June 23, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models [CMS-5517-P]

Dear Acting Administrator Slavitt:

The American Academy of Neurology (AAN) is the premier national medical specialty society representing more than 30,000 neurologists and clinical neuroscience professionals and is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system such as Alzheimer’s disease, stroke, epilepsy, Parkinson’s disease, migraine, multiple sclerosis (MS), and brain injury.

The AAN appreciates the thoroughness of the proposed rule, its attempt to streamline and reduce clinician burdens, and the focus on electronic and qualified clinical data registry (QCDR) submission of data. We also appreciate that the Centers for Medicare & Medicaid Services (CMS) recognized the AAN's previous comments regarding program complexities and the need to reduce reporting requirements. This is evident in the reduction of measures that must be reported and eliminating the linkage of quality measures to National Quality Strategy domains.

However, while the new policies offer more flexibility, in some areas there remains an unnecessary level of complexity and burden, especially on smaller physician groups. According to the AAN’s 2016 membership data, 30 percent of neurologists in the United States identify as being a part of a small or solo practice. We are especially concerned with the impact this proposal will have on their ability to survive in the coming years. In our feedback, the AAN outlines areas where CMS’s proposal may unreasonably impact small and solo neurologists and practical steps the agency can take in the final rule to alleviate the challenges facing these physicians. This is critically important, as research indicates the patients of physicians in small and solo practices have lower rates of preventable readmissions than those
larger practices. Many patients and physicians also deeply value the personal relationships that smaller settings can cultivate.\(^1\) If CMS is truly committed to high-quality, patient-centered care, they will take every step necessary to protect small and solo practices in the final rule.

With these issues in mind, the AAN believes CMS should appoint a dedicated ombudsman to monitor stakeholder concerns regarding the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The ombudsman should be instructed to offer public commentary on a regular basis. A special emphasis should be placed on the challenges small and solo practices face during the implementation phases of MACRA.

Furthermore, neurologists remain concerned that Medicare intends to put their practices at significant financial risk while the agency develops its new quality programs. There are many unanswered questions; some are basic, such as how to assign a physician to a patient and how to appropriately assign costs. Yet more complicated questions exist regarding APMs as a number of Accountable Care Organizations (ACOs) have lost millions of dollars and a number of physicians have individually lost significant sums of money by participating. For many practices, it may not be economically reasonable to meaningfully participate in MIPS or APMs, in what amounts to some as an experimental phase during the first years of MACRA implementation. A practical consequence may be that physicians will limit their Medicare population to the low-volume threshold to avoid participation.

Addressing these concerns, the AAN’s comment outlines steps to further refine the new Advancing Care Information category and ways for CMS to improve quality measurement. We call upon CMS to expand the ability of neurologists to participate in clinical practice improvement activities and stress that neurologists should only be held responsible for the costs over which they have direct control. The AAN also expresses concern with the limited number of current APM options available to neurologists, the high barriers set by CMS regarding Advanced APMs, and length of time for approval of physician-focused models.

Ultimately, physicians did not get into the practice of medicine to become venture capitalists. CMS is now asking physicians to assess financial risk and this is simply not within the clinician’s expertise. This fact does not excuse medical practices that cannot meaningfully show they improve patient outcomes. But the framework behind CMS’s value-based programs places a significant financial risk on physicians and leaves them with the burden to deal with the consequences.

This is fundamentally unreasonable and despite CMS’s best intentions, only furthers the gap of mistrust between physicians and the government. Fortunately, there is still time for CMS to build bridges with the physician community by implementing the AAN’s suggestions for the final rule as we outline in our subsequent comment. Finally, as CMS moves forward, the AAN once again stresses its desire to serve as a resource to CMS as it develops policies related to neurologic care.

---

\(^1\) Health Affairs, “Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions”. Available at: http://content.healthaffairs.org/content/early/2014/08/08/hlthaff.2014.0434.abstract.
American Academy of Neurology Comments on Proposed MACRA Rule

I. Merit-Based Incentive Payment System ................................................................. 5
   A. Clinical Practice Improvement Activities ............................................................ 5
      1. Impact on Small and Solo Practices ............................................................... 5
      2. General Feedback .......................................................................................... 6
      3. Telehealth ...................................................................................................... 8
      4. Continuing Medical Education and CPIAs ..................................................... 8
   B. Advancing Care Information ............................................................................ 10
      1. Impact on Small and Solo Practices ............................................................... 10
      2. General Feedback .......................................................................................... 11
      3. Information Blocking ..................................................................................... 13
   C. Quality ............................................................................................................. 14
      1. Impact on Small and Solo Practices ............................................................... 14
      2. Quality Data Submission Criteria .................................................................. 15
      3. Measures for Inclusion ................................................................................... 15
      4. Peer Review ................................................................................................... 16
      5. National Quality Strategy Domains .............................................................. 17
      6. Quality Measure Benchmarks ........................................................................ 17
      7. Third Party Reporting: Requirements for QCDRs ......................................... 18
      8. CMS Data is Not Actionable ......................................................................... 18
      9. Other Feedback ............................................................................................. 19
   D. Resource Use .................................................................................................... 20
      1. Impact on Small and Solo Practices ............................................................... 20
      2. General Feedback .......................................................................................... 21
      3. Future Modifications to Resource Use Category ............................................ 22
   E. Additional Issues in MIPS ............................................................................... 22
      1. Performance Year .......................................................................................... 22
      2. Two-Year Delay between Performance and Payment ..................................... 23
      3. Risk Adjustment Flaws ................................................................................ 23
      4. MIPS Performance Adjustments .................................................................. 24
      5. Exclusions from MIPS .................................................................................. 24
      6. Feedback from CMS ..................................................................................... 25
      7. Physician Compare ....................................................................................... 26
II. Alternative Payment Models ................................................................. 27

A. General Feedback ....................................................................................... 27

B. Neurologists Lack APM Options ................................................................. 28

C. Physician-Focused Payment Models ............................................................ 29

D. Definitions of Advanced APMs ................................................................. 30

E. Interpretation of Financial Risk Criterion for Advanced APMs .................. 30
   1. Statutory Language .................................................................................. 30
   2. Financial Risk for Monetary Losses ......................................................... 31
   3. In Excess of a Nominal Amount ............................................................... 32
   4. Promoting the Statute’s and CMS’s Policy Goals ..................................... 33

F. Additional Feedback on Nominal Financial Risk ........................................ 34

G. One-Sided Risk ......................................................................................... 35

H. Other Feedback ......................................................................................... 36
   1. Telehealth in APMs .............................................................................. 36
   2. Performance Period ............................................................................. 36
   3. Risk Mitigation .................................................................................... 37
   4. Qualifying Participant ......................................................................... 37
   5. Medical Homes ................................................................................... 37

III. Conclusion .............................................................................................. 37
I.  **Merit-Based Incentive Payment System (MIPS)**

The AAN appreciates the opportunity to comment on this important proposed rule. We thank CMS for its commitment to promoting value in health care. The AAN supports several of the proposed added flexibilities, but we hope the agency will consider modifications in the final rule. The final rule will be one of the biggest changes to physician payment policy in years and we recognize CMS is under tight deadlines as mandated by the MACRA law.

However, as currently written, this proposal may not fix the problems in Medicare that have been identified by CMS and stakeholders. Physicians are faced with the perverse incentive of not complying with this proposal due to the cost burdens associated with compliance. These compliance costs may be greater than potential Medicare payment rewards. Additionally, overall Medicare payment increases over the next four years will be less than the rate of inflation, making it even more difficult for all practices, particularly smaller entities, to comply with these proposed rules and still survive. This may also increase the number of physicians who opt-out of Medicare in some markets.

A.  **Clinical Practice Improvement Activities (CPIAs)**

This new performance category will require careful evaluation by CMS and stakeholders. The AAN asks for evidence that demonstrates these activities improve care. To support such efforts, and with appropriate protections, CMS must share more longitudinal beneficiary data with physician associations like the AAN.

1.  **Impact on Small and Solo Practices**

The AAN is pleased CMS’s proposal attempts to accommodate small practices for the CPIAs performance category by allowing MIPS eligible clinicians or groups to receive partial credit if they perform one activity and full credit if they perform two activities. We disagree, though, that it is reasonable to expect all MIPS eligible clinicians to be able to report two CPIAs in 2017. CMS has proposed over 90 different activities that could be CPIAs, which will require education and training for practices to understand and comply. That education process and training could take several months, and cannot begin until after CMS releases its final rule.

   Additionally, performing CPIAs will require time and attention that diverts physicians from their primary role of patient care, and small practices do not have the capacity to devote to identifying CPIAs, performing them, and documenting them per CMS requirements. Indeed, CMS recognizes this in the proposed rule, stating that “each activity requires at least 90 days and may not necessarily be conducted in parallel, with time allocated to pre-planning and post-planning, which would impact the practice’s limited resources.” The AAN agrees that pre-planning and post-planning are significant phases of implementing CPIAs, and pre-planning should begin only after conducting the education and training described above. The requirement to report CPIAs is being implemented concurrently with other MIPS categories that will require those practices to report quality measures and use electronic health records (EHRs), many for the first time. We additionally suggest that CMS allow practices to

---

complete improvement activities lasting a continuous 90 days even if it spans over two performance periods. CMS could require practices complete at least 45 consecutive days during each period to equal a total of at least 90 days.

Furthermore, these small practices need more training, time, and technical assistance to comply. CMS should grant small practices a one year grace period in which no CPIAs would be required, and phase in the requirements to perform one CPIA in 2018 and two CPIAs in 2019.

The AAN is also concerned about the statement in the proposed rule that CMS would “anticipate the requirement on the number of activities for small practices … will increase in future years as we gather more data on the feasibility of small practices … to perform CPIAs.” It is entirely premature to contemplate increasing the CPIA requirements for small practices in the future. The CPIA is a completely new category for which CMS has no baseline data, and we anticipate that it will take longer than one year to build a baseline from which improvement in future time periods can be measured reliably. The AAN recommends that CMS phase in the CPIA requirements for small practices over a four-year period, and then collect sufficient data to establish a baseline for each of the CPIAs. Only after that would a discussion of increasing the CPIA requirements be appropriate.

2. General Feedback

The AAN has reviewed the proposed inventory of CPIAs and offers the following comments. First, the AAN strongly recommends that CMS strive to limit administrative burdens and streamline reporting tasks so that the delivery of patient-centered care is the principal focus in all clinical settings.

The AAN supports the broad inventory of proposed CPIAs and recommends that CMS maintain in the final rule the policy of having many choices in each of the proposed subcategories of CPIAs. Neurologists are well positioned to perform several of the proposed CPIAs, including:

- Collection of patient experience and satisfaction data, e.g. through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey;
- Management of patients with stroke in a systemic anticoagulation program;
- Collaborate with QIOs to improve the health status of communities affected by Alzheimer’s;
- Participation in clinical trials and data registries for neurologic drugs;
- Reconciling and coordinating medication use, including for opioid drugs;
- Participating in the Transforming Clinical Practices Initiative;
- Linking patients with neurologic disorders to sources of home- and community-based social services;
- Participation in qualified clinical data registries; and
- Performing CPIAs that integrate behavioral and mental health with primary care for individuals with chronic conditions.

---

3 81 Fed. Reg. at 28212.
In general, the AAN supports the flexibility in selecting areas for improvement. In the spirit of quality improvement at the practice level, clinicians should be able to select quality improvement efforts that mitigate their data-supported gaps in care, rather than be tied to prescribed and narrow efforts, which may not lead to improvements at the practice level. While several of the activities are overly specific to particular diseases or therapies, there seems to be several generalizable initiatives that apply to specialists and subspecialists. Also, the AAN hopes in the future CMS will consider participation in designated private payer activities as a clinical practice improvement activity.

CMS requests comments on criteria or factors it should take into consideration to determine whether to weight an activity as medium or high. In general, the AAN believes the proposed weighting and scoring system is unnecessarily complex. Initially, we proposed that all CPIAs should be weighted equally for several years to reduce complexity. We also request that CPIA weights in the future be assigned based on the clinical evidence of their effect on the quality of care.

CMS further seeks comments on how to provide credit for Patient-Centered Medical Home (PCMH) designations in the calculation of the CPIA performance category score for groups when the designation only applies to a portion of the Tax Identification Number (TIN) (for example, only one practice site is a PCMH in a TIN that is comprised of five practice sites). The AAN suggests CMS apply a proportional scoring to the TIN based on the proportion of practices that are PCMHs. For example, if one out of five sites are designated as PCMHs, then CMS could apply 20 percent of the points to the TIN.

CMS also discusses the role of a QCDR in the CPIA category. The AAN is pleased that CMS recognizes the value of QCDRs. From a quality improvement perspective, we note that the QCDR is a means to identify gaps in care, track adherence to best practices, and support the development of quality improvement efforts. We request that participation in a QCDR be recognized as a CPIA, since it is the first step toward benchmarking for many practices.

Furthermore, CMS requests comments on what restrictions, if any, should be placed around CPIA measures and activities that incorporate QCDR participation. Rather than placing restrictions on CPIA activities, the AAN requests that CMMI should further research and identify how the QCDR informs the quality improvement action.

CMS additionally proposes that MIPS eligible clinicians or groups must perform CPIAs for at least 90 days during the performance period for CPIA credit and that where applicable, a CPIA activity that began prior to the performance period and continues for at least 90 days during the performance period would meet the time threshold. This is an acceptable but arbitrary time period. In the spirit of quality improvement science we suggest that shorter time periods may be equally effective and that CMMI research should identify the minimally intrusive, yet effective, participation period.

CMS has also requested comments about allowing QCDRs to define specific CPIAs for specialty and non-patient-facing eligible clinicians or groups through the already established QCDR approval process for measures and activities. The AAN fully supports this proposal, as QCDRs, qualified registries, and EHRs should inform future quality improvement efforts.
Specialty QCDRs may be uniquely qualified to define measures and activities through expert consensus panels and other methods.

3. **Telehealth**

The AAN is disappointed that only two of the 90 MIPS scores proposed by CMS involve telehealth. Congress directed the agency to consider telehealth and remote monitoring as qualifying measures. CMS asks for evidence that telehealth activities are improving care or have value. This is supported by a substantial body of literature. We call upon CMS to add more telehealth-related activities as a part of the CPIAs component of MIPS.

The AAN further agrees with the members of Congress who called upon CMS to incorporate telehealth in its implementation of MIPS. The AAN believes that telehealth has the potential to truly achieve the "triple aim" in health care—better care, improved outcomes, and reduced costs. The promise of telehealth also fits into the Department of Health and Human Services' (HHS) delivery system reform strategy, centered on the three key ideas of paying for quality over quantity, improving care delivery, and creating better access to health care information.

Telehealth embraces care delivery improvement by addressing long-standing barriers to health care access for people in both rural and urban settings. Using technology to deliver care can improve access to providers; yield savings in terms of distance traveled, lost work time and transportation costs for in-person physician visits; and reduce unnecessary trips to an emergency room. Telehealth also supports CMS’s goal of increasing access to information and engaging patients in their own care. The use of technology to remotely track a patient's own health as well as connect with their provider supports consumer and clinician decision making through better information.

4. **Continuing Medical Education and CPIAs**

According to the statute, any CPIA measure must be “relevant to an existing CPIA subcategory (or a proposed new subcategory)” as defined in §414.1365. Unfortunately, those subcategories do not include a specific reference to medical education or a related area. The subcategories outlined in the proposed rule include: (1) expanded practice access; (2) population management; (3) care coordination; (4) beneficiary engagement; (5) patient safety and practice assessment; (6) participation in an APM; (7) achieving health equity; (8) emergency preparedness and response; and (9) integrated behavioral and mental health.

The AAN asks CMS to consider activities of organizations representing physicians and medical groups as practice improvement activities. Specifically, this would include accredited continuing medical education (CME) related to quality improvement, board-certification-related activities, and other initiatives aimed at improving clinical practice.

---


In §414.1355, CMS proposes that CPIA be defined on an annual basis and must meet certain criteria, much of which aligns closely with the goals of CME. While CME related to quality improvement may not be directly relevant to an existing CPIA subcategory, it does improve beneficiary outcomes, leads to practice improvement, can be performed by providers of all types, is feasible to implement, can be validated by CMS, and is evidence-based.

Furthermore, the proposed rule leaves great discretion to the Secretary of HHS to define what will be included in these activities. As stated in the rule’s preamble: “Clinical Practice Improvement Activity (CPIA) means an activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.”

Several CPIA subcategories are relevant to CME, such as population management, care coordination, patient safety practice assessment, and beneficiary engagement. All of the subcategories for clinical practice improvement activities would benefit from provider participation in CME in and around those topics. Additionally, many believe that the previous programs included in MACRA such as the Physician Quality Reporting System (PQRS), Meaningful Use, and Value Modifier would have achieved significantly greater success had physicians received the education and training on these topics that certified CME provides.

To understand the breadth of CME for physicians, according to the Accreditation Council for Continuing Medical Education (ACCME), in 2014 there were 147,024 courses that offered 1,033,615 hours of instruction, and 13,599,687 physician interactions with an additional 11 million other healthcare providers participating in accredited CME courses. CME has long been recognized as a means by which physicians demonstrate engagement in continued professional development. This encourages physicians to develop and maintain the knowledge, skills, and practice performance that leads to optimal patient outcomes.

Lifelong learning, assessment, and improvement are integrally related. Learning is a necessary component of the change process that results in meaningful, sustained clinical performance improvement. Without this professional development, the measurement of adherence to quality metrics and use of health information technology are insufficient to produce clinical performance improvement.

CMS and private payers can also reduce burdens on physicians by counting CME and continuing education related to quality improvement as progress toward program goals. Eligible professionals should be credited for their effort to stay current with clinical practice and quality measures by utilizing CME. The inclusion of CME related to quality improvement as a clinical practice improvement activity recognized by CMS will help these professionals retain credit for the time they invest in learning about practice improvement.

---

6 81 Fed. Reg. at 28380.
Physicians have a professional responsibility to keep up-to-date through CME and there is a preexisting infrastructure to record participation in CME activities. Currently 45 states plus the District of Columbia require participation in CME to maintain licensure. CME is a familiar activity for physicians and giving CPIA credit for participation in CME related to quality improvement will help to align the interests of physicians with the value being driven by CMS’s proposed rule.

The mechanisms already in place ensure that accredited/certified CME activities are designed to address clinicians’ practice-relevant learning needs and practice gaps. The programs are also measured to evaluate the educational and clinical impact of the activity. Finally, they are planned and provided independent from commercial influence or other biases.

B. **Advancing Care Information (ACI)**

The AAN commends CMS for recognizing that the Meaningful Use requirements for the EHR Incentive Program needed significant changes, and supports the re-branding of the program now called “Advancing Care Information.” The changes to Meaningful Use do not alter an underlying problem, however: CMS still expects that all physicians and hospitals should be complying with the Stage 3 rules in 2018. In the Modified Stage 2 final rule, CMS permitted providers who were previously scheduled to be in a Stage 1 EHR reporting period for 2015 to use a lower threshold for certain measures. The AAN recommends that CMS evaluate the rate of EHR adoption in 2015 and 2016, and consider whether a lower threshold will be needed for some Stage 3 rules in 2018.

Additionally, the AAN is concerned that the “significant hardship” exceptions that were part of the EHR Incentive Program will still be needed for some time to come, particularly for small practices. CMS should work with Congress to maintain the progress made in the Patient Access and Medicare Protection Act of 2015, which created a streamlined application for a hardship exception.

1. **Impact on Small and Solo Practices**

The AAN appreciates that several aspects of the proposed changes will help neurologists in solo and small practices, including the proposal to grant partial credit rather than having an “all-or-nothing” standard; the elimination of reporting requirements that are duplicative of the Quality category in the MIPS; and more flexible requirements that permit small practices to select the objectives and measures that are most relevant and achievable for them.

CMS has proposed three situations in which a MIPS-eligible clinician could apply to have the weight of the Advancing Care Information category reduced to zero: 1) demonstrating lack of internet access and insurmountable barriers to obtaining it; 2) describing the impact of a natural disaster; or 3) demonstrating that a majority of outpatient encounters occur in locations where they have no control over the health information technology decisions of the facility. The AAN recommends adding a fourth category that would mirror the criteria for

---

the “significant hardship” exception in the EHR Incentive Program. The AAN recommends that CMS use its authority under Sec. 1848(q)(5)(F) to re-weight the categories for MIPS-eligible clinicians who meet the criteria for a hardship exception for small practices in 2018.

The AAN is concerned about the proposed requirements that make providers significantly accountable for interoperability, as the standard does not appear to have any flexibility for small practices that have had difficulty acquiring and implementing certified EHR technology. As part of the Advancing Care Information category of MIPS, a MIPS-eligible clinician must attest to CMS they: “cooperated in good faith with the surveillance and ONC direct review of his or her CEHRT, did not knowingly and willfully take action to restrict interoperability of CEHRT, and implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure that the CEHRT was connected in accordance with applicable law; compliant with all standards applicable to the exchange of information, implemented in a manner that allowed for timely access by patients to their electronic health information; allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers including unaffiliated providers and with disparate CEHRT and health IT vendors; and responded in good faith and in a timely manner to requests from patients, health care providers and others to exchange health information” (proposed § 414.1375).

The AAN further recommends that CMS create mitigating factors and tiers for compliance with this standard that would reflect the significant differences in resources and capabilities between, for example, a large health system with several hospitals and multispecialty group practices, and a solo neurologist or other specialist physician in a small practice. Understanding the goal of interoperability, the AAN believes it is reasonable to expect interoperability between a solo or small practice and the entities with which it has a business relationship and refers patients.

Finally, the AAN’s new Axon QCDR participants are mostly from small or solo practices. EHRs need to make it easier to participate in quality reporting. For small and solo groups, CMS must recognize smaller EHR vendors are sometimes incapable of querying data or unwilling to support these efforts. Also, if the vendor stores data in the cloud, we are aware of cases where the provider does not own that data and has to pay for it to be in the Axon QCDR. It would be much easier to participate if there were templates from CMS for tracking the required data for quality measures.

2. General Feedback

We applaud CMS’s commitment to reform the Meaningful Use program. Although the AAN appreciates some of the flexibilities in the new ACI program, it also creates unintentional ambiguities. We hope the agency will further clarify some of the objectives, such as “View, Download, Transmit (VDT)” which states: “[d]uring the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician.”9 We would

---

9 81 Fed. Reg. at 28227.
The AAN strongly supports the proposal’s decision to promote telehealth. CMS proposes to “include telehealth services in the definition of patient-facing encounters,”\(^{10}\) which some states and insurers have resisted. We thank CMS for acting on this issue. However, although CMS says the new program is designed to simplify care, neurologists estimate it may take each provider more than 40 hours to comply. This may outweigh the value of any performance bonus. The AAN believes this will serve as an incentive for physicians to remain below the low-volume threshold, particularly in areas and specialties in low supply.

We are also concerned about the Office of the National Coordinator for Health Information Technology’s (ONC) expanded role monitoring the certification program. Specifically, ONC will conduct surveillance to check on the use and capabilities of Certified EHR systems while they are being used by clinicians. The rule says this will happen “in the field”\(^{11}\) and raises the concern that the ONC could revoke certification status of previously certified EHRs. There is the potential for abuse in any surveillance program and we ask for further details.

The AAN also calls upon ONC to hold providers harmless if their EHR does not pass a field inspection because of manufacturer issues and the ONC needs to maintain grace periods that allow providers to switch products if their products are decertified.

Additionally, the proposed rule primarily changes the scoring system without changing the actual measures. We support broadening the patient engagement and health information measures. However, the new program only changes how these measures are counted. Furthermore, there is still a pass-fail element in the base performance score (Protecting Patient Information), which can make up half of the ACI total score.

This measure also requires a security risk analysis and historically that has been challenging for physicians. The AAN recommends CMS publish a dataset of information it will require for patients in APMs so that vendors can prepare to export data in that format. This concept is similar to the CMS standard charge form that all EHRs now prepare. We also believe that CMS should consider the possibility of patients entering their own data into the medical record at each visit, including the chief complaint, concerns over care, and issues they would like addressed at the visit.\(^{12}\)

The AAN is also concerned that the current ACI program specifics are difficult to explain as a part of the larger MIPS program. We encourage CMS to continue its communication efforts on this major change to the Meaningful Use program. We also believe CMS should expand opportunities for innovation. Credit should be given for pilot programs that expand EHR usage and improve patient care, but goes beyond the current goals of CMS. The

---

\(^{10}\) 81 Fed. Reg. at 28175.

\(^{11}\) 81 Fed. Reg. at 28170.

\(^{12}\) The Office of the National Coordinator for Health Information Technology, “Patient Engagement Playbook”. Available at: https://www.healthit.gov/playbook/pe/.
The proposed rule would also require new participants to start reporting under a full calendar year instead of a 90-day reporting period that many stakeholders have wanted.

It is also unfortunate that the new program would reduce alignment between Meaningful Use eligible professionals and eligible hospitals. This reverses gains that CMS achieved in 2015. ACI would be governed by different standards than those which govern Medicaid eligible professionals and all eligible hospitals in Meaningful Use. Staff members that are responsible for Meaningful Use will struggle to keep track of varying program requirements while trying to get their Medicare professionals into MIPS and APMs within a short time period. For example, Meaningful Use eligible professionals that are still eligible for Medicaid Meaningful Use incentives would be required to continue to participate in the Medicaid Meaningful Use program. If they have Medicare Part B claims, they would also need to meet MIPS/APM requirements. This would result in a confusing double-reporting process as providers’ performance is graded differently in Medicaid Meaningful Use and in MIPS/APMs.

CMS asks for feedback on this performance category and hospital-based MIPS eligible clinicians in future years of MIPS and the types of measures that would be applicable and available. The AAN does not think this category can be applied to hospital-based physicians without modifications. They often have no input as to the EHR and its functionality at the hospital. This is particularly true if they are not employed at the hospital.

The AAN asks CMS to reconsider the requirement for clinicians to report specific numerator and denominator numbers for events related to the use of certified EHR systems. This may be overly burdensome for some physicians. Unless an EHR system includes embedded reporting functions that keep track of numerator and denominator events, it is not clear how clinicians can do this accurately. If they are able, it will require massive amounts of time and effort. Additionally, a hand-written prescription or order, for example, would belong in a denominator, but it is not clear where that information comes from or how clinicians count these events.

3. **Information blocking**

We support the proposal that physicians would have to demonstrate that their EHR system is not data blocking. It is critical that CMS have the back-end support tools to help clinicians report their concerns if this regulation is to be successful and diminish information blocking practices. It is also important CMS policies recognize the scope of the eligible clinician’s control and to not place the blame on them in cases where they rely solely on vendors. It is reasonable that the clinician not limit or restrict the compatibility of certified technology, but policies in this area must not be worded in a way that disproportionately focuses on the clinician.

A clinician must be in compliance with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170. However, the AAN doubts most clinicians know these standards. Therefore, this attestation is meaningless at best or could serve as a challenging administrative burden. More education and clarity from CMS is necessary.
This topic is also relevant to the QCDR community and the AAN’s Axon Registry. Unfortunately, this section implies that the source of information blocking is at the level of the provider or hospital rather than the EHR vendor. The AAN has experienced with our Axon Registry situations where the EHR vendor blocks access to patient data. We have also heard from registry participants that some vendors impose excessive fees, effectively blocking registry access to data from EHRs. These fees are often a greater impediment to data access than technical, interoperability barriers.

We recognize the health information technology industry has strong incentives to exercise control over electronic health information. However, some vendors are acting in ways that unreasonably interfere with data exchange and use, including data used for improving patient care. The AAN recommends requiring developers of health information technology, as a condition of certification and maintenance of certification, attest that the developer does not take any action that constitutes information blocking. The AAN also believes that the charging of excessive fees should be considered a form of information blocking. We further recommend that HHS use of the current certification process for EHR products to assess whether information blocking is occurring, and take corrective action against vendors found to be engaging in this activity (e.g., by suspending certification or decertifying products).

C. Quality

CMS appears to have taken advantage of this opportunity to fix things that were not working in the current quality reporting programs. At the same time, by adding unnecessary complexity to the scoring process, benchmarking transition to this new system may not be as seamless and as non-disruptive to clinical practice as hoped.

1. Impact on Small and Solo Practices

The AAN commends CMS for making changes to the quality category of MIPS that will address flaws in PQRS. The proposals for requiring MIPS-eligible clinicians to report six quality measures rather than nine and eliminating the linkage of quality measures to National Quality Strategy (NQS) domains will simplify the process for an individual neurologist to select quality measures to report. The designation of a specialty measure set for neurologists will also be helpful. The AAN appreciates that CMS has established “high priority” measures that can be reported if an outcome measure is not available to a MIPS-eligible clinician based upon their scope of practice. However, we remain concerned about the complexity of the reporting requirements and the administrative burdens they create for small practices.

CMS has proposed to maintain the practice of having multiple options for reporting, including administrative claims, qualified data registries, and EHRs. As noted in our November 16, 2015 comments on the MACRA Request for Information, the AAN believes that MIPS information should be submitted to CMS in a single streamlined manner that reduces administrative burden and complexity for small practices. The AAN appreciates CMS’s proposal to calculate the population-level quality measures using claims data without requiring any submissions from providers, and hopes that this concept can be expanded upon in the final rule. To the maximum extent possible, CMS should refrain from requiring small
practices to collect and submit data that CMS already has in its own systems or can obtain easily from a third party such as a registry vendor.

2. **Quality Data Submission Criteria**

CMS proposes reporting at least six measures including one cross-cutting measure and at least one outcome measure. The AAN supports the reduction in the number of measures required, as the current PQRS requirement of nine measures across three domains was a high standard that often resulted in reporting only for the sake of reporting and subsequently yielded data of little value. Maintaining the nine measure reporting requirement would also have failed to recognize that MIPS increases the total reporting burden of physicians with the addition of the new category of CPIAs.

If an applicable outcome measure is not available, CMS proposes requiring one other high priority measure that the eligible clinician or group would need to choose (appropriate use, patient safety, efficiency, patient experience, and care coordination measures). Moving to more “high value” measures or “measures that matter” is important. However, neurologists should be able to select measures that have the greatest value in driving improvement for their patients. Measures considered “high value” may differ by specialty or patient population.

3. **Measures for Inclusion**

The AAN has reviewed the proposed measures, the measures slated to be removed, and the specialty-specific measures. We provide the following feedback:

- Regarding the proposed measures, the AAN is pleased to see the inclusion of several of our dementia and opioid measures in the MIPS program for 2017. Dementia and opioid addiction are public health issues of great concern and the AAN encourages CMS to continue measuring these conditions.

- Regarding the specialty measures for neurology, the AAN is supportive of having a set of measures that are applicable to general neurologists. However, we are concerned inclusion of the stroke and ALS measures may not be applicable to the general provider.
  - The stroke measure (“Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an antithrombotic at discharge) applies to the patient at discharge which may not apply to the community neurologist tracking the patient after hospitalization.
  - The ALS measures (“Percentage of patients diagnosed with Amyotrophic Lateral Sclerosis (ALS) who were offered assistance in planning for end of life issues (e.g. advance directives, invasive ventilation, hospice) at least once annually”) may be more applicable to larger institutions or centers of excellence. Only neuromuscular neurologists will have an adequate ALS population to report meaningful results.
Regarding 2016 PQRS measures proposed for removal from MIPS reporting in 2017, the AAN is disappointed to see the removal of several neurology relevant measures without conferring with the experts in neurologic care about how CMS defines low bar and if these are standards of care with no gaps.

- Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period.
  - This measure was previously a part of a measures group and was only reportable as a measures group. To align with the proposed MIPS policy of removing measures group as a reporting option, this measure will no longer be reportable as part of a measure group. As an individual measure this is not robust enough to stand alone. CMS proposes to remove this measure because it is considered too low as an individual measure and is standard clinical practice.

- Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period.
  - This measure was previously a part of a measures group and was reportable as a measures group only.

- All patients with a diagnosis of Parkinson’s disease who had an annual assessment including a review of current medications (e.g., medications that can produce Parkinson-like signs or symptoms) and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually.

- All patients with a diagnosis of Parkinson’s disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually.

In an effort to increase transparency in the process, the AAN suggests that prior to the publication of the recommendations, CMS contact the measure developer to make sure CMS conclusions are accurate and to ensure the developer does not have data to suggest otherwise.

4. Peer Review

The proposed rule requires the Secretary of HHS to submit new measures for publication in applicable specialty-appropriate, peer-reviewed journals before including such measures in the final annual list of quality measures. The AAN believes this proposal is highly duplicative of the work of measure developers; it infringes on measure ownership and copyright; and would ultimately limit the availability of and significantly delay the use of measures in MIPS. In this proposal, CMS unnecessarily recreates an existing process and the AAN strongly cautions CMS against this path.

Measure developers produce quality measures and successively develop a manuscript summarizing the measure development process and the resulting measures. Often, measure developers submit the manuscript to their peer-review journal and rely on these publications
as a means to substantiate their efforts, educate their members, and provide scientific validation for the process used and for the measures themselves. As a right of first refusal, the AAN submits its measures to its premier journal for clinical science, Neurology. Neurology and its editors and staff oversee a rigorous peer-review process. Once published in Neurology, the quality measures are submitted to CMS for consideration in quality initiatives and payment programming. This process, the subsequent peer-review, and ultimately the publication can last up to 18 months. The proposed rule would further delay the process of integrating measures into programming.

Measures development requires a substantial investment of resources. The AAN is committed to expending these resources. However, the AAN will continue to insist on the ownership and copyright of its quality measure products. The proposed rule requires measure developers to provide information necessary to draft the journal articles for submission including, but not limited to: background; clinical evidence and data that supports the intent of the measure; recommendation for the measure that may come from a study or the United States Preventive Task Force (USPTF) recommendations; and how this measure would align with the CMS Quality Strategy. This requirement usurps the intellectual property of measure developers and would result in a duplicative manuscript. The AAN cautions this proposal could breach the copyright of the measure owner regarding their measure product and will likely result in hurdles for publication based on the duplicative nature of the effort.

While the AAN appreciates the exceptions to the rule for measures in QCDRs and those included in CMS programming before 2017, we recommend this exclusion be extended to all measures published in a peer-review journal prior to their submission to CMS. This would allow measure developers to maintain their ownership, copyright, prevent duplication, and ensure measures are not stagnated in the peer review and publication process.

5. National Quality Strategy (NQS) Domains

The AAN supports the decision to remove the requirement to report across several NQS domains. These were artificial, arbitrary, and unnecessarily complicated for reporting.

6. Quality Measure Benchmarks

The methods to benchmark provider performance must be tested, transparent, and trusted by physicians. They should include physician input and be clearly communicated. The AAN is concerned that the proposed methods are imprecise and lack details to fully understand the impact they may have. The AAN believes in the long term that benchmarks may not always be relevant in some circumstances. We caution against calculating a benchmark during a period of uncertainty during the early stages of MIPS.

Regarding the proposal to place different benchmarks on the different data submission mechanisms (EHRs, QCDR, claims), the AAN worries that CMS’s concerns with the quality of the data ultimately allow for lower performance based on the data methodology. The AAN believes only data sources with high-quality data should be allowed in these programs.

The rule proposes that all MIPS-eligible clinicians, regardless of whether they report as an individual or group, and regardless of specialty, submit data using the same submission mechanism and would be included in the same benchmark. The AAN believes that physicians should only be compared to similar physicians with similar patient populations in similar settings.

7. Third Party Reporting: Requirements for QCDRs

The AAN is pleased that CMS understands the potential and value of QCDRs and includes QCDRs as a reporting option across several of the MIPS components and CPIAs. For those components where QCDR reporting is an option, such as CPIAs and advancing care coordination, the AAN requests CMS outline specifics as soon as possible to ensure registry technology vendors can meet the needs of neurologists selecting the MIPS pathway.

CMS seeks comments on whether it should propose requiring health information technology vendors, QCDRs, and qualified registries to have the capability to submit data for all MIPS performance categories. In the interest of simplifying a very complex program, the AAN supports efforts that streamline the data submission process for MIPS-eligible clinicians and supports using health information technology vendors, QCDRs and qualified registries as a reporting mechanism across all of the MIPS domains. However, within the proposed rule there is insufficient information regarding the reporting requirements for each of these domains. Without information on what would be required, it is difficult to comment on hypothetical requirements for these capabilities. The AAN recommends that once CMS has identified these elements, it should seek public comment on the requirements.

8. CMS Data is Not Actionable

The AAN joins the rest of the medical community in its concern that CMS’s focus on data feedback may not accomplish its goals and the cost of continuous measurement places significant burdens on practices. Many physicians complain that previous iterations of CMS quality programs turned them into “data entry clerks”. Neurologists shared with the AAN that the CMS data they received was not actionable, hard to understand, and often difficult to access.

An April 2016 report on the Comprehensive Primary Care Initiative illustrates this point:

> Practices also indicated the Medicare FFS data feedback reports lack actionable information from which to draw conclusions. Some practice leadership described the Medicare FFS reports as complicated and did not know how to reconcile the costs being reported with the clinical issues they face in their practice. Moreover, practices noted that the feedback reports do not differentiate between unnecessary and appropriate costs for care consistent with standards of care. Practices also indicated that the Medicare FFS reports would be more helpful if they were provided sooner. Even though CMS also provides practices with patient-level data on
attributed Medicare FFS patients (in addition to the feedback reports themselves), several respondents at both system-owned and physician-owned practices said they did not know this patient-level information was available.\(^{14}\)

Furthermore, one of the physicians in the report is cited as saying: “[The report] leaves it up to us to try to figure out how to study that [the cause of high costs]. So it gives you an aerial view of what is going on but does not help you know where to attack the problem.”\(^{15}\)

CMS’s assistance to providers has not been sufficient to help turn quality data into actionable plans. As an example, we point out the Medicare FFS Physician Feedback Program/Value-Based Payment Modifier: 2014 QRUR and 2016 Value Modifier document.\(^{16}\) This document contains the latest Quality and Resource Use Reports (QRURs) published by CMS. According to CMS, these reports are prepared for every physician who treats Medicare patients. Physicians and their clinics are identified by their TIN.

To help our neurologists better understand their QRURs, the AAN often pointed them to the CMS document on the page titled: “How to Understand Your 2014 Annual QRUR and Supplementary Exhibits.”\(^{17}\) CMS explains the document will provide “tips on how groups and solo practitioners can use the QRUR and supplementary exhibits to understand their performance and identify opportunities for improvement.” This document cites numerous exhibits, offering advice that calls upon eligible professionals to “coordinate”\(^{18}\) and develop “a strategy to improve the efficiency of the care of these beneficiaries, perhaps by adopting care management practices or by educating beneficiaries on self-management techniques.”\(^{19}\)

These documents are not helpful due to their vagueness. CMS must improve these help documents for the new quality program. The tips should be more practical and specific. Additionally, nothing in these documents ever suggests that CMS’s data could be inaccurate.

### 9. Other Feedback

Neurology includes a number of subspecialists. For a subspecialist to participate in MIPS, they will need to report a measure set at the subspecialty level. This may mean reporting fewer measures. Additionally, for providers who report different quality measures in a

---


\(^{17}\) CMS Website, “Understanding Your QRUR”. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-UnderstandingYourQRUR.pdf.


subsequent year, the AAN suggests that they should be requested to provide the rationale for the change. CMS could request the physician report data for the same categories as the prior year to preclude the chance that a physician may be seeking to find loopholes and flaws in the system.

Furthermore, the AAN recommends that CMS set limits on some of the cross-cutting measures. For example, many beneficiaries will see multiple physicians. Hypothetically, it should not be appropriate for the BMI measure to be reported by a patient’s primary care physician, cardiologist, endocrinologist, ophthalmologist, and rheumatologist in the same year.

The AAN was also concerned to learn the CMS Hospital Value-Based Purchasing program gave bonuses last year to 231 hospitals that ranked below average in quality. This raises serious doubts about the incentive process created by CMS quality programs and the ability of the agency to effectively implement quality programs, especially on the scale as proposed by this rule.  

Additionally, specialties that do not have outcome measures or measures in “high priority” areas are at a disadvantage under the proposed quality performance scoring methodology. We also note that CMS proposes to utilize administrative claims based population health measures that were previously part of the Value Modifier. These measures were developed for use at the hospital and community level and have low statistical reliability when applied at the individual physician level and, at times, at the group level.

D. Resource Use

Resource use measures to date have a poor track record identifying efficient physicians and practices. For example, 96 percent of physician practices were scored as “average cost” using similar measures in the 2016 Value-Based Payment Modifier program.  

Given that the MIPS measures will apply to smaller practices, as well as specialties whose discretionary services are not yet captured by well-developed episode definitions, clinicians can generally expect average scores, which offers little motivation to change.

1. Impact on Small and Solo Practices

As in our comments on the quality category of MIPS, the AAN is pleased that CMS has proposed to continue calculation of the resource use measures using administrative claims data that does not require submission of data by practices.

The AAN also appreciates the proposal to limit public reporting on the Physician Compare website to a subset of resource use measures that meet the public reporting standards, and to

---

20 Health Affairs, “Adding A Spending Metric To Medicare’s Value-Based Purchasing Program Rewarded Low-Quality Hospitals”. Available at: http://content.healthaffairs.org/content/35/5/898.abstract.

21 CMS Website, “Physician groups receive upward, neutral, or downward adjustments to their Medicare payments in 2016 based on their performance on quality and cost efficiency measures”. Available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-VM-Overview-PDF-Memo.pdf.
include the total number of patients reported on per measure in the downloadable database to facilitate transparency and more accurate understanding and use of the data. These changes will level the playing field so that small practices do not appear, based on Physician Compare profiles, to be of lower quality or less efficient solely because they are small.

We remain concerned, however, about the impact that small sample sizes have on the reliability of measures of resource use and urge CMS to include in the MIPS Composite Performance Score for a MIPS-eligible clinician only the performance data on resource use that meets the public reporting standards. The AAN also believes that CMS is striking the wrong balance with respect to the reliability of the Medicare Spending Per Beneficiary (MSPB) measure by proposing to use a minimum of 20 cases. The reliability of the measure has been analyzed using inpatient claims, which are not a representative sample to apply to measure the costs of care provided in a physician’s office. Further, the experience with the Value Modifier shows that the measure is more reliable with 125 cases.

2. General Feedback

This is an overly complex section of the proposed rule. We are concerned that current methods do not attribute to physicians the costs they can directly control. The two current neurology-specific episodes of care are limited in number and not reasonably useful. They were developed for CMS under a contract. The process documents illustrate extensive use of consensus and statistical development, but these are not usable. First, the process of attribution is not clear. We continue to urge CMS to use prospective attribution. Second, the attributed physician is held responsible for all costs in the episode, even those over which the physician does not have direct control. Third, the development process was opaque and did not involve consensus criteria by specialty societies.

CMS further continues to use the flawed cost measures utilized in the VM, and the proposed initial methodology makes it difficult to make accurate and equitable comparisons of costs in physician practices. Despite their potential, we are concerned that the episode groups CMS has put out for review are not ready to be employed.

To make this category workable, CMS will need to replace the current hospital-intended cost measures and focus on various methodological improvements, including more sophisticated risk adjustment, more granular specialty comparison groups, and attribution methods that are relevant across specialties and settings. Special effort should be directed at eliminating flaws that have made practices with the most high-risk patients more susceptible to penalties than other physicians.

The AAN is also concerned with the 0.4 reliability threshold CMS plans to use to ensure that MIPS eligible clinicians and groups are measured reliably.22 CMS will use the 0.4 reliability threshold currently applied to measures under the VM to evaluate their reliability. However, a 0.4 reliability threshold would be considered too low in most measurement contexts.

Additionally, the resource use criteria may translate into a burden on physicians to prescribe generic medications despite what they believe is best for their patients. This is especially true

for neurologists who prescribe anti-epileptic medication. Physicians could deny expensive disease modifying treatments for MS. Cheaper medication does not necessarily translate into lower costs overall. Seizure or MS exacerbation will exceed the cost savings of cheaper medication alternatives. Physicians are not responsible for the prices of medications, and as such, should not be penalized for a problem they did not create nor can directly control.

The AAN also continues to strongly discourage the use or reference to “primary care services” in CMS rulemaking. Physicians who see patients face-to-face bill Medicare under new or established patient evaluation and management visit codes. There simply is no code in the Medicare Physician Fee Schedule for “primary care services.” Primary care physicians and cognitive specialists like neurologists bill identical codes and either may coordinate care for individual patients.

The AAN also opposes the proposal to remove specialty type as a risk adjuster for the MSPB measure. Additionally, the AAN implores CMS to support the rapid adoption of subspecialty codes that can be used to define peer groups for the purpose of comparing resource use and calculating a threshold score. Finally, because non-patient-facing clinicians will not be evaluated based on cost, the AAN believes CMS should only compare non-patient-facing to other non-patient-facing clinicians for a more appropriate evaluation.

3. Future Modifications to Resource Use Category

CMS states it intends to consider how to best incorporate Part D costs into the resource use performance category and seeks comment on how to incorporate those costs under MIPS for future years. The AAN stresses that Part D costs should be scaled and risk adjusted appropriately to reflect different patient population needs. Higher drug costs may be necessary in some specialty areas in order to provide the highest quality of treatment.

E. Additional Issues in MIPS

1. Performance Period

The AAN requests that CMS start the reporting period for 2017 on July 1, 2017, instead of January 1, 2017. The start date for MIPS was not known until the proposed rule was released and the final rule will be finalized in the fall. This does not leave physicians sufficient time before the start of MIPS reporting. Some physicians are unlikely to know by January 1, 2017 whether CMS will accept their preferred payment model.

The technical challenges of compliance are also significant. Identifying appropriate measures is a challenging task, along with the fact they must quickly be implemented into information technology systems. There will be a limited time for third-party vendors to update the necessary software so that practices are able to complete their required reporting. Vendors will need to develop and deploy different software to providers based on the final rule’s specifications.
2. **Two-Year Delay between Performance and Payment**

The AAN is concerned with the rule’s proposal to continue using a two-year look back period. Performance in 2017 would impact physician’s 2019 payments in both the MIPS and APM tracks. This continues the problem of delayed feedback for physicians. We understand there are technical challenges on CMS’s end that make it difficult to provide real-time feedback, but this must be a goal that CMS works toward if it wants to improve the cost and quality of care provided by physicians. No professional in any industry can meaningfully reflect in great detail on an analysis of the work they completed two years prior. The two-year look back period is ineffective and CMS should publicly outline plans to change this structure. It also disincentives participation by creating a delayed payment structure.

3. **Risk Adjustment Flaws**

The AAN is concerned the risk-adjustment policy included in the proposed rule does not appropriately factor in low-income patients’ socioeconomic status and demographic challenges. We acknowledge in the proposed rule that CMS says several MIPS measures include risk adjustment in their specifications. For example, CMS says outcome measures in the quality performance category typically have risk adjustment in the calculation specification, but process measures generally do not. Additionally, in the resource use performance category, the proposed total per capita costs for all attributed beneficiaries measured is adjusted for demographic and clinical factors.

CMS states it will closely examine the recommendations from HHS’ Office of the Assistant Secretary for Planning and Evaluation (ASPE) study, once they are available, on the issue of risk adjustment for socioeconomic status on quality measures and resource use as required by § 2(d) of the IMPACT Act and incorporate them as feasible and appropriate through future rulemaking.\(^{23}\)

The AAN urges CMS to follow through with its plan to consider risk adjustment based on the forthcoming ASPE recommendations, and we strongly encourage the agency to include risk adjustment in future rulemaking. ASPE plans to offer feedback to CMS on the burden of disease, illness, or disability on the target patient population. We strongly disagree with sections from previous reports by NQF that at times suggest there should not be risk adjustment.\(^{24}\)

Risk adjustment is generally flawed when it comes to patients seen by neurologists with high-cost conditions like MS, epilepsy, and ALS. Currently, they are placed into the general population mix. One way of fixing risk-adjustment algorithms to create more accurate predictive models is by risk adjusting within these populations.

CMS needs improved risk-adjustment algorithms with more predictive power for the conditions that neurologists see on a daily basis. Where there is no risk adjustment, risk

\(^{23}\) 81 Fed. Reg. at 28187.

adjustment is better than none, and current commonly used algorithms are better than combinations of age, gender, and comorbidity scores.

4. **MIPS Performance Adjustments**

The AAN is concerned with the linear structure of the MIPS performance adjustments. While we understand the program must be budget neutral and Congress mandated the essential provisions of the MIPS payment structure, it must be noted that previous CMS performance analyses were unable to distinguish between large majorities of clinicians. Instead of a linear structure of “winners and losers” across the board, the AAN believes CMS should adjust only those on the high and low end with clinicians in the middle areas receiving adjustments of a de minimis amount. We understand there are statutory questions involved in this decision by CMS, but the AAN thinks CMS can operate within the text of the statute and employ an adjusted linear structure that recognizes the reality that most physicians’ performance will be indistinguishable from one another.

We note that the October 2015 Medicare Payment Advisory Commission (MedPAC) meeting’s analysis of the MIPS program recommends our approach to focus on outliers:

> First is the challenge posed by assessing clinician performance at the individual level. The MIPS … is designed to produce an individual-level payment adjustment. But many quality and resource use measures are not reliable at the individual clinician level, and it is a particular challenge for outcomes measures. **Based on CMS’s experience to date with individual-level payment adjustments, most clinicians will likely look average, and the Medicare program will only be able to reliably identify persistent outliers.**

MedPAC’s staff repeated this claim at the January 2016 meeting. According to the VM results for 2015, CMS found that over 80 percent of eligible professionals could not be differentiated from the average. If CMS cannot detect differences at the individual level for 80 percent or more of the physicians who serve Medicare patients, the proposed linear structure creating a significant number of “winners and losers” will lack a meaningful foundation and foster further mistrust between physicians and CMS, ultimately hurting the CMS goal of improving value in health care delivery.

5. **Exclusion from MIPS**

The AAN recommends that exclusions be applied broadly in the first few years of MIPS as clinicians learn about the program and prepare to comply with the new quality payment system. Furthermore, the AAN recommends that providers should be excluded from MIPS

---


penalties if less than 10 percent of their patients are Medicare patients that can be attributed to that physician. Additionally, there should be no MIPS-related adjustment if the physician had less than 125 cases with patients, or if less than 20 patients are attributed to them. MIPS adjustments should be based solely on prospective attribution—the list of patients the provider receives before the measurement year begins—regardless of whether the provider is part of a group that is participating in a higher-risk Medicare Shared Savings Plan. The AAN believes CMS should model its policies with the MIPS low-volume threshold off the thresholds found in other CMS programs like Meaningful Use and the Value Modifier. The AAN is also concerned about the extent to which certain subgroups of neurologists, like pediatric subspecialists, may have sufficiently low Medicare patients, volume, and revenue, such that they are better off excluded from MIPS.

6. Feedback from CMS

Beginning July 1, 2017, CMS also proposes to provide clinicians with performance feedback on the quality and resource use categories of MIPS. This is meant to ensure that MIPS results are useful and accurate. CMS should pursue this by providing ongoing, real-time feedback on performance and should continuously consult stakeholder groups to determine the best presentation and most meaningful format for sharing actionable performance feedback information with physicians and practices. As technology is constantly changing, it will be critical for CMS to take a continuous approach to improve the way performance information is disseminated to physicians and practices. Stakeholders must be included in this process so that feedback can be provided in a format that works best for physicians and is meaningful to their practice’s ongoing improvement activities.

It would be very helpful to know what patients are actually attributed to the provider, what other providers have partnered in that care, and the care directly attributed to the provider. In general, the power is far greater for CMS to audit and potentially recover money than it is for an eligible clinician to seek an informal review. The AAN believes there should be a more equal power balance between CMS and clinicians in this area. Furthermore, the current feedback reports lack key details to better understand the methodologies used to arrive at the benchmarks and other calculations. This creates frustration and distrust.

Where appropriate, CMS should aim to display feedback and performance measurement information in graphic form with additional details displayed elsewhere. Detailed information should be provided in feedback reports, including the ability to see high-level, overall performance information, as well as detailed tables with individual patient information. CMS must continually consult with stakeholders to ensure displayed data is relevant, meaningful, and understood by the intended audience.

Feedback reports should be accessible to physicians, practice administrators, and related officials. The log-in process for accessing reports must be simple and user-friendly. There have been ongoing problems with accessing reports due to the overly complicated log-in process and cumbersome password requirements which reset at very short intervals, ultimately limiting access to these reports. CMS should make more staff available to help physicians and administrators interpret the reports. The CMS Help Desk is not sufficient.
Finally, CMS must provide a fair and transparent process for providers to appeal findings in feedback reports, and should lengthen the appeals process to at least 90 days.

7. **Physician Compare**

There is debate as to whether transparency efforts work and the steps CMS can take to improve public reporting websites. The AAN believes it is important that physicians have the ability to review source data and information that will be posted before it becomes public. Additionally, physicians should be able to challenge and provide evidence that corrects CMS data.

The AAN agrees with CMS that consumers do not understand most of the categories used to rate providers. Even neurologists are unable to understand them. But if CMS is going to use information to rate physicians, CMS must explain it thoroughly to the public with context. Consumers ought to know, for example, which providers are lowest cost, and to decide whether they want to use those most effective providers. In another example, patients should be able to choose a provider that uses computerized notes since that affects the clinical relationship. However, if quality indicators are included on Physician Compare, they must be risk adjusted for each physician. Additionally, CPIAs should not be reported until its consumer and statistical testing is validated as accurate.

---

II. Alternative Payment Models (APMs)

According to CMS’s policy principles regarding Advanced APMs, the proposed rule states that CMS will: “To the greatest extent possible, continue to build a portfolio of APMs that collectively allows participation for a broad range of physicians,” “[d]esign the program such that the APM Incentive Payment is attainable by increasing numbers of practitioners over time,” and “[m]aximize participation in both Advanced APMs and other APMs.”

These goals are laudable. They are, however, not reflected in reality by the parameters CMS proposes in this rule. The requirements for Advanced APMs are too stringent and greatly limit who can qualify in 2017 and the following years. The number of available models is too small to offer Advanced APM opportunities for neurologists. CMS should re-write the APM section of the rule with a commitment to allow for more Advanced APMs in the early participation years.

A. General Feedback

The AAN understands this proposal furthers the CMS goal of consolidating existing programs and moving toward value-based care. However, even though the proposal seeks to encourage further innovation, it strongly favors existing APM models like ACOs and large integrated systems. The AAN is concerned over time these groups will use their market power to drive up reimbursement on the commercial side, further consolidate clinical care, and stifle innovation in order to preserve infrastructure investments. We are also worried that the process of putting new Advanced APMs into practice will be too slow. As a consequence, many models will only be made available to physicians at a time when the standard to be considered a qualifying participant is significantly higher than in the early performance years.

With this in mind, the AAN believes it is critically important for CMS to establish a clear process to rapidly review, approve, modify, and/or deny physician-focused payment models and Advanced APMs. This will support MACRA and CMS’s goals, help engage and enroll small practices, and in the spirit of true entrepreneurship, lead to better and more cost-effective care.

In some cases, payments under an APM will be made to an entity rather than directly to an eligible physician. In order to ensure that the physicians participating in the APM are able to influence the governance policies of the APM entity, CMS should require such entities to provide for meaningful participation in governance by physicians whether or not the APM entity is a physician-owned organization. APM entities could include physician practices, independent practice associations, physician-hospital organizations, and other organizations. If the organization is a hospital or other entity that is not physician-owned, then it should be required to provide a means for physicians to influence the governing policies of the organization. An example includes having a significant number of practicing physicians represented on the governing board.

---

Additionally, the new APM track does not allow for any “trial and error” period. Physicians are unable to test out different payment models and health record systems to see what will work best for them. We believe this is a flexibility that should be afforded to physicians who make a good faith attempt to join APMs, even if they do not ultimately qualify as participants in an Advanced APM.

Neurologists have stated they find the APM requirements intimidating. Neurologists in very large practices and ACOs will have implementation concerns taken care of, but they will not have control over the process. Many practices will not be able to handle implementation at all. While some will take on the necessary financial risk, they will incur large administrative and information technology costs. This will likely grow as CMS continues to modify and update policies in the coming years, increasing the cost of compliance.

The AAN is also concerned that CMS’s decision not to allow Track 1 ACOs as Advanced APMs will lead to major withdraws from the program. According to a recent survey, 56 percent of respondents said they will drop out of MSSP if it remains ineligible for the five percent Advanced APM bonus.\(^{29}\) We are also concerned the number of Medicare pilot programs will create complexities and set up the potential for conflicts.\(^{30}\)

### B. Neurologists Lack APM Options

CMS should be aware that neurologists currently lack sufficient APM options. As noted in an October 2014 report from the Brookings Institution, despite the proliferation of alternative care models addressing the needs of patient populations with dementia, epilepsy, multiple sclerosis, traumatic brain injury, and complex headaches, there are currently no APMs implemented with a specific focus on complex chronic neurologic conditions.\(^{31}\) Neurologists do not have a true choice, especially in the first few years of this program.

Flexibility for physicians is one of the themes found throughout this proposed rule. However, for neurologists, these flexibilities are less meaningful because they will be forced into MIPS for an indefinite period of time. Asking neurologists to invest time and resources for the possibility—not guarantee—of participation in an Advanced APM is not reasonable. CMS should take this into consideration as it sets standards for Advanced APMs and exclusions for MIPS-related negative adjustments in the first years of the program.

Furthermore, according to the proposed rule, Section 1868(c)(2)(A) of the Act requires the Secretary to establish criteria for physician-focused payment models, including models for specialist physicians, not later than November 1, 2016.\(^{32}\) Congress intended for specialists like neurology to have viable APM options qualifying under MACRA before the first

---


\(^{32}\) 81 Fed. Reg. at 28347.
performance year. Even if models would not yet be approved by CMS, at the least, Section 1868(c)(2)(A) of the Act requires the Secretary to have conceptually established models. However, at the time of the proposed rule’s release, there are only oncology and renal specialist models for the first performance year. This lack of opportunity for neurologists to participate in the APM track of MACRA will continue into the future unless CMS speeds up the timelines for approval of physician-focused payment models.

The AAN implores CMS to focus additional resources on the development of specialty payment models. The Oncology Care Model, the Comprehensive Joint Replacement Model, and the ESRD Service Community Organizations are each designed very differently from one another, because the scope of practice of the physicians being paid under them is unique, and because the patients they serve have highly specialized needs. The AAN would be pleased to partner with CMS on the design of APMs for neurologic conditions. Resources required for such an effort include significant amounts of data, help with data analysis and APM design, and investments in coordination of care and ongoing performance management.

C. Physician-Focused Payment Models

The AAN advocates for a rapid approval or denial decision and the ability to resubmit soon after any potential denial by the Payment Model Technical Advisory Committee (PTAC) or CMS. We also ask for templates and examples of APMs the PTAC would recommend to CMS. CMS should provide clarification to stakeholders on the definition of a physician-focused APM. The AAN and other organizations will also benefit from understanding if the entity is able to recruit participants after submission of the APM to the PTAC and/or CMS.

The APM models being developed by specialty organizations like the AAN will face a significant time delay before they are potentially approved. CMS specifically notes it will not commit to a deadline for reviewing, responding, and testing proposed models. The AAN believes this will be challenging for neurologists as they make strategic decisions on possible payment models to join in the coming years.

Furthermore, CMS specifically states it will not commit to testing models recommended by the PTAC and given a favorable response by the Secretary. This is unacceptable. Section 1868(c) of the Act may not require CMS to test these models, but CMS should hold itself to a higher standard than the bare minimum as required by Congress. The agency is asking physicians in the coming decade to consistently work on improving the quality and value of the care they provide to patients. CMS should devote the necessary resources toward evaluating and improving physician-focused payment models.

The fundamental point behind physician-focused payment models requires groups like the AAN to take on considerable time and expense in the development of models. Even if everything is done correctly and all standards are successfully met, CMS can simply ignore the model. This threatens to destroy the relationship between physicians, medical societies,

33 81 Fed. Reg. at 28346.
34 81 Fed. Reg. at 28346.
and CMS. The AAN stresses that CMS should be more careful with its language and clarify how it intends to handle situations where the agency will not test models recommended by both the PTAC and the Secretary. This requires substantially more communication and consultation with groups like the AAN. CMS stating in the proposed rule “this does not imply that we would not give serious consideration”\(^{35}\) to these models is meaningless without more clarity.

D. **Definition of Advanced APM**

Although the statutory threshold for qualification as an Advanced APM creates a high barrier, we would like to highlight a recent United States House Committee on Ways and Means hearing on MACRA implementation. During the hearing, committee members raised concerns for physicians currently participating in alternative payment arrangements. Rep. Ron Kind (D-WI) pointed out first generation ACOs and Rep. Tom Price (R-GA) highlighted the Bundled Payments for Care Improvement (BPCI) initiatives, both of which would not qualify as Advanced APMs by CMS according to the proposed rule. Rep. Price said, “that doesn’t make any sense at all,” and expressed a hope that certain programs can be “grandfathered in.”\(^{36}\) We share Rep. Price’s sentiment.

E. **Interpretation of Financial Risk Criterion for Advanced APMs**

The AAN is disappointed with CMS’s proposed approach to defining the financial risk criterion for Advanced APMs. We believe that CMS’s interpretation of the financial risk criterion for Advanced APMs is inconsistent with the plain language of the statute and with the statutory intent to encourage proliferation of, and participation in, Advanced APMs. One of the primary goals of MACRA is to give physicians incentives to adopt APMs, but those options will be unavailable to most neurologists either because they are in small practices, are viewed by APM administrators as specialists who are not essential to managing the quality and cost of care, or both.

1. **Statutory Language**

Section 1833(z) of the Act, as added by section 101(e)(2) of the MACRA, requires that an incentive payment be made to Qualifying APM Participants (QPs) for participation in eligible APMs, which CMS has deemed “Advanced APMs.” MACRA also defines an “eligible APM entity” as an entity that participates in an APM that (1) requires participants to use certified EHR technology, (2) provides for payment based on quality measures that are comparable to MIPS, and (3) “bears financial risk for monetary losses under the APM that are in excess of a nominal amount,” or is a medical home expanded under CMMI. The statute does not define “financial risk for monetary losses” or “excess of a nominal amount.”

\(^{35}\) 81 Fed. Reg. at 28346.

2. **Financial Risk for Monetary Losses**

The AAN believes that, consistent with the statute, CMS should adopt a more inclusive definition of “financial risk for monetary losses.” CMS proposes to break this seemingly straightforward third criterion into two complicated multi-part standards. First, CMS extrapolates from the statutory phrase “financial risk for monetary losses” to propose a generally applicable financial risk standard, which would require an Advanced APM to include provisions that, if actual expenditures for which an APM entity is responsible under the APM structure exceed expected expenditures, CMS can (1) withhold payment for services to the APM Entity and/or the APM entity’s eligible clinicians; (2) reduce payment rates to the APM Entity and/or the APM entity’s eligible clinicians; or (3) require the APM entity to owe payment(s) to CMS.\(^{37}\)

CMS interprets the statutory requirement to only encompass “losses” that could be incurred through either direct repayments to CMS or reductions in payments for services. In the Preamble, CMS justifies its very narrow interpretation by arguing that it believes that the “statute supports a financial risk criterion that should be met only by those APMs that are most focused on challenging organizations, physicians, and practitioners to assume financial risk and provide high-value care.”\(^{38}\) The plain language of the statute, however, does not support CMS’s narrow definition of financial loss and precludes many APM structures where providers are taking on “financial risk for monetary losses” as described by the statute. For instance, other APM entities may take on financial risk by requiring significant infrastructure investments that may not be recovered (e.g., if there are no savings) or by relying on payments tied to quality or value.

First, the term “financial risk for monetary losses” in MACRA, by its plain language, refers to any losses in the operations of the APM entity and is not limited to financial losses due to cost of care or to increased spending in the Medicare program. The gains or losses of the APM entity are a function of costs that the entity incurs to implement the model as well as the revenues it receives under the model. If an entity hires or pays for new staff to deliver services to patients under the model, acquires new or different equipment to deliver services, or incurs other kinds of expenses to implement the APM, and those expenses are not automatically or directly reimbursed by Medicare, then the entity is accepting financial risk for monetary losses. These investments can be quite significant. A 2013 survey by the National Association of ACOs found the average start-up costs for an ACO were approximately two million dollars, and described the associated risks as follows:

Estimates in the published literature of ACO start-up costs have ranged widely, with $1.8 million estimated by CMS in the draft regulations being the most often quoted. [The American Hospital Association] estimated in 2011 that they would range from $11.6 to $26.5 million. The average actual start-up costs of the [survey] respondents in the first 12 months of operations were $2.0 million with a range from $300,000 to $6,700,000.

\(^{37}\) 81 Fed. Reg. at 28304.

\(^{38}\) 81 Fed. Reg. at 28304.
Since savings are slow to flow as a result of data and complex reconciliation process, ACOs will have almost a second full year of operations until their cash flow can be replenished with shared savings from CMS (if any). This means that the average ACO will risk $3.5 million plus any feasibility and pre-application costs. We estimate that in total, ACOs on average will need $4 million of startup capital until there is a chance for any recoupment from savings.39

Second, because larger percentages of Medicare reimbursement are tied to quality, APM entities are bearing real financial risk associated with potential reductions in “bonus payments,” such as shared savings payment incentives that vary based on quality performance. Specifically, in January 2015, Secretary Burwell announced the goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018.40 When the vast majority of payments are tied to quality or value, providers are unable to sustain their practices on base payments alone and so-called “bonus payments” tied to quality become essential to a provider’s business model.

Furthermore, under a one-sided shared savings model, an entity incurs financial risk if it incurs costs to implement programs that are designed to reduce Medicare spending, since the provider could fail to qualify for the shared savings payment needed to pay for those costs. CMS recognizes that these one-sided risk models are bearing risk of financial losses by proposing that the Medical Home Model financial risk standard could be satisfied by such reductions in bonus payments. Other APMs with financial risk associated with potential reductions in quality- or value-based payments should similarly be recognized.

3. **In Excess of a Nominal Amount**

The AAN believes that CMS’s definition of “nominal amount” should better reflect the plain language and intent of the statute, and be more inclusive of APM structures. In the Preamble, CMS interprets “nominal amount” to mean “an amount that is lower than optimal but substantial enough to drive performance.”41 CMS then proposes a strict three-part test: For an APM to meet the nominal amount standard: (1) the specific level of marginal risk must be at least 30 percent of losses in excess of expected expenditures; (2) a minimum loss rate, to the extent applicable, must be no greater than 4 percent of expected expenditures; and (3) total potential risk must be at least 4 percent of expected expenditures.42

This standard has no foundation in the statutory language. The common dictionary definitions of nominal are: “existing as something in name only,” “not actual or real” and

---


41 81 Fed. Reg. at 28306.

42 81 Fed. Reg. at 28306.
“very small in amount.”⁴³ There is nothing in the plain meaning of the word “nominal” to suggest that it would be appropriate to interpret nominal to mean “lower than optimal” or “substantial enough to drive performance.” If Congress had wanted Advanced APM entities to accept substantial financial risk, it would have explicitly required that. Because the underlying premise for CMS’s three-part test is inconsistent with the plain meaning of the statute, the test itself is similarly inconsistent with the statute and requires APM entities to bear a significant amount of risk in order to become an Advanced APM entity. The fact that the bar is too high is exemplified by the fact that so few APMs will qualify to be Advanced APMs in 2017.

In discussing the development of its proposal, it is clear that CMS recognizes the precarious interaction between Medicare expenditures, around which CMS’s test is based, and revenues. It is important to understand that even a seemingly small percentage change in Medicare spending could represent a very large percentage of a provider’s revenues, particularly the revenues of a small entity, and it would represent an even larger percentage of that provider’s net margins. As CMS itself notes, this risk is especially high for smaller entities, many of whom are equally capable of being “most focused on challenging organizations, physicians, and practitioners to assume financial risk and provide high-value care”⁴⁴ as larger organizations. Physicians who are part of smaller entities, like many neurologists, want to be able to participate in the APM Incentive Payment program and meet the requirements of Qualified Participants, but the bar CMS proposes to set makes this an impossibility for most neurologists.

Consistent with the statutory language, we recommend that CMS both simplify the test and reduce the amount of risk required for an entity to participate in an Advanced APM.

4. **Promoting the Statute’s and CMS’s Policy Goals**

In addition to being inconsistent with the statute, CMS’s interpretation of the financial risk criterion is not aligned with its policy goals to encourage development of, and participation in, APMs. In the proposed rule, CMS lays out a number of policy principles, which it states are derived from both the MACRA law and the Department’s broad vision, that drive CMS’s decisions in developing the overall framework for making APM Incentive Payments to QPs. These principles include the goals with regard to APMs:

- Building a portfolio of APMs that collectively allows participation for a broad range of physicians and other practitioners;
- Designing the program such that the APM Incentive Payment is attainable by increasing numbers of practitioners over time, yet remains reserved for those eligible clinicians participating in organizations that are truly engaged in care transformation;
- Maximizing participation in both Advanced APMs and other APMs; and
- Creating policies that allow for flexibility in future innovative Advanced APMs.

---


⁴⁴ 81 Fed. Reg. at 28304.
Given the relatively small number of APM entities and clinicians participating in such entities (CMS estimates that 90 percent of clinicians will be in MIPS), CMS is best in a position to achieve these goals by developing inclusive policies regarding Advanced APMs that encourage the development of, and participating in APMs generally, as well as those APM entities that are incorporating EHRs, quality measures, and financial risk into their models in ways that encourage care transformation. CMS should be encouraging these activities not only for large health care networks that can take on significant financial risk immediately, but for smaller organizations and a variety of provider types, who, relative to their size and structure, are taking on substantial risk in their own right. Quality, patient-centered care can come in all shapes and sizes, and CMS should not limit its ability to promote transformative care by so narrowly defining payment models that will meet the definition of Advanced APMs.

The fact that CMS has set the financial risk bar too high is evident by the fact that so few APMs qualify and those that do have small relative enrollment. According to the National Association of ACOs, the vast majority of ACOs participate in a one-sided risk model (and thus do not qualify as Advanced APM entities) and CMS has recognized that taking-on two-sided risk in the MSSP is not a realistic goal in the first six years of an ACO’s operation for the vast majority of ACOs. We encourage CMS to develop financial risk criteria that is more consistent with the statutory language and more achievable for a variety of APMs.

As both clinicians and CMS gain experience with APMs, in subsequent years, CMS could look to modify financial risk criteria that would reflect the state of APMs at that time. Such an approach would allow CMS to develop appropriate criteria for identifying Advanced APMs while encouraging APM entities to craft innovative designs that allow them to succeed through care transformation and the provision of high-value care, and maximize clinician participation in APMs.

Consistent with the statutory language, statutory intent, CMS’s policy goals, and the best interests of patients, we recommend that CMS define financial risk for the 2017 performance year and beyond to include models where providers make major infrastructure investments and one-sided risk models.

F. Additional Feedback on Nominal Financial Risk

As a general matter, the AAN is disappointed that CMS has proposed to limit the Qualifying Participant designation to individuals who participate in Advanced APMs. The AAN notes that the MIPS also requires physicians to take on downside financial risk. CMS’s stated goal of aligning the rules for participation in MIPS and APMs so that physicians can move easily from one payment model to the other will not be achieved by setting the Advanced APM bar so high.

---

CMS’s proposals for Advanced APMs will require neurologists to accept significantly more financial risk than in the MIPS. Basing the nominal amount standard on total Medicare Part A and Part B revenues will result in holding physicians accountable for costs that they cannot control. Further, it will prevent many small practices and specialist physicians from accessing the incentive payments that Congress intended for them to use to implement APMs that would be suitable to their practices. In the early years of APM development, CMS should base the financial risk criteria so that they are equal to the MIPS -- that is, 4 percent of spending on physician services, increasing to 5 percent in the 2018 performance year -- to encourage physicians to join them.

Furthermore, the AAN believes that “more than nominal financial risk” should be defined in a way that allows physicians to take accountability for the services they can truly influence instead of requiring physicians to take responsibility for total Medicare spending on every health problem and service their patients receive. Physicians likely do not know what spending will be on hospital, post-acute care, and other costs that may be included in the APM, so they do not know how much may be at risk. The current structure proposed by CMS is simply too complicated for physicians to digest and will scare potential participants away from these arrangements.

G. **One-Sided Risk**

The AAN points out that CMS counted its one-sided risk accountable care organizations as alternative payment models when it announced the agency had met value-based payment goals. In the proposed rule, CMS states that risk includes accepting the possibility of penalties for missing cost and quality of care goals. But in promoting its one-sided risk models, CMS has sent a signal that operational and investment costs are nominal risks. We believe if one-sided models meet the standard of the agency’s value-based goals, then they should be sufficient to qualify as Advanced APMs in the physician payment system.

Furthermore, the lack of participation in downside risk in MSSP to date is a signal that entities consider downside risk and its effects on their organization. CMS should see this as an opportunity to find the right balance by using MACRA to incentivize providers to participate in two-sided risk models. This balance can be achieved if CMS focuses on the commitments made by entities.

If the agency continues to consider one-sided models as not including enough risk, the AAN believes CMS could soften the transition to two-sided risk by allowing entities to qualify as participating in an Advanced APM if it creates a contractual relationship that transitions to a downside risk component within a set period of time. An example is a five-year contract with two years of one-sided risk followed by three years of two-sided risk. This concession would be an acknowledgement by CMS that the current performance years are too soon. The AAN fears the requirement that entities be in two-sided risk models this quickly will create cynicism and irreparable harm to CMS’s goals within the physician community. A phased-in approach strikes a better balance.

---

46 Department of Health and Human Services, “HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule”. Available at: http://www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html.
H. **Other Feedback**

1. **Telehealth in APMs**

The AAN calls upon CMS to consider the President’s Council of Advisors on Science and Technology’s March 2016 report. Specifically, Recommendation 9, calling for improved regulation and payment to reflect innovation in telehealth. The Council notes the early results for telehealth demonstrated that it can improve access, especially in underserved areas and for adults who have mobility impairments.

Furthermore, telehealth has been applied to expand the skill set of clinicians, such as to manage complex conditions that often require specialty care and to remotely monitor people who may be dealing with cognitive or physical impairments. New technologies, such as greater use of smartphones, sensor technology, and faster Internet, will expand the range of telehealth services and how they may be incorporated into routine healthcare. While there are legislative restrictions on Medicare telehealth coverage, CMS can act by increasingly incorporating telehealth into Alternative Payment Models, demonstration projects, and Innovation Center models.

Additionally, as we previously noted, bipartisan members of the House Energy & Commerce Committee Telehealth Working Group have called upon CMS to incorporate telehealth in APMs established under MACRA. The Working Group explains that telehealth is a natural fit within innovative alternative payment models that focus on patient-centered care, care coordination and integration, and population health management. The role of telehealth in improving outcomes and reducing costs is even more straightforward in models that include risk-sharing, and providers should not face policy obstacles when they are willing to take on shared financial risk for the anticipated benefits of telehealth.

Finally, MACRA incentivizes participation in APMs that meet high standards. Eligible APMs under MACRA, which are required to bear more than nominal financial risk, should not be subject to § 1834(m) telehealth restrictions. Telehealth should be specifically acknowledged and defined as a tool for eligible APMs to meet high standards of care. For example, telehealth could be explicitly identified within the Patient-Centered Medical Home model. The AAN supports these proposals by the House Energy & Commerce Committee Telehealth Working Group.

2. **Performance Period**

Similar to MIPS, the performance period for APM participation is not workable. The 25 percent APM participation threshold for 2019-2020 is the easiest barrier for physicians to meet in order to receive the five percent bonus payments. However, the January 1, 2017 start date will prevent the vast majority of physicians from having any possibility of being

---

47 President’s Council of Advisors on Science and Technology, “Independence, Technology, and Connection in Older Age”. Pages 49-50. Available at: https://www.whitehouse.gov/sites/default/files/microsites/ostp/PCAST/pcast_independence_tech__aging_report_final_0.pdf.

qualified for these payments, and we reiterate our request for a July 1, 2017 start for the performance period.

3. **Risk Mitigation**

The AAN would like clarification from CMS on risk mitigation and protection for physicians under these new payment arrangements. Physicians would not have the same waiver from fraud and abuse laws that exist in an ACO. With a key focus on the hospital-physician relationship, it could create a risk of violating the federal Anti-Kickback Statute.

4. **Qualifying Participant**

For the limited six years that the five percent bonus payment is available, very few practices will be able to achieve the necessary qualifying participant status to receive the bonus for more than a few of the years. Additionally, at times it is confusing to use the term “professional” versus “clinician”. The AAN also believes CMS must be more explicit about payments. If a practice is to receive a five percent lump sum incentive payment for the 2017 performance year they will not see the money until perhaps mid-2019. This is an unnecessarily long delay and will deter groups from participating in the APM track. Payments should be made sooner.

5. **Medical Homes**

The medical home definition is centered on primary care. However, for patients who have conditions substantially managed by specialists, the primary care medical home model can add unnecessary layers of bureaucracy. Neurologists are appropriately trained and best suited to manage a complex neurological condition. Patient care is at maximum quality when the specialist takes responsibly, working in conjunction with other clinicians, for the care of a patient and that patient’s specialty-specific problem. The AAN stresses that the medical home definition should not be limited to “primary care services” and must include “evaluation and management services” to allow for specialty services that may be equally or more effective at delivering value for a population.

We also point out that the concept of a primary-care centered multispecialty medical home is essentially an ACO model. Medical homes should allow for innovation, such as specialty care medical home models, and thus, do not necessarily require primary care as a direct component of the medical home. Medical homes should not seek to merely replicate the ACO models.

III. **Conclusion**

We greatly appreciate this opportunity to express the views of the AAN in response to the proposed rule. The AAN shares with CMS in the ultimate goal of encouraging more value-based patient care. However, this proposal has the potential to create unnecessary and perhaps unforeseen burdens that could harm neurology practices across the country. We implore CMS to take special consideration on the impact the final rule will have on small and solo neurology practices. CMS should also create a pathway for the approval of more
specialty-specific payment models during the 2017 performance year. This is the first of many important steps as the medical community transitions into a new era of CMS quality programs. The AAN believes with the suggested changes as outlined in this comment letter, CMS can better achieve the triple aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care as well as engaging physicians as responsible partners.

If you have any questions regarding this letter, please contact Daniel Spirn, Regulatory Counsel for the AAN, at dspirn@aan.com or (202) 525-2018.

Sincerely,

Terrence L. Cascino, MD, FAAN
President, American Academy of Neurology