Dear Colleague,

The AAN is committed to helping all of our members maximize success under the sweeping changes to physician payment that lie ahead. The Medicare Access and CHIP Reauthorization Act of 2015 or "MACRA" changes the way Medicare pays physicians from payment per service billed (fee-for-service) to payment for value of care provided, and offers financial incentives for providing high value care. The legislation led the Centers for Medicare & Medicaid Services (CMS) to release in October 2016 what has been described as the single biggest set of regulatory policies regarding physician payment in nearly a quarter of a century.

To keep you informed, we have produced a short video series to explain the changes at a high level and we are continually updating a comprehensive MACRA web page on AAN.com. Your colleagues—volunteer members—on various AAN committees of jurisdiction such as Medical Economics, Practice, Government Relations, and the AAN Axon Registry™ are working tirelessly with staff to advocate for needed improvements via the regulatory rulemaking process. At the same time, they are creating resources and tools to help ensure a smooth transition for neurology to the new payment systems.

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And, as always, we’d love to hear from you about these changes and about how you believe that the AAN can best ensure your success. Please submit your questions or comments to MACRA@aan.com.

Respectfully,
Terrence L. Cascino, MD, FAAN
President, AAN

What is MACRA?
What does it do?

MACRA replaces the SGR and transforms health care payments for physicians starting in calendar year 2019—based on performance in calendar year 2017. MACRA creates a new Quality Payment Program under Medicare with two payment pathways. The fee-for-service pathway streamlines multiple existing quality programs and adds one new component to form the Merit-based Incentive Payment System (MIPS). The second pathway provides incentive payments for successful participation in designated advanced Alternative Payment Models (APMs).

Why MACRA?

Health care costs in the US are unsustainable. Physician payment reform is seen by policymakers and payers as an essential component to a multi-faceted solution. CMS and private payers alike are transitioning to value-based payments, defined as higher quality care at appropriate costs.

The idea is that value-driven payments will pay for what really works to create a health care system that is enduring:
- Advance individual patient health (both quality of care and satisfaction with care)
- Improve population health
- Reduce costs

For More Information:
Website: AAN.com/view/MACRA
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Call: (800) 879-1960

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Advanced Alternative Payment Models (APMs)

Elements of an Advanced APM:
- Requires participants to use certified EHR technology;
- Provides for payment based on quality measures that are comparable to MIPS; and
- Bears financial risk for monetary losses that are in excess of a nominal amount or is a medical home expanded under the Center for Medicare and Medicaid Innovation.

Qualifying Participants:
- Are not subject to MIPS payment bonuses or penalties
- Receive an annual lump-sum bonus of 5 percent from 2019–2024
- Enjoy a higher fee schedule conversion factor adjustment (0.75 percent annually as compared to 0.25 percent annually) starting in 2026 and beyond
- Must meet a threshold percentage, that increases over time, of payments linked to value through Medicare or all-payer APM

Minimum Percent of Payments Tied to Advanced APMs Over Time

YOU DECIDE

Merit–based Incentive Payment System (MIPS)

All physicians will participate in MIPS starting in 2017. There are only three exclusions from participation in the MIPS program: you are in your first year of Medicare Part B participation, you are a qualifying participant in an advanced APM, or you have a low volume of Medicare patients.

MIPS Consolidates Three Existing Programs:

Physician Quality Reporting System (PQRS) Value-based Payment Modifier Electronic Health Records (EHR) “Meaningful Use” Program

And Adds One New Component

2017 Performance Category Weights for MIPS

Scoring in the four areas leads to one composite performance score. For the first year of MIPS, the categories are proposed to be weighted as follows:

- Quality (PQRS): 60%
- Improvement Activities*: 15%
- Advancing Care Information (MU): 25%
- Cost: 0%

Based on your composite performance score, Medicare Part B payment bonuses* and penalties within these ranges will follow:

* Additional bonus opportunities for exceptional performance.
**Advanced Alternative Payment Models (APMs)**

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**Minimum Percent of Payments Tied to Advanced APMs Over Time**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare APMs</th>
<th>All Payer APMs</th>
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</thead>
<tbody>
<tr>
<td>2019 and 2020</td>
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<td>50%</td>
</tr>
<tr>
<td>2021 and 2022</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>2023 and Beyond</td>
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Prepare Now for MACRA to Maximize Your Success

The AAN knows that these changes from CMS are a distraction and take time away from caring for your patients. But we have your back! We’ve broken this down to the crucial steps below that you need to take to prepare so you are ready for reporting in 2017.

Visit AAN.com/view/MACRA for more details.

Action Steps

☐ Familiarize yourself with new language and acronyms associated with the new payment systems.
☐ Learn about AAN quality measures.
☐ Ensure that you have an Enterprise Identity Management System (EIDM) account so that you can download your latest Quality and Resource Use Report (QRUR).
☐ Ensure that the EHR that you are using is certified.
☐ Investigate APM options in your geographic area.
☐ Access AAN programming to educate yourself further with these upcoming educational opportunities:
  • Practice Management Series webinars: MIPS, MACRA
  • 2017 Annual Meeting courses, iTalks, Ask the Expert
  • AAN video series on YouTube
☐ Email AAN staff with your additional questions.

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