STRATEGIES FOR MACRA: DOCUMENTATION AND POPULATION MANAGEMENT

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Let's face it, preparing for the MIPS option of MACRA is difficult. Each of these programs have their own rules about the number of required metrics, the type of metrics, and the thresholds for success. The details of each program are extremely important, but they will change annually. Therefore, the most updated source of information is the AAN website[1] and the CMS website.

For this talk, I want to provide some overarching strategies that will help both today and tomorrow, no matter how the rules change. To make this easier to read, I'm going to frame this in a series of questions:

- Question: Why should I care about MACRA/MIPS? Aren't all of these regulations going to be overturned anyway?

This talk is relevant for two reasons. It is true that as of today (early 2017), we can expect at least some parts of the Affordable Care Act (aka ObamaCare) to be overturned. However, MACRA is different from the Affordable Care Act. MACRA was passed by a wide majority of both political parties in 2015; The MACRA legislation overturned the Sustainable Growth Rate (SGR) fix for Medicare. [2] Under SGR, all Medicare physicians would have faced an equal, steep, across-the-board cut in payments. We don't foresee any legislation that is overturning MACRA because no one wants to revert to the method of SGR.

Second, insurance companies are adopting policies of cost control similar to what Medicare has implemented: accountable care, bundled payments, and medical home. Strategies that optimize performance under MIPS are essentially the same as those that optimize performance under managed care. Unless a physician opts out of all insurance payments altogether, these strategies will apply whether dealing with public payers like Medicare or private payers like managed care plans.

This bring us to the first tip: MIPS is a continuation of prior programs

> **Tip #1 MIPS is an extension of existing CMS programs such as Physician Quality Reporting System (PQRS), Meaningful Use, and Value-Based Payment Modifier. Whatever tips you have implemented to optimize performance in those programs will apply to MIPS.**

MIPS is actually four different programs: Quality, Advancing Care Information, Cost, and Clinical Practice Improvement Activities. [3] Therefore, the first tip is retaining any tips you have implemented in the prior Medicare programs; they are still just as relevant.

- Question: How does CMS compare cost of physicians?

This is a fundamental fact: CMS programs do not measure cost of care delivered at the physician level; it does so at the patient level. This may not appear to make sense, so let's try to imagine a world where costs are measured at the physician level:

> A neurologist and an internist are taking care of a patient with epilepsy. If physicians are being compared on costs, the neurologist and internist would want the other physician to order a magnetic resonance imaging scan even if it was clinically appropriate. There would be constant battles among all physicians of the same patient on who is responsible to order expensive tests.

That's not the way that CMS (or any other insurance company) views health care. Insurance companies views health care through the eyes of the patient. It doesn't try to figure out what aspect of care is attributable to which physician. It calculates the total cost of care for that patient, then tries to attribute that patient to a physician.

Here is the next tip:

Tip#2: Check that you are categorized as a neurologist or a neurology subspecialist according to CMS

The attribution rules can be complicated, but in general, it tries to find a primary care provider for a patient first. If the patient has not seen a primary care provider, then it finds the specialist who generated the greatest costs of care for that patient. So, neurologists should confirm their specialty is labelled in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS). [4] Alternatively, one can also look up one's specialty in the CMS Physician Compare website. [5] When Physician Compare and other physician databases such as Open Payments are first published, there are mistakes in the name, address, demographics, and specialty, so it's important to verify that information.

Related to Tip #2 is what to do if patients are attributed to you:

Tip #3: Encourage patients to have a primary care provider!

If your patients are seen a primary care provider as defined in their PECOS account as a specialty of general practice, family practice, internal medicine, or geriatric medicine, then they will never be attributed to a specialist. [6] This may appear like passing the buck to someone else. But to be honest, a neurologist's role in controlling a patient's treatment of cancer, congestive heart failure, or chronic obstructive pulmonary disease are mostly focused on how these chronic diseases impact a patient's neurological condition.

There are scenarios where this attribution logic doesn't work. For example, if the patient's primary care provider practices concierge medicine and doesn't take insurance, then CMS will not be able to identify a primary care provider in its claim files. Therefore, CMS will assign that patient to another physician. In another example, sometimes a specialist, like a cardiologist, serves as the patient's unofficial "primary care provider." But CMS doesn't know that the cardiologist is serving that role; it only knows that the patient doesn't have a physician with a specialty typical of primary care providers, so it then will use its algorithms to identify a specialist for attribution, and that could be the neurologist.

- How can the costs of care between patients be fairly compared? Some patients are sicker than others and they should cost more.
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This is a problem that has been recognized for a long-time. There are obvious incentives for insurance companies to enroll healthy patients and to disenroll sicker patients. To prevent insurance companies that contract with Medicare through Medicare Advantage plans from repeating this behavior, a cost-adjustment method was developed through Hierarchical Classification Category (HCC) codes. [7] These are selected ICD codes that have been shown to predict costs in the future. So, an operation to fix a broken arm may be expensive, but it typically doesn't predict recurring costs in the future. But a chronic disease such as Parkinson's disease will be associated with elevated costs in the future, so that diagnosis carries an HCC weight. To optimize scores based on HCC, remember to

Tip #4 Code as completely as possible, especially on complicated patients

Every patient with a diagnosis of Parkinson's disease carries the same HCC weight. But patients with severe Parkinson's disease will need more care than patients with mild Parkinson's disease. The only way to indicate to CMS that a patient has severe Parkinson's disease is to code all of the complications: depression, aspiration pneumonia, pressure ulcers, etc. This is exceeding difficult to do without an electronic health record. That said, even with an electronic health record, many physicians only file a code for the main condition, but not its complications. In the past, the main reason for picking the correct diagnosis code is to make sure that a test is not rejected by an insurance company. However, it now reveals the full clinical picture of a patient.

Even then, another coding strategy with an even bigger impact is

Tip #5: Do not forget to code chronic conditions that you are treating

Each diagnosis has to be assigned each calendar year if the condition is being "monitored, evaluated, assessed, or treated." Chronic diseases such as coronary artery diseases, diabetes, and chronic obstructive pulmonary disease are not curable; therefore, they should be reassigned annually. However, analyses show that physicians forgot to file these codes again because they are not forming a new diagnosis. [8] Again, EHR software programs that can identify HCC codes and remind you of codes assigned in prior years can be helpful.

To repeat, none of these strategies are specifically tailored for MIPS. But while MIPS may be expected to change year after year, some of these basic principles will remain no matter which payer or quality measurement program is implemented.

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