

Policy Alert

February 9, 2018

Key Points

- Congress amended current law to prevent CMS from applying the “MIPS” payment adjustment to separately billed items like drugs and biologics, which will drastically reduce the total amount of payment adjustments to clinical practices that administer high-cost drugs, and by hundreds of millions of dollars in the aggregate.
- The funding bill also granted CMS three additional years of flexibility to assign a modest 10 percent weight to the MIPS performance category measuring clinicians’ resource use and to set a lower performance standard than the national average, which will decrease the number of practices that face Medicare payment reductions under the program.
- Congress separately reduced the annual update to the 2019 Medicare Physician Fee Schedule from 0.5 percent to 0.25 percent, which will reduce total Medicare payments to clinicians by more than \$100 million next year.



Congress Makes Key Changes to Medicare Physician Payment Programs as Part of Short-Term Government Funding Bill

The President recently signed into law the Bipartisan Budget Act (BBA) of 2018 (H.R. 1892), which along with a Continuing Resolution (CR), to temporarily fund the federal government through March 22, 2018, establishes a two-year agreement on federal spending levels. The spending package includes the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, which makes a number of policy changes to the Medicare program, including extensions of recently expired temporary payments for rural provider services, reforms to the way that the government approaches the treatment of chronic health conditions and modifications to physician payment policy. Although the final legislation does not include a provision that was in the House-passed bill and would have extended the Centers for Medicare and Medicaid Services’ (CMS) initiative to identify and reduce payment for potentially misvalued physician service codes, Section 51003 of the BBA reduces the Medicare Physician Fee Schedule annual update from 0.5 percent to 0.25 percent in 2019.

The BBA also includes what are characterized as “technical changes” to the Medicare Access and CHIP Reauthorization Act (MACRA), Public Law 114-10, but are actually quite impactful reforms to the 2015 law’s Merit-based Incentive Payment System (MIPS). The MIPS program began measuring eligible

Medicare clinicians' performance across several dimensions of care—performance categories for Quality, Cost, Improvement Activities and Advancing Care Information (i.e., use of electronic health records (EHR))—in 2017, and Medicare reimbursement will be adjusted as a result of this performance beginning on January 1, 2019.

MACRA directed the Secretary of Health and Human Services (HHS) via CMS to assess clinician performance based on the following breakdown starting in 2019: Quality (30 percent of total MIPS score), Cost (30 percent), Advancing Care Information (25 percent) and Improvement Activities (15 percent). Section 51003 of the BBA affords CMS three additional years (through performance period 2021) to assign the Cost category a weight as low as 10 percent of the total MIPS score. Additionally, this provision eliminates the improvement component of the Cost performance score for the first five years of the MIPS program (i.e., through 2021), including for the current performance period that began on January 1, 2018. CMS will separately be required to post online by December 31 of each year a list of Cost measures under development, including the time frame for implementation and a description of stakeholder input.

Significantly, Section 51003 rewrites MACRA to limit the MIPS payment adjustment's application to the cost of clinician services and prohibits its application to separately billed items, such as Part B-covered drugs and biologics. This means that payment for separately billed drugs will not be subject to positive or negative adjustments based on the billing clinician's MIPS performance and is a significant break from current policy. This change will have enormous financial ramifications—both positive and negative—for those clinicians and groups whose charges for separately billed drugs dwarf the total dollar value of their in-office services. Similarly, Section 51003 directs CMS to set the “low-volume threshold”—designed to exclude smaller providers from MIPS—based solely on the amount of Medicare charges for professional services without taking into account the cost of drugs and other separately billed items. Currently, clinicians who bill Medicare Part B less than \$90,000 annually are excluded from participating in MIPS.

Section 51003 also extends the current transition rule for setting the “performance threshold,” or the minimum MIPS score needed to avoid a negative payment adjustment. Rather than setting the threshold at the average score in 2019, which would result in approximately half of all eligible clinicians scoring below the threshold and receiving a payment reduction, CMS may continue to use a gradually increasing set point value for the three additional years (i.e., through 2021). The current threshold is set at 15 points, but was required to increase to the average clinician's score next year. Assuming that CMS uses this flexibility to continue to set relatively low performance thresholds, the effects of this change are that fewer clinicians will receive downward payment adjustments under MIPS and that the upward adjustments enjoyed by the majority of clinicians would continue to be modest in nature—far below the statutory maximums, which increase to 9 percent over this same time period.

Finally, Section 51003(b) of the BBA modifies the MACRA process for developing physician-focused payment models and specifically directs the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback to entities that submit proposed models.

Click [here](#) to read the text of the spending bill, or [here](#) to read the Congressional Budget Office's official cost estimate.

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