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NEUROLOGICAL SURGEONS

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August 21, 2017

Seema Verma, MPH, Administrator
Centers for Medicare & 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: Medicare Program; CY 2018 Updates to the Quality Payment Program
Proposed Rule (CMS-5522-P)**

Dear Administrator Verma:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to provide feedback on proposed updates to the Quality Payment Program (QPP) for 2018. The AANS and CNS recognize that implementing the Medicare Access and CHIP Reauthorization Act (MACRA) is a challenging task. We greatly appreciate that this Administration is taking an incremental approach that focuses on ways to drive improvements in patient outcomes in the least burdensome manner possible, that recognizes diversity among clinician practices in regards to patient populations and experience with quality measurement, and that appreciates current limitations related to system capabilities that are often outside of the clinician's direct control. Still, we continue to have overarching concerns about the complexity of this new program and its failure to convert the disjointed and duplicative nature of legacy quality reporting programs into a more streamlined structure.

The QPP, and particularly the Merit-Based Incentive Payment System (MIPS), was intended to replace the siloed structure of programs — such as the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Electronic Health Record (EHR) Incentive Program — with a more simplified and focused program that recognizes investments in innovative approaches to quality improvement. Instead, MIPS has evolved into a program that includes even more requirements and which continues to incentivize box-checking instead of meaningful engagement in actions that truly improve patient care. As CMS works to finalize policies for 2018 and to develop policies for the future, we strongly urge it to focus on ways to simplify this beast of a program and to reward clinicians who engage in a more concentrated and effective set of quality-focused activities rather than diffuse requirements that continue to divert attention away from the patient.

In summary, to effectively engage physicians going forward, and to make meaningful progress on raising the bar on quality, CMS still needs to work to achieve the following critical aspects of MIPS:

- A reporting system that is truly streamlined and not so confusing as to discourage meaningful engagement;
- A flexible approach to measurement that recognizes the diversity of medical practice and allows clinicians to demonstrate their commitment to higher quality care based on their unique setting, specialty, and/or patient population;

- A scoring system that is transparent and simple enough to understand, but also clinically accurate;
- Reporting and performance thresholds that are realistically achievable and do not result in reporting merely for the sake of reporting;
- A short enough measurement/feedback/payment cycle so that MIPS produces more actionable data for both physicians and patients and so CMS can make more timely modifications to the program as necessary.

EXECUTIVE SUMMARY

MIPS Performance Threshold

- The AANS and CNS continue to believe that the current 3 point threshold should be maintained for 2018.

Contribution of Performance Categories to Overall MIPS Score

- The AANS and CNS greatly appreciate CMS's decision to maintain a zero percent weight for the cost category.
- We urge CMS to consider raising the weight of the Improvement Activity category and lowering the weight of the Advancing Care Information category

Performance Period

- We strongly support the agency's proposal to maintain a minimum 90-day performance period for the Advancing Care Information and Improvement Activities performance categories in 2018 and 2019.
- The AANS and CNS do not support CMS's proposal to extend the Quality category performance period to a full calendar year.

Low Volume-Threshold

- The AANS and CNS support CMS's proposal to raise this threshold for exempting physicians from MIPS to clinicians or groups with less than or equal to \$90,000 in Medicare Part B allowed charges or that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries would be excluded from MIPS.

Virtual Groups

- The AANS and CNS support the virtual group concept and appreciate that CMS is not proposing to limit the overall size of virtual groups or to adopt rigid standards regarding their makeup.
- We urge CMS to explore alternative mechanisms that would allow a portion of a group practice of any size — such as members of a specific specialty practicing in a large multi-specialty practice — to carve themselves out of the larger group and participate in MIPS as a more focused subgroup.

Hospital-Based Clinicians

- The AANS and CNS support the proposal to expand the definition of hospital-based clinician to include Place of Service (POS) 19 (Off Campus-Outpatient Hospital) and to create a new exemption for POS 24 (Ambulatory Surgical Center).
- We ask that when CMS evaluates claims history to make these determinations that it consider care provided across all applicable settings in the aggregate, rather than making determinations based on a single POS.
- The AANS and CNS whereby if a simple majority of the group's clinicians meet the definition of hospital-based, as individuals, then the group as a whole would be exempt from the Advancing Care Information category.

- We urge CMS to consider lowering the threshold from 75 percent to more than 50 percent for purposes of the definition of hospital-based clinician, which would make the policy consistent with our recommendations above related to hospital-based group practices.

Use of Facility-Based Measures

- The AANS and CNS support giving facility-based clinicians the opportunity to be evaluated based on their facility's overall performance as long as it remains a voluntary choice.
- We also support including POS 22 (outpatient hospital setting) in the definition of facility-based to ensure this option is widely available.

Complex Patient and Small Practice Bonuses

- The AANS and CNS strongly support the use of a complex patient bonus, but we oppose CMS's proposal to limit this bonus to only up to 3 points.

Accounting for Social Risk: Other Considerations

- The AANS and CNS support adjustments that account for social and other risk factors.

Data Completeness Criteria

- The AANS and CNS support maintaining the 50 percent data completeness threshold for the Quality category; however, we continue to oppose the requirement for Qualified Clinical Data Registries (QCDRs) to report on non-Medicare patients.
- We strongly oppose CMS's proposal to increase the data completeness threshold to 60 percent for each submission mechanism beginning with the 2019 performance year and urge CMS to maintain its current data completeness threshold of 50 percent for 2019.

Multiple Data Submission Mechanisms

- The AANS and CNS support the agency's effort to identify ways to promote more flexible reporting options and to make a broader range of measures available to clinicians,
- We are very concerned that this policy could result in a situation where, under the CMS data validation process, clinicians would be expected to consider all measures available via all possible reporting mechanisms to satisfy the six measure requirement.
- CMS should not look across multiple reporting mechanisms when conducting its Eligible Measure Applicability (EMA) process to validate whether a clinician could have reported on additional measures. The EMA process should be limited to a single reporting mechanism to minimize confusion and limit unreasonable accountability.

Specialty Measure Sets

- The AANS and CNS continue to support specialty-specific measure sets, and we also recommend that CMS consider expanding measure sets so that they are also condition or treatment specific.
- We recommend that CMS remove the MN Community Measurement measures from the Neurosurgical Specialty Set.
- We request that CMS employ a more transparent process for developing specialty measure sets.

Topped Out Measures

- The AANS and CNS request that CMS not finalize its policy to cap the points that may be earned on topped out measures at this time. This is especially critical for QCDR measures, which are all relatively new and should be promoted rather than discouraged.
- We urge CMS to adopt a broader policy of maintaining measures, including topped out measures, in MIPS for at least five years.

Benchmarks and Other Quality Scoring Policies

- The AANS and CNS strongly urge CMS to maintain the definition of Class 2 measures that is currently in use to ensure that any clinician who does not meet the data completeness criteria can still earn 3 points for making an effort to report that measure.
- For measures without benchmarks, rather than offering partial credit, CMS should assign a null value for these measures — that is, recalibrate the denominator used to calculate the total quality score rather than limit the number of performance points tied to the measure. An alternative policy could be to offer clinicians who report on new measures (i.e., measure approved for the program within the last 2-3 years) bonus points.
- We continue to support specialty adjustments for quality measures to ensure that performance comparisons are applied to groups with similar characteristics.

Bonus Points for Using CEHRT

- We continue to recommend that CMS also reward physicians with bonus points for utilizing registries, in general, regardless of their end-to-end electronic reporting capabilities.

Cost Performance Category

- CMS should not hold clinicians accountable for costs until CMS has had an opportunity to test the use of these new codes and clinicians have had an opportunity to become comfortable using them.
- The AANS and CNS reiterate our strong opposition to the ongoing use of the existing, yet flawed, Total Per Capita and Medicare Spending Per Beneficiary measures, and we urge CMS to discontinue their use — even for purposes of confidential feedback.

Advancing Care Information Performance Category

- We continue to urge CMS to offer clinicians the broadest selection of measures to choose from for purposes of both the base and performance Advancing Care Information score and to not require the use of any single measure to receive a score in this category.
- The AANS and CNS urge CMS to recognize the value that clinical data registries bring to health care and promote their use by recognizing physicians utilizing an EHR to participate in a clinical data registry (regardless of whether or not the EHR has a direct interface with the clinical registry) as satisfactorily achieving full credit for the Advancing Care Information MIPS category.
- If CMS believes it needs to maintain the existing structure of this category, then we at least urge it to modify the scoring policies in a way that gives more weight to clinicians who invest in the meaningful use of clinical data registries to improve patient care.
- The AANS and CNS strongly believe that clinicians who do not have access to an immunization registry should, at the very least, be able to earn the full 10 percentage points for reporting to another registry, such as a specialized or clinical data registry.
- We urge CMS to continue its current policy, allowing eligible clinicians to demonstrate “active engagement” using any of the three current options (i.e., completed registration to submit data; testing and validation; and production).
- The AANS and CNS appreciate and support the agency’s proposal not to require clinicians to transition to 2015 Edition certified EHR technology in 2018, and we request that CMS extend this policy beyond 2018.
- We continue to support any effort to broaden hardship exceptions under this program.

Improvement Activities

- In general, the AANS and CNS support the agency’s proposal to maintain most of the existing policies related to this category, including the data submission criteria and attestation mechanism.
- Regarding group reporting of Improvement Activities, we urge CMS to maintain its current policy and not adopt a 50 percent reporting threshold.

- In regards to the Improvement Activities inventory, we continue to have concerns about the arbitrary and non-transparent manner in which CMS makes decisions about which activities to include (and not to include) and how it makes determinations about valuing each activity. As part of this process, CMS also must ensure that specialists have an equal opportunity as non-specialists to select activities that reflect their practice and to earn the maximum score.
- The AANS and CNS continue to urge CMS to assign the registry-focused activities a “high” weight or to alternatively, allow clinicians who participate in a registry and meet certain basic requirements to automatically receive the maximum score in the Improvement Activities category.
- We have several comments regarding the following Improvement Activities proposed for 2018:
 - IA_PSPA_XX: Completion of an Accredited Safety or Quality Improvement Program
 - IA_PSPA_XX CDC Training on CDC’s Guideline for Prescribing Opioids for Chronic Pain: Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course “Applying CDC’s Guideline for Prescribing Opioids”
 - IA_PSPA_XX Consulting Appropriate Use Criteria (AUC) using clinical decision support when ordering advanced diagnostic imaging.
 - IA_AHE_XX: MIPS Eligible Clinician Leadership in Clinical Trials or Community-Based Participatory Research (CBPR)
 - IA_AHE_3: Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision-making capabilities.
 - IA_BE_15: Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the ~~certified~~ electronic health record (EHR) technology.
- The AANS and CNS continue to urge CMS to consider the following activities for inclusion in the 2019 MIPS inventory:
 - Emergency room call coverage by surgical subspecialties to improve patient access to care;
 - Participating in a regular morbidity and mortality (M&M) conferences; and
 - Participating in other self-assessment/ongoing learning activities, such as the CNS program SANS — Self-Assessment in Neurological Surgery (<https://www.cns.org/education/browse-type/sans>)

Self-Nomination Process

- Given our experience with neurosurgery’s QCDR (the NeuroPoint Alliance) for multiple years, we are concerned about the feasibility of the self-nomination process timeline. As we suggested earlier, we recommend that CMS would adopt a multi-year measure approval process — ideally, five years.
- We strongly recommend that CMS adopt a more transparent and more predictable process for working with specialty societies to vet QCDR quality measures and to provide more consistent feedback.
- The AANS and CNS strongly urge CMS to maintain policies that allow QCDR measures to be used as soon as possible, even if they are still undergoing testing, which is often achieved only once the measure is in use.
- We firmly believe that excessive consolidation of QCDR measures threatens to undermine the usefulness of the QCDR mechanism which was designed, in large part, to recognize the complexities inherent in subspecialty care. We look forward to having an open dialogue with CMS as it continues to consider ways to balance these priorities.

Advancing the Role of Third-Party Intermediaries

- The AANS and CNS have concerns about potentially qualifying third party intermediaries based on their ability to deliver longitudinal patient data. CMS should not qualify registries based on this capability.

Public Reporting

- The AANS and CNS request that CMS take a step back and minimize the amount and type of data related to this program that is made available to the public.
- We strongly encourage CMS to extend the 30-day preview period so that clinicians have more time to review and make sense of their data.

Alternative Payment Models (APMs)

- The AANS and CNS strongly encourage the Center for Medicare and Medicaid Innovation (CMMI) to continue to support the development of voluntary specialty-focused APMs and to offer better guidance on how existing APMs could be altered to meet the “advanced” criteria.
- The AANS and CNS support inclusion of other payer arrangements in the definition of Physician-Focused Payment Models.

More detailed comments about specific aspects of the 2018 proposed rule are included below.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

MIPS Performance Threshold

For 2017, CMS set the MIPS composite performance threshold at 3 points, meaning that a clinician or group only has to earn 3 points to avoid a penalty in 2019. This low threshold allows clinicians interested in testing out the program to do very little to avoid a penalty (e.g., report a single quality measure on a single patient). For 2018, CMS proposes to set the performance threshold at 15 points, which means that clinicians will have to do more to avoid a 2020 penalty (e.g., report six measures, including one outcome or other high priority measure, for 50 percent of applicable patients, or attest to 2-4 Improvement Activities). In 2019, CMS is required by statute to set the overall MIPS performance threshold at the mean or median of the final scores for all MIPS eligible clinicians for a prior period specified by the Secretary. CMS expresses concern in this proposed rule that the transition from a 15-point threshold in the 2018 performance to a threshold based on the mean or median in 2019 may be too steep for some providers and seeks comment for setting a lower or higher threshold for the 2018 performance year.

The AANS and CNS urge CMS to keep the overall MIPS performance threshold as low as possible for 2018, despite the statutory requirement to transition to the mean or median in 2019. **We continue to believe that the current 3 point threshold should be maintained for 2018** since this represents only the second year of what continues to be an overly complicated program. Clinicians are still trying to understand the program requirements and invest in reporting mechanisms that make the most sense for their practice. By maintaining a low threshold, CMS can continue to offer an “on-ramp” that will help new eligible clinicians transition and integrate more easily into the program.

At the same time, we agree with the agency’s concerns about the transition from 2018 to 2019. The AANS and CNS are working with Congress to extend CMS’s authority to maintain transition year policies beyond year two of the program. In the interim, we urge CMS to consider ways that it can work within its existing authority to minimize the leap between year two and three, such as relying on the lower of the mean or median threshold for 2019, not including bonus points in mean and median calculations, and capping annual increases in the performance threshold to no more than 10 points.

Contribution of Performance Categories to Overall MIPS Score

Using its authority to assign different weights during the first two years of MIPS, CMS proposes that for the 2020 MIPS payment year, based on 2018 performance, weights will be as follows:

- Quality would continue to account for 60 percent of the final MIPS composite score;
- Cost would remain at zero percent;

- Advancing Care Information would account for 25 percent; and
- Improvement Activities could continue to be valued at 15 percent.

The AANS and CNS greatly appreciate CMS's decision to maintain a zero percent weight for the cost category, particularly given ongoing concerns about that performance category expressed later in this letter. **We urge CMS to consider raising the weight of the Improvement Activity category and lowering the weight of the Advancing Care Information category** since the former recognizes a much broader array of quality actions that reflect a variety of practices whereas the latter continues to focus on inflexible metrics that target EHR functionality more than genuine improvements in quality.

CMS clarifies that for the 2021 payment year and future years of MIPS, it is required by statute to weigh the quality and cost category each at 30 percent of the MIPS final score. The AANS and CNS are working with other professional societies to pursue legislation that would extend MACRA's two-year cost transition period and hope that CMS will support and Congress will adopt this change. In the interim, we remind CMS that there are ways to adhere to the statute without unfairly penalizing clinicians. For instance, CMS does not have to hold clinicians accountable for cost in situations where relevant and actionable metrics do not yet exist or where current measures result in too small of a number of attributed patients to result in meaningful data.

Performance Period

We strongly support the agency's proposal to maintain a minimum 90-day performance period for the Advancing Care Information and Improvement Activities performance categories in 2018 and 2019. However, we do not support CMS's proposal to extend the Quality category performance period to a full calendar year. Each MIPS performance category has its own set of rules and unique scoring methodologies, which makes the program incredibly confusing and daunting. CMS should aim to adopt consistent policies across the MIPS performance categories and from year to year, as often possible. As such, we urge CMS to maintain a 90-day performance period for the Quality category in 2018 and 2019. It is especially critical to keep a 90-day performance period for Quality in light of the constantly shifting measure landscape. CMS typically does not release a final list of MIPS measure specifications until about a month before the start of the performance period. Traditionally, QCDR measures have not been finalized until a few months into the performance period. Once the final measures are released, it takes time for practices to choose the most relevant measures, to familiarize themselves with any new documentation requirements, and to update their billing/medical record systems and train staff and clinicians to capture such data. Given the complexity of this new program, CMS also has encountered serious delays in releasing details related to its MIPS data validation process. As of early August, clinicians still do not have any information about how they will be evaluated under CMS's Eligible Measure Applicability (EMA) process, which is critical for determining which clinicians will be protected from penalties when less than six applicable measures are available. In light of these delays, we believe it is unfair to hold clinicians accountable for a calendar year's worth of quality data in 2018. This program is still too new and too complex to expect clinicians to be prepared to start reporting on day one of the calendar year.

Low Volume-Threshold

CMS proposes to increase the low-volume threshold (LVT), which determines which clinicians are automatically excluded from MIPS. For 2018, CMS proposes that clinicians or groups with less than or equal to \$90,000 in Medicare Part B allowed charges or that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries would be excluded from MIPS. This is compared to the 2017 policy, which excluded those with less than or equal to \$30,000 or providing care for 100 beneficiaries. **The AANS and CNS support CMS's proposal to raise this threshold** because it recognizes the fact that practices are at varying levels of preparedness to participate in MIPS. It is important that the LVT remain consistent for at least three years to minimize confusion regarding participation, to ensure a more

consistent foundation of data on which to base performance benchmarks and other thresholds and to provide CMS with adequate time to evaluate the impact and appropriateness of setting the LVT at a certain level.

Virtual Groups

In this rule, CMS uses its authority under MACRA to propose policies related to the formation of virtual groups. Virtual groups are intended to enable small and solo practices to join together virtually to take advantage of the economies of scale traditionally afforded to larger groups. The AANS and CNS support the virtual group concept and appreciate that CMS is not proposing to limit the overall size of virtual groups or to adopt rigid standards regarding their makeup. Nevertheless, we are concerned about the limited impact of this policy since MACRA only permits groups with 10 or fewer eligible clinicians to form a virtual group. **We urge CMS to explore alternative mechanisms that would allow a portion of a group practice of any size — such as members of a specific specialty practicing in a large multi-specialty practice — to carve themselves out of the larger group and participate in MIPS as a more focused subgroup.** While in some cases the subgroup might focus on a particular specialty, in other situations, it might focus on a particular condition or type of care (e.g., spine care performed by a multi-disciplinary team of clinicians). Specialists and subspecialists in larger multi-specialty practices, facilities, and health systems continue to lack “skin in the game” since they have limited control over the selection of measures and reporting mechanisms that are best for their practice. We encourage CMS to give these clinicians the opportunity to engage more autonomously and more meaningfully in MIPS by recognizing engagement in MIPS at multiple levels that span beyond the billing Taxpayer Identification Number (TIN). Clinicians increasingly work for multiple organizations and across multiple settings. Health system consolidation is also increasingly common, which minimizes the control and level of personal engagement that individual clinicians have over these quality reporting programs. As CMS considers alternative MIPS participation options for the future, we urge it to account for the current realities of modern medical practice and to think about ways to involve individual clinicians at a more meaningful level.

Hospital-Based Clinicians

CMS currently defines a hospital-based clinician under MIPS as an eligible clinician who furnishes 75 percent or more of his or her covered professional services in the following sites of service: inpatient hospital (Place of Service (POS) 21), on-campus outpatient hospital (POS 22), or the emergency room (POS 23) setting. This determination is based on claims for a period prior to the performance period (i.e., claims with dates of service from September 1 of the calendar year two years preceding the performance period through August 31 of the calendar year preceding the performance period). Hospital-based clinicians are automatically exempt from the Advancing Care Information performance category, and the weight of that category (25%) is shifted to the Quality category (for a total of 85 percent towards the MIPS final score).

CMS proposes to expand its definition of hospital-based clinician to include off-campus-outpatient hospitals (POS 19) beginning with the performance period in 2018. Under separate authority, and in accordance with the 21st Century Cures Act, CMS also proposes to define an “Ambulatory Surgery Center-based MIPS eligible clinician” as one who furnishes 75 percent or more of his or her covered professional services in POS 24 (ambulatory surgery center). Similar to the agency’s existing hospital-based policy, these clinicians would be assigned a zero percent weighting for the Advancing Care Information category. However, this policy would apply beginning with the 2017 performance period/2019 MIPS payment year.

The AANS and CNS support the proposal to expand the definition of hospital-based clinician to include POS 19 and to create a new exemption for POS 24. Both of these proposals would appropriately extend the Advancing Care Information category exemption to clinicians who lack control

over EHR adoption and use. However, we request that CMS apply both of these policies starting with the 2017 performance period/2019 MIPS payment year. **We also ask that when CMS evaluates claims history to make these determinations that it consider care provided across all applicable settings in the aggregate, rather than making determinations based on a single POS.** Many of our members and members of other surgical specialties work across multiple settings (e.g., in POS 21 and POS 22 or POS 21 and POS 24) and might not meet the 75 percent threshold based on a determination that only considers services provided in any one of these settings. Since the same barriers exist across all of these settings, they should all be considered for purposes of the Advancing Care Information exemption.

We also request that CMS modify its definition of hospital-based group practice. Under our current interpretation of this definition, 100 percent of the clinicians in a group practice must meet the 75 percent threshold outlined above for the group, as a whole, to be exempt from the Advancing Care Information category. We believe this policy is unnecessarily complicated. It is also inconsistent with what CMS seems to propose for its “facility-based group” definition (see next section). Under the current hospital-based group definition, if less than 100 percent of clinicians in a group is considered hospital-based, then the group is expected to submit ACI data for the portion of clinicians who are not hospital-based, even if that is only a small percentage. The intent of the group practice reporting option is to ease the administrative burden of reporting on behalf of an entire group. It is unreasonable to expect a group, where the majority of clinicians are hospital-based, to parse out the minority of clinicians who are not hospital-based and to report their Advancing Care Information measure data to CMS. **Ideally, we would like to see CMS adopt a policy whereby if the simple majority of the group’s clinicians meet the definition of hospital-based, as individuals, then the group as a whole would be exempt from the Advancing Care Information category.** If CMS were to adopt this modified definition, we would request that it do the same for “facility-based groups,” as discussed in the next section. As an alternative, CMS could apply to hospital-based groups the definition it proposes below for facility-based groups, which is a group of which 75% or more of the MIPS eligible clinician NPIs billing under the group’s TIN meet the definition of hospital-based as individuals.

Furthermore, for consistency sake, **the AANS and CNS also request that CMS consider lowering the threshold from 75 percent to more than 50 percent** for purposes of the definition of hospital-based clinician, which would make the policy consistent with our recommendations above related to hospital-based group practices.

What is most important is that CMS adopt consistent thresholds across the program as much as possible and that it does not change them from year to year. This will ensure that the rules are easy to follow, spur engagement in the program, and ensure that clinician time is not unnecessarily diverted away from patient care.

Use of Facility-Based Measures

CMS proposes to allow certain clinicians to opt to use facility-based measures for assessment under the MIPS quality and cost performance categories starting with performance year 2018. Specifically, CMS proposes that the quality and cost measures that may be used for facility-based measurement are those adopted under the Hospital Value-Based Purchasing (VBP) program. A clinician who opts to be scored based on this measure set would be attributed to the facility at which he/she provided services for the most Medicare beneficiaries during a specified prior period. This policy option would only apply to “facility-based” MIPS eligible clinicians or groups, which CMS defines as MIPS eligible clinicians who provide 75 percent or more of their covered professional services in the inpatient hospital setting (POS 21) or the emergency room (POS 23). CMS also seeks comment on whether the on-campus outpatient hospital setting (POS 22) should be included in its facility-based definition,

The AANS and CNS support giving facility-based clinicians the opportunity to be evaluated based on their facility's overall performance as long as it remains a voluntary choice and provided that CMS communications about these options are clear and timely. **We also support including POS 22 in the definition of facility-based to ensure this option is widely available.** The MIPS program still includes very few measures that are directly relevant to neurosurgeons. This policy would provide them with an additional reporting option, while also reducing reporting burden. We support giving facility-based clinicians notice of their facility-based status and the facility-based score to which they would be attributed *before* the close of the data submission period so that they can make well-informed decisions about whether to opt into facility-based measurement or be evaluated using physician-focused MIPS measures. In situations where a clinician chooses facility-based measurement but also attempts to report via a traditional MIPS mechanism such as qualified clinical data registries (QCDRs), we support CMS relying on whichever approach results in the highest score. Regardless of whether CMS requires a physician to opt into using facility-based measures, or the agency calculates a facility-level score and an individual or group score and automatically use whichever is higher, the system needs to minimize any confusion and regulatory burdens on physicians participating in this program.

By statute, CMS may use, for purposes of this policy, measures used for payment systems other than for physicians, such as measures for inpatient hospitals. However, CMS may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists and anesthesiologists. Although the statute limits the types of measures that can be used under this policy, it does not explicitly dictate how CMS defines "facility-based." Ideally, we would like to see CMS align its definition of "facility-based" clinician with its definition of "hospital-based" clinician and groups to minimize confusion. We believe CMS has the authority to adopt a more flexible definition of facility-based clinician and we encourage the agency to consider doing so.

Complex Patient and Small Practice Bonuses

As a short-term strategy to address the impact that patient complexity may have on final scores, CMS proposes a complex patient bonus for the 2018 MIPS performance period. For 2018, CMS proposes to base the complex patient bonus on the average Hierarchical Conditions Category (HCC) risk score. CMS proposes to calculate an average HCC risk score, using the model adopted for Medicare Advantage risk adjustment purposes, for each MIPS eligible clinician or group. The bonus would be added to the clinician's final MIPS score. CMS also considered an alternative method, under which the agency would apply the complex patient bonus based on a ratio of patients who are dual eligible (i.e., the proportion of unique patients who have dual eligible status among all unique patients seen by the MIPS eligible clinician during a 12-month period).

The AANS and CNS strongly support the use of a complex patient bonus, but we oppose CMS's proposal to limit this bonus to only up to 3 points. Given the clinical significance of treating complex patients, we urge CMS to increase the potential number of bonus points under this policy so that it at least aligns with the MIPS small practice bonus, which would automatically provide small practices with five bonus points simply due to their practice size. Clinicians with complex patient populations are at just as much of a risk (if not more) of their performance suffering for reasons outside of their control as are small practices. MIPS scoring policies should not disincentivize clinicians taking care of the riskiest and neediest patients.

Accounting for Social Risk: Other Considerations

CMS also seeks comment on whether CMS should more generally account for social risk factors in the MIPS, and if so, what method or combination of methods would be most appropriate. Examples include:

- Adjustment of MIPS eligible clinician scores (e.g., stratifying the scores of MIPS eligible clinicians based on the proportion of their patients who are dual eligible);
- Confidential reporting of stratified measure rates to MIPS eligible clinicians;

- Public reporting of stratified measure results;
- Risk adjustment of a particular measure as appropriate based on data and evidence; and
- Redesigning payment incentives (e.g., rewarding improvement for clinicians caring for patients with social risk factors or incentivizing clinicians to achieve health equity).

CMS also seeks public comment on which social risk factors might be most appropriate for stratifying measure scores and/or potential risk adjustment of a particular measure.

In general, **the AANS and CNS support adjustments that account for social and other risk factors.** If these factors are not accounted for, clinicians might be subject to inappropriate penalties, which could disincentivize clinicians to care for riskier or more complex patient populations and even lead to patient access issues for our nation's most vulnerable populations. We encourage CMS to continue to work with clinical experts to evaluate how social and other risk factors can be more appropriately incorporated into measurement and feedback reports.

Scoring Improvement for the MIPS Quality and Cost Performance Categories

CMS proposes policies to incorporate improvement into the calculation of the Quality and Cost performance categories score if there are sufficient data to do so. For the Quality category, CMS proposes to measure improvement at the performance category level. For the Cost category, CMS proposes to measure improvement at the measure level.

The AANS and CNS believe that the underlying MIPS reporting and assessment structure is too new and too complex to ensure that quality improvement is being measured validly and reliably. Without assurances about the integrity of performance assessment under MIPS, **we do not believe there would be adequate data to measure improvement meaningfully and that this policy would instead add to the complexity of the program.** As such, CMS should delay implementing improvement scoring in MIPS to focus on — and strengthen — the foundation of quality reporting and assessment under MIPS. That said, as CMS moves forward, the policy as proposed appears to ensure that improvement would not contribute as heavily to the overall performance category score as achievement and would only serve to help a clinician's score (i.e., it would not result in a lower score). Incorporating improvement helps to level the playing field between those practices that are more experienced and better resourced and those practices with less preparation and fewer resources, who may have lower absolute performance scores but are committed to quality improvement year after year. Regardless, **we would like CMS to move to a system that measures clinician improvement on the same quality measures from year to year since this would result in more accurate assessments.** As this program is still in its infancy, clinicians are still testing the waters by reporting different measures from year to year, which provides insufficient foundational data for measuring improvement on an individual quality measure level. As such, we urge CMS to move in the direction of individual measure assessment only when more consistent data exists.

Quality Performance Category

- **Data Completeness Criteria.** The AANS and CNS appreciate that CMS did not propose to increase for 2018 the current data completeness threshold for the Quality category, which requires clinicians to report on 50 percent of eligible patients for each measures (for claims-based reporting, this applies only to Medicare patients; for reporting via EHR, qualified registry, and QCDR, this applies to all patients, regardless of payer). However, **we continue to oppose the requirement for QCDRs to report on non-Medicare patients.** At least for the first few years of this new quality payment program, CMS should require reporting on no more than 50 percent of applicable Medicare patients across all measures and reporting mechanisms. If CMS must capture data across payers, it should only require a statistically valid sample of patients, such as 20 consecutive patients.

The AANS and CNS also oppose CMS's proposal to increase the data completeness threshold to 60 percent for each submission mechanism beginning with the 2019 performance year. We are not aware of any evidence that suggests that an increase in this reporting requirement will result in data that is any more accurate or reliable. More importantly, constant change to the reporting requirements year after year poses significant administrative challenges for clinicians and their administrative staff. **We strongly urge CMS to maintain its current data completeness threshold of 50 percent for 2019.**

- **Multiple Data Submission Mechanisms.** Based on stakeholder feedback, CMS proposes to permit clinicians and groups to use various data submission mechanisms across a performance category in 2018. For example, if a clinician submitted three measures via claims and three measures via a registry, CMS would combine that data to calculate a Quality category score. Currently, CMS does not combine data submitted across multiple mechanisms and instead relies on measure data submitted via the one mechanism that resulted in the highest performance score. While we greatly appreciate the agency's effort to identify ways to promote more flexible reporting options and to make a broader range of measures available to clinicians, we have concerns about the manner in which this proposed policy would be implemented. **We are very concerned that this policy could result in a situation where, under the CMS data validation process, clinicians would be expected to consider all measures available via all possible reporting mechanisms to satisfy the six measure requirement.** This could mean that a clinician who is only able to identify three relevant claims-based measures would be expected to also identify and invest in a registry to satisfy the additional three measures and avoid a potential penalty. Similarly, a clinician who invests in registry A, which only offers four relevant measures, might be expected to invest in registry B to satisfy the other two measures. Holding clinicians accountable for reviewing the entire universe of MIPS measures, investigating the entire portfolio of qualified registries, EHRs, and QCDRs, and expecting them to invest in multiple mechanisms is completely unreasonable, nonsensical, and contradicts the goals of moving towards a more streamlined reporting system and improving patient care.

If CMS finalizes its policy to recognize reporting across multiple mechanisms, then we strongly recommend that it only offer this as an option that could earn a clinician bonus points that recognize his/her investment in an additional reporting mechanism. **CMS should not look across multiple reporting mechanisms when conducting its Eligible Measure Applicability (EMA) process to validate whether a clinician could have reported on additional measures.** The EMA process should be limited to a single reporting mechanism to minimize confusion and limit unreasonable accountability.

- **Specialty Measure Sets.** The AANS and CNS continue to support specialty-specific measure sets. We also continue to recommend that CMS consider expanding measure sets so that they are also condition or treatment specific. However, we have concerns about the process by which CMS constructs these sets. In February 2017, in response to a CMS request, the AANS and CNS provided the agency with suggestions for a neurosurgical measure set. We heard nothing from CMS since that time and were surprised to find that the Neurosurgical Specialty Set proposed in this rule includes three additional measures that were not included in our recommended set. These measures are highlighted in yellow below:

MIPS #	Title	High Priority	2017 Reporting Mechanisms
21	Perioperative care: Selection of Prophylactic Antibiotic- First or Second Generation Cephalosporin	Y	Claims, Registry
23	Perioperative care: Venous Thromboembolism (VTE) Prophylaxis	Y	Claims, Registry
32	Stroke and stroke rehab: Discharged on Antithrombotic Therapy	N	Claims, Registry
130	Documentation of Current Medications in the Medical Record	Y	Claims, Registry, EHR
187	Stroke and Stroke Rehab: Thrombolytic Therapy	N	Registry
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	N	Claims, Registry, EHR
345	Rate of Post-op Stroke or Death in Asymptomatic Patients undergoing CAS	Y	Registry
346	Rate of Post-op Stroke or Death in Asymptomatic Patients undergoing CEA	Y	Registry
409	Clinical Outcome Post Endovascular Stroke Treatment	Y	Registry
413	Door to Puncture Time for Endovascular Stroke Treatment	Y	Registry
TBD	Average Change in Back Pain Following Lumbar Discectomy and/or Laminotomy (MN Community Measurement)	Y	Registry
TBD	Average Change in Back Pain Following Lumbar Fusion (MN Community Measurement)	Y	Registry
TBD	Average Change in Leg Pain Following Lumbar Discectomy and/or Laminotomy (MN Community Measurement)	Y	Registry

Although we support the MN Community Measurement measures in concept, we have stated on record that they are confusing and flawed as written and needed to be clarified before implementation. In addition to relying on inappropriate definitions, they rely on the Visual Analog Scale (VAS) as the only pain scale despite the existence of equally useful pain scoring systems, such as PROMIS. The measures also fail to capture patients whose symptoms are primarily neurogenic claudication, which is particularly relevant for the Medicare population. Furthermore, capturing these measures for all patients during a reporting period would be very challenging due to ongoing limitations related to data collection that is outside of the clinician’s control.

Given these continuous and assumedly unresolved concerns, **we recommend that CMS remove the MN Community Measurement measures from the Neurosurgical Specialty Set. We also request that CMS employ a more transparent process in the future** where it engages in ongoing consultation with the relevant specialties regarding suggestions received from other stakeholders that might not include appropriate clinical experts or serve as the official voice of the specialty.

- **Topped Out Measures.** CMS proposes a three-year timeline for identifying and removing topped out measures. In the third consecutive year that a measure is identified as topped out, it will be considered for removal through notice-and-comment rulemaking or the QCDR approval process and may be removed in the fourth year. CMS also proposes to phase-in special scoring for measures

identified as topped out for two consecutive periods. These measures could only achieve up to a 6-point cap (out of 10 possible performance points).

CMS proposes to phase in this policy starting with a select set of six highly topped out measures. Thus, the special topped out scoring would apply to these six measures beginning with the 2018 performance period. The first year that these six measures could be proposed for removal based on topped out status is 2020, while the first year that all other measures could be proposed for removal is 2021. Two of the six measures proposed under this initial policy are relevant to our specialty and can be found in the proposed Neurosurgical Specialty Set:

- Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin; and
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).

While we support the intent of this proposed lifecycle, we have concerns about removing or otherwise discouraging the reporting of topped out measures prematurely, particularly when many specialties still find it challenging to identify up to six relevant measures. Removing or capping the score of too many topped out measures could further limit reporting options for these specialists or put them at an unfair scoring disadvantage. Furthermore, it is currently difficult to understand exactly why or to what extent a measure is topped out. For example, some measures could be reported on by the nation's top performers only, which might represent a very small portion of the total applicable population. It is particularly challenging to determine whether performance is indeed topped out in the context of MIPS, which is a brand new program with relatively low participation rates (e.g., only 37% of clinicians are expected to be eligible to participate in 2018). With such a small number of participants, it is virtually impossible to know with certainty whether performance is really at its peak, and as more physicians participate in MIPS, we might see a broader universe of physicians begin to report on these measures, which could alter the measure's topped out status. We also remind CMS that once a topped out measure is removed from the program, there is no way to monitor whether high performance is being maintained over time.

To mitigate some of these challenges, **we request that CMS not finalize its policy to cap the points that may be earned on topped out measures at this time.** This is especially critical for QCDR measures, which are all relatively new and should be promoted rather than discouraged. **We also urge CMS to adopt a broader policy of maintaining measures, including topped out measures, in MIPS for at least five years.** This will not only give CMS more time to consider how to treat topped out measures more carefully, but it will also allow CMS to build a foundation of data to understand whether performance on a measure is truly topped out. Maintaining measures in the program for at least five years will also limit situations where CMS does not have sufficient historical data on a measure to set a benchmark or otherwise evaluate performance. In general, minimizing changes to measures and scoring policies will make MIPS more predictable and make it easier for physicians to plan in regards to reporting strategies.

- **Benchmarks and Other Quality Scoring Policies.** For the 2019 MIPS payment year, CMS finalized two classes of measures:
 - Class 1 measures that can be scored based on performance because they have a benchmark, meet the case minimum requirement, and meet the data completeness standard. These measures can receive scores of 3 to 10 based on performance compared to the benchmark.
 - Class 2 measures that cannot be scored based on performance because they do not have a benchmark, do not have at least 20 cases, or have not met data completeness criteria. These measures receive 3 points for the 2019 MIPS payment year.

CMS proposes to revise Class 2 measures to include only measures that cannot be scored based on performance because they do not have a benchmark or do not have at least 20 cases. Revised Class 2 measure would continue to receive 3 points.

CMS also proposes to create Class 3 measures, which are measures that do not meet the data completeness requirement, to encourage complete reporting and to recognize that data completion is within the direct control of the MIPS eligible clinician. Proposed Class 3 measures would receive 1 point; however, if the measure is submitted by a small practice with 15 or fewer clinicians, the Class 3 measure would receive 3 points given concerns that data completeness may be harder to achieve for small practices with smaller case sizes.

The AANS and CNS do not support this change in policy and strongly urge CMS to maintain the definition of Class 2 measures that is currently in use to ensure that any clinician who does not meet the data completeness criteria can still earn 3 points for making an effort to report that measure. As we noted earlier, we already have concerns that the requirement to report on 50 percent of all applicable patient across all payers is arbitrary and unnecessarily high. If CMS is not going to adjust this threshold, it should at least provide protections for those who attempt but have difficulties satisfying that threshold.

We also continue to have concerns about how CMS treats measures without benchmarks, including some new measures. CMS proposes to continue to offer physicians an automatic three out of 10 possible points when they report measures that do not have sufficient historical or performance year benchmark data, as discussed above. **We suggest that CMS instead assign a null value for these measures.** In other words, CMS should recalibrate the denominator used to calculate the total quality score rather than limit the number of performance points tied to the measure. In general, a physician should not be at a scoring disadvantage for selecting an infrequently reported measure. If anything, CMS should incentivize the reporting of these measures so the agency can establish a benchmark as soon as possible. **An alternative policy could be to offer clinicians who report on new measures (i.e., measure approved for the program within the last 2-3 years) bonus points.** By providing clinicians the opportunity to earn closer to 10 points for these measures, clinicians would be incentivized to report on new measures and contribute to a more robust benchmark.

In general, the AANS and CNS continue to believe that setting historical performance standards based on non-MIPS programs (e.g., PQRS, VM and electronic health record meaningful use) is a potential source of bias and should not be used as a means for penalizing physicians since these programs operated under different authority, different rules, and different incentive structures.

We also continue to support specialty adjustments for quality measures to ensure that performance comparisons are applied to groups with similar characteristics. For example, a neurosurgeon reporting on a perioperative measure should only be compared to other surgeons performing a similar procedure. While a surgeon performing spine surgery should not be compared to a surgeon performing a cholecystectomy, there are also instances where it would be inappropriate to hold all spine surgeons to the same benchmarks since drivers of perioperative quality might differ depending on the type and complexity of the spine procedure.

- **Bonus Points for Using CEHRT.** CMS currently awards one bonus point for each quality measure that is reported using “end-to-end electronic reporting” (up to a cap). This bonus point is awarded when a third party intermediary (e.g., a QCDR) uses automated software to aggregate measure data, calculate measures, and submit the data electronically to CMS. We remind CMS that all registries strive to support end-to-end electronic reporting, many registries still rely on both automated and manual data entry for reasons beyond their control. Most EHRs cannot support all the necessary data elements needed for advanced quality measures or analytics, and therefore registries still support a hybrid approach to data collection, but should nonetheless be recognized and incentivized.

We continue to recommend that CMS also reward physicians with bonus points for utilizing registries, in general, regardless of their end-to-end electronic reporting capabilities.

Registries have the ability to provide more timely and actionable information back to physicians and play a critical role in quality measurement and performance improvement.

Cost Performance Category

As noted earlier, the AANS and CNS very much appreciate CMS's decision to hold again not clinicians accountable for cost measure performance in 2018. Although our members are actively assisting CMS and Acumen with the development of more focused and clinically relevant episode-based cost measures, much work remains to be done in regards to specifying these measures, determining appropriate costs, and developing appropriate risk adjustment and attribution methodologies. CMS also has not yet begun to collect patient relationship code data, which were mandated by MACRA to ensure more accurate attribution and to gain a better understanding of the exact role the clinician plays in the patient's overall care for purposes of cost measurement. **CMS should not hold clinicians accountable for costs until CMS has had an opportunity to test the use of these new codes and clinicians have had an opportunity to become comfortable using them.**

In the interim, **we reiterate our strong opposition to the ongoing use of the existing, yet flawed, Total Per Capita and Medicare Spending Per Beneficiary measures.** These measures often do not capture aspects of care over which individual clinicians have direct control, rarely result in actionable data, and simply cause confusion among clinicians. **As such, we urge CMS to discontinue their use** — even for purposes of confidential feedback — and to focus its resources on the development of better measures instead. As CMS continues this work, we remind the agency of the ongoing need to ensure that cost is not being measured in isolation and that it is directly linked to quality. We also urge CMS to continue to consider ways to account for innovative practices or investments that might have an immediate impact on cost, but that might result in savings over time due to better outcomes or avoided costs elsewhere in the health system.

Advancing Care Information Performance Category

While we appreciate that CMS has not proposed to increase any of the reporting/performance thresholds under this category, this category still misses the mark due to its continued reliance on the rigid structure of the EHR Incentive Program. For example, clinicians must at least satisfy the base requirements to receive a score in the Advancing Care Information category, which is no different than the all-or-nothing approach from which CMS claims to have moved. The metrics under this category are borrowed from Stage 2 and 3 of the legacy program and continue to focus more on EHR functionality than providing physicians with the flexibility to demonstrate meaningful use in a manner that is most relevant to their practices. **We continue to urge CMS to offer clinicians the broadest selection of measures to choose from for purposes of both the base and performance Advancing Care Information score and to not require the use of any single measure to receive a score in this category.**

We also encourage CMS to take more concrete steps to move beyond what is still mostly a one-size-fits-all approach to measurement. Compliance with the current ACI requirements represent significant burden on physician practices, and there is limited evidence demonstrating that specific ACI requirements have a positive impact on the quality of care and patient outcomes, or are relevant to physicians, practices and patients. To realize the full power of data and the potential of information exchange, this category needs to be less prescriptive and to allow clinicians to creatively incorporate a variety of technology, including registries, into their unique clinical workflows in a manner that best responds to their patient's needs.

Ideally, the AANS and CNS urge CMS to recognize the value that clinical data registries bring to health care and promote their use by establishing an alternative pathway that recognizes physicians utilizing certified EHR technology to participate in a clinical data registry (regardless

of whether or not the EHR has a direct interface with the clinical registry) as satisfactorily achieving full credit for the Advancing Care Information category. This would not only further incentivize EHR adoption and participation in clinical data registries, but recognize the value of registries in facilitating a culture of performance improvement that benefits patient care and patient outcomes. We believe CMS has the statutory authority to modify the ACI requirements in this manner since the statute defining “meaningful use” specifies that the meaningful use of certified EHR technology includes the electronic exchange of health information to improve the quality of health care, and reporting on quality measures. Both of these can be achieved by using CEHRT to participate in a registry. The third requirement is that Meaningful Use “shall include the use of electronic prescribing as determined to be appropriate by the Secretary,” which we interpret to mean that CMS has the authority to waive application of e-prescribing requirements as appropriate. The other statutory requirements for meaningful use, including health information exchange and quality reporting, can be achieved by electronically participating in a registry. For other measures that CMS deems important or necessary, such as the security risk assessment measure, we believe that these measures still could be fulfilled through an attestation to a QCDR. Finally, MACRA also provides CMS with substantial discretion to modify meaningful use requirements for incorporation into the ACI component of MIPS to ensure that the application of the MU requirements is “consistent with the provisions of” MIPS.

If CMS believes it needs to maintain the existing structure of this category, then **we at least urge it to modify the scoring policies in a way that gives more weight to clinicians who invest in the meaningful use of clinical data registries to improve patient care.** As currently proposed, this category seriously undervalues the critical contribution of clinical data registries to higher quality care. For example, if a clinician fulfills the Immunization Registry Reporting measure in this category, he/she would earn 10 percentage points towards the performance score. If a clinician cannot meet the Immunization Registry Reporting measure because it is not relevant to his/her practice, the clinician can earn only five percentage points in the performance score for each “other” registry that he/she reports to, up to a maximum of 10 percentage points. While we appreciate that reporting to an immunization registry is not a requirement, this proposal significantly diminishes the value of reporting to specialized or clinical data registries by only awarding five percentage points for each. **The AANS and CNS strongly believe that clinicians who do not have access to an immunization registry should, at the very least, be able to earn the full 10 percentage points for reporting to another registry, such as a specialized or clinical data registry.** Ideally, however, **we would like CMS to award these clinicians an even higher number of points if they can demonstrate minimum basic requirements related to the use of a clinical data registry,** such as information exchange with EHRs (not limited to federally certified EHRs), other registries, and/or other practices; use of the registry to track performance and compare performance to benchmarks; and use of a registry for clinical decision support and/or patient education.

Additionally, with regard to the registry measures proposed for this category, CMS states in the rule that, “A MIPS eligible clinician may [only] count a specialized registry if the MIPS eligible clinician achieved the phase of active engagement as described under ‘active engagement option 3: production’ in the 2015 EHR Incentive Programs final rule with comment period.” This means that the clinician must have completed testing and validation of the electronic submission and that electronic submission of production data is currently occurring. Proposing to require a production level of registry exchange based solely on the *electronic* exchange ignores the realities of registry reporting. We also remind CMS that it has leveraged “end-to-end” electronic registry reporting as a prerequisite for *bonus* points. As we have noted in multiple comment letters, registries can play an important role in quality improvement and also require a granularity of patient data that is not easily captured in the EHR. Many registries, including our own, continue to utilize chart abstraction as a primary method for capturing information. Physicians participating in these registries contribute heavily to national efforts in quality improvement, patient safety, and clinical research and should still be rewarded even if patient information is manually entered. **We therefore recommend removing the term “electronically” from the proposed requirement and**

urge CMS to instead accommodate optimal data extraction methods — already identified and used by professionals in the registry space — as a method to encourage registry participation.

We also remind CMS of the foundational work that still needs to be completed to enhance functional interoperability between vendors and among vendors and registries to ensure incentives for “meaningful use” of health information technology result in improved health care and not another meaningless regulatory burden on physicians. Ongoing barriers related to interoperability and data blocking continue to plague specialists, in particular. Data blocking routinely occurs through EHR vendors levying excessive fees to connect a physician’s EHR to a registry, or the vendors citing technical limitations or outright refusing to connect to a registry. While ONC has created a number of certification criteria addressing quality measurement, at this time, there are no methods available for physicians to incentivize or persuade EHR vendors to develop reasonable solutions to registry interoperability. CMS must continue to work with medical societies and vendors to identify ways to make EHRs more accessible to specialists and the registries they use, to reward physicians for registry participation in a similar manner that CMS rewards use of CEHRT, and to develop better processes to identify and limit data blocking in the near term.

Regarding certification requirements, **we appreciate and support CMS’s proposal not to require clinicians to transition to 2015 Edition certified EHR technology in 2018. We request that CMS extend this policy beyond 2018**, given the ongoing challenges specialties like ours face in regards to identifying, adopting and/or modifying such software — particularly for specialty physician practices, where 2015 Edition CEHRT products are more challenging to identify, secure, modify and implement.

Finally, CMS proposes to rely on new authorities granted under the 21st Century Cures Act to provide expanded significant hardship exceptions under this category of MIPS. These would apply to clinicians in small practices, as well as for those who have EHR technology that has been decertified. **The AANS and CNS support any effort to broaden hardship exceptions under this program.**

Improvement Activities

In general, **we support CMS’s proposal to maintain most of the existing policies related to this category, including the data submission criteria and attestation mechanism.**

Regarding group reporting of Improvement Activities, CMS previously clarified that if one MIPS eligible clinician (NPI) in a group completed an improvement activity, the entire group (TIN) would receive credit for that activity. While CMS does not propose any changes to this policy, it requests comment on whether it should establish a minimum threshold (for example, 50%) of the clinicians (NPIs) that must complete an improvement activity in order for the entire group (TIN) to receive credit in the improvement activities performance category in future years. As noted earlier, the constant flux in reporting requirements year after year poses significant administrative challenges for physicians and their administrative staff. As such, **the AANS and CNS urge CMS to maintain its current policy and not adopt a 50 percent reporting threshold.**

In regards to the Improvement Activities inventory, we continue to have concerns about the arbitrary and non-transparent manner in which CMS makes decisions about which activities to include (and not to include) and how it makes determinations about valuing each activity. To enhance clinician engagement and trust in the program, it is important to ensure relevant experts are involved, or at least have a clear understanding of the reasons behind these decisions. When recommended activities are not accepted, CMS must provide a clear rationale that is more informative than a simple “thank you for your comments” or “we will take these recommendations into consideration in the future.” **As part of this process, CMS also must ensure that specialists have an equal opportunity as non-specialists to select activities that reflect their practice and to earn the maximum score.** Similarly, it is important that CMS utilize a more formal process for making determinations about compliance with these activities. While we appreciate CMS’s intentional use of broad descriptors and its efforts to not be overly prescriptive, this

confuses how to determine whether a particular action would count under a specific activity. Currently, the only mechanism available to clinicians is reaching out to the QPP help desk. Unfortunately, on numerous occasions, the help desk has provided guidance that has conflicted with determinations made directly by CMS staff. This process is in need of a more formal structure.

The AANS and CNS also appreciate CMS preserving the range of activities that recognize various aspects of registry participation. However, we continue to urge CMS to refer to registry use more broadly, rather than restricting activities to “QCDR” use only. Many quality registries are in use by physicians, even though these may not have received official QCDR status for one reason or another. Given the fact that registry participation represents an integral and ongoing part of practice for those who decide to make the investment, **we continue to urge CMS to assign the registry-focused activities a “high” weight or to alternatively, allow clinicians who participate in a registry and meet certain basic requirements to automatically receive the maximum score in the Improvement Activities category.**

Relative to specific Improvement Activities proposed for 2018, we offer more specific comments below:

- **IA_PSPA_XX: Completion of an Accredited Safety or Quality Improvement Program.** We support the proposal to include this as a new activity for 2018 since it would recognize clinicians who complete an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement.
- **IA_PSPA_XX CDC Training on CDC’s Guideline for Prescribing Opioids for Chronic Pain: Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course “Applying CDC’s Guideline for Prescribing Opioids.”** We support this measure but believe that it should be available more frequently than four years, particularly if the course changes or is updated.
- **IA_PSPA_XX Consulting Appropriate Use Criteria (AUC) using clinical decision support when ordering advanced diagnostic imaging.** While the AANS and CNS support the use of AUC and continue to contribute to the development of imaging-focused AUC, we have concerns about this proposed high-weighted activity being specifically tied to participation in the Medicare Imaging AUC Criteria Program. We have overarching concerns that this program represents a potentially duplicative and unnecessary reporting mandate in light of the MIPS program. The program requires clinicians to consult AUC through federally qualified decision support mechanisms (CDSM) for all advanced diagnostic imaging services ordered, which is a huge burden given the reporting requirements that clinicians already face under MIPS. CMS has not yet finalized all of the details of this program, including the codes that would need to be reported, and has delayed the program multiple times due to implementation issues. Furthermore, CMS only announced the first limited set of qualified CDSMs in July 2017, and it is still unclear to what extent they are easily accessible, applicable, and implementable across practices and with various EHRs. The AANS and CNS plan to provide more detailed comments on this program in our 2018 Medicare Physician Fee Schedule comment letter. For purposes of the Improvement Activities category under MIPS, **we encourage CMS to recognize consultation with AUCs more broadly and using a range of mechanisms that make sense to the individual practice, rather than tethering credit to a program that has faced numerous challenges and is of questionable value in light of other efforts.**
- **IA_AHE_XX: MIPS Eligible Clinician Leadership in Clinical Trials or Community-Based Participatory Research (CBPR).** We support the proposal to include this as a new activity for 2018 since it recognizes tools, research, or processes that focus on minimizing disparities in health care access, care quality, affordability or outcomes.
- **IA_AHE_3: Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision-making capabilities.** We support the proposal to

modify this activity so that it supports the use of patient-reported outcome tools more broadly and does not require the use of a QCDR.

- **IA_BE_15: Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified electronic health record (EHR) technology.** We support the proposal to remove the certification requirement from this activity. We agree with CMS that this improvement activity should not be limited to certified EHR technology, given ongoing challenges related to adoption, implementation, and interoperability.

In regards to future consideration of activities, we continue to urge CMS to consider the following activities for inclusion in the 2019 MIPS inventory. If the agency fails to adopt our suggestions, we request that CMS engage us in a discussion and clearly communicate the reasons why these activities were not included on the updated list:

- Emergency room call coverage by surgical subspecialties to improve patient access to care;
- Participating in a regular morbidity and mortality (M&M) conferences; and
- Participating in other self-assessment/ongoing learning activities, such as the CNS program SANS — Self-Assessment in Neurological Surgery (<https://www.cns.org/education/browse-type/sans>)

Third Party Data Submission

- **Self-Nomination Process.** CMS previously finalized that the self-nomination period for the 2018 performance period and future years of the program would be from September 1 of the year prior to the applicable performance period until November 1 of the same year (i.e., September 1, 2017, through November 1, 2017, for the 2018 performance period). We appreciate that this adjusted timeline is intended to allow CMS to finalize the list of available QCDRs as close to the start of the performance year as possible. **However, given our experience with neurosurgery’s QCDR (the NeuroPoint Alliance) for multiple years, we are concerned about the feasibility of this timeline.** A November 1 deadline means that QCDRs will have less than a full year’s worth of data to evaluate when making decisions about whether to retire or modify existing measures for the upcoming year. As we suggested earlier, **we would very much appreciate if CMS would adopt a multi-year measure approval process — ideally, five years.** Under this strategy, QCDRs that wanted to adjust or retire a QCDR measure from year-to-year should still be able to do so, as long as they request such changes by CMS’s self-nomination deadline. However, QCDRs would not be expected to invest time and resources on defending their measures from year to year and could instead shift their focus to more meaningful analytics to help improve patient care.

In this rule, CMS also proposes a streamlined self-nomination process for QCDRs in good standing. As we communicated to CMS on our August 1, 2017, Physician Clinical Registry Coalition (PCRC) call with the CMS QPP team, we greatly appreciate efforts to improve this process. However, this proposal fails to make improvements to aspects of the self-nomination process that are most in need of change — namely the QCDR measure approval process. **We strongly recommend that CMS adopt a more transparent and more predictable process for working with specialty societies to vet QCDR quality measures and to provide more consistent feedback.** For example, CMS could assign a single coordinator for each QCDR and create an official database containing decisions on measures to ensure there are no conflicting messages. This process also should include more reasonable and structured timelines for an initial review period, an appeals process and a final review.

CMS also seeks comment on potentially requiring in the future that QCDRs fully develop and test (i.e., conduct reliability and validity testing) their QCDR measures before submission during the self-nomination process. While we support efforts to ensure the methodological rigor of measures, we believe this requirement counters the intent of the QCDR mechanism, which is to serve as a more

rapid test-bed for nascent and/or innovative measures. **The AANS and CNS strongly urge CMS to maintain policies that allow QCDR measures to be used as soon as possible, even if they are still undergoing testing, which is often achieved only once the measure is in use.** This is particularly important to a specialty like neurosurgery, which lacks a sufficient number of relevant measures in the traditional MIPS set.

Another issue that we have encountered, but which is not addressed directly in the rule, is the agency's desire to eliminate needless overlap between existing measures. While we support harmonization where appropriate, **we firmly believe that excessive consolidation of QCDR measures threatens to undermine the usefulness of the QCDR mechanism which was designed, in large part, to recognize the complexities inherent in subspecialty care.** We look forward to having an open dialogue with CMS as it continues to consider ways to balance these priorities.

- **Advancing the Role of Third-Party Intermediaries.** CMS also seeks comment on multiple questions to further advance the role of third-party intermediaries in both MIPS and APMs. Two of these questions focus on longitudinal care:
 - Should there be additional refinements to the approach to qualifying third party intermediaries which evaluate the degree to which these intermediaries can deliver longitudinal information on a patient to participating clinicians?
 - Should there be a special designation for registries that would convey the availability of longitudinal clinical data for robust measurement and feedback?

The AANS and CNS have concerns about potentially qualifying third party intermediaries based on their ability to deliver longitudinal patient data. While longitudinal data is an overarching goal of most registries, there are many external factors that may limit a registry's ability to track patients over time (e.g., patient movement across providers and geographic locations, the ongoing lack of EHR interoperability, etc.). **CMS should not qualify registries based on this capability.**

We refer CMS to a separate comment submitted on behalf of the PCRC, which echoes these and other concerns and offers some potential solutions.

Public Reporting

Although we support providing the public with data and tools to guide healthcare decision-making, it is critically important that these data accurately represent the quality of the individual clinician's care and are presented in a manner that provides clarity rather than confusion. Since we are still in a transition period, adjusting to this new program and building a foundation of consistent and methodologically rigorous data, **the AANS and CNS request that CMS take a step back and minimize the amount and type of data related to this program that is made available to the public. We also strongly encourage CMS to extend the 30-day preview period so that clinicians have more time to review and make sense of their data.**

ALTERNATIVE PAYMENT MODELS (APMS)

Overall, we continue to have concerns about the lack of relevant APM options available to our specialty. Although we have seen an influx in the number and range of Physician-Focused Payment Models (PFPMs) being submitted for review to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), it is unclear how many of these models will be recommended and adopted as Advanced APMs. **We therefore strongly encourage the Center for Medicare and Medicaid Innovation (CMMI) to continue to support the development of voluntary specialty-focused APMs and to offer better guidance on how existing APMs could be altered to meet the "advanced" criteria.** It seems as if in many cases, it is simply a lack of quality metrics or concerted use of CEHRT

that limit those models from Advanced APM status. If that is the case, we request that CMS work with the developers and participants of those models to make modifications that lead to Advanced APM designation.

CMS previously finalized its definition of a Physician-Focused Payment Models (PFPM) to include an APM “in which Medicare is a payer,” among other criteria. In this rule, CMS seeks feedback on broadening this definition, particularly since the Secretary of Health and Human Services does not have the authority under MACRA to direct the design or development of payment arrangements that might be tested with private payers. CMS proposes a broadened definition of PFPM to include arrangements where Medicaid or the Children’s Health Insurance Program (CHIP) serve as the payer, even if Medicare is not included. **The AANS and CNS support inclusion of these other payer arrangements in the definition of PFPM.** To move the needle and ensure the development of more diversified, but also more relevant PFPMs, it is important that the definition reflect the different patient populations served by the Medicaid and CHIP programs. If properly structured, these models could also incentivize physician participation in these other programs, which could increase patient access to care where it is often needed.

CONCLUSION

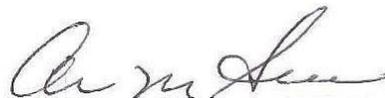
While the AANS and CNS appreciate the agency’s proposals to maintain many of the transition year policies for year two of the Quality Payment Program, we continue to believe the underlying structure of the program is unnecessarily complicated and still focused more on satisfying arbitrary requirements rather than actual quality improvement. Moving forward, we request that CMS maintain these transition year policies as long as possible, continue to work to consolidate further and streamline the four categories of MIPS and to make the program more relevant to a range of provider types.

Thank you for considering our ongoing feedback. We look forward to working with the Agency as it continues to refine the rules for this new program. In the meantime, if you have any questions or need additional information, please do not hesitate to contact us.

Sincerely,



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