Quality Reporting Under MIPS

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At first glance, the Merit-based Incentive Payment System (MIPS) may look somewhat like the Physician Quality Reporting System (PQRS), which closed its door on December 31, 2016, but appearances can be deceiving.

MIPS features 271 quality measures, of which physicians and other eligible clinicians must report six, at least one of which must be an outcome measure. Although the MIPS measures are similar to PQRS, it is vital to understand three distinct characteristics of the new program in order to successfully participate:

1. Pay heed to assigned reporting methods. While there are multiple ways to report quality measures under the MIPS program, each measure is "assigned" a reporting method. Therefore, you cannot choose six measures and assume that you can report them all via your electronic health record (EHR). You must review the method attached to each measure, and ensure that you can report it as required.
2. Recognize that select reporting methods apply to *all* patients who, according to the program, "meet a measure's denominator criteria." The reporting methods of EHR and registry (including Quality Clinical Data Registry) require you to report all patients, not just those covered by Medicare. It is important to note that registry-based reporting under MIPS involves reporting at least 50 percent of all patients who are eligible for the measure; it is no longer adequate to submit just 20 records, as was the standard for PQRS' registry reporting.
3. Scoring under the new MIPS program is based on your performance relative to government-defined benchmarks. It is not sufficient merely to *report* a measure; the percentage you submit will be scored based on your *performance*. Furthermore, the benchmarks are dependent on your reporting mechanism; you may receive different points on the basis of your methodology, even for the same score.

To illustrate, consider a quality measure that is often chosen for reporting – Preventive Care and Screening. This measure is defined as: "Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2."

For MIPS, the measure can be reported by any mechanism: claims, EHR or registry. Your score will be formulated based on your performance according to pre-defined benchmarks. The percentage you report will be sorted by decile, as highlighted in the table presented

below. The decile produces the score, for example, decile 4 equals 4 to 4.9 points; decile 5 equals 5 to 5.9 points; and so on. Decile 3 is the minimum decile for the MIPS program, with 3 points awarded just for submitting your performance.

Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Dec
Claims	41.33 - 45.76	45.77 - 51.46	51.47 - 66.43	66.44 - 90.09	90.10 - 98.60	98.6
EHR	28.73 - 31.80	31.81 - 34.45	34.46 - 37.23	37.24 - 40.19	40.20 - 43.64	43.6
Registry/ QCDR	39.80 - 45.63	45.64 - 50.91	50.92 - 56.68	56.69 - 64.88	64.89 - 75.81	75.8

Source: CMS' 2017 Quality Benchmarks

Assume your percentage was 96.83%. That's good, isn't it? It depends. You would receive approximately 7 points if you submitted that score via claims (requires Medicare patients only), 10 points for EHR-based reporting, or 9 points if the score came in via a registry. (EHR and registry-based reporting require all patients who meet the measure's criteria.)

This example is only one of a handful of quality measures eligible to be reported via all mechanisms. Other popular ones – like "Closing the Referral Loop: Receipt of Specialist Report" – can be reported by only a single methodology; in the case of "Closing the Referral Loop," this metric is availability only through EHR reporting.

Bottom Line: Do not assume that MIPS is just an extension of the Physician Quality Reporting System (PQRS). These three important distinctions — reporting methods, application to all patients and scoring based on relative benchmarks — require careful attention to ensure successful reporting.

As a reminder, you can "pick your pace" in 2017 under MIPS. If you just want to avoid the penalty, the government requires submission of only one measure. This includes one quality measure (regardless of performance), improvement activity, or the base advancing care information (ACI) requirements. For more information about this 2017 exception, please see the April SVMIC Sentinel Article.

Related Links:

MIPS Quality Measures

MIPS Quality Benchmarks: Download the zip file "2017 Quality Benchmarks"

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