MIPS Improvement Activities:
Quality Insights Tips, Tools & Support

March 14, 2017
Maureen Kelsey, MA, Quality Insights, Practice Integration Task Lead
MIPS in 2017

• A MIPS score is calculated by adding together scores from 3 performance categories:

Quality + Improvement Activities + Advancing Care Information = MIPS Score

The cost category will be included in the 2018 MIPS score.
2017 Performance Category Weights

- Weights are assigned to each category based on a 100 point scale.

Quality: 60%
Improvement Activities: 15%
Advancing Care Information: 25%

These are default weights but are adjusted in certain circumstances.
MIPS Payment Adjustments in 2017

<table>
<thead>
<tr>
<th>MIPS Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 points</td>
<td>4% negative payment adjustment</td>
</tr>
<tr>
<td>3 points</td>
<td>No payment adjustment</td>
</tr>
<tr>
<td>4-69 points</td>
<td><strong>Positive payment adjustment up to 4%</strong></td>
</tr>
<tr>
<td>≥ 70 points</td>
<td>Positive payment adjustment up to 4% Eligible for exceptional performance bonus with minimum of additional 0.5%</td>
</tr>
</tbody>
</table>

- Completing one Improvement Activity (IA) guarantees that the clinician or group will not receive the 4 percent Medicare penalty in 2019.

- are awarded towards the MIPS score if the requirements of the IA category are met
IA Scoring & Weights in 2017

- 40 points are needed to earn full credit for the IA category.
- Points are awarded based on the WEIGHT of the activity AND the number of clinicians in the practice (whether there are 15 or fewer or more than 15), the location of the practice, and if a clinician is a non-facing clinician.
- Each activity must be completed for a minimum of 90 days to receive credit.

- HIGH weight = 40 points
- MEDIUM weight = 20 points
  - If your practice has ≤15 clinicians
  - If your practice is located in a rural zip code
  - If your practice is located in a health professional shortage area (HPSA)
  - If you are a non-facing eligible clinician

- HIGH weight = 20 points & MEDIUM weight = 10 points
  - If your practice has >15 clinicians
Special Considerations

- These participants earn full credit for the IA category (40 points):
  - Certified Patient Centered Medical Home (PCMH)
  - Comparable specialty practices
  - APM designated as a Medical Home Model
- Medicare Shared Savings Program Track 1 or the Oncology Care Model automatically receive points based on the requirements of the APM.
  - All current APMS under the APM scoring standard will earn full credit for the IA category (40 points).
  - All future APMS under the APM scoring standard will receive at least half credit for the IA category (20 points).
# IA Submission Methods

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attestation</td>
<td>Attestation</td>
</tr>
<tr>
<td>QCDR</td>
<td>QCDR</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>Qualified Registry</td>
</tr>
<tr>
<td>EHR Vendor</td>
<td>EHR Vendor</td>
</tr>
</tbody>
</table>

[Quality Insights logo]
10 Points Toward ACI if All Base Measures Are Met

- Achieving Health Equity: IA_AHE_2
- Beneficiary Engagement: IA_BE_1; 4; 15; and 21
- Integrated Behavioral Health: IA_BMH_7; and 8
- Care Coordination: IA_CC_1; 8; 9; and 13
- Expanded Practice Access: IA_EPA_1
- Patient Safety and Practice Assessment: IA_PSPA_16
- Population Management: IA_PM_2; 4; 13; 14; 15; and 16
IA Categories

- Achieving Health Equity
- Beneficiary Engagement
- Behavioral & Mental Health
- Care Coordination
- Expanded Practice Access
- Emergency Response
- Population Management
- Patient Safety
Improvement Activities Readiness Assessment & Quality Improvement Tracking Tool

Microsoft Excel Worksheet
Instructions – Tab 1

• Each activity must be completed for a minimum of 90 days, unless otherwise specified, i.e. IA_PSPA_5. The maximum score for full credit is 40 points. The maximum score for full credit is 40 points.

• If your practice has 16 or more MIPS eligible clinicians:
  – HIGH weight activities = 20 points
  – MEDIUM weight activities = 10 points

• If your practice has 15 or fewer MIPS eligible clinicians OR if your practice is located in a RURAL zip code OR if your practice is located in a health professional shortage area OR you are a non-facing eligible clinician:
  – HIGH weight activities = 40 points
  – MEDIUM weight activities = 20 points
Instructions – Tab 1 (cont.)

• MIPS eligible clinicians in recognized patient-centered medical homes, comparable specialty practices, or an Advanced Payment Model (APM) designated as a Medical Home Model will automatically earn 40 points.

• MIPS eligible clinicians in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model, will automatically be scored based on the requirements of participating in the APM.
Instructions – Tab 1 (cont.)

• Clinicians in other APMs will automatically earn 20 points, but can complete other activities to increase the score.
• MIPS eligible clinicians earn points by engaging in certain activities with Quality Insights Quality Innovation Network. These activities are highlighted in green text in the tool.
• The second tab of the tool includes a list of RURAL zip codes for the states of DE, LA, NJ, PA, and WV that are in the Quality Insights network.
• The third tab of the tool includes a list of Health Professional Shortage Areas (HPSA) in the states of DE, LA, NJ, PA and WV that are in the Quality Insights Network.
### The Review and Select Function

- **After you’ve read each Activity, go to the far right hand column to “Click on box to select IA status”**

<table>
<thead>
<tr>
<th>Activity #</th>
<th>Beneficiary Engagement</th>
<th>Weight</th>
<th>ACI: 10 Bonus Points</th>
<th>Click on box to select IA status</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_BE_1</td>
<td>In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) or patient activation measures through use of certified EHR technology, containing this data in a separate queue for clinician recognition and review.</td>
<td>Medium</td>
<td>ACI: 10 Bonus Points</td>
<td>Review and Select Activity Status</td>
</tr>
<tr>
<td>IA_BE_2</td>
<td>Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.</td>
<td>Medium</td>
<td>ACI: 10 Bonus Points</td>
<td>Review and Select Activity Status</td>
</tr>
<tr>
<td>IA_BE_3</td>
<td>Engagement with a Quality Innovation Network-Quality Improvement Organization (QIN-QIO), which may include participation in self-management training programs such as diabetes.</td>
<td>Medium</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>IA_BE_4</td>
<td>Access to an enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.</td>
<td>Medium</td>
<td>ACI: 10 Bonus Points</td>
<td>In Process</td>
</tr>
<tr>
<td>IA_BE_5</td>
<td>Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance with section 508 of the Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities which requires that institutions receiving federal funds solicit, procure, maintain and use all electronic and information technology (EIT) so that equal or alternate/comparable access is given to members of the public with and without disabilities. For example, this includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973.</td>
<td>Medium</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
## Resources Supporting IA

<table>
<thead>
<tr>
<th>Activity #</th>
<th>Achieving Health Equity</th>
<th>Weight</th>
<th>ACI: 10 Bonus Points</th>
<th>Click on box to select IA status</th>
<th>Resource(s) which may provide guidance on improvement activity. This list is not all inclusive.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_AHE_1</td>
<td>Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.</td>
<td>High</td>
<td></td>
<td>Yes</td>
<td>Do you treat Medicaid and/or dual eligible patients?</td>
</tr>
<tr>
<td>IA_AHE_2</td>
<td>Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing. Use of supporting tools that can be incorporated into the certified EHR technology is also suggested.</td>
<td>Medium</td>
<td>ACI: 10 Bonus Points</td>
<td>No</td>
<td><a href="https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/qualified-clinical-data-registry-reporting.html">https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/qualified-clinical-data-registry-reporting.html</a></td>
</tr>
</tbody>
</table>
| IA_AHE_3   | Participation in a QCDR, demonstrating performance of activities for promoting use of patient-reported outcome (PRO) tools and corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments). | Medium |                      | In Process                       | http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.aspx  
http://www.nihpromis.com/?AspxAutoDetectCookieSupport=1#4 |
Activities Supported by Quality Insights

- IA_BE_3, Beneficiary Engagement
- IA_CC_3, Care Coordination
- IA_CC_4, Care Coordination
- IA_EPA_4, Expanded Practice Access
- IA_PM_5, Population Management
- IA_PM_6, Population Management
- IA_PSPA_19, Patient Safety & Practice Assessment
Several IAs are aligned with physician office projects that Quality Insights offers. Examples include:

- Referring Medicare patients with diabetes to diabetes self-management classes
- Care Coordination and Medication Safety
- Antibiotic Stewardship Program
- TCPI (Transforming Clinical Practice Initiative)
- Improving Cardiac Health and Reducing Healthcare Disparities - reporting high blood pressure outcome measures and Million Hearts® measures
- Improving Adult Immunization Rates - reporting on influenza and pneumonia measures
- Increasing Annual Wellness Visits
IA_BE_3: Beneficiary Engagement

• Engagement with a Quality Insights QIN initiative which may include participation in self-management training programs such as diabetes.

• Quality Insights programs support beneficiary engagement:
  – Increasing Annual Wellness Visits (AWV) to Improve Prevention
  – Antibiotic Stewardship
  – Everyone with Diabetes Counts (EDC)
IA_CC_3: Care Coordination

• Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization after technical assistance has been provided related to improving care coordination.

• Quality Insights aims to serve as a cornerstone of care coordination by forming innovative community coalitions that unite providers and stakeholders—including physician practices— with a shared vision of reduced hospital readmissions throughout our region.
  – Reducing Opioid Misuse and Diversion
  – Antibiotic Stewardship
IA_CC_4: Care Coordination

- Participation in the Transforming Clinical Practice initiative (TCPI)
  - Helps clinicians achieve large scale healthcare transformation
  - Strengthens the quality of patient care
  - Designed to spend healthcare dollars more wisely
  - Promotes improved quality and reduced cost by developing a collaborative of institutions that support practice transformation
IA_EPA_4: Expanded Practice Access

- As a result of Quality Insights technical assistance, performance of additional activities that improve access to services.
  - Investment of on-site Diabetes Educator
  - Increasing Annual Wellness Visits
IA_PM_5: Population Management

• Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidence-based practices to improve a specific chronic condition.
  – **Cardiac Health** - Quality Insights helps health care providers improve the Controlling High Blood Pressure outcome measure and other related Million Hearts® measures.
  – **Improving Adult Immunization Rates** - Quality Insights helps healthcare providers improve Influenza and Pneumonia measures.
  – Quality Insights coordinates the Everyone with Diabetes Counts (EDC) program.
IA_PM_6: Population Management

- Take steps to improve healthcare disparities, such as Population Health toolkit or other resources identified by CMS, the Learning Action Network, Quality Innovation Network, or National Coordinating Center. Improve Health Status of Communities.
  - Quality Insights supports health care providers with the Quality Payment Program.
  - We collaborate with local communities, health care providers, partners and stakeholders to provide education and resources to improve healthcare disparities and the health of our communities and strive to increase awareness of racial and ethnic disparities in health care among health care providers and key stakeholders.
• Adopt a formal model for quality improvement (such as PDSA) and create a culture in which all staff actively participate in improvement activities that could include one or more of the following:
  – Train all staff in quality improvement methods; integrate practice change/quality improvement into staff duties; engage all staff in identifying and testing practices changes; designate regular team meetings to review data and plan improvement cycles; or
  – Promote transparency and accelerate improvement by sharing Practice level and Panel level quality of care, patient experience and utilization data with staff; or
  – Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.
IAs Help with Planning for the Cost Performance Category

• For the 2017 transition year, CMS has finalized a weight of zero percent for the cost performance category in the final score. The total MIPS score in 2017 will be determined based on the other three integrated MIPS performance categories.

• **Starting in performance year 2018**, as performance feedback is available on at least an annual basis, the cost performance category contribution to the final score will gradually increase from 0 to the 30 percent level required by MACRA by the third MIPS payment year of 2021.
  - Total per capita costs (Parts A & B) for all attributed beneficiaries
  - Medicare spending per beneficiary (MSPB)
  - 10 episode-based measures
Contacts

• Delaware: Kathy Wild
  877.987.4687, Ext. 108

• Louisiana: Debra Rushing
  225.248.7072

• New Jersey: Maureen Kelsey
  732.238.5570, Ext. 2030

• Pennsylvania: Joe Pinto
  877.346.6180, Ext. 7817

• West Virginia: Debbie Hennen
  800.642.8686, Ext. 4222
Websites

- Quality Insights website: www.qualityinsights-qin.org
- Quality Payment Program website: www.qpp.cms.gov
Quality Insights Is Here to Help