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September 1, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
U.S. Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

**RE: Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements. [CMS-1751-P]**

Dear Administrator Brooks-LaSure,

The American Academy of Neurology (AAN) is the world's largest neurology specialty society representing more than 36,000 neurologists and clinical neuroscience professionals. The AAN 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. These disorders affect one in six people and include conditions such as multiple sclerosis, Alzheimer's disease, Parkinson's disease, headache, stroke, migraine, epilepsy, traumatic brain injury, ALS, and spinal muscular atrophy.

**Telehealth and Other Services Involving Communications Technology**

The AAN wishes to restate its gratitude for the flexibilities CMS enacted during the Public Health Emergency (PHE). According to the Kaiser Family Foundation, "Among the 33.6 million Medicare beneficiaries with a usual source of care who reported that their provider currently offers telehealth appointments, nearly half (45%) said they had a telehealth visit with a doctor or other health professional between the summer (July) and fall of 2020. This translates to just over 1 in 4 (27% or 15 million) of all community-dwelling beneficiaries in both traditional Medicare and Medicare Advantage using telehealth during this time period."[1] These accommodations allowed clinicians to adapt more easily to changing circumstances in order to maintain access and quality to care for patients who may have otherwise had their care compromised.

[1] Koma, W., Cubanski, J., & Neuman, T. (2021, May 19). Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future. Available at https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future.

The AAN supports patient access to telehealth services regardless of location; coverage for telehealth services by all subscriber benefits and insurance; equitable provider reimbursement; simplified state licensing requirements easing access to virtual care; and expanding telehealth research and quality initiatives.[2] Telehealth and communication technology-enabled services (CTBS), such as telephone encounters, have become a lifeline connecting neurology patients with neurology providers. The choice to use telehealth technology is determined by the needs of the patient, the ability to access and use the technology, and the clinical problem to be addressed. Patients and caregivers alike have benefitted from expanded access to telehealth services both before and during the PHE. Patients report that access to care has improved, and that in many instances, telehealth services are more convenient and comfortable, and provide more confidentiality. Benefits accrue to outpatient and inpatient populations and apply to new and established patients requiring physician services and other services such as physical therapy and speech and language therapy.

The expansion of telehealth services for the Medicare population has been particularly beneficial to patients with cognitive and mobility impairments. AAN members report that being able to complete appointments at home has increased patient satisfaction. Often, patients with dementia are reluctant to come to the office for evaluation, partially due to the lack of recognition that a problem exists. The ability to complete telehealth visits eliminates the barrier of coming into a doctor's office to be seen. The ability to conference in additional family members without their needing to take extended time away from work to attend appointments has improved care coordination for this vulnerable population.

The AAN believes that CMS proposals in the 2022 Medicare Physician Fee Schedule are indicative of a positive trend in the ever-growing adoption of telehealth services. As acknowledged by CMS, various telehealth services spiked in their utilization early in the PHE but leveled off thereafter while others maintained a high utilization rate throughout the PHE. This demonstrates that patients and providers were able to identify those visits that were best suited to telehealth. CMS should continue to look for opportunities to furnish this kind of collaborative decision making between patients and providers to increase efficient access to care.

*Extension of Category 3 Medicare telehealth services list*

The AAN applauds CMS for its proposal to extend Category 3 authorization of telehealth services that have not yet been approved permanently through Categories 1 or 2. During the early stages of the PHE, patients and providers alike struggled to adapt to rapidly changing circumstances and the flexibilities CMS approved were critical to easing that transition. It is equally important to ease the transition out of the PHE so as to minimize confusion and disruption to care. By extending Category 3 through a set date, not linked to the end of the PHE, CMS is eliminating the unnecessary suspense and confusion that would have come from a more abrupt change.

[2] Hatcher-Martin, J. M., Busis, N. A., Cohen, B. H., Wolf, R. A., Jones, E. C., Anderson, E. R., Fritz, J. V., Shook, S. J., & Bove, R. M. (2021). American Academy of Neurology Telehealth Position Statement. Neurology, 97(7), 334–339. https://doi.org/10.1212/WNL.0000000000012185.

The AAN is also heartened to see CMS acknowledge the great improvements that have been made in the provision of telehealth services during the PHE. Our members are working diligently to expand the evidence base supporting permanent approval for these services through Categories 1 and 2; the extended timeframe CMS is granting will prove vital to that process.[3] The AAN is adamant that identifying those telehealth services that meet the criteria of Categories 1 and 2 will result in expanded access to high quality care for patients.

*Telehealth services that should be added to Category 3*

The AAN was disappointed to see CMS reject requests to add Neurostimulators, CPT codes 95970 -95972, and Neurostimulators, Analysis-Programming services, CPT codes 95983 and 95984, to the Medicare telehealth services list using the Category 3 criteria. These codes are used for patients who often face unique challenges in accessing in-person care and we believe these services can safely and effectively be performed via telehealth. By not adding these services under Category 3, CMS risks disruption of care for these patients shortly after the PHE ends.

The AAN also believes that the hospital inpatient services, CPT codes 99218-99222, and observation care services, CPT codes 99234-99236, should be included on the Category 3 telehealth services list. While these codes were considered for Category 2 inclusion, the AAN believes that upon upcoming implementation of the E/M billing and documentation changes for inpatient services effective CY 2023, these codes will be eligible under Category 1 as the level selection criteria for these codes will be based solely on time spent on the visit or Medical Decision Making (MDM). Both of these elements can easily be satisfied and documented via telehealth. Removing these services for 2022 only to add them back for 2023 would cause unnecessary confusion and would needlessly bar patients from access to appropriate neurologic care.

*Frequency of in-person visits for continued telehealth care*

The AAN is glad to see CMS evaluating all elements of telehealth policy as the technology and methodology evolve. The AAN believes that removing obstacles to access to care is of upmost importance and therefore the requirement for in-person visits should be relaxed as much as is feasible. A variety of neurology patients have conditions that make travel to see their providers exceptionally difficult and patients of all specialties with socioeconomic vulnerabilities may be barred from the highest quality of care by unnecessary restrictions. In a study conducted by the Michael J Fox Foundation, 62 percent of respondents reported issues accessing health care, including canceled appointments or difficulty obtaining medications.[4] The AAN believes that patients and providers are capable of jointly identifying when an in-person visit is appropriate and thus a blanket restriction is unnecessary. The AAN

[3] Hatcher-Martin, J. M., Busis, N. A., Cohen, B. H., Wolf, R. A., Jones, E. C., Anderson, E. R., Fritz, J. V., Shook, S. J., & Bove, R. M. (2021). American Academy of Neurology Telehealth Position Statement. Neurology, 97(7), 334–339. https://doi.org/10.1212/WNL.0000000000012185.

[4] Brown, E. G., Chahine, L. M., Goldman, S. M., Korell, M., Mann, E., Kinel, D. R., Arnedo, V., Marek, K. L., & Tanner, C. M. (2020). The Effect of the COVID-19 Pandemic on People with Parkinson's Disease. Journal of Parkinson's disease, 10(4), 1365–1377. https://doi.org/10.3233/JPD-202249.

believes that this timeframe should be eliminated or extended to as long as possible, at least to 12 months.

The AAN agrees with the proposal to allow a clinician's colleague in the same subspecialty and practice to satisfy any in-person requirement that does persist. Because of the possibility that an in-person visit requirement could block a patient's access to care, any accommodations that can be made to ease that burden is welcomed. As such, allowing for a clinician's colleague to satisfy this in-person requirement in their stead is appropriate.

*Audio-only telehealth services*

The AAN approves of the recommendation to make permanent the flexibilities for audio-only telehealth visits for behavioral health care. The AAN is glad to see CMS adapt to the ever-changing landscape for telehealth services. The use of audio-only telehealth has been a tremendous benefit for many older patients and others who struggled with audio/video technology for a variety of reasons. During the PHE, 56% of Medicare beneficiaries surveyed reported having a telehealth visit using a telephone only.[5] There is a substantial proportion of the neurology patient base who does not have access to or cannot operate computers or mobile devices that have video and audio capability. Furthermore, there are many patients who cannot afford broadband access or robust cellular data plans that would allow audio/video encounters to take place.

The AAN is disappointed that office/outpatient services, CPT codes 99441-99443, were not added to the telehealth services list as these are critical to access to care for patients that cannot access audio-video services. Older adults and patients without access to high quality broadband would benefit from these services. CMS acknowledges in this proposed rule the utility of audio-only visits for mental health services as many of these services "primarily involve verbal conversation where visualization between the patient and furnishing physician or practitioner may be less critical to the provision of the service." The AAN strongly agrees with this rationale and believes CMS should expand this to include other neurologic services that fit the same description such as headache, seizure, dementia, pain, along with adherence and side-effect follow-up. The AAN does not believe that any additional obstacles or documentation requirements should be placed on audio-only visits that are not currently mandated for audio-visual visits. Parity between these services is critical for ease of access and administration.

*Originating Site*

The AAN agrees with CMS's addition of a patient's home as a permissible originating site for mental health services as well as the removal of the geographic restrictions in § 410.78(b)(4). This is an important step in modernizing virtual care delivery and should be used as the model going forward for inclusion of other appropriate telehealth services, including those related to the neurologic community.

[5] Koma, W., Cubanski, J., & Neuman, T. (2021, May 19). Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future. Available at https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future.

*APP incident to supervision requirement flexibility*

The AAN supports permanently modifying direct supervision requirements so that direct supervision can be performed via real-time interactive audio/video technology in certain cases. Virtual supervision, when appropriately utilized, can be an excellent way to maximize supervised team-based care across a more distributed geography. Providers have demonstrated throughout the PHE that this flexibility has allowed them to expand access without compromising patient care. Therefore, CMS should revise the definition of "direct supervision" to include immediate availability through the virtual presence of the supervising physician or practitioner using real-time, interactive audio/video communications technology without limitation.

The AAN supports the creation of a service level modifier for the purposes of identifying APP (the AAN uses the term Advanced Practice Provider but will be using APP and NPP interchangeably throughout these comments) involvement in care. The AAN believes that this can be used as an information tool to benefit transparency and quality measurement. However, we ask the agency to consult with specialty societies as this change is developed and implemented to make sure there is not an unreasonable burden on providers.

*Virtual check-in services (HCPCS code G2252)*

The AAN approves of the permanent adoption of HCPCS code G2252 to allow for extended virtual check-ins and other brief communication technology-based services. This has proven itself to be a useful tool during the PHE to allow providers to work with patients to determine when office visits or other types of care are necessary. During the PHE this was critical in eliminating unnecessary exposure risks, however, those unnecessary visits were also contributing to the strain on the health care system more broadly. Communication technology-based services allow patients more frequent access to care when needed, eliminates much of the travel cost, and improves access for rural and urban patients alike. Allowing patients easier access to their providers outside of the traditional office visit provides an opportunity for collaborative decision making regarding when further care is needed while minimizing the burden to the patient and the health care system more broadly.

**Evaluation and Management (E/M) Visits**

The AAN applauds CMS for moving forward with the finalized coding and reimbursement structure for evaluation and management (E/M) services. The AAN remains supportive of the new coding and reimbursement policies for outpatient E/M Services since their implementation on January 1, 2021, which allow physicians to select the E/M visit level based on either total time spent on the date of the patient encounter or the medical decision making utilized in the provision of the visit. The AAN was deeply involved in the AMA CPT/RUC process to develop the new structure and concurs with CMS that it will produce a simplified and more intuitive system of E/M coding that is more consistent with the current practice of medicine and better aligns reimbursement with the value of cognitive care.

Currently, there are two sets of guidelines: one for office or other outpatient services and another for the remaining E/M services.

The main differences between the two sets of guidelines are that the office or other outpatient services use medical decision making (MDM) or time as the basis for selecting a code level, whereas the inpatient E/M codes use history, examination, and MDM and only use time when counseling or coordination of care dominates the service. The definitions of time are different for different categories of services.

For E/M services other than office or other outpatient services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home), providers may use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service.

The AAN is encouraged by the steps CMS is taking to update reimbursement rules to keep up with the changing landscape of E/M billing. The AAN also appreciates the clarification from CMS on the distinction between billing incident to a physician compared to billing split (or shared). However, the AAN is concerned about the potential unintended consequences of some of the changes proposed to split (shared) billing rules proposed in the 2022 Physician Fee Schedule.

The change proposed to split (shared) billing rules represents a significant additional administrative burden to the care team and a major deviation from current inpatient coding criteria. This rule change would require physicians and NPPs to track the time they spend according to two different definitions of time to determine how the visit should be billed. While CMS references the changes to E/M billing for office visits, as stated in this rule, those changes do not currently apply to inpatient visits. As such, visits performed by physicians or NPPs would still be billed under the current level selection criteria using unit/floor time or elements of history, physical examination or medical decision making for level selection purposes. However, for determining substantive portion for split (shared) visits time would be measured by the more broad proposed definition of qualifying time. The AAN fears this policy will have the unintended consequence of significantly reducing the number of visits that are billed as split (shared) solely due to the difficulty of compliance. This would discourage team-based care and detract from quality of patient care.

The AAN recommends that CMS refrain from implementing the new time-based definition of the “substantive portion” criteria for split (shared) visits until the E/M revisions for inpatient services take effect. This will prevent a period of confusion as providers have to track the time of their visits according to the proposed definition of qualifying time for split (shared) purposes while still determining the level of service for other inpatient encounters according to the existing criteria. The AAN anticipates the 2023 Physician Fee Schedule to be a more appropriate opportunity to develop a new split (shared) framework as the inpatient E/M changes are being implemented.

While our primary ask of CMS is to delay any changes to the split (shared) billing rules until the inpatient E/M changes are proposed in the 2023 Medicare Physician Fee Schedule, the AAN does have recommendations for what changes CMS should consider at that time.

The AAN does appreciate the attempt to clarify how the "substantive portion" of a visit should be determined and agrees with CMS that merely "poking your head" into a visit is not adequate. However, we believe that rigidly limiting this determination to majority of time spent on the visit does not recognize the importance of contributions made to the key components of an E/M visit by a physician. Regardless of the method of determining level of service for split (shared) visits by time, we recommend that providers be given an alternative method to determine the substantive portion of the split (shared) service, defined as providing one of the three key components of an E/M visit—either the history of present illness (HPI), physical exam, or medical decision-making (MDM). If the physician provided one of these elements, the physician would be identified as the provider who performed the substantive portion of the encounter, would bill for the visit, and would be required to sign and date the medical record.

The AAN recognizes the accepted scope(s) of practice allows each member of the physician-led neurology care team to practice to the full extent of their professional license, training, and abilities. The AAN also recognizes and supports the expanded collaborative role that NPPs play in neurologic care while emphasizing they do not replace the need for neurologists. As such, the AAN appreciates CMS proposed change to split (shared) billing requirements to allow new and established patient visits to be billed split (shared). Eliminating unnecessary barriers to the efficient cooperation of a physician-led neurology care team is a welcome change.

The AAN agrees with CMS that critical care services and services performed in a SNF/NF setting should not be precluded from split (shared) billing. CMS is correct in its assessment of the changes to medical practice that are leading to better integrated team-based care delivery. Physician-led neurology care teams are often comprised of a variety of practitioners that work together to deliver optimal care for their patients.

The AAN is concerned about the potential narrowing of the definition of "group" for split (shared) billing purposes. Restricting this definition to only being inclusive of members of the same specialty would inhibit the coordination of a diverse care team and may have unintended consequences in regard to PAs who are not identified by specialty in the same way physicians are. The AAN believes that members of a care team working in the same practice or billing under the same tax identification number is an adequate justification for split (shared) billing.

The AAN supports the establishment of a modifier for these split (shared) visits that will allow for tracking the contributions of NPPs more easily, increasing transparency. This will allow providers, employers, and CMS to better evaluate the contributions of each member of the care team that will facilitate more efficient care delivery going forward.

**Valuation of Global Surgery Packages**

In the proposed rule, CMS reminds stakeholders that the agency continues to assess values for global surgery procedures, including in particular the number and level of pre-operative and post-operative visits. This work is still ongoing. We write to reaffirm our support of the agency's work in this area.

We concur with the agency's comments in last year's proposed rule, noting that "there are now important, unresolved questions regarding how post-operative visits included in global surgery codes should be valued relative to stand-alone E/M visit analogues." The AAN appreciates that CMS noted the key distinction that while post-operative visits may be similar to stand-alone E/M services, they are not the same. The medical-decision-making for the typical post-procedure outpatient visit is less complex than the typical stand-alone E/M. The post-procedure visit usually is concerned with a well-defined problem; and, by definition, the provider has taken a medical history and examined the patient a short time before the visit in the global period. Practice expense may differ for post-procedure visits, some of which require supplies such as suture removal kits and dressings. The resources required for postprocedural visits in the global period differ from resources needed for the typical office visit and we agree with CMS that these visits should be valued independently of typical office E/M visits. This approach is supported by MedPAC, which recommended "a budget-neutral payment adjustment for ambulatory E&M services – excluding the ambulatory E&M services currently considered when valuing global packages."[6]

The AAN appreciates that CMS is carefully considering the findings from RAND related to the disparity between expected and observed post-operative visits. We note that RAND, the Office of the Inspector General, and other reports support the conclusion that CMS is now paying for many postprocedural visits that do not actually occur.[7,8] The AAN concurs with CMS that "if the number of E/M services for global codes is not appropriate, adopting the AMA RUC-recommended values for E/M services in global surgery codes would exacerbate rather than ameliorate any potential relativity issues." Any investigation of the global billing periods will have limitations, but the AAN is not aware of any independent data that support the number of postprocedural visits indicated in RUC surveys and in current CMS global periods. The AAN is in agreement with CMS's assessment in the 2020 Final Rule that the current body of evidence "suggests that the values for E/M services typically furnished in global surgery periods are overstated in the current valuations for global surgery codes." Given the current evidence, increasing the values of the global surgery codes is in direct opposition to the mandate that services must be resourced-based.

It is of the utmost importance that the valuation of the global packages accurately reflects the work being done and that the values are supported by data. The AAN recommends that CMS continue to work to collect and analyze all relevant data, and to develop a resourced-based payment model.

**Conversion Factor**

The AAN understands that the agency cannot waive its budget neutrality requirement without modification of existing legislation. Nor can CMS unilaterally add additional funds

[6] Rebalancing Medicare's Physician Fee Schedule toward Ambulatory Evaluation and Management Services. June 2018. www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0. p. 79.
[7] Kranz, Ashley M., Teague Ruder, Ateev Mehrotra, and Andrew W. Mulcahy, Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods: Final Report. Santa Monica, CA: RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR2846.html.
[8] Department of Health and Human Services, Office of the Inspector General. Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided, 1 May 2012. oig.hhs.gov/oas/reports/region5/50900054.pdf.

into the Fee Schedule. With that said, the AAN strongly supports the new January 1, 2021 E/M coding and reimbursement structure but notes that the subsequent reduction of the conversion factor may detrimentally impact some clinicians. The AAN is supportive of requests to Congress to waive budget neutrality, and add additional necessary funds into the Fee Schedule, provided that this would not result in a delay or in any way undermine CMS's decision to fully implement the new E/M coding and payment structure that started on January 1, 2021.

**Principal Care Management (PCM)**

The AAN commends the agency's continued focus on the value of care management and coordination services, specifically with the recognition of comprehensive services for a single high-risk disease (that is, principal care management) which are commonly provided by neurologists. We are pleased CMS is proposing to accept the RUC recommended values of four new principal care management codes, 99X22, 99X23, 99X24, and 99X24 which will be effective in CY 2022. The agency is seeking stakeholder feedback whether keeping professional PCM and CCM at the same value creates an incentive to bill CCM instead of PCM when appropriate. We do not think this will be the case as specialty care providers, such as neurologists, often care for a single high-risk disease and did not previously meet the criteria for reporting other care management service codes that require the management of multiple conditions. As the patient population eligible for each service would differ, we do not anticipate an issue.

**Billing for Physician Assistant Services**

The AAN supports the proposal to allow PAs to bill and be paid directly by Medicare. This change will bring parity between PAs and other NPPs which will simplify the billing process for physician-led neurology care teams that are increasingly utilizing NPPs. We also recognize CMS may be proposing this section to comport with new state laws.

With that in mind, we think this is an important moment to note that throughout the coronavirus pandemic, physicians, NPPs, nurses, and the entire health care community have been working side-by-side caring for patients and saving lives. Now more than ever, we need health care professionals working together as part of physician-led health care teams. The AAN vigorously opposes efforts that undermine the physician-patient relationship and physician-led health care teams during and after the pandemic. Nurse practitioners and PAs are integral members of the care team, but the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patient care. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients.

**Appropriate Use Criteria**

The AAN applauds CMS for delaying the payment penalty phase until 2023. We previously supported the agency's decision to extend the educational and operations testing period for the Appropriate Use Criteria (AUC) program through the end of 2021. We believe this could

be extended further. The AAN appreciates that CMS recognized the impact that the ongoing PHE has had on providers' ability to participate in the current educational and operations testing period meaningfully. Delaying this program is necessary because during the PHE providers must ensure that resources are devoted to patient care, rather than compliance with burdensome regulatory programs. CMS acknowledges this, noting in the rule, "we recognize that practitioners have been heavily impacted in their own practice of medicine to respond to the PHE and provide treatment to patients which may have prevented them from focusing on and participating in the educational and operations testing period to prepare for the payment penalty phase."

Due to the PHE, providers are unlikely to have gained the experience they will need to fully participate in the AUC program after the education and testing period has elapsed. The AAN believes that further implementation of this program is likely to have significant detrimental impacts on timely patient access to care, which is already hindered by the ongoing PHE. As such, the AAN urges CMS to consider additional delays in the implementation of the AUC program. CMS should also consider whether the standalone AUC program is necessary or if programmatic requirements have become redundant due to provider participation in the Quality Payment Program.

**Requirement for Electronic Prescribing for Controlled Substances (EPCS) for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan (section 2003 of the SUPPORT Act)**

We previously supported CMS's decision to delay implementation of the statutory requirements related to the electronic prescribing for controlled substances for a covered Part D drug to January 1, 2022 because implementation takes additional time and resources. We further supported this delay because the ongoing PHE may present additional challenges for some prescribers. Because of this, we support the new compliance date of January 1, 2023. We further support the proposal regarding compliance throughout 2023 to consist of letters to prescribers that the agency believes are violating EPCS requirements.

We also agree with CMS that electronic prescribing of controlled substances provides many advantages over the traditional processing of paper prescriptions. These advantages include improved workflow efficiencies; deterring and detecting fraud and irregularities by requiring an extra layer of identity proofing, two-factor authentication and digital signature processes; enhanced patient safety through identity checks, safety alerts, medication menus, electronic history files, and medication recommendations that lower the risk of errors and potentially harmful interactions and providing more timely and accurate data than paper prescriptions by avoiding data entry errors and pharmacy calls to a prescriber to clarify written instructions. We agree electronic prescribing may reduce the burden on prescribers who need to coordinate and manage paper prescriptions between staff, patients, facilitates, other care sites, and pharmacies.

We appreciate that CMS specifically explained its interest in not burdening small prescribers. We agree for prescribers of very few Part D controlled substance prescriptions, the cost of installing EPCS equipment and software may be unduly burdensome relative to its benefits.

We support the proposal to exempt prescribers who prescribe 100 or fewer Part D controlled substance prescriptions per year.

**Quality Payment Program (QPP)**

The AAN continues to support programs that allow neurologists to meaningfully participate in programs that seek to reward high-quality, low-cost care to Medicare patients, including the Quality Payment Program. The AAN appreciates CMS's flexibility during the ongoing PHE and acknowledgment of the exceptional pressures on the health care system and medical providers during this time. Consistent with our position in past years, the AAN urges CMS to extend flexibilities and reduce burdens associated with the QPP, especially for small and solo providers. The AAN continues to strongly support current relief or special scoring for small practices and appreciates CMS's proposed reweighting of the Promoting Interoperability component for these practices in this rule. We urge CMS to continue considering opportunities to offer support and ensure the successful participation of small and solo providers in the QPP, especially in the gradual transition to MIPS Value Pathways (MVPs) over the next several years.

*Performance and Data Completeness Thresholds*

The AAN understands CMS's proposal to gradually increase the performance and data completeness thresholds each year. While we would generally support these increases, the landscape has shifted to include managing the PHE, amongst other stressors. We suggest CMS to consider establishing a separate performance threshold for small practice providers. Historically, small practices struggle significantly to meet the performance threshold compared to larger group practices and clinicians that have a more robust infrastructure in place for data collection and reporting. CMS should reconsider raising the performance threshold to 85 points, especially for small practices.

*Complex Patient Bonus*

The AAN supports CMS's proposal to continue doubling the complex patient bonus for the 2022 performance year. Clinicians remain entrenched in attempting to balance caring for patients in the in-person and virtual environments while navigating through an ongoing PHE, all while participating in a generally burdensome program like MIPS and so the AAN welcomes this continued bonus. The AAN also supports the updated formula to include socially or medically complex patients.

*QPP Flexibilities*

The AAN urges CMS to continue extending the Extreme and Uncontrollable Circumstances Policy to MIPS eligible clinicians, groups and MIPS-APM entities as the COVID-19 public health emergency continues. The regulatory burden related to QPP reporting remains significant from year to year and is especially difficult for small practices to maintain. We appreciate CMS's flexibility and the relief offered to date and hope the option to reweight any or all the MIPS components due to COVID-19 remains for the duration of the PHE.

**Closing the Health Equity Gap in CMS Clinician Quality Programs—Request for Information (RFI)**

The AAN believes that persistent inequities in health care outcomes exist in the United States, including among Medicare patients. We appreciate CMS's efforts to draft this RFI and solicit feedback aimed at closing disparities in health equity. The AAN appreciates CMS's note that a future comprehensive RFI will be focused on closing the health equity gap in CMS programs and policies. As a general matter, we support the creation of confidential reports that allow providers to look at patient impact through a variety of data points, including, but not limited to, LGBTQ+, race and ethnicity, dual-eligible beneficiaries, disability, and rural populations.

To create an inclusive environment to discuss these issues, there must be shared terminology. To this end, the AAN appreciates CMS's definition of equity as established in Executive Order 13985. The definition describes equity as "the consistent and systemic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities who have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality."

In terms of specific proposals, we agree with the CMS Equity Plan for Improving Quality in Medicare, which aims to support Quality Improvement Network Quality Improvement Organizations (QIN-QIOs). We further support efforts as described by CMS which aim to close the health equity gap by providing transparency surrounding health disparities, supporting providers with evidence-informed solutions to achieve health equity, and reporting to providers on gaps in quality.

CMS cites the CMS Innovation Center's (CMMI) Accountable Health Communities Model which includes standardized collection of health-related social needs data. We believe other models from CMMI should include such data. We encourage CMS to use its authority to require EHR vendors to standardize race, ethnicity, gender identity, and sexual orientation data elements so comparisons can be made at the macro, and if possible, the micro-level.

We further support the creation of MIPS Improvement Activities, including one related to the creation and implementation of an anti-racism plan. However, we are unsure how CMS will incorporate activities geared toward disparities into MVPs considering most will want the activities to be disease specific or clinically focused. That said, we agree with CMS, as the agency notes, this improvement activity acknowledges it is insufficient to gather and analyze data by race, and documentary disparities by different population groups. Rather, it emphasizes systemic racism is the root cause of differences in health outcomes between socially defined groups. CMS further proposes to modify five existing improvement activities to address health equity and the AAN supports this proposal.
We additionally support the update to the complex patient bonus formula. CMS cites a report that supports use of the complex patient bonus in MIPS, explaining that it is well supported

because this policy gives additional points to clinicians with a higher share of medically and socially complex patients and does not lower the standard of care.

The AAN especially appreciates CMS's acknowledgment that small practices within the MIPS program often face challenges in many ways. We have consistently supported CMS's policies available for small practices, including the small practice bonus and other special scoring policies. CMS cites its significant hardship exception for small practices for the Promoting Interoperability performance category, another example backed by the AAN.

The AAN supports CMS's commitment to advance health equity by providing data collection to better measure and analyze disparities across programs and policies. CMS says it is considering expanding efforts to provide stratified data for additional social risk factors and measures, optimizing the ease-of-use of results, enhancing public transparency of equity results, and building toward provider accountability for health equity. The AAN would encourage CMS to require standardized data collection given the current disparate data collection and lack of uniform reporting categories for race and ethnicity across EMR platforms.

In the proposed rule, CMS discusses future potential stratification of quality measure results by race and ethnicity. CMS notes that incorrectly classified race or ethnicity may result in overestimation or underestimation in the quality of care received by certain groups of beneficiaries. The AAN agrees. We further support CMS's stated commitment to work with public and private partners to better collect and leverage data on social risk to improve our understanding of how these factors can be better measured in order to close the health equity gap. We are glad CMS has developed many resources, including an Inventory of Resources for Standardized Demographic and Language Data Collection, supported collection of specialized International Classification of Disease, 10th Edition, Clinical Modification (ICD-10-CM) codes for describing the socioeconomic, cultural, and environmental determinants of health, and sponsored initiatives to statistically estimate race and ethnicity information when it is absent. Without standardized data collection and categories across EMRs it will be difficult to implement accurate stratification.

We are encouraged that CMS has worked with contractors to develop two algorithms that indirectly estimate the race and ethnicity of Medicare beneficiaries. We agree with CMS that indirect estimation can help to overcome the current limitations of demographic information and enable timelier reporting of equity results until longer term collaborations to improve demographic data quality across the health care sector materialize. The use of indirect estimated race and ethnicity for conducting stratified reporting does not place any additional collection or reporting burdens on hospitals are these data are derived using existing administrative and census-linked data. However, we believe any public reporting of stratified results using indirectly estimated race and ethnicity must be published with context on the exploratory and informational use of the methodology and should explicitly include estimates of uncertainty.

The AAN believes that despite the high degree of statistical accuracy of the indirect estimation algorithms under consideration, there remains the small risk of unintentionally introducing measurement bias. CMS cites an example that if the indirect estimation is not as

accurate in correctly estimating race and ethnicity in certain geographies or populations, it could lead to some bias in the method results. Such bias might result in slight overestimation or underestimation of the quality of care received by a given group. However, like CMS, the AAN agrees this amount of bias is considerably less than would be expected if stratified reporting was conducted using the race and ethnicity currently contained in CMS's administrative data.

The AAN further appreciates CMS's commitment to improve demographic data collection. We believe the collection and sharing of a standardized set of social, psychological, and behavioral data by clinicians, including race and ethnicity, using electronic data definitions which permit nationwide, interoperable health information exchange, can significantly enhance the accuracy and robustness of equity reporting. This could potentially include expansion to additional social factors, such as language preference and disability status, where accuracy of administrative data is currently limited. The AAN believes this is especially true for patients who have neurologic conditions. We also appreciate CMS's concern for burdens, as the proposed rule notes additional resources, including data collection and staff training may be necessary to ensure that conditions are created whereby all patients are comfortable answering all demographic questions, and that individual preferences for non-response are maintained.

Furthermore, the AAN agrees that advancing data interoperability through collection of a minimum set of demographic data collection, and incorporation of this demographic information into quality measure specifications, has the potential for improving the robustness of the disparity method results, potentially permitting reporting using more accurate, self-reported information, such as race and ethnicity, and expanding reporting to additional dimensions of equity, including stratified reporting by disability status.

Finally, we do urge caution before developing any sort of "equity score." A poorly constructed equity score runs the risk of penalizing providers that choose to care for the most vulnerable and at-risk populations, or are located in areas with underlying socioeconomic inequities that cannot be fully addressed through the health care system. Direct, targeted health equity interventions focused on improving health and patient outcomes are likely to yield more immediate benefits for patients.

**MIPS Value Pathways (MVPs)**

The AAN appreciates CMS's continued efforts to reduce the confusing and burdensome requirements currently required of eligible clinicians participating in MIPS through the establishment of MIPS Value Pathways (MVPs). However, we remain concerned that the new framework will present many of the same issues that MIPS currently suffers from, while also creating additional challenges within many specialty or condition specific pathways that will be difficult to manage and compare for both CMS and stakeholders developing MVPs. We believe MVPs should address the fundamental issues within the current MIPS structure, but the proposals included in this rule do not appear to be make participation, reporting and scoring more simple or straightforward, nor do they demonstrate the clear advantages of MVPs over MIPS. The AAN looks forward to continuing our collaborative relationship with CMS during future MVP development, however, we do have concerns that MVPs will

accomplish little more than MIPS in its current state and in its efforts to transition clinicians into alternative payment models (APMs), described below.

*'Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes' MVP Proposal*

In early 2021, the AAN had the opportunity to weigh in on CMS's MVP proposal included in this rule titled, 'Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes' at CMS's invitation. We appreciated CMS's transparency, collaboration, and regard for our expertise with the condition at hand, some of which is reflected in the proposed MVP. We appreciate CMS's inclusion of our feedback on several of the stroke measures included in the MVP proposal, including our concerns related to small practices' barriers to participation. For future development years, CMS should develop guidance on how MVP topics are prioritized and how stakeholders are identified to participate in the input process.

The AAN understands that the quality measures included in the stroke MVP proposal are relevant to stroke and stroke prevention, but we remain concerned that the measures included are not widely applicable to stroke neurologists. Of the eight quality measures proposed, one is outside the scope of the neurologist (Q344), three are cross-cutting or would often fall to a primary care provider (Q047, Q236, Q441) and one is topped out (Q326), leaving neurologists with three measures to potentially report. The intent of MVPs is to offer more meaningful specialty or condition specific participation; however, we are concerned that this MVP will not be attractive to neurologists given the measures offered and dearth of outpatient stroke measures. We appreciate this MVP as a starting point and find the proposed improvement activities relevant to this MVP. While we note this MVP will include a condition-specific cost measure, we have concerns about its applicability and attribution to outpatient neurologists, as it currently assesses management of inpatient care for stroke patients. CMS should work with specialty societies and provide funding to them to develop clinically relevant, condition-specific cost measures for inclusion in future MVPs. The AAN also requests more information on how MVPs will be maintained and updated as more relevant measures become available that could bring additional clinicians in to participate in the MVP.

Since MVPs are voluntary, the AAN suggests CMS explore incentivizing MVP participation in the first years of implementation, or at the very least, hold clinicians harmless from a penalty for a designated transition period. As noted, while stroke falls within the neurology specialty, we are concerned that this MVP will not be widely applicable or enticing to many neurologists, especially those in small practices. CMS should consider offering an MVP incentive to those practices that participate in MVPs within the first few years of implementation.

*Timeline*

The AAN supports CMS's proposal to gradually transition from traditional MIPS to MVP reporting on a voluntary basis as MVPs ramp up and more become available and clinically relevant to various specialties. While we understand CMS's desire to start this transition in

2023, we are concerned that this timeline is infeasible. The lingering effects of the pandemic, pre-existing administrative burdens related to MIPS and other programs and a new MVP framework to implement, interest and uptake of MVPs may be low.

The AAN understands that MVPs are a repackaging of the MIPS program and so maintaining both MVPs and MIPS long-term would not be necessary or meaningful. We request CMS demonstrate the value of MVPs compared to MIPS before sunsetting traditional MIPS, as we believe many of the issues present in MIPS will transition to MVPs if implemented as proposed. We caution CMS to carefully consider the potential implications a complete sunset of the MIPS program by 2027 would have not only on clinicians participating in MIPS, especially small and solo providers, but on those administrative, support and technical staff that are responsible for implementing yet another program with a new set of requirements within the next few years. This transition would require extensive time and resources for MVP development, including development of cost measures by stakeholders, before the implementation and adoption by end users (i.e., clinicians, group practices, and their support staff).

*Participation Options and Registration*

The AAN urges CMS to remain flexible regarding MVP participation options in the first several years of implementation and delay the requirement for multispecialty groups to break into subgroups by 2025 to a later year. As previously noted, clinicians are grappling with a multitude of factors that place understanding the process and implications for designating subgroups within MVPs at a low priority. While we understand that subgroups may more meaningfully measure clinicians, we are concerned about the administrative burden of maintaining and reporting for subgroups within a multispecialty practice.

CMS should offer clear and robust guidance on registration timelines and expectations. Given that MVP reporting is voluntary, we suggest CMS not only include MVP eligibility in the QPP Participation Lookup Tool, but also consider targeted communications to clinicians that qualify for a given MVP, with detailed information on the election process since traditional MIPS does not require registration.

*Reporting Requirements*

The AAN believes the proposed reporting requirements for MVPs are reasonable, including the population health measure requirement, four quality measures or all those that are applicable, two Improvement Activities and the standard Promoting Interoperability measures. However, we believe that there will be many instances where very few measures in an MVP directly apply to a clinician's work even if the condition falls within its specialty. For example, the proposed 'Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes' MVP is centered around a neurological condition, however, there are few outpatient stroke measures included, thus disqualifying many neurologists from participating meaningfully in the MVP as most of the measures are for the inpatient setting. CMS should prepare for and offer flexibilities for cases such as this. We also support CMS's consideration of connecting MVP reporting with continuing medical education (CME) credit.

CMS should consider offering more flexibility in reporting requirements, including cross-category credit or some type of automatic credit specifically for Improvement Activities. Inherent in many of the measures in MIPS, is a demonstrated commitment to activities that improve practice, resulting in duplicative, burdensome reporting. We suggest offering an automatic credit for Improvement Activities in MVPs similar to the offering in MIPS-APMs. This also would align with the overarching goal to transition from MVPs to APMs in the future.

*Subgroups*

The AAN urges CMS to delay mandatory subgroup reporting for multispecialty groups. Subgroup implementation will pose significant burden on practice administrators if several subgroups are required within a TIN, assuming there are several MVPs that are available and apply across a multispecialty group. The AAN reiterates its request that CMS offer clear and robust guidance on not only MVP registration, but subgroup registration and reporting requirements. The proposed reporting requirements for subgroups could quickly become unwieldy for practices to maintain if multiple subgroups are formed within its TIN, which would be at odds with CMS's goal to develop a more streamlined, less burdensome reporting track via MVPs. CMS should clarify how each component of an MVP will be scored when reporting as a subgroup. For example, both population health and Promoting Interoperability measures are MVP-agnostic; however, CMS is proposing that subgroups can choose which population health measure to select and be scored at the subgroup level, while Promoting Interoperability measures will be scored at the TIN level. These nuanced requirements and changes between group and subgroup reporting are confusing and will be onerous to track and maintain. We encourage CMS to streamline requirements as much as possible within this added layer of complexity in subgroup reporting.

*Performance Feedback and Public Reporting*

The AAN requests further information on CMS's proposal to include comparative performance feedback on MVP performance, including a definition of "similar clinicians". CMS hopes that MVPs will reflect the shared care that patients receive, and that multiple specialties may participate in an MVP by reporting the relevant measures to their specialty. For example, neurologists that practice in the inpatient setting and vascular surgeons may participate in the 'Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes' MVP. We request clarification regarding whether CMS plans to compare and score all clinicians that participate in the MVP amongst each other or if neurologists will be compared to other neurologists that participate in the MVP only.

**Cost Component of QPP**

The AAN continues to have concerns with the MIPS Cost component. We believe that the risk adjustment and attribution methods used by CMS have not been adequately developed for MIPS cost measures. As the Cost component weight continues to increase, we request more education for clinicians that treat complex patient populations, including how this complexity is considered when calculating cost performance. In addition to more education, more transparency within this component is imperative. To date, CMS has not provided user-

friendly, discernable cost measure data for clinicians and groups to familiarize themselves with the component but continues to increase the weight of the component. We request clear, accessible guidance for clinicians who want to understand their cost performance and how it may be impacted by a small population of complex patients. Clinicians need to be aware that they may be attributed to acute hospital care costs, such as patient transportation, hospital overhead charges, some concurrent care during the acute episode, and skilled nursing facility charges. As part of CMS's educational efforts, we also strongly believe CMS should provide a clear rationale to providers as to why providers' reimbursements are tied to factors that are perceived as being out of their control. Examples of case studies to clarify how providers mitigate potential poor performance in the cost component would be helpful to all stakeholders.

For years, the AAN has advocated for more transparency and expanded opportunities for neurologists to be included in cost measures that are reflective of the team-based, interdisciplinary care that so many patients need and receive. While we are heartened to see CMS is willing to collaborate on the cost measure development process, we are concerned that the proposal to outsource cost measure development to stakeholders will have unintended, negative consequences. Since the QPP's inception and with each passing year, the responsibilities of specialty societies like the AAN, and its member volunteers, have increased significantly as it relates to QPP, including development and maintenance of quality measures and qualified clinical data registries (QCDRs). These responsibilities have expanded to development of MVPs, and now potentially development of cost measures. While we agree that specialty societies have unique, expert perspectives that lend themselves to specialty specific work, we encourage CMS to be cautious about foisting yet another burdensome process and responsibility onto stakeholders, especially one that stakeholders feel has lacked transparency over the years and have no control over.

Operationalizing a cost measure development process will take expertise and resources, as well and sufficient access to Medicare data. We suggest a more inclusive, transparent cost measure development process where stakeholders could work with CMS to edit inclusion, exclusion, and selection criteria measurement periods, risk adjustment methodology and benchmarking methods than attempt development at the individual organization level. It takes anywhere from 18-24 months to develop a measure, another 12-24 months to test a measure and additional time for review on the Measures Under Consideration (MUC) list. The timeline for cost measure development is inconsistent with CMS's expectation that measures could be available for MVPs in 2025. Beyond learning and growing expertise amongst staff and clinician members, stakeholders would need to account for the time and resources required for submitting future cost measures to the MUC list, an already burdensome process, in addition to maintaining their current quality measure rosters.

CMS should explore opportunities to work with the professional organizations representing clinicians to incorporate data from a broader group of clinicians in cost measures that have already been developed. In an effort to include more clinicians in cost measure calculations, we suggest that CMS consider alternative cost measurement methods that are based in a more meaningful attribution methodology without developing an unwieldy number of cost measures. For example, within an episode-based cost measure, neurologists could be held accountable for the neurologic-associated costs borne in an episode, such as neurology-

related E/M services, testing, medications, and other therapies, but not the rest of the episode, as the episode is not necessarily measuring a neurological condition. Receiving data related to an episode in which neurology is consulted or considered is valuable and informative, even if not central to the episode. CMS should consider repurposing current measures to incorporate more clinicians that play a role in an episode, not by attributing the entire episode to an individual clinician or TIN who bills a certain percentage of Medicare Part B claims, but by appropriately attributing certain aspects of an episode to the specialists who bear the costs and more accurately capturing the nuance and delineation within a given episode of care across providers.

Furthermore, the AAN requests detailed data on Cost component performance, including by specialty. CMS must share more data with specialty societies for them to feasibly understand and develop cost measures. Without robust, specialty-specific Cost component data, it is difficult for clinicians and practices to understand their Cost performance and difficult for specialty societies and other stakeholders to understand how to best educate membership on how to improve said performance and potentially develop cost measures in the future.

**Quality Measures**

Regarding a timeline to sunset traditional MIPS, CMS should demonstrate that MVP reporting has proven effective and there is buy-in before creating a plan to sunset MIPS. Feedback from individual physicians and EPs indicates low buy-in to using MVP reporting as: 1) measures included do not address cost for most outpatient providers; 2) measures included in MVPs proposed are not meaningful to outpatient providers; and 3) it will require additional IT supports that are cost prohibitive, even to large institutions.

We also wish to address quality measure benchmarks. The AAN believes CMS should use 2019 data. Providers need notice on which measures will have benchmarks. 2019 data allows providers time to review their data, compare their performance to peers, and drive improvement based on the stated benchmark. Using 2022 data prevents meaningful assessment in advance of the performance year and hinders the ability to select measures that will maximize scoring in advance of the year.

CMS further outlined a methodology to estimate the quality performance category score. We believe the proposed methodology and transition from one methodology to another is too complicated. Providers need to understand how their score is calculated and which measures to select to optimize performance. Providers should be rewarded for submitting measures that are believed to be of higher priority.

**Measure Testing**

The AAN agrees with the requirement that all measures approved in 2023 meet face validity in the initial MIPS payment year for which they are approved. The AAN suggests this requirement should be extended for future years. There are two issues that impact implementation of full testing.

First is the current health care environment and pandemic. Our health care providers are burning out due to the many competing priorities of practicing medicine during a global pandemic with no clear end in sight. Testing, even face validity testing, requires time that many clinicians just do not have. The National Quality Forum postponed review of measures in Fall 2021 in recognition of these challenges. CMS should further delay full testing requirements until it is clear providers have the bandwidth to provide high quality patient centered care, and assess measures for face validity.

Second is the CMS measure review process. CMS frequently requests changes to measure specifications during the QCDR application process. Given the revisions requests made by CMS, measures specifications are never static and continuous testing would be the only way to achieve this goal. Timelines do not allow for continuous testing. For example, if CMS suggests changes to a measure in May and the self-nomination period closes on September, four months does not provide sufficient time to modify measure collection, gather data, and complete testing.

Face validity should be sufficient for the initial performance year with an extended period to demonstrate further validity and reliability. The recent pandemic highlights the need to be flexible in adapting measures to meet physician and EP needs and addressing new gaps as they become evident in the field. Requiring additional testing restricts measure development innovation. CMS should be facilitating nimble data collection for meaningful measures.

**Improvement Activities**

The AAN supports the inclusion of health equity in the improvement activities component of MIPS. AAN agrees that activities including health equity should be valued as high and weighted appropriately due to the burden of collecting this data. Additionally, where possible, providers should be encouraged to implement activities for longer than 90 days to track and impact real improvement. The AAN agrees with the changes, removals, and additions to the improvement activities available.

**Interoperability**

EHRs changes resulting from the adoption of FHIR API to capture quality measures and requirements from the Cures Act on patient information sharing will increase burden by changing the way they document. These changes will challenge the usability of EHRs and ultimately will increase levels of provider burnout. The CMS FHIR API proposed rule to capture structured data for quality measurements only impacts small practices with limited means and those who use EHRs with less functionality. To successfully adopt dCQMs/FHIR APIs for eCQMs, health systems will have to modify or update their EHRs infrastructure, clinical workflows and ensure standardization of captured and stored data. For example, workflows that use free-text documentation would require changes to structured data entry. In addition, health IT would have to accommodate time for the iterative process of building templates that capture quality measures discretely and mapping data retrieval, adding more workload.

The AAN believes the transition to the FHIR standard for quality measurements can be facilitated by staged infrastructure support for iterative development, testing, education, and engagement efforts at both a practice level and measurement development levels. Much work is now present to demonstrate the need for systematic socio-technological integration to drive the adoption of technologies at scale. Support for an informatics workforce to facilitate this transition can be considered.

**Digital Quality Measures RFI**

The AAN supports the transition to reporting methods that reduce EP burden to generate data needed for measure calculation. dQMs are one potential solution to reducing burden. The AAN is concerned the 2025 timeline is not realistic. FHIR implementation is not widespread, and provider based FHIR APIs are not widely available. There are privacy concerns related to using provider based FHIR APIs (transmitting and sharing this data) as well as concern solo/small practices might encounter unique challenges, and these concerns have not been fully investigated.

CMS suggests analytic advancements such as NLP, big data analytics, and artificial intelligence can support this evolution. Based on AAN's experience, health care technology companies are not equipped to widely implement these advancements by 2025. Additionally, we would further encourage CMS to include QCDRs as one way to collect dQMs.

**Alternative Payment Models (APMs)**

The AAN continues to support the move towards value-based payment and Advanced Alternative Payment Models (Advanced APMs), however we remain concerned about the lack of approved models that address the patients and services for which neurologists are responsible. While we generally support the MVP framework, it is still unclear how clinicians are expected to transition from an MVP into an Advanced APM in the future. We continue to urge CMS to lay out how the MVP framework’s intended goal to transition clinicians into Advanced APMs will be carried out in practice.

The AAN believes publishing data for both MIPS and APMs is imperative, and to date, CMS has not shared sufficient data on APMs, especially as they relate to specialists. We hope that CMS will provide clinicians and other stakeholders like the AAN with data on Advanced APMs, MIPS APMs, and Other Payer Advanced APMs including detailed participation and performance results, including by specialty. Again, we believe that providing stakeholders with a rich dataset that can offer an overview of the landscape of participation in value-based care models will help with understanding the breadth and opportunity that adaption of these models provides. Clinicians would also benefit from additional education on available APMs and how to determine whether participating in a particular model is appropriate for a particular clinician.

**Conclusion**

We greatly appreciate this opportunity to express the views of the AAN in response to the Proposed Rule. The AAN strongly urges CMS to consider our comments so that the Final

Rule further reduces regulatory burdens on neurologists and promotes the highest quality patient-centered neurologic care. Please contact Daniel Spirn, Senior Regulatory Counsel, at dspirn@aan.com or Max Linder, Government Relations Manager, at mlinder@aan.com with any questions or requests for additional information.

Sincerely,

Orly Avitzur, MD, MBA, FAAN
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