



Support for Small and Rural Practices in 2019

The Quality Payment Program (QPP) was created by the Center for Medicare & Medicaid Services (CMS) in response to a mandate of the Medicare Access and CHIP Reauthorization Act (MACRA) signed into law in March 2015. 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.

Ms. Verma specifically made mention as to the belief that clinicians in small and rural practices performed well. On average, MIPS-eligible clinicians in rural practices earned a mean score of 63 points, while clinicians in small practices received a mean score of 43 points. Recognizing that challenges yet remain for these clinicians, these same scores in Performance Years 2018 and 2019 will still net a neutral or positive payment adjustment in 2020 and 2021, respectively, due to the relatively modest performance thresholds established. These statements were used as evidence that clinicians in small and rural practices can successfully participate in the QPP. Moreover, she added that CMS will continue assistance and support in order to help these clinicians improve with each performance year.

Small and Rural Practice Definitions in the QPP

CMS defines small practices for purposes of the QPP as those that are composed of ≤ 15 clinicians eligible to participate in MIPS, based on the quantity of National Provider Identifier (NPI) numbers billed under a unique Tax Identification Number (TIN) during one of two "determination periods." For Performance Year 2019, these 12-month determination periods run from October 1, 2017 – September 30, 2018, and then again from October 1, 2018 – September 30, 2019. If the practice has ≤ 15 eligible clinicians billing for services during either of these 12-month periods, then the practice will automatically receive the designation as a small practice. Note that for 2019, more types of caregivers are added as eligible clinicians; however, for most nephrology physician practices, the only caregiver that might be considered applicable would be a nutritional professional for which services are billed.



The designation of “rural” is automatically given to an individual eligible clinician with a TIN located in a zip code designated as rural, using the most recent [Health Resources and Services Administration \(HRSA\) Area Health Resource File data](#). If participating as a group, the group must be located in a zip code designated as rural, as above. If that group has multiple practices under its TIN, then more than 75% of the NPIs billing under that group TIN must be located in a zip code designated as rural, as well.

In or Out of MIPS for 2019?

For participation in MIPS in Performance Year 2019, the provider must first meet the definition of an eligible clinician, which clearly all physicians, nurse practitioners, and physician assistants do. As noted above, additional types of caregivers have been added as eligible clinicians this year; however, of these the only type a Nephrology practice might employ is a nutritional professional who bills for services under the group TIN. As in the two previous years, eligible clinicians who are considered qualified participants in an Advanced Alternative Payment Model (APM) are excluded from MIPS. Also as previously indicated, clinicians newly enrolled as Medicare providers during the 2019 Performance Year will not be considered MIPS-eligible until the following year.

Although the low-volume threshold amounts for MIPS participation are unchanged, some alterations in the descriptive details have occurred. The specific volume criteria for MIPS exclusion as quantified during the previously noted two 12-month determination periods using claims data are as follows:

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

Eligible clinicians and groups satisfying any one of the above criteria are excluded from MIPS participation in 2019. *(Note that CMS defines one covered professional service as one professional claim line with positive allowed charges.)*

For eligible clinicians and groups excluded from MIPS due to low-volume thresholds, but who might want to participate in MIPS, there are a couple of options:

1. Voluntary MIPS Participation: The clinician or group can submit data to CMS and receive performance feedback; however, there will not be any MIPS payment adjustment.
2. Opt-in (Newly added for 2019): If the eligible clinician or group meets or exceeds at least one, but not all (*in which case MIPS would be required*), of the low-volume threshold criteria, then MIPS participation will be allowed with all of the requirements and potential payment adjustments of any other MIPS participant. However, once this election has been made, the decision is irrevocable and cannot be changed.

Reporting Options: Individual, Group, or Virtual Group

For Performance Year 2019 there are no changes to the options as to how to participate in MIPS. An individual eligible clinician can report under an NPI number and TIN to where the provider assigns benefits. Secondly, two or more clinicians with NPI numbers assigning their billing rights to a single TIN can report as a group. The third option is as a virtual group and with rules unchanged from 2018. A virtual group is defined as a combination of two or more TINs made up of solo practitioners and groups with ≤ 10 eligible clinicians regardless of specialty or location coming together “virtually” to participate in MIPS for a given performance year. A Virtual Group Identifier is used together



with the participating TINs and NPIs for CMS to recognize the clinician as part of a virtual group. There is no limit to the number of TINs able to participate in a given virtual group; however, as above, the TINs must be comprised of 10 or less eligible clinicians. CMS has developed a Virtual Groups Toolkit easily available for downloading. One cautionary note is that the enrollment period for a given year ends *before* the performance year begins. Likely as a result of the development of these rules in late 2017 with enrollment ending December 31, 2017, there were only two virtual groups participating in MIPS in the 2018 Performance year.

Small Practice MIPS Bonus Points

For MIPS Performance Year 2018 (affecting Payment in 2020), the designation of a small practice conferred the addition of 5 bonus points to the final MIPS score. Although bonus points for Performance Year 2019 are still being given to small practices, the overall impact is lessened. Six (6) bonus points will be given to MIPS eligible clinicians in small practices who submit data on at least 1 quality measure, but these points will be added to the Quality Performance Category, not the final MIPS score. The Quality category contributes only 45% to the Final Score, unless a small practice applies for re-weighting of the Promoting Interoperability Category to the Quality Category (*see below*). Therefore, in the normal circumstance, addition of 6 extra Quality points will only confer an additional 2.7 points to the MIPS Final Score. Small practices will also continue to receive 3 points for submitting quality measures that do not meet data completeness criteria, whereas individuals and groups not in small practices will receive 1 measure achievement point in performance year 2019.

Quality Data Submission by Small Practices

For Year 3 of the QPP, CMS has defined 3 new terms: collection type, submission type, and submitter type. *Collection type* refers to a set of quality measures with defined specifications such as, MIPS clinical quality measures, Qualified Clinical Data Registry (e.g., RPA's QCDR measures), Medicare Part B claims measures, and others. *Submission type* refers to the mechanism by which data is submitted, such as direct, log in and upload, Medicare Part B Claims, and through the CMS Web Interface. *Submitter type* represents the MIPS eligible clinician, group, virtual group or other third party submitting on behalf of eligible clinicians or groups.

In order to provide small practices with more flexibility for submission of Quality data in Performance Year 2019, CMS will allow the Medicare Part B Claims collection type data measures and the Medicare Part B Claims submission type to be available as options only for small practices.

Improvement Activities Performance Category

For Performance Year 2019, the Improvement Activities Performance Category constitutes 15% of the MIPS Final Score. This category contains a total of 118 Improvement Activities to be done over a 90-day performance period within the year, with the activities weighted as either Medium or High depending on the resources and time necessary for completion. Small practices along with clinicians or groups located in rural or Health Professional Shortage Areas will continue to receive double-weight points along with the requirement to only report on no more than 2 activities in order to receive the highest score.

Promoting Interoperability Performance Hardship Exception for Small Practices

Previously call the Advancing Care Information Category, the QPP in Performance Year 2019 has relabeled this category as Promoting Interoperability Performance Category, which constitutes 25% of the Final MIPS score. For



certain MIPS-eligible clinicians, the ability to reweight this category to 0% with the 25% added to the Quality Category has been continued for 2019 from the previous year. CMS recognizes that adopting and implementing Certified electronic health record technology (CEHRT) may be a hardship for some, but not all, small practices. Therefore, clinicians in small practices can complete an application during the Performance Year to have this category re-weighted to Quality. Documentation of the specific hardship is not required in the application; however, CMS recommends that such documentation be retained in the event of an audit. Certain provider types, including physician assistants, nurse practitioners, and clinical nurse specialists, among others, have this re-weighting done automatically without need for applications by virtue of their specific provider-type; however, nephrologists in small practices must apply for this exception.

Complex Patient Bonus

CMS recognizes that Nephrologists routinely provide care for some of the most medically complex patients, as defined by Hierarchical Condition Category (HCC) risk scores. In Performance Year 2019, up to 5 bonus points are available for treating complex patients based on medical complexity as measured by HCC risk scores and a score utilizing the percentage of dual eligible beneficiaries under treatment. MIPS eligible clinicians or groups must submit data on at least 1 performance category during the Performance Year in order to earn the bonus.

The Extreme and Uncontrollable Circumstances Policy

Created in 2017, CMS will continue in 2019 and future years to support this policy that applies to MIPS eligible clinicians located in a region that has been affected by an extreme and uncontrollable event (such as a FEMA-designated major disaster) during the performance year. In 2018, this policy applied to providers affected by Hurricanes Florence and Michael and the California Wildfires. Under this policy, individual MIPS-eligible clinicians in areas affected by such designated disasters, will have all four performance categories weighted at 0%, with the provider automatically receiving a score equal to the established performance threshold for that year. This would result in a neutral payment adjustment during the payment year, *unless* data is submitted for two or more MIPS performance categories as an individual; or, the provider's group or virtual group submits data on his/her behalf. The payment adjustment in those situations will be based on the achieved score. Nonetheless, under this policy, the Cost performance category will always be weighted at 0%, even if data is submitted for other categories. Provisions of this policy do not automatically apply to groups and virtual groups. If, at the group level, the extreme and uncontrollable circumstance impacts the ability to collect data, then the group can complete an application for exemption in a specific MIPS performance category. In addition, an eligible clinician in a MIPS APM will not be automatically covered under this policy; that affected clinician may apply for an exception in the Promoting Interoperability Performance Category.

The QPP – Small, Underserved, and Rural Support Program (QPP-SURS)

In November 2018, CMS Administrator Seema Verma emphasized the agency's devotion to continuing assistance to solo practitioners and clinicians in small and rural practices through the Small, Underserved, and Rural Support Initiative. This initiative was mandated under the MACRA statute, authorizing \$100 million over 5 years to fund technical assistance to applicable clinicians. The initiative is managed through CMS-sponsored contracts with regional health collaboratives, among others. These entities' roles are to offer guidance and assistance on MIPS performance categories as well as to provide assistance to those practices desiring to transition to APM participation.



Obviously, priority is given to practices located in rural or medically underserved areas, as well as to practices found to have low MIPS final scores. The QPP-SURS is comprised of 11 organizations assigned to distinct regions of the nation. More information on this available and free support can be found at <https://qpp.cms.gov/about/small-underserved-rural-practices>.

As mentioned above, this assistance only has funding for 5 years, with 2019 being the third year. Unfortunately, there are no provisions to offer practices direct financial assistance for EHR support or hardware.

