I. GENERAL QUESTIONS

What is MACRA?

The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), commonly referred to as the "Permanent Doc Fix", is a law that establishes a dedicated route toward new Medicare payment systems that align payment with quality performance and cost efficiency outcomes.

The manifest intent of (MACRA) and the mandated Quality Payment Program (QPP) under the MACRA is to:

- Broaden the contemporary movement from fee-for-service volume-based care to value-based care.
- Streamline and strengthen value and quality-based payments for all clinicians.
- Create strong incentives for the delivery of high-quality, coordinated, and efficient care.
- Provide physicians and other healthcare clinicians' variable pathways to follow each with varying degrees of risk and reward that tie payments to value.

The shift from paying for value rather than volume represents a significant change, but it is a change that has been years in the making. Since the Affordable Care Act was passed, the federal government has been transitioning from fee-for-service to a model that delivers high-quality care while lowering costs. The overall goal is summed up by the broad aims of the National Quality Strategy — better care, smarter spending, and healthier people, healthier communities.

What forces led to the bi-partisan supported enactment of the MACRA?

Although the need for improving quality and reducing costs in the health care system has been touted for the past several decades, the paradigm shift from a fee-for-services to a value based reimbursement model can arguably be traced to the publishing of two Institute of Medicine (IOM) seminal reports in 1999 and 2001. In 1999, the IOM published a report entitled "To ERR is Human: Building a Safer Health System (**http://www.ncbi.nlm.nih.gov/books/NBK225182/**). This report, which cited high rates of medical mistakes led to demands by the federal government and other organization for improvement in the quality of medical care in the U.S. health care system. Two years later (2001), the IOM published a widely reviewed report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century" (**https://www.nap.edu/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the?gclid=CLrF-NPwsNQCFUIkgQoduR8Ptw**). This report essentially underscored not simply a gap between the health care delivered in the U.S. and what could be delivered, but rather a wide chasm.

These two reports stimulated further reports identifying 1) the extreme variance in appropriate care for common conditions, 2) the mortality rates associated with medical errors, 3) and the extreme "chasm" between the per capita spending in the U.S. for healthcare and the attendant performance outcomes as compared with other developed countries. Taken together these reports reflect the central theme of the MACRA—Value. In the context of the MACRA value refers specifically to better quality at a lower cost, with quality defined consistent with the IOM definition as "the degree to which health services for

individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

What is the MACRA Effect?

The MACRA directly impacts the way clinicians are reimbursed under Medicare. The Act, as published in the Final Rule:

- Permanently repeals the Sustainable Growth Rate (SGR). No more short term Congressional "patches" or as is more commonly referred to as the "doc fix".
- Locks Part B payment (fee) rates at near zero growth with elimination of fee schedule updates from 2020 to 2025.
- Stipulates the development of a Quality Payment Program (QPP) with two distinct value-based performance payment paths (Merit-Based Incentive Payment System (MIPS) path and Advanced Alternative Payment Models (APMs) path) with varying levels of adjusted reimbursement based on the path chosen and the performance exhibited within the path.

It is important to note that unlike previous quality initiatives promulgated by CMS, the MACRA-QPP does not offer the option for providers to opt-out of participation. This means that eligible clinicians who accepts Medicare patients, and bills Part B is required to report one of the two paths in 2017.

What is the specific impact of the MACRA on the annual increase in the physician fee schedule?

Through 2019 there will be a 0.5% annual increase in the physician fee schedule. Between 2020 and 2025 there will be no overall increases relative to the 2019 fee schedule. As clinicians fixed and variable operating expenses continue to increase, the flat to minimal fee schedule increases may produce a reality-based strain on physicians and their practices. As indicated further in this Q &A, relief from this potential strain may be realized relative to performance under one of the two payment paths identified in the MACRA QPP.

What are the strategic objectives of the MACRA Quality Payment Program (QPP)?

The specific strategic objectives of the MACRA QPP as identified in the Acts Final Rule are to:

- Improve beneficiary outcomes and engage patients through patient-centered Advanced Alternative Payment Models (APMs) and Merit-Based Incentive Payment System (MIPS) policies.
- Ensure the provision of high-quality, patient-centered care embedded in a continuous cycle of improvement.
- Enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools.
- Increase the availability and adoption of robust Advanced APMs.
- Promote program understanding and maximize provider participation.

- Improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders.
- Ensure operational excellence in program implementation and ongoing development.

In effect, the MACRA QPP provides opportunities to improve care delivery by supporting and rewarding clinicians as they implement new approaches to engage patients, families and caregivers and to improve care coordination and population health management. The QPP outlines a system that is designed to reward those physicians who give better, more accessible care instead of simply, more care.

II. IMPACTED CLINICIANS

Who is subject to the MACRA effect in the first performance year (2017), commonly referred to as the Transition Year?

Clinicians who are subject to MACRA participation in the 2017 Transition Year include:

- Physicians (MDs and DOs)
- Physician Assistants (PAs)
- Nurse Practitioners (NPs)
- Clinical Nurse Specialists (CNS)
- Certified Registered Nurse Anesthetists (CRNAs)

Beginning in 2021, CMS can designate additional clinicians. The MACRA Final Rule provides the following specific examples of clinicians **who may be included** in the 2021 performance year:

- Certified Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Registered Dietitians/Nutritionists
- Physical Therapists and Occupational Therapists
- Speech/Language Pathologists
- Qualified Audiologists

Are there any clinicians who are exempt from MACRA for the Transition Year, even though they fall into the "participation category"?

Yes. Clinicians who are subject to MACRA and the QPP in the Transition Year may be exempt if they:

- Are newly enrolled in Medicare (Clinicians who are in their first Medicare Part B calendar year);
- Have recorded Medicare billing charges of less than or equal to $30,000 based on Medicare Part B claims data from September 1, 2015 through August 31, 2016; and/or
- Provide care to 100 or fewer Part-B enrolled Medicare beneficiaries.

How many clinicians are expected to be impacted by the MACRA QPP in the Transitions Year (2017) and beyond?

In the MACRA Final Rule, CMS has estimates that between 592,000 and 642,000 clinicians will be required to participate in MIPS in the 2017 Transition Year. In addition, between 70,000 to 120,000 clinicians will become APM Qualified Participants (QPs) in 2017, with and additional estimated 125,000 to 250,000 clinicians assuming QP status in 2018 through participation in Advanced APMs.
In addition, CMS estimates that 380,000 clinicians will be excluded from the Transition Year (2017) cohort of eligible clinicians based on their low volume participation in the Medicare Program, with an addition estimated 200,000 clinicians excluded from participation in a MIPS or APM path in the Transition Year due to ineligible first year cohort Medicare provider status.

With new Advanced APMs expected to become available for participation in 2018, (e.g., Medicare Shared Saving Program ACO Track 1 Plus), CMS expects an increase in the projected APM alignment of 70,000 to 120,000 eligible clinicians in 2017 to 125,000 to 250,000 eligible clinicians in 2018. It is important to note that throughout the Final Rule, CMS emphasizes the position that participation in APMs will represent a key step in the overall MACRA intent to move the healthcare system from volume-based to value-based care.

How is CMS communicating with practices regarding eligibility for the Quality Payment Program (QPP)?

In late April and running through May, 2017, the CMS Medicare Administrative Contractor who processes Part B claims sent out letters to healthcare practices letting them know which clinicians will be required to participate in the QPP. The letter explains why the practice is receiving the letter, what action need to be taken is the clinician is eligible in the Merit-Based Incentive Payment System (MIPS), or in an eligible Alternative Payment Model (APM), and procedures if the practice, based on their Tax Identification Number (TIN) would like to participate as an individual or group.

CMS has also added a website that clinicians can access to determine their eligibility for participation—**https://qpp.cms.gov/particpation-lookup**.

Are eligible clinicians, and more specifically eligible physicians, up to speed on the MACRA QPP and the MACRA effect?

Not really. Recent surveys of physicians who will be directly impacted by MACRA and the expectations of the MACRA Quality Payment Program (QPP) indicate:
50 % of physicians have never heard of MACRA.

- 32 % of physicians are acquainted with the name MACRA, but do not fully understand the requirements or legal components.
- 20.6 % of primary care physicians and 19.5 % of specialist physicians were somewhat to very familiar with the law.
- Nearly 80 % of physicians prefer traditional fee-for-service or salary-based compensation, opposed to value-based models.
- 74 % of physicians believe performance reporting is burdensome.

- 79 % of physicians do not agree with binding compensation to quality of care, which is a requirement under MACRA.
- Nearly 40% of physicians are more likely to accept risk-based compensation if they are part of a larger organization.

Coupled with the limited understanding of the MACRA effect, a recent Health Affairs Health Policy Brief (March 27, 2017) notes that some strong dissent has surfaced regarding the MACRA. Critics have exclaimed:

- ✓ "…. there's no clear evidence that current measures, or the scoring framework proposed by CMS, will provide anything close to a full and accurate picture of how well an individual doctor does in treating his or her Medicare patients."
- ✓ Paying eligible clinicians based on MIPS scoring is "flawed and irresponsible." (it is important to note that these same critics do not suggest a wholesale dumping of the QPP, but rather simply dumping the MIPS and moving aggressively forward with encouraging eligible clinicians to join APMs.)
- ✓ There is limited evidence to support the argument that improved health care results from initiatives that focus on performance measurement and providing financial incentives as strategies to influence provider behavior.

Primary Sources: 2016 Survey of America's Physicians—Practice Patterns & Perspectives. Survey conducted on behalf of the Physicians Foundation by Merritt Hawkins. September: 2016;
Are Physicians Ready for MACRA and its Changes? 2016 Survey of U.S. Physicians performed by the Deloitte Center for Health Solutions. July: 2016.

When should eligible clinicians take action?

Despite the expressions of critics, the bi-partisan MACRA and the QPP generated in the MACRA Final Rule are reality. The time is **NOW** for taking action. Procrastination could prove detrimental to the future sustainability of your practice. Eligible clinicians can ill afford burying their head in the sand – It is time individual and group clinicians who are impacted by the QPP in the Transition Year and beyond start exploring how other clinicians are preparing, and how their practice--based on specialty and size—will be affected.

III. THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PATH—GENERAL QUESTIONS

How will the MIPS path be initially staged?

The first MIPS performance period is from January 1, 2017 to December 31, 2017. MIPS eligible clinicians have until October 2, 2017 to begin participating in MIPS in order to report a minimum of a continuous 90 day period for 2017.

Data reflecting how a MIPS eligible clinician provided care and used certified electronic health record technology (CEHRT) in the 2017 Transitions year must be submitted by March 31, 2018 to earn a positive payment adjustment in 2019. During the period July 31 through September 30, 2018 CMS will provide

feedback on individual and group performance to MIPS eligible clinicians who submitted performance data in 2017. Positive MIPS payment adjustments will begin January 1, 2019 if a MIPS eligible clinician submits partial or full data for the 2017 Transition Year by March 31, 2018.

The MIPS transition period (2017 Performance Reporting Year – 2019 Payment Year) is intended to ease the conversion to MIPS by not requiring full implementation of all provisions in the initial or Transition Year. During the transitional period, there will be an emphasis on education and encouraging participation. Full implementation will begin in performance year 2018/payment year 2020. This transition accommodation does not, however, alleviate the need for participation in 2017. Importantly, MIPS eligible clinicians who elect **not to submit performance data in 2017** will be subject to a negative 4% payment reduction in 2019.

What are the implications of participating in MIPS as an individual versus participation as a group?

If a MIPS eligible clinician elects to participate as individual (identified as a single National Provider Identifier-NPI):

- The payment adjustment for MIPS in 2019 will be based entirely on the individual clinicians MIPS performance as reported in 2017.
- Individual provider data for each of the MIPS performance categories must be submitted via claims, EHR, Qualified Registry (QR) (e.g., Guardian), or Qualified Clinical Data Registry (QCDR).

If a MIPS eligible clinician elects to participate as part of a group (identified as a set of two or more eligible clinicians with individual NPIs sharing a common Tax Identification Number independent of specialty or practice site):

- The group will receive one payment adjustment in 2019, based on the entire group's performance in 2017.
- All clinicians under the TIN must report as part of the group across all MIPS performance categories**.**
- The group will be required to send group level data for each of the MIPS performance categories through a CMS web interface, claims, Qualified Registry (QR) (e.g., Guardian), or Qualified Clinical Data Registry (QCDR).

It is important to note that if a group elects to report MIPS performance data via a CMS web-interface, the group must:

- For 2017, include 25 or more eligible clinicians.
- Must register to report via a CMS web-interface via the Quality Payment Program website by June, 30, 2017.

If a practice previously used the CMS web-interface for PQRS reporting, CMS has automatically registered the practice for MIPS rep

Under the QPP MIPS path there is no one-size-fits-all formula to determine who should report as a group and who should report individually.

Factors that should be considered when making the decision include:

- ✓ Whether or not your goal is to reach the bonus category for the 2019 payment year or if the intent is simply to avoid a penalty by satisfying the bare minimum reporting requirements in 2017 for the 2019 payment adjustment.

- ✓ Determination of the strengths and weaknesses of eligible clinicians in a group on previous programs (e.g., PQRS and/or Meaningful Use).

How will performance be gauged under the MIPS?

MIPS eligible clinicians will be scored based on their performance across the following four distinct categories:

- Quality
- Cost
- Improvement Activities (IA)
- Advancing Care Information (ACI)

Measures and/or activities identified in each of the MIPS Performance Categories will be converted into points. The points within categories are then calculated into a MIPS Composite Performance Score (CPS) with a range of 0 to 100 points across categories.

Are there different weights assigned to the MIPS Performance Categories?

For performance year 2017 (payment year 2019), the relative weights of each category will be as follows:

- Quality: 60%
- Cost: 0% (The weight of this category will increase as a function of time).
- Improvement Activities: 15%
- Advancing Care Information: 25%.

Each of the four MIPS Performance Categories will be weighted in their contributions to the final provider Composite Performance Score (CPS), with the weights for the Quality and Cost (Resource Use) Performance Categories changing over time.

In performance year 2018 (2020 payment year), the weight of the Quality Performance Category will be reduced to 50%, with an increase in the Cost Performance Category from 0% to 10%. For performance year 2019 (2021 payment year) and beyond, the Quality Performance Category will be reduced to 30% with an increase in the Cost Performance Category from 10% to 30%.

IV. MIPS QUALITY PERFORMANCE CATEGORY

What is required under the MIPS Quality Performance Category?

The MACRA Final Rule identifies a quality performance measurement set composed of 271 measures from which MIPS eligible clinicians can select the specific measures they wish to report. The total MIPS quality measurement set is organized into subsets along specialty lines with the largest number of measures falling into the primary care provider subset. (**NOTE:** A complete list of the quality performance measures broken down by specialty, priority ranking, and submission method is available the Guardian website at **http://itsguardian.com/MIPSQPPRegistry.html** under the MIPS Quality Performance Category.

The requirements for MIPS eligible clinicians reporting as individuals or as a group reporting via a non-web interface (i.e., Qualified Registry, Qualified Clinical Data Registry, claims, and/or EHR) are as follows:

- Eligible clinicians must report on at least six quality measures with at least one being an outcome measure, or if an outcome measure is not available, a high priority measure.
- If the specialty measurement subset contains fewer than six measures, the MIPS eligible clinician must report on all available measures within the subset.
- Alternatively, if a specialty measurement subset contains more than six measures the MIPS eligible clinician can choose six or more measures to report on the set.
- If no outcome measure is listed in the specialty measurement subset, then the MIPS eligible clinician must report on another high priority measure within the measure set instead of an outcome measure.
- In 2017, MIPS eligible clinicians can pick their pace of participation. To be considered a full participant in MIPS, eligible clinicians must report for a minimum of 90 continuous days.
- If a MIPS eligible clinician elects full participation in 2017 they must report on 50% of all their Medicare and non-Medicare patients for each of the six reported measures with a minimum of 20 beneficiaries per measure to be included in the calculation of the Quality Performance Category score. (In the 2018 reporting year this percentage increases to 60%).

MIPS eligible clinicians reporting as individuals or a group using a non-web interface who elect full participation in MIPS in the Transition Year (2017) and report at least six measures have the potential for a higher payment adjustment and potential bonus in the Transition payment year (2019).

The requirements for MIPS eligible clinicians reporting as a group via a CMS web interface are as follows: (**NOTE:** Reporting option for 2017 for groups of 25 or more)

- Eligible clinician must report on all measures included in the CMS web interface (e.g., eligible clinicians participating in a Track 1 Medicare Shared Savings Program (MSSP) ACO will report on the required performance measures for the ACO through the CMS Group Practice Reporting Option (GPRO) web interface).
- Eligible clinician must report on the first 248 consecutively ranked and assigned Medicare patients in the sample for each measure.

- If the sample of eligible assigned Medicare patients is less than 248, then the group must report on 100% of assigned Medicare patients.
- Any measure not reported will be considered zero performance for that measure in the CMS scoring algorithm.
- In 2017, the group is required to report on 15 measures.
- In addition to the group reporting on the fifteen measures, groups will be scored on a claims-based hospital re-admission measure, evaluated and reported by CMS.

The Final Rule indicates that the Quality Performance Category measures will be updated annually on or before November 1st each year.

How will the MIPS Quality Performance Category Score be calculated?

To determine a MIPS eligible clinician's Quality Performance Category Score, CMS will assigned 1 to 10 points to each measure based on performance relative to a baseline (For 2017 the baseline performance data will be set based on available 2015 quality performance data.) Individual MIPS eligible clinicians and clinicians in groups of ≤ 15 who elect to report the full 6 measures for 2017 will be eligible to receive up to **60 points** in the Quality Performance Category.

MIPS eligible clinicians in groups of ≥ 16 who elect to report the full 6 measures for 2017 will be eligible to receive up to 60 points for the reporting measures, and an additional potential **10 points** for performance on a hospital readmission measure calculated by CMS based on claims data. Accordingly, a total potential of **70 points** can be earned for the MIPS Quality Performance Category.

To incentivize MIPS eligible clinicians, CMS will award bonus points to clinicians who report additional "high priority" measures. The bonus points will be capped at 10% of the total points available in the Quality Performance Category.

An eligible clinician's Quality Performance Category Score will represent the sum of the points assigned based on his or her quality reporting divided by the total available points. The Score is then weighted (for the 2017 performance year) to count for 60% of the total MIPS score.

As published in the Final Rule, when a MIPS eligible clinician submits measures for the MIPS Quality Performance Category each measure is assessed against its benchmarks to determine how many points the measure earns. A provider can receive between 3 to 10 points for each measure (not including any bonus points). In the Final Rule, CMS set the "floor" of the Quality Performance Category score at three points for 2017. In short, for the Transition reporting year, a provider can achieve as little as 3 points for a single measure to avoid a negative payment adjustment for the Quality Performance Category in 2019.

Benchmarks are specific to the type of submission mechanism (i.e., EHRs, Qualified Registries, CAHPS, and claims). For the majority of the 271 available quality measures, the primary submission mechanism is a Qualified Registry (e.g., Guardian MIPS Qualified Registry), or a Qualified Clinical Data Registry (QCDR).

V. MIPS COST (RESOURCE USE) PERFORMANCE CATEGORY

What is required under the MIPS Cost (Resource Use) Performance Category?

There is no data submission reporting requirement for MIPS eligible clinicians under the Cost (Resource Use) Performance Category for the Transition Year (2017). During the Transition Year (2017) the MIPS Resource Use Performance Category has been reweighted in the Final Rule to 0%.

Beginning with performance year 2018 (for payment year 2020), MIPS eligible clinicians will be assessed on their performance of total per capita costs and Medicare spending per beneficiary (MSPB). Eligible clinicians will also be assessed on applicable episode-based measures. CMS has indicated that feedback on these measures will be provided sometime during the 2017 Transition Year.

Despite the fact that a MIPS Cost Performance Category score will not be factored into the Transition Year total MIPS Composite Performance Score, CMS will calculate, for informational purposes only, the costs measured for the 2017 performance period. Accordingly, CMS will calculate the two cost measures, total per capita cost, and Medicare spending per beneficiary (MSPB) and compare physicians' score relative to a benchmark set at the beginning of the performance period. Total per capita costs will include all payments under Medicare Parts A and B, but exclude payments under Part D. MSPB includes costs 3 days before and 30 days after an inpatient hospitalization. Condition-based measures previously used in the Value-Based Modifier Program (VBPM) will not be used for the Cost (Resource Use) Performance Category.

CMS will also measure cost through several episode-based measures. Episode-based measures attempt to measure the total cost of care for particular acute episodes, specific procedures, or chronic conditions. CMS will calculate these episode-based measure calculations for 2017 for informational purposes.

CMS will attribute patients to the cost measures through a two-step attribution process. First, a Medicare beneficiary will be assigned to a Tax Identification Number (TIN), combined with a National Provider Identifier (NPI), if the beneficiary receives a plurality of primary care services from a primary care provider. For beneficiaries who did not receive any eligible primary care services from a primary care physician during the reporting period, the beneficiary will be assigned to the TIN/NPI combo that provided the plurality of E/M services to the beneficiary.

CMS has set the attribution threshold at 20 beneficiaries for scoring on the total per capita and 35 beneficiaries on the Medicare Spending per Beneficiary (MSPB) measures.

For episode-based measures, beneficiaries will be attributed to the provider who bills a Medicare Part B claim with a trigger code during the trigger event. A physician must have 20 attributed episodes to be scored on an episode-based measure.

VI. MIPS IMPROVEMENT ACTIVITIES (IA) PERFORMANCE CATEGORY

What is required under the MIPS Improvement Activities (IA) Performance Category?

The Improvement Activities Category represents a NEW CMS performance measurement approach that supports the broad aims in healthcare delivery to enhance care coordination, increase beneficiary engagement, and expand population management. This Performance Category contains **92 individual activities** that are grouped into the following eight sub-categories: (**NOTE:** A full breakdown of the 92 activities broken-down by the 8 sub-categories, the required information to validate an attestation of performance of a given activity, and the suggested documentation that should be available to support attestations is available on the Guardian website at **http://itsguardian.com/MIPSQPPRegistry.html** under the MIPS Improvement Activities Performance Category.

- *Expanded Access to Care:* Example activities include providing 24/7 access to advice about urgent & emergent care; use of telehealth services and analysis of data for quality improvement.
- *Care Coordination:* Example activities implementing standard operations for Transitions of care; timely communication of test results and follow-up between PCPs and specialists; process for updating and sharing care plans with and between patient's, patient's caregivers; and patient's clinicians.
- *Emergency Response and Preparedness:* Example activity includes participation in Disaster Medical Assistance Teams or Community Emergency Responder Teams for a minimum of 6 months.
- *Achieving Health Equity:* Example activities include seeing new and follow-up Medicaid and dual eligible patients in a timely manner; and participation in Qualified Clinical Data Registry (QCDR) demonstrating use of standardized processes and screening for social determinants of health.
- *Population Management:* Example activities include provide longitudinal care management to at-risk patients; manage medications to maximize efficiency, effectiveness, adherence and safety; take steps to improve the health status of communities.
- *Beneficiary Engagement:* Example activities include access to an enhanced patient portal; use of evidence-based decision aids to support shared decision-making; engagement of patients and caregivers in the development of care plans; use of patient engagement tools; provide peer-led support for self-care management.
- *Patient Safety and Practice Assessment:* Example activities include building analytic capability required to manage total cost of care for a practice population, including on-going analysis of data leading to cost efficient care; implement fall screening and assessment programs to identify patients at risk for falls and address modifiable factors; use of tools such as the Surgical Risk Calculator.
- *Integrated Behavioral and Mental Health:* Activities include tobacco intervention and smoking cessation efforts; routine depression screening and follow-up; integration behavior health services to support patients with behavioral health needs.

Each of the 92 activities groups in the eight sub-categories are scored as High (20 points) or Medium (10 points). For the Transition Year (2017) eligible clinicians are required to attest to performing four medium weighted or two high weighted activities to receive full credit in the Improvement Activity Category.

Clinicians participating in a Patient-Centered Medical Home (PCMH) or a MIPS Alternative Payment Model (APM) automatically receive full credit for the Improvement Activities Category.

In the Final Rule CMS reduced the number of activities required to achieve full credit from six medium-weighted or three high-weighted activities to four medium-weighted or two high-weighted activities to receive full credit in this performance category in the 2017 Transition Year. In addition, for small practices, rural practices, or practices located in geographic health professional shortage areas (HPSAs), and non-patient facing MIPS eligible clinicians, CMS reduced the requirement to only one high-weighted or two medium-weighted activities.

(**NOTE:** Examples of the activities that qualify for high or medium point values for each of the eight sub-categories of the MIPS Improvement Activities (IA) Performance Category that can be documented and reported through the use of the Guardian HIE architecture, the Guardian CMS Approved Qualified Registry, and/or the Guardian Health Services Programs and Service Delivery Platforms are provided in an **Attachment** to this document. This Attachment is as well available on the Guardian website at **http://itsguardian.com/MIPSQPPRegistry.html** under the MIPS Improvement Activities Performance Category.

How will the MIPS Improvement Activity Performance Category Score be calculated?

To establish a MIPS eligible clinician's Improvement Activities Category score for the 2017 Transition Year, CMS will divide the sum of the points earned by a MIPS eligible clinician by 40, the total available points for the category in the Transition Year, and multiple the determined value by the percentage weight of the performance category in a MIPS Composite Performance Score.

VII. MIPS ADVANCING CARE INFORMATION (ACI) PERFORMANCE CATEGORY

What is required under the MIPS Advancing Care Information (ACI) Performance Category?

The MIPS Advancing Care Information (ACI) Performance Category provides a facelift to the Medicare EHR Incentive Program, otherwise known as Meaningful Use (MU). The notable changes to the MU Program under this MIPS Performance Category include:

- The MU is no longer an "all-or-nothing" program. MIPS eligible clinicians must report the base measures, but do not have to report all of the measures available.
- Removal the MU threshold requirements. MIPS eligible clinicians do not have to meet a certain percentage.
- Reduced Public Health Registries reporting requirements. Immunization reporting is no longer required but can still be selected for performance points.
- The facelift retires 2 existing MU measures--the Computerized Physician Order Entry (CPOE) and Clinical Decision Support measures.

For the 2017 Transition Year, there are **two distinct MIPS Advancing Care Information (ACI) Performance Category measurement sets** for reporting data, depending upon the edition of the

certified electronic health record technology (CEHRT) used by a MIPS eligible clinician for the 2017 performance reporting period. If a MIPS eligible clinician uses a 2015 edition CEHRT to report ACI, the measurement set consists of **15 measures** broken down into Base Score, Performance Score, and Bonus Score categories. If, on the other hand, a MIPS eligible clinician uses 2014 CEHRT, the measurement set consists of **11 measures** broken down into Base Score, Performance Score, and Bonus Score categories.

The difference between these measurement sets reflects the Meaningful Use capabilities of the 2014 CEHRT versus the 2015 CEHRT. Beginning in MIPS reporting year 2018, **ALL MIPS eligible clinicians** will be expected to report the measures for the Advancing Care Information Performance Category based on 2015 CEHRT.

There are a total of 15 Advancing Care Information Performance Category Objectives and Measures broken down into Base Score, Performance Score, and Bonus Score sub-categories. (NOTE: A detailed description of each of the ACI measures, reporting requirements, denominator/numerator designations, and measure scoring weights is provided on the Guardian Website at Guardian website at **http://itsguardian.com/MIPSQPPRegistry.html** under the Advancing Care Information Performance Category.)

BASE SCORE OBJECTIVES AND MEASURES--There are 5 MIPS ACI Performance Category Base Score objectives and measures. These objectives and measures represent a core level of MIPS ACI participation and, as such must be completed in entirety (all five measures) by all MIPS eligible clinicians. **Failure to meet the base score requirements results in a score of 0 for the entire Advancing Care Information Performance Category. Each of the 5 ACI base measures contribute10 points toward the overall ACI score.** The ACI base objectives and measures include:

#	BASE OBJECTIVE*	BASE MEASURE	POTENTIAL %--POINTS
1	Protect Patient Health Information	Security Risk Analysis	10 Points
2	Engage in Electronic Prescribing	ePrescribing	10 Points
3	Provide Patient Electronic Access	Patient Electronic Access	10 Points
4	Health Information Exchange	Send Summary of Care Report	10 Points
5	Health Information Exchange	Request/Accept Summary of Care Report	10 Points

PERFORMANCE SCORE OBJECTIVES AND MEASURES--To achieve an overall ACI performance score above the Base Score, MIPS eligible clinicians may choose to report on one or more of a set of nine (9) Performance Score Objectives and Measures for a minimum of 90 days during the Transitional reporting period (2017). The ACI performance objectives and measures include:

#	PERFORMANCE OBJECTIVE*	PERFORMANCE MEASURE	POTENTIAL %--POINTS

N/A	**Provide Patient Electronic Access****	**Patient Electronic Access**	**Up to 10 Points**
N/A	**Health Information Exchange****	**Send Summary of Care Report**	**Up to 10 Points**
N/A	**Health Information Exchange****	**Request/Accept Summary of Care Report**	**Up to 10 Points**
6.	Provide Patient Electronic Access	Patient Specific Education	Up to 10 Points
7.	Care Coordination Through Patient Engagement	View, Download, and Transmit VDT	Up to 10 Points
8.	Care Coordination Through Patient Engagement	Secure Electronic Messaging	Up to 10 Points
9.	Care Coordination Through Patient Engagement	Patient Generated Health Data	Up to 10 Points
10.	Clinical Information Reconciliation	Clinical Information Reconciliation (medications, allergies, problem list)	Up to 10 Points
11.	Public Health Reporting	Immunization Registry Reporting	10 Points for YES Attestation

NOTE: The three measures identified **in bold in the performance set are included in both the Base Score measurement set and Performance Score measurement set. For these measures eligible clinicians only need a 1 in the numerator for the Base Score, but will earn additional points toward the performance score for higher values in the numerator in each the measures.

***BONUS SCORE MEASURES*:** In addition to the Base Score and Performance Score objectives and measures, eligible MIPS eligible clinicians can accumulate an additional ACI Performance Category score through bonus points. Eligible clinicians can receive up to 15 points by:

- Reporting data to one or more public health or clinical data registries beyond the Immunization Registry Reporting measure. (5 additional ACI points). This bonus is only available to MIPS eligible clinicians who earn a Base Score, and does not require reporting the Immunization Registry Reporting Performance measure to earn the 5 points.
- Attesting YES to completing at least one of the qualified improvement activities from the MIPS Improvement Activities Performance Category using a CEHRT. (10 additional bonus points). The additional bonus points are available whether the MIPS eligible clinician attests to using CEHRT for one or more of the qualified activities, with the weight of the activities having no bearing on the bonus award.

ACI measures can be reported via EHR, Qualified Registry (QR), or Qualified Clinical Data Registry QCDR). The ability to report ACI measures via a QR or a QCDR is new under MIPS. **CMS has stated in numerous MIPS related publications they are encouraging consolidation of reporting for all categories through a single submission mechanism (e.g., Guardian CMS Approved MIPS Qualified Registry)**

For group reporting, the ACI data must be aggregated for the group, with one numerator and denominator or yes/no answer for the whole group for each measure. If the group is using multiple EHR

technologies, the numbers must be aggregated across the technologies before the data is reported. In addition for the:

- Base objectives and measures, groups only need one clinician to report successfully to achieve a "yes" or a numerator of 1 for each measure to get credit. In effect, as long as one eligible clinician in the group completes all the base measures, then they whole group receives credit for the base measures (50% of the category score).
- For Performance objectives and measures, groups must sum the numerator and denominator across all clinicians using a CEHRT, with the results used as the numerator and denominator for the group. It is not acceptable to submit a numerator and denominator for just one eligible clinician in the group for the performance measures, unless only one eligible clinician is using CEHRT.

CMS will grant hardship exceptions for the ACI Performance Category for the following conditions:

- Insufficient internet connectivity.
- MIPS eligible clinician demonstrates insufficient internet access through an application process.
- Extreme and uncontrollable circumstances.
- Lack of control over the availability of CEHRT.
- Lack of face-to-face patient interaction.

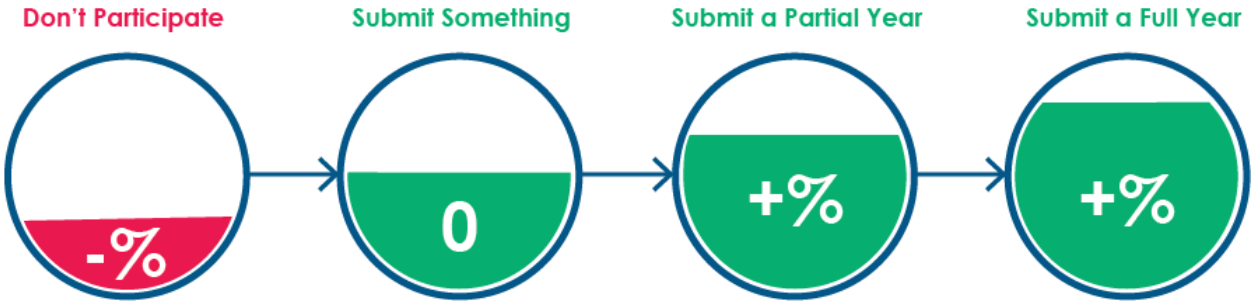
How will the MIPS Advancing Care Information (ACI) Performance Category Score be calculated?

To establish a MIPS eligible clinician's Advancing Care Information (ACI) Performance Category score for the 2017 Transition Year, CMS will add an eligible clinician's or group of clinicians Base Score, Performance Score, and Bonus Score and divide the sum of the points earned by a MIPS eligible clinician by 100, the total available points for the category in the Transition Year, and multiple the determined value by the percentage weight of the performance category in the MIPS Composite Performance Score (CPS) (25%). It is important to note that a MIPS eligible clinician could earn a maximum of 155 points derived by adding the maximum base, performance, and bonus points. Despite this potential, CMS has set the maximum points for the ACI Performance Category at 100. If a provider exceeds the CMS maximum, the experienced points are adjusted back to 100.

VIII. MIPS "PICK YOUR PACE" OPTIONS FOR THE 2017 TRANSITION YEAR

Are there options for participation by eligible clinicians for the 2017 Transition Year?

Yes. For the MIPS Transition Performance Reporting Year (2017), CMS is allowing MIPS eligible clinicians the following "pick your pace" options:



If a MIPS eligible clinician elects **NOT TO** participate in MIPS during the Transition Year, the provider (or group) will be subject to a 4% Medicare negative payment adjustment in the 2019 payment year. This negative payment adjustment does not apply to clinicians who are not required to participate in MIPS in 2017.

If a MIPS eligible clinician elects to "test" MIPS participation in the 2017 Transition Year and submit a minimum amount of data, the provider will 1) avoid a negative payment adjustment in 2019, and 2) not be eligible for an incentive payment increase in 2019. The minimum data submission under this option includes one of the following:

- 1 MIPS Quality Performance Category Measure
- 1 MIPS Improvement Activity
- 4 Advancing Care Improvement Category Measures

If, on the other hand, the MIPS eligible clinician elects to participate for a partial year (90 day period) during the Transition Year, the provider will qualify for a small incentive payment in 2019. The minimum data submission under this option includes reporting one of the following for 90 consecutive days:

- 2 or more MIPS Qualify Performance Category Measures
- 2 or more Improvement Activities
- 4 Required and at least one additional MIPS Advancing Care Information Performance Category measures

MIPS eligible clinicians who elect to engage in full participation in MIPS in the Transition Year will qualify to receive an incentive payment of up to 4% in the 2019 payment year. To fully participate, the MIPS eligible clinician must report ALL of the following:

- 6 MIPS Quality Performance Category Measures
- 4 Improvement Activities
- 9 Advancing Care Information Performance Category Measures, including all of the Base Score Measures

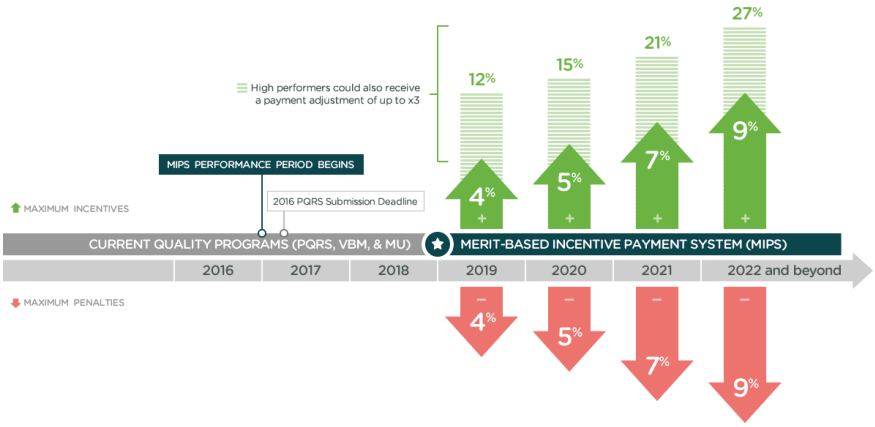
IX. MIPS ECONOMICS

Will the weights for the MIPS Performance Categories change over time?

Yes. As previously indicated, each of the four MIPS Performance Categories will be weighted in their contributions to the final provider Composite Performance Score (CPS), with the weights for the Quality and Cost (Resource Use) Performance Categories changing over time. In the Final Rule, CMS eliminated the Cost (Resource Use) Performance Category for the initial Transition Year. In the 2018 performance year (2020 payment year) the Cost (Resource Use) Performance Category will be set at 10%, with the Quality Performance Category reduced to 50%. In 2019 and beyond, the Cost and Quality categories will be respectively weighted at 30% of the MIPS Composite Performance Score.

What are the positive and negative payment incentives of the MIPS?

Each MIPS eligible clinician's Composite Performance Score (CPS) will be compared to a performance threshold that consists of the mean or median of the Composite Performance Scores for ALL MIPS eligible clinicians during a period prior to the target performance period. If an eligible clinician's CPS score falls above the threshold the clinician will receive a **POSITIVE PAYMENT** adjustment, with the payment adjustment ranging from 4% in the initial Payment Year (2019 for the 2017 Transition Performance Year) to 9% for 2022 and beyond. If, on the other hand, a MIPS eligible clinician's CPS falls below the threshold the clinician will receive a **NEGATIVE PAYMENT** adjustment, with the payment adjustment ranging from - 4% in the initial Payment Year (2019 for the 2017 Transition Performance Year) to - 9% for 2022 and beyond. Graphically, these positive and negative payment adjustments are as follow:



MIPS eligible clinicians whose CPS falls below the threshold but are closer to the threshold will receive proportionally smaller negative payment adjustments. Correspondingly, if a MIPS eligible clinician's CPS is at the threshold the clinician will not receive a MIPS payment adjustment.

The mean or median threshold of the Composite Performance Scores for all MIPS eligible clinicians is reset each performance year. Accordingly, a MIPS eligible clinician's CPS in one year does not affect their CPS the next year.

If the number of MIPS eligible clinicians attaining a high CPS is LOW, the payments can be increased by a factor of up to 3. If, on the other hand, the number of MIPS eligible clinicians attaining a high CPS is

HIGHER than eligible clinicians receiving lower scores, the payments can be scaled down to ensure budget neutrality.

The Final Rule specifies the availability of an additional Incentive Payment funded by $500 million each year from 2019-2024 for exceptional performance. For the initial Transition Payment Year 2019 (for the initial Transition Performance Year of 2017), the threshold for exceptional performance will be set at 70. (MIPS eligible clinicians who present with a Composition Performance Score of ≥ 70 will be have the opportunity to receive a bonus payment paid as a percentage of the MIPS eligible clinician's claims, not exceed 10 percent.)

CMS will award bonus payments on a linear sliding scale, ranging from 0.5 percent for MIPS eligible clinicians achieving a score equal to the threshold (70), and increasing to a maximum of 10 percent for eligible clinicians earning a score of 100. Depending on how well MIPS eligible clinicians perform in the aggregate, the full $500 million may not be awarded each year. If the earned incentive payments exceed $500 million based on the current MIPS parameters, CMS will decrease the starting percentage accordingly until a linear sliding scale may be used without exceeding the 10 percent threshold for the top performers.

MIPS has implications for clinicians across the spectrum of performance, including low performing clinicians. Negative reimbursement will not be subject to any kind of multiplier, but the lowest performing clinicians will make it possible for the multiplier to be awarded to the exceptional performers.

It is important to point out that the additional 3x payment (identified in the graphic above) for exceptional performance will be difficult to achieve, given the budget neutrality of MPS. MIPS eligible clinicians can, however, improve their chances of attaining the 3x multiplier with early adoption of the MIPS process. Through increased understanding of the reporting process and forging an alignment with an entity like Guardian that can provide guidance through the process including fully compliant documentation and reporting of performance data through the Guardian CMS Approved MIPS Qualified Registry, clinicians can make improvements in performance and outcomes going forward, making it easier to attain a positive reimbursement adjustment and possibly earn an exceptional performer multiplier on top of the positive adjustment.

X. MIPS PERFORMANCE TRANSPARENCY

Will eligible clinician performance across the four performance categories be open to transparent public view?

MIPS performance carries with it potential positive or negative consequences for an MIPS eligible clinician's reputation. Within approximately 12 months of the end of a performance period, CMS will publish each eligible clinician's MIPS score and component category scores to the Physician Compare website. Accordingly, consumers will have access to see how their clinicians are rated on a scale of 0 to 100 and how their clinicians compare to peers nationally. This level of transparency and specificity goes

beyond existing programs such as the PQRS Value Based Payment Modifier (VBM), which calculates quality and resource use scores but does not publicly publish the results.

Physician Compare will also release the scores in a freely downloadable and structured format (such as an Excel document or text file), as is currently done for PQRS measure data. In addition, CMS will publish national aggregate information about the MIPS score, including the national average score and the range of scores for all MIPS eligible clinicians. Given the range of clinicians impacted by MIPS, for many of these clinicians, the MIPS score will be the first time their public reputation may be impacted by a 100-point scale placed on a national comparison platform and distributed to an audience of potentially millions.

It is important to note that MIPS eligible clinicians will not learn their MIPS score until late in the year after the performance year (e.g., in late 2018 for the 2017 performance year). If a clinician exhibits a "bad MIPS CPS", the current year will be nearly over, meaning the clinician then can focus only on improving for the following performance year. In effect, a clinician with a bad score in one year may need two or more years to reverse a low MIPS CPS in the public domain. During such a wide gap, a clinician could lose market share to clinicians with higher scores yet not be able to change that score until the damage is already done. The reality is that MIPS eligible clinicians must engage in timely investment in their MIPS performance, with the starting blocks configured in the **HERE AND NOW.**

XI. ALTERNATIVE PAYMENT MODELS (APMs)

What are the criteria for participation in Alternative Payment Models (APMs) under the MACRA QPP?

Although there are many Alternative Payment Models (APMs) operating in the healthcare system, under MACRA only a relatively small subset of APMs (referred to as Advanced APMs) are available in the QPP. The criteria for an Advanced Alternative Payment Model in the QPP include:

- The APM is a CMS Innovation center model, or a select CMS Innovation Center Shared Saving Program track.
- The APM Require participants to use CEHRT.
- The APM reports and bases payments for services on quality measures comparable to those in MIPS.

What APMs are available under the MACRA QPP for the Transition Year?

For the 2017 Transition Performance Year CMS has approved the following to be classified as Advanced APMs:

- Medicare Shared Savings Program (MSSP) Tracks 2 & 3
- Next Generation ACO Model
- Comprehensive ESRD Care Model, Large Dialysis Organization (LDO) arrangement and non-LDO two-sided risk arrangement
- Oncology Care Model (2-sided risk arrangement only)

- Chronic Care for Joint Replacement CEHRT (Track 1)
- Comprehensive Primary Care Plus (CPC+)

In future years beginning in 2018, CMS has proposed in the Final Rule the roll-out of the following additional Advanced APMs:

- ACO Track 1+
- New voluntary bundled payment model
- Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology (CEHRT) track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)

Current available Advanced APMs are, for the most part, focused on primary care, with limited availability of APMs for eligible specialist clinicians. The MACRA Final Rule provides an avenue for introducing new APMs in the QPP through a Physician Focused Payment Model Technical Advisory Committee (PTAC). The PTAC is charged with periodically reviewing physician focused payment models submitted by stakeholders and submit recommendations to the Secretary. The PTAC provides a pathway for stakeholders and the public to submit APMs to be considered for adoption, including the potential of being classified as an Advanced APM.

CMS will publish a final 2018 performance year Advanced APM Model list before January 1, 2018. The Center anticipates re-opening applications for new practices and payers in CPC+ and new participants in the Next Generation ACO model for the 2018 performance year.

XII. ALTERNATIVE PAYMENT MODELS (APMs) ECONOMICS

What are the payment implications for participation in an APM?

Eligible clinicians who participate in one or more CMS eligible Advanced APMs have the potential to receive a lump-sum 5% bonus based on their Medicare Part B payments from the previous year's claims for each year from 2019 to 2024, in addition to any rewards they may receive through the APM itself (e.g., shared savings). To receive a bonus payment under the MACRA Quality Payment Program (QPP) APM path, a provider, or a group of clinicians billing through a common tax ID (TIN) must be considered a **Qualifying Participant (QP)**.

A provider's QP status is determined by his or her participation in a CMS approved Advanced APM entity that **collectively** meets the following revenue **or** patient thresholds for the QPP transition year (2017):

- Minimum Revenue Threshold --The collective Part B payments for Medicare Part B services delivered by the Advanced APM entity's clinicians to Medicare patients who are attributed to that entity represents **at least 25%** of the total payments for Medicare Part B professional services.

- Minimum Patient Count Threshold Requirement— The collective number of patients attributed to the Advanced APM who received Medicare Part B services delivered by the entity's clinicians represents **at least 20%** of the total number of all patients who received Medicare part B professional services from the Advanced APM.

QPs in CMS eligible Advanced APMs that achieve the minimum Revenue or Patient Count thresholds for 2017 are excluded from MIPS requirements. Clinicians participating in CMS eligible Advanced APMs that fall short of the Minimum Revenue or Patient Count Thresholds, but meet lower thresholds, are considered **Partial Qualifying Participants (P-QP)** and are able to choose whether or not they would like to receive a payment adjustment through MIPS.
To opt out of the MIPS payment adjustment, a P-QP must participate in an eligible Advanced APM entity that collectively reaches a Patient Count Threshold of at least 10% or collective Revenue Threshold of at least 20% for 2019 and 2020. The minimum Revenue and Patient Count Thresholds will increase beginning in 2021 with the minimum Revenue threshold set at 75% and Patient Count Threshold set at 50% by 2024 and beyond.

It is important that all physician eligible clinicians must report through MIPS for the first performance year. CMS will calculate whether APM entities meet thresholds at the end of the first performance year (2017). In the Final Rule, CMS announced if they can determine from historical data whether an APM entity is likely to meet an established threshold, CMS will notify the participants and exempt them from MIPS. Independent of the threshold designations, the majority of MACRA QPP eligible clinicians will participate in the MIPS until more Advanced APMs become available.

APM HYBRIDS—THE MIPS APM

Are their APMs that straddle the Advanced APMs and MIPS paths?

Yes. In the transition year (2017), some APMs, by virtue of their structure, will not meet statutory requirements to be categorized as Advanced APMs. Eligible clinicians in these APMs, referred to as MIPS APMs, will be subject to MIPS reporting requirements and the MIPS payment adjustment. In addition, eligible clinicians who are in Advanced APMs but do not meet Qualifying or Partial Qualifying Participation thresholds to be excluded from MIPS for a year will be subject to MIPS reporting requirements.

In the Final Rule CMS has designated the following as MIPS-APMs:

- Medicare Shared Saving Program Tracks 1, 2, and 3
- Next Generation ACO Model
- Comprehensive ESRD Care Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus (CPC+)

To earn MIPS points from a MIPS APM, an eligible provider must specifically:

- Be included in the participant list of a non-Advanced APM that CMS has determined to be a MIPS APM, **OR**

- Be included in the participant list of an Advanced APM entity that did not meet the thresholds to be eligible for the Advanced APM bonus and, therefore, elect to participate in MIPS.

Clinicians participating in a CMS approved MIPS APM, will, in 2017:

- Report the required quality measures for the APM through the APM entity (e.g., the quality measures for participants in a Track 1 MSSP ACO are reported by the ACO).
- Report data for the MIPS Advancing Care Information Performance Category on their own.
- Automatically earn all of the total available points for the Improvement Activities category score.

MIPS APM clinicians will be scored using a **MIP APM Scoring Standard** as opposed to the **MIPS Scoring Standard** by which eligible clinicians in MIPS are evaluated against. Under the MIPS APM Scoring Standard:

- CMS will award the same final MIPS score to all participants in a MIPS APM entity---including for data they reported individually or as a group under a single TIN.
- Since the CMS approved MIPS APMs are already assessed collectively for meeting certain quality and cost metrics, CMS will score the Advancing Care Information and Improvement Activities collectively as well.
- CMS will use an average score for all the participants' scores for Advancing Care Information to determine a group score.
- ALL participants in a qualified MIP APM will receive the same total available score for Improvement Activities.
- CMS will re-weight the MIPS Performance Categories to reflect the specific design of the approved MIPS APMs. The re-weights will be as follows:

  ✓ For MSSP ACOs and Next Generation ACOs, the category weights for 2017 will be: 50% Quality; 0% Cost; 20% Improvement Activities; and 30% Advancing Care Information.
  ✓ For all other models, category weights will be 0 Quality; 0% Cost; 25% Improvement Activities; and 75% Advancing Care Information.

CMS will determine clinicians' eligibility to be scored under the MIPS Scoring Standard by checking three times during a performance year to confirm that the individuals or groups are listed on the APM entities' participant lists. CMS checks will occur on March 31, June 30, and August 30 of the performance year. If a provider is on the list at any time, he or she will be considered as participating in the APM entity.

Are there opportunities for MIPS APMs to become Advanced APMs?

Yes. On December 20, 2016 CMS announced a new Innovations Center Model—The Medicare Accountable Care Organization (ACO) Track 1 + Model. This new model will test a payment design that incorporates more limited downside risk than is currently established in the Track 2 and 3 Models of the Medicare Shared Savings Program.

The manifest intent of the new on the horizon model is to encourage more practices to advance to performance-based risk. Beginning in 2018, the Track 1 + Model will be classified as an Advanced APM

providing an avenue for clinicians to earn incentive payment under the MACRA Quality Payment Program (QPP), Advanced APM Path.

The Track 1 + Model:

- Incorporates elements of the Track 3 Model, including prospective beneficiary assignment that facilitates identification in advance the patient population for which the new ACO will be responsible for.
- Introduction of downside risk that is lower than existing ACO Tracks.
- Provides an option to request a Skilled Nursing Facility (SNF) 3-Day Rule Waiver to provide greater flexibility to coordinate and deliver high quality care.
- Is designed an "on-ramp" in the progression to two-sided risk.

The new Track 1+ Model will be available to new ACOs and ACOs currently in Track 1. ACOs currently in MSSP Track 2, 3, Nest Generation or Pioneer ACOs **DO NOT** qualify for Track 1+.

XIII. IMPORTANT QUESTIONS AND ALIGNMENTS THAT MUST BE ADDRESSED

Do you qualify for the QPP in 2017?

Let's refresh--You qualify if you are included in the initial list of qualified clinicians, it is not your first year with Medicare, or you anticipate being paid Medicare Part B payments in 2017 > $30.000, or you anticipate delivering service to > 100 Medicare Part B patients in 2017.

Are you participating in a MIPS APM or one or more of the CMS approved Advanced APMs?

If you are not participating in a MIPS APM or an approved Advanced APM, and you qualify for the QPP you are subject to participate in MIPS either as an individual eligible clinician or a member of a group of eligible clinicians for 2017. If you participating as a member of a MIPS APM, you are eligible for evaluation under the MIPS APM Scoring Standard as opposed to the MIPS Scoring Standard.

Finally, if you are a member of a CMS qualified APM and you satisfy the revenue and patient count thresholds, you are excluded from MIPS in 2017 and earn a 5% bonus in 2019 as a Qualified Participant (QP) in an Advanced APM. If, on the other hand, you are a member of a CMS qualified APM, but do not satisfy the revenue and patient count thresholds, you have the option to 1) participate in MIPS, or 2) opt out of the MIPS payment adjustment, and participate in an eligible Advanced APM entity that collectively reaches a Patient Count Threshold and Revenue Threshold.

XIV. CONFRONTING THE CHALLENGES OF THE MACRA QPP

What specific steps should be taken to ensure high performance and maximum returns under the MACRA QPP?

In a July 23, 2016 article in Modern Healthcare, entitled, With MACRA Looming, Doctors Can't Waiting to Plumb its Intricacies, the author, Howard Wolinsky stated:

"Meaningful use is first-grade arithmetic and MIPS and MACRA are college-level calculus—it is very complex."

Sorting through and implementing timely responses to the exigencies of the MACRA QPP represents a formidable task. Below, we have identified some action step that you may take to enhance your performance under the new value-based approach to evaluating performance.

Increase your MACRA QPP IQ

To learn more about the MACRA QPP and more specifically the respective MIPS and APM paths, attend one of the seminars offered by Guardian Health Services, and/or visits the Guardian website at **http://itsguardian.com/MIPSQPPRegistry.html** for addition information and resources on the MACRA QPP and the Guardian CMS Approved MIPS Qualified Registry. Guardian and Guardian Health Services offers MACRA QPP impacted clinicians the following compliant solutions they need to ensure a successful and financially rewarding transition into and through the long-term staging of MACRA and the QPP:

✓ A CMS Approved MIPS Qualified Registry that is:

- Web-based
- Integrated, interoperable and customized
- Operates at an enterprise-grade level of functionality
- Easy to use and provides fast-track implementation for clinicians/practices
- Secure
- Designed to ensure compliance with the documentation and reporting requirements of MIPS

✓ A state-of-the-art cloud-based Health Information Exchange (HIE) architecture, referred to as Guardian that 1) connects clinicians and enables access to patient-centric clinical information on demand at the point of care, and 2) enables health information to be exchanged electronically between disparate healthcare information entities and systems while ensuring information integrity. Interoperability and exchange interfaces offered through the Guardian HIE architecture that reflect both the meaning and functionality of the concept of clinical integration.

✓ A portfolio of cost-effective and efficient programs for comprehensive care coordination and care management that are intricately interrelated with the performance requirements across all four performance categories.

✓ A team of knowledgeable and dedicated experts who are ready to:

- Assist in identifying the unique approach individual clinicians and groups need to take to satisfy the requirements of the QPP while at the same time fully reflecting the unique characteristics and focus of their practice.
- Work directly with practice staff in ensuring proper documentation and retrieval of performance data to be submitted to CMS.
- Provide 24/7 support, including on-going targeted education as the MACRA QPP is rolled-out.

Assess your past performance in CMS directed quality programs to determine where improvements may be made

The transition to MIPS may be easier if you are already familiar with the current CMS quality programs. Assess your performance under these programs and as you learn about MIPS requirements, determine what changes you will have to make in your practice to meet the requirements for each MIPS category. More specifically, if you participate in the PQRS and VM programs, and if you have not already reviewed your reports, get to know the type of feedback CMS provides and the data it uses to assess your quality and cost performance. Analyzing your feedback reports will help you prepare for the quality and resource use categories in MIPS. Consider which practice strategies you could implement to optimize performance and improve your scores in 2017.

Review the measures and activities within the MIPS Performance Categories

Take the time to review and identify those measures and activities that best represent your practice, and develop a strategy to ensure timely and proper documentation and reporting of the respective measures and activities. Keep in mind that simply reporting data on quality measures will not be sufficient to earn a high score. Reporting is necessary, but how well you perform on each quality measure is what will control your score. To optimize performance, align care plans, target care delivery, and/or redesign clinical workflows and train your staff so that everyone on your care team is on board to meet each quality measure in 2017. For assistance in identifying appropriate measures and activities and establishing a strategy for ensuring timely documentation and reporting, contact a representative at the Guardian CMS MIPS Qualified Registry. Information and resources on the MACRA QPP and the Guardian CMS Approved MIPS Qualified Registry can be found on the Guardian website at **http://itsguardian.com/MIPSQPPRegistry.html**.

Prepare your practice for potential audits

CMS intends to selectively audit physicians and other eligible clinicians annually to conduct “data validation and auditing” of any data submitted under MIPS. Review your documentation and ensure EHR templates are used with care and that data fields in either EHR and/or paper charts clearly capture the documentation required to support each measure. Prepare to keep a record of which patients you report on per measure and performance period so that your practice can identify medical records easily if you are selected for an audit. To ensure an audit proof posture, consider working with a MIPS Qualified Registry like Guardian to assist in the documentation, reporting, and submission of performance data to CMS.

ATTACHMENT

EXAMPLES OF MIPS IMPROVEMENT ACTIVITIES (IA) PERFORMANCE CATEGORY MEASURES THAT CAN BE DOCUMENTED AND REPORTED THROUGH THE USE OF GUARDIAN HIE ARCHITECTURE AND GUARDIAN HEALTH SERVICES PROGRAMS AND PLATFORMS

The table below provides **examples** of the activities that qualify for high or medium point values for each of the eight sub-categories of the MIPS Improvement Activities (IA) Performance Category that can be documented and reported through the use of the Guardian HIE architecture, the Guardian CMS Approved Qualified Registry, and/or the Guardian Health Services (GHS) Programs and Service Delivery Platforms. This table serves to demonstrate the interrelationship between this MIPS Performance Category and 1) the clinical integration capability of the Guardian HIE architecture, and 2) the range of unique Programs and Platforms operated by Guardian Health Services driven by the Guardian architecture.

SUB CATEGORIES OF THE MIPS IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY	EXAMPLE ACTIVITY AND CLASSIFICATION NOTE: High Rank of Activity = 20 Points; Medium Rank of Activity = 10 Points	RELEVANT GHS PROGRAMS THAT PROVIDE A COMPLIANT AVENUES FOR PROVIDER MAXIMUM PERFORMANCE AND PAYMENT ENHANCEMENT FOR THIS COMPONENT OF MIPS
Expanded Access to Care	✓ Provide 24/7 access to advice about urgent & emergent care (High). ✓ Use telehealth services and analysis of data for quality improvement (Medium). ✓ Collect patient experience and satisfaction data on access to care and develop an improvement plan (Medium).	✓ GHS 24/7 Emergent Care Center Platform; GHS 24/7 Nurse Hotline ✓ GHS Telemedicine Program ✓ GHS Mini-CAHPS Program
Care Coordination	✓ Provide specialist reports back to the referring MIPS provider or group to close referral loop (Medium). ✓ Timely communication of test results and follow-up (Medium). ✓ Implement practices/processes that document care coordination activities (Medium). ✓ Establish standard operations to manage transitions of care (Medium). ✓ Implement practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the patient, the patient's caregiver(s), and the patient's providers (Medium). ✓ Ensure there is bilateral exchange of necessary patient information to guide care, including participation in an HIE (Medium).	✓ GHS Referral Management Program ✓ GHS Referral Management Program ✓ GHS Referral Management Program ✓ GHS Transitions of Care Program; DOCS Hospitalist Program ✓ GHS Complex Care Management Program; GHS HRA/AWV Program ✓ Integration into the Guardian HIE architecture; GHS Referral Management Program
Emergency Response and Preparedness	✓ Participate in Disaster Medical Assistance Teams or Community Emergency Responder Teams for a minimum of 6 months (Medium).	✓ No specific GHS Program to date.
Achieving Health Equity	✓ Seeing new and follow-up Medicaid and dual eligible patients in a timely manner (High).	✓ Coordination of GHS Programs through Agreements with MAOs that offer Dual

SUB CATEGORIES OF THE MIPS IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY	EXAMPLE ACTIVITY AND CLASSIFICATION NOTE: High Rank of Activity = 20 Points; Medium Rank of Activity = 10 Points	RELEVANT GHS PROGRAMS THAT PROVIDE A COMPLIANT AVENUES FOR PROVIDER MAXIMUM PERFORMANCE AND PAYMENT ENHANCEMENT FOR THIS COMPONENT OF MIPS
	✓ Participate in Qualified Clinical Data Registry (QCDR) demonstrating use of standardized processes and screening for social determinants of health (Medium).	Eligible Special Needs Plans (SNPS) ✓ GHS operates a Qualified Registry and will submit application for operating a Qualified Clinical Data Registry beginning in 2018.
Population Management	✓ Document individualized glycemic treatment goals in 60% of medical records in year 1 for Medicare patients with diabetes who are prescribed antidiabetic agents (High). ✓ Take steps to improve the health status of communities (for example collaborate to implement evidence-based practices to improve specific chronic conditions (Medium). ✓ Participate in a CMS Innovations Center Model (e.g., MSSP; Million Hearts Campaign) (Medium). ✓ Proactively engage in the provision of care management and coordination of chronic and preventive care for a panel of chronic disease patients (Medium). ✓ Provide longitudinal care management to at-risk patients (Medium). ✓ Manage medications to maximize efficiency, effectiveness, adherence, and safety (Medium).	✓GHS Care Gap Enhancement Program; GHS Complex Care Management Program ✓Coordination of GHS Programs and Platforms with Medicare and Commercial ACO Contract Agreements ✓Operate 2 Medicare Shared Savings Program ACOs ✓GHS Complex Care Management Program; HRA/AWV Program; GHS Transition of Care Program; GHS Telemedicine Program ✓GHS Complex Care Management Program and Transitions of Care Program ✓GHS Pharmacy Benefit Manager (PBM) Platform; GHS Complex Care Management Program; GHS Transitions of Care Program
Beneficiary Engagement	✓ Access to an enhanced patient portal that provides up-to-date information related to relevant chronic conditions and enables bidirectional communication about medication changes and adherence (Medium). ✓ Collect and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plans (High). ✓ Use evidence-based decision aids to support shared decision-making (Medium). ✓ Engage patients and informal caregivers (family) in the development of care plans and prioritizing their goals for action (Medium) ✓ Use tools to assist patients in assessing their need for self-care management (Medium) ✓ Use group visits for common chronic conditions (Medium) ✓ Provide condition-specific chronic disease self-care management support programs (Medium) ✓ Provide peer-led support for self-care management (Medium).	✓Guardian HIE architecture; GHS Complex Care Management Program; GHS HRA/AWV Program, GHS Transitions of Care Program ✓GHS Mini CAHPS Program ✓GHS Complex Care Management Program; GHS Shared Decision-Making Program ✓GHS Complex Care Management Program ✓GHS Complex Care Management Program; GHS Transitions of Care Program ✓GHS Complex Care Management Program ✓GHS Complex Care Management Program ✓GHS Complex Care Management Program

SUB CATEGORIES OF THE MIPS IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY	EXAMPLE ACTIVITY AND CLASSIFICATION NOTE: High Rank of Activity = 20 Points; Medium Rank of Activity = 10 Points	RELEVANT GHS PROGRAMS THAT PROVIDE A COMPLIANT AVENUES FOR PROVIDER MAXIMUM PERFORMANCE AND PAYMENT ENHANCEMENT FOR THIS COMPONENT OF MIPS
	✓ Provide self-care management materials at an appropriate literacy level and in appropriate language (Medium). ✓ Provide care management interaction between visits with follow-up on care pan and goals (Medium).	✓Guardian HIE architecture; GHS Complex Care Management Program; ✓GHS HRA/AWV Program ✓GHS Complex Care Management Program; GHS Transitions of Care Program
Patient Safety and Practice Assessment	✓ Provide specific measures that are meaningful to their practice (Medium). ✓ Build analytic capability required to manage total cost of care for a practice population, including on-going analysis of data leading to improved cost efficient care (Medium). ✓ Measure and improve quality at the practice and panel level, including routine review of measures of quality, utilization and patient satisfaction (Medium). ✓ Implement fall screening and assessment programs to identify patients at risk for fails and address modifiable factors (Medium).	✓ GHS Qualified Registry; GHS Care Gap Enhancement Program ✓ GHS Medical Analytics Program ✓ GHS Quality Assurance Program; GHS Care Gap Enhancement Program; GHS Medical Analytics Program ✓ GHS HRA/AWV Program; GHS Complex Care Management Program
Integrated Behavioral and Mental Health	✓ Tobacco use—regularly engage in integrated prevention and treatment interventions (including screening and cessation interventions for patients with co-occurring conditions of behavioral or mental health and risk factors for tobacco dependence (Medium). ✓ Routine depression screening and follow-up with integrated prevention and treatment plans (Medium). ✓ Integrate facilitation and promotion of the colocation of mental health services in primary and/or non-primary clinical care settings (High). ✓ Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions, including use of evidence-based screening tools and treatment protocols/interventions (High).	✓GHS Complex Care Management Program; GHS HRA/AWV Program; GHS Care Gap Enhancement Program ✓GHS Complex Care Management Program; GHS HRA/AWV Program; GHS Care Gap Enhancement Program ✓GHS Complex Care Management Program; GHS HRA/AWV Program; GHS Care Gap Enhancement Program ✓GHS Complex Care Management Program