MIPS: SETTING UP QUALITY MEASURES
Today we will cover:

- 2017 Quality Category Requirements
- Selecting Quality Measures
- Setting up Quality Measures
  - Claims/Registry
  - eCQMs
- Quality Performance Scoring
2017 Quality Category Requirements

Select 6 Quality Measures
- 1 MUST be:
  - Outcome/Intermediate Outcome Measure OR
  - High Priority Measure: Appropriate Use
    Patient Experience
    Patient Safety
    Efficiency
    Care Coordination
- Report for a minimum of 90 days

Groups (25 or more ECs) using CMS web interface: Report 15 quality measures for a full year. (Must register as a group by June 30, 2017)

Test Pace (1 of 3 reporting options): Report 1 quality measure to avoid 2019 negative payments.
Report as Individual or as a Group

Individual
EC will be identified using the combination of billing TIN/NPI.

Group
Two or more EC identified by their NPI who have reassigned their billing rights to a single TIN.

MIPS eligible clinicians and groups must use the same identifier for all performance categories

Choose ONE Data Submission Mechanism

Individual
- QCDR
- Qualified Registry
- EHR
- Claims

Group
- QCDR
- Qualified Registry
- EHR
- Administrative Claims
- CMS Web Interface
- CAHPS for MIPS Survey

MIPS Eligible Clinicians may only use ONE submission mechanism per category
Keep in Mind those **BONUS** Points!

EC will receive bonus points when reporting on additional:
- **Outcome Measures** = 2 points/measure
- **High Priority Measures** = 1 point/measure

EC will receive bonus points when electing to submit thru:
- **EHR Reporting** = 1 point/measure
Selecting Measures
CMS QPP Website https://qpp.cms.gov
MIPS Specialty Measure Sets

Allergy/Immunology/Rheumatology
Anesthesiology
Cardiology
  - Electrophysiology Cardiac Specialist
Gastroenterology
Dermatology
Emergency Medicine
General Practice/Family Medicine
Internal Medicine
Obstetrics/Gynecology

Ophthalmology
Orthopedic Surgery
Otolaryngology
Pathology
Pediatric
Physical Medicine
Plastic Surgery
Preventative Medicine
Neurology
Mental Health

Radiology
  - Diagnostic Radiology
  - Interventional
Radiology
  - Radiation Oncology
Surgery
  - Vascular Surgery
  - General Surgery
  - Thoracic Surgery
Urology

Disclaimer
*MIPS eligible clinicians or groups are expected to report on applicable measures. “Applicable” is defined as measures relevant to a particular MIPS eligible clinician’s services or care rendered. MIPS eligible clinicians can refer to the measures specifications to verify which measures are applicable. Not all measures in each Specialty Measure Set will be applicable to all clinicians in a given specialty. If the set includes less than six applicable measures, the eligible clinician should only report the measures that are applicable.
## Outcome/Intermediate Outcome Measures

<table>
<thead>
<tr>
<th>Quality ID #/Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>122</td>
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<tr>
<td>141</td>
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<td>328</td>
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<td>329</td>
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<tr>
<td>330</td>
</tr>
</tbody>
</table>
### Outcome/Intermediate Outcome Measures

<table>
<thead>
<tr>
<th>Quality ID#/Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>335 Maternity Care: Elective Delivery or Early Induction without Medical Indication at &gt; or = 37 and &lt; 39 Weeks (Overuse)</td>
</tr>
<tr>
<td>338 HIV Viral Load Suppression</td>
</tr>
<tr>
<td>342 Pain Brought Under Control within 48 Hours</td>
</tr>
<tr>
<td>343 Screening Colonoscopy Adenoma Detection Rate Measure</td>
</tr>
<tr>
<td>344 Rate of CAS for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Op Day #2)</td>
</tr>
<tr>
<td>345 Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing CAS</td>
</tr>
<tr>
<td>346 Rate of Post-Op Stroke or Death in Asymptomatic patients Undergoing Carotid CEA</td>
</tr>
<tr>
<td>347 Rate of EVAR of Small or Moderate Non-Ruptured Intrarenal AAA Who Die While in Hospital</td>
</tr>
<tr>
<td>348 HRS-3: ICD complications Rate</td>
</tr>
<tr>
<td>354 Anastomotic Leak Intervention</td>
</tr>
<tr>
<td>355 Unplanned Reoperation within the 30 Day Post-Op Period</td>
</tr>
<tr>
<td>356 Unplanned Hospital Readmission within 30 Days of Principal Procedure</td>
</tr>
<tr>
<td>357 Surgical Site Infection</td>
</tr>
<tr>
<td>370 Depression Remission at Twelve Months</td>
</tr>
<tr>
<td>373 Hypertension: Improvement in Blood Pressure</td>
</tr>
<tr>
<td>378 Children Who Have Dental Decay or Cavities</td>
</tr>
<tr>
<td>383 Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
</tr>
<tr>
<td>384 Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery</td>
</tr>
<tr>
<td>385 Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery</td>
</tr>
<tr>
<td>388 Cataract Surgery with Intra-operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy</td>
</tr>
<tr>
<td>389 Cataract Surgery: Difference Between Planned and Final Refraction</td>
</tr>
<tr>
<td>392 HRS - 12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation</td>
</tr>
<tr>
<td>393 HRS-9: Infection within 180 Days of CIED Implantation, Replacement, or Revision</td>
</tr>
<tr>
<td>395 Lung Cancer Reporting (Biopsy/Cytology Specimens)</td>
</tr>
<tr>
<td>396 Lung Cancer Reporting (Resection Specimen)</td>
</tr>
<tr>
<td>397 Melanoma Reporting</td>
</tr>
</tbody>
</table>
Outcome/Intermediate Outcome Measures

Quality ID#/Measure Name

398  Optimal Asthma Control
404  Anesthesiology Smoking Abstinence
409  Clinical Outcome Post Endovascular Stroke
410  Psoriasis: Clinical Response to oral Systemic or Biologic Medications
411  Depression Remission at Six Months
413  Door to Puncture Time for Endovascular Stroke Treatment
417  Rate of Open Repair of Small or Moderate AAA Where Patients are Discharged Alive
420  Varicose Vein Treatment with Saphenous Ablation: Outcome Survey
424  Perioperative Temperature Management
432  Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair
433  Proportion of Patients Sustaining a Bowel Injury at the Time of any Pelvic Organ Prolapse Repair
434  Proportion of Patients Sustaining a Ureter Injury at the Time of any Pelvic Organ Prolapse Repair
435  Quality of Life Assessment for Patients with Primary Headache Disorder
437  Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure
441  Ischemic Vascular Disease All or None Outcome Measure (Optimal Control)
445  Risk-Adjusted Operative Mortality for CABG
446  Operative Mortality Stratified by the Five STS-EACTS Mortality Categories
454  Proportion of Patients who Died from Cancer with more than One Emergency Department Visit in the Last 30 Days of Life
455  Proportion Admitted to the Intensive Care Unit in the Last 30 Days of Life
457  Proportion Admitted to Hospice for less than
Selecting Measures
Example: Keyword – Hypertension; Filter by High Priority

Select Measures

Search All by keyword
- Filtered: Hypertension
- High Priority Measure
- Data Submission Method

Clear All Filters
Yes

Showing 2 Measures
- Controlling High Blood Pressure
- Hypertension Improvement in Blood Pressure

Add All Measures

- Controlling High Blood Pressure
- Hypertension Improvement in Blood Pressure

NQS Domain: Effective Clinical Care
Measure Type: Intermediate Outcome

Measure Number
- eMeasure ID: CMS165v5
- eMeasure NQS: N/A
- NQF 60-64
- Quality ID: 236

Data Submission Method
- Claims
- CMS Web Interface
- EHR
- Registry

Specialty Measure Set
- Internal Medicine
- Cardiology
- Obstetrics/Gynecology
- Preventive Medicine
- Thoracic Surgery
- Vascular Surgery
- General Practice/Family Medicine
Selecting Measures
Additional Documents: Specification Fact Sheet & MIPS Benchmarks
Measure Specification Fact Sheet
Example: Quality ID# 236 - Controlling High Blood Pressure

Measure #236 (NQF 0018): Controlling High Blood Pressure – National Quality Strategy Domain: Effective Clinical Care

2017 OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS ONLY

MEASURE TYPE:
Intermediate Outcome

DESCRIPTION:
Percentage of patients 18 - 85 years of age who had their blood pressure adequately controlled (<140/90 mmHg) during the measurement period or any time within the performance period. The performance period for this measure is 12 months and will be used for performance calculation. This measure includes measures for patients discharged from the hospital and patients treated in an ambulatory setting. The measure is also used for the following measures:

INSTRUCTIONS:
This measure is to be reported a minimum of once per year. The numerator data will be used for performance calculation. This measure includes measures for patients discharged from the hospital and patients treated in an ambulatory setting. The measure is also used for the following measures:

NOTE: In reference to the numerator element, only blood pressure readings from the patient’s home (including readings directly from the patient’s home) are acceptable for numerator compliance with the following criteria:

- Blood pressure readings from the patient’s home (including readings directly from the patient’s home) are acceptable for numerator compliance with the following criteria:
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, contrast for a radiology procedure, endoscopy)

If no blood pressure is recorded during the measurement period, the patient’s blood pressure is considered “controlled.”

Measure Reporting:
The listed denominator criteria are included in this specification and should be reported on the claim.

DENOMINATOR:
Patients 18-85 years of age with diagnosis of hypertension AND diagnosis of hyperlipidemia AND patient encountered during healthcare in 2017:
- G0412, G0413, G0414
- G0438, G0439

Numerator Quality-Data Coding Options:
Patient receiving Hospice Services, Patient Not Eligible:
Denominator Exclusion: G9740:
Hospice services given to patient any time during the measurement period

OR
Patient not Eligible for Recommended Blood Pressure Parameters for Documented Reasons
Denominator Exclusion: G9231:
Documentation of end stage renal disease (ESRD), dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period

OR
Most Recent Blood Pressure Measurement Performed
Systolic pressure (Select one (1) code from this section):
Performance Met: G8752:
Most recent systolic blood pressure < 140 mmHg

OR
Performance Not Met: G8753:
Most recent systolic blood pressure ≥ 140 mmHg

AND
Diastolic pressure (Select one (1) code from this section):
Performance Met: G8754:
Most recent diastolic blood pressure < 90 mmHg

OR
Performance Not Met: G8755:
Most recent diastolic blood pressure ≥ 90 mmHg

OR
Blood Pressure Measurement not Documented, Reason not Given
Performance Not Met: G8756:
No documentation of blood pressure measurement, reason not given
1. Select a tentative list of quality measures.
   **Remember:** 1 required Outcome or High Priority Measure. Additional outcome and high priority measures will yield bonus points.

2. Review Measure Specification Fact Sheet to confirm the measure if applicable to your specialty.

3. Make sure there is a benchmark for each measure you selected.
Setting Up the Measures
Claims or Registry
Check Codes in Practice Manager

Administration>Transaction Tables>Procedure

[Image of the user interface showing the Procedure Lookup window]

- **Procedure Lookup** window with columns: H Code, CPT4 Code, Description, Amount, Unit Value, TOS, PGS, Follow Up Days, Primary Modifier, Second Modifier, RVU, ABLU, RVU Rate.
- The user can search by entering criteria in the search box and clicking the 'Find' button.
Adding New Codes in Practice Manager
Add Procedure Checklist in Chartmaker

1. Click on "Proc List" in the dropdown menu.
2. Select "Proc List" to add the procedure checklist to the chart.
3. The procedure checklist will be added to the "Plan" section of the chart.
Procedure Checklist Set Up

MiPS Quality Measure Codes

Condition Search

Selected Codes

Search/Add Procedures   Add Label   Group Maintenance

Remove from Selected Codes
Setting Up the Measures!

eCQMs

(Electronic Clinical Quality Measures)
### Clinical Quality Measures (CQM 2016 version)
#### 2017 performance year

<table>
<thead>
<tr>
<th>NQF#/Quality ID#</th>
<th>Measure Name</th>
<th>NQF#/Quality ID#</th>
<th>Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD/377</td>
<td>Functional Status Assessment for CHF</td>
<td>TBD/066</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
</tr>
<tr>
<td>0022/238</td>
<td>Use of High Risk Medications in the Elderly</td>
<td>0052/312</td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td>0419/130</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>0069/065</td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
</tr>
<tr>
<td>0024/239</td>
<td>Weight Assessment &amp; Counseling for Nutrition &amp; Physical Activity for Children &amp; Adolescents</td>
<td>0018/236</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>0028/226</td>
<td>Preventative Care &amp; Screening Tobacco Use: Screening &amp; Cessation Intervention</td>
<td>2372/112</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>0033/310</td>
<td>Chlamydia Screening for Women</td>
<td>0032/309</td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td>0041/110</td>
<td>Preventative Care &amp; Screening: Influenza Immunization</td>
<td>0034/113</td>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td>0421/128</td>
<td>Preventative Care &amp; Screening: Body Mass Index (BMI) Screening and Follow Up</td>
<td>TBD/281</td>
<td>Dementia: Cognitive Assessment</td>
</tr>
<tr>
<td>NQF#/Quality ID#</td>
<td>Measure Name</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0043/111</td>
<td>Pneumococcal Vaccination Status for Older Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0055/117</td>
<td>Diabetes: Eye Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0056/163</td>
<td>Diabetes: Foot Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0059/001</td>
<td>Diabetes: Hemoglobin A1c Poor Control (&gt;9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0062/119</td>
<td>Medical Attention for Nephropathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0081/005</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0083/008</td>
<td>Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0088/018</td>
<td>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0108/366</td>
<td>ADHD: Follow-Up Care for Children Prescribe Attention-Deficit Hyperactivity Disorder (ADHD) Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TBD/378</td>
<td>Children who have Dental Decay or Cavities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TBD/373</td>
<td>Hypertension: Improvement in Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TBD/374</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0101/318</td>
<td>Falls: Screening for Future Falls Risk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**eCQM Specifications**

- **Closing the Referral Loop: Receipt of Specialist Report**: CMS / NQF: 50 / X
- **HIV/AIDS: Medical Visit**
- **Hypertension: Improvement in Blood Pressure**
- **Documentation of Current Medications in the Medical Record**
- **Preventive Care and Screening**
- **Screening and Follow-Up Plan**
- **Children Who Have Dental Decayed Teeth**
- **Functional Status Assessment**
- **Conditions**
- **Diabetes: Hemoglobin A1c Poor Control**

### Diabetes: Hemoglobin A1c Poor Control

**CMS / NQF #:** 122 / 0059

**In ChartMaker Clinical:**

In order to qualify for this measure, the provider must have seen the patient (age 18 to 75) at least one time during the reporting period and have the appropriate information documented in the chart:

**Required Data Elements for the Denominator:**

- Office Visit or Face-to-Face Interaction (SNOMED) Code during the measurement period
- Diabetes Diagnosis or SNOMED Code that starts before or during the measurement period and remains active throughout

**Required Data Elements for the Numerator:**

- HbA1c Lab Result (LOINC) Code that occurs during the measurement period with a result of > 9% (OR no occurrence of the code)
Adding SNOMED Codes

- You can only attach SNOMED Codes to procedure and diagnosis codes when you are in a chart note.
- You must set up for each user.
Adding SNOMED Codes to (ICD 10) Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4783006</td>
<td>Maternal diabetes mellitus with hypoglycemia affecting newborn (disorder)</td>
</tr>
<tr>
<td>9859006</td>
<td>Insulin-resistant diabetes mellitus AND acanthosis nigricans (disorder)</td>
</tr>
<tr>
<td>23045005</td>
<td>Insulin dependent diabetes mellitus type IA (disorder)</td>
</tr>
<tr>
<td>28032008</td>
<td>Insulin dependent diabetes mellitus type IB (disorder)</td>
</tr>
<tr>
<td>4405400b</td>
<td>Diabetes mellitus type II (disorder)</td>
</tr>
<tr>
<td>46635009</td>
<td>Diabetes mellitus type I (disorder)</td>
</tr>
<tr>
<td>75682002</td>
<td>Diabetes mellitus due to insulin receptor antibodies (disorder)</td>
</tr>
</tbody>
</table>

SNOMED Selection

Double click an item or Search to add a SNOMED code:

- Type 2 diabetes mellitus without complications

Add to Problem List

- Type 2 diabetes mellitus without complication...
- Type 2 diabetes mellitus with hyperglycemia...
- Type 2 diabetes mellitus with other specified...

Order Sets marked with (*) are linked to this Diagnosis

- Onset: 01/25/2017 10:55:07
- Inactivate
- Deactivate
- Resolve

Disclaimer: Diagnoses to SNOMED mappings are derived using data provided by the National Library of Medicine.
Adding SNOMED Codes to (ICD 10) Diagnosis Codes
Adding SNOMED Codes to (ICD 10) Diagnosis Codes

**Important:**
Click “Save” as User Defaults
Adding SNOMED Codes to (CPT) Procedural Codes
Adding SNOMED Codes to (CPT) Procedural Codes

1. Open the Search List.
2. Enter the SNOMED Code in the search column.
3. Select the search type 'Equals'.
4. Search for the specific SNOMED Code (e.g., 270427003).
5. View the matching result, which is the Patient-initiated encounter.

Matching Results: 1

SNOMED Code: 270427003
Description: Patient-initiated encounter
Adding SNOMED Codes to (CPT) Procedural Codes

IMPORTANT!: Check on the “Save” as User Defaults
Adding LOINC Codes

**In ChartMaker Clinical:**

In order to qualify for this measure, the provider must have seen the patient (again) at least once during the reporting period and have the appropriate information documented.

**Required Data Elements for the Denominator:**

- Office Visit or Face-to-Face Interaction (SNOMED) Code during the measurement period
- Diabetes Diagnosis or SNOMED Code that starts before or during the measurement period and remains active throughout

**Required Data Elements for the Numerator:**

- HbA1c Lab Result (LOINC) Code that occurs during the measurement period with a result of > 9% (OR no occurrence of the code)

If a HbA1c laboratory test was performed, it can be captured by:

- An electronic lab result with a valid LOINC code,
- Adding a numeric result with a valid LOINC code using a numeric control in a note,
- Adding a procedure with a valid LOINC code using the Procedure widget in a note

**LOINC:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17855-8</td>
<td>Hemoglobin A1c/Hemoglobin.total in Blood by calculation</td>
</tr>
<tr>
<td>17856-6</td>
<td>Hemoglobin A1c/Hemoglobin.total in Blood by HPLC</td>
</tr>
<tr>
<td>4548-4</td>
<td>Hemoglobin A1c/Hemoglobin.total in Blood</td>
</tr>
</tbody>
</table>
Adding LOINC Codes
Electronic Lab Results

Edit>System Tables>Condition>Results
Adding LOINC Codes
Electronic Lab Results
Reminder: If you are interfaced with multiple labs, you will need to attach the LOINC code to each Lab’s test.
Adding LOINC Codes
Manually Entered Lab Results

Adding a Condition

Edit>System Tables>Condition>Results
Adding LOINC Codes
Manually Entered Lab Results

Adding a Condition

[Diagram showing a window titled 'Condition Properties' with fields for Condition Name, Diagnosis/Procedure, Result/Complaint, etc.]

Link the LOINC Code

[Diagram showing a window titled 'LOINC Search' with fields for LOINC Code, Description, etc. and a button labeled 'OK']
Adding LOINC Codes
Manually Entered Lab Results

Adding Numeric Field in Template
Adding LOINC Codes
Manually Entered Lab Results

Setting the Properties of Numeric Tool
Adding LOINC Codes
Manually Entered Lab Results

Setting the Properties of Numeric Tool

Numeric Field Properties

Condition: HbA1c

Label

Unit %

Absolute minimum: 0

High warning above: 100

Low warning below: 0

Absolute maximum: 100

Default value: 5%

Settings for decimal places and spinner increment are also shown.

LAB RESULTS

HbA1c: 7.4

ASSESSMENT

DIAGNOSIS:
SCORING
QUALITY MEASURES
**Total Quality Performance Category Score**

\[
\text{Points earned on required 6 quality measures} + \text{Any bonus points} = \text{Maximum number of points}\]

*Maximum Number of Points*

- 60 points – Without the “All-cause Readmission Measure”
- 70 points – With the “All-cause Readmission Measure”

**All-cause Readmission Measure**

- Will Only be score for Groups (16 or more EC) who have beneficiaries attributed to them and meet the minimum case requirement.

- The 30-day All-cause Hospital Readmission measure is risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge.

- Does NOT Require Data Submission – Administrative Claims
ECs will automatically receive 3 points for completing and submitting a measure(s).

If a measure can be reliably scored, then the EC can receive 3-10 points.
Reliable score means:
- Benchmarks exists
- Sufficient case volume (≥ 20 cases (for most measures); ≥ 200 cases for readmission measure
- Data completeness met: Data elements were captured (Numerator) for at least 50% of the measures intended population (Denominator)
  - Claims: 50% of Medicare Part B patients for the performance period
  - QCDR, QR, EHR: 50% of patients across all-payers, including 1 Medicare patient, for the performance period.
Easier for a EC to participate longer (>90 days) to meet the case volume and data completeness criteria needed to receive more than 3 points

Measure without a benchmark, the EC receives 3 points.
- New Measures
- Existing Measure with substantive change for 2017 reporting
This Decile Scale is for Non-Inverse Quality Measures to estimate possible points.

*For Inverse Measures, the order would be reversed. Decile #10 = 3 points
Quality Scoring: Basics

Each measure is converted to points (3-10) + Zero points for a measure that is not reported + Bonus for reporting additional outcomes measures and high priority measures + Bonus for EHR reporting = Total Points

Total points ÷ Total possible points = # × 100 = Quality Performance Category Score

60% is applied to the EC’s Composite Score
STI’s MIPS Assistance Program

The coaches are working with the practices to:

- Educate them on the program and its details
- Quality measures
  - Help them select the 6 measures & Configure the measures
  - Train them on how to document them in Clinical
- Advancing Care Information
  - Make decisions about what measures they will comply with
  - Make any necessary changes in Clinical accordingly
- Clinical Practice Improvement Activities
  - Review the options & Help them select CPIAs
  - Make changes in system to support CPIA as necessary
- Quality Registry Portal
  - Get them access to the portal
  - Familiarize them with the portal functionality
  - Show them how to review and make any corrections to the data
- Touch-base calls during the year to answer questions & assess your progress
- Assist with MIPS Attestation
**STI MIPS Assistance Program**

The cost of the MIPS Assistance Program is $3750 for the 1st provider in the practice and $1875 for each additional provider.

http://sticomputer.com/mips-enrollment

**STI Quality Registry**

The cost for the Quality Registry is $590 per provider, per year. But it’s free for **MIPS Assistance Program clients**.
Additional Help!

Call QPP Service Center:
1-866-288-8292
Available: Monday – Friday 8am-8pm

Send Questions:
QPP@CMS.hhs.gov