MACRA and the Role of Clinical Data Integrity

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President Obama signed into law the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 on April 16, 2015. This legislation repealed the sustainable growth rate (SGR) but also introduced a number of provisions designed to compensate physicians and other healthcare professionals based on the quality of care they provide and utilization of services. In order to judge performance fairly and accurately, a much higher premium will be placed on the integrity of clinical data generated during patient care due to MACRA. This article will provide an overview of two key components of MACRA that will markedly impact Medicare Part B reimbursement and its dependence upon codified data that is accurate and complete.

MACRA Background

Under MACRA the majority of Medicare eligible providers (EPs) will participate in one of two programs that focus on shifting away from fee-for-service reimbursement and towards reimbursement based on quality and utilization. They are referred to as the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs).

MIPS will start January 1, 2019 and consolidates existing quality and utilization-based programs, including the Physician Quality Reporting System (PQRS), the Value-Based Modifier Program (VBM), and the "meaningful use" Electronic Health Record (EHR) Incentive Program Certified EHR Technology (CEHRT). As of press time many of the details surrounding a range of specific requirements were undergoing development and refinement by the Centers for Medicare and Medicaid Services. But the central value of accurate and complete data has never been greater given the implications of MIPS and APMs. Health information management (HIM) professionals will likely find themselves at the center of these efforts.

MIPS Rating Criteria Determines Providers' Score

MIPS consolidates existing Medicare fee-for-service incentive programs into one quality-based assessment program that rates eligible Medicare providers based on four criteria, each with an assigned maximum number of "points" referred to as the provider composite score. Starting in 2019 patients will be able to view their physician's rating based on the quality of care they provide during 2017. Based on the provider composite score, some providers may see up to a four percent increase or decrease in Medicare payments for the entire year in 2019. Over the next several years the potential payment adjustment widens, with providers receiving up to a nine percent negative or positive adjustment in 2022.

The four areas that MIPS will use to determine the provider composite score are: quality, resource utilization, use of a certified EHR, and clinical practice improvement activities. The payment adjustments will last for the entire year, making negative scores highly impactful on practices operating at low profit margins. The impact of low publicly displayed provider composite performance scores may negatively influence patient recruitment and retention.

APMs Still Being Defined

EPs that enroll in approved alternative payment models are not subject to MIPS. APMs will be further defined by Medicare in 2016 and will be based on input from providers and provider organizations. Examples of APMs include Medicare Shared Savings Program Accountable Care Organizations (ACOs), patient-centered medical homes, and bundled payment models.

Data Integrity Vital for MIPS and APMs

The quality-based provider reimbursement and rating programs under MACRA will markedly increase the importance of reliable data. Clinical information, when captured as codes (i.e., ICD-10-CM, SNOMED CT) in health information systems,

needs to have at its core a high level of integrity. Clinical data integrity in this setting can be viewed as having four areas of potential compromise. These include accuracy, completeness, preserved context, and currency.

- **Accuracy:** This refers to whether or not the code represents information correctly. Some terminologies (i.e., ICD-10-CM) use codes that may represent categories of diseases rather than an exact one-to-one representation of a given concept. SNOMED CT is an example of a terminology that allows for greater levels of one-to-one representation of clinical concepts.
- **Completeness:** This refers to whether or not the codified representation of the clinical concept represents the concept in its fullest capacity. An example of this would be severe chronic obstructive pulmonary disease (COPD), which may be defined by pulmonary function study values and other measures. Quality measurements under MACRA will be based on clinical outcomes. Identifying that the patient has severe versus mild or moderate COPD would be important to capture when evaluating providers based on outcomes of care. A patient with severe COPD is more likely to have a poorer outcome than a patient with mild COPD, and the severity of illness will be important to capture as codes that can be used to track and later assess the quality of care that was provided. SNOMED CT is an example of a terminology that was designed to support the use of sanctioned modifier codes for COPD and may other conditions. Allowed modifiers associated with COPD include the terms mild, mild-to-moderate, moderate, moderate-to-severe, severe, fatal, and life-threatening. This allows for the true clinical state of the patient to be captured as codified information in the form of a SNOMED CT clinical expression using post-coordination. Fair determination of care provided based on outcomes will need to factor into the severity of the patient's illness prior to rating positive or negative outcomes.
- **Preserved context:** This refers to the tendency of codified clinical information to be separated from context that is provided in the clinical record. For example, if context is not preserved a patient with a family history of Type 2 diabetes may be inadvertently labelled as having the disorder, not just the family history. The consolidated clinical document architecture (C-CDA) and other standards used to exchange clinical data provide for proper context, however the mechanisms by which information is stored in proprietary EHR databases varies widely.
- **Currency:** Clinical information in the patient's longitudinal record of care requires continuous updating. Unfortunately providers are not directly compensated, with the exception of the Medicare Chronic Care Management Program, for reconciling information in the EHR like problem list items, medications, and other information. Data that is outdated and inaccurate at the point in time when clinical decisions are being made can adversely influence the care provided to patients. In many instances this may not be the fault of the provider, but it may result in compromised clinical outcomes.

Given the healthcare industry shift away from fee-for-service and towards ratings and reimbursement based on clinical outcomes, a full and accurate representation of the care being provided will become paramount for providers. This will include terminology and supporting informatics models, including true semantic interoperability—another stated goal of MACRA.

At this time, few EHR and health information exchange systems have the ability to capture and store data at the point of care using a reference terminology that supports the accuracy and completeness of clinical data. A high percentage of EHR vendors have elected to use an interface terminology at the point of care. Interface terminologies are composed of codes designed to facilitate the capture of information at the point of care, but they in general have limited reference terminology capabilities.

Healthcare Reimbursement Forever Changed

MACRA will change the landscape of healthcare reimbursement by shifting it away from traditional fee-for-service and towards value-based care. MIPS, with few exceptions, will create an environment where physicians and healthcare organizations will face adjustments in compensation and public ratings that may or may not benefit them financially. Given its potential impact on providers and healthcare in general, provider assessments under MIPS and APMs should use data that has the highest level of clinical integrity. Current mechanisms (i.e., PQRS and VBM) are based on claims data and do not provide an accurate and fair representation of care tied to outcomes and utilization.

True and fair representation of the clinical care provided to patients and subsequent outcomes will need to be supported by sophisticated health information technology and terminology models that are beyond the limitations of current systems. MIPS and APMs may create incentives that will lead to improvements in the capture and use of clinical data, a process that could provide benefits to clinical care, utilization, and clinical research.

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