

2018
MACRA

**Quality
Payment
Program**



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The American College of Surgeons

**Resources for the New Medicare
Physician Payment System**

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Simple Steps to Determine If MIPS Applies to Your Practice Situation

Surgeons' practice situations vary. As explained in more detail below, for various reasons surgeons may not be required to participate in the Merit-based Incentive Payment System (MIPS), or they may not be eligible to do so. To determine whether MIPS applies to you, use the following simple steps:

- 1)** Are you a participant in a qualified advanced alternative payment model (A-APM)? If you are unsure, you can use your National Provider Identifier (NPI) number to look up your status at data.cms.gov/qplookup. If you are a qualified participant in an A-APM, you are not only exempt from reporting MIPS data, but you could also **receive a 5 percent bonus** in 2020 for your participation in 2018.
- 2)** Are your MIPS data reported for you by your institution, your employer, or your group? If your data are being reported for you then you need take **no further action. You should contact your institution, employer, or group to confirm that data are being reported for you.**
- 3)** Are you exempt from participating in MIPS based on the **LOW-VOLUME THRESHOLD**? For 2018, an increase in the low-volume threshold is expected to exclude a significant number of providers. To determine if you are exempt based on the low-volume threshold, use your NPI number at qpp.cms.gov/participation-lookup.

If MIPS applies to your practice, you need to make a choice between:

- 1)** Submitting the minimum data necessary to avoid a penalty, and thus accepting a freeze in your payments in 2020 for the 2018 performance period, **OR**
- 2)** Submitting data in an effort to compete for a positive update

If you prefer to submit the minimum amount of data necessary to avoid a penalty, your best option is to complete the requirements for the **Improvement Activities (IA)** component of MIPS. By achieving **FULL CREDIT in this category of MIPS, you will acquire enough points (15) to reach the performance threshold in your MIPS final score to avoid a 5 percent penalty in your Medicare payments in 2020** based on your performance and participation in 2018.

Within the IA category, each activity is assigned either a high (20 points) or medium (10 points) weight.

- To receive **full credit** in the Improvement Activities component, most surgeons must select and attest to having completed between two and four activities for a total of 40 points in the IA category.
- For small practices OR rural practices to achieve full credit, only one high-value or two medium-value activities are required. The Centers for Medicare & Medicaid Services (CMS) defines small practices as those consisting of 15 or fewer eligible clinicians. CMS defines rural practices as those where more than 75 percent of the NPIs billing under the individual MIPS eligible clinician or group's Tax Identification Number



(TIN) are designated in a ZIP code as a rural area or Health Professional Shortage Area (HPSA) (based on the most recent Health Resources and Services Administration Area Health Resource File data set).

Those who fulfill these requirements will receive the maximum score and full credit in the Improvement Activity category toward their MIPS Final Score (15 points). The performance threshold for 2018 is set at 15 points, so those who choose to simply avoid a payment penalty can acquire the necessary 15 points by earning full credit in the IA category and thereby avoid a penalty in 2020 for their performance in 2018.

The reporting requirement for the Improvement Activities category is fulfilled by simple attestation via a qualified registry, qualified clinical data registry (QCDR), an electronic health record (EHR), or the QPP Data Submission System (accessible at qpp.cms.gov/login). The American College of Surgeons (ACS) has two QCDRs, the Surgeon Specific Registry (SSR) and the Metabolic and Bariatric Surgery Quality Improvement Program (MBSAQIP) Data Registry, through which surgeons can attest to IAs.

If you plan to compete for a positive update in 2020 based on your performance in 2018, you should ideally report on the Quality, Advancing Care Information (ACI), and Improvement Activities categories of MIPS. If this is your intent, we suggest you carefully read this manual, visit facs.org/qpp, and make your plan for 2018.

Regardless of your choice, ACS staff in the DC office and the SSR are here to help and can be reached at 202-337-2701 (DC) or 312-202-5408 (SSR).

Understanding the Program

1

Quality Payment Program (QPP)

- a. Operationalization of the Medicare Access and CHIP Reauthorization Act (MACRA)
 - i. Legislation passed in April 2015
- b. Replaced the Sustainable Growth Rate (SGR)
- c. Represents a major change in Medicare physician payment
- d. Advances the policy goal of value over volume

2

Pathways to Participate in the QPP

- a. Merit-based Incentive Payment System (MIPS)
 - i. Most surgeons participate in the QPP via this path
 - ii. Combined Medicare's three previous quality programs into one system and added an additional category
- b. Alternative Payment Models
 - i. Participating in MIPS APMs to improve individual MIPS score
 - ii. Participating in Advanced APMs as a mechanism to achieve EXEMPTION from MIPS

3

MIPS

- a. Four Components
 - i. Quality
 - ii. Cost
 - iii. Advancing Care Information
 - iv. Improvement Activities

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Quality Component

- a. Replaced PQRS reporting
- b. Reporting requirements
 - i. Fewer measures required
 - ii. Report on six measures, including one outcome measure or another high-priority measure if outcome measure not available
 - iii. Measures may be chosen from:
 - 1. MIPS measures list, including MIPS specialty-specific measures sets
 - 2. QCDR measures

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Cost Component

- a. Replaced Value-Based Payment Modifier
- b. CMS will make calculation based on information from available claims data
 - i. Total per capita costs for all attributed beneficiaries
 - ii. Medicare spending per beneficiary
- c. NO REPORTING REQUIREMENTS

6

Advancing Care Information Component

- a. Modifies and replaces the Electronic Health Record Incentive program, known as Meaningful Use, for Medicare physicians
- b. Score derived from three parts
 - i. Base score = 50 points
 - 1. Requires reporting four or five measures depending on your version of Certified Electronic Health Record Technology (CEHRT) and thus the appropriate ACI measure set for reporting
 - ii. Performance = 90 points
 - 1. Achieving the Base score is required before any score can be accrued for the Performance portion
 - 2. Driven by the performance rate on a subset of required measures and optional, self-selected measures from the chosen ACI measure set
 - iii. Bonus score up to 25 points
 - 1. 10-point bonus for submitting data for ACI measures using 2015 Edition CEHRT exclusively
 - 2. 10-point bonus for reporting certain Improvement Activities via CEHRT
 - 3. 5-point bonus for reporting to an additional public health agency or clinical data registry not reported under the Performance score



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Improvement Activities

- a. Each activity is assigned a point value
 - i. High weight = 20 points
 - ii. Medium weight = 10 points
- b. Total of 40 points needed to achieve FULL CREDIT
 - i. Some rural and small practices need to perform only one high-weight or two medium-weight activities to earn FULL CREDIT
 - ii. Small practice = Consisting of 15 or fewer providers
 - iii. Rural practice = More than 75% of the NPIs billing under the individual MIPS-eligible clinician or group's TIN are designated in a ZIP code as a rural area or HPSA based on the most recent Health Resources and Services Administration Area Health Resource File data set
- c. Reported by simple ATTESTATION
 - i. Traditional registry
 - ii. QCDR such as the SSR
 - iii. EHR
 - iv. QPP Data Submission System accessible at qpp.cms.gov/login

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MIPS Final Score

- a. Derived as composite from performance in four components
- b. Weighted by category (assuming each category is reported on and/or scored):
 - i. Quality: 50%
 - ii. Cost: 10%
 - iii. Advancing Care Information: 25%
 - iv. Improvement Activities: 15%

Big Changes in 2018

Topic	MIPS Performance Year 1 (2017)	MIPS Performance Year 2 (2018)
Low-Volume Threshold	Low-volume clinicians excluded from MIPS defined as individual MIPS-eligible clinicians or group practices who, over a 12-month determination period, have Medicare Part B-allowed charges less than or equal to \$30,000 OR provide care for 100 or fewer Part B-enrolled Medicare beneficiaries.	Increase in the low-volume threshold to exclude MIPS-eligible clinicians or group practices who have Medicare Part B-allowed charges less than or equal to \$90,000 OR provide care for 200 or fewer Part B-enrolled Medicare beneficiaries. This will exclude approximately 123,000 additional providers from participating in the MIPS program.
Virtual Groups	CMS chose not to implement virtual groups in 2017.	CMS created a virtual group-level reporting option for 2018 and beyond that is only available to solo practitioners and groups of 10 or fewer eligible clinicians. <ul style="list-style-type: none"> • No restrictions on overall virtual group size or makeup. • 2018 virtual group elections must have been submitted to CMS by December 31, 2017. • Most MIPS group reporting policies apply to virtual groups.
Overall MIPS Performance Threshold	MIPS performance threshold set at 3 points , which is the minimum score needed to avoid a penalty in 2019. Clinicians can earn 3 points by reporting a single quality measure, attesting to a single IA, or satisfying the base score requirements for the ACI component.	MIPS performance threshold is set at 15 points , which means that clinicians will have to report more to avoid a penalty in 2020. Ways to meet this threshold include fully reporting the quality category (for example, at least 6 measures for at least 60% of applicable patients) or obtaining the maximum credit in the IA category.
Cost: Weight	Cost category weighted at 0%. Although cost performance will not impact a clinician's MIPS performance score, CMS will provide confidential feedback to clinicians based on the Total Per Capita Cost measure and the Medicare Spending Per Beneficiary measure.	Cost category weighted at 10% of overall MIPS score (quality category weight reduced to 50%). Clinicians who are attributed a sufficient number of patients will be scored on performance on the Total Per Capita Cost and Medicare Spending Per Beneficiary measures. If not, 10% weight will be transferred to the quality category.



Topic	MIPS Performance Year 1 (2017)	MIPS Performance Year 2 (2018)
Quality: Data Completeness Criteria	<ul style="list-style-type: none"> Clinicians must report quality measures for at least 50% of applicable patients (Medicare patients for claims-based reporting; all-payer patients for traditional registries, QCDRs, and EHRs). Those who do not meet this requirement can only receive 3 out of 10 points per measure reported. 	<ul style="list-style-type: none"> CMS increased the data completeness threshold to 60% of applicable patients (Medicare patients for claims-based reporting; all-payer patients for traditional registries, QCDRs, and EHRs). Each measure that does not meet this requirement will only receive 1 out of 10 points. However, small practices that do not meet the data completeness threshold will receive 3 points per measure.
Bonus Points	<ul style="list-style-type: none"> 1 to 2 bonus points in the quality performance category for reporting more than one outcome, patient experience, or high-priority measure. 1 bonus point in the quality performance category for each quality measure submitted with end-to-end electronic reporting. Up to a 5% bonus in the ACI category for reporting to multiple registries. 10% ACI bonus for attesting to certain IAs. 	<p>In addition to maintaining the 2017 bonuses, CMS finalized additional bonuses:</p> <ul style="list-style-type: none"> Clinicians with more complex patients are eligible for up to an additional 5 points in their final score. There is an automatic 5-point final score bonus for small practices. Those who use 2015 Edition CEHRT will receive a one-time bonus of 10% under the ACI category.
ACI Exceptions	<p>Automatic exception from ACI category for hospital-based clinicians, defined as clinicians furnishing 75% or more of their covered professional services in the inpatient hospital (POS 21), ED (POS 23), or on-campus outpatient setting (POS 22).</p> <p>Other ACI hardship exceptions available:</p> <ul style="list-style-type: none"> Extreme and uncontrollable circumstances Lack of control over the availability of CEHRT Lack of face-to-face patient interaction 	<p>CMS expanded automatic ACI exception for hospital-based clinicians to include those who furnish 75% or more of their covered professional services in the off-campus outpatient hospital setting (POS 19). If a clinician qualifies as hospital-based and is participating in MIPS as an individual, the ACI category will be re-weighted to 0% and the 25% transferred to the quality category. For a group practice to qualify for this re-weighting, 100% of the group's MIPS eligible clinicians must each meet the definition of hospital-based.</p> <p>CMS created an additional exception from the ACI category for Ambulatory Surgery Center (ASC)-based physicians, defined as an eligible clinician who furnishes 75% or more of his or her covered professional services in sites of service identified by the POS 24.</p> <p>In addition to the ACI significant hardship exemption created for 2017, CMS created an ACI significant hardship exception to include small practices.</p>

Navigating MIPS in 2018

The Merit-based Incentive Payment System took a number of steps to streamline Medicare reporting. The MIPS pathway includes tools to help small and rural practices successfully compete. The penalty for not participating for the 2018 reporting period has increased to 5 percent, and over time the maximum penalty for nonparticipation or poor performance will continue to increase. Therefore, it remains critically important that all surgeons make a plan for how they can best participate and succeed in the QPP whether via the MIPS or the APM pathways. Because Medicare reporting requirements can seem burdensome and confusing, this document was created with the intent of explaining the MIPS program requirements for the performance year of 2018. The goal is to guide Fellows of the College through the process of choosing the best way to participate in MIPS that is right for their individual practice.

Background on MIPS and Its Components

MIPS began measuring performance in 2017. The data reported in 2017 will be used to adjust payments in 2019. The data reported in calendar year 2018 will be used to adjust payments in 2020. MIPS combined the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VM), and the EHR Incentive Program commonly referred to as Meaningful Use (MU), added the new component Improvement Activities, and combined them to derive a composite MIPS Final Score. The components of the



Final Score are known as **Quality, Cost, Advancing Care Information, and Improvement Activities**. The weights for the individual components of the Final Score for the 2018 MIPS program performance year (assuming each category is reported on and/or scored) are represented in Figure 1.

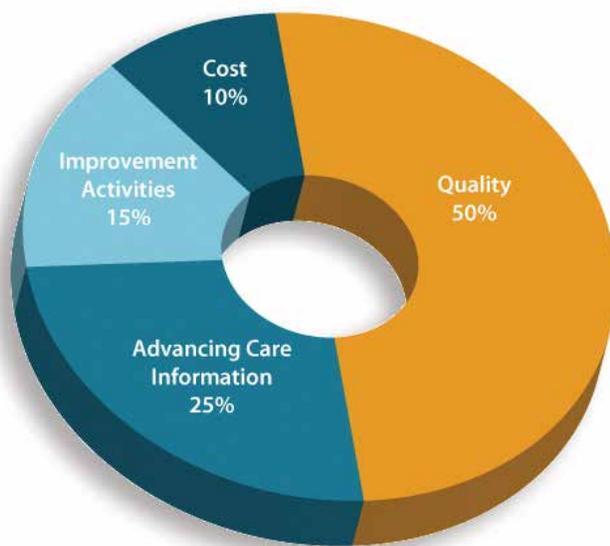


Figure 1.
2018 performance categories weights

Does MIPS Apply to Me?

For 2018, CMS estimates that approximately 40 percent of eligible clinicians will be required to submit data under MIPS. Furthermore, many providers, particularly those who are employed or are in large group practices, will have data submitted on their behalf by their group, institution, or employer. Therefore, it is imperative that as a first step, all surgeons determine whether they are exempt from participating in the MIPS program. If not exempt, surgeons should then determine if their practice situation necessitates that they report their own individual MIPS data for 2018 or, alternatively, if data will be reported for them by their group, institution, or employer.

In order to facilitate this process, the series of steps below are presented in order to assist surgeons to determine what, if any, actions they must take in 2018 to avoid a 5 percent penalty in their 2020 Medicare payments.



Determining If One Is Exempt from MIPS Reporting

CMS estimates that approximately 622,000 of the 1.5 million clinicians billing Medicare Part B will be required to submit data under MIPS. For those clinicians not required to submit data, that exclusion will be based on their participation in an Advanced Alternative Payment Model (A-APM), their failure to meet the low-volume threshold, or the fact that they meet the criteria as a newly enrolled Medicare clinician.

If you are a Qualifying Participant (QP) in an Advanced Alternative Payment Model (APM) you are exempt from reporting MIPS data. If you are unsure of your status as such a participant, you can use your NPI number to determine your status at data.cms.gov/qplookup. QPs are not only exempt from reporting MIPS data, but could also **receive a 5 percent bonus** in 2020 for that 2018 participation.

For 2018, CMS increased the low-volume threshold. It is now set at less than or equal to \$90,000 in Medicare Part B allowable charges OR 200 or fewer Medicare Part B patients seen during the period selected by CMS. Because this represents an increase compared to 2017, it will result in even more providers being exempted from participating in MIPS. It should be noted that failure to meet **EITHER** of these thresholds, \$90,000 in allowable charges OR 200 Medicare Part B patients, is **SUFFICIENT** to exclude one from reporting MIPS data in 2018.

As was the case in 2017, we anticipate that CMS will notify those providers who are exempt based on the low-volume threshold within the first or second quarter of 2018. Alternatively, surgeons may use their NPI to check their status relative to MIPS reporting at qpp.cms.gov/participation-lookup.

MIPS Reporting: Individuals or Groups

If one is required to submit MIPS data, your payment adjustment will be based on your individual performance. For 2018, the **Final Score** will be calculated based on data from all four performance categories: **Quality, Cost, Advancing Care Information, and Improvement Activities**. Since Cost measures will be calculated automatically by CMS based on claims, surgeons are only required to submit data for three of these categories: Quality, Advancing Care Information, and Improvement Activities. Data may be submitted through an EHR, a traditional registry, or a QCDR. Alternatively, quality data may also be submitted through the routine Medicare claims process. Data for Quality, Improvement Activities, and the ACI category may also be submitted through the QPP Data Submission System (accessible at qpp.cms.gov/login).

Surgeons who submit MIPS data as part of a group practice under a single TIN will receive the MIPS Final Score and corresponding payment adjustment in accordance with the assessment made for their group practice (a single MIPS Final Score and corresponding payment adjustment is made for all individuals within the group). Those who choose to report as a group under any of the four categories must report as a group for all of the remaining MIPS categories. However, if the same MIPS clinician also submits individual level data, CMS will use the higher score for that clinician.



Beginning with 2018, providers will be allowed to form virtual groups to be assessed collectively under MIPS. Participating in a virtual group allows certain providers under different TINs to report data together and share the burden of meeting the reporting requirements. CMS has defined a virtual group as a combination of two or more TINs assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians, or both, that elect to form a virtual group for a performance period of a year.

MIPS Reporting: Pathway toward Potentially Receiving a Positive Payment Update

Reporting for Quality

Assuming that a clinician or group is scored under all four performance categories, the Quality component is worth 50 percent of the MIPS final score. For 2018, a clinician is expected to report on a minimum of six measures, including one outcome measure (a high-priority measure may be substituted if an outcome measure is not available). In order to receive a performance score on a measure, the clinician or group must report quality data for **60 percent of all patients for which each measure is applicable** over the course of 12 months. Surgeons can choose from numerous MIPS measures, including CMS' general surgery specialty measure set or use a QCDR such as the ACS Surgeon Specific Registry (SSR), which includes additional quality measures beyond the traditional MIPS quality measures.

For 2018, providers can choose from the following data submission mechanisms for the Quality component:

- Claims
- QCDR
- Qualified registry
- EHR
- CMS web interface (groups of 25 or more)
- CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism)

One major, noteworthy change for 2018 is the data completeness criteria. In 2018, providers who report via claims must submit data on 60 percent of Medicare patients in order to meet the data completeness criteria.



Those who report via other mechanisms need to report on 60 percent of all patients regardless of payer (including no-pay patients). It is important to understand that measures that do not meet these data completeness thresholds will only earn one point out of 10 potential points (three out of 10 points for small practices). In addition to the points earned through the clinical quality measures, providers can earn bonus points for reporting additional outcome and high-priority measures, as well as a bonus for end-to-end electronic reporting of quality measures via CEHRT.

The MIPS performance threshold (15 points) is the minimum number of final score points that must be earned in order to avoid a payment penalty in 2020. While there are multiple ways to achieve 15 points, one way is through full participation in the Quality performance category. For example, a provider can earn at least 15 points by only submitting all six required quality measures **as long as they meet the necessary data completeness criteria detailed above**. The bar is even lower for providers in small practices consisting of 15 or fewer providers. Providers in small practices can report on each of the six measures for a single patient and still earn 15 points and avoid a penalty. This is because providers in small practices will earn three points (as opposed to non-small practice providers who earn one point) for measures that do not meet the data completeness criteria. Under these scenarios in 2018, the provider would not have to report on any other MIPS performance categories to avoid a penalty.

Reporting for Cost

The **Cost** component is worth 10 percent of the MIPS final score. CMS will calculate cost for the 2018 performance period using data from claims. This means that although Cost will be a weighted performance category in 2018, surgeons will not need to take any action with respect to reporting for cost. In other words, **THERE ARE NO REPORTING REQUIREMENTS FOR COST.**

For 2018, CMS will base the cost score on two measures: The Total Per Capita Costs for all attributed Medicare Beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure. CMS intends to provide feedback on 2017 MSPB and Total Per Capita Cost measure performance data no later than July 1, 2018, in order for physicians to better understand their cost score. CMS will also offer feedback on newly developed episode-based cost measures in 2018 that will be used in future performance years.

For those seeking further information, the ACS website (facs.org/qpp) offers additional fact sheets and informational videos on the MIPS program. Additionally, the official CMS website for the QPP (qpp.cms.gov) is a great resource for learning about and selecting quality measures, ACI measures, and Improvement Activities for reporting in 2018.



Reporting for Advancing Care Information

The **Advancing Care Information** (ACI) component is worth 25 percent of the MIPS Final Score. The primary assessment for ACI is a composite score composed of three parts: A Base score, a Performance score, and a Bonus score. To receive credit for the ACI component in 2018, one must have either 2014 or 2015 edition certified electronic health record technology (CEHRT) and report their performance for a minimum of a continuous 90-day period. Additionally, providers are required to complete the “Prevention of Information Blocking Attestation.”

The Base score accounts for 50 percent of the score for the ACI component and takes an all-or-nothing approach, requiring performance on at least one patient or attesting yes for each of four to five measures. Achieving the Base score is required before any score can be accrued for the performance portion.

One of the Base measures, the security risk analysis, created the most challenges for providers under the EHR Incentive Program (Meaningful Use), forcing providers to return their incentive payments and setting them up for future audits. The Office of the National Coordinator for Health IT (ONC) Office for Civil Rights has many resources on how to fulfill the Security Risk Analysis (healthit.gov/providers-professionals/security-risk-assessment).

If the Base measures are satisfied, surgeons also can earn up to 90 percentage points under the Performance score, which is driven by the performance rate for each base measure reported, as well as additional measures voluntarily reported by the clinician.

There are also opportunities for clinicians to earn bonus points (up to 25 percent) for the ACI performance category:

- 10 percent bonus for submitting data for ACI measures using 2015 Edition CEHRT exclusively
- 10 percent bonus for reporting certain Improvement Activities via CEHRT
- 5 percent bonus for reporting to an additional public health agency or clinical data registry not reported under the Performance score

When combined, the total achievable percentage points is 165 percent, but the ACI component is capped at 100 percent, meaning there are multiple opportunities for extra credit to earn a perfect score.

Providers may meet criteria for exceptions from the ACI component entirely. CMS will reweight the ACI component to 0 percent and reallocate its weight (25 percent) to the Quality component for surgeons who meet one of the criteria below:

- Small practices (solo practitioners or groups of 15 or fewer eligible clinicians)
- Hospital-based MIPS eligible clinicians
- Ambulatory Surgical Center (ASC)-based MIPS-eligible clinicians (note this policy was finalized to begin starting in 2017)
- MIPS eligible clinicians whose EHR was decertified during the performance year or the year before the current performance year



Providers can determine if they are classified as a small practice or are considered hospital-based by using the [MIPS Participation Status tool](https://qpp.cms.gov/participation-lookup?) (qpp.cms.gov/participation-lookup?). Providers that are hospital-based or ASC-based will receive an automatic reweighting. Providers that are a small practice or whose EHR was decertified must apply for a hardship exception through the Hardship Application (qpp.cms.gov/mips/advancing-care-information/hardship-exception).

In order for a provider to meet the 15 point performance threshold for 2018 EXCLUSIVELY using the ACI category, a surgeon must score 60 percentage points within the ACI section ($60 \times .25 = 15$). If a surgeon completely reports the ACI Base score measures, they will earn 50 ACI percentage points, which translates to 12.5 points in the final score ($50 \times .25 = 12.5$). To earn the additional 2.5 points necessary to get to 15 for the ACI section, surgeons need to acquire an additional 10 percentage points in the Performance measures. This can be achieved by performing at a rate of 91 to 100 percent on a single measure. It is important to note Base measures may be used to earn performance points. Thus, surgeons may not need to select an additional measure, but rather simply need to perform well on those Base score measures that also provide credit in the performance score.

Reporting for Improvement Activities

The Improvement Activities performance component aims to measure provider engagement in activities that improve clinical practice. Categories within IA include ongoing care coordination, clinician and patient shared decision making, regular implementation of patient safety practices, and expanding practice access. Within the IA category, each activity is assigned either a high (20 points) or medium (10 points) weight.

- To receive full credit, most surgeons must select and attest to having completed between two and four activities for a total of 40 points.
- For small practices OR rural practices to achieve full credit, only one high-value or two medium-value activities are required. CMS defines small practices as those consisting of 15 or fewer eligible clinicians. CMS defines rural practices as those where more than 75 percent of the NPIs billing under the individual MIPS eligible clinician or group's TIN are designated in a ZIP code as a rural area or HPSA (based on the most recent Health Resources and Services Administration Area Health Resource File data set).

Those who **completely fulfill** the requirements for the Improvement Activity category will receive the maximum score in the Improvement Activity category and full credit toward their MIPS Final Score (15 points). Because for 2018 the performance threshold is set at 15 points, those who wish to simply avoid a payment penalty can earn and secure 15 points in the IA category and thereby avoid a penalty in 2020 for their performance in 2018.



The reporting requirement for the Improvement Activities category is **fulfilled by simple attestation** via a qualified registry, QCDR, an EHR, or the QPP Data Submission System. The ACS has two QCDRs, the Surgeon Specific Registry and the Metabolic and Bariatric Surgery Quality Improvement Program Data Registry, through which surgeons can also attest to IAs.

While IA is a new requirement, introduced in 2017, surgeons are likely already familiar with many of the activities included, such as maintenance of certification Part IV (MOC), use of the ACS Surgical Risk Calculator, participation in a QCDR, and registration with their state's prescription drug monitoring program (PDMP). For a complete inventory of the IAs, please visit the CMS Improvement Activities page at qpp.cms.gov/mips/improvement-activities. The ACS has created a condensed list of surgically relevant IAs which can be found at facs.org/quality-programs/ssr/mips/improvement-activities-options.

The MIPS Final Score and Payment Updates

In 2018, participants in MIPS will report data that will result in payment updates (positive, negative, or neutral) in 2020. Payments are applied two years after the performance year. The information reported to the CMS in various categories (Quality, Advancing Care Information, Improvement Activities, and Cost) will be combined into a single MIPS Final Score, which will be compared with a threshold to determine each provider's update. The maximum payment updates, the category weights, and the threshold will all vary over time. How those pieces will fit together to affect Medicare payments is described below.

Component Weights

For the 2018 performance year, Quality, Advancing Care Information, Cost, and Improvement Activities performance will account for 50, 25, 10, and 15 percent of the total MIPS Final Score, respectively. (see Figure 2).



Figure 2.
2018 performance
categories weights



By 2019, Quality and Cost are set to be equally weighted at 30 percent, with ACI and Improvement Activities continuing to account for 25 and 15 percent, respectively. Also of note, once 75 percent of physicians are classified as meaningful users of electronic health records technology, the ACI component weight can be reduced to as low as 15 percent, with the remainder distributed among the other categories. Please see facs.org/qpp and qpp.cms.gov for specific information on measures, reporting methodologies, and scoring within each of the components.

The MIPS Final Score and Payment Adjustments

Each year, provider performance in the four categories will be adjusted based upon that category's weight and combined into a final score between zero and 100. This final score will then be compared against a performance threshold:

- If the score is above the threshold, the provider will be eligible for a positive update
- If the score is equal to the threshold, the update will be neutral
- If the score is below the threshold, payments will be reduced

In general, the maximum positive and negative updates are 5 percent for the 2020 payment year (based on 2018 performance) and will grow annually until they reach +/- 9 percent for 2022 and future years. For the first six years of the program, MIPS providers with the highest performance scores, defined roughly as those with scores in the 25th percentile of the range of scores above the performance threshold, will be eligible to receive an additional positive update of up to 10 percent. Up to \$500 million per year is available for these additional updates.

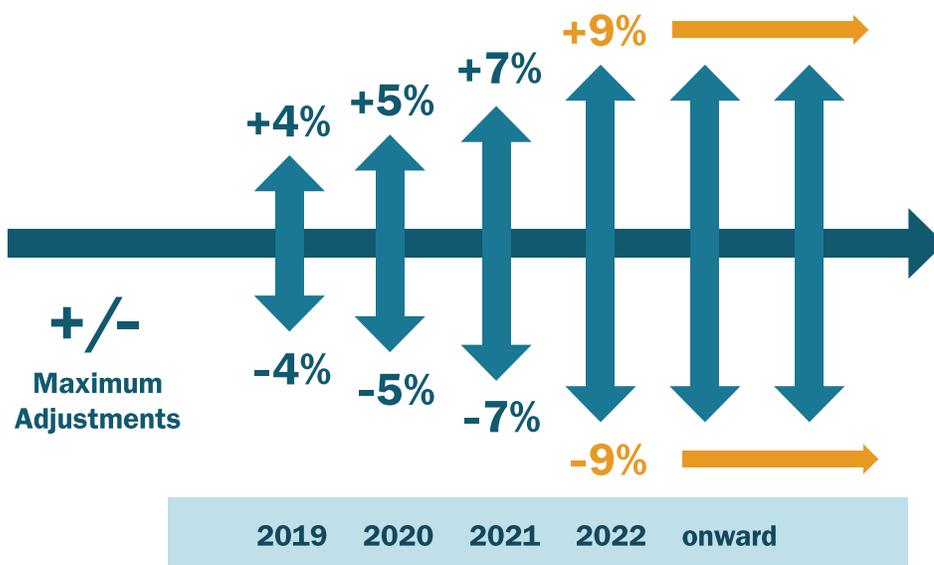
The Performance Threshold

Starting in 2019, the performance threshold will be the mean or median of a prior performance period, but due to the lack of historical data, the Secretary of Health and Human Services has discretion in setting the threshold for the first two years. For the 2017 performance year, the threshold was set at three. For the 2018 performance year, the threshold is set at 15. There are many opportunities for surgeons to reach the threshold. For example, surgeons could complete the required number of Improvement Activities for 90 consecutive days and therefore avoid penalties (for more information on the 2018 requirements, visit facs.org/qpp). This could exempt a significant number of providers from penalties in the 2018 performance period. However, because MIPS is largely a budget-neutral system with negative updates used to offset the positive updates, the positive updates received by eligible providers may be small.

The ACS is committed to helping surgeons understand and succeed in the new payment system, and we will continue to update facs.org/qpp with new resources and information as it becomes available.



How much can MIPS adjust payments?



Graphic from the Centers for Medicare & Medicaid Services

Support for Rural Surgeons and Individual or Small Group Practices

If you are in a small practice or a rural practice, you are eligible for technical assistance and subject to reduced requirements designed to help you succeed in the Quality Payment Program. CMS defines a small practice as one consisting of 15 or fewer eligible clinicians. CMS defines a rural practice as one where more than 75 percent of the NPIs billing under the individual MIPS eligible clinician or group's TIN are designated in a ZIP code as a rural area or HPSA (based on the most recent Health Resources and Services Administration Area Health Resource File data set).

The U.S. Department of Health and Human Services (HHS) will award \$20 million for each of the first five years of the QPP to organizations tasked with helping small practices succeed. These funds will be allocated nationwide but with priority given to rural areas, designated HPSAs, and medically underserved areas (MUAs). This money will be allocated to provide direct outreach and technical assistance, such as helping practices decide which quality measures to report, providing advice on electronic health record selection, and discussing how to improve your MIPS Final Score by receiving full credit for Improvement Activities that you may already be incorporating into your practice. Assistance will also be provided to those interested in exploring participation in APMs. Providers can find these resources and more on the CMS Small, Underserved, and Rural Practices webpage at qpp.cms.gov/about/small-underserved-rural-practices.

There are also certain scoring advantages for small practices built into the MIPS scoring criteria. Specifically, small practices—along with rural



practices and practices located in geographic HPSAs—can receive **full credit in the IA category** of MIPS by attesting to a single high-weighted activity or two medium-weighted activities (half the requirement of larger practices). **Additionally, five bonus points are automatically added to the MIPS Final Score for small practices.**

Small practices may be excluded from MIPS altogether under the low-volume threshold if they do not see many Medicare patients or if they receive a low amount of Medicare Part B payments. Under 2018 requirements, if you or your group practice (TIN) has seen 200 or fewer Medicare patients annually or submit less than or equal to \$90,000 in Medicare Part B allowed charges, you are excluded from MIPS and therefore not eligible for its incentives or subject to its penalties and reporting requirements. CMS expanded the low-volume threshold for 2018 to reduce burden for practices who may have limited engagement with CMS. Under the expanded threshold, an additional 123,000 clinicians will be excluded. To check your MIPS eligibility, you can input your NPI number in to the CMS MIPS participation lookup tool found at qpp.cms.gov/participation-lookup.

Please note that this lookup tool will be updated in 2018 to reflect your 2018 MIPS participation status.

Beginning with 2018, select providers will be allowed to form virtual groups to be assessed collectively under MIPS. Participating in a virtual group allows providers to report data together and share the burden of meeting the reporting requirements, which could be helpful for small and

rural practices. CMS has defined a virtual group as a combination of two or more TINs assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians, or both, that elect to form a virtual group for a performance period of a year. More information on virtual groups can be found in the CMS Virtual Groups Toolkit at [cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2018-Virtual-Groups-Toolkit.zip](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2018-Virtual-Groups-Toolkit.zip).

Furthermore, in 2018 there is a significant hardship exception for the ACI performance category for small practices. This exception reweights the ACI component to 0 percent of the MIPS Final Score for those who apply and qualify. In order to receive this exception, providers must demonstrate the obstacles that prevented them from complying with the ACI requirements. For more information, please visit qpp.cms.gov/mips/advancing-care-information/hardship-exception.



Alternative Payment Models (APMs) and Advanced APMs

APMs provide a model for paying physicians that differs from the traditional fee-for-service construct. The goal of APMs is to improve the quality and value of care provided, reduce growth in health care spending, or both. On the QPP website, CMS describes APMs as payment models that create incentives for clinicians to provide high-quality, cost-efficient care for a specific clinical condition, episode of care, or population.

There are multiple reasons to consider APM participation as part of your QPP success strategy. First, these models may provide tools for improving clinical patient care and lead to increased efficiency. Furthermore, for MIPS-eligible clinicians, the reporting requirements are different for those participating in what is called a MIPS APM (see below for more information) and may be less burdensome. Depending on the payment model, shared savings or other financial incentives for participation may also be available. Surgeons who participate in Advanced APMs (these are APMs that CMS determines are models with sufficient downside financial risk) that meet thresholds for the percent of payments or patients included in the model are considered qualified APM participants and are exempt from the MIPS program. For payment years through 2024 (based on performance through 2022), these qualified clinicians could also receive a lump sum incentive payment equal to 5 percent of their previous year's Medicare Part B charges.

Due to the way APM participation determinations are made, you may be included in a model without even knowing it. Therefore, **all surgeons**

should check their APM participation status on the QPP Qualifying APM Participant Look-Up Tool at data.cms.gov/qplookup.

Although the relevance of APMs has grown, models that recognize the importance of surgeon leadership and the team-based nature of surgical care have been lacking, leaving many surgeons without meaningful opportunities for participation. In response, the ACS is in the beginning stages of a multiyear effort to develop a new model known as the *ACS-Brandeis Advanced-APM (A-APM) proposal*.

APM Participation in MIPS and Beyond

Participating in an APM can improve your chances of attaining a higher MIPS score. CMS created a separate scoring standard in the MIPS for certain APMs to avoid duplicative data reporting requirements for MIPS-eligible clinicians. The models to which this scoring standard applies are referred to as MIPS APMs. To be considered a MIPS APM, participating entities must maintain a participation list of MIPS-eligible clinicians, base payment incentives on clinicians' performance with respect to cost and quality measures, and maintain a participation agreement with CMS or otherwise be approved as a model by law or regulation. Participating in an APM also provides credit in the MIPS IA performance category.

MACRA created additional incentives for enrolling in certain qualified APMs that require participating entities to accept more financial risk, use CEHRT, and adjust payments based on quality measures equivalent to those in MIPS. CMS refers to these as Advanced APMs.



For the 2017 performance year, the following models were available:

- Comprehensive End-Stage Renal Disease Care—Two-Sided Risk
- Comprehensive Primary Care Plus
- Next Generation Accountable Care Organizations
- Medicare Shared Savings Program Tracks 2 and 3
- Oncology Care Model—Two-Sided Risk
- Comprehensive Care for Joint Replacement Payment Model Track 1 with CEHRT requirements

For 2018, we expect this list to grow to include a new ACO Track 1 Plus model and additional models and opportunities to participate in other payer APMs will be added in the future. Check qpp.cms.gov to keep up to date on the addition of new opportunities to participate.

Additional models, including some recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), are expected to emerge in the future. As noted above, ACS has undertaken a multiyear effort to develop an A-APM that recognizes the nature of team-based surgical care.

The ACS-Brandeis A-APM proposal was developed by the ACS and a team at Brandeis University, Waltham, MA. It uses software known as the Episode Grouper for Medicare to group Medicare claims into episodes of care which can then be risk-adjusted based on the care the individual patient has

received or is receiving to set a patient-specific target price. Responsibility for care is automatically attributed to participating surgeons and other providers based upon their role in delivering health care services to the patient, determined through claims filed.

The ACS-Brandeis A-APM recognizes the team-based nature of surgical care and is flexible, allowing providers to design the care pathways that work best for each patient and practice. Quality is measured through an episode-based measure framework based on the College's Surgical Phases of Care concept. Health care professionals who provide quality care would be eligible to share in savings and, because the model is designed to meet the A-APM criteria, may qualify for the 5 percent incentive payment. ACS will continue to work with CMS in 2018 to prepare the model for testing in the Medicare program.



Glossary of Acronyms and Terms

ACI

Advancing Care Information

Component of MIPS representing a modified version of the Electronic Health Record (EHR) Incentive Program or Meaningful Use that serves to measure the extent to which physicians are actively engaged in the use of certified EHR technology. The Office of the National Coordinator for Health Information Technology (ONC) establishes the standards, implementation specifications, and certification criteria that determine whether an EHR is certified for use for the Advancing Care Information (ACI) component of MIPS.

APM

Alternative Payment Model

APMs provide a model for paying physicians that differs from the traditional fee-for-service construct. The goal of APMs is to improve the quality and value of care provided, reduce growth in health care spending, or both. On the Quality Payment Program (QPP) website, CMS describes APMs as payment models that create incentives for clinicians to provide high-quality, cost-efficient care for a specific clinical condition, episode of care, or population.

A-APM

Advanced Alternative Payment Model

MACRA created incentives for participation in certain qualified APMs that require participating entities to accept more financial risk, use certified electronic health record technology (CEHRT), and adjust payment based on quality measures equivalent to those in MIPS. CMS refers to Advanced APMs as a subset of APMs that have been certified by CMS to meet these three requirements. Certain A-APM participants may be excluded from MIPS reporting requirements and payment adjustments.

CEHRT

Certified Electronic Health Record Technology

An electronic health record certified for use in the EHR Incentive Program and the ACI component of MIPS. The Office of the National Coordinator for Health Information Technology (ONC) establishes the standards, implementation specifications, and certification criteria.

CHIP

Children's Health Insurance Program

A federally funded health insurance program that covers certain low-income children.

CMS

Centers for Medicare & Medicaid Services

Federal agency within the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

EHR Incentive Program

(Also known as Meaningful Use)

A CMS quality program used to determine if eligible professionals are actively engaged in the use of certified electronic health record technology. Currently, physicians can be penalized for failing to meet Meaningful Use requirements. In 2017, the Meaningful Use program was modified to form the basis for the Advancing Care Information (ACI) component of the MIPS program.

IA

Improvement Activities

A component of MIPS consisting of activities created as a means of providing credit to physicians participating in the MIPS program, for their efforts to improve their practice or for their work toward participation in an APM.

MACRA

Medicare Access and CHIP Reauthorization Act of 2015

Legislation enacted in April 2015 that repealed the sustainable growth rate (SGR) and set the stage for the new Medicare physician payment program, the Quality Payment Program (QPP). In addition to other policies, the bill also included extensions of CHIP and other health provisions.

MIPS

Merit-based Incentive Payment System

The value-based payment system created by MACRA applied in fee-for-service Medicare that bases annual payment updates on four components: Quality, Resource Use, Advancing Care Information (ACI), and Improvement Activities (IA).

PQRS

Physician Quality Reporting System

CMS' previous quality reporting program for individual physicians and group practices, which (as of January 2017) formed the basis for the Quality component of MIPS.

QCDR

Qualified Clinical Data Registry

A registry, approved by CMS following a qualification process, which functions to collect clinical data for the purpose of patient and disease tracking in order to foster improvement in the quality of care provided to patients. CMS may allow QCDRs the flexibility to define what quality measures participating physicians would choose to report.

QPP

Quality Payment Program

As of January 2017, the new CMS Medicare physician payment program. The QPP represents the operationalization of the MACRA legislation passed in April of 2015. The QPP went into effect on January 1, 2017. The QPP consists of two pathways, the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) Incentive Payment.

SSR

Surgeon Specific Registry

The Surgeon Specific Registry (SSR) is an American College of Surgeons web and mobile software application and database that allows surgeons to track their cases and outcomes in a convenient, easy-to-use manner. Built on the ACS Case Log system, the SSR is available to facilitate reporting of the Quality component and Improvement Activities component of MIPS.

VM or VBM

Value-Based Payment Modifier

CMS' previous quality program used to measure the value of care by evaluating the quality and cost of care. As of January 2017, the portions of the VM focused on resource use formed the basis for the Cost component of MIPS.



Resources

For more information regarding the QPP, please visit the ACS QPP Resource Center at facs.org/advocacy/qpp or the CMS QPP website at qpp.cms.gov.

For more information regarding the ACS SSR, please visit facs.org/quality-programs/ssr/mips or e-mail SSR@facs.org.

For more information regarding the ACS MBSAQIP, please visit facs.org/quality-programs/mbsaqip/resources/data-registry or e-mail mbsaqip@facs.org.

Questions regarding the QPP can be directed to the ACS Division of Advocacy and Health Policy at qualityDC@facs.org or 202-337-2701 or to the CMS QPP Service center at QPP@cms.hhs.gov or 1-866-288-8292.

2018 MACRA

Quality Payment Program



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