USING CUSTOM SOFTWARE FOR MACRA ROI

ABSTRACT

Trying to optimize Medicare Revenue under MACRA, with EHR only, is a "square peg in a round hole". EHR is a clinical tool which provides the raw data for MACRA. But is it reasonable to ask clinical software to also optimize reimbursement from rapidly changing compliance rules? Even CMS, in their Final Rule on MACRA, recommended that Health IT Vendors develop products customized to support analytics and submission mechanics. ROI, in general comes from a combination of time savings, and revenue enhancement. In this paper we identify four software design features to enhance both time efficiency and revenue improvements.

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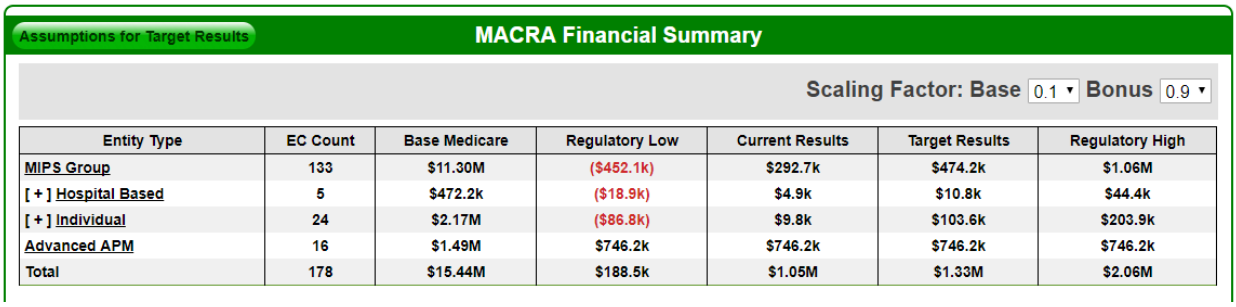
ROI in MACRA Monitor comes from optimizing decisions through insightful data analysis for the new rules under MACRA.

Smart management teams use software to manage ***financial targets tied to operational goals***. Long-term ***analysis of alternatives*** quantifies the effect of participation in ACO, group level submission, or reliance on strong individual performers. ***Quality reporting automation*** takes raw data from EHR or Registry systems and automates the process of picking not only the optimal measures for each individual provider or clinic, but identifying the impact of alternate submission methods. *While EHR systems must provide the raw data of MACRA, they are built for the job of optimizing the capture and presentation of clinical data to aid in treating patients, not for the job of managing CMS Compliance*.

MACRA imposes a burden on management staff to use important data from CMS in driving decisions of measurement and submission. Unfortunately, CMS data is only available via "one at a time" queries, or complex APIs. ***Automating access to CMS*** data is a key factor that streamlines MACRA decision-making and resulting actions, to make it reasonable for scarce knowledge worker resources to be effective.

1. Operational and Financial Budgeting

At the summary level, ***MACRA Monitor*** highlights the range of financial options, from "do-nothing" at full penalty, to "home run" with scores at maximum possible. Of course, since "home run" is based on national comparative rankings, top scores are not reasonable for everyone. But with **MACRA Monitor,** we steer provider groups into their own corporate and personal best.



Assumptions for Target Results

MACRA Financial Summary

Scaling Factor: Base 0.1 Bonus 0.9

Entity Type	EC Count	Base Medicare	Regulatory Low	Current Results	Target Results	Regulatory High
MIPS Group	133	$11.30M	($452.1k)	$292.7k	$474.2k	$1.06M
[+] Hospital Based	5	$472.2k	($18.9k)	$4.9k	$10.8k	$44.4k
[+] Individual	24	$2.17M	($86.8k)	$9.8k	$103.6k	$203.9k
Advanced APM	16	$1.49M	$746.2k	$746.2k	$746.2k	$746.2k
Total	178	$15.44M	$188.5k	$1.05M	$1.33M	$2.06M

Our "Current Results" calculate expected MACRA reimbursements based on ACI and CQM scores as they exist in EHR and Registry systems today. Insightful "Target Results" allow provider groups to define budget-level scores generating financial expectations and are tied to performance expectations for every single provider, regardless of how they may be expected to submit MACRA content. By focusing on the biggest dollar gains between "current" and "target" results, groups use their management time wisely.

With this information, revenue maximization activities are driven by collaboration with the CFO, Medical Staff, IT and MACRA Management teams to most easily identify where the most significant financial opportunities exist, based on what metrics, for what groups, and where improvement is most reasonable to expect.

Under prior programs of Meaningful Use and PQRS, penalty and reward were always measured and assessed at the individual level. MACRA regulations add Clinic, or TIN-level performance into the

financial formula, and **MACRA Monitor** automatically assembles all data into TIN analyses, driven by expected submission levels for each.

TIN Summary

TIN Name	TIN NPI	Assigned ECs	AH ECs	ACI	CQM	CPIA	Composite	Reporting Entity Default
ACO Clinic	123456789	121	121	90	90.3	0	77	MIPS Group
Capitated Specialists		16	16	89	0	100	0	Advanced APM
Group Providers		12	12	89	71	0	65	MIPS Group
Individual Providers	234567890	67	67	31	79.4	0	55	Individual
Kenosha Hospital and ED		13	13	73	80.6	0	69	Hospital Based

Starting with the TINs with highest probability of financial improvement, managers drill down to specific providers falling below reporting entity based targets, and find individual providers where improvement best upgrades the group.

Advancing Care Info Refresh Individual

Only Show Below Target Score ☐ Target Score = 85

Physician (ALL)	Specialty (ALL)	EHR Interface Map (ALL)	Responsible Person(s) (ALL)	ACI Base Score	ACI Performance	ACI Bonus	ACI Total Score
Adam, Andrew, MD	Internal Medicine	Cerner - Code CQM	Nick Adams	50.0	36.0	0.0	86.0
Armstrong, John, MD	Internal Medicine	Cerner - Code CQM	Nick Adams	0.0	38.0	0.0	0.0
Arnold, Peleg, MD	Internal Medicine	Cerner - Code CQM	Nick Adams	50.0	46.0	0.0	96.0
Banister, John, MD	Internal Medicine	Cerner - Code CQM	Nick Adams	0.0	0.0	0.0	0.0
Barnwell, Robert, MD	Internal Medicine	Cerner - Code CQM	Nick Adams	50.0	41.0	0.0	91.0
Beresford, Richard, MD	Internal Medicine	Cerner - Code CQM	Nick Adams	0.0	33.0	0.0	0.0

Of course, knowing which provider is depressing group scores is only helpful if managers know where each provider should improve, so **MACRA Monitor** supports the processes of highlighting shortfall measures at the level of provider and measure … or even at the level of which measures are poor performers across aggregates of providers.

Individual ACI Detail Individual

Physicians: Adam, Andrew

Number of Records: 4

Score	Base	Perf.	Bonus	Total
	50	36	0	86

Req ID	Requirement Short Name	EHR Interface Map (ALL)	Responsible Person(s) (ALL)	MIPS Potential Score	MIPS Score	Current Value	Numerator	Denominator	Date Range
ACI_TRANS_EP_1	e-Prescribing	Cerner - Code CQM	Nick Adams	Yes	Yes	86.3%	82	95	06/01/2017 to 08/31/2017
ACI_TRANS_HIE_1	Health Information Exchange	Cerner - Code CQM	Nick Adams	Yes	Yes	2.0%	1	49	06/01/2017 to 08/31/2017
ACI_TRANS_PEA_1	Provide Patient Access	Cerner - Code CQM	Nick Adams	Yes	Yes	100.0%	196	196	06/01/2017 to 08/31/2017
ACI_TRANS_PPHI_1	Security Risk Analysis	Cerner - Code CQM	Nick Adams	Yes	Yes	Yes	N/A	N/A	N/A

2. Analysis of Alternatives

In the short term of the first year of MACRA, providers need to decide on submitting as group or individual, and on how to calculate and submit Clinical Quality Measures (CQMs). Our analysis of over 12,000 **MACRA Monitor** providers shows that these short-term decisions have a profound impact on the financial result, as well as on the level of effort of mangers to assemble and submit data.

Longer term, many provider groups are analyzing current or prospective ACO relationships. While there are significant intangible benefits of ACO participation, the financial measurements are not all that complex. Apart from MACRA, an ACO generates shared savings that get distributed to providers annually. Unfortunately, based on 2015 CMS statistics, most ACOs have not yet generated sharable savings.

But within MACRA the financial results are clear and determinable and more immediate. ACO MACRA scoring is calculated differently from individual or group level scoring. Within an ACO, individual physicians or even clinic performance is diluted across a broad provider group. And the decision of any given TIN on whether to continue, expand, or exit an ACO relationship is easily measurable, with the right tools.

Analysis TIN of Participation Alternatives

Scaling Factor: Base 0.1 Bonus 0.9

TIN Name	TIN ID	EC Count	Base Medicare	Current ACO (ACO - SSP)	Current Group (MIPS Group)	Current Individual (Individual)	Current Entity Type
☑ ACO Clinic		121	$10.57M	$11.7k	$290.8k	$11.7k	MIPS Group
☑ Capitated Specialists		16	$1.49M	$1.7k	$19.5k	$6.0k	Advanced APM
☑ Group Providers		12	$727.6k	$805	$1.8k	$3.2k	MIPS Group
☐ Individual Providers		67	$2.74M	$0	$67.5k	$9.8k	Individual
☑ Kenosha Hospital and ED		13	$612.7k	$678	$15.1k	$5.5k	Hospital Based
Total		229	$16.15M	$14.8k	$394.7k	$36.1k	

Although providers typically cannot enter or exit an ACO within a given reporting year, the annual process of deciding should incorporate the significant financial implication of MACRA in addition to other factors. High performers under MACRA frequently score better outside the ACO than inside.

3. Quality Reporting Automation

Of the three pillars of MACRA (ACI, CQM and CPIA), Quality Measurement is the most impactful. It also changes more under MACRA than its predecessor program of Meaningful Use.

The big change, of course is the shift from “pay for submission” to “pay for performance”. Under each system, providers (other than ACOs) choose six measures to submit. In pay for submission under PQRS, the selection of which CQMs to submit had no financial or reputational impact. Under MACRA, that selection effects not only MACRA scores and the resulting financial impact, but also results in publication of each provider’s “personal” best on the website, https://data.medicare.gov/data/physician-compare . CMS has also committed to make the Physician Compare website more consumer-oriented as the new quality and MIPS data comes available.

Requirement ID & Title
001|Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Quality Information

CQM Type:	High Priority:	NQF ID:	NQF eMeasure ID:
Intermediate Outcome	Yes	0059	N/A

Benchmarks

Submission Method	Cqm Category	Low Outcome	1st Decile	2nd Decile	3rd Decile	4th Decile	5th Decile	6th Decile	7th Decile	8th Decile	9th Decile	10th Decile
Claims	Normal	Yes	-	-	35.0 - 25.72	25.71 - 20.32	20.31 - 16.23	16.22 - 13.05	13.04 - 10.01	10.0 - 7.42	7.41 - 4.01	4.0 - 0.0
CMS Web Interface		No	-	-	-	-	-	-	-	-	-	-
EHR	Normal	Yes	-	-	54.67 - 35.91	35.9 - 25.63	25.62 - 19.34	19.33 - 14.15	14.14 - 9.1	9.09 - 3.34	3.33 - 0.01	0.0 - 0.0
Registry	Normal	Yes	-	-	83.1 - 68.19	68.18 - 53.14	53.13 - 40.66	40.65 - 30.2	30.19 - 22.74	22.73 - 16.82	16.81 - 10.33	10.32 - 0.0

The trick lies in making the selection of which set is the best "pick six". Each measure earns a MACRA score calculated from its raw numerator / denominator, measured against one of four separate benchmarks. Some measures can earn bonus points, while others have a ceiling on their potential score. Benchmarks, and bonus points are impacted by the method a group chooses to submit as well.

In most cases, providers have 50-150 measures from which to select, depending on how their EHR and Registry systems are configured. Although EHR and Registry systems are critical in the calculation of raw numerator / denominator scores, they seldom are built to manipulate all the variables necessary to optimizing the best MACRA picks.

CQM Selector **Submission Method:** EHR

Armstrong, J | **Entity Type:** Individual | **6 | Template:** None
Internal Medicine
Manual Override:

53.8 / 60 = 89.7
Target Score = 80
Priority Bonus Maximum: 6 points

CQM ID	CQM Name	CQM Category	CQM Type	High/Low Good	Num	Den	CQM Result	Measure Possible Points	Decile Points	Priority Bonus (0)	CEHRT Bonus	Total Points	Selected 6 So Far
236	Controlling High Blood Pressure	Normal	Intermediate Outcome	High	68	94	72.3	10	9.0	0	0	9.0	☑
110	Preventive Care and Screening: Influenza Immunization	Normal	Process	High	291	353	82.4	10	10.0	0	0	10.0	☑
111	Pneumococcal Vaccination Status for Older Adults	Normal	Process	High	263	272	96.7	10	10.0	0	0	10.0	☑
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Normal	Process	High	404	410	98.5	10	9.9	0	0	9.9	☑
119	Diabetes: Medical Attention for Nephropathy	Normal	Process	High	79	86	91.9	10	9.0	0	0	9.0	☑
113	Colorectal Cancer Screening	Normal	Process	High	121	367	33	10	5.9	0	0	5.9	☑
001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Normal	Intermediate Outcome	Low	29	86	33.7	10	4.2	1	0	5.2	☐
130	Documentation of Current Medications in the Medical Record	Normal	Process	High	646	726	89	10	4.2	1	0	5.2	☐
191	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Normal	Outcome	High	0	0		10	3.0	2	0	5.0	☐
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	Normal	Outcome	Low	0	0		10	3.0	2	0	5.0	☐

For a MACRA Manager the process is impossible at the level of individual physician without sophisticated automation. And even at group level, the process is daunting. The role of ***MACRA Monitor*** software is to auto-score every **single** measure, and auto-select the **best** six for each individual provider, and then **again** for each clinic (TIN). Without real-time provider by provider assessment, Medical Groups cannot possibly evaluate the financial impact of group vs. individual submission. ***MACRA Monitor*** enables single-click comparison of any given provider (or TIN) across reporting entity type, submission method, and even application of a specialty-based CQM template.

Many organizations ask about the differences between a Data Submission Vendor (DSV), such as ***MACRA Monitor***, and a Certified Registry. A Registry is a quality tracking organization that accepts CQM content from across a broad population of providers for a specific purpose (i.e., disease state,

practice specialty, geography). Aggregate results are shared back to contributing providers so they can benchmark themselves against the peer group defined by the registry. Registries often provide software to their clinical clients that will assist in the calculation of the CQMs within the registry's content domain.

Under MACRA, Registries can use their software to submit CQM data to CMS on behalf of a client group. However, there are drawbacks to a group on having data submitted to **MIPS** via Registry:

- The population of measures from which to select a providers' "best six" is limited to the measures in the registry's domain. Some providers may score higher using measures other than those outside what the registry reports on.
- For 2017 (and possibly future years as well), the benchmarks CMS uses to derive CQM scores are generally more rigorous under registry reporting, than under the "EHR Direct" option. The result is that the very same measures and raw scores typically result in lower MIPS scores when using registry, rather than EHR direct.
- If the Registry calculates measures using claims data feeds, and / or manual abstraction of chart data to improve raw scores, the group is excluded from claiming the MACRA bonus for "end-to-end-CEHRT" reporting. This bonus adds an extra 10% to the numerator of the MIPS score, which results in a significant increase in score.

Alternatively, you can submit via a Data Submission Vendor (DSV), as an add-on to EHRs. DSVs analyze measures that are calculated via registry and/or EHR, identify the method resulting in the highest MIPS score, and submit to CMS. This approach facilitates not only the best selection of measures and the best-scoring submission method, but also enables "end-to-end-CEHRT" reporting. **The net result is almost always higher Medicare Reimbursement with DSV, than what is achievable via Registries.**

Remember, a DSV does not replace the core reason for registry existence. It simply represents a software approach tailored explicitly to optimizing MACRA reimbursement.

4. Automating access to CMS

For individual providers or small groups, CMS has done a nice job on their MACRA website of enabling inquiries for individual providers. The inquiries tell whether a given provider is to be treated as low volume and exempt from the MIPS portion of MACRA; or is deemed by CMS to be a "non-patient-facing" provider and scored without EHR / ACI measures; or is a Rural / HPSA provider and exempt from CPIA requirements.

While the CMS website works well for individuals, large groups are forced into using the same one-by-one inquiries. With a dozen or two providers, the work is *tedious*. With a hundred, it is *onerous*. With more, the process becomes so time consuming as to be *unlikely*.

In other cases, CMS has developed **APIs** into their datasets for PECOS, MIPS Submission, and MACRA measures. The APIs are helpful, and even necessary to accurate and timely data management. However, by their very nature ***these APIs require software against a dedicated MACRA database***.

Failure to account for a provider population as seen by CMS can have significant impacts. Providers are often registered in PECOS under multiple billing TINs. For MACRA, each TIN must be calculated and submitted separately. Failure to submit a TINs MACRA scores will result in penalties, and in adverse

Quality results being published in a consumer website. EHR data is the principal source for MACRA data submission, and unless each EHR configuration maps perfectly to the appropriate PECOS TIN alignments, MACRA providers in some TINs will be subject to penalties, even though their providers may score well. Dedicated MACRA software needs to interface between the EHR, PECOS and Registry systems to provide exception reporting and optimal data configuration and submission.

Under ACO, CMS can deem some providers to be treated as outside the ACO. MACRA software can interface with ACO / CMS participation lists to identify any excluded providers within each TIN, and treat them as individual or group providers. Unless those excluded providers are so treated and submitted, they will inherit a zero MACRA score and receive the penalties and adverse reputational scores.

Summary

In physician-level execution, MACRA is not all that different from Meaningful Use and PQRS. The impacts of MACRA are most significant at the administrative level, where financial results are driven by new scorekeeping methods. Achieving "targeted" performance requires new and sophisticated measurements beyond the scope of what should be expected of EHR or Registry software, and certainly beyond what is achievable with manual spreadsheets.

The ROI of dedicated MACRA software lies in the ability to analyze complex new data, assess the financial impact of alternatives, automate complex processes and integrate with CMS. For even a modest-sized clinic of 100 or so providers, the difference between "business as usual" and "targeted" performance will easily be hundreds of thousands of dollars, even during MACRA's initial transitional years, with reduced performance goals, and lower incentive / penalty percentages. As time goes forward, CMS increases in required performance levels, and in higher percentage implications per year, MACRA software not only generates ROI, but is likely to become a prerequisite for effectively managing complex compliance programs.

For more information visit https://MACRAMonitor.com

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