Legislative Update: The Future of MACRA

With a proposed rule change currently under consideration, one expert assesses the impact and the future of the new law.

With Lyell K. Jones, Jr., MD

More than two years have passed since the Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law. Although the first payment year is 2019, physicians can begin participating in MACRA-designated programs this year. As rollout of these new programs continues, several recently proposed changes could have an impact on participation in 2018. Ahead, Lyell K. Jones, Jr., MD, Associate Professor of Neurology at the Mayo Clinic College of Medicine and Science in Rochester, MN, offers perspective on the impact of the law and the implications of the proposed changes, if approved.

How would you assess MACRA, both in terms of its immediate impact as well as any possible long-term implications?

Dr. Jones: Physicians who participate in any of the MACRA-designated programs, such as the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (AAPMs) will see their payments adjusted in 2019 based on measured performance in 2017. The immediate impact has therefore been the extent to which physicians have prepared for the new programs. Certainly, those physician groups who have examined their performance on quality and cost measures, pursued meaningful use of their electronic health records, and participated in qualifying improvement activities are well positioned to participate in the MIPS program. As a result of the complexities and incentives embedded in the law, many physician groups have pursued participation in AAPMs, although the extent of AAPM adoption is somewhat slower than initially anticipated by the Centers for Medicare & Medicaid Services (CMS).

The goal of MACRA in the long term is to create incentives for higher quality and lower costs of health care in the US—in other words, to improve the value of care in our system. The extent to which it will succeed remains to be seen. However, the principles embedded in MACRA are very popular among policymakers, payers, and ultimately the public, so we are likely to see the emphasis on value-based care continue for the foreseeable future.

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How are neurologists adjusting to MACRA, and are there any clear positive or negative trends taking shape as the program gets underway?

Dr. Jones: Several legacy CMS programs, such as the Physician Quality-Reporting System (PQRS), Meaningful Use of Electronic Health Records, and the Value-Based Payment Modifier (VBPM) will continue in revised form in the MIPS pathway of the Quality Payment Program (QPP) defined by MACRA. Neurologists who participated in these programs are in general better prepared for MACRA.

It will take some time to determine MACRA's impact on our health care system, but physician practices, large and small, are examining the quality and cost of their care very closely now in the context of MACRA. Understanding performance on these measures is a prerequisite for improvement. The burden of review and compliance with such a complex law is considerable. Anecdotally, many private practice physicians have sought closer relationships with hospitals or health systems, or have moved to fully employed models, given the challenges of navigating a very complex program.

Expert Perspective: MIPS and the Axon Registry

Arguably the most significant program within MACRA is the Merit-based Incentive Payment System (MIPS), a new framework that sets the groundwork for an evolving valued-based care model. It replaces the Medicare Sustainable Growth Rate (SGR) and rolls together various systems for reporting clinical quality measures. Given the impact MIPS is likely to have on clinical practice, the AAN has recommended many items and quality measures for neurologists to use in the new Quality Payment Program (QPP).

In the following section, Anup D. Patel, MD, Section Chief of Neurology and Associate Professor of Neurology and Pediatrics at Nationwide Children's Hospital and The Ohio State University College of Medicine, reflects on several topics of relevance to MIPS participation, including most notably the AAN Axon Registry.

On Advanced Care Information

"Meaningful use was really meant for practices and providers to implement electronic health record (EHR) reporting," Dr. Patel notes. "What Advanced Care Information (ACI) does is expand or move this area forward to enhance and improve communication in medicine by using electronic information available to many."

On Clinical Practice Improvement Activities and Resource Use

"The Clinical Practice Improvement Activities (CPIA) is a new area that will hopefully integrate quality improvement projects into the MIPS program to demonstrate practice improvement using existing quality measures," says Dr. Patel. "The AAN has created several quality measures touching many different areas of neurological illness that can be used in this arena. It has a lot of opportunity to drive patient care improvement and overall improve outcomes of our patients with neurological illness."

On the AAN's Axon Registry

"The Axon registry is the biggest endeavor taken on by the AAN as it relates to its members," Dr. Patel explains. "It is free to all members of AAN, and they need to sign up at AAN.com. Once they are up and running, the Axon Registry can be used to fulfill three of the four areas in the MIPS program. The only one it would not help is the cost component of MIPS, which is based on claims data, so no work is needed for this portion. Providers using the Axon Registry do not need to input additional information, so it will not increase work burden to neurology providers. I strongly recommend that neurologists become a part of the AAN Axon Registry, as I feel that is our best chance of success."

On the Future of MIPS and Payment Models

Given the significant flaws in the fee-for-service model, Dr. Patel believes the core concepts of the new program to move toward a value-based healthcare model are sound. Yet, although MIPS represents a step in the right direction, more work is needed to ensure that physicians' voices are accounted for as implementation continues. "I wish that CMS would involve medical doctors and specifically specialists to be sure that the right choices are made," says Dr. Patel. "This would allow for more efficiency and effectiveness for these changes."

How are neurologists adjusting to MACRA, and what tips would you offer to increase efficiency while complying with the new payment frameworks?

Dr. Jones: First, determine if you are exempt from MIPS participation based on the low-volume threshold, first year of Medicare participation, or sufficient participation in an AAPM. If you are participating in MIPS and also participated in PQRS and Meaningful Use, reviewing your performance in those programs will give you a preview of your likely score in related elements of MIPS. Similarly, reviewing your Quality and Resource Use Reports will give you a sense of prior performance on cost measures down the road.

For the 2017 measurement year, reporting a single quality measure or improvement activity will allow you to avoid the maximum four percent penalty in 2019.

Decide which MIPS quality measures you will report and how you will report them (note that relatively few measures are relevant or specific to neurology, and your reporting mechanism affects which measures you can choose).

Consider participating in a Qualified Clinical Data Registry such as the Axon Registry to monitor quality measure performance and report measures to CMS. Also, consider participation in an AAPM to take advantage of temporary five percent bonus payments and eventually a higher conversion factor available in this pathway.

Can you elaborate on the proposed rule change in the Quality Payment program and the impact this could have, if implemented?

Dr. Jones: There are a few important changes noted in the 2018 proposed rule, which when finalized in the fall of 2017 will determine the rules of engagement for MACRA participation in the 2018 measurement year. First, the MIPS exclusion thresholds were raised to $90,000 in allowed part B charges or fewer than 200 patients, which according to the agency will leave a much smaller number of physicians beholden to the MIPS program in 2018. Second, in a nod to caring for the type of complex patients often cared for by neurologists, CMS is proposing a complex care MIPS bonus based on HCC scores. Third, there are several accommodations made for physicians in smaller practices to ease participation in MIPS. Finally, CMS will raise the MIPS performance score needed to avoid a penalty in the 2020 payment year. Any or all of these proposals could change or be eliminated from the final rule, so neurologists will need to stay tuned.

What is the physician's role in this rapidly evolving legislative and regulatory spectrum, and what should it be?

Dr. Jones: Every MACRA regulatory rule we've seen so far has acknowledged some, though unfortunately not all, of the concerns raised by physician groups. Neurologists need to be engaged with advocacy, especially at the federal level, to ensure policymakers understand our patients' needs.

Ultimately, neurologists are here to take care of patients with neurologic disease. We need to remain focused on delivering the best possible care to our patients.

Given the volatile and unpredictable state of health care from a legislative and regulatory perspective, how would you assess the future of Medicare reimbursement and its relationship to the welfare of both physicians and patients?

Dr. Jones: Most of the political attention on health care this year has focused on the fate of the Affordable Care Act rather than MACRA or broader payment reform. Although it has flown under the radar, the cost of care in our system is probably the foremost long-term concern on the minds of policymakers. The US recently crossed the $3 trillion threshold in total annual health care expenditures. MACRA is largely cost neutral, but it defines a path in federal health care payment that will likely be negative to inflation in the hopes of curbing long-term growth in costs. If these programs are successful in reining in costs, policymakers will need to be held accountable to ensure that the savings don't come at the expense of our patients' well being. ■

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