January 4, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

RE: American Society of Anesthesiologists Support for the American College of Surgeons, ACS-Brandeis Advanced Alternative Payment Model

Dear Committee Members,

The American Society of Anesthesiologists (ASA) appreciates the opportunity to comment on the ACS-Brandeis Advanced Alternative Payment Model (APM). The ASA, along with other specialty societies, have been closely monitoring the development of this model and we offer our support for this model as an effective pathway into advanced APMs for those clinicians who are at the cornerstone of payment and patient care reform yet currently lack access to advanced APM practice opportunities. Specifically, many surgical, procedural and related clinicians should find new opportunities with the implementation of this payment model. The ACS-Brandeis model notably is designed to be applicable across diverse clinical care settings.

The application of the episode grouper application in this proposal is a highly valuable contribution to structuring an adaptable APM model. The proposed overlay of quality-based adjustments represents an important safety valve for an approach that must recognize quality, safety and value. ASA looks forward to contributing quality metrics that address anesthesia-related care in these episodes.

The ASA and the ACS-Brandeis model share a collective vision to recognize high quality surgical care as a team-based, multidisciplinary endeavor. The team-based approach recognizes the contributions of each critical member of a care team, including medical specialists, primary care and all other participants in the continuum of surgical and procedural care delivery. As part of this focus, the ASA has been organizing and partnering with other medical and surgical specialties to implement the Perioperative Surgical Home (PSH) care delivery model in dozens of healthcare organizations across America. The PSH is a system of coordinated patient care, which spans the entire experience from decision of the need for any invasive procedure—surgical, diagnostic, or therapeutic—to discharge from the acute-care facility and beyond. The PSH strives to achieve the triple aim of better patient experience, better healthcare, and reduced expenditures for all patients undergoing surgery and invasive procedures. Early experience with our PSH model shows very encouraging evidence of achieving these goals.

We understand that the composition of the team and the inputs of each member of the team will vary significantly from one setting to the next. For this reason, we take the attribution model described in the ACS-Brandeis submission as an illustrative example that may provide a starting point for individual APM entities to collaboratively develop their own risk-reward distribution model.

The ASA looks forward to having the opportunity to work with the necessary medical specialty society and regulatory stakeholders to further the goals of this payment model as well as the PTAC's broad goals of recommending models that promote quality and value and expanding the CMS APM portfolio to clinicians who currently have limited options to participate.

If you have any questions regarding our comments, please contact Roseanne Fischoff, Economics and Practice Innovations Executive for the ASA, at r.fischoff@asahq.org or (847) 268-9169.

Sincerely,

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