News from the American College of Nuclear Medicine

CMS 2018 Quality Payment Program Final Rule- What Does it Mean for Medical Imagers and Group Practices?

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).

Perhaps the most notable item of interest to our Diagnostic Imaging societies is the continued recognition by CMS of the importance of the use of appropriate use criteria for diagnostic imaging (AUC) "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 Quality Payment Program (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.

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 the 2017 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 2018 final rule, CMS will to 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.
(Portions of the above descriptions are taken from a press release from the American College of Radiology.)

Facts about patient-facing status: CMS has released the list of the 5,702 codes that qualify as patient-facing services and procedures in 2018. Absent from the list are anesthesia, pathology and radiology codes. CMS also decreases the non-patient facing provider's improvement activities requirements. Further information can be found at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-

Sheet.pdf Non-patient facing providers must perform 2 medium-weighted or 1 high-weighted activity (rather than 4 medium-weighted or 2 high-weighted activities for patient-facing providers). Clinicians don't need to tell CMS that they're non-patient facing -- the agency will review claims data to determine who is and who is not patient-facing.

AMA HOD reaction

When the AMA 2017 Interim Meeting House of Delegates convened a week later, a Resolution was included from the American Society of Clinical Oncology and the American College of Rheumatology asking for a specific change to the newly announced 2018 Rule. It was passed as written, and the policy action is as follows:

RESOLVED, That our American Medical Association continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the Merit-Based Incentive Payment System (MIPS) payment adjustment as part of the Quality Payment Program (QPP). (This became Policy H-385.911.)

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