



Quality Payment Program 2018 Final Rule Guide

A Comprehensive Guide to the Quality Payment Program created under the Medicare Access and CHIP Reauthorization Act (MACRA).

This booklet contains information for ophthalmic practices participating in the Quality Payment Program in 2018 and includes the following guides:

- **MACRA Final Rule Overview**
- **Guides on each of the Four Categories of the Merit-Based Incentive Payment System (MIPS):**
 - **Quality**
 - **Advancing Care Information**
 - **Improvement Activities**
 - **Cost**
- **Group vs. Individual Reporting and Virtual Groups**
- **Advanced Alternative Payment Models (APMs) and MIPS APMs**
- **MIPS APM Guide for Medicare Shared Savings Track 1 ACO Participants**

Updated and additional information can be found on the ASCRS•ASOA MACRA Center webpage at:

ascrs.org/macracenter

Quality Payment Program Overview

On November 2, 2017, CMS released the Quality Payment Program (QPP) Year 2 final rule, which includes 2018 policies for both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), impacting 2020 payments. The final rule builds on regulations first established for 2017 performance and 2019 payment related to programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA changed the way Medicare incorporates quality measurement into payments and develops incentives for participation in alternative payment models.

This guide summarizes the Quality Payment Program Year 2 final rule. Full details on 2018 performance requirements, including category guides, will be available on the ASCRS•ASOA MACRA Center website at ascrs.org/macracenter shortly. In addition, we will be hosting webinars and providing other educational opportunities in the coming months. ASCRS•ASOA will be providing comments on the final rule.

Key Provisions Reflect ASCRS•ASOA and Medical Community Advocacy

Following the recommendation of ASCRS•ASOA and the medical community that it scale back its implementation of the first and second year of the QPP in 2017 and 2018, CMS has further sought to ease the transition to MIPS and identify ways to reduce regulatory burden with the 2018 QPP final rule. In addition to creating another transition year of the program, the final rule carves out special protections for small practices with 15 or fewer providers.

The final rule includes several provisions advocated for by ASCRS•ASOA, such as:

- Continued transition flexibility with a MIPS final score threshold of 15 to avoid the 5% penalty; and
- Continuing to allow the use of 2014 Certified EHR Technology.

Unfortunately, CMS did not finalize its ASCRS-supported proposal to weight the Cost category at 0% of the 2018 MIPS final score. Instead, Cost will count for 10% of a physician's final score. CMS also elected to raise the quality measure reporting threshold to 60% of all patients for EHR and registry submissions, and 60% of Part B patients for claims reporting, instead of keeping the requirement at the 2017 level of 50%.

In addition, CMS instituted the following policies to reduce regulatory burdens on small practices with 15 or fewer eligible clinicians:

- Physicians in small practices will receive 5 bonus points added to their final MIPS scores (which can be used to meet the final MIPS score of 15 to avoid a penalty).
- Small practices can claim a significant hardship for the Advancing Care Information (ACI) category. The ACI category weight will be re-weighted to the Quality category, for a total of 75% of the final MIPS score.
- Small practices will continue to receive full credit in the Improvement Activities category by submitting one high-weighted activity.
- Small practices will receive no fewer than 3 points for any quality measure submitted.

Despite ASCRS and medical community advocacy that the small practice determination be made based on the number of MIPS-eligible clinicians, CMS is maintaining its definition of a small practice as 15 or fewer eligible clinicians. By making the determination based on eligible clinicians, defined as providers eligible to participate in Medicare, the practice size may include providers who are not MIPS -eligible, such as new enrollees or those under the low volume threshold.

CMS is also increasing the low-volume threshold to \$90,000 in allowed Part B charges or 200 patients, which should exempt many more ophthalmologists than the 2017 level of \$30,000 or 100 patients.

CMS is also adding a complex patient bonus, up to 5 points, to the final score of an individual or practice of any size if the practice treats certain complex patients. CMS will use the Hierarchical Condition Category (HCC) index, currently used by Medicare Advantage plans and included in Value-Based Payment Modifier risk adjustment calculations. The HCC measures the percentage of patients with certain chronic diseases and those dually eligible for Medicare and Medicaid. It does not include any ocular co-morbidities.

2018 Performance Period for 2020 Payment

For full participation in the MIPS program in 2018, for 2020 payment, **MIPS participants must submit a full year of data for the Quality category, and any period of at least 90 days for the Advancing Care Information and Improvement Activities categories. CMS will calculate the Cost category score from the full year's claims. Physicians do not need to submit any data for the Cost category.**

Final Score and 2018 Performance Threshold

Following ASCRS•ASOA and medical community advocacy, CMS is continuing its transition flexibility to avoid a penalty by submitting minimal data. CMS set the 2018 MIPS final score threshold at 15 points, up from 3 points in 2017. **To avoid the 5% penalty, physicians must earn at least 15 MIPS points.**

The threshold can be met in a variety of ways, such as:

- Full participation in the Improvement Activities category, such as submitting one high-weighted activity or two medium-weighted activities for small practices, or two high-weighted activities, four medium-weighted activities, or a combination of both;
- The Advancing Care Information (ACI) category base score and one quality measure meeting the measure threshold, or data completeness, but not benchmarks;
- ACI base score and one medium-weighted improvement activity; or
- Six quality measures meeting data completeness, but not measure benchmarks.

CMS will continue considering physicians who participate fully and score above 70 as "exceptional performers" who are eligible for an additional bonus above and beyond the yearly available MIPS positive payment adjustment level. Congress set aside additional funds for exceptional performance in MACRA, which is not subject to the budget neutrality requirements of the MIPS payment adjustments.

Virtual Groups

In performance year 2018, CMS is implementing a provision of MACRA that gives MIPS participants the opportunity to join "virtual groups." CMS will allow solo practitioners and small groups of no more than 10 providers to voluntarily join together as a virtual group to have their performance assessed and scored collectively. Virtual group reporting and scoring will work in a similar manner to group reporting under a single TIN. There is no limit to how many physicians and providers may be in a virtual group. Groups of physicians who want to create a virtual group must have a formal written agreement and apply to CMS in the year preceding the performance period. For 2018 performance, the application period opened September 1, 2017, and applications must be submitted by December 31, 2017.

MIPS Performance Categories

MIPS assesses the performance of clinicians based on four categories: Quality, Cost, Advancing Care Information (EHR), and Improvement Activities.

Quality: 50% of Total Score in Year 2 (2018)

CMS maintained most of the 2017 performance requirements in 2018, and adds a statutorily required methodology for scoring improvement in the category. Physicians must report a minimum of six measures, with at least one outcome measure, if available. If no outcome measure is available, he or she would report one "high-priority measure." Unfortunately, **CMS increased the reporting threshold (or data completeness requirement) for quality measures to 60% of Part B patients if reporting via claims, and 60% of all patients for registry or EHR reporting. For full credit in the category, providers have the potential to earn up to 60 or 70 points, depending on practice size. Practices of 15 or fewer MIPS-eligible clinicians must report 6 measures, each with 10 total possible points, while practices of 16 or more eligible clinicians will also be scored on a claims-based hospital re-admission measure in addition to the 6 reported measures, each worth 10 possible points. Physicians receive an achievement score of up to 10 points per measure, relative to pre-set performance benchmarks based on 2016 performance. To score improvement, CMS will compare physicians' and groups' 2017 overall Quality category scores to their**

2018 overall category scores and award up to 10 additional points if the overall category score improves from one year to the next. Improvement will not be scored on an individual measure basis.

Cost: 10% of Total Score Year 2 (2018)

Despite ASCRS and medical community recommendations that Cost continue to be weighted at 0% of the final score, due to the flawed attribution methodology and lack of risk adjustment, **CMS increased the 2018 weight to 10%**. While CMS originally proposed to keep the weight at 0%, it increased the weight in an effort to move toward 2019 performance gradually when the MACRA statute requires Cost to account for 30% of the MIPS final score. CMS will maintain the use of two of the cost measures from 2017—Total Per Capita Costs for all attributed beneficiaries and Medicare Spending per Beneficiary—but will not maintain previously finalized episode-based measures, including for cataract surgery. New episode-based measures have been pilot-tested—but will not be available for use in 2018. ASCRS has been providing input. If a physician or group does not have any attributed Cost measures in 2018, the 10% weight of the category will be reassigned to the Quality category.

Advancing Care Information (ACI): 25% of Total Score Year 2 (2018)

In 2018, CMS will maintain the 2017 ACI category structure, which comprises a score for participating and reporting required measures (base score) and a score for reporting selected measures at various levels above the base score (performance score). **The base score makes up 50 points, and the performance score makes up 90 points. If clinicians earn 100 points or more, they will earn full credit for the ACI category.** CMS proposes to allow physicians to continue use of 2014-certified technology in 2018, but will award 10 bonus points to participants who only use 2015-certified technology. CMS also included a policy retroactive to the 2017 performance period to allow physicians who had 100 or fewer qualifying encounters for either the health information exchange or e-prescribe measures to take an exclusion.

Improvement Activities: 15% of Total Score in Year 2 (2018)

CMS will continue to allow physicians to select activities from a list of more than 90 options, such as care coordination, beneficiary engagement, and patient safety; and added several more activities in 2018. CMS will score medium-weighted activities at 10 points and high-weighted activities at 20 points. Providers must reach a total of 40 points to receive full credit for this category, either by completing two high-weighted, four medium-weighted, or a combination of medium- and high-weighted activities. The weights for each level are doubled for providers practicing in groups of 15 or fewer eligible clinicians (40 points for high-weighted activities and 20 points for medium-weighted activities). Therefore, small practices only have to perform one high-weighted activity or two medium-weighted activities for full credit in the category. Improvement Activities must be performed for at least 90 days during the reporting period.

Incentives and Penalties

MIPS participants will receive a positive, negative, or neutral payment adjustment based on their final score. The **negative adjustment** will be capped at 5% in 2020, 7% in 2021, and 9% in 2022.

For 2020, based on 2018 performance, only physicians who score below the 15-point performance threshold will be subject to a penalty. Physicians scoring in the lowest quartile between 0 and 3.75 points will receive the full 5% penalty. Depending on overall performance in 2018 by all participants, physicians scoring more than 3.75 points but below the 15-point threshold will receive a penalty less than the full 5%.

Under the MACRA statute, physicians with final scores above the threshold will receive **positive payment adjustments**. The higher performance scores will receive proportionally larger incentive payments up to three times the annual cap for negative payment adjustments each year. Positive incentives are increased or decreased by a scaling factor to achieve budget neutrality with the aggregate application of negative adjustments.

Due to budget neutrality requirements, available positive payment adjustments may continue to be limited in the second year; however, funds for exceptional performance remain unaffected.

Advanced Alternative Payment Models (APMs)

CMS continues to encourage participation in Advanced Alternative Payment Models (APMs). Eligible clinicians who participate in APM entities that receive a significant share of their revenues—or treat a certain percentage of patients through an APM that involves more than nominal risk of financial loss, includes a quality measure component, and has the majority of participants using CEHRT—will receive a **5% bonus for each year from 2019 to 2024**. Advanced APMs include Accountable Care Organizations with two-sided risk, as well as medical homes.

For 2020, based on performance year 2018, Advanced APM entities must continue to derive at least 25% of collective eligible payment amounts or 20% of collective eligible patients from an APM for participants to receive the bonus payment. **Clinicians participating in APMs that achieve those thresholds will be excluded from MIPS requirements. These percentages of payment amounts or patients required to qualify for the APM bonus will increase in future years.**

There continue to be no ophthalmology specific advanced APMs. In addition, current available models are, for the most part, focused on primary care, such as ACOs or certified medical homes. Some ophthalmologists currently participate in Medicare Shared Savings Program Track 1 ACOs, but since those models do not include two-sided risk, they are not considered advanced APMs and will not be eligible for bonus payments. **However, CMS is adding the Track 1 Plus model, which would incorporate a lower level of two-sided risk to the list of Advanced APMs for 2018 performance.**

MIPS APMs

For 2018, CMS will continue to give physicians the opportunity to earn points in MIPS by participating in certain APMs and Advanced APMs that CMS determines to be “MIPS APMs.” Each year, CMS will release a list of MIPS APMs prior to the performance period. **CMS has not released the final list of MIPS APMs, but it is likely the list will include 2017 models, such as all tracks of the Medicare Shared Savings ACO program, and Next Generation ACOs.**

To earn MIPS points from a MIPS APM, a provider must:

- **Be included in the participant list of a non-Advanced APM that CMS has determined to be a MIPS APM, or**
- **Be included in the participant list of an Advanced APM entity that did not meet the thresholds to be eligible for the bonus payment and, therefore, elect to participate in MIPS.**

For models that CMS determines to be “MIPS APMs,” in 2018, participants will:

- **Report the required quality measures for the APM through the APM entity (if an APM entity does not report data on behalf of individuals or groups participating in the APM, those physicians will be required to report quality data on their own);**
- **Report data for the Advancing Care Information category on their own; and**
- **Automatically earn at least 50% of the total available points for the Improvement Activities category score. The MACRA statute requires CMS to award at least 50% of the category points if the physician participates in an APM. For 2017 performance, CMS determined that all MIPS APM participants would earn 100% in the Improvement Activities category and may make the same determination in 2018 when it releases the final list of 2018 MIPS APMs later in 2017.**

CMS will maintain the MIPS APM scoring standard in 2018. Similar to determining the thresholds for participation in Advanced APMs, **CMS will award the same final MIPS score to all the participants in a MIPS APM entity—including for data they reported individually or as a group under a single TIN.** Under the terms of the models considered MIPS APMs, participants in the APM entities are already assessed collectively for meeting certain quality and cost metrics; therefore, **CMS will score the Advancing Care Information and Improvement Activities collectively, as well.** CMS will use an average score of all the participants’ scores for Advancing Care Information to determine a group score. All participants in the MIPS APM will receive the same total available score for Improvement Activities. **In accordance with the statutory requirement to measure improvement in the MIPS categories, CMS will incorporate improvement scores into the Quality and Cost calculations.** The MIPS APM entity’s final MIPS score will be applied to the participants in the entity at the TIN/NPI level.

Other Payer Combination APMs

Other Payer Combination APMs include payment arrangements under any payer other than traditional Medicare, including Medicare Advantage and other Medicare-funded plans. **Beginning in 2021** (performance year 2019), these other payers will count toward APM thresholds. To meet the APM thresholds through participation in an Other Payer APM, physicians must also participate in a Medicare Advanced APM. **The 5% bonus for significantly participating in an Advanced APM will be based on traditional Medicare and will not include Medicare Advantage payments.**

2017 and 2018 Hardship Exemptions

Noting the extreme weather conditions experienced in CY 2017, which likely disrupted physician practices significantly, CMS included an interim final rule along with the 2018 QPP final rule that creates an automatic MIPS hardship exemption, without having to submit an application, for physicians in disaster areas. **Physicians in affected areas may still submit MIPS data and be scored, but will not be penalized if they do not submit data in 2017. In addition, the final rule extends the ability to apply for a disaster-related exemption for ACI into 2018.**

Additional Resources

For additional information, ASCRS•ASOA members may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or call the MACRA hotline 703-383-5724.

MIPS Program: 2018 Quality Performance Category

The 2018 Quality Payment Program (QPP) – Year Two final rule continues to implement the programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). For 2018 performance, to impact 2020 payment, CMS agreed with ASCRS and medical community recommendations to continue the transition period for MIPS and provide a pathway for practices implementing the program to meet the MIPS final score threshold and avoid the 5% in 2020 by submitting minimal data.

CMS set the 2018 MIPS final score threshold at 15 points, up from 3 points in 2017. **To avoid the 5% penalty, physicians must earn at least 15 MIPS points.**

The threshold can be met in a variety of ways, such as:

- Full participation in the Improvement Activities category, such as submitting one high-weighted activity or two medium-weighted activities for small practices, or two high-weighted activities, four medium-weighted activities, or a combination of both medium- and high-weighted activities;
- The Advancing Care Information (ACI) category base score and one quality measure meeting the measure threshold, or data completeness, but not benchmarks;
- ACI base score and one medium-weighted improvement activity; or
- Six quality measures meeting data completeness, but not measure benchmarks.

This guide is developed for ASCRS•ASOA members to familiarize themselves with the full requirements of the Quality category, and to assist them in choosing the best participation option for their practice. ASCRS also has developed guides on the other three categories of MIPS. In addition, ASCRS•ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

Quality Category Weight – 50%

For 2018, CMS will weight a provider's Quality performance score at 50% of the overall MIPS final score. In performance year 2019, the third year of MIPS, CMS will lower the weight to 30%. In 2019 and beyond, the Cost category will be 30%, Advancing Care Information 25%, and Improvement Activities 15% of the final MIPS score.

In some cases, CMS may determine that a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference.

Quality Category Performance Period

In 2018, physicians and groups must submit quality measure data for the full calendar year to be considered full participants in the MIPS program.

Quality Reporting Requirements

To achieve full credit for the Quality performance category, physicians must achieve a total of 60 or 70 points, depending on practice size. Practices of 15 or fewer providers must report six measures, each with 10 total possible points, while practices of 16 or more providers will also be scored on a claims-based hospital re-admission measure in addition to the 6 reported measures, each worth 10 possible points. Physicians must report on 60% of all patients, if reporting via registry or EHR, and 60% of all Medicare Part B patients if reporting via claims.

Physicians must report a minimum of 6 measures, with at least one being an outcome measure, if available. If no outcome measure applies to the clinician, he or she would report one "high priority measure." High priority measures are certain CMS designated measures that include all outcome measures.

Each measure reported must have a minimum of 20 cases to be included in the Quality category score.

In addition, CMS intends to publish a list of non-MIPS measures, owned by Qualified Clinical Data Registries (QCDRs), such as the IRIS Registry, that can be reported through such QCDRs for credit under MIPS. The non-MIPS measure list is expected to be released in early 2018.

New for 2018, CMS is implementing the requirement in the MACRA statute that a physician's improvement must be factored into the Quality category score. Physicians have the opportunity to earn up to 10 additional points, not to exceed the 60 or 70 total available points in the category, from year-to-year improvement in the Quality category.

Second Performance Year Scoring Consideration

CMS is continuing its transition policies in 2018, the second year of MIPS. CMS will maintain a measure score "floor" of three points for small practices of 15 or fewer eligible clinicians. For larger practices of 16 or more eligible clinicians, CMS has set a one-point measure floor. If providers report a particular measure, but do not meet the benchmarks or submission thresholds, they will automatically receive a score of three points for that measure if they are in a small practice, and one point if they are in a larger practice.

Quality Achievement Score

Under MIPS, providers must demonstrate achievement on a quality measure, relative to a benchmark performance. For the 2018 performance year, CMS will set a baseline performance benchmark for each measure based on historical performance data. A physician's benchmark score on each measure is known as the "achievement" score. The achievement score will be added to any improvement or bonus points to determine the category score.

For 2018, each measure has specific benchmarks depending on submission method (i.e., claims, EHR, registry) that are scored on a decile, or 10-point, scale. For each submission method, CMS has assigned different levels of performance to each decile. Each decile is a range of performance levels for the measure that correspond to points earned for the measure. For example, if a physician submits data showing 83% performance on a measure, and the 5th decile begins at 72% performance and the 6th decile begins at 85% performance, then he or she will receive between 5 and 5.9 points because 83% is in the 5th decile.

The total possible achievement score in the Quality category depends on the size of the practice:

- Providers in groups of 15 or fewer eligible clinicians are subject to 6 measures and are eligible to receive up to **60 points** in the Quality performance category.
- Providers in groups of 16 or more are subject to 7 measures (6 to be reported, and the hospital readmission measure if 200 patients are attributed) and are eligible to receive up to **70 points** in the Quality performance category. If 200 patients are not attributed, the hospital re-admission measure will not be calculated, and providers will only be scored on the reported 6 measures, for a total possible score of 60 points.

Quality Improvement Score

For 2018 performance, CMS will also calculate a physician's or groups' quality improvement score. Because physicians have the option of choosing which quality measures to report, and may not report the same measures from year to year, CMS is evaluating improvement on a category basis.

CMS will compare a physician's total 2017 achievement score, which is determined based on the physician's performance relative to the benchmarks and excludes any bonus points, and compare it to the 2018 achievement score. CMS will award between 1 and 10 percentage points, up to the total 60 or 70 available for the category, depending on how much a physician's or group's achievement score improved above the prior year.

The improvement score is derived by:

- The increase in quality achievement percent score from prior performance period to current performance period
- Divided by prior performance period quality achievement percent score
- Multiplied by 10%

Improvement scores cannot be less than zero points, and thus a physician who earns a lower achievement score in the current performance period than the prior one will not be penalized.

Due to the 2017 flexibility policies under “Pick Your Pace,” physicians would avoid the 2019 MIPS penalty by submitting as little as one quality measure on one patient. To prevent physicians who did not participate fully in 2017 from achieving high improvement scores, **CMS will only calculate improvement scores for physicians and groups who participated fully in 2017 and earned at least 30% of available points in the Quality category.**

Bonus Points

To incentivize providers to report on additional “high priority” measures, CMS will award bonus points to providers who report these measures. Specifically, CMS will award:

- Two bonus points for each additional outcome measure reported beyond the required one OR
- One bonus point for each additional high priority measure.

Bonus points for reporting additional high priority and outcome measures are capped at 10% of the total available points in the Quality performance category for providers. For example, if a provider is in a small practice and can score up to 60 points, the total bonus points that can be awarded is 6. **Bonus points will be awarded to applicable measures, even if the provider fails to meet the case minimum or data submission thresholds.** For example, if a physician reports an additional outcome measure, but fails to reach the 20-patient case minimum, he or she would receive the initial minimum “floor” score of 3 achievement points for the measure, then be awarded 2 more bonus points, resulting in a total score of 5 for the individual measure.

Quality measures reported through “end-to-end” electronic submissions will earn the provider bonus points. Providers may earn up to 10% of the total available points in the Quality performance category if they submit measures through EHR or a qualified clinical data registry that meet the definition of “end-to-end” electronic reporting. To be considered “end-to-end” electronic reporting, an automated process must be used to aggregate the measure data, calculate measure, perform any filtering of measurement data, and submit the data electronically to CMS. Systems that require manual abstraction and re-entry of data are not considered end-to-end and, therefore, not eligible for a bonus.

Each measure submitted electronically through EHR or qualified data registry will receive one bonus point. For example, if a provider is scored on 60 possible points in the Quality performance category, he or she can earn up to 6 bonus points for electronic submission toward the Quality category score. Electronic bonus points are awarded in addition to bonus points for additional high priority and outcome measures.

Quality Performance Score

A provider's Quality performance category score will be the sum of the achievement, improvement, and bonus points divided by the total available points, depending on practice size. The Quality category score will then be weighted to count for 50% of the total MIPS score.

2018 Sample Quality Performance Score Calculation for a Physician Practicing in a Group of 15 or Fewer				
Measure	Achievement Score	Bonus Points (high priority/outcome measures)	Bonus Points (electronic reporting)	Total
Measure A	3		1	4
Measure B	6		1	7
Measure C (first outcome)	5		1	6
Measure D (additional outcome)	6	2	1	9
Measure E (high priority)	8	1	1	10
Measure F	7		1	8
2018 Achievement Score (2017 Achievement Score of 30)	35			
Total Quality Achievement and Bonus Points (of a possible 60)				44 (or 73%)
Improvement Score				1.6%
Quality Score				74.6% (will be weighted 50% of MIPS score; equals 37.3 final MIPS points)

Global and Population Measures

Through administrative claims, CMS will assess physicians in practices of 16 or more eligible clinicians on an all-cause hospital re-admission measure, previously used to calculate the Value-Based Payment Modifier (VBPM).

CMS will attribute patients to this measure through the same flawed VBPM two-step attribution process, based on which provider bills the plurality of E/M codes during the performance period. ASCRS continues to oppose this attribution methodology and will continue to advocate in our comments on the final rule and in the future that CMS develop more appropriate attribution methodologies that do not hold physicians accountable for the cost of care they did not provide.

Physicians do not need to report on these measures; CMS will score them based on administrative claims.

Data Submission

Physicians and groups may report their quality performance data through claims, registry, EHR, or Web Interface (formerly known as GPRO—and only available for groups of 25 or more).

Physicians or groups do not need to use the same submission mechanism for every category.

Additional Resources

For additional information, contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

2018 MIPS Quality Category Measures and Benchmarks for Ophthalmology

Physicians must report on 60% of all patients, if reporting via registry or EHR, and 60% of all Medicare Part B patients if reporting via claims.

Physicians must report a minimum of 6 measures, with at least one being an outcome measure, if available. If no outcome measure applies to the clinician, he or she would report one “high priority measure.” “High priority” measures are certain CMS-designated measures that include all outcome measures.

Quality measures are scored based on specific benchmarks for each measure, depending on submission mechanism.

This document lists the available ophthalmology measures in the first table, and their benchmarks in the following table.

Ophthalmology Quality Measures

NQF/PQRS Number	Submission Mechanism	Measure Type	Measure Domain	Measure Title
0086/012	Claims, Registry, EHR	Process	Effective Clinical Care	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
0087/014	Claims, Registry	Process	Effective Clinical Care	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
0088/018	EHR	Process	Effective Clinical Care	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
0089/019	Claims, Registry, EHR	Process	Communication and Care Coordination (high priority)	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
0055/117	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	Diabetes: Eye Exam
0419/130	Claims, Registry, EHR	Process	Patient Safety (high priority)	Documentation of Current Medications in the Medical Record
0566/140	Claims, Registry	Process	Effective Clinical Care	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
0563/141	Claims, Registry	Outcome	Communication and Care Coordination (high priority)	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% or Documentation of a Plan of Care
0565/191	Registry, EHR	Outcome	Effective Clinical Care (high priority)	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
0564/192	Registry, EHR	Outcome	Patient Safety (high priority)	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
0028/226	Claims, Registry, EHR, Web Interface	Process	Communication and Care Coordination (high priority)	Preventative Care and Screening: Tobacco Use: Screening and Cessation Information

NQF/PQRS Number	Submission Mechanism	Measure Type	Measure Domain	Measure Title
1536/303	Registry (not available in the IRIS registry for 2018)	Outcome	Person Caregiver-Centered Experience and Outcomes (high priority)	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
N/A/317	Claims, Registry, EHR	Process	Community/Population Health (high priority)	Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
N/A/374	Registry, EHR	Process	Communication and Care Coordination (high priority)	Closing the Referral Loop: Receipt of Specialist Report
N/A/384	Registry	Outcome	Effective Clinical Care	Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery
N/A/385	Registry	Outcome	Effective Clinical Care	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery
N/A/388	Registry	Outcome	Patient Safety (high priority)	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy)
N/A/389	Registry	Outcome	Effective Clinical Care	Cataract Surgery: Difference Between Planned and Final Refraction
N/A/402	Registry	Process	Community/Population Health (high priority)	Tobacco Use and Help with Quitting Among Adolescents

Other Available Measures

CMS continues not to require that one of the quality measures be a cross-cutting measure. However, measures that are deemed cross-cutting are still available for physicians to report.

NQF/PQRS Number	Submission Method	Measure Type	Measure Domain	Measure Title
0018/236	Claims, Web Interface, Registry, EHR	Intermediate Outcome* (high priority)	Effective Clinical Care	Controlling: High Blood Pressure

*Intermediate outcome measures are considered outcome measures.

Ophthalmology Quality Measure Benchmarks

Each decile includes a range of performance rates. Deciles without benchmarks (denoted by a --) indicate that there are no scores available in that decile.

Measure Name	PQRS Number	Reporting Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	Claims	98.99 - 99.99	--	--	--	--	--	--	100
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	EHR	82.75 - 87.40	87.41 - 90.76	90.77 - 93.62	93.63 - 96.16	96.17 - 97.87	97.88 - 98.96	98.97 - 99.99	100
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	Registry	94.70 - 98.14	98.15 - 99.16	99.17 - 99.99	--	--	--	--	100
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Claims	99.60 - 99.99	--	--	--	--	--	--	100
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Registry	64.21 - 81.81	81.82 - 90.85	90.86 - 95.69	95.70 - 98.64	98.65 - 99.99	--	--	100
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	18	EHR	57.14 - 65.83	65.84 - 72.72	72.73 - 78.21	78.22 - 83.12	83.13 - 88.17	88.18 - 92.30	92.31 - 96.32	>= 96.33
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	Claims	--	--	--	--	--	--	--	100
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	EHR	46.15 - 56.85	56.86 - 65.13	65.14 - 72.38	72.39 - 78.21	78.22 - 84.27	84.28 - 89.93	89.94 - 95.41	>= 95.42
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	Registry	52.00 - 72.40	72.41 - 81.47	81.48 - 90.76	90.77 - 96.54	96.55 - 99.99	--	--	100
Diabetes: Eye Exam	117	Claims	88.98 - 98.44	98.45 - 99.99	--	--	--	--	--	100
Diabetes: Eye Exam	117	EHR	84.83 - 92.85	92.86 - 95.32	95.33 - 96.96	96.97 - 98.19	98.20 - 99.17	99.18 - 99.82	99.83 - 99.99	100
Diabetes: Eye Exam	117	Registry	80.91 - 92.85	92.86 - 96.53	96.54 - 98.70	98.71 - 99.99	--	--	--	100
Documentation of Current Medications in the Medical Record	130	Claims	97.20 - 99.23	99.24 - 99.79	99.80 - 99.99	--	--	--	--	100
Documentation of Current Medications in the Medical Record	130	EHR	86.25 - 91.91	91.92 - 94.85	94.86 - 96.69	96.70 - 97.98	97.99 - 98.87	98.88 - 99.54	99.55 - 99.95	>= 99.96

Measure Name	PQRS Number	Reporting Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Documentation of Current Medications in the Medical Record	130	Registry	77.08 - 90.22	90.23 - 95.97	95.98 - 98.60	98.61 - 99.69	99.70 - 99.99	--	--	100
Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	140	Claims	97.33 - 99.99	--	--	--	--	--	--	100
Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	140	Registry	35.90 - 57.88	57.89 - 71.75	71.76 - 86.38	86.39 - 94.22	94.23 - 98.31	98.32 - 99.99	--	100
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Claims	--	--	--	--	--	--	--	100
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Registry	69.40 - 86.96	86.97 - 95.04	95.05 - 97.95	97.96 - 99.64	99.65 - 99.99	--	--	100
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	EHR	83.33 - 88.82	88.83 - 91.81	91.82 - 94.11	94.12 - 95.69	95.70 - 96.88	96.89 - 97.98	97.99 - 99.31	>= 99.32
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	Registry	75.68 - 84.91	84.92 - 91.10	91.11 - 94.35	94.36 - 96.46	96.47 - 97.79	97.80 - 99.99	--	100
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	192	EHR	0.33 - 0.01	--	--	--	--	--	--	0
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	192	Registry	0.50 - 0.18	0.17 - 0.01	--	--	--	--	--	0
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Claims	96.65 - 98.59	98.60 - 99.61	99.62 - 99.99	--	--	--	--	100

Measure Name	PQRS Number	Reporting Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery	385	Registry	--	--	--	--	--	--	--	--
Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy)	388	Registry	--	--	--	--	--	--	--	0
Cataract Surgery: Difference Between Planned and Final Refraction	389	Registry	13.89 - 38.23	38.24 - 58.48	58.49 - 74.99	75.00 - 82.97	82.98 - 91.90	91.91 - 96.24	96.25 - 99.99	100
Tobacco Use and Help with Quitting Among Adolescents	402	Registry	71.85 - 75.75	75.76 - 85.70	85.71 - 89.99	90.00 - 92.58	92.59 - 95.37	95.38 - 97.55	97.56 - 99.99	100

MIPS Program: 2018 Advancing Care Information Category

The 2018 Quality Payment Program (QPP) – Year Two final rule continues to implement the programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). For 2018 performance, to impact 2020 payment, CMS agreed with ASCRS and medical community recommendations to continue the transition period for MIPS and provide a pathway for practices implementing the program to meet the MIPS final score threshold and avoid the 5% penalty in 2020 by submitting minimal data.

CMS set the 2018 MIPS final score threshold at 15 points, up from 3 points in 2017. **To avoid the 5% penalty, physicians must earn at least 15 MIPS points.**

This threshold can be met in a variety of ways, such as:

- Full participation in the Improvement Activities category, such as submitting one high-weighted activity or two medium-weighted activities for small practices, or two high-weighted activities, four medium-weighted activities, or a combination of high- and medium-weighted activities;
- The Advancing Care Information (ACI) category base score and one quality measure meeting the measure threshold, or data completeness, but not benchmarks;
- ACI base score and one medium-weighted improvement activity; or
- Six quality measures meeting data completeness, but not measure benchmarks.

This guide is developed for ASCRS•ASOA members to familiarize themselves with the full requirements of the Advancing Care Information category (previously known as Meaningful Use), and to assist them in choosing the best participation option for their practice. ASCRS also has developed guides on the other three categories of MIPS. In addition, ASCRS•ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

Small Practice Hardship Exemption

For 2018, CMS is offering a small practice hardship exemption for the ACI category. **Practices of 15 or fewer eligible clinicians must submit a hardship application by December 31, 2018, to have the 25% weight of the ACI category re-weighted to the Quality category.**

Advancing Care Information (ACI) Category Weight

For 2018, the ACI category score will continue to be weighted at 25% of the overall MIPS final score. If CMS determines that at least 75% of MIPS-eligible clinicians are “meaningful users” of EHR in future years, the scoring weight for ACI could be lowered to no less than 15% of the overall score.

In some cases, CMS may determine a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider’s quality performance score to make up the difference. If a physician or small practice receives the small practice hardship exemption, the 25% weight of the category will be redistributed to Quality.

Advancing Care Information (ACI) Category Performance Period

For 2018, physicians must report ACI for at least any 90-day period to be considered full participants. Physicians have the option to report more than 90 days, up to a full year.

Use of 2014 or 2015 CEHRT

In 2018, CMS will permit physicians and groups to continue using 2014-certified EHR technology. Participants electing to use 2014 technology must report the “transition” measure set finalized for 2017 performance because 2014 technology will not have all of the functions to complete the measures for 2015 technology.

Participants who report using solely 2015 CEHRT will be eligible for a 10-point bonus. CMS plans to require the use of 2015 technology for the 2019 performance period.

Advancing Care Information Category Score Structure

CMS will structure a provider's ACI category score on a base score and at levels above the base score for a performance score. Providers must meet all of the objectives and measures to achieve the base score. Participants may choose which objectives and measures they want to meet for the performance score. Some measures are included in both the base and performance scores. For those measures, providers only need a 1 in the numerator for the base score but will earn additional points toward the performance score for higher values in the numerator.

There are also several opportunities to earn additional bonus points for reporting on certain optional measures.

When all the possible points for the base and performance scores and potential bonuses are added, there are a total of 165 possible points available in the ACI category. To receive full credit for this category, however, a provider only needs to score 100 points. Any additional points earned above 100 will not increase a provider's total MIPS composite score.

Advancing Care Information Base Score

CMS will award 50 points to providers who achieve all 5 of the measures (listed below) under the base score.

To receive the full base score, providers do not need to meet a specific threshold but must report either a "yes" for measures requiring a yes/no answer or a numerator of at least 1 for numerator/denominator measures.

Failure to meet all of the requirements for the base score will earn a provider an ACI category score of zero, and preclude him or her from achieving any additional points through the performance score.

Advancing Care Information Performance Score

Physicians can earn up to 90 points toward the performance score for achievement on certain measures (listed below). Providers may choose which performance score measures to report. Each measure reported will be calculated individually by dividing the numerator by the denominator. A performance rate of 1% to 10% will be scored 1 point, a performance rate of 11% to 20% will earn 2 points, and so on.

Example: If a provider reports that 85 out of 100 possible patients were included in the Patient-Specific Education Measure, then the performance rate would be 85% and earn the provider 9 points toward the performance score.

The total performance score is the sum of the individual provider's score on each of reported measures.

Bonus Points

For 2018, CMS modified the bonus structure for the ACI category. Physicians can earn five bonus points for reporting to additional public health registries beyond the one identified for the performance score.

Physicians and groups can earn 10 bonus points each for reporting improvement activities using CEHRT and/or reporting using only 2015-certified EHR technology.

Advancing Care Information Objectives and Measures

All providers with 2015 technology must report five measures to achieve the base score. Certain objectives and measures are available to be reported on for the performance score. Objectives and measures included in the base and performance score are noted below.

2018 Base Score Objectives and Measures (2015 CEHRT)

Objective	Measure	Reporting Requirement	Exclusion
Protect Patient Health Information	Security Risk Analysis – Conduct or review a security risk analysis, including addressing the security (including encryption) of electronic personal health information created or maintained by CEHRT; implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process.	Yes/No; must answer “yes”	
Electronic Prescribing	Electronic Prescribing – At least one permissible prescription written by the provider is queried for a drug formulary and transmitted electronically using CEHRT.	Numerator/Denominator; must have at least 1 in the numerator	Any MIPS-eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.
Patient Electronic Access	Patient Access Measure – For at least one unique patient seen by the provider, (1) the patient (or patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information, and (2) the provider ensures the patient’s health information is available for the patient (or patient-authorized representative) to access using any application of his or her choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider’s CEHRT.	Numerator/Denominator; must have at least 1 in the numerator	
Health Information Exchange	Send a Summary of Care Measure – For at least one transition of care or referral, the provider who transitions or refers his or her patient to another setting of care or health care provider (1) creates a summary of care record using CEHRT, and (2) electronically exchanges the summary of care record.	Numerator/Denominator; must have at least 1 in the numerator	Any MIPS-eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.
	Request/Accept Patient Care Record Measure – For at least one transition of care or referral received or patient encounter in which the provider has never before encountered the patient, the provider received, or retrieves and incorporates into the patient’s record, an electronic summary of care document.	Numerator/Denominator; must have at least 1 in the numerator	Any MIPS-eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS-eligible clinician has never before encountered the patient fewer than 100 times during the performance period

Performance Score Objectives and Measures

Objective	Measure	Performance Score
Patient Electronic Access	Patient Access Measure – For at least one unique patient seen by the provider, (1) the patient (or patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information, and (2) the provider ensures the patient’s health information is available for the patient (or patient-authorized representative) to access using any application of his or her choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider’s CEHRT.	Up to 10 points
	Patient-Specific Education Measure – The provider must use clinically relevant information from the CEHRT to identify patient-specific educational resources, and provide electronic access to those materials, to at least one unique patient seen by the provider.	Up to 10 points
Coordination of Care through Patient Engagement	View, Download, Transmit Measure – At least one unique patient (or patient-authorized representative) seen by the provider during the performance period actively engages with the EHR made accessible by the provider. A provider may meet the measure by having a patient either (1) view, download, or transmit to a third party his or her health information; or (2) access his or her health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider’s CEHRT; or (3) a combination of (1) and (2).	Up to 10 points
	Secure Messaging Measure – For at least one unique patient seen by the provider during the performance period, a secure message was sent using the electronic messaging function of the CEHRT to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).	Up to 10 points
	Patient-Generated Health Data Measure – Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for at least one unique patient seen by the provider during the performance period	Up to 10 points
Health Information Exchange	Send a Summary of Care Measure – For at least one transition of care or referral, the provider who transitions or refers his or her patient to another setting of care or health care provider (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.	Up to 10 points
	Request/Accept Patient Care Record Measure – For at least one transition of care or referral received or patient encounter in which the provider has never before encountered the patient, the provider received, or retrieves and incorporates into the patient’s record, an electronic summary of care document.	Up to 10 points
	Clinical Information Reconciliation Measure – For at least one transition of care or referral received or patient encounter in which the provider has never before encountered the patient, the provider performs clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication—Review of the patient’s medication, including the name, dosage, frequency, and route of each medication; (2) Medication Allergy—Review of the patient’s known medication allergies; and (3) Current Problem List—Review of the patient’s current and active diagnoses.	Up to 10 points
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting – The provider is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).	0 or 10 points
	Syndromic Surveillance Reporting Measure – The provider is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined.	0 or 10 points
	Electronic Case Reporting Measure – The provider is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.	0 or 10 points

Performance Score Objectives and Measures

Objective	Measure	Performance Score
	Public Health Registry Measure – The provider is in active engagement with a public health agency to submit data to public health registries.	0 or 10 points
	Clinical Data Registry Measure – The provider is in active engagement to submit data to a clinical data registry.	0 or 10 points
Bonus (up to 25%)		
	Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure (yes/no statement)	5 point bonus
	Report improvement activities using CEHRT (yes/no statement)	10 point bonus
	Report using only 2015 CEHRT (based on measures submitted)	10 point bonus

Alternative Requirements for 2018 Based on CEHRT Certification Year

Providers who do not have 2015-certified EHR technology will not be able to report several of the measures finalized as part of the ACI category. Since providers are not required to have 2015 technology until 2019, CMS has finalized a modified list of objectives and measures for participants using 2014 technology.

2018 Advancing Care Information Transition Objectives and Measures (for participants with 2014 CEHRT)

2018 ACI Transition Objectives	2018 Transition ACI Measures	Required/Not Required for the Base Score	Performance Score	Reporting Requirement	Exclusion
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No statement	
Electronic Prescribing	E-Prescribing	Required	0	Numerator/Denominator	Fewer than 100 permissible prescriptions during the performance period.
Patient Electronic Access	Provide Patient Access	Required	Up to 20 points	Numerator/Denominator	
	View, Download, or Transmit	Not required	Up to 10 points	Numerator/Denominator	
Patient-Specific Education	Patient-Specific Education	Not required	Up to 10 points	Numerator/Denominator	
Secure Messaging	Secure Messaging	Not required	Up to 10 points	Numerator/Denominator	
Health Information Exchange	Health Information Exchange	Required	Up to 20 points	Numerator/Denominator	Fewer than 100 transitions of care during the performance period.
Medication	Medication	Not required	Up to 10 points	Numerator/Denominator	

Reconciliation	Reconciliation				
Public Health Reporting	Immunization Registry Reporting	Not required	0 or 10 points	Yes/no statement	
	Syndromic Surveillance Reporting	Not required	0 or 10 points	Yes/no statement	
	Specialized Registry Reporting	Not required	0 or 10 points	Yes/no statement	
Bonus up to 15%					
	Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure		5 point bonus	Yes/no statement	
	Report improvement activities using CEHRT		10 point bonus	Yes/no statement	

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

MIPS Program: 2018 Improvement Activities Category

The 2018 Quality Payment Program (QPP) – Year Two final rule continues to implement the programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). For 2018 performance, to impact 2020 payment, CMS agreed with ASCRS and medical community recommendations to continue the transition period for MIPS and provide a pathway for practices implementing the program to meet the MIPS final score threshold and avoid the 5% penalty in 2020 by submitting minimal data.

CMS set the 2018 MIPS final score threshold at 15 points, up from 3 points in 2017. **To avoid the 5% penalty, physicians must earn at least 15 MIPS points.**

The threshold can be met in a variety of ways, such as:

- Full participation in the Improvement Activities category, such as submitting one high-weighted activity or two medium-weighted activities for small practices, or two high-weighted activities, four medium-weighted activities, or a combination of high- and medium-weighted activities;
- The Advancing Care Information (ACI) category base score and one quality measure meeting the measure threshold, or data completeness, but not benchmarks;
- ACI base score and one medium-weighted improvement activity; or
- Six quality measures meeting data completeness, but not measure benchmarks.

This guide is developed for ASCRS•ASOA members to familiarize themselves with the full requirements of the Improvement Activities category, and to assist them in choosing the best participation option for their practice. ASCRS also has developed guides on the other three categories of MIPS. In addition, ASCRS•ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

Improvement Activities Category Weight – 15%

For 2018, the second performance year of MIPS, CMS will weight a provider's Improvement Activities score at 15% of the overall MIPS final score.

Improvement Activities Reporting Requirements

Physicians must achieve a total of 40 points from improvement activities during a 90-day reporting period. CMS will score individual improvement activities as either high- or medium-weighted. High-weighted activities are worth 20 points, while medium-weighted activities are worth 10 points. Providers are required to perform four medium-weighted or two high-weighted activities, or any combination of high- or medium-weighted activities for 2018.

Physicians in groups of 15 or fewer are only required to complete one high-weighted or two medium-weighted activities for full credit—40 points—for the category. For small practices, CMS will weigh the improvement activities at double the value for larger practices. Therefore, high-weighted activities are worth 40 points, while medium-weighted activities are worth 20 points. **Providers in groups of 15 or fewer can achieve half of the total category score by completing one medium-weighted improvement activity.**

Providers participating in a patient-centered certified medical home will automatically receive full credit for the Improvement Activities category of MIPS. In 2018, physicians and groups participating in an Advanced APM or MIPS APM will automatically receive the full score for the Improvement Activities category.

Improvement Activities Score

To determine a provider's Improvement Activities category score, CMS will divide the sum of the points earned by the provider by 40, the total available points for the category. The Improvement Activities category score would then be counted as 15% of

the MIPS final score.

Improvement Activities

The final rule includes a list of individual improvement activities. The activities are grouped in eight sub-categories corresponding to CMS' stated goals. Providers may choose any combination of improvement activities, regardless of category.

The categories and examples of activities included are listed below:

- **Expanded Practice Access:** Improvement activities include expanded practice hours, telehealth services, and participation in models designed to improve access to services.
- **Population Management:** Improvement activities include participation in chronic care management programs, participation in rural and Indian Health Services programs, participation in community programs with other stakeholders to address population health, and use of a Qualified Clinical Data Registry (QCDR) to track population outcomes.
- **Care Coordination:** Improvement activities include use of a QCDR to share information, timely communication and follow up, participation in various CMS models designed to improve care coordination, implementation of care coordination training, implementation of plans to handle transitions of care, and active referral management.
- **Beneficiary Engagement:** Improvement activities include use of EHR to document patient-reported outcomes, providing enhanced patient portals, participation in a QCDR that promotes the use of patient engagement tools, and use of QCDR patient experience data to inform efforts to improve beneficiary engagement.
- **Patient Safety and Practice Assessment:** Improvement activities include use of QCDR data for ongoing practice assessments and patient safety improvements, as well as use of tools, such as the Surgical Risk Calculator.
- **Achieving Health Equity:** Improvement activities include seeing new and follow-up Medicaid patients in a timely manner, and use of QCDR for demonstrating performance of processes for screening for social determinants.
- **Emergency Response and Preparedness:** Improvement activities include participation in disaster medical teams or participation in domestic or international humanitarian volunteer work.
- **Integrated Behavioral and Mental Health:** Improvement activities include tobacco intervention and smoking cessation efforts, and integration with mental health services.

For the full list of proposed improvement activities, please refer to the CMS website: <https://qpp.cms.gov/measures/ia>.

Data Submission

Providers can submit improvement activities data using the following mechanisms: qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms.

In 2018, all submission mechanisms must designate a “yes/no” response for submitting improvement activities.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

MIPS Program: 2018 Cost Category

The 2018 Quality Payment Program (QPP) – Year Two final rule continues to implement the programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). For 2018 performance, to impact 2020 payment, CMS agreed with ASCRS and medical community recommendations to continue the transition period for MIPS and provide a pathway for practices implementing the program to meet the MIPS final score threshold and avoid the 5% penalty in 2020 by submitting minimal data.

CMS set the 2018 MIPS final score threshold at 15 points, up from 3 points in 2017. To avoid the 5% penalty, physicians must earn at least 15 MIPS points.

The threshold can be met in a variety of ways, such as:

- Full participation in the Improvement Activities category, such as submitting one high-weighted activity or two medium-weighted activities for small practices, or two high-weighted activities, four medium-weighted activities, or a combination of both high- and medium-weighted activities;
- The Advancing Care Information (ACI) category base score and one quality measure meeting the measure threshold, or data completeness, but not benchmarks;
- ACI base score and one medium-weighted improvement activity; or
- Six quality measures meeting data completeness, but not measure benchmarks.

This guide summarizes the final Cost performance category of MIPS, which is based on the previous Value-Based Payment Modifier (VBPM) program. ASCRS also has developed guides on the other three categories of MIPS. In addition, ASCRS•ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

Cost Category Weight – 10% for 2018 Performance Year

Despite ASCRS and medical community recommendations that the Cost category weight remain at 0% for 2018 to impact 2020 payment, CMS raised the category weight to 10% of a physician's or group's final MIPS score.

We continue to oppose the flawed attribution methodology CMS will use to calculate the cost measures and their lack of risk-adjustment, and believe that CMS should develop episode-based cost measures as an alternative to the current measures. CMS will not include any of the previously finalized episode-based measures or ones currently under development for the 2018 performance year. CMS has made draft feedback reports on the eight episode measures under development, including cataract surgery, available to physicians and groups. ASCRS has provided input on the development of the cataract measure and will continue to seek refinements to improve readability and actionability of the reports.

The weight for this category will increase to 30% in 2021, based on 2019 performance, and continue at 30% in future years.

In some cases, CMS may determine that a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference. If a physician or group does not have any cost measures attributed, the 10% weight in 2018 will be reassigned to the Quality category.

Cost Reporting Requirements

Physicians do not need to submit separate data for the Cost category. Similar to the Value-Based Payment Modifier (VBPM), CMS will determine cost scores through administrative claims.

Cost Measures

CMS will measure providers' resource use by using the two cost measures from the VBPM. For the 2018 performance period, CMS will calculate the two cost measures, total per capita cost, and Medicare spending per beneficiary (MSPB) and compare physicians' score relative to a benchmark set at the beginning of the performance period. Total per capita costs include all

payments under Medicare Parts A and B but exclude payments under Part D. MSPB includes costs 3 days before and 30 days after an inpatient hospitalization.

CMS will not calculate several episode-based cost measures previously finalized for 2017 performance, including cataract surgery. CMS and its contractor Acumen have been developing new episode-based cost measures with physician input. ASCRS has a physician serving on a technical expert panel advising CMS and Acumen on the development of a cataract episode measure. These measures are still in the test phase, and will not be included in 2018 performance. Physicians and groups can download test reports on their performance from the CMS Enterprise Portal.

Patient Attribution

CMS will attribute patients to the cost measures through the same flawed VBPM two-step attribution process. First, a beneficiary will be assigned to a Tax Identification Number (TIN), combined with a National Provider Identifier (NPI), if the beneficiary receives a plurality of primary care services from a primary care provider. For beneficiaries who did not receive any eligible primary care services from a primary care physician during the reporting period, the beneficiary will be assigned to the TIN/NPI combo that provided the plurality of E/M services to the beneficiary. **Due to this attribution method, ophthalmologists may be attributed costs of care they did not provide.**

CMS has set the attribution threshold at 20 beneficiaries for scoring on the total per capita and 35 beneficiaries on the Medicare Spending per Beneficiary (MSPB) measures.

Cost Category Score

Beginning in 2018, the MACRA statute requires CMS to incorporate improvement into a physician's or group's Cost score. The total Cost category score will be the sum of cost measure achievement divided by total possible points in the category, plus up to 1 percentage point of for improvement.

Cost Achievement Score

To determine a provider's Cost achievement score, CMS will assign 1 to 10 points to each measure attributed to the physician or group based on performance relative to the established benchmark. The benchmark for each measure will be determined based on **cost data from the performance period**. CMS would award points for each measure depending on how a provider scored in relation to overall performance.

The total category points possible for a performance year depend on how many measures the provider is attributed. The Cost category achievement score is determined by adding the points scored on each measure and dividing by the total possible points available. For example, if an ophthalmologist is only attributed the total per capita measure, then the total possible points for the category would be 10. If he or she scores 9 on the total per capita measure, the 9 points earned would be divided by the 100 possible points for an achievement score of 90%.

If a provider does not have any attributed measures, the Cost category will not be scored, and the Quality category will be re-weighted to 60%.

Cost Improvement Score

Even though Cost was not included in 2017 MIPS scores, CMS will calculate improvement scores as part of physicians' and groups' 2018 Cost category scores. To calculate the improvement score, CMS will determine whether physicians or groups were attributed each of the cost measures for the current and prior performance periods. For any measure attributed in both years, CMS will determine if there was a statistically significant rate of improvement or decline for the measure.

CMS will add a maximum of one percentage point for improvement to the Cost category percent score.

- If a physician has both cost measures attributed, he or she will earn 0.5% for each measure with significant improvement.
- If a physician has only one measure attributed, he or she will earn 1% if there is significant improvement on the measure.

No physician or group can earn fewer than zero improvement points. Failure to demonstrate significant improvement or not have measures attributed in consecutive years will not result in a penalty. If a physician or group does not have the same measure attributed in two consecutive years, no improvement score will be calculated.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

MIPS Program: Choosing Individual vs. Group Reporting and Virtual Groups in 2018

The 2018 Quality Payment Program (QPP) – Year Two final rule continues to implement the programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

The MACRA statute allows physicians to choose whether they will participate in the MIPS program as an individual or a group. Under the previous quality reporting programs, group reporting—and only for PQRS—was only available to larger practices. However, under MACRA, any physician practicing in a group of two or more has the option to report MIPS data collectively, and solo practitioners have the option to join virtual groups. Group reporting may ease administrative burden for some practices and assist some physicians, especially sub-specialists, in succeeding under MIPS. Use this guide to help you determine whether to report as a group or an individual.

In 2018, CMS is implementing another provision of the MACRA statute to allow physicians to participate in MIPS through “virtual groups.” Solo practitioners and practices with 10 or fewer eligible clinicians may elect to join together as virtual groups and have their performance measured under MIPS collectively. This guide provides information on how to form a virtual group, as well as issues to consider as part of a virtual group.

Please consult ASCRS•ASOA’s guides on MIPS categories, available at ascrs.org/macracenter, for full details on program requirements.

How Do I Decide to Report as a Group or an Individual?

Each physician and practice must carefully evaluate how best to complete the requirements for MIPS. The MIPS program is customizable, with many options for measures and submission mechanisms. These factors will impact each practice differently. There is no one-size-fits-all formula to determine who should report as a group and who should report individually. This guide summarizes requirements for group vs. individual reporting in 2018.

Here are a few ideas to help you make your decision:

- Determine what your goals are for the 2018 performance year. Are you reaching for a bonus in 2020? Or just looking to avoid the penalty? If you simply want to submit a minimum amount of data and avoid the penalty, it may not be worth changing administrative processes, so it may be easier to submit some data individually. If you are going for full participation and a bonus, group reporting may reduce the administrative burden and make meeting the requirements easier.
- If the practice only sought to submit minimal data in 2017 to avoid the penalty, but wants to increase participation in MIPS, group reporting could be an option for 2018. Review the performance of every Medicare provider in your group—ophthalmologists, optometrists, CRNAs, etc.—and determine each participant’s strengths and weaknesses in the previous programs, PQRS and Meaningful Use. Do certain sub-specialists, such as corneal specialists or oculoplastic surgeons, have difficulty finding at least six quality measures? In many cases, cataract surgeons would have ample measures available to make up for other partners in the group who do not. For advancing care information (ACI) measures, many ophthalmology practices struggle to identify other practices they refer to that have EHR and can complete health information exchange. Similarly, many ophthalmology patients are not willing to visit patient portals to complete the patient engagement measures. If your practice struggles with these measures, reporting as a group may reduce the pressure to complete each base measure at least once for each practitioner. It is also important to remember that CMS is offering a 2018 ACI hardship exemption for practices of 15 or fewer eligible clinicians, so small practices may not have to submit any data for this category.
- Identify the submission mechanism you plan on using for MIPS. If you do not have an EHR or registry and plan to report quality data through claims, the group option is not available. Make sure you have the requisite systems in place to participate as a group.

What Is Individual Reporting and How Will It Impact My MIPS Score?

Individual reporting for MIPS is essentially unchanged from previous quality reporting programs. Each MIPS-eligible clinician, identified by a unique TIN/NPI combination, is responsible for completing the requirements for MIPS. In 2018, physicians must individually report data for the Quality, Advancing Care Information (ACI), and Improvement Activities categories. CMS will score the individual physician's performance for 2018, and adjust his or her Medicare payments accordingly for 2020.

Individual MIPS participants may report their data using claims, registry, or EHR. There is no sign-up required, and physicians opting for full participation in 2018 must begin reporting for the Quality category on January 1, 2018. Reporting for the ACI or Improvement Activities may begin reporting any time between January 1, 2018, and October 2, 2018. Groups of physicians practicing under the same TIN may report individually if all providers in the TIN report as individuals.

What Is Group Reporting and How Will It Impact My MIPS Score?

The 2017 MACRA final rule established a process for groups of physicians to report data and be scored collectively. Essentially, group scoring treats all physicians in the group as if they were one individual. All eligible patient encounters for every physician in the group are aggregated together as a total population for the Quality and ACI categories (i.e., measure denominators), and each physician's performance in the group is aggregated (i.e., measure numerators). For the Quality category, the group must select six total measures to report, one of which must be an outcome measure. For ACI, the group works together to meet all the base measures, and can choose which measures in the performance score to complete. Groups of 15 or fewer eligible clinicians may also apply for a 2018 small practice hardship exemption for the ACI category. For the Improvement Activities category, the group is required to attest once for the activity or activities it completed. The group's performance is scored collectively, and each physician participating in the group will earn the same MIPS final score—and the same payment adjustment.

For example, a practice of five ophthalmologists, three of whom perform cataract surgery, decides to report as a group.

- One of the quality measures selected by the group relates to cataract surgery. When reporting the measure, the practice must include all the eligible patients who meet the measure specifications and report the performance from each of the physicians who performed the procedures. So, if the other two physicians did not perform any cataract surgeries, they are not included in the measure calculations; however, they will get credit for the measure through the group reporting.
- For the ACI, all physicians in the group will work toward achieving the measures together. To meet the base score requirements, there must be a 1 in the numerator of each measure. Therefore, the practice only has to have one patient in each measure, and **not** one for each individual physician. The group performance score will be calculated similarly to individual reporters, with a total percentage of all additional patients seen by the group making up the measure numerators and denominators.

Can I Use the Group Reporting Option Just to Avoid a Penalty?

Yes, CMS is continuing transition flexibility in 2018—the second year of MIPS—and set the MIPS final score threshold at 15 points, up from 3 points in 2017. This allows groups, as well as individual reporters, to submit a minimum of data to avoid a penalty in 2020. To avoid the penalty, a group may submit any of the following:

- Full participation in the Improvement Activities category, such as submitting one high-weighted activity or two medium-weighted activities for small practices, or two high-weighted activities, four medium-weighted activities, or a combination of both;
- The Advancing Care Information (ACI) category base score and one quality measure meeting the measure threshold, or data completeness, but not benchmarks;
- ACI base score and one medium-weighted improvement activity; or
- Six quality measures meeting data completeness, but not measure benchmarks.

It is important to remember, however, that claims reporting is not an option for groups, so if the group is reporting quality measures, they must be reported through a registry or EHR.

Visit ascrs.org/macracenter for full details on performance period options.

How Do I Register My Practice for Group Reporting?

There is currently no formal process for registering as a group with CMS, unless you plan to use the Web Interface program (formerly GPRO). Group data may be reported via registry, EHR, or the CMS Web Interface. The Web Interface registration deadline is June 30, 2018, and is only for practices of 25 or more eligible clinicians. Your EHR system or qualified registries may require a set-up process. Check with your software vendor or registry contact to determine what is required for your system.

Who Can Form a Group?

Any group of two or more physicians billing under the same Tax Identification Number (TIN) can report as a group. If choosing group reporting, all physicians billing under the TIN must report as part of the group for every MIPS category.

Exclusions: Certain physicians who are not MIPS-eligible may be excluded from the group.

- **Advanced APM participants:** If a physician billing under a TIN that elects group reporting participates in an Advanced APM, his or her performance is excluded from the group and the group payment adjustments will not impact the APM participant.
- **New Medicare providers:** Physicians in their first year of billing Medicare are excluded from group reporting and payment adjustments.

Low-volume physicians: Physicians who bill less than \$90,000 in allowed Medicare charges, or see fewer than 200 Medicare patients in a year, fall under the low-volume threshold and are excluded from MIPS. However, if a physician who is considered low volume works in a practice that is reporting MIPS as a group, he or she will no longer be considered exempt from MIPS. The low-volume physician's performance will be included in the group score, and he or she will receive the same Medicare payment adjustment as the rest of the group.

Physicians practicing under more than one TIN: If one of the members of a group also bills under a different TIN, he or she is responsible for meeting the MIPS requirements under each TIN. Only the services billed under a particular TIN that is reporting as a group will be included in the group's MIPS score. Services billed under different TINs may be reported individually or as a group. For example, Dr. Smith, a retina specialist, works at Practice A three days a week and Practice B two days a week. Practice A reports as a group and includes Dr. Smith's performance as part of the group. Practice B does not report as a group, so Dr. Smith must report individually for services rendered under that TIN.

What Is a Virtual Group?

A virtual group is made up of two or more solo practitioners and practices of 10 or fewer eligible clinicians all billing Medicare under their own TINs who elect to aggregate their performance to be scored collectively under MIPS. Virtual group reporting and scoring is the same as group reporting and scoring discussed above.

Who May Form a Virtual Group?

Any MIPS-eligible solo practitioner or practice of 10 or fewer eligible clinicians may form a virtual group. If a practice of 10 or fewer elects to join a virtual group, all eligible clinicians practicing under that TIN must join the virtual group. There is no limit to how many clinicians may be part of the virtual group, and there are no limitations related to geographic area or specialty. A physician who practices under two or more different TINs may elect to join a virtual group and have his or her performance under some or all of those TINs aggregated in the same virtual group.

Virtual groups that do not exceed 15 participants in total are also eligible for the 5-point small practice bonus on the MIPS final score and the small practice hardship exemption for the ACI category.

How Do I Form a Virtual Group?

Unlike groups all practicing under the same TIN, virtual groups must apply to CMS prior to the beginning of the performance year and be accepted through the virtual group two-stage election process.

To form a virtual group, the group must be deemed eligible to create a group. Before proceeding with the election process, the group may begin the process with an optional Stage 1 to determine eligibility. Interested clinicians may contact their designated technical assistance representative or the Quality Payment Program Service Center to determine if they are eligible to join or form a virtual group. Visit qpp.cms.gov for contact information.

If the group decides not to begin with Stage 1 to determine its eligibility, its prospective members may still proceed directly to Stage 2. CMS will make the eligibility determination in Stage 2 for any group that did not begin with Stage 1.

In Stage 2 of the election process, the group must submit the following to CMS for approval:

- A written formal agreement between each of the virtual group members; and
- Information about the TIN and NPI associated with the virtual group representative's contact information.

The election information in Stage 2 must be submitted to CMS via email to MIPS_VirtualGroups@cms.hhs.gov no later than December 31 of the year immediately prior to the performance period. **To form a virtual group for 2018, the election information must be submitted by December 31, 2017.**

What Are the Advantages and Disadvantages of Participating in a Virtual Group?

The Congressional sponsors of MACRA intended the concept of virtual groups as a way to reduce burden on small or solo practices who may not be able to implement the MIPS program on their own. Physicians and practices should consider their options carefully before joining a virtual group.

Advantages: Many of the advantages of virtual groups are the same as group reporting. Solo practitioners, especially sub-specialists, may not have enough relevant measures or the resources to implement, track data, and submit. A virtual group could consolidate those functions and reduce burden. For physicians practicing under multiple TINs, virtual groups also offer the opportunity to aggregate total performance and reduce or eliminate duplicative reporting.

Disadvantages: Virtual group participation is a new and untested option requiring cooperation between practices that do not have a current business relationship. CMS requires a formal written agreement between all members of a virtual group. While the agreement would provide some protections, its development could be burdensome, time-consuming, and expensive if legal

services are required. The deadline to submit all election materials to CMS for 2018 participation is December 31, 2017, which will likely be difficult for most practices to meet.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

Alternative Payment Models (APMs)

Advanced APMs and MIPS APMs

2018 Final Rule Guide

On November 2, 2017, CMS released the Quality Payment Program (QPP) Year 2 final rule, which includes 2018 policies for both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), impacting 2020 payments. The final rule builds on regulations first established for 2017 performance and 2019 payment related to programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA changed the way Medicare incorporates quality measurement into payments and develops incentives for participation in alternative payment models.

This guide summarizes the Advanced APM provisions of the final rule and includes information on MIPS APMs, which offer the opportunity for physicians participating in certain models to receive credit under the MIPS program. ASCRS has also developed guides on the full QPP and each of the four components of MIPS, and will continue to provide additional resources and training materials to assist ASCRS•ASOA members in complying with the program in 2018 for 2020 payment.

What Is an Advanced APM?

CMS is encouraging participation in Advanced APMs. Eligible clinicians who participate in advanced APM entities that meet certain revenue or patient thresholds each year will receive a **5% bonus for each year from 2019 to 2024**. Advanced APMs are a subset of APMs that meet the requirements under MACRA.

CMS defines an Advanced APM as a model that:

- Involves more than nominal risk of financial loss,
- Includes a quality measure component, and
- Has the majority of participants using certified EHR technology (CEHRT).

Advanced APMs include Accountable Care Organizations (ACOs) with two-sided risk and medical homes expanded by CMS' innovation center.

For 2018, to impact 2020 payment, CMS expects the following to be considered Advanced APMs:

- Medicare Shared Savings Program (two-sided models: Tracks 1 Plus, 2, and 3)
- Next Generation ACO Model
- Comprehensive End-Stage Renal Disease (ESRD) Care (large dialysis organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM)
- New Voluntary Bundled Payment Model
- Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology [CEHRT] track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)

There are currently no ophthalmology specific advanced APMs. In addition, current available models are, for the most part, focused on primary care, such as ACOs or certified medical homes. Some ophthalmologists currently participate in Medicare Shared Savings Program Track 1 ACOs, but since those models do not include two-sided risk, they are not considered Advanced APMs and will not be eligible for bonus payments under the APM category. Some ophthalmologists may become qualified participants if their Track 1 ACOs become Track 1 Plus ACOs, a new option for 2018 that offers limited downside risk.

In future years, ophthalmologists may be able to participate in bundled payment models, such as for cataract surgery, built off of episode-based cost measures currently under development. There are no formal proposals currently in development for ophthalmic surgery bundled payment models, but there are models in development for non-ophthalmic procedures. ASCRS is providing input to CMS through technical expert panels on the development of the episode-based cost measures—particularly to ensure costs are accurately attributed and risk adjustment is included—and monitoring surgical community efforts to develop bundled payment APMs.

Qualifying Participants and Partially Qualifying Participants

To receive a bonus payment for participation in an Advanced APM, a provider, or group of providers billing through a common tax ID (TIN), must be considered a Qualifying Participant (QP). **A provider's QP status is determined by his or her participation in an Advanced APM entity that collectively meets certain revenue or patient thresholds.**

For 2020, based on performance year 2018, providers are considered QPs for participating in an Advanced APM entity for which either:

- The collective Part B payment for services delivered by the Advanced APM entity's clinicians to patients who are attributed to that entity is at least 25% of the payments for services delivered by the entity's clinicians to all patients who could, but may not, be attributable to the entity ("attribution-eligible").
- The collective number of patients who receive services delivered by the Advanced APM's clinicians and who are attributed to that Advanced APM is at least 20% of the number of all patients who are attribution-eligible and received services delivered by the Advanced APM's clinicians.

Clinicians participating in APMs that achieve those thresholds will be excluded from MIPS requirements. These percentages of payment amounts or patients required to qualify for the APM bonus will increase in future years.

Physicians participating in Advanced APM entities that fall short of requirements for the incentive payments, but meet lower thresholds, would be considered Partial QPs and able to choose whether they would like to receive a payment adjustment through MIPS. **To opt out of the MIPS payment adjustment, the clinician must participate in an Advanced APM entity that collectively reached lower thresholds of Medicare payments or patients. For 2020, the collective threshold is 20% of eligible Medicare payments or 10% of eligible Medicare patients for partial participation. Partial QPs do not qualify for the 5% bonus payment under the APM category.**

If a physician participates in multiple Advanced APMs, and one of the APM entities he or she participates in does not meet the collective thresholds, CMS will determine if the individual physician's total participation in multiple APM entities meets the thresholds for the year. **If the sum of the individual provider's participation in multiple entities hits the threshold, he or she receives the 5% bonus and is exempted from MIPS.**

Revenue or Patient Thresholds for Advanced APMs

CMS finalized thresholds for the percentage of eligible payments or eligible patients derived through Advanced APM entities.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Advanced APM entities must meet payment or patient requirements.)

	2020	2021	2022	2023	2024 or later
Percentage of Payments through an Advanced APM	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	35%	35%	50%	50%

MIPS APMs – Including Medicare Shared Savings ACOs Track 1

Physicians also have the opportunity to earn points in MIPS by participating in certain APMs and Advanced APMs that CMS determines to be "MIPS APMs." Each year, CMS will release a list of MIPS APMs prior to the performance period.

For 2020, based on 2018 performance, CMS will likely consider these APMs as MIPS APMs:

- Medicare Shared Savings Program Tracks 1, 1 Plus, 2, and 3

- Next Generation ACO Model
- Comprehensive ESRD Care Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus (CPC+) Model
- New Voluntary Bundled Payment Model
- Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology [CEHRT] track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)

To earn MIPS points from a MIPS APM, a provider must:

- **Be included in the participant list of a non-Advanced APM that CMS has determined to be a MIPS APM, or**
- **Be included in the participant list of an Advanced APM entity that did not meet the thresholds to be eligible for the bonus payment and, therefore, elect to participate in MIPS.**

For models that CMS determines to be “MIPS APMs,” in 2017 participants will:

- **Report the required quality measures for the APM through the APM entity (if an APM entity does not report data on behalf of individuals or groups participating in the APM, those physicians will be required to report quality data on their own);**
- **Report data for the Advancing Care Information category on their own; and**
- **Automatically earn all of the total available points for the Improvement Activities category score.**

MIPS APM Scoring Standard

Similar to determining the thresholds for participation in Advanced APMs, **CMS will award the same final MIPS score to all the participants in a MIPS APM entity—including for data they reported individually or as a group under a single TIN.** Under the terms of the models considered MIPS APMs, participants in the APM entities are already assessed collectively for meeting certain quality and cost metrics; therefore, **CMS will score the Advancing Care Information and Improvement Activities collectively, as well.** CMS will use an average score of all the participants’ scores for Advancing Care Information to determine a group score. All participants in the MIPS APMs will receive the same total available score for Improvement Activities.

For each model approved as a MIPS APM, CMS re-weighted the MIPS categories to reflect the design of the particular model.

- For all Medicare Shared Savings ACOs and Next Generation ACOs, category weights are: 50% Quality, 0% Cost, 20% Improvement Activities, and 30% Advancing Care Information.
- For all other models, category weights are 0% Quality, 0% Cost, 25% Improvement Activities, and 75% Advancing Care Information.

The MIPS APM entity’s final MIPS score will be applied to the participants in the entity at the TIN/NPI level. If a physician participates in multiple MIPS APMs, CMS will award that physician the score from whichever MIPS APM he or she participates in that has the highest final score.

MIPS APM Participation

Physicians may participate in MIPS APMs at the individual or group level. Not all physicians billing under a particular TIN are required to participate in a MIPS APM entity if one or more physicians billing under that TIN elects to participate in a MIPS APM. Certain specialties, such as ophthalmology, are permitted to participate in more than one ACO.

CMS will determine providers’ eligibility to be scored under the MIPS APM scoring standard by checking three times during the performance year to confirm that individuals or groups are listed on the APM entities’ participant lists. **CMS will check the lists on March 31, June 30, and August 30 of the performance year.**

If a provider is on the list at any time, he or she will be considered as participating in the APM entity. If a provider only participates in the APM entity for a portion of the year, but is only on the list at one or two of the designated dates on which CMS checks the list, he or she is still considered a participant.

If a full TIN joins an APM later in the year, it can be considered a QP or participate in MIPS through the APM if it is listed on an APM’s participant list by December 31 of the performance year. On December 31, only full TINs participating in the APM will

qualify. If not all physicians billing under the TIN join the APM, they must be on the participant list on one of the three earlier dates.

Other Payer APMs

Other Payer APMs include payment arrangements under any payer other than traditional Medicare, including Medicare Advantage and other Medicare-funded plans. **Beginning in 2021** (performance year 2019), these other payers will count toward APM thresholds. However, the 5% bonus for significantly participating in an Advanced APM will be based on traditional Medicare and will not include Medicare Advantage payments. To meet the APM thresholds through participation in an Other Payer APM, physicians must also participate in a Medicare Advanced APM. **The 5% bonus for significantly participating in an Advanced APM will be based on traditional Medicare and will not include Medicare Advantage payments.**

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

MIPS Participation for Medicare Shared Savings Program Track 1 Accountable Care Organization Members 2018 Final Rule Guide

On November 2, 2017, CMS released the Quality Payment Program (QPP) Year 2 final rule, which includes 2018 policies for both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), impacting 2020 payments. The final rule builds on regulations first established for 2017 performance and 2019 payment related to programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA changed the way Medicare incorporates quality measurement into payments and develops incentives for participation in alternative payment models.

This guide provides information on how Medicare Shared Savings Program (MSSP) Track 1 Accountable Care Organization participants will be scored for MIPS under the MIPS APM scoring standard. A MIPS APM is either a payment model that does not meet the definition of an Advanced APM—such as Track 1 ACOs—or is an Advanced APM that has not met patient or revenue thresholds. ASCRS has also developed guides on the full QPP, each of the four components of MIPS, and Advanced APMs and will continue to provide additional resources and training materials to assist ASCRS•ASOA members in complying with the program.

MIPS APM Scoring Standard

Track 1 ACOs do not meet the definition of an Advanced APM. Therefore, participants in those models are not eligible to receive the statutory 5% bonus that MACRA provides and, therefore, but must participate in MIPS. CMS defines an Advanced APM as a model that involves two-sided risk, and since Track 1 ACOs do not involve downside risk, they cannot be considered Advanced APMs.

However, CMS has created a MIPS scoring standard for participants in certain alternative payment models that do not meet the definition of an Advanced APM (such as Track 1 ACOs) or do not meet the required participation or revenue thresholds. The MIPS APM scoring standard allows physicians to continue participating in these models and to use that participation to earn credit under MIPS.

How Do Track 1 ACO Members Participate in MIPS?

To earn points in MIPS under the MIPS APM scoring standard, a provider in a Track 1 ACO must be included in the official participant list of the ACO filed with CMS.

Track 1 ACO participants are required to:

- Report the required quality measures for the ACO through their ACO entity (if the ACO does not report data on behalf of its members, those physicians will be required to report quality data on their own);
- Report data for the Advancing Care Information category on their own; and
- Automatically earn all of the total available points for the Improvement Activities category score.

Track 1 ACO Scores Under the MIPS APM Scoring Standard

CMS will award the same final MIPS score to all the participants in a Track 1 ACO—including for data they reported individually or as a group under a single TIN. Under the terms of the model, participants in the APM entities are already assessed collectively for meeting certain quality and cost metrics; therefore, CMS will score the Advancing Care Information category collectively as well. All ACO participants will receive the total points for the Improvement Activities category. CMS will use an average score of all the participants' scores for Advancing Care Information to determine a score for all participants. All participants in the Track 1 ACO will also receive the same total available score for Improvement Activities.

Under the MIPS APM scoring standard, CMS has re-weighted the MIPS categories to reflect the design of the Track 1 model. For 2017, category weights are: 50% Quality, 0% Cost, 20% Improvement Activities, and 30% Advancing Care Information.

The ACO entity's final MIPS score will be applied to the participants in the entity at the TIN/NPI level. If a physician participates in multiple ACOs or other MIPS APMs, CMS will award separate scores for each entity. CMS will use whichever score is highest to determine the physician's payment adjustment.

MIPS APM Participation

Physicians may participate in Track 1 ACOs at the individual or group level. Not all physicians billing under a particular TIN are required to participate in the ACO entity if one or more physicians billing under that TIN elects to participate. Certain specialties, such as ophthalmology, are permitted to participate in more than one ACO.

CMS will determine providers' eligibility to be scored under the MIPS APM scoring standard by checking three times during the performance year to confirm that individuals or groups are listed on the ACO or other APM entities' participant lists. **CMS will check the lists on March 31, June 30, and August 30 of the performance year.**

If a provider is on the list at any time, he or she will be considered as participating in the entity. If a provider only participates in the APM entity for a portion of the year, but is only on the list at one or two of the designated dates on which CMS checks the list, he or she is still considered a participant.

If a full TIN joins an APM later in the year, it can be considered a QP or participate in MIPS through the APM if it is listed on an APM's participant list by December 31 of the performance year. On December 31, only full TINs participating in the APM will qualify. If not all physicians billing under the TIN join the APM, they must be on the participant list on one of the three earlier dates.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.