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Subject: Draft 2025 MVP Candidate Feedback

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 comment on the 2025 candidate Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs). Our comments below focus on the Surgical Care MVP.

Our primary concern with the Surgical Care MVP is that it attempts to lump numerous unrelated surgical specialties (e.g., general surgery, neurosurgery, cardiac surgery, breast surgery) into a single MVP. This is inappropriate from a clinical perspective and provides little added value — beyond the current MIPS specialty quality measure sets — in terms of assisting surgical specialists with identifying the most relevant MIPS measures. According to the Center for Medicare & Medicaid Services (CMS) MVP guiding principles, “MVPs should consist of limited, connected, complementary sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, and lead to sufficient comparative data.” As currently constructed, this MVP will not satisfy any of those goals. Instead, it will create confusion and discourage movement into MVPs among surgeons, who might assume that CMS plans to evaluate their performance against other unrelated surgical specialties, pitting one specialty against another.

Although CMS has confirmed that it will score MVP participants on individual measures just like under traditional MIPS (i.e., using a performance benchmark that is specific to the particular measure and the measure’s specific collection type, regardless of whether the measure is reported through traditional MIPS or an MVP), CMS also states on the Quality Payment Program website that in addition to providing MVP participants with a final score and payment adjustment, participants will also receive “MVP Comparative Feedback...[which] will highlight how your performance compares at the category level to other clinicians reporting the same MVP.” If CMS finalizes the Surgical MVP in its current form, this would mean that a spine surgeon, for example, might receive feedback comparing their performance in the quality or cost category to a breast surgeon’s performance in those same categories, even if their category scores were based on entirely different measures. We recognize that this feedback would be purely informational, but it would also be meaningless and only increase widespread skepticism about the value of this program.

Adding to our frustration regarding the arbitrary construction of this MVP is that CMS did not consult organized neurosurgery or collectively contact the affected surgical specialties to assess the appropriateness of this particular strategy. One of CMS’s finalized MVP development criteria is that an MVP “be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties.” This MVP was not developed collaboratively. If it were, CMS would have realized early on that

there are more appropriate strategies for constructing MVPs — that are more clinically useful to both patients and physicians — than arbitrarily combining various surgical specialties under the umbrella of “surgery.” In fact, in its 2024 Medicare Physician Fee Schedule proposed rule [comment letter](#), the AANS and the CNS suggested that CMS add measures Q461: Leg Pain After Lumbar Surgery and Q471: Functional Status After Lumbar Surgery to the existing Rehabilitative Support for Musculoskeletal (MSK) Care MVP, and to drop the title’s reference to “rehabilitative support,” to make it more relevant to spine surgeons and more reflective of real-world, multi-disciplinary and team-based MSK care. We also suggested the addition of other quality measures that would be relevant for a broader MSK MVP, including:

- Q039: Screening for Osteoporosis
- Q126: Diabetic Peripheral Neuropathy - Neurological Evaluation
- Q134: Screening for Depression and Follow-up Plan
- Q178: Functional Status Assessment for RA patients
- Q226: Tobacco Screening and Cessation
- Q418: Osteoporosis Management in Women with Fracture

The AANS and CNS continue to believe that an expanded MSK MVP would be preferable and more relevant to spine surgeons than a global Surgical MVP. At the same time, however, we continue to advocate against the use of Q459: Back Pain After Lumbar Surgery (in traditional MIPS and MVPs) since improving back pain is not usually the primary goal of lumbar fusion surgery and, therefore, not a helpful yardstick of success. Put another way, a lumbar spine operation may still be high-quality from a technical and clinical standpoint, even if the patient’s back pain remains constant.

The AANS and the CNS are also concerned that the candidate Surgical MVP includes what CMS might view as generic, all-encompassing surgical measures that apply across surgical specialties, such as Q355: Unplanned Reoperation within the 30 Day Postoperative Period and Q357: Surgical Site Infection. However, if you take a closer look at the specifications of these measures, they do not reflect the range of surgical procedures captured by this MVP. For example, none of the CPT codes representing neurosurgical procedures are included in the denominator of either measure. As a result, a neurosurgeon might be unable to use these measures, making it challenging to meet the MVP four-measure requirement. In selecting four quality measures, a neurosurgeon could conceivably only report on back or leg pain after lumbar surgery, functional status after lumbar surgery, advance care planning, patient-centered surgical risk assessment/communication, or screening for social drivers of health. Only three of these measures directly relate to the quality of surgical care provided, and they are problematic, as we discuss here. This is yet another concern underlying our conclusion that this MVP is, unfortunately, arbitrary rather than a truly useful quality measurement and improvement tool.

We want to use this comment opportunity to highlight other flaws with Q355 and Q357. Although the title and description of these measures seem to suggest that they are broadly applicable across surgical specialties, the denominator codes are almost exclusively focused on general surgery. Even the debridement codes, for example, are not generally applicable across surgical specialties and instead concentrate on debridement involving genitalia and the abdominal wall. In the rare instances where there are more specialty-specific codes, they are not clinically appropriate. For example, the random collection of vascular surgery procedure codes does not capture any of the major procedures a vascular surgeon performs. There is also a considerable range in procedural complexity, from the insertion of lines/ports/feeding tubes (relatively minor procedures) to pelvic exenterations and complex tumor resections (more major, high-risk procedures), which results in faulty performance comparisons of infection and return to the operating room across common/simple and rare/high-risk procedures. Most concerning is that there does not appear to be any risk adjustment when calculating these measures, which, paired with our other concerns, raises major questions about the validity of these measures. Unfortunately, CMS (and perhaps even some surgical specialties) seem to assume that Q355 and Q357 are broadly applicable across surgical specialties based on their titles alone. We request that CMS significantly re-evaluate these measures to address these serious concerns. We also remind CMS of the importance of considering the

actual specifications of a measure and its clinical context when populating MVPs (and when attempting to pair quality and cost measures) rather than making assumptions simply based on a measure's title.

Additionally, we are concerned that there is a lack of internal consistency between the quality and cost measures included in this MVP related to lumbar fusion. For example, quality measures Q461: Leg Pain After Lumbar Surgery, Q471: Functional Status After Lumbar Surgery and Q459: Back Pain After Lumbar Surgery each capture lumbar fusion or discectomy/laminectomy without fusion. On the other hand, the cost measure, Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels, only focuses on fusions. Furthermore, the lumbar fusion quality measures are evaluated at one year post-operation, whereas the lumbar fusion acute episode cost measure ends at 90 days post-operation. As a result, these quality and cost measures are misaligned, do not evaluate the same patient populations in the same manner and will not result in accurate assessments of value. This disparity creates an incentive to delay care, such as physical therapy, until after the acute cost measurement episode has ended.

Finally, we would like to use this opportunity to point out other limitations related to the spine measures included in this candidate MVP. For example, for Q471: Functional Status After Lumbar Surgery, the only acceptable functional assessment tool that can be used to satisfy the measure is the Oswestry Disability Index. The AANS and the CNS urge CMS to work with the measure developer to incorporate other, more appropriate functional outcome measures from tools such as PROMIS® (Patient-Reported Outcomes Measurement Information System). We also remind CMS that all three spine surgery measures included in this MVP continue to lack a benchmark (at least according to the most recent 2023 historic benchmark file). CMS recently instituted a policy that assigns a clinician 0 points for reporting on a measure that lacks a benchmark. The uncertainty and risk associated with selecting measures that lack a benchmark provide little incentive for clinicians to report on these measures. As we have requested in the past, we strongly urge CMS to adopt scoring policies that incentivize clinicians to report on these measures and to build the foundation of data needed to produce reliable benchmarks. These policies should apply to new measures and existing ones that have been in the program for multiple years and are caught in an endless cycle of non-use.

CMS's stated goal of the MVP framework is "to align and connect measures and activities across the MIPS performance categories of quality, cost, and improvement activities for different specialties or conditions.... [in order to] streamline MIPS reporting, reduce complexity and burden, and improve measurement." CMS also has adopted formal MVP development criteria that specifically requires that MVPs have "a clearly defined intent of measurement, have measure and activity linkages, and be clinically appropriate." As outlined in this comment letter, the AANS and CNS view the candidate Surgical MVP as failing to meet any of these goals or criteria.

The AANS and the CNS appreciate the opportunity to provide feedback on the candidate Surgical MVP. We would be happy to discuss with CMS more appropriate ways to ensure that neurosurgeons can utilize MVPs.

Sincerely,



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