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NEUROLOGICAL SURGEONS

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September 11, 2017

Seema Verma, MPH, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Subject: CMS-1676-P Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2018

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 appreciate the opportunity to comment on the above-referenced notice of proposed rulemaking.

EXECUTIVE SUMMARY

Regulatory Reform

Global Surgery Data Collection Project

- The AANS and CNS urge CMS to delay the global surgery data collection project — both claims data and the provider survey — until CMS has addressed outstanding project issues and conducted adequate provider education.
- We recommend that the agency avoid using any data collected in 2017 to revalue global services in 2019, particularly until the validity of such data can be ascertained.
- The AANS and CNS urge CMS to suspend the practitioner survey until it has been thoroughly vetted and the specialties to be surveyed have had an opportunity to review it and provide feedback.
- If CMS can collect useful data, we request that the agency refrains from modifying values for those CPT codes subject to data collection outside of the well-established American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process.

Coding and Reimbursement Issues

Determination of Malpractice (MP) Liability RVUs

- The AANS and CNS believe that using population to weight the premium is incorrect. We urge CMS to use work RVUs instead of population to weight geographic differences that are used to calculate national average premiums.

- The AANS and CNS urge CMS to ask its contractor to identify and obtain alternative surgical premium data, and we recommend that CMS use the previous surgical premiums until more data can be obtained, rather than using blended premiums for MP RVU calculations. The AANS and CNS also urge CMS to continue to work with the RUC PLI workgroup to secure valid alternative sources of nationally-representative malpractice premium data
- We believe that the cross-walk for non-physician providers significantly exceeds the actual premium costs of these non-physician providers. CMS should, therefore, collect premium data for the non-physician specialties and use updated data from all fifty states.
- Neurosurgery has long advocated for the utilization of the most up-to-date data for MP RVUs, and we continue to do so. However, given concerns about accuracy and flaws in the methodology for calculating MP risk factors, the AANS and CNS recommend that CMS not accelerate its schedule for updating MP RVUs based on the GPCI data.
- We commend the agency for accepting the RUC specialty designation “overrides” for very low volume services to prevent significant variation in year-to-year MP RVUs. The AANS and CNS urge the agency to also accept the RUC-recommended “overrides” for services with no Medicare volume for a given year.

CMS Comments on the RUC Process for Valuation of Physician Work

- The AANS and CNS note the agency comments supporting the RUC process. We commend the agency for this recognition, which is a significant improvement from recent years in which CMS had changed many RUC-passed work values, sometimes with significantly flawed rationales.

CMS Designated Misvalued Codes

- We disagree with the designation of CPT Code 27279 (SI Joint Fusion) as misvalued at this time. We understand the RUC has agreed to review the code and remind the agency that this code will be examined as part of the Relativity Assessment Workgroup (RAW) New Technology screen in late 2018.

CMS Valuation of Specific Codes

- The AANS and CNS commend CMS for generally accepting RUC-passed work values, particularly for the codes listed below. Again, we recognize that this is a significant positive change from the pattern of recent years.
 - The AANS and CNS are pleased that CMS has finalized the RUC-passed values for neuroelectrode implantation CPT codes 64553 and 64555.
 - The AANS and CNS appreciate the agency’s proposal to accept the RUC-passed value for the new bone marrow aspiration code 2093X. We note the agency’s questions about an alternative lower value and address those issues in our comments below.
- The AANS and CNS appreciate concerns that E/M documentation requirements may need to be updated and urge CMS to provide ample time for allow all stakeholders to comment. As part of a thorough review of E/M services, the AANS and CNS also request that the agency reinstate consultation codes in the Medicare physician fee schedule.

Quality Issues

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

- Although the AANS and CNS support efforts to promote more efficient and effective use of advanced diagnostic imaging, we are deeply concerned about the complexity and necessity of

this new program. We strongly urge CMS to delay the effective date of the Imaging AUC Program until at least 2021, or until CMS can adequately address technical and workflow challenges with its implementation.

- The AANS and CNS request that CMS fully assess how existing or future policies under Medicare's Quality Payment Program (QPP) can more effectively target the appropriate use of advanced diagnostic imaging. To this end, CMS should work with Congress to reevaluate the necessity and value of this program in the context of the QPP.
- We encourage CMS to expand the use of hardship exemptions if the AUC requirements are implemented.

Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

- To promote even closer alignment with the Merit-based Incentive Payment System (MIPS) and minimize complexity during this transition period, we request that CMS consider using its authority to only require the reporting of one PQRS measure in 2016 to avoid a penalty in 2018. In other words, hold harmless any clinician who attempted to report something.

Physician Compare Downloadable Database — Addition of Value Modifier (VM) Data

- The AANS and CNS support the CMS proposal to rescind its earlier decision to publicly report data related to the 2018 VM (based on 2016 performance data) via the Physician Compare downloadable file

Clinical Quality Measurement for Eligible Professionals Participating in the EHR Incentive Program for 2016

- The AANS and CNS very much appreciate CMS proposing these modifications and recognizing that performance assessments under the VM might not be entirely accurate as a result of the proposed changes in this rule related to the PQRS. At the same time, we remind CMS of our earlier request to hold clinicians who reported on at least one PQRS measure in 2016 completely harmless from VM penalties in 2018.

COMMENTS

Regulatory Reform

Global Surgery Data Collection Project

The Medicare Access and CHIP Reauthorization (MACRA) Act (Pub.L. 114-10, Section 523) requires the Centers for Medicare & Medicaid Services (CMS) to collect information on the number and level of medical visits furnished during the 10- and 90-day global surgery period from a "representative sample" of physicians and in 2019 use this information to improve/validate the accuracy of the valuation of surgical services.

In the CY 2017 Medicare Physician Fee Schedule (PFS), CMS set forth a global codes data collection policy consisting of three components: (1) claims-based data reporting; (2) a survey of practitioners; and (3) data collection from accountable care organizations (ACOs). For claims-based reporting, CMS finalized a policy whereby practitioners who are in groups of 10 or more practitioners and who are located in any one of nine specified states — Florida, Kentucky, Louisiana, New Jersey, Nevada, North Dakota, Ohio, Oregon and Rhode Island — are required to report CPT code 99024 for every post-operative visit that they provide related to any CPT code on a list of 293 10- and 90-day global codes (30 of which are services provided by neurosurgeons) specified by CMS. Additionally,

few details are known about the other two components, namely, the survey of practitioners and data collection from ACOs.

CMS began the implementation of this onerous data collection process on July 1, 2017, despite the fact that the agency has failed to (1) provide a detailed plan for data validation; (2) provide answers to a whole host of outstanding questions; (3) assure physicians that claims submitted with the required data will be captured; and (4) adequately educate physicians subject to the data collection requirements.

The AANS and CNS have recommended that Congress repeal Section 523 of the Medicare Access and CHIP Reauthorization Act (MACRA) as it is unnecessary. CMS already has in place a process for reviewing and adjusting the value of surgical services. Irrespective of Congressional action, **we urge CMS to delay the global surgery data collection project — both claims data and the provider survey — until CMS has addressed outstanding project issues and conducted adequate provider education.** Additionally, **the agency should avoid using any data collected in 2017 to revalue global services in 2019, particularly until the validity of such data can be ascertained.** Furthermore, **CMS should suspend the practitioner survey until it has been thoroughly vetted and the specialties to be surveyed have had an opportunity to review it and provide feedback.** Finally, if CMS can collect useful data (which we doubt), **the agency should refrain from modifying values for those CPT codes subject to data collection outside of the well-established American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process.**

Coding and Reimbursement Issues

Malpractice (MP) RVUs

- **Calculating MP RVUs.** In the proposed rule for CY 2018, CMS outlined a plan to align the update of MP premium data used to determine the MP RVUs with the update of the MP GPCIs. This would accelerate the update of MP RVUs to 2018, instead of the fourth review that must occur no later than CY 2020, and would change updates to MP RVUs to a three-year cycle. **The AANS and CNS disagree with the agency's proposal to update the MP RVUs for CY 2018.** We join with the American College of Surgeons in expressing serious concerns regarding changes to the methodology and data collection processes as discussed below.

MP RVUs are determined in four steps:

- (1) calculate a national average MP premium for each specialty;
- (2) normalize specialty premiums to create a specialty-specific risk factor;
- (3) calculate unadjusted MP RVUs for each service based on the volume of practitioners that perform a service; and
- (4) adjust the RVUs for budget neutrality.

For the first two steps, CMS has proposed data sets and techniques that are deeply flawed, and this will result in aberrant results in steps 3 and 4.

Calculating a national average MP premium for each specialty. During the last MP RVU update in 2015, CMS mapped malpractice premiums for each specialty to the county level, and then specialty premiums were weighted by total RVU per county to calculate a national average MP premium. In CY 2018, CMS has proposed to weight specialty premiums by the county share of the total U.S. population. **We believe that using population to weight the premium is incorrect.** This method does not reflect differences in risk-of-service among different areas of the country. Risk-of-service, not population, indicates how services differ in their contributions to professional malpractice liability. Geographic premium rate differences are based on risk and paid claims, not on how many people

live in a geographic area. Like the American College of Surgeons, **the AANS and CNS urge CMS to use work RVUs instead of population to weight geographic differences that are used to calculate national average premiums.**

Normalizing specialty premiums to create a specialty-specific risk factor. CMS collected information obtained from malpractice insurance premium data from all 50 States, the District of Columbia and Puerto Rico. However, as apparent from the proposed rule, many specialties did not have premium data from all 50 states. CMS, therefore, decided that these data would be used for specialties that met an arbitrary threshold (data available for 35 or more states). Consequently, 40 percent of specialties did not meet this threshold, and normalized specialty premiums were generated using cross-walks to other specialties. For all specialties, premium data are broken down into surgical and non-surgical services premiums. Twenty-four specialties did not have sufficient data for one or the other category, and consequently, CMS has proposed using a derived “blended” premium.

The use of incomplete data and the application of “blended” premiums have led to some patently absurd inversions in normalized premiums. For example, in Table 8 *Proposed Risk Factors by Specialty Type*, the surgical risk factor for neurology — 13.02 — is higher than neurosurgery, which has been assigned a *lower* risk factor of 10.66. In fact, since some carriers categorize neurosurgeons as surgical neurologists, it is critical that the specialty definitions are appropriately applied. Clearly, the data used for this new analysis are flawed, and we do not believe that a single “blended” premium accurately and fairly contributes to the final calculation of MP RVU. The PLI Workgroup of the RUC had previously recommended to CMS alternative sources of malpractice premium data that is nationally representative. **The AANS and CNS urge CMS to ask its contractor to identify and obtain alternative surgical premium data, and we recommend that CMS use the previous surgical premiums until more data can be obtained, rather than using blended premiums for MP RVU calculations. We also urge CMS to continue to work with the RUC PLI workgroup to secure valid alternative sources of nationally-representative malpractice premium data.**

Also, non-physician providers in nine areas did not have data that met the above threshold. Consequently, they were cross-walked to the physician specialty with the lowest MP premium data (allergy/immunology). Unfortunately, this still represents an overestimate of MP premiums for these non-physician providers, and with budget neutrality, this will impact MP RVUs across all specialties. **The AANS and CNS believe that this direct cross-walk significantly exceeds the actual premium costs of these non-physician providers. CMS should, therefore, collect premium data for the non-physician specialties and use updated data from all fifty states.**

- **MPI Variation for Low and No Volume Services.** The AANS and CNS commend the agency for accepting the RUC specialty designation “overrides” for very low volume services to prevent significant variation in year-to-year MP RVUs. The issue of valuing MP RVUs for low volume codes has long been a concern for neurosurgery, the specialty with some of the very highest professional liability insurance premiums. Some codes are so rarely performed, or have such low Medicare volume for a particular year, that the dominant specialty may be incorrect and, therefore, may not accurately reflect the risk. **We agree with the RUC that code-specific “overrides” are essential when the claims data are inconsistent with the specialty that would be reasonably expected to furnish the service.** Some procedures may be very low volume for Medicare, but have greater volume for Medicaid or other payers, further perpetuating errors. This year, the RUC has provided a similar recommendation for procedures that may have no Medicare volume for a given year.

CMS Comments on the RUC Process for Physician Work Valuation

Until recent years, CMS has accepted the majority of RUC-passed values for physician work, recognizing the rigorous process, level of expertise and careful scrutiny given to each new, revised, and potentially misvalued code. We are pleased to see that in the CY 2018 PFS proposed rule, CMS has stated:

In developing proposed values for new, revised, and potentially misvalued codes for CY 2018, we considered the lack of alternative approaches to making the adjustments, especially since many stakeholders have routinely urged us to propose and finalize the RUC recommended values. We also considered the RUC's consistent reassurance that these kinds of concerns (regarding changes in time, for example) had already been considered, and either incorporated or dismissed, as part of the development of their recommended values. These have led us to shift our approach to reviewing RUC recommendations, especially as we believe that the majority of practitioners paid under the PFS, though not necessarily those in any particular specialty, would prefer CMS rely more heavily on RUC recommended values in establishing payment rates under the PFS. For CY 2018, we have generally proposed RUC-recommended work RVUs for new, revised, and potentially misvalued codes. We are proposing these values based on our understanding that the RUC generally considers the kinds of concerns we have historically raised regarding appropriate valuation of work RVUs."

We appreciate the agency's renewed understanding and acknowledgment of the RUC process and hope that the trend for CMS to accept fewer RUC recommendations of the last few years was an aberration.

Validating RVUs for Potentially Misvalued Codes

- **Sacroiliac Joint Fusion, CPT Code 27279.** CMS identified CPT Code 27279 *Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device*, as potentially misvalued based on stakeholder comments. We understand that the RUC has added this code to its agenda for an upcoming meeting. The AANS and CNS joined the AAOS and NASS in surveying and presenting the RUC-passed value for CPT Code 27279, and we recommend the agency refer the question of misvaluation to the RUC. We believe the RUC should use its standard processes for reviewing potentially misvalued and new technology codes such as CPT Code 27279. We note that CPT Code 27279 is scheduled for RUC review in October 2018 through the RUC's new technology screen process. When we presented the code to the RUC, we joined the AAOS and NASS in recommending new technology status and a re-review of the code after three years of utilization data was available. **We, therefore, urge the agency to permit the RUC to wait until that time to reconsider the code value.** If based on the RUC's review, 27279 is misvalued, then the AANS and CNS would support re-survey.

We are aware that some commenters have recommended using a cross-walk approach and re-valuing 27279 prior to the RUC's review by comparing the code to another common spine procedure, 63030 (*Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar*).

We oppose this approach as this cross-walk was not considered valid during the original review of the code at the RUC. The AANS and CNS believe CMS should allow standard RUC protocols to be followed and that this code should be reviewed by the RUC RAW committee in 2018. Change in code valuation outside of the standard RUC review, and in contradistinction to the recommendation of the societies involved in the original valuation, would be inappropriate and not in keeping with the agency's aforementioned support of the RUC process.

Valuation of Specific Codes

- **Implantation of Neuroelectrodes, CPT Codes 64553 and 64555.** The AANS and CNS are pleased that CMS has finalized the RUC-passed values for neuroelectrode implantation CPT Codes 64553 and 64555.

- **Bone Marrow Aspiration CPT Code 2093X.** The AANS and CNS are pleased that CMS is proposing to finalize the RUC-recommended work value of 1.16 RVWs for the new bone marrow aspiration code 2093X. We note that CMS has expressed some concerns about the proposed value of the code and has asked for comment on an alternative cross-walk to a code with a work RVW of 1.00. **The AANS and CNS believe the concerns that the value of 1.16 RVWs would create a rank order anomaly are unfounded and may be put to rest.** CMS stated that CPT code 2093X is a global ZZZ add-on code for CPT Code 38220, and CMS is concerned with maintaining relativity among PFS services, considering that an add-on code typically has significantly less intra-service time and total time compared to the base code. However, CPT code 38220 is not the base code with which CPT code 2093X will be reported. Rather, CPT code 2093X will be used to report bone marrow aspirations for bone grafting in spinal fusion procedures. The base codes for CPT Code 2093X include the following spinal fusion CPT Codes: 22319, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22590, 22595, 22600, 22610, 22612, 22630, 22633, 22634, 22800, 22802, 22804, 22808, 22810, and 22812. Since these spinal fusion codes are assigned higher work RVUs than 2093X, rank order is maintained. In addition, CMS considered an alternative cross-walk to CPT codes 64494 and 64495, which share the same intra-service and total time with CPT code 2093X and have a work RVU of 1.00. This would not be appropriate because CPT code 2093X has a higher intensity than the crosswalks considered by CMS. **We urge CMS to finalize its proposal to accept the RUC-passed value of 1.16 RVWs for CPT Code 2093X** based on survey responses at the 25th percentile and validation cross-walks to CPT codes 64491 and 64636, each having identical intra-service time, total time and intensity to the new CPT code 2093X.

Evaluation and Management (E/M) Documentation

The AANS and CNS appreciate concerns that E/M documentation requirements may need to be updated and urge CMS to provide ample time for allow all stakeholders to comment. We note that CMS points out that the guidelines have not been updated to account for significant changes in technology, especially electronic health record (EHR) use and, therefore, the agency is especially interested in feedback on the way to modify the guidelines for history and exam. Even before the widespread adoption of EHRs, the AANS and CNS were concerned that E/M coding could devolve into a system of “bullet” counting that had little real reflection of the value of the service to the patient.

One issue that should be reconsidered is the use of consultation codes by Medicare. Before 2010, Medicare paid for consultation codes that were commonly reported by specialty physicians. These codes recognized the additional unique physician work associated with assessing the needs of typically exceedingly sick patients that could not be managed by their primary care physicians alone. In January 2010, Medicare arbitrarily eliminated consultation payments. **As part of a thorough review of E/M services, the AANS and CNS urge the agency to reinstate consultation codes in the Medicare physician fee schedule.** We believe that the full consequences of the elimination of the consultation codes have not been adequately analyzed, particularly now that some private payors have followed the CMS lead and stopped paying for these services.

Quality Issues

Imaging Appropriate Use Criteria (AUC) Program

The “Protecting Access to Medicare Act of 2014 (PAMA)” (P.L. 113-93) established an appropriate use criteria (AUC) program for advanced diagnostic imaging services provided to Medicare beneficiaries. Per the statute, beginning Jan. 1, 2017, physicians and other health care professionals who order advanced diagnostic imaging tests (i.e., diagnostic MRI, CT, and nuclear medicine, but not X-ray, fluoroscopy or ultrasound) must consult with AUC using a qualified decision support mechanism (CDSM). Professionals who furnish these tests must document the ordering professional’s consultation of AUC to be paid for the service. The law also directs CMS to require prior authorization beginning in 2020 for

ordering outlier professionals related to specific clinical priority areas. The program only applies to outpatient settings such as physician offices, hospital outpatient departments, and ambulatory surgical centers, but not inpatient settings.

Although this program has been delayed due to operational issues, CMS has been gradually establishing requirements for multiple components of the program. For example, AUC under this program may only be developed by qualified provider-led entities. In 2015, CMS released an initial list of qualified entities. CMS also previously finalized the list of priority clinical areas that will be subject to pre-authorization requirements starting in 2020 if an ordering professional is found to be an outlier on adherence to AUC. These include multiple topics relevant to our membership, including Headache, Low Back Pain, and Cervical or Neck Pain.

In this rule, CMS proposes that clinicians must begin reporting on AUC consultations as of January 1, 2019. CMS refers to this first year as an educational “testing period” and states that it would continue to pay claims whether or not they *correctly* include such information. In contrast, CMS also proposes to offer a *voluntary* reporting period, which would begin July 2018 depending on CMS’s readiness. CMS contrasts the voluntary reporting period in 2018 against the testing period in 2019 by stating that during the voluntary period, AUC consultation and reporting would *not* be required.

Additionally, CMS proposes to establish a series of HCPCS level 3 codes to facilitate the reporting of data under this program. These G-codes would indicate:

- Which qualified CDSM was consulted by the ordering professional;
- Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC was not applicable to the service ordered; and
- Circumstances where a qualified CDSM was not consulted by the ordering professional (e.g., situations where an exception applies, such as imaging service was ordered for a patient with an emergency medical condition)

Per the statute, payment may only be made if the claim for the service includes this specific information. This information, to the extent feasible, would be required on the practitioner’s claim that includes the professional component of the imaging service and on the hospital outpatient claim for the technical component of the imaging service and, if absent, could impact both components of reimbursement.

Although the AANS and CNS support efforts to promote more efficient and effective use of advanced diagnostic imaging, we are deeply concerned about the complexity and necessity of this new program. The program is fundamentally flawed in that it focuses more on regulatory compliance than actual quality improvement. For example, clinicians are required to consult AUC using federally qualified CDSMs for *every* applicable diagnostic imaging order. At the same time, CDSMs are only required to make available AUCs that reasonably address each of the *priority* clinical areas. This means that there will be many instances where relevant AUC are not available to a specialist. Making matters worse, CDSM vendors can “pick and choose” among qualified AUC so long as the tool incorporates AUCs that comprise the entire clinical scope of all priority clinical areas. This is problematic because not all AUCs for the same condition are equal. AUCs may use substantially different methodological approaches, which result in differing appropriateness results. In situations where a relevant AUC is not available, the specialist is required to communicate this to the furnishing professional, who then must report to CMS that no applicable AUC is available related to the service ordered. Overall, the requirements for what must be documented in the CDSM are extremely complex and time-consuming, and will only exacerbate the existing problems clinicians are having with EHRs and with administrative burden, overall. There is also a real concern that these requirements contribute nothing to patient care and in fact, may result in a further erosion of the clinician-patient relationship as attention is further diverted to purely administrative tasks.

Furthermore, the program is duplicative of — and even inferior to — Medicare’s Quality Payment Program (QPP), which already holds clinicians accountable for quality and patient outcomes (something that the AUC program fails to do), as well as for resource use, including the use of diagnostic tests and procedures. Given the implementation of the QPP, this separate program is redundant, and CMS can readily incorporate the use of AUCs for diagnostic imaging into the QPP.

The AANS and CNS believe that this program places an excessive burden on physicians across a broad range of specialties with little evidence of clinical benefit. CMS has acknowledged the number of clinicians affected by the program is “massive,” crossing almost every medical specialty and having a particular impact on primary care physicians since their scope of practice can be vast. Again, this program will require neurosurgeons ordering advanced diagnostic imaging for three of these eight clinical areas — headache, low back pain and cervical or neck pain — to consult with AUC. Neuroimaging is a key component of diagnosing, evaluating and treating disorders of the central nervous system — which includes the brain, spinal cord and vertebral column (spine). A thorough understanding of neuroanatomy, neuropathology, neuropathophysiology and neuroimaging is, therefore, essential to ensure that patients receive high quality, reliable and precise diagnostic imaging studies of the nervous system. Neurological surgeons receive extensive training in these key areas and are therefore qualified and certified to order and interpret diagnostic imaging procedures on the nervous system. Adding this additional requirement to consult AUC for neurosurgeons is, therefore, unnecessary.

Given these concerns, **the AANS and CNS strongly urge CMS to delay the effective date of the Imaging AUC Program until at least 2021, or until CMS can adequately address technical and workflow challenges with its implementation.** There are a number of considerations that must be taken into account before implementing this program, including modifications to Medicare claims forms and the significant demands being placed on the claims forms as a result of this and other programs such as those authorized under MACRA. CMS also only first posted an initial list of federally qualified CDSMs in conjunction with this rule, which will not be finalized until the end of 2017. Before requiring clinicians to use these CDSMs, we strongly urge CMS to evaluate the adequacy of these tools across a range of specialties, including their clinical relevance and the extent to which they are seamlessly interoperable with existing health information technology. **Additionally, CMS should fully assess how existing or future policies under the QPP can more effectively target the appropriate use of advanced diagnostic imaging. Finally, CMS should expand the use of hardship exemptions if the AUC requirements are implemented.**

We also urge CMS to work with Congress to re-evaluate the necessity and value of this program in the context of the QPP. Ultimately, the cost to administer this program — to CMS, to clinicians, and most importantly, to our patients — outweigh any potential savings or benefits in regards to patient outcomes. In the interim, if CMS believes it needs to implement this program, it should do so in a purely voluntary manner that does not result in penalties for inaction.

Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

CMS proposes multiple changes to limit the number of clinicians who will be penalized under the PQRS in 2018. These include:

- Revising the previously finalized satisfactory reporting criteria for the 2016 reporting period to lower the requirement from nine measures across three National Quality Strategy (NQS) domains, where applicable, to only six measures with no domain requirement.
- No longer requiring a cross-cutting measure of reporting via claims of qualified registry and no longer requiring an outcome or other high priority measure is reporting via QCDR.
- No longer requiring larger group practices to administer the CAHPS for PQRS survey.

The AANS and CNS greatly appreciate CMS proposing steps to minimize the number of clinicians

subject to penalties under legacy programs and to help ease their transition to MIPS. **To promote even closer alignment with MIPS and minimize complexity during this transition period, we request that CMS consider using its authority to only require the reporting of one PQRS measure in 2016 to avoid a penalty in 2018.** In other words, hold harmless any clinician who attempted to report something, while still imposing penalties on clinicians who reported nothing.

Physician Compare Downloadable Database - Addition of Value Modifier (VM) Data

In this rule, CMS proposes to rescind its earlier decision to publicly report data related to the 2018 VM (based on 2016 performance data) via the Physician Compare downloadable file in late 2017. **The AANS and CNS very much appreciate and support this proposal** since these data would only serve to confuse the public during this transition year and will not necessarily accurately represent a clinician's performance if other policies in this rule are finalized.

Clinical Quality Measurement for Eligible Professionals (EPs) Participating in the EHR Incentive Program for 2016

To align with other proposals related to the PQRS, CMS proposes to change the reporting criteria from nine clinical quality measures (CQMs) covering at least three NQS domains to six clinical quality measures (CQMs) with no domain requirement for EPs and groups who, in 2016, chose to electronically report CQMs through the PQRS Portal for purposes of the Medicare EHR Incentive Program. Clinicians or groups who satisfy the proposed reporting criteria may qualify for the 2016 incentive and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the applicable EHR reporting period. **The AANS and CNS appreciate CMS's attempt to align reporting requirements across programs to limit complexity. However, similar to our earlier request, we urge CMS to hold harmless any clinician who reported at least one CQM in 2016.**

Value-Based Payment Modifier and Physician Feedback Program

CMS proposes multiple changes to Value Modifier policies that would impact 2018 payment adjustments period. These include reducing the magnitude of penalties automatically assessed on clinicians who fail to satisfy PQRS requirements in 2016 and holding clinicians subject to quality-tiering harmless from downward performance-based payment adjustments in 2018. Since the VM is a budget neutral program, these changes also mean that CMS must reduce the magnitude of upward payment adjustments for those with high performance.

Similar to our other comments, **the AANS and CNS very much appreciate CMS proposing these modifications and recognizing that performance assessments under the VM might not be completely accurate as a result of the proposed changes in this rule related to the PQRS. At the same time, we remind CMS of our earlier request to hold clinicians who reported on at least one PQRS measure in 2016 completely harmless from VM penalties in 2018.** Since clinicians who did not attempt to report anything in 2016 will still incur a penalty, CMS would be assured a pool of funding to reward high performers with upward payment adjustments under the VM. While we recognize that this pool of funding would be smaller than under current policy and thus, result in a smaller upward adjustment for high performers, we believe that the benefit of more widespread penalty protections outweighs any reduction in bonuses.

Patient Relationship Categories and Codes

As mandated under MACRA, CMS is working on a multi-pronged strategy to measure resource use among physicians more accurately. This includes the development of more granular episode-based cost measures and the development of more accurate ways to attribute patients to providers and to evaluate the status of a patient at the time of care. MACRA specifically requires CMS to develop classification codes to identify patient relationship categories that define and distinguish the relationship and

responsibility of a clinician with a patient at the time of furnishing an item or service. In accordance with MACRA, the final Operational List of Categories and Codes must be published in April 2017, and clinicians must begin reporting these codes on all Medicare claims, beginning January 1, 2018.

Based on feedback collected throughout 2016 and early 2017, CMS posted the following operational list of patient relationship categories in May 2017:

- Continuous/Broad Services
- Continuous/Focused Services
- Episodic/Broad services
- Episodic/Focused Services
- Only as Ordered by Another Clinician

In this rule, CMS proposes that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, and should include applicable HCPCS modifiers reflecting the categories listed above, as well as the NPI of the ordering physician or applicable practitioner if different from the billing physician or applicable practitioner. To allow clinicians time to gain familiarity with using these modifiers, CMS proposes that, at least for an initial period, clinicians may *voluntarily* report these codes on claims and that CMS will work with clinicians to educate them about the proper use of the modifiers.

As we have noted in the past, **the AANS and CNS support efforts to ensure more accurate and effective resource use measurement. We also appreciate that in implementing this program, CMS appears to be taking a truly voluntary approach**, unlike our interpretation of the Imaging AUC Program proposal, in that claims would be paid regardless of whether and how the modifiers are included. **Nevertheless, we continue to have concerns that several critical elements of this program have not yet been addressed and that offering a test year in 2018 might even be premature.** For example, what if multiple clinicians claimed the same role over a patient? Similarly, what if multiple specialists are involved (e.g., neurosurgery, neuro-oncology and radiation oncology in the case of brain tumor) in care — can they be "co-in-charge"? What if the clinician's role evolves over the course of care — for example, from episodic to continuous? And what if no clinician claims responsibility for a patient? **We urge CMS to develop a strategy to adjudicate or otherwise address these real-world situations.**

It is also unreasonable to expect the public to be able to determine the adequacy of the current patient relationship categories without a better understanding of the episode-based cost measures to which they will apply. While we appreciate the work that CMS is doing on this front, with Acumen and in consultation with specialty societies, this work is nowhere near complete and attempting to implement this reporting requirement at this time would be putting the cart before the horse. **Only once a considerable number of episodes, spanning a wide variety of specialties, are developed and refined can we accurately assess the suitability of the patient relationship categories.**

As CMS works out these details, **it is absolutely critical that the agency keeps in mind the regulatory burden that these policies could impose on physicians and strive to minimize coding and billing complexity.** Clinicians are still trying to make sense of the complex structure of MIPS and might soon have to comply with the Imaging AUC Program. To minimize clinician burnout and ensure that clinicians spend more time on direct patient care rather than regulatory compliance, CMS must prioritize what it wants clinicians to do and focus on only one of these elements at a time. Expecting high rates of physician compliance with multiple simultaneously implemented programs is unrealistic and fails to recognize the realities of medical practice.

Finally, we would like to remind CMS of our related request not to hold clinicians accountable for resource use until applicable episode-based measures have been developed, risk adjustment mechanisms tested and refined, and these new classifications and codes are carefully vetted in

the context of any new measurement methodologies.

Overall, the patient relationship categories should be reflective of all clinical scenarios across all specialties; should account for the realities of medical practice, including the treatment of multiple, concurrent episodes; should not impose an inordinate regulatory burden on practicing clinicians or their staff; and should only be implemented once multiple critical details described in this letter have been worked out.

CONCLUSION

The AANS and CNS appreciate the opportunity to provide feedback on these specific provisions in the 2018 MPFS proposed rule. If you have any additional questions or need additional information, please feel free to contact us.

Sincerely,



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