Quality Payment Program 2017 Final Rule Guide

A Comprehensive Guide to the Quality Payment Program created under the Medicare Access and CHIP Reauthorization Act (MACRA).

This booklet contains information for ophthalmic practices participating in the Quality Payment Program in 2017 and includes the following guides:

- **MACRA Final Rule Overview**
- **Guides on each of the Four Categories of the Merit-Based Incentive Payment System (MIPS):**
  - **Quality**
  - **Advancing Care Information**
  - **Improvement Activities**
  - **Cost**
- **Group vs. Individual Reporting**
- **Advanced Alternative Payment Models (APMs) and MIPS APMs**
- **MIPS APM Guide for Medicare Shared Savings Track 1 ACO Participants**

Updated and additional information can be found on the ASCRS•ASOA MACRA Center webpage at:

ascrs.org/macracenter

Quality Payment Program Overview

On October 14, 2016, CMS released the final rule on the Quality Payment Program, which includes both the Merit-Based Incentive Payment Program (MIPS) and Advanced Alternative Payment Models (APMs). The final rule establishes regulations on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law in April 2015. The new law changes the way Medicare incorporates quality measurement into payments and develops incentives for participation in alternative payment models.

This guide summarizes the Quality Payment Program final rule; however, ASCRS has also developed guides on each of the four components of the Merit-Based Incentive Payment System (MIPS), and will continue to provide additional resources and training materials to assist ASCRS•ASOA members in complying with the program beginning January 1, 2017, for payment January 1, 2019. In addition, ASCRS•ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

2017 Performance Period Timing for 2019 Payment

ASCRS and the medical community's chief recommendation in comments on the proposed rule was to delay the start date of the new program, so physicians and practices would have time to familiarize themselves with the new requirements and implement new administrative processes and clinical workflows. In response, CMS announced, prior to the release of the final rule, that it would provide several different options for providers to choose their participation level and time period for the first performance year of 2017 for payment in 2019. The final rule provided details for each of the participation options.

For the first performance year of MIPS (2017) CMS is providing several different options for providers to choose their participation level and performance period.

To avoid a penalty for 2019, beginning January 1, 2017, providers can choose to report either:
- **One quality measure for one patient, and not have to meet the measure benchmark, or**
- **One improvement activity, or**
- **The required base measures for Advancing Care Information.**

To be eligible for a small bonus and avoid a penalty, providers can choose to report for at least 90 days:
- **Two or more quality measures on at least one patient, and not have to meet the measure benchmarks, or**
- **More than one improvement activity, or**
- **The required base measures and additional performance measures for Advancing Care Information.**

Providers who report all the required measures and meet thresholds and benchmarks in each of the categories for at least 90 days—or up to the full year—have the greatest potential for a larger bonus and will not receive a penalty. The 90-day performance period can begin anytime between January 1, 2017, and October 2, 2017. Data must be reported no later than March 31, 2018.

- If a MIPS-eligible clinician does not report even one measure or activity in 2017, he or she will receive the full negative 4% payment adjustment in 2019.
- MIPS eligible clinicians who participate in Advanced APM entities that meet the required revenue or patient thresholds will receive a 5% bonus.

MIPS Assessment Categories

MIPS will assess the performance of clinicians based on four categories: Quality, Resource Use (Cost), Advancing Care Information (EHR), and Improvement Activities (referred to as Clinical Practice Improvement Activities in the proposed rule).

Quality: 60% of Total Score in Year 1 (2017)

This category replaces the Physician Quality Reporting System (PQRS) and incorporates all of the ophthalmology measures available in PQRS. For the Quality component, physicians must report a minimum of 6 measures, with at least one outcome

measure, if available. If no outcome measure applies to the provider, he or she would report one "high priority measure." Following ASCRS and medical community advocacy, **CMS lowered the reporting threshold for quality measures to 50% of Part B patients if reporting via claims, and 50% of all patients for registry reporting. For full credit in the category, providers have the potential to earn up to 60 or 70 points, depending on practice size. Practices of 15 or fewer providers must report 6 measures, each with 10 total possible points, while practices of 16 or more providers will also be scored on a claims-based hospital re-admission measure in addition to the 6 reported measures, each worth 10 possible points. Unlike PQRS, which gave participants credit for only reporting the measures, the Quality component score will be based on achievement in each measure, relative to pre-set performance benchmarks based on 2015 performance.**

Resource Use (Cost): 0% of Total Score Year 1 (2017)

This category replaces the Value-Based Payment Modifier program. CMS agreed to ASCRS and medical community recommendations that due to the flawed attribution methodology and lack of risk adjustment, resource use should not be included in the first year's MIPS score. **While Resource Use will not impact providers' payments in 2019, it will be a component of MIPS scores for future years, so CMS will proceed with calculating the measures based on 2017 performance for informational purposes.** CMS will use two of the cost measures previously used in the Value Based Payment Modifier (VBPM) program: Total Per Capita Costs for all attributed beneficiaries and Medicare Spending per Beneficiary. Episode-based measures will also be used to evaluate cost as applicable. For 2017, CMS finalized 10 episode measures, including cataract surgery. Episode-based measures will also be calculated in year 1 for informational purposes.

Advancing Care Information (ACI): 25% of Total Score Year 1

This section replaces the EHR Meaningful Use incentive program. It comprises a score for participating and reporting required measures (base score) and a score for reporting selected measures at various levels above the base score (performance score). **The base score makes up 50 points and the performance score makes up 90 points**. **If clinicians earn 100 points or more, they will earn full credit for the Advancing Care Information category.** For the first transition year, 2017, providers who have 2014-certified EHR technology will be unable to report on certain ACI measures, which correspond to the previous Meaningful Use Stage 3. **Therefore, participants using 2014 technology will be assessed on a sub-set of the ACI measures, which their systems are capable of reporting.**

Improvement Activities: 15% of Total Score in Year 1

Clinicians can select activities from a list of more than 90 options, such as care coordination, beneficiary engagement, and patient safety. There are two types of activities clinicians can choose from: medium-level activities worth 10 points and high-level activities worth 20 points. Providers must reach a total of 40 points to receive full credit for this category, either by completing two high-level, four medium-level, or a combination of medium- and high-weighted activities The weights for each level are doubled for providers practicing in groups of 15 or fewer (40 points for high-level activities and 20 points for medium-level activities). Therefore, small practices only have to perform one high-level activity or two medium-level activities for full credit in the category. Improvement Activities must be performed for at least 90 days during the reporting period.

Final Score and 2017 Performance Threshold

MIPS participants will receive a final score (0–100) based on their performance in these aforementioned categories. Each provider's composite score will be compared to a performance threshold, which will be the mean or median of all composite performance scores for all MIPS eligible professionals during a prior period. Weights may be adjusted if there are not sufficient measures and activities applicable for specialty providers, including assigning a scoring weight of 0 for a performance category.

Since no previous performance statistics are available, and CMS is providing options for different levels of participation for the 2019 payments (based on 2017 performance), the performance threshold for the first performance year, 2017, will be set at a composite score of 3. Therefore, any provider scoring at least 3 points in the MIPS total score will not be subject to a penalty. Providers who participate for at least 90 days and score above 70 qualify as "exceptional performance" and are eligible for an additional bonus above and beyond the yearly available MIPS positive payment adjustment level. Congress set aside additional funds for exceptional performance in MACRA, which is not subject to the budget neutrality requirements of the MIPS payment adjustments.

Incentives and Penalties

Eligible professionals will receive a positive, negative, or neutral payment adjustment based on their composite score. The **negative adjustment** will be capped at 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022.

For 2019, based on 2017 performance, only providers who do not submit any data through the MIPS program will be subject to a penalty. The penalty will be the full 4%.

In future years, providers who fall between zero and one-fourth of the threshold will receive the maximum negative penalty. Providers whose scores are closer to the threshold score will receive smaller negative payment adjustments.

If an eligible professional's composite score is at the threshold, he or she will not receive a MIPS payment adjustment.

Under the MACRA statute, physicians with composite scores above the threshold will receive **positive payment adjustments**. The higher performance scores will receive proportionally larger incentive payments up to three times the annual cap for negative payment adjustments each year. Positive incentives are increased or decreased by a scaling factor to achieve budget neutrality with the aggregate application of negative adjustments. For six years beginning in 2019, providers can also earn additional incentive payments for "exceptional performance."

Due to budget neutrality requirements, available positive payment adjustments may be limited in the first year; however, funds for exceptional performance remain unaffected.

Advanced Alternative Payment Models (APMs)

CMS is encouraging participation in Advanced Alternative Payment Models (APMs). Eligible clinicians who participate in APM entities that receive a significant share of their revenues or treat a certain percentage of patients through an APM that involves more than nominal risk of financial loss, includes a quality measure component, and has the majority of participants using CEHRT will receive a **5% bonus for each year from 2019 to 2024**. Advanced APMs include Accountable Care Organizations with two-sided risk and medical homes.

For 2019, based on performance year 2017, Advanced APM entities must derive at least 25% of collective eligible payment amounts or 20% of collective eligible patients from an APM for participants to receive the bonus payment. **Clinicians participating in APMs that achieve those thresholds will be excluded from MIPS requirements. These percentages of payment amounts or patients required to qualify for the APM bonus will increase in future years.**

There are currently no ophthalmology specific advanced APMs. In addition, current available models are, for the most part, focused on primary care, such as ACOs or certified medical homes. Some ophthalmologists currently participate in Medicare Shared Savings Program Track 1 ACOs, but since those models do not include two-sided risk, they are not considered advanced APMs, and will not be eligible for bonus payments. In the final rule, CMS noted they were in the final stages of approving updated requirements for a Track 1 Plus model, which would incorporate a lower level of two-sided risk and is expected to be included in the list of approved models to be released by January 1, 2017.

Note: All physicians must report through MIPS for the first performance year. CMS will calculate whether APM entities meet thresholds at the end of the performance year. In the final rule, CMS announced—to the extent possible—that if it can determine from historical data whether an APM entity is likely to meet the threshold, it will notify the participants and exempt them from MIPS.

Intermediate Options

Physicians participating in Advanced APM entities that fall short of requirements for the incentive payments would be able to choose whether they would like to receive a payment adjustment through MIPS. To opt out of the MIPS payment adjustment, **the clinician must participate in an Advanced APM entity that collectively reached lower thresholds of Medicare payments or patients. For 2019 and 2020, the collective threshold is 20% of eligible Medicare payments or 10% of eligible Medicare patients for partial participation.** They will not qualify for the 5% bonus payment under the APM category. If a physician participates in multiple APM entities, and one of the entities does not meet the thresholds, CMS will determine if the individual

physician's total participation in multiple APM entities meets the thresholds. If the sum of the participation in multiple entities hits the threshold, the physician receives the 5% bonus and is exempted from MIPS.

MIPS APMs

Physicians also have the opportunity to earn points in MIPS by participating in certain APMs and Advanced APMs that CMS determines to be "MIPS APMs." Each year, CMS will release a list of MIPS APMs prior to the performance period.

For 2019, based on 2017 performance, CMS has approved the following APMs as MIPS APMs:

- **Medicare Shared Savings Program Tracks 1, 2, and 3**
- Next Generation ACO Model
- Comprehensive ESRD Care Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus (CPC+) Model

To earn MIPS points from a MIPS APM, a provider must:

- **Be included in the participant list of a non-Advanced APM that CMS has determined to be a MIPS APM, or**
- **Be included in the participant list of an Advanced APM entity that did not meet the thresholds to be eligible for the bonus payment and, therefore, elect to participate in MIPS.**

For models that CMS determines to be "MIPS APMs," in 2017 participants will:

- **Report the required quality measures for the APM through the APM entity (if an APM entity does not report data on behalf of individuals or groups participating in the APM, those physicians will be required to report quality data on their own);**
- **Report data for the Advancing Care Information Category on their own; and**
- **Automatically earn all of the total available points for the Improvement Activities category score.**

Similar to determining the thresholds for participation in Advanced APMs, **CMS will award the same final MIPS score to all the participants in a MIPS APM entity—including for data they reported individually or as a group under a single TIN**. Under the terms of the models considered MIPS APMs, participants in the APM entities are already assessed collectively for meeting certain quality and cost metrics; therefore, CMS **will score the Advancing Care Information and Improvement Activities collectively, as well.** CMS will use an average score of all the participants' scores for Advancing Care Information to determine a group score. All participants in the MIPS APM will receive the same total available score for Improvement Activities. The MIPS APM entity's final MIPS score will be applied to the participants in the entity at the TIN/NPI level.

For full details on the MIPS APM option, please refer to ASCRS•ASOA's guide on Alternative Payment models.

Other Payer APMs

Other Payer APMs include payment arrangements under any payer other than traditional Medicare, including Medicare Advantage and other Medicare-funded plans. **Beginning in 2021** (performance year 2019), these other payers will count toward APM thresholds. However, the 5% bonus for significantly participating in an Advanced APM will be based on traditional Medicare and will not include Medicare Advantage payments.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

MIPS Program: 2017 Quality Performance Category
(formerly known as PQRS)

Quality Category Weight – 60%

For 2017, the first performance year of MIPS, CMS will weight a provider's Quality performance score at 60% of the overall MIPS composite score. In the second year of MIPS, CMS will lower the weight to 50% and then further lower it to 30% of the overall score for the third year of the program.

In some cases, CMS may determine a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference.

Quality Reporting Requirements

To achieve full credit for the Quality performance category, physicians must achieve a total of 60 or 70 points, depending on practice size. Practices of 15 or fewer providers must report six measures, each with 10 total possible points, while practices of 16 or more providers will also be scored on a claims-based hospital re-admission measure in addition to the 6 reported measures, each worth 10 possible points. Physicians must report on 50% of all patients, if reporting via registry or EHR, and 50% of all Medicare Part B patients if reporting via claims. For 2018 reporting, the reporting threshold will increase to 60% of patients.

Physicians must report a minimum of 6 measures, with at least one being an outcome measure, if available. If no outcome measure applies to the clinician, he or she would report one "high priority measure." "High Priority Measures" are certain CMS designated measures that include all outcome measures

Each measure reported must have a minimum of 20 cases to be included in the Quality category score.

In addition, CMS intends to publish a list of non-MIPS measures, owned by Qualified Clinical Data Registries (QCDRs), such as the IRIS Registry, that can be reported through such QCDRs for credit under MIPS. The non-MIPS measure list is expected to be released in early 2017.

CMS has removed the Measures Group option previously available under PQRS (Cataract and Diabetic Retinopathy Measures Groups for ophthalmology), for which physicians would only be required to report on 20 patients, at least 50% of which would be Part B beneficiaries, through registry. **ASCRS•ASOA opposes the elimination of the measures groups and will be urging CMS to reinstate the Measures Group option in the future.**

First Performance Year Scoring Consideration

Since the measure benchmark scoring is new, in the final rule, CMS finalized a measure score "floor" of three points for the transition performance year of 2017. If providers report a particular measure, but do not meet the benchmarks or submission thresholds, they will automatically receive a score of three points for that measure. This three-point floor corresponds to the overall MIPS composite score benchmark of three, which would be the required score to avoid a negative payment adjustment.

Quality Performance Score

Unlike under PQRS, in which providers simply had to report on certain measures to achieve an incentive or avoid a penalty, **providers under the MIPS program must now demonstrate improved quality above a baseline level. For the 2017 performance year, CMS has set a baseline performance benchmark for each measure based on 2015 performance data.** Providers will be scored on performance in the first year, but must demonstrate improvement in later years.

For 2017, each measure has specific benchmarks depending on submission method (i.e., claims, EHR, registry) that are scored on a decile, or ten point, scale. For each submission method, CMS has assigned different levels of performance to each decile. Each decile is a range of performance levels for the measure that correspond to points earned for the measure. For example, if

a physician submits data showing 83% performance on a measure, and the 5th decile begins at 72% performance and the 6th decile begins at 85% performance, then he or she will receive between 5 and 5.9 points because 83% is in the 5th decile.

The total possible score in the Quality category depends on the size of the practice:

- Providers in groups of fewer than 15 are subject to 6 measures and are eligible to receive up to **60 points** in the Quality performance category.
- Providers in groups of 16 or more are subject to 7 measures (6 to be reported, and the hospital readmission measure if 200 patients are attributed) and are eligible to receive up to **70 points** in the Quality performance category. If 200 patients are not attributed, the hospital readmission measure will not be calculated, and providers will only be scored on the reported 6 measures, for a total possible score of 60 points.

Possible Bonus Points: To incentivize providers to report on additional "high priority" measures, CMS will award bonus points to providers who report these measures. Specifically, CMS will award:

- Two bonus points for each additional outcome measure reported beyond the required one OR
- One bonus point for each additional "high priority" measure.

Bonus points for reporting additional "high priority" and outcome measures are capped at 10% of the total available points in the Quality performance category for providers. For example, if a provider is in a small practice, and can score up to 60 points, the total bonus points that can be awarded is 6. **Bonus points will be awarded to applicable measures for the first transition year, even if the provider fails to meet the case minimum or data submission thresholds.** For example, if a physician reports an additional outcome measure, but fails to reach the 20 patient case minimum, he or she would receive the initial minimum "floor" score of 3 for the measure, then be awarded 2 more bonus points, resulting in a score of 5 for the individual measure.

Quality measures reported through "end-to-end" electronic submissions will earn the provider bonus points Providers may earn up to 10% of the total available points in the Quality performance category if they submit measures through EHR or a qualified clinical data registry that meet the definition of "end-to-end" electronic reporting. To be considered "end-to-end" electronic reporting, an automated process must be used to aggregate the measure data, calculate measure, perform any filtering of measurement data, and submit the data electronically to CMS. Systems that require manual abstraction and re-entry of data are not considered end-to-end and, therefore, not eligible for a bonus.

Each measure submitted electronically through EHR or qualified data registry will receive one bonus point. For example, if a provider is scored on 60 possible points in the Quality performance category, he or she can earn up to 6 bonus points for electronic submission toward the Quality category score. Electronic bonus points are awarded in addition to bonus points for additional high priority and outcome measures.

A provider's Quality performance category score will be the sum of the points assigned based on his or her quality reporting divided by the total available points, depending on practice size. The Quality category score will then be weighted to count for 60% of the total MIPS score.

Sample Quality Performance Score Calculation for a Physician Practicing in a Group of 15 or Fewer				
Measure	Score	Bonus Points (high priority/outcome measures)	Bonus Points (electronic reporting)	Total
Measure A	3		1	4
Measure B	6		1	7
Measure C (first outcome)	5		1	6
Measure D (additional outcome)	6	2	1	9
Measure E (high priority)	8	1	1	10
Measure F	7		1	8
Total Quality Points (of a possible 60)				44
Quality Score				73 points (weighted 60% of MIPS score)

Quality Measures

The final rule includes a list of individual Quality Measures available for MIPS reporting in 2017. In addition, the list is re-ordered to identify the measures by medical specialty. Providers may choose from the list and will need to report six quality measures (including one outcome measure). The ophthalmology specialty measure set, and accompanying benchmarks are listed at the end of this section

Global and Population Measures

In addition to the quality measures listed, CMS originally proposed to score providers on 2 or 3 global and population-based measures, depending on practice size. **ASCRS and others in the medical community opposed the inclusion of these measures in the Quality score due to the flawed attribution methodology, and therefore, CMS did not finalize including <u>all</u> of the measures for the first performance year.**

Through administrative claims, CMS originally proposed to assess providers on acute and chronic care composite measures and an all-cause hospital re-admission measure, previously used to calculate the Value-Based Payment Modifier (VBPM). However, in the final rule, **for the first performance year, CMS will not use the scores calculated on the acute and chronic care composite measures as part of the overall MIPS score, <u>but will include the hospital re-admission measure in the MIPS Quality component score. In addition, only physicians practicing in groups of at least 16 providers and 200 attributed patients will be assessed on the hospital readmission measure.</u>**

CMS will continue to calculate all the measures for informational purposes, and plans to use them toward providers' Quality scores in future years. However, only the hospital readmission measure will count toward the Quality scores of physicians practicing in groups of at least 16 with 200 attributed patients in 2017.

CMS will attribute patients to these measures through the same flawed VBPM two-step attribution process, based on which provider bills the plurality of E/M codes during the performance period. ASCRS continues to oppose this attribution methodology and will continue to advocate in our comments on the final rule and in the future that CMS develop more appropriate attribution methodologies that do not hold physicians accountable for the cost of care they did not provide.

Physicians do not need to report on these measures; CMS will score them based on administrative claims.

Data Submission

For the first performance year of MIPS, providers may report their quality performance data through claims, registry, EHR, or Web Interface (formerly known as GPRO).

Providers do not have to submit data for each of the MIPS categories through the same mechanism in the first year, but CMS proposes to require all MIPS data to be submitted by a single reporting method in future years.

Additional Resources

For additional information, contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

2017 MIPS Quality Category Measures and Benchmarks for Ophthalmology

Physicians must report on 50% of all patients, if reporting via registry or EHR, and 50% of all Medicare Part B patients if reporting via claims. For 2018 reporting, the reporting threshold will increase to 60% of patients.

Physicians must report a minimum of 6 measures, with at least one being an outcome measure, if available. If no outcome measure applies to the clinician, he or she would report one **"high priority measure."** "High priority" measures are certain CMS-designated measures that include all outcome measures.

Quality measures are scored based on specific benchmarks for each measure, depending on submission mechanism.

This document lists the available ophthalmology measures in the first table, and their benchmarks in the following table.

Ophthalmology Quality Measures

NQF/PQRS Number	Submission Mechanism	Measure Type	Measure Domain	Measure Title
0086/012	Claims, Registry, EHR	Process	Effective Clinical Care	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
0087/014	Claims, Registry	Process	Effective Clinical Care	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
0088/018	EHR	Process	Effective Clinical Care	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
0089/019	Claims, Registry, EHR	Process	Communication and Care Coordination **(high priority)**	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
0326/047	Claims, Registry	Process	Communication and Care Coordination **(high priority)**	Care Plan - Percentage of patients 65 and older who have an advanced care plan or designated surrogate decision maker documented in the medical record.
0055/117	Claims, Web Interface, Registry, EHR	Process	Effective Clinical Care	Diabetes: Eye Exam
0419/130	Claims, Registry, EHR	Process	Patient Safety **(high priority)**	Documentation of Current Medications in the Medical Record
0566/140	Claims, Registry	Process	Effective Clinical Care	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
0563/141	Claims, Registry	Outcome	Communication and Care Coordination **(high priority)**	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% or Documentation of a Plan of Care
0565/191	Registry, EHR	Outcome	Effective Clinical Care **(high priority)**	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
0564/192	Registry, EHR	Outcome	Patient Safety **(high priority)**	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
0028/226	Claims, Registry, EHR, Web Interface	Process	Communication and Care Coordination **(high priority)**	Preventative Care and Screening: Tobacco Use: Screening and Cessation Information

NQF/PQRS Number	Submission Mechanism	Measure Type	Measure Domain	Measure Title
1536/303	Registry (not available in IRIS for 2017)	Outcome	Person Caregiver-Centered Experience and Outcomes **(high priority)**	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
N/A/304	Registry (not available in IRIS for 2017)	Outcome	Person Caregiver-Centered Experience and Outcomes **(high priority)**	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
N/A/317	Claims, Registry, EHR (not available in IRIS for 2017)	Process	Community/Population Health **(high priority)**	Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
N/A/374	EHR	Process	Communication and Care Coordination **(high priority)**	Closing the Referral Loop: Receipt of Specialist Report
N/A/384	Registry	Outcome	Effective Clinical Care	Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery
N/A/385	Registry	Outcome	Effective Clinical Care	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery
N/A/388	Registry	Outcome	Patient Safety **(high priority)**	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy)
N/A/389	Registry	Outcome	Effective Clinical Care	Cataract Surgery: Difference Between Planned and Final Refraction
N/A/402	Registry	Process	Community/Population Health **(high priority)**	Tobacco Use and Help with Quitting Among Adolescents

Other Available Measures

CMS did not finalize the proposal to require one of the quality measures to be a cross-cutting measure. However, measures that are deemed cross-cutting are still available for physicians to report.

NQF/PQRS Number	Submission Method	Measure Type	Measure Domain	Measure Title
0018/236	Claims, Web Interface, Registry, EHR	Intermediate Outcome* **(high priority)**	Effective Clinical Care	Controlling: High Blood Pressure

*Intermediate outcome measures are considered outcome measures.

Ophthalmology Quality Measure Benchmarks

Each decile includes a range of performance rates. Deciles without benchmarks (denoted by a --) indicate that there are no scores available in that decile.

Measure Name	PQRS Number	Reporting Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	Claims	99.01 - 99.99	--	--	--	--	--	--	100
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	EHR	73.33 - 82.41	82.42 - 87.39	87.40 - 90.90	90.91 - 94.16	94.17 - 96.57	96.58 - 98.25	98.26 - 99.57	>= 99.58
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	Registry	95.07 - 98.10	98.11 - 99.35	99.36 - 99.99	--	--	--	--	100
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Claims	--	--	--	--	--	100	--	--
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Registry	77.25 - 91.17	91.18 - 98.18	98.19 - 99.99	--	--	100	--	--
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	18	EHR	31.69 - 41.32	41.33 - 49.99	50.00 - 56.97	56.98 - 64.17	64.18 - 70.58	70.59 - 76.97	76.98 - 85.15	>= 85.16
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	Claims	--	--	--	--	--	--	--	100
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	EHR	20.00 - 29.78	29.79 - 38.35	38.36 - 45.70	45.71 - 52.53	52.54 - 60.79	60.80 - 68.80	68.81 - 79.30	>= 79.31
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	Registry	36.21 - 59.99	60.00 - 78.56	78.57 - 89.80	89.81 - 96.22	96.23 - 99.99	--	--	100
Advance Care Plan	47	Claims	13.68 - 34.57	34.58 - 62.86	62.87 - 86.91	86.92 - 97.10	97.11 - 99.59	99.60 - 99.99	--	100
Advance Care Plan	47	Registry	16.52 - 38.11	38.12 - 59.14	59.15 - 74.99	75.00 - 88.71	88.72 - 96.29	96.30 - 99.17	99.18 - 99.99	100
Diabetes: Eye Exam	117	Claims	86.36 - 97.77	97.78 - 99.99	--	--	--	--	--	100
Diabetes: Eye Exam	117	EHR	50.57 - 80.68	80.69 - 90.05	90.06 - 94.11	94.12 - 96.66	96.67 - 98.57	98.58 - 99.99	--	100
Diabetes: Eye Exam	117	Registry	69.39 - 89.68	89.69 - 95.95	95.96 - 98.72	98.73 - 99.99	--	--	--	100
Documentation of Current Medications in the Medical Record	130	Claims	96.11 - 98.73	98.74 - 99.64	99.65 - 99.99	--	--	--	--	100
Documentation of Current Medications in the Medical Record	130	EHR	76.59 - 87.88	87.89 - 92.73	92.74 - 95.35	95.36 - 97.08	97.09 - 98.27	98.28 - 99.12	99.13 - 99.75	>= 99.76

Measure Name	PQRS Number	Reporting Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Documentation of Current Medications in the Medical Record	130	Registry	61.27 - 82.11	82.12 - 91.71	91.72 - 96.86	96.87 - 99.30	99.31 - 99.99	--	--	100
Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	140	Claims	97.50 - 99.99	--	--	--	--	--	--	100
Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	140	Registry	32.26 - 48.38	48.39 - 65.54	65.55 - 78.94	78.95 - 89.99	90.00 - 97.43	97.44 - 99.99	--	100
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Claims	--	--	--	--	--	--	--	100
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Registry	78.95 - 93.68	93.69 - 98.03	98.04 - 99.75	99.76 - 99.99	--	--	--	100
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	EHR	86.61 - 91.42	91.43 - 94.43	94.44 - 96.07	96.08 - 97.35	97.36 - 98.30	98.31 - 99.24	99.25 - 99.99	100
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	Registry	42.89 - 59.56	59.57 - 83.17	83.18 - 91.52	91.53 - 94.84	94.85 - 96.79	96.80 - 99.25	99.26 - 99.99	100
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	192	EHR	0.92 - 0.43	0.42 - 0.01	--	--	--	--	--	0
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	192	Registry	1.60 - 0.75	0.74 - 0.24	0.23 - 0.01	--	--	--	--	0
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Claims	95.60 - 97.85	97.86 - 99.25	99.26 - 99.99	--	--	--	--	100
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	EHR	72.59 - 81.59	81.60 - 86.68	86.69 - 90.15	90.16 - 92.64	92.65 - 94.67	94.68 - 96.58	96.59 - 98.51	>= 98.52
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Registry	76.67 - 85.53	85.54 - 89.87	89.88 - 92.85	92.86 - 95.14	95.15 - 97.21	97.22 - 99.10	99.11 - 99.99	100

Measure Name	PQRS Number	Reporting Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	303	Registry (not available in IRIS for 2017)	5.76 - 9.37	9.38 - 23.80	23.81 - 29.87	29.88 - 43.60	43.61 - 56.69	56.70 - 94.33	94.34 - 99.99	100
Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	304	Registry (not available in IRIS for 2017)	5.32 - 7.68	7.69 - 21.69	21.70 - 26.67	26.68 - 39.60	39.61 - 46.60	46.61 - 83.07	83.08 - 99.99	100
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	317	Claims	42.13 - 50.44	50.45 - 59.06	59.07 - 68.11	68.12 - 78.63	78.64 - 92.67	92.68 - 99.53	99.54 - 99.99	100
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	317	EHR	17.90 - 22.55	22.56 - 25.80	25.81 - 28.83	28.84 - 31.69	31.70 - 34.67	34.68 - 38.96	38.97 - 46.26	>= 46.27
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	317	Registry	24.74 - 35.47	35.48 - 47.87	47.88 - 62.14	62.15 - 71.64	71.65 - 79.36	79.37 - 88.85	88.86 - 98.87	>= 98.88
Closing the Referral Loop: Receipt of Specialist Report	374	EHR	2.70 - 6.24	6.25 - 11.46	11.47 - 18.15	18.16 - 25.57	25.58 - 36.95	36.96 - 51.17	51.18 - 71.87	>= 71.88
Adult Primary Rhegmatogenous Retinal Detachment Repair Success Rate	384	Registry	--	--	--	--	--	--	--	--
Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	385	Registry	--	--	--	--	--	--	--	--
Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy)	388	Registry	0.26 - 0.01	--	--	--	--	--	--	0
Cataract Surgery: Difference Between Planned and Final Refraction	389	Registry	66.67 - 88.45	88.46 - 94.11	94.12 - 98.09	98.10 - 99.99	--	--	--	100
Tobacco Use and Help with Quitting Among Adolescents	402	Registry	74.10 - 81.15	81.16 - 87.49	87.50 - 90.37	90.38 - 92.72	92.73 - 95.15	95.16 - 97.50	97.51 - 99.99	100
Controlling High Blood Pressure	236	Claims	57.69 - 63.44	63.45 - 68.28	68.29 - 72.78	72.79 - 77.06	77.07 - 81.47	81.48 - 86.75	86.76 - 93.42	>= 93.43

Measure Name	PQRS Number	Reporting Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	236	EHR	50.00 - 55.39	55.40 - 59.72	59.73 - 63.59	63.60 - 67.38	67.39 - 71.00	71.01 - 75.33	75.34 - 80.89	>= 80.90
Controlling High Blood Pressure	236	Registry	51.00 - 58.20	58.21 - 63.56	63.57 - 68.27	68.28 - 72.40	72.41 - 76.69	76.70 - 82.75	82.76 - 91.06	>= 91.07

MIPS Program: 2017 Advancing Care Information Category
(formerly known as Meaningful Use)

Advancing Care Information (ACI) Category Weight

For 2017, the first performance year of MIPS, the ACI category score will be weighted at 25% of the overall MIPS composite score. If CMS determines that at least 75% of eligible professionals are "meaningful users" of EHR in future years, the scoring weight for ACI could be lowered to no less than 15% of the overall score.

In some cases, CMS may determine a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference.

Advancing Care Information Category Score Structure

CMS will structure a provider's ACI category score on a base score, and at levels above the base score for a performance score. Providers must meet all of the objectives and measures to achieve the base score. Participants may **choose which objectives and measures they want to meet for the performance score. Some measures are included in both the base and performance scores. For those measures, providers only need a 1 in the numerator for the base score, but will earn additional points toward the performance score for higher values in the numerator.**

There are also several opportunities to earn additional bonus points for reporting on certain optional measures.

When all the possible points for the base and performance scores and potential bonuses are added, there are a total of 155 possible points available in the ACI category. To receive full credit for this category, however, a provider only needs to score 100 points. Any additional points earned above 100 will not increase a provider's total MIPS composite score.

Advancing Care Information Base Score

CMS will award 50 points to providers who achieve all 5 of the measures (listed below) under the base score.

To receive the full base score, providers do not need to meet a specific threshold, but must report either a "yes" for measures requiring a yes/no answer, or a numerator of at least 1 for numerator/denominator measures.

Failure to meet all of the requirements for the base score will earn a provider an ACI category score of zero, and preclude him or her from achieving any additional points through the performance score.

Advancing Care Information Performance Score

Physicians can earn up to 90 points toward the performance score for achievement on certain measures (listed below). Providers may choose which performance score measures to report. Each measure reported will be calculated individually by dividing the numerator by the denominator. A performance rate of 1% to 10% will be scored 1 point, a performance rate of 11% to 20% will earn 2 points, and so on.

Example: If a provider reports that 85 out of 100 possible patients were included in the Patient-Specific Education Measure, then the performance rate would be 85% and earn the provider 9 points toward the performance score.

The total performance score is the sum of the individual provider's score on each of reported measures.

Bonus Points

CMS previously proposed to calculate the Public Health and Clinical Data Registry Reporting Objective as part of the base score, but exclude it from the score for certain specialties who do not administer immunizations, such as ophthalmology. **In the final rule, however, none of the measures in the Public Health objective will be included in the base score. Providers will have the option to report on participation in an immunization registry for 10 points toward the performance score.**

In addition, providers can earn an additional 5 bonus points for reporting on each of the other registries—including a clinical data registry, such as IRIS.

Providers can also earn up to 15 bonus points by reporting to additional registries or reporting the Improvement Activities using CEHRT.

Advancing Care Information Objectives and Measures

All providers must report five measures to achieve the base score. Certain objectives and measures are available to be reported on for the performance score. Objectives and measures included in the base and performance score are noted below.

Base Score Objectives and Measures		
Objective	**Measure**	**Reporting Requirement**
Protect Patient Health Information	**Security Risk Analysis** – Conduct or review a security risk analysis, including addressing the security (including encryption) of electronic personal health information created or maintained by CEHRT; implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.	Yes/no; must answer "yes"
Electronic Prescribing	**Electronic Prescribing** – At least one permissible prescription written by the provider is queried for a drug formulary and transmitted electronically using CEHRT.	Numerator/Denominator; must have at least 1 in the numerator
Patient Electronic Access	**Patient Access Measure** – For at least one unique patient seen by the provider, (1) the patient (or patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information, and (2) the provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of his or her choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT.	Numerator/Denominator; must have at least 1 in the numerator
Health Information Exchange	**Send a Summary of Care Measure** – For at least one transition of care or referral, the provider who transitions or refers his or her patient to another setting of care or health care provider (1) creates a summary of care record using CEHRT, and (2) electronically exchanges the summary of care record.	Numerator/Denominator; must have at least 1 in the numerator
	Request/Accept Patient Care Record Measure – For at least one transition of care or referral received or patient encounter in which the provider has never before encountered the patient, the provider received, or retrieves and incorporates into the patient's record, an electronic summary of care document.	Numerator/Denominator; must have at least 1 in the numerator

Performance Score Objectives and Measures		
Objective	**Measure**	**Performance Score**
Patient Electronic Access	**Patient Access Measure** – For at least one unique patient seen by the provider, (1) the patient (or patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information, and (2) the provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of his or her choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT.	Up to 10 points
	Patient-Specific Education Measure – The provider must use clinically relevant information from the CEHRT to identify patient-specific educational resources, and provide electronic access to those materials, to at least one unique patient seen by the provider.	Up to 10 points
Coordination of Care through Patient Engagement	**View, Download, Transmit Measure** – At least one unique patient (or patient-authorized representative) seen by the provider during the performance period actively engages with the EHR made accessible by the provider. A provider may meet the measure by having a patient either (1) view, download, or transmit to a third party his or her health information; or (2) access his or her health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).	Up to 10 points
	Secure Messaging Measure – For at least one unique patient seen by the provider during the performance period, a secure message was sent using the electronic messaging function of the CEHRT to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).	Up to 10 points
	Patient-Generated Health Data Measure – Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for at least one unique patient seen by the provider during the performance period	Up to 10 points
Health Information Exchange	**Patient Care Record Exchange Measure** – For at least one transition of care or referral, the provider who transitions or refers his or her patient to another setting of care or health care provider (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.	Up to 10 points
	Request/Accept Patient Care Record Measure – For at least one transition of care or referral received or patient encounter in which the provider has never before encountered the patient, the provider received, or retrieves and incorporates into the patient's record, an electronic summary of care document.	Up to 10 points
	Clinical Information Reconciliation Measure – For at least one transition of care or referral received or patient encounter in which the provider has never before encountered the patient, the provider performs clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication— Review of the patient's medication including the name, dosage, frequency, and route of each medication; (2) Medication Allergy—Review of the patient's known medication allergies; and (3) Current Problem List—Review of the patient's current and active diagnoses.	Up to 10 points
Public Health and Clinical Data Registry Reporting	**Immunization Registry Reporting** – The provider is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).	0 or 10 points
	Syndromic Surveillance Reporting Measure – The provider is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined.	5 Point Bonus
	Electronic Case Reporting Measure – The provider is in active engagement with a	5 Point Bonus

Performance Score Objectives and Measures

Objective	Measure	Performance Score
	public health agency to electronically submit case reporting of reportable conditions.	
	Public Health Registry Measure – The provider is in active engagement with a public health agency to submit data to public health registries.	5 Point Bonus
	Clinical Data Registry Measure – The provider is in active engagement to submit data to a clinical data registry.	5 Point Bonus
Bonus (up to 15%)		
	Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure (yes/no statement)	5 point bonus
	Report improvement activities using CEHRT (yes/no statement)	10 point bonus

Alternative Requirements for 2017 Based on CEHRT Certification Year

Providers who do not have 2015-certified EHR technology will not be able to report several of the measures finalized as part of the ACI category. Since providers are not required to have 2015 technology until 2018, CMS has finalized a modified list of objectives and measures for the first performance period (2017) for participants using 2014 technology.

2017 Advancing Care Information Transition Objectives and Measures (for participants with 2014 CEHRT)

2017 ACI Transition Objectives	2017 Transition ACI Measures	Required/Not Required for the Base Score	Performance Score	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/no statement
Electronic Prescribing	E-Prescribing	Required	0	Numerator/denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 20 points	Numerator/denominator
	View, Download, or Transmit	Not required	Up to 10 points	Numerator/denominator
Patient-Specific Education	Patient-Specific Education	Not required	Up to 10 points	Numerator/denominator
Secure Messaging	Secure Messaging	Not required	Up to 10 points	Numerator/denominator
Health Information Exchange	Health Information Exchange	Required	Up to 20 points	Numerator/denominator
Medication Reconciliation	Medication Reconciliation	Not required	Up to 10 points	Numerator/denominator
Public Health Reporting	Immunization Registry Reporting	Not required	0 or 10 points	Yes/no statement
	Syndromic Surveillance Reporting	Not required	Bonus – 5 points	Yes/no statement
	Specialized Registry Reporting	Not required	Bonus – 5 points	Yes/no statement
Bonus up to 15%				
	Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure		5 point Bonus	Yes/no statement
	Report improvement activities using CEHRT		10 point Bonus	Yes/no statement

Additional Resources

For additional information, contact Allison Madson at amadson@ascrs.org or 703-591-2220.

MIPS Program:
2017 Improvement Activities Category
(previously known as Clinical Practice Improvement Activities)

Improvement Activities Category Weight – 15%

For 2017, the first performance year of MIPS, CMS will weight a provider's Improvement Activities score at 15% of the overall MIPS composite score.

Improvement Activities Reporting Requirements

Physicians must achieve a total of 40 points from improvement activities during a 90-day reporting period. CMS will score individual improvement activities as either high- or medium-weighted. High-weighted activities are worth 20 points, while medium-weighted activities are worth 10 points. Providers are required to perform four medium-weighted or two high-weighted activities, or any combination of high- or medium-weighted activities for 2017.

Physicians in groups of 15 or fewer are only required to complete one high-weighted or two medium-weighted activities for full credit—40 points—for the category. For small practices, CMS will weigh the improvement activities at double the value for larger practices. Therefore, high-weighted activities are worth 40 points, while medium-weighted activities are worth 20 points. **Providers in groups of 15 or fewer can achieve half of the total category score by completing one medium-weighted improvement activity.**

Providers participating in a patient-centered certified medical home will automatically receive full credit for the Improvement Activities category of MIPS. Providers participating in an Advanced Alternative Payment Model (APM) will receive 50% of the full score for the improvement activities category of MIPS.

Improvement Activities Score

To determine a provider's Improvement Activities category score, CMS will divide the sum of the points earned by the provider by 40, the total available points for the category. The improvement activities category score would then be counted as 15% of the MIPS composite score.

Despite opposition from ASCRS and the medical community in comments on the proposed rule, CMS will assign scores based on providers' performance or improvement on improvement activities in future years. Since there is no current analogous program to improvement activities to develop baseline performance or benchmarks, CMS will not score performance for the first year.

Improvement Activities

The final rule includes a list of individual improvement activities. The activities are grouped in eight sub-categories corresponding to CMS' stated goals. Providers may choose any combination of improvement activities, regardless of category.

The categories and examples of activities included are listed below:

- **Expanded Practice Access:** Improvement Activities include expanded practice hours, telehealth services, and participation in models designed to improve access to services.
- **Population Management:** Improvement Activities include participation in chronic care management programs, participation in rural and Indian Health Services programs, participation in community programs with other stakeholders to address population health, and use of a Qualified Clinical Data Registry (QCDR) to track population outcomes.
- **Care Coordination:** Improvement Activities include use of a QCDR to share information, timely communication and follow up, participation in various CMS models designed to improve care coordination, implementation of care coordination training, implementation of plans to handle transitions of care, and active referral management.

- **Beneficiary Engagement:** Improvement Activities include use of EHR to document patient-reported outcomes, providing enhanced patient portals, participation in a QCDR that promotes the use of patient engagement tools, and use of QCDR patient experience data to inform efforts to improve beneficiary engagement.
- **Patient Safety and Practice Assessment:** Improvement Activities include use of QCDR data for ongoing practice assessments and patient safety improvements, and use of tools such as the Surgical Risk Calculator.
- **Achieving Health Equity:** Improvement Activities include seeing new and follow-up Medicaid patients in a timely manner, and use of QCDR for demonstrating performance of processes for screening for social determinants.
- **Emergency Response and Preparedness:** Improvement Activities include participation in disaster medical teams or participation in domestic or international humanitarian volunteer work.
- **Integrated Behavioral and Mental Health:** Improvement Activities include tobacco intervention and smoking cessation efforts, and integration with mental health services.

For the full list of proposed improvement activities, please refer to CMS' website: https://qpp.cms.gov/measures/ia

Data Submission

Providers can submit improvement activities data using the following mechanisms: qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms. CMS will be releasing additional guidance for how to submit data through its attestation system. If technically feasible, CMS will use administrative claims data to supplement improvement activities submissions in future years.

For the first performance year, all submission mechanisms must designate a "yes/no" response for submitting improvement activities.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

MIPS Program: 2017 Resource Use (Cost) Category

Resource Use Category Weight – 0% for 2017 Performance Year

For 2017, the first performance year of MIPS, a provider's Resource Use score will not factor into the overall MIPS composite score. Due to the flawed attribution methodology proposed by CMS to calculate the cost measures and lack of risk-adjustment, ASCRS and the medical community recommended the category weight be lowered to 0% so that physicians are not penalized for the cost of care they did not provide. CMS agreed to that recommendation. Therefore, CMS will calculate the proposed cost measures based on the 2017 performance period for **informational purposes only**. **This guide summarizes the policies CMS finalized to calculate the informational resource use scores for 2017.**

The weight for this category will increase in future years to 10% in 2020, based on 2018 performance, and 30% for payment year 2021 and beyond.

In some cases, CMS may determine a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference.

Resource Use Reporting Requirements

Physicians do not need to submit separate data for the Resource Use category. Similar to the current Value-Based Payment Modifier (VBPM), CMS will determine resource use through administrative claims.

Resource Use Measures

CMS will measure providers' resource use by using two cost measures from the VBPM and several episode-based measures, including cataract surgery. For the 2017 performance period, CMS will calculate the two cost measures, total per capita cost, and Medicare spending per beneficiary (MSPB) and compare physicians' score relative to a benchmark set at the beginning of the performance period. Total per capita costs include all payments under Medicare Parts A and B, but exclude payments under Part D. MSPB includes costs 3 days before and 30 days after an inpatient hospitalization. Condition-based measures previously used in the VBPM will not be used for the Resource Use category.

CMS will also measure cost through several episode-based measures, including lens and cataract procedures. Episode-based measures attempt to measure the total cost of care for particular acute episodes, specific procedures, or chronic conditions. ASCRS opposed the inclusion of the cataract episode measure in our comments on the final rule, since CMS has not provided sufficient information on how the episodes are constructed and scored. In addition, we have concerns that the attribution process continues to hold physicians accountable for costs that are beyond their control, and that the measures are not risk-adjusted. We continue to advocate for more transparency in the development and use of these measures, and are participating in several technical expert panels to provide feedback on their development. CMS will also calculate the episode-based measures on 2017 performance, for informational purposes. Previously, CMS calculated these measures for physicians, based on 2014 and 2015 data, for informational purposes. Physicians can review their performance on these measures for 2014 and 2015 by downloading their Supplemental Quality and Resource Use Report from the CMS Portal.

Patient Attribution

CMS will attribute patients to the cost measures through the same flawed VBPM two-step attribution process. First, a beneficiary will be assigned to a Tax Identification Number (TIN), combined with a National Provider Identifier (NPI), if the beneficiary receives a plurality of primary care services from a primary care provider. For beneficiaries who did not receive any eligible primary care services from a primary care physician during the reporting period, the beneficiary will be assigned to the TIN/NPI combo that provided the plurality of E/M services to the beneficiary. **Due to this attribution method, ophthalmologists may be attributed costs of care they did not provide.**

CMS has set the attribution threshold at 20 beneficiaries for scoring on the total per capita and 35 beneficiaries on the Medicare Spending per Beneficiary (MSPB) measures.

For episode-based measures, beneficiaries will be attributed to the provider who bills a Medicare Part B claim with a trigger code during the trigger event. In the case of the cataract episode, the triggering event is when a CPT code—66984 or 66982 for cataract—is billed. If more than one eligible professional bills a triggering claim during the triggering event, the episode is attributed to both providers. In the case of co-management, the episode is attributed to the physician performing the specific procedure, such as cataract surgery.

A physician must have 20 attributed episodes to be scored on an episode-based measure.

Resource Use Score

To determine a provider's Resource Use category score, CMS will assign 1 to 10 points to each measure based on performance relative to the established benchmark. The benchmark for each measure would be determined based on **cost data from the performance period.** CMS would award points for each measure depending on how a provider scored in relation to overall performance.

The total points possible for a performance year depend on how many measures the provider is attributed. The Resource Use category score is determined by adding the points scored on each measure and dividing by the total possible points available. For example, if an ophthalmologist is only attributed the total per capita measure and the cataract episode, then the total possible points for the category would be 20. If he or she scores 10 on the total per capita measure and 6 on the cataract episode measure, the 16 points earned would be divided by the 20 possible points for a score of 80%. In future years, the Resource Use category score will then be weighted as part of the total MIPS score.

If a provider does not have any attributed measures, the Resource Use category will not be scored, and the Quality category will be re-weighted.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

MIPS Program: Choosing Individual vs. Group Reporting

The MACRA statute allows physicians to choose whether they will participate in the MIPS program as an individual or a group. Under the previous quality reporting programs, group reporting—and only for PQRS—was only available to larger practices. However, under MACRA, any physician practicing in a group of two or more has the option to report MIPS data collectively. This option may ease administrative burden for some practices and assist some physicians, especially sub-specialists, in succeeding under MIPS. Use this guide to assist in determining which option works best for your practice.

Please consult ASCRS•ASOA's guides on MIPS categories, available at **ascrs.org/macracenter**, for full details on program requirements.

How Do I Decide to Report as a Group or an Individual?

Each physician and practice must carefully evaluate how best to complete the requirements for MIPS. The MIPS program is customizable, with many options for measures, submission mechanisms, and flexible reporting periods in the first year. These factors will impact each practice differently. There is no one-size-fits-all formula to determine who should report as a group and who should report individually. This guide summarizes requirements for group vs. individual reporting in 2017.

Here are a few ideas to help you make your decision:

- Determine what your goals are for the 2017 performance period. Are you reaching for a bonus in 2019? Or just looking to avoid the penalty? If you simply want to submit a minimum amount of data and avoid the penalty, it may not be worth changing administrative processes, so it may be easier to submit some data individually. If you are going for full participation and a bonus, group reporting may reduce the administrative burden and make meeting the requirements easier.

- Review the performance of every Medicare provider in your group—ophthalmologists, optometrists, CRNAs, etc.—and determine each participant's strengths and weaknesses in the previous programs, PQRS and Meaningful Use. Do certain sub-specialists, such as corneal specialists or oculoplastic surgeons, have difficulty finding at least six quality measures? In many cases, cataract surgeons would have ample measures available to make up for other partners in the group who do not. For Advancing Care Information (ACI) measures, many ophthalmology practices struggle to identify other practices they refer to that have EHR and can complete health information exchange. Similarly, many ophthalmology patients are not willing to visit patient portals to complete the patient engagement measures. If your practice struggles with these measures, reporting as a group may reduce the pressure to complete each base measure at least once for each practitioner.

- Identify the submission mechanism you plan on using for MIPS If you do not have an EHR or registry and plan to report Quality data through claims, the group option is not available. Make sure you have the requisite systems in place to participate as a group.

What is Individual Reporting and How Will It Impact My MIPS Score?

Individual reporting for MIPS is essentially unchanged from previous quality reporting programs. Each MIPS-eligible clinician, identified by a unique TIN/NPI combination, is responsible for completing the requirements for MIPS. In the first performance year of the program, 2017, physicians must individually report data for the Quality, Advancing Care Information, and Improvement Activities categories. CMS will score the individual physician's performance for 2017, and adjust his or her Medicare payments accordingly for 2019.

Individual MIPS participants may report their data using claims, registry, or EHR. There is no sign-up required, and physicians opting for full participation in 2017 may begin reporting any time between January 1, 2017, and October 2, 2017. Groups of physicians practicing under the same TIN may report individually if all providers in the TIN report as individuals.

What is Group Reporting and How Will It Impact My MIPS Score?

The MACRA final rule established a process for groups of physicians to report data and be scored collectively. Essentially, group scoring treats all physicians in the group as if they were one individual. All of the eligible patient encounters for every physician in the group are aggregated together as a total population for the Quality and ACI categories (i.e., measure denominators), and each physician's performance in the group is aggregated (i.e., measure numerators). For the Quality category, the group must select six total measures to report, one of which must be an outcome measure. For ACI, the group works together to meet all the base measures, and can choose which measures in the performance score to complete. For the Improvement Activities category, the group is required to attest once for the activity or activities it completed. The group's performance is scored collectively and each physician participating in the group will earn the same MIPS final score—and the same payment adjustment.

For example, a practice of five ophthalmologists, three of whom perform cataract surgery, decides to report as a group. One of the quality measures selected by the group relates to cataract surgery. When reporting the measure, the practice must include all the eligible patients who meet the measure specifications and report the performance from each of the physicians who performed the procedures. So, if the other two physicians did not perform any cataract surgeries, they are not included in the measure calculations; however, they will get credit for the measure through the group reporting. For the ACI, all physicians in the group will work toward achieving the measures together. To meet the base score requirements, there must be a 1 in the numerator of each measure. Therefore, the practice only has to have one patient in each measure, and **not** one for each individual physician. The group performance score will be calculated similarly to individual reporters, with a total percentage of all additional patients seen by the group making up the measure numerators and denominators.

Can I Use the Group Reporting Option Just to Avoid a Penalty?

Yes, the flexibility offered for the 2017 performance year to "pick your pace" allows groups, as well as individual reporters, to submit a minimum of data to avoid a penalty in 2019. To avoid the penalty, a group may submit one of the following:

- **One quality measure, on one patient, and not have to meet measure benchmarks;**
- **One improvement activity; or**
- **The required base measures of the Advancing Care Information category.**

It is important to remember, however, that claims reporting is not an option for groups, so if the group reports one quality measure, it must be through a registry or EHR.

Visit ascrs.org/macracenter for full details on performance period options.

How Do I Register My Practice for Group Reporting?

There is currently no formal process for registering as a group with CMS, unless you plan to use the Web Interface program (formerly GPRO). Group data may be reported via registry, EHR, or the CMS Web Interface. The Web Interface registration deadline is June 30, 2017. CMS noted in the final rule that it may develop a voluntary registration process sometime in the future. Your EHR system or qualified registries may require a set-up process. Check with your software vendor or registry contact to determine what is required for your system.

Who Can Form a Group?

Any group of two or more physicians billing under the same Tax Identification Number (TIN) can report as a group. If choosing group reporting, all physicians billing under the TIN must report as part of the group for every MIPS category.

Exclusions: Certain physicians who are not MIPS-eligible may be excluded from the group.

- Advanced APM participants: If a physician billing under a TIN that elects group reporting participates in an advanced APM, his or her performance is excluded from the group and the group payment adjustments will not impact the APM participant.
- New Medicare providers: Physicians in their first year of billing Medicare are excluded from group reporting and payment adjustments.

Low-volume physicians: Physicians who bill less than $30,000 in allowed Medicare charges or see fewer than 100 Medicare patients in a year fall under the low-volume threshold and are excluded from MIPS. However, if a physician who is considered low volume works in a practice that is reporting MIPS as a group, he or she will no longer be considered exempt from MIPS. The low-volume physician's performance will be included in the group score, and he or she will receive the same Medicare payment adjustment as the rest of the group.

Physicians practicing under more than one TIN: If one of the members of a group also bills under a different TIN, he or she is responsible for meeting the MIPS requirements under each TIN. Only the services billed under a particular TIN that is reporting as a group will be included in the group's MIPS score. Services billed under different TINs may be reported individually or as a group. For example, Dr. Smith, a retina specialist, works at Practice A three days a week, and Practice B two days a week. Practice A reports as a group and includes Dr. Smith's performance as part of the group. Practice B does not report as a group, so Dr. Smith must report individually for services rendered under that TIN.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

Alternative Payment Models (APMs)
Advanced APMs and MIPS APMs
MACRA Final Rule Guide

This guide summarizes the Advanced APM provisions of the final rule and includes information on MIPS APMs, which offer the opportunity for physicians participating in certain models to receive credit under the MIPS program.

What is an Advanced APM?

CMS is encouraging participation in Advanced APMs. Eligible clinicians who participate in advanced APM entities that meet certain revenue or patient thresholds each year will receive a **5% bonus for each year from 2019 to 2024**. Advanced APMs are a subset of APMs that meet the requirements under MACRA.

CMS defines an Advanced APM as a model that:

- Involves more than nominal risk of financial loss,
- Includes a quality measure component, and
- Has the majority of participants using certified EHR technology (CEHRT).

Advanced APMs include Accountable Care Organizations (ACOs) with two-sided risk and medical homes expanded by CMS' innovation center.

For 2017, to impact 2019 payment, the following are considered Advanced APMs:

- Medicare Shared Savings Program (two-sided models: Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive End-Stage Renal Disease (ESRD) Care (large dialysis organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM) (two-sided risk track available in 2018)

There are currently no ophthalmology specific advanced APMs. In addition, current available models are, for the most part, focused on primary care, such as ACOs or certified medical homes. Some ophthalmologists currently participate in Medicare Shared Savings Program Track 1 ACOs, but since those models do not include two-sided risk, they are not considered advanced APMs and will not be eligible for bonus payments under the APM category. In the final rule, CMS noted that it was in the final stages of approving updated requirements for a Track 1 Plus model, which would incorporate a lower level of two-sided risk and is expected to be included in the list of approved models for 2018.

In future years, ophthalmologists may be able to participate in bundled payment models, such as for cataract surgery, built off of episode-based resource use measures currently under development. There are no formal proposals currently in development for ophthalmic surgery bundled payment models, but there are models in development for non-ophthalmic procedures. ASCRS is providing input to CMS through technical expert panels on the development of the episode-based resource use measures—particularly to ensure costs are accurately attributed and risk adjustment is included—and monitoring surgical community efforts to develop bundled payment APMs.

Qualifying Participants and Partially Qualifying Participants

To receive a bonus payment for participation in an Advanced APM, a provider, or group of providers billing through a common tax ID (TIN), must be considered a Qualifying Participant (QP). **A provider's QP status is determined by his or her participation in an Advanced APM entity that <u>collectively</u> meets certain revenue or patient thresholds.**

For 2019, based on performance year 2017, providers are considered QPs for participating in an Advanced APM entity for which either:

- The collective Part B payments for services delivered by the Advanced APM entity's clinicians to patients who are attributed to that entity is at least 25% of the payments for services delivered by the entity's clinicians to all patients who could, but may not, be attributable to the entity ("attribution-eligible").
- The collective number of patients who receive services delivered by the Advanced APM's clinicians and who are attributed to that Advanced APM is at least 20% of the number of all patients who are attribution-eligible and received services delivered by the Advanced APM's clinicians.

Clinicians participating in APMs that achieve those thresholds will be excluded from MIPS requirements. These percentages of payment amounts or patients required to qualify for the APM bonus will increase in future years.

Physicians participating in Advanced APM entities that fall short of requirements for the incentive payments, but meet lower thresholds, would be considered Partial QPs and able to choose whether they would like to receive a payment adjustment through MIPS. **To opt out of the MIPS payment adjustment, the clinician must participate in an Advanced APM entity that collectively reached lower thresholds of Medicare payments or patients. For 2019 and 2020, the collective threshold is 20% of eligible Medicare payments or 10% of eligible Medicare patients for partial participation. Partial QPs do not qualify for the 5% bonus payment under the APM category.**

If a physician participates in multiple Advanced APMs, and one of the APM entities he or she participates in does not meet the collective thresholds, CMS will determine if the individual physician's total participation in multiple APM entities meets the thresholds for the year. **If the sum of the individual provider's participation in multiple entities hits the threshold, he or she receives the 5% bonus and is exempted from MIPS.**

Note: All physicians must report through MIPS for the first performance year. CMS will calculate whether APM entities meet thresholds at the end of the performance year. In the final rule, CMS announced—to the extent possible—that if it can determine from historical data whether an APM entity is likely to meet the threshold, it will notify the participants and exempt them from MIPS.

Revenue or Patient Thresholds for Advanced APMs

CMS finalized thresholds for the percentage of eligible payments or eligible patients derived through Advanced APM entities.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Advanced APM entities must meet payment or patient requirements.)

	2019	2020	2021	2022	2023	2024 or later
Percentage of Payments through an Advanced APM	**25%**	**25%**	**50%**	**50%**	**75%**	**75%**
Percentage of Patients through an Advanced APM	**20%**	**20%**	**35%**	**35%**	**50%**	**50%**

MIPS APMs – Including Medicare Shared Savings ACOs Track 1

Physicians also may to earn points in MIPS by participating in certain APMs and Advanced APMs that CMS determines to be "MIPS APMs." Each year, CMS will release a list of MIPS APMs prior to the performance period.

For 2019, based on 2017 performance, CMS has approved the following APMs as MIPS APMs:

- **Medicare Shared Savings Program Tracks 1, 2, and 3**
- Next Generation ACO Model
- Comprehensive ESRD Care Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus (CPC+) Model

To earn MIPS points from a MIPS APM, a provider must:

- **Be included in the participant list of a non-Advanced APM that CMS has determined to be a MIPS APM, or**
- **Be included in the participant list of an Advanced APM entity that did not meet the thresholds to be eligible for the bonus payment and, therefore, elect to participate in MIPS.**

For models that CMS determines to be "MIPS APMs," in 2017 participants will:

- **Report the required quality measures for the APM through the APM entity (if an APM entity does not report data on behalf of individuals or groups participating in the APM, those physicians will be required to report quality data on their own);**
- **Report data for the Advancing Care Information Category on their own; and**
- **Automatically earn all of the total available points for the Improvement Activities category score.**

MIPS APM Scoring Standard

Similar to determining the thresholds for participation in Advanced APMs, **CMS will award the same final MIPS score to all the participants in a MIPS APM entity—including for data they reported individually or as a group under a single TIN**. Under the terms of the models considered MIPS APMs, participants in the APM entities are already assessed collectively for meeting certain quality and cost metrics; therefore, CMS **will score the Advancing Care Information and Improvement Activities collectively as well.** CMS will use an average score of all the participants' scores for Advancing Care Information to determine a group score. All participants in the MIPS APMs will receive the same total available score for Improvement Activities.

For each model approved as a MIPS APM, CMS re-weighted the MIPS categories to reflect the design of the particular model.

- For all Medicare Shared Savings ACOs and Next Generation ACOs, category weights are: 50% Quality, 0% Cost, 20% Improvement Activities, and 30% Advancing Care Information.
- For all other models, category weights are 0% Quality, 0% Cost, 25% Improvement Activities, and 75% Advancing Care Information.

The MIPS APM entity's final MIPS score will be applied to the participants in the entity at the TIN/NPI level. If a physician participates in multiple MIPS APMs, CMS will award that physician the score from whichever MIPS APM he or she participates in that has the highest final score.

MIPS APM Participation

Physicians may participate in MIPS APMs at the individual or group level. Not all physicians billing under a particular TIN are required to participate in a MIPS APM entity if one or more physicians billing under that TIN elects to participate in a MIPS APM. Certain specialties, such as ophthalmology, are permitted to participate in more than one ACO.

CMS will determine providers' eligibility to be scored under the MIPS APM scoring standard by checking three times during the performance year to confirm that individuals or groups are listed on the APM entities' participant lists. **CMS will check the lists on March 31, June 30, and August 30 of the performance year.**

If a provider is on the list at any time, he or she will be considered as participating in the APM entity. If a provider only participates in the APM entity for a portion of the year, but is only on the list at one or two of the designated dates on which CMS checks the list, he or she is still considered a participant.

Other Payer APMs

Other Payer APMs include payment arrangements under any payer other than traditional Medicare, including Medicare Advantage and other Medicare-funded plans. **Beginning in 2021** (performance year 2019), these other payers will count toward APM thresholds. However, the 5% bonus for significantly participating in an Advanced APM will be based on traditional Medicare and will not include Medicare Advantage payments.

Additional Resources

For additional information, contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

MIPS Participation for Medicare Shared Savings Program Track 1 Accountable Care Organization Members MACRA Final Rule Guide

This guide provides information on how Medicare Shared Savings Program (MSSP) Track 1 Accountable Care Organization participants will be scored for MIPS under the MIPS APM scoring standard. A MIPS APM is either a payment model that does not meet the definition of an Advanced APM—such as Track 1 ACOs—or is an Advanced APM that has not met patient or revenue thresholds.

MIPS APM Scoring Standard

Track 1 ACOs do not meet the definition of an Advanced APM. Therefore, participants in those models are not eligible to receive the statutory 5% bonus that MACRA provides, and must participate in MIPS. CMS defines an Advanced APM as a model that involves two-sided risk, and since Track 1 ACOs do not involve down-side risk, they cannot be considered Advanced APMs.

However, CMS has created a MIPS scoring standard for participants in certain alternative payment models that do not meet the definition of an Advanced APM (such as Track 1 ACOs), or do not meet the required participation or revenue thresholds. The MIPS APM scoring standard allows physicians to continue participating in these models, and to use that participation to earn credit under MIPS.

How do Track 1 ACO Members Participate in MIPS?

To earn points in MIPS under the MIPS APM scoring standard, a provider in a Track 1 ACO must be included in the official participant list of the ACO filed with CMS.

Track 1 ACO participants are required to:

- **Report the required quality measures for the ACO through their ACO entity (if the ACO does not report data on behalf of its members, those physicians will be required to report quality data on their own);**
- **Report data for the Advancing Care Information category on their own; and**
- **Automatically earn all of the total available points for the Improvement Activities category score.**

Track 1 ACO Scores Under the MIPS APM Scoring Standard

CMS will award the same final MIPS score to all the participants in a Track 1 ACO—including for data they reported individually or as a group under a single TIN. Under the terms of the model, participants in the APM entities are already assessed collectively for meeting certain quality and cost metrics; therefore, CMS **will score the Advancing Care Information category collectively as well. All ACO participants will receive the total points for the Improvement Activities category.** CMS will use an average score of all the participants' scores for Advancing Care Information to determine a score for all participants. All participants in the Track 1 ACO will also receive the same total available score for Improvement Activities.

Under the MIPS APM scoring standard, CMS has re-weighted the MIPS categories to reflect the design of the Track 1 model. **For 2017, category weights are: 50% Quality, 0% Cost, 20% Improvement Activities, and 30% Advancing Care Information.**

The ACO entity's final MIPS score will be applied to the participants in the entity at the TIN/NPI level. If a physician participates in multiple ACOs or other MIPS APMs, CMS will award separate scores for each entity. CMS will use whichever score is highest to determine the physician's payment adjustment.

MIPS APM Participation

Physicians may participate in Track 1 ACOs at the individual or group level. Not all physicians billing under a particular TIN are required to participate in the ACO entity if one or more physicians billing under that TIN elects to participate. Certain specialties, such as ophthalmology, are permitted to participate in more than one ACO.

CMS will determine providers' eligibility to be scored under the MIPS APM scoring standard by checking three times during the performance year to confirm that individuals or groups are listed on the ACO or other APM entities' participant lists. **CMS will check the lists on March 31, June 30, and August 30 of the performance year.**

If a provider is on the list at any time, he or she will be considered as participating in the entity. If a provider only participates in the APM entity for a portion of the year, but is only on the list at one or two of the designated dates on which CMS checks the list, he or she is still considered a participant.

Additional Resources

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