2017 MIPS Quality Performance Category Reporting
Quality Measures Relevant to Geriatrics

SUMMARY

Under the Merit-Based Incentive Payment System (MIPS), part of the Quality Payment Program (QPP) created under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), clinicians will be assessed on the quality of care provided.

If you are a clinician that bills services under the Medicare Physician Fee Schedule, understanding the requirements and payment changes under MACRA is very important since the first measurement period for the QPP began January 1, 2017.

To help members participate in quality reporting under MIPS, **a workgroup of the American Geriatrics Society (AGS) Quality and Performance Measurement Committee** reviewed the 300+ quality measures approved by the Centers for Medicare & Medicaid Services (CMS) for reporting in 2017 and **identified 10 quality measures that were 1) most likely to be relevant to geriatricians' clinical practice and 2) most likely to be measures where geriatricians will perform well relative to other clinicians**. It is important to consider the work, expense, and data recording related to measure collection and reporting when selecting your measures. Listed in no particular order[1]:

- Medication Reconciliation Post Discharge
- Care Plan
- Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
- Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- Preventive Care and Screening: Influenza Immunization
- Pneumonia Vaccination Status for Older Adults
- Documentation of Current Medications in the Medical Record
- Falls: Risk Assessment
- Use of High-Risk Medications in the Elderly
- Dementia: Cognitive Assessment

[1] *NOTE:* The quality measures above are suggestions based on the workgroup's review. Individual clinicians or practices may find other measures better fit their practice. These measures are not part of an official CMS-designated Specialty Measure Set or developed or endorsed by the AGS.

OVERVIEW

Below are some MACRA basics focused on the MIPS Quality performance category, a table outlining the 10 quality measures identified by the workgroup, and an acronym glossary to reference as you review the document.

MACRA and MIPS

MACRA repealed the flawed Sustainable Growth Rate (SGR) formula which had been the basis for determining annual updates to physician reimbursement rates under Medicare Part B established by the Medicare Physician Fee Schedule.

MACRA created a new Medicare value-based reimbursement system, the QPP, which offers two paths for participating providers: Advanced Alternative Payment Models (APMs) and MIPS.

The first MIPS performance year is January 1, 2017 — December 31, 2017, and will be used to determine payment adjustments (either a bonus or a penalty) that will be applied to Medicare Part B reimbursements beginning on January 1, 2019.

MIPS Performance Categories

MIPS combines three existing quality reporting programs—Medicare Electronic Health Record (EHR) Incentive Program, also known as Meaningful Use, the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier—into one new system.

The new system will evaluate the performance of all MIPS eligible clinicians (ECs) or eligible groups[2] across four performance categories: **Quality**, Cost, Advancing Care Information, and Improvement Activities. The **Quality performance category replaces the PQRS.** The Advancing Care Information category replaces Meaningful Use. Improvement Activities is a new category Congress created to encourage practice- and population-level quality improvement initiatives.

Reporting Requirements: Quality Performance Category

The Centers for Medicare & Medicaid Services (CMS) has designated the 2017 performance year a transition year where providers can "pick the pace" of participation in the QPP that fits them best. There are three options under MIPS: test the QPP, participate for part of the calendar year, or participate for the full calendar year.

In 2017, MIPS-ECs can avoid a negative payment adjustment in 2019 by reporting one quality measure, or one Improvement Activity, or certain required measures of EHR use. In future years, requirements for the Quality performance category will increase. Providers will be required to report at least six quality measures, including one outcome measure.

While providers only need to submit one quality measure in 2017 to avoid penalties, gaining experience with these measures will be critical for success in 2018.

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[2] Eligible clinicians (ECs) include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians who bill under Medicare Part B.

Data Submission: Quality Performance Category

For the 2017 performance year, providers may report their Quality performance data through multiple submissions methods:

- Claims: This option may be easiest, in the short term, for solo or small practices
- EHR: CMS anticipates "end-to-end electronic reporting" in the future
- Qualified Data Registry (QDR): Some specialties have developed these to collect quality and outcome data
- Qualified Clinical Data Registry (QCDR): A new option CMS is promoting, primarily for specialties and sub-specialties

In future years, providers will be required to select one single reporting method for the Quality performance category.

Scoring: Quality Performance Category

The four performance categories will be used to calculate the Composite Performance Score (CPS) on a 1 to100 point scale. The CPS will be used by CMS to determine whether or not an EC will receive a bonus payment or will be subject to a payment reduction. **Clinicians, regardless of specialty, will be compared to each other and against a performance threshold.**

In the 2017 performance year, the Quality performance category will account for 60% of the CPS for the 2019 payment adjustment period. The weight of the Quality performance category will decrease to 50% of the CPS in the 2018 performance year and 30% of the CPS in the 2019 performance year and beyond.

Clinicians will be rewarded between 1 and 10 points for each submitted quality measure based on performance against historical benchmarks. In the 2017 performance year, if providers report a single quality measure, but do not meet the benchmark, they will automatically receive a score of 3 points for that measure and will avoid a negative 4% payment adjustment in 2019. With this level of participation, however, there will not be an opportunity to earn additional incentive payments. Providers who choose to participate in part of the year will be eligible for a positive payment adjustment in 2019 and those who choose to participate for the full calendar year will be eligible for maximum positive adjustment in 2019.

Quality Measures: Quality Performance Category

CMS has approved over three hundred quality measures for MIPS reporting in 2017, but many of these will not be relevant to geriatrics. To assist your selection, the AGS has compiled a list of quality measures most likely to be relevant to geriatrics healthcare professionals as follows[3]:

[3] *NOTE:* The quality measures above are suggestions based on the workgroup's review. Individual clinicians or practices may find other measures better fit their practice. These measures are not part of an official CMS-designated Specialty Measure Set or developed or endorsed by the AGS.

Measure Name	Measure Description	NQF/ Quality ID	NQS Domain	Measure Type	High Priority	Data Submission Type	Primary Measure Steward
Medication Reconciliation Post Discharge	The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: – Reporting Criteria 1: 18-64 years of age – Reporting Criteria 2: 65 years and older – Total Rate: All patients 18 years of age and older	97/46	Communication and Care Coordination	Process	Yes	Claims, CMS Web Interface, Registry	National Committee for Quality Assurance
Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	326/47	Communication and Care Coordination	Process	Yes	Claims, Registry	National Committee for Quality Assurance
Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months	N/A/48	Effective Clinical Care	Process	No	Claims, Registry	National Committee for Quality Assurance
Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months	N/A/50	Person and Caregiver-Centered Experience and Outcomes	Process	Yes	Claims, Registry	National Committee for Quality Assurance

Measure Name	Measure Description	NQF/ Quality ID	NQS Domain	Measure Type	High Priority	Data Submission Type	Primary Measure Steward
Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	41/110	Community/ Population Health	Process	No	Claims, CMS Web Interface, EHR, Registry	PCPI
Pneumococcal Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	43/111	Community/ Population Health	Process	No	Claims, CMS Web Interface, EHR, Registry	National Committee for Quality Assurance
Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	419/130	Patient Safety	Process	Yes	Claims, EHR, Registry	Centers for Medicare & Medicaid Services
Falls: Risk Assessment	Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months	101/154	Patient Safety	Process	Yes	Claims, Registry	National Committee for Quality Assurance
Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	22/238	Patient Safety	Process	Yes	EHR, Registry	National Committee for Quality Assurance
Dementia: Cognitive Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period	281	Effective Clinical Care	Process	No	EHR	PCPI

ADDITIONAL RESOURCES

Online

- AGS MACRA Toolkit
- CMS Quality Payment Program Website

Acronym Glossary

Acronym	Definition
APMs	Advanced Alternative Payment Models
CMS	Centers for Medicare & Medicaid Services
CPS	Composite Performance Score
EC	Eligible Clinician
EHR	Electronic Health Record
MACRA	Medicare Access & CHIP Reauthorization Act of 2015
MIPS	Merit-Based Incentive Payment System
PQRS	Physician Quality Reporting System
QPP	Quality Payment Program
QCDR	Qualified Clinical Data Registries
QDR	Qualified Data Registry
SGR	Sustainable Growth Rate