Policy Update

ASN Pushes for Adjustments to the Quality Payment Program for 2018

By David White

Quality and value care reimbursement: Where is it going in the next couple of years? There has been a great deal of talk and action to move health care from volume-based to value-based reimbursement. Most notable has been the creation of the Quality Payment Program (QPP) to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and replace the Sustainable Growth Rate (SGR). The program began this year with Medicare designating 2017 as a transition year with Merit-based Incentive Payment System (MIPS) clinicians getting to "pick your pace." For 2017, the first year, clinicians are only required to report on one measure to avoid a penalty.

The proposed rule was released on June 20, 2017, and the American Society of Nephrology (ASN) submitted its comments and recommendations in a letter on August 21. The proposed rule focused on updates in three primary areas:

- Making participation easier for small (and possibly rural) practices,
- Easing clinicians into reporting requirements, and
- Recognizing the diversity of practices, practice settings, patients, and care models.

Here are some of the highlights from the proposed rule for 2018.

Merit-based Incentive Payment System (MIPS)

The Merit-based Incentive Payment System (MIPS) is one of the two pathways to participation in the QPP. The other pathway is Advanced Alternative Payment Models (AAPMs).

Low-volume exemptions

The Centers for Medicare & Medicaid Services (CMS) has proposed to raise the low-volume threshold in MIPS in 2018. Clinicians would be excluded from MIPS if they do not bill over $90,000 in Medicare Part B allowed charges or do not have over 200 Part B beneficiaries.

Performance Threshold

CMS proposes to set the performance threshold at 15 in 2018. All clinicians in MIPS are able to earn a score between 0 and 100 awarded based on the clinician's reporting in four areas: Quality, Costs, Advancing Care Information, and Improvement Activities. Within that range, Medicare selects a number reflective of a base level of performance it believes a clinician should be able to achieve—that number is the "performance threshold." A score above the performance threshold could result in a bonus adjustment in reimbursement. A score below the performance threshold will result in a negative, downward adjustment in reimbursement. An exact score in the performance threshold will result in no adjustment up or down—neutral.

Zero weight for costs category

The proposal recommends maintaining the weighting of costs at 0% in 2018 as it was in transition year 2017. This was done in large part because the episode groups that CMS intends to use to calculate cost effectiveness are not yet complete. The proposed rule has an alternative proposal placing the weight at 10%. ASN has strongly urged CMS to adopt the primary proposal of 0% and use the time between now and December 31, 2018, to transparently develop episode measures applicable to nephrology caregivers.

Hierarchical Conditions Category Bonus

CMS proposes to add a complex patient bonus, limited to three points, to the final score for the 2020 MIPS payment year for MIPS clinicians who submit data for at least one performance category. CMS proposes to calculate the average Hierarchical Condition Category (HCC) risk score for a clinician or group by averaging HCC risk scores for beneficiaries cared for by a clinician or group during the second 12-month segment of the eligibility period, which spans from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period in the next calendar year (September 1, 2017, to August 31, 2018, for the 2018 MIPS performance period). The proposed rule also contains an alternative proposal, in which CMS would apply a complex patient bonus based on the ratio of patients who are dual eligible.

Because patients with kidney diseases are among the most complex in clinical practice, ASN encouraged CMS to continue working on this issue as there are several aspects of the proposal that need further refinement. The point bonus does not appear robust enough nor does the proposed process sufficiently consider patient population size, as smaller patient populations are statistically problematic. ASN has offered to work with CMS to further refine this recommendation.

Topped-Out Quality Measures

In 2019 and beyond, CMS proposes that any measure identified as topped-out for two consecutive years would not provide more than six measure achievement points in the second consecutive year it is identified as being topped-out. After three years of being identified as topped-out, the measure would be considered for removal through the rulemaking process. ASN does not object to this proposal.

The statistical definition CMS uses to define topped-out measures is exceedingly difficult to reach given the high numbers as, with large populations or numbers of facilities, clinically insignificant differences can be statistically significant. Nephrology's experience with the Quality Incentive Program (the first mandatory pay-for-performance program within Medicare, implemented in 2010) suggests that even if a measure does not meet CMS's statistical definition of being topped-out, there are many circumstances, particularly given the relatively low numbers of patients at each dialysis facility in relation to the much larger number of facilities, where measures are 'clinically' topped-out. When this occurs, the measure may no longer achieve the goal of incentivizing and rewarding quality care but rather prevents individualized patient-centered care.

ASN urges CMS to pursue a robust process to evaluate and remove topped-out measures to ensure optimal patient care and success of the QPP and emphasizes that assessment of whether a measure is 'clinically' topped-out is essential for all metrics.

Continuing Medical Education

CMS included language in the proposed rule to explicitly recognize Continuing Medical Education (CME) as an Improvement Activity (IA) in MIPS. ASN welcomed this inclusion.

Virtual Groups

In 2016, ASN urged CMS to create virtual groups for performance year 2017. ASN supported CMS moving forward on virtual groups for 2018 in the hopes that this will be a helpful path for solo practitioners and small practices.

Data Completeness

CMS proposed that clinicians who report on measures that do not meet data completeness standards receive one point as opposed to three points currently, although small practices will continue to receive three points. Recognizing that the QPP is a young, evolving program, ASN urged CMS to not make this change and maintain the current formula so clinicians will have the opportunity to learn how to interact optimally with this developing program.

Advanced Alternative Payment Models (AAPMs)

Advanced Alternative Payment Models (AAPMs) are the second pathway to participation in the QPP.

As noted in its comment letter from 2016, ASN remains concerned about the relatively small number of Advanced Alternative Payment Models available for clinicians, particularly those who care for patients in multiple settings without focusing on dialysis. While the ESRD Seamless Care Organization program offers one option to nephrologists, it is limited to dialysis care, thereby excluding the nearly 40 million Americans with CKD not yet on dialysis as well the hundreds of thousands who have received kidney transplants who could benefit from integrated care. ASN continues to urge CMS to use every available mechanism to foster the development of AAPMs, including models that span rather than silo stages of kidney diseases and incentivize optimal transitions across care settings.

The QPP also created the Physician-Focused Payment Model (PFPM) Technical Advisory Committee (PTAC) to consider and recommend new models, but the small number of AAPM proposals submitted to the PTAC demonstrates how early in development this path in the QPP remains.

Nominal Risk

For AAPMs, CMS proposed that the definition of nominal risk be just the 8% revenue standard—8% of the average total Medicare Parts A and B for an entity. ASN maintains that 8% is still high and could serve as a barrier to increasing the number of AAPMs—particularly PFPM AAPMs. In 2016, ASN recommended several alternative options:

- Limiting risk on using revenues received by a practice as a metric instead of a percent of total expenditures for patients (at least in some models).
- Not requiring payments back to CMS if the APM entity falls short of its anticipated revenues, as calculated by the physicians, for at least the first 2 years. Simply not receiving a bonus may be sufficient incentive for improving the ability to calculate risk, as physicians learn how to work with the new paradigm.
- Allowing certain APMs to operate for a pre-specified time period as one-sided risk (long enough to test whether a new care delivery model is promising in terms of cost and outcomes) but with the expectation that it would transition into two-sided risk if it were to be expanded/extended.

ASN restated its position that it sees the QPP as an evolving system that needs input and participation from all sectors of health care as all parties move forward.