MIPS/MACRA: 6 Things You Need to Know in 2018

PART 1

The Quality Payment Program (QPP), which resulted from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is designed to reward or penalize physicians based on the quality of patient care they provide. Last year, physicians could “Pick Your Pace” through an introductory program that allowed physicians to test the waters. But in 2018 physicians will have to more fully engage with the program or risk a negative payment adjustment of up to 5 percent in 2020. Successful participation could earn a positive payment adjustment of 5 percent or more in that year.

QPP will be updated annually through the federal rulemaking process. The 2018 rules, released on Nov. 2, made significant changes in six key areas. Physicians participating in the Merit-based

Incentive Payment System (MIPS) track of QPP will need to focus on these changes to succeed during the 2018 performance period.

1. The low-volume threshold rises

In 2017, the Centers for Medicare & Medicaid Services (CMS) set limits below which physicians were exempted from having to participate in MIPS. Those limits exempted physicians who provided care to 100 or fewer Medicare Part B beneficiaries or who received $30,000 or less in Medicare Part B payments.

This year, CMS is raising the low-volume threshold to exempt more small practices and solo physicians from MIPS. Physicians who care for 200 or fewer Medicare Part B beneficiaries or receive $90,000 or less in Medicare Part B payments are exempt. To check your eligibility, use the CMS look-up tool(qpp.cms.gov).

2. Virtual groups become reality

Virtual groups — composed of individual physicians or group practices of up to 10 eligible clinicians who choose to report to MIPS as a unit — will be an option for MIPS participation for the first time in 2018. The intent is to help smaller practices participate successfully in the program.

Under this arrangement, the virtual group's combined performance receives a MIPS score, which is in turn applied to each virtual group member. There are no restrictions on how many individuals or eligible groups can come together to form a virtual group, what types of specialties are allowed, or whether participants have to work in the same town. However, only virtual group members who meet or exceed the low-volume threshold described earlier are eligible for payment adjustments.

To participate in a virtual group, there are several other requirements:

- MIPS-eligible physicians must decide to join a group prior to the start of the applicable performance period and cannot change their decision during the performance period. To participate as a virtual group in 2018, group members must make their elections by Dec. 31, 2017. To participate as a virtual group in 2019, the deadline is Dec. 31, 2018.
- Participants may belong to only one virtual group during a performance period.
- If a group practice elects to participate in a virtual group, the election applies to all MIPS-eligible clinicians in that group.
- The virtual group must provide written agreements among all individuals and groups electing to participate. (See the CMS Virtual Groups Toolkit(go.cms.gov).)

3. Costs are now counted

In 2017, an individual's or group's performance in terms of cost of care did not count toward the MIPS final score. That will change for the 2018 performance period with the Cost category now contributing 10 percent of the final score, and 30 percent in 2019. As the weight of the Cost category increases, the weight of the Quality category will proportionally decrease, dipping from 60 percent in 2017 to 50 percent in 2018 and 30 percent in 2019. The weights of two other categories, Advancing Care Information (ACI), which relates to how physicians use their electronic health records (EHRs), and Improvement Activities, which focuses on practice transformation efforts, will remain at 25 percent and 15 percent, respectively.

Physicians will not have to submit additional data for cost analysis. Instead, CMS will score the category using claims data, specifically Medicare spending per beneficiary and total per capita cost.

Physicians have previously received scores on cost measures in Quality Resource Use Reports (QRUR) provided by CMS. Reviewing these reports will allow physicians to predict how they might score in the Cost category.