2018 Quality Payment Program—Year 2
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. Following ASCRS•ASOA advocacy, Congress made technical corrections to the MACRA statute in February 2018 to assist physicians to succeed in the program. Those changes are reflected in this and other ASCRS•ASOA MIPS guides.

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.

MACRA Statute Technical Corrections

On February 9, 2018 Congress enacted limited technical corrections to the MACRA statute that were advocated for by ASCRS•ASOA and the medical community. These changes include:

- Giving CMS the authority to extend the MIPS transition period for an additional three years before having to set the MIPS performance threshold at the mean or median of the previous year's score;
- Continuing to weigh the Cost category at less than 30% for three additional years and not scoring improvement in the category for three years; and
- Excluding Medicare Part B drugs from MIPS eligibility determinations and payment adjustments.

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. Following passage of the MACRA technical corrections, CMS will have the ability to extend this option for three additional years and not have to set the performance threshold at the mean or median of the previous year's score. In addition to designating 2018 as the second transition year of the program, the 2018 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 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 increase the weight gradually. Originally, the MACRA statute would have required Cost to account for 30% of the MIPS final score starting in 2019, which prompted CMS' gradual increase beginning in 2018. However, the MACRA technical corrections enacted in 2018 now give CMS the authority to weigh the Cost category at less than 30% for three additional years, and not incorporate improvement scoring during that time. For 2018, CMS maintained 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.

The MACRA technical corrections modified language in the original statute that would have based MIPS payment adjustments and program eligibility on all items and services furnished by the physician or group—including Part B drugs. Following enactment of the technical corrections, eligibility determinations and payment adjustments will be only on covered physician services.

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.