

Executive Summary of the CMS Final Rule— Quality Payment Program Year 2

On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) released an [interim final rule with comment period](#) regarding the 2018 Quality Payment Program (QPP). Further comments on certain sections of this 1653-paged regulation are due to CMS by January 2, 2018.

The AAFP is currently analyzing the regulation but is generally pleased with steps CMS took to improve the ability of family physicians to participate successfully in payment reforms envisioned by the bipartisan *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA). The AAFP will provide CMS with further comments that urge the agency to strengthen primary care for Medicare beneficiaries and to support the ability for more physicians to participate in Advanced Alternative Payment Models (AAPMs).

Overview

MACRA repealed the Medicare sustainable growth rate (SGR) formula and established the QPP. CMS began the QPP in 2017 as the performance year that impacts Medicare payments in year 2019. This final rule with comment period applies to the 2018 performance period of the QPP and will impact payments in 2020. CMS offers two tracks for physicians under the QPP:

- The Merit-based Incentive Payment System (MIPS) focuses on quality, cost, improvement activities; and use of certified electronic health record technology (CEHRT).
 - CMS estimates that approximately 622,000 MIPS-eligible clinicians (ECs) (out of 1.2 million clinicians who are eligible and not newly enrolled) will be required to submit data under MIPS in 2018.
- Advanced Alternative Payment Models (AAPMs) represent efforts to move the health care system from volume- to value-based care.
 - Based on participation in the 2018 performance period, CMS estimates that approximately 185,000 to 250,000 clinicians will become Qualifying AAPM Participants (QPs) for the 2020 payment year, and therefore:
 - Be excluded from the MIPS reporting requirements and payment adjustment.
 - Qualify for a lump sum AAPM incentive payment equal to 5% of their estimated aggregate payment amounts for Medicare Part B covered professional services in the preceding year.

2018 MIPS performance categories

- Quality category (50% of 2018 final score)
 - The performance period is January 1, 2018, through December 31, 2018.
 - CMS continues to require the reporting of six measures. One of the six must be an outcome measure (or a high-priority measure if an outcome measure is not available).
 - ECs can report more than six measures, but CMS will use the six with the highest score to calculate the quality score.

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- CMS finalized its methodology for calculating improvement in the quality category, beginning with the 2020 payment year.
 - CMS finalized the data completeness threshold at 60% (instead of 50%) for data submitted on quality measures using qualified clinical data registries (QCDRs), qualified registries, via EHR, or Medicare Part B claims.
 - Measures that fall below the data completeness threshold will receive one point. Small practices (15 or fewer) will receive three points for measures that fall below the data completeness threshold.
 - CMS will phase out topped-out measures over 4 years.
 - No additional cross-cutting measure requirements were added in 2018 and the agency specified that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS continues to be optional.
- Cost category (10% of 2018 final score)
 - CMS had discussed weighing this category at zero—as is the case in 2017, but finalized cost at a 10% weight in the 2018 performance period “to ease the transition to a 30% weight for the cost performance category” in the 2019 performance period.
 - CMS will calculate the cost category for the full 2018 performance period.
 - CMS will continue to use the total per capita costs for the all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted in the 2017 MIPS performance period. However, CMS will not use the 10 episode-based measures that were adopted for the 2017 MIPS performance period. CMS aims to provide performance feedback on the MSPB and total per capita cost measures by July 1, 2018, and will offer feedback on newly developed episode-based cost measures in 2018.
 - CMS finalized its methodology to calculate measure improvement for the cost category, starting with the 2020 payment year.
- Advancing Care Information (ACI) category (25% of 2018 final score)
 - CMS will allow 2014 Edition and/or 2015 CEHRT in the 2018 performance period and provide a 10% bonus for using only 2015 CEHRT.
 - There was no change to the scoring policies for ACI. Clinicians must report all of the base score measures to receive an ACI score.
 - CMS had already finalized policy that the performance period for the ACI performance category ranges from, at minimum, a continuous 90-day period up to and including the full year. In this regulation, CMS finalized similar policy for the 2019 performance period.
 - ECs can earn 10 percentage points in their performance score for reporting to any single public health agency or clinical data registry to meet any of the measures associated with the Public Health and Clinical Data Registry Reporting objective. An EC can earn an additional 5-percentage-point bonus for reporting to more than one such agency or registry.
 - CMS finalized a significant hardship exception for MIPS-eligible clinicians in small practices.
 - ECs can earn a 10% bonus under the ACI category if an IA is completed using CEHRT.
- Improvement Activities (IA) category (15% of 2018 final score)
 - CMS added a new, optional, “medium-weighted” IA pertaining to accredited performance improvement continuing medical education (PI-CME).
 - CMS added a new, optional, “high-weighted” IA if a clinician attests to using appropriate use criteria (AUC) through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting.

- CMS specified that ECs will report IAs for at least a continuous 90 days during the performance period.
- As detailed in Tables F and G of the regulation, CMS finalized 21 new IAs (some with modification) and made changes to 27 previously adopted IAs (some with modification and including one removal).
- CMS changed the weight of the “TCPi Participation” activity to medium. It was weighted as high for the 2017 performance period.
- CMS finalized a 50% threshold regarding the number of practice sites within a tax identification number (TIN) that must be recognized as patient-centered medical homes (PCMHs) for that TIN to receive full credit within the IA category for the 2018 performance period (2020 MIPS payment year) as well as future years.

2018 MIPS policies impacting small practices

- Virtual groups are available as a voluntary option, and those that choose this participation option will need to make an election by December 31, 2017, to qualify for the 2018 performance period. Individuals and groups must be above the low-volume threshold to participate in a virtual group.
- Low-volume threshold changes are estimated to exclude additional individual MIPS-eligible clinicians or groups. While the 2017 performance period threshold is ≤\$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries, for the 2018 performance period, CMS will exclude individual MIPS-eligible clinicians or groups with ≤\$90,000 in Part B allowed charges OR ≤200 Part B beneficiaries. CMS will continue to review this threshold for future performance years.
- The agency’s definition of certified PCMH will consider the term “recognized” to mean the same as “certified” for a PCMH or comparable specialty practice, as was the case in the 2017 performance period.
- Small-practice bonus points will also be available. Five points will be added to the final scores of practices with 15 or fewer ECs who submit data for at least one MIPS performance category.
- Annual hardship exception added for the ACI category for practices of 15 or fewer eligible clinicians.
- CMS will no longer require self-identification for small practices, non-patient facing MIPS ECs, or practices located in rural areas or geographic health professional shortage areas (HPSAs). CMS will use historical claims data to make small practice determinations. This is based on the number of NPIs billing under the TIN and could include NPIs that are not MIPS eligible clinicians.

Additional 2018 MIPS performance period policies

- The performance threshold is being raised to 15 points for the 2018 performance year (from three points in the 2017 performance period). The threshold for exceptional performance remains 70 points.
- CMS will measure improvements in the quality and cost performance categories, and ECs are eligible for potential bonus points for improvement.
- Complex-patient bonus points will be available. Clinicians can earn up to five bonus points for treatment of complex patients (the sum of the average Hierarchical Condition Categories (HCC) risk score and the proportion of dually eligible beneficiaries treated). In the proposed rule, the agency proposed up to three points for such patients.
- Part B drug costs will be included in MIPS payment adjustments.
- For ECs impacted by hurricanes Irma, Harvey, Maria, wildfires, and other natural disasters, CMS will automatically reweight the quality, ACI, and IA performance categories at 0% of the final score. These ECs would not be subject to any 2019 payment adjustment.

Major provisions for AAPMs

- Generally applicable nominal amount standard - CMS extended the 8% revenue-based standard (i.e. total potential risk under the APM must be equal to at least 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018) through performance period 2020.
- Medical Home Model financial risk standard – CMS originally proposed that, starting in the 2018 performance period, the Medical Home Model financial risk standard would not apply for APM Entities owned and operated by organizations with more than 50 eligible clinicians. However, CMS is keeping the “50 eligible clinician cap” in place, except for clinicians who are participating in the first round of the Comprehensive Primary Care Plus (CPC+) model.
- Medical Home Model nominal amount standard – CMS finalized that the minimum total potential risk for an APM Entity under the Medical Home Model standard is 2.5% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2018. CMS plans to increase the nominal risk standard more slowly than the agency had originally discussed.
- QP performance period & QP & Partial QP determination – CMS specified that the 2018 QP performance period remains the same as in 2017, which is January 1–August 31 each year.

Key policies for MIPS APMs

- CMS further clarified how ECs participating in selected APMs (known as MIPS APMs) will be assessed under the APM scoring standard. This special standard is intended to reduce burden for MIPS APM participants who do not qualify as QPs, and are therefore subject to MIPS.
- CMS added December 31 as a fourth snapshot date to determine participation in full TIN MIPS APMs, but will not use it to make QP determinations or extend the QP performance period past August 31.
- For MIPS APMs, CMS is “waiving sections of the statute” that require all Virtual Group participants to receive their MIPS payment adjustment based on the Virtual Group score. This means that participants in APM Entities in MIPS APMs who are also participating in a Virtual Group would receive their MIPS payment adjustment based on their APM Entity score under the APM scoring standard.

AAFP Resources

- MACRA Ready [resources including:](#)
 - [FAQ](#) on MACRA and Medicare Payment Reform
 - Understanding QPP Payment Paths [infographic](#)
 - Get MACRA Ready with QPP [video](#)
 - [2017 MIPS Playbook \(free to members\)](#)
- [Press statement](#) on the 2018 QPP regulation
- Regulatory [comment letter](#) in response to the 2018 proposed QPP regulation

CMS Resources

- Medicare Quality Payment Program [website](#)
- [Executive summary](#) of the final rule
- [Press release](#) and [fact sheet](#) about the regulation
- Technical Assistance - gpp@cms.hhs.gov or 1.866.288.8292