Key Decisions to Optimize Your MIPS Quality Score
Speakers

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Agenda

• What’s Happening in the Field
• Concept Map for Optimizing MIPS Quality
• Top 3 MIPS Quality Decisions
• Q & A
What’s Happening in the Field

• CMS MIPS eligibility tool released
• 2018 QPP Proposed Rule coming soon
• Provider organizations making decisions to optimize the MIPS Quality category score. Importance:
  • Financial
  • Reputational
  • Score permanently attached to clinicians
Why Revisit Your 2016 Quality (PQRS) Decisions?

• Changed from all-or-nothing/pay-for-reporting to MIPS continuous scoring scale and pay-for-performance

• PQRS reporting methods and measures have changed
  • e.g. no registry measures groups

• Pitfalls of not revisiting PQRS decisions:
  • Not checking for EHR vendor support
  • Under-scoping or over-scoping the set of required data sources
  • Underestimating data extraction time and cost
  • Defaulting to CMS Web Interface method when less burdensome method is available
  • Staying with measures whose MIPS benchmarks are unfavorable
Concept Map for Optimizing MIPS Quality

MIPS Quality Score

- Financial Impacts
- MIPS Eligibility
- Reporting Method Selection
- Measure Selection
- Performance Monitoring
- MIPS Predictive Analytics
- Measure Leverage Analysis
- Workflow Optimization
- Clinician Engagement
- MIPS Quality Benchmarks
- Data Completeness Requirements
- Individual vs Group
- Administrative Costs
- Data Submission
- Data Sources & Extraction
- Vendor Selection
Top 3 MIPS Quality Decisions:

1. Selecting Reporting Method & Measures
2017 MIPS Quality Reporting Methods

MIPS Category

Quality

Submission Type

EHR Direct
Qualified Registry
QCDR
Claims
Web Interface

Participation Options

Individual
Group
Individual
Group
Individual
Group
Individual
Group
Individual-Clinician vs Group Reporting

• MIPS permits reporting clinicians individually or as a group identified by tax identification number (TIN)
• Differences in administrative effort and cost
• Differential scoring and public exposure of individuals vs a group
• MIPS scores and payment adjustments can vary significantly between the two participation options:
  • Selecting measures for individuals vs for a group
  • Group reporting must include individually-excluded clinicians’ data
  • Individual clinicians may not have sufficient data, while the group does
Benchmark Regulation Review

**Example: Assigning Points Based on Deciles**

<table>
<thead>
<tr>
<th>DECILE</th>
<th>Decile 1</th>
<th>Decile 2</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>Possible POINTS</td>
<td>1.0-1.9</td>
<td>2.0-2.9</td>
<td>3.0-3.9</td>
<td>4.0-4.9</td>
<td>5.0-5.9</td>
<td>6.0-6.9</td>
<td>7.0-7.9</td>
<td>8.0-8.9</td>
<td>9.0-9.9</td>
<td>10</td>
</tr>
</tbody>
</table>

Example of decile breaks for a specific quality measure

Eligible clinician with 19% performance rate would get approximately 3.3 points (based on distribution within the decile).

Eligible clinician with 95% performance rate would get 10 points.

Source: Centers for Medicare and Medicaid Services.
Impact of effort with a Topped-out Measure

Use of Imaging Studies for Low Back Pain (EHR Direct Decile Scale)

<table>
<thead>
<tr>
<th>Decile</th>
<th>Range of Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 3rd</td>
<td>Below 83.12%</td>
</tr>
<tr>
<td>3rd Decile</td>
<td>83.12% to 90.47%</td>
</tr>
<tr>
<td>4th Decile</td>
<td>90.48% to 96.14%</td>
</tr>
<tr>
<td>5th Decile</td>
<td>96.15% to 99.99%</td>
</tr>
<tr>
<td>6th Decile</td>
<td></td>
</tr>
<tr>
<td>7th Decile</td>
<td></td>
</tr>
<tr>
<td>8th Decile</td>
<td></td>
</tr>
<tr>
<td>9th Decile</td>
<td></td>
</tr>
<tr>
<td>10th Decile</td>
<td>100%</td>
</tr>
</tbody>
</table>

Example 1:
Existing Performance 60%
13% INCREASE in performance
Yields only 1 more point

Example 2:
Existing Performance 96%
any INCREASE in performance
Yields less than 1 point
Impact of Effort Based on Different Methods

Flu Vaccine in Older Adults
Claims vs. EHR Direct

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Data Sources and Data Extraction

- Conducting inventory of data sources to meet data completeness requirements is crucial
  - e.g. special rules apply to clinicians on multiple EHRs

- Quality data export capabilities vary widely among certified EHR products

- May be additional vendor fees for data export
  - e.g. cost for EHR QRDA3 file

- May be hidden costs not included in vendor fees
  - e.g. creating custom extracts
### Summary of Method Pros and Cons

<table>
<thead>
<tr>
<th>EHR Direct</th>
<th>Registry/QCDR</th>
<th>CMS Web Interface</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Pros</strong></td>
<td><strong>Pros</strong></td>
</tr>
<tr>
<td>• eCQMs available in all CEHRT</td>
<td>• Many measures available for all provider specialties</td>
<td>• Good for multi-EHR environment</td>
</tr>
<tr>
<td>• Monitoring available throughout the year</td>
<td>• Data can be extracted outside of discrete data fields</td>
<td>• Required for Track 1 ACOs</td>
</tr>
<tr>
<td>• Bonus points for end-to-end reporting</td>
<td>• Multi-EHR environment</td>
<td></td>
</tr>
<tr>
<td><strong>Cons</strong></td>
<td><strong>Cons</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td>• Fewer measures</td>
<td>• Additional costs for submission</td>
<td>• Labor intensive</td>
</tr>
<tr>
<td>• Under represents specialists</td>
<td>• Utilizes staff for data abstraction</td>
<td>• Medicare-only vs. all-payer data</td>
</tr>
<tr>
<td>• Data must be gathered in discrete data fields</td>
<td>• Difficult to monitor throughout the year</td>
<td>• Small % of practice represented</td>
</tr>
</tbody>
</table>

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Measure Selection Factors

• Submitting measures that maximize the Quality score – performance points plus bonus points
• Level of relevance to workflows to drive clinician engagement
• Not all measures may meet data completeness requirements
• Alignment with other quality initiatives or value-based programs – clinicians can only absorb so many measures
The Method & Measure Selection “Decision Spiral”

- Method selection and measure selection are interrelated, so quickly iterate to a decision and start monitoring ASAP
- June 30 CMS deadline to opt into CMS Web Interface method
Top 3 MIPS Quality Decisions:

2. Deciding Which Clinicians to Report
Deciding Which Clinicians to Report: Why It is Important

• Not reporting eligible clinicians thought to be ineligible results in penalties you could've avoided

• For group reporting, not including quality data for individually-excluded clinicians could violate data completeness requirements

• May want to report clinicians who are ineligible in 2017, but will be eligible in 2019 to get CMS MIPS feedback report in Fall 2018

• Clinicians and/or TINs reported and their associated data sources impact administrative costs and return-on-investment
Impacts of Individual-Clinician MIPS Exclusions on Data Completeness Requirements

<table>
<thead>
<tr>
<th>Individual-Clinician MIPS Exclusion</th>
<th>Quality data Required?</th>
<th>ACI data Required?</th>
<th>MIPS EC payment adjustment?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-Year Medicare</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>QPP p212, 2006, 2010</td>
</tr>
<tr>
<td>Individual Reporting:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Reporting</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Volume/$</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>QPP p220, 2003, 2010</td>
</tr>
<tr>
<td>Individual Reporting:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Reporting</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Low Volume/$ calculated at TIN level for Group reporting.</td>
</tr>
<tr>
<td>Advanced APM QP or PQP not opting into MIPS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>QPP p218, 2007, 2009, 2010</td>
</tr>
<tr>
<td>Individual Reporting:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Reporting</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Best Practices for Deciding which Clinicians to Report

1. Aggregate clinician NPIs across TINs, EHRs, and billing systems to derive a consolidated clinician list

2. Validate eligibility using the MIPS eligibility tool (updated twice a year) on the CMS QPP website
   - Eligibility determined per TIN/NPI combination - consult CMS if unsure which TIN each practice name corresponds to

3. For group reporting, include data for individually-excluded clinicians in the group submission

4. For individual reporting, decide which 2017 excluded or ineligible clinicians to report to receive MIPS performance feedback in 2018
Top 3 MIPS Quality Decisions:

3. Identifying Where to Focus Quality Improvement Efforts
## Concept of Measure Leverage

<table>
<thead>
<tr>
<th>Leverage Rank</th>
<th>Measure Title</th>
<th>Performance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hemoglobin A1c Control, Eye Exam</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Influenza Immunization</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Pneumonia Vaccination</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Breast Cancer Screening</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Colorectal Cancer Screening</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Body Mass Index and Follow Up</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Screening for Depression and Follow Up</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Use of Aspirin or Another Antiplatelet</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Tobacco Use Screening and Cessation</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Controlling High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Screening for Fall Risk</td>
<td></td>
</tr>
</tbody>
</table>

### Performance

- **Current Performance**
  - Baseline MIPS Score = 65

- **Improvement on #1 Measure**
  - Improved MIPS Score = 65 + 5 = 70

- **Improvement on #2 Measure**
  - Improved MIPS Score = 65 + 3 = 68
Example of Measure Leverage Identification

Group MIPS score increases per unit of measure performance improvement.

**Measure Leverage Factors:**
• Measure benchmarks
• Current measure performance
• Time left in the performance year
  
  [Diagrams showing varying leverages for different measures]
Other Factors Influencing Where to Apply Improvement Efforts

• Measures aligned with multiple initiatives or programs
• Clinicians’ individual ability or desire to change
• Modality of change
  • e.g. EHR re-configuration versus workflow/behavior change
• Individual-clinician versus group reporting
  • “Write off” certain clinicians or not?
Summary of the Top 3 MIPS Quality Decisions

1. Selecting Reporting Method & Measures
2. Deciding Which Clinicians to Report
3. Identifying Where to Focus Quality Improvement Efforts

Key Takeaway:
These decisions are interrelated and differ compared to pre-MIPS, so revisit them and start monitoring clinician MIPS scores ASAP.
Q & A

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