

# Why Real Improvement Pays in Your MIPS Improvement Activities Strategy

written by Dave Halpert | August 3, 2017



What separates MIPS from its quality program predecessors? On the [Quality Payment Program website](#), the only component that isn't a reincarnation of a previous program is the Improvement Activities (IA) category. Although the IA category has a smaller weight than the Quality category, it has the potential to be just as important, if not more so for your composite MIPS score.

How can 15 points compare to 60? The answer lies in the way in which those 60 points are earned. It also derives from a fundamental flaw of CMS quality reporting initiatives, to date.

## The Problem: The Focus On Reporting Has Led to “Flat Line” Outcomes

A long-term emphasis on reporting has marginalized the importance of performance—specifically, outcomes, adverse events and disease progression. CMS began utilizing the AMA's CPT Category II codes for tracking quality metrics more than a decade ago,

as a part of the Physician Voluntary Reporting Program (PVRP), which morphed into the Physician Quality Reporting Initiative (PQRI). PQRI started small, encouraging providers to report on quality metrics. Those who did were rewarded with incentive payments, and those who do not were simply passed over.

Performance and improvement were not factored into incentives—these early iterations were the building blocks of an eventual risk-based program. Improvement came from providers' intrinsic desire to get better, with a little bit of the Hawthorne Effect (knowing that you are being observed is often enough to change behavior) thrown in for good measure.

As PQRI transitioned into the mandatory Physician Quality Reporting System (PQRS), those of us who would become Qualified Clinical Data Registries developed analyses and tools for benchmarking quality data across practices, providers and networks, as well as tracking outcomes over time. With our clients, we created programs from quality reporting results in order to improve outcomes, close gaps in care, and identify at-risk patients before those patients incurred high costs.

The challenge was this: Without a requirement to enact additional quality improvement projects or a penalty for maintaining the status quo, not all quality departments could make the financial case to their leadership for the necessary resources. This was particularly true when resources were committed to activities for private health plans, which were tied to performance.

As expected, those who put their efforts into fulfilling requirements have been successful reporters, but have not seen the improved outcomes and decreased costs experienced by those who have focused on outcomes and successfully intervened. In MIPS, flat-line outcomes have put organizations in a bind—they are hard pressed to find an outcome measure with superior performance, and have discovered that a disproportionate number of their long-standing process measures are “topped out” and worth only a fraction of the possible total. In short, a long-term reporting strategy has put the MIPS category worth the most points in jeopardy. Without a plan to stop the spiral, your group will continue looking for superficial fixes that will not address the problem—and the bill will come due.

## The Solution: Leverage the Improvement Activity Requirement to End Stagnation

Maintaining consistent year-to-year reporting and performance may have served groups well in previous years, but is no longer sufficient. Demonstrating exceptional performance under MIPS is far more challenging, and those who have been living by the “report, repeat” philosophy will

find that performance deciles and “topped out” measures have deflated previous results when scoring performance.

At first glance, the [IA category](#) may not contribute as much to the MIPS score, but only if you consider it in a vacuum. When reviewing Improvement Activities as they relate to patients’ health and providers’ MIPS scores, understand this: Without strategically selecting and performing your activity, MIPS will continue to be a yearly jump through administrative hoops. There will be no benefit to your patients, and the same year-to-year results will eventually lead to penalties, as the playing field becomes more competitive. Although CMS may only be looking for a “Yes” when it comes time to attest that you’ve done your Improvement Activity, you should view this as more than a “check the box” program requirement, and should avoid taking shortcuts (i.e. attesting for an activity that you are already doing). This is an opportunity to use this requirement as a stepping-stone toward improved outcomes.

## The Plan: Use a QCDR to Identify Opportunities, Track Results and Earn IA Credit

Your goal should be to ensure that your Improvement Activities meaningfully contribute to your performance, rather than simply drain administrative resources. To that end, the first step is to select an activity that addresses an issue you’ve identified—and to recognize that it may be a challenge.

### Finding the Right Patients, Helping the Right Way

A Qualified Clinical Data Registry can help identify these deficiencies. For example, you should be able to view your current measure performance on demand, and be able to view any measure with a Registry Reporting option, and, if your QCDR is [ONC-Certified](#), see EHR-based measures, as well. Grouping all of the outcome measures together, you’ll clearly see where to focus your efforts. Do patients with hypertension have controlled blood pressures? Do patients with diabetes have controlled Hemoglobin A1c? If your performance in these measures is in a high decile, that’s great news, and an indication that you should focus your efforts on another set of patients. If performance is low, you’ve identified a population that can benefit from intervention.

Reports from CMS and [CAHPS Survey](#) vendors are also helpful when identifying potential areas for improvement. QCDRs can pinpoint opportunities here, as well. Analyzing your Quality and Resource Use Reports (QRURs) against your practice’s data, a QCDR can help you identify which patients are contributing to higher episodic costs, ambulatory care sensitive condition admissions, and more. A QCDR can also utilize CAHPS Survey data by creating customized

templates for collecting and trending patient feedback and comparing results.

Once you have identified your target population, the next step is to identify actions that you plan to take and define how these steps will fit into your workflow. Start with a small subset of patients before full deployment. Your QCDR can track the results on this group and provide you with a mechanism to record what has worked and what has not, either logistically or clinically. If the results are favorable, more providers and patients may be added to the activity. If there are no changes (or things get worse), examine the results with your QCDR to determine what changes are necessary prior to expansion.

## With a QCDR, Your Activities Translate Cleanly into IA Points

Of the 92 available Improvement Activities, QCDR use is a required component for 13 of them. That isn't to say that you cannot use a QCDR for others, but that some have been explicitly designed for practice-QCDR collaboration.

The key is to [track the results and learn from them](#), rather than merely to carry out a project for the sake of an attestation. In the previous examples, the goal is to bring hemoglobin A1c and/or blood pressure under control. Not only will these improved intermediate outcomes bring you up into higher performance deciles for two challenging outcome measures, but they also reduce these patients' risk of complications, hospitalizations or worse.

This is what makes the Improvement Activities so valuable—the point value of the activity may be comparatively small, but the effect the activity has on Quality and (eventually) Cost will be what separates those who do well from those who reach the “Exceptional Performance” Category. More importantly, IAs have the potential to affect the lives of the people behind the MIPS points—the patients. Lowering blood pressure or hemoglobin A1c can slow (or curb) disease progression, reduce hospitalizations and cut patients' out-of-pocket costs. Strategic selection of activities with a well-defined purpose and plan can tighten the bond between better scores and better care.

*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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