June 18, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201
Submitted electronically: http://regulations.gov

RE: [CMS-1607-P] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program

Dear Administrator Tavenner:

The American Academy of Neurology (AAN) is the premier national medical specialty society for neurology representing more than 27,000 neurologists and clinical neuroscience professionals. It 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 stroke, Alzheimer’s disease, epilepsy, Parkinson’s disease, migraine, multiple sclerosis, and brain injury.

The AAN has reviewed the fiscal year (FY) 2015 Inpatient Prospective Payment Systems (IPPS) proposed rule published in the Federal Register on May 15, 2014 and respectfully offers comments on these important topics:

- **2026: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following an acute ischemic stroke hospitalization**

- **2027: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization**

The AAN is disappointed that CMS adopted the stroke mortality and readmission measures in the Inpatient Quality Reporting (IQR) program given the risk-adjustment issue. We believe that these measures fail to accurately measure a hospital’s stroke performance, and we do not understand why CMS has decided to retain these measures particularly in face of the strong opposition from the stroke community. We therefore urge CMS to work closely with the AAN and other organizations to improve these measures by accounting for stroke severity.
• **Proposed Removal of “Topped Out” Chart-Abstracted STK Measures from the IQR Program**

The AAN supports CMS’ proposal to remove chart-abstracted stroke measures STK-2, STK-3, STK-5 and STK-10 from the IQR program. Based on CMS’ analysis, these measures are “topped out” because the 75th percentile has achieved a 100% performance rate. We also support CMS’ proposal to retain these stroke measures as electronic clinical quality measures.

• **Proposed Changes to the Review and Award Process for Resident Slots under Section 5506 of the Affordable Care Act**

**There is strong evidence that the shortage of neurologists will only increase over time.** We urge CMS to view neurology as a shortage specialty and to protect current neurologic residency slot allocations. CMS should also consider increasing the cap for neurology as is being done with primary care.

**2026: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following an acute ischemic stroke hospitalization/ 2027: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization**

The AAN is disappointed that CMS adopted the stroke mortality and readmission measures in the IQR program given the risk-adjustment issue. While we applaud the Agency’s commitment to preventing and improving treatment of stroke, we continue to believe that these measures miss the mark. Last year, the AAN submitted comments justifying our strong opposition to these stroke outcome measures. The arguments outlined in that letter reinforce our continued opposition to the in-hospital acute stroke mortality measure and the 30-day stroke outcome measures.

Neurologists have particular expertise in the treatment of stroke and often represent the first line of treatment for stroke patients. As such, we support the creation and implementation of stroke measures that lead to quality improvement. However, it is essential to ensure that such measures are not only properly constructed, but that they do not result in unintended consequences. Unfortunately, the stroke mortality and readmission measures adopted by CMS are not appropriately risk-adjusted, and therefore could inaccurately characterize hospital performance and ultimately harm patient care. For example, the measures may encourage hospitals to “cherry pick” stroke patients with mild or moderate strokes while discouraging hospitals from accepting patients who have the most severe strokes. This is of particular concern because hospitals are aware that the resulting mortality and readmissions data will be publicly available on the Hospital Compare website without benefit of an adequate risk adjustment. We reiterate our emphasis that there are no peer-reviewed articles or published data to support either of these measures or to delineate what limitations, if any, were identified through data analysis. Therefore, our concerns regarding whether the measure models will provide adequate discrimination and prevent unintended consequences remain.

The strongest predictor of short-term outcomes among stroke patients is baseline stroke severity. The National Institutes of Health Stroke Scale (NIHSS) has more predictive power than all other baseline variables (demographics, co-morbidities, etc.) combined.\(^1\)\(^2\) Therefore, evaluating short-term outcomes without adjusting for baseline stroke severity will always be subject to missing variable bias. The AAN along with other organizations, like the American Heart Association/American Stroke Association, support the creation of an ICD-10 NIHSS code. It is our understanding that there are

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efforts underway to create an ICD-10 NIHSS code to capture stroke severity. One of the advantages of ICD-10-CM is the ability to add severity designation which will allow for more appropriately adjusted stroke outcome measures for mortality and readmission.

CMS has made it clear that while these measures are not ideal, they are here to stay. To that end, the AAN recommends that CMS actively engages and works closely with the stroke community to improve these measures by accounting for stroke severity.

Proposed Removal of “Topped Out” Chart-Abstracted STK measures from the IQR Program
CMS conducted an analysis of the hospital IQR measure set to identify potentially “topped out” measures using the most recent clinical process of care data that covered measurement period January- June 2013. Based on that analysis, CMS identified four chart-abstracted stroke measures that have been topped out— the 75th percentile has achieved a 100% performance rate. The AAN supports CMS’ proposal to remove chart-abstracted stroke measures STK-2 (Discharged on antithrombotic therapy), STK-3(Anticoagulation therapy for atrial fibrillation/flutter), STK-5 (Antithrombotic therapy by the end of hospital day two) and STK-10 (Assessed for rehabilitation) from the IQR program. We agree that by removing these chart-abstracted measures, the Agency would alleviate some of the maintenance costs and administrative burden to hospitals associated with retaining them. We also support CMS’ proposal to retain these stroke measures as electronic clinical quality measures so that the Agency can continue to monitor and ensure that hospitals maintain high levels of performance.

Proposed Changes to the Review and Award Process for Resident Slots under Section 5506 of the Affordable Care Act
The AAN is deeply concerned by CMS’ proposal to re-allocate Graduate Medical Education (GME) slots of teaching hospitals that close. Under the proposed rule, if a teaching hospital closes, its direct GME FTE slots can be awarded to another hospital, but it is not necessary that the GME FTE slots be allocated to the same specialty. This is extremely troubling because evidence strongly indicates that there is a current shortage of neurologists which is only expected to increase over time. A recent study of the neurologic workforce concluded that in 2012 there was an 11% shortage of neurologic FTEs to meet the needs of patients. In 2025, this shortage will be nearly 20%. Similar shortages are also being described for primary care specialties like family medicine and general internal medicine. Yet, CMS’ policy goals only focus on increasing training in primary care and general surgery.

Neurologists typically care for patients with complex chronic diseases who require care coordination. Often times, the neurologist becomes that patient’s principal physician and serves as the patient’s interface with the healthcare system. For example, 72.2% of patients with multiple sclerosis (MS) saw a neurologist for their usual MS care. In addition, more than 90% of individuals with MS receive treatment and education about their disease from a neurologist.

It is important to note that many, if not most, of the diseases impacting the Medicare population such as Alzheimer’s disease, stroke and Parkinson’s disease are neurologic conditions. In addition, a number of neurologic disorders are increasing in frequency as our population ages. Currently, no

treatment interventions exist to prevent or modify the course of these disorders. Projections suggest that beyond the personal and family burden and tragedy, the societal burden will outstrip resources at both the federal and state levels. The leading example is Alzheimer’s disease. While other specialties and even non-physician providers care for these populations, it is neurologists who are attempting to identify effective treatments through research.

**Given the neurology workforce crisis, the AAN recommends that neurology be viewed as a shortage specialty as legitimately recognized for others with identical current shortages.** Further, current neurologic residency slot allocations should be protected and consideration should be given to increasing the cap to assure that there is an adequate supply of neurologists in the future. **The AAN also recommends that CMS encourage teaching hospitals not only to maintain their current neurology slots, but also to use additional slots either to establish or expand a neurology program.**

Protecting if not increasing GME and IME funding and slot allocation for neurology should be a critical priority for CMS.

The AAN appreciates the opportunity to provide comments on this proposed rule. Should you have questions about our comments or require further information, please contact Ms. Daneen Grooms, Manager of Regulatory Affairs, at dgrooms@aan.com or (202) 525-2018.

Sincerely,

Timothy A. Pedley, MD, FAAN
President, American Academy of Neurology