Using QPP Data Analytics to Impact Strategic Decision Making and Maximize MIPS Scores

Webinar | September 27, 2018

Bruce Maki, MA
M-CEITA / ALTARUM
Regulatory & Incentive Program Analyst

Jacob Makowski, MSN, RN
QPP Resource Center & MIPScast® / ALTARUM
Senior Health Informatics Analyst
Agenda

• Brief overview of the Quality Payment Program
• MIPS Final Score and the Performance Threshold
• What do you need to maximize scores?
• Group vs Individual Reporting
• MIPS Performance Category Considerations & Using a MIPS Data Analytics Tool to Track, Evaluate and Inform
  • Promoting Interoperability data analytics
  • Quality performance category data analytics
  • Improvement Activities data analytics
  • Cost Performance category considerations
• MIPS Final Score data analytics and improvement strategies
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides two participation tracks:

- **MIPS**
  - The Merit-based Incentive Payment System (MIPS)
  - *If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.*

- **Advanced APMs**
  - Advanced Alternative Payment Models (Advanced APMs)
  - *If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.*
MIPS Year 2 (2018)
Calculating the Final Score

- Comprised of four performance categories in 2018.
- **So what?** The points from each performance category are added together to give you a MIPS Final Score.
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.
• The Performance Threshold increase from 3 to 15 points raises the bar for 2018 and will be increased again in 2019 (proposed threshold = 30)

<table>
<thead>
<tr>
<th>Transition Year (2017) Final</th>
<th>Year 2 (2018) Final</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Final Score 2017</strong></td>
<td><strong>Payment Adjustment 2019</strong></td>
</tr>
</tbody>
</table>
| >70 points       | - Positive adjustment  
                 - Eligible for exceptional performance bonus—minimum of additional 0.5% | ≥70 points | N | - Positive adjustment greater than 0%  
                 - Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 4-69 points      | - Positive adjustment  
                 - Not eligible for exceptional performance bonus | 15.01-69.99 points | Y | - Positive adjustment greater than 0%  
                 - Not eligible for exceptional performance bonus |
| 3 points         | - Neutral payment adjustment | 15 points | Y | - Neutral payment adjustment |
| 0 points         | - Negative payment adjustment of -4%  
                 - 0 points = does not participate | 3.76-14.99 points | Y | - Negative payment adjustment greater than -5% and less than 0% |
|                  |                      | 0-3.75 points | Y | - Negative payment adjustment of -5% |
MIPS Year 2 (2018)
Reporting Options

OPTIONS

Individual
1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

Group
2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

Virtual Group
3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.
What’s needed to Maximize Scores?

• Clinicians and Orgs need to **track** several categories of information

• They need to **understand** performance changes over time
  • Final Scores & Category Scores

• They need to **evaluate** reporting options to determine best approach
  • Different measures available, specifications vary, benchmarks vary

• They need to **identify** areas of strength and weakness as well as track the effect of improvement efforts

• **Potential solution?**
  • Clinicians and Orgs need to track, organize and evaluate these data, putting them in the proper context to **maximize** MIPS scores
MIPS Analytic Tools

• Example Applications:
  • MIPScast®
  • MyMipsScore™
  • Stratis Health MIPS Estimator
  • Purdue Healthcare Advisors MIPS Calculator

MIPScast®

• Quality Measure data or MIPS score predictions for >4,500 clinicians
  • GLPTN, QPP SURS, and Commercial Consulting
  • Data is either manually entered or imported via a QRDA III file or QR/QCDR xml file
  • Almost 2000 MIPS scores analyzed
Group vs Individual Reporting?

- Consider differences in Medicare volume relative to MIPS scores?
  - If your top performers also bill the most Medicare, group reporting could hurt the bottom line more than individual reporting *(top performer scores drop when aggregating scores with lower performers)*
  - If your lower performers bill the most Medicare, group reporting could be advantageous since their scores will be higher under group reporting *(their scores rise due to higher performers)*

<table>
<thead>
<tr>
<th>Provider</th>
<th>Medicare Volume</th>
<th>MIPS Scores A</th>
<th>MIPS Scores B</th>
<th>Group MIPS Score = 55.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$500,000</td>
<td>99</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>$500,000</td>
<td>99</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>$200,000</td>
<td>50</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>$150,000</td>
<td>20</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>$100,000</td>
<td>10</td>
<td>99</td>
<td></td>
</tr>
</tbody>
</table>

Assessment: Group Reporting = BAD, Group Reporting = GOOD
Group vs Individual Reporting?

• However, from the “Group Participation in the Merit-based Incentive Payment System (MIPS) in 2018” resource on qpp.cms.gov, we know:

  A group electing to submit data at the group level would have its performance assessed and scored across the TIN, which could include covered professional services furnished by individual NPIs within the TIN who are not required to participate in MIPS. A MIPS eligible clinician participating via a group will get the group’s score. However, if the same MIPS eligible clinician also submits individual level data, CMS will use the higher of the two final scores for that clinician.

• So with this in mind, the best overall strategy is:
  • **Always Group report!**

Then, if an EC can report individually *(not an option for ACO participants)* and his/her individual MIPS Final Score is better than the group score, ALSO report that clinician’s individual data to CMS.

With this strategy:

• Lower performer scores are raised by the higher group score, and
• Higher performers are not negatively affected by lower performers, because CMS will adjust reimbursement rates off their better individual scores instead of the lower group score.
Promoting Interoperability (PI) Category Scoring

Base Score
- Earns 50 POINTS of the total Promoting Interoperability Performance Category Score

Performance Score
- Makes up to 90 POINTS of the total Promoting Interoperability Performance Category Score

Bonus Points
- Earn up to an add’l 15 POINTS in the total Promoting Interoperability Performance Category Score

Category Score
- Earn 100 or more points and receive the full 25 POINTS in the Promoting Interoperability Category of the MIPS Final Score
## Promoting Interoperability (PI) Base Score

<table>
<thead>
<tr>
<th>2018 PI/ACI Transition Objectives</th>
<th>2019+ PI/ACI Objectives (2015 CEHRT/Stage 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>eRx</td>
<td>eRx</td>
</tr>
<tr>
<td>Health Information Exchange (Create/Send Summary of Care)</td>
<td>Send Summary of Care (Patient Care Record Exchange)</td>
</tr>
<tr>
<td>Security Risk Analysis</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Provide Patient Access (Patient Access)</td>
<td>Provide Patient Access (Patient Access)</td>
</tr>
</tbody>
</table>

**Base Score**
- Earns **50 POINTS** of the total Promoting Interoperability Performance Category Score
## PI Performance Score

### PI/ACI Transition Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>20 pts</td>
</tr>
<tr>
<td>View Download Transmit</td>
<td>10 pts</td>
</tr>
<tr>
<td>Patient-specific Information</td>
<td>10 pts</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>10 pts</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>20 pts</td>
</tr>
</tbody>
</table>

### PI/ACI Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>10 pts</td>
</tr>
<tr>
<td>View Download Transmit</td>
<td>10 pts</td>
</tr>
<tr>
<td>Patient-specific Information</td>
<td>10 pts</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>10 pts</td>
</tr>
<tr>
<td>Send a Summary of Care</td>
<td>10 pts</td>
</tr>
<tr>
<td>Request/Accept a Summary of Care</td>
<td>10 pts</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>10 pts</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>10 pts</td>
</tr>
<tr>
<td>Patient-generated Health Data</td>
<td>10 pts</td>
</tr>
</tbody>
</table>
Calculating PI Performance

How is the Performance Score Calculated?
The performance score is calculated by using the numerators and denominators submitted for measures included in the performance score, or for one measure, by the yes or no answer submitted.

The potential total performance score is 90%. For each measure with a numerator/denominator, the percentage score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures reported under the 2018 Transition Measures, which are worth up to 20 percentage points.

<table>
<thead>
<tr>
<th>Performance Rates for Each Measure Worth Up to 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Rate 1-10 = 1%</td>
</tr>
<tr>
<td>Performance Rate 11-20 = 2%</td>
</tr>
<tr>
<td>Performance Rate 21-30 = 3%</td>
</tr>
<tr>
<td>Performance Rate 31-40 = 4%</td>
</tr>
<tr>
<td>Performance Rate 41-50 = 5%</td>
</tr>
<tr>
<td>Performance Rate 51-60 = 6%</td>
</tr>
<tr>
<td>Performance Rate 61-70 = 7%</td>
</tr>
<tr>
<td>Performance Rate 71-80 = 8%</td>
</tr>
<tr>
<td>Performance Rate 81-90 = 9%</td>
</tr>
<tr>
<td>Performance Rate 91-100 = 10%</td>
</tr>
</tbody>
</table>

Example: If a MIPS eligible clinician submits a numerator and denominator of 85/100 for the Patient-Specific Education measure, their performance rate would be 85%, and they would earn 9 out of 10 percentage points for that measure.
Calculating the “Base” PI Category Score

<table>
<thead>
<tr>
<th>BASE MEASURES</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Performance Score</th>
<th>Threshold</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>eRx</td>
<td>2718</td>
<td>2827</td>
<td>96%</td>
<td>Numerator &gt;/= 1 Patient</td>
<td>YES</td>
</tr>
<tr>
<td>VDT - Access</td>
<td>429</td>
<td>432</td>
<td>99%</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>HIE/SoC</td>
<td>21</td>
<td>83</td>
<td>25%</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>SRA</td>
<td>N/A</td>
<td>N/A</td>
<td>YES</td>
<td>Yes/No</td>
<td>YES</td>
</tr>
<tr>
<td><strong>TOTAL BASE SCORE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>
Calculating the “Performance” PI Category Score

<table>
<thead>
<tr>
<th>PERFORMANCE MEASURES</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Performance Score</th>
<th>Decile Score</th>
<th>Performance Weighting</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIE/SoC</td>
<td>21</td>
<td>83</td>
<td>25%</td>
<td>3</td>
<td>Up to 20%</td>
<td>6%</td>
</tr>
<tr>
<td>VDT - Access</td>
<td>429</td>
<td>432</td>
<td>99%</td>
<td>10</td>
<td>Up to 20%</td>
<td>20%</td>
</tr>
<tr>
<td>VDT - Use</td>
<td>186</td>
<td>432</td>
<td>43%</td>
<td>5</td>
<td>Up to 10%</td>
<td>5%</td>
</tr>
<tr>
<td>Patient Education</td>
<td>418</td>
<td>432</td>
<td>97%</td>
<td>10</td>
<td>Up to 10%</td>
<td>10%</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>307</td>
<td>332</td>
<td>92%</td>
<td>10</td>
<td>Up to 10%</td>
<td>10%</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>31</td>
<td>432</td>
<td>7%</td>
<td>1</td>
<td>Up to 10%</td>
<td>1%</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>N/A</td>
<td>N/A</td>
<td>YES</td>
<td>N/A</td>
<td>0 or 10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**TOTAL PERFORMANCE SCORE** 62%
Calculating the Overall PI Category Score

<table>
<thead>
<tr>
<th>BONUS MEASURES</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Performance Rate</th>
<th>Performance Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Public Health Reporting</td>
<td>N/A</td>
<td>N/A</td>
<td>YES</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Report Specific IA using CEHRT (See Fact Sheet for List)</td>
<td>N/A</td>
<td>N/A</td>
<td>NO</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL BONUS SCORE</strong></td>
<td><strong>5%</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring Example Totals:
- Base 50%
- Performance 62%
- Bonus 5% *(bonus pts often not needed)*

Total PI Score: 117%, capped at 100%

EC would earn the maximum 25 PI points towards total MIPS Final Score
Category Scoring

- Base Score
- Performance Points
- Bonus Points
- Exclusions

**Measure** | **Numerator** | **Denominator** | **%** | **Performance Points**
--- | --- | --- | --- | ---
E-Prescribing* | 3173 | 3541 | 89.60 | N/A
Health Information Exchange* | 2 | 2236 | 0.08 | 2
• Mean Score: 65.94%
• 2.4% selected re-weight
• Among those who reported required measures and earned Base Points:
  • Mean Score: 92.89
  • Mean Bonus: 4.84
  • Mean Performance: 42.56

• Among the 29% who scored 0 points*, most (65.9%) had entered data that would have earned performance or bonus points had the required measures been entered.

*HIE exclusion added on 11/22/17 – some scores were not updated since exclusions were added.
Score distribution clearly shows that most practices/clinicians fall into 2 buckets:
- Do not have CEHRT / not reporting required measures = 0 points
- Performing well, at or near maximum score for category

Most clinicians who met MU in previous years will earn full credit in this category

Report all measures – even measures that previously did not meet MU pass/fail thresholds earn points in MIPS

For most, this category will be weighted at 25% or 30% in 2018. This means that going from 0 points to 90+ points in the category is a 22-30 point swing in the Final Score.

Unless your Quality Category is scoring at <50% (and even then), this will likely be your primary focus if you are presently scoring 0 points.
Quality Performance Category Considerations

• Use your patient population to guide measure selection
  • Pick clinically relevant measures (if you can)
  • What’s important to you and/or aligns with practice goals?
  • Specialty measure sets may not be your best option
  • Registries can also create/use their own measures (aka non-mips measures)
    • Good for Specialists with limited measure options

• Low quality measure scores could be caused by:
  • Vendor issues
  • Configuration issues (i.e. LOINC code not properly mapped)
  • Data entry issues
  • Actual “quality” issues

• Data submission options matter under the Quality performance category
  • Benchmarks
  • Consider cost of submission option
  • More measure options via “Registry” than “EHR/eCQM”

• Topped Out measures
# MIPS Data Submission Options

- Different data submission options don’t affect the MIPS Final Score...except for Quality

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Mechanisms for Individuals</th>
<th>Submission Mechanisms for Groups (Including Virtual Groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>QCDR Qualified Registry EHR Claims</td>
<td>QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Cost</td>
<td>Administrative claims (no submission required)</td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Attestation QCDR Qualified Registry EHR</td>
<td>Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>Attestation QCDR Qualified Registry EHR</td>
<td>Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>

---

Please note:

- Continue with the use of **1 submission mechanism per performance category in Year 2 (2018)**. Same policy as Year 1.

- **The use of multiple submission mechanisms per performance category is deferred to Year 3 (2019).**
Data Submission Options Change Quality Scores

Formula = \( x + (q-a) / (b-a) \)
Your Performance Rate = 62

<table>
<thead>
<tr>
<th>CLAIMS</th>
<th>EHR</th>
<th>REGISTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \frac{x + (q-a)}{b-a} )</td>
<td>( \frac{x + (q-a)}{b-a} )</td>
<td>( \frac{x + (q-a)}{b-a} )</td>
</tr>
<tr>
<td>( 5 + (62 - 46.94) / (62.62 - 46.94) )</td>
<td>( 8 + (62 - 52.14) / (63.12 - 52.14) )</td>
<td>( 6 + (62 - 57.07) / (64.78 - 57.07) )</td>
</tr>
<tr>
<td>5 + (15.06) / (15.68)</td>
<td>8 + (9.86) / (10.98)</td>
<td>6 + (4.93) / (7.71)</td>
</tr>
<tr>
<td>5 + 0.960</td>
<td>8 + .897</td>
<td>6 + .639</td>
</tr>
</tbody>
</table>

Total Points Awarded: 5.96
Total Points Awarded: 8.90
Total Points Awarded: 6.64

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure ID</th>
<th>Submission Method</th>
<th>Decile_3</th>
<th>Decile_4</th>
<th>Decile_5</th>
<th>Decile_6</th>
<th>Decile_7</th>
<th>Decile_8</th>
<th>Decile_9</th>
<th>Decile_10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care &amp; Screening: Influenza Immunization</td>
<td>110</td>
<td>Claims</td>
<td>23.29 -</td>
<td>33.14 -</td>
<td>46.94</td>
<td>62.63 -</td>
<td>74.36 -</td>
<td>86.05 -</td>
<td>97.34 -</td>
<td>99.99 -</td>
</tr>
<tr>
<td>Preventive Care &amp; Screening: Influenza Immunization</td>
<td>110</td>
<td>EHR</td>
<td>14.55 -</td>
<td>21.84 -</td>
<td>29.01 -</td>
<td>36.00 -</td>
<td>43.54 -</td>
<td>52.14 -</td>
<td>63.13 -</td>
<td>&gt;= 78.43</td>
</tr>
<tr>
<td>Preventive Care &amp; Screening: Influenza Immunization</td>
<td>110</td>
<td>Registry/CDR</td>
<td>26.89 -</td>
<td>40.49 -</td>
<td>50.00 -</td>
<td>57.07</td>
<td>64.79 -</td>
<td>73.08 -</td>
<td>82.71 -</td>
<td>&gt;= 96.44</td>
</tr>
</tbody>
</table>

\( x = \text{decile column} \quad q = \text{your performance rate} \quad a = \text{low-end of decile column} \quad b = \text{high-end of decile column} \)

How you report your quality data to CMS could have a significant effect on your MIPS Final Score!
“Topped Out” and “Topped Out Capped” Quality Measures

What is the significance?

- A measure may be considered topped out if meaningful distinctions and improvement in performance can no longer be made.
- Topped out measures could have an impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

Topped Out Measures:

- Topped-out measures will be removed and scored on 4 year phasing out timeline.
- Topped out measures with measure benchmarks that have been topped out for at least 2 consecutive years will receive up to 7 points.
- The 7-point scoring policy for the 6 topped out measures identified for the 2018 performance period is finalized. These measures are identified on the next slide.
- Topped out measures will only be removed after a review of performance and additional considerations.
- Topped out policies do not apply to CMS Web Interface measures, but this will be monitored for differences with other submission options.

“Topped Out Capped” Quality Measures in 2018

What is the significance?

- A measure may be considered topped out if meaningful distinctions and improvement in performance can no longer be made.
- Topped out measures could have an impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

Topped Out Measures:

The six topped out measures include the following:

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21)
- Melanoma: Overutilization of Imaging Studies in Melanoma. (Quality Measure ID: 224)
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23)
- Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262)
- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359)
- Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52)

Be Wary of Using “Topped Out” Quality Measures

• Several measures are topped out but not yet capped at 7pts:

  CMS 68: Documentation of Current Medications in the Medical Record (QPP 130)

<table>
<thead>
<tr>
<th>Submission Method</th>
<th>Measure Type</th>
<th>Benchmark</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
<th>Topped Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Process</td>
<td>Y</td>
<td>96.11 - 98.73</td>
<td>98.74 - 99.64</td>
<td>99.65 - 99.99</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>100</td>
</tr>
<tr>
<td>EHR</td>
<td>Process</td>
<td>Y</td>
<td>76.59 - 87.88</td>
<td>87.89 - 92.73</td>
<td>92.74 - 95.35</td>
<td>95.36 - 97.08</td>
<td>97.09 - 98.27</td>
<td>98.28 - 99.13</td>
<td>99.13 - 99.75</td>
<td>&gt;=99.76 Yes</td>
<td></td>
</tr>
<tr>
<td>Registry/QCDR</td>
<td>Process</td>
<td>Y</td>
<td>61.27 - 82.11</td>
<td>82.12 - 91.71</td>
<td>91.72 - 96.86</td>
<td>96.87 - 99.31</td>
<td>99.31 - 99.99</td>
<td>--</td>
<td>--</td>
<td>100</td>
<td>Yes</td>
</tr>
</tbody>
</table>

• Although not yet topped out, scoring options are limited for many measures:

  CMS 2: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (QPP 1)

<table>
<thead>
<tr>
<th>Submission Method</th>
<th>Measure Type</th>
<th>Benchmark</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
<th>Topped Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Process</td>
<td>Y</td>
<td>11.54 - 30.67</td>
<td>30.68 - 62.06</td>
<td>62.09 - 94.03</td>
<td>94.04 - 99.45</td>
<td>99.46 - 99.99</td>
<td>--</td>
<td>--</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>EHR</td>
<td>Process</td>
<td>Y</td>
<td>1.22 - 2.93</td>
<td>2.94 - 5.93</td>
<td>5.94 - 11.09</td>
<td>11.09 - 17.87</td>
<td>17.88 - 30.29</td>
<td>30.29 - 51.32</td>
<td>51.32 - 72.63</td>
<td>&gt;=72.64 No</td>
<td></td>
</tr>
<tr>
<td>Registry/QCDR</td>
<td>Process</td>
<td>Y</td>
<td>2.01 - 5.26</td>
<td>5.27 - 14.88</td>
<td>14.89 - 32.90</td>
<td>32.91 - 50.42</td>
<td>50.42 - 64.98</td>
<td>64.98 - 85.25</td>
<td>85.25 - 99.99</td>
<td>100 No</td>
<td></td>
</tr>
</tbody>
</table>

Quality Category
MIPScast® scoring support

- Scoring Measures
  - Reporting Methods
  - Benchmarks (or lack thereof)
  - Required Measure
  - Data Completeness
  - Minimum Cases
  - Bonus Points
    - Outcome/High Priority
    - Electronically Reported

![Scoring Measures Table]

**Category Score**
84.67%

![MIPScast® Scoring Screen]

**Registry** 24.9/60 Points 41.50%

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>N</th>
<th>ID</th>
<th>%</th>
<th>Decile</th>
<th>Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Measure Unreported</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>238</td>
<td>0</td>
<td>200</td>
<td>0.00%</td>
<td>10.0</td>
<td>0</td>
</tr>
<tr>
<td>317</td>
<td>355</td>
<td>836</td>
<td>42.46%</td>
<td>4.6</td>
<td>0</td>
</tr>
<tr>
<td>130</td>
<td>748</td>
<td>881</td>
<td>84.90%</td>
<td>4.3</td>
<td>0</td>
</tr>
<tr>
<td>431</td>
<td>13</td>
<td>35</td>
<td>37.14%</td>
<td>3.0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Performance**
Performance % = Numerator / (Denominator - Excl - Excep)
Data Completeness % = None

**Reported Measure Info**

<table>
<thead>
<tr>
<th>Identiﬁer</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Excl</th>
<th>Excep</th>
<th>Performance %</th>
<th>Data Completeness %</th>
<th>Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>465</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>21.85</td>
<td>100.00</td>
<td>true</td>
</tr>
<tr>
<td>Calc</td>
<td>99</td>
<td>463</td>
<td></td>
<td></td>
<td>21.85</td>
<td>100.00</td>
<td>true</td>
</tr>
</tbody>
</table>

**Scoring Rule Info**

<table>
<thead>
<tr>
<th>Min. Cases (50)</th>
<th>Min. Data % (50)</th>
<th>Inverse</th>
<th>Benchmark</th>
<th>Outcome/HP</th>
<th>Topped Out/Capped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass</td>
<td>Pass</td>
<td>False</td>
<td>Present</td>
<td>False</td>
<td>False</td>
</tr>
</tbody>
</table>

**Benchmark Data**

<table>
<thead>
<tr>
<th>Decile</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.22</td>
<td>31.92</td>
<td>31.93</td>
<td>35.34</td>
<td>35.35</td>
<td>38.76</td>
<td>38.77</td>
<td>42.88</td>
<td>42.89</td>
<td>49.19</td>
<td>64.63</td>
</tr>
</tbody>
</table>

![Additional MIPScast® Scoring Information]
Quality Category
Analysis of Data

- Average Score: 61.76%
- Average Bonus Points 2.06 (out of up to 12)
- Only 2 instances (0.2%) where practice/clinician highest score was a specialty measure set
- Required Outcome* measure reported: 72.5%
  - Category score when reported: 69.2%
  - Category score when not reported: 42.1%

*or High Priority if no Outcome available

• Reporting Method

<table>
<thead>
<tr>
<th>Method</th>
<th>% of Scores</th>
<th>Avg. Score</th>
<th>Avg. Bonus</th>
<th>Outcome Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR</td>
<td>67.1%</td>
<td>65.9%</td>
<td>2.46</td>
<td>82.97%</td>
</tr>
<tr>
<td>Registry</td>
<td>30.2%</td>
<td>52.81%</td>
<td>1.17</td>
<td>47.1%</td>
</tr>
<tr>
<td>Claims</td>
<td>2.7%</td>
<td>59.33%</td>
<td>2.05</td>
<td>95%</td>
</tr>
</tbody>
</table>

Distribution of Quality Scores

Count of TIN/NPI

Quality Score Range

0-10: 16
10-20: 19
20-30: 29
30-40: 73
40-50: 89
50-60: 120
60-70: 117
70-80: 96
80-90: 82
90-100: 103
Quality Category
Strategies to Improve Scores

• Report all available measures
  • Measures beyond your “top 6” can earn bonus points
    • Even a low scoring high priority/outcome measure still earns bonus points
  • Measures without a benchmark are worth 3 points, but could earn much more if a benchmark is established
  • Not reporting an Outcome measures can really hurt your score
  • Report electronically end-to-end if possible (up to 10% bonus)
• Focus on 1 or 2 measures to improve
• Usually the greatest gains are available for the 5th or 6th best measures
• Pick measures that:
  • Are not already near 100% performance
  • Are not “topped out”
  • May be improved just through better documentation

Example:
• Required measure missing is costing at least 5 points
• Would not focus on measure 130 (very difficult to score well with <99% performance)
• Measures 317 & 431 are both screening and follow-up/counseling measures where improvement can be made
• Submitting only 6 measures. If Registry has more measures available, score could greatly increase
Improvement Activities (IA) Performance Category Considerations

• 15% of Final Score in 2018

• 112 activities available from which to choose
  ➢ Attesting to activity being implemented for at least 90 days in the program year
  ➢ If still implemented, can attest to the same activities from year to year

• 40 pts to maximize category
  ➢ Medium weight = 10 pts
  ➢ High weight = 20 pts
  ➢ Point values are doubled for Small Practice ECs/Groups

• A simple “yes” is all that’s required to completing an Improvement Activity

• Certain IAs earn PI bonus points

• For group reporting (and virtual groups), only (1) MIPS EC in a TIN (or virtual group) must perform the IA for the TIN (or virtual group) to receive credit.

• PCMH: the term “recognized” is equivalent to the term “certified” as a PCMH or comparable specialty practice
  ➢ Additionally, 50% of practice sites within a TIN (or TINs in a virtual group) need to be recognized as PCMH for the TIN (or virtual group) to receive full IA category credit
Category Scoring

• Small, Rural, and HPSA practices/clinicians *(and now non-patient facing for 2018)*
• PCMH
• Participating in an APM
• Participating in CMS study on burdens
• Selection of medium or high weight activities

**Category Score**
75.00%
30 / 40

- Most participants - Attest that you completed up to 4 improvement activities for a minimum of 90 days.
- Groups with fewer than 15 participants, in a rural or health professional shortage area, or non-patient facing clinicians - Attest that you completed up to 2 activities for a minimum of 90 days.
- Participants in certified/recognized patient-centered medical home - You will automatically earn full credit. *(note: at least 50% of practices within a TIN need to be patient-centered medical homes for that TIN to get full credit)*
- Participants in an APM - You will automatically earn full credit. MIPS APMs will receive a full score for the improvement activities performance category. Most Advanced APMs are also MIPS APMs.
- Participated in CMS study on Burdens Associated with Reporting Quality Measures

<table>
<thead>
<tr>
<th>Activity Name</th>
<th>Subcategory</th>
<th>Weight</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide 24/7 access to eligible clinicians</td>
<td>Expanded Practice Access</td>
<td>High</td>
<td>20</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>Behavioral and Mental Health</td>
<td>Medium</td>
<td>10</td>
</tr>
</tbody>
</table>
Mean Score: 95%
Most common activities selected other than TCPI (GLPTN participants) were 24/7 access, CAHPS, Tobacco Use, and Depression Screening
62% Small/Rural/HPSA
9% PCMH

### Activity Analysis

<table>
<thead>
<tr>
<th>Count</th>
<th>Activity Name</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>406</td>
<td>TCPI participation</td>
<td>High</td>
</tr>
<tr>
<td>116</td>
<td>Provide 24/7 access to eligible clinicians or groups who have real-time access to patient’s medical record</td>
<td>High</td>
</tr>
<tr>
<td>77</td>
<td>Participation in CAHPS or other supplemental questionnaire</td>
<td>High</td>
</tr>
<tr>
<td>42</td>
<td>Tobacco use</td>
<td>Medium</td>
</tr>
<tr>
<td>28</td>
<td>Depression screening</td>
<td>Medium</td>
</tr>
<tr>
<td>26</td>
<td>Practice improvements for bilateral exchange of patient information</td>
<td>Medium</td>
</tr>
<tr>
<td>22</td>
<td>Implementation of use of specialist reports back to referring clinician or group to close referral loop</td>
<td>Medium</td>
</tr>
<tr>
<td>20</td>
<td>Consultation of the Prescription Drug Monitoring program</td>
<td>High</td>
</tr>
</tbody>
</table>

#### Distribution of IA Scores

![Distribution of IA Scores](image)
Most practices/clinicians were able to get full credit (100% or 40 points)

Those scoring 0 points did not document any activities in MIPScast®

Practices/clinicians analyzed are mostly TCPI/GLPTN, small, rural or HPSA, and they are choosing these activities:
  - Provide 24/7 access to eligible clinicians or groups who have real-time access to patient’s medical record
  - Participation in CAHPS or other supplemental questionnaire
  - Tobacco use
  - Depression screening
  - Practice improvements for bilateral exchange of patient information
  - Implementation of use of specialist reports back to referring clinician or group to close referral loop
  - Consultation of the Prescription Drug Monitoring program
Cost Performance Category Considerations

- 10% of MIPS Final Score in 2018; will increase over time until worth 30%
- 10 episode-based measures adopted in 2017 are not being used in 2018
  - This year’s cost category score will be the average of:
    - Medicare Spending per Beneficiary (MSPB) measure (35+ episodes needed), and
    - Total per Capita Cost (TPCC) (20+ episodes needed) measure
  - If only one can be scored for an EC, it will serve as the category score
  - Calculated via Administrative Claims (no add’l submission requirement)
- Prior year data can be found on PQRS/Quality Resource Use Report (QRUR) which can be accessed via QualityNet.org (practice level, not provider level data)
- Although not used in 2017, CMS provided feedback which can be used to evaluate current state
  - Note: 2018 comparison for scoring done in same performance year, not previous year benchmarks
- “Double dip” by choosing related quality measures so improvements there also affect your cost performance category
- Keep in mind, with only a 10% weight in 2018, a significant/notable 10% increase in the category will only amount to a 1% increase in MIPS Final Score. Until it’s worth more (and we know more), improvement efforts may be better focused in areas with greater impact
MIPS Final Score
MIPScast® Scoring Support

- Scoring each category and weighting appropriately
- APM alternate weights
- Visual feedback on each category
- Download PDF report
- Run multiple scenarios
- Track progress over time
- Save and finish later
MIPS Final Score
Data Analysis

• All previous data was analyzing 1 score per TIN/NPI
• We evaluated high score, and were looking at either “Complete” scores, or incomplete scores >15
• Does not include CMS Web Interface Reporting Method
• 6.7% indicated APM participation
• Mean Score: 67.52
• Median Score: 70.5
Highest correlation between category or category subcomponent and final score were

- Quality category % and Final Score (0.84)
- PI category % and Final Score (0.704)
- No strong correlation for IA category or for bonus points in PI or Quality.
- No strong or medium correlations between categories (*i.e. those with high Quality scores don’t necessarily have high PI scores, etc.*)
MIPS Final Score
Strategies to Improve Scores

• Practices/clinicians who are low performers cannot improve every category, all at once
• Prioritize which category will have the biggest impact
• IA category was lowest weight in 2017, but there may be some “low hanging fruit” in the list of activities that practices are having success implementing
• Cost category in 2018 is 10% weight and you won’t know where you are performing until the end of the year (score is based on 2018 claims, not prior year benchmark)
MIPS Final Score
Strategies to Improve Scores

• Biggest improvement (and highest correlation with Final Score success) is in **PI** and **Quality** Categories

• If your PI category is at 0 points, start there. If you have CEHRT but were not previously a Meaningful User, you can earn significant points in the MIPS program if you have minimum data required

• Before you do any deep dives on Quality Measure improvement, contact your Registry or EHR to see how many measures you can report. Reporting more than 6 measures may earn you additional bonus points or uncover a hidden gem in a measure currently without a benchmark

• Remember, if you submit more than one set of data (i.e. via claims and EHR), CMS will score both and use whichever is more advantageous

• Identify 1-2 quality measures that have opportunity for measurable improvement (not topped out, has a benchmark, ability to report)
In Summary...

- Participating in MIPS requires a great deal of data collection and analysis with multiple facets and options which affect scoring.
- ECs need to track several categories of information, some of which may overlap and affect other categories.
- ECs need to track change over time.
- ECs need to evaluate the various reporting options and how they each affect the MIPS Final Score.
- ECs need to identify areas of strength and weakness to determine the best improvement strategy.
- While you CAN do some of this manually, find and use a tool that can track, trend and analyze your data to help you boost scores.
Technical Assistance
Available Resources and Organizations...FOR FREE

• Practices With More Than 15 Billing Clinicians
  • You can request technical assistance from the Quality Innovation Networks - Quality Improvement Organizations (QIN-QIOs).

  Holly Standhardt
  Quality Program Manager
  MPRO, Helping Healthcare Get Better
  22870 Haggerty Road, Suite 100 | Farmington Hills, MI 48335
  hstandhart@mpro.org
  www.mpro.org

• Small, Underserved and Rural Practices
  • qppinfo@altarum.org
  • qppresourcecenter.org
How satisfied are you with the information we provided today?
(On a scale from 1 to 5 – with 5 being Very Satisfied)
Questions?

www.qppresourcecenter.org
qppinfo@altarum.org

Bruce Maki
bruce.maki@altarum.org
734-302-4744

Jacob Makowski
jacob.makowski@altarum.org
734-302-4789