Optimizing Your MIPS Score: Quality Measure Benchmarks and Reporting Mechanisms

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The Medicare Quality Payment Program has officially launched, meaning most physicians (and most non-physician practitioners) now are in the initial performance period under the Merit-Based Incentive Payment System (MIPS). With 60% of the MIPS composite score based on quality measures, the selection of the most appropriate measures, and the manner in which to report, is critical.

The Basics

To maximize one's quality component score, a physician must report individually, or as part of a group, on a minimum of six measures, at least one of which must be an outcome measure. Under MIPS' predecessor, the Physician Quality Reporting System (PQRS), most physicians reported on a small subset of their Medicare patients. With MIPS, however, a physician or group must report on at least 50% of their relevant patient population depending on their submission type.

The following table lists the various methods of quality reporting and corresponding measure and data completeness requirements:

Table 1. Reporting Requirements for MIPS Quality Component

Manner of Participation	Submission Type	Measure Requirements	Data Completeness
Individual	**Part B Claims**	6 measures (at least 1 outcome measure) OR specialty-specific measure set	50% of Part B patients (60% in 2018)
Individual or Group	**QCDR, Qualified Registry, or EHR**	6 measures (at least 1 outcome measure) OR specialty-specific measure set	50% of individual's or group's patients who meet measure denominator (60% in 2018)
Group	**CMS Web Interface** (register by 06/30/17)	All measures (15) included	CMS-selected sample of Part B patients

A physician's or group's quality component score will be calculated by comparing the physician's or group's score on each individual measure to that measure's historical benchmark. CMS has calculated those benchmarks based on how physicians using the same submission method scored on that measure during prior reporting periods. Stated another way, each measure has up to four separate historical benchmarks, one for each method by which the measure has been reported (*i.e.*, Part B claims, EHR, registry, and CMS web interface).

On December 28, CMS released the 2017 quality measure specifications (*i.e.*, numerators and denominators) and benchmarks for all of the nearly 300 MIPS quality measures. With this information now available, physicians can make informed decisions regarding MIPS quality reporting.

Key Considerations in Quality Measures Selection

The first step in measure selection is identifying those measures relevant to one's patient population, starting with CMS' 30 specialty-specific measure sets. Specialists for whom CMS has not provided a measure set may look to their specialty societies for guidance.

Physicians also should review those measures on which they previously reported for PQRS or other pay-for-reporting programs. However, simply sticking with the measures one already knows may prove unwise. For PQRS, many physicians selected measures on which to report based in large part on ease of data collection, as the actual score achieved on the measure did not impact payment. Now, under MIPS, the object of the game is maximizing one's scores.

Thus, before deciding to continue with the same measures, a physician or group should compare their historical scores to the aforementioned benchmarks. Keep in mind that all scores are relative: a score of 95% isn't worth much if 90% of physicians scored at 96% or above.

Also, keep in mind that the same measure may have up to three different benchmarks, depending on the number of ways in which data may be reported for that measure. For some measures, data can be reported three different ways (by administrative claims, EHR, or registry), whereas some measures require data to be reported in one specified manner (*e.g.*, registry only).

Take, for example, the measure for "Tobacco Use Screening and Cessation Intervention," which requires physicians to screen adult patients for tobacco use every 24 months and intervene if the patient identifies as a tobacco user. For this measure, a physician or group may report by administrative claims, EHR, or registry. As demonstrated in the following table, the benchmarks for this measure vary significantly based on the data submission method:

Table 2. Sample Quality Measure and Performance Thresholds

Measure Name	Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (#226)	Claims	95.60 - 97.85	97.86 - 99.25	99.26 - 99.99	--	--	--	--	100	Yes
	EHR	72.59 - 81.59	81.60 - 86.68	86.69 - 90.15	90.16 - 92.64	92.65 - 94.67	94.68 - 96.58	96.59 - 98.51	>= 98.52	No
	Registry/ QCDR	76.67 - 85.53	85.54 - 89.87	89.88 - 92.85	92.86 - 95.14	95.15 - 97.21	97.22 - 99.10	99.11 - 99.99	100	No

Source: CMS Quality Measure Thresholds for 2017 MIPS Reporting (qpp.cms.gov)

If a physician elects to report by Part B claims, he or she could receive no more than five points on this measure if the physician or group failed to screen or intervene for a *single* tobacco user. By comparison, physicians and groups who report through their EHRs or through a registry would receive more points for less-than-perfect performance.

Not every benchmark favors EHR or registry reporting over Part B claims; in some cases, the opposite is true. The 2017 quality measure benchmarks are full of discrepancies by submission method, just like this example.

Physicians should look for meaningful quality measures that present a fair opportunity to score well relative to the established benchmarks. One indicator of such opportunity is whether a measure is "topped out" – meaning there is little difference between the worst and best performers on the measure. Once a measure tops out, it is on the short road to retirement, as there is no longer an opportunity for improvement in the performance it measures.

As the tobacco cessation measure demonstrates, a measure may be topped out if reported in one way, but not others. Of the 63 measures that may be reported by Part B claims, 70% are topped out. If a physician reports on one of these measures by administrative claims, it will be difficult for the physician to earn even intermediate points if they fall short of 100% performance on that measure.

Table 3. Topped Out Measures by Reporting Mechanism

Submission Type	Total Benchmarked Measures	Topped Out Measures	Topped Out Percentage
Claims	63	44	**70%**
EHR	51	5	**10%**
Registry/QCDR	285	129	**45%**

Source: CMS Quality Measure Thresholds for 2017 MIPS Reporting (qpp.cms.gov)

Nearly half of the 285 measures reported by registry are topped out, while only 10% of the 51 EHR-reported measures are topped out. Based on this metric alone, EHR reporting may present the greatest opportunity for physicians to earn higher points for quality measures.

So How Does One Decide?

The equation for measure selection for purposes of optimizing one's quality component score requires consideration of several variables. As before, one must evaluate different measures' relevance to one's practice and the relative ease and reliability of data collection. A physician or group also must consider the extent to which existing workflows will need to be modified to improve performance on a specific measure.

And now, with CMS' publication of the 2017 quality measure benchmarks, physicians and groups will need to evaluate the level of performance required to earn a specific number of points toward their quality component score. As part of this evaluation, physicians and groups also must decide the manner in which they will report, as an individual physician or group must report on all measures in the same manner. For example, if a physician identifies three measures on which he or she wants to report, and those measures require registry reporting, the physician then could not select measures that require another manner of reporting (*i.e.*, Part B claims or EHR).

With our extensive experience in quality reporting and our in-depth knowledge of MIPS requirements, PYA can assist in optimizing composite scores through appropriate measure selection. We also can help with implementing changes in work flow and data collection to realize improved performance.

Across all MIPS components, physicians have timing and participation flexibility for meeting MIPS requirements in 2017. CMS considers 2017 a transition year during which physicians can meet fewer requirements for shorter periods of time to avoid any financial penalties. The first performance year, 2017, remains an excellent opportunity for physicians to attempt to meet full requirements with little downside (time and effort) and the potential for significant financial upside (up to +12% of base FFS payments in 2019).