Best Practice MIPS Quality Reporting: QCDR Group with Individual Accountability

written by Dave Halpert | June 15, 2017

The “transition” phase of the Merit-Based Payment System (MIPS) is half over, and so, too, is the time needed to prepare for the full rollout in 2018. Yet during the 2017 MIPS “transition” year, many providers are still trying to pigeonhole MACRA’s MIPS into the previous quality program, PQRS. That choice may have worked for simple quality reporting, but it doesn’t work for MACRA’s more comprehensive approach. Among other things, it overlooks a key decision—whether to base quality reporting on group practice or individual provider results.

The problem is this: MIPS is not PQRS. It is a full-fledged Value-Based Health Care program. The choice between Individual or Group Practice quality reporting has huge implications for future revenues, public quality reports, and possibly consumer and payer choice. The financial stakes are high—within three years, there will be a financial gap of 18 percent between providers at each end of the scoring spectrum. The financial rewards (or penalties) are derived from the differences in patients’ outcomes and experience.

How Individual and Group Quality Reporting Methods Differ

Practices at the Tax Identification Number (TIN) level have the choice of reporting as individual clinicians or as a Group Practice. Group Practice reporting means that the *Group Practice is scored as a whole*. Some providers will have a larger impact on scoring than others, but, in the end, the practice is scored as a collective unit. Organizations do not need to register for Group Practice reporting in 2017, unless reporting directly through the CMS web interface.

Individual reporting requires that *each provider meet successful reporting criteria,* so more measures will be used under this method than under Group Practice Reporting. Individual reporting is exactly that—one provider's scores may differ substantially from another's, even if they're in the same practice.

Organizations that choose to report individual providers share a few common reasons:

> They want to hold providers accountable for meeting quality measures by maintaining measures for everyone, or
> Their structure of TINs, practice subunits and multiple locations are too complicated to reward providers for efforts based on unique group results, or
> Certain providers do not want to be linked to metrics that are not exclusively based on the care that they've provided.

Individual Reporting Focuses on the Provider, Not the Patient

Under Individual reporting, the organization's focus is on provider-based results. How? Because they are focused on changing provider behavior, making providers more accountable, or meeting provider interests. The organization has pursued individual accountability for the purpose of fairness, making sure that all providers have quality measures and are doing their part to meet specialty standards of quality.

Let's be clear: it is not necessarily bad to pursue a path of fairness or comprehensive quality metrics. But even if it is not bad practice, it may be poor quality reporting. Why? Because the incentives of MIPS scoring are focused on the group and not individual providers. The complex scoring of MIPS does not create a good reward structure for individual practitioners because most of the other scoring components fall as a group. Further, the poor-quality reporting that results from ensuring enough specialty measures for every practitioner can bring down the organization's total score.

Performance Measurement Should Focus on the Patient

The real downside to an overemphasis on providers and provider comparisons, however, is that it misses the point of performance measurement—the patient.

Performance measurement that is patient-centric is designed to determine whether patients received the care they should have, and whether their outcomes are improving. A patient-centric performance measurement focuses on patient results while still linking all providers to that patient.

For example, a primary care physician and an orthopedic surgeon will trigger different sets of measures, but each provider's care for a common patient will affect the other's quality scores. The primary care provider won't be performing a total knee replacement, but a successful TKR may mean the difference between a sedentary patient and an active patient, and that active patient will have a much better chance of lowering A1c, blood pressure or BMI.

On the flip side, a patient who has stopped smoking and whose chronic conditions are well controlled will be less likely to experience complications following surgery. This means lower costs surrounding the procedure, which means better cost scoring for the surgeon in a bundled payment initiative and in MIPS. Cost will be increasingly important as a scoring factor in MIPS, and as mentioned above, it's calculated at the TIN level already. More important, a lower episodic cost means that the patient had a better outcome and experience.

Differential Benefits of External Quality Reporting Versus Performance Measurement

Organizations can and should see performance measurement as an opportunity to discuss shared goals that focus on patient care. Performance measurement can encompass measurement of specialty-driven outcomes as well as improvement in patient outcomes over time. The regulatory disadvantages of quality measures, for example, can be relaxed under an organizational performance measurement program—and they should be.

For example, a MIPS hypertension measure evaluates the percentage of adult patients with hypertension whose blood pressure was adequately controlled. Under this measure, blood pressure must be taken once in 12 months. However, organizations that are really focused on improving hypertension management will instead plan to measure how patients with poor control progress over time with frequent readings. The MIPS hypertension measure meets reporting requirements and allows for crude comparisons between providers. But by internally evaluating their measure results over time, the organization is in a better position to assess the

status of patient care.

The same goes for the application of measures across providers. It is completely possible to include all providers under a performance measurement process, yet choose MIPS Quality Reporting on a smaller set of measures as a group practice.

Satisfying MIPS Quality Reporting is a complicated process of numbers—number of providers, number of measures, "topped out" performance, deciles and patient volume. MIPS Quality Reporting represents a scoring algorithm, not a quality program. Quality Reporting can also be "gamed" by careful selection of measures to best represent high performance areas. This is an advantage to organizations that also have a comprehensive and ambitious performance measurement and improvement program, because they will have many more measures that "fit the bill" for high MIPS Quality Scoring.

The smart way is to do both: concentrate on provider excellence and on patient results, and create a split path of performance measurement and quality reporting.

Best Practice Dual Path Combines QCDR Group Quality Reporting and Performance Measurement

Group Reporting and Individual Accountability are not mutually exclusive. Practices should maintain individual provider views, as these are critical for benchmarking and identifying discrepancies in outcomes, so that they may be addressed. However, patient outcomes change and are influenced by providers across the spectrum of care. It takes coordinated efforts across the group to produce a measureable difference, and fragmentation pulls time and resources from your overall strategy. The goal should be to improve outcomes over time, maximize Value-Based Care incentives, and provide the best care to patients.

Here's the path:

> MIPS Quality Reporting as a Group Practice, while simultaneously tracking individual measures, and
> A comprehensive performance measurement based on both MIPS and customized measures across the organization.

A QCDR with capabilities across all MIPS components can enable both single- and multi-specialty practices to *report at the group level while maintaining individual accountability among all providers*. We call this a "dual path" because it satisfies both the need for comprehensive measurement across the organization and all providers for quality and cost

performance, and a MIPS-focused strategy for Group Practice quality reporting.

Provider organizations that have not reported as groups are often leery of Group Practice reporting, fearing that providers and administrators will lose the ability to look at individual performance. They needn't worry; a good QCDR can maximize ability to succeed in MIPS while maintaining providers' individual results in both analytics and registry views.

A word of caution: Provider organizations who choose Group Practice reporting should confirm with their QCDR or other Health Information Technology vendor that the data will be submitted at the group level. The provider organization should have the opportunity to review your results on an ongoing basis and prior to submission, at both the group level (to maintain reporting focus) and provider level.

Why a QCDR is Critical to the Best Practice Approach

Why is this the territory of a QCDR? Because a QCDR that can measure both quality and cost performance as well as conduct performance improvement (unfortunately, not all QCDRs have these functionalities) will be able to measure outcomes over time, gather discrete data to clarify performance results, and create non-MIPS measures to customize performance improvement. These are necessary for a full scale, all-patient performance improvement approach.

A provider determined to focus on what he or she believes are the most important and clinically relevant metrics or strategies is an asset to any group. Single-specialty groups are largely aligned already when it comes to quality measurement, but they need to retain the ability to benchmark and compare for internal quality purposes. Even though multi-specialty groups see patients across the spectrum, they benefit from group reporting as well, while retaining the ability to pursue broader initiatives to measure and improve quality and cost performance.

Under the dual path of performance measurement and quality reporting, a provider's data results may contribute to the QCDR's database for measuring performance and contributing to other cost and improvement projects, but that provider may also contribute to quality scoring if that benefits the group.

The dual path provider who refuses to play any part in quality reporting stands out as inactive and below par because of absent results. This warrants the organization's legitimate concern and creates the basis for follow-up. It's true that many quality reporting initiatives have previously been relegated to IT or administrative staff, but the Quality Payment Program (both MIPS and APM paths) have changed the landscape. Providers who reject the concept of

performance measurement create impediments to improvement, which is harmful for MIPS, but, more importantly, to patients.

Other Benefits of Group Versus Individual MIPS Quality Reporting

In our experience, *no organization that has previously reported as a group has gone back to individual reporting*. They've found that Individual reporting is too much of an administrative burden and has a tendency to leave certain providers in a precarious position with regard to reporting options; not everyone has the same measures available.

MIPS has shifted extra administrative burden onto those who choose to report as individuals. In fact, reporting as a group eliminates the tedious process of confirming each individual's MIPS Eligibility status. Even if a provider is MIPS-eligible, that provider may qualify for automatic re-weighting within the Advancing Care section. This actually shifts extra weight to the provider's Quality score, which is one more thing to track. It was challenging enough in PQRS to ensure that each individual was meeting reporting requirements—adding two additional modules (Improvement Activities and Advancing Care Information) triples that burden.

While it's true that Group Reporting will include providers who may not be "MIPS-Eligible Clinicians" on their own, the administrative burden is still eased considerably. Painstakingly entering providers' NPIs into the CMS look-up tool (and then bringing the eligible clinicians up to speed) is a wasted effort—you're better served by coordinating care efforts and improving processes going forward.

Syncing quality reporting efforts means that practices can set outcome-based goals, rather than scramble to ensure that everyone is meeting numeric (but not necessarily meaningful) MIPS thresholds. By selecting and performing improvement activities to achieve your objectives, groups can work strategically to improve quality and cost scores, simultaneously earning credit for your activities. Once again, rather than struggling to confirm that everyone is checking the right boxes, an organization that aligns practice creates better processes to deliver better care. The result is a win-win: higher MIPS scores and healthier patients.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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