American Society of Anesthesiologists®

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September 8, 2015

Acting Administrator Andrew Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-1631-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Dear Acting Administrator Slavitt:

The American Society of Anesthesiologists (ASA), on behalf of over 52,000 members, appreciates the opportunity to comment on several of the issues in the above-captioned proposed rule published in the July 15, 2015 *Federal Register*. As the medical specialty representing the recognized leaders in patient safety and quality, ASA welcomes the opportunity to work with you to ensure high quality and high value care for Medicare patients.

In this letter, ASA provides comments on the following issues:

1. Malpractice Relative Value Units
2. Potentially Misvalued Services
   - -Review of High Expenditure Services across Specialties with Medicare Allowed Charges of $10,000,000 or More
   - -Valuing Services that include Moderate Sedation as an Inherent Part of Furnishing the Procedure
   - -Improving the Valuation and Coding of the Global Package
3. Refinement Panel
4. Target for Relative Value Adjustments for Misvalued Services
5. Phase-in of Significant RVU Reductions
6. Valuation of Specific Codes
7. Advance Care Planning
8. Medicare Telehealth Services
9. Technical Correction: Waiver of Deductible for Anesthesia Services Furnished on the Same Date as a Planned Screening Colorectal Cancer Test
10. Request for Input on the Provision Included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
11. Value-Based Payment Modifier and Physician Feedback Program
12. Physician Self-Referral Updates
13. Physician Compare
14. Physician Quality Reporting System

Anesthesiology is a "complex, high-risk, dynamic patient care system" (IOM, 1999) and to ensure maximum patient safety, it should be undertaken under the direct administration or supervision of a physician who has the extensive and necessary education, training and expertise. ASA commends the Centers for Medicare and Medicaid Services (CMS) for maintaining the current federal physician supervision safety standard for anesthesia services. Substituting nurse anesthetists for highly trained physician anesthesiologists would significantly decrease patient safety and quality of care. Further, such a substitution provides the Medicare program and taxpayers no additional cost savings since Medicare **pays the same for anesthesia services** whether nurse anesthetists or physician anesthesiologists furnish them. Substituting nurse anesthetists for anesthesiologists would not enhance access to surgical and anesthetic care for Medicare beneficiaries.

Malpractice Relative Value Units

The Centers for Medicare and Medicaid Services (CMS) updates the malpractice (MP) components of the physician fee schedule at five year intervals. The MP update was calculated and applied to services paid under the Resource Based Relative Value System (RBRVS) for the CY 2015 Medicare Physician Fee Schedule. ASA was pleased that CMS recognized the unique aspects involved in updating the MP component associated with anesthesia services and delayed the anesthesia MP update until the CY 2016 fee schedule to consider methods to make this update.

Payment for anesthesia services is not determined via the RBRVS. This separate payment methodology generates the need to use imputed relative value unit (RVU) proxies to calculate this update. We thank the agency for taking the extra time and steps to ensure the accuracy of this component of anesthesia payment.

Potentially Misvalued Services Under the Physician Fee Schedule— Review of High Expenditure Services across Specialties with Medicare Allowed Charges of $10,000,000 or More

Codes for emergency intubation and intravascular catheterization procedures (CPT Codes 31500, 36556, 36620 and 93503) appear in Table 8 as potentially misvalued per the high expenditure screen. Details on why we feel these codes should NOT be identified as potentially misvalued are outlined below.

31500— Intubation, endotracheal, emergency procedure

The first priority in the care of all trauma patients is the affirmation of a patent airway to ensure adequate oxygenation and ventilation. The ABCs of resuscitation begin with the airway evaluation, and effective airway management is imperative in the care of a patient with critical injury. Patients may require emergency tracheal intubation for various reasons following injury including hypoxia, hypoventilation, or failure to maintain or protect the airway owing to altered mental status. The reporting of this code parallels recognition of the value of securing an airway and utilization is unlikely due to a misvaluation. Utilization has fluctuated in recent years, which is a consequence of increased patient complexity and severity of illness– both as a result of and as underlying co-morbidities when confronted with a new emergency situation. We recommend that this code not be identified as potentially misvalued for 2016.

36556— Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

This service, and code 36620 (*arterial line*- see below) have experienced decreased utilization over the last several years, supporting an argument that they should not be identified as misvalued. Although the total expenditures for these services are greater than $10M, if they were misvalued, we would expect to see increasing utilization, not decreasing utilization. We recommend that this code not be identified as potentially misvalued for 2016.

36620— Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
Arterial line placement is a procedure in various critical care and procedural settings. Intra-arterial blood pressure measurement is more accurate than measurement of blood pressure by noninvasive means, especially in the critically ill. Intra-arterial blood pressure management permits the rapid recognition of blood pressure changes that is vital for patients on continuous infusions of vasoactive drugs. Arterial cannulation also allows repeated arterial blood gas samples to be drawn without injury to the patient. Utilization of this code has decreased since its last review in 2007. Decreasing utilization contradicts an assertion of potential misvaluation. We recommend that this code not be identified as potentially misvalued for 2016.

93503— Insertion and placement of flow directed catheter (e.g., Swan-Ganz) for monitoring purposes
Utilization of code 93503 has been steadily and significantly decreasing since 2004 and if this trend continues, the expenditures may very well be under $10M for 2015, removing it from this screen. We recommend that this code not be identified as potentially misvalued for 2016.

Potentially Misvalued Services Under the Physician Fee Schedule— Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing the Procedure
As part of the discussion on "Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing the Procedure," CMS asks if anesthesia code 00740— *Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum*— and code 00810— *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum* should be revalued because of the "significant change in the relative frequency with which anesthesia codes are reported with colonoscopy services."

Increased utilization of anesthesia for lower endoscopy procedures is NOT indicative of misvalued services. CMS itself has recognized the importance of screening colonoscopy and anesthesia services associated with such screening for all the reasons stated in last year's MPFS Final Rule. CMS's actions (eliminating co-pays and deductibles in many cases) encourages patients to undergo these procedures, especially when provided with anesthesia, which then mimics what might be expected if the codes were misvalued. In this case, it is not any valuation anomalies that drive increased utilization, but CMS's own recognition (with which we heartily agree) that these services are of such importance that patients are encouraged to undergo the procedures through the use of appropriate payment policies.

Similarly, the increased use of anesthesia with upper endoscopy procedures decreases patient discomfort, reactions such as gagging and vomiting, and complications associated with performing upper GI endoscopy procedures in non-anesthetized patients. It also creates optimal conditions for the endoscopist to complete the procedure efficiently and comprehensively with reduced recovery time compared to use of fixed agents, such as narcotics and sedative hypnotic agents. The cost-avoidance associated with these untoward effects offsets the costs of the anesthesia services utilized to achieve that cost-avoidance.

The American Cancer Society (ACS) very clearly states how important it is that patients undergo colorectal cancer screening. The ACS notes that, ***"Not only does colorectal cancer screening save lives, but it also is cost effective. Studies have shown that the cost-effectiveness of colorectal screening is consistent with many other kinds of preventive services and is lower than some common interventions. It is much less expensive to remove a polyp during screening than to try to treat advanced colorectal cancer."*** Additional information available here:
http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-importance-of-crc-screening

It is important that patients undergo this screening procedure. If safe and effective anesthesia care encourages them to do so, the costs of the anesthesia along with the colonoscopy are far outweighed by the overall benefits to both patient and population health. In essence, CMS needs to consider not only dollars spent, but also dollars saved.

Payment for anesthesia services are determined by the "base+time" methodology in which each anesthesia code is assigned a base unit value that conveys intensity, effort, judgment, technical skill and physical efforts required to perform each specific anesthesia service. The base unit values currently assigned to codes 00740 and 00810 are already well aligned within the anesthesia code set. There have not been any questions about whether the work involved in providing this important care has changed. We do not agree that the increase in utilization supports potential misvaluation.

Improving the Valuation and Coding of the Global Package

In this proposed rule, CMS reiterates its reasons for transitioning codes with a 10 or 90 day global period to a zero day global period. We are pleased that CMS seems to be taking a measured and deliberate approach in this rule. We believe this approach is appropriate and look forward to participating in future Open Door Forums and other venues on this important undertaking.

The Medicare Access and CHIP Reauthorization Act (MACRA) mandates specific data collection activities to identify the number and type of services and items that are provided to Medicare beneficiaries as part of a global surgical package. Reporting that care with modifier 24 – *Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional during a Postoperative Period* may be one less administratively cumbersome initial approach.

Accurate base line data for all services is going to be essential as we move away from fee-for-service (FFS) models of payment toward bundled and episodic payments. ASA is supportive of efforts to develop new payment methods that increase the quality and efficiency of care and lower costs. Our comments on this matter from last year's proposed rule still stand:

> "We share CMS's concerns about ensuring that current payment systems should not act as obstacles to new payment models, such as ASA's Perioperative Surgical Home (PSH). PSH is a patient-centered, innovative model of delivering health care during the entire patient surgical/procedural experience; from the time of the decision for surgery until the patient has recovered and returned to the care of his or her Patient Centered Medical Home or primary care provider. A comprehensive PSH provides coordination of care through all of the clinical microsystems of care and embeds all of the above strategic principles into its framework. **Current Medicare payments undervalue anesthesia care as demonstrated by "the 33% problem" (Medicare payments are approximately 33% of the commercial payer rate), and ASA appreciates CMS's efforts to ensure the accuracy of existing payment systems for the sake of future models."**

Refinement Panel

While we understand the reasoning behind CMS's proposal to eliminate the Refinement Panel process, we have concerns about the timing and the transparency of the process.

The transition to the new timeframe for CMS to receive RUC recommendations to allow for publication of proposed values in the proposed rule is not complete. CY 2017 will be the first full year under this new schedule. It is possible that even when fully transitioned, some unanticipated problems could present.

We see the need for additional caution to ensure transparency of CMS's valuation process. The U.S. Government Accountability Office (GAO) recently published a report titled Medicare Physician Payment Rates — Better Data and Greater Transparency Could Improve Accuracy (GAO-15-434 Medicare Physician Payment Rates). One of the recommendations offered by GAO is that CMS *"better document the process for establishing relative values for Medicare physician services, including the methods used to review RUC recommendations and the rational for final relative value decisions."* While CMS has indicated it concurs with this recommendation, its decisions about the values of new/revised/revalued services are published in the *Federal Register* with very little supporting rationale.

ASA recommends that until the complete transition to the new timeline has been in place for at least a full year, and until CMS offers more robust rationales for its valuation decisions, the Refinement Panel process should be maintained.

Target for Relative Value Adjustments for Misvalued Services

CMS is proposing a means by which to implement certain provisions within the Achieving a Better Life Experience Act of 2014 (ABLE) and the Protecting Access to Medicare Act of 2014 (PAMA). PAMA called for a 0.5% target for 2017 through 2020. ABLE subsequently superseded PAMA and applies the target to 2016, 2017 and 2018 with a 1% target for 2016 and a 0.5% for 2017 and 2018. If the revaluation of misvalued services reaches the established target, the savings are redistributed to other services within the fee schedule. If the target is not met, the difference between achieved savings and the target is taken out of the total fee schedule spend (outside of budget neutrality). ASA shares several of the concerns expressed by the AMA/Specialty Society RVS Update Committee including the need for transparency within the process. Both the actual target amount and the method by which it is calculated should be published in a proposed rule by CMS prior to any fee schedule adjustments. We further agree that since the RUC and the specialty societies have been addressing potentially misvalued codes since 2006, there should be a way to include revaluations made back to 2006 in the calculation of the target.

Phase-in of Significant RVU Reductions

When the value of a specific service undergoes review due to potential misvaluation, the provider community may not be aware that the values associated with these established services may change significantly. Under the current process, physician practices receive very little advance notice of these changes. This combined with other payment and policy revisions subject physician practices to a great deal of economic pressure. Effective in 2016, when an established service that has been flagged as potentially misvalued and will lose value of 20% or more of its total assigned relative value units, the reduction will be phased-in over a two-year period. We believe that the adjustment should be evenly split between the two years. We believe that such a phase-in is appropriate and will help physician practices in their efforts to provide patients the care they need in the setting most appropriate to patient needs.

Valuation of Specific Codes

In Table 10: Invoices Received for Existing Direct PE Inputs, CMS proposes to reduce the price on file for a radiofrequency generator (equipment code EQ214) from $32,900 to $10,000, which would have a significantly negative impact on the practice expense for the services associated with this piece of equipment. Per Table 10, these services are:

CPT Code	2015 Descriptor
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session
43228	(code deleted from 2015 CPT)
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)

The radiofrequency generator on the invoice CMS received with a price of $10,000 is not the radiofrequency generator used to perform the services described by CPT code 64633, 64634, 64635 and 64636. Rather, it appears applicable to Ear/Nose/Throat radiofrequency ablation procedures. As such, it should be assigned an equipment code separate from existing code EQ214.

Advance Care Planning Services

For CY 2015, the CPT Editorial Panel created two new codes describing advance care planning (ACP) services (CPT codes 99497 and 99497). ASA supports CMS's proposal to pay physicians for advance care planning services. Advance care planning early in the course of illness and before a patient becomes seriously ill is a crucial component of end of life care. Physician anesthesiologists often care for patients for whom they have no background or history, such as trauma patients, and a well-documented advance directive from a primary care physician can help the physician anesthesiologist make treatment decisions and identify the appropriate family member or friend to discuss time-sensitive and crucial issues. For that reason, it is imperative that CMS provide coverage for advance care planning services for patients who are not yet seriously ill as well as chronically ill patients. We support the payment of advance care planning, as an optional element, particularly at the annual wellness visit (AWV) under section 1861(hhh)(2)(G) of the Affordable Care Act.

Medicare Telehealth Services

ASA agrees with CMS's decision not to include critical care on the list of services that may be provided via telehealth. As CMS stated in 2009, Category 1 criteria do not apply; critical care is not similar to any services currently on the telehealth list because of patient acuity. CMS denied this subsequent request for inclusion based on Category 2 criteria because cited literature found no evidence of clinical benefit.

While we understand that CMS is proposing to add nurse anesthetists to the list of providers who may provide telehealth services because some states allow them to perform some services on the list of telehealth services (e.g. evaluation and management services), we encourage vigilance and

caution to ensure that patients receive care only from those who are properly trained and qualified to provide it.

Technical Correction: Waiver of Deductible for Anesthesia Services Furnished on the Same Date as a Planned Screening Colorectal Cancer Test

We thank CMS for revising the definition of colorectal cancer screening to include anesthesia care, resulting in the waiver of beneficiary deductible and co-insurance. Currently, when the procedure includes polyp removal, only the deductible is waived and the beneficiary is responsible for any co-insurance. While we believe that coinsurance should also be waived under this circumstance, we understand that CMS may not have the statutory authority to make this change. If CMS were to receive such authority, we hope that it will make the associated regulatory change as quickly as possible so that beneficiaries will be further encouraged to seek this important screening.

Request for Input on the Provision Included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Merit-based Incentive Payment System (MIPS)

ASA is eager to work with CMS to ensure that opportunities for cross-specialty collaboration are available in the MIPS framework. Unlike office-based physicians, anesthesiologists are almost always collaborating in the care of a patient with other physicians. This is an important consideration in approaching the development of systems to measure patient outcomes, resource utilization, quality improvement efforts and other features of the MIPS framework.

Low-volume 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"). Since these three items are not yet known, the appropriate low-volume threshold cannot yet be determined.

Clinical practice improvement activities

MACRA defines clinical practice improvement activities (CPIA) as, "activities that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, are likely to result in improved outcomes." Further, the act specifies that approved clinical practice improvement activities must include at least the follow subcategories:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an APM

We appreciate the opportunity to offer comments on activities that could be classified as CPIA per the MACRA definition. Qualifying activities could include (but would not be limited to) participation in a data registry or in Maintenance of Certification programs.

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)

The American Board of Medical Specialties (ABMS) has adopted a structure to recognize multi-disciplinary, collaborative patient safety and practice assessment activity under its MOC framework (Portfolio Program) and CMS should seek to align with the ABMS framework not only on its merits, but to avoid conflicting or duplicative requirements.

The American Board of Anesthesiology, Inc. (ABA) recently released its MOCA Part 4 Requirements. Anesthesiologists may choose from a list of activities that are well-aligned with the subcategories established for CPIA within MACRA.

Anesthesiologists are well positioned to contribute to multi-disciplinary system improvements in the facilities in which they practice. Our members often represent the single common pathway for all surgical patients across subspecialties in surgery. Nonetheless, the CPIA framework under MIPS should recognize not only individual activities, but also those activities that involve multiple providers. We believe including these activities will be powerful opportunities for producing improvements in quality and efficiency.

Alternative Payment Models

We are also interested in working with CMS in the development of alternative payment models (APMs). ASA has devoted significant resources to the development of the Perioperative Surgical Home (PSH).

PSH is an innovative model of delivery health care during the entire patient surgical/procedural experience; from the time of the decision for surgery until patient recovery. With the PSH model, the patient's experience of care is coordinated by a Director of Perioperative Services, additional Surgical Home Leadership, and supportive personnel, working as an interdisciplinary team. The expected outcomes includes improved operational efficiencies, decreased resource utilization, a reduction in length of stay and readmission, and a decrease in complications and mortality— resulting in a better patient experience of care.

After several years in the making, ASA sponsored a Learning Collaborative which has helped define, pilot and assess this model of care delivery in 44 settings across the nation. We will be launching a second collaborative next year as interest among our members continues to be strong, especially considering the results accrued to practices currently participating in the collaborative.

We look forward to engaging with CMS via the upcoming Request for Information and face-to-face meetings to identify how our PSH model can be integrated with the APM provisions under MACRA. This opportunity could represent the necessary incentive framework to proliferate the work pioneered in our Learning Collaborative.

Value-Based Payment Modifier and Physician Feedback Program

In this proposed rule, CMS announces its intention to apply the value-based payment modifier (VBM) to specific non-physician practitioners (NPPs), (i.e., Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists). Such practitioners reporting under and practicing within a tax identification number (TIN) comprised solely of non-physicians would not be subject to downside VBM risk should their cost and quality metrics not meet specified criteria. However, those in TINs that include physicians would be subject to downside risk. This creates a disparity in accountability. CMS should consider the implications of holding a NPP within a physician-led group to a different standard than those in a non-physician group. ASA believes all EPs should be held to the same standard.

We understand that others have suggested through a recent comment period that CMS should pay, via BPCI and other quality/value programs, all provider types the same amount if they purport to provide the same services. Such calls seemingly neglect the fact that not all practitioners have been subject to the full application of the VBM; in actuality, they have often been shielded from downside risk. The VBM mechanism has not established that their quality/costs are in fact comparable in any care setting.

Patient safety must remain the prime consideration. In the interest of patient safety and quality of care, ASA believes the involvement of an anesthesiologist in the perioperative care of every patient assures optimal care. Virtually all anesthesia care is either provided personally by a physician anesthesiologist or by a physician-led team of anesthesia providers where patient safety ultimately and appropriately rests with the physician anesthesiologist.

Physician Self-Referral Updates

ASA appreciates CMS's efforts to reduce the burden on health care providers associated with compliance of Section 1877 of the Social Security Act, also known as the physician self-referral law, by clarifying certain terms and requirements in the proposed rule.

We would like to request additional clarification related to the Third Circuit opinion in *U.S. ex. Re. Kosenske v. Carlisle HMA*. We understand from the proposed rule that CMS believes a physician's use of a hospital's resources such as exam rooms, nursing personnel, and supplies at no charge, would not be considered remuneration where the physician merely bills for his/her professional services and the hospital bills for the technical portion of such services. However, it is not clear whether a hospital's promise to provide the space exclusively to a physician group (as was the case in *Kosenske*) would constitute remuneration that establishes a financial relationship between the physician group and the hospital. It is also unclear whether a hospital's condition to forgo an existing (and valuable) right to exclusively contract in a hospital department in exchange for the physician group's right to continue to serve as the exclusive contractor elsewhere in the hospital would create such a financial relationship.

Another area of concern for ASA is the creation of "anesthesia companies", that appear to be self-referral models. In the so-called "company model," referring physicians (e.g. gastroenterologists, ophthalmologists, orthopedists) generally create a separate "anesthesia company" that contracts with or hires physician anesthesiologists and/or non-physician anesthetists to provide anesthesia services for the referring physicians' patients who are undergoing procedures or surgery. The sole purpose of the anesthesia company is to provide anesthesia services to the referring physicians within the HOPD or other facility, bill and collect for the anesthesia services and retain the revenue after paying the anesthesia personnel— creating the potential for overutilization and increased cost on federal programs.

In the past several years, as hospitals have acquired ambulatory surgery centers and single specialty centers, ASA has heard reports of hospitals requesting or insisting that the exclusive anesthesia group agree to a carve-out from exclusivity for the hospital outpatient department (HOPD) or another free-standing facility, so that the referring physicians, whose practices and centers are being acquired, can either implement or continue to operate a company model arrangement and capture the anesthesia revenue stream.

The physician self-referral law has continued to grow in complexity since its initial passage more than twenty years ago. Although its premise (to limit the influence of financial relationships on physician referrals) is understood, its application has been the subject of considerable uncertainty in the provider community. Supplemental guidance, particularly with regard to integrated health care delivery models, such as the Perioperative Surgical Home, will be vital in the successful transition from traditional fee-for-service to value based payments. As integrated health care delivery models implicate a myriad of laws, it is critical for CMS to align with other agencies, such as the Office of Inspector General, Federal Trade Commission, Internal Revenue Service and various state agencies, to reduce regulatory barriers and risk for providers.

Physician Compare Website

The expansion of public reporting via Physician Compare must be done in a manner that accurately reflects the quality that physician anesthesiologists provide to their patients. We look forward to working with CMS to ensure that publicly reported measures are clinically relevant and accurate. In addition, ASA requests that CMS provide sufficient opportunities for specialty societies to comment on measures for display on Physician Compare.

While we recognize that CMS will continue to test consumer understanding of measures for Physician Compare, we ask that CMS be sensitive to the variation among specialty measures. ASA believes it is important to consider this variation when testing consumer knowledge and their understanding of measures. ASA also requests guidance on how to develop consumer-friendly descriptions that will meet both CMS and patient expectations.

We are concerned about the proposal to include a check mark identifying individual eligible professionals (EPs) and group practices that receive upward VBM adjustments. This would indicate whether EPs and group practices deliver higher quality care at a lower cost, higher quality care at an average cost or average quality care at a lower cost. Current attribution methodologies have resulted in a majority of anesthesiologists receiving an average rating. ASA believes this check mark may unfairly discriminate against practices that may deliver superior care but have been labeled as average due to structural issues.

ASA recognizes CMS's interest in expanding public reporting of individual eligible provider (EP)-level Physician Quality Reporting System (PQRS) and non-PQRS measure data submitted through the Qualified Clinical Data Registry (QCDR) mechanism. Since CMS is proposing that QCDRs be allowed to collect group level data, we encourage CMS to extend group-level reporting to participants in the QCDR. Anesthesiologists work in care teams and case attribution is often difficult to report at the individual level. Ideally, CMS would explore and implement ways for quality reporting to be publicly available at the level of the entire care team. The care team could include, but not be limited to, surgeons and other providers as well as the facility. This would allow patients to understand the combination and comprehensiveness of the care they receive.

We agree that measure data should be collected for PQRS and non-PQRS QCDR measures for at least one year before they are displayed on Physician Compare. Measure testing continues to be a significant and necessary part of measure development. By allowing data to be collected for one year, QCDRs can ensure that the reportable measures have identified a meaningful and proven

measure gap, reflect a critical mass of participants and have an opportunity to drive quality improvement in the future.

Physicians and the public will benefit from a standard method of benchmarking that is proven, accurate and defensible. We appreciate that CMS has identified Achievable Benchmark of Care™ methodology for application to PQRS measures. The methodology should 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.

ASA also believes many of the proposed data elements will encourage patient engagement with their health care providers. Likewise, we strongly support the inclusion of additional data in the downloadable file (e.g. the 2018 VBM quality tiers for cost and quality). The inclusion of utilization data in the Physician Compare downloadable file could be an added benefit for physicians and researchers in understanding the costs incurred to the health care system. In particular, ASA sees this data as assisting us in determining additional ways for anesthesiologists to contribute to lowering the cost of health care and improving outcomes.

Collecting quality measure data stratified by race, ethnicity and gender could be beneficial for quality improvement and in understanding disparities in care and research. However, collection of such data may prove onerous for some 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 do not. ASA requests further clarification on CMS's rationale here and whether reporting stratification could be satisfied through sampling and statistical inference (e.g. beneficiary ZIP code).

Physician Quality Reporting System (PQRS)

For the second year, CMS approved the Anesthesia Quality Institute's National Anesthesia Clinical Outcomes Registry (AQI/NACOR) as a QCDR – an action that expands the number of measures physician anesthesiologists may report. However, while the QCDR option may benefit those practices that have the ability to submit data electronically, 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.

We strongly support the group practice reporting option for members to satisfactorily participate in PQRS via the QCDR mechanism. The availability of this option will be beneficial to ASA members. Some anesthesia subspecialties, such as pain medicine physicians and those practicing in ambulatory care environments, have a limited number of applicable QCDR measures. Group reporting will alleviate this problem for many of our mixed-specialty group practices. ASA also supports the revision that specifies a 12-month reporting period from January 1, 2016 through December 31, 2016 for group practices participating in the Group Practice Reporting Option (GPRO) to participate in a QCDR for the PQRS 2016 reporting year.

Anesthesiologists have benefited from the creation of and continued expansion of the QCDR reporting mechanism. ASA looks forward to the expanded role QCDRs will play in the future, especially considering its central position within the recent passage of the MACRA. The QCDR option is a forward-thinking mechanism, which allows specialty societies the opportunity to engage members in local measure development, vet the measures as they apply to the broader specialty and then to use those measures within the QCDR. We find this process ensures that our members capture outcomes that are meaningful to their work and their patients. In addition, our list of

published AQI/NACOR measures serves to guide anesthesiologists and vendors in streamlining and improving processes that include, but are not limited to, developing measurement software that more accurately capture clinical processes and patient outcomes. Moving QCDR measures from the non-PQRS QCDR side to official PQRS status remains a priority. This transition and greater analysis of data captured from a diversity of practices and anesthesiologists allows us to further engage and improve the science of measurement for our specialty.

In general, we believe that the proposal to group PQRS measures by specialty will provide some clarity for those who are unsure of which measures may apply to them. In 2014, this uncertainty was amplified by requirements for reporting cross-cutting measures. The cross-cutting measure requirement for claims and registry-based reporting challenged anesthesiologists and their practices that struggled to identify relevant cross-cutting measures to report. The inclusion of the proposed four cross-cutting measures would do little to address anesthesiologists' needs, and may worsen the situation. In previous comments, we explained our fear that the cross-cutting measure requirement would lead to both an increased reporting burden on our members and duplicative efforts between multiple physicians. Although the majority of ASA members report anesthesia Current Procedure Terminology® (CPT) codes, a significant number of our members have been affected by measures that have little relevance to their practice. ASA strongly recommends that CMS provide specific guidance for those specialties or consider a reporting exemption for certain specialties. We propose providing an exemption through a physician's Provider Enrollment, Chain and Ownership System (PECOS) specialty designation.

CMS should also consider that anesthesiologists practice in a number of different clinical environments and encounter a diverse group of patients. 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 that include, but are not limited to, Ambulatory Care Measures, Pain Medicine Measures, Critical Care Measures and Pediatric Measures. ASA continues to explore shared accountability measures with other specialties that our members interact with on a daily basis. We appreciate CMS's encouragement of such measures and ask that CMS consider including shared accountability measures when determining measure gaps to fill in the future. Such measures could be made available for all contributing specialists— one example might include mortality after cardiac surgery.

ASA strongly supports the inclusion of the five proposed PQRS anesthesia measures. These measures include: Prevention of Post-Operative Nausea and Vomiting (PONV), Perioperative Temperature Management, Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post-Anesthesia Care Unit (PACU), Post-Anesthetic Transfer of Care Measure: Use of Checklist or Protocol for Direct Transfer or Care from Procedure Room to Intensive Care Unit (ICU) and Anesthesiology Smoking Abstinence. The measures were initially developed and reviewed by ASA members and select committees and further refined by the Anesthesiology and Critical Care workgroup convened by the American Medical Association-Physician Consortium for Performance Improvement. Since 2014, the measures have been included in the AQI/NACOR QCDR and a number of providers have already reported performance data. ASA has provided supporting arguments for their inclusion through public commenting periods, including the National Quality Forum-convened Measures Applications Partnership (MAP). The NQF Consensus Standards Approval Committee recently recommended endorsement of the Perioperative Temperature Management measure proposed in this rule.

ASA strongly supports and requests that CMS allow the reporting of these five anesthesia care measures via the claims-based reporting mechanism. 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.

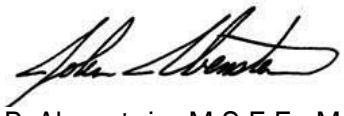
ASA is concerned with the proposal to transition PQRS #44: Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery to a registry-based reporting option only. We request the claims option continues until a sufficient number of practitioners have transitioned to alternate reporting mechanisms. We ask CMS and Quality Insights of Pennsylvania to please reconsider this proposal and allow for a more pragmatic transition away from the claims-based mechanism for this particular measure. We are apprehensive that should all proposals for measures be finalized as proposed, anesthesiologists reporting via claims would have just one measure to report– PQRS #76: Prevention of Central Line Catheter (CVC)-Related Bloodstream Infections. Such a scenario would make measure reporting for many of our practices impractical.

ASA looks forward to continue working with CMS to ensure our members are able to report a sufficient number of measures that are meaningful to physician anesthesiologists, pain medicine physicians, critical care physicians, patients, CMS and the broader health care community. We also appreciate the time and care CMS has put into developing educational materials for our members on how to report quality measures. In particular, measure workflow documents for claims-based and registry measures have greatly improved our members' understanding of how to report anesthesia measures.

Finally, we applaud CMS's consideration of measures that have not yet received NQF endorsement and appreciate the specific circumstances outlined in the proposed rule where such decisions were based. This balance is important to ensure that all physicians and providers have ample opportunity to report measures that reflect their current practice and drive quality improvement. ASA expects to engage and submit measures to organizations that endorse measures when appropriate and we look to future measure collaboration activities with CMS, NQF and interested stakeholders aimed at delivering quality care.

Thank you for your time and consideration of our comments. If you have any questions, please contact ASA's Director of Payment and Practice Management, Sharon Merrick, M.S., CCS-P (s.merrick@asahq.org) or ASA's Director of Quality and Regulatory Affairs, Matthew Popovich, Ph.D. (m.popovich@asahq.org) at (202) 289-2222.

Sincerely,



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