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10 Things to Know about the 2018 Quality Payment Program

November 9, 2017

Beginning in 2019, eligible clinicians (including most physicians) will be paid for Medicare Part B services under the new Quality Payment Program (QPP), and they will elect to either be subject to payment adjustments based upon performance under the Merit-based Incentive Payment System (MIPS) or to participate in the Advanced Alternative Payment Model track (APM). Eligible clinicians choosing the MIPS pathway will have payments increased, maintained or decreased based on relative performance in four categories: use of information technology, clinical quality, cost and clinical improvement activities. Eligible clinicians choosing the APM pathway will automatically receive a bonus payment once they meet the qualifications for that track. CMS will publish the CY 2018 Final Rule for Quality Payment (CMS-5522-FC and IFC) in the Federal Register on November 16, 2017.

- *Final Rule is available for download **here***
- *CMS Fact Sheet is available **here***
- *CMS Executive Summary is available **here***

For more information on the CMS Quality Payment Program visit the **McDermottPlus MACRA Resource Center** or contact Sheila Madhani or Piper Su.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS Timeline			
CY 2017	**CY 2018**	**CY 2019**	**CY 2020**
Year 1 Performance Period	**Year 2** Performance Period	**Year 3** Performance Period	**Year 4** Performance Period
		Year 1 Payment Year	**Year 2** Payment Year

1. In CY 2018, MIPS will apply to only 40% of eligible clinicians and 66% of Part B allowed charges.

In the 2017 Final Rule, CMS estimated that MIPS would apply to approximately 59.2% of eligible clinicians while in 2018 that estimate dropped to 40%. This drop in eligible clinicians is due largely to the change in the low volume threshold exception which went from ≤ $30,000 in Part B allowed charges/OR ≤ 100 Part B beneficiaries in the 2017 QPP Final rule to ≤ $90,000 in Part B allowed charges/OR ≤ 200 Part B beneficiaries for 2018. CMS estimates that in 2018 approximately 540,347 clinicians will be excluded due to the low volume threshold exception.

Projected Number of Clinicians Ineligible for or Excluded from MIPS in CY 2018, by Reason

Reason for Exclusion	Count of Medicare Clinicians (TIN/NPIs) Remaining After Exclusion	Part B Allowed Charges Remaining After Exclusion ($ in millions)	Count of Medicare Clinicians (TIN/NPIs) Excluded	Part B Allowed Charges Excluded ($ in millions)
ALL MEDICARE CLINICIANS BILLING PART B	1,548,022	$124,029		
Subset to clinician types that are eligible for 2020 MIPS payment year	1,314,733	$101,733	233,289	$22,296
Exclude Newly Enrolled Clinicians	1,232,779	$101,243	81,954	$490
Additionally, Exclude Low Volume Clinicians	692,432	$88,247	540,347	$12,996
Additionally, Exclude Qualifying APM Participants (QPs)[1]	621,700	$81,921	70,732	$6,326
TOTAL REMAINING IN MIPS AFTER EXCLUSIONS	**621,700**	**$81,921**		
% ELIGIBLE CLINICIANS REMAINING IN MIPS AFTER EXCLUSIONS	**40%**	**66%**		

Source: Table 75, 2018 QPP Final Rule (CMS-5522-FC and IFC)

[1] It should be noted that while in this table CMS indicated 70,732 clinicians would be excluded from MIPS due to their QP status, elsewhere in the Final Rule CMS estimates that 185,000-250,000 clinicians would be designated as QPs.

2. The bar to avoid a payment penalty under MIPS has increased from 3 points out of 100 to 15 out of 100.

Beginning in 2019, physicians participating in MIPS will be eligible for positive or negative Medicare Part B payment adjustments that start at 4% and gradually increase to 9% in 2022. Distribution of payment adjustments will be made on a sliding scale and will be budget neutral. In Performance Year 2017 for Payment Year 2019 the MIPS adjustment was +/- 4%; for Performance Year 2018 for Payment Year 2020 the adjustment will be +/-5%.

Under the MIPS scoring system, a participant's MIPS score ranges from 0-100 points, and the payment adjustment applied is based upon that score. The "performance threshold" represents the score that is needed to receive a neutral to positive payment adjustment for the year. A score below the performance threshold will result in a negative payment adjustment; while a score above the payment threshold will result in a positive payment adjustment (a score at the payment threshold will result in a neutral payment adjustment). There is an additional $500 million each year from 2019 to 2024 to award "exceptional performance" bonuses to MIPS providers with the highest composite performance scores. CMS will set an exceptional performance threshold to award these bonuses.

Thresholds	Payment Year	
	2019	2020
Performance Threshold	3	15
Exceptional Performance Threshold	70	70

3. CMS will evaluate eligible clinicians on the Cost Performance Category beginning in the 2018 Performance Year.

In 2017, CMS did not implement the Cost Performance Category but they will be implementing it in the 2018 Performance Year. CMS will calculate cost measures based on administrative claims data; MIPS eligible clinicians will not have to report any additional information.

CMS will be using two measures in 2018: the Medicare Spending Per Beneficiary (MSPB) Measure and the Total Per Capita Cost Measure. CMS is in the process of developing episode based measures for use in future years of the program.

Performance Category	2019 Payment Year	2020 MIPS Payment Year	2021 MIPS Payment Year & Beyond
Quality	60%	50%	30%
Cost	0%	10%	30%
Improvement Activities	15%	15%	15%
ACI	25%	25%	25%

It should be noted that since many clinicians across the country have been affected by hurricanes Harvey, Irma, and Marie, CMS is establishing a hardship exception policy for these clinicians. It will provide relief from reporting requirements associated with QPP in the 2017 and 2018 Performance Periods for eligible clinicians who are impacted by "extreme and uncontrollable circumstances." Request for consideration in 2017 is due by December 31, 2017, and the application is due by December 31, 2018 for the 2018 Performance Year.

4. MIPS adjustments will apply to Part B drugs.

In the 2018 Final Rule, CMS clarified that MIPS payment adjustments will be made to payments for both items and services under Medicare Part B, including Part B drugs. These adjustments apply to all of the Medicare Part B items and services furnished by, and billed under, the combined Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) of a MIPS eligible clinician and not only to services paid under the Medicare PFS.

If an eligible clinician reassigns all of their billing rights to a facility, such as a Federally Qualified Health Centers and/or a Rural Health Clinic, the MIPS payment adjustment won't apply to Part B items and services billed by the facility under the facility's all-inclusive payment methodology or prospective payment system methodology.

The cost of Part B drugs will also be used in the calculation of cost measures.

5. CMS will allow participation in MIPS using "virtual groups" beginning in Performance Year 2018.

The MACRA statute allows CMS to establish "virtual groups" for purposes of reporting and measuring performance under MIPS. CMS did not implement virtual groups in 2017, but for 2018 CMS is allowing solo practitioners and groups of 10 or fewer eligible clinicians to come together "virtually" with at least one other solo practitioner or group to participate in MIPS. CMS notes that all NPIs billing under the TIN joining the virtual group must participate. Each TIN/NPI will receive a final score based on the performance of the virtual group and the payment adjustment will be applied at the TIN/NPI level. For the CY 2018 Performance Period, the deadline to elect to be in a virtual group is December 31, 2017.

6. CMS is implementing a complex patient bonus, a small practice bonus, and improvement scoring in Performance Year 2018.

For the complex patient bonus, CMS will apply an adjustment of up to 5 points for the treatment of complex patients (based on the combination of the Hierarchical Conditions Category (HCC) risk score and the number of dually eligible patients treated). For the small practice bonus, CMS will add 5 points to any MIPS eligible clinician or small group who is in a small practice (defined as 15 or fewer eligible clinicians), as long as the MIPS eligible clinician or group submits data on at least one performance category in an applicable performance period.

The MACRA statute allows CMS to implement improvement scoring that rewards improvement in performance for an individual MIPS eligible clinician or group for a current performance period compared to the prior performance period. Improvement scoring did not apply in the first year of the MIPS program, but CMS will implement it for the 2018 Performance Year. For Quality, CMS will measure improvement at the performance category level, and 10 percentage points will be available. For Cost, CMS will base improvement scoring on statistically significant changes at the measure level. Up to one percentage point is available in the Cost Performance Category.

7. Facility-based measurement will be an option beginning in the 2019 Performance Year.

MACRA authorized CMS to use measures from other payment systems (e.g., inpatient hospitals) for the Quality and Cost Performance Categories for "hospital-based" MIPS eligible clinicians but excluded measures from hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists. The intent of facility-based measurement is to reduce the reporting burden and collect more meaningful data.

In Payment Year 2021 (Performance Year 2019), a MIPS eligible clinician or group may elect to be scored in the Quality or Cost Performance Categories using facility-based measures. CMS will implement a voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program. This option would be available only for facility-based clinicians who have 75 percent of their covered professional services supplied in the inpatient hospital or emergency department setting. The facility-based measure option converts a hospital Total Performance Score into MIPS Quality and Cost scores.

ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

8. CMS expects over twice as many participants in the Advanced APM track in Performance Year 2018 compared to 2017.

In the 2017 QPP Final Rule, CMS estimated that 70,000 to 120,000 eligible clinicians would qualify to earn incentive payments for Advanced APM participation. For 2018, CMS estimates that number to increase to 185,000 to 250,000. This increase is partially due to new Advanced APMs expected to be available for participation in 2018, including the Medicare ACO Track 1 Plus Model, and the addition of new participants from current Advanced APMs.

9. CMS will pursue a demonstration project to allow participation in Advanced APMs under Medicare Advantage (MA) to count towards the Medicare APM threshold.

CMS intends to pursue a demonstration program that would allow organizations participating in Advanced APMs under MA to count that participation toward the Medicare participation threshold rather than only the All-Payer option. CMS signals a strong intent to proceed with this option unless there are "significant methodological or other obstacles."

10. CMS finalizes Advanced APM criteria.

CMS finalizes the Advanced APM criteria as proposed for 2018, specifying that the threshold for nominal risk will be 8% of the average estimated Parts A and B revenue of the participating APM entities for performance years 2018, 2019 and 2020. The Final Rule also finalizes the proposed change to the risk threshold under the Medicare Medical Home criteria, slightly relaxing the required amount to allow participants more leeway to meet the phased-in threshold. While it is always possible that CMS could later modify these requirements, it is clear that the agency is seeking to offer a predictable risk pathway by offering multi-year criteria.

As 2021 approaches, CMS is also moving forward with the necessary steps to qualify non-Medicare models as Advanced APMs under the forthcoming All-Payer eligibility track. The rule confirms the APM model requirements and the process that payers and eligible clinicians may use to submit a specific payment arrangement for consideration as a qualified Advanced APM requirement. Beginning in 2019, payers can seek approval of models paid under Medicaid, Medicare Advantage or Medicare-aligned programs by submitting required information to CMS. Eligible clinicians may also submit these models if a payer has not already sought approval, and other payers will be eligible to use a similar process for their models in future years.

For more information on the CMS Quality Payment Program visit the **McDermottPlus MACRA Resource Center** or contact Sheila Madhani at (202) 204-1459 or Piper Su at (202) 204-1462.