4 changes to your practice that can make MIPS easier to ace

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Quality Payment Program

Make your merit-based incentive payment system (MIPS) reporting easier and higher-scoring by streamlining some operations to prepare for the proposed 2018 regulations, which raise the floor of required measures from three to 15.

1. Line up chronic care management (CCM) with MIPS. CMS has been trying to convince practices that CCM is not only good care but a cost-efficient way of handling patients with multiple chronic conditions (*PBN 11/1/16*). But what might persuade practices to try the CCM model is that it helps with MIPS reporting.

Several improvement activities (IAs) relate specifically to CCM, as well as other coordination models such as transitional care management (TCM). The IAs include "care coordination agreements that promote improvements in patient tracking across settings," "care transition documentation practice improvements" and "implementation of condition-specific chronic disease self-management support programs."

"If you want to get the biggest bang, look at programs in parallel," says Tom Lee, CEO of SA Ignite in Chicago. "When you plan it out, look at the things you have to do for CCM and ask: What process things, with or without slight tweaks, could help us also do well on MIPS?"

For example, counseling on and administration of vaccines may be relevant to a chronic care patient's overall health — and may also help you meet the "preventive care and screening: influenza immunization" quality measure.

Practices often "luck into" health interventions that meet MIPS measure requirements, but "the idea is to be more intentional about optimizing across all programs," says Lee. Make sure that when you go into these encounters with patients, you're prepared to not only address their issues, but also make sure that a positive response that correlates with MIPS is noted in both the patient record and in whatever MIPS reporting repository you're using.

2. Identify and motivate providers who'll move the MIPS needle. When people talk about population health, they usually refer to patient populations. But Lee suggests you "take a population view of your clinicians" to see where you're going to get the meat of your MIPS measures done.

"If I want to move the needle in terms of reimbursement and MIPS scores, it has to do with the clinicians' performance," says Lee. "Can I get where I want to for my program by focusing my efforts on a subset of clinicians? Or do I have to talk to all of them?"

"Talking to all of them" is what Lee calls "the spread-the-peanut-butter approach — talk to everyone about doing every measure." But that's often wasteful, as some providers, based on the kind of medicine and procedures they perform, will not yield more measurable MIPS results if you spend time educating them on how to do so.

On the other hand, says Lee, "you may look at clinicians and measures and find that, for a third of measures, if you improved your performance by a certain achievable amount, that would yield 90% of the possible score increase — and you only need to engage 60% of your clinicians to do it."

For example, maybe nearly every provider in the practice is providing blood pressure checks and following up appropriately on high numbers, so you can count on meeting and scoring well on the "controlling high blood pressure" quality measure. But maybe only a few providers will be treating the diabetes patients relevant to the multiple measures aimed at that population.

At Ignite, they call this "point gain analysis." "It's analogous to being a campaign manager in a presidential election," says Lee. "You're managing your performance on MIPS and your goal is to get to a target — the metaphorical equivalent of 270 electoral votes. There are various paths to get to it. I can get the path with California or not. If you plan to take California, you have to monitor your progress there. If it looks like you can't take California, what's your back-up set of states you need to win?"

3. Don't sleep on outcome measures. Process measures are about "how care is provided," while outcomes measures are about "how the patient ultimately turned out," says Min Matson, senior director of Point B, San Francisco. For years, CMS focused on process in quality reporting to help get patients on board, but its plan was always to transition to outcome measures. "Under PQRS [physician quality reporting system], for example, CMS was updating measures to be more outcomes-based, with an increasingly lower ratio of process measures," Matson says.

Providers are required to report at least one outcome measure — or a high-priority measure if an outcome measure is not available to them — among their minimum of six quality measures under MIPS. But if you expect to be reporting quality in the future, you should get used to reporting more outcome measures.

Many providers are used to and comfortable with process measures, and "after years of reporting for other programs, many providers have identified specific process measures that they capture in an automated fashion and can easily report," says Matson. "The big challenge providers face is improving infrastructure to report data that accurately reflects the care provided. They can do this through use of clinical data registries or upgrades to their own systems."

4. Capture the right data in your EHR. You may have a great registry for your MIPS data, but it won't help if you don't send your information in the appropriate form. Part of Point B's business is to identify shortfalls in an EHR's capacity to record and transmit MIPS data, says Matson. "For example, it may look like you have care management programs set up in a structure that records the data, but some of it is going to a comments field or some other narrative format from which you have to do manual review or perhaps miss it altogether," he says.

Or the problem may be simpler. "You might find that you're doing a measure and you're only compliant at 60% and the doctors are saying, 'No, we think we do it pretty much all the time,'" says Charles Saunders, M.D., CEO of Integra Connect in West Palm Beach, Fla. "It may be that you're documenting incorrectly — for example, in a narrative field [instead of a structured field]. Or [you may be] spelling it wrong so it's not recognized by the extraction software."

"There may be ways to automate the data so that it actually reflects the services that were provided," says Matson. Talk to your vendor or, if their answers aren't satisfactory, a consultant to make sure this is working. — *Roy Edroso (redroso@decisionhealth.com)*

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