Piecing the QPP Categories Together to Complete the MIPS Puzzle

Lisa Gall, DNP, FNP, LHIIT-HP
Candy Hanson, BSN, PHN, LHIIT-HP

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Disclaimer

Content provided in this presentation is based on the latest information made available by the Centers for Medicare & Medicaid Services (CMS) and is subject to change.

CMS policies change, so we encourage you to review specific statutes and regulations that may apply to you for interpretation and updates.
The Lake Superior Quality Innovation Network (Lake Superior QIN) is a partnership of three quality improvement organizations:

- Stratis Health in Minnesota
- MetaStar in Wisconsin
- MPRO in Michigan
Objectives

1. Learn the QPP reporting requirements for the 2019 performance year
2. Understand the changes to the promoting interoperability category
3. Learn how to use the Stratis Health MIPS Estimator to plan and implement improvement strategies
Overview of the Quality Payment Program
**What Is the Quality Payment Program?**

2015: MACRA Quality Payment Program replaces the defective SGR formula with a performance based payment system with 2 possible tracks

- **MIPS**
  - Merit-based Incentive System
  - Subject to performance based MIPS Payment Adjustments
  - MIPS Eligible Clinician

- **Advanced APM**
  - Advanced Alternative Payment Model
  - Medicare bonus payment PLUS APM benefits
  - Qualified Professional in Advanced APM
Who Participates in the Program?

- Physicians
  - Certified Registered Nurse Anesthetists (CRNAs)
  - Physical Therapists
  - Clinical Psychologists
  - Registered Dietitians or Nutritional Professionals

- Physician Assistants (PAs)
- Occupational Therapists
- Speech-Language Pathologists
- Audiologists

- Nurse Practitioners (NPs)
- Clinical Nurse Specialists (CNSs)

• Newly eligible in 2019
  - You can also participate as a group if the group includes at least one of the clinician types listed above.

Low-Volume Threshold Criteria

Bill more than $90,000 for covered professional services under the Medicare Fee for Service schedule AND Furnish covered services to >200 Medicare beneficiaries AND Provide >200 covered professional services under the PFS

You can choose to Opt-In if you meet one or two of the three criteria:

1) Billed > $90,000
2) Furnish covered services to >200 beneficiaries
3) Provide >200 covered professional services under FFS

• MIPS payment adjustments apply

• Opt-in is irrevocable
Basic MIPS Exemption Criteria - similar

1. First year enrolled in Medicare

2. Significantly participating in an Advanced Alternative Payment Models (Advanced APM)
   1. 50 percent of Medicare payments paid through Advanced APM
   2. 35 percent of Medicare beneficiaries seen through Advanced APM

3. Low Volume Threshold (covered in previous slides)
Clinicians participating as a group are assessed as a group across all four MIPS performance categories. The same is true for clinicians participating as a virtual group.

Two Paths for QPP: MIPS and APMs

Path One: APMs

Advanced APMs and MIPS APMs
Path One: Advanced Alternative Payment Models (APM)

Alternative Payment Models
New models of paying for health care that incentivize quality and value over volume by moving away from traditional Medicare Part B Physician Fee Service.

Advanced APMs
Subset of APMs that receive a 5 percent bonus payments if ECs meet thresholds to become Qualified Professionals

Three statutory requirements:
1. Participants must use **certified electronic health record (EHR) technology**
2. Payment for covered services based on **quality measures** comparable to MIPS
3. Entity is either 1)
   — a **Medical Home Model** expanded under CMS Innovation Center authority OR
   — Requires participants to bear **more than a nominal amount of financial risk**
What Are MIPS APMs?

Middle ground between reporting to MIPS categories and participating in a full-fledged Advanced APM

Example: EC in Advanced APM who does not meet thresholds for Advanced APM
Medicare Shared Savings Program ACO Re-Design

- Begins 7/1/19
- Tracks 1, 2, 3 replaced by five levels of upside/downside risk
- Had to have completed Non-Binding Notice of Intent to Apply by 1/18/19
- Limits time to be in upside risk
- Expanded use of Tele-Health and 3 Day SNF Waiver Eligibility
- Incorporates billing codes for advance care planning, administration of health risk assessment, annual depression screening, alcohol misuse screening, and alcohol misuse counseling

Two Paths for QPP:

Path Two: MIPS
Merit-Based Incentive Payment System
Path Two: Merit-Based Incentive Payment System

Four MIPS category scores compiled for MIPS final score worth up to **100 points**

<table>
<thead>
<tr>
<th>Previous Category – Year</th>
<th>Quality</th>
<th>Cost</th>
<th>Improvement Activities</th>
<th>Promoting Interoperability</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>45%</td>
<td>15%</td>
<td>15 %</td>
<td>25%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>10%</td>
<td>15 %</td>
<td>25%</td>
</tr>
</tbody>
</table>
# MIPS 2019 Scoring (0-100 Points)

Increase in performance threshold and payment adjustment

<table>
<thead>
<tr>
<th>Points</th>
<th>Eligibility and Payment Adjustment</th>
</tr>
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<tr>
<td>≥75 points</td>
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<tr>
<td>0 – 7.5 points</td>
<td>-7 percent negative payment adjustment</td>
</tr>
</tbody>
</table>
MIPS: Quality category
Quality Category

Earn up to 45 MIPS percentage points

- Performance period - full year
- 250+ MIPS measures

- Multiple collection types are allowed
  - If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring
  - EXCEPTION: CMS Web Interface measures cannot be scored with other collection types other than the CMS-approved survey vendor measure for CAHPS for MIPS and/or administrative claims measures

Quality Category - Individuals

• Individual eligible clinicians can submit measures via multiple collection types:
  — MIPS Clinical Quality Measures (CQM) (formerly registry)
  — Electronic Clinical Quality Measure (eCQM) (electronic health record [EHR])
  — Qualified Clinical Data Registry (QCDR) measures

• Small practices (ONLY) can submit via claims either as individuals or as a group

Quality Category – Groups and Virtual Groups

• Eligible clinicians in groups can submit measures via multiple collection types:
  — MIPS CQM (formerly registry)
  — eCQM (EHR)
  — QCDR measures
  — CMS Web Interface (groups of 25+)

• Small practices *(ONLY)* can submit via claims either as individuals or as a group

Quality Category - Requirements

• Six measures required, including one outcome or one high priority measure

• Specialty measure sets can be used

• If fewer than six measures available, clinicians must submit all measures in measure sets

• The all cause readmission measure continues with a 200 case minimum

Data Completeness Requirements

- Data completeness requirements same as Year 2

- Small practices will continue to receive 3 points on measures that don’t meet the data completeness threshold

- Large practices that don’t meet data completeness threshold will receive 1 point

Topped-Out Measures

- Continue to receive 7 points (58 measures) – only four listed on fact sheet

- Extremely topped-out measures may be proposed for removal in the next rule making cycle

- QCDR measures are excluded from the topped-out measure lifecycle and special scoring policies

Quality Measure Scoring (excludes CMS web interface)

1-10 Points per Measure

3-10 points if measure:
- Meets the data completeness criteria
- Has a benchmark
- Volume of cases is sufficient (> 20 cases)

Quality Measure Scoring (excludes CMS web Interface)

Three points if measure meets the data completeness criteria but either

1. Doesn’t have a **benchmark** and/or
2. The **volume** of cases you’ve submitted is insufficient (<20 cases for most measures)

If measure doesn’t meet **data completeness** criteria

- One point for large practices
- Three points for small practices

Bonus Points

• Two points for additional outcome and patient experience measures
• Two points for other high priority measures
• High priority bonus points are discontinued for CMS Web Interface reporters
• High priority measures now include opioid related measures
• Outcome measures include intermediate outcome and patient reported outcome measures
• End-to-end certified EHR technology (CEHRT) reporting still provides bonus points
• Bonus points continue to be capped at 10 percent

Quality Category Improvement Scoring

• Same as Year 2:
  — Based on improvements in total category score
  — Higher improvement results in more points

• Need to have participated for a full year in 2018 to qualify for the improvement score

Small Practice Bonus

- Five bonus points removed from MIPS final score calculation (2018)

- Six bonus points added to numerator of the Quality performance category for clinicians in small practices
  - Must submit data on at least one quality measure

Eligibility Measurement Applicability (EMA) Process
EMA Process

• ONLY applies to claims and CQM (formerly registry) reporting

• Triggered if you don’t submit enough measures

• If process finds more measures, CMS will adjust your score
  • Measures don’t have to meet data completeness threshold to be eligible for EMA process
MIPS: Cost Category
Cost Category

Earn up to 15 percentage points
• Category score weight will increase to 30% by 2021
• No data submission required;
  • Calculated from administrative claims if case minimum of attributed patients met

• TWO measure scores are averaged (or any one available)
  • Medicare Spending per Beneficiary (MSPB)
  • Total Per Capita Cost

MSPB Measure – Episode Window

- All Medicare Part A & B charges prior to, during, and after episode of care
- Compares observed costs to expected costs
- Based on clinical condition/procedure that triggers the episode

The TPCC measure is calculated through the following steps:

1. Attribute beneficiaries to TIN-NPIs
2. Calculate payment-standardized per capita costs
3. Annualize costs for partial year-enrolled Medicare beneficiaries included in the measure
4. Risk-adjust costs
5. Specialty-adjust costs
6. Calculate the TPCC measure for the TIN-NPI or TIN, and
7. Report/express the TPCC measure for the TIN-NPI or TIN
## Cost Category – New Measures

<table>
<thead>
<tr>
<th>Measure Topic</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Outpatient Percutaneous Coronary Intervention (PCI)</td>
<td>Procedural</td>
</tr>
<tr>
<td>Knee Arthroplasty</td>
<td>Procedural</td>
</tr>
<tr>
<td>Revascularization for Lower Extremity Chronic Critical Limb Ischemia</td>
<td>Procedural</td>
</tr>
<tr>
<td>Routine Cataract Removal with Intraocular Lens (IOL) Implantation</td>
<td>Procedural</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>Procedural</td>
</tr>
<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
<td>Acute inpatient medical condition</td>
</tr>
<tr>
<td>Simple Pneumonia with Hospitalization</td>
<td>Acute inpatient medical condition</td>
</tr>
<tr>
<td>ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)</td>
<td>Acute inpatient medical condition</td>
</tr>
</tbody>
</table>
Episodic Measures

Consist of:

• Episode triggers & windows
• Item and service assignment
• Exclusions
• Attribution methodology
• Risk adjustment variables

Attribution

- Cost measures attributed at the individual (TIN-NPI) level

- Cost measure performance score attributed either at the
  - individual clinician level
  - or group level (aggregated score)

- The method used to attribute beneficiary costs to MIPS eligible clinicians at the TIN-NPI level differs for each measure

Measure Attribution

• For **procedural** episodes:
  o Attribution made to each eligible clinician who renders a trigger service (identified by HCPCS/CPT procedure codes)

• For **acute inpatient medical condition** episodes:
  o Attribution made to each MIPS eligible clinician who bills inpatient E & M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E & M claim lines in that hospitalization

Payment Standardization

Allowed amounts for Medicare services can vary across geographic areas due to:

1. Regional differences in labor costs and practice expenses

2. Differences in the relative price of inputs in local markets where a service is provided

3. Extra payments from Medicare in medically under-served regions

4. Policy-driven payment adjustments such as those for teaching hospitals

Benchmarks

- A single, national benchmark for each cost measure
- Benchmarks based on data from performance period, not a historical baseline period
- CMS can’t publish the actual numerical benchmarks for the cost measures before the start of each performance period
  - 2019 Cost performance category score will be based on 2019 claims data
Cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.
MIPS: Improvement Activities (IA) Category

Quality

Cost

Improvement Activities

Promoting Interoperability
Earn up to 15 percentage points

• Performance period 90 days or up to a full year

• *PI bonus points have been removed*

• Reporting options:
  •  CEHRT vendor (EHR, registry, QCDR)
  •  Yes/No attestation
    —  claims, CMS Web, vendor not reporting on your behalf
Improvement Activities Category

- Six activities added
- Five activities modified
- One activity removed

Special Scoring 2019

• Full credit (40 points) for clinicians in
  o Patient-centered medical home (PCMH)
  o Medicare Shared Savings Program (MSSP)
  o Next Generation APM

• Half credit (20 points) for clinicians in
  o Other APMs

• Double points for clinicians in
  o Small, underserved or rural settings
  o Non-patient facing clinicians/groups

Path Two: MIPS

Promoting Interoperability (PI) category
Promoting Interoperability: AKA…

Medicare Meaningful Use

Advancing Care Information

Promoting Interoperability

2010-2016

QPP/MIPS/APMS 2017 -->
Earn up to 25 percentage points

- Maximum category score 100 points
- Re-designed for 2019 to prioritize interoperability

- **REQUIRES** the use of 2015 CEHRT to receive any points in this category
  - Performance period 90 days or up to a full year
  - Bonus from IA category eliminated
2019 Promoting Interoperability

• New scoring methodology
• Eliminates base and bonus scores
• Retains performance-based scoring at the individual measure-level

In order to earn a score greater than zero for the Promoting Interoperability category, participants must

1. Attest “yes” to 3 questions (and be able to prove it)
   • Prevent Information Blocking
   • ONC Direct Review, if applicable
   • Complete a Security Risk Analysis (SRA) during the calendar year in which the MIPS performance period occurs

2. Report the required measures from each of the four objectives

Source: CMS Promoting Interoperability Fact Sheets for 2019
Promoting Interoperability – Objectives and Measures

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td><strong>Bonus:</strong> Query of Prescription Drug Monitoring Program (PDMP)</td>
<td></td>
</tr>
<tr>
<td><strong>Bonus:</strong> Verify Opioid Treatment Agreement</td>
<td></td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic Referral Loops by Sending Health Information</td>
</tr>
<tr>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information</td>
<td></td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>Provide Patients Electronic Access to Their Health Information</td>
</tr>
<tr>
<td>Public Health and Clinical Data Exchange</td>
<td>Choose any two of the following:</td>
</tr>
<tr>
<td></td>
<td>Syndromic Surveillance Reporting</td>
</tr>
<tr>
<td></td>
<td>Immunization Registry Reporting</td>
</tr>
<tr>
<td></td>
<td>Electronic Case Reporting</td>
</tr>
<tr>
<td></td>
<td>Public Health Registry Reporting</td>
</tr>
<tr>
<td></td>
<td>Clinical Data Registry Reporting</td>
</tr>
</tbody>
</table>

Source: CMS presentation / webinar screenshot from Dec. 2018
Promoting Interoperability

• Clinicians are required to report certain measures from each of the four objectives
  • Exclusions can be claimed for some measures, in which case that score weight moves to other measures (i.e. eRX)

• Two new optional measures for e-Prescribing objective:
  o Query of Prescription Drug Monitoring Program (PDMP)
  o Verify Opioid Treatment Agreement as optional with bonus points available

• Bonus points available for optional measures
## Sample Scoring for PI

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Numerator/Denominator</th>
<th>Performance Rate</th>
<th>Max. Points Available</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electronic Prescribing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>e-Prescribing</td>
<td>200/250</td>
<td>80%</td>
<td>10 points</td>
<td>8 points</td>
</tr>
<tr>
<td><strong>Bonus</strong>: Query of Prescription Drug Monitoring Program (PDMP)</td>
<td></td>
<td>25/75</td>
<td>33%</td>
<td>5 point bonus</td>
<td>5 bonus points</td>
</tr>
<tr>
<td><strong>Bonus</strong>: Verify Opioid Treatment Agreement</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>5 point bonus</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Health Information Exchange</strong></td>
<td>Support Electronic Referral Loops by Sending Health Information</td>
<td>135/185</td>
<td>73%</td>
<td>20 points</td>
<td>15 points</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information</td>
<td>145/175</td>
<td>83%</td>
<td>20 points</td>
<td>17 points</td>
</tr>
<tr>
<td><strong>Provider to Patient Exchange</strong></td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>350/500</td>
<td>70%</td>
<td>40 points</td>
<td>28 points</td>
</tr>
<tr>
<td><strong>Public Health and Clinical Data Exchange</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>83 points</td>
</tr>
</tbody>
</table>

Source: CMS 2019 Final rule webinar. Dec 2018
2019 Promoting Interoperability

• **Reweighting** - same as 2018
  - Includes newly eligible clinicians
  - 25% of PI category weight shifted to the Quality category (45%) for total of 70% weighting of Quality category score
2015 CEHRT requirement:

- 90-day PI measurement period can start as soon as all the functionality exists to fulfill PI objectives/measures
- EHR can be 2015 “certified” on last day of measurement period but could impact quality submission score
MIPS Scoring and Reporting

Quality  Cost  Improvement Activities  Promoting Interoperability
Increase in performance threshold and payment adjustment

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<tr>
<th>Points Range</th>
<th>Payment Adjustment and Performance Bonus Payment</th>
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Optimizing Performance in the Quality Payment Program
Optimizing Quality Category

- Use the MIPS estimator to determine which method will score the highest per measure
  - new version to be released – Spring 2019

- Use 2015 CEHRT to maximize bonus points

- Align improvement efforts with measures previously reported on to show improvement
Use the Stratis Health MIPS Estimator to Compare Quality Measure Scores

Your current reporting method: Claims

1. Choose Quality Measure:
   128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

   **Full Measure Name:**
   128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Process</th>
</tr>
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<tbody>
<tr>
<td>High Priority Measure?</td>
<td>No</td>
</tr>
<tr>
<td>Benchmark available?</td>
<td>Yes (Measures without benchmarks can only earn 1 or 3 points.)</td>
</tr>
<tr>
<td>Topped Out Measure?</td>
<td>No (Topped out measures have limited ability to earn high scores.)</td>
</tr>
<tr>
<td>Minimum case size of 20 eligible cases?</td>
<td>Yes</td>
</tr>
<tr>
<td>Methods Available</td>
<td>Claims, EHR, Registry, QCDR</td>
</tr>
</tbody>
</table>

   **Numerator:** 85  
   **Denominator:** 100  
   **Result:** 85.00%

   Were the cases included in this reporting method > 60% of all Medicare FFS beneficiaries for this measure?  
   Yes  No

   **Measure Score:** 6.11
Use the Stratis Health MIPS Estimator to Compare Quality Measure Scores

**Your current reporting method:**

1. **Choose Quality Measure:**
   - 128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

   **Full Measure Name:**
   - 128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

   **Measure Type:**
   - Process

   **High Priority Measure?**
   - No

   **Benchmark available?**
   - Yes (Measures without benchmarks can only earn 1 or 3 points.)

   **Topped Out Measure?**
   - No (Topped out measures have limited ability to earn high scores.)

   **Minimum case size of 20 eligible cases?**
   - Yes

   **Methods Available**
   - Claims, EHR, Registry, QCDR

   **Numerator:** 85  
   **Denominator:** 100

   **Result:** 85.00%

   **Were the cases included in this reporting method > 60% of all cases for this measure?**
   - Yes
   - No

   **Will you report this measure "end to end" using CEHRT?**
   - Yes
   - No

   **Measure Score:** 9.96
Use the Stratis Health MIPS Estimator to Compare Quality Measure Scores

Your current reporting method:

1. Choose Quality Measure:
   128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

   Full Measure Name:
   128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

   Measure Type: Process
   High Priority Measure? No
   Benchmark available? Yes (Measures without benchmarks can only earn 1 or 3 points.)
   Topped Out Measure? No (Topped out measures have limited ability to earn high scores.)
   Minimum case size of 20 eligible cases? Yes
   Methods Available: Claims, EHR, Registry, QCDR

   Numerator: 85
   Denominator: 100

   Result: 85.00%

   Were the cases included in this reporting method > 60% of all cases for this measure?
   Yes

   Will you report this measure "end to end" using CEHRT?
   Yes

   Measure Score: 7.87
Optimizing Cost Category

• Work towards appropriate attribution

• Assure Medicare beneficiaries are accessing preventive services (i.e., Medicare wellness visits)

• Check with your EHR vendor for reporting capabilities related to cost measures

• No certainty about CMS providing QRUR “like” reports for 2019
Use the Stratis Health MIPS Estimator to Estimate Cost Category Score

<table>
<thead>
<tr>
<th>PROVIDER 1</th>
<th>Cost Score: 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candy</td>
<td></td>
</tr>
</tbody>
</table>

You may either leave this score blank for “0” points, or estimate a cost category score between 1 and 10 to be applied to your estimated MIPS score. If you are unsure how you did for the cost category, we suggest entering 5 points as a median score for the least impact on estimated score variation.
Optimizing Improvement Activities Category

• Use the Improvement Activities Validation file to learn what CMS recommends for proof

- View documentation details for Improvement Activities and Promoting Interoperability on MIPS Data Validation Criteria (zip file)

• Read through all of the activities
Use the Stratis Health MIPS Estimator to See Your Total Improvement Activities Score

3. Improvement Activities (IA)

Provider 1
Candy

IA Score: 40 / 40

1. Choose Activity

IA_PSPA_6 - Consultation of the Prescription Drug Monitoring Program

Full Activity Name:
IA_PSPA_6 - Consultation of the Prescription Drug Monitoring Program

Activity Weight:
High

Description:
Clinicians would attest to reviewing the patients’ history of controlled substance prescription using state prescription drug monitoring
Optimizing PI Category

• Understand the PI specifications
  • Know which measures have exclusions and how points will be re-distributed

• Plan to have 2015 CEHRT during the performance year

• Check with your vendor for PI measures and their plan to have them available
  • Application Programming Interface/API required for patient portal

• Check the registries you have available to you

• If you haven’t enabled your patient portal, learn what needs to happen to make it available

• What HIE options do you have?
  • Direct secure messaging
  • HIE exchange with other settings
Use the Stratis Health MIPS Estimator throughout the Year

1. Practice / Provider Information

Instructions:

Let’s get started! Please answer all of the practice and provider questions below to get started with your MIPS estimation.
Use the Stratis Health MIPS Estimator Throughout the Year

See how ECs compare to each other and to group performance

<table>
<thead>
<tr>
<th>Provider</th>
<th>Registry</th>
<th>Selected Reporting Method</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa G</td>
<td>Registry</td>
<td>Selected Reporting Method</td>
<td>82.95</td>
</tr>
<tr>
<td>Candy H</td>
<td>Registry</td>
<td>Selected Reporting Method</td>
<td>91.20</td>
</tr>
<tr>
<td>Erik Z</td>
<td>Registry</td>
<td>Selected Reporting Method</td>
<td>76.55</td>
</tr>
</tbody>
</table>

**Estimated Group MIPS Score**

- Registry: Selected Reporting Method
- Score: 84.95

Source: Stratis Health MIPS Estimator, https://www.mipsestimator.org
See how each MIPS Performance Category contributes to Score

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>Earned Category Base Score</th>
<th>Earned Bonus Points</th>
<th>Earned Category Total</th>
<th>Category Points Cap (Maximum)</th>
<th>Earned % of Category Points</th>
<th>MPS Category Weight</th>
<th>Earned Total Category Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Activities</td>
<td>40</td>
<td>N/A</td>
<td>40</td>
<td>40</td>
<td>100%</td>
<td>15</td>
<td>15.00</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
<td>100</td>
<td>N/A</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Quality</td>
<td>33</td>
<td>0</td>
<td>33</td>
<td>60</td>
<td>55%</td>
<td>75</td>
<td>41.25</td>
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<tr>
<td>Cost</td>
<td>4</td>
<td>N/A</td>
<td>4</td>
<td>10</td>
<td>40%</td>
<td>10</td>
<td>4.00</td>
</tr>
<tr>
<td>Small Practice Bonus</td>
<td>N/A</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
</tr>
<tr>
<td>Complex Patient Bonus</td>
<td>N/A</td>
<td>2</td>
<td>N/A</td>
<td>5</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED MIPS SCORE:** 67.25

Save, view, print and download reports

Source: Stratis Health MIPS Estimator, https://www.mipsestimator.org
Resources and Tools
Resources

1. QPP Technical Assistance:  
   QPPHelp@stratishealth.org

2. Lake Superior QIN Resources  
   LSQIN Home page: https://www.lsqin.org  
   Previous and upcoming webinars and Regional Office Hours: 
   https://www.lsqin.org/events/

Quality Payment Program Support and Technical Assistance

CMS Website:  
www.QPP.CMS.Gov

CMS QPP Help Desk  
866-288-8292  
Email: QPP@cms.hhs.gov
Questions?

Lisa Gall
lgall@stratishealth.org

Candy Hanson
chanson@stratishealth.org
This material was prepared by Lake Superior Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The materials do not necessarily reflect CMS policy. 11SOW-MN-D1-19-27 022819