Memorandum

AMERICAN ACADEMY OF NEUROLOGY®

To:	CMS MIPS Value Pathways (MVP) Team
From:	AAN MVP Workgroup (Daniel Ackerman, MD, FAAN; Sonya Knight, DO; Robert Kropp, MD, MBA, CHIT, FAAN; Mary Angela O'Neal, MD, FAAN)
Copy:	Amanda Becker CAE; Amy Bennett, JD; Max Linder; Leslie Kociemba, MPH
Date:	February 8, 2021
Subject:	AAN Feedback on "Optimal Clinical Support for Neurological Conditions"

The American Academy of Neurology (AAN) appreciates the opportunity to provide feedback on CMS's draft MVP on "Optimal Clinical Support for Neurological Conditions." We appreciate CMS recognizing the AAN as key experts and stakeholders in this MVP, however we believe comprehensive input from AAN subject matter experts and stakeholders at the outset of development would have been appropriate. The AAN would appreciate additional time to coordinate efforts. The AAN is unable to develop a fully comprehensive response to this proposal in the one week provided. The AAN supports the inclusion of all the below measures for neurology as neurology care is often specialized. A physician treating patients with multiple sclerosis or children with refractory epilepsy will face different quality and improvement challenges and conversations than a physician treating patients with dementia or end-stage ALS. As a result, it is difficult to reconcile all these populations into one proposal. Overall, the AAN has several concerns with the proposal as written, as we believe it does not meet the MVP guiding principles and development criteria previously communicated by CMS. General concerns are described below:

- We would like to clarify that we did not submit any candidate MVPs during our 2021 discussions, and the preliminary concepts discussed were condition-specific and intended for the AAN to better understand CMS's appetite for one of the concepts in the future. It was not our intention or recommendation to develop what appears to be a "catch-all" neurology MVP, as we do not believe this will meaningfully or appropriately measure care, offer more accurate comparison amongst clinicians, or reduce burden amongst neurologists compared to traditional MIPS.
- This MVP does not describe a limited, connected, complementary set of measures and activities that are meaningful to neurologists. Instead, it includes a large set of neurology measures akin to the Neurology Specialty Measure Set currently used in MIPS, and does not have a meaningful cost measure, especially for outpatient neurologists which make up most neurologists. We believe these realities will impact participation in this MVP were it to move forward. It would be more meaningful to focus on a smaller, defined condition-specific population with more specific subsets of measures (e.g., geriatric or headache). Several of the rationales in the quality measure section cite removing a given measure to reduce the number of measures to choose from in the MVP. We disagree with this approach to exclude relevant neurology measures in an effort to reduce the number of measures in an MVP. Instead, we recommend developing condition-specific MVPs with appropriate cost measures in the future. The AAN appreciates that the recently approved MVP on "Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes" included a subset of stroke-specific quality and cost measures and aligns with the overarching goal of MVPs to offer more relevant, meaningful subsets of measures and activities for clinicians to report.
- The MVP does not capture a clinically definable population of patients. Neurological conditions and patients are incredibly diverse, ranging from pediatric to geriatric with an equally broad set of conditions. While the list of proposed quality measures is substantive, the cost measure does not account for outpatient neurology which renders the MVP less meaningful. If the MVP is meant to address all neurological patients, the AAN encourages CMS to include cross-cutting neurology measures (i.e., AAN25 and AAN34) to make the MVP more applicable to general and pediatric neurologists.
- The AAN QCDR measures are validated for outpatient use only. The AAN's QCDR is currently collecting outpatient care data, but the available cost measure for this proposal is limited to inpatient care. This creates a disconnect for reporting providers who utilize QCDR measures. These providers would have a quality component tracking outpatient improvement but cost component tracking inpatient data. In the alternative, if CMS excludes QCDR measures there are few meaningful measures available to general neurologists as measures would be limited to patients with dementia, epilepsy, ALS, and Parkinson's disease. The AAN requests clarification for including QCDR

measures in MVPs, as the QCDR measures included in this proposal are a benefit to Axon Registry® participants only.

- The AAN believes care partners are essential to the treatment team and eliminating metrics related to their wellbeing is short-sighted and will have negative implications for care provided.
- While we have these above concerns and recommend developing neurology condition-specific MVPs when applicable cost measures are available, our feedback on CMS's proposal is detailed below.

Quality performance category: (If applicable: Red - recommend removal; Green – recommend adding; Yellow – additional recommendations for potential removal).

Quality Measures (13 Quality Measures Total: 8 quality measures & **6** QCDR measures)	**CMS Response/Rationale**	**AAN Response**
Q047: Advance Care Plan (Medicare Part B Claims, MIPS CQM) High Priority	We agree with the inclusion of this measure within the MVP, as it is very appropriate for this patient population. However, in an effort to minimize the number of quality measures and maximize the utilization of MVP topic specific quality measures, we recommend reviewing this measure for removal as we believe other measures may more closely align with the intent of the MVP.	We recommend including this measure as it is a cross-cutting measure applicable to neurologists with meaningful impact on patient care.
Q130: Documentation of Current Medications in the Medical Record (Medicare Part B Claims, eCQM, MIPS CQM) High Priority	We recommend removing this quality measure because this measure is at the end of the topped-out lifecycle. This continued high performance rate may limit the measure's long-term viability for MIPS and the MVP.	If this measure is topped out and will be removed from the QPP due to its topped out status, it should not be included in the MVP. However, we believe topped out measures should still be included as they measure important clinical actions and offer valuable feedback and tracking for providers. Assigning points via the topped out point policy may be appropriate.
Q181: Elder Maltreatment Screen and Follow-Up Plan (Medicare Part B Claims, MIPS CQM) High Priority	We recommend removing this quality measure because this is a broadly applicable measure, and we believe other measures may more closely align with the intent of this MVP.	This measure is topped out but not subject to the seven-point cap per the 2022 benchmark guidance. If this measure is topped out and will be removed from the QPP due to its topped out status, it should not be included in the MVP. However, we believe topped out measures should still be included as they measure important clinical actions and offer valuable feedback and tracking for providers. Assigning points via the topped out point policy may be appropriate.
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	We recommend removing this quality measure because this is a broadly applicable measure, and we believe other measures may more closely align with the intent of this MVP.	We recommend including this measure as it is a cross-cutting measure applicable to neurologists with meaningful impact on patient care.

AAN22: Quality of Life Outcome for Patients with Neurologic Conditions (QCDR) High Priority, Outcome	We agree with the inclusion pending approval for future performance periods and all criteria met for inclusion of QCDR within an MVP.	We recommend including this measure in the MVP.
AAN25: Pediatric Medication reconciliation (QCDR)	We recommend removing this measure because this is a broadly applicable measure, and we believe other measures may more closely align with the intent of this MVP.	We recommend including this measure to address pediatric neurologists and pediatric neurological patients if this MVP is intended to measure performance for all neurology patients.
AAN34: Patient reported falls and plan of care (QCDR) High Priority, Outcome	We recommend removing this measure as this clinical topic is captured in an improvement activity: IA_PSPA_21: Implementation of fall screening and assessment programs.	We recommend including this measure given the prevalence of falls in patients with neurologic conditions. This outcome measure can be meaningful for neurology in a 12-month calendar year time period.
Q419: Overuse of Imaging for the Evaluation of Primary Headache (MIPS CQM) High Priority	We agree with the inclusion of this measure within the MVP. We would like to note that the 2022 benchmarking file shows this measure is in the 2nd year of the topped out lifecycle. This continued high performance rate may limit the measure's long term viability for MIPS and this MVP.	If this measure is topped out and will be removed from the QPP due to its topped out status, it should not be included in the MVP. However, we believe topped out measures should still be included as they measure important clinical actions and offer valuable feedback and tracking for providers. Assigning points via the topped out point policy may be appropriate.
AAN5: Medication Prescribed for Acute Migraine Attack (QCDR)	We recommend removing this measure because we believe AAN30: Migraine Preventive Therapy Management would be more applicable to the MVP topic, and by focusing on migraine prevention this will hopefully decrease acute attacks.	We recommend including this measure given its relevance to patients with migraines, a neurological condition. While AAN30 addresses prevention, clinicians should be measured and scored for those patients that do experience migraine attack via AAN5.
AAN30: Migraine Preventive Therapy Management (QCDR)	We agree with the inclusion pending approval for future performance periods and all criteria met for inclusion of QCDR within an MVP.	We recommend including this measure in the MVP.
AAN31: Acute Treatment Prescribed for Cluster Headache (QCDR)	We recommend removing this measure in favor of retaining AAN32 in order to minimize the number of quality measures within the MVP. This is based upon the gaps in care cited literature in the QCDR measure rationale: According to a 2016 study by Lademan et al, "guideline-adherent treatment in cluster headache is about 70% for acute treatment and about 35% for prophylactic treatment."	We recommend including this measure given its relevance to patients with cluster headaches, a neurological condition. Acute attacks occur despite adherence to preventive medications and the measure is meaningful.
AAN32: Preventive Treatment Prescribed for Cluster Headache (QCDR)	We agree with the inclusion pending approval for future performance periods and all criteria met for inclusion of QCDR within an MVP.	We recommend including this measure in the MVP.

Q268: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy (MIPS CQM)	We agree with the inclusion of this measure within the MVP.	We recommend including this measure in the MVP.
AAN29: Comprehensive Epilepsy Care Center Referral or Discussion for Patients with Epilepsy (QCDR)	We agree with the inclusion pending approval for future performance periods and all criteria met for inclusion of QCDR within an MVP.	We recommend including this measure in the MVP.
Q281: Dementia: Cognitive Assessment (eCQM)	We agree with the inclusion of this measure within the MVP. However, would flag as a potential to remove in order to minimize quality measure selection given that this is the only quality measure available as an eCQM.	We recommend including this measure in the MVP. Measure type should not prevent inclusion.
Q282: Dementia: Functional Status Assessment (MIPS CQM)	We agree with the inclusion of this measure within the MVP.	We recommend including this measure in the MVP.
Q286: Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia (MIPS CQM) High Priority	We agree with the inclusion of this measure within the MVP. We would like to note that the 2022 benchmarking file shows this measure is at the end of the topped out lifecycle. This high performance rate may limit the measure's long term viability for MIPS and this MVP.	If this measure is topped out and will be removed from the QPP due to its topped out status, it should not be included in the MVP. However, we believe topped out measures should still be included as they measure important clinical actions and offer valuable feedback and tracking for providers. Assigning points via the topped out point policy may be appropriate.
Q288: Dementia: Education and Support of Caregivers for Patients with Dementia (MIPS CQM) High Priority	We recommend removing this quality measure because we believe the focus of this MVP should reflect meaningful interactions between the patient and their treating clinician. This quality measure is a valuable concept within MIPS, although we believe the MVP should strive to provide performance data specific to the clincial needs of the patient being treated.	We recommend including this measure in the MVP, as caregivers are integral members in providing dementia care and are extremely relevant to the patient being treated. Caregivers often act as surrogates to dementia patients and inclusion of caregiver education and experience should be included to reflect the importance and relevance of their role in this care.
Q290: Assessment of Mood Disorders and Psychosis for Patients with Parkinson's Disease (MIPS CQM)	We agree with the inclusion of this measure within the MVP. However, in order to minimize quality measure selection we would recommend include either Q290 or Q291: Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease.	We disagree that choosing between Q290 and Q291 to reduce measure selection is the appropriate tactic as they measure separate, important clinical actions.
Q291: Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease (MIPS CQM)	We agree with the inclusion of this measure within the MVP. However, in order to minimize quality measure selection we would recommend include either Q291 or Q290: Assessment of Mood Disorders and Psychosis for Patients with Parkinson's Disease. We would like to note that measure Q291 is	If this measure is topped out and will be removed from the QPP due to its topped out status, it should not be included in the MVP. However, we disagree that choosing between Q290 and Q291 to reduce measure selection is the appropriate tactic as they measure separate, important clinical

	at the end of the topped-out lifecycle. This continued high performance rate may limit the measure's long-term viability for MIPS and the MVP.	actions. We believe topped out measures should still be included as they measure important clinical actions and offer valuable feedback and tracking for providers. Assigning points via the topped out point policy may be appropriate.
Q293: Rehabilitative Therapy Referral for Patients with Parkinson's Disease (MIPS CQM) High Priority	We agree with the inclusion of this measure within the MVP.	We recommend including this measure in the MVP.
AAN9: Querying About Symptoms of Autonomic Dysfunction for Patients with Parkinson's Disease (QCDR)	We agree with the inclusion pending approval for future performance periods and all criteria met for inclusion of QCDR within an MVP.	We recommend including this measure in the MVP.
Q386: Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences		We recommend adding this measure as it meaningfully impacts end-of-life care for patients with ALS.

Improvement activity performance category: The table below illustrates the suggested improvement activities for this MVP candidate. (If applicable: Red - recommend removal; Green – recommend adding).

Improvement Activities (12 Improvement Activities Total)	**CMS Response/Rationale**	**AAN Response**
IA_AHE_3: Promote Use of Patient-Reported Outcome Tools (High weight)	We agree with the inclusion of this health equity-related improvement activity within this MVP.	We recommend including this improvement activity in the MVP.
IA_BE_4: Engagement of patients through implementation of improvements in patient portal (Medium weight)	We recommend the inclusion of this improvement activity that represents the patient voice and patient engagement within this MVP.	We recommend including this improvement activity in the MVP.
IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings (High weight)	We recommend the inclusion of this improvement activity that represents the patient voice within this MVP.	We recommend removing this improvement activity. This activity more likely falls to the health system than an individual clinician.
IA_BE_16: Promote Self-management in Usual Care (Medium weight)	We indicated this improvement activity would be evaluated for inclusion within this MVP. Our research indicates this is not a frequently attested to improvement activity for neurology; therefore, we recommend it not be included.	We recommend including this improvement activity in this MVP as we believe it is applicable to neurology.
IA_BE_24: Financial Navigation Program	We agree with the inclusion of this beneficiary engagement improvement	We recommend including this improvement activity in the MVP.

(Medium weight)	activity to allow patient options related to the high cost of stroke care within this MVP.	
IA_BMH_4: Depression screening (Medium weight)	We agree with the inclusion of this improvement activity within this MVP.	We recommend including this improvement activity in the MVP.
IA_BMH_8: Electronic Health Record Enhancements for BH data capture (Medium weight)	We agree with the inclusion of this improvement activity within this MVP.	We recommend including this improvement activity in the MVP.
IA_CC_1: Implementation of use of specialist reports back to referring clinician or group to close referral loop (Medium weight)	We recommend the inclusion of this care coordination improvement activity within this MVP.	We recommend including this improvement activity in the MVP.
IA_EPA_2: Use of telehealth services that expand practice access (Medium weight)	We agree with the inclusion of this improvement activity within this MVP as it enhances patient access to care.	We recommend including this improvement activity in the MVP.
IA_PM_11: Regular review practices in place on targeted patient population needs (Medium weight)	We recommend including this health equity-related improvement activity within this MVP.	We recommend including this improvement activity in the MVP.
IA_PM_16: Implementation of medication management practice improvements (Medium weight)	We agree with the inclusion of this improvement activity within this MVP.	We recommend including this improvement activity in the MVP.
IA_PM_21: Advance Care Planning (Medium weight)	We agree with the inclusion of this improvement activity within this MVP.	We recommend including this improvement activity in the MVP.
IA_PSPA_21: Implementation of fall screening and assessment programs (Medium weight)	We agree with the inclusion of this improvement activity within this MVP.	We recommend including this improvement activity in the MVP.

Cost performance category:

Cost Measure(s)	**Response/Rationale**	**AAN Response**
Medicare Spending Per Beneficiary (MSPB) Clinician	We recommend the inclusion of this cost measure within this MVP. MSPB Clinician may be attributed to neurologists working in inpatient settings.	This measure does not account for outpatient neurology costs which renders the MVP less meaningful for a large proportion of neurologists.