American Society of Anesthesiologists®

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November 17, 2015
Acting Administrator Andrew Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC2
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-3321-NC2. Medicare Program; Request for Information Regarding Implementation of the Merit Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

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

Dear Acting Administrator Slavitt:

The American Society of Anesthesiologists® (ASA®) appreciates the opportunity to provide input in response to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) regarding implementation of the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM) provisions within the Medicare Access and CHIP Reauthorization Act (MACRA). ASA is a more than 52,000 member educational, research, and advocacy organization dedicated to improving the medical care of patients and raising standards in the science and art of anesthesiology. Since its founding in 1905, ASA's achievements have made it the leading voice and the foremost expert in American medicine on matters of patient safety in the perioperative environment and pain medicine.

Anesthesia practice is inherently collaborative. Physician anesthesiologists regularly collaborate not only with other physicians and facility staff in the care of the individual patient, but also at the institutional or health care system level. Anesthesiology serves as the common pathway for all surgical and procedural patients.

The collaborative nature of anesthesia practice underpins the conceptual framework of the Perioperative Surgical Home (PSH). ASA initiated and continues to invest heavily in the development of the PSH with the vision that this new patient-centered model will achieve the triple aim of improving health, improving the delivery of healthcare and reducing the cost of care. These goals will be met through shared decision-making and seamless continuity of care for the surgical patient, from the decision for surgery through recovery, discharge and beyond. PSH activities are most typically built around specific surgical episodes of care and rely on anesthesiologist partnerships with varying groups of professionals depending on the nature of the disease entity or procedure being addressed. The expertise of anesthesiologists in preoperative

optimization, the management of acute and chronic pain, critical care and palliative care positions us to contribute to the continuum of care for patients with many diseases.

We view these collaborations as the building blocks of more global or population health exercises. This is the focused work in which we can clearly identify the participants, duration and goals. These are the ideal points of entry for specialist contributions to the broader population health agenda. The parallels with the CMS initiatives on episode-based bundles are clear. We believe that the collaborative nature of anesthesia practice and our efforts to date in developing the PSH model of care have established a solid foundation on which to begin the transformation of health care delivery. We encourage CMS to consider ways in which the agency can join with us to accelerate the development of the PSH model.

**MIPS Issue 1: MIPS EP Identifier and Exclusions**

Physician anesthesiologists provide care in a variety of practice arrangements. Such arrangements include large groups covering multiple facilities across multiple states, facility-based anesthesiology group practices with individual members involved in different surgical subspecialty areas (either exclusively or dividing time among them) and private groups ranging in size from single provider to hundreds of members providing care at single or multiple sites. This important feature of anesthesia practice is an important consideration when making decisions about identifying EPs and attributing performance to them.

Current programs use a variety of identifiers including the National Provider Identifier (NPI) at the individual provider level, the Tax Identification Number (TIN) at the group level and, in some instances, a combination of these identifiers. As delivery systems evolve to align with MIPS, the need for mechanisms to accurately and precisely identify eligible professionals (EP) participating in MIPS increases. Determination of eligibility, participation and performance under MIPS is predicated on proper identification of the EPs in the program and the circumstances under which they practice. Under MIPS, quality, resource use and other significant program metrics may need to be to be assessed at the individual EP level, the TIN level and/or on the episode level encompassing teams of health care professionals from multiple TINs. We recognize the potential value of the virtual group concept and that new approaches to identifiers may be needed to actualize this concept.

The administrative platform for implementing MIPS must support innovative approaches while minimizing the burden on participants. We urge CMS to recognize the need for a high level of flexibility and design a system that will be able to accommodate different practice patterns (such as those seen in anesthesiology practice as previously described). For example, use of the combination of the NPI and the TIN will facilitate calculation of an EP's performance when the EP practices under multiple TINs without increasing the administrative burdens to the EPs in the program. Current program requirements for re-validation and update to a provider's Medicare enrollment information via the Medicare Provider Enrollment, Chain and Ownership System (PECOS) may also serve the MIPS program with re-validation aligned with a MIPS performance period.

**MIPS Issue 2: Virtual Groups**

The concept of the virtual group seems to have considerable potential as the catalyst for making this transition from fee-for-service (FFS) to MIPS and APMs in MACRA. Given the contributions that anesthesiologists can make to the care of patients in collaboration with multiple different providers, virtual groups are of particular interest in our specialty.

Anesthesiologists and anesthesiology groups will find themselves participating in multiple virtual groups because of the broad scope of anesthesia practice intersecting with so many diverse diseases and procedures. Additionally, our members are increasingly practicing in multiple facilities so that the other physicians and facilities with whom they form virtual groups will be diverse on this basis, too. Creating administrative processes to implement such arrangements will be challenging and the goal should be to limit the administrative burden to the greatest extent possible. Adapting the existing set of provider identifiers, if possible, would align with this goal.

Within these multidisciplinary collaboratives there should be maximal latitude in internal distribution of savings so that the incentives to contribute to efficiency and quality are not limited by the historical structure of the current FFS elements of the Physician Fee Schedule (PFS). This is of special importance to anesthesiologists inasmuch as the present PFS provides payments represent 33% of prevailing commercial anesthesia rates as compared to 80% in the other specialties. In addition to repealing the Sustainable Growth Rate (SGR) formula and all the problems associated with it, we hope MACRA can provide an opportunity for anesthesiologists to address this long-standing and as yet unresolved problem peculiar to our specialty.

For virtual groups or APMs to power care improvements and innovation, monetary rewards are necessary. Such financial encouragement would allow these groups to invest in additional time and expertise in re-engineering and improving upon the care they provide.

We would caution that arbitrary limits to the size of virtual groups could stymie groups working in high volume service lines (e.g., joint replacement, colon surgery), especially in centers of excellence where the number of patients treated can be enormous and the multidisciplinary teams involved likewise substantial.

**MIPS Issue 3: Quality Performance Category**

ASA recognizes the challenges that CMS faces when striking the right balance between an accessible and responsible measure development pathway while focusing on measurement that is linked to cost control efforts. We also know that the current state of performance measure development and reporting remains a challenging experience for many specialties, notably our own, and the Agency should continue to be mindful of the burden that quality reporting places upon eligible professionals (EPs) and measure developers. There is solid rationale for measuring quality in the clinical areas in which cost control efforts are undertaken. This is different from intertwining the performance scoring in these separate categories of MIPS which would introduce an unintended and undesirable double jeopardy situation and blur the categories defined in statute.

Physician anesthesiologists add significant value, both in providing patient-centered care and decreasing healthcare costs, to the hospitals and facilities where they work. ASA supports opportunities to ensure our members can adequately meet MIPS criteria through any and all mechanisms already approved in the Physician Quality Reporting System (PQRS). Physician anesthesiologists continue to overwhelmingly use the claims-based reporting option. We urge CMS to continue this reporting option and allow for a sufficient number of anesthesiology measures to be reported via claims. ASA supports the continued use of the Measure-Applicability Validation (MAV) process for applicable mechanisms as well. We offer strong support for measures that promote shared accountability across multiple specialties and practitioners, including surgeons, anesthesiologists and other members of a patient's care team who work together to improve procedural and surgical outcomes. Merging facility and provider measures may be a valuable approach in aligning incentives through shared accountability for those, like anesthesiologists, providing facility-based care. This approach has the added advantage of limiting duplicative reporting burdens among providers.

ASA looks forward to the expanded role Qualified Clinical Data Registries (QCDR) will play in MACRA and in measure development. The QCDR option is a forward-thinking mechanism that facilitates development of relevant specialty and sub-specialty measures. We believe that the QCDR will facilitate innovation in measure development and practice implementation and positively impact the nature of each reporting mechanism, including claims-based reporting. Data gathered by the QCDR will lead to an expansion of measures available for EPs practicing in different types of facilities. We also know that a careful consideration of QCDR measures will lead to their use by EPs using non-QCDR reporting mechanisms. This remains an important consideration since not all of our practices have the resources in personnel, facility support, or electronic systems to truly implement processes that could capture the data necessary to succeed via the QCDR reporting mechanism. For these reasons, we are adamant that claims-based reporting must be continued.

ASA asks that CMS also be consistent in its approach and direction through the rule making process. In the past three years, CMS has offered confused direction for specialty societies and our members to follow. For instance, in the 2014 Physician Fee Schedule, CMS included the phrase when finalizing measures: *"In an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used, all new measures incorporated in PQRS are available via registry-only."* A year later, CMS announced its intention to eliminate the claims-based reporting option in future rule-making. Yet this past year, CMS finalized nearly a third of all new measures for claims-based reporting. ASA was disappointed that CMS did not finalize several of our measures for claims-based reporting – an action that would have allowed many of our members who have limited resources to continue to have a sound and trusted mechanism to report PQRS 2016. This inconsistency in policy regarding measurement has left many of our members in regulatory limbo, not knowing whether or not their way of reporting will be preserved.

CMS should maintain all reporting options for PQRS under MIPS in order to ensure physician anesthesiologists have ample opportunities to meet reporting requirements. Even though we are witnessing a number of physician anesthesiologists making the transition to other mechanisms,

claims-based reporting remains the primary reporting mechanism for anesthesia providers. ASA appreciates the inclusion of additional measures into PQRS 2016 but is disappointed that the agency did not finalize the use of such measures in a way conducive to the reporting mechanism that most anesthesia providers report. For practices with limited resources, we fear they will be unfairly disadvantaged by regulatory limitations to participation.

Individuals and groups should have the ability to collect and submit data through various mechanisms and not be penalized if multiple mechanisms are attempted. CMS should retain its current policy of allowing EPs to submit data successfully under at least one reporting mechanism to be deemed as satisfactory reporting. ASA cautions against combining data from multiple reporting mechanisms, especially related to the EHR and QCDR reporting mechanisms. In these cases, the calculation of such scores may not precisely match, especially when considering data capture capabilities and proprietary risk-adjustment models.

CMS should maintain similar reporting criteria under MIPS as under PQRS; however, ASA believes the reporting requirements should reflect the number of relevant, available measures for an individual EP. Although ASA and our members have invested significant time and energy in developing measures that apply to a large percentage of our physicians, we recognize that measure gaps remain. ASA is focused on addressing a number of measure gaps where our physicians have difficulties meeting established criteria.

ASA opposes the continuation of the existing cross-cutting measure requirement. This requirement for claims and registry-based reporting has challenged anesthesiologists and their practices as they struggled to identify relevant cross-cutting measures to report. Application of such a requirement should be predicated on the availability of cross-cutting measures that enhance quality reporting.

ASA continues to explore shared accountability measures with other specialties that our members interact with on a daily basis. Such measures could be made available for all contributing specialists, and could potentially take the place of the existing cross-cutting measures included in PQRS. We ask that the Agency consider further development of shared accountability measures when determining funding for quality measure development and measure gaps to fill. The synergy with episode-based bundles of care is clear.

The debate over process vs outcomes measures raises valid points on both sides. While we support the concept of moving towards outcomes measures, we believe that there remain significant barriers to the development of a variety of meaningful outcomes measures in our specialty. The immaturity of reliable risk adjustment models and standardized definitions of patient outcomes among specialties make the continued availability of well-developed process of care measures very important. In this way, the measure development and approval process must be flexible and hospitable to diverse stakeholders, specialties and sub-specialty organizations. Moreover, the lack of a well-defined and appropriate attribution methodology further complicates outcomes measurement by making comparative analysis across providers and organizations nearly impossible and difficult at best.

It is for these reasons that we urge CMS to not place any requirements on the types of measures EPs need to report, nor should CMS weight measures differently.

ASA understands the arguments in support of so-called "high-value measures." Such measures include, but are not limited to outcome measures, patient-reported outcomes (PROs) and process measures that are closely linked by empirical evidence to outcomes. However, the process of vetting and approving measures must be amenable and hospitable to process measures. For outcome measures, we encourage CMS to ensure outcomes measures are fully vetted and are based on transparent processes before being implemented under MIPS to ensure that consistent, fair, reliable, and meaningful data will be collected and assessed.

CMS must consider several important issues when considering an expanded role of CAHPS and other tools that measure patient satisfaction and experience. Assessing and improving patient satisfaction and experience with anesthesia has been a priority of ASA and our members. We support the direction of CMS and other health care advocates who seek to build off of previous initiatives by doubling efforts to engage patients in a variety of ways including, but not limited to, developing patient-reported outcome measures, engaging advocates on measure panels and communicating with patients before and after their procedures.

Today anesthesiologists receive little meaningful data from CAHPS. Since CG-CAHPS is directed toward measuring patient satisfaction and care received from a primary care physician and H-CAHPS focuses on patient satisfaction at the facility level, ASA believes that additional options and flexibility should exist for physician anesthesiologists to receive credit for engaging patients and gathering patient feedback. CMS should seek to reduce provider burden, duplicative efforts and patient burnout on the number of surveys they receive (and in a variety of mediums no less). Simply put, when CAHPS fails to provide actionable information to anesthesia practices, the opportunity to fill the gap with additional, focused practice-driven patient feedback surveys is limited by the willingness of patients to endure multiple, duplicative and overlapping survey exercises.

ASA believes that innovation in assessing patient experience and in improving the care our members provide should be encouraged. Physician anesthesiologists should receive credit for conducting patient surveys that are meaningful, tested and validated (a number of vendors provide these services already) and reflective of local practice and patient interests and needs. The added burden for providers to implement patient survey tools can be mitigated if they are afforded this ability to select more relevant tools for their specific patient population which will offer more meaningful feedback from their patients. As in many areas, the necessity of aligning facility requirements with those of our members is essential.

For specialties that do not have enough measures to meet defined criteria, ASA supports the continued use of the MAV process. MIPS EPs should not be penalized for relying upon the MAV or for circumstances that are outside of their control. Such instances include, but are not limited to, lacking resources to effectively capture measures based on reporting mechanism or lacking a sufficient number of reportable measures. In both cases, we request CMS not penalize EPs whose circumstances render them unable to meet such requirements.

CMS should not require that reporting mechanisms include the ability to stratify data by demographics characteristics such as race, ethnicity and gender. Collecting quality measure data stratified by race and ethnicity, in particular, could be beneficial for quality improvement and in understanding disparities in care and for research purposes. Collection of such data may prove onerous for providers and registries. In particular, collection of this data would represent a significant burden for individual providers and QCDR vendors. While hospitals routinely capture this information on admission, most physician practices and billing systems generally only capture patient gender. Since a majority of anesthesia providers submit quality data under the claims-based reporting option and face challenges inherent in collecting this data, collection of these additional parameters should be encouraged when available but not mandated.

We agree that thresholds need to be in place to confirm accuracy, completeness and reliability of data. Responsibility for data integrity should remain within the realm of the QCDR, qualified registry or other vendors who facilitate the collection and submission of data. These entities should be responsible for correcting any missing or inaccurate data elements. At the same time, if the reporting entity was previously tested and met CMS standards, then any EP reporting via that mechanism should be held harmless if data integrity standards come into question. The burden should fall to the reporting entity to correct any mistakes. If the reporting entity does not meet data integrity standards, CMS should employ a transparent and measured consequence for that entity.

Regarding use of CEHRT for reporting quality data, ASA believes that Anesthesia Information Management Systems (AIMS) must be integrated into CEHRT in a way that allows the AIMS data to update the EHR but also allows the EHR to update the AIMS with relevant and necessary clinical data. Such CEHRT should reflect the practical nature of how anesthesiologists use electronic resources. ASA believes this aligns with the interoperability goals set by Office of the National Coordinator for Health IT in both the 2015 Edition Health IT Rule and the Interoperability Roadmap. We are likewise concerned that while larger practices may be able to invest in EHRs and AIMS to adequately prepare for meeting such criteria, smaller practices and those whose financial margins are already thin, notably often those serving a preponderance of Medicare patients, will struggle to procure the necessary technology to comply with any CEHRT requirements in MIPS.

Effective use of EHR technology in anesthesia practice requires interoperability with hospital systems. Hospital systems manage patient clinical information such as allergy repositories, medication administration history, laboratory studies and other data sources that influence decision-making in anesthesia care. It is critically important that facilities are incentivized to create and support these interfaces. Without them, meaningful use of EHR technology in anesthesiology will remain elusive.

ASA recommends additional support and encouragement from CMS to ensure vendors and clinical data registries can more readily extract and communicate quality measures. The key elements in making this possible are the standardization of data definitions and calculation logic for derivation of quality measures from electronic health data. Achieving consistent and verifiable quality measurement depends on the ability of data warehouses to contain homogenous information. A substantial benefit will be shifting the quality reporting work from bedside to

registries, avoiding costly, inconsistent and duplicative creation of mechanisms for this at each local installation. In many instances, the provider workflow impact of quality reporting can be mitigated by derivation of quality reports from clinical data rather than provider attestation. This should be the overarching vision of how EHRs support quality reporting. Transmission of quality data to and from registries will come naturally from this evolution. However, until substantial progress is made in this direction, CMS should not be prescriptive about the route of quality measure transmission.

**MIPS Issue 4: Resource Use Performance Category**

Measurement of resource use at the individual EP level will not result in progress toward the Triple Aim in many areas of medicine. For anesthesiologists and other health care professionals involved in episodic care (rather than continuous or ongoing care to an identified panel of patients), relevant data is best obtained when approached at the episode level and includes the performance of all involved in providing care during the episode. Collaborations built around specifically defined episodes of care are well suited to measurement of resource use. We envision that the spending per beneficiary in the defined episode could be the shared resource utilization metric for the participants in the collaboration, with appropriate adjustment for confounding factors such as comorbid conditions, socioeconomic status and age. For an individual professional or practice group, the aggregate scoring in the resource utilization domain of MIPS could be a balanced reflection of all the collaborations in which the eligible professional(s) participate in a year. The advantages of diversifying the risk in this category would serve as an incentive to seek opportunities for more collaboration, amplifying the contributions of participants.

Consideration must be given to protecting professionals from excessive risk in undertaking improvements to the care of patients with high acuity and complex diseases and procedures especially organ transplant, multiple trauma and others. These are all areas in which there are certainly rich opportunities for improvement and the implementation of the law should encourage, not penalize, undertaking this work.

The MIPS program includes Quality Performance and Resource Use as separate and distinct components. We agree with that approach which is unlike the current Value-Based Payment Modifier (VM) where satisfactory reporting of PQRS is required in order to avoid a VM penalty. We understand that resource use is linked to quality and proper quality measures must be reported. However, increased resource use that results in a disproportionate increase in quality should be considered a desirable result. For example, if resource use increases by 10% and quality increases by 15%, the additional resource use is justifiable and should not have a negative impact on scoring of resource use. Similarly, reduction in resource consumption achieved with stable quality metrics at threshold should drive a favorable scoring result.

When considering cost/use measures, it is important that CMS consider services that may be viewed as "overused" but actually reduce overall costs. For example, post-operative nerve blocks may be seen as overuse as the frequency and FFS payment for these services increases. However, the use of such blocks may reduce *overall* costs by reducing hospital stays, encouraging ambulation, reducing the incidence of atelectasis or venous emboli.

CMS requests feedback on how to apply the Resource Use category to EPs for whom there are no applicable resource use measures. To avoid unfair penalization, such EPs should not be scored in the category and the remaining categories should be rebalanced. However, if resource use is based on an episode of care and is attributable to all involved in providing care relevant to the episode, then applicable measures would be available. This approach would allow for recognition of contribution to savings and better encourage true progression toward higher quality/lower cost care.

**MIPS Issue 5: Clinical Practice Improvement Activities Performance Category**

We note that when offering examples of activities that could qualify as Clinical Practice Improvement Activities (CPIA) under MIPS, CMS appears to be considering mainly a primary care-centric environment. CPIA for anesthesiology will look very different from CPIA for primary care and we encourage the agency to approach this matter with an open and broad perspective. The CPIA framework under MIPS should recognize not only individual activities, but also those activities that involve multiple providers. We believe these activities will be powerful opportunities for producing improvements in quality and efficiency. Anesthesiologists are well positioned to contribute to multi-disciplinary system improvements in the facilities in which they practice. Our members represent the single common pathway for all surgical patients across subspecialties in surgery.

Our members undertake reporting of prescribed clinical practice improvement work under the American Board of Anesthesiology (ABA) Maintenance of Certification Part IV programs. While these are typically designed for the improvement of the individual anesthesiologist's practice, there are enormous opportunities for improvement of practice across multiple disciplines in the models previously described. Institutional programs to reduce surgical site infection, control unnecessary laboratory testing or blood administration represent genuine and important practice improvement work with benefits to multiple professionals and, most importantly, to patients. These are typical of the programs in which anesthesiologists play a central role. A pathway to recognizing these activities should be part of the MIPS framework. The Agency should carefully examine the American Board of Medical Specialties Portfolio Program (http://mocportfolioprogram.org/about/) designed to recognize multispecialty collaborative improvement work in Maintenance of Certification programs. This approach is especially appealing to anesthesiology because of the nature of our practice and the ways in which we contribute to institutional quality and efficiency. This framework is solidly aligned with the episode-based APM model described, episode level resource utilization measurement and associated quality metrics.

ASA supports a diverse curriculum to provide our members opportunities to satisfy the Maintenance of Certification in Anesthesiology requirement of the American Board of Anesthesiology. These include an extensive series of modules guiding members to measuring the results of their practice in specific clinical areas, designing improvement strategies and reassessing their performance. More than 1,400 anesthesiologists enrolled in this activity during 2015.

Anesthesiology has been the leader in the use of simulation in practice improvement and has developed a nationwide network of endorsed simulation centers whose curriculum and faculty meet standards established by ASA and endorsed by the ABA. This Simulation Education Network has been serving anesthesiologists for almost a decade. These simulation training exercises focus on the management of selected uncommon and high risk emergencies and also on principles of Crisis Resource Management emphasizing effective teamwork and communication. An important component of the simulation experience is the development and execution of a practice improvement action plan based on opportunities identified during the simulation experience. There remain, however, significant barriers to universal access to high fidelity simulation centers (distance, time and cost). However, the opportunity to experience simulation-based training does not require such a center. Meaningful and impactful simulation exercises can be conducted with minimal technology in so called "table top" or "in-situ" simulation. The AHRQ TeamStepps program, among others, relies principally on this approach. A MIPS CPIA framework should recognize the value of these activities.

Physicians participating in these MOC Part IV activities must report them to the certifying board and often their medical staff and/or state licensing authority, professional liability carrier or others. The MIPS CPIA category should be designed to accept annual physician attestation or develop a mechanism by which the sponsor of the CPIA activity does so on behalf of the participating physician. The sponsor may be an accredited provider of continuing education or a health care institution sponsoring a multidisciplinary practice improvement activity as described in the ABMS Portfolio Program. In designing the MIPS framework for the Clinical Practice Improvement Activity (CPIA) category, the agency should mitigate the risk of duplicative standards and reporting. For example, initially, an EP might attest to completion of CPIA activities for MIPS purposes through a CMS system or portal. As the process evolves, specialty society registries and learning management systems (specifically those educational activities aligned with ABMS's portfolio requirements and MOCA 2.0) could serve as a trusted vehicle of choice for attestation. Quality checks and data validation is important and ASA commitment to this is implicit in our mission.

Participation in one or more clinical data registries should also be seen as a qualifying CPIA. Infrastructure and framework is already in place and fully operational. For anesthesiologists, that could mean participating in one or more of the clinical data registries within the Anesthesia Quality Institute. Registries currently available include:

- National Anesthesia Clinical Outcomes Registry (NACOR)
- Anesthesia Incident Reporting System (AIRS)
- MOCA® Practice Performance Assessment and Improvement (PPAI)

We are very supportive of the MIPS CPIA category recognizing the domestic and international humanitarian volunteer work of anesthesiologists. Such recognition would serve to encourage this work and better enable the medical community to meet the needs of individuals needing surgical and obstetrical care in the context of natural disasters and severe economic hardship. Clinical practice under these adverse conditions provides insight into practice unavailable elsewhere; lessons learned in the field have implications for our normal practices. We especially note the value of sharing clinical skills in low resource settings to expand capacity in these

environments. The educational value of these experiences was best expressed by the Rev. Dr. Martin Luther King, Jr. who said "to teach is to learn twice."

With respect to the inclusion of incentives to address health disparities, it is worth noting that anesthesiologists, as hospital-based specialists, generally do not select the patients to whom they render care. The patient population of an anesthesiologist is reflective of the community served by the facilities in which they practice.

**MIPS Issue 6: Meaningful Use of Certified EHR Technology Performance Category**

ASA supports CMS looking beyond the scope of Meaningful Use Stage 3 in MACRA to recognize how individual EPs use technology in a variety of ways that improve patient care, patient outcomes and communication between patients and physicians. The requirements and stimulus within HITECH for EHR acquisition generally were incompatible with the use of EHRs for anesthesiology. CMS recognized this defect through the specialty's existing exemption from EHR penalties.

Physician anesthesiologists provide care to patients in a variety of facilities and care settings that include hospitals, ambulatory surgery centers and office-based locations. Many anesthesiologists deliver care at a combination of these settings. Thus, anesthesiologists may interact with a variety of technology, facility administrations and patient populations in these settings with their own facility-specific workflow challenges.

We remind CMS and ONC that the capacity of anesthesiologists to meaningfully participate in the program, as determined by the eight criteria and Clinical Quality Measures (CQMs), may be substantially under the control of where anesthesiologists practice and/or the vendors with whom the facility contracts. Most anesthesiologists will continue to be dependent on a hospital or facility's EHR system, if available. Even in the uncommon scenario in which an anesthesiology practice commits its own resources to deploy health information technology in a facility-owned operating room, linked to facility-owned anesthesia equipment, the effective use of this technology will still be highly dependent on the facility's commitment to establishing and maintaining interfaces with the other clinical data systems in the environment. We remain deeply concerned that our ability to achieve the desired level of EHR utilization is in large measure beyond the sole control of the anesthesiologist.

Performance score for this category should not be based solely on full achievement of meaningful use. ASA hopes that CMS will take this opportunity to address barriers to EHR implementation in anesthesia practices as well as providing a clear vision of how anesthesiologists' EHR use may fit within the MACRA framework. We are prepared to work with the Agency to develop and adopt standards under MACRA that represent a pathway to optimal use of EHRs and Health IT in our specialty. We anticipate that this would indeed be a pathway, recognizing that the barriers described above have put anesthesiologists several years behind office-based specialties that enjoyed the benefits of federal stimulus funding for EHR adoption. This phenomenon, along with our dependency on facility commitment, must be addressed so that anesthesiologists can engage in the EHR category of MIPS. We are especially concerned about creating this opportunity by 2019.

Steps along the pathway should prioritize creating the necessary incentives (EPs and facilities) for meaningful use in anesthesiology. The scoring of performance in this category should be done in a graduated fashion against a progressively maturing framework. Where necessary, the opportunity to opt-out of this category without prejudice may be required.

ASA supports a graduated scale and asks for continued evaluation in its fairness and effectiveness for EPs. Determining a fair tiering system would be highly dependent on the validity of defining peer groups and the resources that practices may have to implement and use EHRs. For instance, anesthesiologists in urban settings may work in well-financed university operations with plenty of EHR tech and financial support whereas anesthesiologists who work in less affluent settings may have or already encountered difficulties in procuring resources and technology to support implementation and use. Small practice size and patient population may affect implementation and lead CMS to unfairly penalize providers with limited resources.

We encourage a broad and inclusive view of how physician anesthesiologists use technology in a variety of ways beyond the limited scope of Stage 3. Several examples may further illustrate this point. An isolated AIMS that captures digital physiologic data may support aggregation and analysis of patient care data in a way to improve clinical practice and lead to an understanding of the variability in the care provided. Systems such as AIMS improve efficiency in the operating room (often enhancing patient satisfaction with timeliness and efficiency) and allow anesthesiologists to receive real-time, critical information. Such information supplements anesthesiologist knowledge and serves not just to improve quality and reduce resource costs, but to ensure patient safety as well. Patient-physician communication can be supported by use of a web portal allowing a patient to complete a pre-operative health assessment online in a way that supports a greater understanding of patient needs before, during and after the procedure.

Part of our concern with MACRA rests with the limited ability for anesthesiologists to submit meaningful quality measures. As currently finalized, Stage 3 fails to adequately address the underlying challenge for anesthesiologists to report specialty-specific measures that are meaningful to individual practices. We request a critical evaluation of CQMs under MACRA (not solely based on Stage 3 criteria) and their applicability to physician anesthesiologists as this may unfairly affect composite scores.

**MIPS Issue 7: Other Measures**

When CMS seeks to determine what types of measures (process, outcomes, populations, etc.) used in other payments systems could be included in MIPS's quality and resource use categories, we note that most measures, especially episode-based measures, are compatible with the nature of anesthesia practice and allow for opportunities to drive quality, safety and efficiency. Anesthesiologists collaborating with surgeons, nurses and facilities to implement Early Recovery After Surgery (ERAS) protocols are an excellent illustration of a platform for shared accountability. ASA sees opportunity for hospital-based professionals to share quality metrics reported at the facility level. In fact, there have already been efforts to align some of ASA's PQRS measures with measures in the Joint Commission's Surgical Care Improvement Project (SCIP). We see it as an unnecessary burden for providers to report separately on measures that

address similar domains but have different levels of analysis. CMS and the specialties should review measures used under the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program or other quality reporting or incentive programs to identify potential conjoint performance measures that would be reflected in the EPs participation in the MIPS quality reporting domain. The emphasis on implementing procedural episodes of care bundles will provide opportunities for such reporting.

CMS should consider attribution of such measures as reflective of the facility and by allowing an opportunity for EPs to develop a portfolio of individual level measures and team (facility-based) measures for each EP according to the nature of their practice. These actions will provide a way for CMS to attribute performance on the measures used under other quality reporting or value-based purchasing programs to MIPS EPs.

Global and population-based measures should be included in MIPS. ASA understands episodes of care-to be one of the building blocks of population health. For global and population health, MACRA and CMS have become too focused on primary care and may need to amend processes reflective of the valuable contributions anesthesiologists contribute to improving population health. Anesthesiologist contributions may be assessed within an episode but CMS should also be mindful of using ICD-10-CM diagnosis codes or other mechanisms to hold physicians accountable for patient outcomes. Global or population-based measures should be implemented in a manner where the burden should be attributable to diseases using categorical attribution.

The definition of face-to-face encounter and the related reporting requirements require re-examination. We appreciate CMS's concerns about fairly defining the professional types that typically do not have face-to-face interactions with patients. ASA believes that the current meaning of "face-to-face" interactions in the cross-cutting measure requirement for the claims-based and qualified registry options for PQRS is narrow and incomplete. Anesthesiologists have face-to-face encounters, communicate with patients during preoperative evaluations and postoperative follow-up and, most important, coordinate patient care throughout the perioperative period. We recognize the challenges CMS faces to differentiate types of providers and while a list of CPT Codes may function in the short-term, CMS may wish to incorporate terminology not dependent upon CPT Codes into their attribution models

**MIPS Issue 8: Development of Performance Standards**

ASA sees an opportunity to use historical quality and cost data, where available, but would caution against establishing high level, historical quality and cost benchmarks as there may be a high risk of overlooking important local variation in doing so. Using an individual EPs historical performance might be more equitable and accurate lens to assessing and scoring an EP.

ASA supports recognition of both performance and improvement. The methodology used to assess performance under the value-based payment modifier program could provide a good framework for defining performance under MIPS. ASA recognizes there are instances where measures might achieve topped out status, where there is no opportunity for providers to show statistically distinguishable performance at certain levels. In these instances, we would caution that fairness be given to those providers who exceedingly achieve high performance and are

deemed high achievers. Removal of "topped out" measures could mean that these high achievers no longer have meaningful measures to report on, paradoxically reducing their "performance" status.

Specific performance improvement activities addressing health equity should be available *as an option* for EPs. Patient population is not of the anesthesiologist's choosing. Equitable access to care and patient population is based upon surgical and hospital characteristics.

The ASA agrees with the principles around the Achievable Benchmark of Care (ABC$^{TM}$) methodology. Such methodology is based on the following principles: (1) benchmarks represent a measurable level of excellence; (2) benchmarks are demonstrably attainable; (3) benchmarks are derived from data in an objective, reproducible and predetermined fashion; (4) providers with high performance are selected to define a level of excellence in a predetermined fashion; and (5) providers with high performance on small numbers of cases do not influence unduly benchmark levels.

The ABC$^{TM}$ method has been used in many studies to identify benchmark levels of performance on process measures and has contributed to an increase in the use of benchmarking procedures by health care providers. The method's used of the arithmetic mean as the measure of central tendency was found to be robust. Although appropriate for process of care measures, the ABC$^{TM}$ method may not be appropriate for outcomes measures.

Physicians and the public will benefit from a standard method of benchmarking that is proven, accurate and defensible. We appreciate that CMS has identified ABC$^{TM}$ methodology but argue that the methodology be scrutinized at routine intervals to ensure that data is accurately calculated and displayed. We believe benchmarking should accurately reflect the care an anesthesiologist provides. Because the proposed methodology on its face appears quite complex, we ask that CMS provide robust educational guidance for our members and their groups through the benchmarking process.

**MIPS Issue 9: Flexibility in Weighting Performance Categories**

Variation in current practice (at the individual, group and specialty levels) means that some in the MIPS program will not be able to meet the criteria to be fairly evaluated in all the MIPS performance categories. In those instances, scoring should not include those categories and the remaining ones should be re-weighted to allow for full recognition of an EP's performance via categories that remain. Since the composite scores are compared across specialties rather than only to scores from those in similar practices, this is the only way to achieve fair and accurate results. Specifics such as how to re-weight the categories may be specialty dependent because the reasons for EPs to be unable to meet criteria will vary.

**MIPS Issue 10: MIPS Composite Performance Score and Performance Threshold**

The purpose of establishing a low-volume threshold is to ensure that the assessment of a MIPS eligible professional's (EP's) total performance based on the EP's Medicare Part B patient volume— individuals, services, or allowed charges— reflects the EP's "true" performance. That

is, in calculating an overall performance measure based on a (Medicare FFS) sample of the EP's total patients, the sample size should be sufficient such that the sample-based estimated central moments (e.g., mean and standard deviation) of the EP's population are reasonably accurate. Therefore, the established threshold should be based on statistically sound rationale, rather than arbitrary stakeholder opinions or a threshold drawn from other CMS reporting programs. The appropriate threshold must depend on three primary factors: (1) the probability distribution of the performance measures, (2) the magnitude of the difference that is to be detected (ability to discriminate), and (3) the desired level of significance (probability of Type I error: the incorrect rejection of a true null hypothesis, a "false positive"). We believe that this outlines the most valid approach to developing such a threshold.

**MIPS Issue 11: Public Reporting**

Collecting quality measure data stratified by race, ethnicity and gender could be beneficial for quality improvement and addressing disparities in care and research. However, we believe that few practices and their vendors will be able to collect such data in a uniform manner. In addition, we worry that the display of such data may serve to confuse the public rather than focus on where care can be improved. For these reasons, we recommend CMS delay any decision on displaying practice-level quality measure data stratified by race, ethnicity or gender in public reporting.

Further, we note that the nature of anesthesiology practice is such that access to our services is driven by the surgeons and facilities in which we provide care. A public report on the racial, ethnic or gender characteristics of our patient population may potentially and erroneously infer that the profile reflects anesthesiologist choice.

**MIPS Issue 12: Feedback Reports**

CMS should include all information that is used to assess an EP's composite score, including a description of the algorithm used to determine such a score. Additional transparency in the process with information that is approachable and understandable will facilitate provider-level understanding of how assessments were made and what actions the EP must take for maintaining or improving their performance.

CMS should work to ensure that feedback reports are updated routinely and made available at regular intervals throughout the year. We strongly recommend that feedback reports for EPs using claims-based reporting mechanisms are updated quarterly. This process would allow those EPs to correct any discrepancies in their data throughout the year.

Regarding feedback reports, ASA supports a continuity of processes between current and future systems. CMS should also be transparent, as they have been with Westat in the Physician Compare space, on clear instructions for providers to follow when filing an appeal, understanding their reports or updating their demographic information. Individual EPs and their authorized representatives should be able to access their reports.

**Alternative Payment Models**

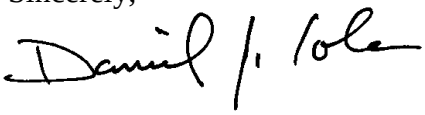
We understand that the agency faces both timeline and resource challenges but firmly believe that APMs must be developed in an open and collaborative manner if they are to succeed in meeting the goals of the Triple Aim as expressed by the Institute of Healthcare Improvement. We encourage CMS to take full advantage of all resources available to develop and evaluate APMs including the Physician-Focused Payment Model Technical Advisory Committee and the expertise already present within many specialty societies.

ASA is very interested in working with CMS and with other specialties to develop APMs. The Perioperative Surgical Home should have a place in any procedure-based APM that includes a procedure that requires anesthesia care. This work represents procedurally-focused care improvement and coordination collaboration that, with a suitable business framework, fits our vision of an Alternative Payment Model or a virtual group for the purpose of MIPS.

ASA has invested heavily in developing care coordination projects in which our members have eagerly participated under the Perioperative Surgical Home umbrella. ASA's Learning Collaboratives have helped define, pilot and assess this model of care delivery in 44 settings across the nation. The innovative work by the collaborative's participants (a group from multiple specialties) is a significant step toward better care and overall population health. The high-risk patients in the PSH population are potentially the highest-cost patients for the year in each community. Some 60 to 70 percent of U.S. healthcare dollars are spent on procedural care, with 40 percent spent after discharge. Thus, the case can be made that the greatest impact in healthcare outcomes improvement and cost savings will come from procedural care—that is, from the domain of the PSH. Despite being a justified and valid focus, most population health initiatives will deliver most of their impact and savings over a longer period of time, perhaps a decade or more. Innovations such as the PSH in the procedural arena have the potential to deliver material savings as soon as the next quarter. We encourage CMS to consider its role in accelerating the development of the PSH model. Building a CMMI demonstration around our PSH work would be worth considering. Enabling the creation of the economic framework necessary to accept a PSH collaborative as an alternative payment model likewise would advance the transformation of payment in the direction embodied in MACRA.

We appreciate this opportunity to provide feedback to CMS both in the form of our overall vision for healthcare and to some of the specific details within the Request for Information. Please contact Sharon Merrick, M.S., CCS-P, Director of Payment and Practice Management at s.merrick@asahq.org or Matthew Popovich, Ph.D., Director of Quality and Regulatory Affairs at m.popovich@asahq.org if you have any questions or to follow up on any of the issues we have raised.

Sincerely,



Daniel J. Cole, M.D.
President