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Medical Group Management Association
Missouri

COMMUNIQUE

Dec/Jan
2016

Letter from the President

Jeff Ruch, CPA, MBA
President, MGMA-MO

In October, I wrote about change and how to go through change with your coworkers. At that time, I did not realize how ironic my next article would be. I am going through much change of my own as I write this. A change that is going to take me out of Missouri to work and therefore unable to fulfill the remainder of my service to all of you as President of MGMA Missouri. I am writing this with very mixed emotions as I truly wanted to complete my term. Your Board of Directors were planning some positive strategies to build attendance to the membership and annual conference. I am confident that this work will continue in whatever form the Board deems necessary.

Susan Reichert, Past President this year, has graciously agreed to step back into the role as President for the next seven months. I appreciate her willingness to serve and carry on the work that has been set in motion from her productive year as President. The remainder of the Board will remain in their current roles until the annual business meeting where the new slate of officers will be put in front of the membership for approval. I have no doubt that the association will remain strong during this transition with the quality and competence of the remaining board members.

I have been blessed to have served for such a caring and dedicated group of people over the years that I've been associated with MGMA Missouri. I have built some strong relationships that I will truly miss and that won't ever be replaced. I feel fortunate to have gotten to know many of you through my years with the Board and will cherish the memories we have had together. MGMA Missouri is a strong, dynamic association that I am confident stands out in the country as one of the best. This has been built by previous Board members and each of you that are committed to making the delivery of healthcare better for those we serve in Missouri and surrounding states. I thank each past president and member for building such a strong association that is prepared for the future that holds so much change for everyone.

I also want to thank each of the current Board members for serving with me and making my years on the Board successful. I will miss each of you and wish you all the best.

My term will end on December 19, 2016. I pray for each one of you that you will have success in your professional and personal lives and that you may be blessed with health and wisdom for the future ahead. God willing, may our paths cross again.

- Jeff Ruch, CPA
MGMA-MO President
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MGMA-MO 2017 Spring Conference
Leader Champions / Practice Champions
May 7-9, 2017 • Tan-Tar-A Resort

Hard to believe we are less than six months away from the 2017 MGMA Missouri Annual Conference. Time to start jockeying for position. Your conference planning committee has been hard at work compiling a great field of local, state and national speakers. Sunday night, Jay Rifenbary, an internationally renowned speaker, will be speaking about Incorporating Core Values, Accountability and Balance in your Life and Career. We are very excited Donn Sorensen, FACMPE Mercy St. Louis President and current AMGA Board Chair, will be joining us to discuss Big-Hearted Leadership in his keynote address on Monday morning. Monday afternoon, Attorney Rich Sanders will be speaking on The Early Days of the Trump Administration and Its Impact on Healthcare. And on Tuesday, National MGMA Government Affairs will presenting the latest from Washington as well as assisting us in staying on track understanding and implementing MACRA and whatever other changes await the Healthcare industry in the coming years. We will also be joined on Tuesday by Joe Mull, an energetic and entertaining speaker on Motivating Employees in an Era of Change. Watch for the conference brochure coming out soon for additional speakers.

The committee has also been compiling a wide-ranging assortment of sponsors and exhibitors, offering beneficial resources to our practices and the opportunity to forge relationships to assist Practice Managers in being the Champions of their practices. Our sponsors and exhibitors are also beneficial in continually allowing us to bring high-quality, informative speakers to our state year after year. There are still some opportunities to sponsor or exhibit, if you are interested, or you know of a resource you think would benefit our state's Practice Managers.

The Annual Conference is not just about great speakers and resources. It is also about the attendees themselves and the benefit of networking with colleagues. A chance to learn from those who have been around the track for a while as well as up and coming Practice Managers and those interested in learning more about medical practice management. The conference is a wonderful opportunity to share trials and triumphs, ask questions, obtain how-to's and make connections with peers across the state who are only a phone call, text or e-mail away.

Time to start jockeying for position, will you be at the starting gate or left in the paddock? Join us at the MGMA Missouri Spring Conference May 7-9, 2017 at Tan-Tar-A Resort in Osage Beach. And don't forget, wouldn't be Derby days without a flamboyant Hat and outfit—you never know, you might win best hat Sunday night!

- Sharon E. Sagarra, MBA, FACMPE
2017 Conference Chair and President-Elect
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Upcoming Member Webinar

Getting Ready for 2017: The Reimbursement Landscape for Medical Practices

December 14th, 12:00-1:15pm

Elizabeth Woodcock, MBA, FACMPE, CPC

Discover how shifts in the health care landscape will impact your practice in 2017 - and beyond. In this dynamic presentation, national speaker, trainer and author Elizabeth Woodcock gives you the lowdown on emerging trends that can pose both opportunities and threats to your practice in the coming year. You'll have a front row seat as Elizabeth shares today's hot button topics, such as the:

· Final Medicare reimbursement for 2017 - what specialties will feel pain, which ones gain
· Summary of the CPT® changes for 2017
· Massive revisions to coding and billing for care management services
· Payment cuts for the government's "voluntary" incentive programs, including the value-based payment modifier
· Compliance with the Merit-based Incentive Payment System in 2017

Educational webinars is just one of the many benefits of your MGMA-MO membership. Please visit mgma-mo.org to register.

Summary of 2017 CPT Changes

Moderate Sedation
99151-99157 Moderate Sedation code section has been replaced, (prior codes 99143-99150 are deleted). A careful review of Appendix G will prepare practices to separately report Moderate (Conscious) Sedation. This change decreases the value of the codes listed in Appendix G and will require separate documentation of the patient age and sedation time to code 99151-99157. The new codes are based on age groups (younger or older than age 5) and time increments of 15 minutes.

Evaluation and Management changes
Two new medicine codes have been added to replace 99420 (Administration of Health Risk Assessment instrument). The new codes are found in the Medicine Section for a patient focused (96160) or a patient caregiver focused (96161) questionnaire.

Physical Therapy
New Physical Therapy (PT) Occupational Therapy (OT) and Athletic Training (AT) codes have been introduced and now include reporting of three levels of evaluation and one re-evaluation, based on several factors including a patient history and an examination with development of a plan of care. The three levels of clinical decision making are low, moderate and high complexity using a standardized patient assessment instrument. The definitions of the extent of physical examination and complexity of decision making are unique to Physical Medicine and Rehabilitation and do not match the Evaluation and Management definitions of these terms.

The tiered evaluation codes provide the opportunity to base coding on decision making instead of the episode of care (old codes were described as “initial” and “Re-Evaluation”). Codes 97161-97164 (PT), 97165-97168(OT), and 97169-97172 (AT) are resequenced code numbers that appear before the Modalities subsection.

Surgery changes
Spinal Instrumentation codes have been replaced to identify intervertebral biomechanical devices and interspinous process stabilization devices. Refer to section 22853-22859 and 22867-22870.

Laryngoplasty code 31582 has been replaced by 4 new codes describing surgery for laryngeal stenosis (congenital or acquired) by several methods (31551-31554). New codes 31591 and 31592 describe procedures on the larynx to treat weakness or stenosis.

Nancy M. Enos, FACMPE, CPC-I, CPMA, CEMC, CPC

Endovenous ablation therapy code report a combination of mechanical and chemical methods to ablate the veins (36473 and 36474)

New Dialysis Circuit codes (36901-369096) A new subsection of nine codes report services that allow repeated access to blood vessels to perform hemodialysis. CPT code report two segments of this service, the peripheral dialysis segment and the central dialysis segment. The definitions and guidelines for the new codes cover 2 full pages and should be reviewed before using the new codes. Watch for bundling of imaging and radiological supervision and interpretation (S&I) required to perform the angioplasty

Spinal injections (62320-62327) series reports epidural and subarachnoid injections, with or without imaging guidance, reported by spinal region. These codes replace 62311-62318.

Transluminal balloon angioplasty codes have been replaced with four new codes (37246-37249) that replace the eight deleted codes that streamline reporting and include all necessary imaging and radiological S&I.

Radiology
Mammography codes have been simplified and there are new three new codes to replace five deleted codes. Each of the three new codes include computer-aided detection (CAD). Two codes report diagnostic mammography (77065 unilateral and 77066 bilateral) and 77067 reports bilateral screening mammography with CAD detection when performed.

Summary of 2017 CPT Changes, continued

Pathology and Laboratory
Drug screening codes have been expanded to report screening based on the method ()80305-80307). New guidelines say to report the new codes only one per test regardless of the number of drugs classes tested. New codes for genomic sequence analysis have been added to identify cardiac conditions, fetal chromosomal abnormalities and central nervous system infection.

Medicine Section
Several vaccination codes have been revised to eliminate age from the description, such as nine influenza codes, and are now reported by dosage.

Psychotherapy codes 90832-90838 have been revised to include time with informants. CPT 90846 and 90847 are reported with "utilizing family psychotherapy techniques focusing on family dynamics" with or without the patient present. Time duration for this code is 50 minutes, and may be reported with the time exceeds 26 minutes (rounding rule).

Cardiovascular codes have been introduced to report repair of paravalvular leak, based on the site of the leak (mitral valve or aortic valve) using 93590-+93592.

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MACRA Questions – a Q&A with Dr. David Nilasena

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created the new Quality Payment Program, which allows physicians and clinicians to choose one of two payment program options: the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (APMs). In preparation for a webinar hosted by the TMF Quality Innovation Network Quality Improvement Organization (QIN-QIO) on Thursday, Dec. 8, 2016, to address the Quality Payment Program (QPP), speaker David Nilasena, MD, a chief medical officer from the Centers for Medicare & Medicaid Services (CMS), answered a few QPP questions.

Physician Questions Regarding the Quality Payment Program

Question: I*n the MACRA final rule, CMS modified its proposal on which clinicians will be considered hospital-based and thus not required to fulfill the* ***Advancing Care Information (ACI)*** *category of MIPS to "75% or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22), or emergency room (POS 23) setting based on claims for a period prior to the performance period as specified by CMS." When is this "period prior to the performance period as specified by CMS"?*

Dr. Nilasena: We intend to use claims with dates of service between Sept. 1 of the calendar year two years preceding the performance period through Aug. 31 of the calendar year preceding the performance period. In the event it is not operationally feasible to use claims from this time period, we will use a 12-month period as close as practicable to this time period.

Question: *As a MIPS/APM entity multi-specialty group with a single taxpayer identification number (TIN) that will do group reporting, how will our* ***Clinical Practice Improvement Activities (CPIA)*** *scores coordinate with the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) improvement activities performance category?*

Dr. Nilasena: We are revising our proposal regarding the scoring of the improvement activities performance category for the Shared Savings Program. We will assign an improvement activities score for the Shared Savings Program based on the improvement activities required under the Shared Savings Program. We consider all Shared Savings Program tracks together for purposes of assigning an improvement activities performance category score because the tracks all require the same activities. All APM entity groups in the Shared Savings Program will receive that baseline improvement activities score. To develop the improvement activities score for the Shared Savings Program, we will compare the requirements of the Shared Savings Program with the list of improvement activities measures in section II.E.5.f. of this final rule with comment period and score those measures in the same manner that they would otherwise be scored for MIPS-eligible clinicians. We will assign points for improvement activities toward the score for the Shared Savings Program based on documented requirements for improvement activities under the terms of the Shared Savings Program. We have published the assigned scores for Shared Savings Program for the Transition Year on the CMS website at: https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf. The assigned score represents the maximum improvement activities score; therefore, these APM entity groups will not need to report additional improvement activities.

Question: *How do I identify* ***Clinical Practice Improvement Activities*** *for MIPS?*

Answer: CMS' Quality Payment Program website provides a list of improvement activities: https://qpp.cms.gov/measures/ia

Question: *Will our Group Practice Reporting Option (GPRO) under the MSSP ACO count for the* ***Quality*** *category for all providers? Will we be able to achieve more than an "average" as we report through the GPRO option?*

Dr. Nilasena: Reporting quality measures through the web interface is a requirement of the MSSP, and this data will be used to determine the APM entity (ACO) quality category score for MIPS under the MIPS/APM Scoring Standard. In the event that a Shared Savings Program ACO does not report quality measures as required under the Shared Savings Program regulations, then scoring on all MIPS performance categories will be at the ACO participant TIN level, and the resulting TIN-level final score will be applied to each of its constituent TIN/NPI combinations. For purposes of both the Shared Savings Program quality performance requirement and the APM scoring standard, any "partial" reporting of quality measures through the CMS Web Interface that does not satisfy the quality reporting requirements under the Shared Savings Program will be considered a failure to report. We note that in this scenario, each ACO participant TIN would need to report quality data to MIPS according to MIPS group reporting requirements in order to avoid a score of zero for the quality performance category.

Question: *Since we already submit Consumer Assessment of Healthcare Providers and Systems (CAHPS) to CMS for our ACO, will that count toward our extra credit?*

Dr. Nilasena: The Shared Savings Program quality performance data that is not submitted to the CMS Web Interface, for example the CAHPS survey and claims-based measures, would not be included in the MIPS/APM quality performance category score.

ACMPE News

Merry E Mullins, MBA, FACMPE

We all know that growth and development are important personally as well as in our career and professional satisfaction. Have you thought about investing the time to become a **Certified Medical Practice Executive** or a **Fellow in the American College of Medical Practice Executives**?

Do you know that there is a demonstrated ROI (Return on Investment) for those individuals who pursue Certification and Fellowship status in ACMPE? MGMA's Management Compensation Surveys show that administrators of medical groups with 7 to 25 physicians had significant differences in compensation, when looking at the ACMPE status of the respondents.

"I don't have the time!" you say. I get it. Just start with baby steps. Confirm eligibility. Join the study group, or maybe purchase a study guide. One small step at a time, and a year from now you will thank yourself.

Take the opportunity to stand out among the over 22,000 MGMA members. Since there are only about 2,800 Certified Members and about 724 Fellows (as of mid-June 2016), earning the advanced ACMPE credentials truly IS noteworthy.

NEW: The eligibility requirements for Certification are changing soon! As of Jan. 1, 2019, a bachelor's degree will be required to enter the board certification program. Also, Fall 2017 the essay part of the exam is being restructured, so keep these factors in mind in planning your career goal time-frame.

Now is the time! As we are quickly approaching the New Year, consider making certification a goal. Whatever your motivation may be, I am here to help you achieve that goal of becoming a Certified Medical Practice Executive or Fellow. As the MGMA-Missouri ACMPE Forum Rep, please reach out to me at merry.mullins@hmekc.com or simply visit the MGMA website at www.mgma.com for more information. I am available to help and encourage you in any way I can, assisting you with links to educational resources or maybe just a motivational boost. Contact me today if you need assistance in this pursuit.

- Merry E Mullins, MBA, FACMPE
MGMA-MO ACMPE Forum Representative
merry.mullins@hmekc.com

2017 Exam Dates

Exam Dates	Registration
March 11 – 25, 2017	Jan. 30 – Feb. 10, 2017
June 10 – 24, 2017	April 24 – May 5, 2017
September 9 – 23, 2017	July 24 – August 4, 2017
December 2 – 16, 2017	October 23 – November 3, 2017

2017 Fellowship deadlines

- June 2, 2017 - Outline due (Recommended due date)
- August 4, 2017 - Final manuscript due (Required due date)

Missouri election results mirror federal results

Come January, when newly elected governor Eric Greitens is inaugurated, in a way the state executive and legislative branches will be a microcosm of the national picture. Pundits indicate that the surprisingly strong phenomenon led by President-elect Donald Trump helped keep voters in firm support of Republicans in down-ticket races as the GOP swept all statewide offices. Conjecturing as to the direction of statewide policy may be premature. However, one can be reasonably sure that Medicaid expansion is even further off the table with Republican super-majorities in both legislative chambers and Republicans in the governor's and lieutenant governor's offices.

Pre-filing of bills started on December 1 with 300 or so bills filed. The term "health" is in nine bills. Time will tell when/if healthcare legislation is addressed.

Federal issue – HHS/CMS Appointees & MACRA-MIPS/APM Final Rule Issued

On the federal level, it will be interesting to see what Rep. Tom Price, R-Ga., Trump's choice to lead Health and Human Services, will accomplish. Price is a former orthopedic surgeon who has been a fierce critic of the Affordable Care Act. Price has advocated for more personal responsibility and less government in healthcare reform.

Another interesting Trump choice is the hiring of antitrust lawyer David Higbee, who has been critical of the role hospital consolidation has played in driving up healthcare costs.

Trump's pick to lead CMS, Seema Verma, is a consultant who helped lead Indiana's Medicaid expansion under Obamacare. She worked closely with Indiana Gov. Mike Pence, the vice president-elect.

CMS has issued the final rule on its Quality Payment Program with 2017 being a "transition year". According to CMS, "Through a staged approach, we can develop policies that are operationally feasible and made in consideration of system capabilities and our core strategies to drive progress and reform efforts," notes CMS. "We envision that it will take a few years to reach a steady state in the program, and we therefore anticipate a ramp-up process and gradual transition with less financial risk for clinicians in at least the first two years."

John Marshall
Legislative Liaison

These first two years will be used to focus MIPS on "encouraging participation and educating clinicians," CMS writes. They will also be used to expand on Advanced Alternative Payment Models (advanced APMs), which allow participating providers to avoid MIPS reporting. The agency hopes advanced APMs will ultimately overtake MIPS in the pay-for-performance arena. Following is a summary/overview of the Major Provisions of the Quality Payment Program per CMS.

Transition Year and Development Period

Given the wide diversity of clinical practices, the initial development period of the Quality Payment Program implementation would allow physicians to pick their pace of participation for the first performance period that begins January 1, 2017. Eligible clinicians will have three flexible options to submit data to MIPS and a fourth option to join Advanced APMs to become QPs, which would ensure they do not receive a negative payment adjustment in 2019.

In the transition year CY 2017 of the program, this rule finalizes a period during which clinicians and CMS will build capabilities to report and gain experience with the program. Clinicians can choose their course of participation in this year with four options:

(1) Clinicians can choose to report to MIPS for a full 90-day period or, ideally, the full year, and maximize the MIPS eligible clinician's chances to qualify for a positive adjustment. In addition, MIPS eligible clinicians who are exceptional performers in MIPS, as shown by the practice information that they submit, are eligible for an additional positive adjustment for each year of the first 6 years of the program.

(2) Clinicians can choose to report to MIPS for a period of time less than the full year performance period

December 2016 MGMA-MO Legislative Report, continued

2017 but for a full 90-day period at a minimum and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.

(3) Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment. Alternatively, if MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4 percent adjustment.

(4) MIPS eligible clinicians can participate in Advanced APMs, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5 percent bonus incentive payment in 2019.

This is but a sampling of information from the final rule. For example, new rules apply to small practices that raise the revenue level which makes reporting mandatory. To access the entire Executive Summary of the Quality Payment Program, go to: https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf

- John Marshall
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Feel free to contact John regarding any of these issues.

Anesthesiologists Treating Chronic Pain Patients

Nearly every hospital in the United States provides anesthesia services to patients. Most offer surgical services with general anesthesia, providing for safe operative care of patients. Such services bring risk exposures, many of which you can proactively mitigate.

An emerging area of risk for anesthesiologists involves treating chronic pain patients.
Some anesthesiologists sub-specialize in pain management, in addition or instead of traditional anesthesia services. Some patients prefer facilities that provide chronic pain management.

Pain management presents unique risks requiring proactive assessment, direction, and mitigation. Allegations against physicians in this area can include, but are not limited to, failure to treat, accidental overdose, causing addiction, or death.

Considerations when Managing Chronic Pain Patients
Start by assessing whether your facility has anesthesiologists and/or other physicians managing chronic-pain patients. If yes, consider several important issues.

Do you have a designated area or clinic for treating chronic pain patients?
A centralized location for treating these patients helps your facility:

1. track patients and providers; and
2. establish facility-wide policies and procedures for handling this unique medical population.

Another consideration when providing care for chronic–pain patients is the physician's qualifications for treating these patients. Pain management is a growing healthcare subspecialty, due in part to a reported 100 million Americans suffering from chronic pain.1 According to the American Board of Medical Specialties, pain medicine is a subspecialty of anesthesiology, emergency medicine, and family medicine.

Consider employing board-certified pain medicine specialists in your clinic to treat chronic pain patients. These specialists' additional education and training will help ensure your chronic pain patients are being treated by qualified physicians.

Your facility can implement policies and procedures to help lessen potential risks of treating patients who require pain management.

A strong risk-reduction strategy may require each patient to enter into a pain management contract with the treating physician. This contract clearly and concisely outlines the physician's expectations of the patient and may include:

- The patient agrees not to accept narcotics prescriptions from other providers.
- The patient will not give or sell narcotics to others.
- The patient agrees to refrain from using drugs not specifically authorized by the physician.
- The patient is responsible for managing his or her medication to ensure he or she doesn't run out before scheduled visits/refills.
- The patient agrees to random drug testing.

This is not a comprehensive list for a pain management contract. Consult with your physicians and legal counsel to create a document that best fits your institution's needs.

Consider having a policy for ending your pain-management program's relationship with its patients. While best handled on a case-by-case basis, a policy aids consistency. Situations such as illicit narcotics use, persistent

missed appointments, or suspected drug diversion are more common instances that typically require action.

Also consider what to do when a chronic pain patient enters your facility's ED. When these patients become addicted to opioid medications, they often run out of prescriptions early, and then try to secure narcotics by visiting the ED. An integrated EHR may help notify ED physicians these patients are being treated by a pain specialist; it may further aid understanding that the patient may not receive narcotic pain medications without consulting the pain-management physician.

Lastly, depending on your state, physicians may be able to monitor chronic-pain patients' prescription history via an electronic prescription monitoring program. Several states implemented such programs to help fight prescription drug abuse and diversion. Depending on the state, physicians may review a patient's prescription history. Be sure to review your state's rules to understand what you may access.

Key Considerations for Your Hospital's Anesthesia Services

The following summaries can help you and your facility's leadership review policies and procedures to mitigate risks involved with anesthesia services, including those for chronic-pain patients.

- Does your facility treat chronic pain patients or have a pain management clinic?
- Do you utilize board-certified pain management specialists?
- Do your pain management physicians utilize a pain management contract? Is it sufficient?
- Does your ED have a protocol in place for handling potential drug-seeking patients?
- Do your ED physicians know how to determine whether patients are currently being treated by your pain management clinic or pain management physicians?

It is important for patient care and hospital liability that you take steps to proactively manage the risk around your facility's provision of anesthesia and care of chronic-pain patients. Establishing sufficient protocol and frequently checking in with staff to ensure their understanding are essential steps in effective anesthesia management and addressing the needs of chronic pain patients.

- Jeremy Wale, JD
ProAssurance Risk Resource Advisor

MGMA-Missouri Scholarships

Did you know that MGMA-MO has several scholarship and professional enrichment awards available to its members and a scholarship award for the dependent of an active member?

Through our mission to develop and equip our members to create dynamic, successful medical group practices that meet the needs of today's patients through education, building relationships, advocating, and providing tools that focus on the delivery of excellence in patient care the MGMA-MO Board of Directors has established the following scholarships and professional enrichment awards:

- **The Presidential Scholarship** will be awarded to an Active Member of MGMA-MO who is pursuing higher education through a formalized degree program. The applicant must be employed at the time of submission. **($2,000)**

- **The Judith Hillyard Professional Development Scholarship** will be awarded to an Active Member of MGMA-MO who is pursuing continuing education either through a formalized degree program or registration/lodging for a national MGMA sponsored conference or other national MGMA conference designed to strengthen management skills. The applicant must be employed at the time of submission. **($1,000)**

- The **MGMA-MO Conference Professional Enrichment Award** will be awarded to an Active Member of MGMA-MO interested in pursuing continuing education through attendance at the MGMA-MO Annual Conference. The applicant must be employed at the time of submission. **(Registration & Two Nights Lodging)**

- The **ACMPE Professional Enrichment Award** is awarded to an Active Member of MGMA-MO who is pursuing certification or fellowship through the American College of Medical Practice Executives (ACMPE). The applicant must be employed at the time of submission. **($250)** This award is available on a quarterly basis throughout the year.

The MGMA-MO Board of Directors, in recognition of the need for college level education in the development of future professionals, established one scholarship in support of a dependent of an active member engaged in pursuing a college degree. Also, one scholarship is to be awarded to a current student in support of their attendance to the State conference.

- The **Dependent Education Scholarship** will be awarded to the dependent of an Active MGMA-MO Member planning to pursue higher education through a formalized degree program and submitting a completed application by the deadline. **($1,000)**

- The **Vincent A. Schneider, Jr. Scholarship** will be awarded to a Student Member of MGMA-MO or local chapter affiliate and full-time student majoring in healthcare at an accredited college or university in the state of Missouri. The scholarship will be awarded to a student interested in pursuing continuing education through attendance at the MGMA-MO Annual Conference. The applicant must be enrolled as a student at the time of submission. **(Registration & Two Nights Lodging)**

Each of these scholarships and awards will help MGMA-MO fulfill its mission and promote the professional development of its members. If you are an active member and pursuing higher education, please take the time to apply for any of these scholarships or awards and encourage your colleagues to do so as well. Applications are available online at www.mgma-mo.org. For more information please contact the MGMA-MO office via email at info@mgma-mo.org.

Scholarship Applications are due March 31, 2017.

MACRA final rule: Four tenets to establish a proactive quality payment program strategy

With final rule on the Medicare Access and CHIP Reauthorization Act now in hand, physician practices across the nation are preparing for the most dramatic healthcare payment reform this generation has seen.

MACRA and its associated Quality Payment Programs replace former Sustainable Growth Rate provisions for physician Medicare reimbursement and signal the industry's tipping point in the move to value-based care. Fee for Service Models in place today will quickly transform to reflect the seriousness of a cost-conscious era of quality-based reimbursement.

Research conducted in early 2016 suggests that only 43 percent of practices have compensation tied to quality or value of care heading into MACRA. The study also cites regulatory and paperwork burden as the biggest deterrent to practice satisfaction among physicians. The Centers for Medicare and Medicaid Services new policy framework, more than eight years in the making, works to address those concerns, combining several previously unintegrated healthcare reporting initiatives into a unified QPP that most healthcare providers will qualify for.

With pick-your-pace options, flexible measure selection, reporting period flexibility and small-practice provisions cemented by the final rule, providers have a unique opportunity to engage new value-based strategies slowly without penalty. The march toward MACRA is officially underway. This article lays out four key focus areas to help providers successfully navigate the new pay-for-performance model in 2017's inaugural reporting year: financial, clinical, technical and staff training.

Understanding the MACRA landscape: two paths to participation

Under MACRA, eligible clinicians can begin collecting performance data on care given and technology utilized anytime between Jan. 1, 2017 and Oct. 2, 2017. Data captured by providers during the 2017 reporting period is due by Mar. 31, 2018. Eligible clinicians have two reporting track options to participate in QPPs under MACRA which are the Merit-based Incentive Payment System and the Advanced Alternative Payment Model. Of those eligible clinicians, 90 percent are expected to participate in MIPS and 10 percent in APMs

MIPS: This QPP option combines outcome and quality-based payments with reduced fee-for-service reimbursement. MIPS integrates three payment programs—the Physician Quality Reporting System, Meaningful Use, and Value-based Payment Modifier—with an assessment of clinical practice improvement initiatives to establish an annual Composite Performance Score that reflects a physician's standing relative to reporting peers, on a scale of 1-100. That score determines Medicare incentive or penalty payments for physicians at a 4 percent adjustment rate starting in 2019, and up to a 9 percent adjustment rate by 2022.

Justin T. Barnes

While cost will be tracked by CMS in 2017, cost category determinants will not be factored into payment adjustments until 2018. Under MIPS, providers can choose quality reporting objectives and measures that best align with medical practice specialty and workflow specifics. Only physicians practicing under Medicare for the first time in 2017 and those who anticipate billing less than $30,000 for fewer than 100 Medicare Part B patients are exempt (unless of course you are in a CMS Advanced APM).

Clinicians have four "pick-your-pace" avenues for payment program participation in MIPS:

Option 1: Nonparticipation
Providers who do not submit 2017 QPP data will suffer a 4 percent negative payment adjustment.

Option 2: Submit partial data
Providers who submit QPP data on at least one quality measure or improvement activity, or the required measures in advancing care information can avoid a negative payment adjustment.

Option 3: Partial reporting period
Providers who submit more than one quality measure, more than one improvement activity, or more than the required measures in advancing care information for a period of 90 days can earn a neutral or small positive payment adjustment.

Option 4: Full reporting
Providers who submit for a full 90-day period or a full year of 2017 data in all categories may earn a moderate (or full) positive payment adjustment.

MACRA final rule: Four tenets to establish a proactive quality payment program strategy, continued

Clinicians can report MIPS data independently or with a group entity. For the initial transition year under MIPS, reporting thresholds have been lowered and an additional $500 million has been provisioned annually for "exceptional performance" bonuses to clinicians who achieve a final score of 70 or higher.

Advanced APMs: The second category of QPP under MACRA is Advanced APMs. Less than 10 percent of MACRA-eligible providers are expected to qualify for an Advanced APM in the first reporting year under this regulation. Physicians who qualify to report under an Advanced APM get a 5 percent bonus each of the first six years of MACRA, and base payment updates higher than those under MIPS from 2026 onward, when the reporting party earns significant revenue (25 percent) or sees sufficient patient volumes (20 percent) through qualifying Medicare or payer models.

Payment adjustments based on 2017 performance data will go into effect on Jan. 1, 2019. The MACRA final rule provisions $20 million each year for five years to fund training and education for small practices of 15 or fewer clinicians and practices in rural areas.

Four keys to navigate the transition

Implementing a comprehensive strategy is critical to provider success under MACRA. Assessing infrastructure before layering in payment program initiatives ensures future plans are built on a solid foundation. Practices should focus on four areas in evaluations and strategic planning: financial, clinical, technical and staff training.

Financial success

The best place to start when evaluating infrastructure is the existing revenue cycle. Stabilize and optimize revenue streams to ensure the practice isn't leaving money on the table. Renewed emphasis on accurate coding, documentation support, self-audits and denial management can help plug revenue leaks, potentially shoring up funds that may serve the practice elsewhere. It's important to understand key performance indicators, trending and the cost of operation heading into QPP participation.

Providers should know how to scrutinize their payer reimbursements. Analyze contracts and variance rates to ensure revenue due to the practice is collected. It's also important to understand any value- and risk-based contracts a practice may qualify for. Reach out to the commercial payers engaged with the practice to determine what is available in the area. Many plan-specific and state-based incentive programs that exist are not advertised.

Clinical success

With performance on quality targets accounting for 60 percent of MIPS scores in the first year of QPP, quality measures will be an essential aspect of success. Understanding where the practice has performed strongly in previous years and aligning those services to MIPS measures, will influence quality measure focus going forward and can help practices be competitive. Take advantage of measures that appear across multiple categories to reduce reporting burdens.

Population health and care coordination are at the heart of QPP models. Focus on expanding communication with beneficiaries and patient care teams as well as specialists. Much of the care coordination measures center around collecting and sharing patient information with care teams, referred providers and the patient themselves. Optimize outcomes by partnering with facilities across the continuum of care. Be consistent in using existing functionality for electronic data exchange and messaging or identify new, cost-effective opportunities for patient engagement, communication, education and empowerment.

Technical success

Technology infrastructure is paramount to reporting under MACRA. Establish a firm understanding of the measures and the existing EHR functionality that is available to track for the adopted payment model. Practices will need to integrate data from financial and clinical sources to monitor and report on required measures and factors. In many instances, we have found that providers have not been able to optimize the most recent functionality enhancements in the EHR and health IT systems they already have.

In some cases, EHR template and workflow customization as well as dashboard creation can help practices quickly and routinely target measures and KPIs pertinent to practice objectives. Test the process for submitting reporting metrics ahead of time, streamline workflows and leverage technology wherever possible to create efficiencies for patient engagement and throughput.

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Staff success

Securing inside expertise on new payment models, health information management and technology implementation is a major challenge for practices today. Practices need to align with partners who can help shoulder the burden of expertise and implementation, educating practice stakeholders along the way while still allowing them to focus on patients as priority number one. Look for partners who will keep practice staff informed, proactively evaluate payment models, offer coaching on how to go engage payers and help management flesh out strategic initiatives.

Involve and educate appropriate staff members at different points in the planning process and make sure the team has a collective general understanding of practice objectives so everyone is working toward the same goals. Take advantage of resources such as Medicare's Physician Compare and Quality Resource Use Reports to benchmark and compare physician performance and reporting practices.

Moving past provider hesitation

Competing priorities, limited resources and general unfamiliarity with MACRA and the final rule have contributed to market hesitation to embrace reform, even with MACRA's commencement close at hand. That said, there will not likely be a more ideal time for physicians to prepare for the QPP transition.

Flexible, scaled participation options mean physicians can stave off first-year losses and potentially earn incentive and bonus payments via partial reporting as clinicians learn to navigate the new system. In rewriting policy, close attention was paid to identifying quality measures that were applicable across multiple models to incentivize providers for improving outcomes while simplifying the reporting process. Diminished reporting data thresholds have been implemented during the first reporting year. CMS also built in small and rural practice training resources to counter market concern.

Care providers who proactively engage with new payment and care delivery models, and cultivate the right partnerships and expertise, will unequivocally have more opportunity in the future. These three steps quickly engage stakeholders and establish proactive momentum for the MACRA journey:

• Take advantage of every resource available to learn about QPP specifics and support practice efforts

• Engage partners with the needed expertise or designate internal resources to lead the charge

• Establish a strong game plan that begins by January 2017

The average practice can easily qualify for incentives under the new QPP, but many lack the internal resources necessary to succeed under MACRA. Proactive leadership and expert partnerships are essential to juggle the new initiatives and cultivate a value-based business strategy. Look for partners that will go "at-risk" with you. Tie them to your success, that way everyone is guaranteed to win.

Embracing a business approach for value-based care

There is real opportunity for practices to be a catalyst for change within communities. Patient growth, panel participation, partnership opportunities and care model invitations are among the benefits that proactive practices stand to reap, all of which could have big implications for coordinated care and population health initiatives. Practices that lead the charge, participate in broader patient and community engagement and grow the care ecosystem will have the long-term advantage.

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About the Author:
Justin Barnes is a nationally recognized business and policy advisor who serves as Chairman Emeritus of the HIMSS EHR Association as well as Co-Chairman of the Accountable Care Community of Practice. As Chief Growth Officer with iHealth, Justin assists providers with optimizing revenue sources and transitioning to value-based payment and care delivery models. Justin has formally addressed Congress and the last two Presidential Administrations on more than twenty occasions on the topics of MACRA, value-based medicine, accountable care, interoperability, consumerism and more. He is also host of the weekly syndicated radio show "This Just In."

Welcome New Members

Encourage your colleagues to become members of MGMA-Missouri. They will reap the benefits of education, valuable networking, and learn about many issues dealing with practice management, legislation, and professional growth. To obtain a membership application, call the MGMA-MO office at (573) 556-6111, or sign up for membership on-line at www.mgma-mo.org.

MGMA-Missouri
Membership Figures For October 2016

261	Active Members	6	Faculty/Student Members
47	Business Partner Members	29	Life Members
5	Associate Members		

Total Membership - 349

Active Member

Kathy Choate
The Heart Health Center
St. Louis

Deirdre Welfenberg
Benrus Surgical at Barnes Jewish
St. Peters

Laura Nation
CoxHealth Infectious Diseases
Specialty Clinic
Springfield

Faculty Member

Kathie Huttegger
Lifestyle Leadership

Business Partner Member

Tiffany Holiman
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MEMBER NEWS

Please join us in congratulating Kathy Luber, RN on her retirement.

Kathy is retiring from SSM Health Neurosciences Service Line. Kathy started working with medical practices when she was a senior in high school. She then went to school to become an RN and has spent the last 35 years working with SSM and their physician organization in many roles. Most recently, she served as the Director of the Neurosciences Service line for the St. Louis region which covers services of neurology and neurosurgery and neuro-diagnostics at 5 hospitals. She has worked with pediatricians, family practice, internal medicine, gastroenterology, urology, general and vascular surgery, endocrinology, rheumatology, and pulmonology.

Kathy has been an Active MGMA-MO member for many years and we wish her continued success in her retirement. **Congratulations Kathy!**