



## **2018 Quality Payment Program Final Rule Highlights**

One year ago, the Centers for Medicare and Medicaid Services (CMS) issued the first Quality Payment Program (QPP) final rule. Since that time the AMA, with input from the Federation, has continued to actively engage various parts of the Administration to improve the program. As a result, a number of the policies that were proposed for the 2018 performance year and have now been finalized are based on our recommendations. Although CMS reversed a few positive proposals that were included in its proposed rule and that AMA had supported, CMS did finalize several important policy changes, including several to help physicians in small practices. The final rule's impact analysis projects that 97% of eligible clinicians will avoid a penalty in 2020 based on their QPP participation in 2018.

The 2018 final rule is over 1,600 pages long and AMA staff will be continuing to immerse themselves in the details in the coming weeks.

Here are some of the highlights from our initial read of the proposed rule:  
(The thumbs up signs reflect policies that address concerns raised by the AMA).

### **Additional accommodations for small practices**

- 👍 Significantly expands the low-volume threshold to \$90,000 or less in Medicare Part B allowed charges OR 200 or fewer Medicare Part B patients (previously the threshold was \$30,000 in allowed charges or 100 patients) – CMS estimates that only 37% of clinicians who bill Medicare will be subject to MIPS;
- 👍 Creates virtual groups to assist small practices;
- 👍 Adds 5 bonus points to the final MIPS scores for practices of 15 or fewer clinicians;
- 👍 Favorable scoring under the quality category—minimum of three points for reporting on a quality measure regardless if it meets data completeness and practices of 15 or fewer clinicians are exempt from the All-Cause Readmission measure; and
- 👍 Adds a hardship exception from the Advancing Care Information (previously Meaningful Use) category for practices of 15 or fewer clinicians.

### **General MIPS Policies**

- 👍 Includes an automatic extreme and uncontrollable circumstance hardship exemption for physicians affected by recent hurricanes and wildfires;
- 👍 Adds up to 5 bonus points to the final MIPS score for clinicians that treat complex patients (CMS had proposed up to 3 bonus points for complex patients);
- 👍 Begins measuring improvement in the quality and cost performance categories in 2018;
- 👍 Sets the 2018 performance threshold at 15 points and maintains the exceptional performance threshold at 70 points;

- 👉 Delays implementation of the facility based measurement option in the quality and cost performance categories until 2019; and
- 👉 Includes Part B drug costs in MIPS payment adjustment.

The AMA is pressing Congress to clarify that drug reimbursement should not be subject to MIPS payment adjustments.

### **Advancing Care Information**

- 👉 Allows the use of 2014 edition certified electronic health records technology (CEHRT) past 2017 – CMS will not mandate that physicians update their EHRs in 2018;
- 👉 Increases opportunities for bonus percentage points;
- 👉 Finalizes exclusions for e-prescribing and health information exchange measures; and
- 👉 Permits physicians to continue to report on Modified Stage 2 measures in 2018 instead of new Stage 3 measures.

The AMA will continue to seek more flexible ACI measures.

### **Quality**

- 👉 No additional cross-cutting measure requirements added in 2018;
- 👉 Maintains CAHPS for MIPS as optional;
- 👉 New and modified specialty measure sets for the 2018 performance period, including the removal of cross-cutting measures from most of the specialty sets;
- 👉 Decreases the quality performance category weight to 50% in 2018 (due to the Cost category weight increasing to ten percent as opposed to the proposed zero percent);
- 👉 Maintains the number of quality measures a physician must report for full participation in the Quality performance category. (AMA asked that physicians be required to report even fewer quality measures in 2018); and
- 👉 Proposes a phased-in approach to identify and remove topped out measures. However, CMS increased the maximum number of points a physician can earn on topped out measures from six points to seven points; and
- 👉 Increases the reporting threshold on quality measures from 50% to 60% of applicable patients in 2018.

The AMA will continue to urge CMS to retain topped out measures, but if the agency insists on periodically removing them it should implement a more systematic and evidence based process.

### **Cost Category**

- 👉 Replaces its proposal to weight costs at zero in the 2018 performance/2020 payment year with a 10% cost weight (the cost weight would rise to 30% in 2019/2121);
- 👉 Cost scores will be based on two AMA-opposed carry-over measures from the value-based payment modifier—total per patient cost and total spending around a hospital admission; and
- 👉 10 previously-finalized episode-based cost measures will be replaced in the future with measures developed with more input from clinical experts and stakeholders.

The AMA had supported CMS's decision to keep costs at zero next year and urged CMS to keep this weight for several more years and will continue to urge CMS and Congress to limit the weight of this category.

### **Improvement Activities**

- 👍 CMS continues to allow physicians to report on IAs through simple attestation;
- 👍 Creates stability in program requirements by not changing the number of IAs physicians must report; and
- 👍 Broadens existing IAs and develops new IAs, including activities related to diabetes prevention programs and the use of digital health tools; and
- 👍 Increases the number of IAs eligible for the ACI bonus.

The AMA will continue to work with CMS to increase the number of IAs available to physicians and strive to align IA with the other performance categories.

### **Alternative Payment Models**

- 👍 The revenue standard for more than nominal financial risk remains at 8% of revenues for an additional two years;
- 👍 The lower financial risk standard for medical homes, which ranges from 2.5% to 5% of revenues, will be phased in more gradually than initially planned;
- 👍 Other Payer APMs will also have access to the 8% of revenues standard for more than nominal risk;
- 👍 Participants in the first round of the one medical home model currently recognized as an Advanced APM, Comprehensive Primary Care Plus (CPC+), will have access to the lower nominal risk standard that applies to medical homes even if they have more than 50 clinicians;
- 👍 CMS will develop a demonstration project to test the effects of allowing credit for participation in Medicare Advantage APMs starting in 2018; and
- 👍 CMS anticipates that the second round of CPC+ and the start of the Track 1+ ACO model will increase opportunities for physicians to participate in Advanced APMs.

The AMA also welcomed a separate Request for Information that CMS issued on a new direction for the Center for Medicare and Medicaid Innovation to increase opportunities for APM participation.