



MACRA Overview

Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) with overwhelming bipartisan support in the March of 2015. MACRA did three things of particular importance to nephrologists:

1. Repealed the Sustainable Growth Rate (SGR)
2. Sunsetting three standalone physician facing CMS incentive programs
 - a. The Physician Quality Reporting System (PQRS)
 - b. The Electronic Health Records Incentive Program (aka Meaningful Use)
 - c. The Physician Value-based Payment Modifier (VM)
3. Established a new program-The Quality Payment Program (QPP) which directly impacts the Medicare Physician Fee Schedule

Although the QPP has several stated objectives, this incentive-based program's main intent is to move Medicare away from simply a fee-based system to one where quality and cost containment were greater emphasized. Now in its third year of implementation, those eligible clinicians participating in the QPP in Year 1 (2017) are this year (2019) receiving the positive, neutral, or negative adjustments to Medicare invoices based on total points from that first performance year.

In a [CMS blog post](#) released November 8, 2018, CMS Administrator Seema Verma formally announced participation data from Performance Year 1. In summary, 93% of the nearly 1.06 million eligible clinicians participating in the Merit-Based Incentive Payment System (MIPS) received a positive payment adjustment while only 5% received a negative payment adjustment. Admittedly, the establishment of a relatively low threshold score of 3 points out of a possible 100 in the first year of implementation represented the reason so many clinicians ended up with a positive adjustment. The same explanation accounted for the fact that the positive payment adjustments were rather modest (maximum of +1.88% added to all traditional Medicare payment invoices in 2019). Although for Performance Year 2019 the maximum payment adjustment is stated to be +7%, the actual amount of positive adjustments must by law be equal to the amount of negative adjustments. With a rather modest threshold score predicted for the immediate future, it appears likely that the actual amount will not approach the stated maximum potential adjustment in payment year 2021.

With rare exception, all physicians and advanced practitioners are participating in the QPP. Excluded from the QPP are:

1. Providers new to Medicare
2. Providers who do not clear the low volume thresholds established by the final rule:



- Bill \$90,000 or less in Medicare Part B allowed charges for covered professional services payable under the Physician Fee Schedule (PFS), or
- Provide covered professional services for 200 or fewer Part B-enrolled individuals, or
- Provide 200 or fewer covered professional services to Part B-enrolled individuals

If you're exempt from MIPS for Performance Year 2019, you're not required to participate. You may choose to opt-in to MIPS if you exceed 1 or 2 of the low-volume threshold criteria. [Check your status](#) throughout the year if you make any changes that may affect your eligibility.

Importantly, a provider's performance within the QPP directly impacts his or her Medicare Physician Fee Schedule (PFS) two years later. Specifically, QPP performance in 2019 determines the adjustment to the provider's 2021 PFS (the payment year).

Two Paths: MIPS and Advanced APMs

The QPP establishes two distinct paths for providers:

- 1. The Merit-based Incentive Payment System (MIPS)**
- 2. Advanced Alternative Payment Models (Advanced APMs)**

MIPS will be the most common path for nephrologists in the early years of the program.

MIPS

MIPS basically rolled up components of the three standalone quality programs which MACRA sunset, and adds a fourth category to the mix. The four MIPS categories include:

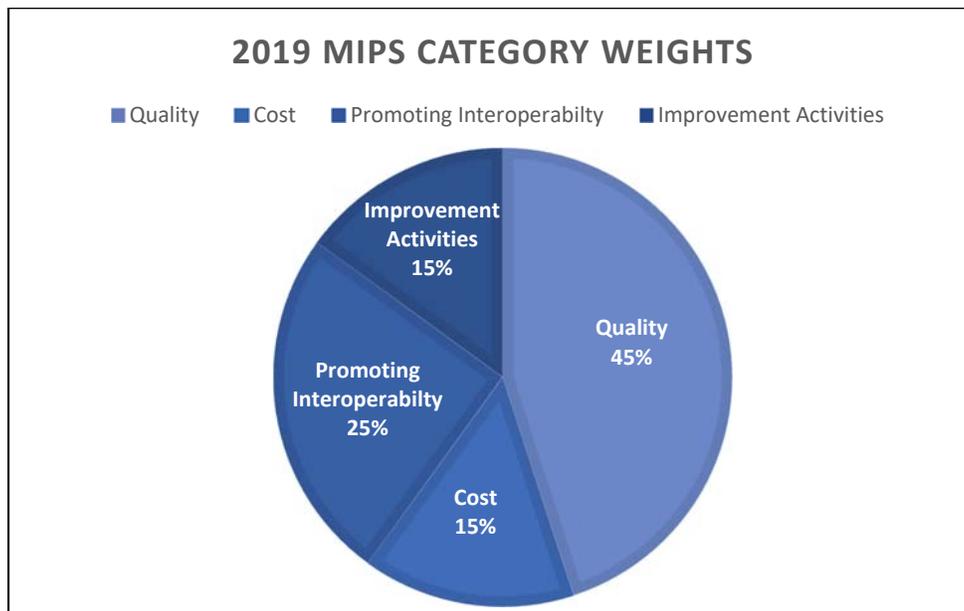
- Quality
- Cost
- Promoting Interoperability
- Improvement Activities (IA)

At a very high level, quality looks a lot like PQRS but it's pay for *performance* as opposed to pay for *reporting*. Cost utilizes many aspects of the cost side of the Physician VM. Promoting Interoperability is basically Meaningful Use, but easier to understand. And Improvement Activities is a new category which is defined as "an activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery, and that the Secretary determines, when effectively executed, is likely to result in improved outcomes".

The four categories vary in relative weight. The provider's performance across these four categories is rolled up into a score on a scale from 1-100 which is referred to as the composite performance score. The provider's MIPS score is then compared with the performance of all other providers around the nation, and it's that score which dictates the update to the provider's PFS during the payment year. MIPS is a budget neutral program, such that providers receiving a positive PFS adjustment are effectively paid with funds collected from providers receiving a negative PFS



adjustment.



Nephrology providers are most likely to participate in MIPS either as individual providers at the NPI level, or as a group at the TIN level. .

MIPS Scoring Framework

- Each category has a score
- The category scores for Quality and Improvement Activity are based on your performance on measures you choose to report Most measures are scored based on performance – not just yes/no
- Measure performance compares you to all data submitted from prior years

Complex Patient Bonus

A bonus of up to 5 points will be added to the final score for clinicians who treat medically complex patients as well as those with social risk factors.

The bonus consists of two indicators:

1. The average Hierarchical Condition Category (HCC) risk scores, and
2. The proportion of patients with dual eligible status.



Nephrologists in Alternative Payment Models

Of note, nephrologists participating in Alternative Payment Models (like a track 1 MSSP ACO) will take a slightly different approach to MIPS. The Quality component for MIPS will be derived from the quality component of the APM. In many instances participating in the APM generates credit for the Improvement Activities category within MIPS. The Cost category in MIPS is not scored for those in an APM. That leaves Promoting Interoperability which functions as it does in MIPS. Importantly, all participants in the APM will receive the same MIPS score and as such will see the same PFS update during the payment year.

Advanced APMs

The second path within the QPP is participation in an Advanced Alternative Payment Model. The QPP places APMs into one of two categories; MIPS APMs, like the track 1 MSSP ACO example above, and Advanced APMs. The ESRD Seamless Care Organization or ESCO is the Advanced APM most familiar to nephrologists. The principle distinction between a MIPS APM and an Advanced APM is that Advanced APMs must:

- Require participants to use Certified EHR Technology
- Base payments for services on quality measures comparable to those in MIPS
- Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a significant financial risk.

Each year CMS will publish the list of APMs that meet the criteria to be classified as an Advanced APM. Participation in an Advanced APM creates two potential advantages for nephrologists:

1. Exclusion from MIPS, and
2. Potential for receipt of bonus equivalent to 5% of the provider's Medicare Part B allowable payments

These benefits occur when the APM entity clears the thresholds necessary to become a Qualifying Participant (QP). Important points about the QP calculation include:

- The QP designation applies equally to all of the participants in the Advanced APM.
- There is a patient count and a revenue QP calculation, clearing either one achieves the QP designation.
- The QP calculation is performed three times during the year if necessary (once an Advanced APM clears either the patient count or the revenue QP threshold, the APM entity is a QP and the calculation is not repeated).
- The patient count and revenue QP thresholds increase over time.



Requirements for APM Incentive Payments for Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Providers within an Advanced APM designated as a QP in 2019 are excluded from MIPS in 2019, and in 2021 those providers receive a lump sum bonus payment equivalent to 5% of their estimated aggregated amounts paid for Medicare Part B covered services in 2020. Advanced APM participants who do not achieve the QP designation may be considered Partial QPs (by achieving a threshold below the QP threshold). Partial QPs do not receive the 5% bonus, but as Partial QPs, participation in MIPS is optional for that year. Finally, nephrologists within an Advanced APM that fails to clear the Partial QP hurdles will be subject to MIPS and the approach will be similar to the one outlined above for Track 1 MSSP ACO participants (see *Nephrologists in Alternative Payment Models*).

