

## MIPS Primer, Part 2—the *Proposed* Rules for Resource Use, ACI, and CPIAs

**E**arlier this year, CMS published its proposed regulations for a new payment system—the Merit-Based Incentive Payment System (MIPS)—that it intends to launch on Jan. 1, 2017.<sup>1</sup> MIPS will consist of 4 performance categories:

- Quality, which replaces the Physician Quality Reporting System (PQRS) and was discussed in last month’s *EyeNet*
- Resource use, which replaces the Value-Based Modifier (VBM) program
- Advancing care information (ACI), which replaces the electronic health record (EHR) meaningful use (MU) program
- Clinical practice improvement activity (CPIA), which is an entirely new performance category.

Last month’s *EyeNet* focused on the quality performance category and also defined the MIPS eligible clinician (EC)—which is the term CMS uses for MIPS participants—and discussed the 3 categories of ECs who are excluded from the program.

**Stay tuned for the final rule.** CMS has been tasked with finalizing the regulations no later than Nov. 1, 2016. The agency is currently reviewing the extensive feedback that it received. Some of the Academy’s recommendations are highlighted below (look for “Feedback to CMS”), and you can review all 49 pages of the Academy’s feedback online.<sup>2</sup> For updates, read *Washington Report Express*, which is emailed to you each Thursday.

### Resource Use Proposals: You’ll Be Scored on 3 Measure Types

Under the proposed resource use regulations, there are no reporting requirements for ECs. Instead, CMS will base your evaluation on Medicare claims data for patients that it attributes to you. Your score will be based on up to 3 measure types—2 of which are carried over from the VBM program, warts and all. CMS proposes that this performance category should count towards 10% of your final score (see “Calculating the CPS” on page 66). But because of the flaws described below, the Academy urges CMS to reduce that percentage.

**Total per capita cost measure.** This measure represents the total amount of allowable Medicare charges associated with Medicare patients attributed to a MIPS EC. The EC will be assigned the total Medicare Part A and Part B costs for these patients. For this measure, CMS will attribute patients who do not see a primary care physician during the year to the specialty physician who provides the plurality of primary care services, including E&M services, to that patient. *Feedback to CMS: This measure is largely the same as the equivalent measure under VBM, which is seriously flawed. The risk adjustment methodology is problematic and attribution strategies are unreliable, with ophthalmologists held responsible for costs that are not related to eye care (e.g., cost of hernia repair). The measure excludes outpatient prescription drugs, which skews scoring*

*against physicians who pursue procedural interventions rather than putting patients on maintenance medications. Meanwhile, the measure does include physician-administered drugs paid for under Part B, further disadvantaging these specialists. Furthermore, this measure won’t help ECs to boost efficiency—which is supposed to be the goal—unless it is correlated with appropriate quality measures. The Academy has gone to great lengths to develop outcome measures, and these should be utilized in CMS’ determination of resource use. Without doing so, it is impossible to know whether resource use is high because the patient population is sicker than average or because of overuse.<sup>2</sup>*

**Medicare Spending Per Beneficiary (MSPB) measure.** This measure focuses on costs associated with a hospital admission. It defines the episode of care as starting 3 days before the patient is admitted to hospital and ending 30 days after he or she is discharged. The costs—which include all Medicare Part A and B charges—are attributed to the provider who provides the most Part B covered services (measured by Medicare allowed charges) to a beneficiary during the hospitalization, even if the hospital admission is unrelated to that provider’s specialty. *Feedback to CMS: This measure is not relevant to ophthalmology. Yet given the prevalence of chronic eye conditions in the Medicare population, many of these episodes of care will be unfairly attributed to ophthalmologists.<sup>2</sup>*

**Episode-based measures for specific conditions and procedures.** CMS is

proposing more than 40 new measures that are based on episodes of care for various conditions and procedures, including 1 for cataract surgery. (At time of press, CMS had just added 2 episodes for glaucoma and 4 for retina for possible future inclusion.) These episode-based measures replace measures in the VBM program that were deemed irrelevant to many practices (namely, the 4 total cost per capita measures that focused on specific conditions, such as congestive heart failure). CMS applies these measures to MIPS ECs in various ways, depending on the type of episode (e.g., acute-condition episode, outpatient-procedure episode), the trigger code (e.g., an E&M visit code), and the trigger event (e.g., initial treatment). The same episode can be attributed to more than 1 MIPS EC. CMS acknowledges that these episode-based measures haven't previously been used as part of a payment and they're not sure how many they'll include in the final regulations after they've reviewed stakeholders' feedback. **Feedback to CMS:** *The cataract measure has some serious flaws—for example, it includes several CPT codes that are unrelated to cataract removal. The measure should not be used until those problems are fixed.<sup>2</sup> At time of press, the Academy was still assessing the recently added glaucoma and retina measures.*

### Resource Use: How You'll Be Scored

The proposed scoring system would take into account geographic payment adjustments and some beneficiary risk factors.

**If you have at least 20 attributed cases for a resource use measure, you will be scored on that measure.**

This applies to the total per capita cost measure, the MSPB measure, and the episode-based measures. (Under the VBM program, the MSPB measure has a minimum case threshold of 125.)

**Feedback to CMS:** *The 20-case minimum threshold is too low to offset the impact of outliers. CMS should reinstate the larger threshold size to ensure greater statistical reliability.<sup>2</sup>*

**What if you don't have 20 cases for a measure?** The measure won't count

## MIPS Resources Online

Visit [aao.org/medicare](http://aao.org/medicare) to access a comprehensive online resource for the new Quality Payment Program, which includes MIPS. Resources include a glossary, a list of frequently asked questions, further information on each of the 4 MIPS performance categories, and links to the latest MIPS news.

Whether its advocacy, education, or practice management, when it comes to the new CMS payment policy, the Academy has got you covered.

against you. (It won't be included in your overall score for resource use.)

**Each measure that meets the 20-case threshold will be assigned a score of 1-10 points.** The scoring system will be very similar to that proposed for the quality performance category (see MIPS, Part 1 in last month's *EyeNet*). Your performance for a measure is compared against a benchmark, which is broken into deciles, with lower costs representing better performance. If your performance falls into the tenth decile, you'll receive the full 10 points; if it falls into a lower decile, your score will depend on where you land within that decile (e.g., 7.0-7.9 points if you land in the seventh decile). Unlike the quality category, there are no bonus points. (The benchmark will be based on performance data from the current performance year.) **Feedback to CMS:** *CMS is developing patient condition codes and patient relationship codes that would be submitted on the claim form and are intended to help with attribution and risk adjustment. It published its proposals recently and asked for feedback by mid-August. At time of press, the Academy was reviewing the codes and preparing its feedback for CMS. The Academy has already told CMS that the risk adjustment methodology that it uses in the VBM program is seriously flawed and insufficient, and should not be carried over to MIPS.<sup>2</sup>*

**Calculating your resource use category performance score.** Like the quality category performance score, this is based on 2 values: the numerator (your cumulative score for all measures that received a score) and the denominator (the cumulative maximum score you could have received for those measures). Next, CMS will divide

the numerator by the denominator and turn the resulting fraction into a percentage—this is your resource use performance score.

Suppose, for example, you are assigned scores for total per capita cost and MSPB, but didn't meet the case threshold for any episode-based measures. Your denominator (maximum possible score) would be 20. If your numerator (actual score) was 15, then your resource use performance score would be 75% (15/20).

**Feedback to CMS:** *The proposed regulations for resource use are seriously flawed. There is a better way to measure resource use—clinical data registries, such as the IRIS Registry, can be used to simplify, streamline, and carefully align such efforts with quality improvement, a key goal that CMS has emphasized.<sup>2</sup>*

### Advancing Care Information Proposals

Under the proposed regulations, advancing care information (ACI) is the new name for the electronic health records (EHRs) meaningful use (MU) program.

**You will be assessed at 2 levels of involvement**—the base score and the performance score. Under the proposed regulations, these will reward MIPS ECs for a basic and more advanced level of participation, respectively.

**Use of CEHRT.** There are 2 types of certified EHR technology (CEHRT) certification—the 2014 edition and the 2015 edition. For the 2017 MIPS performance year, you can use either edition or—if you're taking a modular approach to EHR—you can use some combination of the 2. However, the 2014 edition, which most providers currently use, doesn't support all of the

objectives and measures that CMS has proposed for the 2017 performance year. For the 2018 performance year, CMS plans to make both stage 3 of MU and 2015-edition certification compulsory. **Feedback to CMS:** *For the 2017 performance period, MIPS ECs with a 2014-certified EHR have fewer measures to report than ECs with a 2015-certified EHR and therefore may be at a disadvantage because there are fewer measures which they could report and earn points for. The methodology should be modified to level the playing field.*<sup>2</sup>

**Key proposed changes:**

- MIPS would eliminate MU’s clinical quality measures (CQMs), which currently overlap with some PQRS reporting requirements. This will reduce the overall burden of reporting.
- Two of MU’s current requirements—the Clinical Decision Support objective and the Computerized Provider Order Entry objective—and their associated measures have been dropped from MIPS.
- While CMS has proposed to reduce the 2016 reporting period to 90 days for the MU program, it is proposing a 12-month 2017 reporting period for ACI.
- Group-level reporting will be an

option for ACI, whereas you can only currently participate in MU as an individual provider.

- Under ACI, MIPS ECs can allow third-party entities—such as EHR vendors or clinical data registries (like the IRIS Registry)—to attest on their behalf. **Feedback to CMS:** *The reporting period for ACI should be reduced to 90 days. This is particularly important during the initial 2 years, when MIPS ECs are 1) transitioning to the new regulations, 2) updating their EHR system to one that has the 2015 certification, and 3) getting up to speed on stage 3 of MU. And while the Academy welcomes the CMS proposal to allow third-party entities (e.g., the IRIS Registry) to attest ACI data, it may take significant time and resources to build out that functionality—especially if some EHR vendors don’t cooperate. CMS can address such data blocking by requiring EHR vendors to comply with physicians’ requests to exchange data with third parties, such as registries.*<sup>2</sup>

**ACI: How You’ll Be Scored**

**Base score—you will score either 50 points or 0 points.** If you successfully report measures for the required objectives (which are similar to the

current MU measures; see the Web Extra, “ACI—Base Score: Objectives and Measures”), you will get the full 50 points. You get 0 points for the base score and for the entire ACI category if your reporting falls short (even if just by 1 measure). Fortunately, compared with MU, the reporting threshold is fairly low: For some measures you report on just 1 case; for others you respond yes to measures that require a yes/no response (including the security risk analysis measure). **Feedback to CMS:** *The all-or-nothing scoring is unfair; instead, MIPS ECs should be able to earn partial credit in the base score for the measures that they do successfully report.*<sup>2</sup>

**Earn a bonus point for your base score.** For the Public Health and Clinical Data Registry Reporting objective, you are only required to report 1 measure: the Immunization Registry Reporting measure. However, most ophthalmologists will qualify for the exclusion from this measure. MIPS ECs can earn a bonus point by reporting any of the optional measures, including the specialized registry measure, which includes IRIS Registry participation.

**Performance score—earn up to 80 points by reporting on 8 measures.** These proposed measures fall within 3 objectives:

- Patient electronic access: patient access (10 points); patient-specific education (10 points)
- Coordination of care through patient engagement: view, download, or transmit (10 points); secure messaging (10 points); patient-generated health data (10 points)
- Health information exchange: patient care record exchange (10 points); request/accept patient care record (10 points); clinical information reconciliation (10 points)

For each measure, you can score up to 10 points. For example, if you are able to have 33 percent of patients view, download, or transmit their health information, you would score 3.3 out of 10 points for that measure. See “ACI—Sample Performance Score” (left) for an example of how a practice’s performance score would be calculated under the proposed regulations. **Feedback**

ACI—Sample Performance Score			
Objective	Measure	Performance Rate	Score
Patient Electronic Access	Patient Access	95%	9.5
	Patient-Specific Education	65%	6.5
Coordination of Care Through Patient Engagement	View, Download, and Transmit	33%	3.3
	Secure Messaging	31%	3.1
	Patient-Generated Health Data	25%	2.5
Health Information Exchange	Patient Care Record Exchange	21%	2.1
	Request/Accept Patient Care Record	38%	3.8
	Clinical Information Reconciliation	57%	5.7
Total score:			36.5

to CMS: The Academy opposes those objectives and measures that evaluate a MIPS EC based on the actions of a patient or other health care provider. For example, the patient electronic access objective disadvantages specialties such as ophthalmology that tend to have older patients who won't all have easy access to the Internet.<sup>2</sup>

#### How to calculate your ACI score.

Add together your 50-point base score, your performance score (0-80 points), and—if applicable—your bonus point (1 point). If the total is greater than 100, reduce it to 100.

Next, CMS will turn that total into a percentage by simply appending a percentage symbol.

**Feedback to CMS:** *To encourage use of clinical data registries, such as the IRIS Registry, CMS should give full ACI credit to MIPS ECs who electronically participate in a specialty registry, such as the IRIS Registry. (Or as an alternative to giving specialty registry participants full ACI credit, CMS could give full base score points to those ECs.)<sup>2</sup>*

## CPIA Proposal

Clinical practice improvement activities (CPIAs) are intended to focus on processes that have a proven association with improved health outcomes.

The proposed rule lists 94 CPIAs, and each either has a high or a medium weighting (meaning that it can earn you either 20 points or 10 points, respectively). To maximize your score, you will need to review your options carefully. The CPIAs are grouped into the following subcategories:

- Expanded practice access (4 measures—3 medium; 1 high)
- Population management (16 measures—12 medium; 4 high)
- Care coordination (14 measures—13 medium; 1 high)
- Beneficiary engagement (24 measures—23 medium; 1 high)
- Patient safety and practice assessment (21 measures—20 medium; 1 high)
- Achieving health equity (5 measures—4 medium; 1 high)
- Emergency response and preparedness (2 measures—both medium)
- Integrated behavioral and mental health (8 measures—6 medium; 2 high)

**Report activities using an attestation (yes/no) approach.** To successfully report an activity, you affirm that you performed the activity for at least 90 days of the performance year. Under the proposed regulations, you can either attest directly to CMS or to a third party, such as an EHR vendor or the IRIS Registry.

**How to calculate your CPIA performance score.** The score is capped at 60 points. If you score 60 or more points, your CPIA performance category score is 100%; if you score 30 points, it is 50%. Note: CMS proposes special treatment for small groups (15 ECs or fewer) and individual ECs that practice in small groups, as well as for MIPS ECs or groups that are located in a rural area or in a health professional shortage area (HPSA). These only have to report any 2 CPIAs regardless of their weight to score 100%. Other exceptions apply to non-patient-facing MIPS ECs, MIPS ECs or groups that are in an APM, and patient-centered medical homes that are participating in MIPS.

**Feedback to CMS:** *Too few activities get a high weighting, which means that many MIPS ECs will be required to report on 6 medium-weighted activities, which is too onerous, especially during the early years of a completely new reporting program. Since clinical data registries (such as the IRIS Registry) support the national goals of improved quality, better outcomes, and lower costs, all activities that involve such a registry should get a high weighting. CMS should provide guidance on how they will audit the CPIA performance category.<sup>2</sup>*

## Calculating the CPS

For each of the 4 performance categories, you will receive a score that is expressed as a percentage (as described above). You can calculate your composite performance score (CPS) based on those 4 performance scores, with each performance category receiving its own weighting. For instance, for the 2017 performance year, CMS proposes weighting the categories as follows: quality (50%), resource use (10%), ACI (25%), and CPIA (15%). This means that your 2017 CPS would be (quality score  $\times$  0.5) + (resource use score  $\times$  0.1)

+ (ACI score  $\times$  0.25) + (CPIA score  $\times$  0.15).

CMS will compare your CPS score to a benchmark (average score), and, based on how far your 2017 CPS falls from that benchmark, will determine the payment adjustment that it will apply to your Medicare payments in 2019 (see Web Extra, "Payment Adjustments").

## What Next?

CMS has proposed a Jan. 1, 2017 launch for MIPS.

**Get prepared.** Even though the rules haven't yet been finalized, you should start preparing your practice for MIPS now. Start by designating a physician to oversee MIPS planning. Next, prioritize the MIPS sessions at next month's Academy annual meeting (see "More at AAO 2016," a Web Extra that accompanied last month's Practice Perfect).

**Sign up for the IRIS Registry; consider EHR adoption.** If you haven't yet integrated your EHR system with the IRIS Registry ([aao.org/irisregistry](http://aao.org/irisregistry)), you should look into doing so in 2017—the proposed regulations promote the use of Qualified Clinical Data Registries (QCDRs), such as the IRIS Registry, for electronically reporting 3 of the 4 performance categories. And CMS has made it clear that it plans to expand QCDRs' role in MIPS as the regulations evolve. (And if you are still on the fence about EHR adoption, this new Medicare payment program might prompt you to visit the vendors on the exhibition floor at AAO 2016.)

1 [www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf](http://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf). Accessed July 13, 2016.

2 [aao.org/eye-on-advocacy-article/academy-seeks-maca-protections-ophthalmologists](http://aao.org/eye-on-advocacy-article/academy-seeks-maca-protections-ophthalmologists); click on "The Merit-Based Incentive Payment System." Accessed July 13, 2016.



**MORE ONLINE.** For a summary of the payment adjustment methodology and a list of ACI base score objectives and measures, see this article at [aao.org/eyenet](http://aao.org/eyenet).

For Part 1, on the proposed rules for quality performance, and for a list of MIPS events at AAO 2016, see the August Practice Perfect at [aao.org/eyenet/archive-back-issues](http://aao.org/eyenet/archive-back-issues).