American Society of Anesthesiologists®

1501 M Street, N.W., Suite 300 ▪ Washington, D.C. 20005 ▪ (202) 289-2222 ▪ F: (202) 371-0384 ▪ asahq.org

February 6, 2017

Molly MacHarris
Health Insurance Specialist
Quality Measurement and Value Based Incentives Group
Center for Clinical Standards & Quality
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Request for comments on implementation of facility-based measures for the Merit-based Incentive Payment System (MIPS)

[Submitted via email: molly.macharris@cms.hhs.gov]

Dear Ms. MacHarris:

The American Society of Anesthesiologists® (ASA), on behalf of our over 52,000 members, appreciates the opportunity to comment on the implementation of facility-based measures for the Merit-based Incentive Payment System (MIPS). ASA supports the concept of using facility-based measures as a proxy for the MIPS quality and cost performance categories for Eligible Clinicians. ASA welcomes the opportunity to work with you to ensure that our members can successfully participate in MIPS and continue to provide Medicare beneficiaries high-quality and high-value healthcare.

ASA thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to join the recent listening session on Thursday, January 26, 2017. We appreciate the agency's efforts to address the challenges of MIPS participation for facility-based Eligible Clinicians. The listening session discussion confirmed ASA's initial thinking that while this concept would be a worthy and beneficial addition to the MIPS program, its implementation will be complex and a number of structural challenges will need to be addressed.

Certain facility-based Eligible Clinicians, such as anesthesiologists, face unique challenges meeting many of the MIPS reporting requirements. The current reporting methodology is not well-suited for anesthesiologists and other Eligible Clinicians 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. We believe that, if appropriately implemented, facility-based measures and measure sets will have the potential to capture the efforts of a larger number of clinicians who contribute to a patient's care. We also believe this concept will help reduce the reporting burden for facility-based Eligible Clinicians and reduce the redundancy in data reporting with facilities.

ASA supports CMS efforts to make the MIPS program more efficient. Measures that reflect the performance of both the facility and the MIPS eligible clinicians should be integrated where appropriate. We also approve of the concept of using a hospital's quality score as a proxy for an individual physician. We believe that this shared accountability can incentivize collaboration among physicians and the facilities in which they provide services.

ASA has considered the practicality and implementation of this concept since the release of the MACRA RFI in September 2015. From this comment period, as well as the discussion during the recent listening session, the complexity and challenges of truly implementing what we believe will be a worthy and beneficial addition to the MIPS program is quite apparent. The challenges range broadly 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 Eligible Clinicians 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 this program in a "hold-harmless" fashion, allowing CMS to test methodologies and to further understand the implications of this policy across facility-based Eligible Clinicians. Initially, CMS could release this data as informational only or as a means to earn bonus points. CMS should also make participation optional. There is precedent for such an approach. Recent examples of CMS slowly transitioning into a new initiative include the transition of PQRS as a voluntary "bonus-only" program in 2007 to penalties beginning in 2015. Another example is the Value-Based Payment Modifier (VM) program. As you are well aware, under the VM, physicians may earn an upward, neutral or downward payment adjustment based on performance on quality and cost measures. CMS initially disseminated Quality and Resource Use Reports (QRURs) as informational only prior to implementing them as part of the VM. Participation of providers in the VM program was staggered applying first to larger practices (100 or more) in 2015 and, by 2017, applying to solo practitioners and groups of two or more Eligible Professionals.

We recognize the purpose of this policy to use facility-based measures as a proxy for quality and cost in the MIPS program is to grow participation in MIPS. In the MACRA Final Rule, CMS revised the definition of hospital-based to include on-campus outpatient hospital (POS 22), expanding the definition from previously proposed settings of inpatient hospital (POS 21) and emergency room (POS 23). CMS also lowered the threshold of professional services furnished in a certain site of service to determine hospital-based MIPS eligible clinicians from 90 percent to 75 percent. ASA was pleased to see CMS implement these provisions.

Yet the relationship between the clinician and facility extends beyond inpatient, outpatient (on and off campus) and the Ambulatory Surgical Center (ASC) setting. Our members provide care to patients in a variety of facilities and care settings that include inpatient hospital settings, outpatient hospital departments, ASCs and office-based locations. The rationale for making the distinction for hospital-based clinicians is to recognize the integration of clinicians with the facility on both a clinical and administrative level.

While we appreciate and believe the modification in the Final Rule is heading in the right direction, we urge CMS to further expand the definition of hospital-based physicians to include ASCs (POS 24) and Off Campus Outpatient-Hospital (POS 19). Insofar as the 21st Century Cures legislation recognizes the challenges faced by clinicians who furnish services in the ASC setting to meet the requirements for use of Certified Electronic Health Records and the Advancing Care Information component of MIPS and provides an accommodation for such clinicians, this further supports the argument for the inclusion of the ASC setting (POS 24) under the “hospital-based” definition. In addition, when determining whether or not individual clinicians meet the hospital-based (facility-based) definition, CMS should consider encounters in all of the hospital-based (facility-based) places of services cumulatively.

Thank you for your consideration of our comments. ASA is keen to support CMS in this important initiative. We offer the services of our highly experienced staff and clinical leadership to work with CMS to better understand how to implement such a policy and the impact of a specific proposed methodology on facility-based physicians such as anesthesiologists. 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,

J Plagenhoef MD

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