Summary of Small and Rural Provisions within the 2018 Quality Payment Program (QPP) Proposed Rule

Small Practice Eligibility Determination

In the CY 2017 QPP final rule, CMS defined the term "small practice" as a practice consisting of 15 or fewer clinicians and solo practitioners. The eligibility determination was based on practice attestation. In the CY 2018 proposed rule, CMS is proposing that eligibility determinations for small practices for performance periods occurring in 2018 and future years will be based on claims data. The small practice determination period would be a 12-month assessment period consisting of an analysis of claims data that spans from the last 4 months of a calendar year 2 years prior to the performance period followed by the first 8 months of the next calendar year and includes a 30-day claims run out. This would allow CMS to inform small practices of their status near the beginning of the performance period as it pertains to eligibility relating to technical assistance, applicable improvement activities criteria, the proposed hardship exception for small practices under the advancing care information performance category, and the proposed small practice bonus for the final score. ***CMS is soliciting comment on this proposal regarding how the Agency would determine small practice size.***

Rural Area and Health Professional Shortage Area (HPSA) Practices

CMS is proposing to create a threshold for identification of rural and HPSA designations. For performance periods occurring in 2018 and future years, CMS proposes that an individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN or TINs within a virtual group would be designated as a rural or HPSA practice if more than 75 percent of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group, as applicable, are designated in a ZIP code as a rural area or HPSA. ***CMS is soliciting comment on this proposal.***

Small Practice Bonus

CMS is proposing to adjust the final score of any eligible clinician or group who is in a small practice (defined as 15 or fewer clinicians) by adding 5 points to the final score, as long as the eligible clinician or group submits data on at least one performance category in an applicable performance period. ***CMS is requesting comments on this proposal and whether the small practice bonus should also be given to those who practice in rural areas as well.***

Virtual Group Participation Option

In the 2017 Final Rule CMS defined two ways to participate in MIPS- as an individual or as a group. In the 2018 Proposed Rule, CMS has proposed the creation of a new, third category, the so-called "virtual group" in order to assist small, independent practices.

Virtual groups would be composed of solo practitioners and groups of 10 or fewer eligible clinicians, eligible to participate in MIPS, who come together "virtually" with at least one other such solo practitioner or group to participate in MIPS for a performance period of a year.

There are two types of practices that can form virtual groups: (1) MIPS-eligible solo practitioners who bill under a single Tax Identification Number (TIN) with a single NPI; and (2) a group with 10 or fewer MIPS eligible clinicians. In the virtual group option, two or more of either of these types of practices can voluntarily participate in MIPS together. There are currently no proposed restrictions in terms of geography, specialty of the practices, or number of practices that can form a Virtual Group as long as the criterion for the size of each practice is met. MIPS performance measures for the virtual group will be assessed on the basis of the combined performance of the entire group, payment adjustments will be made on an individual TIN/NPI level. Eligible practices may only be a part of one virtual group. CMS plans to make technical assistance available for the 2018 and 2019 performance years for practices implementing virtual groups.

Low volume threshold for virtual groups

Solo practitioners or groups with 10 or fewer clinicians that are below the low-volume threshold are not eligible to participate in MIPS as an individual, group, or virtual group.

Small practice status for virtual groups

Virtual groups with 15 or fewer clinicians (NPIs) would qualify as small practice, this is the same threshold for group practices.

Self-referral in virtual groups

Participation in a virtual group will not change the financial relationship between a clinician and/or group and an entity furnishing health services for the purposes of self-referral.

Non-patient facing clinicians in virtual groups

In the 2017 Final Rule, CMS mandated that a group could be defined as "non-patient facing" if more than 75% of the NPIs billing in the group met the definition of a non-patient facing individual MIPS eligible clinician (100 or fewer patient facing interactions). In the 2018 proposed rule, CMS proposes that the 75% threshold will also be applied to virtual groups.

Increasing the Low-Volume Threshold

In response to public comments received after publication of the CY 2017 QPP final rule, CMS is proposing to increase the threshold to exclude individual MIPS eligible clinicians or groups with ≤ $90,000 in Part B allowed charges or ≤ 200 Part B beneficiaries during a low-volume threshold determination period that occurs during the performance period or a prior period. CMS believes that increasing the low-volume threshold would reduce the burden on individual MIPS eligible clinicians and groups practicing in small practices and designated rural areas.

This change would exclude approximately 134,000 additional clinicians from MIPS from the approximately 700,000 clinicians that would have been eligible based on the current 2017 low-volume threshold. Almost half of the additionally excluded clinicians are in small practices and approximately 17 percent are clinicians from practices in designated rural areas. Sixty-five percent of Medicare payments would still be captured under MIPS compared to 72.2 percent of Medicare payments under the 2017 QPP final rule.

Modification to Low-Volume Threshold Determination Period

Additionally, CMS is also proposing a modification to the low-volume threshold determination period, in which the initial 12-month segment of the low-volume threshold determination period would span from the last 4 months of a calendar year 2 years prior to the performance period followed by the first 8 months of the next calendar year and include a 30-day claims run out; and the second 12-month segment of the low-volume threshold determination period would span 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 in the next calendar year and include a 30-day claims run out. This proposal would only change the duration of the claims run out, not the 12-month timeframes used for the first and second segments of data analysis. Low volume threshold determinations are made at the individual and group level, not at the virtual group level.

Expansion of Ways to Define Low-Volume Thresholds

CMS has assessed the option of establishing a low-volume threshold for items and services furnished to Part-B enrolled individuals by a MIPS eligible clinician. Defining items and services by patient encounters would assess each patient per visit or encounter with the MIPS eligible clinician. CMS believes that defining items and services by using the number of patient encounters or procedures is a simple and straightforward approach for stakeholders to understand. CMS does have concerns that this definition could incentivize clinicians to focus on volume of services rather than the value of services provided to patients. ***CMS is soliciting comments on the methods of defining items and services furnished by clinicians.***

Future Ability of Providers to Opt-in if not all Low-Volume Thresholds are Met

For the 2021 MIPS payment year, CMS is proposing to provide clinicians the ability to opt-in to the MIPS if they meet or exceed one, but not all, of the low-volume threshold determinations, including as defined by dollar amount, beneficiary count or, if established, items and services. ***CMS is requesting comment on this proposal. CMS also seeks comments on how to address***

any potential impact on their ability to create quality benchmarks that meet sample size requirements.

New Hardship Exception for Clinicians in Small Practices Under the Advancing Care Information Performance Category

CMS is proposing a significant hardship exception for the advancing care information performance category for MIPS eligible clinicians who are in small practices. This exception would be available to MIPS eligible clinicians in small practices with 15 or fewer clinicians and solo practitioners. The Agency is proposing to reweight the advancing care information performance category to zero percent of the MIPS final score for those who qualify for this exception. This exception would be available beginning with the 2018 performance period and the 2020 MIPS payment year. CMS is proposing that a MIPS eligible clinician seeking to qualify for this exception would submit an application in the form and manner specified by the Agency by December 31st of the performance period. CMS is also proposing that those seeking this exception must demonstrate in the application that there are overwhelming barriers that prevent the MIPS eligible clinician from complying with the requirement for the advancing care information performance category. The exception would be subject to annual renewal.

CMS is soliciting comment on other categories or types of clinicians who might similarly require an exception.

Quality Performance Category Points

CMS recognizes that many small practices may have less experience with submitting quality performance category data and may not yet have systems in place to ensure they can meet the data completeness criteria. Therefore, CMS is proposing that these clinicians in small practices would continue to receive 3 points for measures that do not meet data completeness.

Improvement Activities Performance Category

CMS maintains the provision that the weight for any improvement activity selected is doubled for small, rural, HPSA practices, and non-patient facing MIPS eligible clinicians, so that these practices and MIPS eligible clinicians only need to select one high-weighted or two medium-weighted improvement activities to achieve the highest score of 40 points to receive full credit.

Cost Performance Category

In order to improve clinician understanding of cost measures and continue the development of episode-based measures that will be used in the cost performance category, CMS proposes to continue to weigh the cost performance category at zero percent of the final score for the 2018 MIPS performance period and 2020 MIPS payment year. CMS is also proposing to adopt the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were implemented for the 2017 MIPS performance period. In addition, CMS is proposing to not use the 10 episode-based measures that were adopted for the 2017 MIPS performance period. Rather, CMS is in the process of developing new episode-based

measures with significant clinician input and believes it would be more prudent to introduce these new cost measures over time.

CMS Resources

CMS remains committed to providing education and support to providers, including awarding $100 million to help small practices succeed in the Quality Payment Program. CMS refers providers to their website for additional resources.

The ACR will continue to review the Quality Payment Program proposed rule and will prepare comments to be submitted by the August 21st deadline.