THE CLINICIANS GUIDE TO

MACRA & MIPS

FAMILY MEDICINE PA & CLINICAL IT DIRECTOR

- Dallas Family Medicine, est. 1951 - Dallas, OR
- 4 providers, 25 employees
- Family Medicine in rural Polk Co, pop 20K

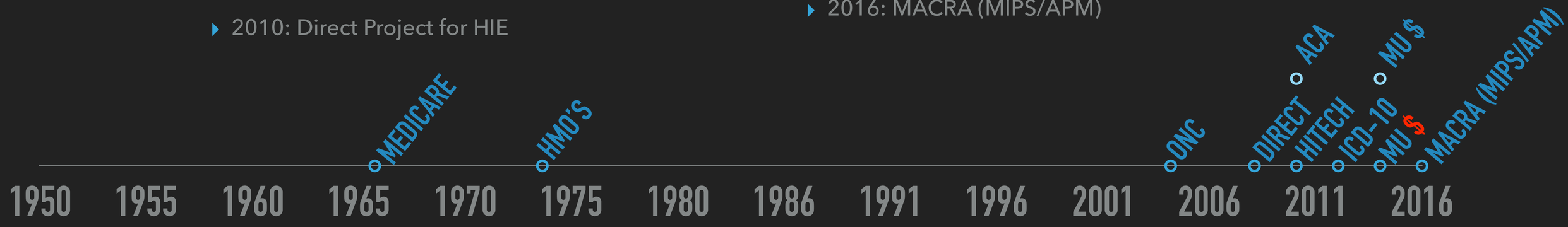
SETTING

- 1830's: Germ Theory
- 1847: AMA Founded
- 1873: First State Medical Board for Licensing (Alabama)
- 1918: Public Health & Epidemiology (1918 Flu Pandemic)
- 1948: World Health Organization (WHO) Founded
- 1951: DFM Founded
- 1954: Transplantation
- 1966: Medicare
- 1973: HMO's
- 1980's: Patient Centered Care and Primary Care Home Concept Introduced
- 1996 HIPAA
- 2004: ONC Created
- 2009: HITECH Act
- 2010: Direct Project for HIE
- 2010: Affordable Care Act
- 2011: Meaningful Use Medicare Incentive Payments Begin
- 2015: ICD-10 Implementation
- 2015: Meaningful Use Medicare Penalties Begin

SETTING

The last 10 years have seen more significant overhaul of health care delivery and regulation than the prior 1/2 century

- 1966: Medicare
- 1973: HMO's
- 2004: ONC Created
- 2009: HITECH Act
- 2010: Direct Project for HIE
- 2010: Affordable Care Act
- 2011: Meaningful Use Medicare Incentive Payments Begin
- 2015: ICD-10 Implementation
- 2015: Meaningful Use Medicare Penalties Begin
- 2016: MACRA (MIPS/APM)



SETTING

- SGR
- PQRS
- VBM
- EHR Incentive (MU)

WE ARE HALFWAY THROUGH THE PROCESS OF COMPUTERIZING AND DIGITIZING HEALTHCARE SETTINGS, BUT ONLY 5% OF THE WAY THROUGH REDESIGNING WORK FLOWS…

Farad Mostashari, MD
Former National Coordinator for Health IT, May 2013

MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015

- Quality Payment Program
- HHS & CMS Priorities:
  - Increased flexibility in MU
  - User-friendly technology designed around how a provider works and interacts with patients
  - Improved interoperability and ability of providers & patients to move and receive info between different systems

MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015

- Merit-Based Incentive Payment System (MIPS)
- Advanced APM’s (participation incentives)

MIPS

- Quality
- Resource Use
- Clinical Practice Improvement
- Advancing Care Information

MIPS: QUALITY

- 50%
- Replaces PQRS
- Providers can select measures (general vs speciality) to be evaluated on
- Still proposed (Final by 11.1)

MIPS: RESOURCE USE

- 10% weight
- Replaces Value Modifier: Is it cost-effective?
- Care Episodes against Clinical Condition Groups
- Based on Claims

MIPS: CLINICAL PRACTICE IMPROVEMENT

- 15%
- Brand New Category
- The more activities the more credit
- Full credit for patient-centered medical home

MIPS: ADVANCING CARE INFORMATION

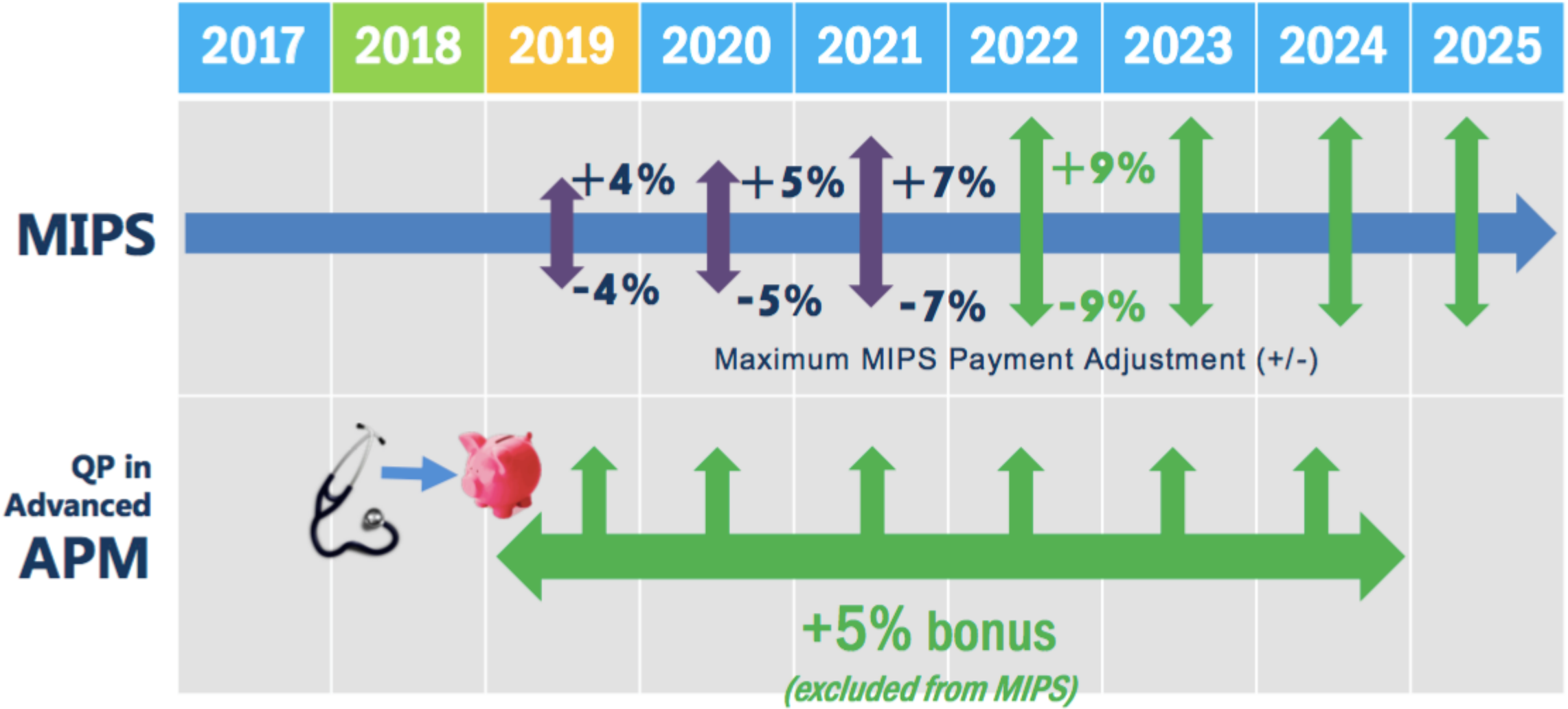
- 25%
- Replaces EHR Incentive (MU)
- Composite Score (Base + Performance + Bonus Points)
  "Scoring based on key measures of health IT interoperability and information exchange" - MACRA presentation 5.2016
- Clinicians selects measures

MIPS: PAYMENT ADJUSTMENTS

- Based on 2017 performance for payments in 2019
- Payment Adjustments of +/- **4%** in 2019 to +/- **9%** in 2022

ADVANCED APM

- Use certified EHR technology
- Payment based on quality measures
- Either:
  - bear financial risk
  - expanded Medical Home model
- APM-specific awards & annual 5% bonus


2017
2018
2019
2020
2021
2022
2023
2024
2025
MIPS
+4%
-4%
+5%
-5%
+7%
-7%
+9%
-9%
Maximum MIPS Payment Adjustment (+/-)
QP in Advanced APM
+5% bonus
(excluded from MIPS)

MACRA KEY POINTS

- Payment is for quality
- Requires a strategy for knowing and proving quality
- Interoperability and health information exchange is key
- Requires actual collaboration across health systems and disparate EMR's in timely and clinically meaningful ways

INTEROPERABILITY

- Interoperability describes the extent to which systems and devices can exchange data, and interpret that shared data. For two systems to be interoperable, they must be able to exchange data and subsequently present that data such that it can be understood by a user. - HIMSS

SETTING: DFM

- Deployed EMR 2011
- Successfully attested for MU
- Tier 3 PCPCH
- Providers overwhelmed
- Patients weary

THE PREDICAMENT & THE RESPONSE

- The many pressures to meet standards, achieve incentives, and avoid penalties left few resources to focus on what we valued as a family practice.
- This realization motivated an alignment of our efforts to pursue change that mattered to our providers and would improve the care of our patients.
- The introduction of MACRA requires strategic planning and a new approach to interoperability

WHAT MATTERS TO DFM

- Excellent Medicine
- Reasonable Workload
- Happy Patients
- Well-Trained & Reliable Staff & Efficient Workflows
- Getting Paid

THE PRACTICE OF MEDICINE WILL BE VERY MUCH AS YOU MAKE IT — TO ONE A WORRY, A CARE, A PERPETUAL ANNOYANCE; TO ANOTHER, A DAILY JOB AND A LIFE OF AS MUCH HAPPINESS AND USEFULNESS AS CAN WELL FALL TO THE LOT OF MAN, BECAUSE IT IS A LIFE OF SELF-SACRIFICE AND OF COUNTLESS OPPORTUNITIES TO COMFORT AND HELP THE WEAK-HEARTED, AND TO RAISE UP THOSE THAT FALL.

Sir William Osler, MD

EXCELLENT MEDICINE

- 15-25 common conditions account for majority of US health services, nearly all chronic
- more than 40% of chronically ill individuals are affected by >1 chronic condition
- Evidenced-Based Practice Guidelines take an avg of 17 years to be adopted
- Improving DFM’s care for chronic illness improves the lives of our patients, and captures quality-based payments

EXCELLENT MEDICINE

- DFM identified DM as a major chronic illness with multiple co-morbidities
- Providers want to improve DM care and recognize we are not fully utilizing our IT to improve the care of our DM population
- Decide to focus 2017 on DM care with pro-active planning around MIPS guidelines

DFM DIABETIC CARE UNDER MACRA

- Quality : Select DM Quality Measures
- Resource Use: Based on Claims, ensure adequate communication fo disease burden (including complications) to payors (note: additional incentives programs available)
- Clinical Practice Improvement: PCPCH
- Advancing Care Information: Select measures that have most impact on DM patients and their care

DEMO: CPS SPECIFIC WORKFLOWS AROUND DM

GET PAID

- Develop a strategy for care delivery in an quality-based payment system, that doesn't rely solely on claims data
- Develop a strategy for collaborative care as part of an APM
- Real-time data feedback and transmission of clinical quality measures
- Real-time data on APM empanelment and gaps in care
- Flexible and scalable IE for information exchange and data submission

HEALTH IT PROMISES MANY BENEFITS FOR IMPROVING QUALITY AND EFFICIENCY. HOWEVER, THE INTRODUCTION OF HEALTH IT CAN BE VERY DISRUPTIVE TO EXISTING WORKFLOWS…A GOOD WORKFLOW WILL HELP ACCOMPLISH GOALS IN A TIMELY MANNER, LEADING TO CARE THAT IS DELIVERED MORE CONSISTENTLY, RELIABLY, SAFELY, AND IN COMPLIANCE WITH STANDARDS OF PRACTICE.

Agency for Healthcare Research & Quality

CLINICIAN DRIVEN CHANGE & MEANINGFUL INTEROPERABILITY

- Invest in reliable, scalable, flexible, well-supported IT
- Improve connectivity and health information exchange with with strategic service providers
- Improve data entry and availability of outside health info at the point of care
- Focus on provable and reimbursable quality driven care