AMERICAN ACADEMY OF NEUROLOGY®

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Chairman Fred Upton
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Chairman Dave Camp
House Committee on Ways & Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Upton and Chairman Camp:

The American Academy of Neurology (AAN), representing more than 26,000 neurologists and neuroscience professionals, again welcomes the opportunity to submit comments in response to the joint Energy & Commerce and Ways & Means request for feedback on the second iteration of your proposal to repeal and reform the Medicare Sustainable Growth Rate (SGR) formula.

The AAN fully supports the repeal of the Medicare SGR formula and reform of the physician payment system to ensure better access to care for all Medicare beneficiaries.

The Academy's responses to specific questions raised by the joint committees in the second iteration proposal follow:

Questions for Phase II

- *How should the Secretary address specialties that have not established sufficient quality measures?*

Specialty physicians want to participate in health care reform and demonstrate the quality and value of the care that they provide their patients. Specialty associations and their members are actively engaged in developing evidence-based and clinically relevant quality measures. The AAN recommends that the Secretary implement a plan that addresses both short-term and long-term needs for meaningful specialty quality measures.

Specialists want meaningful measures of the unique care they provide to patients. Unfortunately, in specialty care there is often a lack of

high-quality evidence that supports intermediate and long-term patient outcomes.

Possible short-term solutions the Secretary might consider include measures that assess implementation of evidence-based processes of care; the degree to which patient care is coordinated across acute, primary, and specialty care; whether access to appropriate specialty care is available; and patient experience with specialty care. Specialists should be allowed and encouraged to submit general quality measures that pertain to all health care providers, such as medication reconciliation, advising patients about fall risks, care coordination, and suicide detection, as ways to improve the quality of their care.

For long-term priorities, the Secretary might address some of the barriers to specialty measure development, including lack of resources to develop, test, and shepherd measures through the national endorsement processes. National priorities for measurement have rightly focused on areas of highest impact. However, this focus on the most common chronic diseases has diverted resources and attention from specialty care measurement. While it is not realistic to expect that measures be developed for every subspecialist, the Secretary could focus national attention and resources on developing measures for specialty care. Ideally, such measures could be developed at a more rapid rate. However, the rigorous process to develop meaningful measures that can meet national endorsement requirements would realistically take one or more years. The Secretary might consider evaluating whether the process and requirements of national endorsement has hindered the availability of specialty measures.

- *Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?*

  Caution must be taken to avoid making quality improvement a zero sum game. The inherent goal should be for all physicians to practice high-quality medicine. In other words, the assumption shouldn't be made that quality "winners" must offset "losers." The goal of any reward program should be to recognize and retain current high performers while encouraging lower performers to improve. Programs should include rewards based upon achievement of specific quality goals compared to peers and for quality improvement over time. Performance thresholds reward existing high performers because they are near the top to begin with and percent improvement criteria tend to favor low performers because they have more room to improve.

- *Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?*

Despite a growing number of efforts to measure and report on health care quality there has been little attention nationally to quality improvement based on the data. Using data for quality improvement is a shift in the culture of medicine, especially when the focus of participation in these programs has been to receive rewards or avoid penalties. The AAN recognizes the purpose is broader and that these efforts must improve the quality of health care and patient outcomes. The AAN has developed Maintenance of Certification: Part IV Performance in Practice modules and we readily believe that the number of modules ought to increase. However, there are significant resource limitations. The time to completion of a MOC module can be up to a year.

Specialists and subspecialists should be encouraged to participate in quality improvement collaboratives through their medical neighborhood. These activities could be similar to the activities of Maintenance of Certification but orient providers to care coordination within their medical neighborhood. Again, developing and implementing quality collaboratives requires significant resources. The time to develop a collaborative could be around six to eight months.

To address knowledge needs, the AAN is focusing on providing quality improvement education and to address the culture the AAN will be sharing quality improvement success stories. These efforts are underway and will continue to be part of the AAN's strategies.

- *Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?*

  Merely pooling or aggregating data across multiple clinics or providers will not address the statistical significance of the data if it is reported out on an individual clinic or physician level. To facilitate shared coordination and accountability, the Secretary might consider aggregating and reporting data on the "medical neighborhood" level.

  The AAN believes that care must be coordinated across primary, specialty, and acute settings in a medical neighborhood. Data for all providers in a geographic region ought to be aggregated and reported across medical neighborhoods. Medical neighborhoods must have shared accountability for the health of their communities. Sharing across the neighborhood will also reduce duplication of reporting on similar measures (e.g., all providers reporting on tobacco use). Participants in the medical neighborhood should be able to determine which measures address their community's quality improvement needs.

Small practices may belong to several naturally occurring "medical neighborhoods" and it may be challenging for these smaller practices to handle significant data and administrative work. Therefore, any new reporting policies must not make it harder to be in a solo or small practice. A centralized data repository may need to be created on a regional level to facilitate regional or neighborhood the quality reporting; for example, through Quality Improvement Organizations or Independent Physician Associations. Data must be able to be reported through electronic health records (EHRs).

Questions for Phase III

- *How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?*

  Attributing groups for the majority of their care (quality and cost) through the group practice reporting option (GPRO) is already done reasonably well. Individual quality measurement and attribution for some physicians for preventive care is already good where patient allocation is clear. By contrast, specialist measures and attribution have lagged far behind. In fact, it may be difficult to ever accurately attribute costs through individual physician measurement or attribution because patients rarely see only one physician.

  Perfect (measurement) should not be enemy of the good. Emphasizing what works—group and virtual group quality and cost measures—should perhaps take precedence over individual attribution and measurement. Though there are physicians who might resist sharing in the collective responsibility for the actions of others in their neighborhood, this is necessary. It may take bold reforms like this to really begin to change the climate of spending in our health care system.

- *Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?*

  Paying physicians and providers for efficiency (or cost) should only be done after quality standards are met or exceeded.

Questions for APM Adoption

- *What do you believe will be necessary to support provider participation in new payment models?*

  Models will need to be simple and straightforward. Ambiguity in payment structure and reporting requirements will lead to hesitation to adopt new models. Rewards and feedback need to be timely to allow for change in behaviors.

Providers and groups will need guidance to change their structure and function to analyze data and change care processes to focus on better outcomes and lower cost. The incentives offered will have to offset the risks. Non-financial incentives like improved autonomy, less paperwork, and other unique resources would be needed to compel individuals and groups to make this change.

Finally, the Secretary should consider allowing APMs to be regionally directed to ensure fit with the local community.

- *What is a reasonable time frame for CMS to approve and adopt APMs?*

The Secretary should take many factors into account when determining a time frame for APM approval and adoption. A one-size-fits-all approach may not be feasible. Instead, a careful balance is needed to get new APMs into practice without rushing the process and compromising patient care. Developers of APMs also need a clear idea of risks and rewards. Pilot programs should be used to work out problems and ease widespread adoption.

- *Should providers be able to participate in more than one payment model?*

Some providers may need to be involved in more than one model. Resource limitations (e.g., not enough specialists in an area) may make this a necessity. However barriers to participating in more than one model need to be addressed in these cases. Administrative costs, data analysis, and reporting should be universal and simple. Pilots would likely be needed to determine best practices.

Questions for Current Law Improvements

- *What improvements upon current law do you believe will be required to support alternate payment model adoption?*

Due to the relative lack of experience with APMs, there will have to be ample incentives and safeguards for groups to take on the risk of adopting alternative payment models. Shared savings models should have different benchmarks than their own historical performance to compete against. This may also be improved with more consistent Stark and anti-trust relief.

- *What improvements upon current law will help ease the administrative burden upon medical providers and allow more time caring for Medicare beneficiaries?*

The administrative burdens under the current quality reporting requirements are disproportionately high for those in small and solo practice. Streamlining quality measures in all programs will be a critical component to mitigating the burden. Maximizing the flexibility for providers to choose how and what measures to report on is also essential.

The focus on the patient outcomes and their functional status should be emphasized over narrowly-focused disease or process measures.

The use of technology should be encouraged and supported financially to aid in reporting.

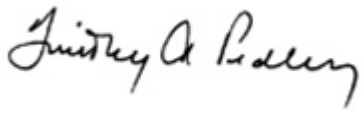
- *What improvements upon current law would support the provision of quality health care delivery for Medicare beneficiaries?*

  In order to increase physician participation in quality-based payments, incentives need to be of sufficient value to offset barriers to reporting. The current incentives offered under the Medicare Physician Quality Reporting System have resulted in insufficient physician participation for these reasons. Approximately 7-10% of a physician's payment should be based on performance on quality and cost (inside a group/medical neighborhood). Additionally, consider the equivalent of a "race-to-the bottom" phenomenon for quality measure selection. If it remains complicated for physicians, particularly specialists, to identify and incorporate reporting into daily practice, the measures perceived to be the "easiest" to report will be duplicated for same patient seeing multiple physicians resulting in little actual improvements in quality.

  Further, it is essential that the barriers identified in our February letter be taken seriously. Specifically the administrative and technical compliance requirements for National Quality Forum (NQF) endorsement, which is a condition of acceptance for the PQRS program, are so rigid that 17 of the last 18 measures the AAN submitted for endorsement were turned down. This is despite the fact that leading neurologists believe these measures would improve care. The current administrative and technical hurdles significantly hinder the ability of specialty medical organizations to develop specialty-specific measures, which has a negative impact on the potential to improve quality of care.

The AAN appreciates the continued opportunity to provide comments on this important topic and looks forward to assisting your committees in their final deliberations on Medicare payment reform.

Sincerely,



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