On Friday, October 14, 2016, the Centers for Medicare & Medicaid Services (CMS) released its final rule to implement the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA. MACRA is designed to link Medicare provider payments to quality patient care. The law fundamentally changes how Medicare pays physicians and other clinicians who participate in the program.

In the final rule, CMS reaffirmed its plan to create a “Quality Payment Program” that replaces old reporting programs but with several modifications to its proposed rule. This new program involves a two-track system for Medicare reimbursement:

- Merit-based Incentive Payment System (MIPS), which consolidates components of the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program
- Advanced alternative payment models (APMs)

Along with this summary and other AAN resources, we encourage members to review CMS’ new Quality Payment Program website. CMS offers a fact sheet that provides details on this new program. Practices also can identify organizations to help them with MACRA.

**Pick Your Pace**

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 you do not receive a payment penalty in 2019 based on your 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 if you choose not to submit any 2017 data then you will receive a negative 4-percent payment penalty. CMS also announced that it anticipates providing a similar transitional approach in 2018. Specific proposals will be announced in 2017.

**Exclusions**

CMS states in the final rule that it will exclude eligible clinicians that 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, 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.

**MIPS Categories and Scoring**

The rule finalizes the 2017 MIPS performance period, which begins on January 1 and ends on December 31 for all measures and activities. 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. This program replaces the Meaningful Use incentive program and is intended to reflect the use of technology in day-to-day practice with an emphasis on interoperability and information exchange. CMS emphasizes that, unlike current reporting program requirements, this category would not require all-or-nothing EHR measurement or redundant quality reporting.

- **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 aims to provide feedback on a more frequent basis, as well as providing feedback on the performance categories of improvement activities and advancing care information. CMS also
finalized a targeted review process under MIPS wherein an eligible clinician may request the agency review the calculation a 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 (QCDRs), 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.

**Advanced Alternative Payment Models**

Medicare will provide bonus payments to doctors who participate in Advanced Alternative Payment Models. Models included in this category are those under which clinicians accept both risk and reward for providing coordinated, high-quality care. Examples cited in the proposed rule include the Comprehensive Primary Care Plus model and the Next Generation Accountable Care Organization model. Medicare physicians who participate to a sufficient extent in APMs could be exempt from MIPS reporting requirements and qualify for financial bonuses. In the final rule, CMS states its intention 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.

Additionally, CMS announced a new initiative to engage physician practices across the country during this transition into MACRA. Each of the 10 CMS regional offices will oversee local meetings to take input from physician practices within the next six months and regular meetings thereafter. These local meetings will result in a report with targeted recommendations to the CMS administrator in 2017. CMS also announced the launch of an 18-month pilot program to reduce medical review for certain physicians. Under the program, providers practicing within MACRA-specified Advanced APMs will be relieved of some scrutiny under certain medical review programs. After the results of this pilot program are analyzed, CMS will consider expansion along various dimensions including additional Advanced APMs, specialties, and provider types.