# MACRA

*A View Towards 2018*

himformatics

# Objectives

1) MACRA: What is it and where did it come from?
2) MIPS overview
3) Onslow Memorial Hospital Regulatory Council

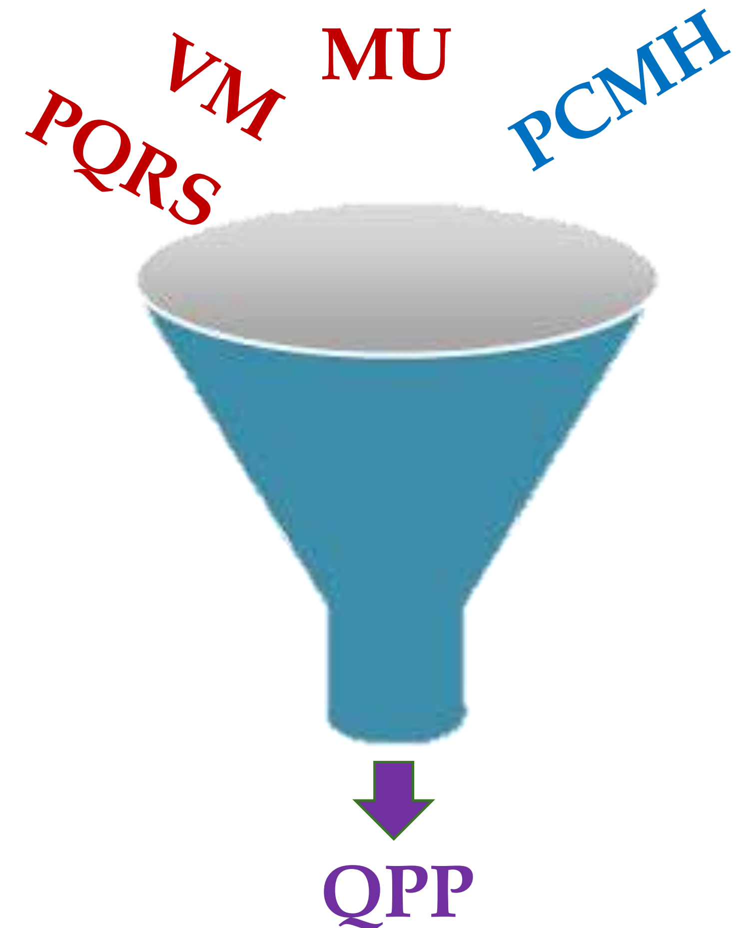
# What is MACRA?

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):

- Passed April 15, 2015.
- Replaces Medicare Sustainable Growth rate (SGR).
- Merit-based reimbursement.
- Implemented through Quality Payment Program (QPP)
- Methods of payments:
  1. Merit-based Incentive Payment System (MIPS)
  2. Advanced Alternative Payment Model (AAPM)

# Quality Payment Program

CMS consolidated existing programs into the **Quality Payment Program** to streamline efforts toward value-based reimbursement.

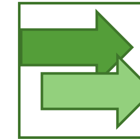


# QPP: Two Paths

## MIPS

- Payment based on performance in:
  - ✓ Quality
  - ✓ Improvement Activities (IA)
  - ✓ Advancing Care Information (ACI)
  - ✓ Cost/Resource Use
- Performance weighted to calculate final score (0-100)
- Payment adjustments are **budget neutral and based on performance from two years prior**
- CMS projects 83%- 90% will participate in 2017

***OR***

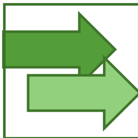


## AAPMs

- **Rewards for risk stratification.**
- Exclude clinicians from MIPS
- Medicare payments equal to 5% of last year's FFS payments
- Qualifying criteria:
  - ✓ Certified EHR technology
  - ✓ Report quality measures comparable to measures under MIPS
  - ✓ Bear financial risk or is a Medical Home Model
  - ✓ >= 25% of Medicare Payments ***OR*** >= 20% Medicare Patients

# QPP: Two Paths (cont.)

MIPS



AAPM

| | | | | | |
|---|---|---|---|---|---|
| 1 | ACO | MSSP | 2 Up to 60% shared savings | 3 Up to 75% shared savings | NG Up to 100% shared savings |
| 2 | Bundled Payment | CEC | LDO | ESRD | |
| 3 | Medical Home | CPC + | 1 ~ $15/pt/mo. | 2 ~$28/pt/mo. | |

MSSP Track 1 falls under MIPS

**2018 Changes**

- ACO Track 1+ to qualify for AAPM
- Advancing Care Coordination thru Episode Payment Models Track 1
- New Voluntary

# MIPS Overview

- Eligibility & Reporting
- Timeline/Budget Neutrality
- Category Definitions & Scoring

# MIPS Eligibility

## Eligible

**Eligible Clinicians**

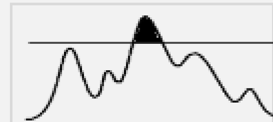
- Physician
- PA
- NP
- Clinical Nurse Specialist
- CRNA

>75% of covered professional services at POS 21, 22, or 23

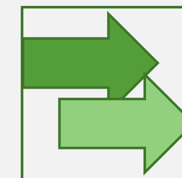
**Hospital-based Eligible Clinicians**

## Excluded

**Year 1 billing**
Medicare Part B



**Below threshold**
< $30,000 in Medicare billing charges
**or**
< 100 Medicare patients care provided year 1



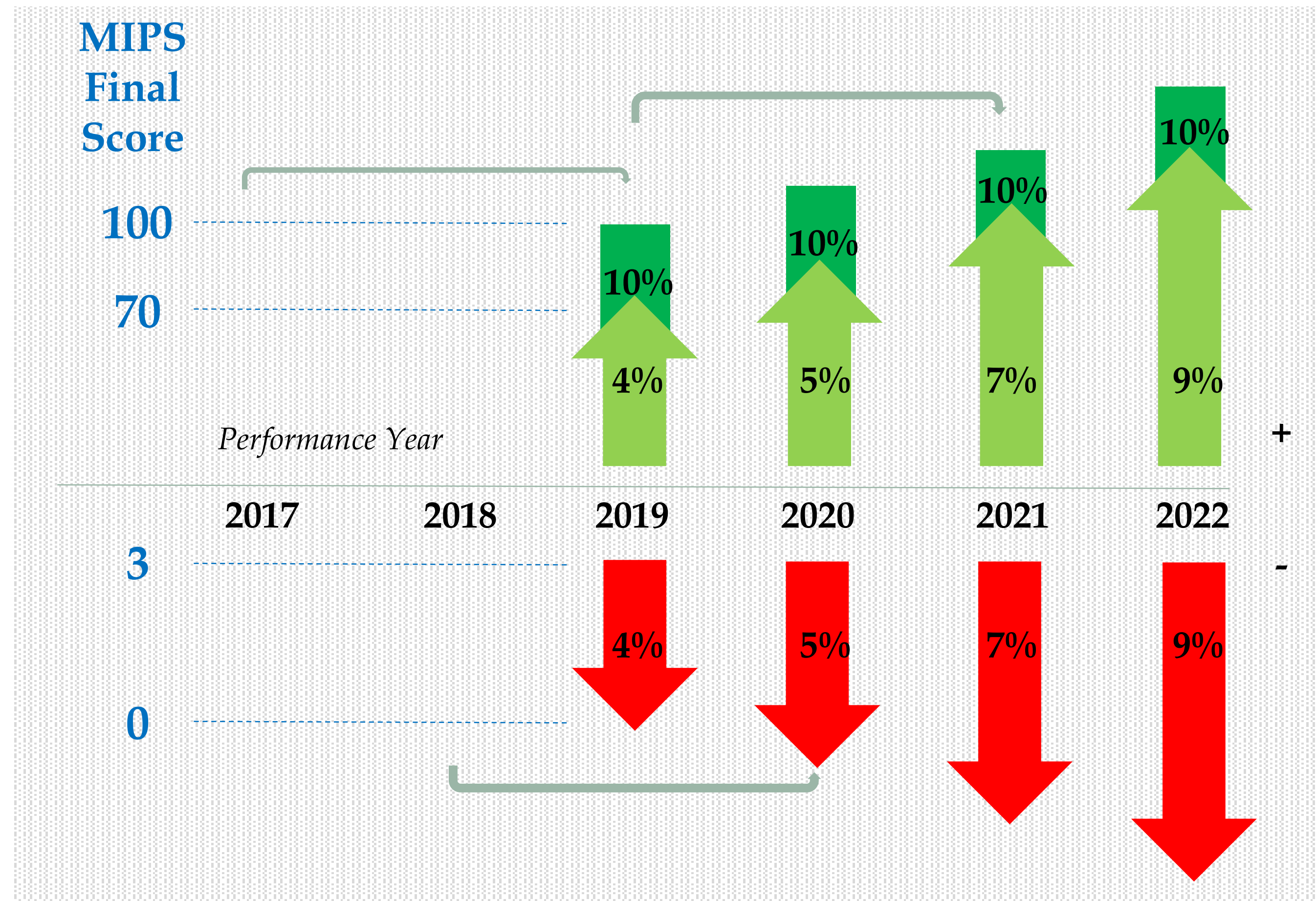
**AAPM**
Qualifying participants in APMs
25% Medicare payments
or
20% Medicare patients

# MIPS Reporting

- Report as group under TIN or individual under TIN/NPI.
- Clinicians reporting as a group assessed on highest performance scores across all categories.
- Different reporting methods. For example:
  - EHR
  - CMS web
  - Attestation
  - Registry
- Can submit data using different methods, but only one per category.
- Proposed virtual group.

# MIPS Timeline / Budget Neutrality

- **Two year look back**
- **The time is now to prepare**
- Every Group competes with others, nationally, on **Quality** and **Cost**
- No automatic annual increases
- **Additional $500M** capped at 10% for exceptional performers
- **Zero-sum game**



# MIPS Categories & Definitions

**Quality**: To assess clinician performance. Six reported measures consistent with PQRS system.

**IA**: New area for attestation with 92 measures to choose, such as expanded access, population management, care coordination.

**ACI**: Evaluate how clinicians are using EHR and drives towards interoperability, information security, and data exchange.

**Cost**: Payment is total per capita costs for attributed patients and Medicare spending per beneficiary via claims data.

# MIPS Quality

Quality Measures
(271 Total)

➡

6
Measures

1
Outcome Measure

or

1
High-Priority Measure

+

Total Earned Points / Total Possible Points

Bonus Points

- Additional outcomes reporting
- Patient reporting

**2018 Changes**
- 50% of CPS
- 60% Data Completeness
- Topped Out Measures re-scored or removed

# MIPS Improvement Activities

### Subcategories

| | | |
|---|---|---|
| Expand Practice Access | Beneficiary Engagement | AAPM Participation |
| Population Management | Patient Safety | Integrating Behavioral and Mental Health |
| Care Coordination | Achieving Health Equity | Emergency Preparedness and Response |

**92 Improvement Activities**

Select up to 4

=

40 points total

**Improvement Activity Examples**

Participation in systematic anticoagulation program: 20 p

Tobacco Use: 10 points

Glycemic management services: 20 points

Diabetes screening: 10 points

**2018 Changes**

ACO Participants receive half credit

(Still report for 90-day period)

# MIPS Advancing Care Information

## Baseline Score

**50 points**

- Protected patient health information
- E-prescribing
- HIE
- Provide patient access

+

## Performance Score

**90 points**

- HIE
- Provide patient access
- View, download, transit
- Secure messaging
- Med reconciliation
- Immunization registry reporting

● 20 points

+

## Bonus Points

**15 points**

- Specialty registry
- Syndromic surveillance
- Improvement activities
- (CEHRT measure)

**2018 Changes**

- **2015 CEHRT Required**
- ACI Objectives (Stage 3 Objectives) 90 days
- 5 Base Objectives (Request/accept Summary of Care added)

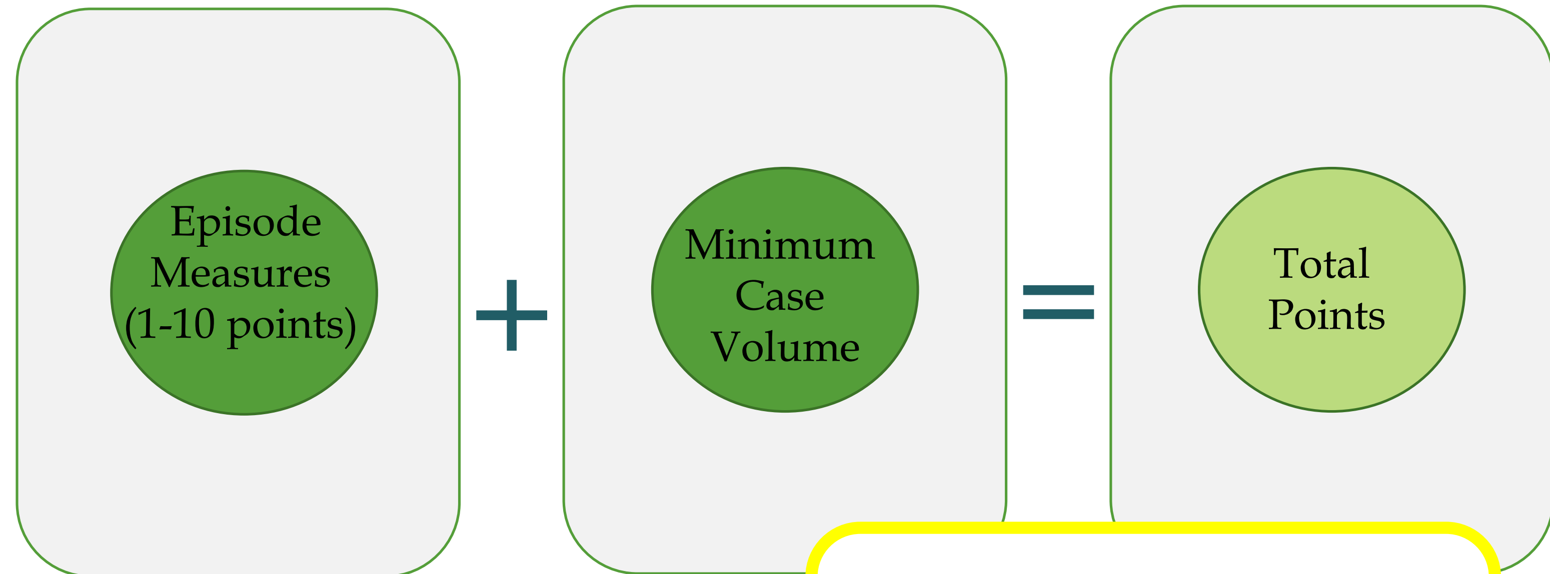
*No data for **each** baseline category = No ACI score*

***CHERT 2015** is required for all participants in **2018***

*To meet the requirement, **send data**!*

# MIPS Cost

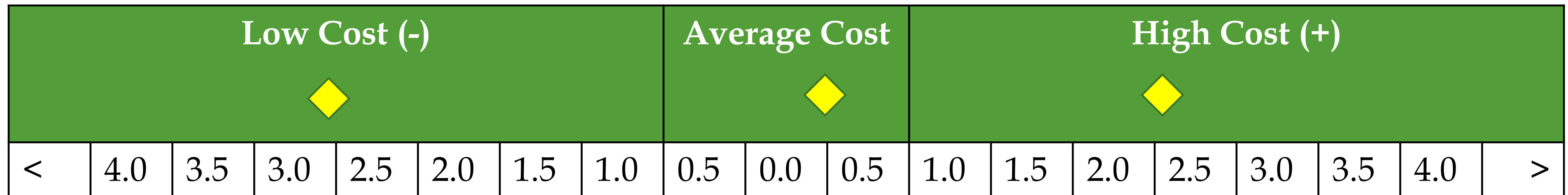
- 0% of final score for 2017
- Medicare claims data
- May be same measures as VM, **scoring is different**
- Added 40+ episode-specific measures




**2018 Changes**
- 10% of CPS
- 0% for ACO participants
- Report Full Year

# MIPS Cost Example

- National comparison among peers
- Calculated from claims data
- **Accurate coding is critical**
- Goal **control cost of delivering care**




**Standard deviations from the peer group (negative scores are better)**

# MIPS Cost Coding

## What is it?

- **Hierarchical Condition Categories** (HCC).
- **Risk factor score** for serious or chronic illness based on health conditions and demographics.
- **Identified via ICD-10 codes** supported by clinical documentation and claims.
- More than 9,000 **ICD-10 codes** that **map to** 79 **HCC codes**.

## Why is it important?

- **Compensates** for treating **complexities** that **impact outcomes** and **cost of care**.
- ICD-10 and HCC codes submitted have **direct impact on cost score** and **reimbursement**.

## Ways to address?

- **Clinical informatics** and **EHR**
- **Clinical documentation improvement program** (CDI).
- Au**dit/coding** compliance
- **Clinician engagement** and **education**
- HCC workgroup

# MIPS Cost Preparation

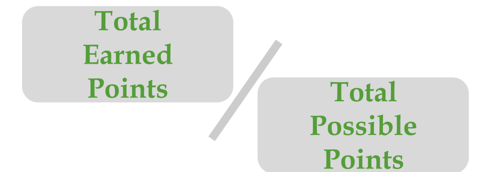
MIPS

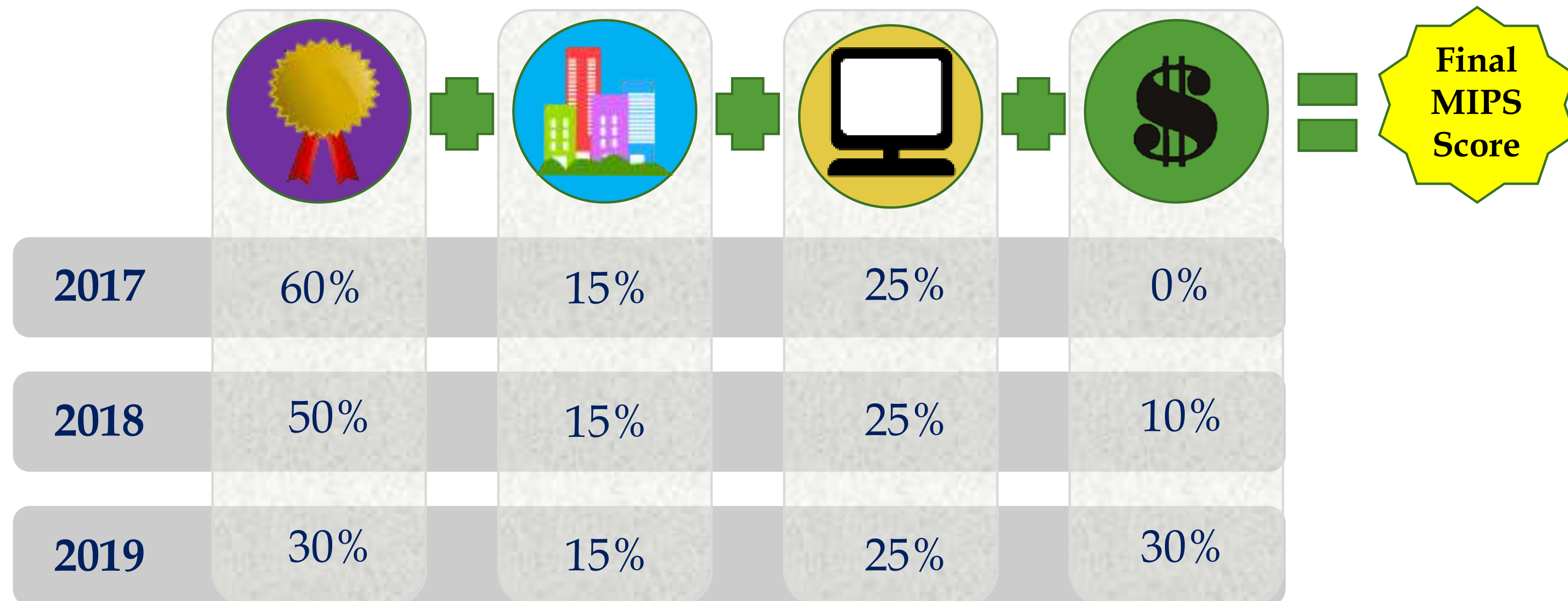
**Use 2017 wisely!**

- Track utilization and per capita spend
- QRUR performance
- Cost accounting
- National cost benchmarking
- Close gaps
- Skill sets and process design
- Risk stratification
- Data analytics

# MIPS Scoring

- Weighted value as percentage of total composite MIPS score.
- Earned points divided by the possible points.
- Comparatively scored to peers.



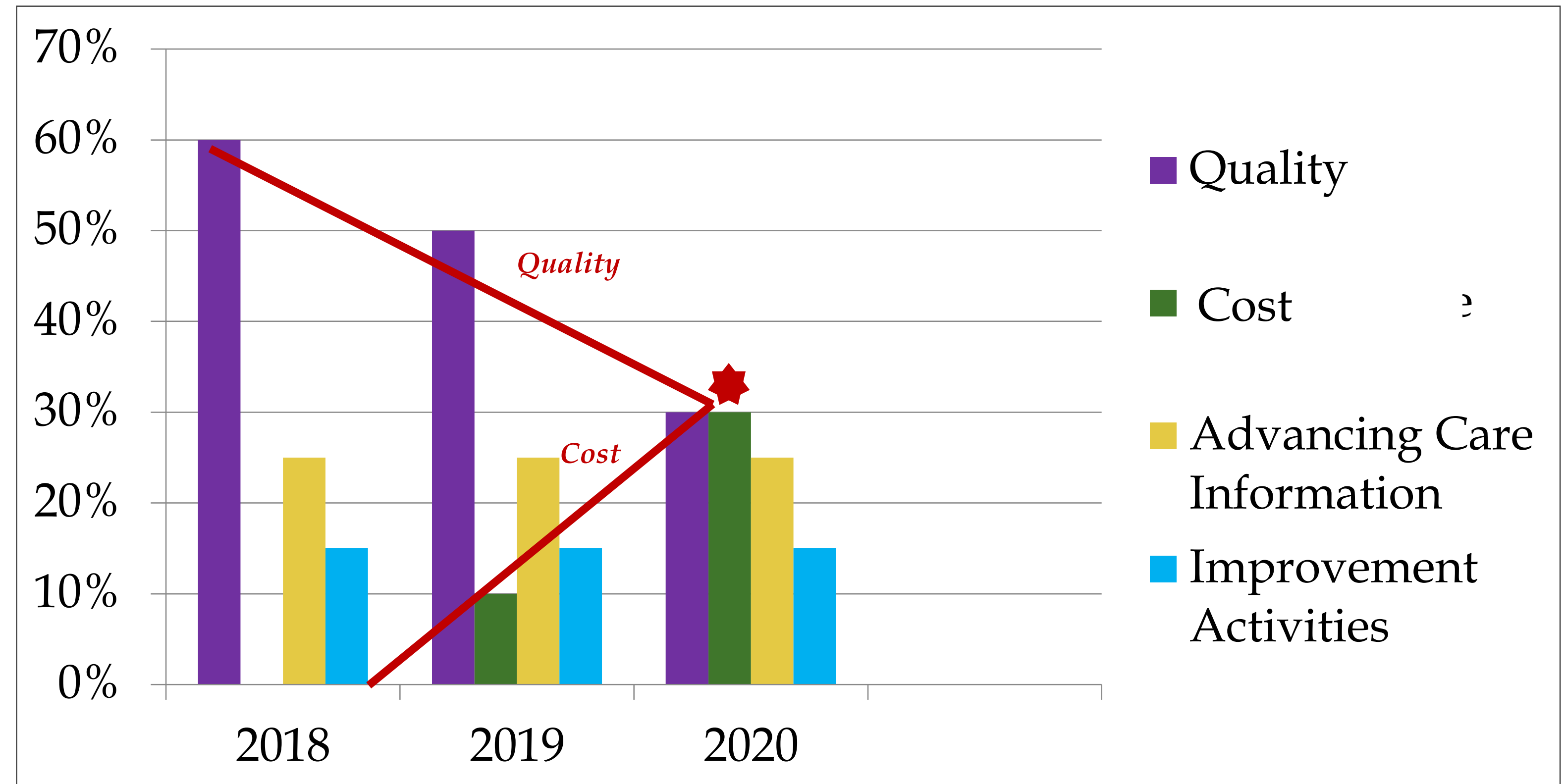




| Year | | | | |
|---|---|---|---|---|
| 2017 | 60% | 15% | 25% | 0% |
| 2018 | 50% | 15% | 25% | 10% |
| 2019 | 30% | 15% | 25% | 30% |

*

# MIPS Category Weights

- **Understanding cost is critical!**
- Increased emphasis on cost and reduced emphasis on quality.
- ACI and IA will hold steady.



# ONSLOW MEMORIAL HOSPITAL

Regulatory Council

# About Onslow Memorial Hospital

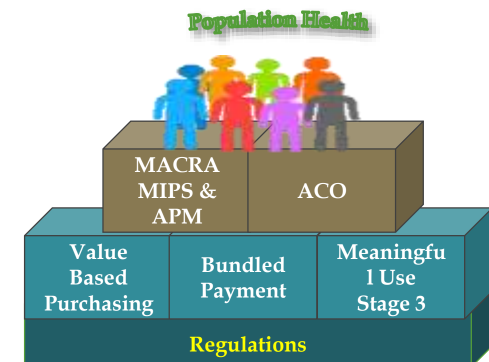
- 162-bed acute care community hospital
- 6 ambulatory clinics
- Located in Jacksonville, NC
- Serves the greater Onslow county
- Mission *to provide excellent patient health services in a healing and family-centered environment*

# Regulatory Council Charter

- Positions Onslow for continued success in moving to value-based care.

## Charter:

*A multifunctional committee that monitors and interprets regulatory requirements principally related to quality, reimbursement, and reporting to help guide a uniform understanding across the organization, ensures accurate and timely reporting, prioritizes focus, and provides recommendations on ways Onslow may address the requirements.*



# Regulatory Council Structure

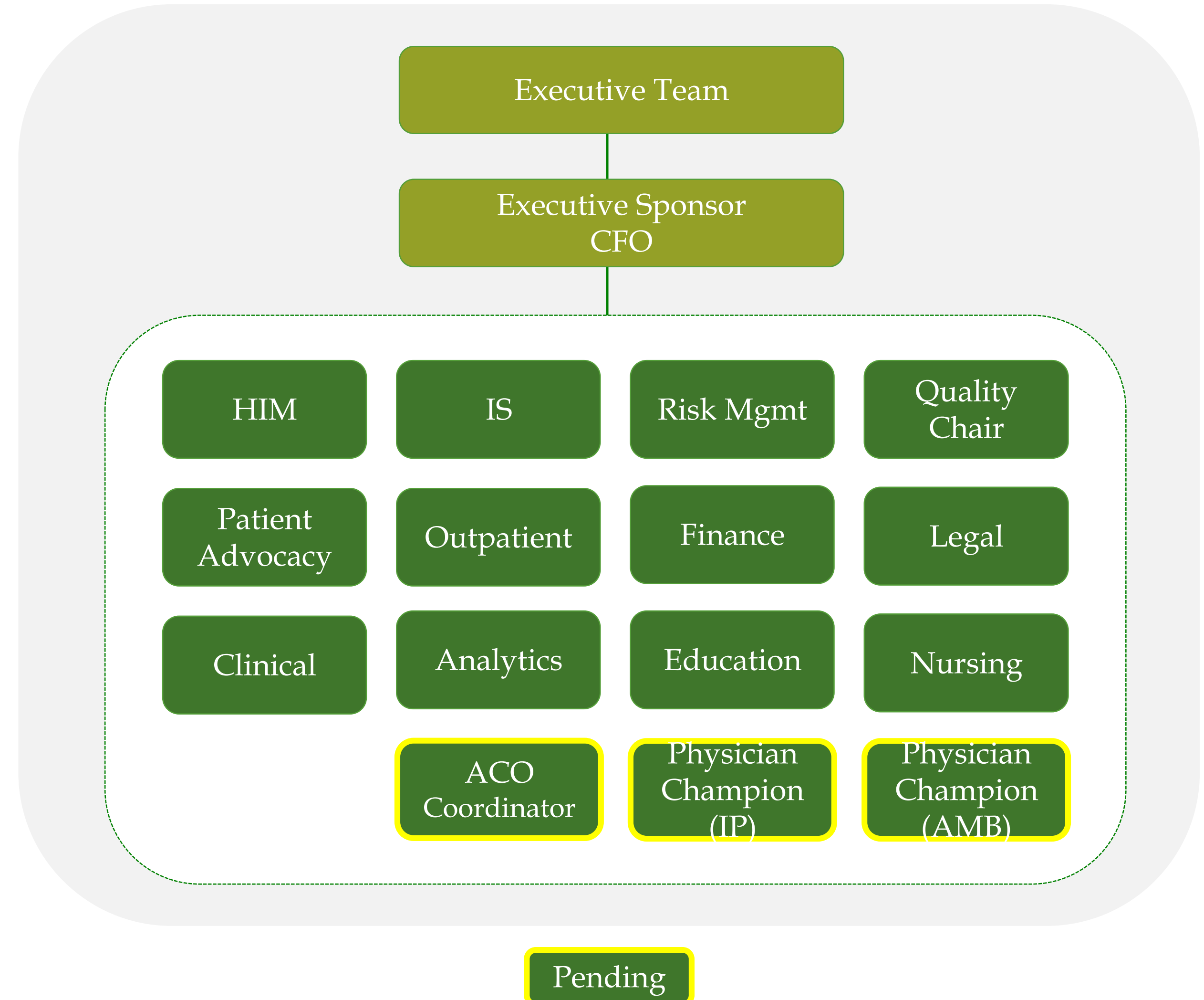
**Key Functions**

**Council Chair:**

- Sets and communicates clear direction for the council
- Leads meetings
- Communicates activities to CFO

**Council Members:**

- Cross-section of representation
- Lead by example
- Promotes provider and operational accountability via supporting engagement and change adoption



# Guiding Principles

1) Serve as a **multifunctional committee** that emulates Onslow Health Care System mission, vision, and values.

2) Be **transparent in decision making** and prioritization.

3) Consider **best practice and shared experience** for addressing regulatory initiatives.

4) Focus on **priorities** defined by the regulatory council.

5) Use an **incremental, flexible approach focused on metrics** to ensure **improved outcomes.**

# Roles and Responsibilities

1) **Stay abreast of new and changing regulatory requirements**.
2) **Identify and interpret regulatory changes** and the **impact** to the organization.
3) **Document decisions** involved with evaluating, prioritizing, and approving recommendations.
4) Assure that **proposed recommendations** adhere to regulatory council **guiding principles**.
5) **Provide guidance and collaboration** on regulatory requirements and initiatives that impact clinical care, strategic direction and business goals.
6) **Work efforts** generated from the council's recommendations will be **driven by respective areas.**
7) Provide **provider/clinic performance** metrics/dashboards and **education.**

# What’s next?

- Develop subgroups as needed to address specific changes/updates. For example:
  - MIPS Hospital and Ambulatory
  - MU Stage 3
- Submission prioritization
- Subgroups report efforts to council
- Discuss upcoming CAHPS
- Develop metrics
- Work in progress…

# Questions?