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Subject: 2024 Cost Measure Field Testing-Wave 6 Movement Disorders Cost Measure

To whom it may concern:

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 episode-based cost measure currently being field tested titled, "Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)."

The AANS and the CNS appreciate the iterative and collaborative process that Acumen and the Centers for Medicare & Medicaid Services (CMS) have undertaken to develop these measures. One of our members, Jason Schwalb, MD, a stereotactic and functional neurosurgeon specializing in surgery for neurological disorders that impact movement, serves on the measure development workgroup and actively participates in the workgroup discussions. After consulting with Dr. Schwalb, other neurosurgeons who treat these same disorders, and a member who has served on earlier Acumen cost measure development workgroups, we assembled the feedback below in response to Acumen's survey questions. **Above all, the Movement Disorders cost measure should accurately reflect the role and value of neurosurgeons. It should not create real, or even perceived, disincentives that discourage neurologists and other clinicians from referring patients with disabling conditions for effective neurosurgical procedures that are evidence-based and considered standard of care. These procedures can dramatically improve quality of life over non-surgical management. In many cases they are actually more cost-effective over the long term, especially when accounting for improvements in patient independence.**

General Comments/Concerns

- An ongoing concern since the initiation of this project is the failure of these measures to evaluate cost in the context of quality. If quality considerations are not directly factored into measurements of cost, then cost measures could have the unintended consequence of disincentivizing appropriate care that is evidence-based and accounts for patient preferences. The AANS and the CNS continue to strongly urge Acumen and CMS to work with clinical experts to build algorithms and/or incorporate clinical data sources, such as registry data, so that performance measures simultaneously evaluate both cost and quality and assess how variations in cost impact the quality and appropriateness of care.
- While the AANS and the CNS appreciate CMS and Acumen's efforts to improve cost performance feedback reports over the years, they are still extremely confusing — even to clinicians who serve on the measure development workgroup. If a clinical expert who spent

countless hours on webinars discussing the intent, methodology and specifications of this measure is overwhelmed by and cannot make sense of the information presented, then there is little chance that other recipients will know what to do with the data in these reports. The feedback reports could benefit from more detailed explanations and additional pop-up boxes describing what each table and data point is trying to convey, why a clinician should care about this information, and what the clinician can do with this information to improve patient care. We also strongly recommend that Acumen add dummy data to the mock reports and accompanying spreadsheets. Without dummy data, these documents are of little value. We suggest that Acumen pick a representative real-life clinician's report — perhaps one with near-median performance — and present those data in an anonymized way.

Specific Comments/Concerns

- 1) Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).**

The triggers identify any patient seen as an outpatient, including via telemedicine. However, the fact that only eight neurosurgeons met the criteria for being considered during the pilot analysis throws the process into question. We estimate that only about 100-150 neurosurgeons perform more than 20 surgeries for the Parkinson's Disease patient cohort. At least two of these neurosurgeons, who perform more than 50 surgeries a year, did not meet the case minimum of attributed patients to qualify for a field test report, which seems to align with the intent of the measure as specified by the workgroup. This makes us wonder about the characteristics of the 5% or so of neurosurgeons that were, in fact, captured by this measure. **We would appreciate it if Acumen could provide us with more detailed information about the characteristics of this small cohort of neurosurgeons, including an explanation of what makes these particular subspecialists methodologically unique compared to their peers.** The fact that this measure currently captures only a fraction of the neurosurgeons performing surgeries on these patients raises the question of whether it is even appropriate to include neurosurgeons as a potentially attributable specialty.

The AANS and the CNS request that Acumen remove surgical attribution entirely from the measure to improve the results' accuracy. If the numbers are already so small, then including surgeons as an attributable clinician type will not reflect anything of value. **At the very least, Acumen must refine the subgrouping and risk adjustment approach, as described below, to minimize any negative incentives for surgical referrals.**

- 2) Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.**

Episodes should not be attributed to non-prescribing clinicians. If the goal of MIPS is to control costs and ensure quality, it does not make sense to attribute episodes to a group with no control over either. At the same time, PT/OT and speech therapy services should be accounted for in the analysis of costs and quality to determine if they are of added value in appropriate subpopulations attributed to managing clinicians.

- 3) Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson's and fit the**

measure's intent?

G23 includes Pantothenate Kinase-Associated Neurodegeneration (PKAN), Progressive Supranuclear Palsy (PSP), Multiple System Atrophy (MSA), Fahr's Syndrome, Shy-Drager Disease, and other basal ganglia abnormalities should not be included in this measure. These are heterogeneous and tend to have quite poor prognoses, leading to high costs. If Acumen excludes Huntington's Disease due to a small sample size and heterogeneity, it should exclude these far rarer conditions.

- 4) **Clinician Expert Workgroup members provided feedback that the current measure name, "Movement Disorders," isn't reflective of the conditions currently included (Parkinson's and Related Disorders, MS, and ALS) in the measure. The Clinician Expert Workgroup recommended changing the name to "Progressive Neurological Disorders Affecting Movement" to better encompass the conditions included in the measure. Does the new proposed name appropriately account for Parkinson's and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?**

The AANS and the CNS believe that the proposed name is an improvement over "Movement Disorders" since no neurologist or neurosurgeon would consider ALS or MS a movement disorder (nor does ICD-10). However, the problem with "Progressive Neurologic Disorders Affecting Movement" is that it is too broad and all-encompassing and suggests that the measure captures conditions like spinal muscular atrophy, hereditary ataxias and dystonia, among others. Instead, we recommend titling the measure "Parkinson's Disease, Multiple Sclerosis and Amyotrophic Lateral Sclerosis."

- 5) **Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?**
- Decompression of peripheral nerve is not relevant to these conditions.
 - "Other or therapeutic nervous system procedure" is so vague as to be meaningless.
 - The inclusion of DRG 23 and 25 is problematic since this could be used for implantation of a deep brain stimulator, which should be encouraged in appropriate patients, or a craniotomy for a subdural hematoma from a fall, which is bad and could be the result of poor outpatient management (assuming the patient is compliant with recommendations). There does not seem to be a way to account for this.
 - Including deep brain stimulation (DBS) as a cost in a shared payment model will disincentivize utilization of the standard of care for many patients. We recommend the exclusion of neurosurgical care in this population.
- 6) **Are there any changes that should be made to the current risk adjustors, such as to add or remove variables? Are there measure-specific variables that should have their specifications updated?**

As noted earlier, more accurate subgrouping and risk adjustments would help to address our concerns about this measure creating disincentives for surgical referrals. **Most importantly, we believe that it is critical that episodes captured by this measure are further stratified by surgical and non-surgical care.** Sub-grouping in this manner will result in more accurate and meaningful clinical comparisons by ensuring that the measure fairly compares clinicians with a similar case mix. **We also recommend that CMS include a short description at the top of the score reports clarifying that this is a cost measure examining the performance of surgical and non-surgical management independently so that anyone reviewing the report knows that this large cost driver has been considered.** Other comments related to subgrouping and

risk adjustment are listed below:

- **We are concerned about Acumen's standard use of Hierarchical Condition Category (HCC) codes as risk adjusters without carefully considering the clinical circumstances.** HCC was developed for the Medicare Advantage program. It is not a robust model for that purpose, let alone this exercise. **We would argue that some items listed as risk adjusters would be more appropriately accounted for using subgroups, regardless of the underlying diagnosis.** For example, quadriplegia and paraplegia (HCC 70 and 71) should be subgroups instead of risk adjusters. Quadriplegia and paraplegia are common concerns for ALS patients, but not Parkinson's Disease patients. A Parkinson's Disease patient with quadriplegia has something else more pressing going on and would not be clinically relevant to the rest of the patient population.

Another example is Spinal Cord Disorders/Injuries (HCC72), which is included as a risk adjuster despite ALS being a type of spinal cord disorder. At the same time, spinal cord injury patients should be excluded from this measure. Similarly, HCC73 is itself ALS, so this measure is risk adjusting for one of the conditions it is measuring.

Listed below are the HCCs that we have concerns within the context of a measure that attempts to evaluate numerous different neurological disorders simultaneously:

- HCC70: Quadriplegia
 - HCC71: Paraplegia
 - HCC72: Spinal Cord Disorders/Injuries
 - HCC73: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
 - HCC74: Cerebral Palsy
 - HCC75: Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
 - HCC76: Muscular Dystrophy
 - HCC77: Multiple Sclerosis
 - HCC78: Parkinson's and Huntington's Diseases
 - HCC79: Seizure Disorders and Convulsions
 - HCC80: Coma, Brain Compression/Anoxic Damage
 - HCC99: Intracranial Hemorrhage
 - HCC100: Ischemic or Unspecified Stroke
 - HCC103: Hemiplegia/Hemiparesis
 - HCC166: Severe Head Injury
 - HCC173: Traumatic Amputations and Complications
 - HCC189: Amputation Status, Lower Limb/Amputation Complications
 - HCC77: Multiple Sclerosis
- Patients undergoing DBS or pump placement in the episode should be sub-grouped, or at a minimum, the occurrence of each should be a risk adjuster. Their short-term costs are inherently higher. Again, this measure should not disincentivize surgical treatments that are the standard of care for appropriate patients.
 - For patients with ALS or MS, there should be risk adjustment for the pre-existing presence of an implanted intrathecal pump and recent complications related to the pump.
 - Past DBS: The lookback window for this is only four months, which means a patient could have had a long-standing DBS implant that is doing fine and does not meet criteria for this risk adjuster. The ICD-10 codes that Acumen is looking for to make this determination are:

- T85110: Breakdown (mechanical) of implanted electronic neurostimulator of brain electrode (lead)
 - T85120: Displacement of implanted electronic neurostimulator of brain electrode (lead)
 - T85190: Other mechanical complication of implanted electronic neurostimulator of brain electrode (lead)
 - T85731: Infection and inflammatory reaction due to implanted electronic neurostimulator of brain, electrode (lead)
 - Z4542: Encounter for adjustment and management of neurostimulator
 - Z9682: Presence of neurostimulator
- This risk adjuster would be better titled "history of DBS with recent complication" since one of these codes would have to be listed no earlier than four months before the episode starts. We recommend that Acumen use two separate adjusters: 1) history of DBS without recent complication and 2) history of DBS with complication.
 - There is no accounting for patients with long-standing implants who are doing well. Many patients may have programming every 6 to 12 months and not be captured in the four-month lookback window but then be captured during the year of the measure. There are also maintenance costs for patients with DBS who are doing well that need to be accounted for in this model.
 - Z45.42 and Z96.82 are not specific for DBS and include spinal cord and peripheral nerve stimulators. There needs to be specificity to ensure that spinal cord stimulator (SCS) and peripheral nerve stimulator (PNS) implants are not part of the risk adjustment.
 - 4% of patients with MS have facial pain, which may be treated with stereotactic radiosurgery and rhizotomy and, in rare cases, with craniotomy and microvascular decompression. These codes should also be included in risk adjustment. Neurologists in participating TINs should not be discouraged from referring patients with pain to appropriate care to reduce suffering.

7) Should any patient cohorts be considered for exclusion from the measure? How might such patients be identified using Medicare claims data?

The AANS and the CNS believe that neurosurgical treatments should be excluded if patients undergoing surgical treatment for these conditions cannot be adequately represented, if quality related to these procedures cannot be adequately measured, and if clinicians will be economically disincentivized from referring patients for appropriate procedures that could improve quality of life and long-term costs that are accrued over greater than a one-year episode.

8) Which quality measures are the most relevant to the Movement Disorders measure to assess the value of care? Are there other indicators of quality that are not currently captured in a MIPS quality measure?

The most relevant measures of the value of care for these conditions are:

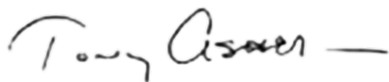
- Maintaining independence;
- Reducing falls;
- Aspiration pneumonia, pressure ulcers, and subsequent complications (sepsis, intubation, etc.);
- Reducing non-elective hospital admissions; and
- Prolonging life with a good quality of life.

Other than the two existing MIPS measures evaluating falls, **no MIPS quality measures currently assess these factors within this patient population.**

Conclusion

The AANS and the CNS thank Acumen and CMS for the opportunity to participate in this process and for considering its ongoing feedback. We look forward to continuing to work with the Agency as it continues to refine this measure and the feedback reports associated with it. We would be happy to schedule a meeting with you to discuss these concerns and more appropriate ways to approach cost measurement in the future. Please do not hesitate to contact us if you have any questions or need additional information.

Sincerely,



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