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November 20, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW, Mail Stop 314G
Washington, DC 20201

Submitted electronically via CMMI_NewDirection@cms.hhs.gov

SUBJECT: Innovation Center New Direction – Request for Information

Dear Administrator Verma:

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we thank you for the opportunity to respond to the Centers for Medicare and Medicaid Services (CMS) Innovation Center New Direction Request for Information (RFI). We appreciate the Administration's effort to seek public feedback on a new direction for the Innovation Center, which was created under the Affordable Care Act to test innovative payment reforms. We are also encouraged by its interest in promoting more patient-centered and market-driven reforms that increase choice while also aiming to improve outcomes and the overall value of care.

The AANS and CNS fully support payment and delivery reforms that incentivize higher quality and better value care, but the current manner in which quality and value are defined and measured is problematic and flawed. The future direction of value-based payment reform needs to be guided by those treating patients at the bedside and must not result in excessive regulatory burdens that distract from more meaningful activities.

Listed below are some issues that the AANS and CNS ask CMS to consider as it determines the future direction of the Innovation Center:

- **The development and testing of more specialty-focused models**. One of organized neurosurgery's biggest concerns is the ongoing lack of specialty-focused payment models being tested through the Innovation Center. Without such models, specialists lack the opportunity to contribute to future payment reforms but also lack the opportunity to participate in the Quality Payment Program's (QPP) Advanced Alternative Payment (APM) Model track. **We encourage CMS to broaden the scope of models it tests so that they are more inclusive of the unique dynamics of specialty care, even if that means small-scale testing at the local level.**

- **Minimize administrative burden and shift focus to more meaningful investments**. We are very encouraged by the Administration's interest in lowering physician burden. Future payment

models need to more judiciously focus on what is meaningful and important to both the clinician and the patient rather than an arbitrary number and type of required quality measures. As noted earlier, federal investments must be made to build further the infrastructure that will allow for more seamless data collection. Until then, individual clinicians should not be saddled with the burden of tracking and satisfying their responsibilities under multiple complex and confusing reporting mandates. To date, federal efforts to promote value-driven reform have resulted in a burgeoning industry of hospital and practice administrators focused solely on ensuring that the "right boxes are checked" and that the correct paperwork is filed to avoid penalties. This misdirection of resources is unfortunate since we observe that it is doing little, if anything, to improve health care quality. Just like CMS is interested in promoting value over volume, the agency should adopt that same approach in its strategies for future payment reform. **Payment reforms of the future must shift the focus away from what has become arbitrary and burdensome and towards a system that focuses resources on the most relevant and impactful interventions.**

- **Only hold physicians accountable for costs they can control**. Many of our members have been frustrated and concerned about their inability to influence post-acute care (PAC). While these costs often contribute substantially to neurosurgically-relevant episodes of care, neurosurgeons usually have little control over the decisions and costs associated with PAC**.** Similarly, there are frequent attribution errors when defining our members' involvement within various episode methodologies, leading to inaccuracies in cost and quality calculations. **It is critical that as CMS continues to test payment models that it ensure that physicians are only held accountable for costs that they can directly control.**

- **Better methodologies to identify and adjust for riskier patients**. Value-driven payment models also need to better account for the costs of high-risk patients. Our members find that under many current bundled payment model contracts, there are insufficient mechanisms to account for fragile or more complex patients, which not only drives up the cost of the bundle but creates disincentives to treat patients most in need. Adding to that problem is our ongoing inability to precisely determine ahead of time which patients will cost more so that proper adjustments and stratifications can be applied. **While payers are making gradual progress on these fronts, there is still a great need for better data to better understand patient risk factors and their impact on outcomes**. As described below, we believe that clinical data registries can play a critical role here.

  - **Incentivize investments in clinical data registries**. In many specialty areas, existing clinical information systems (particularly administrative systems) are grossly inadequate to provide even the most fundamental insights essential to defining quality, such as allowing for the identification of specific and comparable patient cohorts. Furthermore, basic information regarding expected outcomes for specific conditions/interventions that are most meaningful to patients (such as improvements in pain or disability) is currently absent in common data structures. Without such information, we can never hope to move the quality needle meaningfully. The AANS and CNS believe that clinical data registries, if properly incentivized and adopted more broadly, can help to fill many current information gaps regarding how patients with different clinical and socioeconomic characteristics respond to various treatments, what sets of parameters allow for comparable clinical scenarios, how clinicians compare in regards to performance on outcomes and resource use, and how patients can make better decisions about their careUnfortunately, many current barriers prevent more widespread adoption of registries, such as electronic health record (EHR) vendor data blocking practices and misguided reporting mandates that focus solely on system functionalities rather than on the quality of data being collected. **As payment reform continues to evolve, we strongly urge CMS to adopt policies that further incentivize both the collection and meaningful application of data gathered through clinical data registries,**

along with efforts to improve the accuracy and collection efficiency of high-value clinical data.

- **Incentivize, rather than mandate, participation**. **It is critical that CMS maintain voluntary participation in models that allow hospitals, as well as surgeons, to tailor bundled and other innovative payment reforms to their specific patient populations, practice settings, administrative capabilities, and resources**. Mandatory models unfairly target providers who might have avoided testing such models for legitimate reasons. These providers, many of whom are in small or rural practices, hospitals or systems, face real challenges, such as a lack of resources to better coordinate care (including a lack of access to interoperable EHRs), insufficient patient volumes, and/or a lack of negotiating power in their community. These challenges will not be resolved, and will only be exacerbated, by forcing providers in different settings and with varying resources into the same box. What these providers need is more flexibility, better support and guidance, and stronger incentives — not a restrictive mandate. It is simply erroneous, and even dangerous for patients, to assume that providers across the nation would fit into and benefit from the same payment model.

- **Preserving the role of the physician**. No APM, particularly a surgery-focused APM, can achieve success without hospital/physician alignment. The recent trend in health care consolidation is crippling independent practice, which poses a serious threat to innovation. While the hospital might be in the best position to manage certain aspects of a bundled payment model, only physicians have the clinical expertise to ensure that care is redesigned in a way that truly improves outcomes and does not impede patient access or choice. For acute care models, in particular, physicians make the decisions that can result in the success (or failure) of a bundled payment model. **Therefore, it is critical that physicians and other relevant clinical experts have a leading role in defining episodes, appropriate risk adjustment and attribution methodologies, and fair mechanisms for distributing payments under APMs**. If CMS is going to hold physicians accountable for entire episodes of care, then physicians must have the ability to take ownership and control and define their own roles

- **Protect beneficiary choice and access to specialty care**. The AANS and CNS strongly support CMS' interest in giving "beneficiaries and health care providers the tools and information they need to make decisions that work best for them." Standardized care metrics and care models create barriers to treatments for those individuals that do not meet "average" thresholds. When patients cannot access treatments that work for them, our health care system bears the cost of reduced treatment adherence, increased hospitalization, and other acute care episodes. **Innovative payment and delivery models should not rely on one-size-fits-all metrics and should not limit beneficiary access to high-value specialty care. Furthermore, CMS should adopt metrics to monitor beneficiary access to specialty care and ensure that choice is preserved**.

- **Greater patient involvement in payment and delivery reforms**. We also urge CMS to consider a greater emphasis on patient and consumer involvement in payment reforms. Few payment models to date incentivize consumers (e.g., through lower cost sharing) to choose providers and care models that are less expensive and meet their needs, nor do they place any responsibility on the patient to make lifestyle choices that could contribute to better outcomes (e.g., smoking cessation or weight loss). Again, future payment and delivery models should only hold physicians accountable for factors they can directly control. At the same time, **CMS should continue to explore ways in which it can better account for patient actions in accountability models and incentivize patient decision-making that is proven to lead to better outcomes**.

- **Preserve innovation**. **We urge CMS to test models that encourage innovations in care delivery and promote personalized services based on new diagnostics and big-data capabilities**. In this age of personalized medicine, there are opportunities to reduce costs by better targeting treatments shown to work on patients with similar characteristics, needs and preferences. For example, providing patients with a pre-existing condition a therapy tailored to their individual needs early in their disease process can prevent them from requiring more aggressive and expensive treatments in the future. **Future value-driven payment reforms must consider cost and quality equally and must put the individual needs of the patient first**.

- **Preserve fee-for-service as a viable payment model**. There are numerous examples across the country where specialists have moved services and procedures from expensive inpatient settings to lower-cost outpatient settings, while also reducing gaps in quality and variations in care. For these specialists, fee-for-service (FFS) remains the most appropriate reimbursement structure, and CMS should provide them with the opportunity to stay in that system. **Physicians who can continue to prove to be high value under the current system should maintain the choice to remain in FFS**.

- **Private contracting**. The AANS and CNS appreciate CMS' consideration of models that would allow beneficiaries to contract directly with health care providers. Under current law, Medicare beneficiaries that choose to see physicians who do not accept Medicare are required to pay the physician's charge entirely out of personal funds; Medicare does not pay any part of the charge. Also, physicians who choose to provide covered services to Medicare beneficiaries under private contracts must "opt out" of the Medicare program for two years, during which time Medicare does not pay the physician for any covered services provided to Medicare beneficiaries.

  The AANS and CNS have long maintained that these discriminating policies are inappropriate and an impediment to Medicare beneficiaries' freedom of choice. **We urge the agency to allow physicians and Medicare beneficiaries to enter into private contracts on a case-by-case basis**. Medicare beneficiaries should not be prevented from using their Medicare benefits if they choose to see a physician that does not accept Medicare, and physicians should not face penalties or be forced to "opt-out" of the Medicare program to contract with Medicare beneficiaries privately. At the same time, we recognize that not every Medicare beneficiary will choose to exercise their right to contract privately, and in some cases, private contracting may be inappropriate. For private contracting models to be successful, **we encourage the inclusion of appropriate protections for low-income and dual-eligible beneficiaries, as well as beneficiaries with emergency or urgent conditions, or those who do not have a choice of physicians**.

- **Population health measures**. We believe there is value in evaluating quality and outcomes at the population level, and recognize that doing so could result in less administrative burden for individual physicians. At the same time, we are concerned that a heedless move toward more general, population-based measures could leave specialists with no way to demonstrate their value. Furthermore, a movement to fewer measures that are used by all physicians fails to account for the differences across the different specialties and their patients. **One size definitely does not fit all, so we request that CMS continue to work with specialties to identify the appropriate balance of measures that are meaningful to both physicians and patients**.

- **Provide physicians help in obtaining the data and analytical support needed to design APMs**. One of the most significant barriers physicians face in developing and implementing new approaches to care delivery and payment is their inability to obtain data on the full range of services their patients are receiving today. Physicians do not have access to information about the

other services their patients are receiving that would enable them to identify and quantify opportunities for savings or take action to achieve these savings. Furthermore, APM developers also need assistance with technical issues such as risk stratifying patients and risk adjusting payments. **CMS should, therefore, create more effective and user-friendly mechanisms through which physicians can access and analyze CMS claims data and provide financial support to physicians to help them gather and analyze relevant clinical data that is not contained within claims data**.

- **Medical liability reform**. Without meaningful medical liability reform, physicians will continue to engage in defensive medicine, which will skew the intent and results of potentially promising payment models. **We realize this is outside of CMS' jurisdiction, but request that CMS put pressure on Congress to enact long overdue, meaningful reforms**.

Once again, the AANS and CNS are pleased that CMS is taking a fresh look at physician payment reform and seeking out new directions to address current obstacles that divert effort from steps that could truly improve outcomes that matter to patients. We look forward to working with the agency to evolve this strategy and test innovative reforms. In the interim, feel free to contact us with any questions.

Sincerely,

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American Association of Neurological Surgeons

Ashwini D. Sharan, MD, President
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