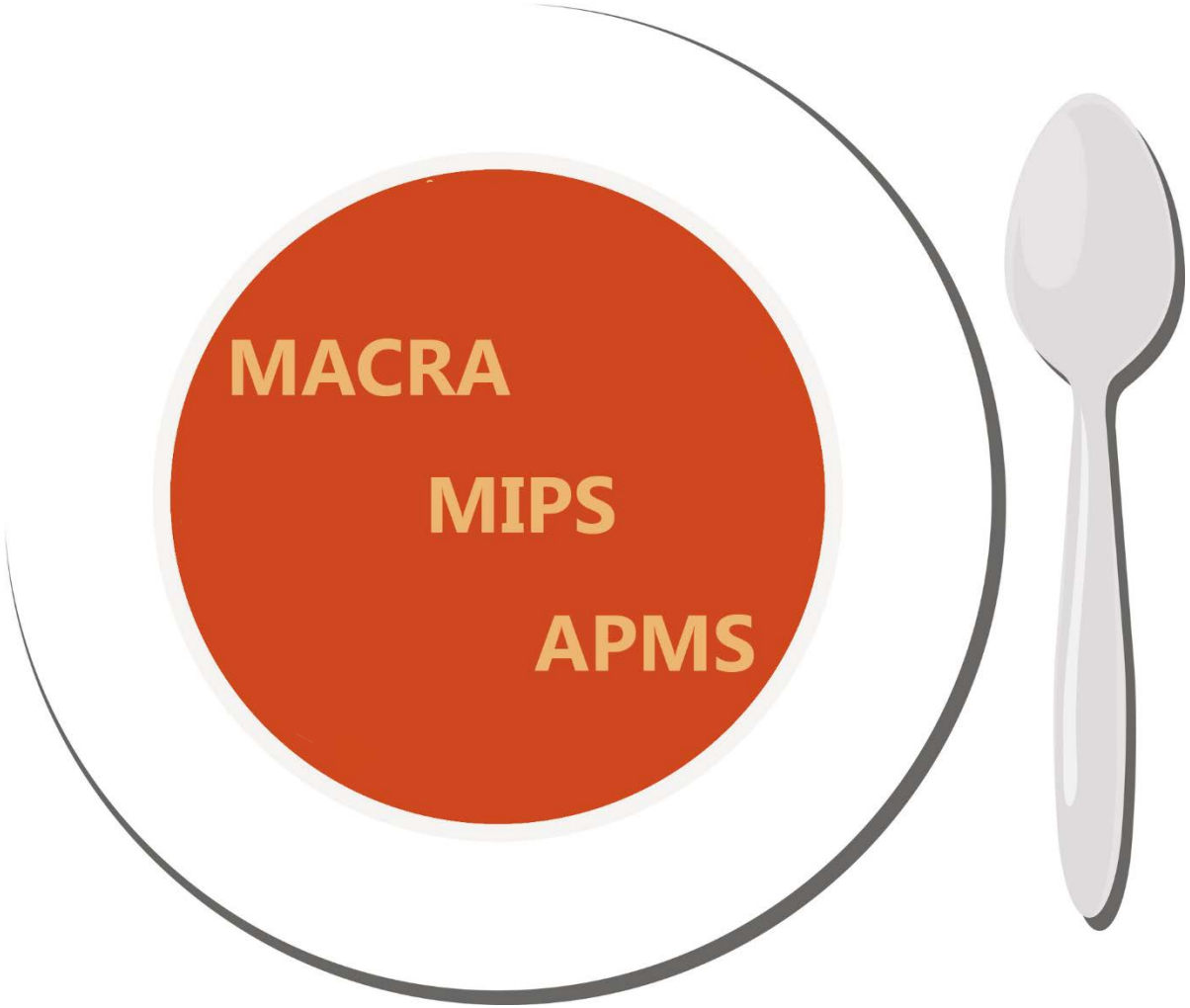
MACRA Update



California Best Practices & GPRA Measures Conference / Diabetes Day

Presented by:

Kerry Luciani
BSIE, MBA Finance
HRG Business Intelligence Director

Marilyn Freeman
RHIA, CHPS, CHC, HIM/Compliance Officer, California Area Indian Health Service

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Presenters

- Kerry F. Luciani MBA (of HRG Business Intelligence), has over 25 years of Healthcare Revenue Cycle Management experience, on both the payer and provider side. Over the years, he has developed an abundance expertise in Medicare Part B reimbursement, and has had several comments published in the Federal Register.
- Marilyn Freeman, RHIA, CHPS, CHC is the HIM/Compliance Officer for the California Area Indian Health Service. She serves as the Area Meaningful Use Coordinator. Marilyn has over 30 years of HIM experience in a variety of settings.

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Disclaimer

This PowerPoint presentation is an educational tool to provide basic information.

The information is the sole view of the author and was put together based on experience, research and expertise in the healthcare finance profession. It is not intended to be an exhaustive review and should not be considered a substitution for Billing or Coding Guidelines.

The presenters do not accept any responsibility or liability with regard to errors, omissions misinterpretations or misuse by the audience.

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Objectives

- Learn the basics of MACRA – CMS's landmark value based payment system and what you need to do in 2018
- Review select changes to the 2017-2018 MACRA plan
- Examine MACRA quality measure(s) that make up 50% of the MIPS performance score.
- Identify some of the ways CDI interacts with MACRA
- Identify areas to focus for providers to reach optimal results

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2018 ICD-10-CM Diagnosis Code X37.1XXA: Tornado, initial encounter

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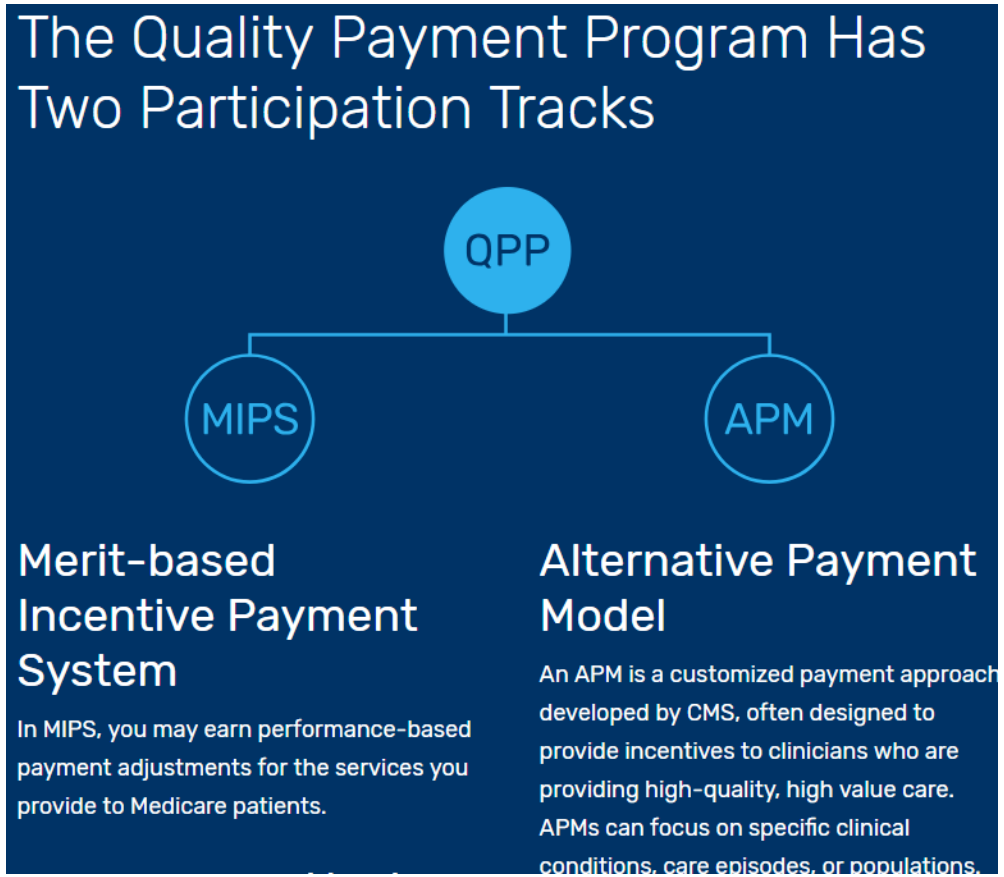
Background

- MACRA=the Medicare Access and CHIP Re-authorization Act of 2015
- MACRA repeals the legacy Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula and replaces it with the QPP (a new value-based reimbursement system impacting Part B payments)
- The QPP consists of two major tracks:
  - The Merit-based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)
- February 2018, Congress passed the Bipartisan Budget Act of 2018 which made some modifications to the MIPS program for 2018 and future years (~ +transition period)
- CMS predicts that 600,000 Part B clinicians will be subject to MIPS in 2018

Background (continued)



Merit-based incentive payment system (MIPS)

Combines legacy programs:

- Physician Quality Reporting System (PQRS)
- Value-Based payment Modifier (VM)
- Medicare EHR Incentive program for Eligible Professionals (MU)

Question: How are events from 2 years ago impacting your Medicare Part B payments today???

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Quality Payment Program Goals:

Goals QPP:

- Improve beneficiary outcomes
- Enhance clinician experience
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

qpp.cms.gov.

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Number #1! - Are you eligible (2018 PY)?

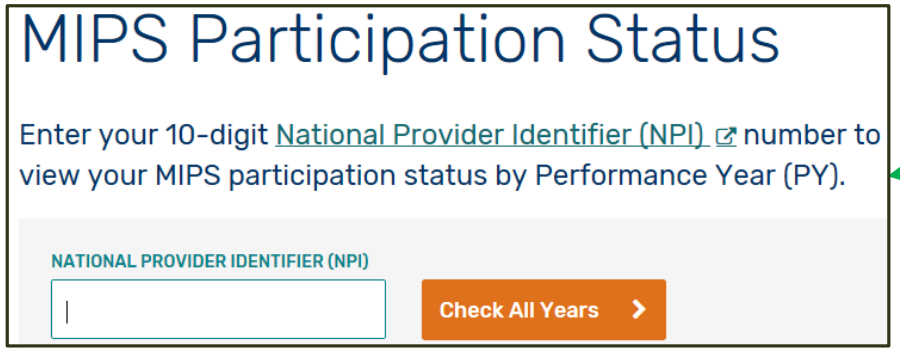
MIPS Eligible Clinicians

- Physicians
  - MD, DO (Dentist, Podiatrist, Optometrist, Chiropractor)
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Low-Volume Threshold

- > $90,000 Medicare Part B allowed charges, AND
- >200 Part B Medicare Enrolled Beneficiaries

You can check today!



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Exemptions

MIPS Year 2 (2018)

Who is Exempt?

No Change in Basic Exemption Criteria*

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to **$90,000** a year

OR

- See **200** or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

**Only Change to Low-volume Threshold*

Payments excluded from MIPS payment adjustments:

- Medicare Part A
- Medicare Advantage Part C
- Medicare Part D
- CAH Method I facility payments
- Federally qualified health center (FQHC), rural health clinic (RHC),
  ASC's, home health agency, hospice, or
  Hospital OP fac payments billed under the facility's all-inclusive payment methodology or PPS methodology

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Individual Clinician Versus Group Scoring

- For each performance year, a provider organization may choose to report MIPS data for clinicians individually ***or*** as a group of clinicians billing (common TIN).
- This decision must apply equally across all MIPS categories for a given performance year (i.e. a clinician cannot choose to be subject as an individual for some categories and relying on a group for other categories).
- ***The decision to report as a group or by individual clinicians has significant financial and reputational ramifications that need to be considered***.
- For 2018, Virtual groups (practices <=10 Clinicians) can also be created, though the deadline has passed (31Dec17).

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MIPS - Your Final Score

MIPS Performance Categories Year 2 (2018)

- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

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Category-ACI (Advancing Care Information/PI)

2018 Advancing Care Information Transition Measures & Scores

Required Measures for 50% Base Score
Security Risk Analysis
e-Prescribing
Provide Patient Access*
Health Information Exchange*

*Note that these measures are also included as performance score measures and will allow a clinician to performance score ntributes to the

- **OR:** You may not need to submit if these measures do not apply

Bonus points are available!

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Category-Improvement Activities (CPIAs)

Measures clinician/group of clinicians ability to engage in activities that improve clinical practice or care delivery

- **Most participants:** Attest to up to 4 activities
- **Groups with <15 participants or in small, rural or underserved areas:** Attest to up to 2 activities
- **Groups in Certified PCMH and APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1:** Automatically earn full credit.
- For group participation, only 1 MIPS EC has to perform the activity for full credit

Examples
Practice access 24/7
Population management
Care coordination
Consulting AUC Using Clinical Decision Support~Ordering Advanced Img
Behavioral health – tobacco intervention

Bonus points are available!

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Category-Cost

Resource Use goal: To compare risk adjusted resources used to treat similar **care episodes** and **clinical condition groups** across practices.

Cost Performance Category

10% of Final Score

2 Cost Measures

Medicare Spending Per Beneficiary	Total Per Capita Cost
• Episode based by Practice/Group (TIN) • 3 days prior to admission + 30 days post admission	• Practitioner Based (TIN-NPI) • Full Year

No Bonus points are available!

Note: Attribution (or mapping of patients) may be at the Physician or Group level

2 Industry concerns:

1. Many in the Provider community continue to oppose the primary care-based attribution model (which is viewed as flawed), because it potentially holds Providers responsible for the cost of care they did not provide or is out of their control;
2. Many oppose the lowering the beneficiary threshold of the MSPB measure (from 125 to 35 [2018]). It may improperly attribute pts.

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Category-Quality

Quality measures are tools that help us measure health care processes, outcomes, and patient experiences of their care. Quality measures also help us link outcomes that relate to 1 or more of these quality goals for health care that's: Effective, Safe, Efficient, Patient-centered, Equitable & Timely. There are more than 270 quality measures that are final for reporting for the 2018 performance period in the Quality Payment Program.

Quality measure classifications		
Process measures Process measures show what doctors and other clinicians do to maintain or improve the health of healthy people or those diagnosed with a given condition or disease. These measures usually show generally accepted recommendations for clinical practice. For example: The percentage of people getting preventive services (such as mammograms or immunizations). *Process measures can:* • *Tell consumers about the medical care they should get for a given condition or disease.* • *Help improve health outcomes.*	**Outcome measures** Outcome measures show how a health care service or intervention affects patients' health status. For example: -Pain Brought Under Control Within 48 Hours. -Depression Remission at Twelve Months. -Optimal Asthma Control.	**High priority measures** High priority measures include these measure categories: • Outcome • Appropriate use • Patient experience • Patient safety • Efficiency measures

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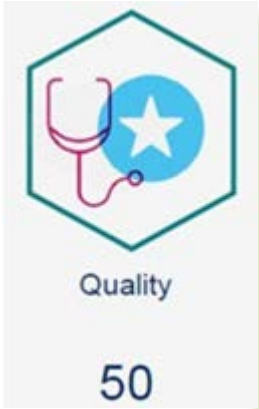
Bonus points are available!

Category-Quality



Starting in 2018, there is a 12-month Quality performance period (January 1 – December 31, 2018). With a full year report of quality data, a more complete picture of performance and a greater chance to earn a higher positive payment adjustment.

There is also a chance to raise your 2018 Quality category score based on the improvement from the Quality category score in the transition year.

To meet the Quality performance category requirements for most data submission mechanisms, a clinician, group, or Virtual Group has to report the following:

- Six quality measures (or a complete specialty measure set) for the 12-month performance period.
- The six measures must include at least 1 outcome measure or another high priority measure in the absence of an applicable outcome measure.

Bonus points are available!

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Quality – Measure Example (Id: 325)

Adult Major Depressive Disorder (MDD): coordination of care of patients with specific comorbid conditions

RATIONALE:

Depressive disorders are more common among persons with chronic conditions (e.g., obesity, cardiovascular disease, diabetes, asthma, arthritis, and cancer) and among those with unhealthy behaviors (e.g., smoking, physical inactivity, and binge drinking). Comorbidities are more common in the elderly. The highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%). The coordination of care for patients with depression and certain comorbid conditions is important for managing both the patient's depression and the other present medical condition.

Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stage 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition.

Measure Number	**NQS Domain**	**Measure Type**
• eMeasure ID: N/A • eMeasure NQF: N/A • NQF: N/A • Quality ID: 325	• Communication and Care • Coordination	• Process
High Priority Measure	**Data Submission Method**	**Specialty Measure Set**
Yes	• Registry	• Mental/Behavioral Health

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Capturing Comorbidities

- Documentation
- Coding
- Communication to providers treating the comorbid conditions

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Quality – One Measure Example (continued)

Id:325 - Adult Major Depressive Disorder (MDD): coord. of care of patients with specific comorbid conditions

NUMERATOR:
Medical records of patients with communication to the clinician treating the comorbid condition

Definition:
Communication Transmission of relevant clinical information which specifies that the patient has MDD

Numerator Options:
Performance Met: Clinician treating Major Depressive Disorder communicates to clinician treating comorbid condition **(G8959)**

OR

Denominator Exception: Clinician treating Major Depressive Disorder did not communicate to clinician treating comorbid condition

Definition:
Comorbid condition – For the purposes of this measure, only the following comorbid conditions will be included:
1) Diabetes
2) Coronary artery disease
3) Stroke, including ischemic stroke and intracranial hemorrhage
4) Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease
5) Congestive Heart Failure

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-10-CM): F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
AND
Patient encounter during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Diagnosis for diabetes (ICD-10-CM): E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.3211, E10.3212. E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, E10.3299, E10.3311,

SAMPLE CALCULATIONS:

Data Completeness=

$$\frac{\text{Denominator Exclusion (x=0 procedures)+Performance Met (a=4 procedures)+Denominator Exception (b=1 procedure)+Performance Not Met (c=2 procedures)=7 procedures}}{\text{Eligible Population / Denominator (d=8 procedures)}} = \textbf{87.50\%}$$
$$= 8 \text{ procedures}$$

Performance Rate=

$$\frac{\text{Performance Met (a=4 procedures)}}{\text{Data Completeness Numerator (7 procedures)- Denominator Exclusion (x=0 procedures) – Denominator Exception (b=1 procedure)}} = \frac{4 \text{ procedures}}{6 \text{ procedures}} = \textbf{66.67\%}$$

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Quality – Measure Example (Id: 163)

Diabetes: Foot Exam

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year

MEASURE NUMBER	NQS DOMAIN	MEASURE TYPE
• eMeasure ID: CMS123v5 • eMeasure NQF: None • NQF: 0056 • Quality ID: 163	ECC	Process
HIGH PRIORITY MEASURE	**DATA SUBMISSION METHOD**	**SPECIALTY MEASURE SET**
No	• EHR	• Internal Medicine • General Practice/Family Medicine
PRIMARY MEASURE STEWARD		
National Committee for Quality Assurance		

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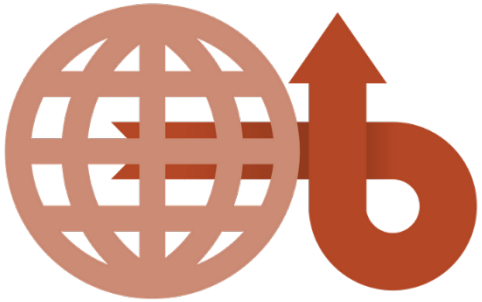
Outpatient CDI

Expanding under MACRA

CDI program framework transitioned from acute care to physician offers

Goal: high level of specificity in physician documentation

Welcome to the world of risk scores!



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First Stop - Registration

Risk Scores Based On Demographics

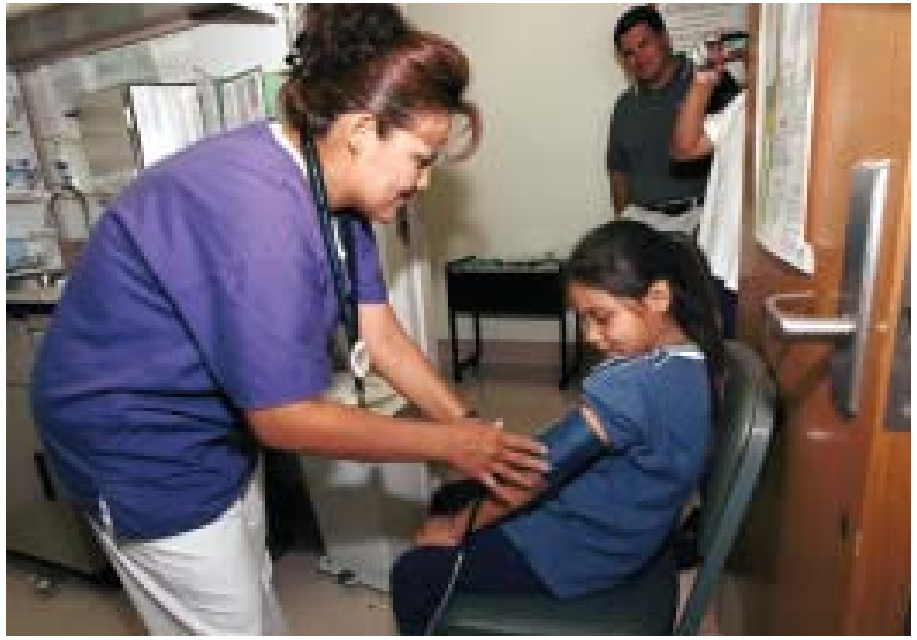
Age

Gender

Point-Of-Care Documentation

Clinical care team-all persons who document in the patient record

Traditional model burdens the provider and creates a bottleneck



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It Takes The Whole Team!!

Providing and documenting effective care!

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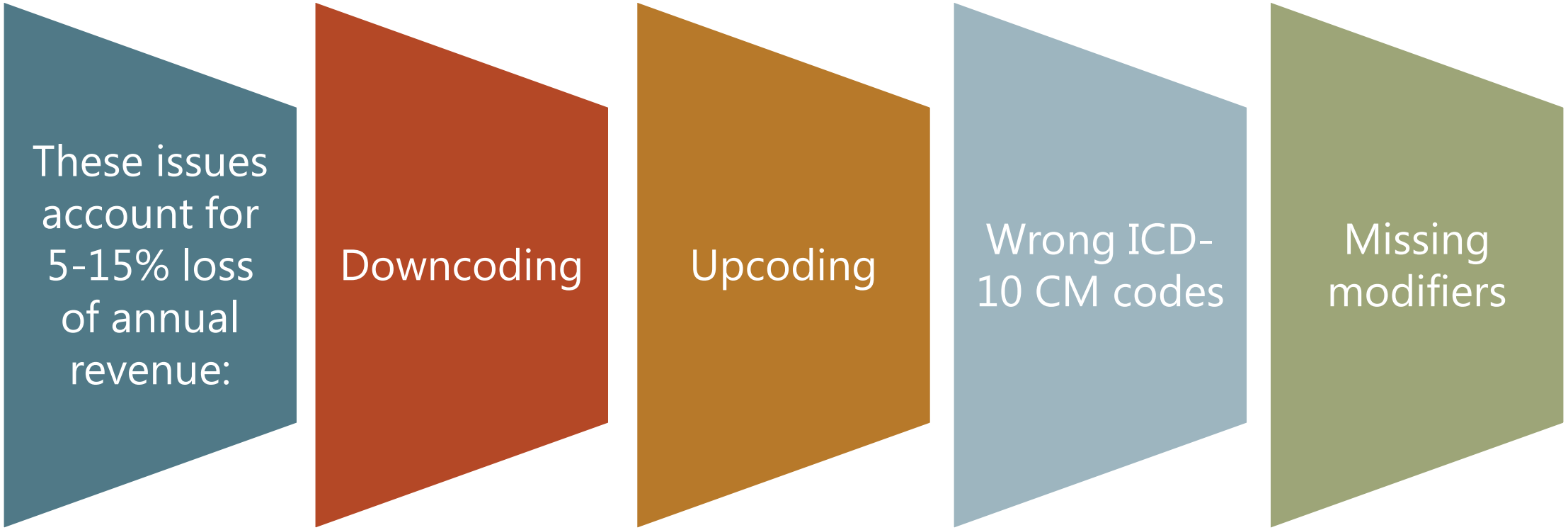
NOW – Look To Correct



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Focus On Documentation FOR:

- ICD-10 diagnosis coding specifics
- HHC coding
- Targeted specialty-centric code focus
- Accurate documentation at the point of care
- Emphasis on ICD 10 coding guidelines
- Understanding common coding misses

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Coding For Risk Adjustment

Codes in claim submissions directly impact reimbursement

Provider documentation is required to support diagnoses that map to HCC codes

Reimbursement linked to how 'sick' the patient is

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Example: COPD Chronic Condition

- The condition must be documented at least one per calendar year to weigh into risk adjusted score
- A condition (chronic or otherwise) should only be coded if it is addressed during a visit
- The attention to the condition must be documented in order to be coded
- To support attention to a condition there are no discrete documentation guidelines
- An adequate example might be: “COPD-stable status lungs clear, MDI Rx refilled today”

Understanding Common Coding Scenarios

Show current state of disease process

Signs and symptoms are acceptable if there is no definitive diagnosis

Show relationship in diagnosis to other disease process through linking conditions with ‘due to’, ‘with’, ‘caused by’, and ‘secondary to’

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Telling The Whole Story In ICD-10

Where are the gaps in the story now?

- Consistency/conflict/ambiguity (clarify as needed to keep the record accurate)
- Disease type (for atrial fibrillation, is it persistent, paroxysmal or chronic)
- Disease acuity (acute, chronic or acute-on-chronic)
- Disease stage (for diagnoses such as chronic kidney disease and pressure ulcers)
- Etiology and manifestations (such as diabetes, encephalopathy, anemia, ulcers)
- Details needed for combination codes (instructions in the ICD-10 Tabular list)
- Nicotine, alcohol and drug use/abuse/dependence

Example: Neoplasms

- Is cancer current and under active treatment or history of?
- Consider guidelines for assignment of these diagnoses.
- Would we capture colostomy?
- Is cancer a secondary cancer or metastasis?
- Is there anemia and is it drug induced?
- Are any secondary diagnosis complications from the cancer or the treatment?

MACRA Update (2017 vs. 2018 Perf Category compare)

2017 vs 2018 Reporting

Transition Year 1 (2017) Final

Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option
Cost	Not included. 12-months for feedback only.
Improvement Activities	90-days
Advancing Care Information	90-days

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Advancing Care Information	90-days

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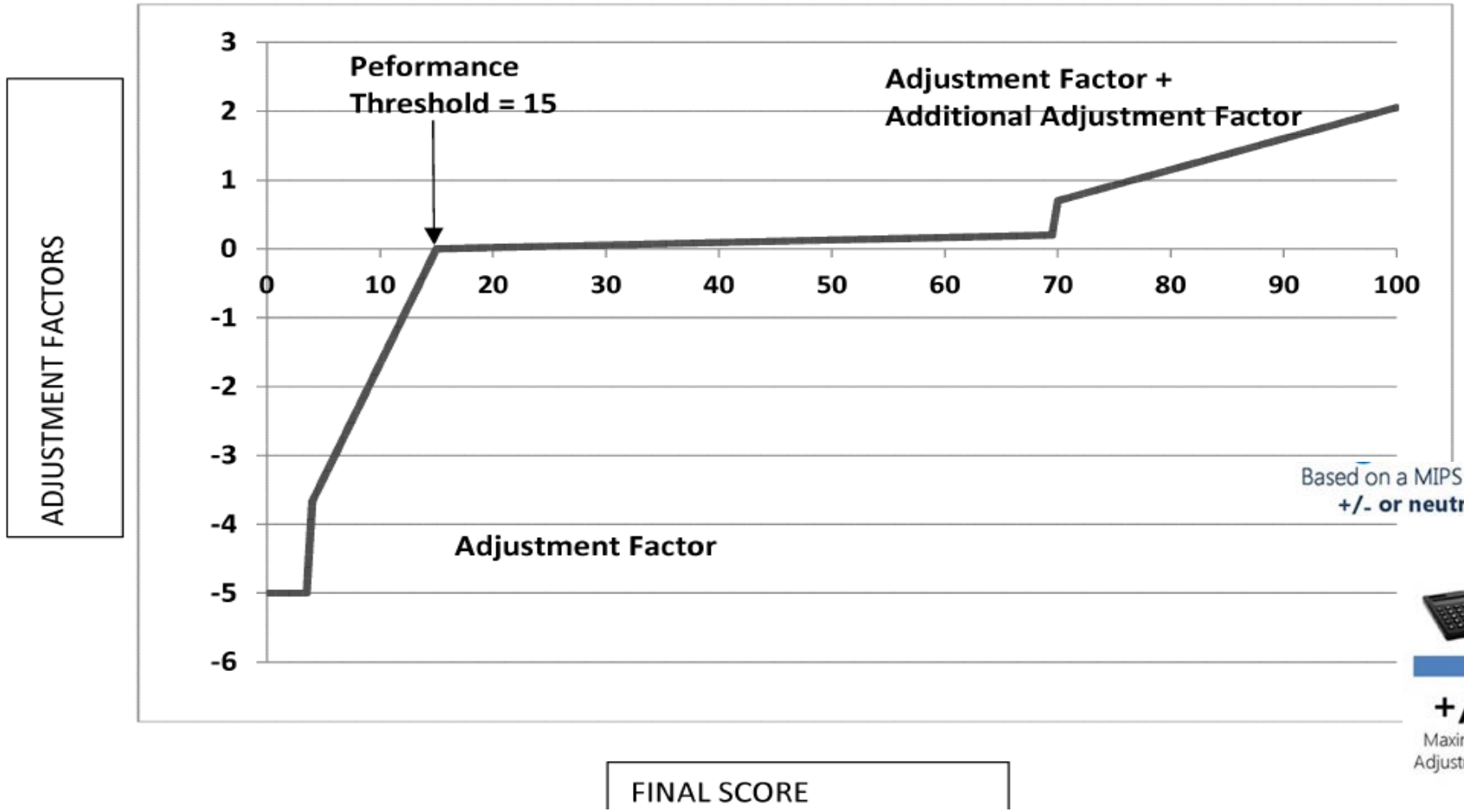
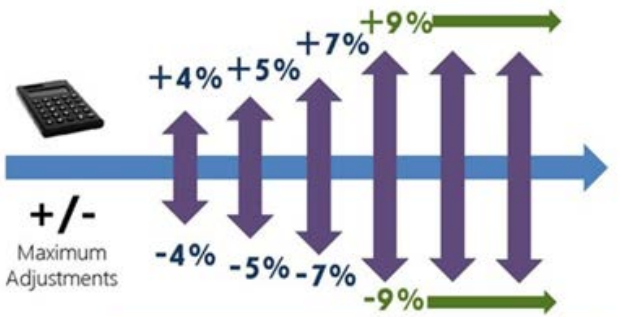
FIGURE A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2020 MIPS Payment Year



Based on a MIPS Composite Performance Score, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



2019	2020	2021	2022 onward
Merit-Based Incentive Payment System (MIPS)			

MIPS Impact to Reputation

- Approx. 12 months after a performance period, MACRA requires CMS to publish each eligible clinician's annual MIPS score and performance category scores.
- More than 500,000 CY2017 MIPS scores will be publicly available around the end of CY2018, identifiable by Group/Clinician.
- Potential patients/existing patients will be able to see their clinicians rated against national peers on a scale of 0 to 100. To make it more user friendly, a 5-star rating scale will be applied to every MIPS performance measure for peer comparisons.
- Although MIPS financial adjustments can change annually based on clinician performance, damage to a clinician's online public reputation may take years to reverse. Conversely, high publicly-reported scores can become a persistent strategic advantage over competitors.
- Lastly, the score will *follow* the Clinician (upon organization change).

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MIPS Changes for 2018-Special Status for small practices and rural and health professional shortage areas

Special Status	Component	Year 2 (2018) Final	Application
Small Practice	Definition	• Practices consisting of 15 or fewer eligible clinicians.	• **No change** to the application of these special statuses from Year 1 to Year 2.
Rural and Health Professional Shortage Areas	Rural and HPSA practice designations	• An individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN (or TINs within a virtual group) with **more than 75 percent** of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group in a ZIP code designated as a rural area or HPSA.	

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New: Small Practice Bonus

New: Small Practice Bonus

- **5 bonus points** added to final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians), so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.

- Burden Reduction Aim:
  - We recognize the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements.

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Bonus Opportunities (continued)

New: Complex Patient Bonus

…CMS's…goal when considering a bonus for complex patients is two-fold:
(1) To protect access to care for complex patients and provide them with excellent care; and
(2) to avoid placing MIPS eligible clinicians who care for complex patients at a potential disadvantage while we review the completed studies and research to address the underlying issues.

…CMS's…identified two potential indicators for complexity: Medical complexity as measured through Hierarchical Condition Category (HCC) risk scores and social risk as measured through the proportion of patients with dual eligible status

New: Complex Patient Bonus

- Up to **5 bonus points** available for treating complex patients based on medical complexity.
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries.
- MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period to earn the bonus.

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MACRA Update (submission approach)

No change: *All of the submission mechanisms remain the same from Year 1 to Year 2*

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
Quality	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Advancing Care Information	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

Please note:

- Continue with the use of 1 submission mechanism per performance category in Year 2 (2018). Same policy as Year 1.
- The **use of multiple submission mechanisms** per performance category is deferred to Year 3 (2019).

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Why is this Program Important to You?

The purpose of these next two slides is to provide oversight and support for Patient Registration and Benefits Coordination's roles and responsibilities in the QPP:

- Claims Based Reporting: When a provider choses to report using Claims Based Reporting:
  - Individuals ONLY
  - Based on Medicare Populations ONLY
- To receive credit individuals must report on a percentage of their Medicare Patients seen in the specified Reporting Period who meet the selected Measure Denominator Criteria.
  - 2018 Year 60 percent
- It is imperative that all Medicare Eligible' s Information (demographic and eligibility) is captured in a complete and timely manner.

How You Can Help (CY 2018)

How can Patient Registration and Benefits Coordination assist with QPP?

- Capture Data and Billing in a timely manner will also determine whether a group or individual provider can be exempt from reporting (less than $90,000 billed approved charges OR less than 200 Medicare Part B patients seen).
- There is a “Cost” component to the calculation that have a positive/negative impact.
- Capture if beneficiary has new Medicare card number (Medicare Beneficiary Identifier).

MIPS Planning/Future path……

Start Early (think ***TEAM***!)

Get a plan and achieve a comfortable level with VBP programs

Develop level of 'clinical sophistication'

- Add new metrics to your coding plan
- Drill down on non-specific code use
- Optimize clinical documentation

Interoperability to support accurate data capture (EHR and people)

Track progress throughout the year. Leverage info to get to 70 points (i.e. Exceptional Performance)

Get ready for change!!!!!!

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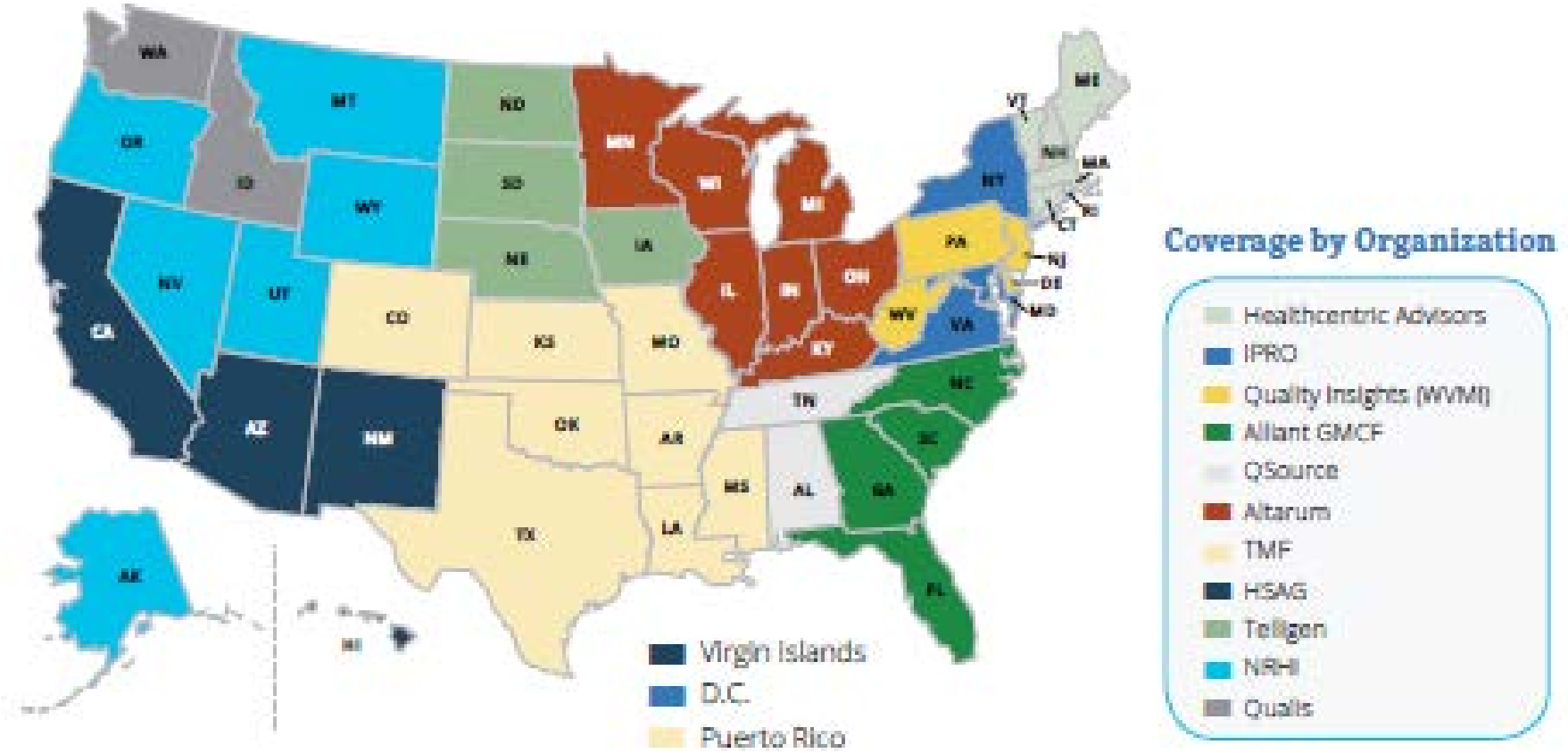
CMS Technical Assistance Resource Guide

Small, Underserved, & Rural Support



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Questions?

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