QPP Year 2 Final Rule
CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

PAI-Healthsperien Summary
The final rule is available here, and a CMS Fact Sheet is available here.

On November 2, the Centers for Medicare and Medicaid Services (CMS) released a final rule with updates to the Quality Payment Program (QPP) for CY 2018 and beyond. CMS has maintained many of the 2017 transition year policies for 2018, but it has also finalized new policies to help physicians and other clinicians prepare for full implementation in 2019, year 3 of the program. Additionally, CMS also included details about its newly-launched “Patients Over Paperwork” Initiative aimed at reducing unnecessary burden, increasing efficiencies, and improving patient experience. A high-level summary of the policies of the final rule policies and the “Patients Over Paperwork” Initiative are provided below.

Flexibilities for Small Practices
CMS finalized several policies offering flexibilities to small practices, defined as those with 15 or fewer eligible clinicians (ECs). These include the following:

- Small practices will automatically receive 3 points for submitting some data on quality measures (even if below the data completeness standards as discussed in detail below).
- Significant hardship exception will be available for the ACI category for MIPS ECs in small practices.
- 5 bonus points will be added to the final scores for MIPS ECs who are in small practices; however, this is only for the 2020 payment adjustment year.

Merit-based Incentive Payment System (MIPS) Low-Volume Thresholds
For the 2017 performance period, the low-volume threshold was less than or equal to $30,000 in Medicare Part B allowed charges or providing care to 100 or fewer Medicare Part B patients. CMS has increased the low-volume threshold so that physicians and other eligible clinicians (ECs), individuals and groups, will be excluded from MIPS participation if they have less than or equal to $90,000 in Medicare Part B allowed charges or provide care for less than or equal to 200 Medicare Part B patients.

MIPS Submission Mechanisms
As part of the proposed rule, CMS had proposed permitting ECs and groups to use multiple submission mechanisms to report data for a MIPS category. However, CMS did not finalize this policy for 2018, so ECs will continue to be limited to using one submission mechanism per performance category to report the applicable data. The flexibility to submit data using multiple submission mechanisms per category, however, will be available beginning in 2019.

MIPS Performance Category Weights
For the 2017 performance period, the weights for the MIPS performance categories are as follows:

- Quality – 60%
Advancing Care Information (ACI) – 25%
Improvement Activities – 15%
Cost – 0%

CMS sought feedback on whether to maintain the cost category at 0% for the 2018 performance period, and for the 2020 payment adjustment, or increase its weight to 10% for the 2018 performance period, since, by statute, the weight of the cost category must increase to 30% in 2019. CMS finalized the latter, so the weight for the cost category will be 10% or the 2018 performance period, and then, as statutorily required, 30% for the 2019 performance period. Thus, the final weights for all MIPS categories for the 2018 performance period will be as follows:

- Quality – 50%
- ACI – 25%
- Improvement Activities – 15%
- Cost – 10%

MIPS Performance Periods
As part of the 2017 MIPS and APM Final Rule, the agency finalized several “transition year” policies to help physicians and other ECs transition and become more familiar with MIPS. These policies included a minimum 90-day performance period for the quality, improvement activities, and ACI categories. CMS has finalized the continuation of the 90-day performance period for the ACI and improvement activities categories, but increased the quality category performance period to a minimum 12-month period for the 2018 performance year. Thus, the 2018 performance periods for each of the MIPS categories will be as follows:

- Quality – 12-month period
- ACI – Continuous 90-day period
- Improvement Activities – Continuous 90-day period
- Cost – 12-month period

Additionally, measures reported through the CMS Web Interface and CAHPS, as well as the readmission measure will continue to be measured for a 12-month period in 2018.

MIPS Quality Category
In the proposed rule, the agency proposed maintaining the data completeness criteria for quality category measures at 50% for the 2018 performance period, and sought comments on whether to decrease the minimum number of points that were awarded for measures that don’t meet the data completeness criteria, which is currently 3 points for the 2017 performance period. The agency has finalized increasing the data completeness threshold to 60% for the 2018 performance period for all submission mechanisms except for the CMS Web Interface and CAHPS, and decreased the number of points to 1 point for measures that do not meet the 60% data completeness threshold. However, small practices who report measures without meeting the data completeness threshold will continue to receive 3 points for reporting some
quality measures data. Additionally, quality measures will continue to receive 3-10 points, and measures that do not have a benchmark or meet the case minimum will continue to receive 3 points.

CMS also finalized policies for topped out measures, or measures for which overall performance by ECs is at or near 100%. CMS will use a 4-year phasing out timeline for removing topped out measures. As part of this timeline, if measures are topped out for at least 2 consecutive years, they will receive a maximum of 7 points, and this policy will be implemented beginning in 2018 (CMS has identified 6 topped out measures for 2018). However, CMS Web Interface and CAHPS measures will be excluded from topped out scoring for now.

**MIPS ACI Category**
CMS has finalized the continuation of many of the 2017 transition year policies into 2018 for the ACI category. These include allowing ECs to continue using either 2014 certified electronic health record technology (CEHRT) or 2015 CEHRT, or a combination, for the 2018 performance period; however, ECs can earn 10 percentage bonus for using only 2015 CEHRT during the 2018 performance period.

Additionally, ECs will have the option to report the ACI Transition Objective and Measures or the ACI Objective and Measures, and they will continue to have the ability earn bonus points for 2018 as follows: 10 percentage points for reporting to a single public health agency or clinical data registry for the Public Health and Clinical Data Registry Reporting objective, an additional 5 percentage points for reporting to more than one public health agency or clinical data registry, and 10 percentage bonus for reporting improvement activities using CEHRT.

Hardship exceptions that allow the reweighting of the ACI category will be continued in 2018, however, the application requesting a reweighting of the ACI category must now be submitted by December 31 of the performance period.

Lastly, CMS has finalized exclusions for the e-Prescribing and Health Information Exchange objectives for the 2017 performance period.

**MIPS Improvement Activities Category**
CMS did not make any major changes to the improvement activities category for the 2018 performance period. CMS finalized 21 new improvement activities and made changes to 27 current improvement activities (including 1 removal).

**MIPS Cost Category**
In the 2017 MIPS and APM Final Rule, 10 episode-based measures were finalized for the cost performance category that would be scored beginning with the 2018 performance period, in addition to the total per capita costs measure and the Medicare Spending per Beneficiary (MSPB) measure. The agency proposed and finalized a policy to replace the previous 10 episode-based cost measures with new measures, so the existing episode-based measures will not be used for the 2018 performance period. The 2018 cost category score will be based on performance only for the total per capita costs measure and the MSPB measure.
MIPS Performance Scoring
The MIPS final score and related payment adjustment for ECs and groups is determined based on their performance compared to a MIPS performance threshold. Currently, for the 2017 MIPS performance period, the threshold is set at three points. The agency proposed and finalized a policy increasing the threshold to 15 points, but has retained the exceptional performance threshold at 70 points for the 2018 performance period.

Additionally, CMS has finalized policies that allow for improvement scoring for the quality category and the cost category measures beginning in 2018. CMS has also finalized a complex patient bonus, but only for the 2020 payment adjustment year, which allows ECs to earn up to 5 points for treating complex patients. The number of points awarded will be determined using the number of dual-eligible patients treated and the Hierarchical Condition Category (HCC) scores.

CMS has pushed back the adoption of facility-based measures until 2019, or year 3 of the program, due to operational constraints.

The 2020 payment adjustment, based on 2018 performance, will be +/- 5%, which will be applied to the Medicare paid amount.

Virtual Groups
CMS has finalized virtual groups as a participation option beginning with the 2018 performance period. Virtual groups are defined as a combination of two or more tax identification numbers (TINs) assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer ECs that elect to form a virtual group for a performance period for a year. However, solo practitioners and groups would need to exceed the low-volume threshold in order to participate in a virtual group. Additionally, all ECs under a TIN that participates in a virtual group would have their performance assessed as part of the virtual group, unless an EC is a MIPS APM, in which case the MIPS APM scoring standard would apply instead of the virtual group score.

CMS has finalized a two-stage virtual group election process for the 2018 and 2019 performance periods, which runs from October 11 through December 31, with stage 1 being an optional eligibility step and stage 2 being the actual formation of the virtual group. All virtual groups must have a formal written agreement among each party of the virtual group, and they must aggregate their data for measures and activities across their TINs.

MIPS APMs
MIPS APMs are an alternative participation option to “strict” MIPS participation and “strict” Advanced APM participation. There are two ways ECs and groups can participate in a MIPS APM: 1) if they are part of an APM Entity that is participating in an Advanced APM but do not achieve a QP determination exempting them from MIPS performance; and 2) if they are part of an APM Entity that is participating in an APM that may not be considered an Advanced APM, for example, MSSP Track 1 ACOs. These ECs and groups have a special scoring standard applied to them based on their participation in the APM. For the 2017 performance period, the agency assigned different category weights depending on the type of MIPS APM an EC or group
is participating in. However, the agency proposed and finalized the same category weights for all MIPS APMs: quality at 50%, improvement activities at 20%, ACI at 30%, and cost at 0%.

Additionally, CMS has added a fourth snapshot date of December 31 that would only be used to identify ECs in APM Entities in MIPS APMs that require full TIN participation; this fourth snapshot date will not be used to make Qualifying Advanced APM Participant (QP) determinations.

**Advanced APMs**

In the final rule, CMS estimates that approximately 185,000 to 250,000 ECs will be considered QPs for the 2020 payment year based on the 2018 performance year.

As part of the proposed rule, CMS sought comments on whether to have a lower revenue-based nominal amount standard for small practices and those in rural areas for the 2019 and 2020 performance periods. CMS had finalized a policy maintaining the revenue-based nominal amount standard at 8% for the 2019 and 2020 performance periods. Additionally, CMS finalized a ramp-up of the revenue nominal amount standard for the Medical Home Model as was proposed.

**QP Performance Period**

CMS will maintain the 2017 QP performance period of January 1 through August 31 going forward, as well as the three snapshot dates to make QP determinations. However, CMS did include a new policy specifying that if an Advanced APM starts or ends during the QP Performance Period and operates continuously for a minimum of 60 days during the QP Performance Period for the year, CMS will make QP determinations using payment or patient data only for the dates and times that the APM Entities were able to participate in the Advanced APM, not for the full QP Performance Period.

**All-Payer Combination Option / Other Payer Advanced APMs**

Beginning with the 2019 performance period, ECs and groups will have the opportunity to have their participation in non-Medicare, Other Payer Advanced APMs count towards their QPP participation for the QP/Partial QP (PQ) determinations. Beginning with the 2019 performance period, payers can submit the following types of payment arrangements for consideration for Other Payer Advanced APMs: Medicaid APMs and Medicaid Medical Home Models; CMS multi-payer models; and Medicare health plans (including Medicare Advantage, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and PACE). CMS will consider commercial and other private payers for the Other Payer Advanced APM option in future years.

CMS also finalized requirements for the Payer Initiated and EC Initiated Submission of Information and Data for the Other Payer Advanced APM determination and All-Payer Combination determination. However, important to note, is that CMS changed an element of the information ECs or APM Entities would have to submit as part of their All-Payer Combination determination. Previously, CMS was going to permit ECs and APM Entities to submit an attestation from the payer that the information they submitted on payment arrangement was accurate. However, CMS has eliminated this requirement, and ECs and APM Entities will now have to certify that the information they submit is accurate.

Other Payer Advanced APMs would meet the generally applicable revenue-based nominal amount standard if the total amount an APM Entity potentially owes the payer or forgoes under the other payer.
arrangement is equal to at least 8% of the total combined revenues from the payer or providers and suppliers in participating APM Entities, and the payment arrangement is defined expressly in terms of revenue. This standard is in addition to the expenditure-based standard that was previously finalized in the 2017 MIPS APM Final Rule.

The 2019 and 2020 QP Performance Period for the All-Payer Combination option will be from January 1 through August 31, with the same three snapshot dates as the Medicare QP determination, March 31, June 30, August 31. Additionally, requirements for the Payer Initiated and EC Other Payer Advanced APM determination process for submitting information were finalized. CMS finalized a policy that would allow QP determinations under the All-Payer Combination Option to be assessed at the individual or APM Entity level. CMS also finalized a policy that will calculate the EC’s Medicare threshold scores both individually and using a weighted methodology (reflecting the EC’s individual Medicare volume as part of the APM Entity), and CMS will then use most advantageous calculation when making the QP determination under the All-Payer option.

**Patient Over Paperwork Initiative**

On October 26, CMS Administrator Seema Verma announced the launch of CMS’s “Patients Over Paperwork” Initiative. The purpose of this initiative is to begin gathering information on the impact of regulations on physicians, in order to determine which can be eliminated or scaled down. The stated ultimate goal of the initiative is to reduce the regulatory burden on physicians to allow for more time to be spent with patients. In the final rule, CMS provided additional information on policies that were finalized as part of this initiative including the following:

- Increasing the low-volume thresholds for MIPS exclusion.
- Addressing “extreme and uncontrollable circumstances,” e.g., natural disasters, as they relate to QPP and MIPS participation.
- Adding the virtual groups participation option.
- Allowing ECs to receive QP determinations for participating in Advanced APMs that may begin or end during a QP Performance Period.