AAN Lobbying Helps Ease Impact of MACRA Changes on Neurologists

In one of the biggest changes in the history of Medicare, the Centers for Medicare & Medicaid Services (CMS) announced in October its final rules on the 2017 implementation of MACRA—the Medicare Access and CHIP Reauthorization Act of 2015.

The AAN and other stakeholders pressed CMS to make MACRA easier on physicians, especially those in small, solo, and rural practices. Over the summer, the Academy submitted neurology-specific comments and met with CMS on the proposed rule.

In the final rule, CMS reaffirmed its plan to create a “Quality Payment Program” that replaces old reporting programs. This new program involves a two-track system for Medicare reimbursement: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). But CMS made several modifications to its previously proposed rule.

“The release of the final rule shows that our intensive work on behalf of our members to share their concerns and suggestions with CMS was successful,” said AAN President Terrence L. Cascino, MD, FAAN. “Neurologists using the MIPS reporting system will be able to select their own pace of reporting in the first year of this new payment program. The low-volume threshold should be a big help to smaller practices that see relatively few Medicare patients. And our early development of new Alternative Payment Models for headache and epilepsy have us on the right track for answering the needs of neurologists seeking to participate in this part of the program.”

Merit-based Incentive Payment System (MIPS)

The Merit-based Incentive Payment System (MIPS) consolidates components of the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program. The rule finalizes the 2017 MIPS performance period, which begins on January 1 and ends on December 31 for all measures and activities.

CMS will begin measuring performance for physicians and other clinicians through MIPS in 2017, with payments based on those measures beginning in 2019. However, CMS announced a modification to this timeline that makes four choices available for physicians to “pick their pace” of participation in the first MACRA performance period that begins on January 1, 2017. Neurologists may choose from any one of the four options to ensure that they do not receive a payment penalty in 2019 based on their 2017 data:

- **Full-year reporting:** this offers an opportunity to earn a moderate positive payment bonus
- **Partial-year reporting:** by submitting 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment bonus
- **Test-option reporting:** through the submission of a minimal amount of 2017 data to Medicare, such as one quality measure or one improvement activity, you can avoid a payment penalty
- **APMs:** participating in an Advanced Alternative Payment Model (APM)

CMS states that eligible physicians who choose not to submit any 2017 data will receive a negative four-percent payment penalty. CMS also announced that it anticipates providing a similar transitional approach in 2018. Specific proposals will be announced in 2017.

The final rule defines how CMS will exclude eligible clinicians who do not exceed the low-volume threshold: those with $30,000 or less in Medicare Part B allowed charges or 100 or fewer Medicare patients as measured at the TIN/NPI level for individual reporting, the TIN level for group reporting, and the APM Entity level for reporting under the APM scoring standard.

CMS projects that nearly 25 percent of neurologists will be excluded in the first year, primarily because they fall below the low-volume threshold. Others will be excluded because they are newly enrolled Medicare providers or participants in Advanced APMs. Excluded clinicians under this low-volume threshold are not eligible to participate in MIPS.

The final rule further outlines the four MIPS performance categories, each comprising a different percentage of an overall performance score in the first year of implementation which determines how the provider is paid. The final rule lowers the required amount of measures that must be reported and also adjusts the weights for the quality and cost categories:

- **Quality – 60 percent of the score.** Most clinicians will need to report up to six measures from a range of options that accommodate differences among specialties and practices. This is required for a minimum of 90 days. If fewer than six measures apply to a clinician or group, then they will only be required to report on each measure that is applicable.
- **Advancing care information – 25 percent of the score.** In the final rule, CMS reduced the total number of required measures from 11 to five measures. All other measures are optional for reporting. However, clinicians can choose to report up to nine customizable measures for a minimum of 90 days for additional credit.
Clinical practice improvement activities – 15 percent of the score. This is intended to reward activities like care coordination, beneficiary engagement, and patient safety. CMS lowered the threshold requirements in the final rule, stating that most participants will need to attest to having completed four “medium-weighted” or two “high-weighted” activities for a minimum of 90 days to receive full credit. Groups with fewer than 15 participants, or those located in a rural or health professional shortage area, may attest to having completed up to only two “medium-weighted” or one “high-weighted” activity for a minimum of 90 days.

Cost – 0 percent of the score. Counted starting in 2018, the score will be based on Medicare claims, which means there are no reporting requirements for clinicians. This category will use episode-specific measures to account for differences among specialties.

Additionally, CMS finalized a process for providing performance feedback to MIPS eligible clinicians. Initially, the agency will provide feedback on an annual basis. In the future, CMS desires to provide feedback on a more frequent basis, as well as providing feedback on the performance categories of improvement activities and advancing care information. The final rule included a targeted review process under MIPS wherein an eligible clinician may request the agency review the calculation and MIPS payment penalty.

The agency also is finalizing requirements for third-party data submission to MIPS with an aim to decrease the burden on individual clinicians. Qualified clinical data registries, like the AAN’s Axon Registry™, will have the ability to act as an intermediary on behalf of a neurologist under MIPS to submit data to CMS across the quality, improvement activities, and advancing care information performance categories.

“While it’s great to hear that members can opt to take a test reporting option in 2017 in order to avoid a penalty in 2019, all of us need to prepare for future years when the minimum requirements will increase,” said Orly Avitzur, MD, MBA, FAAN, a member of the AAN Board of Directors and chair of the Medical Economics and Management Committee. “The best opportunity to earn incentives likely lies in the APM track in future years. Look for opportunities to become involved like joining your institution’s ACO board, so that neurology can get fair representation.”

Advanced Alternative Payment Models (APMs)

CMS continues to work on finding the appropriate levels of risk for Alternative Payment Models but did finalize a number of proposals to establish Advanced APMs. CMS intends to broaden opportunities for clinicians to participate in Advanced APMs by working to include some existing models as meeting the necessary criteria and working with the CMS Innovation Center to create new models, including those recommended by the Physician-focused Payment Models Technical Advisory Committee (PTAC).

The AAN has created two condition-based APMs for neurology that will be submitted to the PTAC. The initial APMs focus on two common disease areas, headache and epilepsy, and the AAN plans to develop more condition-based APMs. In the future, these models may qualify under the APM track of MACRA and allow neurologists to negotiate new arrangements with payers. Learn about the AAN-developed draft alternative payment models at AAN.com/practice/alternative-payment-models/neurology-specific-apms.

“We are still waiting for CMS to fill in some details about APMs, but are pleased that CMS seems to be trying to make it easier for physicians to participate in APMs,” said Joel M. Kaufman, MD, FAAN, member of the Medical Economics and Management Committee. “This is important for smaller practices and a key message from the AAN to CMS. Our work-to-date at the AAN required that we make some assumptions as to the direction CMS might go regarding APMs, and it was nice to see that our aim was correct. We ask that neurologists keep tuned in the coming year as we present our APM models to PTAC and the CMS Innovation Center. More to come!”

Free Webinar and Additional Resources

Check out AAN resources for additional information on MACRA at AAN.com/view/MACRA. The AAN will host a free practice management webinar, “Decoding the 2017 Medicare Fee Schedule and MACRA Rule,” on December 13, 2016, from 12:00 p.m. to 1:00 p.m. ET. Members are encouraged to review CMS’ new Quality Payment Program at https://qpp.cms.gov. CMS offers a fact sheet that provides details and infographics on this new program, and practices can identify organizations to help them with MACRA.