

2018 Quality Payment Program Final Rule

Summary

On Thursday, November 3, 2017, CMS issued the 2018 Quality Payment Program (QPP) final rule. Comments on the final rule are due January 1, 2018.

The QPP encompasses the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) program, which were implemented this year to replace the sustainable growth rate. CMS says it developed the QPP with the following objectives in mind:

1. Improve beneficiary outcomes and engage patients through patient-centered Advanced APM and MIPS policies;
2. Enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools;
3. Increase the availability and adoption of Advanced APMs;
4. Promote program understanding and maximize participation through customized communication, education, outreach and support that meets the diversity of physician practices and patients, especially the unique needs of small practices;
5. Improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders;
6. Promote IT systems capabilities that meet the needs of users and are seamless, efficient and valuable on the front and back end;
7. Ensure operational excellence in program implementation and ongoing development; and
8. Address extreme and uncontrollable circumstances, such as hurricanes and other natural disasters, for both the transition year and the 2018 MIPS performance period.

MIPS Highlights

In the 2017 QPP final rule comments, ASTRO, in collaboration with other medical specialty groups, urged CMS to continue a more cautious, deliberative implementation of the MIPS program, allowing eligible clinicians and their practices an appropriate amount of time to fully prepare for successful participation in the MIPS program. We are pleased that many of the changes that CMS proposed for the 2018 program have been deferred to future years, allowing practices more time to adapt to the complexities of the program.

We are also pleased that CMS is responding to ASTRO's concerns regarding challenges facing small radiation oncology practices, as well as how the complexity of treating cancer patients could negatively impact radiation oncologists' ability to successfully participate in MIPS. ASTRO has long argued that treatment for cancer patients is inherently costly because of its complexity. CMS has finalized the addition of a complexity bonus to account for complex patients, such as cancer patients. We are also pleased that CMS finalized bonus points and modified participation requirements for small practices.

In the 2018 final rule, CMS seeks to more fully implement the reporting requirements of the MIPS program, while also extending several provisions established in the 2017 transition period. The Agency believes this allows for iterative learning and development as physicians progress toward full implementation of the program. The 2018 performance period begins on January 1, 2018, and eligible clinician performance during the 2018 performance period will be reflected in the 2020 payment period.

Key rule modifications include an increase in the MIPS low volume threshold from \$30,000 in Medicare Part B payments and 100 Medicare Part B beneficiaries to \$90,000 in Medicare Part B payments and 200 Medicare Part B beneficiaries. Exceeding both criteria in the low volume threshold means that a physician or group will be included in the MIPS program for the 2018 performance year. This expands the likelihood that many small practices or solo practitioners will not be eligible for participation in MIPS. The Agency estimates that 3,240 radiation oncologists will be determined eligible clinicians during the 2018 performance period, however given the new thresholds ASTRO questions whether more radiation oncologists actually may be ineligible. Of those expected participants, CMS estimates 97 percent of radiation oncologists are expected to experience a positive payment adjustment, and 3 percent will experience a negative payment adjustment. CMS anticipates that the combined impact of the MIPS program on the specialty to be a positive one percent payment adjustment.

According to the final rule, eligible clinicians will be required to submit a full year's worth of data for the Quality Performance Category. ASTRO opposed the increased reporting period. The weight for the Quality Performance Category will be 50 percent for performance year 2018, allowing 10 percent for the Cost performance category, which will also be assessed at a full performance year. The reporting periods and weights for the Improvement Activities and Advancing Care Information Performance Categories will remain at their 2017 levels. Reporting is required for a continuous 90 days and the weights for each category will remain at 15 percent and 25 percent respectively.

CMS also finalized standards for establishing achievement and improvement scoring for the Quality and Cost performance categories. Additionally, CMS finalized the addition of a 5-point bonus for small practices of 15 or fewer clinicians and up to a 5-point bonus for complex patients.

APM Highlights

In the final 2018 QPP, CMS finalizes Advanced APM policies associated with nominal revenue at risk, as well as the Qualified APM Participant (QP) performance period and determination status. The final rule also provides additional information regarding the establishment of an All-Payer APM and clarification regarding MIPS APMs.

In the 2017 QPP finale rule, CMS proposed increasing the revenue-based nominal amount standard from 8 percent to as high as 15 percent in future years. ASTRO joined other medical

specialty organizations in opposition to this proposed increase, citing the complexities of APM participation and the need for time to analyze savings and outcomes in the early stages of any APM Model. ASTRO is pleased that the 2018 QPP final rule extends the revenue-based nominal amount standard at 8 percent through performance year 2020.

The 2018 QPP final rule aligns the performance and status determination periods for qualified APM participants (QP) participating in All Payer Advanced APMs with those of the Medicare Advanced APM program. The Agency also finalized provisions regarding the establishment of “Other Payer Advanced APMs,” as well as the determination process by which Other Payer Advanced APMs can become Advanced APMs and be included in the All Payer Advanced APM program.

Effective January 1, 2018, the MIPS APM program is modified to include the Quality Performance Category, as required by MACRA. The Cost Category will continue to be weighted as zero for MIPS APMs.

Below are more details on key provisions in the 2018 Quality Payment Program proposed rule.

Merit-based Incentive Payment System (MIPS)

Clinician Eligibility

In the 2018 QPP final rule, CMS increased the low volume threshold for eligible clinicians. The 2017 threshold require eligible clinicians to meet both a Medicare expenditure threshold of \$30,000 in Medicare Part B payments and 100 Medicare Part B beneficiaries. The final rule increased the Medicare payment and beneficiary low-volume threshold to \$90,000 in Medicare Part B payments and 200 Medicare Part B beneficiaries. This excludes more physicians, including radiation oncologists, and groups from MIPS participation. The Agency did not finalize a proposal to allow excluded physicians to opt-in to the program if they exceed one of the two thresholds.

Additionally, beginning in the 2018 performance year, solo practitioners and groups with ten or fewer MIPS eligible clinicians may establish a Virtual Group. For all performance categories, the performance of individual members of the Virtual Group will be combined to determine the entire groups’ performance. Virtual Groups must complete required contracting and notify CMS of their intention to become Virtual Groups by December 31, 2017.

Bonus Points for Complex Patients

For 2018, CMS finalized the addition of up to five bonus points to the overall Composite Performance Score (CPS) for complex patients based on the combination of the dual eligibility¹ ratio and the average Hierarchical Conditions Category (HCC) risk score.

CMS will average the HCC risk scores for beneficiaries cared for by the MIPS eligible clinician during the 12-month segment of the eligibility period, which spans from the last four months of a calendar year one year prior to the performance period, followed by the first 8 months of the performance period in the next calendar year (September 1, 2017 to August 31, 2018, for the 2018 performance period). The dual eligibility ratio will be calculated based on the proportion of unique patients who have dual eligible status seen by the MIPS eligible clinician among all unique patients seen during the second 12-month segment of the eligibility period, which spans from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period.

CMS finalized that MIPS eligible clinicians must submit data on at least one measure or activity in a performance category to receive the complex patient bonus. According to Agency modeling, 22.7 percent of radiation oncology patients are dual eligible. The average HCC risk score for all specialties is 1.08, with the average for radiation oncology set at 1.79, just above the average. This indicates that radiation oncologists are more likely than other physicians to receive bonus points.

Small Practice Bonus

CMS finalized the addition of five points to the final MIPS score of small practices for the 2018 performance year to be applied to the 2020 payment year. To receive the small practice bonus, eligible clinicians must submit data on at least one performance category. This applies to group practices, virtual groups, or MIPS APM entities that consist of 15 or fewer clinicians. CMS will assess on an annual basis whether to continue the small practice bonus, and how the bonus should be structured.

The Agency determined that because there was less than a 1-point difference between scores for MIPS eligible clinicians who practice in rural areas, and those who do not, they did not propose a bonus for those who practice in a rural area, but plan to continue to monitor the impact of the QPP on the performance of those who practice in rural areas.

¹ “Dual eligible beneficiaries” is the general term that describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through a “Medicare Savings Program” (MSP) category.

Quality Performance Category

In the 2018 QPP final rule, the Agency increased the Cost category weighting to 10 percent and decreased the Quality category to 50 percent for the 2018 performance year. The Agency also finalized a full calendar year performance reporting period for 2018 for both the Quality and Cost categories.

CMS increased the data completeness threshold from 50 percent to 60 percent for both 2018 and 2019 performance years, with a minimum of 20 cases per measure. Practices that do not meet data completeness requirements in 2017 receive three points toward their Quality score. However, CMS modified the scoring for 2018, so that practices will only receive one point if they do not achieve data completeness. This policy will not apply to small practices who will continue to earn three points for submitting measures that do not meet data completeness.

Beginning with the 2018 performance year, CMS will begin to score achievement as well as performance improvement, if sufficient data is available. The Agency finalized measuring improvement in the Quality performance category based on percentage changes in achievement from one performance year to the next. Percentage changes in achievement are calculated for the entire Quality category, rather than on a measure-specific basis, in each performance period. CMS finalized an overall calculation to allow physicians to retain the ability to report on different quality measures from year to year. Performance periods are compared to one another to determine if the eligible clinician qualifies for an improvement award that is added into the Quality score. CMS will cap the size of the improvement award at 10 percentage points.

Additionally, CMS is implementing a four-year process for identifying and phasing out “topped out measures,” which are measures in which performance is so high and unvarying that meaningful measurement of change or improvement can no longer be achieved. Special scoring, featuring a 7-point measure cap, will be applied to measure benchmarks that have been topped out for at least two consecutive years. If during one of the three performance periods, the measure benchmark is not topped out, then the cycle would start again at year one.

Cost Performance Category

CMS finalized a 10 percent weight for the Cost category for the 2018 performance period, and 30 percent in 2019 and in future years.

Cost measures include Medicare Spending Per Beneficiary (MSPB) and total per capita cost for all attributed beneficiaries. The Agency proposes to provide performance feedback on the MSPB and total per capita cost measures by July 1, 2018. The Agency plans to provide a new set of episode-based cost measures in 2018 for future use.

Similar to the Quality performance category, CMS will begin measuring improvement in the Cost category. As a reminder, the Cost category weight is set to 0 percent for 2017. Practices will

receive data on their performance, however, they will not be rewarded or penalized based on this information. The data received for 2017 will be used as a baseline in 2018 to assess improvement. Because cost measures are calculated based on Medicare administrative claims data, measuring Cost category improvement can be done at the measure level rather than at the performance category level, as proposed for the Quality category. Improvement will be based on statistically significant changes at the measure level with up to 1 percentage point available in the Cost performance category.

Improvement Activities Performance Category

CMS did not make any changes in weighting for the Improvement Activities performance category and retains the 90-day minimum performance period. The category will remain weighted at 15 percent, based on a selection of medium and high weighted activities. CMS added several new Improvement Activities, including Accredited Safety or Quality Improvement Program; clinician leadership in clinical trials or community-based participatory research; and CDC training on CDC guidelines for prescribing opioids for chronic pain. The Agency retained the policy wherein a complete group may receive credit for an improvement activity that was completed by one eligible clinician.

Improvement Activity scores continue to be based on simple attestation in 2018.

Advancing Care Information Performance (ACI) Category

CMS is extending the use of 2014 Edition CEHRT for 2018. CMS will award a 10 percent bonus for those eligible clinicians who report the ACI objectives and measures for the 2018 performance period utilizing 2015 Edition CEHRT. Additionally, the Agency retains the 25 percent weight for the ACI category, as required by MACRA, and extends the 90-day minimum performance period through 2018.

The ACI standard measures remain unchanged for the 2018 performance period. The Agency proposes to establish a 5-point bonus for reporting on any one of four Public Health and Clinical Data Registry reporting objectives:

1. Syndromic Surveillance Reporting or Specialized Registry Reporting
2. Electronic Case Reporting
3. Public Health Registry Reporting
4. Clinical Data Registry Reporting

In the 2017 final rule, CMS established a 10-point bonus for eligible clinicians who attest to completing at least one specified improvement activity using CEHRT. The Agency identified additional improvement activities for the 2018 performance year that qualify for the bonus. The full list of thirty activities includes the provision of clinical-community resources and advance care planning among others.

CMS continues the ACI hardship exemption for the 2018 performance period. The Agency believes this is particularly important for small practices (those with 15 or fewer clinicians). The exemption for small practices re-weights the ACI category to zero, shifting an additional 25 percent to the Quality category, similar to ACI exemptions in the 2017 performance year. CMS finalized the deadline for the exemption application for 2017 and future years to December 31 of the performance year. Additionally, the Agency revised the definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19), which also receive an exception from the ACI Category.

MIPS Scoring Methodology

For 2018, CMS is proposing the following weights for the four MIPS Performance Categories:

- Quality – 50%
- Improvement Activities – 15%
- Advancing Care Information – 25%
- Cost – 10%
- Additionally, five bonus points for small practices and up to five bonus points for complex patients could be added to the MIPS overall score, known as the Composite Performance Score (CPS).

For 2018, CMS increased the performance threshold needed to avoid the payment penalty from 3 to 15 CPS points. The exceptional performance threshold remains at 70 points for 2018.

The payment adjustment for 2020 (based on 2018 performance) is set to range from -5 percent to +5 percent, plus any scaling to achieve budget neutrality, as required by MACRA.

Other MIPS Provisions

Performance Feedback

CMS proposes to provide eligible clinicians with QPP performance feedback on an annual basis. The Agency commits to providing more frequent feedback in future years.

Data Submission Requirements

CMS postponed the 2018 proposal allowing eligible clinicians to submit data using multiple submission mechanisms per performance category because the Agency cannot aggregate data on the same measure across submission mechanisms. The 2018 rules will be the same as 2017: measures must be submitted using only one mechanism per performance category.

QCDRs

CMS finalized revisions to the Qualified Clinical Data Registry (QCDR) nomination process. The Agency will establish a web-based tool beginning in 2019 that will allow QCDRs to continue participation in the MIPS program. Additionally, the Agency proposes to replace the term “non-MIPS measures” with “QCDR measures”.

Definition of “Small Practice” and Qualifications for Rural or HPSA Designation

CMS defines a “small practice” as a practice consisting of 15 or fewer clinicians and solo practitioners. CMS recognizes that it must account for small practice size in advance of the performance period and finalized a proposal to identify small practices through claims data. A 12-month determination period would span the last four months of the calendar year two years prior to the performance period through the first 8 months of the next calendar year. Practices that meet the small practice definition would then be eligible for the reduced reporting requirements in the Improvement Activities performance category; exempt from the ACI performance category; and be eligible for the small practice bonus.

CMS finalized a modification to the rural practice designation. The modified determination requires that more than 75 percent of clinicians in a practice be located in a Rural and Health Professional Shortage Area (HPSA) designated zip code.

Extreme and Uncontrollable Circumstances

Recognizing that extreme and uncontrollable circumstance occur, making it difficult for clinicians to submit data, CMS issued an Interim Final Rule for Extreme and Uncontrollable Circumstances. For the 2017 performance year, the Agency will automatically weight the Quality, Advancing Care Information, and Improvement Activities performance categories at 0 percent of the final score for clinicians impacted by hurricanes Irma, Harvey, and Maria, and other natural disasters. Clinicians are not required to submit a hardship request for the 2017 performance year for these categories, and will not have a negative adjustment. For the 2018 performance year, the Agency is requiring clinicians to submit a hardship request for these categories.

If a MIPS eligible clinician’s CEHRT is unavailable as a result of extreme and uncontrollable circumstances, the clinician may submit a hardship exception application for reweighting of the Advancing Care Information performance category. This application is due by December 31, 2017.

Clinicians that do submit data will be scored on their submitted data, allowing them to be rewarded for their performance in MIPS. Clinicians have to submit data on two or more performance categories to receive a positive payment adjustment. This applies to individuals (not groups), but all individuals in the affected area will be protected for the 2017 performance period. This policy does not apply to APMs.

The Agency invites public comment on the automatic extreme and uncontrollable circumstance policy for individual MIPS eligible clinicians for the 2017 MIPS performance period, as well as alternatives to these policies, such as using a shortened performance period, which may allow CMS to measure performance, rather than reweighting the performance categories to zero percent.

ASTRO is pleased that CMS is recognizing the hardships caused by the severe hurricanes in 2017 and is adjusting its policies accordingly.

Alternative Payment Model (APM) Program

In the final 2018 QPP, CMS finalizes Advanced APM policies associated with determining Qualified APM Participant (QP) status and nominal revenue at risk. The final rule also provides additional information regarding the establishment of All-Payer APMs, as well as clarifying information regarding MIPS APMs.

Qualified APM Participant (QP) Performance Period and Status Determination

The 2017 final rule established the definition of qualified APM participants (QPs), as those eligible clinicians who have met the established Medicare Part B beneficiary or Medicare Part B expenditure thresholds for participation in an Advanced APM, thus exempting them from MIPS participation. In the 2018 proposed QPP, CMS proposed replacing the term “QP Performance Period” with a definition for an “All Payer QP Performance Period” and a “Medicare QP Performance Period”. The All Payer QP Performance Period would begin January 1 and end on June 30 of the calendar year that is two years prior to the payment year. The Medicare QP Performance Period, as currently defined, begins on January 1 and ends on August 31 of the calendar year that is two years prior to the payment year. The Agency did not finalize this proposal in the 2018 QPP final rule; instead, CMS aligned the All Payer QP Performance Period with the Medicare QP Performance Period, thus retaining the term “QP Performance Period”.

In the 2018 QPP final rule, CMS also finalized its policy regarding the timeframe for which payment amount and patient count data are included in the QP threshold determination for Advanced APM status. CMS recognizes that not all APM entities can participate in Advanced APMs within the full January 1 to August 31 performance period. The Agency finalized a policy recognizing participation for a continuous 60-day period as sufficient to determine Advanced APM QP status. This policy does not apply to those APM Entities that had an opportunity to participate in an Advanced APM during the full performance period but chose not to do so.

CMS also provided clarification in the final rule that it will use the entire performance period to make QP determination for those eligible clinicians participating in multiple Advanced APMs. Additionally, should an APM Entity, either voluntarily or involuntarily, terminate from the Advanced APM, then the eligible clinicians will no longer be designated QPs.

Nominal Revenue at Risk

CMS finalized its proposal to retain the nominal revenue at risk requirement for Advanced APMs at 8 percent through performance year 2020. In the 2017 QPP rule, CMS stated that it was considering incremental increases up to 15 percent in future years. ASTRO joined other medical specialty organizations in opposition to this proposed increase, citing the complexities of APM participation and the need for time to analyze savings and outcomes in the early stages of any APM Model. ASTRO is pleased that the 2018 final rule contains a provision that seeks to extend the revenue-based nominal amount standard at 8 percent through performance year 2020.

Application of Nominal Revenue at Risk on Small and Rural Practices

In the 2018 QPP proposed rule, CMS sought comment on whether it should consider a different, potentially lower, revenue-based nominal amount standard for small practices and those in rural areas, particularly whether such an exception should be expanded to small or rural practices that are joining with a larger APM entity to participate in an APM. In the 2018 QPP final rule, CMS chose not to adopt a policy that would reduce the nominal amount standard for small and rural practices, but stated that the impact of the policy would be monitored and potentially considered again in future rule making.

All-Payer Advanced APM Arrangements

Beginning in payment year 2021 (performance period 2019), eligible clinicians may participate in All-Payer Advanced APM arrangements. The All-Payer option does not replace or supersede the Medicare Advanced APM option; instead it allows eligible clinicians to become QPs by meeting the QP thresholds through a pair of calculations that assess Medicare Part B covered professional services furnished through Advanced APMs, and a combination of both Medicare Part B covered professional services furnished through Advanced APMs and services furnished through Other Payer Advanced APMs.

All-Payer Advanced APM QP Payment Amount Thresholds

QPs must meet specific payment amount and patient count thresholds to participate in All-Payer APM arrangements. Effective 2021, the QP payment amount determination threshold is set at 50 percent of total payments, of which 25 percent must be Medicare payments. The patient threshold is set at 35 percent of total patients, of which 20 percent must be Medicare patients. The threshold requirements for QP status determination incrementally increase over a four-year period, topping out at 75 percent total/25 percent Medicare payment and 50 percent total/20 percent Medicare patients in 2024 and future years.

Because CMS cannot verify the payment amounts or patient counts attributed to other payer APMs, the Agency requires that eligible clinicians submit to CMS the information on all relevant payment arrangements with other payers.

CMS-Multi-Payer Models

CMS-Multi Payer Models are defined as an Advanced APM that CMS determines has at least one other payer arrangement that is designed to align with the terms of the Advanced APM. A current example of a CMS-Multi Payer Model is the Oncology Care Model (OCM). Advanced APM determination of other payer arrangements is performed during the first performance period, CMS does not automatically confirm Advanced APM status on other payer arrangements participating in an CMS-Multi Payer Model.

Other payer arrangements that are aligned with a CMS-Multi-Payer Model, by definition, are not APMs, and thus cannot be Advanced APMs under the Medicare option. However, payers and eligible clinicians participating in these arrangements may seek approved CMS designation as an Other Payer Advanced APM.

Other Payer Advanced APM Criteria

In the 2017 final rule, CMS determined that Other Payer Advanced APMs meet the following criteria: 1) require at least 50 percent of participating eligible clinicians in each APM entity to use CEHRT to document and communicate clinical care; 2) utilize quality measures that are comparable to MIPS quality measures; and 3) require APM Entities to bear more than nominal financial risk if the actual aggregate expenditures exceed the expected aggregate expenditures.

The 2017 final rule established the nominal risk requirement for Other Payer Advanced APMs. The requirement contains three components: 1) Marginal risk of at least 30 percent; 2) Minimum loss rate of no more than 4 percent; and 3) Total risk of at least 3 percent of the expected expenditures for which the APM entity is responsible.

In the 2018 QPP proposed rule, CMS sought to add a revenue-based, generally applicable nominal risk amount, similar to the Medicare Advanced APM requirement. CMS proposed that the revenue-based nominal amount that an APM Entity potentially owes the payer or forgoes is equal to at least 8 percent of the total combined revenues from the payer of providers and suppliers in participating APM entities.

In the 2018 QPP final rule, CMS finalizes this policy with a clarification. The Agency will look at estimated total combined revenues of providers and other entities participating in the Other Payer APM Entity to determine if the arrangement meets the nominal risk standard. This methodology will apply to the 2019 and 2020 performance periods, and it will only be applicable in arrangements in which the risk is explicitly defined in terms of revenue.

CMS finalized the Other Payer Advanced APM determination process in the 2018 QPP final rule. APM Entities or eligible clinicians may request Other Payer Advanced APM determination between August 1 and December 1 prior to the performance year. CMS will make a

determination and notify APM entities and eligible clinicians as soon as practicable after the submission deadline.

MIPS APMs

In the 2017 final rule, CMS finalized the following requirements for MIPS APMs: 1) APM entities participate in an APM under an agreement with CMS or by law or regulation; 2) the APM requires that the APM Entities include at least one MIPS eligible clinician on a Participation List; and 3) the APM bases payment incentives on performance (either at the APM entity or eligible clinician level) on cost/utilization and quality measures; and 4) the APM is not either a new APM for which the first performance period begins after the first day of the MIPS performance period for the year, or an APM in the final year of operation for which the APM scoring standard is infeasible. CMS posts the lists of MIPS APMs prior to the first day of the MIPS performance period. A list of MIPS APMs can be found at www.qpp.cms.gov.

An APM scoring standard is applied to MIPS APMs that recognizes the unique arrangements of MIPS APMs. MIPS eligible clinicians participating in MIPS APMs will be scored at the APM Entity group level, and each MIPS eligible clinician will receive the APM Entity groups final score. The final score will be applied at the TIN/NPI level for each of the MIPS eligible clinicians in the APM Entity. In the 2018 Final QPP, CMS confirms the definition of a full TIN APM to mean an APM where participation is determined that the TIN level. Therefore, all eligible clinicians who have assigned their billing rights to a participating TIN are considered to be APM participants.

The Agency also finalized adding a fourth snapshot date to the series of dates for which physicians can be considered part of, and benefit from participating in a MIPS APM. In addition to March 31, June 30 and September 30, CMS has added December 31 as a snapshot date.

Other MIPS APMS

In the 2018 QPP final rule, CMS provided clarification that there are two subcategories of MIPS APMs. Those that are “Web Interface reporters” (currently the Shared Savings Program and Next Generation ACO Model), and “Other MIPS APMs”. Web Interface reporters are a subset of MIPS APMs where the terms of the APM require APM Entities to report quality data using the Web Interface.

CMS finalized its proposal to define the term Other MIPS APM as a MIPS APM that does not require reporting through the Web Interface. For the 2018 MIPS performance period, Other MIPS APMs include the OCM.

MIPS APMS – Performance Categories

In the 2017 final rule, CMS determined that the MIPS Quality and Cost categories did not apply to MIPS APMs because participation in an APM inherently include improvements in quality and

reduced costs. For the 2018 performance period, the Agency is moving forward, as required by MACRA, with the implementation of a Quality Performance Category for MIPS APMs, effective January 1, 2018.

The MIPS APM Quality Performance Category involves a quality measures list for use in the APM scoring standard. The quality measure sets for each MIPS APM are unique. The MIPS APM quality measures set for the OCM includes three radiation oncology specific measures: 1) Medical and Radiation – Pain Intensity Quantified; 2) Medical and Radiation – Plan of Care for Pain; and 3) Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer. The measures are tied to payment as described by the terms of the APM; are available for scoring near the close of the MIPS submission period; require a minimum of 20 reportable cases; and have a benchmark.

The 2018 QPP finalizes the submission, scoring and weights of each of the performance categories for MIPS APMS as follows:

APM Scoring Standard Performance Category Weights – Beginning with the 2018 Performance Period²

MIPS Performance Category	APM Entity Submission Requirement	Performance Category Score	Performance Category Weight
Quality	The APM Entity will be required to submit quality measures to CMS as required by the MIPS APM. Measures available at the close of the MIPS submission period will be used to calculate the MIPS quality performance score. If the APM Entity does not submit any APM required measures by the MIPS submission deadline, the APM entity will be assigned a zero.	CMS will assign the same quality category performance score to each TIN/NPI in an APM Entity group based on the APM Entity’s total quality score, derived from available APM quality measures.	50%
Cost	Not Applicable	Not Applicable	0%

² Table 12: APM Scoring Standard Performance Category Weights – Beginning with the 2018 Performance Period, Quality Payment Program 2018 Final Rule, November 2, 2017.

Improvement Activities	MIPS eligible clinicians are not required to report improvement activities data; if the CMS-assigned improvement activities score is below the maximum improvement activities score, APM Entities will have the opportunity to submit additional improvement activities to raise the APM Entity improvement activity score.	CMS will assign the same improvement activities score to each APM Entity based on the activities involved in participation in the MIPS APM. APM entities will receive a minimum of one half of the total possible points. In the event that the assigned score does not represent the maximum improvement activities score, the APM entity will have the opportunity to report additional improvement activities to add points the APM Entity level score.	20%
Advancing Care Information	Each MIPS eligible clinician in the APM Entity group is required to report advancing care information to MIPS through either a group TIN or individual reporting.	CMS will attribute the same score to each MIPS eligible clinician in the APM Entity group. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinician will be averaged for a single APM Entity score.	30%

APM entities are eligible for additional bonus points if they report on high priority measures or measures submitted via CEHRT. The total number of awarded bonus points may not exceed ten percent of the APM entity’s total available achievement points for the MIPS Quality performance score.

The Agency recognizes that there may be instances where a MIPS APM may not have measures available to score for the performance category. Under these circumstances the Agency will reweight the Quality performance category to zero, the Improvement Activities category to 25 percent and the Advancing Care Information category to 75 percent.

Physician Focused Payment Models (PFPMs)

CMS established the parameters around the development of Physician Focused Payment Models and the process by which they are considered and approved for recommendation to CMS by the Physician Focused Payment Model Technical Advisory Committee (PTAC) in the 2017 final rule.

In the 2018 QPP proposed rule, CMS sought comment on whether additional consideration should be given to PFPMs that include Medicaid or the Children's Health Insurance Program (CHIP) as payers. The Agency also solicited comment on whether modifications should be made to the definition of PFPM so that they align with APM standards, and what additional resources can be provided to PFPM applicants as part of the PTAC process.

The Agency did not make any specific proposals with regard to these topics and in the final rule did not adopt any new policies. CMS continues to accept feedback on the role of PTAC and the resources that should be made available to PFPM applicants.

Additional QPP resources

The 2018 QPP final rule can be found at the following link: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-24067.pdf>

ASTRO guidance on the QPP program can be found at the following link: www.astro.org/qpp

A CMS Fact Sheet on the 2018 QPP final rule:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html>

CMS Quality Payment Program Year 2 Overview: <https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf>