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September 9, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1715-P
P.O. Box 8011
Baltimore, MD 21244-1850 Merit-Based Incentive Payment System (MIPS)

SUBJECT: CY 2020 Revisions to Payment Policies under the Physician Fee Schedule

Dear Ms. Verma,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), we appreciate the opportunity to provide comments on the quality-related provisions of the proposed 2020 Medicare physician fee schedule. We will address issues related to the coding, reimbursement and other payment issues in a separate letter.

Merit-Based Incentive Payment System (MIPS)

MIPS Value Pathways (MVPs) framework. In this rule, the Centers for Medicare & Medicaid Services (CMS) propose to apply a new MIPS Value Pathways (MVPs) framework to future proposals beginning with the 2021 MIPS performance year. MVPs are intended to create a more cohesive and meaningful participation experience for clinicians by moving toward an aligned set of measures that are more relevant to a clinician's scope of practice, while further reducing reporting burden and easing the transition to APMs through enhanced and timely performance feedback. Under the framework, a clinician or group would participate in one MVP associated with their specialty or with a condition, reporting on the same measures and activities as other clinicians and groups in that MVP. Measures and activities would cover all four MIPS performance categories and could include fewer total measures than currently required under MIPS.

The AANS and the CNS support efforts to simplify MIPS, to offer clinicians a more meaningful participation experience, and to provide enhanced and actionable performance feedback to assist clinicians with transitioning to value-based alternative payment models (APMs). Nevertheless, we are concerned that the MVP framework, as currently set forth, misses the mark in terms of addressing some of the most fundamental problems with MIPS. Below is a summary of recommendations that we believe are necessary to make this a successful endeavor:

- Deconstruct the MIPS category silos. To minimize complexity and encourage more meaningful engagement among clinicians, it is critical that the MVP framework truly deconstruct the silos that currently separate each MIPS performance category rather than simply bringing together existing performance categories and their distinct rules under a common theme. The MVP framework must unify the MIPS performance categories through streamlined reporting and more simplified

scoring strategies, including cross-category credit, that alleviate duplicative reporting and allow clinicians to spend more time tracking their performance than tracking compliance.

- Preserve clinician choice. It is essential that clinicians maintain the ability to choose the most appropriate MIPS participation pathway — whether that is through an MVP or traditional MIPS. We also strongly oppose CMS automatically assigning a specific MVP to a clinician or group. MVP determinations should be for guidance only.

- Promote policies that incentivize participation among specialists. This includes preserving a diverse inventory of specialty-specific measures, incorporating scoring policies that encourage the use of these measures, and adopting policies that encourage investments in Qualified Clinical Data Registries (QCDRs).

- Consider condition- or procedure-specific MVPs rather than specialty-specific MVPs. Neurosurgery, for example, is divided into multiple sub-specialties that have important distinctions in terms of patient populations, procedures, and patterns of care.

- Avoid the use of administrative-based population health measures, which have inherent limitations and do not produce relevant or actionable feedback for specialists. At a recent meeting with specialty societies, CMS noted that its rationale for measuring population health is that "we are all in this together" and that this "is what the ACO model is about." While we appreciate CMS' attempt to assist clinicians with the transition to APMs, those who are not yet in APMs and still participating in MIPS do not necessarily have the infrastructure in place to fully account for APM-like care coordination and shared risk. As such, we do not view population health measures as appropriate for a clinician-level program such as MIPS. Instead, we recommend that CMS incorporate more specialty-specific measures into MVPs, including QCDR measures, and simultaneously adopt policies that incentivize the use of these measures.

- Recognize more innovative and cross-cutting ways of measuring clinicians under the Promoting Interoperability category. CMS should look beyond electronic health record (HER) functionality and instead recognize the sharing and use of electronic health data to improve clinical outcomes (e.g., implementation of practice improvements based on clinical data registry data that incorporates EHR data).

- Use the MVP approach as an optional alternative to sub-group reporting. This would allow multi-specialty practices to more comprehensively capture the range of the items and services furnished by specialists and subspecialists in group practices.

- Improve transparency and collaboration. We recognize that recently CMS has made an attempt to hold more frequent meetings with provider groups; however, we nevertheless believe that improvements could be made to these engagements. The AANS and CNS encourage CMS to work with relevant clinician stakeholders *on an ongoing basis* to develop MVPs in a transparent and collaborative manner.

- Timely feedback. Continue efforts to provide enhanced and timelier clinician feedback, particularly data over which specialists have control.

- Implement the MVPs gradually through pilot testing that focuses initially on relatively simple conditions/procedures impacting relatively homogenous patient populations that also have existing measures and activities.

For a more detailed discussion regarding these recommendations, we refer CMS to the Alliance of Specialty Medicine's comment letter.

MIPS Policies Proposed for 2020 and Beyond. Organized neurosurgery's biggest concern about policies proposed for 2020 and beyond is that our members believe that they are constantly chasing a moving target. Year after year, CMS continues to change the rules of MIPS, which not only adds to the complexity of the program but prevents CMS and clinicians from accurately evaluating participation trends and performance patterns. As CMS continues to work with stakeholders to develop the MVP framework and address more fundamental reforms to MIPS, it should simultaneously ensure that the traditional MIPS track remains as consistent as possible so that clinicians can engage more meaningfully and so that CMS can more precisely assess the feasibility and value of current program policies.

In regards to specific MIPS proposals for 2020 and beyond, we offer the following comments:

- Quality Category. CMS proposes to remove two measures from the neurosurgical specialty set because they are duplicative of other measures in the program:

  #345: Rate of Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) Who Are Stroke Free or Discharged Alive. CMS believes this is duplicative in concept and patient population to #344: Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients without Major Complications (Discharged to Home by Post -Operative Day #2).

  #346: Rate of Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA) Who Are Stroke Free or Discharged Alive. CMS believes this is duplicative in concept and patient population to #260: Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post -Operative Day #2).

  The AANS and CNS agree that measures #344 and #260 are appropriate replacement measures for #345 and #346. However, since measures #345 and #346 are currently part of the Neurosurgical Specialty Measure Set, we request that CMS add the replacement measures to the set, as well. Currently, measures #344 and #260 are not proposed for inclusion in the Neurosurgical Specialty Measure Set.

  We also strongly oppose policies that disincentivize meaningful participation by specialists, including CMS' ongoing elimination of topped out measures and its new proposal to remove quality measures that do not meet case minimum and reporting volumes for benchmarking for two consecutive years, especially since current CMS scoring policies discourage the reporting of new or infrequently used measures.

- Cost Category. The AANS and the CNS oppose CMS raising the weight of the Cost category from 15% to 20%, while simultaneously decreasing the weight of the Quality category from 45% to 40% due to ongoing concerns regarding the existing set of cost measures and the fact that clinicians continue to have far more direct control over quality measures than they do over cost measures. AANS and CNS members served on the Wave 2 Lumbar Fusion Subcommittee and Workgroup, as well as two other Wave 2 Subcommittees. While we appreciate CMS' ongoing

work with clinicians to develop more focused episode-based cost measures, our members most closely involved in this effort continue to have concerns with the measure development process. These include an inadequately brief field-testing period, which prevented CMS from gathering meaningful input, and the ongoing lack of a clear mechanism to incorporate relevant measures of quality into these cost measures to produce a valid metric of value. We are also concerned that only three of the 18 episode-based cost measures proposed for 2020 have been endorsed by the National Quality Forum (NQF). Of the eight measures developed during Wave 1, only three were reviewed and eventually endorsed by the NQF Cost and Resource Use Committee. The other five did not pass muster with the Scientific Methods panel and were unable to move on for formal evaluation by the Cost Committee, yet are currently being used in MIPS.

Similarly, none of the Wave 2 measures, including the Lumbar Fusion cost measure, have been considered by the NQF yet. We are very concerned that CMS is moving ahead with using these measures for accountability when the Measures Application Partnership (MAP) provided conditional support for the use of these measures pending NQF endorsement. Given these concerns, we do not believe that CMS should increase the weight of the Cost category at this time. We also urge CMS to continue to make improvements to the field-testing period, such as extending the timeline to access and provide feedback on the reports. Finally, we recommend that CMS continue to make improvements in regards to education and outreach since many clinicians, including some that participated in the development process, still do not fully understand the measure specifications, the measure results, and what to do with these data.

- Improvement Activities Category. Starting in 2020, CMS proposes that a group would be able to attest to an Improvement Activity only if at least 50 percent of MIPS eligible clinicians in the group participate in or perform the same activity for the same continuous 90 days. The AANS and CNS strongly oppose this proposal since it represents yet another confusing shift in the requirements of MIPS and because it does not take into consideration the realities of clinical practice, particularly in a multi-specialty practice, where it would be impractical to require half the clinicians in practice to perform the same activity over the same 90 day period.

- Promoting Interoperability Category. We appreciate improvements made to this category in recent years, but continue to strongly urge CMS to recognize a more diverse inventory of measure options that better reflect the use of technologies to harness and share clinical data. As we have stated in the past, this category must move beyond certified EHR technology functionality and instead rewards actions such as the implementation of practice improvements based on clinical data registry data that incorporates EHR data.

- QCDR Proposals for 2020 and Beyond. In general, the AANS and the CNS have been frustrated by CMS' attempt to unreasonably raise the bar on QCDR requirements in ways that do not have demonstrated links to higher quality or higher-value care. This proposed rule contains a series of new requirements for QCDRs, which will impose significant burdens and costs on them and force additional QCDRs to end their participation in MIPS.

For a more detailed discussion about the MVP Framework and MIPS proposals for 2020 and beyond, we refer CMS to the Alliance of Specialty Medicine's comment letter. For more in-depth feedback on the QCDR proposals, we refer CMS to the Physician Clinical Registry Coalition's (PCRC) comment letter. The AANS and the CNS are members of both groups and support these comment letters as well.

Thank you for considering our comments. If you have any questions or need additional information, please do not hesitate to contact us.

Sincerely,

Christopher I. Shaffrey, President
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Ganesh Rao, MD, President
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