 2023 Anesthesia CF is $20.7191, in comparison to the 2022 Anesthesia CF of $21.5623. This reduction of $0.84 represents a -3.91% adjustment. The 2023 proposed RBRVS CF is $33.0775. This represents a decrease of $1.53 or -4.42% from the 2022 RBRVS CF of $34.6062. The resulting specialty level impact on Anesthesia, Interventional Pain Management and Nurse Anesthetists is -1% with greater negative impacts on non-facility practices than facility practices.

**ASA has serious concerns about the magnitude of the cuts to payments for the services of physician anesthesiologists. We recognize the limited authority CMS has to modify statutorily mandated budget neutrality adjustment 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 as it relates to updates to the fee schedule and processing claims.**

The magnitude of the proposed cuts to the Anesthesia and RBRVS CFs is significant and will potentially have a devastating impact on physician 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 10% payment cut in 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%). ASA fears these drastic cuts will put practices and patients’ access to care at risk.

In addition to the weight of the pandemic, inflation rates continue to increase. Physician payment, however, is not increasing in concordance with these rates. In fact, when adjusted for inflation in practice costs, Medicare physician pay declined 20 percent from 2001 to 2021, or by
1.1% per year on average.\textsuperscript{1} Absent Congressional action, CY 2023 will be the third year in a row that physicians will face Medicare payment cuts. Since the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), Medicare physician payment has remained essentially flat. We also note a 3.75% cut to the conversion factor resulting from increases in valuation of evaluation and management codes was lifted in 2021 through the Consolidated Appropriations Act of 2021 and again in 2022 through the Protecting Medicare and American Farmers from Sequester Cuts Act. This is illustrated in the table below.

\textbf{Table/Graph 1: Anesthesia Conversion Factor (CF) Compared to Inflation Over Time}

We also 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 1989 to July 2021 to account for inflation would lead to a more reasonable budget neutrality threshold of $43.3 million.\textsuperscript{2}

Valuation of Specific Codes

Somatic Nerve Injections (CPT® codes 64415-64417 and 64445 - 64448)

CPT codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management. In recent years these codes have been frequently reported (over 75% of the time) with imaging (CPT code 76942 (Ultrasound image guidance)). Due to the frequent reporting of imaging, these codes were identified by the CPT Editorial Panel and the RVS Update Committee (RUC) to be revised and imaging was bundled into the procedure codes. The codes were surveyed at the October 2021 RUC meeting for the CY 2023 Medicare physician fee schedule cycle.

Elsewhere in this proposed rule, CMS discusses proposals to address the opioid crisis and the importance of non-opioid alternatives. Addressing the opioid crisis is a critical priority that falls upon CMS, as well as on those physicians who treat patients with substance use disorder or patients who are at risk for this diagnosis. The injection services described by the codes in this family can be used as an alternative to opioids for acute pain management. It is now well recognized that use of opioids to treat acute pain following surgical intervention is the triggering event for substance use disorder in a vulnerable subset of patients. While the agency should always strive for fair and appropriate payment for physician services, the role these procedures play in providing an alternative to opioids for pain management makes an even more compelling case to ensure appropriate payment and access to these services.

A recent interagency task force report on pain management best practices is aligned with this position. The report, released by the Department of Health and Human Services (HHS) in May 2019, recommends non-opioids be used as a “first-line therapy” whenever clinically appropriate. The report found peripheral nerve injections to be advantageous in that they allow for quicker discharge times in ambulatory settings, less postoperative nausea and vomiting because less opioid medication is used, and improved patient satisfaction. To address inconsistencies and delays in insurance coverage, the report encourages CMS and private payers to provide consistent and timely insurance coverage for evidence-informed interventional procedures early in the course of treatment when clinically appropriate. This report, released by HHS, provides further support for CMS to ensure fair and appropriate payment for these important services.

Work RVU Recommendations
For the seven somatic nerve injection codes, CMS accepted RUC work RVU (wRVU) recommendations for three of the codes and rejected wRVU recommendations for four of the codes. In the instances where CMS rejected the RUC recommendations, the agency has proposed lower values than recommended by the RUC.

Table/Graph 2: Somatic Nerve Injection Codes RUC Recommendations vs CY 2023 Proposed wRVUs

ASA is pleased to acknowledge the agency’s support of the RUC wRVU recommendations for CPT codes 64417, 64447, and 64448. The RUC recommendations were based on the 25th percentile of a robust response to the RUC survey fielded by ASA. The survey respondents had direct experience performing these services in a wide range of practice settings. Survey data from clinicians experienced in providing the service is the strongest evidence available when assessing the relative wRVU value of a service.

**ASA urges CMS to finalize its proposed valuation of 1.31 wRVUs for code 64417, 1.34 wRVUs for code 64447, and 1.68 wRVUs for code 64448.**

ASA was disappointed CMS chose to reject the RUC recommendations for the remaining codes: 64415, 64416, 64445, and 64446. Instead, CMS proposed wRVU values below those recommended by the RUC. The society notes that the RUC recommendations for all the surveyed codes were significantly below the CY 2022 values for these services when imaging is billed separately.

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>RUC wRVU Recommendation</th>
<th>CY 2023 Proposed wRVU</th>
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<tbody>
<tr>
<td>64415</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed</td>
<td>1.50</td>
<td>1.35</td>
</tr>
<tr>
<td>64416</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed</td>
<td>1.80</td>
<td>1.65</td>
</tr>
<tr>
<td>64417</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed</td>
<td>1.31</td>
<td>1.31</td>
</tr>
<tr>
<td>64445</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed</td>
<td>1.39</td>
<td>1.28</td>
</tr>
<tr>
<td>64446</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed</td>
<td>1.75</td>
<td>1.64</td>
</tr>
<tr>
<td>64447</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed</td>
<td>1.34</td>
<td>1.34</td>
</tr>
<tr>
<td>64448</td>
<td>Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed</td>
<td>1.68</td>
<td>1.68</td>
</tr>
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</table>
ASA notes that, similar to the previous codes (64417, 64447, and 64448), the RUC recommendations for codes 64415, 64416, 64445, and 64446 were all based on the 25th percentile of a robust survey response from physician anesthesiologists who had extensive experience with the services in question.

**Time and Intensity**

In explaining their rationale for reduced values for 64415, 64416, 64445, and 64446, CMS indicated an across-the-board concern that the RUC recommendations indicated an increase in the relative intensity for each procedure. The agency noted, “we do not believe the recoding of services in this family has resulted in a significant increase in their intensity...”. ASA believes that there is a fundamental error in how CMS views the process of combining a procedure code with an ultrasound guidance code. The issue is not simply that a second task has been added, which is performed simultaneously with the first. Rather, adding ultrasound guidance significantly increases the required training, skill, and intensity of work to perform these procedures accurately and safely. Blindly injecting local anesthetic into the interscalene groove is relatively easy, in comparison to guiding the needle tip into proximity with the nerve, without contacting the nerve fibers, and avoiding all the critical adjacent structures. Real-time ultrasound guidance is significantly more taxing but provides optimal effect from the local anesthetic injection, minimizes the dose of anesthetic required, produces the lowest possible rate of complications, and leads to the best possible outcome for the patient. All of this requires the ability to acquire and interpret live images of exacting anatomy while simultaneously executing an advanced level of bimanual skill to safely guide the needle through the structures identified. Adding ultrasound guidance necessarily increases the intensity of work of the base code on a consistent basis.

Patients benefit from the increased use of appropriate resources and increased intensity associated with using ultrasound guidance. Studies have found that the blind technique may be associated with a higher failure rate and injury to the nerves and surrounding structures.

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The images that follow illustrate the increased complexity and intensity associated with ultrasound guidance for peripheral nerve blocks.

**Image 1: 64415 – Interscalene (Brachial Plexus) Block**

<table>
<thead>
<tr>
<th>Post-Operative Analgesia of the Shoulder and Upper Arm</th>
<th>Historical “Blind” Technique</th>
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</thead>
</table>

This image illustrates the approach to an interscalene (64415 - brachial plexus) block. On the left, the patient has been positioned and marked appropriately before beginning the procedure. On the right, the anesthesiologist is using a traditional approach to guide needle placement, simply palpating the surface anatomy.
This image illustrates the addition of ultrasound guidance. On the left the anesthesiologist has positioned the ultrasound screen to visualize the anatomical image and the procedure site simultaneously. On the right, the needle is advanced slowly with care to maintain its path within the one-millimeter-wide ultrasound beam while avoiding critical adjacent structures.

This image illustrates the real-time image acquisition and interpretation required for ultrasound guidance of an interscalene block. On the left is the precise image required, obtained through
probe manipulation (location, orientation, and angle to the skin’s surface) by the anesthesiologist. On the right, some of the critical muscular, nerve, and vascular structures that must be identified are labeled.

**Image 4: 64415 – Ultrasound Guided Block Placement**

This image illustrates actual performance of the interscalene block. On the left, the needle is carefully advanced while maintaining its visibility in the ultrasound plane until the tip is adjacent to the nerve roots, but outside of the fibrous sheaths (injection into the nerve sheath can result in prolonged or permanent nerve injury). On the right, the minimum volume of local anesthetic required is injected visualizing the spread amongst the nerve roots.

The increased intensity derived from the RUC recommended wRVU values for 64415, 64416, 64445, and 64446 is also related to the stable or reduced intra-times. ASA believes the reduced or stable intra-times, when imaging is bundled into the service, is appropriate. By definition, component-image guidance codes have substantial intra-service time overlap with the intra-service time of the component base surgery codes with which they are reported. The real-time imaging is guiding the surgical work of the base procedure.

When valuing the combined procedure and ultrasound guidance codes in this instance, CMS proposed to use a sum of sequential time ratios derived from the total reported time for each component code included in the bundled service. This approach errs by ignoring much of the intra-service work performed. The needle placement and injection occur in parallel with the ultrasound guidance, regardless of the coding structure. When all of the work is described by a new bundled code, performing the procedure and ultrasound guidance in parallel should logically result in a new combined work intensity which is an aggregate of the intensity of the component codes. The component codes were previously valued with the understanding that the typical provider is performing both the base procedure and the ultrasound guidance themselves.
Crosswalk and Comparison Codes
To provide support for its proposed values, the agency selected alternative crosswalks and comparison codes that were identified through the RUC process. ASA has significant concerns with the codes selected and we do not believe they are appropriate comparators. In general, ASA has found them to be less intense in comparison to the surveyed codes and several do not include imaging. As previously noted, the addition of imaging will increase the intensity of a procedure. We are concerned that the comparison codes have been arbitrarily selected without any valid clinical rationale beyond that they fit a desired wRVU value. The table below summarizes ASA’s concerns with the comparison codes selected by CMS.

Table/Graph 4: ASA Comments on CMS Crosswalks and Comparison Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>RUC Rec.</th>
<th>CY 2023 Proposed wRVU</th>
<th>CMS Crosswalk and Comparison Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>64415</td>
<td>1.50</td>
<td>1.35</td>
<td>11982. Removal, non-biodegradable drug delivery implant (1.34 wRVU)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• ASA disagrees with this crosswalk as there is no imaging guidance included with this procedure. The need for imaging guidance increases work intensity.</td>
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<tr>
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<td>33285. Insertion, subcutaneous cardiac rhythm monitor, including programming (1.53 wRVU)</td>
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<td></td>
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<td></td>
<td>• ASA disagrees with this comparator as there is no imaging guidance included with this procedure. The need for imaging guidance increases work intensity.</td>
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<td>64486. (Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)) (1.27 wRVU)</td>
</tr>
<tr>
<td></td>
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<td>• While this comparator code does include imaging, code 64415 is a significantly more risky and intense procedure than 64486. Code 64486, a TAP block, describes the injection of a fascial abdominal plane. This is less risky and complex than an injection in the area of the brachial plexus that is described by code 64415. For 64486, the needle tip merely needs to be positioned in a large two-dimensional fascial plane between the internal oblique and transversalis muscles without adjacent nerve roots or major vessels. Furthermore, correct placement of the local anesthetic does not require identification of individual nerves.</td>
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### CMS Crosswalk and Comparison Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>RUC Rec.</th>
<th>CY 2023 Proposed wRVU</th>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>64416</td>
<td>1.80</td>
<td>1.65</td>
<td>6448</td>
<td>Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed) (1.60 wRVUs)</td>
<td>While this comparator code does include imaging, code 64416 is a significantly more risky and intense procedure than 64488 Code 64488 a TAP block, describes the injection of a fascial abdominal plane. This is less risky and complex than an injection in the area of the brachial plexus that is described by code 64416. For 64488, the needle tip merely needs to be positioned in a large two-dimensional fascial plane between the internal oblique and transversalis muscles without adjacent nerve roots or major vessels. Furthermore, correct placement of the local anesthetic does not require identification of individual nerves. Using the bilateral procedure (64488 is not a suitable comparator for placement of a catheter in proximity to the nerves in questions (64416).</td>
</tr>
<tr>
<td>64445</td>
<td>1.39</td>
<td>1.28</td>
<td>62325</td>
<td>(Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or</td>
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- **11982.** Removal, non-biodegradable drug delivery implant (1.34 wRVU)
  - ASA disagrees with this comparator as there is no imaging guidance included with this procedure. The need for imaging guidance increases work intensity.

- **58100.** Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (1.21 wRVU)
  - ASA disagrees with this comparator as there is no imaging guidance included with this procedure. The need for imaging guidance increases work intensity. Blind sampling of the endometrium is not clinically comparable to precisely locating a needle next to the brachial plexus while avoiding critical adjacent structures and placement of a catheter.
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<td>thoracic; with imaging guidance (ie, fluoroscopy or CT) (2.20 wRVU)</td>
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<td><strong>62327</strong> Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT) (1.90 work RVU)</td>
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<td>• In both cases, the codes have identical intra-service times and similar total times, yet code 64445 involves less intense physician work and is, therefore, appropriately valued lower than the key reference codes.</td>
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<td></td>
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<td>• ASA believes the survey 25th percentile is a more appropriate rationale for the valuation of this service.</td>
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<tr>
<td>64446</td>
<td>1.75</td>
<td>1.64</td>
<td><strong>64448</strong> Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed (1.68 wRVUs)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• ASA disagrees with this comparator code due to its lesser intensity compared to code 64446. The sciatic nerve (i.e., 64446) is typically located 7-10 cm deep to the dermis. The femoral nerve is typically located 2-3 cm deep. Ultrasound guided access and placement of a catheter in close proximity to the sciatic nerve necessarily requires a significantly higher degree of work intensity than the same procedure for the femoral nerve.</td>
</tr>
<tr>
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<td><strong>36573</strong> Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older (1.70 wRVUs)</td>
</tr>
<tr>
<td></td>
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<td>• ASA disagrees with this comparator code due to its lesser intensity compared to code 64446.</td>
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<td>• Code 36573 requires imaging guidance to intentionally puncture a vein located roughly 1cm</td>
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American Society of Anesthesiologists®

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<tr>
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<td>deep to the dermis and placement of a catheter. 64446 requires imaging guidance to place a catheter adjacent to a nerve located 7-10 cm deep without contacting or injuring the nerve. The intensity of work for 64446 is expected to be much higher than for 36573 due to the complexity of the technique.</td>
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**Relationship Between 64416 and 64446**

The RUC survey resulted in identical intra-time and total times, but the RUC recommended a higher wRVU for code 64416 based on the surveyed relative work intensities. CMS indicated in the proposed rule that they believe it is best to assign 64416 and 64446 the same wRVU value to preserve rank order within the family.

ASA does not believe that the concept of “rank order within a family” applies to this set of codes. The differing complexity and work intensity for these two codes is related to the distinct anatomical locations of the injections. The specific conditions associated with each procedure were recognized by the survey respondents and reflected in the RUC recommendations.

In summary, the ASA believes the RUC recommendations were clinically appropriate and were based on a robust survey response from physicians experienced in providing these services. **ASA urges CMS to accept the RUC recommendation of 1.50 wRVUs for code 64415, 1.80 wRVUs for code 64416, 1.39 wRVUs for code 64445, and 1.75 wRVUs for code 64446.**

**Chronic Pain Management Services**

CMS is proposing the creation of two codes in 2023 for chronic pain management (CPM), GYYY1 and GYYY2, acknowledging the importance to improve the care experience for individuals with acute and chronic pain, expand access to evidence-based treatments for acute and chronic pain, and address and improve equity. The agency has proposed to create these two HCPCS G-codes to describe monthly chronic pain management services beginning in CY 2023.

Anesthesiologists play a unique role in 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 is a leader in the advancement of acute and chronic pain management best practices. ASA is very pleased that the agency is establishing a way to pay for chronic pain management services more appropriately. Currently, the payment for these services is inadequate.
ASA supports CMS’ proposal to establish coding and billing describing chronic pain management services.

In the proposed rule, the agency spoke of primary care physicians reporting GYYY1 and GYYY2. **ASA urges CMS to ensure there is appropriate flexibility in the billing rules for these services to allow physician anesthesiologists and pain medicine specialists to report these codes.**

The descriptor for the codes includes “administration of a validated pain rating scale or tool.” The agency requested feedback on the appropriateness of the inclusion of this language in the descriptor. **ASA highlights the potential unintended consequence of using a pain rating scale or tool for validation and suggests the addition of a measurement that uses objective measures. ASA urges the agency to consider alternative language.** Several studies cite the practice of prescribing specific doses of opioid analgesics based solely on specific pain intensity. Pain intensity scales/tools are subjective measures that are unpredictable even within the same patient. The addition of an objective measure to determine pain levels in patients will provide physicians and others with more detailed information to make better informed decisions on the patient’s course of treatment and contribute to the fight against the opioid epidemic.

ASA is pleased the agency is taking steps to establish payment for critical pain management services where there currently is not a means for reimbursement. 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 is unclear if the current descriptor and payment level is appropriate. **ASA urges the agency to monitor the utilization of these services and request ongoing feedback from stakeholders as they gain experience with the codes to determine if adjustments in the code descriptor or reporting requirements are needed; and to assess if the reimbursement level is appropriate.**

CMS also asked commenters whether they should consider creating additional coding and payment to address acute pain. **ASA supports the development of coding and billing describing acute pain management services.** When a continuous nerve/plexus catheter is inserted for post-operative analgesia and the patient is sent home, the patient receives daily phone calls from anesthesiologists to help manage the catheter and their pain until the infusion is stopped and the catheter is removed. Since this service is provided by the anesthesiologist and not the surgeon, the service is not part of the global period for the surgical procedure. Currently, the anesthesiologist does not receive credit for managing these patients.

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Indirect Practice Expense Methodology
CMS is seeking comments from the public on how to better refine their practice expense methodology, including the collection of better data, the cadence of future updates, and how to appropriately value direct practice expenses. Implemented in 2010, CMS uses data from the AMA’s Physician Practice Information Survey to determine practice expense relative values. This survey utilizes data from 2006. The agency has received public comments expressing concerns regarding the agency’s approach to indirect practice expense allocation and seeks a way to move towards a standardized and routine approach to valuation of indirect PE. CMS seeks comments on a survey methodology as well as alternatives.

ASA supports more frequent updates to indirect practice expense data to reflect current costs associated with running a practice. Market consolidation, shifts in workforce alignment, and the evolution in the type of business entities predominant in healthcare markets all suggest significant transformation in practice expenses. The survey currently used to determine indirect practice costs is extremely dated and significant administrative changes have occurred leading to additional costs.

We support the concept of an AMA-led survey to refine practice expense methodology. Since 2006, there has been a significant amount of change that would not have been captured, such as artificial intelligence (AI) technology and cybersecurity. Improving methodology and capturing up-to-date data is essential for projecting meaningful and accurate PE relative values.

The collection of indirect practice expense data will be a large, challenging, and complex undertaking. It will also have a significant impact on the allocation of resources in the fee schedule. Every effort must be made to ensure its success. ASA believes partnership with the AMA will provide the means for the physician community to provide critical expertise and insight on how the current practice environment has evolved since the last survey and how that will impact data collection, survey methodology, and even the best means to field the survey. CMS should collaborate with the AMA on this new data collection effort to ensure consistency and reliability in physician payment.

Rebasing and Revising the Medicare Economic Index (MEI)
The MEI is a measure of annual price changes for various inputs involved in furnishing physician services. There are two components to the MEI: physician time and physician practice expense. While it is no longer used to update the physician conversion factor, today the MEI is used to update the Geographic Practice Cost Index (GPCI) cost share weights and to calibrate the total pool of aggregate PE RVUs relative to the pool of work and malpractice RVUs.

The MEI was last updated in 2014. In this rule, CMS proposes to rebase the index year to 2017 and update the data sources by relying heavily on data from the U.S. Census Bureau and disaggregate certain categories. The intent of these changes is to use data that better reflects current market conditions for physician practices. This change would also allow the MEI to be updated on a more regular basis moving forward. The impact of this proposal would be budget neutral, as it would not change overall spending on physician fee schedule (PFS) services, but it
would likely result in significant changes to payment for specific PFS services. For example, Table 148 in the rule indicates that the full impact of proposed MEI changes would have a 0% impact on non-facility anesthesiology practices and a -6% impact on facility-based anesthesiology practices. CMS is not proposing to implement this in 2023, but instead seeks comment on an implementation time frame, including a possible multi-year transition period given the significance of the proposal.

**ASA urges CMS to delay rebasing and revising the Medicare Economic Index until after the end of the public health emergency (PHE) and when more current data is available.**
**ASA strongly recommends that when new data is used, it is applied over a multi-year transition period to mitigate any negative impact on individual practices or specialties.**

While ASA supports the concept that payment rates should be based on the most current and accurate data, we believe it would be inappropriate to implement these changes at this time as it would result in significant shifts in payment. As discussed in this comment letter, anesthesiology and pain practices, as well as other physician practices in general, are facing multiple payment cuts in 2023 including a 4.2% decrease in the RBRVS CF, a 2% Medicare sequestration cut which was reimplemented fully on July 1, 2022, and a 4% statutory sequestration that is set to be implemented in 2023, barring Congressional action. Practices are forced to absorb these cuts while they continue to experience challenges due to the COVID-19 pandemic.

In addition to these across-the-board payment cuts, CMS has been updating direct PE data since 2019 which has caused swings in PE RVUs due to budget neutrality rules. Supply and equipment PE data was updated from 2019-2022. CMS also initiated a four-year transition to clinical labor data in 2022 that will run through 2025. Due to the budget neutrality nature of the payment system, these updates have also contributed to the ongoing year-to-year instability in the PFS.

ASA also believes another benefit to waiting to implement an MEI update is that it would allow the agency to use more current data. The MEI was last revised in 2014 and the agency is proposing to use 2017 data. In the rule, the agency indicates that 2020 was more comprehensive, however, the presence of the COVID-19 PHE “raised questions regarding the representativeness and stability of the data given impacts on the utilization of physicians’ services and associated expenses.”

While ASA does not disagree with the agency’s perspective regarding the 2020 data, we question if the disruption to the fee schedule that would be caused by the 2017 data, which is already outdated, is worth all this effort. We believe it would be wiser to delay the update until data that is more reflective of current market conditions is available.

Finally, ASA urges the agency consider the timing of the MEI update with respect to other major data PFS updates. For example, the previously discussed indirect practice expense update will also have a significant impact on anesthesiology and other practices. When considering these updates and their timing, the agency should take a holistic approach and consider the overall impact of all of the various policy changes in PFS cycle that could impact a practice.
Expansion of Medicare Coverage Policies for Colorectal Cancer Screening

CMS proposed two updates to expand Medicare coverage policies for colorectal cancer screening to align with recent United States Preventive Services Task Force and professional society recommendations. The first proposal is to expand Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment limitation to 45 years. The second proposal is to expand the regulatory definition of colorectal cancer screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.

ASA supports the CMS proposal to reduce minimum screening age for colorectal cancer to 45 years and expand the regulatory definition of colorectal screening tests to include a follow-on screening colonoscopy after a positive result from a CRC screening stool-based test. ASA also reminds the agency that these policies should also apply to any related anesthesia services for these procedures.

The United States Preventive Services Task Force are nationally recognized experts in evidence-based recommendations for prevention, whose guidelines should be adopted. Offering these preventive services at an earlier age and without financial barriers has the potential to increase access and improve cancer patient outcomes.

Proposed Delay of New Split (Shared) E/M Visit Policy

CMS is proposing to delay the split (or shared) visits policy that was finalized in CY 2022 for the definition of substantive portion, as more than half of the total time, for one year with a few exceptions. For CY 2023, the substantive portion of a visit may be met by any of the following elements: history, performing a physical exam, making a medical decision, spending time (more than half of the total time spent by the practitioner who bills the visit).

ASA supports the delay of this policy and urges CMS to reconsider its future installation. ASA recommends CMS permanently finalize this alternative policy that allows physicians or qualified health care professionals to bill split or shared visits based on time or medical decision making. Billing based on 50 percent of total time could disrupt team-based patient care. Additionally, significant variability exists around how much time it takes to perform elements of a patient’s visit depending on clinical experience and training of the physician or qualified health professional. Medical decision making may not require the most time in a patient visit but requires a significant amount of critical thinking and is the most impactful component of the appointment and should carry more weight as a result.

Medicare Part A and B Dental Services

Medicare currently pays for dental services typically outside of preventive measures that are integral to the treatment of a patient. CMS is proposing and seeking comment on payment for other dental services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures that may be inextricably linked to, and substantially related and integral to, the clinical success of an otherwise covered medical service. CMS also is requesting comments on other types of clinical scenarios where
ASA supports the CMS proposal to pay for dental examinations and dental treatment preceding an organ transplant. Poor dental health has proven to be highly associated with chronic disease and higher cardiovascular risks. Ensuring organ transplant patients have access to dental examinations is proper continuation of care to promote an optimal environment for the transplant to have lasting clinical success.

ASA commends CMS for expanding dental services for Medicare patients. Dental health has implications for readiness and outcomes for invasive procedures including cardiac surgery (e.g., valve replacements). It is important to address dental health as part of transplant evaluation. Multiple studies have indicated a significant impact of preoperative dental care on preventing postoperative infection and inflammation. During a preoperative assessment by anesthesiologists, such as comprehensive assessments conducted as part of a Perioperative Surgical Home (PSH), anesthesiologists might recommend dental care (e.g., extractions) to minimize risk of infection during an invasive procedure but also to minimize complications during intubation when teeth are loose or infected. Since the evaluation would be conducted as part of preoperative assessment, physician anesthesiologists would refer patients to a dentist or an oral surgeon.

Proposed Payment Adjustments for NIOSH-Approved Domestic Surgical N95 Respirators
In the fiscal year 2023 Inpatient Prospective Payment System (IPPS) proposed rule, CMS requested public comments on potential payment adjustments for the Medicare inpatient and outpatient payment systems for wholly domestically made National Institute for Occupational Safety & Health (NIOSH)-approved surgical N95 respirators. CMS is proposing to make a payment adjustment under the OPPS and IPPS to compensate hospitals for the additional resource costs of acquiring domestically made NIOSH-approved surgical N95 respirators for cost reporting periods beginning on or after January 1, 2023. ASA supported this proposal in our outpatient proposed rule comments.

Our nation’s recent experience with the COVID-19 pandemic has brought to the forefront the importance of domestically produced personal protective equipment (PPE) such as N95 respirators. The pandemic demonstrated the potential limitations of globalized supply chains. Federal policy actions such as the payment adjustment proposed by CMS can support efforts to bolster domestic manufacturing. This effort to support domestic manufacturing will help prevent future shortages of lifesaving PPE by helping to sustain the domestic supply chain.

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are often faced with the choice of purchasing more expensive domestic N95s versus the cheaper foreign made masks. The payment adjustment will incentivize the purchase of the more expensive domestically manufactured masks.

While ASA was pleased to see this proposal in the CY 2023 outpatient proposed rule, we were disappointed to not also see a similar proposal in the CY 2023 Medicare PFS Proposed Rule. Physician practices also must be incentivized to purchase domestically manufactured N95s and other PPE. **ASA urges CMS to implement payment adjustments in the Medicare physicians fee schedule for the purchase of domestically made and approved N95s.**

**Medicare Shared Savings Program**
The proposed changes for the Medicare Shared Savings Program (MSSP) indicate CMS’ investment in making this program more efficient and reflective of patient needs. ASA commends CMS for their proposed changes and incentives that will encourage physicians and hospitals that are reluctant to or cannot participate in the program due to infrastructure investments and/or lack of experience in performance-based models to explore participation in the MSSP.

**Shared Savings Program: Advance Investment Payments**
ASA commends CMS for providing financial payments to support low-resourced organizations. ASA would also like to see similar financial payments provided for practices that need assistance in transitioning to electronic health records (EHRs). Anesthesia practices face significant financial barriers in moving from paper records to EHRs. Financial support from CMS may expedite a broad transition to digital records in the anesthesia specialty.

**Shared Savings Program: Health Equity Adjustment for ACOs**
ASA supports this proposal that promotes equity in a value-based care program. ASA is supportive of the upside-only reward to those providers who provide excellent care for underserved populations. Many anesthesia groups have recognized that implementing a Perioperative Surgical Home (PSH) service delivery model has improved care coordination and health equity practices. For those groups, the PSH provides the infrastructure to incorporate any quality and cost improvements, including health equity practices.

**Updates to the Quality Payment Program (Section IV.)**
**Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs – Request for Information (RFI)**
ASA previously responded to CMS’ RFI on digital quality measurement and FHIR use in the CY 2022 PFS proposed rule and we appreciate the opportunity to provide additional feedback on how the transition to digital quality measures is implemented. We hope this RFI on “Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs” will allow CMS to improve its strategy and develop a timeline that acknowledges the opportunities and challenges measure stewards face during this transition.
In previous years, ASA expressed concern for the proposed five-year timeline CMS established for moving to full digital quality measurement. CMS should provide a progress update and allow stakeholders to evaluate whether the timeline is feasible. ASA appreciates the expanded and refined definition of digital quality measures (dQMs). Through this process, CMS has managed expectations and, we believe, can adjust timelines based on the results-to-date on the ongoing transition to digital quality measurement.

We recommend CMS work comprehensively 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 the transition to dQMs will only 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 dQMs, especially since the digitization of quality measures has the potential to provide 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 continue to move prudently in assessing which measures should be prioritized for digitization while, at the same time, understanding that not every physician or group will have an opportunity or the resources to use digital measures.

• Do you have feedback on the potential refined definition of digital quality measures (dQMs)?

ASA primarily agrees with the revised definition of dQMs, including the removal of the term “software” to avoid confusion. ASA also appreciates that CMS maintained its inclusion of potential dQM data sources accompanying its dQM definition, including administrative systems, electronically submitted clinical assessment data, case management systems, and EHRs, among other sources to provide a more comprehensive assessment of the complexity for digitizing measures. ASA requests additional information on the term “interoperable.” This term has multiple interpretations and could refer to interoperability between EHRs, hospitals, health systems, physicians, and data submitted to a registry. We recommend CMS seek input from measure stewards in providing a clear definition of “interoperability.”

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 clinical definitions are used in dQMs. For example, the Anesthesia Quality Institute National Anesthesia Clinical Outcomes Registry (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 federal stakeholders and EHR vendors to incorporate structural data elements and facilitate standard definitions for perioperative data. Based on our prior experience, we believe vendors will be receptive to this approach.

- Do you have feedback on potential considerations or challenges related to non-EHR data sources?

Anesthesiologists provide care to patients in a variety of facilities and care settings including hospitals, ambulatory surgery centers, and office-based locations where an anesthesiologist does not control or own the EHR. 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. Efforts to standardize dCQMs in anesthesia care will prove especially challenging given the volume and complexity of anesthesia’s non-EHR data sources. Many anesthesiologists work in facilities that continue to use paper charting for anesthesia records. Further, these anesthesia records contain multiple clinical data points and free text that are not always easily translatable to EHR formats. This is especially true in ambulatory surgery centers and office-based environments where most anesthesiologists continue to work with paper charting and medical records.

- Do you have feedback on the specific implementation guides we are considering, additional FHIR implementation guides we should consider, or other data and reporting components where standardization should be considered to advance data standardization for a learning health system?

ASA believes it will be beneficial to incorporate the four listed HL7 Implementation Guides into CMS’ advancement of FHIR data collection: US Core Implementation Guide; Quality Improvement Core (QI Core) Implementation Guide; Data Exchange for Quality Measures (DEQM) Implementation Guide; and Quality Measure (QM) Implementation Guide. We believe HL7 standards have the potential to create more unified language and processes for digitizing and sharing health records.

However, we acknowledge the current limitations of HL7 and other standardization efforts, particularly as the complexity of anesthesia records has yet to be fully realized by these efforts. Even as HL7 implementation guides are developed, the reality is that HL7’s standards have not yet been adopted on a widespread scale within the anesthesia specialty. Moreover, USCDI elements are not necessarily applicable to anesthesia records yet.

ASA has actively engaged with HL7 and ONC to address gaps in standardization efforts and many of the challenges in digitizing anesthesia records as previously described. In late 2021, we submitted a proposed data element to ONC for USCDI Version 3 aimed at capturing difficult airway conditions in patients under the existing “Problems” data class. ASA’s “Airway Management” proposed element was not included in the final release of USCDI v3 with the explanation from ONC that this submission was too narrow and specific for the broader and
more general scope of the standards. While ASA will continue to engage with HL7 and ONC to enable easier digitization of anesthesia records, we believe it is important for CMS to address near-term challenges for specialties not currently met by national standardization efforts.

- **Are there additional venues to engage with implementors during the transition to digital quality measurement?**

**Clinical data registries like AQI NACOR should be consulted during and after the transition to dQMs.** For both near-term FHR/FHIR-based eCQMs and future dQMs, we urge CMS to rely on its relationships with medical specialty society clinical data registries throughout the digital quality measure transition. CMS previously envisioned 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. The transition to digital quality measurement may also benefit from CMS convening groups of specialists, contractors, data registries, and groups and clinicians who report measures.

**Advancing the Trusted Exchange Framework and Common Agreement (TEFCA) – Request for Information**

ASA supports the objectives of TEFCA to scale interoperability and allow for the free, efficient, and safe exchange of data. Pursuing greater interoperability between health care systems will improve workflow efficiency and could reduce burdens on anesthesiologists related to sharing and obtaining health information. We understand that TEFCA is relatively new, but it is important to note this broad framework may not be entirely applicable to many specialties, including anesthesiology. The complex and disparate nature of anesthesia records and the records used by other specialties will present significant obstacles to the interoperability promoted by TEFCA. ASA hopes ONC and CMS will work closely with specialty stakeholders to develop TEFCA into a more applicable framework for data exchange across the health care spectrum.

- **What concerns do commenters have about enabling exchange under TEFCA? Could enabling exchange under TEFCA increase burden for some interested parties? Are there other financial or technical barriers to enabling exchange under TEFCA? If so, what could CMS do to reduce these barriers?**

ASA requests more clarity on how specialty and subspecialty records that remain in legacy data sources will be affected by TEFCA moving forward. As mentioned in our response to the “Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs” RFI in this rule, paper charting is still common for anesthesia records and the content of these records can be difficult to
translate into existing EHR formats. Even digitized anesthesia records in TIFF or PDF formats would be considered legacy data sources that cannot be exchanged under TEFCA. This prominence of records stored in legacy data sources is common in other specialties as well, with radiology images, lab information systems and microbiology data, and pathology data all often recorded in formats not covered by TEFCA. ASA encourages CMS to work with ONC to address the barriers to TEFCA exchange participation across specialties and subspecialties and develop pathways for clinicians and groups in these specialties to more freely participate in these exchanges of data.

**MVP and APM Participant Reporting Request for Information**

In previous years, ASA asked CMS to identify specific pathways that an eligible clinician (EC) or group could take to move from the traditional Merit-based Incentive Payment System (MIPS) to MIPS Value Pathways (MVPs) to Alternative Payment Models (APMs). We are proud that CMS has approved the Patient Safety and Support of Positive Experiences with Anesthesia MVP for reporting in 2023. Reporting that MVP is one of the first steps that anesthesiologists and their groups can take in demonstrating their value not just to patients but to APM entities as well. CMS’ goal for MVPs should also foster opportunities for ECs and groups to join APMs, and we believe that anesthesiologists and their groups will join an APM based upon whether that particular specialty group is accountable to the patient and payer, if it has a “seat at the table” and has responsibilities for patient safety, quality care, and cost management.

We appreciate that CMS has taken the opportunity to ask ASA and other stakeholders for their input on how the agency can facilitate the movement of groups from traditional MIPS to APMs.

- *How should [CMS] use MVPs to obtain more meaningful performance data from both primary care and specialty clinicians and drive improvements for APP reporters and APM participants? What are the associated pros and cons for the suggested solution(s)?*

Although anesthesiologists and their groups have not participated extensively in MIPS APPs or APMs, there are two features of those programs that could be instructive to earning additional buy-in from all specialists. The first opportunity is ensuring anesthesiologists and other specialists have a sufficient number of quality measures to report and/or track as part of the group’s performance in an APP or APM. The second opportunity for buy-in rests with CMS, the APP or APM entity, and hospitals sharing quality measure data either at the physician or facility level.

ASA has encouraged our members who participate in accountable care organizations (ACOs), APMs, and academic settings to explore opportunities to track anesthesia measures as they relate to patient safety, quality, and outcomes. But for many groups, participation in defining their ACO or facility goals often does not require close scrutiny of anesthesia or even ACO measures. Instead, their touchpoint on quality programs often relies on the hospital, surgeon, or primary care physicians within their group to facilitate general measure reporting on preventive care, immunizations, or patient satisfaction. CMS could encourage meaningful performance data by allowing flexibility in the types of measures that are reportable by the group. *Groups*
participating in the APP or in APMs should be allowed to choose anesthesia measures to report in combination with other surgeon and/or primary care focused measures.

Anesthesiologists are also at a disadvantage when understanding how their care compares with others in their APP, APM, or facility-setting. Some groups have established a means to share quality data with one another and across specialties. Although anesthesia process measures may seem siloed from surgical process measures, anesthesiologist actions contribute to patient outcomes such as prevention of surgical site infections, length of stay, patient satisfaction and experience, and patient-reported outcomes. Data on quality measures could be used to take into account the actions of other physicians, clinicians, and the hospital in general and would be beneficial to the anesthesiologist to know, understand, and act upon. **CMS should consider requirements for sharing quality performance data among all specialists participating in the APP or within an APM.**

We are increasingly concerned that APMs are either considering or have already acted upon removing specialists from their participation rolls. ASA requests that CMS assess whether these accounts of specialists being removed from APMs are materializing within the MIPS, APP and APM databases on qualified participants. ASA would welcome the opportunity to work with CMS to address this issue should data indicate APMs are losing specialists at a rate higher than previous years.

- **How should we better align clinician experience with MVPs and APMs, and ensure that MVP reporting serves as a bridge to APM participation?**

ASA has consistently argued that CMS must establish MVPs that reflect the end policy goal of joining an APM that lowers costs, delivers better quality, and improves care coordination efforts. Physician anesthesiologists represent one of the few specialties that contribute to nearly all surgical and procedural patient care. Anesthesiologists provide care coordination and are instrumental in improving quality and delivering more cost-effective care. Anesthesiologists provide patient care in many settings, including but not limited to, inpatient, outpatient, office-based and non-operating room anesthetizing locations. Many anesthesiologists have subspecialty expertise in, among others, ambulatory care, critical care medicine, obstetrics, and pain medicine. Although it may appear that anesthesiologists should be a part of an APM, the movement of anesthesiologists into an APP or Advanced Alternative APM has not been realized. With ASA, CMS should better identify an end point or APM that anesthesia groups participating in MVPs could explore or join.

- **Should we require APP participants to focus on those clinicians who work in the associated quality measurement clinical area and require subgroup reporting of relevant MVPs for others?**

ASA recommends that CMS first assess how groups are participating in MVPs before requiring subgroup reporting for those groups participating in the APP. CMS must balance the burden placed on practices for reporting a variety of MVPs with the opportunities that future MVPs may present. As currently structured, MVPs are siloed and would require some multispecialty groups
to report an extensive amount of measures via subgroups. CMS should therefore take 2023 as an opportunity to assess which groups are reporting MVPs, whether there are opportunities for groups in APPs to reduce burden by reporting MVPs, and whether there are patient benefits if APPs report an MVP.

- **Should we develop a process for a composite score that incorporates both APP measures and other MVP specialty measures?**

ASA supports a process for developing MVPs focused on a patient's episode of care. Such processes may include a composite score where multiple specialists within a facility or health system contribute their quality measures and have their cost measures assessed. Since its inception, MIPS has suffered from policies that have siloed specialists from other physicians. Such siloing of measures has resulted in a fragmented program where quality measures are chosen for their ease of use and compatibility with workflows instead of being selected as a group of measures that relevant hospital specialists can assess as a group. ASA supports CMS exploring opportunities not just for composite measures but also for cross-specialty MVPs focused on an episode of care.

- **What other policy options for MIPS specialty clinician performance data reporting should we consider?**

CMS should identify additional incentives for primary care, surgeons, and specialists to work together and report common MVPs. In 2021 and 2022, CMS failed to provide incentives for an individual or group to report an MVP. Although we recognize CMS wishes to maintain consistency between traditional MIPS and MVPs, the most salient burden reduction policy is reporting fewer measures. We request that CMS consider awarding additional points for those groups participating in MVPs. Unless there is a clear incentive, groups will delay moving into MVPs from traditional MIPS, and those participating in APPs and APMs will have fewer incentives to report via an MVP.

**MVP Development and Reporting Requirements**

ASA supports CMS proposals that encourage transparency and engagement with specialties when developing new and maintaining current MVPs. Over the past two years, CMS has gradually shifted its MVP policy from a closed system of review and assessment into a more transparent process. We recognize that more can be done but appreciate CMS has proposed that new MVPs will be posted online for a 30-day comment period. ASA recommends that CMS also limit the persons and/or organizations that can submit MVPs. Such stakeholders and reviewers should be limited to specialty societies, patient advocacy groups, and others directly participating in MIPS. ASA encourages CMS to guard against MVP proposals that do not consult relevant parties or are submitted by organizations without significant physician or patient representatives.

ASA also supports the CMS proposal to engage relevant specialty stakeholders in maintaining and updating current MVPs. Like quality measures, MVPs must be reviewed on an annual basis to assess participation rates, scores, and relevance to clinical outcomes and costs. Scrutiny of
MVPs will be needed to ensure continued buy-in and relevance and prevent any increases to reporting burden. ASA looks forward to partnering with CMS in future years to maintain and strengthen the anesthesia MVP.

**Subgroup Reporting**

CMS should establish processes to notify a registry when a group or subgroup has registered to report an MVP. When qualified clinical data registries like the AQI NACOR submit their data to CMS, they should be able to know whether individuals and groups participating in their registry are reporting an MVP or an MVP as a subgroup. Currently, registries have no way of knowing whether CMS has provided a subgroup or MVP identifier to a given registry participant. This raises the likelihood of errors and incorrect data being submitted to CMS.

Knowing the MVP or subgroup status of our participants would allow AQI NACOR to verify that the data we submit on behalf of those participants is aligned with CMS registration. Notification to registries would also enable registries to better inform groups and clinicians on how they can optimize their choice of measures and how to maximize their available points under MIPS or MVPs. **ASA recommends that CMS share a group’s MVP or subgroup status directly with registries and create a mechanism that encourages groups to share this information with their registry.**

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. 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 was that CMS intended to allow for cross-specialty collaboration. We hope 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 using 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. As previously mentioned, many anesthesia groups in large ACOs have been frustrated that anesthesia measures are not incorporated into their measure set. Group and subgroup reporting for MVPs may 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 believe their
interests are specialty-specific, they should have the option to split their TIN and form subgroups.

Within anesthesia, there may be instances where an anesthesia group is made up of anesthesiologists and pain medicine physicians. In such a group, some anesthesiologists 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. 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.

Data Completeness Criteria (MIPS Performance Category Measures and Activities)
ASA opposes CMS’ proposal to raise the MIPS data completeness criteria from 70 percent to 75 percent for the CY 2024 and CY 2025 performance periods. ASA has observed significant variance in reporting rates across measures, likely attributable to the complexity of those measures. For more complex measures, 75 percent may not be a feasible benchmark for data completeness by CY 2024. Increasing the data completeness threshold would unnecessarily increase physician and group reporting burdens.

Higher data completeness requirements could be disproportionately burdensome for those smaller practices. Groups often spend the first few months of the year focusing on submitting and validating data from the previous reporting year. At the same time, groups need adequate staff to implement new or updated measure specifications for the current reporting year. These significant challenges in keeping up with data collection and reporting are especially true for smaller practices with fewer resources and less staff support. CMS should not add undue burden for the clinicians and groups collecting and reporting data. **CMS should not finalize its proposal to increase the data completeness criteria to 75 percent in CY 2024 or CY 2025.**

Selection of MIPS Quality Measures (MIPS Performance Category Measures and Activities)
ASA opposes the removal of MIPS 076 “Prevention of Central Line Catheter-Related Bloodstream Infections.” As a measure aimed at reducing infections and ensuring patient safety, we believe MIPS 076 remains an important barometer of quality and patient safety. The measure should continue to be scored for MIPS. The measure is endorsed by the National Quality Forum and is consistently reported by anesthesiologists, surgeons, hospitalists, and other non-anesthesiologists.

MIPS 076 is proposed for removal on the claim that it has reached the end of the topped-out lifecycle. We do not believe the topped-out claim can be made at this time, as other specialties outside of ASA’s data collection report this measure. We ask CMS to review the totality of data across specialties before removing the measure from MIPS scoring. We also ask CMS to review data that shows high performance of this measure as closely associated with reduced infections during a patient’s length of stay.
Anesthesiology Measure Set
ASA does not support the removal of MIPS 076 from the MIPS measure set or the anesthesiology measure set. As noted in the previous paragraph, the measure prevents hospital infections, ensures patient safety, and is reportable across a number of specialties. Removing the measure from MIPS and the Anesthesiology Measure Set will limit the opportunities for anesthesiologists from meeting base MIPS quality performance category requirements via the Qualified Registry reporting option.

Unfortunately, ASA is unable to make a recommendation on whether the Social Determinants of Health measure should be included in the Anesthesiology Measure Set. We value the need to include health equity measures that are reportable by anesthesiologists and especially measures aimed at reducing health disparities and improving care among surgical patients. However, we are concerned that the measure steward and CMS have not been forthcoming with how the measure can be collected or reported. ASA contacted both CMS and the measure steward for the “Screening for Social Drivers of Health” measure specifications. We are disappointed that neither CMS, nor the measure steward, provided us with measure specifications. We are also concerned that a published survey on the topic, which is the basis for the measure steward’s assertions about physicians identifying the importance of social determinants of health, cites multiple medical specialties as participating in the survey, but fail to mention anesthesiology.

ASA must be able to assess measure specifications to ensure they are relevant to our specialty. One of these assessments includes looking at the CPT codes listed in the measure. Without even a draft specification to review, it limits our ability to determine the relevance of a measure. Additionally, this review would allow us to determine the likelihood of our registry’s ability to collect and report this measure on behalf of our members. Waiting until Final Rulemaking to see the specification would create confusion among our registry participants, members, and others who may think they can report the measure when, in reality, they may be unable to do so.

At this time, ASA does not know whether anesthesiologists will be able to report this measure or if anesthesiologists will have access to data showing that the patient was screened prior to their surgical procedure. This lack of transparency to us indicates that the measure is ill-prepared for wide-spread inclusion in the MIPS program. Future measure proposals intended to capture health equity throughout a patient’s care must demonstrate that physicians can actually report the measure. CMS and measure stewards should strive to distribute and make public the measure specifications for any proposed measures.

MIPS Quality Performance Category Health Equity Request for Information

• How would a measure best capture health equity needs under MIPS (individual clinician or their group) in the future?

ASA supports the development and inclusion of health equity-related measures as part of a larger MIPS strategy. Quality measures that best capture health equity, as a starting point, could
be built around patient self-reported demographics as well as preferred language, insurance type, education level, income, and home and food security. These screening questions would need to be standardized across the nation and across medical systems, facilities, and staff. For anesthesiologists, capturing these self-reported measures in preoperative clinic visits prior to surgical procedures may present some obstacles, especially how an anesthesiologist would obtain standardized screening question responses and how to consistently screen for these health inequities in different practice settings. In addition, once these health inequities are revealed, we question whether an anesthesiologist would be able to influence or modify the health outcomes without a larger patient-centered support team.

CMS has selected five drivers of health in its proposed Screening for Social Drivers of Health Proposed Measure: food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety. These drivers are derived directly from the CMS Accountable Health Communities (AHC) Model. We ask for additional details on whether the model has been validated with demonstratable results before implementing related quality measures at the individual physician level.

For an individual physician or group to identify and understand a patient’s drivers of health does not necessarily mean they themselves will be empowered to adequately address identified disadvantages. A patient may have compromised health from lack of prescription medication insurance coverage or lack of transportation to attend clinical appointments, but a clinician, though aware of such disadvantages a patient faces, may be unable to consistently remove those obstacles to care – anesthesiologists even less so than primary care physicians. Thus, to measure clinicians or groups by a measure like the proposed Screen Positive Rate for Social Drivers of Health may face significant barriers related to quality and effective clinical care.

Yet there are several opportunities for anesthesiologists to contribute to better care, both at the individual level and within the facility. Anesthesiologists are often at the mercy of the facility to provide data, including patient demographics. If a hospital or facility could share reliable and comparable patient characteristics, the anesthesiologist could look at application of best practices between patient populations. For instance, postoperative nausea of vomiting prophylaxis, which is an accepted MIPS measure, could be assessed based upon the medications that a patient received to demonstrate equitable care. Another potential measure would assess whether the anesthesia plan for a given procedure or as part of an enhanced recovery protocol was equitably carried out between population groups.

- How would a measure’s quality action provide actionable information and link to improvement in the quality of care provided to populations with health inequities? Would a measure be meaningful to clinicians in small practices or Federally Qualified Health Centers that may have limited or no access to referral services?

ASA recognizes that health disparities exist throughout our health care system and must be addressed by CMS, payers, facilities, and physicians. We believe that effective data collection and assessing how and when data is collected and acted upon are key factors to developing health equity measures. For anesthesiologists, standardized screening tools and assessments
gathered by administrative staff and used or shared during the preoperative period would be instructive to helping anesthesiologists engage their colleagues and hospital staff on the patient’s individual needs. Sharing of data would allow anesthesiologists to better organize care coordination efforts, including those in the postoperative period.

Before CMS develops or endorses additional measures, we ask that readily available data be used to identify gaps in care and disparities within currently available measures. From there, measure stewards and CMS, in consultation with specialty societies, must assess if it is possible to attribute health equity to individual physicians or if such attribution should be made at the facility or population level. For anesthesiologists, such attribution seems elusive, especially when considering previous efforts to attribute costs and health outcomes to individual physicians.

- **What, if any, would be the limitations in data interpretation if a future health equity-related measure would not be risk-adjusted?**

We ask CMS to provide additional details on the types of measures that would be prioritized for risk adjustment. CMS and other stakeholders, including measure stewards, have begun to understand how health disparities might be captured in current measures. Each patient is unique and addressing health equity for each patient is a complex process that requires deliberate and accurate assessments. For physicians and others to be scored and paid based upon quality measures, appropriate, defensible, and meaningful risk-adjusted measures will need to be explored. When considering future measures and patient outcomes, especially in light of societal inequities, access to care, patient demographics, and other features that affect outcomes, CMS should provide guidance and best practices regarding risk stratification and determine if it is feasible to assess an individual physician against patient outcomes.

- **Would there be any concerns if a future health equity-related measure did not specify requirements for use of consistent tool(s) for data collection under such a measure? Should such a future measure support flexibility in choice of tools while requiring standardized coding of responses to support interoperability?**

ASA supports the standardization, to the greatest extent possible, of assessment tools used for collecting data on health equity measures. A standardized process, tool, or assessment would help facility staff and physicians have a common understanding and benchmark for assessing patients. We also suggest that collected data should be shared between physicians, facilities, and health systems. Yet a common tool and objective assessment by the patient and facility staff may be difficult to implement since many areas of health equity are subjective. For instance, “transportation problems” may be assessed differently between urban, suburban, and rural areas. Housing insecurity, utility help needs, and interpersonal safety are other issues where precise documentation and assessment will require training for staff to accurately document the patient’s current situation.

- **Which self-reported patient characteristics, including but not limited to those listed above, are important to collect in a standardized format to facilitate future use in quality
measures, such as stratification? Which characteristics would you consider lower priority for CMS to collect for use in quality measurement?

We appreciate that CMS has requested our feedback on two potential approaches for measuring health equity in MIPS and MVPs and assessing the collection and use of self-reported patient characteristics. We believe CMS should take a prudent approach regarding how best to encourage clinicians to collect social risk information, including through the development of a measure that tracks the completeness of self-reported patient characteristics such as race, ethnicity, preferred language, gender identity, sexual orientation, disability status, income, education, employment, food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.

ASA believes that these features of self-reported patient characteristics are a good starting point. As CMS further develops and hones its interests in health equity measures, the agency may wish to expand into other areas, such as pediatrics where a patient’s parent or guardian characteristics may also influence access and quality of care. We recommend assessing a patient’s health literacy, including education level and primary language, since that question would allow patients to indicate how physicians can best communicate the information to a patient during the perioperative period. Additionally, CMS may wish to explore not just interpersonal safety, but also a patient’s social support structures and connections, whether via family, friends, or neighbors.

• How important is it to use a standardized tool with coded questions and data elements to collect self-reported patient characteristics across clinicians and practices and what challenges and limitations present without use of a coded and standardized instrument?

As previously described, standardized data collection and assessment is needed to better understand and address health disparities. Without the use of a coded or standardized instrument, patient characteristics collected for health equity evaluation will vary among hospital systems. For example, income brackets may differ in cut-offs and dollar ranges, education levels may not be consistent, and race may have several to dozens of options. Definitions for food insecurity and housing instability may also differ among facilities.

ASA recognizes self-reported patient characteristics are currently considered a gold standard, but we encourage CMS to study the issue more closely. Many patients are reluctant to share personal information with physicians and facility staff for several reasons. 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 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.

• What is a meaningful approach for monitoring improvement in standardized collection of self-reported patient characteristic data while minimizing reporting burden?
ASA supports CMS efforts to assess the current level of data collection on patient self-reported patient characteristics and then build a plan and benchmarks to improve data collection. Currently, few hospitals and physicians routinely collect data, let alone data that is well defined. As mentioned in previous questions, CMS should convene stakeholders to identify common data elements that should be collected. Those data elements should be clearly defined so that facilities, physicians, and health information technology can be updated to reflect common data definitions and standards. Once defined, a standardized electronic screening tool that a patient can complete would minimize the data collection burden on the hospital or physician. Ideally, this data would automatically be associated with the health care system and allow physicians and others to access that data during the patient’s perioperative episode.

- In addition to quality measures, cost measures, and improvement activities applicable to the clinical aspect of an MVP, each MVP includes a foundational layer of population health and promoting interoperability measures, broadly applicable to most, if not all, clinicians. Is the proposed quality measure, “Screening for Social Drivers of Health,” appropriate for use in the foundational layer of MVPs (we refer readers to section IV.A.10.c.(1)(d) and Table Group A of Appendix 1 of this proposed rule for the proposed measure)? If so, then such inclusion would require most or all eligible clinicians to screen for social drivers of health during patient encounters.

We do not believe that the Screening for Social Drivers of Health is an appropriate population health measure for 2023. ASA was unable to review this measure specifications even after reaching out to CMS and the measure steward. At this time, ASA does not know whether CMS could attribute anesthesiologists to this measure or if anesthesiologists will have access to data showing the patient was screened prior to their surgical procedure. Future measure proposals that are intended to capture health equity throughout a patient’s care must demonstrate physicians can actually report the measure or that the measure can be attributed to an individual or group.

The reality for anesthesiologists is that few, if any, characteristics identified in the measure are likely to be collected by an individual or anesthesia group. This information is collected as part of an admission process and, from a patient or family perspective, should only be collected once during a perioperative episode. Since MIPS is focused on individual and group actions, attributing a facility-based measure where the data is generally collected by administrative staff instead of physicians or other eligible clinicians would present significant attribution challenges.

- Is it appropriate to develop a quality measure to assess clinician referrals to community-based services upon screening positive for a social driver of health, including food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety?

CMS could encourage greater care coordination efforts and referral systems by developing, testing, and validating methods for a physician to work with facility staff to identify community-based resources for specific patients. Each patient is unique and has specific needs that may
affect their postoperative outcomes. An anesthesiologist is not trained to individually diagnose what is needed from a health equity perspective for an individual patient or to understand the community-based resources that may or may not be available for the patient. Instead, hospital leadership would need to work with anesthesiologists and others on developing a structure that could identify the appropriate services the patient may need.

Those anesthesiologists and groups that offer preoperative clinics may be well-positioned to screen for social drivers of health inequity prior to a procedure. However, the anesthesiologist or group would need to establish relationships with the patient’s larger care team and support staff to identify what resources would be most useful for the patient postoperatively. Quality measures that assess referrals to community-based services instead of in-hospital experts, would be very challenging for most anesthesiologist groups who are hospital-based.

- **Would it be beneficial to: stratify either outcome or process measures by patient demographics; and/or stratify either outcome or process measures by identified social needs, such as food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety?**

ASA supports CMS and measure stewards appropriately testing measures to determine when outcome or process measures should be stratified by social needs such as food insecurity, housing instability, transportation problems, utility help, and interpersonal safety. We also encourage CMS to identify other stratification analysis that may further identify patient needs. Such stratification features could include comorbidities such as prevalence of hypertension and diabetes as well as whether a patient has impaired access to care, an inability to pay for prescriptions, or even a mistrust of their local health care systems. Without the understanding of all the relevant contributors to a clinical entity, stratification may not involve the correct drivers of health.

**MIPS Cost Performance Category**

We appreciate continued efforts by CMS to engage ASA and other specialty organizations when considering developments for appropriate attribution of anesthesiologists in cost measures. Earlier this year, we submitted a detailed response to the Wave 5 cost measures that described the limitations that anesthesiologists have when considering perioperative costs. Our members have participated in several cost measure development panels, and we hope to continue these collaborative efforts with CMS and work toward a cost measure that fairly and consistently provides attribution to anesthesiologists.

For the 2023 Cost Performance Category, we recognize that the Medicare Spending Per Beneficiary (MSPB) cost measure is not always attributed to an anesthesiologist or their group. Because of this, we have consistently supported the use of facility-based scoring as an appropriate proxy for scoring anesthesiologists. We encourage CMS to reimplement that mechanism, even if the public health emergency continues through 2023 and 2024. With two years of COVID-19 data collected, CMS should have sufficient data to benchmark and assess how facility costs have changed since 2020.
MIPS Improvement Activities Performance Category
ASA applauds CMS for proposing several improvement activities that reflect priorities within health care, particularly priorities centered on advancing health equity. We believe that newly proposed improvement activities should be finalized and made available for ECs and their groups to report. ASA understands the reasons why CMS has combined PSPA_20 with PSPA_19. For continuity, we request that CMS replace PSPA_20 in the Patient Safety and Support of Positive Experiences with Anesthesia MVP with PSPA_19. We believe CMS can implement this change and continue to maintain the intent of the MVP.

CMS should approve an improvement activity for groups that assist measure stewards with measure development and testing efforts. At ASA, measure development often 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 take immediately. We were disappointed that CMS did not propose an Improvement Activity that would encourage and support measure testing activities.

Promoting Interoperability Performance Category
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. Likewise, we support the continued use of the special status designation and its exemptions within the MIPS Value Pathway reporting option. We recognize that individuals, especially pain medicine physicians, and groups may elect to report promoting interoperability measures. The changes proposed by CMS offer clarity on the importance of the Prescription Drug Monitoring Program access measure and other features of this performance category that encourage information sharing to support patient care and care coordination activities.

Patient Access to Health Information Measure – Request for Information
ASA believes anesthesia health information should be accessible for patients and should enable them to understand the care they received and any impacts it will have on their health. ASA supports broader efforts in health care to encourage patients to access their health information, particularly where it can lead to greater awareness of personal health best practices and positive patient outcomes.

- What are the most common barriers to patient access and use of their health information that have been observed? Are there differences by populations or individual characteristics? For example, are there barriers caused by lack of accessibility to patients due to disability or limited English proficiency?
ASA members have observed that many barriers to patient access and use of health information are centered on the massive volume of information available to patients and the complexity of that information. Most health indicators and metrics are primarily intended for clinician use and may not be clear or useful for patients. Some records have an even narrower scope of use. For example, anesthesia records and procedure notes are highly specialized and may be difficult to interpret even for non-anesthesia clinicians. To overcome these barriers, it may be valuable to develop processes or tools that curate and translate health information into a format that is understandable to patients and centered on key indicators of health outcomes. ASA welcomes the opportunity to work with CMS to identify solutions to improve patient health literacy related to anesthesia care.

- If patient portals connected to a network participating in the recently launched TEFCA, would this enable more seamless access to individual health information across various patient portals?

As discussed in our response to the “Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)” RFI in this rule, many physicians and groups in certain specialties are not currently able to participate in data exchanges under TEFCA due to a continued reliance on legacy data sources. This will pose an immediate obstacle in enabling anesthesiologists and their groups to leverage TECFA for expanded patient access to data.

**MIPS Final Score Methodology**
ASA supports several of the policy updates to the MIPS Final Score Methodology. We support CMS’ proposal to amend the benchmarking policy to score administrative claims measures in the quality performance category using a benchmark calculated from performance period data. We believe same-year scoring is especially helpful for clinicians and groups in tracking their status, as well as measure stewards in maintaining their measures. ASA also supports the continuation of CMS’ policy on topped-out measures. We agree with the continuation of a 7-point cap on measures in the quality performance category that have topped out for two historical performance periods.

**MIPS Payment Adjustments**
ASA supports CMS continuing to use 75 points as the MIPS performance threshold. In the past three years, CMS has allowed most ECs and their groups to apply for a COVID-19 hardship exemption via the Extreme and Uncontrollable Circumstances (EUC) exception application. This policy has resulted in fewer positive payment adjustments for most MIPS participants. For ECs and groups submitting MIPS data, many received a neutral adjustment even if they exceeded the minimum threshold and expected to earn a positive payment adjustment. The policy has diminished how ECs and groups perceive the long-term feasibility and use of the QPP and MIPS.

*We ask CMS to develop a strategy to provide an on-ramp for ECs and groups who have taken previous COVID-related hardship exemptions for reentering the MIPS program.* We recognize that the pandemic is still affecting patient access to care and medical staff resources. At the same time, ECs and groups, including the facilities where they work, have established
policies and procedures to mitigate some of the most disruptive aspects of the COVID-19 pandemic. For those seeking an exemption, CMS should require sufficient documentation from a group to support their hardship application. A rigorous process should be used to assess whether COVID-19 would likely have had an impact on quality measure performance (e.g. cancelled elective surgeries, staff absenteeism, problems with data support/capture related to COVID-19). Although blanket exemptions may provide widespread burden relief, they discourage quality improvement at the local and national level.

Requirements Specific to QCDRs
ASA and AQI NACOR provide MIPS quality, promoting interoperability, and improvement activity performance category support for MIPS participants using either a Qualified Registry or a Qualified Clinical Data Registry (QCDR). ASA and AQI NACOR have been proponents of measure licensing agreements that have facilitated the sharing of quality measures across QCDRs. We ask that CMS further support the transparent licensing of QCDR measures and implement processes to support measure stewards. ASA and AQI NACOR license our measures to several QCDRs but we are unclear on whether those QCDRs are accurately implementing or submitting data on those measures to CMS. Each year, CMS should notify QCDR measure stewards on the QCDRs that have submitted data for their QCDR measures. Such notification would allow measure stewards to verify their measure license agreement requirements and open additional avenues for assessing the appropriate implementation of each measure.

ASA supports the continuation of CMS policy to limit QCDRs to those registries that are physician-led and focused on clinical quality improvement. ASA and AQI NACOR believe CMS should use established methods and regulations to ensure that approved QCDRs are clearly focused on clinical quality improvement in addition to MIPS reporting. ASA and AQI NACOR are pleased with the progress CMS has made in steering vendors who do not provide quality improvement or other measure development services to be Qualified Registries. We believe the narrowing of available QCDRs has been beneficial to MIPS participants and CMS should continue to enforce existing regulations.

The introduction of MVPs, and QCDR measures available via the MVP pathway, has unfortunately opened a door for non-clinician registries and billing companies to seek recognition as QCDRs. We appreciate that CMS has indicated to us that Qualified Registries may not report QCDR measures, including those included in an MVP. Each MVP has a sufficient number of MIPS measures for a group to adequately report and be scored on should the individual or group report via a Qualified Registry.

QCDR Measure Approval Process
We support CMS’ initial proposal to delay requirements for “full testing” of measures at least one year. We also support CMS delaying “fully tested” measure criteria until at least two years after the end of the public health emergency (PHE) or until two years after the EUC exceptions are discontinued, whichever comes first. For measure stewards and registries, decreased participation in MIPS has adversely affected registry participation,
measure benchmarks and measure testing requirements. Because fewer ECs and groups have reported data, several measures that have been in the program for a year or more do not have established benchmarks. The lack of data has affected the “full testing” requirements that CMS may require for 2023 and 2024 measure submissions. Decreased registry participation has also meant uncertainty in developing and testing new measures.

**CMS should delay requirements for full testing of QCDR measures that are included in MVPs.** CMS has established a number of MVP policies that reflect the traditional MIPS program. As two examples, measures reportable via traditional MIPS are included in MVPs and the established scoring for traditional MIPS is similar to MVPs. ASA agrees with CMS that ECs and groups will need encouragement to report an MVP. Reducing the amount of quality measures available in MVPs, especially among MVP participants who were reporting QCDR measures in traditional MIPS, will increase the burden for MVP participants to identify a sufficient number of measures to report. It is unclear to ASA why CMS would hold quality measures in the MVP to a different testing standard than those in traditional MIPS. In short, reducing the number of measures available in an MVP would disincentivize groups to report via the MVP option.

**CMS should allow measure stewards to determine the feasibility of “full testing” of QCDR quality measures.** In previous comments, we have offered several solutions to work with CMS to ensure our measures accurately reflect the quality of care anesthesiologists provide to their patients each day. First, medical society measure stewards should be able to proactively share our testing plans with CMS and describe why such testing should be considered “full testing.” ASA believes this policy would promote data transparency and ensure that testing will meet CMS expectations. Second, we believe measures should only need to be tested once. More testing could be required if there are substantial changes to the measure. Third, we ask CMS to 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. We recognize that anesthesiologists are not alone among specialties in expressing our concern with measure availability and testing. We hope CMS will work constructively with measure stewards on a reasonable process to meet the testing challenges ahead.

**Request for Information on Third Party Intermediary Support of MVPs**

- Should third party intermediaries have the flexibility to choose which measures they will support within an MVP?

Yes, ASA agrees that third party intermediaries, including Qualified Registries and QCDRs, should choose the measures they will support within an MVP. ASA has embraced an MVP policy that would include measures from a variety of specialties targeted at a surgical episode of care. We expect that this future MVP structure would include surgical measures that would likely not be reportable to an anesthesiology registry. In encouraging cross-specialty MVP reporting, CMS should embrace a policy that allows MVP participants to report data to a registry that would
enhance their quality improvement initiatives beyond MIPS. CMS should support this vision of cross-specialty MVPs and encourage specialties to continue to report to their specialty’s QCDR.

- **What are the barriers/burdens that third party intermediaries face to supporting all measures within an MVP?**

Although CMS has become more transparent in its MVP development and approval processes, the agency can subjectively include quality measures within an MVP regardless of public feedback. Such a process does not consider whether a specialty’s registry can collect that measure data from their participants. With ASA seeking CMS policy changes to include multiple surgical specialties and anesthesia measures into specific MVPs, our registry would not be able to handle, nor would we expect to enroll, surgeons reporting their specific surgical measures. At the same time, QCDRs are limited to just 30 quality measures to collect and report. Since anesthesiologists participate in nearly all surgeries and procedures, a future state of cross-specialty collaboration based upon surgical episode would balloon the number of surgical and anesthesia measures our registry would need to report well past the 30-measure cap. Although many QCDRs have ample space to include additional measures, requiring QCDRs to report on up to ten measures per MVP would limit their ability to maintain measures that are focused on their clinical specialty.

- **What type of technical educational resources would be helpful for QCDRs, qualified registries, and Health IT vendors to support all measures within an MVP?**

As a Qualified Registry for nearly a decade and a QCDR since 2014, AQI NACOR is equipped to collect data from eligible clinicians and their groups. We expect that anesthesiologists would report to an anesthesia-related registry just as a surgical specialty would report to their respective registries. Technical educational resources that would address how a surgical measure could be reported to an anesthesia registry would likely not be necessary.

**Request for Information on National Continuing Medical Education (CME) Accreditation Organizations Submitting Improvement Activities**

ASA recognizes that CMS is attempting to reduce the burden on physicians who wish to avoid reporting their CME credit twice—once as part of their state board requirements and a second time to earn credit for the MIPS Improvement Activities category. Although we generally support this exemption to the rules governing Qualified Registries and QCDRs that require the reporting of quality, cost, and promoting interoperability categories, we are concerned that such an exemption would undermine participation in Qualified Registries and QCDRs.

Having multiple pathways to report an improvement activity also confounds the customer service aspects of operating a registry. When a participant in our Qualified Registry or QCDR is identified as falling short in their improvement activities, our staff contacts that participant and their group. This CMS proposal has no requirements for an accrediting organization to notify the individual or group’s primary reporting entity. **CMS should require National Continuing Medical Education Accreditation Organizations who submit improvement activities on**
behalf of eligible clinicians to notify the Qualified Registry or QCDR that is reporting the individual or their group’s other quality measures and improvement activities.

We are concerned this policy could also be extended to other entities who operate proprietary programs identified within the existing Improvement Activities inventory. For instance, completion of TeamSTEPPS, Joint Commission Evaluation Initiative, and the completion of an accredited safety program are just three programs where the entity could feasibly report completion of an improvement activity to CMS. Should this reporting door be opened, we fear that CMS will have created a fragmented and inefficient way for MIPS reporting. We hope this policy proposal will not be extended to allow any other entities to report on one specific improvement activity to CMS and skirt the requirements for an intermediary to report quality, cost, and improvement activities categories.

Public Reporting on the Compare Tools hosted by HHS
ASA believes the proposed changes to HHS’ Care Compare tool will promote greater transparency and empower patients in making informed health care decisions. The addition of a telehealth indicator to clinician profiles would be beneficial in helping connect patients with the best clinician for them, particularly when patients have constraints that may make in-person visits challenging. Incorporating utilization data into these profiles would also promote transparency and help patients find the right clinician. However, we encourage CMS and HHS to consider how best to add context to this utilization data in the interest of preventing any confusion or misconceptions about a clinician’s utilization. These two proposed changes would not apply to much of anesthesia care, but they would be relevant and beneficial for pain medicine.

Incorporating Health Equity into Public Reporting Request for Information
CMS’ efforts to leverage the Care Compare tool to address health equity could be an important step in empowering patients and reducing health care disparities across the US. ASA supports these efforts and recommends that any inclusion of health equity measures and data into the tool include the context of whether a given clinician had the opportunity to report this data. Some specialties, including anesthesiology, do not generally report health equity measures as their workflows often lack the process necessary to collect such data. It will be important to note that health equity measures are not applicable to these specialties, so that clinicians of these specialties are not negatively implicated by the absence of health equity information on their profile.

Overview of APM Incentive
It remains a challenge for specialists, like anesthesiologists, to meaningfully participate in APMs. There are limited APMs available in which anesthesiologists can participate, from the type of model to the lack of measures that anesthesiologists can report. To better facilitate this transition, ASA recommends CMS provide financial incentives to practices that need support to make investments to switch to EHRs.

ASA also requests that the agencies consider providing an investment for more meaningful inclusion of more specialists in APMs. APMs are intended to coordinate care to achieve lower
costs and better patient outcomes. To decrease silos among all the providers that participate in an APM, incentives need be in place that encourage the APM entities to include all the necessary providers in the attribution models.

As previously mentioned, ASA has learned that anesthesiologists are being excluded at higher rates than in previous years from the attribution models of APM arrangements at their hospitals and systems. Anesthesiologists play key roles in helping achieve APM targets of decreased costs and better patient outcomes in surgical procedures. For example, anesthesiologists are often key leaders in doing so through implementation of the Perioperative Surgical Home (PSH) service delivery model throughout the U.S. It is also through implementation of a PSH that groups have found care coordination and health equity practices are more feasibly implemented. PSH has provided the infrastructure for many anesthesia groups to incorporate quality and cost improvements, including health equity measures. **CMS should take action to prevent anesthesiologists from being excluded in APM attribution models.**

**Request for Information Regarding QP Determination Calculations at the Individual Eligible Clinician Level**
ASA has previously expressed concerns that with current available Advanced APMs there are limited opportunities for specialists to become QPs.

Thank you for your consideration of our comments. We welcome the opportunity to speak with you further about our feedback. Please contact Matthew Popovich, ASA Quality and Regulatory Affairs Executive (m.popovich@asahq.org); Helen Olkaba, ASA Director of Payment and Practice Management (h.olkaba@asahq.org); or Matthew Goldan, ASA Regulatory Affairs Operations Associate (m.goldan@asahq.org), for questions or further information.

Sincerely,

Randall M. Clark, MD, FASA
President
American Society of Anesthesiologists
APPENDIX A: SUMMARY OF RECOMMENDATIONS

Calculation of the CY 2023 PFS RBRVS and Anesthesia Conversion Factors (CFs)

- ASA has serious concerns about the magnitude of the cuts to payments for the services of physician anesthesiologists. We recognize the limited authority CMS has to modify statutorily mandated budget neutrality adjustment 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 as it relates to updates to the fee schedule and processing claims.

Valuation of Specific Codes

Somatic Nerve Injections (CPT® codes 64415-64417 and 64445 - 64448)

- ASA urges CMS to finalize its proposed valuation of 1.31 wRVUs for code 64417, 1.34 wRVUs for code 64447, and 1.68 wRVUs for code 64448.
- ASA urges CMS to accept the RUC recommendation of 1.50 wRVUs for code 64415, 1.80 wRVUs for code 64416, 1.39 wRVUs for code 64445, and 1.75 wRVUs for code 64446.

Chronic Pain Management Services

- ASA supports CMS’ proposal to establish coding and billing describing chronic pain management services.
- ASA urges CMS to ensure there is appropriate flexibility in the billing rules for these services to allow physician anesthesiologists and pain medicine specialists to report these codes.
- ASA highlights the potential unintended consequence of using a pain rating scale or tool for validation and suggests the addition of a measurement that uses objective measures. ASA urges the agency to consider alternative language.
- ASA urges the agency to monitor the utilization of these services and request ongoing feedback from stakeholders as they gain experience with the codes to determine if adjustments in the code descriptor or reporting requirements are needed; and to assess if the reimbursement level is appropriate.
- ASA supports the development of coding and billing describing acute pain management services.

Indirect Practice Expense Methodology

- ASA supports more frequent updates to indirect practice expense data to reflect current costs associated with running a practice.
- We support the concept of an AMA-led survey to refine practice expense methodology. Since 2006, there has been a significant amount of change that would not have been captured, such as artificial intelligence (AI) technology and cybersecurity. Improving methodology and capturing up-to-date data is essential for projecting meaningful and accurate PE relative values.
Rebasing and Revising the Medicare Economic Index (MEI)
- ASA urges CMS to delay rebasing and revising the Medicare Economic Index until after the end of the public health emergency (PHE) and when more current data is available. ASA strongly recommends that when new data is used, it is applied over a multi-year transition period to mitigate any negative impact on individual practices or specialties.

Expansion of Medicare Coverage Policies for Colorectal Cancer Screening
- ASA supports the CMS proposal to reduce minimum screening age for colorectal cancer to 45 years and expand the regulatory definition of colorectal screening tests to include a follow-on screening colonoscopy after a positive result from a CRC screening stool-based test. ASA also reminds the agency that these polices should also apply to any related anesthesia services for these procedures.

Proposed Delay of New Split (Shared) E/M Visit Policy
- ASA supports the delay of this policy and urges CMS to reconsider its future installation. ASA recommends CMS permanently finalize this alternative policy that allows physicians or qualified health care professionals to bill split or shared visits based on time or medical decision making.

Medicare Part A and B Dental Services
- ASA supports the CMS proposal to pay for dental examinations and dental treatment preceding an organ transplant.

Proposed Payment Adjustments for NIOSH-Approved Domestic Surgical N95 Respirators
- ASA urges CMS to implement payment adjustments in the Medicare physicians fee schedule for the purchase of domestically made and approved N95s.

Updates to the Quality Payment Program
- CMS must continue to move prudently in assessing which measures should be prioritized for digitization while, at the same time, understanding that not every physician or group will have an opportunity or the resources to use digital measures.
- Clinical data registries like AQI NACOR should be consulted during and after the transition to dQMs.
- Groups participating in the APP or in APMs should be allowed to choose anesthesia measures to report in combination with other surgeon and/or primary care focused measures.
- CMS should consider requirements for sharing quality performance data among all specialists participating in the APP or within an APM.
- ASA recommends that CMS share a group’s MVP or subgroup status directly with registries and create a mechanism that encourages groups to share this information with their registry.
- Allowing for multispecialty groups to report to the same MVP would open the door to using cross-cutting measures that can be directly linked to MVP-relevant conditions and care coordination.
• CMS should not finalize its proposal to increase the data completeness criteria to 75 percent in CY 2024 or CY 2025.
• ASA opposes the removal of MIPS 076 “Prevention of Central Line Catheter-Related Bloodstream Infections.”
• CMS should replace PSPA_20 in the Patient Safety and Support of Positive Experiences with Anesthesia MVP with PSPA_19.
• CMS should approve an improvement activity for groups that assist measure stewards with measure development and testing efforts.
• ASA supports CMS continuing to use 75 points as the MIPS performance threshold.
• CMS should develop a strategy to provide an on-ramp for ECs and groups who have taken previous COVID-related hardship exemptions for reentering the MIPS program.
• Each year, CMS should notify QCDR measure stewards on the QCDRs that have submitted data for their QCDR measures.
• ASA supports the continuation of CMS policy to limit QCDRs to those registries that are physician-led and focused on clinical quality improvement.
• We support CMS' initial proposal to delay requirements for “full testing” of measures at least one year. We also support CMS delaying “fully tested” measure criteria until at least two years after the end of the public health emergency (PHE) or until two years after the EUC exceptions are discontinued, whichever comes first.
• CMS should delay requirements for full testing of QCDR measures that are included in MVPs.
• CMS should allow measure stewards to determine the feasibility of “full testing” of QCDR quality measures.
• CMS should require National Continuing Medical Education Accreditation Organizations who submit improvement activities on behalf of eligible clinicians to notify the Qualified Registry or QCDR that is reporting the individual or their group’s other quality measures and improvement activities.
• CMS should take action to prevent anesthesiologists from being excluded in APM attribution models.