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June 13, 2017

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

Submitted electronically via <https://www.regulations.gov/>

Subject: Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information CMS-1677-P

Dear Ms. Verma,

On behalf of more than 4,000 practicing neurosurgeons in the United States, the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), we appreciate the opportunity to comment on the above-referenced CMS hospital inpatient prospective payment system proposed rule.

SUMMARY OF COMMENTS

Request for Information on Physician-owned Hospitals

- The AANS and CNS strongly support availability and expansion of physician-owned hospitals.

Eliminating Inappropriate Medicare Payment Differentials for Similar Services in the Inpatient and Outpatient Settings

- The AANS and CNS continue to believe that inpatient status should be determined by the admitting surgeon.

Proposed Quality Data Reporting Requirements

• **Hospital IQR Program**

- The AANS and CNS support the inclusion of stroke severity in the Acute Ischemic Stroke Hospitalization Measure using data from NIHSS but have several concerns about this measure as described below.
- The AANS and CNS continue to have concerns about the Spinal Fusion Clinical Episode-Based Payment Measure and urge the agency to work to develop more homogeneous lumbar fusion cohorts.

DETAILED COMMENTS

Physician-owned Hospitals

We appreciate the agency's request for comments on the on the role of physician-owned hospitals in the nation's health care delivery system. The AANS and CNS have long supported physician-owned hospitals, which foster innovation and improved mechanisms to allow physicians to efficiently and effectively deliver care to their patients. We believe that the current statutory restrictions on physician-owned facilities prevent Medicare beneficiaries from having the full range of options to seek the care they need from the physician and provider of their choice.

Physician-owned hospitals consistently receive excellent quality scores under current law. For instance, in 2015, 42 percent of physician-owned hospitals received five stars under the Hospital Star Rating Program. In the Medicare Hospital Value-Based Purchasing (VBP) Program in 2015, seven of the top 10 hospitals receiving quality bonuses were physician-owned, although such hospitals represent less than 5 percent of the 5,700 hospitals nationwide. Further, only 8 percent of physician-owned hospitals have been penalized for three years in the VBP Program versus 22 percent of other for-profit hospitals. In addition, fewer (25 percent) physician-owned hospitals have been penalized all three years under the hospital readmission program compared to 70 percent of other for-profit hospitals.

Opponents of physician-owned hospitals continue to make erroneous claims that these facilities are "cherry-picking" patients. This argument is based on an outdated, incomplete study of physician-owned hospitals. In fact, a comprehensive, peer-reviewed study of all physician-owned hospitals published in August 2015, in the highly regarded *British Medical Journal*, successfully debunks this assertion. The authors of the study concluded that physician-owned hospitals see the same patients as hospitals that are not owned by physicians, and they are not leaving their competitors with sicker, lower-income patients. In fact, lead author Daniel Blumenthal, MD, a clinical fellow at Massachusetts General Hospital said, "By and large, physician-owned hospitals have virtually identical proportions of Medicaid patients and racial minorities and perform very similar to other hospitals in terms of quality of care." The authors also conclude that physician-owned hospitals are not providing lower-value care or threatening the financial viability of surrounding hospitals.

The AANS and CNS opposed the provision of the Affordable Care Act (ACA) that banned construction of new facilities and placed significant restrictions on the ability of existing physician-owned hospitals from growing. In effect, this provision removed an excellent model for expanding physician-led patient care. Since passage of the ACA, organized neurosurgery has advocated for the repeal of these restrictions. To that end, the AANS and CNS are currently encouraging Congress to pass the Patient Access to Higher Quality Health Care Act of 2017 (H.R. 1156/S. 1133). We, therefore, urge the agency to work with Congress to create favorable regulatory and legal policies that allow physician-owned hospitals to thrive and contribute to better health care for Americans. These innovative facilities provide high-quality care and allow physicians to effectively and directly manage the many variables contributing to excellent outcomes for their patients.

Eliminating Inappropriate Medicare Payment Differentials for Similar Services in the Inpatient and Outpatient Settings

We understand that the agency continues to look for ways of identifying and eliminating inappropriate payment differentials for similar services provided in the hospital inpatient and outpatient settings. The AANS and CNS have always believed that the admitting surgeon should determine the post-operative setting for care, based on the needs of the patient. As the agency struggles with defining and determining payment differentials for inpatient and outpatient care, we would suggest that inpatient

status is for patients requiring decision making for complex medical conditions, which often necessitate patients to remaining in the hospital for more than just observation post-anesthesia. Outpatient care should be reserved for patients who are not expected to have complications or other post-surgery recovery needs and can be discharged on the same day of service as their surgery. Some patients admitted emergently or in the early morning simply are not ready to go home later that same day. Rather, they must stay until the next day (or perhaps longer). The AANS and CNS hope that any future proposals regarding facility payment differentials for inpatient and outpatient settings will have ample opportunity for comment by all stakeholders to allow for thorough consideration of implications for the care and cost to beneficiaries.

Hospital Inpatient Quality Reporting (IQR) Program

Refinement of the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Acute Ischemic Stroke Hospitalization Measure for the FY 2023 Payment Determination and in Subsequent Years

CMS proposes to adopt a refined version of this measure that would rely on a risk adjustment methodology that incorporates stroke severity using NIH Stroke Scale (NIHSS) data elements derived from ICD-10-CM codes in the administrative claims. The current version of this measure includes 42 risk variables but does not include an assessment of stroke severity because, previously, these data elements were not available in claims data and were not routinely performed by all providers. However, the feasibility of capturing stroke severity has changed now that scores can be obtained through more nuanced ICD-10 claims data. CMS also cites the increased use of the NIHSS among providers as a result of the AHA/ASA guidelines that recommend administering the NIHSS on all stroke patients.

The agency proposes that the first measurement period for this refined measure would include discharges between July 1, 2018, and June 30, 2021, for public reporting in FY 2022 for the FY 2023 payment determination. Because many hospitals would have to create new clinical workflows to assess and document the NIHSS in patients' medical records, as well as include the appropriate ICD-10 CM code for the documented NIHSS score in the claim they submit, CMS proposes to provide hospitals with dry-run results of this refined measure via confidential hospital-specific feedback reports prior to implementation of the new measure. CMS anticipates using claims data, which would include ICD-10 CM codes for the NIH Stroke Scale, for discharges occurring between October 1, 2017, and June 1, 2020, to calculate measure results for the dry-run anticipated in CY 2021.

The AANS and CNS support the decision to incorporate stroke severity into this measure using the NIHSS. The proposed refinements also create a more parsimonious risk model by reducing the total number of risk adjustment variables from 42 to 20, while resulting in a modestly higher c-statistic compared with the risk-adjustment model in the current Stroke 30-Day Mortality Rate (0.81 vs. 0.75). As a result, the updated measure is expected to differentiate the risk of mortality among patients in a clinically meaningful manner.

Although the AANS and CNS are pleased with the decision to incorporate stroke severity into this measure, we continue to have other ongoing concerns about this measure. For one, we are concerned about the measure's reliance on ICD-10 data. We cannot assume that just because providers are presented with many descriptive options under the stroke category that they will necessarily choose the correct one. Although reliance on ICD-10 claims data is an improvement over ICD-9 and allows for the capture of more specific data elements that help to characterize stroke severity, we encourage CMS to continue to evaluate whether clinical data collected through registries is a more feasible option to either supplement or supplant administrative claims data.

We are also concerned about the source and timing of the NIHSS used within this payment system. One must be careful to define which provider's NIHSS will be used. Much of the required repetitive NIHSS scoring is done by overburdened nurses, under the criteria specified for Stroke Center care. Are these also to be used for payment purposes? It would seem that the physician's scoring would be more appropriate if there is financial risk to providers. Also, is the initial score prior to any resuscitation to be used to categorize the patient in a payment system, or a post-resuscitation score, or one done at the end of the 72-hour recovery period? These details will greatly affect the ultimate use of the scoring data.

Another concern is that the measure still seems to lack an adjustment for tPA administration and thrombectomy. These are crucial aspects of care that are rapidly increasing in frequency, could have a significant effect on the outcome, and must be addressed. We are equally concerned that the measure's risk adjustment methodology also still fails to incorporate socio-demographic (SDS) factors. It would be helpful to know if, during the development of the model and in an attempt to create parsimony, these variables were intentionally eliminated through acceptable methodology (stepwise backward or forward elimination). Otherwise, we get the impression that important covariates have been left out.

As we noted in previous comments, organized neurosurgery is also concerned about the handling of transferred patients. It appears that a patient sent from an emergency room at one hospital and admitted to another hospital is counted for the admitting hospital. However, by contrast, it appears as if patients transferred from one hospital (inpatient) to another get counted toward the first (transferring) hospital. This seems inconsistent and may bias the data.

Finally, this outcomes measure continues to exclude patients age <65, which may impact its generalizability to all stroke patients. It would be worthwhile to evaluate whether younger patient outcomes can also be tracked using this measure since there are a reasonable number of patients in this category with significant care implications.

Spinal Fusion Clinical Episode-Based Payment Measure

CMS previously finalized this claims-based payment measure for use in the Hospital IQR Program starting with the FY 2019 payment determination. Although we appreciate the work that CMS has done to date to refine this measure so that it results in a less heterogeneous patient population, we continue to have concerns about this measure. We urge CMS to continue to work with the surgical spine community to further refine the measure so that it results in even more homogeneous lumbar fusion cohorts that are each held to their own separate standard.

We would ask that CMS continue to use CPT codes to refine the patient populations assessed in this, and other, quality systems. Using CPT definitions, as opposed to more heterogeneous MS-DRG-based patient groupings, will provide for more homogeneous patient populations and more accurate data. The inclusion of ICD-10-CM codes may further homogenize the patient population by adding diagnosis information. This is another opportunity to achieve greater specificity of patient populations within the episodes and subtypes.

In general, we remind CMS about the overall limitations of relying on administrative datasets and urge the agency to evaluate ways to incorporate better clinical data collected from registries when feasible. We also remind CMS of the critical importance of adjusting for factors such as patient socioeconomic status, obesity, tobacco use, and other population health variables that significantly impact clinical outcomes.

Organized neurosurgery and our spine care experts look forward to continuing to work with the agency and measure developer to further refine and test this measure, and to ensure that the full range of clinical

and potential patient factors are considered and appropriate adjustments are made.

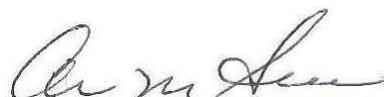
CONCLUDING REMARKS

The AANS and CNS appreciate the opportunity to comment on this proposed regulation. We look forward to working with CMS to make improvements to the IPPS program. In the meantime, if you have any questions or need further information, please feel free to contact us.

Sincerely,



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