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August 15, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted electronically via www.regulations.gov

Subject: Request for Information; Episode-Based Payment Model (CMS-5540-NC)

Dear Administrator Brooks-LaSure,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to provide feedback on the Center for Medicare & Medicaid Innovation's (Innovation Center) request for input on the design of future episode-based payment models.

The AANS and CNS appreciate the Center for Medicare & Medicaid Services (CMS) effort to build on lessons learned from its experience with the Bundled Payments for Care Improvement (BPCI) initiative and other models to design and implement a new episode-based payment model focused on accountability for quality and cost, health equity and specialty integration, along with the agency's interest in embedding these types of models within broader population-focused models. However, the request for information (RFI) does not specify any conditions a potential episode-based payment model would target. Thus, given the limited details, the AANS and the CNS request that CMS carefully consider the following broader issues as it contemplates potential future payment models.

- **Incentivize, Rather than Mandate, Participation.** In this RFI, CMS states that it "anticipates this model would require participation by certain entities, such as Medicare providers or suppliers or both located in certain geographic regions, to ensure that a broad and representative group of beneficiaries and participants are included. Further, requiring participation would also help to overcome voluntary model challenges such as clinical episode selection bias and participant attrition." The AANS and CNS are very concerned about this statement and oppose mandatory participation in models. Alternative payment models (APMs) should not be forced on physicians, particularly those that lack the requisite infrastructure, data and analytical capabilities, staffing and capital to assume downside risk. Instead, the agency should provide appropriate incentives to allow practices to ready themselves for new value-based models. In addition, as new models are implemented, CMS should provide participants with ongoing technical assistance and data/analytic support.

- **Ongoing Involvement of Clinical Experts.** CMS must include practicing physicians with relevant clinical expertise throughout the design and implementation phases of any new model to ensure that it is feasible to administer and produces data that are directly actionable for that specialty and

results in the most appropriate care for patients. Similarly, CMS must offer models that specialists have direct control over — rather than some larger, elusive entity such as an accountable care organization.

- **Emphasize Specialty-Developed Quality Measures and Harness the Power of Clinical Data Registries.** The Medicare Access and CHIP Reauthorization Act specifically emphasized developing and prioritizing specialty-focused quality measures. Despite heavy specialty society investments in registries and more clinically appropriate measures, CMS continues to adopt policies that make it exceedingly challenging to justify investment in registries and measures for federal quality reporting programs. As the Innovation Center takes inventory of its work and looks to the future, we urge it to carefully consider the critical role of physician-led clinical data registries. Clinical data registries are uniquely positioned to drive the health care system forward and ensure that clinicians participating in alternative payment and delivery models can raise the bar on quality and value in the most meaningful manner. Registries promote improvements in quality by supporting longitudinal evaluations of clinician performance, identifying best practices and gaps in care that require more attention and providing timely and actionable feedback to clinicians. They can be used to compare outcomes based on alternative treatment paths and support continuous learning cycles by producing statistically valid and timely inter-practice and national benchmarks and the data needed to develop evidence-based guidelines. Registries are also a critical source of real-world evidence, including patient-reported outcomes data informing the value of specialized care. Most notably, registries are unique in their ability to capture more nuanced clinical and sociodemographic data elements that simply cannot be extracted from administrative claims data. This allows for more accurate risk adjustments and a more complete understanding of the myriad factors impacting the quality of care. Basic information regarding expected outcomes for specific conditions/interventions that are most meaningful to patients (such as improvements in pain or disability) is currently absent in common data structures. Additionally, it remains challenging to determine *a priori*, which patients will cost more precisely, so proper adjustments and stratifications can be applied. Without such information, which can be collected through registries, we can never hope to move the quality needle meaningfully.

- **Increased Transparency**. We urge CMS to adopt a more transparent approach to developing and evaluating new payment models than in the past. CMS should also leverage its administrative data and analytic capabilities to carefully assess and share with the public analyses of how models impact access to specialty care and the outcomes of specialty patient populations. Similarly, CMS should make administrative claims data more accessible to specialty societies so that they can conduct their own analyses.

- **Alignment of Measures and Reporting Requirements.** CMS should strive to align quality and cost measures and reporting requirements as much as possible across its various programs and payment models, as well as with private payers, to minimize administrative burden. For example, measures currently reported under BPCI-Advanced are not recognized in the Merit-Based Incentive Payment System (MIPS) even though they are often the same measures, which results in unnecessary, duplicative reporting. Aligning reporting requirements is as important as the alignment of measure sets and helps ensure that physician time with patients is not diverted to administrative compliance. Physicians should be able to satisfy the reporting requirements of multiple public and private payer initiatives at once. It is equally important that CMS ensure that specialists can achieve APM Qualifying Participant (QP) status and qualify for a MIPS exemption if participating in a more focused episode-based model. Additionally, specialty-specific quality and cost measures used in any new nested model must be aligned with MIPS so that even if a specialist does not achieve QP status, they can still receive credit simultaneously under both initiatives.

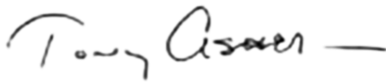
- **Only Hold Physicians Accountable for Care Decisions in their Direct Control.** Episode-based and condition-specific models should appropriately reward specialists for care that they can actually control. As noted above, current population-focused models rely on measures that may be important for public health purposes, but they provide very little information about the outcomes related to a specific surgical procedure — hindering improvements in surgical care and decision-making for surgical patients.

- **Abandon One-Size-Fits-All Approaches.** As we have repeatedly recommended, CMS must remember that one size will not fit all when it comes to specialty integration into population-based models. A strategy that might work for one specialty and its patient population might not work for another. Even when considering specific episodes, CMS must carefully consider the heterogeneity of patient populations and appropriate interventions. Additionally, CMS should not simply carry over the methodologies of existing episode-based models, some of which are flawed and pose challenges to specialists regarding long-term participation. For example, many of our members that actively participated in BPCI-A have been forced to pull out because of barriers, such as the ratcheting effect, whereby target prices are continually lowered over time for practices that effectively provide high-value care — making it impossible to sustain long-term participation.

- **Ensure that Evaluations of Cost Simultaneously Account for the Impact on Quality.** The agency's efforts to assess value have been flawed because they measure cost in isolation. CMS' ability to identify a quality measure with a similar title to a cost measure does not mean that CMS is capturing the same patient population and evaluating the effect that cost reductions have on quality and outcomes. If quality is not factored into the value equation, then cost measures could have the unintended consequence of disincentivizing appropriate care that is evidence-based and accounts for patient preferences. Additionally, CMS needs to think carefully about the length of episodes under consideration and not adopt arbitrary cutoffs tied to the claims-based payment system calendar.

The AANS and the CNS thank CMS for requesting input from the public on how best to proceed with episode-based payment models. Our members have assisted the agency with developing and maintaining current payment and delivery models, and we are willing to participate in these efforts moving forward. In the meantime, please contact us if you have any questions or need additional information.

Sincerely,



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