Quality Payment Program
2020 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 (QPP) in 2020 and includes the following guides:

- **QPP Final Rule Overview**
- **2020 Key MIPS Changes**
- **Guides on each of the Four Categories of the Merit-Based Incentive Payment System (MIPS):**
  - **Quality**
  - **Promoting Interoperability**
  - **Improvement Activities**
  - **Cost**
- **2020 Cataract Episode-Based Cost Measure**
- **Group vs. Individual Reporting and Virtual Groups**
- **Advanced Alternative Payment Models (APMs) and MIPS APMs**
- **MIPS APM Guide for Medicare Shared Savings Basic Track ACO Participants**

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

ascrs.org/macracenter

2020 MIPS: Key Changes for Ophthalmology Practices

2020 is the fourth performance year of the Merit-Based Incentive Payment System (MIPS). While many of the requirements for 2020 are the same as they were for previous years, there are a few key changes that ophthalmology practices should be aware of to be successful in the program. This guide outlines key changes for 2020. For other resources, including in-depth guides to each of the categories of MIPS, visit the ASCRS ASOA MACRA Center web page at ascrs.org/macracenter.

Key 2020 MIPS Changes

MIPS Performance Threshold

- The 2020 MIPS performance threshold is 45 points, increased from 30 points in 2019. Physicians and practices must score at least 45 total points to avoid a 9% penalty in 2022.
- The exceptional performance threshold increased to 85 points.
- Because the MIPS program is budget neutral, the highest bonus levels have not reached total possible available in past years—a trend that is expected to continue. However, with the increased possible penalty and increased requirements in the MIPS program, CMS estimates that bonuses in 2022 for participants who score 100 points could reach upward of 5%.

Cost Category

- Cost will count for 15% of a physician's final MIPS score in 2020—no change since 2019.
- CMS modified the attribution methodology in the total per capita cost measure to exclude ophthalmologists and optometrists.
- Physicians and groups do not need to submit any data for this category. CMS will calculate the score based on administrative claims.

Quality Reporting

- The data completeness threshold increased to 70% of Medicare Part B patients if reporting through claims, and 70% of all patients, regardless of payer, if reporting electronically or through the registry.
- Two cataract outcome measures were removed:
    - Measure 192, Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures, and
    - Measure 388, Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy).

Improvement Activities

- Modified group reporting to require that at least 50% of the group participants complete the reported activity. Group members completing the activity do not have to complete the activity during the same 90-day period.

Quality Payment Program—Year 4
2020 Overview

On November 1, 2019, CMS released the 2020 Medicare Physician Fee Schedule (MPFS) final rule, which includes the Quality Payment Program (QPP) Year 4, beginning January 1, 2020, and impacting 2022 payments. The QPP includes both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

This guide provides an overview of the Quality Payment Program Year 4. In-depth guides on each of the categories of MIPS and other elements of the program are also available.

Additional details on the QPP are available on the ASCRS ASOA MACRA Center website at ascrs.org/macracenter.

Key Changes to the QPP

The 2020 MPFS final rule implemented several modifications to the QPP, Specifically, these changes include:

- **Continuing MIPS transition flexibility by setting the MIPS performance threshold at a level other than the mean or median of the previous year's scores.** For 2020, the MIPS performance threshold is set at 45 points, up from 30 points for 2019. In addition, CMS set the 2021 threshold at 60 points. MIPS participants must score at or above the 45-point performance threshold to avoid a penalty in 2022.

- **Increasing the exceptional performance threshold:** CMS modified its original proposal of setting the exceptional performance threshold at 80 points and increased it to 85 points in the final rule.

- **Continuing to increase the weight of the Cost category gradually before reaching a final weight of 30% of the MIPS final score.** At the request of ASCRS and the medical community, CMS modified its proposal to weight the Cost category at 20% of the final MIPS score for 2020 and instead will keep the category weight at its 2019 level of 15%.

- **Modified the attribution methodology of the total per capita cost measure that will exclude ophthalmologists, optometrists, and other non-primary care specialists from attribution of this measure.** ASCRS has long opposed the attribution methodology for this measure because it potentially holds physicians responsible for the cost of care they did not provide.

- **Increasing the Quality reporting data completeness threshold to 70%:** MIPS participants must report on at least 70% of Medicare Part B patients for claims reporting, and 70% of all patients, regardless of payer, for registry or electronic reporting.

- **Modified the group reporting requirements for Improvement Activities:** CMS finalized its proposal to require that at least 50% of the participants in a group complete the improvement activities reported but modified it slightly so that participants would not all have to complete the activity within the same 90-days.

2020 Performance Period for 2022 Payment

For full participation in the MIPS program in 2020, for 2022 payment, **the performance period for the Quality and Cost categories is a full year, and any period of at least 90 days for the Promoting Interoperability and Improvement Activities categories.**

Final Score and 2020 Performance Threshold

Using authority gained from the ASCRS-supported MACRA technical corrections, CMS is continuing its transition flexibility by setting the 2020 performance threshold at a level other than the mean or median of the previous year's scores. **CMS set the 2020 MIPS final score threshold at 45 points, up from 30 points in 2019**. **To avoid the 9% penalty in 2022, physicians must earn at least 45 MIPS points in 2020.** In addition, CMS set the 2021 threshold, for 2023 payments, at 60 points.

CMS increased the 2020 exceptional performance threshold to 85 points, up from the 75-point threshold for 2019. MIPS participants who score above the 85-point threshold 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. CMS noted in the final rule it will keep the exceptional performance threshold at 85 points in 2022.

Because the total possible penalty is increasing, and the MIPS requirements have become more difficult in 2020, including an increase of the exceptional performance threshold to 85 points, CMS expects potential bonuses to be higher in 2022. CMS estimates that participants scoring 100 points in 2020 are estimated to earn an approximate 5% bonus in 2022, which is inclusive of the exceptional performance bonus.

Small Practice Accommodations in MIPS

CMS will continue providing certain reporting and scoring accommodations in MIPS for small practices of 15 or fewer Medicare-eligible clinicians. Specifically, these include:

- Continue the small practice hardship exemptions for the Promoting Interoperability category.
- Continue to receive full credit in the Improvement Activities category by submitting one high-weighted activity.
- Small practices will receive no fewer than 3 points for any quality measure submitted.
- The small practice bonus of 6 points will continue to be added to Quality category score.

Low-Volume Threshold and MIPS Opt-In

CMS maintained the low-volume threshold of $90,000 in allowed Part B charges or 200 patients, or 200 or fewer covered professional services. If a physician falls below at least one of these criteria, he or she is considered low volume. Physicians falling below the low-volume threshold are exempt from MIPS and would not receive a 2022 payment adjustment.

CMS will continue to allow physicians who exceed at least one of the criteria of the low-volume threshold to opt in to MIPS and be eligible for payment adjustments.

Complex Patient Bonus Points

CMS is maintaining the complex patient bonus of up to 5 points added to the final score of an individual or practice of any size if the practice treats certain complex patients. CMS will continue to use the Hierarchical Condition Category (HCC) index to determine bonuses. The HCC measures the percentage of patients with certain chronic diseases and those dually eligible for Medicare and Medicaid. It does not take into account any ocular comorbidities. ASCRS has recommended that CMS develop new methodologies to determine patient complexity and risk adjustment that can be applied to other categories, especially the Cost category.

MIPS Performance Categories

MIPS assesses the performance of clinicians based on four categories: Quality, Cost, Promoting Interoperability (EHR), and Improvement Activities.

Quality: 45% of Total Score in Year 4 (2020)

CMS maintained the previous reporting requirements of a minimum of six measures, with at least one outcome measure, if available. If no outcome measure is available, the clinician or group must report one "high-priority measure." CMS increased the reporting threshold (or data completeness requirement) for quality measures to 70% of Part B patients if reporting via claims, and 70% of all patients for registry and EHR reporting. **Large practices of 16 or more Medicare-eligible clinicians are not permitted to submit quality measures via claims reporting.** In addition, as part of the ASCRS-opposed topped-out measure methodology, CMS removed two measures: Measure 192, Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures, and Measure 388, Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy). Following opposition from ASCRS and the medical community, CMS did not finalize its proposed problematic claims-based population health measure, All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions for 2021.

Cost: 15% of Total Score in Year 4 (2020)

Following advocacy from ASCRS and the medical community CMS will maintain the category weight in 2020 at the 2019 level of 15% of the final score. **Following years of ASCRS advocacy dating back to the sunset Value-Based Payment Modifier program, CMS updated the attribution methodology for the total per capita cost measure to better target costs to primary care physicians**. Under the proposed methodology, CMS will exclude any physician who does not provide primary care, such as ophthalmologists and optometrists, from attribution to the measure. **CMS will continue to include episode-based cost measures, including cataract surgery, in the Cost category. Unfortunately, CMS has not indicated if it will remove the drug currently on pass-through status from this measure. We will continue to advocate that pass-through drugs be excluded from calculations of the cataract episode measure.**

Promoting Interoperability (PI): 25% of Total Score in Year 4 (2020)

Following the 2019 overhaul of this category, which included removing or modifying measures that relied on the actions of patients or other physicians and simplifying the category scoring, CMS did not make major changes for 2020. While ASCRS supported the 2019 modifications to the category, we were concerned that the category maintained the "all-or-nothing" scoring because clinicians would receive no points for the entire category if they failed to report on all measures. We will continue to advocate that CMS remove the all-or-nothing scoring and provide full credit in the category for physicians who use EHR fully integrated with a QCDR, such as the IRIS Registry.

Improvement Activities: 15% of Total Score in Year 4 (2020)

CMS did not change its scoring policies for this category; therefore, small practices will continue to receive full credit for reporting one high-weighted or two medium-weighted activities. However, CMS modified its policy for group reporting of this category. Previously, if only one clinician in the group is participating in an improvement activity, then the entire group may report it for credit. Instead, CMS will require that at least 50% of the group's clinicians participate in the improvement activity for the entire group to receive credit toward the category score. However, the group participants do not all have to complete the activity in the same 90-day period.

MIPS Value Pathways (MVPs)

In the proposed rule, CMS sought feedback on a potential new pathway for MIPS participation in 2021 called MIPS Value Pathways (MVPs.) MVPs would be designed to integrate measures across all categories of MIPS around a specific condition or specialty and allow physicians to report on clinically meaningful measures. While we have advocated that

CMS should streamline the MIPS program and give credit across the components, the system CMS put forward in the request for information is far from what ASCRS and the medical community envisioned.

Chiefly, we opposed that CMS was considering making the MVPs mandatory and requiring specific measures or activities in each of the categories. In the final rule, CMS notes that is not making any proposals related to the MVPs until the 2021 rulemaking cycle but based on the feedback received from ASCRS and the medical community, was still determining whether it would make the MVPs mandatory.

Based on the details provided in the 2020 proposed rule, CMS envisioned assigning a set of quality measures to each MVP, which could be fewer than the current six required quality measures and could vary based on the individual MVP. In addition, the MVPs would include required improvement activities related to the condition or specialty of the MVP and would continue to use the existing episode-based cost measures, such as cataract surgery, and the all-cost measures, such as total per capita costs and Medicare spending per beneficiary. Clinicians would continue to be required to report the Promoting Interoperability category in the same manner as they currently do, but CMS noted in the proposed rule they are open to comments on other types of technology that could be used other than CEHRT. No cross-category credit would be awarded. CMS anticipates that quality and cost measures would continue to be scored on a 10-point scale relative to benchmark scores, and the Improvement Activities and Promoting Interoperability categories will also be scored in the same way as they are currently. ASCRS and the medical community have advocated that CMS modify the MIPS scoring methodology to simplify it and provide multi-category credit for certain measures or activities, and recommended CMS rethink the structure of MVPs rather than rely on the current scoring methodology in our comments on the proposed rule.

In addition to our opposition to the mandatory nature of the MVPs, ASCRS and the medical community strongly opposed CMS' plan to integrate several flawed claims-based population health measures into the Quality component of MVPs. CMS has not proposed specific population health measures but is seeking feedback on which measures may be included, such as ones currently used by payors for HEDIS scores and those used in the ACO program, including the All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions that CMS proposed for inclusion in the Quality category for 2021, but did not finalize (discussed above). These measures, which are primary-care based, have long been opposed by ASCRS and the medical community because they potentially hold physicians responsible for the quality and cost of care they did not provide.

CMS notes that as it develops proposals for the MVPs beginning in 2021, it will work with stakeholders to incorporate their input. We will recommend that CMS allow physicians to choose whether they continue to report in the existing MIPS program or participate in the MVP.

Incentives and Penalties

Based on the MACRA statute, MIPS participants will receive a positive, negative, or neutral payment adjustment based on their final score. The **negative adjustment** will be capped at 9% in 2022.

For 2022, based on 2020 performance, only physicians who score below the 45-point performance threshold will be subject to a penalty. Physicians scoring in the estimated lowest quartile will receive the full 9% penalty. In the final rule, CMS estimates that based on previous years' performance, the lowest quartile of scores for 2020 performance will include scores between 0 and 15 total MIPS points.

Under the MACRA statute, physicians with final scores above the 45-point performance 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. Despite the potential to earn up to three times the annual cap on penalties, it is unlikely that participants will earn significant bonuses, due to the budget neutrality requirement. MIPS positive payment adjustments are funded using the penalties collected from low-scoring participants. Since CMS has made it relatively easy to avoid penalties during the MIPS transition years, bonus amounts are predicted to remain modest.

Participants who score above the 85-point exceptional performance threshold will receive an additional bonus. The MACRA statute set aside funds for exceptional performance that are not subject to the MIPS payment adjustment budget neutrality.

As noted above, since the total possible penalty is increasing, and the MIPS requirements have become more difficult in 2020, including an increase of the exceptional performance threshold to 85 points, CMS expects potential bonuses to be higher in 2022. CMS estimates that participants scoring 100 points in 2020 are estimated to earn an approximate 5% bonus in 2022, which is inclusive of the exceptional performance bonus.

Advanced Alternative Payment Models (APMs)

CMS continues to encourage participation in Advanced Alternative Payment Models (A-APMs). The MACRA statute awards a 5% bonus to eligible clinicians who participate in APM entities that collectively 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. Each year, to be considered a qualifying participant in an A-APM and receive the bonus, the A-APM entity in which a clinician participated must collectively meet increasingly higher participation or revenue thresholds. The MACRA statute provides this bonus for payment years 2019 to 2024. Payments are based on the same two-year lookback as MIPS; therefore, the participation level in an A-APM in 2020 will determine whether the clinician receives the 5% bonus on 2022 payments. A-APMs include Accountable Care Organizations (ACOs) with two-sided risk, as well as medical homes.

For 2020 performance and 2022 payment, at least 50% of collective eligible payments or 35% of collective eligible patients must be derived from an A-APM for participants to receive the bonus payment in 2022. **Clinicians participating in APMs that achieve those thresholds will be excluded from MIPS requirements. These percentages of payment amount or patients will increase in future years.**

There continue to be no ophthalmology specific Advanced APMs. In addition, current available models are, for the most part, focus on primary care, such as ACOs or certified medical homes. Some ophthalmologists currently participate in Medicare Shared Savings Program Basic Track ACOs (formerly Track 1), but since those models do not include two-sided risk, they are not considered A-APMs and will not be eligible for bonus payments under the APM category. Furthermore, CMS' recent Medicare Shared Savings Program (MSSP) Rule only went into effect in July of 2019, and its impact on whether ACOs without two-sided risk will be able to stay in the MSSP is unclear at this time.

MIPS APMs

For 2020, CMS will continue to give physicians the opportunity to earn points in MIPS by participating in certain APMs and A-APMs that CMS determines to be "MIPS APMs." Each year, CMS will release a list of MIPS APMs prior to the performance period. **CMS has not released the final list of 2020 MIPS APMs, but included a list of models they anticipate will be considered MIPS APMs in the final rule because the models have not changed substantially from previous years (see ASCRS MIPS APM/APM Guide for full list).** CMS recently finalized an overhaul of the Medicare Shared Savings Program (MSSP) that simplified the ACO tracks by characterizing them as "basic," with no down-side risk, and "advanced," with down-side risk. Basic MSSP ACOs will continue to be considered MIPS APMs only, and not eligible for the A-APM bonus.

As noted above, MSSP ACOs are still determining their path forward under the new rule. **ASCRS recommends that any ophthalmologists participating in Basic Track 1 ACOs reach out to their ACO's managers for details about their specific ACOs under this new policy.**

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

- **Be included in the participant list of a non-A-APM that CMS has determined to be a MIPS APM, or**

- **Be included in the participant list of an A-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," 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 Promoting Interoperability category on their own; and**
- **For 2020 performance, automatically earn full credit for the Improvement Activities category score.**

CMS will maintain the MIPS APM scoring standard in 2020. Similar to determining the thresholds for participation in A-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 Promoting Interoperability and Improvement Activities categories collectively, as well.** CMS will use an average score of all the participants' scores for Promoting Interoperability to determine a group score. CMS finalized to allow MIPS APM participants to report Promoting Interoperability data either individually or as a full TIN group practice in 2020 but will still average the scores across the entire APM entity. 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.

MIPS Program: 2020 Quality Performance Category

Quality Category Weight – 45%

For 2020, CMS will weight a provider's Quality performance score at 45% of the overall MIPS final score.

Prior to passage of technical corrections to the MACRA statute in early 2018, CMS was required to increase Cost category weight to 30% in 2019, to impact 2021 payments. The Quality category weight was scheduled to decrease to 30% in 2019. However, now CMS has the authority to keep the Cost category weight below 30% for three additional years and set it at 15% for 2019 and 2020, which keeps the Quality category at 45%.

If a physician or group does not have any cost measures attributed, the weight of the Cost category is transferred to Quality. The MACRA statute requires the Quality category weight to be no lower than 30%.

In some cases, CMS may determine that 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 Category Performance Period

In 2020, physicians and groups must submit quality measure data for the full calendar year to be considered full participants in the MIPS program.

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 6 measures, each worth up to 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 up to 10 possible points. Physicians must report on 70% of all patients, if reporting via registry or EHR, and 70% of Medicare Part B patients if reporting via claims.

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.

****Following a policy implemented in 2019, only practices of 15 or fewer Medicare eligible clinicians may submit quality measures through claims.**

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 2020.

In 2020, CMS will continue to measure a physician's improvement on quality measures prior to the previous year. Physicians have the opportunity to earn up to 10 additional points, not to exceed the 60 or 70 total available points in the category, from year-to-year improvement in the Quality category.

Topped-Out Measures

After determining that several ophthalmology measures—predominantly those reported via claims—have been "topped out" for multiple years, meaning that overall performance is consistently high, **CMS began capping the total possible**

points for these measures at seven points in 2019, instead of the usual ten possible points per measure. Therefore, if a physician or group reports only capped measures, that physician or group cannot earn the full available points for the category. This impacts nearly all ophthalmology measures, as well as many for other specialties, reported via claims and some reported via registry and EHR. **CMS will release the quality measure benchmarks, which will include the list of capped measures, in late December 2019.**

Despite ASCRS and medical community advocacy, CMS did remove two cataract outcome measures for 2020:

- Measure 192, Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures, and
- Measure 388, Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy).

ASCRS and the medical community have consistently opposed the topped-out measure methodology and argued that physicians should continue to receive full credit for maintaining high quality. We will continue to work with the medical community to address this issue.

Multiple Submission Methods

In 2019, CMS instituted an option that allows physicians to submit measures through multiple submission types. Physicians and groups may select any six measures and submit them through a variety of options. For example, a physician may report four measures through claims, but meet the full required six by submitting two more through registry. In addition, for measures that have multiple submission options, the physician or group may submit through both mechanisms, and CMS will include whichever one has the highest score in the final category score. **If physicians or groups use a submission type that has fewer than six measures they can report, they are not required to identify other measures in an additional submission mechanism to make up the full six measures.**

Transition Period Scoring Consideration

CMS is maintaining a measure score "floor" of three points for small practices of 15 or fewer eligible clinicians. For larger practices of 16 or more eligible clinicians, CMS has set a one-point measure floor. 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 if they are in a small practice, and one point if they are in a larger practice.

Quality Achievement Score

Under MIPS, **providers must demonstrate achievement on a quality measure, relative to a benchmark performance. For the 2020 performance year, CMS will set a baseline performance benchmark for each measure based on historical performance data. A physician's benchmark score on each measure is known as the "achievement" score. The achievement score will be added to any improvement or bonus points to determine the category score.**

For 2020, each measure has specific benchmarks depending on submission method (i.e., claims, EHR, registry) that are scored on a decile, or 10-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. If a physician or group has submitted a measure through multiple submission mechanisms, CMS will use whichever score is highest toward the achievement score.

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

- Providers in groups of 15 or fewer eligible clinicians 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 re-admission 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 re-admission measure will not be calculated, and providers will only be scored on the reported 6 measures, for a total possible score of 60 points.

Quality Improvement Score

For 2020 performance, CMS will also calculate a physician's or group's quality improvement score. Because physicians have the option of choosing which quality measures to report and are not required to report the same measures from year to year, CMS is evaluating improvement on a category basis.

CMS will compare a physician's total 2019 achievement score, which is determined based on the physician's performance relative to the benchmarks and excludes any bonus points and compare it to the 2020 achievement score. CMS will award between 1 and 10 percentage points, up to the total 60 or 70 available for the category, depending on how much a physician's or group's achievement score improved above the prior year.

The improvement score is derived by:

- **The increase in quality achievement percent score from prior performance period to current performance period**
- **Divided by prior performance period quality achievement percent score**
- **Multiplied by 10%**

Improvement scores cannot be less than zero points, and thus a physician who earns a lower achievement score in the current performance period than the prior one will not be penalized.

CMS will only calculate improvement scores in 2020 for physicians and groups who participated fully in the Quality category in 2019 and earned at least 30% of available points in the Quality category.

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 number of bonus points that can be awarded is 6. **Bonus points will be awarded to applicable measures, 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 achievement points for the measure, then be awarded 2 more bonus points, resulting in a total 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 QCDR 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 the 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 QCDR 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.

If a physician or group reports the same measure through multiple submission types and would be awarded bonus points for that measure through one of the submission mechanisms, the bonus points would still be added to the score even if the measure's highest achievement score is for a mechanism that does not include a bonus. For example, a physician may submit a measure through the EHR, which would result in a one-point bonus for end-to-end reporting. However, if he or she submitted the same measure through claims and, based on the benchmarks, would score more achievement points, CMS would take the claims measure's achievement points and still add the electronic end-to-end bonus.

Small Practice Bonus

In 2019, CMS moved the small practice bonus—which had previously been added to the MIPS final score—to the Quality category and will continue this policy for 2020. For 2020, 6 bonus points will be added to the Quality category score of any small practice. Similar to the other bonuses discussed above, small practice bonus points will only be awarded up to the total 60 points available for the category.

Quality Performance Score

A physician's or group's Quality performance category score will be the sum of the achievement, improvement, and bonus points divided by the total available points, depending on practice size. The Quality category score will then be weighted to count for 50% of the total MIPS score.

2020 Sample Quality Performance Score Calculation for a Physician Practicing in a Group of 15 or Fewer				
Measure	Achievement Score	Bonus Points (high priority/outcome measures)	Bonus Points (electronic reporting)	Total
Measure A submitted via claims	8			8
Measure A submitted via EHR	4 (not included in category score since claims submission was higher)		1 (bonus still counts even though claims score was higher)	1
Measure B submitted via EHR	6		1	7
Measure C (first outcome) submitted via EHR	5		1	6
Measure D (additional outcome) submitted via EHR	6	2	1	9
Measure E (high priority) submitted via EHR	8	1	1	10
Measure F submitted via EHR	7		1	8
2019 Achievement Score (2018 Achievement Score of 30)	40			
Small Practice Bonus			6	6
Total Quality Achievement and Bonus Points (of a possible 60)				55 (or 91.67%)
Improvement Score				1.0%
Quality Score				92.67% (will be weighted 45% of MIPS score; equals 41.67 final MIPS points)

Global and Population Measures

Through administrative claims, CMS will assess physicians in practices of 16 or more eligible clinicians on an all-cause hospital re-admission measure, previously used to calculate the Value-Based Payment Modifier (VBPM).

CMS will attribute patients to this measure 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

Physicians and groups may report their quality performance data through claims, registry, EHR, or Web Interface (formerly known as GPRO—and only available for groups of 25 or more).

Physicians or groups do not need to use the same submission mechanism for every category.

2020 MIPS Quality Category Measures for Ophthalmology

Physicians must report on 70% of all patients, if reporting via registry or EHR, and 70% of all Medicare Part B patients if reporting via claims.

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.

NQF/Quality 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
0089/019	Registry, EHR	Process	Communication and Care Coordination **(high priority)**	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
0055/117	Claims, 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
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
0028/226	Claims, Registry, EHR, Web Interface	Process	Community/Population Health **(high priority)**	Preventative Care and Screening: Tobacco Use: Screening and Cessation Information
N/A/303	Registry (not available in the IRIS registry)	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 the IRIS registry)	Outcome	Person Caregiver-Centered Experience and Outcomes **(high priority)**	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
N/A/317	Claims, Registry, EHR	Process	Community/Population Health **(high priority)**	Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
N/A/374	EHR, Registry	Process	Communication and Care Coordination **(high priority)**	Closing the Referral Loop: Receipt of Specialist Report
N/A/384	Registry	Outcome	Effective Clinical Care **(high priority)**	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 **(high priority)**	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery
N/A/389	Registry	Outcome	Effective Clinical Care **(high priority)**	Cataract Surgery: Difference Between Planned and Final Refraction
2803/402	Registry	Process	Community/Population Health	Tobacco Use and Help with Quitting Among Adolescents

Other Available Measures

CMS continues not to require that one of the quality measures 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.

MIPS Program: 2020 Promoting Interoperability Category

2020 Updates Following 2019 Category Overhaul

Following a major overhaul of this category in the 2019 performance year, CMS did not finalize any major changes for the 2020 performance year. For 2020, CMS did make some minor changes, which are limited to: removing one of the opioid-related measures implemented in 2019 and retaining the remaining opioid measure as voluntary. In addition, CMS confirmed that it was updating its previous regulation, and effective beginning in 2019, if a clinician or group takes an exclusion on either of the health information exchange measures, the weight of the measure will be transferred to the Provide Patients Electronic Access to Their Health Information measure.

As a reminder, the 2019 overhaul of the category was prompted by advocacy from ASCRS and the medical community that the previous scoring methodology was confusing, and the program retained several measures that relied on the actions of patients or other physicians. The 2019 updates simplified the scoring and removed or modified the measures that were not within the physician's direct control. ASCRS supported these modifications but continues to oppose the "all-or-nothing" scoring methodology and will advocate that CMS make further changes to provide for partial credit in future years.

Small Practice Hardship Exemption

For 2020, CMS is continuing to offer a small practice hardship exemption for the PI category. **Practices of 15 or fewer eligible clinicians must submit a hardship application by December 31, 2020, to have the 25% weight of the PI category re-weighted to the Quality category.**

Promoting Interoperability (PI) Category Weight

For 2020, the PI category score will continue to be weighted at 25% of the overall MIPS final score. If CMS determines that at least 75% of MIPS-eligible clinicians are "meaningful users" of EHR in future years, the scoring weight for PI 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. If a physician or small practice receives the small practice hardship exemption, the 25% weight of the category will be redistributed to Quality.

Promoting Interoperability Category Performance Period

For 2020, physicians must report PI for at least any 90-day period to be considered full participants. Physicians have the option to report more than 90 days, up to a full year.

Use of 2015 CEHRT

Implemented in 2019, all participants must continue to use 2015 certified electronic health technology (CEHRT) in 2020.

Promoting Interoperability Category Score

A physician's or group's PI category score will be based on the cumulative performance on each of the required measures. The streamlined measure set includes four objectives, with five required measures and one bonus measure. **Physicians must report on all required measures or receive zero points for the entire category.**

Each measure will be scored based on the submission of a numerator and a denominator, except for the measures associated with the **Public Health and Clinical Data Exchange objective and, new for 2020, the optional Query of Prescription Drug Monitoring Program (PDMP)**, which require "yes" or "no" submissions. **All measures must have at least 1 in the numerator or answer "yes" to receive credit for the measure.**

The measures will be scored by dividing the numerator by the denominator and multiplying by the designated weight of the measure. The measures are assigned points similarly to the previous methodology, where performance between 1% and 10% equals 1 point, 11% and 20% equals 2 points, etc. Each measure score is then multiplied by the individual measure's weight, which varies from measure to measure. For example, if a practice reports that 85 out of 100 possible patients were given electronic access to their health information, then the performance on the measure is 85%. Since this measure's weight is worth up to 40 points, the clinician's score would be a total of 34 points toward the total category score.

Bonus Points

In 2019, CMS added two new measures to the **e-Prescribe objective** that seek to curb opioid abuse. Since CMS was not able to predict whether all EHR systems would be able to offer the measures for 2019, they were both voluntary. Following feedback from the vendor community on feasibility and other legislative action by Congress to address the nation's opioid crisis, CMS determined that it would remove one measure, Verify Opioid Treatment Agreement, and modify the remaining Query of PDMP measure to be a "yes" or "no" measure. For 2020, this measure is still voluntary and clinicians that report a "yes" will receive 5 bonus points.

There are no longer any bonus points available for using 2015 CHERT or reporting to additional registries.

Security Risk Analysis

The Security Risk Analysis is no longer a measure included in the PI category. However, since physicians and practices are required to review electronic security protocols under HIPAA, they will still have to attest that a security risk analysis was performed sometime during the performance year when reporting 2020 PI data for MIPS. **This attestation will not be included in the category score, but if the physicians or groups fail to attest to performing the security risk analysis, they will receive zero points for the category, regardless of whether they reported any other data.**

Public Health and Clinical Data Exchange Objective

For 2020, CMS will continue to include a **Public Health and Clinical Data Exchange objective**, which requires that participants report on at least two of the five types of registry reporting. There are exclusions available for each type of registry, so if physicians or groups do not have a total of two registries available to report to, they may claim an exclusion for one or both required registries. Alternatively, if physicians or groups have two of the same type of registry available to report to, they may attest to reporting to both registries of the same type to fulfill the requirement for the objective. Ophthalmologists who report to the IRIS Registry may attest to the **Clinical Data Registry measure**; however, they likely will not have another available registry of any type and will be required to take an exclusion for the second registry.

To receive credit for reporting to any of the data registries, a physician or group must answer "yes" when attesting or claim the exclusion. Answering yes or claiming exclusions for two registries will earn the physician or group the full 10 points for the objective.

2020 PI Objectives and Measures

Objective	Measure	Reporting Requirement	Exclusion	Maximum Points
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	**Any MIPS-eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.**	**10 points**
	Bonus: **Query of Prescription Drug Monitoring Program (PDMP)—**For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS-eligible clinician uses data from CEHRT to conduct a query of PDMP for prescription drug history, except where prohibited and in accordance with applicable law.	Yes/No; must answer "yes"		**5 bonus points**
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information—**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 healthcare 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	**Any MIPS-eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.**	**20 points**
	Support Electronic Referral Loops by Receiving and Incorporating Health Information—For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS-eligible clinician was the receiving party of a transition of care or referral, or for patient	Numerator/Denominator; must have at least 1 in the numerator	**(1) Any MIPS-eligible clinician who is unable to implement the measure for a MIPS performance period in 2020. (2) Any MIPS-eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patient never before encountered during the**	**20 points**

	encounters during the performance period in which the MIPS-eligible clinician has never before encountered the patient, the MIPS-eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.		**performance period.**	
Provider to Patient Access	**Provide Patients Electronic Access to Their Health Information**—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		**40 points**
Public Health and Clinical Data Exchange	Choose two of the following: **Immunization Registry Reporting**	Yes/No; must answer "yes"	**Any MIPS-eligible clinician meeting one or more of the following criteria: (1) does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period; (2) operates in a jurisdiction for which no immunization registry or immunization information system is capable of**	**10 points**

			accepting the specific standard required to meet the CEHRT definition at the start of the performance period; (3) operates in a jurisdiction where no immunization registry or immunization information system had declared readiness to receive immunization data as of 6 months prior to the start of the performance period.	
	Electronic Case Reporting		**Any MIPS-eligible clinician meeting one or more of the following: (1) does not treat or diagnose any reportable diseases for which data is collected by his/her jurisdiction's reportable disease system during the performance period; (2) operates in a jurisdiction for which no public health registry is capable of receiving electronic case reporting data in the specific standard required to meet the CHERT definition at the start of the performance period; (3) operates in a jurisdiction where no public health agency has declared readiness to receive electronic care reporting data 6 months prior to the start of the performance period.**	
	Public Health Registry Reporting		**Any MIPS-eligible clinician meeting one or more of the following: (1) does not diagnose or directly treat any disease or condition associated with a public health registry in the MIPS-eligible clinician's jurisdiction during the performance period; (2) operates in a jurisdiction for which no public health agency is capable of accepting electronic**	

			registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period; (3) operates in a jurisdiction where no public health registry for which the MIPS-eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.	
	Clinical Data Registry Reporting		Any MIPS-eligible clinician meeting one or more of the following: (1) does not diagnose or directly treat any disease or condition associated with a clinical data registry in his/her jurisdiction during the performance period; (2) operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transaction in the specific standards required to meet the CEHRT definition at the start of the performance period; (3) operates in a jurisdiction where no clinical data registry for which the MIPS-eligible clinician is eligible had declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.	
	Syndromic Surveillance Reporting		Any MIPS-eligible clinician meeting one or more of the following: (1) is not in a category of healthcare providers from which ambulatory syndromic surveillance data is collected by his/her jurisdiction's syndromic surveillance system; (2)	

			operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required to meet the CEHRT definition at the start of the performance period; (3) operates in a jurisdiction where no public health agency had declared readiness to receive syndromic surveillance data from MIPS-eligible clinicians as of 6 months prior to the start of the performance period.	

MIPS Program:
2020 Improvement Activities Category

Improvement Activities Category Weight – 15%

For 2020, the third performance year of MIPS, CMS will weight a clinician's or group's Improvement Activities score at 15% of the overall MIPS final 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 2019.

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. Physicians and groups participating in an Advanced APM or MIPS APM will automatically receive full credit for the Improvement Activities category.

Group Reporting Participation Threshold

New for 2020, CMS is requiring that for groups reporting MIPS, at least 50% of the participants in the group must complete the improvement activity reported. However, participants completing the activity are not required to complete it within the same 90-day period. Previously, CMS only required that at least one person in the group completed the activity to receive credit for the entire group.

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 final score.

Ophthalmology Improvement Activity

In 2019, CMS added an ophthalmology specific improvement activity: Comprehensive Eye Exam, which is still available for 2020. For this medium-weighted activity, participants must promote the importance of a comprehensive eye exam, which may be accomplished by providing literature or facilitating conversation about the topic using materials created by the American Academy of Ophthalmology or the American Optometric Association.

Improvement Activities

The final rule includes a list of all 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, as well as 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 the 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. In 2020, all submission mechanisms must designate a "yes/no" response for submitting improvement activities.

MIPS Program: 2020 Cost Category

Cost Category Weight – 15% for 2020 Performance Year

Following advocacy from ASCRS and the medical community, CMS is maintaining the Cost category weight at 15% of the final MIPS score in 2020—the same level as the 2019 performance period.

In 2018, Congress enacted ASCRS-supported technical corrections to MACRA that allow CMS to extend the flexibility included in the first three years of MACRA and weight this category at less than 30% of the final MIPS score for three additional years. The Cost category must account for 30% of the final MIPS score beginning in the 2022 performance year.

In some cases, CMS may determine that 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. If a physician or group does not have any cost measures attributed, the 15% weight in 2020 will be reassigned to the Quality category.

Cost Reporting Requirements

Physicians do not need to submit separate data for the Cost category. CMS will determine cost scores through administrative claims.

Cost Measures

For 2020, this category maintains several episode-based cost measures, including one for cataract surgery. In addition, CMS has retained population-health total per capita cost measure (TPCC) and the Medicare spending per beneficiary (MSPB) measure but has updated the attribution methodology. Following years of advocacy from ASCRS and the medical community, dating back to the Value-Based Payment Modifier when these measures were first used, CMS will now exclude ophthalmologists, optometrists, and other specialists who do not provide primary care from attribution to the TPCC measure.

The MSPB measure was also updated but remains an inpatient-focused measure that is not likely to include ophthalmology.
For 2020, ASCRS expects that ophthalmologists will only have the cataract surgery episode-based cost measure attributed in this category.

The episode-based measures, including cataract surgery, seek to measure the cost of care related to a specific procedure or condition and include the total costs of pre-operative testing, the surgery itself, facility fee, some drugs separately payable under Part B (including one administered during surgery), anesthesia costs, and additional post-operative care billed separately from the surgery, such as additional procedures as a result of a complication. The measure includes costs 60 days prior to the surgery and 90 days following it. Each year, the episode measures will be updated to include new Part B drugs on a case-by-case basis.

CMS has not yet released the specifications for the cataract measure in 2020. We will notify members at that time. However, in 2019, the following Part B drugs are included in the cataract surgery episode measure in conjunction with certain diagnoses:

HCPCS Code	Description	Included Diagnoses
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	Included regardless of diagnosis
J0278	Injection, amikacin sulfate, 100 mg	H44.021, H44.022, unspecified purulent endophthalmitis
J0713	Injection, ceftazidime, per 500 mg	H44.021, H44.022, unspecified purulent endophthalmitis
J3370	Injection, vancomycin hcl, 500 mg	H25.11, H25.12, age-related nuclear cataract; H25.811, H25.812, combined forms of age-related cataract; H26.8, other specified cataract; H26.9, unspecified cataract; H44.021, H44.022, unspecified purulent endophthalmitis
J3465	Injection, voriconazole, 10 mg	H44.021, H44.022, unspecified purulent endophthalmitis; H44.011, H44.012, panophthalmitis (acute)

The cataract surgery episode measure is sub-grouped to compare the costs of cataract surgeries performed under similar conditions. Specifically, the measure divides cataract surgery between ASC and HOPDs and unilateral surgery versus bilateral surgery when the second eye is operated on within the first eye's global period. To calculate the measure, CMS will compare the costs of each sub-group of surgeries with the cost of other surgeries nationwide. For example, if a surgeon performs some surgeries in an ASC and others in an HOPD, the cost of the surgeries in the ASC will be compared to a national average of cataract surgeries in ASCs, and the surgeries performed in the HOPD will be compared to the national average cost of cataract surgeries in HOPDs.

To calculate the total measure score, CMS will evaluate each surgery, or episode, and compare it to the national average expected cost for its sub-group. This comparison is done by dividing the observed cost of the episode by its expected cost, which expresses the observed cost's deviation from the expected cost as a ratio. CMS will then add all the episodes' ratios together, across all sub-groups, and then divide that sum by the total number of episodes to determine the total average of the surgeon's episodes' deviations from the expected costs. That figure is then multiplied by a national average total cost to represent the surgeon's average deviation from expected costs as a dollar figure.

In addition, the measure is risk-adjusted to remove all patients with ocular co-morbidities. The list of excluded co-morbidities is identical to the list of exclusions for the MIPS quality measure 191, 20/40 or Better Visual Acuity 90 Days following Cataract Surgery.

The complete measure specifications for the cataract episode measure are available on the ASCRS website.

CMS and its contractor Acumen developed the episode-based cost measures with physician input, including that of ASCRS. An ASCRS physician continues to serve on a technical expert panel advising CMS and Acumen on the development of the cataract and other episode measures.

Patient Attribution

For the cataract episode measure, an ophthalmologist will be attributed a patient that meets the following characteristics:

- **Medicare Part B patient;**
- **Performed uncomplicated cataract surgery and billed only 66984; and**
- **Did not have one of the exclusionary ocular co-morbidities.**

The attribution threshold is 10 patients for the cataract surgery episode measure. If physicians or groups bill at least 10 surgeries that meet the above specifications, they will be attributed this measure.

As mentioned above, the TPCC measure now excludes ophthalmologists and optometrists from attribution, and the MSPB measure is based on inpatient care and unlikely to be attributed to ophthalmologists or optometrists. However, if an ophthalmologist or optometrist practices in a large, multispecialty group, such as an academic practice, that reports MIPS as a group, these measures may be included in the final group score if other clinicians in the group, such as primary care or hospital-based specialists, are attributed.

Cost Category Score

To determine a provider's Cost category score, CMS will assign 1 to 10 points to each measure attributed to the physician or, if reporting as a group, the entire group based on performance relative to the established benchmark. The benchmark for each measure will 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 category points possible for a performance year depend on how many measures the physician or, if reporting as a group, the group is attributed. Each attributed measure has the same weight toward the category score. The Cost category score is determined by adding the points scored on each measure and dividing by the total possible points available. **However, since it is likely that most ophthalmologists will only have the cataract episode measure attributed, the entire category score will be based on the performance on this measure.**

If a provider does not have any attributed measures, the Cost category will not be scored, and the Quality category will be re-weighted to 60%.

The MACRA statute originally required CMS to incorporate improvement into a physician's or group's Cost score beginning in 2018. However, following enactment of the MACRA technical corrections, CMS is not required to score improvement for three additional years.

MIPS Program: 2020 Cataract Episode-Based Cost Measure

What Are Episode-Based Cost Measures?

Episode-based cost measures seek to measure the total costs of caring for a patient related to a specific "episode" of care, such as a surgical procedure or inpatient hospital stay for a particular condition**. For procedural episodes, such as the cataract surgery measure, which were implemented in 2019, the measure includes the cost of pre-op care, the surgery itself, the facility payment, anesthesia costs, and any separately billable services furnished in the global period, such as the cost of surgery related to complications**. Cost calculations are based on the allowed charge. **Some measures may include separately payable drugs. In the case of the the cataract surgery measure, there is one drug on pass-through and several drugs used post-operatively to treat endophthalmitis.** These drugs will be updated on an annual basis. ASCRS ASOA opposes the inclusion of any drug on pass-through in the episode measure and is advocating to have it removed.

ASCRS ASOA opposes the inclusion of drugs on pass-through because it defeats the purpose of pass-through to provide separate payment for certain higher-cost new and innovative drugs administered during a surgical procedure and to provide time to introduce the drug into the marketplace. Following the three-year pass-through period, CMS measures the utilization of the drug, adjusts the facility fee using a formula to account for the cost of the drug based on its usage and other factors, and bundles the drug into the facility fee. ASCRS ASOA believes including pass-through drugs in the episode measure will inappropriately influence the utilization data for new drugs and is advocating that no pass-through drug be included in the episode measure.

ASCRS has met with CMS and Acumen, the contractor developing the measure, and submitted letters to advocate removing pass-through drugs from the episode measure. CMS indicated that our point related to influencing the utilization data was well taken, but that the agency could not comment while in rule-making. The AMA has also advocated that pass-through drugs not be included in the episode measures. **However, CMS did not address the issue in the 2020 Medicare Physician Fee Schedule. CMS could still address this when issuing the updated specifications for 2020. We will continue to monitor and keep members updated.**

To be scored on the cataract episode measure, a surgeon must have at least 10 attributed cases. The episode measure is scored based on a surgeon's total cost related to the cataract surgery, compared to a national average, and awarded points based on a 10-point scale.

Episode-based measures were developed as an alternative to existing population-based, or all-cost, measures, such as total per capita costs (TPCC) and Medicare spending per beneficiary (MSPB), which were first used in the Value-Based Modifier Program and continued into MIPS. Population-based measures seek to measure the total cost of care for a patient in a year and may hold physicians responsible for the cost of care they did not provide. As a result of our advocacy, CMS has removed ophthalmologists and optometrists from attribution to the TPCC measure.

As an alternative to population-based measures, ASCRS ASOA and others in the medical community have long advocated for the development of episode-based measures to ensure that physicians are only evaluated on the costs of care that they can influence. ASCRS participated in a technical expert panel that provided input in the measure and was successful in ensuring accurate attribution, risk adjustment, and sub-grouping to compare surgeries performed in ASCs and HOPDs separately, as well as whether one eye was operated on in the global period or both eyes.

Cataract Episode-Based Measure Reporting Requirements

Similar to other Cost measures, physicians do not need to submit separate data for the cataract episode measure. CMS will determine scores through administrative claims.

Cataract Episode-Based Measure Attribution

Ophthalmologists will be attributed the cataract surgery episode measure if they perform uncomplicated cataract surgery on a Medicare Part B patient during the performance year. This includes only surgeries billed with CPT code 66984. No other cataract surgeries, such as 66982, complex cataract surgery, will be included in the measure.

Surgeons must have at least 10 cases that meet the attribution criteria to be attributed and scored on this measure.

In addition, ASCRS was successful in advocating for excluding any patients with significant ocular co-morbidities from this measure. These co-morbidity exclusions are identical to the exclusionary criteria for the cataract quality measure 191, 20/40 or Better Visual Acuity 90 Days following Cataract Surgery.

Any patient that has any of the following diagnoses will be not be included in the cataract episode cost measure:

Significant Ocular Condition	Corresponding ICD-10-CM Codes
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.021, H20.022, H20.023, H20.031, H20.032, H20.033, H20.041, H20.042, H20.043, H20.051, H20.052, H20.053
Amblyopia	H53.001, H53.002, H53.003, H53.011, H53.012, H53.013, H53.021, H53.022, H53.023, H53.031, H53.032, H53.033, H53.041, H53.042, H53.043
Burn Confined to Eye and Adnexa	T26.01XA, T26.02XA, T26.11XA, T26.12XA, T26.21XA, T26.22XA, T26.31XA, T26.32XA, T26.41XA, T26.42XA, T26.51XA, T26.52XA, T26.61XA, T26.62XA, T26.71XA, T26.72XA, T26.81XA, T26.82XA, T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.221, H26.222, H26.223
Central Corneal Ulcer	H16.011, H16.012, H16.013
Certain Types of Iridocyclitis	H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.821, H20.822, H20.823, H20.9
Chorioretinal Scars	H31.001, H31.002, H31.003, H31.011, H31.012, H31.013, H31.021, H31.022, H31.023, H31.091, H31.092, H31.093
Choroidal Degenerations	H35.33
Choroidal Detachment	H31.411, H31.412, H31.413
Choroidal Hemorrhage and Rupture	H31.301, H31.302, H31.303, H31.311, H31.312, H31.313, H31.321, H31.322, H31.323
Chronic Iridocyclitis	A18.54, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.01, H17.02, H17.03, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.821, H17.822, H17.823
Corneal Edema	H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.231, H18.232, H18.233, H18.421, H18.422, H18.423, H18.43
Corneal Opacity and Other Disorders of Cornea	H17.01, H17.02, H17.03, H17.11, H17.12, H17.13, H17.89, H17.9
Degeneration of Macula and Posterior Pole	H35.30, H35.3110, H35.3111, H35.3112, H35.3113, H35.3114, H35.3120, H35.3121, H35.3122, H35.3123, H35.3124, H35.3130, H35.3131, H35.3132, H35.3133, H35.3134, H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233, H35.341, H35.342, H35.343, H35.351, H35.352, H35.353, H35.361, H35.362, H35.363, H35.371, H35.372, H35.373, H35.381, H35.382, H35.383
Degenerative Disorders of Globe	H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.21, H44.22, H44.23, H44.311, H44.312, H44.313, H44.321, H44.322, H44.323, H44.391, H44.392, H44.393
Diabetic Macular Edema	E08.311, E08.3211, E08.3212, E08.3213, E08.3311, E08.3312, E08.3313, E08.3411, E08.3412, E08.3413, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.37X1, E08.37X2, E08.37X3, E09.311, E09.3211, E09.3212, E09.3213, E09.3311, E09.3312, E09.3313, E09.3411, E09.3412, E09.3413, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.37X1, E09.37X2, E09.37X3, E10.311, E10.3211, E10.3212, E10.3213, E10.3311, E10.3312, E10.3313, E10.3411, E10.3412, E10.3413, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.37X1, E10.37X2, E10.37X3, E11.311, E11.3211, E11.3212, E11.3213, E11.3311, E11.3312, E11.3313, E11.3411, E11.3412, E11.3413, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.37X1, E11.37X2, E11.37X3, E13.311, E13.3211, E13.3212, E13.3213, E13.3311, E13.3312, E13.3313, E13.3411, E13.3412, E13.3413, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.37X1, E13.37X2, E13.37X3
Diabetic Retinopathy	E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312,

	E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593
Disorders of Optic Chiasm	H47.41, H47.42, H47.43, H47.49
Disorders of Visual Cortex	H47.611, H47.612
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	H30.101, H30.102, H30.103, H30.111, H30.112, H30.113, H30.121, H30.122, H30.123, H30.131, H30.132, H30.133, H30.141, H30.142, H30.143
Focal Chorioretinitis and Focal Retinochoroiditis	H30.001, H30.002, H30.003, H30.011, H30.012, H30.013, H30.021, H30.022, H30.023, H30.031, H30.032, H30.033, H30.041, H30.042, H30.043
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.1110, H40.1111, H40.1112, H40.1113, H40.1114, H40.1120, H40.1121, H40.1122, H40.1123, H40.1124, H40.1130, H40.1131, H40.1132, H40.1133, H40.1134, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.151, H40.152, H40.153, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.2210, H40.2211, H40.2212, H40.2213, H40.2214, H40.2220, H40.2221, H40.2222, H40.2223, H40.2224, H40.2230, H40.2231, H40.2232, H40.2233, H40.2234, H40.231, H40.232, H40.233, H40.241, H40.242, H40.243, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.821, H40.822, H40.823, H40.831, H40.832, H40.833, H40.89, Q15.0
Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes	H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.811, H40.812, H40.813, H40.821, H40.822, H40.823, H40.831, H40.832, H40.833, H40.89, H40.9, H42
Hereditary Choroidal Dystrophies	H31.20, H31.21, H31.22, H31.23, H31.29
Hereditary Corneal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59
Hereditary Retinal Dystrophies	H35.50, H35.51, H35.52, H35.53, H35.54, H36
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.02XA, S04.031A, S04.032A, S04.041A, S04.042A
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	H54.1131, H54.1132, H54.1141, H54.1142, H54.1151, H54.1152, H54.1213, H54.1214, H54.1215, H54.1223, H54.1224, H54.1225
Nystagmus and Other Irregular Eye Movements	H55.01
Open Wound of Eyeball	S05.11XA, S05.12XA, S05.21XA, S05.22XA, S05.31XA, S05.32XA, S05.51XA, S05.52XA, S05.61XA, S05.62XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.91XA, S05.92XA
Optic Atrophy	H47.20, H47.211, H47.212, H47.213, H47.22, H47.231, H47.232, H47.233, H47.291, H47.292, H47.293
Optic Neuritis	H46.01, H46.02, H46.03, H46.11, H46.12, H46.13, H46.2, H46.3, H46.8, H46.9
Other and Unspecified Forms of	H30.21, H30.22, H30.23, H30.811, H30.812, H30.813, H30.891, H30.892, H30.893, H30.91, H30.92,

Chorioretinitis and Retinochoroiditis	H30.93
Other Background Retinopathy and Retinal Vascular Changes	H35.021, H35.022, H35.023, H35.051, H35.052, H35.053, H35.061, H35.062, H35.063
Other Corneal Deformities	H18.70, H18.711, H18.712, H18.713, H18.721, H18.722, H18.723, H18.731, H18.732, H18.733, H18.791, H18.792, H18.793
Other Disorders of Optic Nerve	H47.011, H47.012, H47.013
Other Disorders of Sclera	H15.831, H15.832, H15.833, H15.841, H15.842, H15.843
Other Endophthalmitis	H16.241, H16.242, H16.243, H21.331, H21.332, H21.333, H33.121, H33.122, H33.123, H44.111, H44.112, H44.113, H44.121, H44.122, H44.123, H44.131, H44.132, H44.133, H44.19
Other Proliferative Retinopathy	H35.101, H35.102, H35.103, H35.111, H35.112, H35.113, H35.121, H35.122, H35.123, H35.131, H35.132, H35.133, H35.141, H35.142, H35.143, H35.151, H35.152, H35.153, H35.161, H35.162, H35.163, H35.171, H35.172, H35.173
Other Retinal Disorders	H35.61, H35.62, H35.63, H35.81, H35.82, H35.89
Pathologic Myopia	H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.21, H44.22, H44.23, H44.30
Prior Penetrating Keratoplasty	H18.601, H18.602, H18.603, H18.611, H18.612, H18.613, H18.621, H18.622, H18.623
Profound Impairment, Both Eyes	H54.0X33, H54.0X34, H54.0X35, H54.0X43, H54.0X44, H54.0X45, H54.0X53, H54.0X54, H54.0X55
Purulent Endophthalmitis	H44.001, H44.002, H44.003, H44.011, H44.012, H44.013, H44.021, H44.022, H44.023
Retinal Detachment with Retinal Defect	H33.001, H33.002, H33.003, H33.011, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, H33.041, H33.042, H33.043, H33.051, H33.052, H33.053, H33.8
Retinal Vascular Occlusion	H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, H34.8110, H34.8111, H34.8112, H34.8120, H34.8121, H34.8122, H34.8130, H34.8131, H34.8132, H34.8310, H34.8311, H34.8312, H34.8320, H34.8321, H34.8322, H34.8330, H34.8331, H34.8332
Scleritis and Episcleritis	A18.51, H15.021, H15.022, H15.023, H15.031, H15.032, H15.033, H15.041, H15.042, H15.043, H15.051, H15.052, H15.053, H15.091, H15.092, H15.093
Separation of Retinal Layers	H35.711, H35.712, H35.713, H35.721, H35.722, H35.723, H35.731, H35.732, H35.733
Uveitis	H44.111, H44.112, H44.113, H44.131, H44.132, H44.133
Visual Field Defects	H53.411, H53.412, H53.413

Costs Included in the Cataract Episode Measure

As noted above, the episode-based measures seek to measure the cost of care related to a specific procedure or condition—what CMS terms an "episode." The following costs are included in a cataract episode:

- Pre-operative testing,
- The physician's professional fee for the surgery itself,
- The facility fee,
- Some drugs separately payable under Part B, including one on pass-through administered during surgery,
- Anesthesia, and
- Additional post-operative care billed separately from the surgery, such as additional procedures as a result of a complication.

The measure includes costs 60 days prior to the surgery and 90 days following it. Costs are calculated based on the allowed charge.

Each year, the episode measures will be updated to include new Part B drugs on a case-by-case basis. **Currently, only one pass-through drug is included in the episode: injection of phenylephrine and ketorolac (Omidria). No other drug currently paid on pass-through is included. As noted above, ASCRS ASOA opposes the inclusion of any pass-through drug in the episode measure and will advocate that annual updates to the measure do not include any pass-through drugs. It is also important to remember that using the current pass-through drug on a patient who is otherwise excluded from the measure, such as through complex surgery or because he or she has one of the exclusionary co-morbidities, will not be included, and therefore, will not impact the episode measure score.**

CMS has not released updated specifications for 2020; however, for 2019, the following Part B drugs were included in the episode measure, either at all times or in conjunction with certain diagnoses:

HCPCS Code	Description	Included Diagnoses
C9447	Injection, phenylephrine and ketorolac, 4 ml vial **(currently on pass-through)**	Included for all attributed cases
J0278	Injection, amikacin sulfate, 100 mg	H44.021, H44.022, unspecified purulent endophthalmitis
J0713	Injection, ceftazidime, per 500 mg	H44.021, H44.022, unspecified purulent endophthalmitis
J3370	Injection, vancomycin hcl, 500 mg	H25.11, H25.12, age-related nuclear cataract; H25.811, H25.812, combined forms of age-related cataract; H26.8, other specified cataract; H26.9, unspecified cataract; H44.021, H44.022, unspecified purulent endophthalmitis
J3465	Injection, voriconazole, 10 mg	H44.021, H44.022, unspecified purulent endophthalmitis; H44.011, H44.012, panophthalmitis (acute)

Cataract Surgery Episode Sub-Groups

Because the cost of cataract surgery varies greatly depending on whether it is performed in an ASC or an HOPD, the cataract episode separates surgeries into sub-groups to compare the cost of similar surgeries. In other words, the cost of surgery performed in an ASC will only be compared to others performed in ASCs, and those performed in HOPDs will only be compared to others in HOPDs. To further sub-divide the episodes, there are sub-groups for whether one surgery was performed within the 90-day window of the measure (unilateral) or if the second eye was operated on within the 90-day global of the first surgery.

Therefore, the measure assigns each episode to one of four sub-groups:

- ASC, unilateral
- ASC, bilateral
- HOPD, unilateral
- HOPD, bilateral

Cataract Episode Measure Score

To calculate the total measure score, CMS will evaluate each surgery, or episode, and calculate an “observed” cost, then compare it to the national average “expected” cost for its sub-group. The observed cost is based on the Medicare allowed charge; however, CMS standardizes the charges to account for geographic differences and does risk adjustment based on Hierarchical Category Codes (HCC), which account for patient complexity but do not include any ophthalmic conditions. The comparison from the national average is done by dividing the observed cost of the episode by its expected cost, which expresses the observed cost’s deviation from the expected cost as a ratio.

CMS will then add all the episodes’ ratios together, across all sub-groups, and divide that sum by the total number of episodes to determine the total average of the surgeon’s episodes’ deviations from the expected costs. That figure is then multiplied by a national average total cost to represent the surgeon’s average deviation from expected costs as a dollar figure. If the surgeon is reporting MIPS as part of a group, then the group’s combined average cost is calculated.

CMS then compares the physician’s or group’s average cost to a benchmark and assigns the measure a score of 1 to 10 points. The benchmark will be determined based on **cost data from the performance period.** The lower the average

cost of the cataract episode, the higher the measure score will be. Physicians or groups will not lose or receive negative points for higher costs, but their measure score will be lower.

Once the cataract episode measure is scored, CMS then determines the Cost category score for the physician or group.

The total category points possible for a performance year depend on how many measures the physician, or if reporting as a group, the group is attributed. However, since ASCRS and the medical community were successful in advocating for updated attribution methodology, CMS will now exclude ophthalmologists, optometrists, and other non-primary care specialists from the total per capita cost measure, which is still in the Cost category. In addition, the Medicare spending per beneficiary measure remains, but it is based on inpatient care and unlikely to be attributed to ophthalmologists. Therefore, it is likely that the only cost measure an ophthalmologist is attributed is the cataract episode-based measure, and CMS will base the entirety of the category score on that measure.

If a provider does not have any attributed measures, the Cost category will not be scored, and the Quality category will be re-weighted to 60% to account for the 15% from the Cost category.

Cataract Episode Cost Measure FAQs

Q: I perform all my surgeries in an HOPD because there is no ASC available locally. Will I receive a lower score because the facility fee is greater?

A: Because of the sub-groups, these surgeries performed in an HOPD will only be compared to other surgeries performed in HOPDs. CMS calculates the expected national average cost for each sub-group and then determines by what percentage the surgeon is deviating from that average expected cost for that type of surgery.

Q: Will I receive a lower measure score for using Omidria?

A: It depends. If you use Omidria for its primary indication of pupil dilation, the patient will be excluded from the measure as long as you are using the drug on a patient undergoing complex cataract surgery (66982) or who has one of the listed co-morbidities. Therefore, using the drug would not impact your score at all because those cases would not be included. However, if you use it on every case, it will likely increase your average costs and earn a lower score because those patients without co-morbidities will be included. ASCRS ASOA continues to advocate that the cost of this drug, or any other pass-through drug, be excluded from the episode.

Q: Will I receive a lower measure score for using any other drug currently paid on pass-through or those that will become available this year and paid on pass-through?

A: In 2019, no other pass-through drug was to be included in the episode. None of the drugs that came onto the market since the measure was developed in 2017 were added to the specifications nor count toward the cost of the episode in 2019. The 2020 measure specifications have not yet been released and will likely be released prior to the beginning of 2020. CMS has indicated to ASCRS, however, that adding other drugs, including those on pass-through, would require input from the technical expert panel (of which ASCRS is a member), which has not occurred. ASCRS ASOA continues to advocate that any pass-through drug be excluded from the episode, and we will advocate that individual drugs are not added to the measure through the annual measure update process. We will update members when the 2020 measure specifications are released.

Q: Will using other drugs separately payable under Part B increase my costs?

A: It depends on the drug. As listed above in this guide, there are four other Part B drugs included in the measure when they are used to treat endophthalmitis following cataract surgery. Because these drugs are administered as a result of a complication and paid separately, they are considered as additional costs in the episode and will impact the measure score. If a physician administers these drugs to treat another condition with any diagnosis not listed in the measure specifications, then they will not be included in the measure and will not impact the score.

Q: I perform MIGS or other glaucoma procedures in conjunction with cataract surgery. Will this increase my costs?

A: No, any patient with glaucoma is excluded from the cataract episode measure. Performing additional glaucoma procedures in conjunction with cataract surgery will not impact your cataract episode measure score. In fact, a surgeon who specializes in glaucoma procedures may not have the required 10 cases that meet the attribution criteria of uncomplicated cataract with no co-morbidities and, therefore, would not have the cataract episode measure attributed to him or her at all.

MIPS Program: Choosing Individual vs. Group Reporting and Virtual Groups in 2020

The MACRA statute, which created MIPS, 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 solely 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, and solo practitioners have the option to join virtual groups. Group reporting may ease administrative burden for some practices and assist some physicians, especially sub-specialists, in succeeding under MIPS. Use this guide to help you determine whether to report as a group or an individual.

In 2020, CMS is continuing another provision of the MACRA statute to allow physicians to participate in MIPS through "virtual groups." Solo practitioners and practices with 10 or fewer Medicare-eligible clinicians may elect to join together as virtual groups and have their performance measured under MIPS collectively. This guide provides information on how to form a virtual group, as well as issues to consider as part of a virtual group.

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 and submission mechanisms. 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 2020.

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

- Determine what your goals are for the 2020 performance year. Are you reaching for a bonus in 2022—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.

- If the practice only sought to submit minimal data in previous years to avoid the penalty, but wants to increase participation in MIPS, group reporting could be an option for 2020. Review the performance of every Medicare provider in your group—ophthalmologists, optometrists, CRNAs, etc.—and determine each participant's strengths and weaknesses. 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 Promoting Interoperability (PI) measures, many ophthalmology practices struggle to identify other practices they refer to that have EHR and can complete health information exchange. If your practice struggles with these measures, reporting as a group may reduce the pressure to complete each required measure at least once for each practitioner. It is also important to remember that CMS is continuing to offer a 2020 PI hardship exemption for practices of 15 or fewer eligible clinicians, so small practices do not have to submit any data for this category if they apply for the hardship.

- Identify the submission mechanism you plan to use for MIPS. Implemented in 2019, small groups may use the claims submission mechanism for Quality and be scored as a group. Groups using claims submission must submit data for the other categories as a group for CMS to score the quality measures collectively. **Also, CMS has eliminated the claims reporting option for any group of 16 or more Medicare-eligible clinicians, regardless of whether they report as a group or individually.** 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?

For individual reporting, each MIPS-eligible clinician, identified by a unique TIN/NPI combination, is responsible for completing the requirements for MIPS. In 2020, physicians must individually report data for the Quality, Promoting Interoperability (PI), and Improvement Activities categories. CMS will score the individual physician's performance for 2020 and adjust his or her Medicare payments accordingly for 2022.

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 2020 must begin reporting for the Quality category on January 1, 2020. Reporting for the PI or Improvement Activities may begin any time between January 1, 2020, and October 1, 2020. 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 2017 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 eligible patient encounters for every physician in the group are aggregated together as a total population for the Quality and PI 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 PI, the group works together to meet all the required measures. Groups of 15 or fewer Medicare eligible clinicians may also apply for a 2020 small practice hardship exemption for the PI category. For the Improvement Activities category, at least 50% of the group's participants must complete the activity or activities; however, the group is required to attest once collectively for the activity or activities its members 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 PI, all physicians in the group will work toward achieving the measures together. For each required measure, there must be a 1 in the numerator. Therefore, the practice must only have one patient in each measure, and **not** one for each individual physician. The group's category score will be calculated similarly to individual reporters, with a total percentage of all 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, CMS is continuing to increase the MIPS performance threshold gradually in 2020—the fourth year of MIPS. This allows groups, as well as individual reporters, to submit some data to avoid a penalty in 2022. The 45-point threshold can be met in a variety of ways, but given the higher threshold in 2020, may vary by group. For assistance determining the best way to meet the threshold for your practice, call the ASCRS ASOA MACRA Hotline at 703-383-5724, and regulatory staff will be available to help you.

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, 2020, and only applies to practices of 25 or more eligible clinicians. 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 $90,000 in allowed Medicare charges, see fewer than 200 Medicare patients in a year, or perform 200 or fewer Medicare professional services, 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.

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.

What Is a Virtual Group?

A virtual group is made up of two or more solo practitioners and practices of 10 or fewer eligible clinicians all billing Medicare under their own TINs who elect to aggregate their performance to be scored collectively under MIPS. Virtual group reporting and scoring is the same as group reporting and scoring, discussed above.

Who May Form a Virtual Group?

Any MIPS-eligible solo practitioner or practice of 10 or fewer eligible clinicians may form a virtual group. If a practice of 10 or fewer elects to join a virtual group, all eligible clinicians practicing under that TIN must join the virtual group. There is no limit to how many clinicians may be part of the virtual group, and there are no limitations related to geographic area or specialty. A physician who practices under two or more different TINs may elect to join a virtual group and have his or her performance under some or all of those TINs aggregated in the same virtual group.

Virtual groups that do not exceed 15 participants in total are also eligible for the 6-point small practice bonus in the Quality category and the small practice hardship exemption for the PI category.

How Do I Form a Virtual Group?

Unlike groups all practicing under the same TIN, virtual groups must apply to CMS prior to the beginning of the performance year and be accepted through the virtual group two-stage election process.

To form a virtual group, the group must be deemed eligible to create a group. Before proceeding with the election process, the group may begin the process with an optional Stage 1 to determine eligibility. Interested clinicians may contact their designated technical assistance representative or the Quality Payment Program Service Center to determine if they are eligible to join or form a virtual group. Visit qpp.cms.gov for contact information.

If the group decides not to begin with Stage 1 to determine its eligibility, its prospective members may still proceed directly to Stage 2. CMS will make the eligibility determination in Stage 2 for any group that did not begin with Stage 1.

In Stage 2 of the election process, the group must submit the following to CMS for approval:

- A written formal agreement between each of the virtual group members, and
- Information about the TIN and NPI associated with the virtual group representative's contact information.

The election information in Stage 2 must be submitted to CMS via email to MIPS_VirtualGroups@cms.hhs.gov no later than December 31 of the year immediately prior to the performance period. **To form a virtual group for 2020, the election information must be submitted by December 31, 2019.**

What Are the Advantages and Disadvantages of Participating in a Virtual Group?

The Congressional sponsors of MACRA intended the concept of virtual groups as a way to reduce burden on small or solo practices who may not be able to implement the MIPS program on their own. Physicians and practices should consider their options carefully before joining a virtual group.

Advantages: Many of the advantages of virtual groups are the same as group reporting. Solo practitioners, especially sub-specialists, may not have enough relevant measures or the resources to implement, track data, and submit. A virtual group could consolidate those functions and reduce burden. For physicians practicing under multiple TINs, virtual groups also offer the opportunity to aggregate total performance and reduce or eliminate duplicative reporting.

Disadvantages: Virtual group participation is relatively low across all of medicine, and few physicians have experience in these groups. In addition, virtual groups require cooperation between practices that do not have a current business relationship. CMS requires a formal written agreement between all members of a virtual group. While the agreement would provide some protections, its development could be burdensome, time-consuming, and expensive if legal services are required. The deadline to submit all election materials to CMS for 2020 participation is December 31, 2019, which will likely be difficult for most practices to meet.

Alternative Payment Models (APMs)
Advanced APMs and MIPS APMs
2020 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. ASCRS also has developed a guide on MIPS participation for Medicare Shared Savings Program Basic Track Accountable Care Organizations (ACOs) and guides on the full QPP and each of the four components of MIPS. We will continue to provide additional resources and training materials to assist ASCRS and ASOA members in complying with the program in 2020 for 2022 payment.

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 participating in the Comprehensive Primary Care Plus model.

For 2020, to impact 2022 payment, the following are considered Advanced APMs:

- Medicare Shared Savings Program (enhanced track)
- Next Generation ACO Model
- Comprehensive End-Stage Renal Disease (ESRD) Care (large dialysis organization arrangement)
- Comprehensive Primary Care Plus Model (CPC+)
- Oncology Care Model (OCM)
- Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology [CEHRT] track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- Maryland Total Cost of Care Model (Maryland Primary Care Program)
- Independence at Home Model

Currently, there is no ophthalmology specific Advanced APM. 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 Basic Track (formerly 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 future years, ophthalmologists may be able to participate in bundled payment models, such as for cataract surgery, built from episode-based cost measures. There are no formal proposals currently in development for ophthalmic surgery bundled payment models; however, there are bundled payment models for non-ophthalmic procedures. ASCRS continues to provide input to CMS through technical expert panels on the development of the episode-based cost measures—particularly to ensure costs are accurately attributed and risk adjustment is included—and monitor 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 collectively meets certain revenue or patient thresholds.**

For 2022, based on performance year 2020, providers are considered QPs for participating in an Advanced APM entity for which either:

- The collective Part B payment for services delivered by the Advanced APM entity's clinicians to patients who are attributed to that entity is at least 50% 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 35% 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 or patients required to qualify for the APM bonus will continue to 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 2022, the collective threshold is 40% of eligible Medicare payments or 25% of eligible Medicare patients for partial participation. Partial QPs do not qualify for the 5% bonus payment under the APM category. While Partial QPs may opt out of MIPS, it is important to remember that they may qualify for a bonus if they do select to participate in MIPS.**

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.**

Revenue or Patient Thresholds for Advanced APMs

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

	2022	2023	2024 or Later
Percentage of Payments through an Advanced APM	**50%**	**75%**	**75%**
Percentage of Patients through an Advanced APM	**35%**	**50%**	**50%**

MIPS APMs – Including Medicare Shared Savings ACOs Basic Track

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 2022, based on 2020 performance, CMS will likely consider these APMs as MIPS APMs:

- **Medicare Shared Savings Program All Tracks**
- Next Generation ACO Model
- Comprehensive ESRD Care Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus Model (CPC+)
- Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology [CEHRT] track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- Maryland Total Cost of Care Model
- Independence at Home 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 2020 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 Promoting Interoperability (previously Advancing Care Information) category on their own; and**
- **Earn full credit for the Improvement Activities category score.**

Medicare Shared Savings ACOs Final Rule

Separate from the 2019 MPFS final rule, CMS released a final rule for the MSSP in December 2018 that seeks to accelerate ACOs' transition to taking on downside risk, which could impact some ophthalmologists participating in MIPS through Track 1 ACOs. Under the new rule, beginning in July 2019, CMS created two tracks, basic and enhanced. New ACOs would begin in the basic track and not have to bear risk for two years, as opposed to the current six-year period allowed before taking on risk. Current Track 1 ACOs would have one year to move to the enhanced, risk-bearing track. **ASCRS recommends that any ophthalmologists who were previously participating in Track 1 ACOs reach out to their ACO's managers for details about their specific ACOs under this new policy.**

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 Promoting Interoperability and Improvement Activities collectively, as well.** CMS will use an average score of all the participants' scores for Promoting Interoperability 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% Promoting Interoperability.
- For all other models, category weights are 0% Quality, 0% Cost, 25% Improvement Activities, and 75% Promoting Interoperability.

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.

If a **full TIN** joins an APM later in the year, it can be considered a QP or participate in MIPS through the APM if it is listed on an APM's participant list by December 31 of the performance year. On December 31, only full TINs participating in the APM will qualify. If not all physicians billing under the TIN join the APM, they must be on the participant list on one of the three earlier dates.

Other Payer APMs

Other Payer APMs include payment arrangements under any payer other than traditional Medicare, including Medicare Advantage, other Medicare-funded plans, and Medicaid. Beginning in 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. To meet the APM thresholds through participation in an Other Payer APM, physicians must also participate in a Medicare Advanced APM. **The 5% bonus for significantly participating in an Advanced APM will be based on traditional Medicare and will not include Medicare Advantage payments**.

MIPS Participation for Medicare Shared Savings Program Basic Track Accountable Care Organization Members 2020 Final Rule Guide

This guide provides information on how Medicare Shared Savings Program (MSSP) Basic Accountable Care Organization (ACO) 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 a basic track ACO—or an Advanced APM that has not met patient or revenue thresholds. ASCRS has also developed guides on the full QPP, each of the four components of MIPS, and Advanced APMs, and will continue to provide additional resources and training materials to assist ASCRS and ASOA members in complying with the program.

Medicare Shared Savings ACOs Final Rule

Separate from the 2019 MPFS final rule, CMS released a final rule for the MSSP in December 2018 that seeks to accelerate ACOs' transition to taking on downside risk, which could impact some ophthalmologists participating in MIPS through Track 1 ACOs. Under the new rule, beginning in July 2019, CMS created two tracks, basic and enhanced. New ACOs would begin in the basic track and not have to bear risk for two years, as opposed to the current six-year period allowed before taking on risk. Track 1 ACOs would have one year to move to the enhanced, risk-bearing track. **ASCRS recommends that any ophthalmologists who were previously participating in Track 1 ACOs reach out to their ACO's managers for details about their specific ACOs under this new policy.**

MIPS APM Scoring Standard

Basic Track, previously 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 basic ACOs do not involve downside risk, they cannot be considered Advanced APMs.

However, CMS has created a MIPS scoring standard for participants in certain APMs that do not meet the definition of an Advanced APM (such as basic track 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 Basic Track ACO Members Participate in MIPS?

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

Basic Track 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 Promoting Interoperability (PI) category (formerly Advancing Care Information) on their own; and**
- **Automatically earn at least 50% the total available points for the Improvement Activities category score. However, CMS has indicated that all participants will receive full credit in this category for 2020.**

Basic Track ACO Scores Under the MIPS APM Scoring Standard

CMS will award the same final MIPS score to all the participants in a basic Track 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 PI 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 PI 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 2020, category weights are 50% Quality, 0% Cost, 20% Improvement Activities, and 30% PI.

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.

New for 2020, if a MSSP ACO that is a MIPS APM fails to report quality data, CMS will determine whether the individual or group TINs participating in the ACO reported their own quality data. If so, CMS will calculate the individual TIN level Quality category scores and average the scores across the participants of the ACO, similar to how it calculates the PI score, and award all the participants in the ACO the same Quality score. If, for example, an ophthalmology practice continued to report quality data through the IRIS registry, in the event its ACO failed to report data, CMS would use the data submitted through IRIS toward the collective Quality category score.

MIPS APM Participation

Physicians may participate in basic track 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.

If a **full TIN** joins an APM later in the year, it can be considered a QP or participate in MIPS through the APM if it is listed on an APM's participant list by December 31 of the performance year. On December 31, only full TINs participating in the APM will qualify. If all physicians billing under the TIN do not join the APM, they must be on the participant list on one of the three earlier dates.