# CMS Unveils Numerous Changes to Quality Payment Program (QPP)

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The number of clinicians required to heed Medicare's Quality Payment Program (QPP) next year and beyond got smaller, thanks to new language in the program's final rule for 2018. In issuing the rule on November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) effectively raised the bar for physician participation to $90,000 in Medicare Part B total allowed charges or 200 Medicare patient encounters, removing an estimated 123,000 clinicians from the program. Eligible clinicians include physicians, as well as physician assistants, nurse practitioners, certified registered nurse anesthetists and clinical nurse specialists. If you are an eligible clinician by training and licensure, but fall below those thresholds, as of January 1, 2018, you no longer need to be concerned about the QPP.

For the thousands of clinicians whose annual Medicare charges or patient visits exceeds the new limits, there will still be a choice to make on which QPP track to embark: join an advanced alternate payment model (aAPM) or become an active participant in the Merit-based Incentive Payment Program (MIPS).

MIPS retains its four core components: quality, advancing care information (ACI), improvement activities and cost. Despite its earlier proposal to hold off scoring related to "cost" for another year, the CMS ruling establishes cost as a measure and gives it a 10% weighting. What's more, cost — calculated based on the Medicare Spending per Beneficiary (MSPB) and total per capita cost measure — will increase to a 30% weighting in MIPS for 2019 and beyond. In sum, for the 2018 calendar year, the measures and their relative contributions to eligible clinicians' MIPS scores will be: quality (50%); ACI (25%); improvement activities (15%); and cost (10%).

A ray of good news for some is that CMS will continue to allow practices to continue using their 2014-certified electronic health (EHR) systems although the program offers bonus points for reporting exclusively on the 2015 edition. That said, the total points required to avoid the penalty in 2018 climbs to 15, up from just three needed during the 2017 transition year. Other notable components of the final rule deal with:

Reporting mechanism. Practices may use only one mechanism - for example, EHR or registry - to report quality measures in 2018, a reversal of the flexibility hinted at when the rule was initially proposed. While acknowledging the need for flexibility in how quality measures are reported, CMS now says it will not offer this sought-after flexibility until 2019.

Reporting periods. Quality and cost measures must be reported for a period of 12 months in 2018, though the ACI and improvement activity categories remain at 90 days. It's worth noting here that several quality measures have "topped out," meaning one cannot score at the highest level in them even with perfect performance. The best response from clinicians may be to continue reviewing their quality measures each reporting year to determine which ones to submit to CMS. Although cost will be based on 12 months, it is a "behind-the-scenes" calculation made by CMS, thus not requiring any reporting.

Small practices. In 2018, practices with 15 or fewer clinicians receive an automatic bonus of five points towards their overall score, plus an automatic "base" three points per quality measure, regardless of data completeness. Small practices may also seek exemption from the ACI category in 2018 by submitting an application for this exception by the end of the calendar year.

Complex patients. Five bonus points are available for the "treatment of complex patients" in 2018. CMS will use both the dual eligibility ratio and the average Heierarchial Condition Categories (CMS-HCC) risk score in making this determination.

ASC physician exemption. The new rule gives physicians based at ambulatory surgical centers (ASCs) exemption from ACI, retroactive to the current (2017) reporting year. The exemption also extends to physicians practicing in off-campus-outpatient hospitals (Place of Service -19) as they are now assimilated into the "hospital-based physician" definition.

ACI measure excmptions. Another important ACI retroactive exemption goes to clinicians who write less than 100 permissible prescriptions: they are relieved of being measured in the e-prescribing category. Furthermore, clinicians who transfer patients to other settings or refer patients fewer than 100 times during the performance period will be excmpt from the health information exchange/summary of care measures. These exemptions apply to 2017 - and future years.

Improvement Activities. CMS adds 21 new improvement activities and makes changes to 27 previously adopted improvement activities; in total, 121 will be available in 2018.

Medical practices get some good news in the final rule with CMS now allowing virtual groups to form by joining with other practices in order to participate in MIPS. The final rule also addresses what happens when practices join an aAPM in the middle – or near the end – of the reporting year: the practice can be officially incorporated into the entity based on an alteration in CMS' look-back period, as long as the practice was able to participate for at least 60 continuous days during the performance period.

Of course, there's plenty more to peruse in the final rule which, despite CMS' pronouncements of greater flexibility, remains most certainly complex at 1,653 pages.

Here is the Final Rule for the Physician Fee Schedule (11/15)

Here is the Final Rule for the Quality Payment Program (11/16)

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