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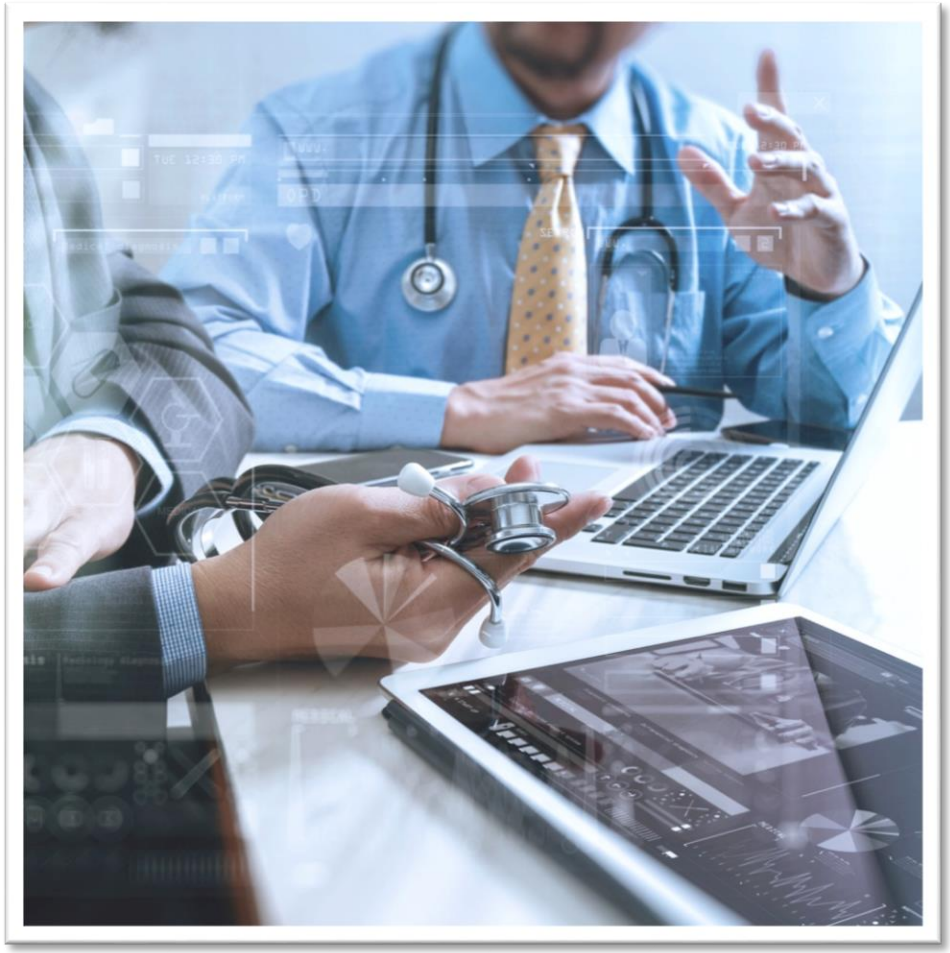
Quality Payment Program Success aka MACRA

Collaboration is Key: Technology/Governance/CDI

October 5, 2017

Today's Agenda

1. MACRA Overview
2. Medicare and the new Quality Payment Program
3. Merit-base Incentive Payment System
4. Information Governance and Clinical Documentation Integrity
5. Summary
6. Question & Answer



Primary Topic Today

How Health Information Governance & Clinical Documentation Integrity are changing under the new MACRA legislation

More emphasis on clinical documentation integrity

- Vital with performance-based payments directly linked to quality measures

Greater focus on payment changes and reforms

- Payment directly ties the quality of health care treatment under the Medicare Access and CHIP Reauthorization Act (MACRA):
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Payment Models (APMs)

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MEDICARE AND THE NEW QUALITY PAYMENT PROGRAM

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The Medicare Marathon in the 20th Century

Medicare Modeled on Private Insurance Plans

"We proposed assuring the same level of care for the elderly as was then enjoyed by paying and insured patients; otherwise, we did not intend to disrupt the status quo. **Had we advocated anything else, it never would have passed."** (Ball, 1995)

Modeling Medicare on private insurance plans allowed for:

- Faster implementation
- Political acceptability

The Medicare Marathon in the 20th Century

Disadvantages of this approach included:

- Payment methods are inflationary
- Private insurance companies hamper control of the program
- Medicare benefit package not designed for some specific needs of the elderly

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The Medicare Marathon in the 21st Century

The Balanced Budget Act of 1997 amended Section 1848(f) of the Social Security Act to replace the **Medicare Volume Performance Standard** (MVPS) with the **Sustainable Growth Rate** (SGR)

Goal:

- To ensure that the yearly increase in expenses per Medicare beneficiary did not exceed the growth in US GDP

Process:

- CMS sent an annual report to the Medicare Payment Advisory Commission which advised Congress on target expenditures
- On March 1 of each year, the physician fee schedule was updated accordingly … and then suspended or adjusted by Congress. (i.e., "doc fix")

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

MACRA is a bipartisan legislation signed into law on April 16, 2015.

- ✓ **Ended** the Sustainable Growth Rate (SGR)
- ✓ **Beginning** of the Quality Payment Program (QPP)

Source CMS

Three Business Considerations

REVENUE

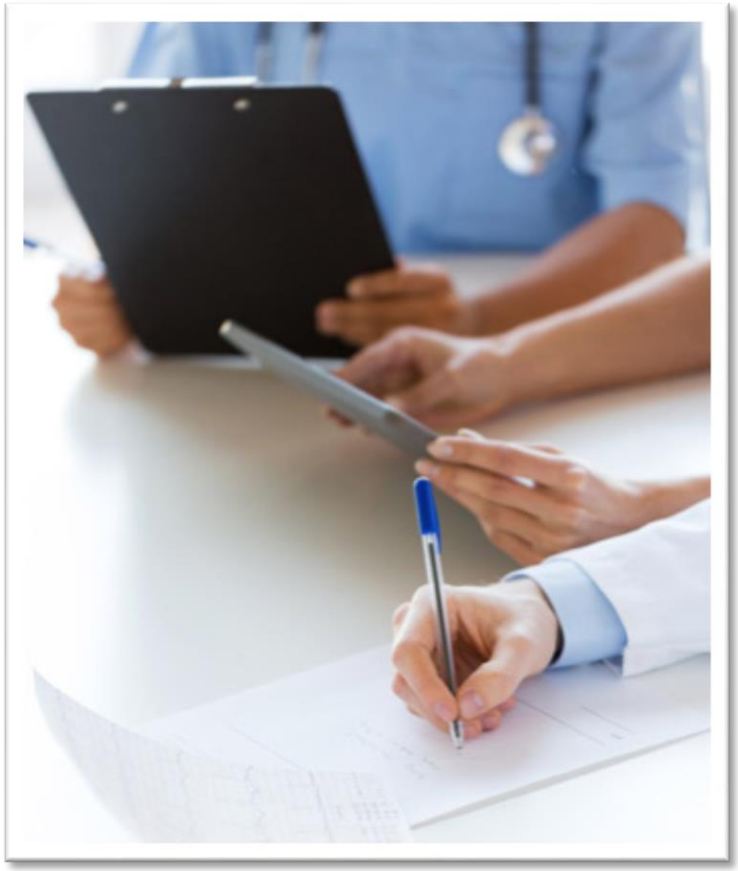
- Fewer fee-for-volume payments
- Shift to **value-oriented** reimbursement models

TECHNOLOGY

- Mandates to increase secure **information-sharing** and **patient access**
- Emphasis on technology and practice improvement

REIMBURSEMENTS

- **Shared risk**



MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

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Quality Payment Program: Two Paths

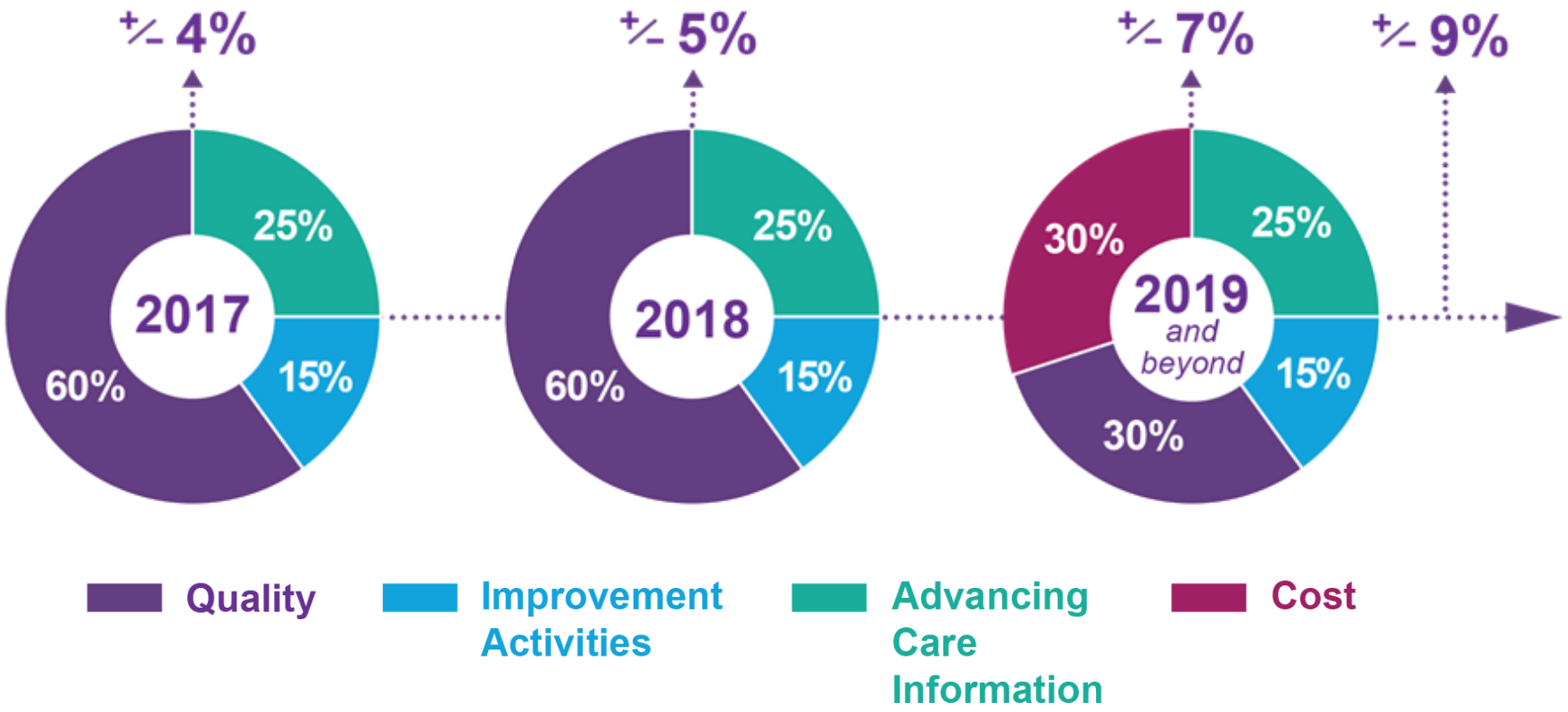
Merit-Based Incentive Payment System (MIPS)

Advanced APM

- **Streamlined reporting** of known quality programs
- **Four MIPS categories**:
  - Quality
  - Cost (Resource Use)
  - Improvement Activities
  - Advancing Care Information
- **Increased risk and greater opportunity** over time
- Qualifying APM Participants (QPs) are exempt

- **Full Population Health Management**
  - *MSSP ACO Track 1+ (coming in 2018)*
  - MSSP ACO Track 2
  - MSSP ACO Tracks 3
  - Next Generation ACO
- **Primary Care, Service-Line Specific**
  - Comprehensive ESRD Care (CEC)
  - Oncology Care Model (OCM)
  - Comprehensive Primary Care Plus (CPC+)
  - Comprehensive Care for Joint Replacement Payment Model
- Fixed upside bonus of 5% for the next six years

Quality Payment Program: MIPS



MIPS is a very dynamic path with both increased risk over time and shifting scoring weights

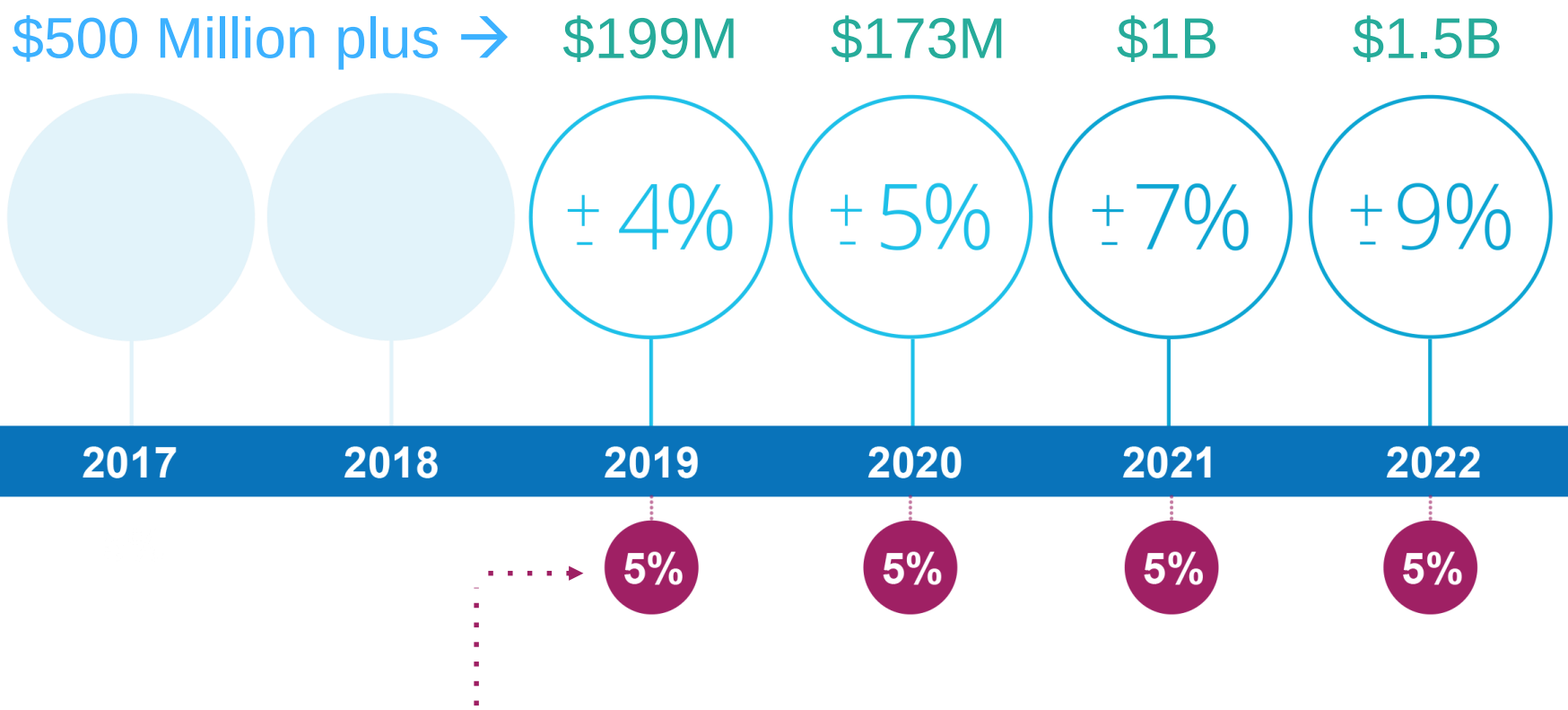
Quality Payment Program: Real Numbers

Non-Participation	Medicare Billings			Negative Adjustment
	2019	$40,000,000	x	-4% = ($1,600,000)
	2022	$40,000,000	x	-9% = ($3,600,000)

Full-Year Participation	Medicare Billings			Positive Adjustment
	2019	$40,000,000	x	4% = $1,600,000
	2022	$40,000,000	x	9% = $3,600,000
(9% *x* 3) + 10%	**2022**	**$40,000,000**	**x**	**37% = $14,800,000**

Advanced APM	Medicare Billings			Positive Adjustment
	2019	$40,000,000	x	5% = $2,000,000
	2024	$40,000,000	x	5% = $2,000,000

Quality Payment Program: % Adjustments

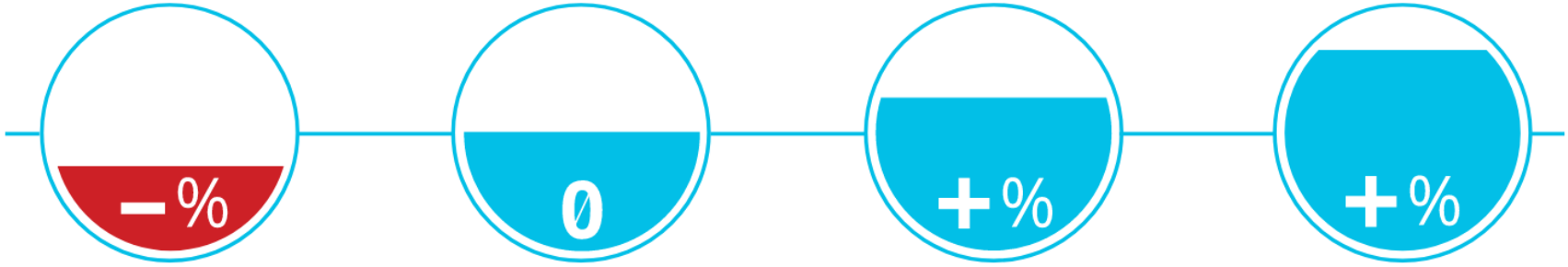


Advanced APMs have a fixed incentive rate / bonus of 5% for several years

MIPS Program Size

- Between 592,000 and 642,000 eligible clinicians will be required to participate in MIPS in year one (2017)
  - Down from an original estimate of between 687,000 and 746,000
- CMS expects that MIPS payment adjustments will be approximately $199 million to MIPS eligible clinicians
  - Significantly down from proposed-rule with estimate of $833 million

Pick your pace reporting options



Not participating in the Quality Payment Program:

If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:

If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Partial:

If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment and may even earn the max adjustment.

Full:

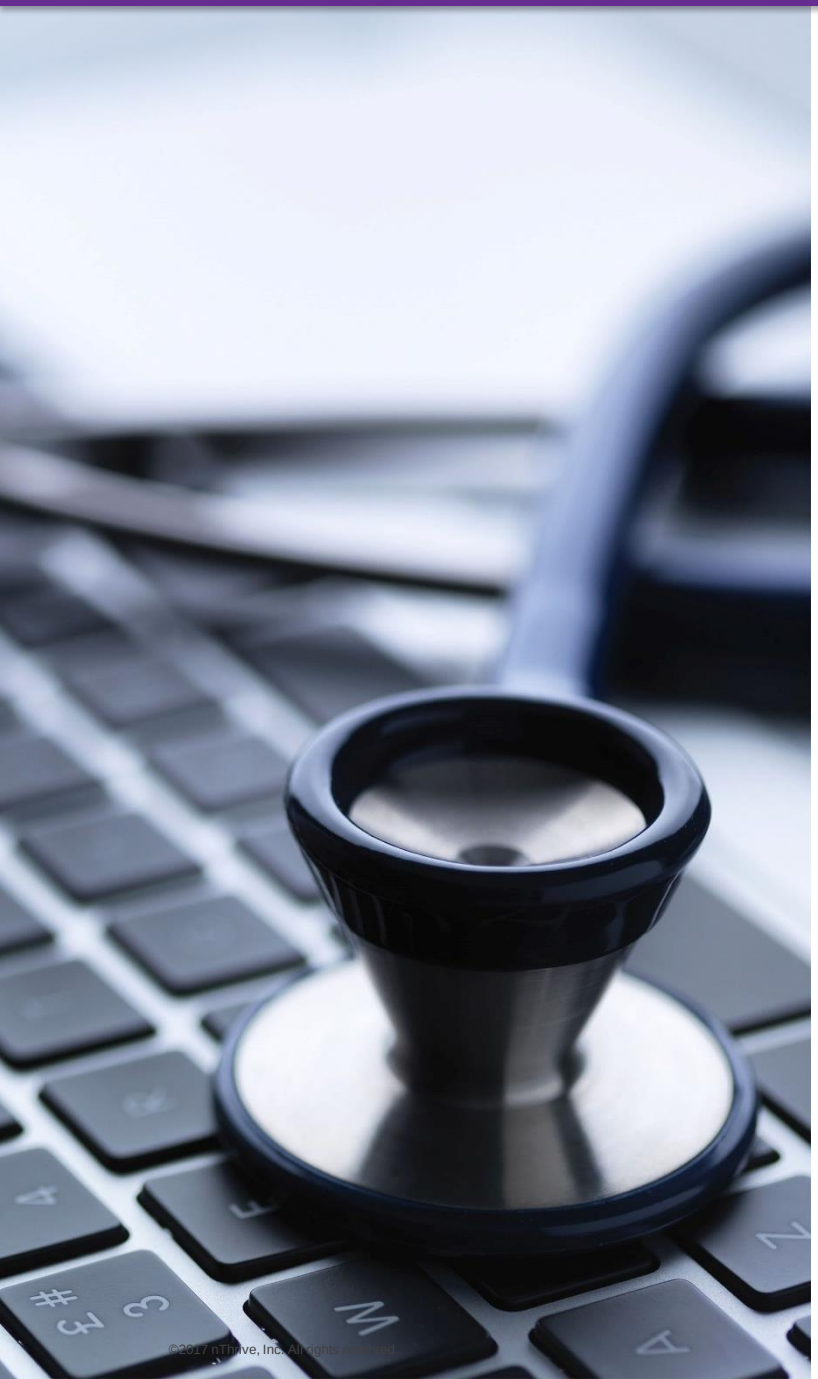
If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

Source CMS

Moving towards value

Only about **50% of practicing physicians** have heard of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), according to Deloitte's 2016 Survey of U.S. Physicians.

INFORMATION GOVERNANCE



Information Governance

- Provides compliance parameters
- Ensures that the use and management of health information is legally compliant
- Strives to protect and assure the ethical use of health information

Leading your Information Governance Initiative

Other industries recognize the need to control their information and this especially makes sense in health care

- **Clinical data integrity requires governance**
- **Governance requires adoption and ingraining of principles, a framework, rules and managed processes**

The time has come for the health care eco-system to adopt governance of information

- **Trust in health information depends on it**

Why Information Governance?

We are living in the information age

- **Technological advances** enable creation, capture and retention of more data and information from more sources
- Data and information are **changing the way we live, work, socialize, communicate and conduct business**.

Why Information Governance in HC

- The nature of health care creates unique challenges
  - Changing payment approaches and care delivery models
  - Need for IG to be rooted in the **'source of truth'**
- Meeting the changes requires information that can be trusted
- IG across health care ensures **trust in the integrity of clinical documentation and coded data**

HIM OVERSIGHT ROLE IN INFORMATION GOVERNANCE

MANAGING CLINICAL DOCUMENTATION & INFORMATION

- MACRA Compliance
- CMI
- Severity of Illness
- POA/HAC
- Core Measures
- Patient Safety
- Point of Entry
- Care Summary
- Discharge Summary
- Outcome Measures

CLINICAL DOCUMENTATION INTEGRITY

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ENSURING CLINICAL DOCUMENTATION INTEGRITY

Accurate Clinical Documentation

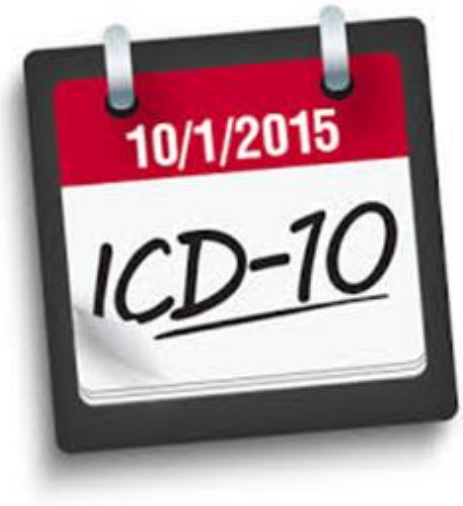
- ✓ Patient safety and coding
- ✓ Compliance
- ✓ CMI
- ✓ Severity of illness
- ✓ POA/HAC
- ✓ Core measures
- ✓ Medical necessity
- ✓ Coding
- ✓ Audits
- ✓ Outcome measures

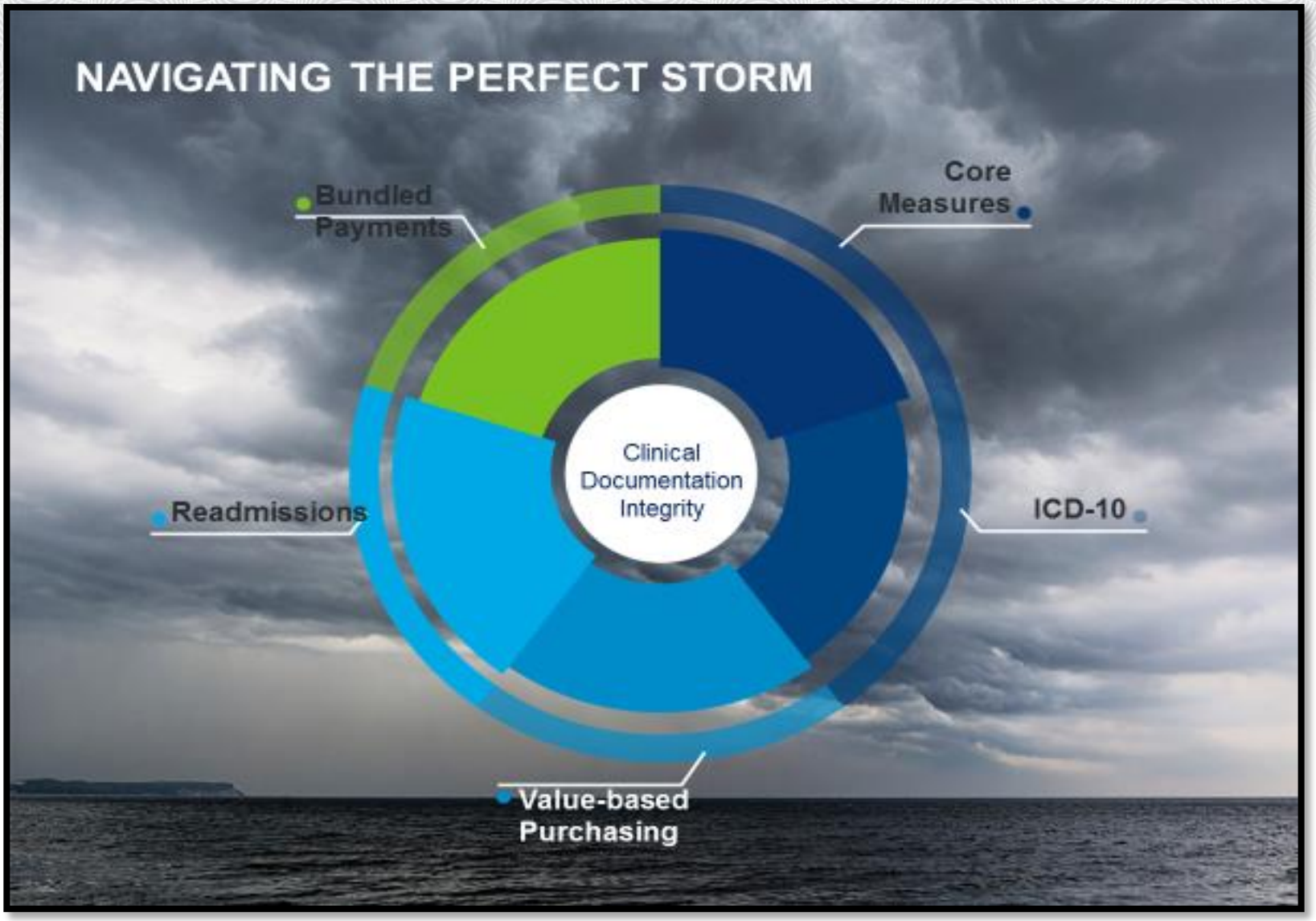
EHRs: Clinical Documentation Integrity

- Clean-up on clinical documentation **“after the fact”** is no longer a viable option
- **EHR point-and-click documentation methods produce less complete**, less accurate and often less compliant clinical documentation
- **Industry needs a clinically-integrated, intelligent solution that enables physicians to rapidly document the complete patient story**

What ICD-10 Showed us

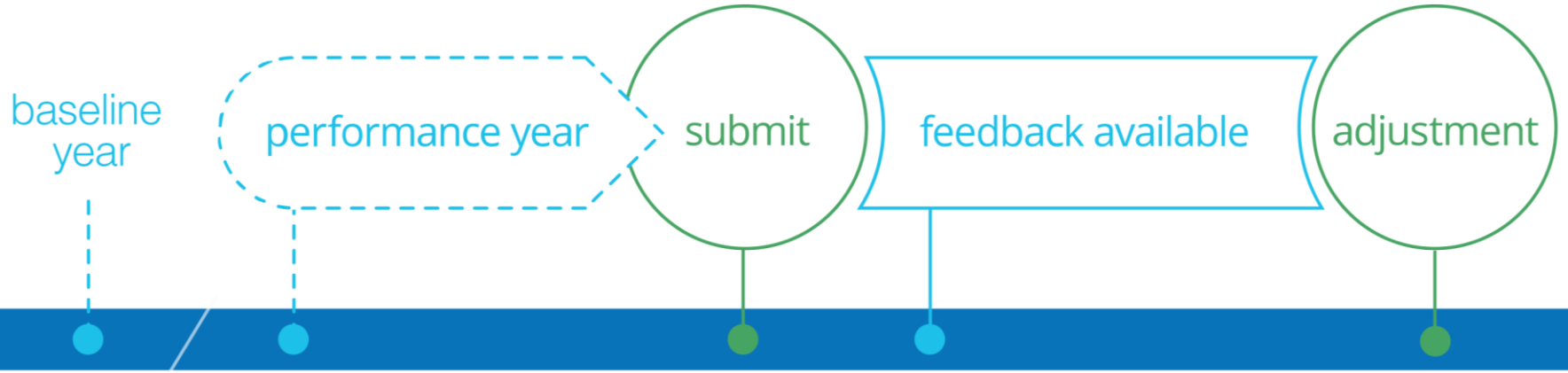
Connection of **clinical documentation integrity** to accurate facility and physician coding, profiling, appropriate severity of illness and risk of mortality scores, improved patient safety indicator ratings, proper reimbursement, and decreased denials.





WHAT'S NEXT?

MIPS Program Timeline



- January 1, 2017 is the first performance year of MACRA
- Calendar Year 2018 is also going to be considered transitional as the Quality Payment Program moves towards a steady state
- By 2019 the MIPS category weights will be fully matured (including Cost) and fully enforced

Quality Payment Program – Year 2

2017 MACRA "Transition Year"

- Low-Volume Threshold
  - $30,000 in Part B allowed charges
  - 100 Part B beneficiaries
- One submission mechanism per performance category

NO:

- Virtual Groups
- Improvement scoring
- Small practice bonus
- Complex patients bonus

2018 QPP "Year 2"

- Low-Volume Threshold
  - $90,000 in Part B allowed charges
  - 200 Part B beneficiaries
- Multiple submission mechanism per performance category

YES:

- Virtual Groups
- Improvement scoring
- Small practice bonus
- Complex patients bonus

MIPS Scoring Thresholds

Final Score 2017	2019 Adjustment Year	Final Score 2018	2020 Adjustment Year
70+ points	• Positive adjustment • Eligible for exceptional performance bonus	70+ points	• Positive adjustment • Eligible for exceptional performance bonus
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus	16-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment	15 points	• Neutral payment adjustment
1-2 points	• Not applicable	1-14 points	• Negative payment adjustment
0 points	• Negative payment adjustment of -4%	0 points	• Negative payment adjustment of -5%

ACTION ITEMS

Documentation and Coding are KEY Components to Quality Reporting

Documentation and coding accuracy ensure correct provider profiles and a true reflection of patient severity, including:

- Documentation and coding of **chronic conditions** included in Hierarchical Condition Categories (HCCs).
- **Specific secondary diagnosis codes** equate to HCCs and impact the Risk Adjustment Factor for Medicare Advantage beneficiaries as well as some commercial payer beneficiaries
- HCCs are also found within **Advanced APMs** and are important in capturing the acuity, severity and chronicity of patient conditions

Quality Reporting Documentation and Coding Components

MACRA will impact to providers over the next several years

Both HIM professionals and clinical documentation professionals will play a critical role in quality reporting for all providers across the continuum of care

Documentation + Coding is Key:

- Reimbursement linked to how sick the patient is and adjusts risk based on specific diagnoses
- Chronic condition documentation should be included at each patient encounter and include the specific evaluation or treatment for each condition coded

MACRA increases need for CDI

Documentation and coding accuracy both ensure correct provider profiles and a true reflection of patient severity

- MACRA has intensified the need for organizations to consider **CDI in different outpatient settings**
- MACRA and upcoming quality and reimbursement impacts to providers during 2017 as there is an **increased importance placed on complete and accurate documentation**

The focus on quality documentation in the outpatient setting, including physician practices, will continue to increase in importance

HIM and CDI

We cannot be 'acute care focused' without thinking about HIM and CDI across the continuum of care

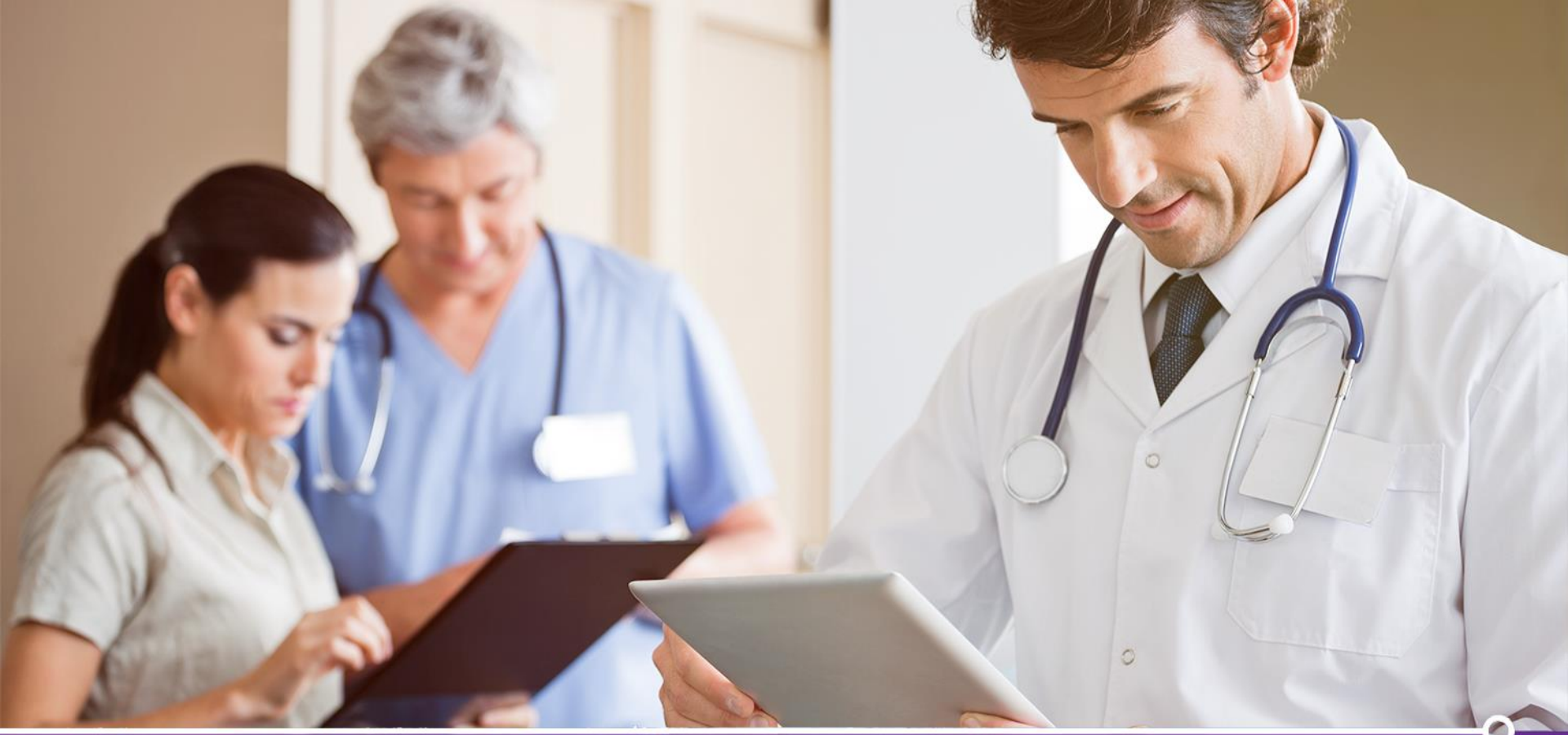
Now is the time to:

- **review the initiatives** associated with MACRA
- **consider the necessity of education and training** for both providers and staff

It will be important to review current documentation and coding practices and identify the potential benefits of CDI programs in the physician practice setting

Why IG for my Organization?

- Reduced costs associated with managing and finding information
- Avoidance of costly data breaches
- Enhanced analytics capabilities, including those necessary coordination of care and population health management
- Better integration of information and its management in mergers and acquisitions
- More effectively meeting compliance challenges
- Increased workforce awareness and adherence to information policies
- Alignment with and support of strategic goals and competitive advantage



SUMMARY

In Summary

- **Hospital reimbursement and compliance is becoming increasingly dependent upon:**
  - **Timeliness**
  - **Completeness**
  - **Accuracy**
- **Important measures, include:**
  - **Quality of documented care**
  - **Information governance**
  - **Clinical documentation integrity**
- **Collaboration with clinicians and colleagues are key to your success**

In Summary

Your organization can prepare for their most critical task, ensuring the integrity of clinical information at the point of care, by:

- Being Champions for Clinical Documentation Integrity
- Embracing population health management/VBR/P4P and creatively developing new analytic tools and techniques
- Implementing an Information Governance infrastructure.
- Excelling in terminology, coding, and classification systems
- Serving as the Data Steward
- Initiating Collaboration!

Clinical Documentation Integrity: Explore the Value Chain to find opportunities

From this point forward…

we must accept one another as equal shareholders of a partnership called

“The Future State of Clinical Documentation Integrity”

QUESTION & ANSWER

Thank you!

Introduction

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