American Society of Anesthesiologists®

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June 13, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1677-P Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices, Proposed Rule

[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 features of the Medicare Inpatient Prospective Payment Systems for Acute Care Hospitals proposed rule. Physician anesthesiologists provide care to patients in a variety of facilities and care settings that include inpatient hospital settings, outpatient hospital departments, ambulatory surgical centers (ASC) and office-based locations. ASA welcomes the opportunity to work with CMS to ensure that our members are appropriately recognized in their delivery of high quality and high value healthcare to Medicare beneficiaries.

Although the bulk of this proposed rule refers to hospital and facility-based payment and quality measurement, our members are nonetheless impacted by several of its components related to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the 21st Century Cures Act. Physician anesthesiologists represent the common pathway for nearly all surgical and procedural care patients and can contribute to improved quality and more cost-effective care. In addition, physician anesthesiologists specializing in pain medicine, a separate medical subspecialty recognized by the American Board of Medical Specialties, have additional training and education that make them uniquely qualified to diagnose and treat patients with complex pain conditions.

Our letter offers these key recommendations:

- ASA recommends extending the Electronic Health Record (EHR) technology decertification exemption to Eligible Clinicians (ECs) participating in the Quality Payment Program (QPP).

- ASA supports CMS exempting those ECs who furnish 75 percent or more of their covered professional services in an ASC setting.
- ASA supports the proposed changes to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) pain management survey questions.
- ASA supports the concept of using a hospital or facility's quality measure scores to serve as a proxy in the QPP Merit-based Incentive Payment System (MIPS) Quality and Cost Components for ECs and their groups.

Ambulatory Surgical Center (ASC)-Based Eligible Professionals (EPs)

ASA thanks CMS for its proposal to allow eligible professionals, eligible hospitals and critical access hospitals (CAHs) seeking to avoid the Medicare payment adjustment 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 urge CMS to continue this exemption for ECs in the Merit-based Incentive Payment System, as they will continue to experience similar hardships with unexpected EHR technology decertification.

In the 2018 IPPS Proposed Rule, CMS proposes to implement a provision in the 21st Century Cures Act where no payment adjustments under MIPS will be applied to ECs who furnish "substantially all" of their covered professional services in an ASC. CMS is proposing two definitions: 75 percent or more of covered professional services in an ASC (POS 24) or 90 percent or more of covered professional services in an ASC (POS 24).

ASA applauds the proposals to exempt those ECs who furnish "substantially all" of their services at ASCs from the 2017 and 2018 Medicare payment adjustments. Of the two proposed definitions, ASA requests that CMS exempt those ECs who furnish 75 percent or more of their covered professional service in an ASC setting. ASA urges CMS to consider applying the exemption to include physician anesthesiologists who work principally in facility settings. ASA believes using POS 24 is an appropriate method to identify those ECs in an ASC. In addition, ASA recommends CMS consider including clinicians furnishing services in off-campus hospital (POS 19) under the exemption.

We believe CMS should implement the provision by allowing for services provided in all the identified outpatient facility settings to be *summed cumulatively* to determine which ECs 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 of the cited places of service. It would be illogical and unfair to subject such a physician to a penalty simply because he/she does not achieve the threshold in a single setting.

ASA requests that CMS consider combining services furnished in both ASC settings and qualifying hospital settings cumulatively for future exemptions applicable to facility-based physicians as well. ASA understands that CMS will collect comments specific to the Merit-based Incentive Payment System in the anticipated MACRA rule later this year. ASA urges that if an EC furnishes a substantial number of services in an ASC and a substantial number in a qualifying hospital setting such that cumulatively the total number of services exceeds the 75 percent threshold, the physician should be treated as hospital- or facility-based for purposes of determining if the eligible clinician is exempt from the MIPS Advancing Care Information (ACI) category.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey – Communication About Pain

ASA is pleased CMS is proposing refinements to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. As noted in prior comments to CMS, ASA is concerned the pain management dimension impacts opioid prescribing practices. The original questions included in the HCAHPS survey inadvertently place pressure on physicians to prescribe opioids and do not adequately focus on the goals of reducing pain, improving patient function and decreasing the period of time before patients can return to normal activities.

We commend the focus on effective communication with the newly proposed questions and believe the proposed composite name change from pain management to communication about pain demonstrates the importance of this issue. ASA previously recommended that any revised questions should revolve around the specific discussion between health care providers and their patients, such as whether alternative methods of managing pain were offered or provided to the patient, including multimodal pain care, which includes non-opioid analgesics, interventional pain procedures and regional analgesia, in addition to opioid medications.

ASA supports the newly proposed questions and thanks CMS for hearing our concerns and responding accordingly. The new questions focus on how providers communicate with patients about pain, including treatment options. Although the questions are greatly improved, ASA would like to make one suggestion with respect to question HP3. As currently worded, usage of the word "treat" is problematic. Treat implies that complete pain relief will be achieved, which is not always possible. Instead, ASA suggests phrasing this part of the question as "manage or treat," as this provides a more accurate expectation for patients.

We are grateful that CMS has proposed these refinements to the pain management dimension of the HCAHPS Survey. The newly proposed questions, even with existing wording, is preferable to the original questions. While revising the questions alone will not resolve the prescription opioid epidemic, ASA is hopeful that this is a key part of a comprehensive solution to preventing the unintended consequences of opioid use.

Hospital Inpatient Quality Reporting (IQR) Program

ASA has consistently supported previous policy proposals for physician anesthesiologists and other ECs to use their hospital or facility's IQR measures scores as a proxy for the individual EC or group's quality and/or cost composite scores under the QPP. Facility-based measures that are developed and tested with appropriate attribution models may better capture the quality of care physician anesthesiologists and other clinicians provide to patients. Shared accountability measures, based off such measures, can better incentivize collaboration among physicians and the facilities where they provide services.

Certain facility-based ECs, such as physician anesthesiologists, face unique challenges meeting many of the MIPS reporting requirements. The current reporting methodology under MIPS is not well-suited for anesthesiologists and other ECs who provide care in a team-based environment. Although the anesthesiologist's clinical actions meaningfully contribute to high quality outcomes and reduced resource use in a value-based environment, these contributions may not be easily captured by MIPS measures and objectives. Therefore, we believe facility-based measures, appropriately implemented, have the potential to capture the efforts of a larger number of clinicians who contribute to a patient's care.

ASA agrees with proposals that allow for the voluntary reporting of several hospital and facility-based quality measures until sufficient and objective data and benchmarks can be gathered and established.

ASA recognizes the challenges CMS faces from understanding the concept of using facility measures as a proxy, developing a scoring methodology to accurately translate scores based on a facility's performance to an individual provider and addressing ECs who practice at multiple facilities. In addition, we recognize the challenges of aligning different quality program measure cycles and measurement type (e.g., facility versus individual measure, measure domain) across a spectrum of measures and specialties. For these reasons, we urge CMS to initially roll-out any program that attributes facility-based measures to individual ECs or group practices in a "hold-harmless" fashion, allowing CMS to test methodologies and to further understand the implications of this policy across facility-based ECs. Regardless, ASA supports CMS in this important initiative and we look forward to working with CMS to better understand how to implement such a policy in the future.

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.
President
American Society of Anesthesiologists