

MIPS—What's New for 2019, Part 2: Quality, Improvement Activities, and Cost

How will changes to the Merit-Based Incentive Payment System (MIPS) impact ophthalmology practices? Part 1 of this two-part series reviewed changes to payment adjustments, eligibility criteria, and how your MIPS final score is calculated. It also summarized the revamped promoting interoperability (PI) performance category. Part 2 reviews what's new with the other three performance categories.

Why MIPS matters. If you don't take part in MIPS in 2019, your payments for Medicare Part B services in 2021 could suffer a -7% penalty.

Use the IRIS Registry. It is free for Academy members; it focuses exclusively on ophthalmology; and—as a qualified clinical data registry (QCDR)—it can develop subspecialty-specific quality measures. You can use it to manually report quality measures, improvement activities, and PI measures. Furthermore, if you integrate your electronic health record (EHR) system with the IRIS Registry, you can use an automated process to extract the data that are needed for quality reporting, get credit for PI's Clinical Data Registry Reporting measure, and perform the QCDR-related improvement activities.

Learn more about the IRIS Registry and MIPS at aao.org/iris-registry and aao.org/medicare.

What's New With Quality

Claims-based reporting: Expanded access for small practices; not an option for large practices. In 2019, clinicians in large practices can no longer report quality measures via Medicare Part B claims. However, clinicians in small practices can continue to do so and—new this year—can do so when reporting as a group, not just when reporting as individuals. Warning: Many claims-based quality measures are topped out at a low decile, which hinders your ability to get a high score for quality with claims-based reporting.

Facility-based scoring for hospital-based clinicians. Facility-based scoring will be available to you only if you provide at least 75% of your covered professional service—based on claims submitted between Oct. 1, 2017, and Sept. 30, 2018—at an inpatient hospital (place of service [POS] code: 21), on-campus outpatient hospital (POS code: 22), or emergency room (POS code: 23), with at least one service at an inpatient hospital or emergency room.

Bonus points for opioid-related measures. In response to the opioid epidemic, CMS now considers opioid-related quality measures to be high priority. The IRIS Registry developed an opioid-related QCDR measure for oculoplastic surgeons (see IRIS37, listed on the next page).

Bonus for electronic reporting now requires 2015-edition CEHRT. Like last year, you can earn bonus points if you report quality measures using a certified EHR technology (CEHRT) for end-to-end reporting, but in 2019 you will get this bonus only if you are using the 2015-edition CEHRT.

Some topped out measures may be retired early. CMS considers a measure to be topped out when a lot of clinicians are attaining, or almost attaining, maximum performance for that measure (e.g., the average performance rate is 95% or higher). CMS had previously established a four-year life cycle for such measures—if they are topped out for at least two years, they would be subject to a seven-point cap; topped out for three consecutive performance years, they would be eliminated in the fourth year. Now CMS is accelerating that process in some cases: If a measure is *extremely topped out* (e.g., the average performance rate is 98% or higher), it can be removed from MIPS in the following year, even if it hasn't been topped out for three consecutive years. (Note: Topped out QCDR measures also are on an accelerated timetable for removal, even if they aren't extremely topped out.)

In rare cases, a measure might be "suppressed." During the course of 2019, changes in clinical guidelines may mean that continued adherence to a measure could result in patient harm and/or provide misleading results as to good quality care. In the unlikely event that this happens with one of ophthalmology's measures, CMS could

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suppress that measure. This means that if you submitted data on the measure before it was suppressed—because, for example, you were reporting by claims—1) you wouldn't score points for that measure and 2) when CMS calculates your quality score it would reduce your denominator by 10 points (so you wouldn't be penalized for reporting the measure).

Small practice bonus is moved to quality. For 2019, CMS will no longer apply a 5-point small practice bonus when calculating the MIPS final score; instead, when calculating your quality score, it will apply a 6-point bonus to your numerator for that performance category—but only if you report data on at least one quality measure.

New QCDR measures available via the IRIS Registry. The Academy, working with subspecialty societies, has developed six new QCDR measures:

- IRIS35: Improvement of Macular Edema in Patients With Uveitis
- IRIS36: Visual Acuity Improvement Following Cataract Surgery Combined With a Trabeculectomy or an Aqueous Shunt Procedure
- IRIS37: Postoperative Opioid Management Following Oculoplastic Surgery
- IRIS38: Endothelial Keratoplasty: Dislocation Requiring Surgical Intervention
- IRIS39: Intraocular Pressure Reduction Following Trabeculectomy or an Aqueous Shunt Procedure
- IRIS48: Adult Surgical Esotropia: Postoperative Alignment

IRIS Registry adds three MIPS CQMs for manual reporting. In addition to the new QCDR measures, three additional MIPS clinical quality measures

(MIPS CQMs) are available if you report manually via the IRIS Registry:

- Measure 154: Falls: Risk Assessment
- Measure 236: Controlling High Blood Pressure
- Measure 474: Zoster (Shingles) Vaccination

CMS removed some MIPS CQMs.

The eliminated measures include three MIPS CQMs that had been useful for Academy subspecialists:

- Measure 18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Measure 140: AMD: Counselling on Antioxidant Supplement
- Measure 224: Melanoma: Avoidance of Overutilization of Imaging Studies

Eight QCDR measures removed.

These 2018 QCDR measures are not available in 2019:

- IRIS9: Diabetic Retinopathy: Documentation of the Presence or Absence of Macular Edema and the Level of Severity of Retinopathy
- IRIS11: Nonexudative AMD: Loss of Visual Acuity
- IRIS17: Acute Anterior Uveitis: Post-Treatment Grade 0 Anterior Chamber Cells
- IRIS20: Idiopathic Intracranial Hypertension: No Worsening or Improvement of Mean Deviation
- IRIS25: Adenoviral Conjunctivitis: Avoidance of Antibiotics
- IRIS26: Avoidance of Routine Antibiotic Use in Patients Before or After Intravitreal Injections
- IRIS31: Avoidance of Genetic Testing for AMD
- IRIS34: AMD: Disease Progression.

What if you use multiple collection types? Suppose, for example, you report six measures by Medicare Part B claims and you report the same six measures manually via the IRIS Registry portal. If you did that during the 2018 performance year, CMS would 1) assess your score for the six claims-based submissions, 2) assess your score for the six IRIS Registry-based submissions, and 3) assign you the higher of those two scores (i.e., your score would be based on either the six measures reported by claims or the six measures reported via the IRIS Registry portal).

During the 2019 performance year, CMS will make that comparison for individual measures—so your final quality score could, for example, be based on five measures that were reported via the IRIS Registry and one reported via claims.

What's New With Improvement Activities

The improvement activities performance category remains largely the same as in 2018—though 10 additional activities are available to report via the IRIS Registry, including one for eye exams.

An improvement activities score of 100% is no longer enough to avoid the payment penalty. As in 2018, if your 2019 improvement activities score is 100%, you will earn 15 points toward your MIPS final score. In 2018, that would have been enough to avoid a future MIPS payment penalty, but not in 2019. Because the threshold for avoiding a penalty has increased to a MIPS final score of 30 points, you should also try to score points for quality measures and/or PI measures.

Improvement activities no longer contribute to your PI score. In 2018, certain improvement activities would earn you a PI bonus if CEHRT was used to help you perform those activities. This is no longer the case in 2019.

Ten improvement activities have been added to the IRIS Registry. When you report activities manually via the IRIS Registry, you can choose from 34 activities (up from 24 in 2018).

Two of the additions are high-weighted improvement activities:

- Provide education opportunities for new clinicians (IA_AHE_6)
- Participation in population health research (IA_PM_17)

Eight of the additions are medium-weighted improvement activities:

- Leveraging a QCDR for use of standard questionnaires (IA_AHE_4)
- Evidence-based techniques to promote self-management into usual care (IA_BE_16)
- Improved practices that disseminate appropriate self-management materials (IA_BE_21)
- Improved practices that engage

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patients pre-visit (IA_BE_22)

- Use of telehealth services that expand practice access (IA_EPA_2)
- Participation in user testing of the Quality Payment Program website: <https://qpp.cms.gov> (IA_EPA_5)
- Participation in private payer clinical practice improvement activities (IA_PSPA_12)
- Comprehensive eye exam (IA_AHE_7).

Performing the eye exam activity (IA_AHE_7). According to CMS, this medium-weight activity is intended for “1) nonophthalmologist/optometrists who refer patients to ophthalmologists/optometrists, 2) ophthalmologists/optometrists caring for underserved populations at no cost [participating in EyeCare America may help you fulfill this activity; aao.org/volunteer], or 3) any clinician providing literature and/or resources on this topic.” CMS also states that this “activity must be targeted at underserved and/or high-risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams.”

What's New With Cost

New cataract measure. In 2019, CMS will start scoring ophthalmologists on a new episode-based measure: Routine Cataract Surgery With Intraocular Lens (IOL) Implantation (0-10 points).

Attribution. An episode of cataract surgery will be attributed to the clinician who performed the procedure, as identified by HCPCS codes or CPT codes.

Case minimum. This cataract measure has a case minimum of 10 episodes, which means that it will contribute to your cost score only if at least 10 episodes of cataract surgery are attributed to you.

What costs are included? The measure takes into account only the cost of items and services that are related to the cataract procedure (unlike the Total Per Capita Cost measure, which includes all services provided to a patient over a given time frame). Your costs for the measure will undergo payment standardization and risk adjustment, in an attempt to account for cost variations

New Terminology

In 2018, CMS used “submission mechanism” as a term that, depending on the context, could refer to 1) the entity that submits the data to CMS (e.g., the IRIS Registry), 2) the method of submitting the data (e.g., via claims or via attestation), and 3) certain types of measures (e.g., electronic clinical quality measures). CMS has said that in 2019, instead of referring to submission mechanism, it will start using the three distinct terms below.

Submitter type. This refers to the individual or organization that submits the MIPS data to CMS, and it includes MIPS eligible clinicians, groups, and virtual groups, as well as any third parties (e.g., the IRIS Registry) that submit data on their behalf.

Submission type. This refers to the mechanism that a submitter type uses to submit data to CMS. Examples include direct, log in and upload, log in and attest, and Medicare Part B claims.

Collection type. This refers to types of quality measure that have comparable specifications. Examples include:

- eCQMs: electronic clinical quality measures
- MIPS CQMs: MIPS clinical quality measures (reported manually)
- QCDR measures
- Medicare Part B claims measures

Example. The Diabetes Eye Exam quality measure exists in three different collection types: If you report via IRIS Registry-EHR integration or via your EHR vendor, you would use the eCQM version; if you report via manual entry into the IRIS Registry web portal, you would use the MIPS CQM version; and if you report via Medicare Part B claims, you would use the claims version. These three versions of the Diabetes Eye Exam measure each have their own specifications and their own benchmark.

What about QCDR measures? QCDRs, such as the IRIS Registry, can develop subspecialty-specific measures. Most of the IRIS Registry's QCDR measures have two different versions—one for manual reporting and the other for reporting via IRIS Registry-EHR integration.

that are beyond your control, such as geographic variations in wage levels and patient characteristics that might lead to increased spending.

Other cost measures. As in 2018, you get a score for the Total Per Capita Cost measure (0-10 points) only if at least 20 patients are attributed to you. Patients are attributed to you if they were not seen by a primary care clinician and you billed the majority of their primary care services, which can include evaluation and management (E&M) service codes but not Eye visit codes. There also is a Medicare Spending Per Beneficiary measure (MSPB; 0-10 points), but it rarely will apply to ophthalmologists.

Calculating your cost performance category score. Like last year, your cost performance category score = cost

achievement points ÷ available cost points, and is reported as a percentage.

Example. Suppose CMS scored you as follows:

- 5 points for the Total Per Capita Cost measure (out of 10 available points);
- 7 points for the cataract episode-based measure (out of 10 available points)

Your cost achievement points would be 12 (5 + 7) and your available cost points would be 20 (because you were only scored on two cost measures). So your cost score would be cost achievement points (12) ÷ available points (20) = 0.6, or 60%.

Cost can contribute up to 15 points to your 2019 MIPS final score; a cost score of 60% would therefore contribute 9 points (60% of 15 points) to your MIPS final score.