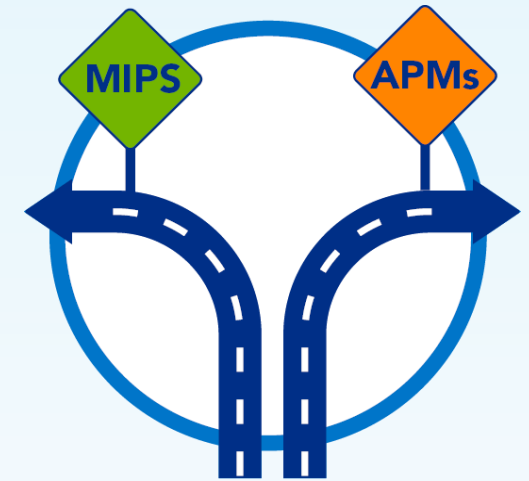




A TALE OF TWO PATHS



This webinar presentation is brought to you by **GUARDIAN**—a robust health information exchange (HIE) clinical integration architecture that drives a comprehensive array of care coordination and care management programs and service delivery platforms, including a CMS approved Qualified Registry for the abstraction, documentation, verification, and reporting of the full spectrum of payment associated quality performance measures identified in the MACRA Quality Payment Program (QPP). Guardian is your dedicated partner in achieving long-term success and independence under MACRA and the every changing value-based healthcare environment.

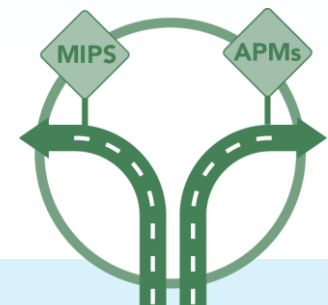


- **What is the QPP? MACRA? MIPS? Etc.**
- **What are the Challenges All Physicians Face**
- **What are the Opportunities Unique to us**
- **How can Guardian assist you in succeeding under MACRA**



What is MACRA?

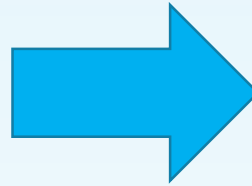
- ✓ The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), commonly referred to as the “Permanent Doc Fix”, is a law that establishes a dedicated route toward new Medicare payment systems that align payment with quality performance and cost efficiency outcomes.
- ✓ Through 2019 there will be a 0.5% annual increase in the physician fee schedule.
- ✓ Any other change in Fee Schedule will be an incentive or penalty



MACRA QPP DIRECTLY IMPACTED CLINICIANS BEGINNING IN 2017—THE TRANSITION YEAR

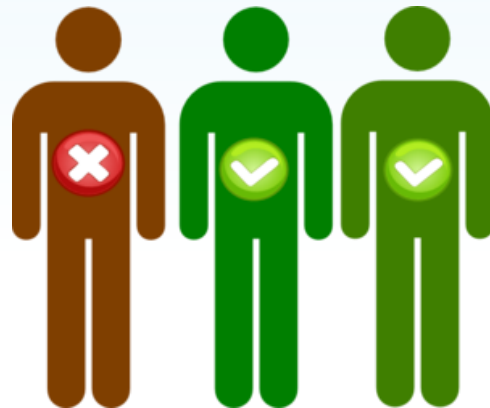
Clinicians subject to MACRA participation in the 2017 Transition Year include:

- ✓ 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 payment year:

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



MACRA QPP EXCLUDED CLINICIANS AS OF THE TRANSITION YEAR-2017

Newly enrolled Medicare Clinicians—Clinicians who are in their first Medicare Part B calendar year.

Clinicians below a Medicare patient volume threshold—Clinicians who:

- ✓ **Have recorded Medicare billing charges of less than or equal \$30,000.**
- ✓ **Providing care to 100 or fewer Part-B enrolled Medicare beneficiaries.**



PHYSICIAN AWARENESS OF MACRA



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.**



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.

Take Action Now!



THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PATH



THE INITIAL STAGING OF MIPS

**FIRST MIPS
PERFORMANCE YEAR
TRANSITION YEAR
2017**

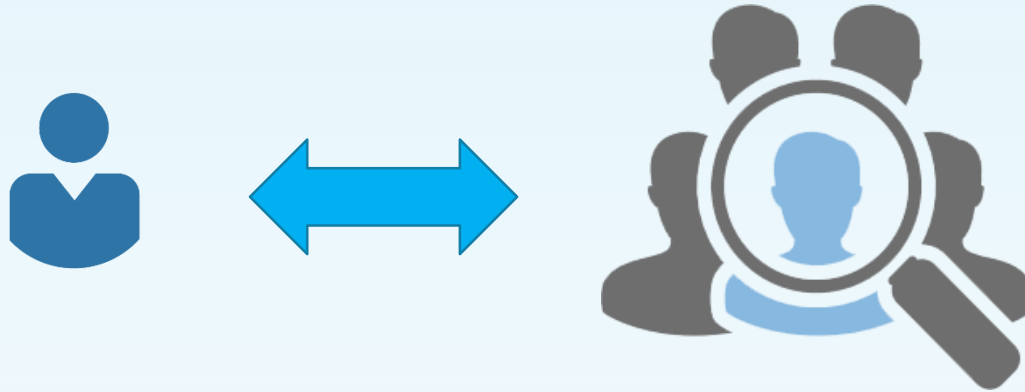
**DEADLINE FOR
SUBMITTING
TRANSITION YEAR
DATA
MARCH 31, 2018**

**CMS PERFORMANCE
FEEDBACK MID TO
LATE 2018**

**MIPS PAYMENT
ADJUSTMENT +/-
BASED ON 2017
PERFORMANCE DATA
JANUARY 1, 2019**



MIPS PARTICIPATION AS AN INDIVIDUAL CLINICIAN OR AS A GROUP OF CLINICIANS?



If you engage as an individual MIPS eligible clinician (identified as a single National Provider Identifier-NPI):

- ✓ Your payment adjustment will be based entirely on your MIPS performance.
- ✓ You will be required to send your individual data for each of the MIPS performance categories via an EHR, and/or a CMS approved Qualified Registry.

If you engage as a group (identified as a set of eligible clinicians with individual NPIs sharing a common Tax Identification Number independent of specialty or practice site):

- ✓ The group will receive one payment adjustment based on the entire group's performance.
- ✓ The group will be required to send group level data for each of the MIPS performance categories through a CMS web interface, and/or EHR, and/or CMS approved Qualified Registry. (NOTE: To submit data through a CMS web interface, the group must register as a group by June 30, 2017.)



THE FOUR PIECES OF THE MIPS PAYMENT PUZZLE— THE MIPS PERFORMANCE CATEGORIES COMPOSITE PERFORMANCE SCORING (CPS) METHODOLOGY

MIPS is composed of the following four distinct Performance Categories.



The MIPS unified scoring system results in the calculation of a **MIPS Composite Performance Score (CPS)** for all MIPS eligible clinicians that represents performance in the four categories on a scale of 0-100 points.

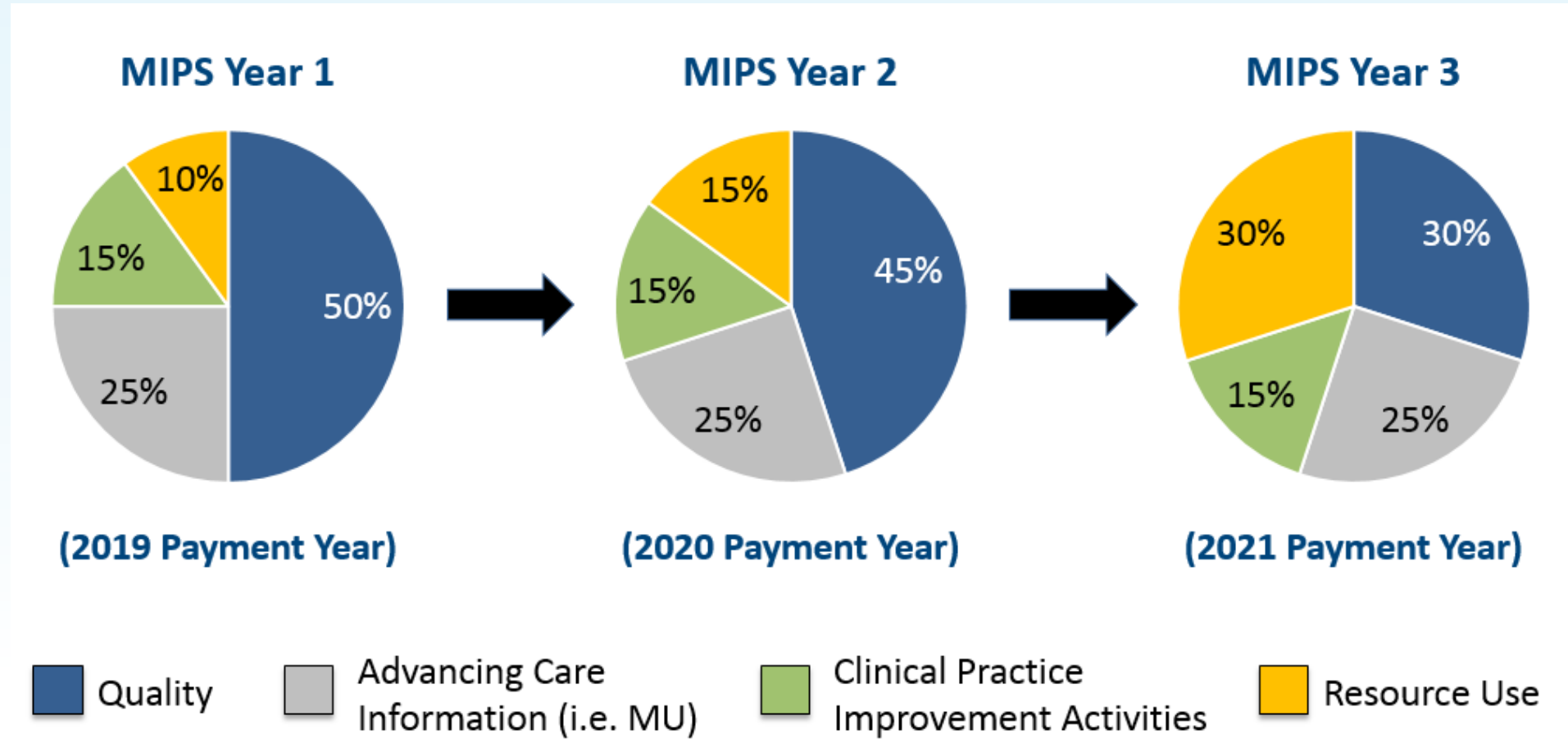
=



MIPS Composite
Performance Score



Each performance category is assigned a weighted value, which can change each performance year.





THE MIPS **QUALITY** PERFORMANCE CATEGORY

The 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.





THE MIPS **QUALITY** PERFORMANCE CATEGORY

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):

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.





THE MIPS **QUALITY** PERFORMANCE CATEGORY

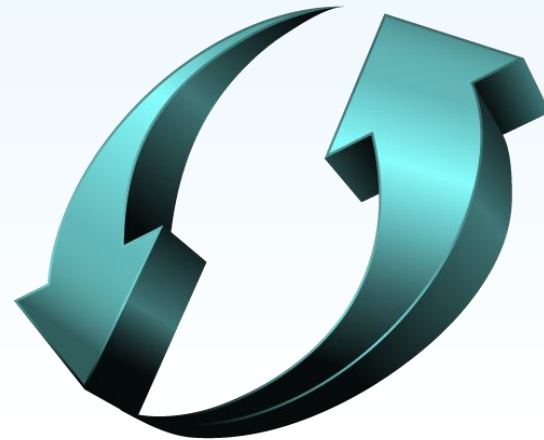
Requirements for MIPS eligible clinicians reporting as a group via a CMS web interface:
(Reporting option for groups of 25 or more)

- ✓ 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).
- ✓ 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.





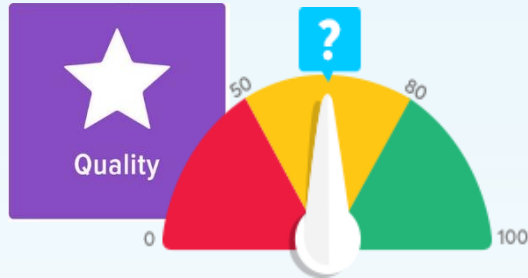
The Quality performance category measures will also be updated annually on or before **November 1st each year.**



Formula:

$$\text{Sum of Points for Individual Quality Measures} \div \text{Total Possible Quality Performance Category Points} = \text{Quality Performance Category Score (\%)}$$

$$\times \text{Weight of the Quality Performance Score in the MIPS Composite Performance Score} = \text{Final Quality Performance Category Score}$$



$$\text{Dr. Jones Earns a Total of 45 Points for 6 measures} \div \text{Total Possible Category Points for Transition Year 2017—60 Points} = \text{Quality Performance Category Score (75\%)}$$

Example:

$$\times \text{60\% Weight in the MIPS Composite Performance Score (CPS)} = \text{Dr. Jones earns 45 points toward his CPS}$$



MIPS RESOURCE USE PERFORMANCE CATEGORY

- ✓ There is no data submission reporting requirement for MIPS eligible clinician under the 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).
- ✓ MIPS 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.





Improvement
Activities

THE MIPS **IMPROVEMENT ACTIVITIES** 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.**





THE MIPS IMPROVEMENT ACTIVITIES



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.





THE MIPS **IMPROVEMENT** ACTIVITIES

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.





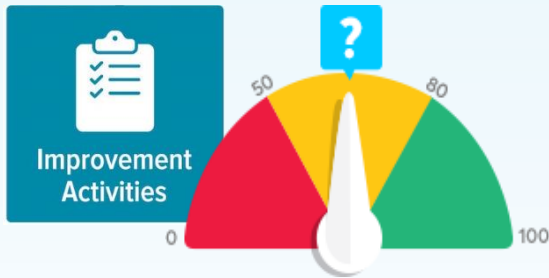
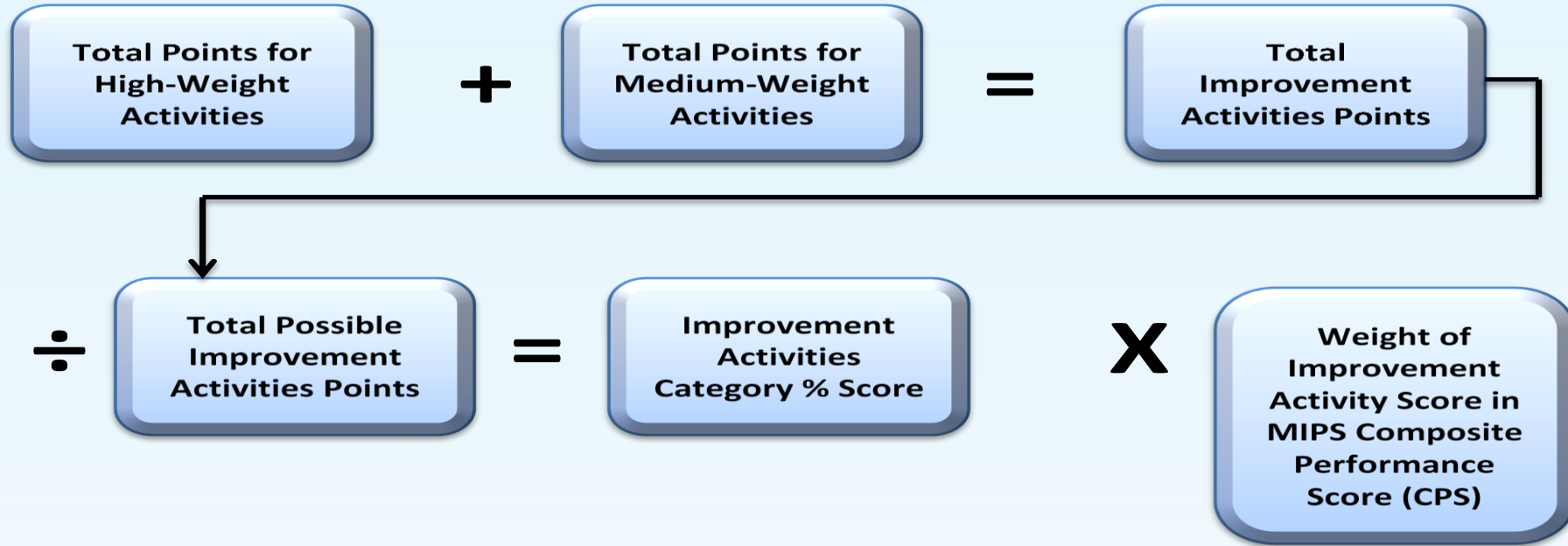
Improvement Activities

THE MIPS IMPROVEMENT ACTIVITIES

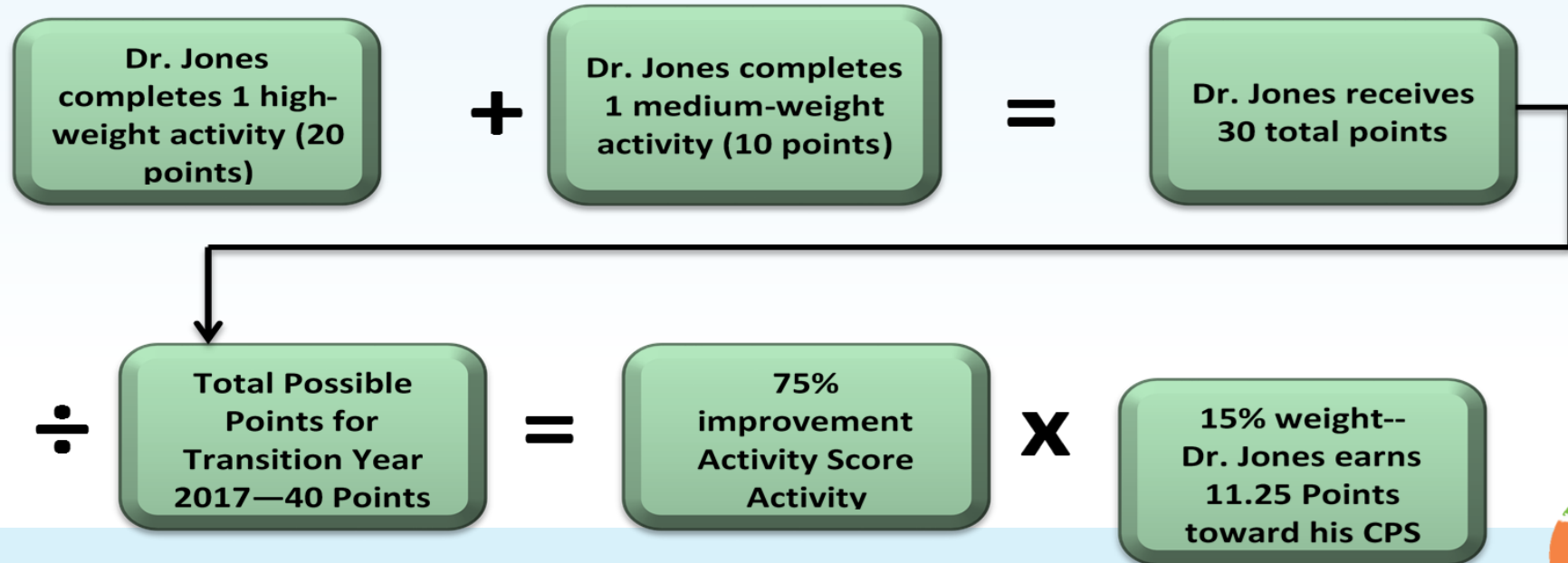
- ✓ Each of the 92 activities groups in the eight sub-categories are scored as High (20 points) or Medium (10 points).
- ✓ For the Transition Year (2017) clinicians are required to attest to performing four medium weighted or two high weighted activities to receive full credit in the Improvement Activity Category.
- ✓ Clinicians participating in a Patient-Centered Medical Home (PCMH) or a MIPS APM (to be discussed later in the presentation) will automatically receive full credit for the Improvement Activities Category. NOTE: If one practice under the TIN has PCMH recognition, the entire TIN will qualify for full points this performance category.



Formula:



Example:





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:

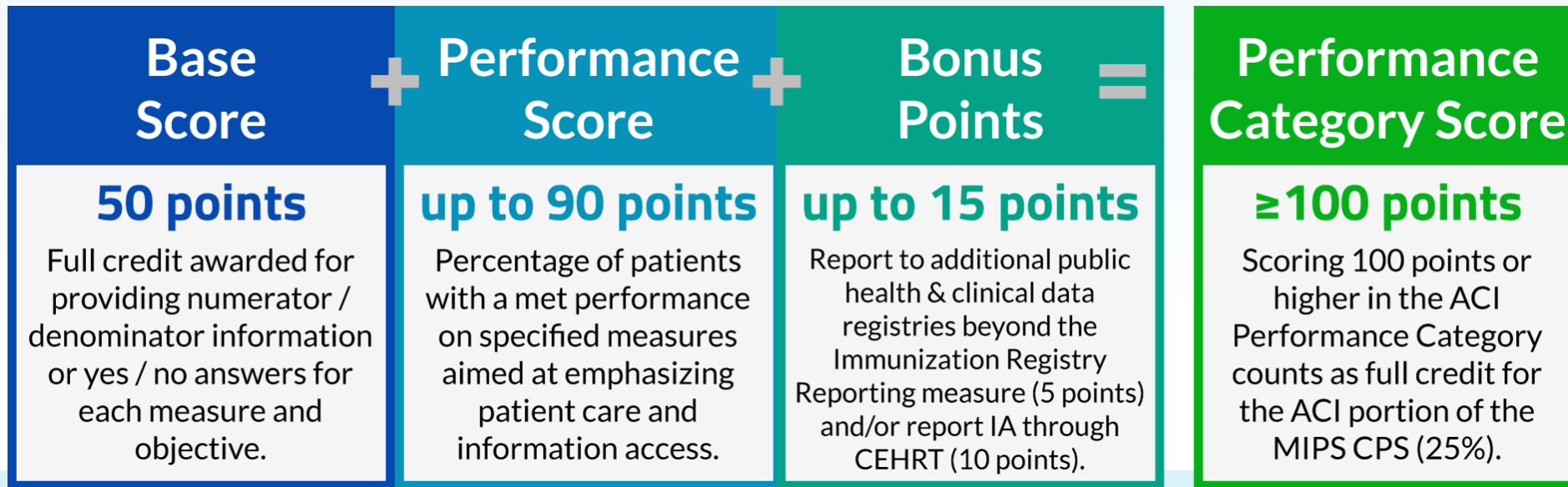
- ✓ The MU is no longer an “all-or-nothing” program. MIPS eligible clinicians must report the base measures, but do not have to report all of the measures available.
- ✓ Removal the MU threshold requirements. MIPS eligible clinicians do not have to meet a certain percentage.
- ✓ Reduced Public Health 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.





THE MIPS **ADVANCING CARE INFORMATION (ACI)** PERFORMANCE CATEGORY

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.





THE MIPS **ADVANCING CARE INFORMATION** **(ACI)** 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 contribute 10 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





THE MIPS **ADVANCING CARE INFORMATION** **(ACI) PERFORMANCE CATEGORY**

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

****NOTE:** The three measures identified in red 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.





THE MIPS **ADVANCING CARE INFORMATION** **(ACI)** PERFORMANCE CATEGORY

#	PERFORMANCE OBJECTIVE*	PERFORMANCE MEASURE	POTENTIAL %--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





Advancing Care
Information

THE MIPS **ADVANCING CARE INFORMATION** **(ACI)** PERFORMANCE CATEGORY



Bonus score
(up to 15%)

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. Provider 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.

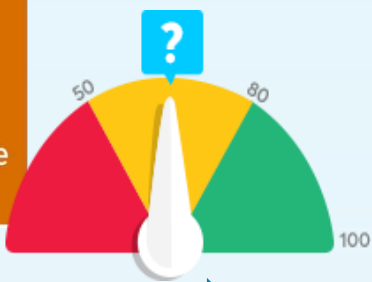




THE MIPS **ADVANCING CARE INFORMATION (ACI)** PERFORMANCE CATEGORY

ACI measures can be reported via EHR, Qualified Registry (QR), Qualified Clinical Data Registry (QCDR), and attestation. 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., Qualified Registry)**





$$\begin{matrix} \text{Base Score} & + & \text{Performance Score} & + & \text{Bonus Score} & = & \text{Total Provider ACI} \\ \text{50 Points} & & \text{Maximum 90} & & \text{Maximum} & & \text{Performance} \\ & & \text{Points} & & \text{15 Points} & & \text{Category Points} \end{matrix}$$

Formula:

$$\frac{\text{Total Possible ACI Performance Category Points}}{\text{Total Possible ACI Performance Category Points}} \times \text{Weight of the ACI Performance Category Score in the MIPS Composite Performance Score} = \text{Provider Final ACI Performance Category Score to be added to Provider's MIPS CPS}$$

Example:

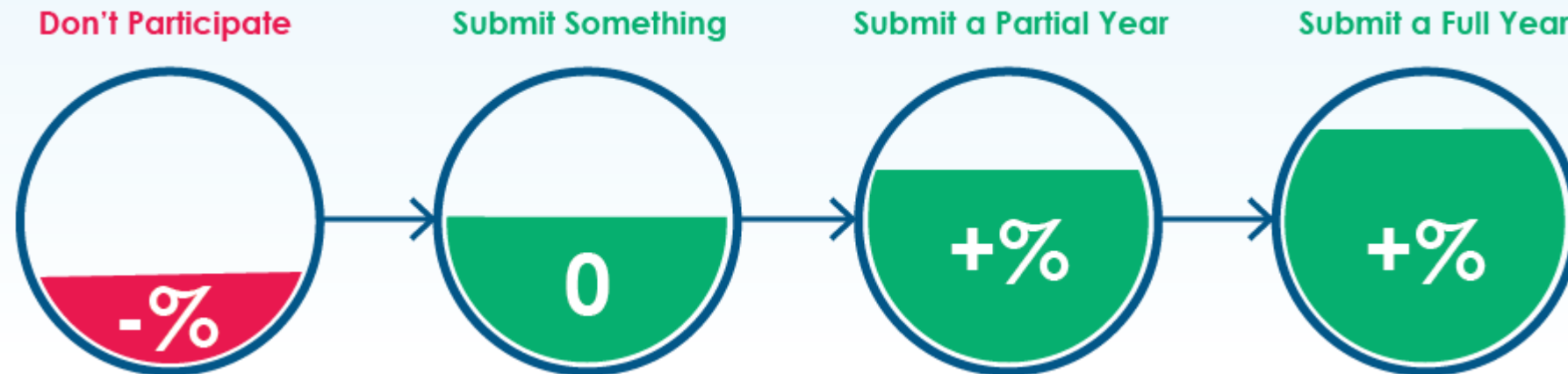
$$\begin{matrix} \text{Earns 50} & + & \text{20 Performance} & + & \text{5 Bonus} & = & \text{Dr. Jones Total ACI} \\ \text{Base Points} & & \text{Score Points} & & \text{Score Points} & & \text{Performance} \\ & & & & & & \text{Category Score is} \\ & & & & & & \text{75} \end{matrix}$$

$$\frac{\begin{matrix} \text{Total Possible ACI} \\ \text{Points for 2017} \\ 100 \\ 75 \div 100 = .75 \text{ or} \\ 75\% \end{matrix}}{\text{Total Possible ACI Points for 2017 100}} \times \begin{matrix} \text{Weight of the ACI} \\ \text{Performance Category Score} \\ \text{(25\%)} \\ .75 \times .25 \end{matrix} = \begin{matrix} \text{Dr. Jones Final ACI} \\ \text{Score (points) to} \\ \text{be added to his} \\ \text{MIPS CPS is 18.5} \end{matrix}$$

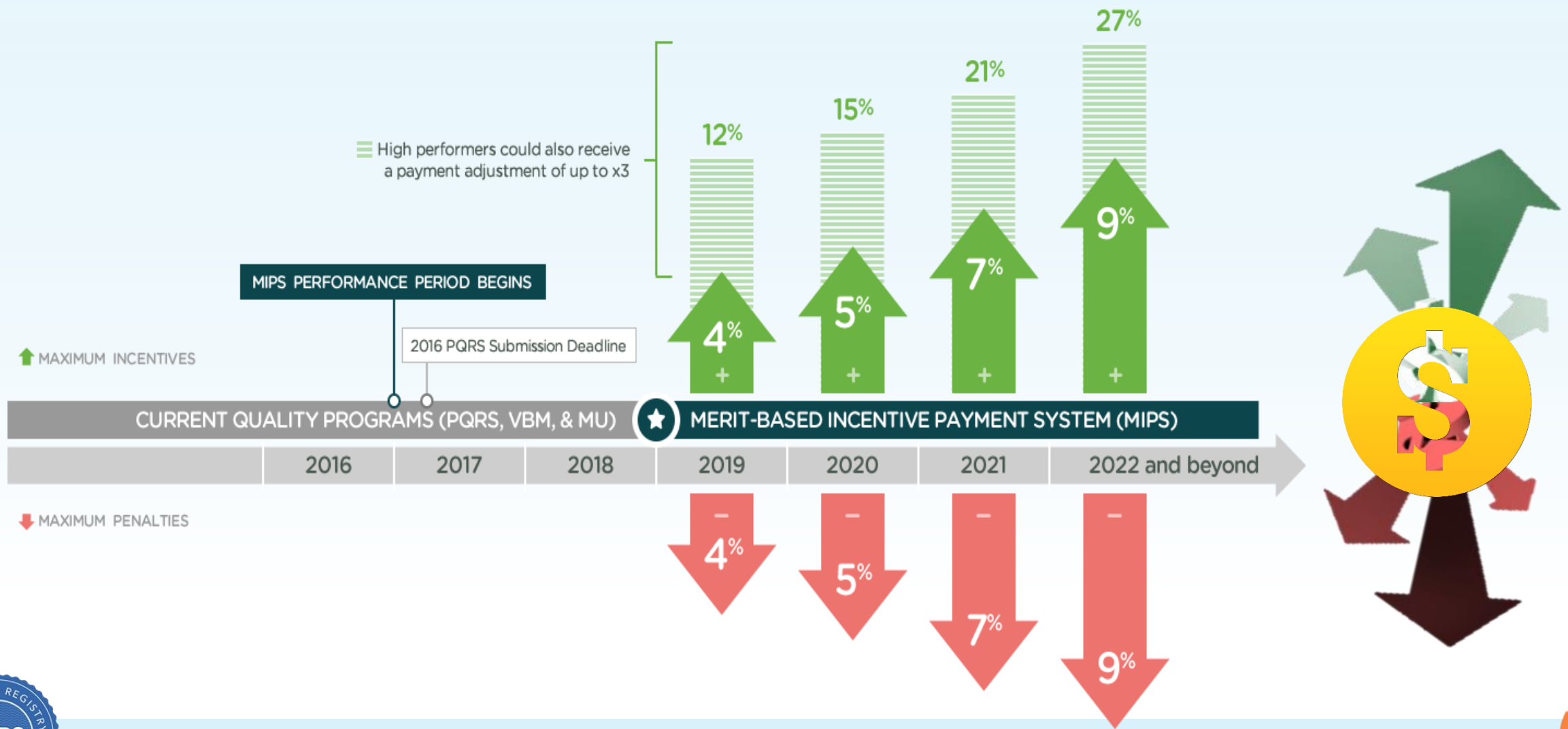


MIPS “PICK YOUR PACE” OPTIONS FOR THE 2017 TRANSITION YEAR

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



MIPS ECONOMICS—**NEGATIVE**/**POSITIVE** PAYMENTS AND INCENTIVES OVER TIME





MIPS PERFORMANCE TRANSPARENCY

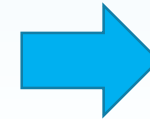
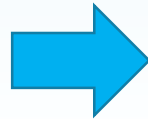
- ✓ MIPS performance carries with it potential **positive** or **negative** consequences for an MIPS eligible clinician's reputation.
- ✓ Within approximately 12 months of the end of a performance period, CMS will publish each provider's MIPS score and component category scores to the Physician Compare website.
- ✓ For the first time, 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.





MIPS PERFORMANCE TRANSPARENCY

- ✓ 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.
- ✓ 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.



THE ALTERNATIVE PAYMENT MODELS (APMs) PATH



What is an APM?

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.



What is an AAPM?

Advanced APMs are a subset of APMs, and let practices earn more for taking on some risk related to their patients' outcomes. You may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM.

The criteria for an Advanced Alternative Payment Model in the QPP include:

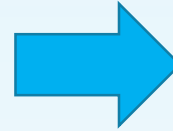
- ✓ The APM is a CMS Innovation center model, or a select CMS Innovation Center Shared Saving Program track.**
- ✓ The APM Require participants to use CEHRT.**
- ✓ The APM reports and bases payments for services on quality measures comparable to those in MIPS.**
- ✓ The APM is a Medical Home Model expanded under the Innovation Center authority OR the APM requires participants to bear more than nominal financial risk for losses.**



MACRA QPP DIRECTLY IMPACTED CLINICIANS BEGINNING IN 2017—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)



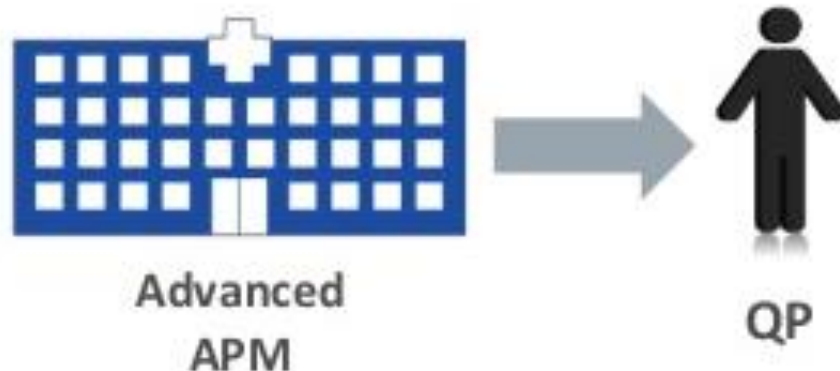
Benefits of being in an AAPM



QUALIFYING PARTICIPANT (QP) IN A CMS ELIGIBLE ADVANCED APM

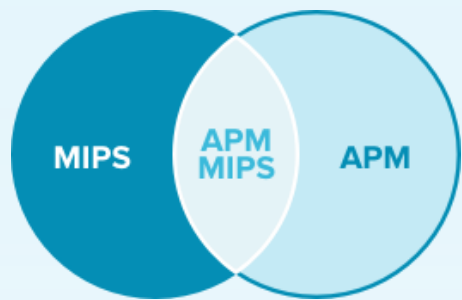
A provider's QP status is determined by his or her participation in a CMS approved Advanced APM entity that **collectively** meets the following revenue **or** patient thresholds for the QPP transition year (2017):

- ✓ **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.



Minimum % of patients/payments
through Advanced APM

Lower % for medical home APMs (CPC+)



STRADDLING THE MIPS AND ADVANCED APM PATHS—THE MIPS APM

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.



A UNIQUE OPPORTUNITY ON THE HORIZON

- ✓ On December 20, 2016 CMS announced a new Innovations Center Model—The Medicare Accountable Care Organization (ACO) Track 1 + Model.
- ✓ This new model incorporates limited downside risk 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 Payments under the MACRA



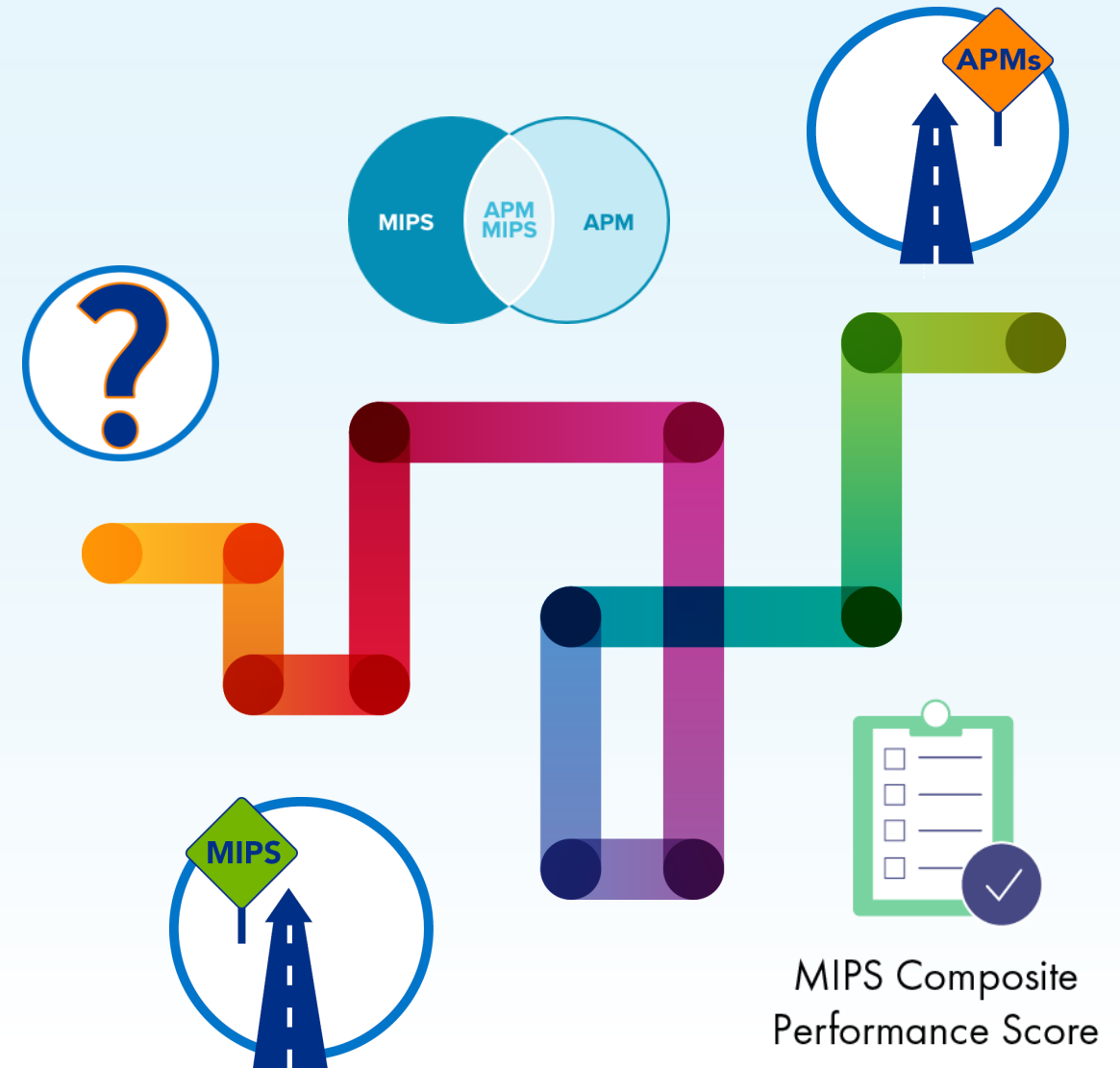
THE TRACK 1+ ACO MODEL:

- Prospective beneficiary assignment
 - 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.
 - ✓ FACS is Morphing for a Track 1+ ACO for Increased QPP Bonuses



THE FACTS--

- ✓ The challenges of MACRA and the payment paths under the Quality Payment Program (QPP) are real and upon us.
- ✓ To survive and flourish under the MACRA QPP clinicians/practices must commit and be connected.
- ✓ Impacted clinicians must be able to align their practice with technology that provides interoperability, the edge to engage in real-time clinical integration, care coordination, and care management, and an efficient avenue for compliant documentation and reporting to CMS across the four performance categories.



THE FACTS--

- ✓ In a July 23, 2016 article in Modern Healthcare, entitled, *With MACRA Looming, Doctors Can't Wait 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.
- ✓ The challenge is not simply to survive, but rather to thrive.



THE SOLUTION:



Guardian and Guardian Care Management 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, Clinically Integrated, interoperable and customized for you
- ✓ Operates at an enterprise-grade level of functionality
- ✓ Secure and Easy to use, it provides fast-track implementation for clinicians/practices
- ✓ Designed to ensure compliance with all documentation and reporting requirements of the QPP - MIPS

