American Society of Anesthesiologists®

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March 1, 2016

Attn: Eric Gilbertson, CMS MACRA Team
Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 240
Phoenix, AZ 85016-4545

Submitted electronically via: MACRA-MDP@hsag.com

RE: Comments on the CMS Draft Measure Development Plan

Dear Mr. Gilbertson,

On behalf of the more than 52,000 members of the American Society of Anesthesiologists® (ASA), I appreciate the opportunity to provide comments on the first Measure Development Plan (MDP) that the Centers for Medicare & Medicaid Services (CMS) has issued. The recent passage of the Medicare Access and CHIP Reauthorization Act (MACRA) has given CMS, physicians and other stakeholders in the health care industry an opportunity to create innovative pathways for developing and instituting quality measures for reporting under the new law. ASA looks forward to working with CMS to ensure measures reflect the high quality of care our members provide to patients each day.

CMS should prevent deficiencies in current quality programs from migrating to MACRA/MIPS.

MACRA and, in particular, the Merit-Based Incentive Payment System (MIPS) allows CMS and physicians to improve upon past quality programs and address many of the deficiencies inherit within such programs. Although we recognize the need to provide some continuity between past programs and future ones, we worry that without the use of new approaches for fairly and accurately assessing physician anesthesiologists, many eligible professionals (EPs) may find it difficult to participate and be successful in the Quality, Resource Use, Meaningful Use (MU) and Clinical Practice Improvement Activities (CPIA) categories under MIPS.

As noted in the MDP, anesthesiologists have traditionally had few measures to report in the Physician Quality Reporting System (PQRS). A "core measure set" for anesthesiologists may work for a majority of anesthesiologists, but many subspecialties within the practice of anesthesiology, such as ambulatory care, pain medicine and critical care, may not find the core measures particularly meaningful or even reportable. We ask for additional nuance to ensure all anesthesiologists, whether they practice in an outpatient setting or a hospital, can satisfactorily meet MACRA requirements.

In the case where physician anesthesiologists may not have a sufficient number of measures to report, we strongly encourage CMS to implement a system, similar to the Measure-Applicability Validation (MAV) process, to assess physician performance. While we reaffirm our support for the MAV, at the same time we are concerned that the pass/fail option does not take into consideration the care our members provide on the measures they satisfactorily report. Therefore, we strongly encourage CMS to award partial credit to EPs who would, by definition, fail MAV even though they have satisfactorily reported several measures.

The lack of measures also extends to the Value-Based Payment Modifier (VM). Oftentimes, the measures used for the VM rarely assign a sufficient number of patients to the anesthesiologist or practice, resulting

in our members being unable to receive an accurate or meaningful VM assessment. When considering Resource Use measures, we ask that CMS identify fair and defensible attribution methods and measures that give our members an opportunity to succeed in this category. ASA requests CMS redesign and remake the Quality and Resource Use Reports into a new feedback loop that is more descriptive and understandable to EPs and their practices.

ASA appreciates recent statements from CMS leadership regarding the MU component of MIPS, including a greater recognition that MU Stage 3 must be supplemented by recognizing local activities aimed at using electronic resources and health IT to improve patient care. For MU, we continue to support the hardship exemption for anesthesiologists, an exemption that recognizes the state of commercially available EHR technology for anesthesiologists, workflow challenges and the nature of the patient-anesthesiologist relationship.

But for anesthesiologists who have access to Anesthesia Information Management Systems (AIMS) or enterprise Electronic Health Records (EHRs), CMS should recognize that the prospect for developing robust electronic Clinical Quality Measures (eCQMs) for anesthesia remain several years in the future. The emphasis on eCQMs and performance scores derived from EHRs should take into consideration the limitations that physician anesthesiologists have to report such measures.

ASA supports a number of proposals within the CMS Measure Development Plan.

ASA finds a number of helpful initiatives within the MDP that address measure gaps and have the potential to ensure anesthesiologists will have a sufficient number of measures to report. ASA supports and will seek further collaboration between private and public payers, patients and stakeholders to identify appropriate measures for anesthesiologists to use. ASA appreciates CMS encouragement of shared accountability measures that could be used by a variety of physicians and clinicians who contribute to a patient's care. CMS should facilitate processes for multiple specialties and related stakeholders to receive credit for these measures (e.g. patient outcome measures). We also welcome CMS proposals to ensure physicians operating under MIPS and those whose payments are through Alternative Payment Models (APMs) are similar in nature.

Anesthesiologists often share responsibility for a number of quality of life and patient and family-centered care and experience initiatives within the episode of surgical care. CMS can foster increased collaboration among developers and payers when addressing patient-centered outcomes and resource use measures. In addition, use of shared decision making aids and measures concerning appropriate use of preoperative testing, such as those potentially derived from Choosing Wisely elements or within pre-op testing locations, can also be used to fill measure gaps. In addition, CMS can facilitate a transparent and robust process that allows hospitals and other facilities to report similar measures as individual providers. ASA has long supported providing EPs the option to have facility measures ascribed to individuals for performance purposes.

We believe that collaboration between CMS, American Health Insurance Plans and other stakeholders in the Core Quality Measures Collaborative provides a starting point for determining the most relevant measures and episodes of care the health care industry seeks to address. However, we are concerned that the proposed measure sets fail to consider all specialties. We ask CMS to not disadvantage those specialties whose primary measures were not included in Collaborative measure sets. ASA welcomes a future opportunity to participate in the Collaborative and other similar initiatives, including those administered by the National Quality Forum (NQF).

As a Qualified Clinical Data Registry (QCDR) and the primary association of anesthesiologists in the United States, the ASA has allowed our non-PQRS QCDR measures to be used by other anesthesia-care QCDRs. We have also engaged those QCDRs to develop a shared set of optional measures for inclusion in their QCDRs so that our members and all anesthesia providers, no matter which QCDR they choose, will be consistently and fairly scored with one another.

Yet at the same time, we recognize that not every measure can be harmonized and not every measure should be included in each QCDR or for each physician within quality reporting programs. We agree that parsimony among available measures should be sought, that harmonization occur and that, when appropriate, measures be expanded to include a wider array of physicians. We are cognizant that efforts for harmonization in the past have often fallen short of the intended goal described by CMS.

CMS should continue to strengthen the QCDR reporting option and further embrace use of clinical data registries for participation in MACRA.

Clinical data registries, including QCDRs, provide the necessary venue for physicians to participate in MACRA by supporting local quality and performance improvement activities and measurement. 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.

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 beyond current methods may prove onerous for some providers and registries. While hospitals routinely capture this information on admission, many physician practices and billing systems do not. ASA requests further clarification on whether reporting stratification could be satisfied through sampling and statistical inference (e.g. beneficiary ZIP code).

We also caution against using risk-adjustment for QCDR measures that have limited data and are not as mature as current PQRS or NQF-endorsed measures. The methods for how to risk-adjust outcomes is still evolving, and hence incentive measures or programs of this kind should be advocated with caution unless appropriately tested, including determination of the risk of unintended consequences.

As a registry beyond QCDR, the Anesthesia Quality Institute's National Anesthesia Clinical Outcomes Registry (AQI NACOR) also supports our members and anesthesia providers in new payment models and in coordinating and delivering care. Open and available to all anesthesia providers to participate in and use, AQI NACOR will continue to be a force in driving quality improvement and improving patient outcomes. AQI NACOR works with participants in the Perioperative Surgical Home (PSH), an innovative delivery care model that aims to transform delivery of perioperative care by enhancing clinical quality, improving patient safety and lowering the cost of care, by collecting and displaying actionable data for practices. Collecting data and defining measures for local implementation have allowed many participants in the PSH to demonstrate cost savings to public and private payers.

Clinical Practice Improvement Activity (CPIA) measures should include multiple methods for measurement, including measures with a yes/no assessment.

CPIA measures should take into consideration differences between specialty prerogatives and those of primary care. Priorities for each of these physicians may not squarely align and CMS should determine which aspects of CPIA apply to all EPs and which activities might apply to a subset of physicians. For instance, enabling local innovations to allow each community to meet its needs and fostering learning organizations to promote learning and education as key parts of quality programs and initiatives might stretch across most, if not all, EPs. At the same time, a subset of measures for EPs participating in APMs built around episodes of care are necessary as well.

The MDP requests stakeholders consider CPIA measures where benchmarking and a demonstration of improvement over time would be required (structured as a denominator and numerator). The ASA sees these measures for CPIA as necessary but should not be used in all cases to assess CPIA under MACRA. The inclusion of traditional performance measure structures for CPIA, where a measure could be topped out quickly, would present a moving target for some practices as they attempt to capture new measures year over year to show improvement. For other practices, the notion of showing improvement on a

measure that is already "topped out" or benchmarked at a high level might remain elusive or difficult to show continued improvement.

There are multiple opportunities for EPs to receive credit just for participating in CPIA activities at the local level. ASA sees greater alignment between EPs receiving credit for MIPS CPIA with fulfilling Maintenance of Certification requirements (as aligned with American Board of Medical Specialties Portfolio Program) as beneficial. We also strongly encourage CMS to acknowledge participation in a clinical data registry, not just a QCDR, as another pathway for EPs to receive credit.

Use of Clinical Practice Guidelines (CPGs) should be balanced with the need to address identifiable measure gaps.

As one of the first societies to publish CPGs, ASA recognizes the importance of measure developers to use such practice parameters, in particular those with high-quality evidence, as a basis for performance metrics. We see this link as improving patient care by reducing the dissemination time of such guidelines for changes in practice. The ASA guideline development process involves rigorous grading of evidence and the review cycle can be, in most cases, accommodating of measure development and maintenance activities. Although publication in a journal may be an additional burden on measure developers, we recognize this aspect as codified in MACRA.

At the same time, we are concerned that some CPGs will lead solely to process measures without an identifiable gap to address. We also express concern with some CPG recommendations that EPs and practices follow may be able to implement but cannot be currently captured in a common and reliable way. We request that CMS provide adequate flexibility for QCDRs and measure developers to identify CPGs most relevant to driving quality improvement, especially process measures that directly lead to improved patient outcomes. We request CMS take a deeper look into how and who reports such measures and not discount a measure as being topped out among those EPs who can capture and report such data without an understanding of who is unable to report such a measure.

CMS should provide adequate support for the development of and credit for the use of specialty-specific patient experience and satisfaction surveys.

ASA appreciates CMS intention to expand surveys available for patients and EPs to include specialty-specific patient and caregiver experience and satisfaction surveys. Our members who have sought to report PQRS measures via the Group Practice Reporting Option (GPRO) have often found requirements related to using CAHPS surveys as costly and burdensome while not necessarily offering meaningful feedback to their practices and practice improvement activities.

Should CMS decide to expand the menu of applicable surveys, surveys related to anesthesia care as guided by ASA documents on patient surveys and often executed by third-party vendors, is just one step of the process. Validation of survey tools is important but flexibility for awarding credit to practices for implementing and analyzing local surveys should be included in the short term. Regardless, ASA would welcome the opportunity to work with CMS and other stakeholders to develop common surveys for patients who received care from an anesthesiologist.

CMS should assess the use of EHRs and eCQMs on an EP-by-EP basis.

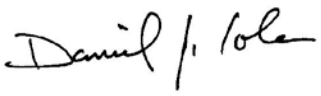
ASA sees the potential for EHRs and eCQMs to give EPs a more efficient and accurate ways to report measures while lessening the reporting burden. However, as has been described in a number of venues and among different stakeholders, the use of EHRs and eCQMs must acknowledge that measure specifications or how measures are calculated take some time to mature. Although EHRs and eCQMs are required for some APMs, CMS should be careful that the EHR mechanism is balanced with consideration of local limitations and the applicability of eCQMs to anesthesia care.

We remind CMS that the capacity of anesthesiologists to use EHRs may be substantially controlled and determined by the facility, the vendors with whom they contract, and where anesthesiologists practice. Anesthesiologists interact with a variety of technology, facility administrations and patient populations with their own facility-specific workflow challenges. In addition, some measures may be applicable to an anesthesiologist in one setting (perhaps a pre-op clinic) but that same measure may not apply to that same anesthesiologist practicing in a different setting (operating room) the next day.

Effective use of EHR technology in anesthesia practice necessitates interoperability within and between hospital systems. Hospital systems manage patient clinical information such as allergy repositories, medication administration history and other data that influence anesthesia care decision-making. Facilities must be incentivized to create and support these interfaces. ASA also sees some difficulties related to alignment across various AIMS that our members use in relation to reporting via a CMS certified EHR vendor or QCDR vendor. At times, the user or anesthesiologist has limited capacity to encourage vendors to align quality measures with an AIMS competitor or peer user. Ultimately, CMS should ensure that the use of EHRs and eCQMs are an option for EPs to report their quality data and protect EPs with limited resources from unfair and inaccurate assessments of the care they provide to patients.

ASA thanks CMS for its time and consideration of these comments. Should you have any questions or request further information, please feel free to contact Matthew Popovich, Ph.D., (m.popovich@asahq.org), Director of Quality and Regulatory Affairs, via email or by phone at 202-289-2222.

Sincerely,



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cc: Kate Goodrich, M.D., M.H.S., Director, Center for Clinical Standards & Quality, CMS