Quality Payment Program—Year 2
Proposed Rule Guide

On June 20, 2017, CMS released a proposed rule on the Quality Payment Program (QPP) Year 2, which includes 2018 proposals on both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), impacting 2020 payments. The proposed 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 proposed rule. ASCRS•ASOA will be providing comments on the proposed rule. A final rule is expected sometime in the fall of 2017, for implementation on January 1, 2018. Full details on the programs under MACRA for 2017 performance, impacting 2019 payments, are available on the ASCRS•ASOA MACRA Center website at ascrs.org/macracenter.

Key Proposals 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 Proposed Rule. In addition to creating another transition year of the program, the proposed rule carves out special protections for small practices with 15 or fewer providers.

The proposed 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;
- Retaining the Cost category weight at 0% for 2018;
- Maintaining the 2017 measure thresholds—also known as data completeness requirements—in the Quality category at 50%;
- Continuing to allow the use of 2014 Certified EHR Technology.

In addition, CMS is proposing the following to reduce regulatory burdens on small practices with 15 or fewer providers:

- 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 85% 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.

CMS is also proposing to increase 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 proposes to add a complex patient bonus, up to three points, to the final score of an individual or practice of any size if the practice treats certain complex patients. CMS proposes to use the Hierarchical Condition Category (HCC) index, currently used by Medicare Advantage plans and included in Value-Base 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 take into account any ocular co-morbidities. ASCRS will be recommending that CMS develop new methodologies to determine patient complexity and risk adjustment that can be applied to other categories, especially the Cost category.

2018 Performance Period for 2020 Payment

For full participation in the MIPS program in 2018, for 2020 payment, **CMS proposes a year-long performance period for the Quality and Cost categories, and any period of at least 90 days for the Advancing Care Information and Improvement Activities categories. Cost will continue to not be included in the final score, but CMS will calculate the category score for information purposes.**

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 proposes to set the 2018 MIPS final score threshold at 15 points, up from 4 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;
- 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 proposes to continue qualifying 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 proposes to implement a provision of MACRA that gives MIPS participants the opportunity to join “virtual groups.” CMS proposes to 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. CMS proposes virtual group reporting and scoring to work in a similar manner to group reporting under a single TIN. There is no limit for 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 by December 1 of the year preceding the performance period. For 2018 performance, the application period opens September 1, 2017, and applications must be submitted by December 1, 2017.

MIPS Performance Categories

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

Quality: 60% of Total Score in Year 2 (2018)

CMS proposes to maintain the 2017 performance requirements in 2018, but adds statutorily required proposals 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.” Following ASCRS and medical community advocacy, **CMS proposes to maintain the reporting threshold (or data completeness requirement) for quality measures to 50% of Part B patients if reporting via claims, and 50% of all patients for registry 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 providers must report 6 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 receive an achievement score on each measure, relative to pre-set performance benchmarks based on 2016**

performance. CMS proposes to compare physicians' and groups' 2017 Quality category scores to their 2018 category scores and award up to 10 points in the category for improvement.

Cost: 0% of Total Score Year 2 (2018)

CMS continues to agree with ASCRS and medical community recommendations that due to the flawed attribution methodology and lack of risk adjustment, Cost should not be included again in the Year 2 MIPS score. **CMS proposes to maintain the 0% weight but will continue to calculate the measures based on 2018 performance for informational purposes.** CMS proposes to 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 are currently being developed—and ASCRS is providing input—but will not be available for use in 2018. CMS is also seeking feedback on an alternate proposal to weight the category at 10% for performance year 2018 in order to create a more gradual transition to performance year 2019, when the weight will go up to 30% per the law. ASCRS•ASOA and the medical community will continue to recommend that Cost be weighted at 0% in comments on the proposed rule.

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

In 2018, CMS proposes to 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.

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

CMS proposes to 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 proposes to add several more activities in 2018. CMS proposes to again score medium-level activities at 10 points and high-level activities at 20 points. Providers must reach a total of 40 points to receive full credit for this category, either by completing two high-level, four medium-level, 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 (40 points for high-level activities and 20 points for medium-level activities). Therefore, small practices only have to perform one high-level activity or two medium-level activities for full credit in the category. Improvement Activities must be performed for at least 90 days during the reporting period.

Incentives and Penalties

Based on the MACRA statute, 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 proposing the addition of a 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 proposes to 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 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 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 proposes to 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 proposes to 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 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**.

Additional Resources

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