The 2018 Quality Payment Program Final Rule: What You Need to Know

written by Dave Halpert | November 9, 2017

Halloween may be over, but CMS has given us one more scare—a 1,653-page Final Rule for Year 2 of the Quality Payment Program.

The Proposed Rule represents the next phase of the transition into a full-fledged Quality Payment Program. For eligible providers, more is required to avoid penalties, but CMS has defined the process to favor those making efforts to avoid penalties. Of course, the program is designed to facilitate improvement—not just to meet a minimum participation threshold. Success will not be quantified in terms of avoiding penalties but, rather, by demonstrating exceptional performance and improvement.

With these guidelines established for 2018 and beyond, CMS's intent is clear—2018 marks the end of the transition period. If your strategy involves "getting by" in 2018, you'll find yourself in a heap of trouble when 2019 rolls around. Here are ten keys to success in 2018 that will help you achieve an optimal position in 2019:

1. A "Test Submission" Will Be a Failed Submission

In 2017, clinicians can avoid penalties by submitting data on a single measure, even if the data completion threshold isn't met. For the current calendar year, the minimum participation requirement is to earn 3 points. With each quality measure worth a minimum of 3 points, even if only one response is provided, it shouldn't be challenging to avoid a penalty. Similarly, performing an Improvement Activity or meeting base Advancing Care Information requirements will also protect against penalties. In 2018, however, the minimum threshold rises to 15 points, meaning more (or better) reporting will be required.

2. The "Low Volume Threshold" Has Been Increased, but Consider Your Options (Especially Small Practices)

As proposed, providers will not be considered "MIPS-Eligible Clinicians" unless that clinician (as defined by the combination of Practice Tax Identification Number and Individual NPI) has at least $90,000 of Medicare Part B charges or has more than 200 Medicare Part B beneficiaries. If you are reporting as a Group Practice, these same standards are applied at the TIN level, which will make it possible for some practices to participate.

Why participate in MIPS as a group if you'd be able to skip as an individual? First, while it may be possible to opt out now, Value-Based Health Care is here to stay, and it's easier to build momentum now than to start from scratch during full rollout. Furthermore, if you are in a small practice (15 or fewer providers), you will be scored more generously than larger ones, giving small practices an opportunity to earn incentive payments. Small practices will receive outright bonuses of 5 points at the end of the year and can earn full credit even if they complete fewer Improvement Activities.

3. Clinicians May Participate in "Virtual Groups"

The 2018 Rule allows multiple practices with 10 or fewer providers (note that this a smaller practice than those referred to throughout the remainder of the Rule as a "small practice") to join together and submit data as a "Virtual Group." The group is scored as if it were one group practice. The "Patient-Facing" criteria that contribute to eligibility in the Advancing Care Information component is applied to Virtual Groups in the same manner as Group Practices: at least 75 percent of the individual clinicians must be "Non-patient Facing" for the group to be considered as such. Providers and practices wishing to participate in Virtual Groups must self-nominate by the end of the preceding year, so if you want to take advantage of the Virtual Group method in 2018, don't wait to register! Deadline is December 31.

4. Quality Component Challenges, Part 1: More Reporting, Over A Longer Timeframe

For several reasons, earning points for quality reporting will be more difficult in 2018 than it was in 2017. First, the reporting period itself has increased to a full year. In 2017, a measure could be scored against a benchmark with only 90 days of reporting. In 2018, the reporting period will go from January 1 to December 31, similar to PQRS in prior years.

Furthermore, the amount of reporting required to earn full scoring on a measure has also increased, from 50 percent to 60 percent. Under PQRS and in the 2017 year of MIPS, a measure met the "data completeness threshold" if at least 50 percent of the denominator-eligible cases were reported. For example, you could score performance on a measure with 50 eligible instances if at least 25 of those cases were reported.

In 2018, CMS has ruled that the data completion threshold has increased to 60 percent. Measures reported for fewer than 60 percent of cases will only be worth a single point, which is also a decrease from 2017, when these measures are worth 3 points. However, small practices will continue to earn 3 points for measures with fewer than 60 percent of eligible instances reported.

5. Quality Component Challenges, Part 2: "Topped Out" Measures and Measures Without Benchmarks

As is the case in 2017, every measure reported to the minimum data completion threshold will continue to earn at least 3 points. While this may provide some comfort, those striving to demonstrate excellence face continued challenges related to measures that are "topped out" (measures universally performed well) and measures that CMS has not benchmarked.

In 2017, it is still possible to earn 10 points on a topped out measure, although performance must be perfect. In 2018, this will not be possible for certain topped out measures, as CMS has finalized its plan to phase out several. There are 6 measures on track for removal, and for these measures, a maximum of 7 points may be earned. This will be particularly challenging to surgeons, as two of these are the remaining perioperative care measures (Measures #21 and #23, related to perioperative antibiotic selection and VTE prophylaxis, respectively).

CMS maintains its stance that if a measure cannot be benchmarked, it cannot be reliably scored and may only earn a nominal number of points. Therefore, non-benchmarked measures will remain capped at 3 points.

6. The Big Surprise: Cost WILL Be Weighted, Making Up 10 Percent of Your MIPS Score

Despite the proposal to weight Cost at 0 percent for an additional year, CMS has decided to reinstate Cost in the final MIPS composite, worth 10 percent of the total. This 10 percent will come from the Quality Component, which will be worth 50 percent of the MIPS composite score in 2018.

Only two measures will be used to calculate this score: the Medicare Spending Per Beneficiary (MSPB) and the Total Per Capita Cost (TPCC) measures. These are global measures, calculated by CMS using its claims data—no submission is required.

MSPB looks at costs associated with hospitalizations and procedures, specifically, charges in the days immediately preceding the index admission, inpatient care and the care following the procedure. TPCC is based on all patients attributed to a practice, looking at any costs associated with those patients (regardless of who provided the care).

The Cost composite will be the average of these two measures, unless one of them does not have sufficient data for CMS to calculate. In that case, the remaining measure will make up the entirety of the Cost composite. It is expected that additional episodic cost measures will be introduced in future years, potentially including the measures that CMS has field-tested this year.

7. Improvement Activities and Advancing Care Information Are Largely Unchanged

These two categories largely carry over as is. Improvement Activities will continue to be worth 15 percent of the total MIPS score, which may be earned by completing 40 points worth of activities (between 2 and 4 activities for large practices and 1 or 2 activities for small practices, depending on activity weights). An additional 20 Improvement Activities have been added to the possible selections.

Advancing Care Information retains its 25 percent portion of the MIPS composite score, again requiring that clinicians meet EHR standards by earning a base score and selecting from a variety of other measures to earn the remaining score. There are more bonus points available in 2018 for reporting to Clinical Data Registries and Public Health Registries. Clinicians may also earn a bonus for using exclusively 2015 Certified EHR Technology (CEHRT), although 2014 CEHRT is still allowed.

8. There Are More Opportunities to Earn Bonus Points (Including IMPROVEMENT)

There are already opportunities to earn bonus points in MIPS. Providers can increase their Quality score up to 10 percent by reporting (and performing well) on additional outcome and/or high-priority measures, in addition to the one that is required. Additional bonus points can also be earned in Advancing Care Information by performing EHR-related Improvement Activities or reporting to other entities. These provisions will continue in 2018.

In addition to what's carrying over, there are additional opportunities to earn bonus points in MIPS. Most telling for CMS's long-term goals: CMS is offering a bonus of up to 10 percent for significant year-to-year improvement. *Bonuses will also be granted to those who take care of particularly complex patients, based on Hierarchical Condition Category (HCC) score*—a big break for Academic Medical Centers and others whose patient pools include a larger proportion of high-risk patients. This is a huge signal to practices that the game has changed from quality reporting to performance improvement.

9. Provisions for MIPS APMs and Advanced APMs Remain Consistent

The biggest change to MIPS APMs is that a new determination period has been added, ending December 31. For some providers in ACOs, this will mean the difference between being considered as a part of a MIPS APM (and scored according to that standard) and being scored exclusively in MIPS. There are also additional clarifications to the MIPS APM scoring methodology.

On the Advanced APM front, CMS has extended the standard for nominal risk for the next two years: at least 8 percent of average estimated Medicare Part A and Medicare Part B revenue must be at stake. However, the Medical Home nominal standard will be eased gradually, as proposed. In terms of structure, APMs must continue to meet the same three standards for APM considerations (MIPS-comparable measures, CEHRT use and financial risk).

10. All-Payer Advanced Alternative Payment Model Roll-Out Continues

The Final Rule continues to lay the foundation for an All-Payer Advanced APM. The proposed risk standards (marginal risk of at least 30 percent, a minimum loss rate that doesn't exceed 4 percent, and a total risk of at least 3 percent) were approved. For All-Payer APMs defined in terms of revenue, CMS approved an 8 percent nominal amount standard, meaning that at least

8 percent of expected revenue must be at risk. CMS states that the nominal standard cannot be used in place of the expenditure-based standards, but recognizes that it may be the only viable option for certain All-Payer APMs.

Qualified Participant determination is also similar to traditional advanced APMs and will be performed on three snapshot dates (March 31, June 30, August 31); the QP or Partial QP threshold must be met by one of these three dates, maintaining a timeframe consistent with Medicare APMs.

An Additional Note on "Extreme and Uncontrollable Circumstances"

Also present in this rule, but not applicable to all, is a provision on "Extreme and Uncontrollable Circumstances." Over the last several months, we've seen Hurricanes Harvey, Irma and Maria wreak havoc on portions of the country; CMS addresses these in the Final Rule by re-weighting (either automatically or through an application) some or all components of MIPS, both in 2017 and 2018.

A Final Note: There is a Comment Period, and CMS Reads Your Comments

Although the Rule is considered "final," it is still possible to comment. CMS states that they have attempted to make it easier to participate by reducing the burden while maintaining flexibility. Over 1,200 people have commented on proposals, and many of the finalized rules are made on the basis of those comments. If you do not believe that the program's measures or activities are relevant and meaningful, if your burden has increased, care coordination has not improved, or your path to success is not clear, let CMS hear your voice.

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