American Society of Anesthesiologists®

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August 21, 2017
Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-5522-P Medicare Program; CY 2018 Updates to the Quality Payment Program

[Submitted via http://www.regulations.gov]

Dear Administrator Verma:

The American Society of Anesthesiologists® (ASA), on behalf of our over 52,000 members, appreciates the opportunity to comment on several of the issues in the above-captioned proposed rule. ASA has invested heavily in initiatives aimed at improving the safety, quality and efficiency of care for the surgical patient. We have sponsored the Perioperative Surgical Home (PSH) Collaboratives in almost 60 large and small health care institutions. PSH is a patient-centered delivery system that aligns with the National Quality Strategy (NQS) to achieve the triple aim of improving health, improving the delivery of healthcare and reducing costs.

The Quality Payment Program (QPP) is composed of two tracks: the Merit-based Incentive Payment System (MIPS), program that provided performance based payment adjustments based on the reporting of measures and other data and the Advanced Alternative Payment Model (APMs) a payment model that provides opportunities for eligible clinicians to earn incentive payments for taking on risk.

The QPP is a highly complex program that challenges clinicians to evolve and innovate to fulfill a vision of a future health system of increased quality of care to Medicare beneficiaries and reduced cost to the Medicare system. ASA shares this vision with CMS, but we also appreciate the significant work ahead for clinicians and CMS to turn this vision into a reality. The demands for a practice to meet a variety of reporting requirements, capacity to evaluate their own performance data and determine how to report in MIPS or participate in an Advanced APM is significant. For these reasons, we appreciate the agency's continued commitment to a gradual transition to the QPP. We appreciate and support many of the proposed policies to accommodate certain types of eligible clinicians and to reduce the burden on physicians. While we are supportive of many of the proposed policies, we continue to have concerns with certain policies that we urge CMS to address and we request clarification in other areas.

Such an all-encompassing, highly complex program also requires the agency to provide detailed guidance based on evidence-based policies that have been thoroughly vetted. Throughout our comments and recommendations for this proposed rule, ASA requests that CMS provide more information and greater clarity on several specific proposals. ASA strongly believes that the requested information is critical in our assessment of these proposals and we will not be able to determine whether we can support these proposals unless the requested information and details are provided. We also believe the greater understanding of these details is necessary for eligible clinicians to be fully informed of their options and the implications of their choices as they participate in MIPS or Advanced APMs.

ASA appreciates that the QPP is still in its infancy and the burden on CMS of rolling out this program is enormous. We look forward to a robust and collaborative relationship with CMS as the QPP develops and matures. Appendix A of this letter provides a complete listing of all our recommendations.

Merit-based Incentive Payment Systems (MIPS)

Under MIPS, beginning in the 2019 payment year, eligible clinicians earn a payment adjustment (positive, neutral, or negative) based on their performance in four performance categories: Quality, Improvement Activities (IA), Advancing Care Information (ACI), and Cost.
In this section of the letter we will be commenting in the following areas:

- General Policies: performance period, multiple submission mechanisms, facility-based measures, and virtual groups
- MIPS Payment Adjustment: Part B drugs, MIPS performance threshold, and payment adjustments distorting the Cost performance category
- Registries: self-nomination period, public posting of Qualified Clinical Data Registry (QCDR) measure specifications, probation and disqualification of registries submitting MIPS data, third party data submission, auditing of registries submitting MIPS data, and CMS API real-time data collection
- Quality Performance Category: Anesthesiology Specialty Measure Set, data completeness threshold, measure scoring, improvement scoring, topped out measures, and the complex patient bonus
- ACI Performance Category: general exclusions, 21st Century Cures exclusion for ambulatory surgical center (ASC)-based eligible clinicians, reweighting of ACI, decertification, summary of care measure, and new ACI measures
- Cost Performance Category: clinical subcommittees and other outreach activities, attribution, and 2018 weight for the Cost performance category
- Improvement Activities: new improvement activities, IA inventory, and scoring for small practices

General Policies

In this section we address overarching policies related to the implementation of MIPS.

Performance Period

For 2017, the first year of QPP, CMS implemented a slow on-ramp transition to MIPS referred to as "Pick Your Pace." Under Pick Your Pace CMS will accept a minimum of continuous 90 days

of data within 2017 for Quality, IA and the ACI performance categories to potentially earn an incentive. CMS is not implementing the Cost performance category in 2017. Pick Your Pace also includes a "Test" option where individuals or a group may submit a minimal amount of data (*e.g.* one Quality measure or one IA) at any point in 2017 to avoid a downward payment adjustment.

For the 2018 performance year, CMS proposes to maintain a 90-day performance period for IA and ACI and to increase the performance period for the Quality performance category to twelve months (January 1 – December 31, 2018). Again in 2018, CMS is proposing not to implement the Cost performance category.

ASA generally supports the 12-month reporting period for the Quality performance category, however this support is conditional upon CMS's release of the 2018 QCDR specifications by December 1, 2017. It is imperative that CMS give clinicians, registries, vendors and other third-party intermediaries, ample time to implement QCDR measures for reporting during the performance period. This lead time is necessary to provide all stakeholders with sufficient time to prepare and test systems and processes.

ASA supports a 12-month reporting period for Quality so long as CMS approves 2018 QCDR measure specifications by December 1, 2017.

Multiple Submission Mechanisms

For the 2017 performance year, eligible clinicians are required to use only one submission mechanism per performance category. For 2018, CMS proposes to allow individual MIPS eligible clinicians and groups to submit measures and activities through multiple submission mechanisms within a performance category as available and applicable. While ASA appreciates the flexibility CMS is trying to provide by allowing for multiple submission mechanisms, we are concerned with the unintended consequences and confusion that could ensue if CMS does not provide an administrative structure and guidance that will ensure the necessary information flow to ensure that eligible clinicians have access to accurate and timely information regarding their performance status.

Eligible clinicians rely on registries[1] to provide accurate information on their individual or group performance status. If eligible clinicians are allowed to submit data through multiple submission mechanisms, CMS should provide a means for eligible clinicians to easily access timely and current data on their performance status in MIPS performance categories. As proposed, the burden on a registry will increase significantly because the registry would not have the ability to accurately validate if an appropriate number of quality measures were submitted or the numbers of attestations for IA were received. Either the registry must be provided this information directly from CMS or there should be a means for eligible clinicians to access such data (*e.g.* online dashboard). Without such an infrastructure, we fear eligible clinicians who use multiple mechanisms may not have an accurate view of their yearly performance. We are particularly concerned that the proposal did not address who would be responsible for Eligible Measure Applicability (EMA) outreach, the system that determines whether an eligible clinician reported

[1] The term 'registry' is used within this letter to designate both the Qualified Registry and Qualified Clinical Data Registry (QCDR) reporting options. When necessary (*i.e.* describing measures) ASA will differentiate between the two terms in our comments.

the required number of measures in the Quality performance category, when participants report measures and activities through multiple submission mechanisms.

ASA believes it is premature to implement reporting via multiple mechanism in each category without further development and vetting through the public comment process. Such a process should address administrative structure, information flow and responsibilities for the various entities involved when eligible clinicians submit measures and activities through multiple submission mechanisms.

Facility-based Measures
The Medicare Access and CHIP Reauthorization Act (MACRA) authorized CMS to use measures from other payment systems (*e.g.*, inpatient hospitals) for the Quality and Cost performance categories for "hospital-based" MIPS eligible clinicians but excluded measures from hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

For 2018, CMS proposes to implement a ***voluntary*** facility-based scoring mechanism using the Hospital Value Based Purchasing Program (HVBP) as a proxy. This option would be available only to facility-based clinicians who have 75 percent of their covered professional services supplied in the inpatient hospital or emergency department setting. The facility-based measure option converts a hospital's Total Performance Score into MIPS Quality and Cost scores.

ASA supports allowing clinicians to use their facility's HVBP score as a proxy for their Quality and Cost performance category scores. For some practices, we believe this provides opportunities for meaningfully reducing the reporting burden. While we appreciate the potential benefits of such a proposal, we have similar concerns as previously raised on the multiple submission mechanisms proposal. For eligible clinicians who both participate in registries and who opt for the HVBP option, ASA asks that CMS provide eligible clinicians with clarification as to how an eligible clinician will be scored and assessed compared with the scores they view on their registry participant dashboard.

CMS proposes that in instances where there is both HBVP data and individual or group Quality score under MIPS, they will select the higher score. ASA believes this is a fair and reasonable approach which we support.

Like all medical specialties, ASA desires that our members have the best opportunity to succeed under MIPS. However, we want to ensure that participants understand that their scores within the registry may not necessarily reflect their final score, should they opt for the facility-based measurement score.

ASA supports the concept of the *voluntary* use of facility-based measures as a proxy for Quality and Cost performance category scores for hospital-based eligible clinicians, but we urge CMS to further develop and clarify how these eligible clinicians will be informed of their performance status. CMS should finalize the proposal to automatically choose the score that is more favorable to the eligible clinician.

Virtual Groups
The MACRA statute allows CMS to establish "virtual groups" for purposes of reporting and measuring performance under MIPS. Virtual groups can be composed of solo practitioners and small group practices that join together to report on MIPS requirements as a collective entity. The members of a virtual group share the same financial adjustments as the result of that reporting. The statute envisions virtual groups as a pathway for smaller practices to pool resources and achieve efficiencies. Virtual groups were not implemented in 2017.

For the 2018 performance period, CMS proposes to allow solo practitioners and groups of 10 or fewer eligible clinicians to come together "virtually" with at least one other solo practitioner or group to participate in MIPS; CMS notes that all NPIs billing under the TIN of the group participating in virtual group must participate in the virtual group. ASA supports opportunities for solo practitioners and small practices to participate in MIPS and have an equal opportunity at receiving positive payment adjustments as larger groups.

ASA believes that groups larger than 10 NPIs could benefit from the participation in a virtual group. While we understand that size of the practice that can participate in a virtual group is currently limited by statute, we believe that CMS should monitor the establishment and the ongoing functioning of virtual groups. **If benefits are borne out, ASA encourages CMS to explore if there are other pathways for the agency to implement a virtual group type of model for groups larger than 10 NPIs per TIN.**

ASA appreciates CMS's efforts to make MIPS reporting as flexible as possible, through the establishment of virtual groups. ASA plans to explore virtual group reporting for our registry but remain cautious. We are concerned that the reporting mechanisms made available for virtual groups involve multiple layers of legal and operational complexity. Anesthesia Quality Institute (AQI) National Anesthesia Clinical Outcomes Registry (NACOR) is a Patient Safety Organization (PSO) and our internal data governance standards are heavily influenced with PSO compliance. We are concerned that legal agreements made between different individuals and small groups may complicate PSO requirements AQI NACOR must follow when contracting with individual registry and single TIN participants. **ASA recommends that CMS should provide distinct instructions to registries on how to handle data sharing among virtual groups with respect to PSO regulations.**

ASA is also concerned about how quality data will be collected, aggregated and displayed for members of the virtual group. In AQI NACOR, participants in a TIN may view their information and that of the other members of the TIN. **ASA requests clarification if members of the virtual TIN would be allowed to view the quality data of their virtual TIN colleagues.** This particular scenario is one area where we believe PSO status may challenge our ability to allow virtual group participation.

It is unclear to ASA from the discussion in the proposed rule as to the responsibility of a registry to verify if a virtual group reporting through the registry has all the appropriate legal agreements in place prior to their participation in the registry. While CMS proposes to require that individuals within a virtual group sign a formal agreement with one another, we believe further details are needed to better understand how this proposal will be implemented and the role of

registries that virtual groups may use for reporting. **ASA requests additional information on what is necessary within the agreement and how a registry would need to validate such agreement for participation as a virtual group.**

Finally, we have concerns about how to meet eligible clinician requirements to report a sufficient number of measures. Although we have made a variety of measures available for eligible clinicians to report, should ASA wish to offer virtual group reporting, we believe ASA may need to increase the available measures to report, regardless of the measure's relationship to anesthesia. **ASA urges CMS to provide more guidance on what are its expectations for registries supporting virtual group reporting, especially when considering the role of specialty registries and the MIPS Quality performance category.**

<u>MIPS Payment Adjustment</u>
MACRA authorized MIPS payment adjustments (to the annual update) of +/- 4 percent beginning in 2019 and going up to +/- 9 percent by 2022. A payment adjustment of +/- 5 percent is scheduled for 2020. Providers in the top 25% of all aggregate MIPS scores receive additional positive adjustment factor (2019 – 2024); the bonus is capped at 10% per eligible provider.

Part B Drugs
The MACRA statute authorizes that the MIPS payment adjustment applies only to the amount otherwise paid under Part B for items and services furnished by MIPS eligible clinicians during the year in which the MIPS payment adjustment is applied. In the 2018 QPP Proposed Rule, CMS states that those billed Medicare Part B allowable charges relating to the purchasing and administration of Part B drugs would be included in the payment adjustment if CMS is able to associate with a MIPS eligible clinician.

ASA acknowledges that CMS's position that the MIPS adjustment applies to Part B drugs is consistent with the statutory phrase "items and services," however we are concerned that applying payment adjustments to Part B drugs and biologicals -- especially when limited to those charges that can be associated with a MIPS-eligible clinician -- is not consistent with the intent of the MACRA statute. The MACRA statute was designed to reward eligible clinicians for providing high quality care; it was not designed to reward or penalize eligible clinicians based upon the prices of drugs and biologicals that are medically necessary for the treatment of their patients. The issue of the true price of drugs is already very confusing and muddied with the various rates, discounts and other adjustments. Not only is this policy inconsistent with the goals of MACRA, we fear that this policy will only further confuse providers and create unwarranted differentials among clinicians based on practice settings and specialties.

ASA urges CMS to support any Congressional efforts to exclude application of the MIPS payment adjustment to Part B drugs. Absent any Congressional intervention, we urge CMS to use administrative authority to limit its impact.

Performance Threshold
Under the MIPS scoring system, a participant's MIPS score ranges from 0-100 points, and the payment adjustment applied is based upon that score. The "performance threshold" represents the score that is needed to receive a neutral to positive payment adjustment for the year. As

required by statute, starting in the *2019 performance year, the performance threshold* is determined annually as the *mean or median* of the MIPS scores.

ASA requests CMS provide information on how they will choose between the mean or median to set the performance threshold and the implications of each option. ASA urges CMS to use a transparent approach to make this decision. ASA also urges CMS to release as early as possible easily accessible performance information on eligible clinicians. This will allow eligible clinicians to better understand their individual performance and how they performed relative to their peers.

Payment Adjustments Distorting the Cost Performance Category
Under the MIPS program, Medicare Part B payments for eligible clinicians in a payment year will be adjusted either positively or negatively based on the MIPS eligible clinician's MIPS final score in the performance year, which occurs two years prior.

As we mentioned in our comments on the 2017 Proposed Rule, ASA is concerned that MIPS eligible clinicians who receive positive adjustments may be disadvantaged in future years if the adjustment is not removed from the assessment of their performance in the Cost performance category because they have relatively higher Medicare payment than those who receive neutral or negative adjustments for furnishing the same services. We do not believe this would be the intent of CMS but it is a technical issue that will arise in coming years that needs to be addressed.

While we understand that the Cost performance category is not yet implemented, once it is, ASA urges CMS to remove positive and negative payment adjustments along with geographic and other adjustments that do not reflect the utilization and intensity of services when calculating Cost performance category scores.

<u>Registries</u>
ASA appreciates the continued support that CMS has shown in this proposed rule concerning the use of physician-led clinical data registries. Many physician anesthesiologists and their practices encountered significant difficulties and costs when moving from claims-based reporting to registry reporting. However, ASA has witnessed more physician anesthesiologists engaged with how to capture and report data, learning how data can be used to improve patient care and looking for opportunities to improve efficiencies. These experiences support the provision of evidence-based, high quality care. We also know that practices experience fewer burdens once they have implemented data collection and registry reporting in their practice. The AQI NACOR continues to meet the intent of the QPP by ensuring ASA members and practices submit data efficiently to CMS. But more can be done to reduce physician and registry burden – ASA has identified several areas where CMS can reduce burdens and improve program efficiency.

Self-Nomination Period
To become a qualified registry for MIPS, registries must annually self-nominate. For the 2017 performance year, the nomination period ran from November 15, 2016 through January 15, 2017. For the 2018 performance period CMS is proposing a nomination period that runs from

September 1, 2017 through November 1, 2017. ASA supports the registry self-nomination period deadline of November 1, 2017.

We hope that by moving the self-nomination period deadline to November 1, CMS will be able to better accommodate registries, other third-party intermediaries, and eligible clinicians and groups as they implement and prepare for MIPS reporting each year. Timing of the various moving parts in this complex system is critical and we reiterate our ask that CMS approve the 2018 QCDR measure specifications by December 1, 2017 to allow for adequate time to prepare for the 2018 performance year.

Public Posting of QCDR Measure Specifications
CMS proposes to require QCDRs to post their measure specifications on a public website in a manner that is consistent with previous MIPS measure postings. ASA supports such a proposal and agrees that there would be a great benefit in making such information easily accessible to eligible clinicians. Moreover, ASA has enjoyed working with Physician Quality Measure Meeting (PQMM) staff on MIPS measures and find the MIPS measure review and approval process to be efficient and transparent. The materials published by PQMM represent a good example for how QCDR measures should be made available to individuals and group practices.

Eligible clinicians choosing a QCDR should have the opportunity to access and review potential measures for feasibility and applicability to the practice's patient population before they register. Additionally, QCDRs should be able to determine opportunities for measure harmonization or licensing agreements with measure owners.

CMS should develop a mechanism or guidance to remove barriers to publishing certain CPT® Code descriptors. For example, when new codes are publicly available or in other instances where measures include CPT code descriptors, we realize that there may be publishing limitations due to copyright unless a proper legal agreement has been reached. In these instances, QCDRs should not be penalized if there are outside factors that may limit their ability to publish measure specifications.

ASA urges CMS to implement the proposal to require QCDRs to post their measure specifications on a public website. We also ask CMS to clarify and provide guidance on appropriate publication of the underlying codes as well as accommodate any QCDRs that may not be able to publish measure specifications due to factors outside of their control.

Probation and Disqualification of Registries
CMS proposes that registries with data inaccuracy affecting 3-5% of the total eligible clinicians and groups, will be placed on probation for the next performance year. The same process will apply the following year. Error rates must fall below 3% within 2 years or the registry will be disqualified from MIPS. Error rates affecting 5% or more of eligible clinicians and groups will result in disqualification the following year.

Individual and group participants must be able to trust the accuracy of registries. Even more so, the robust development of MIPS is intricately linked and dependent on outside entities and third-party intermediaries. For these reasons, ASA supports policies that will ensure the validity of

registries participating in MIPS. Nevertheless, ASA has several concerns about that these proposals may unduly increase the burden on registries and QPP participants.

ASA remains concerned that the criteria CMS uses for error rates is not transparent and has resulted in errors having been assessed to the registry that were beyond the control of the registry. For instance, in a previous performance year, CMS noted an "error" based upon ASA submitting data for registry participants who did not have any Medicare Part B patients. Although our registry received attestations from participants stating that they billed Medicare, the registry was not provided with verifiable information beforehand on which eligible professionals billed Medicare in the performance year. The error was not related to data or data auditing but rather the status of the individual physician or eligible professional. This was an especially confused process considering the structure of the Physician Quality Reporting System program and low threshold for eligibility. In this instance, ASA did not understand what constituted an error and did not have access to a CMS-endorsed dataset that could have been used to validate such status prior to our submission. These sorts of non-technical errors, beyond the control of the registry, should not be considered an "error." **ASA requests that CMS detail the types of circumstances that will constitute an "error" with respect to identification of data inaccuracies as it relates to probation and disqualification of registries.**

We appreciate that this "error" may soon be corrected based upon CMS proposals. CMS will allow registries to report data on any eligible clinician regardless of their MIPS participation status. However, CMS can reassure registries and participants that their data submissions are accurate by defining data "errors."

Yet ASA recognizes that there are legitimate data errors that registries sometimes experience. A circumstance referenced in CMS provider calls and previous proposed rules relate to when a registry submits more quality measure numerator tallies than available denominators. ASA sees this sort of scenario as the responsibility of the registry. It would be the responsibility of the registry to effectively identify and address this data discrepancy prior to data submission to CMS. The registry would use its available information to contact the practice and practice vendors to understand and effectively address this problem.

In defining data errors, CMS would give power to registries to mitigate data problems early in the year. Qualified registries and QCDRs have both been available for reporting data for the last three years. In this time, ASA believes that CMS has collected a sufficient amount of information from a variety of registries to appropriately differentiate between true data errors and errors outside of the control of the registry. **ASA requests clarification related to CMS's reference to and calculation of data inaccuracies for registries.**

CMS should provide resources to registries so they can accurately identify practices that are part of an Advanced APM. We suggest including a NPI/Tax Identification Number (TIN) lookup tool for Advanced APM to ensure the registry is submitting data for the appropriate entities. This information may help us confirm MIPS participation or that the entity has submitted similar measures as their colleagues within MIPS.

We have concerns that the 3-5% threshold is too low for certain registries. Depending on the size of the registry, errors affecting one larger group reporting to a registry could disproportionally affect the registry's inaccuracy rate. For smaller registries with large group practices, the error rate could be significant. For registries with a more diverse set of practices, should errors occur, the error rate could be spread more evenly. CMS should consider an appeal process, consistent with previous approaches that can be used to determine if a vendor, biller or individual practice submitted erroneous data to the registry.

An example based upon the previously mentioned situation involving eligible clinicians who do not bill Medicare Part B but affirmed to the registry that they did bill for Medicare Part B can be used to illuminate this challenge. In this hypothetical scenario, the registry reports data for 100 practices and 10,000 eligible clinicians. One hypothetical practice within the registry reports data for 2,000 eligible clinicians and claims that these eligible clinicians bill Medicare Part B. It later turns out that 1,000 eligible clinicians were found to not bill Medicare Part B. In our previous experience with CMS, the error rate would be 10% for the registry even though the error was based upon just 1% of the groups reporting via the registry.

ASA believes CMS desires to identify poor registry performance and mitigate data error problems – not to penalize good faith efforts on the part of registries. Registries with the knowledge of what constitutes a data error can redouble their vigilance in identifying potential errors.

ASA recommends that CMS develop a more flexible system for assessing data errors and penalizing poor registry performance. We recommend that in addition to the established data error rate threshold that CMS institute an alternative error rate per TIN.

Third Party Data Submission
We also note that CMS is proposing to expand the requirement that third party intermediaries attest to CMS that all data submitted on behalf of a MIPS eligible clinician or group, to the best of their knowledge is true, accurate and complete (in addition to MIPS eligible clinicians and groups also attesting to this before submitting to the third-party intermediary).

Third party intermediaries currently attest at the time of submission of the data that they are in compliance with their CMS approved data validation plan, which CMS previously confirmed is the third-party intermediaries method to ensure the data it submits is accurate. CMS noted the following in response to a comment to the Official Rule for the 2017 Performance Period that the third-party intermediary should not be held responsible for the accuracy of data provided or stored by eligible clinicians and groups when the third party is not in a position to assess the validity of the data (81 FR 77390):

"We would like to explain that the primary purpose of auditing third party intermediaries is to ensure that accurate data is submitted and to maintain the integrity of MIPS payment adjustments made in accordance with program determinations and scoring that are based on data submitted by third party intermediaries. Thus, as part of the qualification and approval requirement to comply with auditing criteria third party intermediaries must ensure that the data they submit to us on behalf of MIPS eligible clinicians and groups is accurate. To meet this requirement, third

party intermediaries must have a data validation plan in place, they must execute this plan after they submit data to us, and they must send us the results of their data validation execution report. Please note we also expect third party intermediaries to notify us if their data validation results include a finding that data submitted by a MIPS eligible clinician or group is invalid. Those third party intermediaries who fail to comply with these data validation requirements, as part of their auditing compliance, will be considered non-qualified or non-approved for future MIPS program years."

CMS also acknowledged in the same commentary (81 FR 77366) that data validation plans are sufficient to ensure accuracy of data. Therefore, requiring that third party intermediaries attest more broadly to submission of true, accurate and complete data is unnecessary given that the current attestation already accomplishes this in a clear and concise manner. Broadening the attestation without providing guidance to third party intermediaries on how they can confidently make such an expansive assertion is not reasonable and does not help achieve CMS' intended purpose to develop a program that is meaningful, understandable and flexible.

ASA believes current regulations and attestations are adequate for third party intermediaries and we oppose the proposal to expand them.

Auditing of Registries Submitting MIPS Data
ASA believes that CMS can reduce physician and registry burden by identifying and implementing a fair and consistent data retention policy. The current system of data retention for billing, data submission and improvement activity documentation is fragmented and confusing. For instance, a registry must retain MIPS data submitted to CMS for a minimum of 10 years and practices must maintain certain documents for six years and three months. A streamlined and clear policy will also reduce the burden and confusion among all stakeholders: registries, eligible clinicians, and billing companies.

In reference to the proposal requiring registries to retain data submitted to CMS for at least ten years, ASA requests that CMS provides a definition for "retain." We request clarification whether retention refers to the original data files submitted to the data registry, or raw data within the registry that was used to generate information for CMS.

A streamlined and consistent approach to data retention will reduce burden and assuage practice anxiety. We request that CMS simplify the data retention policies for registries and QPP participants. The registry has implemented previous CMS rules and regulations to retain documents for 10 years. For simplicity, we ask that CMS finalize that MIPS participants retain documentation of compliance for six years instead of the proposed six years and three months. We recognize that this is not a simple fix and that many practices may also be required to retain billing and claims data as required by CMS or state law. Both the provider and the registry should be informed of their responsibilities and what they need to do to comply with CMS regulations.

ASA recommends that CMS provide a more consistent approach to assigning QPP retention policies for registries at 10 years and individuals and group participants at six years.

CMS API Real-Time Data Collection
CMS is exploring options with an API, which could allow authenticated third party-intermediaries to access the same data that the registry uses to provide confidential feedback to the individual clinicians and groups on whose behalf the third-party intermediary reports for purposes of MIPS.

ASA appreciates CMS intention to use QCDRs and qualified registries as laboratories to provide real-time, validated data to practices and individual eligible clinicians. We have appreciated previous discussions on this topic and would welcome additional information. Our concern lies with ensuring that practices and eligible clinicians receive accurate and defensible scoring. This action would represent something our members would appreciate as they try to determine their MIPS final score.

ASA urges CMS to provide additional details on the API real-time data collection proposal including proposed implementation, methodology, data validation and program testing and evaluation.

Quality Performance Category
Physician anesthesiologists participating in MIPS will most likely have 85% of their MIPS final score assessed under the Quality performance category because of their non-patient facing and hospital-based MIPS status. The reliance on this MIPS component for several medical specialties compels CMS to design a system that is fair and accurately reflects the quality of care eligible clinicians provide to patients each day.

Anesthesiology Specialty Measure Set
CMS is proposing to make changes to the Anesthesiology Specialty Measure Set. CMS proposes to add:

- MIPS #226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- MIPS #402 – Tobacco Use and Help with Quitting Among Adolescents
- A.5 – Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)

We believe the Anesthesiology Specialty Measure Set should only contain measures where the denominator set is solely composed of anesthesia service codes (00100-01999). While we recognize that some anesthesiologists may report E/M services, the majority of anesthesiologists do not report these codes. If the intent of the Specialty Set is to provide measures specific to a specialty, measures generally aimed at or reported by primary care physicians should not be included in the anesthesiology specialty measure set. Including measures that are reportable by E/M codes only, within the Anesthesiology Specialty Set has been confusing to many anesthesiologists. After several years of including such measures in our registry, we have found that very few anesthesiologists report MIPS #130 (Documentation of Current Medications in the Medical Record), MIPS #226 and MIPS #317 (Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented). We have never included MIPS #402 in our registry and believe performance on this measure will reflect similar data gathered on MIPS #130, MIPS #226 and MIPS #317.

ASA recognizes, however, that anesthesiologists who are able to report these measures may do so as part of a more comprehensive role in patient care – an important opportunity that participants in Perioperative Surgical Home (PSH) sites take advantage of in locations throughout the country. For those physicians, if they wish to report MIPS #130, MIPS #226, MIPS #317 or MIPS #402, we believe that the structure of MIPS allows them to report such measures regardless of their inclusion in a Specialty Measure Set.

ASA supports the inclusion of A.5 Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics) into the Anesthesiology Specialty Measure Set.

ASA opposes the addition of measure #226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention) and #402 (Tobacco Use and Help with Quitting Among Adolescents) to the Anesthesiology Specialty Measure Set.

ASA requests the removal of MIPS #317 (Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented) from the Anesthesiology Specialty Measure Set.

ASA supports the removal of MIPS #130 (Documentation of Current Medications in the Medical Record) from the Anesthesiology Specialty Measure Set.

Data Completeness for the Quality Performance Category
CMS proposes that the data completeness threshold for the Quality performance category will remain at 50%. Measures not meeting the data completeness threshold will receive one point. Robust data completeness requirements are essential to ensure reported data is representative of true performance. With the continued emphasis on quality measures that demonstrate a meaningful performance gap, it is more important than ever that performance data submitted to MIPS be complete and an accurate reflection of eligible clinician performance. **ASA supports the proposed data completeness threshold for reporting quality measures at 50% of eligible cases.**

Measure Scoring
For the 2018 performance year, CMS proposes to maintain certain policies around measure scoring. Measures, both those with and without a benchmark, will continue to receive at least three points in the 2018 performance year. Scoring methodology, including bonus points for reporting additional outcome and high-priority measures, will remain the same from the 2017 performance year.

ASA supports the continuation of a three-point floor for all measures, with or without a benchmark, that meet the data completeness threshold. Additionally, we encourage CMS to consider potential differences in the rigor of measures between specialties when determining scores and performance thresholds in future performance years.

Improvement Scoring for Quality
Clinicians that demonstrate significant improvement in this category between consecutive performance years will be eligible to receive additional points towards the overall Quality component score. The improvement percentage score cannot exceed 10 percentage points and is applied at the category level, not individual measure level.

Generally, ASA supports rewarding those eligible clinicians and groups that demonstrate improvement between consecutive performance years. However, we have concerns that this improvement scoring could penalize those eligible clinicians and groups who are high-performers at the outset of MIPS. Given that the potential for increased payment is based on a threshold determined by the previous year's data, improvement scoring for MIPS Quality performance category measures could have unintended consequences of rewarding lower performers.

In the evaluation of improvement scoring for quality, ASA recommends that the maintenance of high-levels be considered just as favorable as improvements from lower to high levels.

Topped Out Measures
CMS is proposing a process to remove topped out measures from MIPS. These are measures, whose overall performance is so high that CMS denotes that the measures are no longer meaningful to collect and report. CMS has implemented similar processes to remove such measures in other payment systems. For the MIPS, CMS is proposing a three-year timeline for topped out measures (Year 1 = 2017). Beginning in the second consecutive year of being topped out, measures will have special scoring applied (Year 2 and 3). After three consecutive years, measures will be removed from MIPS reporting (Year 4).

ASA agrees that topped out measures must be addressed differently than non-topped out measures. However, CMS must consider the impact of removing topped out measures from a Specialty Measure Set, compared to removing a primary care measure. **ASA recommends CMS examine topped out measures on a case by case basis to ensure specialties with very few measures are not disproportionately disadvantaged by the removal of topped out measures.**

In addition, CMS should consider the impact of the three-year timeline on other measure-related timelines. Development of new measures to replace topped out measures requires at least four years (1 year of development + ≥1 year for data collection and testing + 2 years from the Measures Under Consideration (MUC) submission to inclusion in MIPS). NQF endorsement further extends this timeline. **ASA recommends CMS explore ways to incorporate new measures into MIPS in a more streamlined and timely fashion so that removal of topped-out measures does not aggravate inadequacy of available measures.**

Complex Patient Bonus
CMS is proposing special consideration of eligible clinicians who care for complex patients by adding a complex patient bonus to the MIPS final scores of eligible clinicians and groups for the 2018 performance year if they submit data for at least one performance category. CMS identified two potential indicators for complexity: medical complexity as measured by the Hierarchical

Condition Category (HCC) risk scores and social risk as measured through the proportion of patients with dual eligible status. CMS envisions the complex patient bonus as a short-term strategy and proposes the bonus only for the 2018 performance year and will assess the bonus on an annual basis.

CMS is proposing bonuses that would be calculated using HCC risk scores and applying the average score (between 1-3 points) to the MIPS final score. Table 36 in the proposed rule indicates that the average addition to the final MIPS score would be 1.75 points. HCC risk scores are calculated for an individual beneficiary and are based on the beneficiary age and risk; whether the beneficiary is eligible for Medicaid; first qualified for Medicare on the basis of disability or lives in an institution (usually a nursing home); and the beneficiary's diagnoses from the previous year. CMS indicated that they selected HCC risk scores since clinicians have some familiarity with them since they have been used in the value-based modifier program to apply an additional upward adjustment.

CMS is also seeking guidance on an alternative proposal of applying a complex patient bonus based on a ratio of patients who are dual eligible.

We agree that factors reflected in the HCC may be relevant. Yet, we are concerned that certain specialties may be at an advantage relative to others based on factors independent of the actual complexity of the patient (*e.g.* specificity of ICD-10 coding in some areas versus others, coding practice patterns). **ASA asks CMS to test using HCC risk scores for the implementation of the complex patient bonus and analyze its results prior to full implementation.**

<u>Advancing Care Information</u>

Anesthesiologists provide care to patients in a variety of facilities and care settings that include hospitals, ASCs and office-based locations. They interact with a variety of technology, facility administrations and patient populations with their own facility-specific workflow challenges. In addition, some measures may be applicable to an anesthesiologist in one setting (perhaps a pre-op clinic) but that same measure may not apply to that same anesthesiologist practicing in a different setting (operating room) the next day. Regardless of previous participation by anesthesiologists in the MIPS ACI performance category or Electronic Health Record Incentive Program, we nonetheless offer the following comments to improve the effectiveness of the QPP.

General Exclusions

Prior to the implementation of the QPP, ASA supported the continued use of the general hardship exemption for anesthesiologists. Under the current QPP rules and in relation to the 21st Century Cures Act, we recognize that some anesthesiologists who have the appropriate technology and work in certain settings may wish to participate in ACI to diversify their scores.

ASA thanks CMS for the increased flexibility in the ACI performance category; the additional exemptions and scoring exclusions will be helpful to our members. ASA is pleased with the exclusions for E-Prescribing and Send a Summary of Care.

ASC-based MIPS Eligible Clinicians Automatically Reweighted to Zero (21st Century Cures)
ASA appreciates the ASC-based MIPS eligible clinician proposal to automatically reweight the ACI performance category to zero.

In the 2017 QPP Final Rule, CMS finalized an ACI exemption for eligible clinicians who practice in the inpatient, on-campus outpatient or emergency department settings that will function in a similar fashion to the aforementioned ASC policy. We believe CMS should extend this policy to the ASC setting and allowing for services provided in all the identified outpatient facility settings to be summed *cumulatively* to determine which eligible clinicians meet the threshold. This approach fully captures the intent of the provision. It has been generally accepted that physicians practicing in a facility environment have less control of their administrative environment and thus may not have access to the appropriate EHRs or the ability to use them in a meaningful way; this consideration is applicable to all facility-based places of service identified above. It would be illogical and unfair to subject a physician who provides services predominantly in facility settings to a penalty simply because he/she does not achieve the threshold in a single setting.

ASA urges CMS to apply the exemption to include physician anesthesiologists who work principally in facility settings beyond ASCs by pooling the utilization of services provided in the inpatient (POS 21), on-campus outpatient (POS 22), off-campus outpatient (POS 19), emergency room (POS 23), and ASC (POS 24) settings.

Reweighting
In 2017, when ACI is zeroed out, CMS will redistribute the weight of the ACI performance category to the Quality performance category, which results in the following weights for the MIPS final score: Quality (85 percent); IA (15 percent); ACI (0 percent); and Cost (0 percent). For 2018, CMS is proposing either maintaining the same approach to redistribution or adopting an alternative option for reweighting the ACI performance category where the weight would be redistributed between Quality and IA, which results in the following weights for the MIPS final score: Quality (75 percent); Improvement IA (25 percent); ACI (0 percent); and Cost (0 percent).

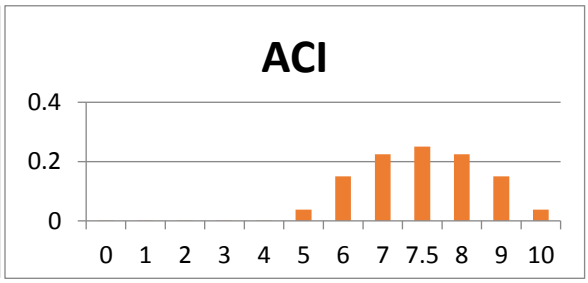
ASA believes that spreading the weights across the remaining two performance categories creates a bias against for those clinicians not reporting ACI. Nearly all users of EHR technology will qualify for the ACI "base score" of 50 percent. Reweighting ACI to Quality or IA, which do not have a base score of 50 percent, puts these eligible clinicians at a disadvantage because the distribution of ACI scores and Quality scores are inherently different.

ASA recommends that for clinicians who do not have ACI scores, instead of zeroing the ACI score and expanding the Quality or Quality and IA scores, CMS substitute a score with a 50 percent base and the clinician's Quality score (adjusted to a 50-100 scale) for the ACI performance score. This approach aligns with the CMS stated goal of allowing the Quality score to carry additional weight when an ACI score is unavailable, while correcting the fundamental disadvantage against these MIPS eligible clinicians unable report ACI measures created due to the difference in distribution of scores between the Quality and ACI performance categories.

The figures below illustrate how this can be achieved.

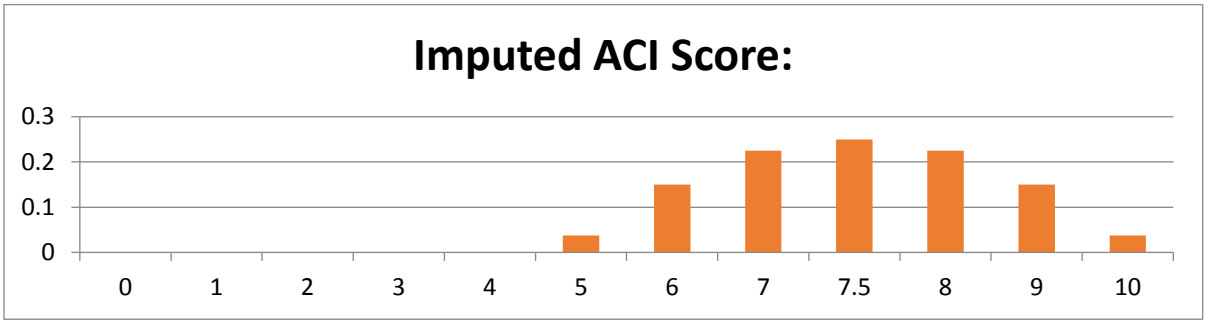
Distribution of Quality and ACI Scores

The distribution of scores under the Quality and ACI Performance categories are different because the ACI Performance Category essentially has a 50% minimum.



Distribution of Imputed ACI Score

Under this model, eligible clinicians who are exempt from ACI, instead of zeroing out ACI and expanding the weight of the Quality Category, the ACI Performance category is substituted with a score set at 50% base and the Quality Score scaled from 50-100%.



Decertification

ASA thanks CMS for its proposal to allow eligible clinicians to apply for a decertification exemption. Such an exemption would recognize the potential financial loss participants in these programs face when the Office of the National Coordinator for Health IT and CMS decertify their vendor's EHR technology during the performance year. This is an issue that can unexpectedly impact practices and our members would appreciate this additional protective measure.

We request that CMS also contemplate the actions an eligible clinician must take once their CEHRT is decertified. MIPS participants must understand whether they must proceed with ACI data submission if he/she does not have an exclusion or if that exclusion is not granted until the end of the year. If the exclusion is valid, the eligible clinician would not be able to submit ACI measures during the year – a situation that imposes unreasonable jeopardy on the MIPS participant.

Since these eligible clinicians do not have the capacity to report, they would be unable to establish the capacity to report on ACI while they are awaiting a decision on the decertification

exemption. **ASA urges CMS to make the decertification exemption policy permanent and requests clarification on whether an eligible clinician must proceed as if he/she is not granted an exemption. Based on their situation, these clinicians would not have the means to establish a capacity to report and requiring them to do so would be unreasonable.**

Summary of Care Measure
The Summary of Care measure references "transfer of care" and indicates that an eligible clinician provides a summary of care record "when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient." ASA requests CMS provide eligible clinicians with additional clarification or example on what is meant by "transfer of care" under this ACI measure. **ASA suggests that CMS confirm that transfers of care are intended to mean from one facility to another rather than from one location to another within the same facility.**

New ACI Measures
ASA has submitted two ACI measures for consideration in the CY 2019 QPP Proposed Rule, Description of Airway Management and Home Care Instructions for Peripheral Nerve Block Patients. ASA has requested in previous comment periods that CMS open the measure submission process to include specialty-relevant measures. We are grateful that CMS has opened this process and we look forward to feedback and collaboration from the agency.

ASA also supports the continued emphasis of CMS on IAs linked to work in Maintenance of Certification programs. We believe that physician anesthesiologists who complete such certification should receive credit in the IA performance category.

Cost Performance Category
In this proposed rule, CMS is proposing to weight the Cost performance category at zero percent of the final score for the 2020 MIP payment year. The agency continues to believe that more time is necessary to allow clinicians to better understand the methodology and impact of the cost measure, and to allow CMS time to develop measures that will be used in this category in future years. It plans to use 2018 for outreach to clinicians

The MACRA statute requires a 30 percent weight for the Cost performance category for the 2021 payment year that appears ineligible for waiver by the agency. In the proposed rule, CMS acknowledges that maintaining the zero percent weight for Cost for the 2018 performance year will result in a sharp increase in the Cost performance category percentage to 30 percent in performance year 2019.

The Cost performance category is unique from the other performance categories in MIPS in that nothing is reported by the eligible clinicians but rather the measurement is extracted from claims data. These data were developed for another purpose and are not always reliable. In addition to the plethora of reasons that eligible clinicians are uneasy about the implementation of claims measures, this seeming lack of control with the data contributing to how they are measured understandably adds to the uncertainty clinicians feel about the Cost performance category. Over time a robust and evidence-based process has evolved to develop quality measures. This has

resulted in the creation of more mature and meaningful measures over the years. Measures have transitioned from process-based measures to outcome-based measures. ASA anticipates that a similar maturation in the development of the cost measures will be established over time.

While ASA is concerned about the pace of the introduction of the Cost performance category, our comments and concerns are grounded in the belief that being accurate about costs is central to the overall mission of the QPP specifically and value-based care in general: more efficient and high-quality care for Medicare beneficiaries.

Clinical Subcommittees and Eligible Clinician Outreach
ASA appreciates the efforts of the agency in gathering input from eligible clinicians; feedback ASA has received from its members who have participated in these committees has been positive and confirms the complexity of the challenges ahead in developing Cost measures. **ASA supports the use of clinical subcommittees to gather input from eligible clinicians and urges CMS to conduct a wide-ranging outreach, reaching out to various types of providers. Of particular concern and interest to ASA is that CMS has not yet developed an alternative cost measurement approach for non-patient facing MIPS eligible clinicians. We urge CMS to continue working on this critical issue.**

In addition to forming clinical subcommittees, in the past year CMS has used the sub-regulatory process to vet proposed episode groups and other technical issues related to the development of cost measures. We believe these have been productive exercises and provide a means to collect information outside of the limitations of the proposed/final rule processes. **ASA urges CMS to continue to use the sub-regulatory process to vet proposals related to the Cost performance category.**

Attribution
Anesthesiologists play a unique role in the episode of care. Our members' mixed experience with the Quality Resource Use Reports (QRURs) reflects the challenge facing the agency in attributing cost and resource use to anesthesiologists. We wish to highlight the unique role of physician anesthesiologists as it relates to attribution of costs.

In the typical practice environment for physician anesthesiologists, purchasing and acquisition decisions related to a procedure in which anesthesia is required is most often not within the control or discretion of the anesthesiologist. As such, ASA believes it would be most appropriate that these resources and their accountability be shared with the surgeon and the facility **ASA recommends that resources be attributed to all providers and facilities involved in rendering the service. We believe such a methodology is aligned with the concept of shared accountability.**

Weight of the Cost Performance Category in 2018
The MACRA statute *requires* a 30 percent weight for the Cost Performance category by 2021 that the agency believes it does not have the authority to waive; maintaining the zero percent weight for Cost for the 2018 performance year is expected to result in a sharp increase in the Cost performance category to 30 percent in the 2019 performance year. In order to avoid such a large increase, CMS is seeking comments on an alternative approach of weighing the Cost

performance category at 10 percent for the 2018 performance period. **ASA does not support the alternative approach of weighting the Cost performance category at 10 percent for 2018; we believe it is premature to include the Cost performance category measures in the MIPS total score.**

Like CMS, ASA is very concerned about weighting of the Cost performance category at 30 percent weight in the2019 performance year when that category is finally introduced.

ASA urges CMS to consider alternatives to increasing the weight of the Cost performance category to 30 percent in 2019. ASA supports legislative approaches to address the problem, if necessary. If the 30 percent weight requirement for the 2019 performance year is not adjusted legislatively, we urge CMS to consider ways to limit the exposure to the negative impact by program design. For example, we believe the implementation and rollout of the value-based modifier and the current Pick-Your-Pace program for the first year of MIPS are examples of how CMS has used its administrative authority to mitigate the exposure to a program that was required by statute but where CMS was still developing the tools necessary to implement appropriately. We believe these limited options are especially significant for non-patient facing eligible clinicians.

While the agency works on developing cost measures, the agency continues to collect data on costs and resource use. CMS should begin to release preliminary findings from these data. While we understand that the agency intends to continue to release the QRUR reports, our members have found these difficult to obtain and, when they are obtained, the information included has been confusing and unhelpful. Accurate measurement of costs is critical, but the data also must be translatable to eligible clinicians in ways that are meaningful and actionable**. We urge CMS to address these issues in any rollout of data on costs to eligible clinicians. Additionally, cost measures should be tested and validated prior to their implementation in a fashion that limits risk for eligible clinicians**.

<u>Improvement Activities Performance Category</u>
ASA supports the new improvement activities CMS has proposed for 2018 attestation. In particular, we strongly support the inclusion of "PSH Care Coordination" as an Improvement Activity. As stated in the proposed rule, this Improvement Activity allows for "reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a [Perioperative Surgical Home]" and provides specific examples of meeting the activity. We also thank CMS for recognizing the comprehensive nature of PSH Care Coordination activities by assigning the IA as eligible for the ACI bonus. Participation involves time and resource intensive work for physicians to work collaboratively across service lines and with varying patient populations. Allowing clinicians the opportunity to receive credit commensurate with this work is important to the continued adoption of these vital activities.

Improvement Activities Scoring for Eligible Clinicians in Small Practices
For 2018, CMS is proposing that practices of 15 of fewer will continue to have IAs reweighted to 20 points for a medium weighted activity and 40 points for a high weighted activity. This is double the standard scoring methodology for IA (10 points for medium weighted activities and

20 points for high weighted activities). **ASA supports the continued doubling of scoring for IA for non-patient facing and urges CMS to expand this policy to hospital-based clinicians.**

Improvement Activities Inventory
CMS provided clarification on a number of IAs including IA with activity ID # PSPA_2. CMS identified participation in the ASA Simulation Education Network activity as fulfilling the requirements for PSPA_2. **ASA appreciates the clarification that for PSPA_2, participation in the ASA Simulation Education Network fulfills the requirement for this Improvement Activity. We recommend CMS finalize this proposed clarification.**

Advanced APMs
ASA recognizes that the vast majority of participating physician within the QPP will reporting through the MIPS pathway, we, nevertheless, see the potential value of Advanced APM participation for our members and other specialists. ASA urges the agency to continue its efforts moving from volume to value.

In this section we will be commenting on:
- Definition of Physician Focused Payment Models (PFPMs)
- All-Payer Combination Option
- Development of More Inclusive Models

Definition of PFPMs
In this Proposed Rule, CMS seeks comments on whether to broaden the definition of PFPMs to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer, even if Medicare is not included as a payer. CMS notes that by broadening the definition in this way it may complement the policies the agency is proposing within this rule for the All-Payer Combination Option.

ASA is encouraged by CMS' willingness to approach solutions to broaden the reporting opportunities for clinicians in practices that do not primarily service Medicare beneficiaries. Non-Medicare patient populations have different needs and creating provider payment frameworks centered around these differences is vital. ASA is keenly aware of these differences due to our organizing and partnering with other medical specialties to implement the PSH care delivery model in healthcare organizations across the United States.

The PSH is a patient-centered, physician-led, interdisciplinary and team-based system of coordinated patient care, which spans the entire experience from decision of the need for any invasive procedure—surgical, diagnostic, or therapeutic—to discharge from the acute-care facility and beyond. It strives to achieve the triple aim of better patient experience, better healthcare, and reduced expenditures for all patients undergoing surgery and invasive procedures.

As the PSH model has continued to grow, use of the model in the pediatric field has continued to show positive results in the management of children. As we outlined in our March 28, 2017 response to the CMS Request for Information on Pediatrics Alternative Payment Model Concepts, the recognition that children and adults have different needs is critical. Therefore,

payment models should be adjusted accordingly to reflect the differences in care and long-term management of patients.

ASA also approves of the proposed broader definition because widespread adoption of Advanced APMs will require CMS and other payers to gain experience across different patient populations. An expanded definition for PFPMs that allows for non-Medicare populations to serve as a valuable component of a clinician achieving QP status via the All-Payer Combination Option is an important step in expanding adoption of this important pathway.

ASA urges CMS to finalize the proposal to broaden the definition of PFPMs to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer, even where Medicare is not included as a payer.

All-Payer Combination Option

For payment years 2019 and 2020, eligible clinicians can reach Qualifying APM Participant (QP) status via Medicare-only APMs. Starting in payment year 2021, a clinician may now alternatively achieve QP status through the All-Payer Combination Option. ASA supports the development of the All-Payer Combination. We are pleased that CMS chose to spend considerable amounts of time and effort laying out the initial details of its implementation. While the details of the All-Payer Combination provide necessary flexibility to the diverse needs of clinicians, ASA urges CMS to build out the option as robustly as possible using a transparent approach to encourage broad adoption from a wide range of payers.

The success of this option is dependent on the involvement of a diverse group of payers that are diverse both geographically and in the types of patients they cover. Geographic areas which have highly concentrated commercial insurance markets remain vulnerable to low participation, as the refusal of one payer to participate in an APM agreement can severely limit an individual model's reach. This is especially worrisome for payment years 2023 and beyond when a minimum of 50% of payments or 15% of patients must be received through other payers. While CMS may have limited options due to statute, the agency should pursue any reasonable measure that allows for flexibility in reporting options for most clinicians.

ASA urges CMS to further develop the All-Payer Combination Option, taking a transparent and collaborative approach, to encourage the participation of a wide-range of payers.

Development of More Inclusive Models

ASA, along with a cohort of other procedure-focused medical specialties, remain concerned with the lack of procedure-focused alternative payment models. We understand that the way forward is not by allowing the creation of separate APMs for every condition or procedure, which will only encourage the fragmentation of care and may not lead us to the ultimate goal of increased quality of care for Medicare beneficiaries and reduced costs for the Medicare program.

While the expanded definition of PFPMs and the inclusion of the All-Payer Combination Option are good first steps, there are other opportunities to encourage the meaningful participation of anesthesia and other specialists that will support reduced costs and increased quality. The

Physician-Focused Payment Model Technical Advisory Committee (PTAC) will play an important role here. We are eagerly awaiting the agency's response to the PTAC recommendations that were submitted to the HHS Secretary on two new PFPMs at the April 11, 2017 public meeting.

We urge CMS to consider all recommendations for new APMs under the rubric of a unified, reasonable system that balances the need not to fragment care but to provide APM participation opportunities across the range of specialties. This will involve allowing ample time for stakeholder feedback on all HHS decisions, as well as continuing an open dialogue with the physician and provider community to ensure models are created to enable improved patient care across the country.

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

Sincerely,

Jeffrey Plagenhoef, M.D., FASA
President
American Society of Anesthesiologists

APPENDIX A – SUMMARY OF RECOMMENDATIONS

MIPS

General Policies

Performance Period

- ASA supports a 12-month reporting period for Quality so long as CMS approves 2018 QCDR measure specifications by December 1, 2017.

Multiple Submission Mechanisms

- ASA believes it is premature to implement reporting via multiple mechanism in each category without further development and vetting through the public comment process. Such a process should address administrative structure, information flow and responsibilities for the various entities involved when eligible clinicians submit measures and activities through multiple submission mechanisms.

Facility-based Measures

- ASA supports the concept of the *voluntary* use of facility-based measures as a proxy for Quality and Cost performance category scores for hospital-based eligible clinicians, but we urge CMS to further develop and clarify how these eligible clinicians will be informed of their performance status. CMS should finalize the proposal to automatically choose the score that is more favorable to the eligible clinician.

Virtual Groups

- If benefits are borne out, ASA encourages CMS to explore if there are other pathways for the agency to implement a virtual group type of model for groups larger than 10 NPIs per TIN.

- ASA recommends that CMS should provide distinct instructions to registries on how to handle data sharing among virtual groups with respect to PSO regulations.

- ASA requests clarification if members of the virtual TIN would be allowed to view the quality data of their virtual TIN colleagues.

- ASA requests additional information on what is necessary within the agreement and how a registry would need to validate such agreement for participation as a virtual group.

- ASA urges CMS to provide more guidance on what are its expectations for registries supporting virtual group reporting, especially when considering the role of specialty registries and the MIPS Quality performance category.

MIPS Payment Adjustment

Part B Drugs

- ASA urges CMS to support any Congressional efforts to limit the application of the MIPS payment adjustment to services on the Medicare Physician Fee Schedule. Absent

any Congressional intervention, we urge CMS to use administrative authority to limit its impact.

MIPS Performance Threshold

- ASA requests CMS provide information on how they will choose between the mean or median to set the performance threshold and the implications of each option. ASA urges CMS to use a transparent approach to make this decision. ASA also urges CMS to release as early as possible easily accessible performance information on eligible clinicians. This will allow eligible clinicians to better understand their individual performance and how they performed relative to their peers.

Payment Adjustments distorting the Cost Performance Category

- While we understand that the Cost performance category is not yet implemented, once it is, ASA urges CMS to remove positive and negative payment adjustments along with geographic and other adjustments that do not reflect the utilization and intensity of services when calculating Cost performance category scores.

<u>Registries</u>

Public Posting of QCDR Measure Specifications

- ASA urges CMS to implement the proposal to require QCDRs to post their measure specifications on a public website.

Probation and Disqualification of Registries Submitting MIPS Data

- ASA requests that CMS detail the types of circumstances that will constitute an "error" with respect to identification of data inaccuracies as it relates to probation and disqualification of registries.

- ASA requests clarification related to CMS's reference to calculation of data inaccuracies for registries.

- CMS should provide resources to registries so they can accurately identify practices that are part of an Advanced APM.

- ASA recommends that CMS develop a more flexible system for assessing data errors and penalizing poor registry performance. We recommend that in addition to the established data error rate threshold that CMS institute an alternative error rate per TIN.

Third Party Data Submission

- ASA believes current regulations and attestations are adequate for third party intermediaries and we oppose the proposal to expand them.

Auditing of Registries Submitting MIPS Data

- In reference to the proposal requiring registries to retain data submitted to CMS for at least ten years, ASA requests that CMS provides a definition for "retain."

- ASA recommends that CMS provide a more consistent approach to assigning QPP retention policies for registries at 10 years and individuals and group participants at six years.

CMS API Real-Time Data Collection

- ASA urges CMS to provide additional details on the API real-time data collection proposal including proposed implementation, methodology, data validation and program testing and evaluation.

Quality Performance Category

Anesthesiology Specialty Measure Set

- ASA supports the inclusion of A.5 Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics) into the Anesthesiology Specialty Measure Set.

- ASA opposes the addition of measure #226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention) and #402 (Tobacco Use and Help with Quitting Among Adolescents) to the Anesthesiology Specialty Measure Set.

- ASA requests the removal of MIPS #317 (Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented) from the Anesthesiology Specialty Measure Set.

- ASA supports the removal of MIPS #130 (Documentation of Current Medications in the Medical Record) from the Anesthesiology Specialty Measure Set.

Data Completeness Threshold

- ASA supports the proposed data completeness threshold for reporting quality measures at 50% of eligible cases.

Measure Scoring

- ASA supports the continuation of a three-point floor for all measures, with or without a benchmark, that meet the data completeness threshold.

Improvement Scoring for Quality

- In the evaluation of improvement scoring for quality, ASA recommends that the maintenance of high levels be considered just as favorable as improvements from lower to high levels.

Topped Out Measures

- ASA recommends CMS examine topped out measures on a case by case basis to ensure specialties with very few measures are not disproportionately disadvantaged by the removal of topped out measures.
- ASA recommends CMS explore ways to incorporate new measures into MIPS in a more streamlined and timely fashion so that removal of topped-out measures does not aggravate inadequacy of available measures.

Complex Patient Bonus

- ASA asks CMS to test using HCC risk scores for the implementation of the complex patient bonus and analyze its results prior to full implementation.

ACI Performance Category

21st Century Cures Exclusion for Ambulatory Surgical Center (ASC)-based Eligible Clinicians

- ASA urges CMS to apply the exemption to include physician anesthesiologists who work principally in facility settings beyond ASCs by pooling the utilization of services provided in the inpatient (POS 21), on-campus outpatient (POS 22), off-campus outpatient (POS 19), emergency room (POS 23), and ASC (POS 24) settings.

Reweighting of ACI

- ASA recommends that for clinicians who do not have ACI scores, instead of zeroing the ACI score and expanding the Quality or Quality and Improvement Activity scores, CMS substitute a score with a 50 percent base and the clinician's Quality score (adjusted to a 50-100 scale) for the ACI performance score.

Decertification

- CMS to make the decertification exemption policy permanent and requests clarification on whether an eligible clinician must proceed as if he/she is not granted an exclusion. Based on their situation, these clinicians would not have the means to establish a capacity to report and requiring them to do so would be unreasonable.

Summary of Care Measure

- ASA suggests that CMS confirm that transfers of care are intended to mean from one facility to another rather than from one location to another within the same facility.

Cost Performance Category

Clinical Subcommittees and Other Outreach Activities

- ASA supports the use of clinical subcommittees to gather input from eligible clinicians and urges CMS to conduct a wide-ranging outreach, reaching out to various types of providers. Of particular concern and interest to ASA is that CMS has not yet developed an alternative cost measurement approach for non-patient facing MIPS eligible clinicians. We urge CMS to continue working on this critical issue.

- ASA urges CMS to continue to use the sub-regulatory process to vet proposals related to the Cost performance category.

Attribution

- ASA recommends that resources be attributed to all providers and facilities involved in rendering the service. We believe such a methodology is aligned with the concept of shared accountability.

2018 Weight for the Cost Performance Category

- ASA does not support the alternative approach of weighting the Cost performance category at 10 percent for 2018; we believe it is premature to include the Cost performance category measures in the MIPS total score.

- ASA urges CMS to consider alternatives to increasing the weight of the Cost performance category to 30 percent in 2019.

- We urge CMS to address these issues in any rollout of data on costs to eligible clinicians. Additionally, cost measures should be tested and validated prior to their implementation in a fashion that limits risk for eligible clinicians.

IA Performance Category

Improvement Activities Scoring for Eligible Clinicians in Small Practices

- ASA supports the continued doubling of scoring for IA for non-patient facing and urges CMS to expand this policy to hospital-based clinicians.

IA Inventory

- ASA appreciates the clarification that for PSPA_2, participation in the ASA Simulation Education Network fulfills the requirement for this Improvement Activity. We recommend CMS finalize this proposed clarification.

Advanced APMs

Definition of Physician Focused Payment Models (PFPMs)

- ASA urges CMS to finalize the proposal to broaden the definition of PFPMs to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer, even if Medicare is not included as a payer.

All-Payer Combination Option

- ASA urges CMS to further develop the All-Payer Combination Option, taking a transparent and collaborative approach, to encourage the participation of a wide-range of payers.

Development of More Inclusive Models

- We urge CMS to consider all recommendations for new APMs under the rubric of a unified, reasonable system that balances the need not to fragment care but and to APM participation opportunities across the range of specialties.