Tales from The Trenches: 
An Inside Look at How Different Organizations Account for and Meet the Challenges of MACRA

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Laser Spine Institute

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Advanced Regional Center for Ankle and Foot Care

AGENDA

Lessons Learned

- Overall Key Points
- Communications
- Measures – End to End
- Auditing/Monitoring
- Changing Registries

The Future of MACRA

Resources and Reference Library
Poll Question

How many years have you been working with MIPS?

- Less than one year
- More than one year
- I go way back to the PQRS and Meaningful Use days

Laser Spine institute, LLC
MACRA Committee Members

- Vice President of Medical Operations
- Senior Director–ASC and Nursing Operations
- Regional Clinical Director
- Manager of Risk and Patient Safety
- Vice President Revenue Management
- EHR Manager
- Information Technology Manager
- Regulatory Compliance Manager
- Acting Corporate Compliance Officer
100%

PLANNING
TEAMWORK
COMMUNICATION
TRAINING

Advanced Regional Center for Ankle and Foot Care
MACRA Committee Members

- Owner
- Clinical Manager
- Revenue Cycle Manager
- Compliance Officer
  - Liaison with IT, EHR Company, Registry

Lessons Learned

OVERALL TIPS

- **C-Suite buy-in “MUST HAVE”**

- **Plan Early! Delays happen**
  - Have technical requirements in place and tested
  - Staff education and monitoring process complete

- **Take Credit! Identify Exceptions and Special Statuses promptly**
  Ex. Low volume threshold, non-patient facing, rural, facility, etc.
  *Avoid accidentally submitting data for ‘rewighted’ categories

- **Hardship exceptions** – Apply for a PI exception due to incomplete, OR delayed implementation, training OR testing

- **Know reporting timeframes**

- **Create easy access measure reference sheets with numerator/denominator criteria**

- **Use the CMS Resources – Fact Sheets, Final Rules, annual Decile updates; and free QPP inquiry services**
PI – Apply for the Exception

- **Year One**
  - i. Applied for, and was granted an exception for PI (ACI). **Result:** Quality accounted for 70%

- **Year Two**
  - i. Deemed non-patient facing, therefore PI (ACI) are waived. **Result expected:** Quality will count for 85%*

- **Year Three**
  - i. Preparations in process, in case non-patient facing is not met again. **Result expected:** Quality counts for 85%*

- **When Cost category score does not apply, Cost is included in Quality category. Check Fact Sheets for Cost category details.**

- **Apply for the Hardship Exception** - If valid reason exists, there is NO reason not to!
  - Your Quality Score will count for 70% of your total MIPS score:
    - [https://qpp.cms.gov/mips/exception-applications](https://qpp.cms.gov/mips/exception-applications)

- **Cite one of the following specified reasons for review and approval:**
  - MIPS-eligible clinicians in small practices
  - MIPS-eligible clinicians using decertified EHR technology
  - Insufficient Internet connectivity
  - Extreme and uncontrollable circumstances
  - Lack of control over the availability of CEHRT

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Special Status – Where and Who

**Special Status Clinicians**

- Hospital-based MIPS-eligible Clinicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Non-Patient facing clinicians
- Ambulatory Surgical Center (ASC)-based MIPS-eligible Clinicians

[https://qpp.cms.gov/mips/exception-applications](https://qpp.cms.gov/mips/exception-applications)
Where to find YOUR special status
https://qpp.cms.gov/user/dashboard

Lessons Learned

OVERALL TIPS

• Involve key stakeholders early and provide continuous feedback through monitoring/auditing

• Be audit ready -- Document and save supporting material in real time

• Make IT/EHR team your best friend

• Be Informed – Know your expected SRA completion date
SHARE THE NEWS - TELL EVERYONE!

ONE TEAM!
As a result of changes in the regulatory landscape, we have an opportunity to improve our reputation and future revenue results.

On October 1, we will begin participating in the Merit-based Incentive Payment System (MIPS), an option under the Medicare Access and CHIP Reauthorization Act (MACRA).

Starting in 2019 and going forward, physicians and groups participating in MIPS will face a range of Medicare payment adjustments. This can include bonuses up to 12 percent in 2019 and up to 27 percent thereafter. There could also be potential penalties of up to four percent to nine percent in later years that could apply to non-participating providers and to providers with less than satisfactory performance.

Our participation and performance is important to our company and our providers. Although this is a Medicare-driven program, all insurance companies and prospective patients will have easy access to our outcomes. As a result, they will make decisions about our dedicated providers based on our performance, and we are confident in our procedures, our outcomes and our teammates.

Our participation in this enterprise-wide initiative involves dedicated resources from many departments. Payment adjustments take effect in 2019 based on 2017 performance, so in the near future, our MACRA team will be rolling out training for all surgical, clinical and ASC teammates. Please watch for notification and attend the training events announced by your Clinic and ASC leaders.

If you have any questions on the training or on the MACRA/MIPS program, please email MACRA@yourorg.com.

Communicate Results Routinely: Past and Present

TEAM, Please take time to review your providers’ MACRA performance, on the attached report.

We have one month left to improve our scores for increased Medicare reimbursement and public access to our results.

If any help is needed identifying/coaching our under-performing providers, please do be in touch. Our 2017 submission data compared to our current results, is shown below, along with the related gain/loss.

QM 047 Advance Directives: 12/31/2017: 45.58% 9/18/2018: 76.19% [+30.61%] 10/23/2018: 78.46% [+2.27%]
11/23/2018: 78.84% [+0.38%]

QM 130 Medication Documentation: 12/31/2017: 86.46% 9/18/2018: 90.77% [+4.31%] 10/23/2018: 91.1% [+0.33%]
11/23/2018: 79.85% [-11.25%]

QM 048 Urinary Incontinence – Kudos for your Excellent Performance! Please congratulate all providers for outstanding results on this measure, and continue the great work! 12/31/2017: 99.67% 9/18/2018: 99.17% [-0.5%]
10/23/2018: 99.15% [-0.02%] 11/23/2018: 99.18% [+0.03%]

QM 131: Pain Assessment: Excellent results! This is obvious proof we can reach perfection!
12/31/2017: 36.8% 9/18/2018: 90.67% [+53.87%] 10/23/2018: 91.38% [+0.71%] 11/23/2018: 91.21% [-0.17%]
Reports - EMR with Integrated Registry

Our Registry provides standardized reports
We select certain reports, based on intended audience, purpose and adaptability

- **Practice Summary** – For the MACRA Committee – overview results of each measure with numerator/denominator/exceptions and **Performance Met %**

- **Provider Dashboard** – For each location of each provider by each measure ****

- **Provider Patient Reports** – For front line coaching - Detailed reports distributed for coaching with individual providers (Published every 2-4 weeks)

****Distribute these reports to management, for their coaching with individual providers.

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Report: MACARA Committee and CMS Submission

### Practice Summary Report

<table>
<thead>
<tr>
<th>Program: 2018 Registry (P4010) Group</th>
<th># Patients</th>
<th>Performance</th>
<th>Nat. Benchmarks</th>
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<tbody>
<tr>
<td>Measure Start Date - 1/1/2018, Measure End Date - 12/31/2018</td>
<td>DEN</td>
<td>NUM</td>
<td>EXCP</td>
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<td></td>
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<td>2018 Quality ID 047 Medicare Part B</td>
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<tr>
<td>Non Medicare Part B</td>
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<tr>
<td>Total</td>
<td>40050</td>
<td>40052</td>
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<td>Non Medicare Part B</td>
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<tr>
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<tr>
<td>2018 Quality ID 203</td>
<td>91</td>
<td>5</td>
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</table>
Communication – Scoring: Why Your Attention Matters Now

Timing: 16% of the year remains, take every opportunity To Make a Difference

- Impact: Minor increase could earn points now, and improve PR later
- Public Reporting: Physician Compare – Results viewable to all, especially potential patients
- Where we are, where we want to be, what is needed to get there
- Use monitoring reports to identify exactly who needs coaching

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Current % score</th>
<th>Goal (%)</th>
<th>+/- Change % Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>021 Prophylactic antibiotic:</td>
<td>97.13</td>
<td>99.11</td>
<td>+ 1.98</td>
</tr>
<tr>
<td>047 Advance Directives</td>
<td>78.46</td>
<td>88.72</td>
<td>+ 10.26</td>
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<tr>
<td>048 Urinary Incontinence</td>
<td>99.15</td>
<td>99.99</td>
<td>+ 0.84</td>
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<td>130 Medication Documentation</td>
<td>91.1</td>
<td>91.72</td>
<td>+ 0.62</td>
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<td>131 Pain Assessment</td>
<td>91.38</td>
<td>91.43</td>
<td>+ 0.05</td>
</tr>
<tr>
<td>238 High Risk Meds*</td>
<td>30.37</td>
<td>14.95</td>
<td>- 15.42</td>
</tr>
</tbody>
</table>

*N/A - Change is not expected

**High Priority – 131: next goal 99.03%

Lessons Learned

MEASURES

- Take a proactive approach – Avoid current and future topped out measures
- Forecast and incorporate future decile friendly measures
- Monitor Tech Specs – Review and consider specialty measure groups
  Closely communicate with your registry on their schedule of updates
- Avoid all gaps – ID all visits meeting measure criteria, confirm templates exist and providers are educated
- Leverage resources in all departments to bridge gaps – Verify HOW and WHEN Performance is MET
- Monitor/Audit Provider Lists – Groups: verify all providers are loaded in registry and included in submission
- Monitor Performance – Generate reports, communicate results to all staff levels, make coaching tools available
**Poll Question**

Have you encountered any measures that have recently been topped out?

- Yes
- No

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### Selecting Decile Friendly Measures

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>QM ID</th>
<th>Type</th>
<th>Benchmark</th>
<th>Average</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
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<th>Topped_Out_PY2019</th>
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<td>21</td>
<td>Proc</td>
<td>Y</td>
<td>94.6</td>
<td>98.57 - 99.99</td>
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<td>-</td>
<td>-</td>
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<td>Yes</td>
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<tr>
<td>Care Plan</td>
<td>47</td>
<td>Proc</td>
<td>Y</td>
<td>66.1</td>
<td>64.53 - 65.01</td>
<td>64.02 - 65.74</td>
<td>65.75 - 62.16</td>
<td>62.17 - 91.89</td>
<td>91.90 - 97.31</td>
<td>97.32 - 99.71</td>
<td>99.72 - 99.99</td>
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<td>No</td>
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<td>Documentation of Current Medications in the Medical Record</td>
<td>134</td>
<td>Proc</td>
<td>Y</td>
<td>82.6</td>
<td>68.26 - 90.77</td>
<td>90.26 - 97.73</td>
<td>97.26 - 95.58</td>
<td>95.51 - 99.99</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Pain Assessment and Follow-Up</td>
<td>134</td>
<td>Proc</td>
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<td>65.1</td>
<td>55.80 - 59.99</td>
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<td>62.79 - 84.05</td>
<td>84.06 - 95.25</td>
<td>95.26 - 99.54</td>
<td>99.55 - 99.99</td>
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<td>0.28 - 0.41</td>
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<td>Falls Risk Assessment</td>
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<td>60.22 - 63.99</td>
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<tr>
<td>Prevention of Post-Operative Nausea and Vomiting (PONV)</td>
<td>403</td>
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<td>Y</td>
<td>94.3</td>
<td>95.66 - 87.17</td>
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<td>99.22 - 99.63</td>
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</tbody>
</table>

**HIGHLIGHT KEY:**

*Preferred: Green     **Plan To exclude: Gold     ***Replacement required ASAP: Pink
Monitor Tech Specs:

I review the measures:

- Print out a copy
- Circle important details
- Suggest who may be responsible with performing the measure (reception, clinical/provider, other)

Examples of what we do:

Avoid All Gaps:

We will take a look at a few quality measures that we both report but approach these measures differently.

47 – Care Plan

128 – BMI

130 – Documentation of Current Meds

238 – High Risk Meds

Challenges we faced and how we overcame those barriers.
Pro-Active Approach to Monitor/Auditing

Example of data that is used to identify patients ahead of visits that are eligible or completed for certain measures. These are printed and given to each staff member at the beginning of each day for that day’s patients. Quality Measures 126, 127

Report details include:

- Patient Name
- Account number
- Appointment Time
- Doctor
- Location
- Blanks (incomplete)
- Dates (complete)
- Staff Initials
- Comments (if patient refuses, etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Acct#</th>
<th>Type</th>
<th>Appt Time</th>
<th>FOLDER</th>
<th>ASSG0</th>
<th>Foot Exam</th>
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</table>

Reports for Each Audience and Purpose

Avoid all gaps – ID all visits meeting measure criteria

Provider Dashboard:
- Details results for each provider
- Identify Providers with Treatment Opportunities

Identify Treatment opportunities by provider, by measure
Report:

- Reports Quality Measures
  i. Group
  ii. Provider
  iii. Measure Specific

- Reports ACI (PI) Measures
  i. Group
  ii. Provider
  iii. Measure Specific

Poll Question

Has any one considered changing registries?

- Yes
- No
Lessons Learned

CHANGING REGISTRIES:

• Work closely with your EHR team to determine best integrated method, consider the benefits of data transfer via sequel server
• Verify submitter: “End-to-End Reporting”
• Determine if your submission vendor handles all measures, avoid lost time!
• Select more measures than required, then prioritize best
• Vendor Performance: Include Contract Service Level Agreement on ‘implementation time on new measures’
• Reporting Delivery: Specify required reporting and prevent registry from retiring existing reports without your approval

Past, present and where we want to go
How MACRA can help take us there

Laser Spine Institute

Tracking MACRA – Views
  • 2017 – Year #1 - Find MACRA footing while aiming for positive adjustment
  • 2018 – Year #2 - Focus on scores
  • 2019 – Year #3 - Forecast QMs via decile information
  • 2020 – Year #4 AND Beyond - Make your data work for you!

Goal - Become a ‘Center of Excellence’

How - Embrace challenges of complex measures
  • ID outcome measures proving quality
  • Use measures highlighting your expertise
  • Address overwhelming barriers with strategic planned solutions
  • Leverage all departments, identify all gaps, plan through trial periods

Advanced Regional Center for Ankle and Foot Care

Tracking MACRA – Views
  • 2017 – Year #1 - To obtain a positive payment adjustment
  • 2018 – Year #2 - Focus on increasing our decile scores
  • 2019 – Year #3 - Finding new measures that we can use as some have become topped out
  • 2020 – Year #4 AND Beyond - Make your data work for you!

Goal - Put the patients and staff needs first ‘Patient Centric’

How - Develop better workflows with clinicians and providers
  • Find outcome based measures we can use
  • Review specialty specific measures
  • Provide multi-prong education opportunities - in-person, video
  • Identify gaps thru pre and post-assessments
  • Work to implement surveys (CAHPS)

Assess your ‘roadmap’ continuously
Track patient reported outcomes, use data to raise quality, improve process while lowering cost
Use results in marketing and expansion initiatives
Find measures that will help YOU grow and show HOW you shine
The Next Best Quality Step – Beyond Payment Adjustments

QM Examples: Patient reported functional outcome measures
• QM 469 - Average Change in Functional Status Following Lumbar Spine Fusion Surgery
• QM 471 - Average Change in Functional Status Following Lumbar Discectomy
• QM 473 - Average Change in Leg Pain Following Lumbar Spine Fusion Surgery

Benefits:
• Key complex measures with positive impact from MACRA, Research, QI, payor contracting and business perspectives
• Serve as a cross check of patient’s condition compared to other sources of patient information
• Acts as another clinician tool, used in decision for patient’s surgical plan

Roadmap to success:
• Engage all stakeholders - discuss all pros and cons
• ID all gaps in current processes
• Determine processes to meet complex and challenging criteria
• Set trial period and contingency plans
• Clarify rewards, disadvantages and ongoing monitoring plan
• Surveys - Monthly and CAHPS

The Next Step for PI (Promoting Interoperability)

2018 Measures
Base measures
• E-Prescribing
• Health Information Exchange
• Provide Patient Access
• Security Risk Analysis

Performance measures
• Health Information Exchange
• Provide Patient Access
• Medication Reconciliation
• View, Download, or Transmit (VDT)
• Patient Specific Education
• Secure Messaging
• Immunization Registry Reporting

2020 Measures
Medicare Scoring Methodology in CY 2020

Will continue to be 90 days 2015 CEHRT Required

*Security Risk Analysis is retained, but not included as part of the scoring methodology.
### 2019 MIPS

<table>
<thead>
<tr>
<th>Quality</th>
<th>Cost</th>
<th>Promoting Interoperability</th>
<th>Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>45% 45 MIPS points Maximum</td>
<td>15% 15 MIPS points Maximum</td>
<td>25% 25 MIPS points Maximum</td>
<td>15% 15 MIPS points Maximum</td>
</tr>
</tbody>
</table>

### By 2021 MIPS

<table>
<thead>
<tr>
<th>Quality</th>
<th>Cost</th>
<th>Promoting Interoperability</th>
<th>Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>30% 45 MIPS points Maximum</td>
<td>30% 15 MIPS points Maximum</td>
<td>25% 25 MIPS points Maximum</td>
<td>15% 15 MIPS points Maximum</td>
</tr>
</tbody>
</table>

*From Bipartisan Budget Act*

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### Resources

- **QPP website** - qpp.cms.gov
- **QPP Resources** - https://qpp.cms.gov/about/resource-library
- To obtain, view and download your score, create a QPP Account
- To obtain, view and download your Cost score, create an EIDM Account https://portal.cms.gov/wps/portal/unauthportal/home/
- **Monthly webinars via HiTech Answers for MACRA**
- **Review on Physician Compare** – Comparing MIPS Score; ensure your top CPT Codes are paying the same as other physicians in your area
Thank You

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