Guide to MIPS 2017, Part 1: Know the Basics

Medicare's new payment system—the Quality Payment Program (QPP)—launches on Jan. 1, 2017, though you don't necessarily have to start participating until later in the year (see "Performance Period").

The Quality Payment Program provides 2 pathways: MIPS and APMs. You can participate either in the Merit-Based Incentive Payment System (MIPS) or in an advanced alternative payment model (APM). MIPS includes a hybrid option—the MIPS APM—for clinicians who are in certain types of accountable care organizations (see the Web Extra, "APMs in Brief").

This series will focus on MIPS. Advanced APM options will initially be limited for ophthalmology, so most Academy members will be MIPS participants. If you have participated in CMS' previous quality reporting programs—such as the Physician Quality Reporting System (PQRS)—then many aspects of MIPS reporting will seem familiar to you.

Some initial wiggle room. For MIPS' inaugural year, CMS has increased reporting flexibility, eased the reporting requirements, and made it quite easy to avoid the payment penalty (see next page).

More help online. In addition to the current series of *EyeNet* articles, you can go online for explanatory materials from CMS (https://qpp.cms.gov) and the Academy (aao.org/medicare).

QUALITY—Submission Mechanisms & Measure Types

How you opt to submit data for the quality performance category will determine the type(s) of quality measure that you can report.

Data Submission Mechanism:	Need EHR?	Used by:	It Involves:	Measures Types*:
Medicare claims	No	Individuals	Real-time reporting	MIPS†
IRIS Registry Web portal	No	Individuals or groups	Manual data entry into Web portal	MIPS,† non-MIPS
IRIS Registry/EHR integration	Yes	Individuals or groups	Automated data extraction	eCQMs, MIPS,† non-MIPS†
EHR vendor	Yes	Individuals or groups	A possible fee	eCQMs

Measure Types include: **MIPS measures, which are published in the MIPS regulations (Appendix: Tables A and E); **non-MIPS measures,** ophthalmology-specific measures that were developed by the Academy, with the help of subspecialty societies, for use with MIPS; **eCQMs**, electronic clinical quality measures.*

†Some measures might not be available to you (e.g., some MIPS measures can't be reported via claims; the MIPS and non-MIPS measures that are available to you via IRIS Registry/EHR integration depend on which EHR you are using).

***NOTE:** The CMS web interface has its own reporting requirements, its own set of measures, which are mostly primary care–based, and a 1-year performance period. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey and MIPS APMs also have different reporting requirements.*

Scoring, Bonuses, and Penalties

You will receive a final score (0-100 points) for your 2017 performance that will impact your 2019 payments. If your 2017 final score is:

- **0 points,** your 2019 Medicare payments will suffer a payment penalty of 4%
- **3 points,** you'll get no penalty and no bonus
- **More than 3 but less than 70,** you will get a small bonus
- **70-100 points,** you will get a modest bonus

Where the bonus money comes from. The penalties imposed on some clinicians are used to finance the bo-

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nuses paid to their colleagues. Because it is easy to avoid the penalty during the 2017 performance year, that bonus pool will be small. However, CMS is also putting $500 million into a second bonus pool that will be used to augment the bonuses of those MIPS participants who have a final score of 70 or more.

The final score is based on 3 performance categories. Two of the 3 evolved out of earlier CMS programs, though with some sweeping changes:

- **Quality** replaces PQRS. For larger practices, it includes a population-based measure from the Value-Based Modifier (VM) program. Quality contributes 60% to the final score for the 2017 performance year, falling to 50% for 2018, and 30% for 2019.
- **Advancing care information (ACI)** replaces the electronic health record (EHR) meaningful use (MU) program. It counts for 25% of the final score.
- **Improvement activities** is entirely new. It counts for 15% of the final score. (Note: This category was called clinical practice improvement activities in the initial draft of the regulations.)

Next year, cost is added to the equation. Starting in 2018, a fourth performance category will contribute to the final score:

- **Cost** replaces the VM program. It contributes 0% to the final score in 2017, 10% in 2018, and 30% in 2019. (Note: This category was called resource use in the initial draft of the regulations.)

Avoid the Payment Penalty

During the inaugural year of MIPS, avoiding the penalty is easy. For the 2017 performance year, attain a final score of at least 3 points to avoid a penalty. To do that, you can:

- Submit data on 1 quality measure 1 time on 1 patient to score 3 points or
- Report on 1 improvement activity to score 10 points

MIPS tips. Keep in mind the following:

- Consider reporting more than 1 quality measure for a period of more than 1 day and more than 1 improvement activity—just in case there is a problem with the first one that you report.
- If you are reporting a quality measure

QUALITY OVERVIEW: Reporting at a Glance

Pick how you will report quality measures: First, choose how you will submit your data. If you use claims, the IRIS Registry (Web portal or EHR integration), or your EHR vendor,* you can avoid the payment penalty by reporting on 1 quality measure; however, to maximize your score, you should:

- Submit data on at least 6 quality measures
- Include at least 1 outcome quality measure (if no outcome measure is available, report another type of high-priority measure)
- Include data for at least 1 Medicare patient for at least 1 quality measure

All-Cause Hospital Readmission (ACR) measure: Larger groups (>15 MIPS eligible clinicians) with at least 200 ACR cases will also be scored on the ACR measure (up to 10 points). You don't report anything for this measure; assessment is based on administrative claims. Most ophthalmologists will not be evaluated on this measure.

Submission thresholds: For each quality measure that you report, you should do both of the following:

1) **Meet the data completion criteria:** Submit data for at least 50% of ...
   - Medicare patients (if submitting data by claims) or
   - Medicare and non-Medicare patients (if submitting data via the IRIS Registry or your EHR vendor)

   ... who were seen during a period of at least 90 consecutive days† and for whom the measure applies.
2) **Meet the case minimum criteria:** Report at least 20 cases.

QUALITY OVERVIEW: Scoring Summary

How you are scored: If you submit data for a quality measure, CMS determines whether you met both of the submission thresholds:

- If so, you get 3-10 points (based on how you compare against a benchmark for that measure)
- If not, you get 3 points

High-priority bonus points: You get no bonus points for your first high-priority measure, but after that you get:

- 2 points for an outcome or patient experience measure
- 1 point for an appropriate use, care coordination, efficiency, or patient safety measure

CEHRT bonus points: You may get 1 point for each quality measure submitted using EHR or IRIS Registry/EHR integration.

Up to 12 (or 14) bonus points: The high-priority and CEHRT bonuses are each capped at 6 or—if you are scored on the ACR measure—7 points.

Your quality score: 1) CMS determines your numerator, which is your total points earned on as many as 6 reported measures plus, if applicable, your ACR points (if you report more than 6 measures, CMS will determine which 6 would give you the highest quality score); 2) CMS divides that numerator by your denominator, which is 60 (or 70 if the ACR measure applies); and 3) CMS turns the resulting fraction into a percentage (capped at 100%). This is your quality performance score. It contributes up to 60 points to your final score (e.g., if you score 50%, it contributes 30 points).

**MIPS APMs and the CMS web interface involve different requirements.*

†For some measures, you may need a longer performance period if you are going to satisfy the case minimum criteria (e.g., cataracts: 20/40 or better visual acuity within 90 days following cataract surgery). And some measures have benchmarks based on 12 months of data.

For more on this performance category, *see "Guide to MIPS 2017: Quality" (February 2017), which will be posted at aao.org/eyenet ahead of print.*

ACI OVERVIEW: Reporting at a Glance

Pick how you will report advancing care information (ACI) measures. Individuals and groups can report ACI measures by attestation through the CMS Web portal, their EHR vendor, or the IRIS Registry.

You must use CEHRT. There are 2 types of certified EHR technology (CEHRT): the 2014 edition and the 2015 edition. For the 2017 performance year, you can use either edition or—if you're taking a modular approach—a combination of the 2. In 2018, you will need to use the 2015 edition.

There are base ACI measures and performance ACI measures. If you take part in ACI, you must report the former; some of the latter are optional. The minimum performance period is 90 consecutive days.

Exemptions. As with the EHR MU program, you can apply for a hardship exemption following the performance year.

ACI OVERVIEW: Scoring Summary

Base score (0 or 50 points). The base measures represent a core level of participation. If you successfully report all of the base measures, you will get the full 50 points. If you fall short, even if by only 1 measure, you get 0 points for both the base score and the entire ACI performance score.

Report on 4 or 5 base measures. Report from a list of 4 base measures or a partially overlapping list of 5 measures; the former option is available to all CEHRT users, the latter to those with 2015-certified CEHRT.

The reporting threshold is fairly low. For some measures, you just have to report that you performed the measure in at least 1 case (e.g., e-prescribing). Other measures require a yes/no response (e.g., security risk analysis); to report these successfully, you must respond yes.

Performance score (0-90 points). Performance measures represent a more advanced form of participation.

Mandatory or optional? Some performance measures are also base measures, and are therefore required for ACI participants; the rest are optional.
MIPS tip. It is possible to score 155 ACI points, but the ACI score is capped at 100 (see "Your ACI Score"). This means that you may be able to get a high ACI score even if you skip some of the optional measures.

If your CEHRT is 2015-certified: Report on up to 9 measures—3 are required and 6 are optional (score up to 10 points for each of the 9).

If your CEHRT is 2014-certified: Report on up to 7 measures—2 are required (score up to 20 points each) and 5 are optional (score up to 10 points each).

Scoring for most measures is based on your performance rate. For instance, if you are able to provide patient-specific education to 30% of patients, you would score 3 points for that measure.

Bonus points (0-15 points). Earn extra points as follows:

- 5 points if you report to 1 or more public health or clinical data registries (e.g., the IRIS Registry)
- 10 points if you use CEHRT to report improvement activities

Your ACI score. If you earned the 50-point base score, CMS adds this to your performance measure score (0-90 points) and your bonus score (0-15 points). The total—which is capped at 100—is turned into a percentage by appending a percentage symbol. This is your ACI score. It contributes up to 25 points to your final score (e.g., if you only achieve the base score, you get an ACI score of 50%, which contributes 12.5 points to your final score).

For more on this performance category, *see "Guide to MIPS 2017: Advancing Care Information" (March 2017), which will be posted at aao.org/eyenet ahead of print.*

by claims, submit it multiple times—just to make sure it goes through.
• Get up to speed during 2017—rather than reporting the bare minimum, try to maximize your reporting so you'll be ready for future years when the requirements aren't so flexible.

Performance Period

For 2017, CMS has set the performance period at 90 consecutive days. You don't have to tackle all the performance categories at the same time—each category could have a different 90-day performance period. Note: For quality, although you must satisfy this 90-day threshold in order to score more than 3 points on a measure, you can still score 3 points with a shorter performance period (see "Quality Overview").

Consider reporting for more than 90 days. You are likely to get a better quality score with a longer performance period—ideally a full calendar year. You will, for instance, increase the likelihood that you meet the case minimum threshold for quality measures (see "Submission thresholds" in "Quality Overview"). And for some quality measures, your performance will be judged against benchmarks that are based on 12 months of data. Furthermore, you will boost your preparedness for the 2018 performance year, when the performance period for quality becomes 1 calendar year.

MIPS tip. If you are using IRIS Registry/EHR integration to submit quality data, an automated process is used to extract that data—so there is no extra reporting burden associated with submitting data for the full calendar year.

Who Does (and Doesn't) Take Part in MIPS

CMS introduces a new term—the MIPS eligible clinician. MIPS eligible clinicians are defined as physicians (which, for this purpose, includes optometrists), physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, as well as groups that include such clinicians.

Not all MIPS eligible clinicians must participate in MIPS. You are exempt from MIPS if 1 of the following 3

exclusions applies.

Exclusion 1—MIPS eligible clinicians who are new to Medicare. If you enroll in Medicare for the first time in 2017, and have not previously submitted claims under Medicare, you will be exempt from the MIPS rules for the 2017 performance year.

Exclusion 2—MIPS eligible clinicians who are below the low-volume threshold. You will be exempt from the MIPS rule if, over a 12-month period (see below), you:

- Bill Medicare Part B for no more than $30,000 or
- Care for no more than 100 Medicare Part B beneficiaries.

You have 2 chances to qualify for the low-volume exemption. To see if you are exempt for the 2017 performance year, CMS will review your data for 2 time periods:

- Sept. 1, 2015, to Aug. 31, 2016
- Sept. 1, 2016, to Aug. 31, 2017

If you are below the low-volume threshold during either of these time periods, you will be exempt—even if you surpass the threshold in the other time period.

Exclusion 3—MIPS eligible clinicians in advanced APMs. If you are participating in an advanced APM (see the Web Extra, "APMs in Brief"), you may be exempt from the MIPS rule if you satisfy the APM track's reporting thresholds.

Next Steps

Decide how you will report. You don't have to use the same reporting mechanism across all performance categories. For instance, you can report quality and improvement activities using the IRIS Registry and report ACI using your EHR vendor. However, within each performance category, you typically must use just 1 reporting mechanism—the exception is the CAHPS for MIPS survey, which can be used as a second data submission mechanism for quality but won't be applicable for most ophthalmologists.

The IRIS Registry is expected to be the MIPS tool of choice. The IRIS Registry (aao.org/registry) provides 2 platforms for MIPS quality reporting—one involves EHR (automated extraction of data from your records) and the other doesn't (manual entry of data into a Web portal). The IRIS Registry is also planning to offer reporting options for ACI and improvement activities. (Note: Registries that are used for MIPS reporting are recertified annually; CMS isn't scheduled to recertify 2017 registries and their 2017 non-MIPS measures until April 2017.)

Consider group reporting. Your practice can report as a group if it includes at least 2 MIPS participants. You don't need to register as a group unless you're planning to report via the CMS web interface or the CAHPS for MIPS survey. Note: You must participate in the same way (either as an individual or a group) for all performance categories.

MIPS tip: If a practice takes part in MIPS as a group, and 1 MIPS eligible clinician within that group reports an improvement activity, the whole group can get credit for that activity.

IMPROVEMENT ACTIVITIES OVERVIEW: Reporting at a Glance

Pick how you will report activities. Individuals and groups can attest to their performance via the CMS website, EHR vendor, or IRIS Registry.

Choose what to report. In order to get the maximum score, the number of activities that you need to report can range from 1 to 4 (see below). These activities are meant to support broad goals such as care coordination, population management, and beneficiary engagement.

MIPS tip: When selecting your activities, you should note that certain activities can also contribute to the ACI performance category.

A yes/no approach to reporting. Reporting of improvement activities involve submission of a yes or a no. To score points for an activity, affirm (yes) that you performed that activity for at least 90 consecutive days.

IMPROVEMENT ACTIVITIES OVERVIEW: Scoring Summary

How many points do you get for an activity? It depends on how the activity is weighted (and whether you're able to double the score). If the weight is:

- Medium—10 points (double score: 20 points)
- High—20 points (double score: 40 points)

Who scores double? Individuals and groups that are in small practices (<16 MIPS eligible clinicians), in rural practices, or in practices in geographic health professional shortage areas (HPSAs), and non–patient-facing MIPS participants.

Maximum score is 40 points. So a small group could max out with 1 high-weighted activity.

Your improvement activities score: CMS divides your total number of points by 40 and turns the resulting fraction into a percentage (e.g., a score of 30 points would be 75%). This is your improvement activities score. It contributes up to 15 points to your final score.

For more on this performance category, *see "Guide to MIPS: Improvement Activities" (April 2017), which will be posted at aao.org/eyenet ahead of print.*

Physician leadership is crucial. Although CMS has made it easy to avoid the payment penalty during MIPS' inaugural year, the reporting requirements—and the payment penalties—are expected to ramp up rapidly over the next 2 or 3 years. Because so much money will ultimately be at stake, a physician ought to oversee your practice's MIPS planning and processes, which should be implemented by experienced staff who are knowledgeable about MIPS' precursors (PQRS, EHR MU, and VM).

PLEASE NOTE: This article was based on the information that was available at time of press; CMS is still publishing its subregulatory guidance for MIPS.

MORE ONLINE. For brief guides to MIPS APMs and the use of TINs and NPIs as MIPS identifiers, see this article at aao.org/eyenet.

EXTRA

Use of TINs and NPIs as Identifiers

Individuals. If you are participating in MIPS as an individual, CMS will use both your Tax Identification Number (TIN) and National Provider Identifier (NPI) to distinguish you as a unique MIPS participant. You must use the same TIN/NPI combination for all performance categories. If you report more than 1 TIN/NPI combination—because, for instance, you practice in more than 1 location or you move to a new practice—you will be assessed separately for each TIN. Physicians in such situations should meet the reporting requirements at both NPI/TIN combinations where they practice during the performance year.

MIPS groups. If you and your colleagues choose to participate jointly as a group, the group's TIN alone will be your identifier for all 4 categories. Typically, no registration is required to participate in MIPS as a group; the exception is if you are using the CMS Web Interface.

APM entity group. If you and your colleagues participate jointly as an APM entity group, each MIPS eligible clinician within that group would be identified by a unique APM participant identifier. For example, all clinicians participating in a track 1 ACO will receive the same score.

Bonuses and penalties. Payment adjustments will be applied at the TIN/NPI level, regardless of whether you participate in MIPS as an individual, as part of a MIPS group, or as part of an APM entity group.

Your payment adjustment will follow you to your next practice. Your final score for the 2017 performance year will impact your payment adjustment during the 2019 payment year, and—unlike PQRS—this is the case even if you move to a new practice after the 2017 performance year finishes. In other words, when CMS determines your 2019 payment adjustment, it will look at the 2017 final score that was associated with the TIN you were using in 2017, not the 2017 final score that is associated with your new practice's TIN.

EXTRA

APMs in Brief

What is an alternative payment model (APM)? APMs are voluntary models that change the way the CMS pays physicians. Some examples may include accountable care organizations, patient-centered medical homes, and bundled payment models.

What is an advanced APM? Advanced APMs constitute 1 of the 2 pathways for participating in MIPS. CMS defines an advanced APM as a model that:

1) Requires participants to use CEHRT;
2) Provides payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and
3) Either: (A) is a Medical Home Model expanded under CMS Innovation Center authority; or (B) requires participating APM entities to bear more than a nominal amount of financial risk for monetary losses.

CMS listed 6 models in the MIPS regulations that would qualify as an advanced APM starting in 2017:

- Comprehensive End Stage Renal Disease Care Model;
- Comprehensive Primary Care Plus;
- Medicare Shared Savings Program—track 2 and track 3;
- Next Generation ACO Model; and
- Oncology Care Model 2-Sided Risk Arrangement

A qualifying APM participant (QP) is a MIPS eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an advanced APM entity. QPs can qualify for a 5% Medicare Part B incentive payment. These clinicians would also be exempt from MIPS payment adjustments for years 2019-2024.

A partial qualifying APM participant (partial QP) is a MIPS eligible clinician determined by CMS to have met the relevant partial QP threshold for a year. CMS has established lower thresholds for partial QP status. This status allows these clinicians to opt out of the MIPS payment adjustments but does not confer all the benefits of QP status. CMS is providing "partial credit" to encourage participation in Advanced APM entities even if that participation is not sufficient to earn the APM bonus.

MIPS APMs

What is a MIPS APM? Certain APMs include MIPS eligible clinicians as participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries. This type of APM is called a MIPS APM. Most advanced APMs are also MIPS APMS. This means that if a MIPS eligible clinician participating in the advanced APM does not meet the threshold to become a QP, the eligible clinician will be scored under MIPS according to the APM scoring standard.

Different reporting requirements and scoring. These models can have MIPS data submission requirements and MIPS category scoring weights differing from those of other MIPS eligible clinicians. The final score for MIPS APMs weights the performance categories as follows—quality: 50%; ACI: 20%; and improvement activities: 30%.

Different types of MIPS APM. CMS listed 8 models in their final rule that would qualify as a MIPS APM:

- Comprehensive End Stage Renal Disease Care Model (all arrangements)
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program—track 1, 2, and 3 (track 1 did not qualify as an Advanced APM)
- Next Generation ACO model
- Oncology Care Model (OCM)—1- and 2-Sided Risk Arrangement.

MIPS tip. If you are part of an ACO that is considered a MIPS APM, you should report quality measures independently of the ACO and can do so using the IRIS Registry. If the ACO is successful in its MIPS reporting, CMS will ignore the quality measures that you reported. But if your ACO is unsuccessful in its MIPS reporting, your quality reporting can safeguard you from the 4% payment penalty.

All Payer Combination

For 2021 and later, MIPS eligible clinicians may become QPs through a combination of participation in advanced APMs and other payer advanced APMs. This will be known as the All Payer Combination option. This option would allow eligible clinicians to become QPs by meeting a relatively lower threshold based on Medicare Part B covered professional services through advanced APMs and an overall threshold based on services through both advanced APMs and other payer advanced APMs. Medicare Advantage plans will be considered under this option.

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