MACRA: New Incentive-Based Physician Pay Program
ASN Responds to CMS

By Rachel Meyer

In the coming months, the Centers for Medicare & Medicaid Services (CMS) will begin implementing a 2015 law that changes how doctors who provide care to Medicare beneficiaries are paid. ASN is working with CMS to help the Agency get the new system—which aims to reward value over volume—right for nephrology clinicians and the patients with kidney disease they serve.

Last year, Congress repealed and replaced the sustainable growth rate (SGR), the outdated physician payment system that called for substantial annual cuts to physician reimbursement, by passing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

“One thing everyone agrees upon in Washington was that the old payment system was broken, and ASN advocated for its repeal and replacement. The new payment system aims to move healthcare in the right direction, emphasizing quality of care instead of quantity of care and reducing administrative burdens so physicians can focus their efforts on providing the highest quality of care to patients,” said ASN President Raymond C. Harris, MD, FASN. “ASN delivered nearly 20 pages of recommendations concerning how to improve and successfully implement the new system and achieve the goals Congress outlined when it enacted MACRA.”

The new payment system—termed the Quality Payment Program—will offer two tracks for Medicare physician payments: MIPS (Merit-Based Incentive Payment System) and APMs (Alternative Payment Models) (Table 1).

On June 27, 2016, ASN submitted extensive recommendations to CMS regarding its 962-page proposal for putting in place the significant changes called for by MACRA. CMS is expected to issue a final rule on MACRA implementation in the fall of 2016, taking into account input from ASN and other stakeholders. The society emphasized several key themes, described here:

Delay the start of data collection
MACRA requires that the new Quality Payment Program take effect starting January 1, 2019. Although CMS proposed to start collecting data on physicians’ quality of care, resource use, and other aspects of care starting January 1, 2017, ASN believes that an additional six-month period is needed to educate clinicians. The society recommended that CMS delay the start of the performance period until July 1, 2017.

ASN believes that clinicians will need this time period to familiarize themselves with the final rule and prepare their practices to deliver the best patient care possible in the new payment system. The society urged CMS to develop a robust educational program to help clinicians—radiologists, pathologists, and nephrologists, given that they treat patients with varying degrees of sickness and complexity in multiple types of facilities—approach the pathways available in the Quality Payment Program. ASN also intends to complement and amplify educational programs developed by CMS with its own educational tools.

The delay ASN proposed (to July 1, 2017) would allow clinicians time to come up to speed and to review their data before their payments start to be adjusted on January 1, 2019.

Factor in how patients with kidney disease are unique
Throughout its 19-page commentary to CMS, ASN emphasized the complex needs of kidney patients and their status as among the most vulnerable in the entire Medicare program. Kidney disease disproportionately affects under-represented minorities, and patients with advanced kidney diseases suffer from multiple other serious chronic co-morbidities, including diabetes, hypertension, peripheral vascular disease, and heart failure. More than 50% of patients with CKD have 5 or more other co-morbid conditions, and CKD care for patients age 65 and older exceeded $50 billion in 2013—representing 20% of all Medicare spending in this age group.

ASN also emphasized the heterogeneous nature of nephrology care: nephrologists typically provide medical care in multiple settings with variations in patient population characteristics and health status and differential access to electronic health records (EHRs)—variations that may influence their ability to be successful in the MIPS program and should be considered by CMS.

The society recommended a number of modifications to MIPS’ proposals based on these two factors of unique patient status and practice structure. In particular, ASN recommended that CMS require that reporting mechanisms include the ability to stratify the data by demographic characteristics such as race, ethnicity, and gender—and ASN urged CMS to use its resources in an active effort to continually improve the risk adjustment methodology employed within MACRA implementation. The need for appropriate quality measures that reflect the value of care nephrologists provide is also paramount.

Modify MIPS reporting requirements
In large part reflecting the unique patient and practice issues in nephrology, ASN also recommended a number of changes to the MIPS program. Specifically, the society promoted:

• Reducing the number of patients on whom clinicians must report quality data to lower than that proposed by CMS in the “Quality” category.
• Adjusting the “Resource Use” component of MIPS downward so that it makes up less of the total performance score: CMS proposed that Resource Use account for 10% of the total.
• Increasing the number of proposed “Clinical Practice Improvement Activity” categories that qualify as “high value,” more accurately reflecting the effort clinicians put into improving their practices.
• Implementing less stringent standards for use of EHRs (which CMS has branded “the Advancing Care Information” category of MIPS).

ASN collaborated with a number of other organizations in developing comments—including the American College of Physicians and the Council of Medical Subspecialty Societies—which echoed similar comments regarding making the MIPS program less onerous.

Create greater flexibility for APMs to form
APMs will provide new ways to pay health care providers for the care they give Medicare beneficiaries. APMs aim to deliver more coordinated, comprehensive care that focuses on population health and value, and they also take on an element of financial risk if the care that they deliver does not, in fact, provide good value. For the time being, every APM is a demonstration project currently being tested by the Centers for Medicare and Medicaid Innovation (CMMI). CMS proposed that clinicians who participate in APMs will get certain bonuses in the MIPS program—and ASN has urged the agency to give as much credit as possible to these clinicians, reflecting the challenges of practice transformation necessary to become an APM.

However, only clinicians who participate in Advanced APMs will be exempt from the MIPS program—and, these clinicians will receive a 5% bonus in the first few years of the Quality Payment Program. ASN is concerned that CMS proposed a very stringent defini-

Policy Update

Table 1. MIPS vs. APMs

<table>
<thead>
<tr>
<th>Merit-Based Incentive Program (MIPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• MIPS consolidates three existing Medicare programs—the Physician Quality Reporting System, the Value-Based Modifier, and the Electronic Health Record (EHR) Meaningful Use program</td>
</tr>
<tr>
<td>• The program will assess physicians’ EHR use, quality of care, use of resources, and “Clinical Practice Improvement Activities,” to calculate a total performance score that will impact how much they are reimbursed by Medicare.</td>
</tr>
<tr>
<td>• Physicians will see their payments adjusted up or down depending on their performance in these four areas. Starting in year one (2019) the maximum adjustment will be 4%, but that percent will grow over time with more latitude for risk or reward based on performance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Payment Models (APMs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• APMs are currently demonstration projects being tested by the Centers for Medicare and Medicaid Innovation.</td>
</tr>
<tr>
<td>• Participating physicians will receive certain benefits under MIPS.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advanced Alternative Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physicians participating in APMs that meet CMS’s criteria as Advanced APMs would be exempt from the MIPS reporting requirements.</td>
</tr>
<tr>
<td>• Advanced APMs must accept “more than nominal” financial risk under value-based payment systems</td>
</tr>
<tr>
<td>• The majority of physicians must use certified EHRs.</td>
</tr>
<tr>
<td>• Physicians in Advanced APMs may earn bonus payments and avoid potential Medicare reimbursement cuts. They will also receive an annual 5 percent lump sum bonus between 2019 and 2024.</td>
</tr>
</tbody>
</table>

Continued on page 16.
Future Physician Payment

Continued from page 15

tion of Advanced APMs, one that re-
quires a significant amount of financial
risk. Indeed, just six CMMI models
currently being tested would meet the
proposed financial risk criteria. As cur-
rently proposed, the substantial financial
risk for losses for Advanced APMs will
likely limit physician-driven participa-
tion and slow achievement of the goals
of MACRA.

ASN believes the principle of com-
prehensive, integrated care inherent in
APMs is a vital concept to advance to improve patients' outcomes. The society urged CMS to create as
many mechanisms as possible for inter-

ested physicians to establish and partici-
pate in APMs and Advanced APMs. In
particular, the society encouraged CMS
to consider alternate—still appropriately
rigorous, but alternate—definitions of
financial risk for "physician-focused pay-
ment models." Physician-Focused Pay-
ment Models are an important aspect of
MACRA that call for the creation of
APMs centered on physician leader-
ship—a concept that ASN strongly sup-
ports.

Set the stage for a comprehensive physician-led CKD model

At this time, CMS was not seeking recommendations for new APMs or
Physician-Focused Payment Models. However, ASN indicated that it antici-

pates putting forward a "comprehen-
sive CKD," Physician-Focused Payment
Model for consideration in the future.

A potential comprehensive CKD
Physician-Focused Payment Model
would put nephrologists at the helm
of helping patients navigate the entire
course of their advanced CKD. En-
compassing all patients with advanced
CKD, including kidney transplant re-
ipients, such a model could focus on
slowing the progression of kidney dis-
ease and other complex chronic condi-
tions that are common in patients with
advanced kidney disease. Inclusion of
transplant patients for the duration of
their lives within the scope of this mod-
el would create inherent incentives to
promote transplantation for the great-
est number of patients possible who
are candidates, in addition to dialysis.

Similarly, ASN envisions that a poten-
tial comprehensive CKD model would
include palliative and/or conservative
care options as those become appropri-
ate considerations.

"I would like to commend the mem-
bers of the Public Policy Board, led by
John R. Sedor, MD, FASN, and by the
ASN Quality Metrics Task Force, led by
Daniel E. Weiner, MD, FASN, for their
hard work in assessing and comment-
ing on this proposed rule," Harris said.
Moving forward over the coming weeks
and months, "ASN will be providing re-
sources and insights to help our mem-
bers understand how to prepare for and
succeed in the Quality Payment Pro-
gram, and will continue to engage with
CMS to ensure a smooth transition go-
ing into 2019."

Home Dialysis: Advocates Urge Better Telehealth Access, Education about Dialysis Options

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H

H