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September 4, 2012

Marilyn Tavenner, Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1590-P  
Mail Stop C4-26-05  
7500 Security Blvd  
Baltimore, MD 21244-1850

**RE: CMS-1590-P Medicare Program; Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2013**

Dear Administrator Tavenner:

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), we appreciate the opportunity to comment on the above referenced Notice of Proposed Rulemaking (NPRM) published in the *Federal Register* on July 30, 2012. Below are our views on a number of payment and quality issues.

**SUMMARY OF COMMENTS**

***Valuation Issues***

- *Practice Expense (PE) for Low Volume Services.* The AANS and CNS concur with the RUC concerns about the difficulty of establishing PE values for CPT codes reported for Medicare fewer than 100 times in a year. We urge CMS to seek input from the appropriate dominant specialties for these codes, similar to the policy established by CMS in 2011 for Professional Liability Insurance for low volume services.
- *Practice Expense (PE) for CPT Code 63650.* The AANS and CNS note that CMS has referred Code 63650 to the American Medical Association (AMA)/Specialty Society Relative Value Update Committee (RUC) for valuation in the non-facility setting. We agree with the RUC that it is not necessary to review physician work and PE in the facility setting, as the service was recently valued in 2010.
- *Evaluation and Management Services in the Global Surgical Period.* The AANS and CNS believe that the CMS goal of assuring appropriate valuation of work in the global surgical period will be accomplished as the RUC continues to review high volume codes that have not been previously RUC-reviewed.
- *Care Coordination Services.* The AANS and CNS believe the agency has overstated the likely utilization for coordination of its proposed new code for Transitional Care Management (TCM). We recommend that CMS consider the work of the CPT and RUC in establishing payment for care coordination services and that specialties other than primary care be eligible to use the new code if they provide the required services.

- *Advance Primary Care Practice (Medical Home)*. The oversight and evaluation of any expansion to a national payment for a “medical home” practice is essential. Inaccurate assumptions about savings and an overstatement of the benefit provided can prove unproductive at a time when the Medicare program is struggling to implement many new initiatives.
- *CRNA Provision of Pain Management Services*. The AANS and CNS opposed the proposed new national policy expanding the ability of Certified Registered Nurse Anesthetists (CRNA) to provide chronic pain management services without the supervision of a physician.

### **Quality Issues**

- The AANS and CNS recommend that CMS allow physicians to report on PQRS measures in order to satisfy both meaningful use quality reporting requirements and PQRs for purposes of aligning these programs.
- The AANS and CNS recommend that CMS clearly outline in the final rule the methodology and break down how various specialties would be evaluated under the Administrative option.
- We urge CMS to commit significant resources to developing clear explanations of each program’s various reporting options.
- Since practices that are comprised of 25 or more physicians will be subject to the Value-Based Payment Modifier (VBPM), we urge CMS to institute flexibility in terms of the measures available for reporting within the group practice reporting option (GPRO) web-interface.
- For the 2015 PQRs payment adjustment, CMS has adopted CY 2013 as the reporting period. We question the appropriateness of basing a payment penalty on care that took place two years prior to the adjustment year and reiterate our opposition to this policy.
- We urge CMS to seriously consider, in future rulemaking, recognizing registry efforts that are occurring outside of PQRs data collection methods and tools.
- Neurosurgery is supportive of an informal review process for eligible professionals and group practices subject to a PQRs payment adjustment. However, CMS must institute a clear timeline as to how long an appeals process will take and provide practices with timely feedback reports so they can evaluate whether they were incorrectly penalized.
- CMS should re-evaluate its decision to use 2013 as the basis for applying the 2015 VBPM.
- Due to the broad definition CMS intends to apply to defining eligible professional for purposes of applying the VBPM, we urge CMS to expand the minimum number of physicians in practices that would be subject to the modifier.
- The AANS and CNS highly encourage CMS to allow groups flexibility in reporting measures to CMS to avoid the VBPM adjustment. For groups of 99 or more physicians, they are forced to participate in the GPRO web-interface, but GPRO measures are a limited subset of measures that are primary care focused. Many specialists, such as neurosurgery, cannot report on the vast majority of measures within the GPRO web-interface.
- Neurosurgery is concerned with CMS’ proposal to calculate a total per capita cost measures for all beneficiaries and per capita cost measures for beneficiaries with four specific chronic conditions. For the value based payment modifier. Physicians should be compared to their specialty and not all of medicine.

- The AANS and CNS urge CMS to consider adopting a Corrective Action Plan, or similar program, to allow physicians the opportunity to improve prior to being held to a payment adjustment through the VBPM.
- CMS has been extremely vague in its efforts to construct episode-based cost measures and before moving forward CMS must have a transparent process for evaluating episodes. Whatever CMS puts in place should be a phased-in approach to learn issues before anything becomes punitive. Neurosurgery would be happy to work with CMS in defining appropriate episode based cost measurers.
- CMS must not move forward with its proposed expansion of including more detailed information on Physician Compare until the infrastructure of the website is appropriately constructed.

## **DETAILED COMMENTS: VALUATION ISSUES**

### ***Practice Expense***

*Practice Expense for Low Volume Services.* The AANS and CNS support the RUC position to maintain the use of the dominant specialty for Practice Expense (PE) for low volume codes such as CPT code 22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar. CMS should seek RUC and specialty society input to determine the dominant specialty for these codes, especially for codes with extremely low Medicare volume, as in the case of CPT Code 22857.

*Practice Expense for CPT Code 63650 in Non-facility Setting.* CMS has asked the RUC to value CPT code 63650 Percutaneous implantation of neurostimulator electrode array, epidural in the non-facility setting for work and PE. We are aware that CMS received a request to have the procedure valued for PE in the non-facility setting and agree that a referral of the issue to the RUC is appropriate. Although the procedure is not typically performed in the non-facility setting, the frequency data show that over one third are performed in that setting. The RUC's Relative Assessment Workgroup (RAW) will consider a multispecialty proposal for the code at its meeting on October 4, 2012. In its comment letter on the NPRM, the RUC has stated that a review of the physician work and PE in the facility setting for CPT Code 63650 is not warranted, as the physician work was reviewed in February 2008 and again in October 2010 at the request of CMS. We agree with the RUC on this point and hope that CMS will accept RUC-approved non-facility PE recommendations for CPT Code 63650.

### ***Evaluation and Management Services in the Global Surgical Period***

The AANS and CNS support CMS's plan to get better information before taking action on concerns raised by recent HHS Office of Inspector General (OIG) audits of evaluation and management (E/M) work in the global surgical period. The OIG reports are flawed in many ways. The number of claims for each individual service reviewed is low and the report only reviews the number, not the level, of the visit. Of particular concern for neurosurgery is the fact that only one spine procedure was reviewed in the HHS OIG report on musculoskeletal procedures -- and that was dropped in the final analysis because of concerns about overlapping global periods for codes sometimes reported together. Global surgical services are based on the typical patient and any individual case could include more or fewer visits. We note the possibility that E/M work is under-reported in the patient record, precisely because the codes are not separately reportable. This issue could be addressed with improved education about the importance of accurately documenting that the visits have taken place. As CMS has pointed out, the recently RUC-reviewed codes are clearer in terms of evaluation and management work and we believe the RUC is the appropriate venue to address the valuation of the global surgical package. At the request of CMS, the RUC is in the process of examining high volume and high expenditure codes that have not

been previously reviewed. We believe that this review by the RUC is the most effective method of addressing the issue. In conclusion, we maintain that improved education and RUC review of high expenditure codes that have not been previously reviewed will adequately address concerns about the appropriate valuation of global surgical services.

### ***Coordination of Care***

Better coordination of care for Medicare patients who have been treated in facility settings and are returning to the community is important and has been the focus of the CPT and RUC for several years. While we understand the constraints of budget neutrality, the redistributive impact estimated in the proposed rule for the creation of the new Transition Care Management (TCM) code is a significant concern at a time when many smaller specialties with long training periods are at risk of undersupply. Some of our concerns are outlined below.

*Transitional Care Reporting by Physicians Who Report a Discharge Day Management Code.* The AANS and CNS urge CMS to consider comments submitted by the RUC and the American College of Surgeons regarding the distinction between discharge day management services and the new transition care management service. The CPT and RUC workgroups have provided scenarios in which physicians who also report discharge day management codes could appropriately report the TCM code. CMS should review and adopt the RUC recommendations on this issue.

*Transitional Care Reporting by Physicians Who Report a 010- or 090-Global Surgical Service.* While we understand that CMS intends the new TCM payment to be primarily for coordination of care services provided by a patient's primary care physician, we echo the comments of the American College of Surgeons and the RUC and ask the agency to consider possible scenarios in which a physician reporting a global period may provide coordination of care services not part of the discharge day management or follow-up visits. Finally, we continue to believe that elimination of the use of CPT codes for consultation services for Medicare was a mistake and removed one effective tool that CMS could use to track and value coordination of care services for specialty medicine. While CMS is recognizing the work of primary care physicians in coordinating care for patients who have been in a facility, the agency should also recognize that coordination is a two-way street. Specialist physicians consulting with their primary care colleagues also frequently incur uncompensated coordination work unrelated to the specific treatment provided, and Medicare's policy should be balanced and inclusive to reflect this fact.

*Assumptions of Utilization for Coordination of Care Services.* We agree with comments from the RUC, the American College of Surgeons, the American Medical Association and others regarding the overestimation of utilization for the new TCM payment. CMS has assumed that the new TCM code would be reported for approximately 10 million discharges in calendar year (CY) 2013, a number that CMS states, "roughly considers the total number of hospital inpatient and SNF discharges, hospital outpatient observation services and partial hospitalization patients that may require moderate to high complexity decision-making." This would be an assumption that almost 30 percent of Medicare patients discharged from a facility would require moderate to high complexity decision making for coordination of care not currently captured by the discharge day management services or by visits currently provided by physicians for these types of patients. The RUC and CPT have been examining the issue of appropriate valuation of coordination of care services and we would urge CMS to work with them to determine a more accurate estimate of Medicare utilization for the TCM code.

*Medical Home.* The AANS and CNS urge CMS to proceed with caution as it considers the implementation of payment for complex chronic care coordination services, or "medical homes." Should CMS go forward with the TCM payment in 2013, a reasonable amount of time should be allowed to assess the impact of that change before implementing a new national program to pay a monthly fee to "advanced primary care practice environments," or medical homes. The RUC conducted extensive work

on the issue of the medical home in 2008 and we urge the agency to consider that work in the implementation of a new service for the coordination of care for patients with complex chronic conditions.

*CRNAs and Chronic Pain Management Services.* We have deep concerns about the CMS proposal to change the language regarding the description of CRNA services. In the NPRM, CMS clearly states that some Medicare Administrative Contractors (MACs) have concluded that the statutory description of “anesthesia services and related care” does not encompass chronic pain services provided by CRNAs. Therefore, CMS proposes to add regulatory language to define CRNA services to include “medical and surgical services that are related to anesthesia and that a CRNA is legally authorized to perform by the State in which the services are furnished.” This is essentially a national directive for the MACs to cover chronic pain procedures provided by CRNAs, if they are covered when performed by physicians and legal for CRNAs in the state in which they are furnished. We believe the change in language is unnecessary and inadvisable. The evaluation and assessment skills required to treat chronic pain involve complex medical decision making, and, as CMS has acknowledged, the field is rapidly evolving. Chronic pain is treated by many physician specialties, including neurosurgery, and encompasses a wide variety of procedures, some of which involve surgical implantation of devices around the delicate structures of the spine and nerves. We believe expanding the language to add “surgical services” to the description of CRNA practice unnecessary reduces the ability for MACs to determine best quality pain services offered to a very vulnerable population of Medicare beneficiaries and inappropriately inserts the agency into the practice of medicine.

## **DETAILED COMMENTS: QUALITY ISSUES**

### ***2013 Physician Quality Reporting System***

*Reporting Options.* The AANS and CNS greatly appreciate CMS’ proposed efforts to maintain flexibility in terms of PQRS reporting, especially given 2013 is the year physicians will be measured for 2015 penalties. We also commend CMS for trying to better align PQRS reporting requirements with its other quality reporting programs. However, the reporting alignment needs to take into account that the measures available for reporting in meaningful use or the shared savings programs are not generally applicable to neurosurgeons and thus this alignment needs to take into account the differences among the various specialties within medicine.

The AANS and CNS recommend that CMS allow physicians to report on PQRS measures in order to satisfy both meaningful use quality reporting requirements and PQRS. Reporting on measures within PQRS is much more adaptable, takes into account that physicians provide a wide range of differing services and in the end, will be more meaningful. Meaningful use requires physicians to report on core measures and pick one measure from each domain, which is a one-size fits all approach that is not flexible. Also, CMS highlights in the 2012 MPFS that if a physician reports zero values for any of their quality measures in meaningful use, it would not count towards satisfying PQRS. For neurosurgery, this is problematic because the meaningful use quality reporting measures are not relevant to most neurosurgeons.

We also applaud CMS for proposing flexible methods for avoiding the 2015 PQRS reporting adjustment. In 2011, only 30 percent of physicians participated in PQRS, which is a fairly low number considering physicians must report starting in 2013.<sup>1</sup> Therefore, it is imperative that CMS maintain its proposal to allow physicians to only report one measure successfully, or, if a physician attempts to satisfy PQRS requirements in 2013 but misses the target, he or she can still avoid the penalty. We do have concerns, however, with the Administrative Claims reporting option. The measures CMS proposes for the administrative method are geared towards primary care and internal medicine so it is difficult to decipher how a neurosurgeon would be evaluated and/or penalized. Also, CMS is not clear in the rule on the

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<sup>1</sup> 2011 CMS PQRS Experience Report

methodology. The AANS and CNS recommend that CMS clearly outline in the final rule the methodology and break down how various specialties would be evaluated under the Administrative option. Without this information it is difficult to make recommendations to our members on whether it is a viable choice for avoiding the penalty.

In addition, as reporting options become more flexible, numerous, and tied to penalties, they also become more complex, requiring physicians to sacrifice valuable patient time to understand which programs and reporting criteria are best suited for their practice. As we have mentioned in previous comment letters, efforts to measure quality that impose unnecessary administrative burdens on physicians or otherwise adversely interfere with the patient-physician relationship will do little to improve care and may even have the opposite effect of reducing quality. Therefore, we urge CMS to commit significant resources to developing clear explanations of each program's various reporting options and how the specific requirements of different programs overlap. More specifically, we recommend that CMS develop clear and succinct decision trees and user-friendly fact sheets that help physicians identify exactly what options apply to their individual practice and how to most efficiently and effectively meet the reporting requirements of multiple programs. These instructions should not be buried in multiple, lengthy implementation guides posted on separate webpages or websites.

Group Reporting Option (GPRO). In terms of group reporting, CMS proposes to define a group practice as a single tax identification number (TIN) with 2 or more eligible professionals, as identified by their individual NPI, who have reassigned their Medicare billing rights to the TIN. CMS is also proposing to change the number of eligible professionals comprising a PQRS group practice from 25 or more to 2 or more to allow all groups of smaller sizes to participate in GPRO. Neurosurgery is supportive of the proposed changes to GRPO, but is concerned with the reporting requirements. Neurosurgeons often practice in a multi-specialty practice so if a practice would like to participate as a group it may not be feasible due to the fact that all members in the group having to report on the same measures. Practices must have the option to report on multiple measures and not be forced to pick arbitrary measures for all physicians to report on or measures that do not appropriately evaluate the care provided.

We are also concerned with the timeline groups must notify CMS if they would like to participate in GPRO. CMS requires physicians to notify them by January 31, 2013. However, the final rule is not released until Nov. 1, 2012 and there will most likely not be a "fix" to prevent pending payment cuts under the sustainable growth rate until the end of the year. Thus it does not provide much time for practices to evaluate their reimbursement and reporting options and determine if GPRO is a feasible and appropriate option.

In addition, the GPRO web-interface measures are not applicable to neurosurgery since the majority deal with chronic conditions, such as diabetes and hypertension and are therefore, very internal medicine focused. Since practices that are comprised of 25 or more physicians will be subject to the VBPM, we urge CMS to institute flexibility in terms of the measures available for reporting within the GPRO web-interface. CMS includes allied health professionals, such as physician assistants and physical therapists in determining the number of eligible professionals within a practice so many practices will fall under the 25 or more category. See the section on the Value-Based Payment Modifier for further discussion.

Satisfactory Reporting Criteria- Payment Adjustments. For the 2015 payment adjustment, CMS previously adopted CY 2013 as the reporting period, which will give physicians a full calendar year to meet the reporting criteria while still providing CMS with enough time to collect and analyze data without having to make retroactive payment adjustments in 2015. While we understand that this is a logistical issue for CMS, we question whether it is appropriate -- or even legal -- to base a payment penalty on care that took place two years prior to the adjustment, particularly since many physicians may not have even been aware of the penalty. We urge CMS to push back the reporting period on which it will base the 2015 payment penalty and at the very least CMS must thoroughly educate physicians about the upcoming penalty. One way to accomplish this education and notification is to provide information on a

physician's remittance advice indicating there is a upcoming penalty for non-compliance with PQRS and to refer them to a website for more specific information or to contact the Quality-Net Help Desk for assistance.

*Satisfactory Reporting Criteria—Payment Incentives.* With respect to reporting measure groups, CMS is proposing to change the requirement from 30 Medicare patients to 20 Medicare. For reporting measure groups via a registry, CMS proposes to change the criteria to require reporting for "at least 20 patients, a majority of which must be Medicare Part B Fee-for-Service patients" for both the 12-month and 6-month reporting options. Neurosurgery is supportive of this change as it will make it much easier for neurosurgeons to report PQRS through our National Neurosurgery Outcomes Database (N<sup>2</sup>QOD), which captures significant information on non-Medicare patients.

*Qualified Registries.* The AANS and CNS plan to nominate the National Neurosurgery Outcomes Database (N<sup>2</sup>QOD) to become a qualified 2013 PQRS qualified registry and hope that in the future CMS will provide credit for physicians who participate in national registries that analyze and collect outcomes data. Presently, if physicians want to receive credit for participating in a national registry they must report on PQRS measures and this system does not evaluate data in real time or significantly evaluate outcomes very well. Clinical data registries are valuable tools that support evidence development, performance assessment, comparative effectiveness studies, and the adoption of new treatments into routine clinical practice. Registries can provide high-quality evidence on par with randomized clinical trials while offering the added value of documenting patient experiences in everyday clinical practice rather than under strict eligibility and treatment protocols. Regularly observing patient responses to treatment can provide important insights into which healthcare strategies work best in actual practice. Neurosurgery's N<sup>2</sup>QOD program will allow any U.S. neurosurgeon or orthopedic spine surgeon, practice group, or hospital system to contribute to and access aggregate quality and outcomes data through a centralized, nationally coordinated clinical registry.

The primary goals of this registry are to:

1. Establish risk-adjusted national benchmarks for the cost and quality of common neurosurgical procedures.
2. Allow practice groups and hospitals to analyze their individual morbidity and clinical outcomes in real-time and, in doing so, facilitate the development of new care initiatives.
3. Generate both quality and efficiency data to support claims made to public and private payers.
4. Demonstrate the comparative clinical effectiveness of neurosurgical procedures.
5. Facilitate the conduct of essential multicenter trials and other cooperative clinical studies.

Currently, we have 40 leading practice groups from all regions of the United States, including academic and private groups in both rural and urban settings participating in the registry. The primary aim of our first project related to spine surgery is to demonstrate the feasibility of collecting high-quality, validated, aggregate practice data on a national scale. Neurosurgery initiated the registry effort with a lumbar spine module because of the pressing need expressed by many groups around the country for outcomes data in this practice area. It should be noted that the N<sup>2</sup>QOD is the first and only national registry in the U.S. assessing one-year quality of life after surgical treatment. As the registry grows, we will be adding additional subspecialty modules to evaluate care in the areas of cerebrovascular, trauma, tumor, pain and functional neurosurgery.

The current spine portion of the registry project, called the National Spine Surgery Quality and Outcomes Database (S<sup>2</sup>QOD), has been developed in conjunction with several national spine-care stakeholders including multidisciplinary spine care providers, patient advocacy organizations, payer groups, employers, quality care researchers and epidemiologists. This comprehensive quality project will be conducted jointly with orthopedic spine groups. The S<sup>2</sup>QOD contains a number of unique and important structural features, including clinical variables that allow for appropriate risk adjustment and patient-

reported outcomes and utilization metrics along with longitudinal follow up, the latter of which will allow for determination of the sustainability of treatment effects. Through longitudinal follow-up, the S<sup>2</sup>QOD has the capability and intent to assess effectiveness of care. Collecting and reporting on validated outcomes that are important to, and reported by, the patient, such as pain, quality of life, function, and satisfaction, will enhance the information gleaned through this effort.

In recognition of the comprehensive nature of ours and other clinical outcomes data registries, the AANS and CNS urge CMS to consider recognizing these efforts that are occurring outside of the current PQRS data collection methods and tools.

### ***PQRS Quality Measures for 2013 and 2014***

Under section 1848(k)(2)(C)(i) of the Social Security Act, PQRS quality measures generally include measures endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act (currently NQF), but CMS may include other measures not endorsed under certain circumstances. Neurosurgery urges CMS to institute this discretion when dealing with specialties, like neurosurgery that do not have measures within PQRS. We recently responded to CMS' call for 2014 PQRS by proposing two new measure groups. However, the process to receive NQF approval is not timely and we are concerned our measures will not be evaluated in time for the 2014 program. It is also problematic to have to propose measures two and one-half years prior to implementation due to the Measure Application Partnership (MAP) having to review all measures in CMS quality programs. NQF only provides a time limited endorsement of measures for three years. Therefore, the measure(s) proposed and included in the program will potentially be different from the NQF reviewed and approved measure(s).

If approved by NQF or CMS, the two neurosurgery patient centric proposed measures groups will be reported via a registry and will address the quality of surgical outcomes in lumbar spine surgery and other neurosurgical care. The first group focuses on lumbar spine surgery and utilizes existing measures. The second group addresses surgical outcomes for the majority of neurosurgical procedures and expands on existing NCQA measures.

Given the unique ability of neurosurgical diseases to impact patients' quality of life and activities of daily living, quality improvement programs in our specialty have significant potential to produce positive gains in patient outcomes. Although the PQRS program is designed in large part to promote quality healthcare, few, if any, existing measures groups are relevant to neurosurgical practice. The lack of relevant measures groups for our specialty represents a lost opportunity to promote improved care in those patient populations that may experience disproportionate benefit from systematic quality interventions. Due to the limitations of current measures, neurosurgical participation in the present PQRS program is poor. Only 19 percent of neurosurgeons participated in the 2010 PQRS program, and the number for "successful" participation<sup>2</sup> is even lower. We believe developing a set of quality measures that more accurately reflects the clinical experience of practicing neurosurgeons will significantly improve compliance with the program. The proposed measures groups focus upon well accepted quality metrics that should be standard elements of any neurosurgery practice.

*Lumbar Spine Measures Group.* This proposed measures group addresses prevention, surgical outcomes and appropriateness of surgery and shared decision making in lumbar spine surgery – the most prevalent set of neurosurgical procedures. The measures group would consist of:

- PQRS Measure #148, Back Pain: Initial Visit
- PQRS Measure # 226, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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<sup>2</sup> CMS 2010 PQRS and eRx Experience Report. [www.cms.gov/pqrs](http://www.cms.gov/pqrs). Accessed on 7/30/12.

- NQF Measure #0310, Low Back Pain: Shared Decision Making
- NQF Measure #1789, Hospital Wide All Cause Unplanned Readmissions
- NQF Measure #0493, Participation in a Systematic Clinical Database Registry (newly proposed for 2013 PQRS)

*Neurological Surgery Measures Group* This proposed measures group focus on prevention, surgical outcomes and appropriateness of surgery and shared decision making along the continuum of neurosurgical procedures and pathology. This measures group would include:

- Neurosurgery: Initial Visit
- Neurosurgery: Shared Decision Making
- PQRS Measure # 226, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- NQF Measure #1789, Hospital Wide All Cause Unplanned Readmissions
- NQF Measure #0493, Participation in a Systematic Clinical Database Registry (newly proposed for 2013 PQRS)

Over the next year, organized neurosurgery plans on refining the proposed measure specifications to ensure feasibility and measure harmonization.

### ***Informal Review Process***

Neurosurgery is supportive of an informal review process for eligible professionals and group practices subject to a PQRS payment adjustment. However, CMS must institute a clear timeline as to how long an appeals process will take and provide practices with timely feedback and meaningful feedback reports so they can evaluate whether they were incorrectly penalized. Without access to data it will be extremely difficult for physicians to determine whether the payment adjustment was appropriately applied or not. In addition, with penalties now applying for unsuccessful reporting, a formal appeals process should balance consistency in decision-making with timely resolution of cases. If physicians already know something is wrong or inaccurate midway through the program, they should be given an opportunity to fix it upon request. As CMS becomes more familiar with reviewing appeal requests, we hope that it will work with Congress to implement a more formal appeals process that includes standardized and transparent rules for submitting and reviewing evidence, especially since the evaluation period starts in 2013.

### ***The Electronic Prescribing (eRx) Incentive Program***

The AANS and CNS thank CMS for proposing to expand the hardship exemption to those physicians participating in the electronic health record (HER) incentive program. This new proposed exemption will allow practices to avoid reporting on both programs. Also, we thank CMS for maintaining the additional hardship exemptions as the vast majority of neurosurgeons qualified for an exemption. Neurosurgeons prescribe a high volume of narcotics which prohibits them from electronically prescribing.

### ***Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program***

Beginning January 1, 2015, the Secretary is required to apply a value-based payment modifier (VBPM) to specific physicians and groups of physicians the Secretary determines are appropriate. Not later than January 1, 2017, the Secretary is required to apply the payment modifier to all physicians and groups of physicians. The Secretary is also required to provide confidential Physician Feedback reports to physicians that measure the resources used in providing care to Medicare beneficiaries. Finally, the Secretary is authorized to include information on the quality of care furnished to these Medicare beneficiaries in these reports. Neurosurgery understands the need to move the Medicare program from

one that pays strictly on volume to one that rewards quality; however, we have major concerns with the construct of the program.

Physicians currently face an onslaught of overlapping regulatory mandates and reporting requirements, many of which are also being backdated. Problems associated with the Quality Resource Use Reports (QRURs) demonstrate the breadth of unresolved challenges related to measuring resource use and the application of the value-modifier. Premature implementation will only make these problems worse, creating further confusion among both patients and physicians and imposing additional financial and administrative burdens that will harm, rather than improve, quality. Therefore, CMS should re-evaluate its decision to use 2013 as the basis for applying the 2015 payment adjustor.

*Proposals for the Value-Based Payment Modifier.* For purposes of this proposed rule, physicians are defined as in section 1861(r) of the Act to include doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors and CMS proposes to use the definition of an eligible professional as specified in section 1848(k)(3)(B). Furthermore, CMS proposes to initially include all groups of physicians with 25 or more eligible professionals in the payment modifier. Due to the broad definition CMS intends to apply in defining eligible professional for purposes of applying the VBPM, we urge CMS to expand the minimum number of physicians. We do not believe CMS thoroughly considered the number of practices that would be subject to the value modifier in 2015 based on the current definition. Many practices that might have only 6-10 physicians can potentially fall under the 25 or more eligible professionals (EPs) due to the number of allied health practitioners that practice in their practice. Most physicians are not aware of the VBPM, and since CMS proposes to use 2013 as the reporting period it does not provide enough time to educate practices on the program and how to avoid the VBPM penalty.

Physicians need more information and education to ready their practices for the tasks associated with participating in these programs. When considering participation in the PQRS as described in CMS' most recent experience report, the agency shows that more than 1 million providers were eligible to participate in the 2010 PQRS, yet less than a quarter participated. This is a very low number given that the program has been in place since 2006. If education and awareness remain key factors for PQRS participation, we can only imagine how these same challenges will compromise the VBPM program.

Neurosurgery also strongly urges CMS to recognize additional quality improvement activities, including those not sponsored by the federal government. The quality of care in VBPM will be measured in part based on a provider's participation in the PQRS program. When providers do not participate in the PQRS, CMS will use claims data to generate an assessment of the physician's provision of quality care and will automatically be subject to the downward VBPM adjustment. Numerous specialty societies, private payers and other non-government entities have engaged specialists in a variety of quality improvement programs and many of these programs have demonstrated themselves to be more meaningful for improving care and health outcomes – leading to increased physician participation.

We recognize that it is difficult to formulate the perfect way to measure quality and credit physicians for their efforts in these various quality improvement programs. However, we nevertheless strongly encourage CMS to recognize participation and engagement in other quality improvement activities, government-sponsored or not, as a means by which CMS could deem a physician as providing high quality and valuable care to Medicare beneficiaries. Examples might include participation in a specialty society-sponsored registry (not necessarily tied to PQRS), maintenance of certification (MOC), private payer quality improvement programs, or any other well-organized, trackable quality improvement activity. CMS should create a process by which entities could seek "deemed" status so the providers who are engaged in those activities can avoid financial penalties associated with the VBPM, since their quality will be based on activities that are not necessarily tied to PQRS or arbitrary quality measures derived from Medicare claims. Neurosurgery welcomes the opportunity to discuss developing and implementing these ideas with you further.

*Value- Based Payment Modifier -- Payment Adjustment.* While we again urge CMS to credit physicians for participating in non-PQRS quality programs, until such time as that system is in place, physicians should only be subject to the automatic VBPM adjustment if they fail to participate in PQRS. Practices should not be penalized for not satisfactorily reporting PQRS measures, given that PQRS-related errors often reflect coding problems and do not reflect the quality of medical care delivered. Physicians should receive credit for attempting to comply, if not they will be subject to two -- PQRS and VBPM -- penalties.

We also encourage CMS to provide some reprieve for groups of 99 or more who must report the GPRO web-interface measures, but cannot fully do so because the measures are primary care focused and the practice is made up of specialists or primarily consists of specialists.

*Value-Based Payment Modifier -- Quality Measure Reporting.* As mentioned above, the AANS and CNS have concerns about the proposed requirements for reporting PQRS quality measures in order to avoid the VBPM adjustment. CMS proposes that groups of 25 or more physicians must participate in PQRS GPRO to avoid the VBPM adjustment. However, participating in GPRO requires all physicians in the practice to report the same measures. Reporting the same measures is not always a feasible option since practices consist of various specialties and subspecialties. If a member in a group participates individually, the group will be subject the negative one percent VBPM adjustment. In addition, CMS does not allow for measure group reporting in order to satisfy GPRO reporting for the VBPM and PQRS. Many physicians prefer reporting a measure group because it follows an episode of care and it is much easier to evaluate a patient's progress and improved clinical care. We therefore recommend that CMS re-evaluate its proposal for satisfactorily reporting and allow measures groups to meet the VBPM requirements. We also highly encourage CMS to allow groups flexibility in reporting measures to CMS to avoid the adjustment. Furthermore, for groups of 99 or more physicians they will be forced to participate in the GPRO web-interface, but GPRO web-interface measures are a limited subset of measures that are primary care focused. Many specialists, such as neurosurgery cannot report on the vast majority of measures within the GPRO web-interface, so CMS needs to address this problem before applying the VBPM adjustment to these such practices.

*Value Based Modifier- Proposed Cost- Measures.* Neurosurgery is concerned with CMS' proposal to calculate a total per capita cost measure for all beneficiaries and per capita cost measures for beneficiaries with four specific chronic conditions – COPD, heart failure, coronary artery disease, and diabetes – for the VBPM. The measure has not been reviewed or approved by NQF and treats all physicians the same regardless of their specialty or if they treat a high priority of patients with chronic conditions. Physicians should be compared to their specialty and not to all of medicine. Each specialty practices medicine differently and therefore the cost to treat patients varies accordingly. A one-size-fit-all approach does not work, especially since the program is punitive.

*Physician Feedback Reporting Program- Quality and Resource Use Reports.* For a preview of the impact of the VBPM on physicians' payments, large group practices and nearly 24,000 individual physicians in Iowa, Kansas, Nebraska and Missouri have previously received Quality and Resource Use Reports (QRURs) based on 2010 data. However, as we have learned from receiving feedback from our members, many practices did not receive reports for individual physicians within their practice or they received reports for physicians who are no longer in the practice due to inaccuracies and on-going PECOS problems. In addition, practices had an extremely difficult time obtaining the reports. More often than not, AANS and CNS staff had to contact the national CMS office to obtain the reports. It should not be so difficult for physicians to obtain these reports – particularly if the information on the report is tied to penalties.

Based on our review of the reports, we recommend that CMS modify them to highlight information relevant to individual specialists who will be receiving the reports. One means by which CMS could do

this would to develop QRUR templates based on specialty codes. Additionally, those that have received a report to date found it to be long and cumbersome with no actionable information.

Neurosurgeons that were able to access their QRUR found it to be extremely confusing and cumbersome. More often than not, the data did not apply to them, and if it did, they could not make sense of the report, despite explanatory language in the front matter of the report. If the QRUR recipients wanted to learn more about the QRUR, obtaining answers was a challenge. Specialty society staff attempting to assist members had little information or education on how to interpret the reports.

Furthermore, the VBPM aims to adjust payments to those physicians deemed as low quality, high-cost performers based on physician feedback reports. The modifier is budget-neutral, meaning there will be winners and losers, and most specialists see this is a lose-lose situation for them. It is unfair for physicians to be penalized when they have no understanding of where they have gone astray in the eye of CMS, and without an opportunity to improve their "score" before being penalized. This is particularly important since most physicians have not had a chance to receive a feedback report, and those who did, found them to be unhelpful, overall. We urge CMS to consider adopting a Corrective Action Plan, or similar program to allow specialists and opportunity to improve prior to being held to a payment adjustment.

*Physician Feedback Reporting Program- Episode Based Costs.* Beginning in 2013, CMS plans to include episode-based cost measures for several conditions in the Physician Feedback Reports. CMS has been extremely vague in its efforts to construct episode-based cost measures and before moving forward CMS must have a transparent process for evaluating episodes. In order to proceed, the bundle must be clearly defined, with appropriate risk adjustments and adequate payment. Also, whatever CMS puts in place should be a phased-in approach to work out any kinks before it is fully implemented and any penalties apply. Neurosurgery would be happy to work with CMS in defining appropriate episode based cost measures for areas relevant to neurosurgeons.

### ***Physician Compare***

Neurosurgery is extremely concerned with CMS' proposal to expand *Physician Compare* given the website has been tremendously flawed since its inception. The AANS and CNS are aware of CMS' efforts to make improvements to Physician Compare; however, the website is still flawed and misleading to beneficiaries. Data continues to be incorrect or information is missing. Difficulties with the website continue to be reported to organized neurosurgery from members across the country, so we urge CMS to address these problems to ensure that Medicare beneficiaries have access to accurate and helpful information.

Our primary concern with *Physician Compare* is that neurosurgery is not listed as a specialty on the drop down menu on the homepage and we ask CMS to make this change as soon as possible. Neurosurgeons are grouped with neurologists or listed as a subspecialty within neurology. A user would not know that they have the option to search for a neurosurgeon until they click on "neurologists" and then select the subcategory "surgery-neurological". This simply is not an accurate way to classify our specialty. This grouping is clinically inaccurate, inappropriate and does not help patients find a neurosurgeon when they need one. Providing neurosurgery with its own specialty designation is appropriate as neurosurgery is:

1. a specialty recognized by the American Board of Medical Specialties (ABMS), with its own Board– the American Board of Neurological Surgery;
2. a specialty recognized by the Accreditation Council of Graduate Medical Education (ACGME), with its own Residency Review Committee – the RRC for Neurosurgery;
3. a specialty recognized by CMS on the Medicare provider enrollment form; and

4. a specialty recognized by CMS in the Medicare Physician Fee Schedule -- specialty code designation number 14.

Clearly, neurosurgery merits its own designation, but at the very least we should be listed as “surgery” on the dropdown down menu and then as “surgery-neurological” in the surgical subcategory listings.

Our second concern involves the inaccuracy of physician data contained in the *Physician Compare* database. In regards to querying information, when we have performed a search on a random sample of a few of our Medicare-participating members by specifying the town, state and last name, the site turns up “0” results. Only when their specific name is entered does their entry come up. As a result of this faulty search function, patients may never find out about some highly qualified neurosurgeons in their area.

Another example points out the problems with the search function. One of our members searched for neurosurgeons in his immediate area and found that only one of his former partners, a **neurologist**, is listed under “surgery-neurological,” but none of his **neurosurgical** partners are listed – despite the fact that there are multiple neurosurgeons participating in Medicare in his town. A neurologist should not be categorized as “surgery-neurological” since they are two different specialties. Furthermore, a query which merely listed neurosurgeons a few hundred miles away demonstrates the obvious flaws with the current system. Both of these search outcomes are unacceptable and, once again, misleading to users.

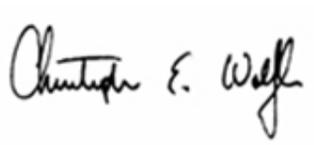
CMS’ proposes to publicly report quality information on all groups that participate in GPRO. Since groups of 25 or more physicians must participate in GPRO in order to avoid the VBPM it will mean a large percentage of physicians will be subject to having their quality information publicly reported and possibly categorized and reported on incorrectly. CMS must not move forward with its proposed expansion of including more detailed information on *Physician Compare* until the infrastructure of the website is appropriately constructed.

Thank you for your consideration of our comments. If you have any questions or need additional information, please feel free to contact us.

Sincerely,



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