Happy New Year everyone!

I trust 2017 is off to a great start for you. MGMA of MS wishes you the best in our New Year and we are looking forward to partnering with you as we navigate through the rapidly changing Healthcare landscape.

Your MGMA of MS board is committed to providing you with value-added educational opportunities and tools to enhance your practice management experience. I am proud of the many benefits MGMA of MS has to offer and hope you will take advantage of them.

We will continue the FREE monthly webinars to our MGMA of MS members. February will feature Michelle S. Houchin, MSL, CMPE, President, Adkisson Search Consultants leading a presentation entitled, “Developing a Career Plan for Career Change in Healthcare Management.” March will feature Jennifer Thompson with MWG Employer Services presenting “2017 HR and Labor Outlook.” Be on the lookout for event notifications that will give you the topic and date of each month’s webinar.

The annual Insurance Forum will be on Friday, February 10 at the Belhaven Center in Jackson. This event allows all members and staff the opportunity to meet representatives from your insurance carriers and discuss 2017 changes and opportunities for improvement one-on-one. Bob Williams, Director of Life and Health Actuarial with the Mississippi Insurance Department, will kick-off the meeting. MGMA of MS has secured commitments from all of the major insurance carriers in our market to attend. We encourage at least one person from your organization to attend, particularly managers and billing personnel responsible for submitting and processing insurance claims. There is still time to register by visiting our web site at www.mgmams.com.

Also, I am excited to announce we are combining our summer meeting with MGMA of Louisiana. Make plans now to join us August 16-18, 2017, in New Orleans at the Hilton Riverside as we take on our role as Ringmasters in Healthcare. President-elect, Jeremy Pittman and his planning committee are working on an outstanding summer conference lineup. Hotel reservations can be made by calling (504)584-3999.

A new feature this year is our Friday Focus. A question will be emailed each Friday with the results shared on Monday. Thank you to those who participated in our first Friday Focus; we received over 65 responses!

Our Outreach Committee is busy planning and scheduling local outreach meetings throughout the year. If you would like to assist in planning or have ideas for topics, please contact Kristina Romero at info@mgmams.com.

Last, mark your calendars for our Annual Fall Meeting Friday, November 10, at the Clyde Muse Center in Pearl.

I am looking forward to seeing you at all of our upcoming events. I am honored to serve as your MGMA of Mississippi President. As always, if there is anything I can do to help you or your practice succeed, please reach out to me.

Let’s make 2017 a great year!
Recent estimates place the number of doctors remaining in private practice to be around 30 percent and it is predicted that trend will continue.

For years, economic stresses escalated for smaller practices as overhead costs soared and reimbursements stagnated. And now in more recent years, practices are being further assailed with increasing regulatory burdens and costs. It is further predicted that most small practices will suffer negative reimbursements under the new Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rules when it rolls out in 2019. It is no wonder that doctors want out of the business of running a medical practice.

However, many doctors are standing strong in the face of these attacks. While many predict the demise of private practice, those standing strong will survive but it will take effort and adaptations to be made. We cannot just continue with the traditional model of care and expect to stay afloat.

How can private practices survive the coming onslaught?

- Perhaps, the most important first step is to know your practice’s finances. Study the accounts receivable and see how you are performing in your billing. If you do not have time to do this yourself, there are many companies out there who will perform a practice analysis for you. Many doctors rely on their billers and office managers to track this information. As the practice owner, you need to know it as well, otherwise you are probably losing money you should be collecting.

- After you evaluate your financials, fix any problems you find. You should be getting paid for almost all of your claims within 30 days. If you are not, find out why and make the necessary changes to ensure that you are.

- After making sure you maximize your reimbursements, review your overhead costs and see where you can make reductions. Don’t just make practice purchases with your usual vendors. Compare costs. Often, the cheapest supplies can be found on Amazon.com, but most physicians don’t think of buying medical supplies there. Also, look into joining a buying group to purchase supplies. These groups are often given discounts.

- Keep up with all the new regulations being passed. To begin with, if you don’t comply with these regulations, you can be fined or face negative adjustments on your payments. Make the necessary adjustments in your practice to avoid these financial losses. A good example is the Meaningful Use program. By participating in this program, doctors not only avoided financial penalties, but they were paid incentives in the tens of thousands of dollars. Don’t leave any money you may be entitled to on the table.

- If you need to purchase an expensive medical instrument, time your purchase right. Many companies will offer better discounts at the end of a quarter. Also, many vendors will tell you that if you don’t buy their product within so many days, you will lose the promotional discount. This simply is not true; they can give you the promotion whenever they like.

- Evaluate your staff. Are you over or under staffed? Watch the work your employees are doing and see where inefficiencies seep in. Angry patients are also a lost revenue to you. Do you have a receptionist that your patients don’t like? As doctors, we are trained to be compassionate. But, as the owner of a business, you need to run it as a business. You should have the right staff doing the right jobs otherwise you stand to lose money.

- Don’t waste money on advertising where it typically doesn’t work, such as newspapers. Look to establish social media presences where you can advertise for free or relatively cheaply.

- Talk with other physicians in your geographic location and you can share stories of what works and what doesn’t. Also, this may help establish coverage for when you need time off rather than paying an expensive locum tenems fill in.

- Consider alternative models of practice, such as Direct Primary Care, where the patient pays the doctor directly with no third-party involvement.

- Evaluate your third parties. Drop those who aren’t paying you well or on time.

Many doctors fear running their own practices, but it is still feasible. In our medical education, we were not taught any business skills and this fact cost many doctors to fail in this regards. We must empower ourselves by gaining this business knowledge and incorporating it into our practices. Using this knowledge and hiring the right people can mean the life or death of a medical practical practice. If more doctors embraced this model of care, we will all become more successful.

- By Linda Girgis, MD

Physicians Practice

www.physicianspractice.com
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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.

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.

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.

Continued on page 5
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.

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.

Involves 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.

- Justin T. Barnes
(404) 538-0707 | @HIAdvisor
This Just In Radio | HIMSS Radio

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.”

Magnolia Minutes

Continued from page 4

JANUARY 2017 | 5
2017 Insurance Forum

Friday, February 10
Belhaven Building, Jackson

Meet the representatives who process your insurance and discuss your issues with them face to face!

Join us as we start off our day with a word from Bob Williams, Director of Life and Health Actuarial. We will then hear from the top MS payers who process your day to day claims. If you have any questions you would like to ask during the forum, please send them to our office at info@mgmams.com so that we may send them to the payers. There will also be time for one on one questions and networking with our payers.

Lunch will be provided.

We will hear from:

- Aetna
- Blue Cross Blue Shield
- Magnolia
- Medicare/Medicaid
- Cigna
- United Healthcare
- Humana

COST: Only $50 for MGMA MS members, $75 non-members.

Join us! Click here to register now

To register multiple attendees, email our office for assistance: info@mgmams.com

2017 Calendar of Events

Visit our website at mgmams.com for event details and registration!

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Member Webinar
Tuesday, January 10
Insurance Forum
Friday, February 10
Member Webinar
Tuesday, February 14

Member Webinar
Tuesday, March 14

Member Webinar
Tuesday, April 11

Member Webinar
Wednesday, May 17

Member Webinar
Tuesday, June 13

Member Webinar
Tuesday, July 11

Member Webinar
Tuesday, August 8

Summer Conference
August 16-18

Member Webinar
Wednesday, October 18

Member Webinar
Tuesday, November 14

Fall Meeting
Friday, November 10

Member Webinar
Tuesday, December 12

Wehirs are FREE for MGMA-MS members!
WEBINAR SCHEDULE

February 14, 12pm

*Developing a Career Plan for Career Change in Healthcare Management*

ABOUT THE WEBINAR:
The webinar will provide a framework of how to create a career plan to establish clear goals when in search of a career change. In addition, you will gain insight to what organizations are seeking in candidates and provide guidance on how to best present yourself through writing an effective resume, networking and interviewing.

March 14, 12pm

*2017 MWG Employer Services HR & Labor Outlook*

This webinar will focus on HR and Labor changes to come with new White House administration:
- Affordable Healthcare Act (Obama Care)
- Immigration Regulations and overview of new I-9 form
- OSHA reporting and requirements
- New EEO reporting requirements and forms

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*Based on data from CMS as of Jan. 2016 for ‘complete’ certification product classification, for Alabama eligible providers in an ambulatory setting.

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ACMPE EXAM ENHANCEMENTS

The American College of Medical Practice Executives (ACMPE) is pleased to announce enhancements to the board certification program as a means to strengthen the recognition of certification in the marketplace.

The enhancements were proposed by the ACMPE Certification Commission, with support from a national certification consultant, and approved by the MGMA Board of Directors. The Certification Commission’s work with the consultant highlighted the psychometric strength of the certification requirements and the examinations process and identified areas of improvement to enhance the program.

These enhancements include:
1. Transition of the essay exam to a scenario-based, objectively scored exam
2. Implementation of an education requirement for entry into the certification program

Crosswalk of changes/Timeline:

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<td>CHANGE - pass scenario-based exam instead of essay exam</td>
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ACMPE FAQs

Examination updates

What specifically is changing and when?

The existing essay exam is being replaced with a new objectively scored examination, which will present the examinee with scenarios, much as our current essay exam proposes a scenario for which the examinee must craft a response. Instead of having the examinee write an essay to respond to the scenario, the examinee will answer 5-7 questions based on the scenario.

The new scenario-based exam will be delivered beginning with the September 2017 exam window. The June 2017 exam window will be the last opportunity to take the essay exam in its current form.

Why change the essay exam?

To align with best practices and standards in the certification industry and to provide a more reliable, valid and psychometrically sound certification program. This change follows careful and extensive consideration of changes recommended by an outside consultant’s review of our certification requirements.

Is the multiple choice exam changing?

No. The multiple choice portion of the examination will remain the same. You must still take and pass the multiple choice exam as part of the board certification requirements.

If I have already taken and passed the essay exam, will I need to also take and pass the scenario-based exam?

No. If you have already passed the essay exam, you do not need to pass the scenario-based exam as well. You will only need to complete those requirements that you have not yet met.

How many questions will I need to answer for the scenario-based exam? How long is the exam?

The scenario-based exam will present examinees with 18-25 scenarios. The scenarios will be real-life situations that you may face as a practice executive. You will be asked to answer five to seven questions in response to each scenario. Examinees will have two hours to complete the exam.

How will the scenario-based exam questions be written and what will constitute a passing grade?

ACMPE is partnering with its examination vendor, Castle Worldwide, to facilitate the exam-writing process. An Exam Development Committee, consisting in part of current and previous Examinations Committee members, will write questions. Castle Worldwide and other volunteer groups will review and validate those questions. A standard-setting study will then be completed to determine the passing point for the scenario-based exam.

Are there any grandfathering provisions?

ACMPE will offer the current essay examination through the June 2017 examination window. Beginning in September 2017, examinees who have not passed the essay exam must take the scenario-based exam.
Education requirement updates

What is the new education requirement for board certification and when does it take effect?
As of Jan. 1, 2019, a bachelor’s degree or the equivalent of 120 college course credit hours will be required to enter the board certification program.

Why implement an education requirement?
An education requirement will take effect in order to elevate the certification and increase its relevance and value in the marketplace.

Will I still be required to demonstrate two years of healthcare management experience?
Yes, the existing eligibility requirements will remain the same. You must still submit a $250 application fee and demonstrate two years of healthcare management experience, including six months of supervisory experience. The education requirement is in addition to these existing requirements.

Are there any grandfathering provisions?
CMPEs and Fellows who do not hold at least a bachelor’s degree (or 120 hours of college course credit hours) will be grandfathered into the change.

I am a nominee who doesn’t have a bachelor’s degree. What do I need to do to become compliant?
Any existing nominees who advance to CMPE status prior to Jan. 1, 2019, will not be subject to the education requirement. Effective Jan. 1, 2019, all nominees will be required to meet the education requirement.

Fellowship requirements

Are the Fellowship requirements affected by this change?
No. The Fellowship requirements will remain unchanged.
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