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Neurology Advocacy 2.0: Post SGR Reform

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On April 16, 2015, the Medicare Access and Children's Health Insurance Program Reauthorization Act, known as MACRA, was signed into law. The following week, the American Academy of Neurology held its annual meeting where many neurologists openly questioned: "What now?"

Repeal of the Medicare Sustainable Growth Rate (SGR) formula, as part of MACRA, is historic. Enacted in 1997, the SGR formula was designed to reduce health care costs by calculating what "sustainable growth" within the system would be and reducing physician reimbursement if it was over this rate. However, such cuts (typically in the double digits) were vigorously opposed by the physician community. As a result, over the past 12 years, Congress intervened 17 times to temporarily halt the SGR cuts. These last minute fixes were costly to taxpayers, required a substantial lobbying effort by organizations such as the American Academy of Neurology (AAN), and caused significant uncertainty amongst practitioners. Repealing the SGR required a sustained effort by the entire physician community for over a decade. Resolving the SGR issue provides a significant opportunity for neurologists to focus on other issues including advocating for better recognition of cognitive care services, improving the practice of neurology, and strengthening the neuroscience pipeline.

Stabilization of Medicare payments is an improvement to the practice of neurology, but significant hurdles remain. The challenges include those associated with an evaluation and management-based (E/M) specialty. For the neurologist, the current system continues to disincentivize the thoughtful and complete care required to treat a patient with neurological disease. Many of our patients have chronic conditions, and management requires labor intensive time. In addition, with the aging population, there is an increasing demand for neurologists and fewer trainees pursuing the field.¹ As the practice environment evolves, neurologists must also acclimate in order to succeed in a value-based system. Our advocacy

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efforts need to focus on optimizing opportunities for neurologists and other cognitive specialists providing E/M based care.

There are several approaches to this. In one approach, increased recognition of care coordination may help neurologists. The existing chronic complex care management code has too many requirements to allow most neurologists to benefit from it. Increasing the rate and liberalizing the use of this code may help providers be appropriately reimbursed for the non face-to-face efforts required to care for their patients. A second approach would be to support an overall re-valuation of E/M codes. It is clear that not all level 5 visits are created equal. Requesting that the Centers for Medicare and Medicaid Services (CMS) study the E/M codes would have the potential to better value the time and efforts required for the diagnosis and management of patients with neurological disease. We need to pursue all available avenues to increase and incentivize E/M-based care, regardless of specialty. Additionally, as MACRA unfolds, we will continue to advocate for neurology as an E/M-based specialty in need of support to care for these complex and chronically ill patients.

The funding and support of neuroscience research is also critically important. The support for such work remains very low and challenges those individuals attempting to bring cures to patients. For example, it costs over \$250 billion dollars annually to care for individuals with Alzheimer's disease or stroke, and \$157 billion dollars annually to care for individuals with cancer.^{2,3,4} However, in fiscal year 2014, within the National Institutes of Health (NIH), Congress directed over \$5 billion dollars for cancer research, and \$862 million dollars at Alzheimer's or stroke research.⁵ It is challenging to convince neurology residents to pursue a career in research and equally challenging for those individuals in neuroscience research to maintain it with historically low funding paylines. This is paradoxical to the opportunities that novel imaging techniques, the advent of high-throughput sequencing, and other technologies afford researchers. These opportunities and challenges require us to redouble our efforts to increase neuroscience research funding.

These efforts require two approaches. Firstly, we continue to address the challenges detailed above in an effort to broadly increase NIH funding. As background, NIH funding is provided through the appropriations process, which begins in the U.S. House of Representatives. Typically, the President provides the House a draft budget, and both the House and Senate will generate their own budgets. These budgets are large and complex, and it is difficult to dramatically change the budget for any one item (e.g., NIH funding). For efforts such as these to be successful, they will require a true groundswell of support from physician and patient organizations. Given the varied interests of both patient organizations and physicians, fractures by disease research priorities limit these efforts. Nonetheless, we continue to support an overall increase to NIH funding. Other federal organizations that support neuroscience research, including the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), are also subject to the appropriations process and require yearly efforts to at least renew current support.

The second approach is to identify specific research areas or focuses in an effort to increase research funding in a more targeted fashion. A recent example is the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. This initiative was introduced

in 2013 with a goal to develop the next generation of technologies to understand brain function and disease. This initiative has several aspects for support that are appealing, including private sector investment and the collaborative work of several funding agencies (NIH, DoD, etc). The AAN continues to advocate for full funding of this important initiative through the annual appropriations process. From an advocacy standpoint, this is a simpler approach because it is directed at a specific initiative and it is easier to make the connection between the funding to the treatment of brain diseases. Another example is the Alzheimer's "bypass budget" initiative. This unique initiative would allow NIH to determine the optimal funding level needed for Alzheimer's research that is not subject to the annual budget process. This is the most sustainable and direct approach to influence research in a specific disease area. This effort will require a sustained and coordinated advocacy effort amongst those patient organizations and other professional organizations, such as the AAN, to bring this initiative to fruition.

New opportunities utilizing a targeted funding approach include the 21st Century Cures Act, which is a broad ranging bill, but does specifically support increased surveillance of neurological diseases such as Parkinson's and Multiple Sclerosis. In fact, many of our recent successes in supporting neuroscience research funding have come as the result of a more targeted approach. This is a challenging tactic for neurologists to take given the wide range of diseases we care for. It is critically important to balance opportunities to further the research in specific areas like Alzheimer's while striving to strengthen funding for overall neuroscience research. The costs and prevalence of neurologic disease in the U.S. justify a greater investment in the institutions and individuals conducting neuroscience research.

In the end, post-SGR advocacy will center on improving the recognition and value for E/M-based providers and increasing the support for neuroscience research through a variety of approaches. It is our strong hope that these efforts will improve access to neurologists, strengthen the profession of neurology, and further the treatments that the neurologist is able to offer.

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