

CMS Releases 2018 Quality Payment Program Final Rule

On November 2, 2017 the Centers for Medicare and Medicaid Services (CMS) released its final rule on the 2018 Quality Payment Program established under the MACRA (Medicare Access and CHIP Reauthorization Act of 2015). In this rule CMS describes changes to policies for implementation of the second transition year for the Merit-Based Incentives Payment System (MIPS) and for Advanced Alternative Payment Models (APMs). Of particular interest to radiology is recognition by CMS of the importance of the use of appropriate use criteria (AUC) for diagnostic imaging by physicians who order and furnish the services as a qualifying high-weighted improvement activity if they attest they are using AUC through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered.

Other areas of interest are the easing of requirements for small and rural practices by lowering the threshold for physicians being exempt from the QPP if they bill for less than or equal to \$90,000 to Medicare or treat less than or equal to 200 patients per year. In addition, small and rural practices will receive 3 points for all measures reported regardless of data completeness and 5 bonus points added to their total for QPP2 participation.

CMS implements the use of virtual groups and defines them as being composed of solo practitioners or groups of 10 or fewer eligible clinicians who come together virtually to participate in MIPS. This would allow for small and rural practices (that exceed the low volume threshold) to join other small groups and jointly work towards meeting MIPS requirements if they are determined to be MIPS eligible. The definition of patient-facing would be the same for these groups as it is currently defined for individuals and groups for 2017. If 75% of the members of the group are patient-facing, the entire group is considered patient-facing. The same rule applies for non-patient facing. Currently CMS' election period to disclose that a practice wants to be a virtual group is open until December 31. CMS has released a tool kit on how to appropriately apply to CMS and make contractual arrangements to be part of a virtual group for 2018. Please go to the CMS website at qpp.cms.gov for more information.

CMS has finalized that the cost category under MIPS for 2018 to be set to 10%. Therefore the quality category will remain at 50%. The other MIPS category percentages are 25% for advancing care information and 15% for improvement activities.

In last year's QPP final rule, CMS created several different ACI reweighting/exemption options, including one for "hospital-based" eligible clinicians who perform 75% or more covered professional services in the inpatient hospital, on-campus outpatient hospital, and/or emergency room settings. In this year's final rule, CMS will extend the hospital-based determination to include off-campus outpatient hospital settings (POS 19). CMS is also allowing for new reweighting/exemption options, including one for small practices who face an overwhelming barrier to ACI compliance.

Finally for APMs, Medicare keeps the same qualifying performance periods for participants but adds a new category for the All-Payer QP (Qualified Provider) performance period. This is in preparation for recognition of providers who begin to work in APMs under different payer arrangements besides Medicare in 2019. Medicare also finalized the extension of the revenue-

based nominal amount standard for two more years which allows APMs to meet the financial risk criterion for APM participants to bear a total risk of 8% of Part A and Part B revenues.

ACR's MACRA Committee and staff are reading and digesting this rule and will prepare a more detailed summary for publication in the near future. In the meantime, [click here](#) to read CMS' extensive fact sheet on the major changes in this rule for the second year of Medicare's Quality Payment Program for physicians who are required to participate in either APMs or MIPS.