

Please Provide Responses to the Fields Below Electronically to be Accepted

Medicare *Red Tape* Relief Project

Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 25, 2017

Name of Submitting Organization: American Association of Neurological Surgeons/Congress of Neurological Surgeons

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Statutory **Regulatory**

Please describe the submitting organization's interaction with the Medicare program:

The American Association of Neurological Surgeons (AANS), founded in 1931, and the Congress of Neurological Surgeons (CNS), founded in 1951, are the two largest scientific and educational associations for neurosurgical professionals in the world. Timely access to quality neurosurgical care is essential to the health and well-being of society, and as the voice of neurosurgery before legislative, regulatory and other health care stakeholders, the AANS and CNS advocate for our specialty and patients on a wide-variety of health care policy matters, including Medicare policy. Neurological surgery is the medical specialty concerned with the prevention, diagnosis, treatment and rehabilitation of disorders that affect the entire nervous system, including the spinal column, spinal cord, brain and peripheral nerves. For more information, please visit www.aans.org, www.cns.org and www.neurosurgeryblog.org.

Please use the below template as an example of a submission regarding statutory or regulatory concerns, and submit any further concerns past those listed below in a separate Microsoft Word document in the same format. Submissions must be in the requested format or they will not be considered.

In the case of listed Appendices, please attach as PDF files at the end of the submission, clearly marked as "Appendix [insert label]"

In the case of a multitude of submissions, it is recommended that they be submitted in order of priority for the submitting organization or individual.

Short Description: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Improvements (Priority Issue #3)

Summary:

Pursuant to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub.L. 114-10, Sections 101-106), CMS has established the Quality Payment Program (QPP) implementing both the Merit-Based Incentive Payment System (MIPS) and the advanced alternative payment model (APM) pathway for physician payment. Under MIPS, clinician performance is assessed across four categories, with each category ultimately contributing to a specified portion of the total performance score:

1. Quality (30 percent)
2. Resource use/cost (30 percent)

3. Use of certified electronic health records (now called “advancing care information”) (25 percent)
4. Adoption of clinical practice improvement activities (15 percent).

Based on performance across these four categories relative to a “performance threshold,” clinicians may receive upward or downward adjustments to their Medicare payments beginning in 2019.

MACRA provided flexibility to the Secretary of Health and Human Services (HHS) to phase in changes under MIPS during the first two years. For example, MACRA specified that the resource use category weight could be less than 30 percent for the first two years of the MIPS program. Additionally, MACRA provided discretion for the HHS Secretary to set a lower composite performance threshold in the first two years of the program, before ultimately establishing the national mean or median of performance as the performance threshold by year three. CMS took advantage of this flexibility in the QPP’s initial year, adopting the “pick-your-pace” program, which allowed physicians to avoid payment penalties and in some instances receive modest bonus payments. The agency also zeroed out the resource use category given ongoing work in this policy area. Going forward, CMS plans to ramp-up the reporting burden.

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. Additionally, CMS has experienced challenges with implementation, particularly around the resource use category, and significant work is still underway to not only develop meaningful and applicable cost measures that are also valid, reliable, and actionable by affected clinicians, but also to translate performance on such measures into performance ratings (for example, based on clinicians’ relationship to patients). Furthermore, clinicians will not receive information on their performance on final measures for several years, such that they will have limited information on how to target improvement efforts to increase their performance under the resource use category during a transition period. Physicians are finding the QPP a challenge, as the reporting requirements are burdensome, irrelevant to practice and/or not seamless in terms of physician workflow. Finally, the scoring system is complex and unintelligible.

Related Statute/Regulation:

- 42 USC 1395w–4(q)
- 42 CFR 414.1300-1465
- CY 2017 MIPS and APM Final Rule, 81 Fed. Reg. 77008
- <https://qpp.cms.gov/>

Proposed Solution:

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.

To address some of these challenges, the AANS and CNS urge Congress to continue policies allowing for a gradual transition to the MIPS framework and to improve the program. CMS can use this flexibility to reduce the complexity and encourage more physicians to participate in the program. Actions to be taken could include:

1. Allow full MIPS credit for at least the quality, advancing care information (ACI) and clinical practice improvement activities (IA) for physicians reporting through a qualified clinical data registry (QCDR).
2. Adopt a standard reporting period — no more than 90-days — across the MIPS categories, while allowing physicians to report up to a full year to receive higher bonus payments.
3. Provide the Secretary flexibility to adjust the resource use category such that it may be weighted lower than 30 percent, at least until such time that the methodology for assessing and scoring clinicians is fully established and stable, and until clinicians have regular and timely feedback on their performance.
4. Provide the Secretary flexibility to set the performance threshold at a lower level than the mean or median performance to promote successful participation.
5. Provide the Secretary flexibility to increase the IA category weight to greater than 15 percent.
6. Simplify the MIPS scoring system.