MACRA Implementation for Small and Rural Practices

Background

The Medicare Access and CHIP Reauthorization Act (MACRA) legislation was signed into law in March 2015. Following release of the Proposed Rule in October 2015, CMS released the Final Rule implementing the legislation on November 4, 2016, and in response to numerous comments received on the proposed rule the Agency included provisions to bolster support for small and independent practices. Efforts to this end included higher threshold limits for physician inclusion in the programs created by MACRA, as well as allocation of $100 million over five years to create support activities for smaller practices, particularly those in rural areas, through contracted entities. Moreover, program requirements are being incrementally phased in with the objective to achieve buy-in of greater numbers of those eligible to participate as well as to assist all eligible clinicians.

For 2017 eligible providers include physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists. Providers will **not** be required to participate in the MIPS program if they are:

- Newly enrolled in Medicare for the first time during the performance period
- Below the low-volume threshold, defined as Medicare Part B allowed charges of ≤ $30,000 a year or ≤ 100 Medicare Part B patients a year
- A qualified participant in an Advanced APM

Within the Final Rule, CMS used 2015 data to predict the number of practitioners that might be excluded from MIPS participation. In that analysis, the number of MIPS-eligible nephrology practitioners (by TIN/NPIs) was 11,089, or roughly 0.9% of all eligible clinicians. Of nephrology practitioners, 3.3% were newly enrolled, 2.4% were qualifying Advanced APM participants, and 15.4% were excluded based on activities below volume thresholds set in the Final Rule. Altogether, 21% of nephrology practitioners were excluded, with 79% expected to be included in MIPS.

Although MACRA provides that solo and small practices may join "virtual groups" and combine their MIPS reporting, the law limits the virtual group option to no more than 10 practitioners. However, CMS did not implement this provision for 2017, as stakeholder engagement is being requested to assist in the development of the structure and implementation strategy such that it might become "simple and meaningful" in future years of the program.

On June 20, 2017, CMS released its proposed 2018 updates to the Quality Payment Program. Although the Final Rule will come later in the year, special emphasis is being placed in this proposal on assistance to small and rural practices. Specific changes adding more flexibility for such providers include:

- Increasing the low-volume threshold to exclude individual MIPS-eligible practitioners or groups with ≤$90,000 in Medicare Part B allowable charges or ≤200 Part B beneficiaries during the determination period to be defined for 2018.
- For 2018, solo practitioners or groups of ≤10 eligible practitioners will be allowed to participate in Virtual Groups for a performance period of a year. These groups may be formed regardless of where members are located or what their medical specialties might be. Generally, practitioners will report as a Virtual Group across all 4 performance categories and meet the same measure requirements as non-virtual MIPS groups.
- The use of 2014 Certified Electronic Health Record Technology (CEHRT) for the 2018 performance period will continue to be allowed; however, use of 2015 edition CEHRT is encouraged by the awarding of bonus points.
- Under the Advancing Care Information (ACI) category, for small practices (defined as ≤15 practitioners) a new category of hardship exceptions is being created. This would allow ACI to be re-weighted to 0% with the usual weighting of 25% to be reallocated to the Quality Performance Category.
- For 2018, CMS proposes to adjust the score of providers in small practices (as defined above) by adding 5 points to the final MIPS score, as long as minimum performance requirements were satisfied.
- CMS also proposes to add up to 3 bonus points to the final MIPS score for all practitioners caring for complex patients, as defined by Hierarchical Condition Category (HCC) scores. (**Nephrologists by this methodology are recognized as caring for the most complex patients of any specialty**. **In previous MIPS rulemaking, RPA had opposed CMS' decision to eliminate use of the specialty-specific risk-adjustor, given the complexity of kidney disease patients; by using of the HCC scores to account for risk adjustment, CMS seems to be addressing this concern)**

MACRA also included provisions requiring an examination of the pooling of financial risk for physician practices, particularly smaller ones. The required analysis was done by the Government Accountability Office (GAO) and reported to Congressional Committees in December 2016. The report was entitled, "Medicare Value-Based Payment Models: Participation Challenges and Available Assistance for Small and Rural Practices." Insights into potential challenges faced by small and rural practices were gained by interviewing 38 stakeholders. Examples of such challenges are noted in the following table included in the GAO report:

Key topic area	Examples of challenges
Financial resources and risk management	Practices may lack financial resources needed to make initial investments, such as those to make electronic health record (EHR) systems interoperable, and recouping investments may take years.
Health IT and data	Practices need to hire and train staff, as well as develop experience using EHR systems and analyzing data needed for participation.
Population health management care delivery	Patient populations in diverse geographic locations can affect practices' ability to manage their care, especially rural physician practices whose patients may have to travel long distances.
Quality and efficiency performance measurement and reporting	Small and rural practices with small patient populations may have quality and efficiency measurement more susceptible to being skewed by patients that require more or more expensive care.
Effects of model participation and managing compliance with requirements	Practices with fewer staff have difficulty balancing and finding the time needed for direct patient care, care management activities, and additional administrative duties needed for model participation.

Examples of Challenges Faced by Small and Rural Physician Practices, by Key Topic Area

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

Although the GAO report did suggest collaborative efforts that might mitigate these challenges for smaller practices, barriers remain nonetheless. The following represents statements quoted directly from this document:

> *We found that organizations that can help small and rural practices with challenges to participating in value-based payment models can be grouped into two categories: partner organizations and non-partner organizations. Partner organizations share in the financial risk associated with model participation and provide comprehensive services. Non-partner organizations do not share financial risk but provide specific services that can help mitigate certain challenges. However, not all small and rural physician practices have access to services provided by these organizations.*

Examples of non-partner organizations, some publicly funded, include Health IT vendors, Regional Extension Centers, Quality Improvement Networks-Quality Improvement Organizations, and Practice Transformation Networks. Further details are given in the GAO Report.

CMS contends that the current MACRA Final Rule provisions will allow small and solo practices to respond to MIPS by participating at a rate close to that of other practice sizes. Using 2015 data, CMS noted in the Final Rule that their two sets of analyses (based on assumptions that all practice size groupings would show achievements of either 80% or 90% participation rates) estimated that over 90% of MIPS eligible clinicians would receive a positive or neutral MIPS payment adjustment in the transition year, and that at least 80% of clinicians in small or solo practices with 1-9 clinicians would receive a positive or neutral payment adjustment.

Accessing Available Resources

As noted above, MACRA allocated $20 million annually for five years for resources to help support smaller and rural practices to achieve full participation in either MIPS or APM programs. This funding will underwrite contracts with 11 organizations nationwide to develop and provide these support services, known as Quality Payment Program – Small, Underserved and Rural Support (QPP-SURS). The webpage will lead to a CMS Fact Sheet on QPP-SURS, where these support organizations with contact information are identified, and a color map identifying which of the entities a given state's eligible providers should contact for assistance.

Services provided by the QPP-SURS are available to all practices with 15 or fewer clinicians in any location. In particular, emphasis is being placed on these practices in rural locations, health professional shortage areas, and medically underserved regions. For example, for providers in Texas, TMF Quality Innovation Network provides direct technical assistance involving one-on-one consulting, webinars, educational events and materials. Practices in contact with TMF can sign up for a free account to be able to access developed materials, helpful links, and recorded educational presentations related to this CMS contract. As noted above, this assistance is only funded for five years. Unfortunately, there are no provisions to offer practices direct financial assistance for HIT support or hardware.

The stated intent of the QPP-SURS program is to support smaller and rural practices in their navigation of the Quality Payment Program, while allowing them to continue to be able to focus on the needs of their patients. The stated objectives of all of the contracted organizations are to:

- Select and report on appropriate measures and activities to satisfy requirements of performance categories under MIPS
- Engage in continuous quality improvement
- Optimize Health Information Technology
- Evaluate options for joining an Advanced APM