How MACRA Changes HIM

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is widely viewed as one of the most significant and complex changes to Part B Medicare reimbursement in several decades. The Centers for Medicare and Medicaid Services (CMS) created the Quality Payment Program (QPP) that includes two MACRA programs: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The QPP will impact health information management (HIM) professionals that manage organizations that bill for Medicare Part B or are involved with Advanced APMs. This article is not meant to be comprehensive, but it will explore representative components of the QPP that will benefit significantly from the involvement of skilled HIM professionals.

MIPS Eligibility

HIM professionals may have a role in determining which clinicians are eligible for MIPS in their organization. For the first two years of MIPS, physicians (including MDs, DOs, podiatrists, optometrists, and chiropractors) as well as physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists are all MIPS-eligible unless the clinician meets one or more of the following exclusion criteria:

- Total annual Medicare Part B allowed charges is $30,000 or less
- Total annual number of Part B Medicare patient encounters is 100 or less
- The clinician is newly enrolled in Medicare during the performance year
- The clinician is a Qualified or Partially Qualified Advanced APM Participant

Hospital-based clinicians are MIPS-eligible under MACRA, including hospitalists and pathologists, anesthesiologists, and radiologists that bill Part B Medicare. CMS will use claims data from the previous year and the performance year to determine whether a Part B eligible clinician is "patient facing." Eligible clinicians that bill for 100 or fewer patient-facing encounters are considered "non-patient facing" clinicians. Groups of clinicians are considered non-patient facing when more than 75 percent of the group's NPI billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period. For 2019, CMS will initially identify non-patient facing MIPS eligible clinicians based on 12 months of claims data starting from September 1, 2015 to August 31, 2016. To account for additional non-patient facing eligible clinicians and group during the 2017 performance period, CMS will conduct another eligibility determination analysis based on 12 months of claims data from September 1, 2016 to August 31, 2017. Non-facing clinicians and groups may not have adequate performance measures applicable for practice or specialty. When this occurs, CMS may reweight MIPS performance categories—for example, reducing the weighting of the Advancing Care Information (ACI) performance category to as low as zero. For hospitalists that meet the definition of hospital-based MIPS-eligible clinician and do not have sufficient applicable measures available, CMS will assign a weight of zero to the ACI performance category.

Starting with the 2019 performance year, CMS may include additional clinicians in the MIPS program, including clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists.

HIM professionals will likely play a central role in determining MIPS eligibility based on current and emerging guidance from CMS.

MIPS Performance Category Weightings

The final MIPS composite performance score for the 2017 performance year performance categories will have weightings of 60 percent (Quality), 25 percent (ACI), 15 percent (Improvement Activities), and zero percent (Cost [Resource Use]). Cost

will increase to 10 percent in the performance year 2018 and Quality will be reduced to 50 percent. For the 2019 performance year, Cost will rise to 30 percent and Quality will be reduced to 30 percent. These numbers may be adjusted further if CMS determines that an adequate number of clinicians are "meaningful users" of certified electronic health record (EHR) technology. In that case the weighting of the ACI category may be reduced, but not to less than 15 percent. Any additional percentage points will be redistributed to other performance categories.

A large subset of eligible MIPS clinician—specifically, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists—will have the ACI performance category weighted at zero percent during the 2017 performance year when there are not sufficient measures applicable and available, giving them time to become familiar with the reporting options.

Understanding the weightings for performance categories each year will allow HIM professionals to set goals and to focus attention on areas that will be the most impactful to their organizations.

MIPS Performance Periods

During the 2017 "transition year" MIPS-eligible clinicians and groups will have the option of avoiding a four percent negative payment adjustment by reporting at least one quality measure or by engaging in one clinical improvement activity, or reporting the base measures for ACI. Submitting additional data for a minimum of 90 days will increase the practice's likelihood of receiving a neutral or positive payment adjustment for Medicare Part B payments in 2019. Submission of data for 90 days or longer in 2017 could result in a moderate positive payment adjustment. High performers may be eligible for an additional payment adjustment for exceptional performance.

CMS has established that for purposes of the 2020 MIPS payment year, the improvement activities and ACI reporting period will be a continuous 90-day period during the 2018 performance year. For other performance categories in the 2018 performance period, the reporting period may be the full year.

MIPS Quality Performance Category

Individual clinicians and groups, other than those reporting via the CMS Web Interface, need to report on six quality measures, or if there are fewer than six applicable measures, all that apply. For the 2017 performance year one of the measures needs to be an outcome measure, unless no outcome measures are applicable, in which case the practice will need to report a high priority measure. If the practice is reporting through a qualified registry, a qualified clinical registry, or through their EHRs, they will need to report on 50 percent of all applicable patient encounters regardless of payer. Measures vary by benchmarks and reporting mechanisms. Those reporting via the CMS Web Interface must report on all 15 measures included in the interface.

In the 2018 performance period CMS may require practices to include at least one cross-cutting measure. They will also need to report on 60 percent of applicable patients for each measure seen during the reporting period.

The CMS Web Interface (formerly GPRO) may be a reporting option for groups of 25 or more MIPS-eligible clinicians if they meet the CMS Web Interface eligibility reporting requirements. Reporting via the CMS Web Interface requires the practice to report on all applicable CMS Web Interface measures (i.e., 15 measures) for the first 248 Medicare patients seen during the performance year.

Regardless of the reporting mechanism chosen, HIM professionals may be tasked with helping clinicians and other staff members understand how to implement optimal quality performance reporting. This may start by working with the clinical staff to identify quality measures that would be most applicable to their patient volumes and workflows, establishing data capture mechanisms (i.e., alerts and reminders) and customizing clinical content within EHRs. Reporting and documentation need to be synchronized to prevent "check box" recording of measure compliance activities without supporting documentation.

HIM professionals may be involved with assisting clinicians with attaining the highest possible quality performance scores by helping them choose measures based on clinical considerations, benchmarks, and reporting mechanisms. They can also monitor performance trends and perform root cause analyses when performance is suboptimal.

MIPS ACI Performance Category

Practices will need to use 2014 Edition (Modified Stage 2) or 2015 Edition (Stage 3) Certified EHR Technology (CEHRT) in 2017, but all practices will need to use 2015 Edition CEHRT for the 90-day minimum reporting period in 2018.

The required (base) and optional (performance) measures that are reported depends upon the certification edition. For practices using 2014 Edition CEHRT, there are four required base measures and seven performance measures. For organizations using 2015 Edition CEHRT, there are five required base measures and nine performance measures. Both certification editions have the option of reporting two bonus measures (one for participating with a registry other than an immunization registry, and one for using CEHRT to accomplish specific objectives in a subset of the improvement activities).

Meeting the base measure reporting requirements, regardless of which EHR edition is being used, will earn the practice 50 percentage points toward their ACI score. The optional performance measures and bonus measures can total as high as 115 additional points, but the maximum point total cannot exceed 100 percentage points. If the practice were to achieve 100 percentage points they would be credited with 25 total MIPS points, as ACI is weighted at 25 percent in the 2017 performance year.

The base measures require either “yes/no” attestation or a minimum of one patient with a numerator of at least one. For example, to meet the minimum requirement for the “Sent Summary of Care” base measure, a patient care summary has to be sent for a single patient during a transition of care or referral.

The performance measures are scored based on “Yes/No” attestation (one measure) or the numerator/denominator values achieved by the practice. They are weighted at between 10 and 20 percentage points of the total ACI score. Scoring for each measure is determined by performance. For example, if a practice achieved a performance rate of 85 percent on a performance measure, they would be credited with nine of the possible 10 points for that measure. This would be summated with the base score (50 points) and performance on the performance measures and bonus scores.

If a practice met the ACI base score reporting requirements (50 points) and achieved an additional 30 points from the performance measures and bonuses, they would have achieved a total ACI score of 80 points. Since ACI is weighted at 25 percentage points for the total MIPS score, 80 ACI percentage points would earn the practice 20 total MIPS points from the ACI category.

This represents a significant change from the “pass/fail” reporting requirements based on meeting minimal thresholds under the “meaningful use” EHR Incentive Program. HIM professionals will play an important role in helping their organizations transform into a true performance environment.

MIPS Clinical Practice Improvement Activities

Practices choose from 92 improvement activities identified by CMS as part of MIPS. Highly weighted improvement activities are valued at 20 points, and medium-weighted activities are valued at 10 points. For practices of more than 15 clinicians, the maximum point total is 40 points in this category. For practices of one to 15 clinicians, the maximum point total is 20 points. For example, a large group that reports active engagement in one highly weighted and two medium weighted improvement activities would achieve the maximum of 40 points. Since this performance category is weighted at 15 percent of the total MIPS score, the 40 points earned for improvement activities would earn the practice 15 points towards the total MIPS score.

Clinicians must meet all requirements of the activity to receive credit for that activity. However, if at least one clinician within a group of MIPS-eligible clinicians is performing the activity for a continuous 90 days in the performance period in 2017, the entire group may report on that activity.

MIPS Cost (Resource Use)

CMS will use claims data to track expenditures and attribute utilization of services to individual clinicians or groups. There is no reporting requirement. For the 2017 performance year cost is weighted at zero percent, as noted above. CMS will continue to track this information and performance feedback will be provided to practices.

Accurate ICD-10-CM coding is of importance for this category, as the Medicare expenditures attributed to a patient are risk-adjusted based on disease history and other factors. Practices will need to ensure that their disease and condition coding and documentation—including comorbid conditions—is as specific, accurate, and complete as possible.

Advanced Alternative Payment Models

The options to join an Advanced APM were somewhat limited in 2017, but CMS anticipates that participation will grow significantly over the next several years as more Advanced APMs are formed and new models are approved by Medicare.

Qualified APM Participants (QPs) are excluded from MIPS and will receive a five percent lump sum incentive payment at the beginning of each payment year. Minimum patient volume and reimbursement levels need to be met in order for clinicians to become QPs, and the thresholds increase substantially over the first several years of the program.

HIM professionals may be tasked with assessing their organization's Advanced APM participation options, including an assessment as to whether their clinicians or practice will meet current and future patient volume and reimbursement requirements. They will also likely play an active role in assisting the Advanced APM with meeting its reporting requirements.

Focus on Performance

One of the most significant changes under MACRA is the shift towards a competitive system that awards practices based on quality of care and resource utilization performance. For example, the send Summary of Care measure in the Modified Stage 2 "meaningful use" EHR Incentive Program only required that greater than 10 percent of patients involved in transitions of care had a summary of care record sent electronically to the clinician or facility receiving the patient. Under the MIPS this has become an ACI performance measure that is worth zero to 20 points (for practices using 2014 Edition CEHRT). Practices that achieved a 15 percent performance rate with this measure for "meaningful use" would have more than met the minimum satisfactory reporting requirement. However, under MIPS this would represent low performance and only three of the 20 possible ACI points would have been earned. A 95 percent performance rate on this measure would earn the practice 20 total ACI percentage points. Under MIPS, practices have an incentive to achieve higher performance rates for this and other measures. Under MACRA high levels of performance can only be achieved through accurate data capture, reporting, and creation of supporting documentation. HIM professionals may be tasked with monitoring performance trends throughout the reporting period and intervening as needed when measure performance is suboptimal.

Additional Positive Payment Adjustment

As mentioned previously, exceptional performance based on total MIPS composite performance scores may make practices eligible for additional positive payment adjustments in the first six years of the MIPS, from a fund of $500 million per year. This payment adjustment is capped at +10 percent, but is in addition to other positive payment adjustments. For performance year 2017, CMS has set the additional positive payment threshold at 70 total MIPS points. Practices that achieve greater than 70 MIPS points based on 2017 performance will receive additional positive payment adjustments that could represent significant income for their organization in 2019.

HIM Part of MACRA Success

HIM professionals will play a central role in many organizations as they strive to perform at levels that would make them eligible for additional positive payment adjustments, as well as achieve the highest levels of performance under MACRA. Given their role as stewards of healthcare information, HIM professionals are also poised to assume an even bigger role in the areas of change management, information governance, patient data analytics, and quality reporting. HIM professionals have a unique opportunity in MACRA's first year to help establish data management protocols in physician practices and medical groups embarking on QPP adoption.

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