

Medicare Releases Final Rule for the Second Year of the Quality Payment Program

On Nov. 2, 2017, CMS issued the Calendar Year 2018 Quality Payment Program (QPP) final rule for the second transition year for physicians to begin participation in either the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs). CMS now refers to the 2018 year as QPP Year 2. CMS is offering further flexibility and easing of requirements to help physicians to make the transition to the new payment systems. The second transition year continues with the set 5 percent incentive for those qualified participants in advanced APMs, and increases the MIPS payment adjustments to +/- 5 percent in payment year 2020. The final rule has a 60-day comment period ending on Jan. 1, 2018. These policies become effective on Jan. 1, 2018.

For 2018, CMS increased the low volume threshold to billings of $\leq \$90,000$ or providing services to ≤ 200 Medicare beneficiaries. If a radiologist or practice falls below this threshold, they are exempt from participating in the Quality Payment Program.

The most significant change in the QPP year 2 is CMS' decision to allocate 10 percent of the performance score to the cost category. Medicare will use the Medicare Spending Per Beneficiary (MSPB) and total per capita cost measures to determine physician performance in the category with respect to lowered costs. These two measures are carried from the cost domain under the value modifier program. The ACR is reviewing the MSPB measure to determine how this might affect radiologists moving forward.

With the cost category weight at 10 percent, the quality category will be weighted at 50 percent of the performance score, 25 percent for advancing care information and 15 percent for improvement activities for 2018. The cost category is mandated to increase to 30 percent for 2019. CMS chose to move forward with the 10 percent to allow for a more gradual increase in preparation for the significant role the cost category will play by way of total performance in the future.

CMS will increase the MIPS final score performance threshold from 3 points to 15 points. This performance threshold defines the total points required to earn a neutral payment adjustment and avoid a negative payment adjustment. MIPS eligible clinicians who score higher than the threshold (16 points and above) may earn a positive payment adjustment. Physicians who earn 70 or more points are eligible for an "exceptional" performance bonus points for a higher positive adjustment.

Additionally, 5 bonus points will be added to the final scores of MIPS eligible clinicians who are in small practices (defined as 15 or fewer clinicians) and up to 5 points for those physicians who care for complex patients such as radiation oncologists. No additional bonus was finalized for rural practice. CMS does not believe the performance of rural MIPS eligible clinicians is any different than non-rural performance.

CMS expanded the performance period for the quality category to a minimum 12 months, while maintaining 90-day reporting periods for the "Advancing Care information" and "Improvement

Activities” performance categories. CMS will calculate measures in the cost category based on 12 months of claims data.

The table below summarizes the reweighting scenarios of the four MIPS performance categories finalized for the QPP performance year 2 determining the final score for payment year 2020. Many diagnostic radiologists will continue to benefit from the potential “special statuses” (non-patient facing, hospital based, small practice, rural/HPSA) that will determine reweighting for the Advancing Care Information category. And in many cases, radiology groups may have the cost category reweighted as well if measure data is not available.

TABLE 29: Performance Category Redistribution Policies for the 2020 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Advancing Care Information
No Reweighting Needed				
- Scores for all four performance categories	50%	10%	15%	25%
Reweight One Performance Category				
-No Cost	60%	0%	15%	25%
-No Advancing Care Information	75%	10%	15%	0%
-No Quality	0%	10%	45%	45%
-No Improvement Activities	65%	10%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Advancing Care Information	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	50%	50%
-No Cost and no Improvement Activities	75%	0%	0%	25%
-No Advancing Care Information and no Quality	0%	10%	90%	0%
-No Advancing Care Information and no Improvement Activities	90%	10%	0%	0%
-No Quality and no Improvement Activities	0%	10%	0%	90%

Quality

As mentioned above, the quality category performance period is a the full 2018 calendar year. Additionally, CMS is increasing the data completeness requirement to 60 percent for all submission mechanisms except for Web Interface and CAHPS. CMS will maintain the quality scoring standards as such:

- 3-point floor for measures that can be reliably scored against a benchmark
- 3 points for measures without a benchmark or not meeting case minimums (20 cases)
- Bonus for additional high priority measures (up to 10 percent of quality category denominator)
- Bonus for end to end reporting (up to 10 percent of quality category denominator)

CMS proposed that MIPS eligible clinicians be allowed to report measures through multiple submission mechanisms to allow more flexibility in Year 2 to meet the requirements of each performance category Quality, Improvement Activities or Advancing Care Information. However, CMS finalized that individual MIPS eligible clinicians and groups may elect to submit

information via multiple mechanisms. However, they must use the same identifier for all performance categories and only use one submission mechanism per performance category.

Facility-based Measures

CMS will allow clinicians to use facility-based measurement in year 3 (2019) of the Quality Payment Program. They will use the 2018 year to ensure operational readiness to offer facility-based measurement and educate the eligible provider community.

Topped-out Measures

CMS finalized a 4-year timeline for identifying and removing topped out measures. For a measure to be “topped out” it must be identified as such for at least 2 consecutive years and be available for comment prior to rule-making for the 4th year. Starting from year 2, special scoring considerations will be used for topped out measures, namely there will be a maximum score of 7 points. For most current measures, determination of “topped out” will be based on comparison to the 2018 performance period. Thus, the earliest most measures can be removed is 2021. It is important to note that a measure could be deemed topped out in one reporting mechanism, but not reach topped out status in another. In this scenario, the measure would only undergo topped out methodology within the reporting mechanism it has been deemed topped out. CMS defines a topped out measure as one whose median performance is 95 percent or higher. CMS describes topped out measure performance as “so high and unvarying that meaningful distinctions and improvement in performance can no longer be made.”

CMS finalized six quality measures that CMS proposes to regard as “topped out” for the 2018 performance period. Of these, one is pertinent to diagnostic radiology: Quality Measure 359 - “Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging” and 2 may be relevant to interventional radiologists (# 21, Perioperative Care – Selection of Prophylactic Antibiotic and #23, Perioperative Care VTE Prophylaxis. For these six measures, CMS finalized special rules for scoring which involves a cap of 7 points for these measures.

Advancing Care Information (ACI) Category

Reweighting/Exempting ACI

CMS will continue offering the various options for reweighting (i.e., exempting) the Advancing Care Information (ACI) category in performance year 2018/payment year 2020, including automatically reweighting “non-patient-facing” as well as “hospital-based” MIPS-eligible clinicians. Most importantly for radiology, the calculation used by CMS to determine “hospital-based” eligible clinicians would be expanded to include off-campus outpatient hospital settings (POS 19), thus significantly expanding the number of “patient-facing” radiologists who would be determined hospital-based.

CMS added several new ACI reweighting options — most notably a manual application option for MIPS-eligible clinicians in small practices (15 or fewer clinicians and solo practitioners) who faced an overwhelming barrier to ACI compliance. CMS’ deadline for applications to reweight

ACI of Dec. 31 or later, as specified by CMS, for the performance period in question (2017 as well as 2018).

Participating in ACI

For those radiologists who plan to participate in ACI, CMS will continue allowing use of 2014 Edition certified EHR technology (CEHRT) as well as the alternative/transitional ACI measures during the 2018 performance year. CMS provides for a 10 percent ACI bonus for those participants who used 2015 Edition CEHRT, thereby increasing the total possible ACI bonus points for that subset of ACI participants from 15 to 25 percent. CMS will continue to award a 10 percent bonus for the advancing care information performance category if a MIPS eligible clinician attests to completing at least one of the specified improvement activities using CEHRT. Table 6 in the rule outlines those improvement activities that are eligible for the ACI performance category bonus including “Consulting AUC using clinical decision support when ordering advanced diagnostic imaging” for the ordering physician.

The ACI measures and alternative/transitional measures in 2018 will remain essentially the same as 2017 with a few administrative changes and error corrections. Exclusions with base score credit from the e-prescribing and health information exchange-related ACI measures would be available for certain participants. Additionally, CMS finalized that a MIPS eligible clinician may earn 10 percentage points in the performance score for reporting to any single public health agency or clinical data registry to meet any of the measures associated with the Public Health and Clinical Data Registry Reporting Objective, as well as earn a 5 percent bonus for reporting to an additional registry.

Improvement Activities

CMS defines improvement activities as those that support broad aims within health care delivery, including care coordination, beneficiary engagement, population management and health equity. In the final rule, improvement activities remain weighted at 15 percent for the 2018 MIPS performance year final score. CMS asserts that MIPS-eligible clinicians can continue attesting improvement activities. However, in future years, CMS intends to score the improvement activities based on performance and improvement, rather than simple attestation.

In addition, CMS makes no changes to the number of activities (two high-weighted or four medium-weighted) that MIPS-eligible clinicians have to report to reach the total of 40 points to receive full credit. CMS also maintains the policy that the weight for any activity selected is doubled for small, rural, health professional shortage area practices, and non-patient facing MIPS-eligible clinicians, so that these practices and ECs only need to select one high-weighted or two medium-weighted improvement activities to achieve the highest score of 40 points. Also, under the MIPS APM scoring standard, all clinicians identified on the Participation List of an APM will receive at least one-half of the highest score applicable to the MIPS APM with the opportunity to report additional improvement activities to add points to achieve the full 40 points.

In the rule, CMS retains the current inventory of 92 improvement activities. However, CMS modifies 27 improvement activities and added an additional 10 new improvement activities,

including consultation of Appropriate Use Criteria (AUC) when ordering advanced diagnostic imaging. The AUC improvement activity will allow MIPS eligible ordering clinicians to earn a high-weighted improvement activity by attesting that they are using AUC through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered. The list of improvement activities with their relative weightings is available on the QPP website. Of relevance to radiologists, several QCDR-based activities continue to be included as medium-weight activities as well as the seven medium-weighted improvement activities that may be obtained by participation in the ACR's Radiology Support Communication and Alignment Network program (R-SCAN).

Cost Performance Category

Despite the fact that CMS is currently in the development stage for episode-based cost measures and thus will not be in use for 2018, CMS has decided to move forward with assigning a weight of 10 percent to the cost performance category for the 2018 MIPS performance period and 2020 MIPS payment year. The performance in this category will be determined by CMS' internal calculations using total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were used in the 2017 MIPS performance period. Again, CMS will not use the 10 episode-based measures that were adopted for the 2017 MIPS performance period. Rather, CMS is in the process of developing new episode-based measures with significant clinician input and believes it would be more prudent to introduce these new cost measures over time. The first eight draft episode-based cost measures are currently out for field testing until Nov. 20, 2017.

Virtual Groups

Definition of a Virtual Group

CMS finalized the creation of the “virtual group” in order to assist small, rural and independent practices to be able to participate in MIPS. There are two types of practices that can form virtual groups: (1) MIPS-eligible solo practitioners who bill under a single Tax Identification Number (TIN) with a single NPI; and (2) a group with 10 or fewer eligible clinicians. In the virtual group option, two or more of either of these types of practices can voluntarily come together as a group to participate in MIPS. There are currently no proposed restrictions in terms of geography, specialty of the practices, or number of practices that can form a virtual group as long as the criterion for the size of each practice is met. MIPS performance measures for the virtual group will be assessed on the basis of the combined performance of the entire group, payment adjustments will be made on an individual TIN/NPI level. Eligible practices may only be a part of one virtual group. Participation in a virtual group will not change the financial relationship between a clinician and/or group and an entity furnishing health services for the purposes of self-referral.

There is currently an open election period where any solo practitioner or group of 10 or fewer MIPS eligible clinicians may apply to be part of a virtual group. This period ends Dec. 31, 2017. CMS has also developed a virtual group toolkit of which can be found on their website at qpp.cms.gov.

Non-patient Facing MIPS-Eligible Clinicians

In the CY2018 Quality Payment Program (QPP) final rule, CMS maintains the definition of a non-patient facing MIPS-eligible clinician for MIPS as an individual MIPS-eligible clinician that bills 100 or fewer patient-facing encounters and a group that provided more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS-eligible clinician during the non-patient facing determination period.

To address the addition of virtual groups for the 2018 MIPS performance year, CMS finalized its proposal to modify the definition of a non-patient facing MIPS eligible clinician to include a virtual group, provided that more than 75 percent of the NPIs billing under the virtual group's TINs meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period. CMS also notes that other previously finalized and proposed policies related to non-patient facing MIPS eligible clinicians would also apply to virtual groups. CMS did not make any policy changes in the final rule to the re-weighting of the advancing care information performance category for non-patient facing MIPS-eligible clinicians. Specifically, MIPS-eligible clinicians and groups who are considered to be non-patient facing will have their advancing care information performance category automatically reweighted to zero for the 2018 MIPS performance year and future years.

CMS also maintains the policy that the weight for any improvement activity selected is doubled for non-patient facing MIPS-eligible clinicians, so that these practices and ECs only need to select one high-weighted or two medium-weighted improvement activities to achieve the highest score of 40 points to receive full credit for the improvement activities performance category.

CMS did not make any changes to the publication date of the list of patient-facing encounter codes for 2018, which will be posted at qpp.cms.gov by the end of 2017. In addition, CMS did not make any policy changes to allow stakeholders the opportunity to review and provide feedback on the patient-facing codes through formal notice-and-comment rulemaking rather than sub-regulatory guidance.

Advanced Alternative Payment Models (APMs)

APMs that meet the criteria to be Advanced APMs provide the pathway through which eligible clinicians, who would otherwise fall under the MIPS, can become Qualifying APM Participants (QPs), thereby earning incentive payments for their Advanced APM participation. QPs who have met a threshold of 25 percent of revenues earned or 20 percent of patients treated through an Advanced APM would be excluded from MIPS for 2018, and receive a 5 percent APM Incentive Payment. This 5 percent bonus is applicable for each year they are QPs beginning in 2019 through 2024.

In the final rule, CMS finalized that for Advanced APMs that start or end during the Medicare QP Performance Period and operate continuously for a minimum of 60 days during the Medicare QP Performance Period for the year, CMS will make QP determinations by using payment or patient data only for the dates that APM Entities were able to participate per the terms of the Advanced APM and not for the full Medicare QP Performance Period. Eligible clinicians who

participate in Advanced APMs but do not meet the QP or Partial QP thresholds of are subject to MIPS reporting requirements and payment adjustments.

Medicare publishes a list of qualifying Advanced APMs each year. They anticipate that new Advanced APMs will be available for participation in 2018 including the Medicare ACO Track 1 Plus (1+) Model, and expanded participation in current Advanced APMs, such as the Next Generation ACO Model and Comprehensive Primary Care Plus (CPC+) Model. CMS anticipates the amount of QPs to grow in subsequent years of the program and estimates that approximately 185,000 to 250,000 eligible clinicians may become QPs for payment year 2020 based on Advanced APM participation in performance year 2018.

To be considered an Advanced APM the APM **must meet all three of the following criteria:** (1) over 50 percent of its participants must be using CEHRT; (2) The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS and; (3) The APM Entities must bear more than nominal amount of financial risk, or be a Medical Home Model.

For QP Performance Periods in 2017 and 2018, the total amount of risk must be equal to at least either 8 percent of the average estimated total Medicare Parts A and B revenue of participating APM Entities (the revenue-based standard); or for all QP Performance Periods, 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (the benchmark-based standard). CMS finalized its proposal to maintain the generally applicable revenue-based nominal amount standard at 8 percent for 2019 and 2020, however participants in Round 1 of the CPC+ Model (as of Jan. 1, 2017) are exempt from the 50 eligible clinician limit as proposed. CMS will address the revenue-based nominal standard for QP Performance Periods after 2020 in future rulemaking.

CMS finalized policies as to how other payer participation in APMs may be considered in order for QPs to meet their percentage thresholds beginning in 2019. There are a few major differences to be highlighted: 1) To become a QP through the All-Payer Combination Option, an eligible clinician must participate in an Advanced APM with CMS, as well as an Other Payer Advanced APM. 2) Other Payer Advanced APM participation may be identified by information submitted by eligible clinicians, APM entities, and in some cases by payers, including states and Medicare Advantage Organizations. 3) The other payers must meet the same three criteria as Medicare APMs as noted above, and 4) The eligible clinician or the APM Entity must submit information to CMS so that CMS can determine whether the eligible clinician meets the required QP threshold of participation.

In order to provide eligible clinicians with the most opportunities to attain QP status and in response to concerns raised by commenters, CMS did not finalize its proposal to conduct all QP determinations under the All-Payer Combination Option at the individual eligible clinician level, rather CMS finalized a policy that an eligible clinician may request a QP determination at the eligible clinician level, and that an APM Entity may request a QP determination at the APM Entity level. In addition, CMS is requesting comments on whether in future rulemaking, CMS should also add a third alternative to allow QP determinations at the TIN level when all clinicians who have reassigned billing to the TIN are included in a single APM Entity and

whether this would more closely align with eligible clinicians' existing recordkeeping practices, and thereby be less burdensome.

Physician-Focused Payment Models (PFPMs)

Section 101 (e)(1) of MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to make comments and recommendations to the Secretary of the Department of Health and Human Services on proposals for Physician-Focused Payment Models (PFPMs) submitted by individuals and stakeholders. The Secretary is required by MACRA to establish criteria for PFPMs and to review the comments and recommendations on proposed PFPMs and to post a detailed response to those comments and recommendations on the CMS website.

In the proposed rule, CMS discussed broadening the definition of PFPMs to include payment arrangements that involve Medicare, Medicaid or the Children's Health Insurance Program (CHIP) (or some combination of these) as a payer. In addition, CMS requested feedback on the Secretary's criteria and whether the criteria are appropriate for evaluating PFPM proposals and are clearly articulated. In the final rule, CMS did not make any changes to the PFPM criteria and maintains the current definition of a PFPM to include only payment arrangements with Medicare as a payer. CMS asserts this definition preserves focus on APMs and Advanced APMs, which would be proposals that the Secretary has more direct authority to implement, while maintaining consistency for PTAC's review.

MIPS APM Scoring Standard

The MIPS APM scoring standard is designed for MIPS-eligible clinicians participating in certain types of APMs to reduce participant reporting burden of submitting data for both MIPS and their respective APMs. In the final rule, CMS moves forward with adding a fourth "snapshot" assessment date of Dec. 31 to identify MIPS-eligible clinicians (ECs) who participate in a full TIN APM (ECs who reassign their billing rights to a TIN participating in a full APM, such as a Medicare Shared Savings Program (MSSP) ACO) to ensure ECs who join the full TIN APM late in the performance year would be scored under the APM scoring standard. CMS notes that the fourth "snapshot" assessment date is not used for determining Qualifying APM Participant (QP) status and will not extend the QP performance period beyond August 31.

For a side-by-side comparison of CY 2017 and CY 2018 final rules, please refer to CMS' Fact Sheet: <https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf>.

The ACR's MACRA Committee and staff are further analyzing and digesting this rule for the membership to prepare future tools and materials. The ACR will also submit comments on the final rule before the end of the year.