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Submitted electronically via: MACRA-MDP@hsag.com

SUBJECT: Draft CMS Quality Measure Development Plan: Supporting the Transition to MIPS and APMs

To whom it concerns:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to provide feedback on CMS' draft Quality Measure Development Plan. The AANS and CNS appreciate that the plan — which CMS is required to share with the public under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) — prioritizes the adoption of measures that will promote more efficient data collection, better alignment and coordination across programs, settings, and payers, better provider accountability, and more meaningful data that consumers can use to make informed health care decisions.

Quality Measure Development Funding

Section 102 of MACRA includes a total of $75 million, to be used over five years beginning with fiscal year 2015, to expand and enhance existing measures and to develop new measures to fill performance gaps. The AANS and CNS are concerned that CMS has yet to allocate the first installment of this funding, especially since the first Merit-based Incentive Payment System (MIPS) performance year is less than a year away. Measure development and maintenance requires a significant investment of time and resources that are often not available to the clinical experts that have the specific knowledge to drive well-informed efforts. The historical lack of technical and financial support in this area has contributed to many existing measurement gaps.

We strongly urge CMS to begin using these funds as soon as possible and to prioritize measure development projects that are provider-led and rely on relevant clinical experts that can most appropriately determine how to fill gaps in measurement for both MIPS and APMs. **Furthermore, we encourage CMS to ensure broad access to these funds**. Traditionally, CMS has funneled resources to only a handful of stakeholders, including contractors who lack the nuanced clinical expertise to conduct this type of work and larger multi-stakeholder groups whose agendas do not support more specific or innovative projects. Going forward, CMS should consider investing in more diverse measure

development projects, including collaborations with individual specialty societies, such as the AANS and CNS. Finally, it is important that CMS set aside some of this funding to assist relevant stakeholders in the development and testing of electronic specifications that can be used across multiple electronic health records (EHRs) since this has been a particularly challenging aspect of measure development.

CMS Measure Development Priorities

Listed below are organized neurosurgery's comments on specific priorities identified by CMS:

- **Specialty Measures:** Organized neurosurgery very much appreciates that CMS recognizes that reporting ability varies significantly across different types of clinicians and that it intends to evaluate gaps in measures for both specialties and subspecialties so as to increase the number of reportable quality measures relevant to all specialties under the MIPS.

- **Population-Based Measures**: While we understand CMS' interest in these types of measures, applying measures at this level will require very careful consideration of how to most accurately attribute responsibility to the individual provider. We remind CMS of the challenges it has encountered while attempting to use the Medicare Spending Per Beneficiary (MSPB) measure and other broad-based, per-capita measures used to evaluate physician resource use under the Value Modifier. The MSPB's flawed approach of attributing costs to a single practice responsible for the plurality of services performed during an index hospitalization has resulted in many specialists being inappropriately tagged as the provider primarily responsible for the total costs associated with an episode of care — even though most of those costs were associated with decisions that remain outside of the direct control of these clinicians. If anything, population-based measures (and other similarly structured measures) should be reserved for integrated delivery systems and system-level accountability, not clinician-level accountability.

- **Outcome Measures:** The AANS and CNS support higher value outcome measurement, including patient-reported outcomes measures, but remind CMS that the definition of "high value" will continue to differ by specialty, setting and patient. Process measures that are evidence-based can be integral to improved outcomes in some specialties, and this foundational step must be preserved as an incremental step to more robust outcome measurement. As such, we are pleased that the draft plan highlights the need for outcomes measures, balanced with process measures that are proximal to outcomes. There is also an ongoing need for better risk-adjustment and attribution methodologies to ensure that outcomes measures result in fair and accurate assessments of providers. Qualified Clinical Data Registries (QCDRs) remain an important mechanism for testing the transition to more robust outcome measures and associated methodologies needed to ensure the validity and reliability of such data.

- **Patient Experience Measures**: While patient experience is a critical aspect of high-quality neurosurgical care, patient experience surveys often reflect aspects of care over which physicians do not have direct control. As such, physicians should not be held accountable for patient experience under the quality measure component of MIPS. Rather, this aspect of measurement would be more appropriate as an optional clinical practice improvement activity.

- **Resource Use Measures:** CMS notes in its draft plan that existing measures from the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM) and the EHR Incentive Program will be the starting point for measures to be used in MIPS and APMs, while development of new measures funded under MACRA will begin to address gaps in the current measure portfolio. While we appreciate this attempt to transition more gradually to MIPS and to preserve investments made to date, we believe that the resource use measures currently used under the

VM program are so flawed and result in absolutely no actionable information for most physicians that they should be retired immediately and not carried forward into MIPS. Organized neurosurgery supports CMS' efforts to develop more specific episode-based and other alternative cost measures, as well as its efforts to refine its attribution and risk-adjustment methodologies. Transparency and clinician involvement in these processes will be critical, and we look forward to working with CMS on this front.

We once again **emphasize the need to develop <u>new</u> resource use measures** — in consultation with specialty societies — **to replace, not expand upon, the current set of VM cost measures.** There is also still a critical need for specialty societies and other measure developers to have broader access to a user-friendly, consolidated, all-payer database that would allow us to conduct more robust analyses of spending, the cost of care and efficiency. Until such data are readily available, it will be challenging to arrive at more accurate and actionable resource use measures.

- **Appropriate Use Measures:** Many specialties and boards have developed and continue to expand and refine clinical practice guidelines and appropriate use criteria. The Choosing Wisely® campaign is a related, but different, activity that was intended to promote dialogue between patients and providers around potentially unnecessary tests, treatments and procedures. **Neither the Choosing Wisely recommendations nor appropriate use criteria should be considered absolute recommendations regarding the appropriateness of a given test, treatment or procedure**. Rather these should both serve as the basis for patient-centered shared decision-making. As such, use of these criteria and recommendations should be recognized under the Clinical Practice Improvement Activity component of MIPS. Specialty societies and boards might choose to create resource use or appropriate use quality measures based on these criteria and recommendations, but that decision should remain in the control of the specialty and their clinical experts.

- **Multi-Payer Applicability:** We support efforts to align better measures across payers, but remind CMS of all the work that still needs to be done before measures can indeed be aligned across payers. This includes the development of standard data definitions and shared logical constructs, which should be guided by relevant clinical stakeholder expertise.

- **Applicability of Measures Across Healthcare Settings:** Where appropriate, CMS should give physicians the option to elect to be measured based on hospital or other facility-level performance as a surrogate for physician-level performance. However, it is critical that this decision remains in the control of the physician, given the implications for payment and public reporting.

- **Coordination and Sharing Across Measure Developers**: CMS voices concern in this section about Qualified Clinical Data Registry (QCDR) measures receiving variable quality assurance checks and testing before deployment since they are not required to go through a consensus-based endorsement process and are not reviewed under the Measures Application Partnership (MAP) pre-rulemaking process. To support broader consideration and integration of QCDR measures in MIPS, CMS proposes to promote knowledge sharing across measure developers and QCDRs to foster the consistent use of standardized processes. While the AANS and CNS support efforts to achieve greater transparency and collaboration among measure developers, we remind CMS that the original statutory language authorizing QCDRs — the American Taxpayer Relief Act of 2012 — explicitly prohibits CMS from applying the National Quality Forum (NQF) and Measures Application Partnership (MAP) processes to QCDR measures. MACRA preserves that policy as it applies to QCDR measures and incudes other policies to reduce the regulatory

burden of measure development. Going forward, it is critical that CMS preserve the fluid and flexible nature of the QCDR mechanism, which allows for the rapid development, testing and implementation of more innovative and potentially more meaningful measures that are not otherwise possible under the lengthy and more resource intensive formal consensus-based vetting process.

- **Evidence Base for Non-Endorsed Measures**. We agree with MACRA's charge that measures selected for inclusion that are not endorsed by a consensus-based entity must have a focus that is evidence-based. However, we are concerned about CMS' proposal to require measures that are not NQF-endorsed to align with NQF requirements for its consensus review process. The NQF process is simply too cumbersome and too unpredictable to allow for dynamic and timely testing of new measures.

- **Clinical Practice Improvement Activities (CPIAs)**: MACRA requires CMS to consider CPIAs for identifying possible areas for future measure development and identifying existing gaps with respect to such measures. CMS must keep in mind that not all CPIAs will easily translate into quality measures. Congress created this category specifically to capture activities that result in better patient care, but do not necessarily translate easily into traditional quality measures. It is critical that CMS preserve the Congressional intent of this category by giving physicians credit for engaging in or completing specific activities, rather than CMS trying to formulate arbitrary metrics to capture performance on these activities. This could be done through a simple web-based attestation process that occurs annually.

  Furthermore, CMS should allow for the broadest interpretation of CPIAs possible. Physicians should have the freedom to choose the CPIAs that are most beneficial and appropriate for their type of practice and patient population. Subcategory domains should only serve as a guide for defining CPIAs and no category should be mandatory. There might be an opportunity in the future to translate some of these activities into more traditional quality measures, but this should only be done in consultation with clinical experts and not until a sufficient foundation of data is first collected and tracked over the long run. Some specific activities that neurosurgery would like to see recognized as CPIAs include**:**

  - Participation in a QCDR and in registries run by other government agencies such as FDA or private entities such as a hospital, or medical specialty.
  - Serving on-call to the hospital emergency department.
  - Attending and participating as faculty in ACCME-accredited events (e.g., the AANS and/or CNS Annual Meetings, and other CME offerings).
  - Maintenance of certification (MOC) and other continuing medical education activities.
  - Fellowship or other advanced clinical training completed within a certain window of a performance year.
  - Physician practice accreditation, such as accreditation achieved by the National Committee on Quality Assurance (NQCA) or other recognized accreditation organizations.
  - Engagement in private quality improvement initiatives, such as those sponsored by health plans and health insurers.
  - Consulting evidence-based clinical practice guidelines or contributing to the development of such guidelines.
  - Use of patient experience surveys (not limited to CAHPS).

- **Consideration for Electronic Specifications**: While we support CMS' interest in shifting towards e-specified measures, we remind the agency of the barriers that continue to stand in the way of this goal. As noted earlier, development and implementation of electronic clinical quality

measures (eCQMs) is a complex and technical process that requires a substantial investment that many measure developers cannot afford. Specialty societies need greater assistance from CMS to develop and test electronically captured data elements and ensure they translate into realistic clinical workflows. We also need CMS to invest more and coordinate efforts to develop standard data models, measure logic approaches, and value sets so that measure developers have the standardized data elements necessary to support successful eCQM implementation without adding the long delays and costs associated with site recruitment, data acquisition, and field testing by individual measure developers. A critical part of this process is the adoption of standards that promote data sharing across platforms (i.e., EHR vendors and other data sources), as well as settings of care. As CMS conducts this work, it is critical that it work with relevant clinical experts and with EHR vendors to incorporate appropriate eCQM specifications and other standards into the EHR certification process.

Overall, the AANS and CNS urge CMS to prioritize measures and reporting processes that are more meaningful to both physicians and their patients, but that also maximize the use of existing clinical workflows and decrease the collection burden on physicians. Clinical data registries play a critical role in achieving these goals. We appreciate CMS' enhanced recognition of registries to date and request that it preserve this approach going forward. The success of MACRA, and particularly MIPS, is fundamentally contingent on all specialties having a sufficient portfolio of actionable and relevant quality measures, and clinical data registries have helped substantially in achieving that goal.

We look forward to the opportunity to work with CMS to more thoughtfully pursue measure development strategies that meaningfully evaluate physician quality and appropriately incentivize higher value care. Thank you for considering our comments. In the meantime, if you have any questions, please feel free to contact us.

Sincerely,

H. Hunt Batjer, MD, President
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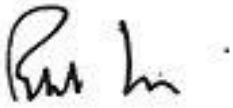

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