Key Changes to the Quality Payment Program for 2018

On Thursday, November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule for the 2018 performance period. The rule finalizes modifications to payment and policy to the Quality Payment Program (QPP) first implemented in 2017. The QPP is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

In the final rule, CMS reaffirmed its commitment to easing physicians’ transition into the QPP, and noted that Year 2 continues many of the flexibilities included in the transition year. However, to support full implementation in Year 3, CMS has increased the threshold for minimum participation for most clinicians.

Along with this summary and other AAN resources, we encourage members to review CMS’ new Quality Payment Program website. CMS offers a fact sheet that provides details on this new program.

MIPS

CMS will continue to measure performance for clinicians through MIPS in 2018, with payments based on those measures in 2020. Starting in 2018, CMS will measure clinicians’ performance in all four MIPS categories, each comprising a different percentage of an overall performance score which determines how the provider is paid.

- **Quality:** 50 percent of the score (down from 60 percent in 2017). As in 2017, most clinicians may report up to six measures including one outcome measure. For most providers, quality measures are worth between 1 and 10 points, depending on performance and data completeness. Starting in 2018, clinicians must report one year of data (January 1, 2018, to December 31, 2018).

- **Advancing Care Information:** 25 percent of score. As in 2017, clinicians must fulfill an “all or nothing” base score to receive credit in this category. For this category, CMS is granting bonus scores for submitting to public health agencies or registries, attesting to certain Improvement Activities, and using 2015 Certified EHR Technology exclusively. Small practices may claim hardship exceptions and reallocate these points to another performance category. Clinicians must report data for 90 days for this category.
• **Improvement Activities**: 15 percent of the score. As in 2017, CMS requires most participants will need to attest to having completed four “medium-weighted” or two “high-weighted” activities for a minimum of 90 days to receive full credit. Small and rural practices do not need to report more than two activities to receive full credit. Clinicians must report data for 90 days for this category.

• **Cost**: 10 percent of the score. In 2018, CMS will begin to assess clinician performance using Total Per-Capita Cost Measures and Medicare Spending Per Beneficiary. These will be calculated using Medicare claims, which means there are no additional reporting requirements for clinicians. In future years, this category will use episode-specific measures to account for differences among specialties. The performance period for this category is one year (January 1, 2018, to December 31, 2018).

Clinicians must achieve an overall MIPS score of 15 points during the 2018 performance year to avoid a penalty in 2020. Clinicians who score above 15 points are eligible for a positive payment adjustment of up to 5 percent; as in 2017, those who score 70 points or more will be eligible for a “high performance bonus.”

**Exclusions**
For 2018, CMS has raised the low-volume threshold to clinicians with $90,000 or less in Medicare Part B allowed charges or 200 or fewer Medicare patients as measured at the TIN/NPI level for individual reporting, the TIN level for group reporting, and the APM Entity level for reporting under the APM scoring standard. At this time, CMS has not finalized a policy to allow excluded clinicians to “opt-in” to reporting for MIPS and compete for positive-payment adjustments. CMS estimates that only 40 percent of eligible clinicians will remain in MIPS in 2018 after exclusions. This means a large number of neurologists may not face any reporting requirements or potential payment adjustments.

**Support for Small and Solo Practitioners**
CMS included several flexibilities for small and solo practitioners in the 2018 final rule.

**Bonus Points**
Any clinician in a small or solo practice (groups less than 15 eligible clinicians) will automatically have five points added to their final MIPS score if they submit data on at least one performance category in an applicable performance period.

**Virtual Groups**
Starting in 2018, CMS is making virtual groups available as a reporting option for small and solo practices (groups less than 10 eligible clinicians). Eligible clinicians in these practices can come together to share the burden of reporting and pool performance to potentially compete for a higher overall performance score.

**Hardship Exceptions**
Clinicians in a small or solo practice (groups less than 15 eligible clinicians) can submit a new hardship exception to the Advancing Care Information Category to have these points reweighted to other categories.
Data Completeness
Small and solo practices (groups less than 15 eligible clinicians) will receive a minimum of three points for all quality measures, even if they do not meet the data completeness threshold (60 percent of patients in 2018).

Other Flexibilities

Bonus Points for Complex Patients
Clinicians who treat complex patients can receive up to five bonus points. CMS uses Hierarchical Condition Categories (HCC) scores and the number of dually eligible patients treated to assess patient complexity.

Extreme and Uncontrollable Circumstances
Clinicians who were affected due to Hurricanes Harvey, Irma, and Maria are granted many hardship exceptions for 2017 and 2018.

Advanced Alternative Payment Models
In 2018, CMS will continue to provide bonus payments to doctors who participate in Advanced Alternative Payment Models (A-APM). As in 2017, models included in this category require use of Certified EHR Technology, leverage quality metrics similar to those used in MIPS, and under which clinicians accept both risk and reward for providing coordinated, high-quality care. In addition to those models identified in the 2017 Final Rule, CMS finalized that the Medicare ACO Track 1+ Model would be considered an A-APM.

Physician-Focused Payment Models and the Physician-Focused Payment Model Technical Advisory Committee (PTAC)
In the final rule, CMS reiterated its commitment to broaden opportunities for clinicians to participate in A-APMs by working with the CMS Innovation Center to create new models, including those recommended by the Physician-Focused Payment Models Technical Advisory Committee (PTAC). It did not finalize modifications to the definition of Physician-Focused Payment Models (PFPMs) to include those in which Medicaid or the Children’s Health Insurance Program (CHIP) are payers. Similarly, it did not finalize modifications to the PFPM criteria for PTAC consideration or to the process or timeline for review of proposed PFPMs.

The AAN has created two condition-based APMs for neurology, one of which has been submitted to the PTAC. The initial APMs focus on two common disease areas, headache and epilepsy, and the AAN plans to develop more condition-based APMs. In the future, these models may qualify under the APM track of MACRA and allow neurologists to negotiate new arrangements with payers. Learn about the AAN-developed draft alternative payment models.

For more information, visit AAN.com/practice/MACRA, or email your questions or concerns to MACRA@aann.com. We also encourage you to register for our December 5, 2017, practice management webinar: New Year, New Rules: Preparing for 2018.