AMERICAN ACADEMY OF NEUROLOGY®

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October 31, 2022

The Honorable Ami Bera, MD
172 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Bucshon, MD
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, MD
1123 Longworth House Office Building
Washington, DC 20515

The Honorable Michael Burgess, MD
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
1111 Longworth House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup, DPM
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Bradley Schneider
300 Cannon House Office Building
Washington, DC 20515

The Honorable Mariannette Miller-Meeks, MD
1716 Longworth House Office Building
Washington, DC 20515

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks,

The American Academy of Neurology (AAN), the world's largest association of neurologists representing 38,000 professionals, is strongly committed to improving the care and outcomes of persons with neurologic illness in a cost-effective manner. One in six people live with a brain or nervous system condition, including Alzheimer's disease, Parkinson's disease, stroke, epilepsy, traumatic brain injury, ALS, multiple sclerosis, muscular dystrophy, and headache. The American Academy of Neurology (AAN) thanks you for the opportunity to respond to this Request for Information (RFI) regarding MACRA and actions Congress could take to stabilize the Medicare payment system.

We recognize the financial pressures of the Medicare system and the importance of finding a financially stable solution. Given this, we are concerned about the unsustainable nature of the temporary fixes to combat conversion factor cuts, and the financial impacts of statutory PAYGO requirements. However, we remain supportive of requests to Congress to offset the cost of the temporary relief measures by appropriating funds to the Medicare Physician Fee Schedule. We also request an inflation update to the Medicare conversion factor from Congress, similar to what exists for nearly every other area of the health care sector, to aid patient access to care and stability of neurology practices serving all communities. Beyond these fundamental reforms, many more specific and nuanced changes can be made to MACRA to improve its effectiveness in improving care delivery, which are outlined below.

Merit-Based Incentive Payment System

We appreciate ongoing efforts by many stakeholders to bring about value-based care; however, MIPS in its current form falls short of its intention. While the theoretical maximum MIPS payment adjustment in 2022 is 9%, historical data indicates that in recent years the highest performing MIPS-eligible clinicians have received a positive payment adjustment of approximately 1.8% and that no clinician has been able to receive the maximum.[1] Consequently, there are added burdens on the part of practices, without sufficient increases in benefits. Many providers have been able to reach the performance benchmarks set out for them, yet there is uncertainty on whether the metrics used to assess processes and outcomes ultimately changed care delivery in a significant way. MIPS puts too much emphasis on an individual clinician's role in the healthcare system in respect to cost and holds clinicians responsible for expenditures that they may have no control over. There is great concern that increased administrative requirements and compliance burdens contribute to burnout, further exacerbating problems with the inadequate supply of clinicians in the workforce.

MIPS data has a two-year lag time in distributing the data collected through the process, which makes it difficult to drive improvement. This has been a consistent challenge, but the pandemic illustrates the difficulty of implementing changes based on delayed data. **To promote a more nimble and adaptable care delivery system, clinicians need to be provided with timely data and support in both understanding their scores and how to improve them.** Qualified Clinical Data Registries (QCDR) are a valuable tool in providing this timely data and should continue to be used in this process.

Advanced Alternative Payment Models

The AAN supports the move toward value-based payment, including Advanced Alternative Payment Models (Advanced APMs). However, we are concerned about the end of the 5% APM incentive payment for eligible clinicians who become qualifying participants. These payments are essential in facilitating the transition into APM models, where financial performance is linked more to quality and outcomes rather than volume. These incentive payments also function as critical support to smooth the transition to APMs and mitigate the increased downside risk associated with inexperience and while optimizing processes.

Currently 78% of medical practices do not have an Advanced APM option that is clinically relevant to their practice,[2] thereby missing out on the support for this transition. While neurologists do have access to a stroke care model, this does not apply to every neurology practice. Many neurology practices are still largely unable to receive incentive payments due to the dearth of approved models that address the patients and services for which neurologists are responsible.

Immediately after the enactment of MACRA, the AAN developed and submitted for testing a potential model, called the Patient-Centered Headache Care Payment (PCHCP), to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Developing this model required significant time and investment. Yet the PTAC never formally reviewed the PCHCP model, and those APMs that were fortunate enough to be reviewed and formally recommended by the PTAC didn't see wide scale adoption either. The lack of meaningful APMs for neurology and other specialties is a significant barrier to promoting value.

The AAN strongly urges the development of APM participation opportunities that are relevant to neurologists, other specialists, and their patients, and for the opportunity to benefit from the incentive payments while transitioning to Advanced APMs. Incentives are imperative to clinician

consideration and participation of APMs to further value-based care. Neurologists should be able to receive this needed support as they transition into these models. **We ask that the 5% incentive bonus be extended for an additional 5 years along with the development of more APM models relevant to neurologists.**

Other incentives, such as potential shared savings and exemption from MIPS reporting, are appreciated by participating clinicians, but it does not address the problem of insufficient models for participation. The AAN supports detailed participation and performance data for specialists in APMs to help strengthen involvement. We believe that offering stakeholders this information can help participants understand the breadth and opportunity available by adopting these models. Clinicians will also benefit from additional education on the available models and how to determine the appropriate model in which to participate, if applicable.

MIPS Value Pathways

MIPS Value Pathways (MVPs) are an appreciated effort to make quality measurement through the MIPS program more meaningful to clinicians. The AAN remains concerned that the new framework will present many of the same issues from which MIPS currently suffers. Furthermore, there is little evidence to support the idea that MVPs will be more successful than MIPS in driving quality of care or containing costs. **We are pleased that out of 12 new MVPs that are available, three are relevant to neurologists, but the AAN remains concerned about MVPs being developed to steer providers into APMs. This pathway is ineffective for neurologists when there are so few meaningful opportunities to participate in APMs.** The AAN is concerned about the continued lack of meaningful cost measures for outpatient neurology eligible providers, and the consequent impact on providers. We believe that collaboration among CMS, specialty societies, and other stakeholders is instrumental in the development of these measures.

We are also concerned about the cost of implementing these new systems on practices, and that this will be yet another factor that will continue driving small or solo practices to close, with less than 50% of practices being independent, marking the worsening of a worrisome trend. [3]
There are additional barriers for clinicians to transition into MVPs as **the health care system is stressed with the effects of COVID-19 and ongoing workforce shortages. When faced with the potential burden of implementing multiple MVPs in clinical settings, we believe that there is little appetite among providers to voluntarily participate without first seeing demonstrated value.** There is a significant concern that MVP participants may perform worse and suffer a negative payment adjustment or a lesser positive payment than MIPS eligible providers not participating in MVPs.

Quality and Digital Health

Measuring Quality is an important aspect of value-based care. However, testing and validating these quality measures is an intensive process, and in some cases has taken AAN up to 2 years to complete. Additionally, there are concerns that these testing requirements do not effectively reflect nor improve the quality of care delivered. **Small changes could go a long way to improving quality measures' usefulness, such as providing greater transparency and clarity in the process and ensuring that approved measures go unchanged for a prolonged period.**

Digital health technology proves to be instrumental in the move towards value-based care, and **the integration of reporting through existing electronic health record (EHR) technology would be**

beneficial to providers, especially if MVP requirements are integrated in EHR technology to identify visits that fit MVP criteria and aid in measure reporting. Additionally, steps towards standardizing EHRs and data elements, along with **providing incentives for informatics and EHR builds for solo and small practices that allow for collection of meaningful data elements** would be significant improvements as well.

Evaluation and Management

Neurologists are considered cognitive specialists and provide evaluation and management (E/M) services to care for individuals with complex medical conditions. Around 70% of neurology practice billings are for E&M services.[4] These face-to-face services require a high level of expertise and often lead to the specialist coordinating both specialized and primary care for patients with chronic conditions. The main component of E/M services is face-to-face time spent with patients, which is important for care management and is valued by patients. In the process of setting payment rates for thousands of physician fee schedule services, Medicare underprices certain services, such as E/M office visits, relative to other services, such as procedures.[5] This imbalance contributes to significantly higher incomes for physicians in procedural specialties relative to those who rely more extensively on E/M type visits.

Each year the relative valuation of E/M is eroded due to budget neutrality requirements, which negatively impacts the conversion factor. While this impacts other services, procedural oriented specialties often have other factors that can help offset these impacts, such as relying on a wider range of services thereby increasing their opportunities for positive updates and gaining efficiencies in their procedures through technology advancements. These options are not possible for E/M services, which are largely time based. AAN is concerned with this passive devaluation of E/M services that accumulate over time and are limited by the structural process by which the relative values of code sets are updated.

The 2020 revaluation of E/M outpatient services provided a much-needed boost to these codes, the result was long overdue and only modestly improved reimbursements. It took more than 20 years for the E/M Services Guidelines to be updated and it only occurred after a problematic proposal to do so was put forward unilaterally by the previous administration.[6] While the 2020 E/M changes were historic, we cannot afford to wait another two decades or longer for a future review considering the structural challenges that exist that erode E/M's value over time.
We ask that Congress ensure that E/M codes be reviewed on a regular basis. We believe this change will help ensure that these codes, which provide the fundamental underpinnings of primary and complex chronic care, remain financially viable and competitive with non-E&M procedures and other services. **Without this change, history will likely repeat itself through the slow and steady devaluation of E/M services, creating a new significant challenge for patients, clinicians, and Congress.**

Conclusion

Thank you for your continued leadership focused on ensuring that physician practices around the country remain economically viable and available to serve patients in their communities. If you have any questions or requests for additional information, please contact Madeline Turbes, Health Policy Manager at mturbes@aan.com, or Derek Brandt, Director of Congressional Affairs at dbrandt@aan.com. We look forward to working with you as we all strive to care for all Americans.

Sincerely,

Orly Avitzur, MD, MBA, FAAN
President, American Academy of Neurology