Kidney Medicine

Early Nephrologist Performance in the Merit-Based Incentive Payment System: Both Reassurance and Reason for Concern

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In an effort to control increasing health care costs, lawmakers passed the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) with bipartisan support in 2015. MACRA coincided with repeal

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of the Sustainable Growth Rate (SGR) formula, which imposed strict caps on physician payments but had been ineffective due to annual postponements.[1] While replacing the SGR with MACRA eliminated the looming threat of large SGR payment cuts to physicians, it represented a shift in physician reimbursement toward value-based payment. The vast majority of Medicare physician providers are now required to participate in 1 of 2 MACRA tracks, the Merit-Based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (AAPM). Under these tracks, MACRA seeks to reward high-quality cost-efficient clinicians with reimbursement bonuses while imposing financial penalties on lower-quality more expensive clinicians.

Most patients with kidney failure have Medicare coverage, making virtually all practicing US nephrologists subject to MACRA's payment incentives. Most nephrologists, 91% in 2017, are not part of an AAPM and are therefore enrolled in MIPS. This includes nephrologists reporting as individual clinicians, clinician groups, or as a part of an Alternative Payment Model (APM) that does not satisfy the stringent risk requirements necessary to qualify as an AAPM.[2] MIPS evaluates physicians annually by combining their performance in the following 4 distinct measure categories into a single "final score": Quality, Promoting Interoperability, Improvement Activities, and Cost.

Because MIPS evaluates physician performance across all specialties and primary care disciplines, some specialties may fare better than others[3] and clinician, patient, and geographic characteristics may influence performance under MIPS. For instance, clinicians who care for patients at high social risk have been found to perform worse in MIPS, whereas clinicians affiliated with large health systems may perform better.[4,5] Nephrologists care for medically complex patients in a wide range of settings and commonly care for patient populations at high social risk. If performance measures included in MIPS do not fully account for the complexity and range of settings in which nephrologists provide care, performance in MIPS could be affected.

In this issue of *Kidney Medicine*, Tummalapalli et al[6] examine MIPS performance among nephrologists in 2018, which was the first nontransitional year of the program's implementation. The authors use publicly available data published by the Centers for Medicare & Medicaid Services (CMS) on program experience reports to examine nephrologists' final MIPS scores and scores in each measure category. They use a multivariable regression model to identify nephrologist characteristics associated with MIPS performance.

In general, nephrologists performed well under MIPS in 2018, with 52% of nephrologists achieving the maximum final score. The percentage of nephrologists with maximum score varied by measure category. In the Quality Score category, 45% of nephrologists had the maximum score. In Promoting Interoperability, 70% of nephrologists had the maximum score. In Improvement Activities, 95% of nephrologists had the maximum score, while 3% of nephrologists had the maximum score for the Cost category. Only 0.3% of nephrologists received an MIPS payment reduction based on 2018 performance, while 99.5% received a positive payment adjustment. In an examination of practice characteristics, physicians affiliated with APMs and physicians reporting as groups (rather than individuals) performed better, and performance varied geographically. In a stratified analysis of nephrologists who were not enrolled in APMs, physicians practicing in health care professional shortage areas and affiliated with hospitals performed worse on MIPS.

Clinicians who are not affiliated with an APM must select from more than 200 MIPS quality measures to report. Tummalapalli et al used 2 methods to assess the validity of the quality metrics most commonly selected by nephrologists. First, they compared commonly reported MIPS quality metrics with ratings from a prior examination of kidney quality metrics.[7] This prior examination involved a panel of nephrologists applying structured metric evaluation to a comprehensive list of national kidney quality metrics.[7] Tummalapalli et al also assessed commonly reported quality metrics by referencing a previously generated "nephrology specialty set" consisting of 15 nephrology-focused measures.

Six of the top 10 MIPS quality measures reported by non-APM nephrologists in 2018 were in the nephrology specialty measure set and 5 of 10 were given the highest rating from nephrologists in the structured evaluation. Because APM participants must select from a more limited set of quality measures, only 2 of the top 10 APM quality

measures were on the nephrology specialty set and only 3 received a high rating in the structured evaluation.

In addition to demonstrating that nephrologists performed relatively well on MIPS in 2018, the study by Tummalapalli et al highlights several interesting trends. The finding that nephrologists participating in APMs performed better than non-APM nephrologists is consistent with prior studies demonstrating better MIPS performance among APM participants. Like physicians in other areas of health care, nephrologists participating in APMs may benefit from more developed infrastructure and access to resources that facilitate the collection, analysis, and reporting of measures to CMS.[1,5]

Similar to studies of MIPS in other areas of health care, there was variation across clinicians in MIPS performance. The overall significance of this finding is uncertain because its interpretation depends critically on how well MIPS performance actually reflects meaningful differences in quality and value. Previous research has demonstrated regional differences in the quality of care, such as worse cardiovascular outcomes in health professional shortage areas (HPSAs).[8] If differences in MIPS performance actually reflect meaningful differences in quality and value, worse performance by some nephrologists (ie, those affiliated with hospitals and those practicing in HPSAs) highlights a need to improve care in these settings. Alternatively, if MIPS performance does not reflect meaningful differences in quality and value, variation in payment adjustments is arbitrary. Disproportionate financial penalties under MIPS to clinicians caring for patients in underserved areas is a concern in other areas of health care.[9] In dialysis, hospital-affiliated facilities serve a function as safety-net providers.[10] Although financial penalties for nephrologists were minimal under 2018 MIPS, this could change in future MIPS iterations. If hospital-affiliated nephrologists providing safety-net dialysis care and nephrologists in HPSAs become arbitrarily penalized for their service, future efforts would need to focus on better accounting for key social and geographic characteristics in measure design and better aligning MIPS measures with quality and value.

The finding that many of the quality measures selected by non-APM nephrologists received high validity ratings is encouraging and suggests that MIPS performance may capture meaningful differences in the quality of care provided. At first glance, many of the measures commonly selected by nephrologists, such as screening for and controlling high blood pressure and medication documentation, seem clinically important. However, performance in these measures may still not be within nephrology providers' control and many external factors may affect a physician's performance. For example, underlying patient health characteristics, social determinants of health, and characteristics of the broader health system could all affect a nephrologist's performance. It will be important for future research to more formally evaluate the validity of MIPS quality measures reported by nephrologists.

Citing numerous concerns, the Medicare Payment and Advisory Commission (MedPAC) has urgently recommended for CMS to take a different direction than MACRA.[11] Other organizations, joining with the American Medical Association, have called for major fixes to the existing system.[12] Whether MIPS is ultimately repealed, overhauled, or modestly modified, insights highlighted by Tummalapalli et al can help inform the path forward for nephrology. As MedPAC points out in their critique, by comparing different physician specialists and generalists against all other physicians, MIPS has the potential to create inequities. In 2018, this process appears to have worked in nephrologists' favor; nephrologists generally performed well and overwhelmingly received payment increases from MIPS. However, the unique characteristics of patients with kidney disease could have the opposite effect on future performance in MIPS or other value-based payment systems.

MIPS looks very different in 2021 than it did in 2018. The potential payment reduction from MIPS has increased each year according to a phased implementation scheme, with potential positive or negative payments of ±5% in 2020 that increase to ±9% in 2023. Meanwhile, the relative weights of different components of MIPS scores have changed.[13] An increasing role of cost measures is particularly notable, and of concern, for nephrologists. In 2018, only 3% of nephrologists received the maximum score on cost measures. Relatively low performance on cost measures did not substantially influence final MIPS scores in 2018, when cost contributed only 10% of the total score. However, by 2022, cost will contribute 30% of the final score. As more of the final MIPS score depends on costs, nephrologists' MIPS performance could decline. It will be important to know whether nephrologists have continued to perform well in subsequent MIPS systems and whether provider characteristics continue to play the same role as key features of MIPS evolve. Most importantly, the findings by Tummalapalli et al highlight the need to better understand how well MIPS performance assesses quality and value. Only by having measures that are clinically relevant and that individual physicians can influence can the MIPS program hope to achieve its goals of encouraging the delivery of cost-efficient and high-quality care.

ARTICLE INFORMATION

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