MIPS Performance Categories

Quality

In general, to receive a quality performance score and qualify for a potential MIPS upward payment adjustment, clinicians must report on at least 6 measures, including one outcomes measures or another high priority measure (appropriate use, patient safety, efficiency, patient experience, or care coordination measure) if an outcomes measures is not available. Clinicians must report on each measure for 50% of applicable patients (Medicare-only for claims reporting; all-payer data for qualified registry, QCDR, and EHR) over at least a 90-day period. The clinician also must have at least 20 applicable patients for a given measure in order to receive a performance score higher than the automatic minimum score given for simply reporting a measure.

Measures not meeting the 50% data completeness threshold or the 20 patient minimum sample can only earn 3 points. Measures that do meet these requirements will be assessed against performance benchmarks to determine how many points the measure earns. A clinician can receive anywhere from 3 to 10 points for each measure, as well as additional bonus points (up to a cap) available for reporting on additional high priority measures and/or using end-to-end electronic reporting to submit such measures. These historic benchmarks are based on actual performance data submitted to PQRS in 2015, where available.

For group practices with more than 15 MIPS eligible clinicians, CMS will automatically calculate a ***30-day All-Cause Hospital Readmission*** measure based on administrative claims. This measure is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. CMS will only score a group practice on this measure if at least 200 cases are attributed to the group based on the measure specifications. This measure requires no additional data submission on the part of the practice.

To achieve a maximum score in the Quality category, clinicians would either have to earn the highest possible performance score (i.e., 10 points) on up to 6 reported measures plus the calculated 30-day All-Cause Hospital Readmission measure, if applicable, or supplement less than perfect performance with bonus points available for reporting on high priority measures (1-2 points, up to a cap) or end-to-end electronic reporting of such measures (1 point, up to a cap).

> **Example:**
> Measure A = 10/10 points
> Measure B (outcomes measure) = 10/10 points
> Measure C = 10/10 points
> Measure D (additional high priority measure) = 8/10 points + 1 bonus point
> Measure E = 8/10 points
> Measure F (less than 20 patients- measure unable to be scored) = 3/10 points
> Measure G (All-Cause Hospital Readmission measure) = 8/10 points
> **TOTAL Score** = (57+1/70 points) x (quality category weight of 60 points) =
> **50 points toward the total MIPS composite score of 100**

While CMS encourages the reporting of 6 measures, it recognizes that certain specialties do not have 6 relevant measures. CMS will use a process similar to the Measures Applicability Validation (MAV) process used under PQRS to determine whether there were truly no other measures available to a clinician who reports on less than 6 measures. If CMS determines that to be true, it will recalibrate the

weight of each measure so that the clinician may still earn up to the maximum performance score for the Quality category.

Example:
Measure A = 10/10 points
Measure B (outcomes measure) = 10/10 points
Measure C = 8/10 points
TOTAL SCORE = (28/30 points) x (quality category weight of 60 points) =
56 points toward total MIPS score

Keep in mind that clinicians can only be scored on measures reported via a *single* reporting mechanism. In other words, a clinician cannot be scored on 3 measures submitted via claims and 3 measures submitted via registry. Clinicians are encouraged to choose a single reporting mechanism. However, if a clinician submits measures via multiple reporting mechanisms, CMS will calculate a score for each mechanism and use whichever is highest.

There are currently over 250 measures in the MIPS quality measure inventory. To help clinicians navigate this list and find measures most relevant to their practice, CMS created specialty and sub-specialty measure sets. Clinicians are not required to report from these sets - they are merely suggestions. There are currently no specialty sets related specifically to hospice or palliative care. However, other sets might be relevant depending on the clinician's type of practice. HPM clinicians are encouraged to use the CMS MIPS measure search tool to determine what measures or specialty measure sets are most relevant to their practice. More detailed measure specifications are available for download here.

Some MIPS measures that might be relevant to HPM clinicians include:

- #143: Oncology: Medical and Radiation- Pain Intensity Qualified (registry, EHR)
- #144: Oncology: Medical and Radiation- Plan of Care for Pain (registry)
- #342: Pain Brought Under Control Within 48 Hours (registry)
- #386: ALS Patient Care Preferences- percentage of patients diagnosed with ALS who were offered assistance in planning for end of life issues (registry, EHR)
- #453: Proportion of Patients Receiving Chemotherapy in the Last 14 Days of Life (registry)
- #456: Proportion of Patients Who Died from Cancer Not Admitted to Hospice (registry)
- #457: Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (registry)
- #454: Proportion of Patients Who Died from Cancer with >1 ED visit in last 30 days of life (registry)
- #455: Proportion of Patients Admitted to ICU in Last 30 days of Life (registry)
- #456: Proportion of Patients Who Died from Cancer Not Admitted to Hospice (registry)
- #457: Proportion of patients Who Died from Cancer and Admitted to Hospice for < 3 days (registry)

Note that clinicians and groups that opt to participate in a QCDR to submit quality data will have access to other non-MIPS measures developed by the QCDR that might be more relevant to your practice. CMS is expected to post a list of QCDRs qualified for 2017 MIPS reporting in the spring of 2017. This list will include the unique measures offered by each QCDR. In the meantime, you might want to review the list of QCDRs from the 2016 PQRS.