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Changes to the Merit-based Incentive Payment System Pertinent to Small and Rural Practices, 2018

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Purpose

This brief highlights key regulatory changes to the Merit-based Incentive Payment System (MIPS) in 2018. We discuss the importance of these changes, particularly as they affect small and rural practices.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare Sustainable Growth Rate formula system and replaced it with a new approach to provider payment, the Quality Payment Program (QPP).^{1,2} QPP is another step in transitioning Medicare provider payment from pay-for-volume (fee-for-service) to pay-for-performance.³ The program seeks to further align Medicare provider payment with the quality of care delivered to Medicare beneficiaries.¹ To achieve these aims, the QPP consolidates several existing pay-for-quality programs—the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (also known as Meaningful Use)—into a unified, cohesive program designed to avoid redundancies.^{2,3} The Centers for Medicare & Medicaid Services (CMS) began implementing QPP in calendar year (CY) 2017 (Year 1), with an initial goal of achieving full implementation in CY2019 (Year 3).^{3,4}

The QPP program has two tracks: Advanced Alternative Payment Models (APMs) and MIPS.¹ To be eligible for the MIPS track, the provider must be a physician or one of eight classes of non-physician provider (dentist, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, chiropractor, optometrist or podiatrist).⁵ Additionally, providers must not be in their first year of Medicare participation.¹ Eligible providers who surpass a predetermined billing and patient volume threshold are required to participate in the MIPS program.¹

MIPS participants may receive a positive or negative Medicare Part B payment adjustment based on their performance in four categories of measures: (1) Quality, (2) Improvement Activities, (3) Promoting Interoperability (formerly, Advancing Care Information), and (4) Cost (starting in 2018).^{1,4,6} Participants receive points for their performance on these measures, and their final MIPS score (0 to 100 points) is compared against a points-based performance threshold (a predetermined number of points set by CMS). Each category of measures has a different share or weight of the final MIPS score with quality having the largest weight (set to reduce over time) and cost the lowest weight (set to increase over time) [see



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Appendix]. Participants whose final MIPS score falls above the performance threshold receive a positive payment adjustment and those whose scores fall below receive a negative payment adjustment. MIPS participants receive their payment adjustments two years after the year of participation (i.e., payment adjustments for the Year 1 performance year [CY2017] will be made in the Year 3 payment year [CY2019] and payment adjustments for the Year 3 performance year [CY2019] will be made in the Year 5 payment year [CY2021]).¹

Regulatory changes: CMS Rules

In 2016, CMS published its final rules for implementing the QPP program starting in Year 1 (CY2017).³ Updates to these rules for Year 2 (CY2018) and beyond were published in the CY2018 QPP final rule.⁵ An overview of the original MIPS regulatory framework and 2018 changes are presented in the Appendix. As part of CMS's gradual transition towards full implementation of the MIPS track, the new rule increased the performance threshold in Year 2 (CY2018), likely increasing the number of providers who will receive a neutral or negative payment adjustment.^{3,4}

To ease the burden of reporting MIPS measures, the new CY2018 final rule allows MIPS participants to use multiple mechanisms for submission of performance data (i.e., via EHR, qualified registries, CMS Web Interface, and others) starting in Year 3 (CY2019), rather than one mechanism of submission per performance category for Years 1 and 2 (CY2017 & CY2018).^{3,4} The new rule also introduces facility-based measurement starting in Year 3 (CY2019). Under facility-based measurement, facility-based clinicians can elect to submit the performance data of their respective health facilities from existing value-based purchasing programs (such as the Hospital Value-Based Purchasing program) in place of individual performance on MIPS cost and quality measures.⁵ In addition to reducing the burden of reporting on individual clinicians, facility-based measurement is expected to further align the incentives of clinicians and their health facilities to improve quality of care while reducing cost.⁵

The CY2018 final rule also made the following changes to MIPS measures or activities, scoring and payments:

- The 10 episode-based cost measures initially adopted (but not used in scoring for Year 1 [CY2017]) were dropped for Year 2 (CY2018) and beyond, with a plan to develop new measures with stakeholder input in the future.^{3,4}
- Activities under the Improvement Activities category were updated based on recommendations from clinicians, patients, and other stakeholders.^{3,4}
- A four-year phase-out period was introduced for topped-out quality measures.^{3,4} Topped-out measures are quality measures whose benchmarks have been achieved in at least two consecutive years. Removal of topped-out measures is expected to curb redundancy and ensure continuous efforts towards quality and cost performance improvement. A scoring cap will be applied to topped-out measures during the phase-out period.^{3,4} However, measures submitted via the CMS Web Interface are exempt from this scoring cap.
- A 10-percentage-point bonus for clinicians who exclusively use the 2015 edition of Certified Electronic Health Records Technology (CEHRT) in Year 2 (CY2018) was added to encourage adoption of this edition of CEHRT, which has improved features that (among other improvements) aid care coordination.^{3,4} Clinicians may continue to use the 2014 edition or a combination of both the 2014 and 2015 editions but will not receive the bonus.
- Clinicians can earn bonus points on their Year 2 (CY2018) final score for treating complex patients.^{3,4} This bonus is determined based on the proportion of patients that are dual-eligible and the case mix (specifically, the mean Hierarchical Condition Categories risk score).
- The criteria for receiving full credit as a patient-centered medical home was changed under the Improvement Activities category. Starting in Year 2 (CY2018), at least 50 percent of the practice sites under a group's tax identification number (TIN) must be recognized or certified as patient-centered medical homes to receive full credit.^{3,4} Previously, only one practice site under the TIN had to be a patient-centered medical home to receive full credit.

Regulatory changes: small and rural practices

Certain provisions were incorporated into the CY2018 final rule to reduce the burden of MIPS participation on small and rural practices. One of these provisions was an increase in the threshold beyond which providers are involuntarily enrolled in MIPS (the low-volume threshold). The billing threshold was increased from the Year 1 (CY2017) value of \$30,000 to \$90,000 in Part B allowed charges starting in Year 2 (CY2018).⁴ The volume threshold was also increased from the Year 1 (CY2017) value of 100 to 200 Part B beneficiaries, also starting in Year 2 (CY2018). These changes in the low-volume threshold will exclude more small and rural practices from participating involuntarily in MIPS. For practices that exceed this low-volume threshold, the CY2018 rule introduced virtual groups as an alternative way to participate in MIPS. Solo practitioners and provider groups of 10 or fewer MIPS-eligible providers can form virtual groups regardless of their specialty or practice location.^{3,4}

The CY2018 rule further entrenched the lower reporting requirements and favorable differential scoring for small and rural practices introduced by the CY2017 rule (see Appendix). Beginning in Year 2 (CY2018), practices in rural areas or geographic health professional shortage areas (HPSA),⁷ small practices (15 or fewer MIPS-eligible clinicians), and non-patient facing MIPS-eligible clinicians (clinicians with 100 or fewer patient-facing encounters) will no longer be required to report these identities to CMS.³ Rather, CMS will identify those providers from existing data.⁵ Furthermore, while other practices will earn 1 point in the Quality category for measures that do not meet data completeness requirements (compared to 3 points in Year 1 [CY2017]), small practices will continue to earn 3 points for those measures.⁴ Additionally, 5 bonus points will be added to the Year 2 (CY2018) final scores of small practices for as long as the practice reports data on at least 1 performance category for the performance period.⁴ The CY2018 final rule also adds a new hardship exception for the Promoting Interoperability category that is specific to small practices.⁴ This hardship exception allows small practices to have their score in the Promoting Interoperability category reweighted to zero percent of the final score—from 25 percent—to avoid the penalty for not having CEHRT or for other technical issues such as poor internet connectivity.^{4,8,9}

Legislative changes: Bipartisan Budget Act of 2018

The Bipartisan Budget Act of 2018 (BBA) was passed into law in February 2018 and also made changes to the MIPS.^{10,11} Under the original MACRA law, full implementation of MIPS was scheduled to begin in Year 3 (CY2019), with a performance threshold set at the national mean or median (at CMS's discretion) of historical performance.^{12,13} The original law gave CMS the discretion to set performance thresholds for Years 1 and 2 (CY2017 and CY2018). However, the BBA postpones implementation of the full performance threshold (i.e., historical performance) to Year 6 (CY2022) and extends CMS's authority to set performance thresholds through Year 5 (CY2021).^{12,13} The Act also requires CMS to increase the performance threshold annually in gradual increments through Year 5 (CY2021) to provide a smooth transition toward full implementation in Year 6 (CY2022) and allow providers more time to adapt to the new payment system.¹²

Prior to the BBA, MIPS cost measures were set to account for 10 percent of the final MIPS score for the Year 2 performance period (CY2018) and increase to 30 percent of the score for Year 3 (CY2019).¹⁴ The BBA, however, gave CMS the discretion to keep the cost measures' share of the MIPS score as low as 10 percent, with a cap of 30 percent for Years 2-5 (CY2018-CY2021). The BBA also eliminates the year-to-year improvement scoring from the Cost category for Years 2-5 (CY2018-CY2021).¹³ During this period, providers will be assessed only on their cost performance relative to their peers, not to their own previous year's cost performance.¹⁵ These changes were in response to providers' requests for more time to adjust to the MIPS program before cost measures form a major component of their MIPS scores.¹⁴

Furthermore, the law includes a provision that limits the application of payment adjustments to services delivered by clinicians and not the items they provide (i.e., durable medical equipment, drugs, and biologics, etc.).^{12,15,16} In line with the provisions of MACRA, CMS included a provision in the CY2018 final rule that would include Part B reimbursements for drugs in the calculation of payment adjustments and the determination of eligibility for the low-volume exception.^{13,15,17} Specialists expressed concern with this provision, citing their tendency to administer more Part B drugs (commonly intravenous drugs administered in clinical settings), which are often expensive.^{11,14} The inclusion of Part B drugs in MIPS payment

adjustments could lead to significant changes in reimbursement for some specialists, with penalties/rewards as high as 16 percent, in contrast to an estimated 4 percent payment swing for their primary care counterparts.¹⁷ The financial instability resulting from such payment swings could lead to access issues for patients receiving specialized care. Providers in small practices and rural areas, who are less equipped to handle such volatile payment swings, might become less inclined to administer Part B drugs. Similarly, the BBA also excluded Part B reimbursements for drugs and other items from the determination of eligibility for the low-volume exclusion.¹² This will likely lead to the exemption of more providers, including small and rural practices, from MIPS participation.^{12,18}

Lastly, the BBA mandates CMS to publish on its website annual updates on MIPS cost measures (including those under development and associated time frames for their development), a description of stakeholder engagement on cost measures, and the proportion of Medicare expenditures that will be covered by cost measures.¹¹

Policy Considerations

The flexibility built into the MIPS program by the original regulatory framework and further enhanced by changes over the past year is essential to providers—particularly those in small and rural practices—as they transition to this new pay-for-performance system. A recent Government Accountability Office report on the performance of providers in MIPS precursor programs (PQRS and VM) revealed that small practices performed worse than large practices; i.e., they did not meet reporting requirements for PQRS or did not meet cost and quality performance targets for VM. This trend—poorer performance of small practices in pay-for-performance programs—is expected to continue into the MIPS.¹⁹ Rural providers have often struggled with implementing new pay-for-performance programs due to lack of the technical infrastructure and support needed for successful implementation.²⁰⁻²² However, providing exemptions from MIPS participation or reporting may not be the best means of addressing rural practice challenges. Exemptions from MIPS may exclude rural Medicare beneficiaries and providers from a payment system designed to reward providers for maximizing health care value. Rather than providing exemptions, rural providers could be provided with incentives and support to adopt the tools (e.g., CEHRT) necessary for meaningful participation in MIPS. The Small, Underserved, and Rural Support (SURS) initiative established by the original MACRA legislation is a step in this direction. This initiative provides clinicians in rural and other underserved areas with free technical assistance in choosing and reporting MIPS performance measures, as well as assistance to improve health information technology systems and clinical care quality.^{9,23} However, this program is funded for only five years (FY 2016-2020).^{9,24} Rural providers may need support for additional years to convert fully to new systems and therefore continuously participate in MIPS. Furthermore, adequate rural representation during planned consultations with stakeholders on MIPS measures could go a long way in ensuring that the measures developed are sensitive to the unique context of rural practice.

The QPP program—including MIPS—is in a state of ongoing review. For example, the Medicare Payment Advisory Commission has recommended that Congress “repeal and replace” the MIPS model with an alternative quality payment model.²⁵⁻²⁷ Changes to, or replacement of, the QPP may lead to additional differential impacts on providers in small and rural practices. The latest QPP rule, the CY2019 final rule, implements changes to MIPS enacted in the BBA and includes additional changes to the program but not to the magnitude of changes discussed in this brief (see Appendix).²⁸

APPENDIX

Changes to the MIPS in 2018/2019 and the implications for small and rural practices^{2,5,10,28,29}

	Original Framework (MACRA & CY2017 final rule)	Changes in 2018/2019		Implications for small and rural practices
		CY2018 final rule*	Bipartisan Budget Act & CY2019 final rule**	
MIPS-eligible provider types	Physician, dentist, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, chiropractor, optometrist, and podiatrist.	No changes	- New provider types added: occupational therapist, physical therapist, qualified audiologist, qualified speech-language pathologist, clinical psychologist, and registered dietician or nutrition professional.	-
Low-volume threshold	Practices that meet or fall below \$30,000 in Part B allowed charges OR 100 Part B beneficiaries are excluded from MIPS.	Practices that meet or fall below \$90,000 in Part B allowed charges OR 200 Part B beneficiaries are excluded from MIPS.	- Practices that meet or fall below \$90,000 in Part B allowed charges OR 200 Part B beneficiaries OR 200 services covered under the Physician Fee Schedule are excluded from MIPS. - Practices can opt-in to MIPS if they exceed at least one of the threshold criteria	The increase in the low-volume threshold will mean fewer small and rural practices will have to participate in MIPS
Virtual groups	Not applicable	Practices that exceed the low-volume threshold (all three criteria) and have 1-10 MIPS-eligible providers can come together (regardless of location or specialty) as virtual groups to participate in MIPS.	Practices no longer need to exceed all three threshold criteria to participate in a virtual group. Exceeding only one of the criteria is sufficient for virtual group participation.	Under virtual groups, providers could combine resources for a more successful MIPS participation. This could encourage participation among small and rural providers who may not have sufficient resources on their own for meaningful participation in MIPS.
Part B items exclusion	CMS is required to include both Part B professional services and items in the determination of payment adjustments and the low-volume threshold exclusion.	No changes	Starting with the Year 2 performance period, Part B items will be excluded from payment adjustments and the low-volume exception determination.	The exclusion of Part B items from payment adjustments could bring more stability in reimbursements for providers, especially specialists. Stable reimbursements are particularly important for small and rural providers who are more sensitive to changes in revenue.

	Original Framework (MACRA & CY2017 final rule)	Changes in 2018/2019		Implications for small and rural practices
		CY2018 final rule*	Bipartisan Budget Act & CY2019 final rule**	
Performance threshold	<ul style="list-style-type: none"> - CMS has the discretion to set the performance threshold for Years 1 & 2. Threshold is set at 3 points for those years - The full implementation threshold (national mean or median of historical performance) begins in Year 3. 	Threshold is increased to 15 points for Year 2	<ul style="list-style-type: none"> - CMS's discretion to set thresholds is extended to Year 5. The threshold will be increased annually in gradual increments. - Threshold is set at 30 points for Year 3 - The full implementation threshold begins in Year 6. 	The delay in implementing the full threshold gives providers more time to adjust to the MIPS program before having to meet higher performance targets. This is particularly important for small and rural providers who have often struggled with pay-for-performance programs.
MIPS Reporting	MIPS participants are limited to 1 mechanism of reporting per performance category for Years 1 & 2.	Participants can use multiple mechanisms of reporting starting in Year 3.	No changes	The increased flexibility in reporting is particularly important to small and rural practices who may not have the capacity (e.g., manpower and EHR technology) to meet certain reporting requirements.
	Practices in rural areas or HPSAs, small practices, non-patient facing MIPS-eligible clinicians, and patient-centered medical homes have to self-identify as such.	Self-identification is no longer required for small practices, non-patient facing MIPS-eligible clinicians and practices in HPSAs or rural areas. CMS will determine these identities from existing data.		
Facility-based measurement	Not applicable	Starting in Year 3, clinicians can submit the performance data of their health facilities in other value-based programs in place of individual MIPS performance data.	No changes	Facility-based measurement will reduce the burden of reporting MIPS performance for facility-based clinicians, including those in rural areas.

	Original Framework (MACRA & CY2017 final rule)	Changes in 2018/2019		Implications for small and rural practices
		CY2018 final rule*	Bipartisan Budget Act & CY2019 final rule**	
Quality category	Weight of final MIPS score: - 60% for Year 1 - 50% for Year 2 - 30% for Year 3	No changes	The weight for Year 3 is increased to 45%	-
	Submitted measures that do not meet data completeness requirements will earn 3 points.	Submitted measures that do not meet data completeness requirements will earn 1 point, except for those submitted by small practices, which will continue to earn 3 points.	No changes	This favorable differential scoring of quality measures reported by small practices could ease the burden of participation on small practices.
	Not applicable	- Measures whose benchmarks have been topped out in at least 2 consecutive years will be phased out over a 4-year period. - A 7-point scoring cap will be applied during the phase-out period except for measures submitted via the CMS Web Interface.	Measures that are extremely topped out may be phased out in less than 4 years.	-
Improvement Activities category	Weight of final MIPS score: 15%	No changes	No changes	-
	At least one practice site under a group's TIN must be a patient-centered medical home to receive full credit.	At least 50 percent of the practice sites under a TIN must be patient-centered medical homes to receive full credit		
Cost category	Weight of final MIPS score: - CMS has the discretion to set this category's weight of the final score for Years 1 and 2 performance periods, although with a cap of 10% for Year 1 and 15% for Year 2. For Year 3 and beyond, CMS is required to set the weight at 30% - The weight for Year 1 is set at 0%.	The weight for Year 2 is set at 10%.	- CMS's discretion to set weights extended to Year 5, but weights must be within a range of 10%-30%. For Year 6 and beyond, CMS is required to set the weight at 30% - The weight for Year 3 is set at 15%.	These changes allow providers (including those in small and rural practices) more time to adjust to the MIPS program before cost becomes a major determinant of their payment adjustments.
	Year-over-year improvement scoring for this category starts in Year 2.	No changes	Year-over-year improvement scoring is eliminated for Years 2-5.	

	Original Framework (MACRA & CY2017 final rule)	Changes in 2018/2019		Implications for small and rural practices
		CY2018 final rule*	Bipartisan Budget Act & CY2019 final rule**	
Promoting Interoperability category	Weight of final MIPS score: 25%	No changes	No changes	-
	No small practice-specific hardship exception is available.	Small practice-specific hardship exception: Small practices can apply to have their score in this category reweighted to 0% of the final score (the weight is reallocated to the Quality performance category) to avoid being penalized for technical issues (e.g., lack of CEHRT).		Small practices are more likely to face the technical issues that limit performance under this category. This hardship exception prevents small practices from scoring low in this category due to technical limitations, thus reducing their chances of receiving negative payment adjustments due to those limitations.
Bonuses (for CEHRT, complex patients, and small practices)	Not applicable	<ul style="list-style-type: none"> - Five bonus points are added to the final score of small practices that submit data on at least one performance category for the performance period (Year 2 only) - Ten percentage point bonus is available for exclusive use of CEHRT 2015 edition (Year 2 only) - Up to 5 bonus points are given for treating complex patients (Year 2 only). 	<ul style="list-style-type: none"> - The small practice and complex patient bonuses are retained - The small practice bonus is increased to six points and will no longer be added to the final score but rather to the Quality performance category score. The small practice bonus will only apply to small practices that submit data on at least one quality measure. 	The bonuses may encourage continued MIPS participation and adoption of updated EHR technology by small and rural practices.

*Changes take effect starting in Year 2 (CY2018) except where specified.

**Changes take effect starting in Year 3 (CY2019) except where specified.

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