MAKING SURE YOU GET PAID UNDER THE NEW HEALTH CARE LAWS: MACRA OVERVIEW AND AAN RESPONSE

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This is an unprecedented time in US Healthcare, as the evolution of regulations governing healthcare has skyrocketed since the late first decade of the new millennium. The value equation of medicine is:

$$\text{Value} = \frac{\text{Quality} * \text{Patient Satisfaction}}{\text{Cost}}$$

Costs of medicine and medical care have spiraled out of control, and comparisons to healthcare received within the Organization of Economic Co-operation and Development (OECD) countries suggests that while the US is a high outlier in cost of care, quality of care (inclusive of mortality data) is a negative outlier. Additionally, the hospital trust fund which finances Medicare is projected to be insolvent by 2030. The Institute of Medicine has published data that healthcare providers commit medical errors threatening patient safety[1] and that they demonstrate tremendous variation in the delivery of quality care[2]; additionally, doctors perform intended care in a number of diseases with indisputable evidence approximately 50% of the time.[3, 4]

In order to address the value crisis within healthcare, and because of the threat to resources financing access to care for Medicare enrollees, the Physician Quality Reporting Initiative demonstration program started in 2007; Title XIII (HITECH) evolved from the American Recovery and Reinvestment Act (ARRA) in 2009 established the electronic health record incentive program, aka meaningful use (MU)[5]; the Patient Protection and Affordable Care Act (PPACA, aka Obamacare) in 2010 established many reforms, the greatest of which was value based payments along with the evolution of the incentive PQRI program to an evolving penalty program known as the Physician Quality Reporting System (PQRS)[6]; and the most recent legislation passed in 2015, known as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)[7]. Click here to view a set of four short videos made to explain MACRA to neurologists.

The MACRA legislation passed in an overwhelming bipartisan fashion due to the repeal of the sustainable growth rate formula that was in place since the 1990's; this is known as the "doctor fix." This indeed was a true victory for organized medicine, as threat to access for Medicare beneficiaries was perennially at risk. The only way that Congress could financially create the "doctor fix" was to ensure that enough money was available to ensure better control over spending. In order to accomplish this, MACRA allows the Secretary for Health and Human Services to implement the Quality Payment Program, or QPP, creating value based payments for healthcare professionals and systems for the foreseeable future. (Click here for a list of abbreviation definitions).

The QPP sets forth two pathways for providers to participate in Centers for Medicare and Medicaid Services (CMS) payments: the Merit Based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs) pathways. (click here to learn more about the side by side comparison between MIPS and APMs). CMS' has two goals: to eliminate straight fee for service reimbursement through payments tied to alternative payment models in 50% of cases by the end of 2018, and to tie 90% of all payments to quality and value by the end of 2018.

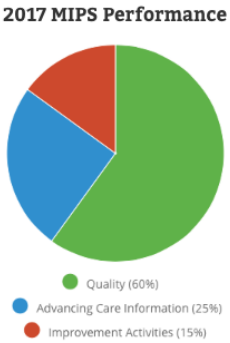
MIPS combines three legacy programs including PQRS, MU, and the value based payment modifier into one program, adding a clinical practice improvement activity (CPIA) component as well. There is always a 2-year lookback when CMS awards positive or negative payment adjustment: for instance, a physician's performance in 2017 will impact 2019 payments. Under the legacy programs, payments to physicians in 2017 and 2018 were subject to a 10% penalty with no bonus potential. The MIPS pathway sets out a plan for a gradual increase in positive and negative payment adjustments from 2019 to 2022, going from +/- 4% to +/- 9% over those four years. There is also an annual update for RVUs of 0.5% for 5 years, and then it is frozen until 2026, at which time there is a 0.25% update for those still on MIPS and a 0.75% update for those in APMs. While the APM pathway is certainly likely to be the way of the future (click here to read more about APMs), many neurology practices in

different practice settings are now confronted with how to navigate the MIPS pathway. This course is intended to show neurologists pragmatic ways to avoid a negative payment adjustment (penalty) and receive either a bonus to their Medicare payments.

MIPS will adjust the clinician's reimbursement by positive or negative payment adjustments based on performance in four categories: quality, cost, advancing care information (ACI), and CPIAs. Approximately 25% of neurologists will be excluded from participation in MIPS. Exclusions from the MIPS pathway are through four mechanisms:

1. You are participating in advanced APMs (about 1.6% of neurologists)
2. You are in your first year of Medicare participation (about 4.8% of neurologists)
3. You have <$30,000 of Medicare part B charges OR less than 100 Medicare patients (about 18.5% of neurologists)

The first measurement year is 2017 for an adjustment that will occur two years later in 2019; this means that by the time of this course clinicians will be almost five months into the measurement year. In 2017, only quality, ACI, and CPIAs will be measured; cost measurement is deferred to 2018 though CMS will gather data on cost in 2017. The breakdown of how MIPS performance will be measured is shown here:



Note that Quality is 60% of the breakdown, ACI (appropriate use of an electronic medical record) is 25%, and CPIAs are 15%. Neurologists can submit individually or as groups by using the CMS web interface if they register by June 30, 2017; groups can also use a qualified clinical data registry (QCDR). If neurologists report as a group, performance is assessed at the group level for all MIPS categories and the group receives a payment adjustment based on group performance. In order to give more time for clinicians to acclimate to the MIPS program, CMS has developed a "pick your pace" strategy, and the "categories" below refer to quality, ACI, and CPIA:

1. **Submit Nothing → Maximum payment penalty in 2019 (-4%)**
2. **Submit Something → No payment penalty in 2019**
   a. Submit data on 1 Quality Measure ***or*** 1 Improvement Activity ***or*** required Advancing Care Information measures
3. **Submit data for 90 days → Neutral to small bonus**
   a. Submit data for 3 categories for 90 days
4. **Submit data for full year → Small to maximum bonus (+4%)**
   a. Submit a complete year of data in 3 categories
   b. Potential to earn additional bonus $$$

Data submission for the 2017 performance year must be completed by March 31, 2018. Feedback is available July 2018. Here is how to maximize your score in each area:

1. **Quality:** 60% in 2017, will go down to 30% by 2019 as cost rises to 30% in 2019.
   a. The best option for doing the quality metrics is to participate in the Axon Registry ®
      i. Watch videos here about the Axon registry, developed specifically to help with value based care
      ii. Submit your name here to participate in the axon registry

b. If you choose to not do the axon registry, go here to access the quality payment program measures selection tool.
c. Set the filter in the middle of the page to Neurology
d. Select "High Priority Measure"
e. Depending on how you wish to submit your data, select the appropriate Data Submission Method
f. If you wish to report on a select group of neurology measures sets such as Dementia, Epilepsy, Opioid use, Parkinson's disease, etc, then select that filter as well
g. Remember, you must report at least one outcome measure; if not available, then choose another high priority measures.
h. Download the CSV file of the measures you have selected for your records which shows you how to meet that metric
i. REPORT ALL SIX REQUIRED MEASURES FOR A FULL YEAR PERIOD TO MAXIMIZE LIKELIHOOD OF POSITIVE ADJUSTMENT IN 2017 REPORTING YEAR.
    i. Each measure is converted to points
    ii. Bonus points for reporting additional outcomes, patient experience, appropriate use, patient safety
    iii. Bonus points for Certified EHR Reporting
    iv. Total points / Total possible points = Quality Performance Category Score

2. **Cost:** Comprises 0% of composite score in 2017, 10% in 2018, and 30% in 2019 and beyond
    a. Calculated using Medicare claims—no separate reporting is required
    b. Although it will not affect the composite MIPS score in 2017, CMS will calculate cost scores and provide them as informational
    c. 10 episode-based measures available in 2017, developing additional episodes for use in future years
    d. There are none specific to neurology in 2017
    e. New patient condition groups and patient relationship codes are being developed to assist with attribution starting in 2018
    f. SEE DR. CHENG'S LECTURE TO LEARN HOW TO ENSURE YOUR PATIENTS REFLECT THAT MOST ACCURATE RISK SCORE WHICH INFLUENCES COST CALCULATION BY CMS.

3. **ACI:** 25%. There are two options for reporting, and the option that you'll use to send in data is based on your certified EHR technology. See the tool for help in understanding how you will report.
    a. Go here to access the ACI help tool
    b. ACI base score is made of 5 components: value = 50% of score
        i. Security Risk Analysis (Yes/No statement)
        ii. E-Prescribing (numerator/denominator)
        iii. Provide Patient Access (numerator/denominator)
        iv. Send Summary of Care (numerator/denominator)
        v. Request / Accept Summary of Care (numerator/denominator)
    c. ACI Performance score is made up of 4 components: value = 90% of score
        i. Patient electronic access
        ii. Coordination of care through patient engagement
        iii. Health Information Exchange
        iv. Public health and Clinical Data Registry Reporting
    d. ACI Bonus Score opportunities: value = up to 15% of score
        i. Public Health Registry
            1. Immunization registry reporting required
            2. Can report on others
        ii. Use Certified EHR technology to complete certain improvement activities in the improvement activities performance category
    e. ACI total composite score = Base score + performance score + bonus = up to 155%, earn 100% for complete credit
    f. The AAN is working on a calculator tool to help you understand ACI better for your practice.

4. CPIA: 15%
    a. An easy way to do this is to participate in the Transforming Clinical Practice Initiative (TCPI)
    b. If you do not participate in TCPI, then select options from a menu of 90+ activities
        i. Some activities worth 20 points (high weight) and some worth 10 points (medium weight)
        ii. Full credit achievement is 40 points*
    c. Full credit for those who participate in MIPS APMs
    d. Must attest to performing the activity for a minimum of 90 days
    e. May receive preferential scoring in ACI category by using certified EHR technology to perform one or more of 18 designated improvement activities

In summary, MIPS will require some homework for your practice, but ultimately if you spend some time to decide how your practice can best participate, you may be financially rewarded for the investment. Please use resources at the Practice website on www.aan.com/practice/ for further information on MACRA and other tools that can help your practice.

References

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