American Society of Anesthesiologists

1501 M Street, N.W. • Suite 300 • Washington, D.C. 20005 • (202) 289-2222 • Fax: (202) 371-0384 • mail@ASAwash.org

August 30, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1524-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **CMS-1524-P**, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012; Proposed Rule, July 19, 2011

Dear Dr. Berwick:

The American Society of Anesthesiologists (ASA), on behalf of its over 46,000 members, appreciates the opportunity to comment on several of the issues in the above-captioned proposed rule published in the July 19, 2011, *Federal Register*. As the recognized leaders in patient safety and quality, we always welcome the opportunity to work with you to ensure high quality and high value care for our Medicare and Medicaid patients.

Improvements to the Physician Feedback Program and Establishment of the Value-Based Payment Modifier (Effect of Sections 3003 and 3007 of ACA)

ASA shares CMS's goals related to the value-based payment modifier, including improving quality and lowering per-capita growth in expenditures. In fact, we believe that anesthesiologists have achieved these goals for many years through their Institute of Medicine (IOM)-recognized leadership in patient safety despite the reality of our "33 percent Medicare problem" detailed later in this letter. In short, anesthesiologists have been doing more than their share to reduce health care system expenditures and provide high quality care before and after passage of the Patient Protection and Affordable Care Act (ACA).

We also acknowledge the arduous task imposed upon CMS by Congress in implementing much of the health reform legislation, but especially the value-based payment modifier. We appreciate the expressed desire of CMS to move "both deliberately and carefully because [you] recognize the complexities of calculating a reliable and valid measure that compares physicians against their peers and uses the measure to differentiate payment."

With respect to quality of care measures that CMS proposes to use for the value-based payment modifier, we can understand the initial desire to move toward a core set of measures that will afford the opportunity to benchmark physicians. While this approach affords administrative simplification, unfortunately it fails to account for the variations in practice among specialties, including anesthesiology. While pediatric growth charts, colorectal cancer screening and beta blocker therapy for coronary artery disease patients with a prior myocardial infarction are all important initiatives and efforts, they are not directly relevant to the practice of anesthesiology and whether a patient will safely endure a surgical intervention with no adverse events, no side effects and at the lowest feasible cost to the system. **Therefore, given the varying practice of many specialties, we encourage CMS to avoid use of only one core set of quality measures for all physicians**; rather, multiple sets of quality measures should exist or be developed to afford flexibility and applicability to the broad range of physician services provided to Medicare and Medicaid beneficiaries every day.

In the proposed rule, CMS requests that specialists provide feedback on the measures CMS should use in developing the payment modifier beyond the proposed measures contained in the rule. We appreciate that CMS acknowledges that many of the proposed measures emphasize primary care. **With respect to measures CMS should adopt for evaluation of anesthesiologists, we believe that the agency should start with the measures already adopted by CMS (and endorsed by the National Quality Forum (NQF)) for use in PQRS, namely Measures 30 (Timely Administration of Prophylactic Antibiotics) and 193 (Perioperative Temperature Management).** We believe these measures provide a simple and evidence-based approach to assessing quality of care provided by anesthesiologists.

ASA has worked for years to review the evidence and identify performance measures of relevance to the specialty. For instance, prevention of ventilator-associated pneumonia is an NQF-endorsed measure that was first approved by the ASA House of Delegates (HOD). The ASA HOD has also approved measures for comprehensive planning for chronic pain management, management of postoperative hypothermia, antibiotic redosing and post-operative nausea and vomiting; however, for various reasons NQF has not considered or endorsed these measures to date. CMS may want to consider adoption of these measures as well.

ASA believes that transfer of care and care coordination are important areas of focus for providers and patients. We applaud CMS's focus on this area, though we believe there are additional coordination areas beyond discharge and transfers between facilities. For this reason, ASA has devoted resources to examine and develop a measure focused on post-anesthesia transfer of care protocols from the procedure room to the intensive care unit. Our Board of Directors recently approved this measure, and our HOD plans to review it in October 2011. Assuming the measure is approved, we look forward to discussing with CMS its potential to improve the quality of care provided to Medicare and Medicaid patients.

Anesthesiologists are critical to achieving the goals of reduced health care costs and improved quality of care. **With respect to the CMS call for systems-based approaches, ASA strongly recommends CMS consider the concept of a coordinated surgical home model.** We believe this model will achieve better value for beneficiaries through care coordination and process improvements led by anesthesiologists. The surgical home is the counterpart to the primary care-led medical home and would assist hospitals and facilities in effectively managing health care expenses, approximately 60-70% of which are incurred in the surgical setting.

Why should anesthesiologists play a leadership role in a surgical home? Anesthesiologists routinely interact with physicians and other providers from virtually all care settings and assess and monitor the patient from an overall perioperative perspective; thus, anesthesiologists are ideally suited to effectively assess and manage risk across the full continuum of the perioperative setting. Anesthesiologists partner with hospitals, proceduralists, and surgeons in selecting cost-effective implants and pharmaceuticals to provide better quality of care at a lower cost. Further, anesthesiologists serve as physician managers and coordinators of operating and procedure rooms. In addition to managing patient flow and triage through the surgical experience, anesthesiologists evaluate and help optimize patients for proposed operative procedures. For those situations where multiple pathways of care are available, anesthesiologists play a central role in helping patients determine the most appropriate course of care. Evidence-based Cost Utility Analysis can play a role in informing the patient's decision-making. Some patients may elect to have less expensive conservative management after such counseling, creating savings for Medicare. These savings are directly attributable to the anesthesiologist's participation. Additional savings would be derived from decreased testing and consultations, through pre-operative evaluations performed in anesthesiologist-run Pre-Anesthesia Testing (PAT) clinics, as well as reduced hospital lengths of stay and hospital readmissions arising from 1) selection of appropriate candidates for surgery, including interventions with those who are highly unlikely to benefit, 2) identification of optimal timing for surgical interventions, to avoid rescheduling, 3) reduction of complications such as surgical or catheter-related infections, poor perioperative glycemic control, and postoperative nausea and vomiting that increase length of stay or necessitate admission following outpatient surgery, and 4) improved perioperative management of pain and anxiety to ensure the best possible patient care experience.

With respect to the cost component of the payment modifier, we share the Government Accountability Office's (GAO) concerns[1] about the challenges CMS faces in implementing Phase III of the program in a manner that will result in reliable, credible and useful information that physicians can apply to their practices before payment policies take effect in 2015. Application of a methodology attributing costs directly to individual physicians is daunting as the care of patients continues to evolve into a team-based approach; however, ASA has recognized the importance of this task. We are attempting to identify a methodological approach that could be used to identify costs and resources attributable to an anesthesiologist. This task will not be easy and will take some time, but we would be willing to discuss our findings with CMS once known. **For this reason, we are requesting that anesthesiologists not be included in the 2015 group of physicians for whom the value-based payment modifier is applied.**

---

[1] U.S. Government Accountability Office. *Medicare Physician Feedback Program: CMS Faces Challenges with Methodology and Distribution of Physician Reports*, GAO-11-720. Washington, DC: Government Accountability Office, 2011. http://www.gao.gov (accessed August 22, 2011).

Potentially Misvalued Services Under the Physician Fee Schedule

ASA reiterates its previous recommended review of Medicare payments for anesthesia services as possibly misvalued and potentially undervalued. As CMS is aware, anesthesiology suffers from a significant payment disparity under the Medicare system. While modest disparities between Medicare and commercial physician payment rates are longstanding and well-recognized, the disparity in payments for anesthesia services is unique. In July 2007, a GAO report confirmed for the public and Congress what anesthesiologists have known and struggled with for years: Medicare payments for anesthesia services are drastically low.[2] According to the GAO, Medicare payments for anesthesia services represent only 33 percent of the prevailing commercial insurance payment rates for the same service. In contrast, the Medicare Payment Advisory Commission (MedPAC) consistently reports Medicare's payments for other physician services represent approximately 80 percent of commercial rates when averaged across all physician services and geographic areas. Accordingly, we believe the unique level of the disparity known as the "33 percent problem" warrants consideration as "misvalued." The anesthesia relative value scale is separate from the RBRVS, employing "base" and "time" relative value units to determine payment. Using a formula based on the ratio of the anesthesia and RBRVS conversion factors and percentage of anesthesia conversion factor allocated to work, one may convert from anesthesia units to RBRVS work RVUs. We assert the internal rank order of the anesthesia base units is correct; however, we believe the linkage to RBRVS values through the conversion factor relationship is incorrect and represents a misvaluation of anesthesia services in the fee schedule.

We understand that CMS intends "to establish a more extensive validation process of relative value units (RVUs) in the future in accordance with the requirements of section 1848(c)(2)(L) of the [Social Security] Act," and we are pleased that CMS states that "any proposals we would make on the formal validation process would be subject to public comment and we would consider those comments before finalizing the policies. " ASA is concerned, however, that CMS currently appears to use several different methodologies, which we do not believe have ever proceeded through the formal rulemaking process. As ASA noted in its comment letter on the Fourth Five Year review,

> *We are concerned that recently CMS has increasingly chosen to ignore RUC-recommended values based on survey results. We believe that values should be reflective of the best evidence and data available. If CMS has determined that specific alternative methodologies are preferable to surveying providers, an approach with roots in Hsiao's original work for HCFA in the 1980's and a cornerstone of RBRVS valuation since that time, this would represent a significant change that should be publicly disclosed and subject to comment.*

[2] U.S. Government Accountability Office. *Medicare and Private Payment Differences for Anesthesia Services*, GAO-07-463, Washington, DC: Government Accountability Office, 2007.

Multiple societies also expressed similar concerns in a July 5, 2011, letter to CMS, emphasizing CMS's recent history with respect to recommendations received from the AMA/Specialty Society RVS Update Committee (the RUC). In that letter, the societies noted, "While we understand that CMS has intensified its scrutiny of the work valuations of codes, CMS' decisions must be made using a transparent consistent process, and must be based on credible data."[3]

We support the CMS proposal to modify the Five Year Review process, as we believe the method outlined will better align with the work already underway for review of potentially misvalued services. Further, it will provide a greater opportunity to improve the accuracy of the entire fee schedule since all stakeholders will be able to propose a code for review on an immediate basis, rather than having to wait until the next scheduled review. Currently, CMS and the RUC can bring a code forward for review whenever they have reason to believe it may be misvalued; however, physicians, other healthcare providers, specialty societies and other stakeholders are restricted to a five-year cycle. **We further agree that the review should include both work and practice expense, and we encourage the agency to continue its efforts to insure that professional liability valuations are as current as possible.**

ASA understands that CMS is proposing to require anyone bringing forward a code as potentially misvalued to provide supporting documentation and a summary of evidence supporting the assertion. CMS will then review those materials and make a determination as to whether that code should be reviewed. Elsewhere in the notice of proposed rulemaking (NPRM), CMS requests that the RUC review of codes that have not been caught up in any of the existing screens used to identify potential misvalued services under its authority to request review of "other codes determined to be appropriate by the Secretary." We expect that the standards to claim codes are potentially misvalued will be the same whether the claim is for overvaluation or undervaluation, and that all assertions will be fairly and consistently considered. For example, we appreciate the specificity CMS has provided regarding the requirements imposed upon stakeholder organizations seeking to bring forth a code for consideration as misvalued under the Five Year Review process; however, we request that CMS also provide a similar degree of information and support required of outside stakeholders when CMS identifies and subjects a code to the Five Year Review process. The legitimacy of the relative value system requires this balance.

CMS is proposing another review of Evaluation and Management (E/M) services because "the focus of primary care has evolved from an episodic treatment-based orientation to a focus on comprehensive patient-centered care management in order to meet the challenges of preventing and managing chronic disease." We believe the rationale for this proposal is to ensure an adequate supply of primary care providers in the years ahead. If this is the case, we question whether this is the proper approach to address that concern. E/M codes are not used solely by primary care physicians but are widely used throughout medicine. Implementing payment policies that compensate the same care with different

[3] See: http://www.asahq.org/For-Members/Advocacy/Washington-Alerts/~/media/For%20Members/Advocacy/ASA%20in%20Washington/RUC%20letter%20Surgical%20Specialties%20FINAL.ashx

payment amounts distinguished only by specialty designation will create further inaccuracies in the fee schedule. Further, this is contrary to the most fundamental principle of the Resource-Based Relative Value Scale (RBRVS): the same RVUs are attributed for the same work irrespective of specialty type. **ASA believes that CMS is concerned that coordination of care is not addressed within the current E/M codes and valuation; however, there are separate codes to use for this work.**

We believe that if it is the agency's intention to enhance patient care, change the delivery of care, improve care coordination while reducing costs, and help ensure an adequate supply of primary care practitioners, then a more deliberative approach is necessary. CMS should first determine what motivations attract physicians to primary care and then implement actions and policies that address these matters. We encourage CMS to work with the AMA and other relevant stakeholders in a strategic and methodological manner to identify the best way to address this issue. Another RUC review of E/M will be highly unlikely to achieve the desired results.

Code Specific Issues

Site of service anomalies; Epidural Lysis (62263), Intrathecal Epidural Catheters and Pumps (62350, 62355, 62360, 62361, 62362, 62365) and Neurostimulators (63650, 63685)

The valuation of these services has been under review for several years. When first flagged for review, the RUC removed the inpatient visits and ½ a discharge as an interim measure. The codes were then surveyed and RUC submitted to CMS recommended values based on those survey results. CMS then encouraged use of a building block to value the services and proposed a building block method that was deeply flawed. That action resulted in another CMS request for RUC review. While a building block should not be the sole method used to value a service, the specialty societies offered a building block that supported the values the RUC had already submitted to CMS.

In this NPRM for the CY 2012 fee schedule, CMS is using inconsistent methodologies to value these procedures. These methods include:

- The flawed building block when it corresponds to varying points of the survey results (e.g., the median for some of the codes and the 25th percentile for others); and
- Comparison to another code with similar times (but not necessarily similar work or intensity)

We remain concerned that CMS still assumes that the starting values for these services were correct since it asserts that removing work equivalent to 5.4 RVUs yields a resulting value that is lower than the RUC recommendations and the survey results. **Given that valuation of these codes is clearly not a simple process, we would suggest that they maintain their current interim values until such time as CMS has proposed and heard comments on methods to validate RVUs in a transparent and open manner.**

Physician Quality Reporting System (PQRS)

ASA applauds CMS for retaining the claims-based reporting mechanism for 2012. While we support the transition to and use of registries, including the Anesthesia Quality Institute (AQI) registry[4], and electronic health records (EHRs), we recognize that this transition will take considerable investment, time, and implementation by many practices across the nation.

ASA opposes, however, the CMS proposal to eliminate the 6-month reporting period for claims-based reporting of individual measures and measures groups and registry-based reporting of individual measures. We do not agree with the CMS statement that elimination of these 6-month reporting periods "will help to streamline and simplify the reporting requirements." Rather, elimination of this alternative reporting period will establish an unnecessary obstacle for the claims-based reporting mechanism that is available to nearly all eligible professionals and is contrary to CMS's intent to optimize participation in PQRS. We are unable to determine what costs such an alternative reporting period would add to the system. Further, retaining the 6-month reporting period for other reporting mechanisms (i.e., registry-based reporting for measures groups), but eliminating for claims-based reporting, especially for eligible professionals who lack any other alternative reporting mechanism, places an unfair burden on such PQRS participants. Finally, allowing for a 6-month reporting period for registry-based reporting of measures groups, but not for individual measures, creates an unjustified benefit to those specialties and eligible professionals for whom CMS has identified measures groups. **Therefore, we urge CMS to retain the 6-month reporting period for claims-based reporting and registry-based reporting of individual measures.**

ASA applauds CMS's proposal to provide interim feedback reports to eligible professionals (EPs) reporting individual measures and measures groups via claims for 2012 and beyond. We believe this will provide PQRS participants with important feedback regarding their performance in the program. These reports would be helpful for participating EPs to gauge whether they are satisfactorily reporting and to make changes accordingly if they are not before the end of the performance period. Further, we believe that the CMS anticipated timing of the release (*i.e.*, summer of 2012) provides an additional justification for retaining the 6-month reporting period for the claims-based reporting mechanism. One of the primary criticisms of this reporting mechanism was the inability of EPs to know whether they were correctly reporting on their measures during the reporting period. In prior years, the EP would learn he/she erred in reporting when it was too late to correct and earn the incentive. For 2012, CMS is proposing to provide interim feedback reports, which the specialty community has requested since the inception of the PQRI program, and CMS is proposing to eliminate the ability to use such feedback reports to effectively correct behavior and earn an incentive through the alternative 6-month reporting period. ASA supports the CMS proposal to provide interim feedback reports, but urges CMS to retain one of the prime motivations for the call for such reports – the ability to course correct and earn an incentive payment during the year (*i.e.*, retain the 6-month reporting periods for claims-based reporting).

[4] http://www.aqihq.org

We are concerned with the CMS proposal to use PQRS data supplied with respect to services provided on or between January 1, 2013, and December 31, 2013, for purposes of the 1.5% payment adjustment incurred in 2015 for unsuccessful eligible professionals. ACA provided the following language with respect to the 2015 payment adjustment:

> With respect to **covered professional services furnished by an eligible professional during 2015** or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for such services furnished by such professional during the year…shall be equal to the applicable percent…(Social Security Act (42 U.S.C. 1395w-4(a))) (emphasis added)

The "applicable percent" as noted in ACA is 98.5 percent of the fee schedule amount for 2015 and 98 percent for 2016 and each subsequent year. We believe the bolded clause of ACA, "covered professional services furnished by an eligible professional during 2015" limits CMS to review of only those services actually performed in 2015 for purposes of the payment adjustment. We acknowledge that Congress defined "quality reporting period" as "with the respect to a year, a period specified by the Secretary," and thus, CMS likely views this provision as affording it the opportunity to define the quality reporting period to 2013. ASA believes, however, that the phrase "with respect to a year" was inserted by Congress to restrict the Secretary to defining the quality reporting period at some point within the particular year the covered services were provided. For instance, the Secretary could provide that the quality reporting period would be January 1, 2015, through June 30, 2015, similar to the PQRS 6-month reporting period. If Congress had intended to permit the Secretary to use data for payment adjustments incurred two years hence, it would have simply defined quality reporting period to say, "a period specified by the Secretary." This is further supported by the lack of specific deadlines Congress chose to impose upon CMS in other sections, such as section 3007, Value-Based Payment Modifier Under the Physician Fee Schedule. **Thus, we do not support the proposed review of covered services performed during 2013 for purposes of the 2015 payment adjustment.**

<u>Anesthesia Conversion Factor</u>

The NPRM includes an estimate of the RBRVS conversion factor (CF) ($23.9635) but not the anesthesia CF contrary to previous assurances from the Centers for Medicare & Medicaid Services (CMS) that future proposed rules would include this information. In fact, the explanation and justification for the RBRVS CF is appropriately comprehensive providing the public with sufficient notice of the changes in the CF. While ASA applauds the transparency with respect to the RBRVS CF, we hope that the anesthesia CF will receive in the final rule comparable explanation and justification as the RBRVS CF. We also request that in future years CMS provide calculations for the anesthesia CF in the proposed rule, affording the public the appropriate opportunity to review such calculations and provide comments.

Electronic Prescribing (eRx) Incentive Program

ASA generally supports the purpose of section 312 within the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), namely, to increase efficiency, reduce medical prescription errors and improve patient care through the adoption of an electronic prescribing program (eRx). As recognized leaders in patient safety and quality care, anesthesiologists understand the tremendous benefits electronic prescribing can bring to the quality of care provided to millions of patients.

Unfortunately, many of ASA's members have been unable to participate in the incentive program due to the nature of their practice. ASA is concerned about the agency's plan to begin instituting payment adjustments in 2012 regardless of whether the "eligible professional" is capable of participating in the eRx incentive program. ASA believes that if healthcare providers cannot meet the incentive program requirements due to limitations of an eRx measure or practice restrictions, then the government should not unfairly penalize them.

Anesthesiologists can generally be divided into three main categories: "traditional" operating room (OR) anesthesia, pain medicine, and critical care. Anesthesiologists who practice in the OR setting generally do not prescribe many medications for their patients; rather, an anesthesiologist typically orders and administers medications as part of the anesthesia care plan. Therefore, anesthesiologists who work in this setting have difficulty meeting the eRx program's eligible visit and 10 percent threshold requirements. ASA applauds CMS for recognizing and creating a hardship exemption for physicians who have insufficient opportunities to write prescriptions as a result of their practice.

Consequently, we urge CMS to adopt the proposed hardship exemption to exclude eligible professionals who prescribe fewer than 100 prescriptions during a 6-month, payment adjustment reporting period.

Anesthesiologists practicing pain medicine typically prescribe a significant volume of narcotics across their practice. Due to various local, state, or federal prohibitions, narcotic prescriptions are precluded from electronic transmissions. Government requirements that prohibit physicians from electronically prescribing certain drug therapies should not have a negative effect on a physician's payment rate. **ASA fully endorses the agency's proposal that allows physicians who prescribe narcotics to request an exemption from application of the 2013 and 2014 eRx payment adjustment.**

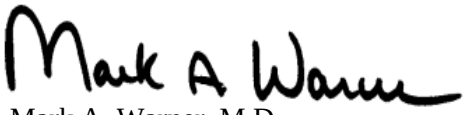
Medicare Telehealth Services for the Physician Fee Schedule

ASA supports the American Telemedicine Association and the Marshfield Clinic's request to add smoking cessation services (CPT Codes 99406, 99407) to the list of approved telehealth services. We believe that smoking cessation counseling can be performed effectively via this mode of delivery and this CMS proposal will help expand access to this counseling and promote better health.

ASA also supports the CMS decision to <u>not</u> add critical care services (CPT Codes 99291, 99292) to the list of approved telehealth services. As CMS states, critical care patients are more acutely ill than patients who typically receive telehealth services. Further, critical care services do not fit the CMS established process for adding services to the list of Medicare telehealth services. First, critical care services do not fit the criteria for Category 1 in that they are not "similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services." As CMS acknowledges, it is impossible to provide the full range of services critical care patients require via telehealth. In addition, critical care services do not fit the Category 2 criteria because the use of a telecommunications system to deliver critical services is unlikely to produce "similar diagnostic findings or therapeutic interventions as compared with the in-person delivery of the same service."

We appreciate your consideration of our comments. If you have any questions regarding our comment letter, please feel free to contact Jason Byrd, J.D., ASA's Director of Practice Management, Quality and Regulatory Affairs at 202-289-2222 or j.byrd@asawash.org.

Sincerely,



Mark A. Warner, M.D.
President
American Society Anesthesiologists