

FLEXIBILITIES AND SUPPORT FOR SMALL PRACTICES

Summary

On April 27, 2016, the Department of Health and Human Services issued a Notice of Proposed Rulemaking to implement key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), bipartisan legislation that replaced the flawed Sustainable Growth Rate formula for clinician payment in Medicare with a new approach to paying clinicians for the value and quality of care they provide. The proposed rule would implement these changes through the unified framework called the “Quality Payment Program,” which includes two paths:

- The Merit-based Incentive Payment System (MIPS) or
- Advanced Alternative Payment Models (APMs)

Small practices (typically defined as 15 or fewer clinicians) and practices in rural or health professional shortage areas play a vital role in the care of Medicare patients with diverse needs. The Centers for Medicare & Medicaid Services (CMS) is sensitive to the unique challenges that small practices face in different types of communities, and the Quality Payment Program as proposed would provide accommodations for various practice sizes and configurations. In addition, CMS is sensitive to the concerns expressed by the proposed rule’s regulatory impact analysis, which was perceived to show that the Quality Payment Program would negatively impact small practices. This regulatory impact analysis is based on 2014 data when many small



and solo practice physicians did not report their performance. It also does not reflect the accommodations in the proposed rule that are intended to provide additional flexibility to small practices. This paper details the flexibility and support available to small practices and practices in rural or health professional shortage areas in the proposed rule. CMS is committed to a continued dialogue regarding the obstacles and challenges these practices encounter, both during the rulemaking period and throughout the implementation of the Quality Payment Program.

For more information about the Quality Payment Program and the proposed rule, please visit the [Quality Payment Program site](#), which includes links to the [proposed rule](#) as well as [fact sheets](#) and [webinars](#) explaining the details of the program.

MIPS: Flexible Measurement

Currently, Medicare measures the value and quality of care provided by doctors and other clinicians through a patchwork of programs, including the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program. Through the law, Congress streamlined these programs into MIPS, which is how most Medicare clinicians will initially participate in the Quality Payment Program. MIPS may increase, decrease, or not affect a clinician's Medicare payment rates for a year based on performance.

CMS envisions a MIPS program that equips clinicians with the tools and incentives to focus on improving health care quality, efficiency, and patient safety for all their patients. The proposed rule acknowledges that clinicians in small practices and practices in rural or health professional shortage areas have unique needs and challenges. Therefore, CMS proposes flexibilities in MIPS to account for diversity among practices:

- **Low Volume Exclusions:** Clinicians or groups who have less than or equal to \$10,000 in Medicare charges and less than or equal to 100 Medicare patients are excluded from the MIPS payment adjustment. CMS is looking for feedback about the criteria for this exclusion.
- **Flexibility in MIPS Scoring Based on Applicable Measures:** If there are not sufficient measures and activities applicable and available in a MIPS performance category, then the category would not be included in the MIPS score. For example, if a clinician does not have applicable measures in the cost category, then CMS proposes to not include this category in the MIPS score and adjust the weight of the other MIPS performance categories to make up the difference in the MIPS score.
- **Group Reporting:** Under MIPS, clinicians will have the option to be assessed as a group across all four MIPS performance categories. The law provides that solo and small practices may join "virtual groups" and combine their MIPS reporting. CMS is seeking public comment on how virtual groups should be constructed, and anticipate being able to implement virtual groups in the second year of the program. CMS wants to make sure the virtual group technology is meaningful and simple to use for physicians.
- **Multiple Paths to Success:** CMS attempts to accommodate practice diversity in size, specialty, and patient population with flexible scoring and requirements that allow for multiple paths to success in MIPS. For example, the MIPS scoring proposals include

opportunities to earn bonus points or credit through additional reporting or participating in an APM.

- **Burden Reduction:** CMS would remove unneeded measures and reduce administrative burden while still providing meaningful rewards for high-quality care. For example, CMS proposes to reduce the number of required measures in the quality category and the Advancing Care Information category.
- **Single Reporting Mechanism:** Clinicians and groups may submit information for the Quality, Advancing Care Information, and Clinical Practice Improvement Activities through a single reporting mechanism in order to reduce burden and encourage simplification. Clinicians do not need to report information for the cost performance category.

For those Medicare physicians or other clinicians who participate in MIPS, CMS proposes flexibilities within each of the performance categories, including to account for the unique circumstances of small practices or practices in rural or healthcare profession shortage areas:

- **Quality (50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program):** The Quality category of MIPS provides flexibility for small practices or individual clinicians. For individual clinicians and small groups (2 to 9 clinicians), MIPS calculates only two population measures based on claims data, instead of the three population measures required for larger groups. For example, the total possible points for a group of nine or less would be 80 points versus a group of 10 or more would be 90 points.

In addition, the Quality category reduces the reporting burden across the board by generally requiring physicians and other clinicians to only report on six rather than nine quality measures. It also allows for partial credit for measures and allows physicians and clinicians to choose the measurements and reporting systems that best fit their practices. CMS also provides bonus points to physicians who report quality measures through electronic sources and who report outcomes measures.

- **Advancing Care Information (25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as Meaningful Use):** CMS proposes moving away from a pass-fail program design to a flexible design that allows clinicians to select a customizable set of measures that reflects how they use electronic health records (EHRs) in their day-to-day work. There are no longer one-size-fits-all performance requirements; instead, there are multiple paths to success in the Advancing Care Information category. The category emphasizes interoperability and information exchange. If a clinician only has data for a portion of the year, CMS may allow the clinician to be scored based on the data they are able to submit.
- **Clinical Practice Improvement Activities (15 percent of total score in year 1):** CMS proposes to reward clinicians for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. Clinicians participating in Medical Homes earn full credit in this category, and those

participating in APMS and Advanced APMs who choose to report through MIPS will earn at least half credit.

- To accommodate small practices and practices located in rural or health professional shortage areas, this category allows clinicians to submit a minimum of one activity of any weight (e.g., medium or high) to achieve partial credit or two activities of any weight to achieve full credit. This is a reduced requirement than for other clinicians who would need to report at least three high priority measures in order to receive full credit.
- **Cost (10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use):** The score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties. If a clinician does not have enough patient volume for any cost measures, which is generally a minimum of 20 cases pertaining to a particular measure, then a cost score would not be calculated. CMS would reweight the Cost category to zero, and adjust the other MIPS performance category scores to make up the difference in the MIPS score.

Advanced Alternative Payment Models: Flexibility for Practices

For clinicians who take a further step towards care transformation, the law creates another path. Clinicians who participate to a sufficient extent in Advanced APMs would qualify for incentives (lump-sum payments for years from 2019 through 2024, and a favorable payment update for years beginning with 2026) and would not be subject to MIPS payment adjustments. The APMs that would qualify as Advanced APMs under the terms of the proposed rule for the first performance year are:

- Comprehensive End Stage Renal Disease Care Model (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program – Track 2
- Medicare Shared Savings Program – Track 3
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement) (available in 2018)

Under the proposed rule, CMS would update this list annually to add new Advanced APMs as they become available. CMS may also modify existing APMs in coming years to make Advanced APMs. The proposed rule provides flexibility to allow small practices or practices in rural or healthcare professional shortage areas to qualify for the incentive payment in Advanced APMs by providing special rules for Medical Home Models. Under the proposed rule, Medical Home Models could qualify as Advanced APMs under different rules than those for other APMs; these rules are tailored to small primary care practices to ensure that they have the opportunity to participate in the Advanced APM track.

The rule proposes a definition of Medical Home Models, which focus on primary care and accountability for empaneled patients across the continuum of care. Because Medical Homes

tend to have less experience with financial risk than larger organizations and limited capability to sustain substantial losses, CMS proposes unique Advanced APM financial risk standards, consistent with the statute, to accommodate Medical Homes that are part of organizations with 50 or fewer clinicians. An example of a Medical Home Model is CPC+, which will be available in approximately 20 regions and will offer two tracks with incrementally advanced care delivery requirements and payment options to meet the needs of primary care practices in the United States. CPC+ is explicitly designed to support a diversity of practice sizes by encouraging practices within a region to collaborate with other practices and other payers to build improvement infrastructure and share staffing resources to support practice transformation. The majority of practices in the precursor model (CPC) are small and/or rural practices.

Education, Training, and Technical Assistance for the Quality Payment Program

CMS has embarked on a significant outreach effort to engage clinicians and to help them successfully participate in these programs. CMS is developing convenient, easily accessible educational materials, such as webinars and fact sheets, that will be available on-demand. These materials will focus on helping clinicians understand the programs and how to participate in them successfully. CMS is currently conducting “train the trainer” webinars with medical societies and associations so that clinicians receive free support and guidance through a variety of channels. For the latest educational materials and events, please visit the [Quality Payment Program site](#).

In addition, CMS will support small practices in the Quality Payment Program through:

- **\$100 million over 5 years in technical assistance:** The legislation provides technical assistance via organizations such as Quality Improvement Organizations and Regional Extension Centers to MIPS eligible clinicians in practices with 15 or fewer clinicians. This assistance will help practices improve their performance in MIPS and transition into APMs. The assistance will focus on small practices in rural and health professional shortage areas. On April 13, 2016, CMS posted a solicitation to award multiple contracts for this technical assistance, and expects to make awards in the near future.
- **Transforming Clinical Practice Initiative:** This Initiative supports implementation of the Quality Payment Program among medical group practices, regional health care systems, regional extension centers, and national medical professional association networks. In September 2015, CMS awarded \$685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients’ access to information, and spend dollars more wisely. These efforts will help clinicians expand their quality improvement capacity, engage in greater peer-to-peer learning, and utilize health data to determine gaps and target intervention needs. The initiative has two major components:
 - **Twenty-nine Practice Transformation Networks** will provide technical assistance and peer-level support to assist clinicians in delivering care in a patient-centric and efficient manner. Examples include providing dedicated

coaches to help practices better manage chronic diseases, supporting improved patient access to practitioners through e-mails and other information technology applications, and helping to advance improved access to remote and virtual care.

- **Ten Support and Alignment Networks** will focus on such initiatives as creating a collaborative for emergency clinicians to address appropriate utilization of tests and procedures and forming collaboratives between psychiatry and primary care providers so patients can receive basic mental health care from their primary care providers. These will especially support practices serving small, rural, and medically underserved communities and play an active role in the alignment of new learning.
- **Health Care Payment Learning and Action Network:** The [Health Care Payment Learning and Action Network](#) is a public-private partnership to align efforts in moving towards alternative payment models and value-based payments. The Network serves as a forum where small practices and other stakeholders can come together to discuss, track, and share best practices on how to transition towards alternative payment models that emphasize value.

Beginning a Dialogue

In implementing the new law, CMS was guided by the same principles underlying the bipartisan legislation itself: streamlining and strengthening value and quality-based payments for all physicians; rewarding participation in Advanced APMs that create the strongest incentives for high-quality, coordinated, and efficient care; and giving doctors and other clinicians flexibility regarding how they participate in the new payment system.

This proposed rule incorporates input received to date, but it is only a first step in an iterative process for implementing the new law. CMS welcomes additional feedback from patients, caregivers, clinicians, health care professionals, Congress, and others on how to better achieve these goals. HHS looks forward to feedback on the proposal and will accept comments until June 27, 2016.

Comments may be submitted electronically through our e-Regulation website at <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking>

For the latest educational materials and events, please visit the [Quality Payment Program site](#). To learn more about our efforts on Delivery System reform, please visit <http://www.hhs.gov/healthcare/delivery-system-reform/index.html>.