PRACTICE PERFECT

Guide to MIPS 2017, Part 2: How to Report Quality Performance

This year, most ophthalmologists will start participating in the Merit-Based Incentive Payment System (MIPS), which is part of Medicare's new Quality Payment Program. Last month's *EyeNet* provided a general MIPS overview; this month's issue takes a more detailed look at the MIPS quality performance category. Learn about your choice of reporting mechanism, what you need to report, and how you'll be scored.

Quality's Place Within MIPS

Your 2017 MIPS final score will be based on 3 performance scores—with an emphasis on quality. In 2017, your final score (0-100 points) will be based on the following 3 performance scores.

Quality score, which contributes up to 60 points. The quality performance category replaces the Physician Quality Reporting System (PQRS).

Advancing care information (ACI) score, which contributes up to 25 points. The ACI category replaces the electronic health record (EHR) meaningful use (MU) program.

Improvement activities score, which contributes up to 15 points. This category is entirely new.

In 2018 and 2019, your MIPS final score will be based on 4 performance scores. Next year, CMS plans to start factoring in your score for a fourth performance category—cost—which will contribute up to 10 points to the

Timeline for Reporting Quality via IRIS Registry

Start of 2017. MIPS launched on Jan. 1, but you can start taking part later in the year and still avoid the payment penalty or even earn a bonus.

2017 is a transition year—make the most of it. Although MIPS has a lot in common with PQRS and the EHR meaningful use program, CMS recognized that there will be a significant learning curve. Consequently, during the program's inaugural year, CMS has relaxed the reporting requirements and has also provided an easy way to avoid the payment penalty. You should use 2017 to:

Determine your best MIPS strategy. Should your practice's clinicians report individually or as a group? Which quality reporting mechanism should you use? If you don't have an EHR system, this might be the year to implement one—but make sure it can be integrated with the IRIS Registry.

Establish and fine-tune your MIPS procedures. Use the IRIS Registry to track your MIPS progress. Reporting quality data for several months—ideally a year—won't just boost your quality score (see "The Performance Period," page 68), it also will make you more prepared for the 2018 performance year, when MIPS' quality component will have a 12-month performance period.

In spring, you can start using the IRIS Registry to report a full year of quality data. CMS approves Qualified Clinical Data Registries, such at the IRIS Registry, and their non-MIPS measures annually. This year, those approvals won't happen until April or May. Because the IRIS Registry doesn't involve real-time reporting, you can submit a full year of quality data even if you don't start reporting until spring or later.

Deadlines—if you want to sign up for IRIS Registry/EHR integration: Sign up by June 1, integrate your EHR with the IRIS Registry by Aug. 1, 2017, and submit your data release consent form by Jan. 15, 2018.

Deadlines—if you want to sign up for the IRIS Registry web portal: Sign up by Oct. 31, 2017, and then enter all your reporting data into the portal and submit your data release consent form by Jan. 15, 2018.

final score in 2018 and up to 30 points in 2019. Meanwhile, your quality score's contribution to the final score will be reduced to a maximum of 50 points in 2018 and 30 points in 2019, with the contributions of your ACI and improvement activities scores remaining unchanged. Unfortunately, there are some serious problems with the proposed rules for assessing cost

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performance, which incorporates many elements of the former Value-Based Modifier program. Fixing those flaws is one of ophthalmology's advocacy priorities.

Your 2017 final score will impact your 2019 payments—and there is a low threshold for avoiding the payment penalty. Your final score will affect your Medicare payments as follows:

• If you don't participate in MIPS at all, you will get a 2017 final score of 0 points, and your 2019 Medicare payments will be subject to a 4% penalty.

• Score 3 points, and you will get neither a bonus nor a penalty (see "How to Avoid the Payment Penalty," sidebar, next page).

• Score more than 3 points, and you may get a small bonus.

• Score at least 70 points, and you will get a modest bonus.

Select a Reporting Mechanism

Your choice of reporting mechanism will depend, in part, on whether or not you have an EHR system.

If your practice does not have a certified EHR, you can report quality via:
• Medicare Part B claims, or
• The IRIS Registry web portal, which—unlike claims—doesn't involve real-time reporting and doesn't involve entering patients multiple times.

If your practice has a certified EHR, you also can report quality via:
• Your EHR vendor, or
• IRIS Registry/EHR integration. An automated process will extract the relevant data from your records.

Your choice of reporting mechanism will determine which measures you can report. You can use each of the 4 reporting mechanisms listed above to report at least some of the MIPS measures; only the IRIS Registry web portal can be used to report the ophthalmology-specific non-MIPS options (see "MIPS and non-MIPS Measures," next page). Also keep in mind that the MIPS measures that are available to you via IRIS Registry/EHR integration may depend on which EHR system you are using.

Large practices can report via the CMS web interface. This option is only available to practices with 25 or more

Quality—Summary of Reporting Options

How you choose to report quality will determine the type(s) of measures that you can submit.

Data Submission Mechanism	Medicare Claims	IRIS Registry Web Portal	IRIS Registry/ EHR Integration	EHR Vendor
Need EHR?	No	No	Yes	Yes
Used by	Individuals	Individuals or groups	Individuals or groups	Individuals or groups
It involves	Real-time reporting	Manual data entry into web portal	Automated data extraction	A possible fee
Measure types*	MIPS[†]	MIPS[†], non-MIPS	MIPS (including eCQMs)[†]	MIPS eCQMs

*****MIPS measures** are those measures that are published in the MIPS regulations; **non-MIPS measures** are ophthalmology-specific measures that were developed by the Academy, with the help of subspecialty societies, for use with MIPS; **eCQMs** are electronic clinical quality measures. These were originally developed for EHR MU, then they were used as a way to satisfy PQRS reporting requirements, and now some have become MIPS measures.
[†]Some measures might not be available to you (e.g., some MIPS measures can't be reported via claims).
Note: The CMS web interface has its own reporting requirements. The CAHPS for MIPS survey and MIPS APMs also have different reporting requirements.

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MIPS participants. It differs from the other reporting mechanisms in several ways. It has its own set of measures, which are mostly primary care–based, and it requires a 1-year performance period. Few ophthalmologists are likely to use this reporting mechanism.

Select just 1 reporting mechanism for quality. When reporting quality, you typically can use only 1 reporting mechanism.

What happens if you use more than 1 reporting mechanism? Suppose, for instance, you use both claims and the IRIS Registry web portal to report quality measures. CMS will not give you an aggregate score that combines claims-based submissions with IRIS Registry–based submissions. Instead, CMS will (1) assess your score for the claims-based submissions and (2) assess your score for the IRIS Registry–based submissions, and (3) assign you the higher of those 2 scores.

You do not have to use the same reporting mechanism across all performance categories. For instance, you could report quality via IRIS Registry/ EHR integration and report ACI and

improvement activities via your EHR vendor.

Consider reporting as a group. Why report as a group? Suppose a practice consists of 2 comprehensive ophthalmologists, a pediatric ophthalmologist, and a neuro-ophthalmologist. The latter 2 might find it a challenge to choose 6 measures to report for themselves, but it wouldn't be a problem for the group as a whole. When clinicians report quality as a group, all the clinicians in that group must use the same reporting mechanism for that performance category, and they must also report as a group for the other 2 performance categories: ACI and improvement activities. In general, you can report as a group without first registering as a group. The exceptions are if you plan to report via the CMS web interface or the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey, in which case you must register by June 30, 2017.

If you're in an accountable care organization (ACO), you should still report MIPS quality measures in case your ACO's reporting is unsuccessful.

Under PQRS, a number of ACO-affiliated ophthalmologists were penalized because their ACO failed to successfully meet the PQRS requirements. Under MIPS, you should report quality measures independently of the ACO and can do so using the IRIS Registry. If the ACO is successful in its MIPS reporting, CMS will ignore the quality measures that you reported. But if your ACO is unsuccessful in its MIPS reporting, your quality reporting can safeguard you from the 4% Medicare payment penalty in 2019.

MIPS and Non-MIPS Measures

What are MIPS measures? MIPS measures are those quality measures that are published in the MIPS regulations—there are more than 200 of them, but most of them won't be applicable to ophthalmologists.

Which reporting mechanisms can be used for MIPS measures? Some measures can be reported by all 4 reporting mechanisms—claims, IRIS Registry/EHR integration, IRIS Registry web portal, and EHR vendor—and others by just 1 or 2. For your convenience, the Academy has compiled a list of the 31 MIPS measures that are most relevant to ophthalmology. For each measure, this list indicates which reporting mechanism can be used, offers reporting tips, and provides a link to the measure's full description (see "Academy Resources," next page).

What are non-MIPS measures? Non-MIPS measures are created by subspecialty societies for use with Qualified Clinical Data Registries, such as the IRIS Registry. Although they can be used in MIPS, CMS refers to them as non-MIPS measures. This is to distinguish them from the MIPS measures that were published as part of the regulations.

Which reporting mechanisms can be used for non-MIPS measures? Ophthalmology's non-MIPS measures can be reported via the IRIS Registry web portal.

Don't confuse the MIPS ophthalmology measure set with the former PQRS ophthalmology measures groups. CMS published the MIPS measures as a long list, but it also groups many of those same measures into specialty-specific measure sets, including an ophthalmology measures set. CMS created these specialty-specific measure sets so you wouldn't have to search through the entire list of measures for those that are relevant to your practice. Ophthalmology's measure set should not be confused with the PQRS ophthalmology measures groups—the cataracts measures group and the diabetic retinopathy measures group—neither of which was carried over to MIPS. The Academy is urging CMS to reinstate these 2 measures groups for the 2018 performance year.

What to Report

If you are reporting by claims, the IRIS Registry (EHR integration or the web portal) or your EHR vendor, here's how you can maximize payment.

Report on at least 6 quality measures. The measures available to you will depend on your choice of reporting mechanism. For instance, the non-MIPS measures are only available if you report via the IRIS Registry web portal.

At least 1 measure should be an outcome measure. A measure that is listed as an intermediate outcome measure would be sufficient.

If no outcome measure is available, you must report another high-priority measure instead. Alternative high-priority quality measures include appropriate use, patient safety, efficiency, patient experience, and care coordination. The Academy's list of ophthalmology-relevant MIPS measures indicates which of them are high priority (see "Academy Resources," next page).

What if you can't report on 6 measures? If you can't report on 6 measures, report on as many as you can. CMS instructs you to report on as many as are applicable, and it defines applicable to mean "measures relevant to a particular MIPS eligible clinician's services or care rendered."

What if you report on more than 6 measures? If you report on 7 or more measures, CMS will determine which 6 of those measures will give you the highest quality score.

Meet the submission thresholds. In order to score more than 3 points for reporting a measure, you must meet both the case minimum requirement and the data completeness criteria.

How to Avoid the Payment Penalty

In 2017, there is a low threshold for avoiding the penalty. You only need a final score of 3 points to avoid the 2019 payment penalty. You can do that by reporting just 1 quality measure, even if you don't meet the normal quality-reporting thresholds. However, most practices should use 2017 as an opportunity to get up to speed for future performance years: By 2018, the reporting requirements will be more challenging, and the learning curve much steeper.

Who should consider using the 3-point option? This may, for example, be a reasonable option if you are planning to retire before 2019. Suppose your retirement plans change—although you sell your practice, you decide that you want to work part time. With a minimal amount of reporting in 2017, you can protect your 2019 Medicare payments. But if you don't participate in MIPS at all, your 2019 Medicare payments would be subject to a 4% penalty, which might deter a practice from hiring you.

Warning—quality performance scores will be published on the Physician Compare website. The Academy has asked CMS to clarify whether it will make an allowance in how it reports quality scores for clinicians who choose to take the 3-point option this year.

Warning—given what is at stake, you would be ill advised to report 1 quality measure just once. If you are reporting quality by claims, keep in mind that if your claim is denied, the MIPS reporting for that claim will also fail. Report more than 1 quality measure for more than just 1 day. For added reassurance, you should also try to score points in more than 1 performance category.

The case minimum requirement: Submit data on at least 20 patients.

The data completeness criteria: These depend on your choice of reporting mechanism:

• Submit data on at least 50% of *applicable* patients who were seen during a performance period of at least 90 consecutive days.

▪ If you are submitting data via claims, applicable patients are Medicare patients for whom the measure applies.

▪ If you are submitting data via the IRIS Registry (EHR integration or web portal) or your EHR vendor, applicable patients are Medicare patients and non-Medicare patients for whom the measure applies.

• Report at least 1 Medicare patient for at least 1 measure.

What if you don't report enough patients? During the 2017 transition year, if your reporting for a measure fails to meet the data completeness criteria (50% of applicable patients over at least 90 days) or the case minimum requirement (20 patients), you will receive 3 points for that measure.

Larger practices will be assessed on the All-Cause Hospital Readmission (ACR) measure. In addition to the 6 measures that you must actively report,

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Academy Resources

As you transition to MIPS, your to-do list should include the following:

• Bookmark the Academy's Medicare Physician Payment and MIPS pages: aao.org/medicare and aao.org/mips.

• Review a list of the MIPS quality measures that ophthalmologists are most likely to use: aao.org/practice-management/regulatory/mips/quality-reporting-measures.

• Find out when Codequest is coming to your state; these sessions will include MIPS implementation strategies: aao.org/codequest.

• Check your email every Thursday for *Washington Report Express,* which will help keep you current on the latest developments.

the quality performance category includes 1 population measure—the ACR Measure—that is carried over from the Value-Based Modifier program. This measure only applies to larger groups (16 or more MIPS participants) that meet the case minimum requirement of 200 cases (10 times larger than the case minimum requirement for the reportable measures). The reporting period will be the calendar year. Practices don't need to report this measure; they will be evaluated based on administrative claims data. As with the reported quality measures, the ACR measure will have a floor of 3 points during the 2017 performance year.

The Performance Period
In 2017, if you want to score more than 3 points for a quality measure, there is a minimum performance period of 90 consecutive days.

Why you should consider reporting for more than 90 days:

Improve your quality score. You are likely to get a better quality score with a longer performance period—ideally, a full calendar year. For instance, you will boost your chances of meeting a measure's case minimum threshold of 20 cases. Furthermore, your performance will be compared against benchmarks that are based on how clinicians performed over 12 months.

With IRIS Registry/EHR integration, the reporting burden is low. Since this reporting mechanism uses an automated process to extract the relevant data, submitting 12 months of data might involve the same effort as submitting 90 days.

Get ready for 2018. During the 2018 performance year, the quality performance category will feature a 12-month performance period.

How You'll Be Scored
For each quality measure that you report, you get at least 3 points. In MIPS' inaugural year, to reduce your financial risk during the transition period, CMS has set a floor of 3 points for every quality measure that you report— even if you don't meet the minimum submission thresholds (see "What to Report," above).

How to score more than 3 points for a measure. Provided that a measure has a benchmark (see "Use of Benchmarks," sidebar on next page), you can attain 3-10 points if you meet the minimum submission thresholds.

Your score (3-10 points) will depend on how your performance compares against a benchmark. The benchmark is broken into deciles, and the number of points you receive will depend on which of those deciles you fall into:

• If you fall within the first 2 deciles, you will receive 3 points. (This is because MIPS measures have a floor of 3 points during the 2017 performance year.)

• If you fall in deciles 3 through 9, you will receive partial points depending on where you fall within that decile. (For instance, if you fall in the ninth decile, you could receive 9.0-9.9 points.)

• If you fall within the 10th decile, you'll receive the full 10 points.

Bonus points for reporting high-priority measures. You get no bonus points for your first high-priority measure, but after that you get:

• 2 points for an outcome or patient experience measure.

• 1 point for an appropriate use, care coordination, efficiency, or patient safety measure.

Note: There is no bonus point for the first high-priority measure because you are required to report at least 1 outcome measure (or, if no outcome measure is available, an alternative high-priority measure). You are eligible for bonus points even if you report fewer than 6 measures.

Bonus points for using Certified EHR Technology (CEHRT). You also can earn 1 bonus point for each measure that is submitted using "end-to-end electronic reporting" by means of CEHRT. This can include measures reported via IRIS Registry/EHR integration or your EHR vendor.

You can score up to 12 (or 14) bonus points. Your high-priority and CEHRT bonuses are each capped at 6 points or—if you are scored on the ACR measure (see "What to Report")—7 points.

Calculating your quality score. This is a 3-step process:

1. CMS determines your numerator, which is your total points earned

Use of Benchmarks

When you submit data for a measure and satisfy the submission thresholds (at least 20 cases and 50% of applicable patients during at least 90 days), your performance on that measure will be compared against a benchmark, and you will earn a score of 3-10 points.

Most benchmarks are based on historical data. For the 2017 performance year, a measure's benchmark will typically be based on performance data from 2015. However, if a measure is new in 2017, its benchmark will be based on data from the 2017 performance year. In either case, the benchmark will be based on performance data drawn from all clinicians who use the measure.

Where possible, benchmarks will be published in advance. When a measure's benchmark is based on historical data, CMS will publish the benchmark before the performance year begins or as soon as possible after it has started.

If a measure lacks sufficient performance data for a benchmark, you can't score more than 3 points. CMS won't assign a benchmark to a measure unless the performance data include a minimum of 20 individual clinicians or groups that met the data submission thresholds and had a performance greater than zero. With an established measure, you will know in advance whether or not it has a valid benchmark; but with a new measure, you won't know whether it has a vaild benchmark until the performance year is over.

Different benchmarks will be established for the various reporting mechanisms. For instance, a measure will have one benchmark for claims reporting and another benchmark for EHR reporting.

Benchmark Comparison: An example of how benchmarks will be used to assign points.*		
Benchmark Decile	**Sample Benchmarks**	**Possible Points**
Decile 1	0.0-9.5%	3
Decile 2	9.6-15.7%	3
Decile 3	15.8-22.9%	3.0-3.9
Decile 4	23.0-35.9%	4.0-4.9
Decile 5	36.0-40.9%	5.0-5.9
Decile 6	41.0-61.9%	6.0-6.9
Decile 7	62.0-68.9%	7.0-7.9
Decile 8	69.0-78.9%	8.0-8.9
Decile 9	79.0-84.9%	9.0-9.9
Decile 10	85.0-100.0%	10

*This example is taken from the MIPS regulations.

(including bonus points) on up to 6 reported measures plus—if applicable—your score for the ACR measure (this population measure only applies to large practices—see "What to Report").

2. CMS divides that numerator by your denominator, which is 60 (or 70 if the ACR measure applies).

3. CMS turns the resulting fraction into a percentage, which is capped at 100%.

This is your quality performance score. It contributes up to 60 points to your final score.

Example. Suppose you report only 4 measures and your total score for those measures (including bonus points) is 30 points. The ACR measure applies, and you receive 5 points for that. Your numerator (total score) is 35, your denominator is 70, and your quality performance score is 50% (35/70). This would contribute 30 points (50% of 60) to your final score.

Use the IRIS Registry

As with PQRS, the Academy IRIS Registry (www.aao.org/iris-registry) will provide 2 platforms to help you tackle MIPS—one involves EHR (integrating your EHR system with a clinical data registry) and the other doesn't (manual data entry via a web portal). In ophthalmology, the IRIS Registry will be the MIPS tool of choice. Here's why:

Gain access to additional ophthalmology-specific measures. The Academy developed the non-MIPS measures specifically for ophthalmology (see "MIPS and Non-MIPS Measures," page 67).

Use the dashboard to monitor performance. The IRIS Registry dashboard can act as an early warning system, alerting you to problems with your quality reporting while you still have time to address them.

Reduce your reporting burden. Compared with other reporting options, the IRIS Registry involves less labor and—thanks to its dashboard—less uncertainty.

Rely on a reporting mechanism that is focused exclusively on ophthalmology. The Academy developed the IRIS Registry as part of its mission to support ophthalmologists and their patients.

Registries will play an increasingly important role in MIPS. Under MIPS, the IRIS Registry will play an even more prominent role than under earlier CMS reporting programs, particularly in the improvement activities performance category.

CMS recertifies the IRIS Registry each year. CMS is scheduled to recertify registries for MIPS reporting and their attendant non-MIPS measures in April 2017. The Academy expects most of its non-MIPS measures to get approved.

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