THE REIMBURSEMENT SHIFT: PREPARING YOUR PRACTICE FOR PATIENT-CENTERED PAYMENT REFORM

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TODAY'S PRESENTERS

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Your phone has been automatically muted. Please use the Q&A panel to ask questions during the presentation!
AGENDA

• Healthcare yesterday & today
• Accountable Care Organizations
• Patient Centered Medical Homes
• Bundled Payments
• Quality Measure Programs

FOR EACH REFORM MODEL:

• Program definition
• Current status
• How can this help your organization?
• Key things to know
• How can Galen help?
HEALTHCARE – WHERE WE ARE NOW AND HOW WE GOT HERE
Facts that Illustrate the Problem

• U.S. Infant Mortality Rates (2011) – 6.07 per 1,000 live births
  • 26th out of 29 OECD (Organisation for Economic Co-Operation and Development) Countries
  • Top 2 countries: Japan and Finland have Infant Mortality rate of 2.3 deaths per 1,000 live births.

• U.S. Life Expectancy (2011) – 78.49 years
  • 50th in the world

• U.S. Healthcare Expenditures
  • $8,508 per capita
  • 17.7% national Gross Domestic Product (GDP)

• Other Countries
  • The next closest country spent 11.9% of its GDP on health care
  • OECD average - $3,322 per capita
Why do we spend more and get less?

• The Acute treatment paradigm
  • Disregards preventive medicine
  • Chronic illnesses have become epidemic

• Overutilization
  • Duplication of services
  • Lack of financial risk

• Fragmentation of Care

• Fee-For-Service (FFS)
  • Payment for each discrete service provided
  • Rates determined based on what is Usual, Customary and Reasonable
  • No incentive to provide efficient care or avoid unnecessary care
Where are we headed?

• Exploring opportunities to control cost via Value-Based Care Reimbursement models

• Healthcare Reimbursement/Payment Reform
  • Accountable Care Organizations
  • Patient Centered Medical Homes
  • Bundled Payments
  • Quality Measure Programs
ACCOUNTABLE CARE ORGANIZATION (ACO)
Accountable Care Organizations (ACOs)

What is it?

- Accountable Care Organization (ACO)
  - Entity for organizing and aligning healthcare services

- Reward providers that meet performance standards on quality of care while constraining healthcare costs

- Eligible providers, hospitals, and suppliers participate in the Medicare Shared Savings Program through an Accountable Care Organizations (ACOs)
How are ACOs paid?

- Bonuses for keeping costs down
- Benchmarks and quality performance measures linked to financial savings
- CMS’s Medicare Shared Savings Program
  - One-sided model: Share in savings only
  - Two-sided model: Share in savings and losses
What does this mean for you?

• Participating in an ACO is voluntary

• Apply to CMS to become a Medicare ACO

• ACO responsible for patient-centered focus
  • Evidence-base medicine
  • Patient engagement
  • Report on quality, costs and coordination of care
How can you prepare?

- Keep abreast of trends in outcome base payment models
- Streamline current billing systems
- Develop relationships early with potential ACO partners
- Analyze readiness to become an ACO
  - Improving care delivery
  - Improving population health
  - Reducing growth in costs
- Support provider transition to new payment models
PATIENT CENTERED MEDICAL HOMES (PCMH)
What is a PCMH?

- A team-based model of care led by a personal physician who provides continuous and coordinate care throughout a patient’s lifetime to maximize health outcomes

- Characteristics:
  - Physician-directed team-based medical practice
  - Whole person orientation
  - Coordinated and/or integrated care
  - Quality and safety
  - Enhanced access
  - Payment
What does this mean for you?

- **Recognition Process**
  - Quality, effective, efficient healthcare delivery
  - Payment incentives

- **Benefits**
  - Reduction in overall costs and spending
  - Improved patient outcomes
  - Investments offer short and long term savings

- **Cost**
  - Practice size
  - Existing practice capabilities
  - Costs required to become a qualified PCMH
  - Availability of subsidized practice and patient-support services
  - Characteristics of the patient population
# Why the Medical Home Works: A Framework

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| Patient-Centered         | Supports patients and families to manage & organize their care and participate as *fully informed partners* in health system transformation at the practice, community, & policy levels | • Dedicated staff help patients navigate system and create care plans  
• Focus on strong, trusting relationships with physicians & care team, open communication about decisions and health status  
• Compassionate and culturally sensitive care | Patients are more likely to seek the right care, in the right place, and at the right time |
| Comprehensive            | A team of care providers is wholly accountable for patient’s physical and mental health care needs – includes prevention and wellness, acute care, chronic care | • Care team focuses on *whole person* and *population health*  
• Primary care could co-locate with behavioral and/or oral health, vision, OB/GYN, pharmacy  
• Special attention is paid to *chronic disease* and complex patients | Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated |
| Coordinated              | Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health | • Care is *documented and communicated* across providers and institutions, including patients, specialists, hospitals, home health, and public health/social supports  
• Communication and connectedness is enhanced by *health information technology* | Better management of chronic diseases and other illness improves health outcomes |
| Accessible               | Delivers *consumer-friendly services* with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations | • More efficient appointment systems offer *same-day* or *24/7 access* to care team  
• Use of *e-communications* and *teledicine* provide alternatives for face-to-face visits and allow for after hours care | Focus on wellness and prevention reduces incidence/severity of chronic disease and illness |
| Committed to quality and safety | Demonstrates commitment to quality improvement through use of *health IT* and other tools to ensure patients and families make best use of health care resources | • EHRs, clinical decision support, *medication management* improve treatment & diagnosis.  
• Clinicians/staff monitor *quality improvement goals* and use data to track populations and trends | Cost savings result from:  
• Appropriate use of medicine  
• Fewer avoidable ER visits, hospitalizations |
How can you prepare?

• Understand the recognition process
• Assess the readiness of your practice
• Allow time for the recognition process
• Organize the project teams
• Learn from others
BUNDLED PAYMENTS

• Comprehensive Care for Joint Replacement (CCJR)
What is a Bundled Payment?

The Goal of bundled payments is to “align the financial incentives of hospitals and surgeons around the common goal of coordinating care and improving quality and cost-efficiency.”

“The essence of this new approach does not rest in how we get paid for the product but rather in how we define the product for which we expect to get paid.”

-Froimson et al., 2013
Overview

Comprehensive Care for Joint Replacement (CCJR)

What is it?

“The Centers for Medicare & Medicaid Services (CMS) is proposing, through the notice and comment rulemaking process, a new model to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR). This model, called the Comprehensive Care for Joint Replacement Model, would test bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.”
Why & how did this program come about?

- Quality of care, readmission due to complications, & procedure costs vary greatly amongst providers & geographical areas, up to 3x higher in some areas

- CMS expects to save $150+ million on these procedures, by incentivizing increased coordination of care amongst caregivers

Most common surgeries

400,000 procedures = $7+ billion in hospitalization
How does it work and what does this mean for you?

- Starts on 4/1/2016 and to run for 5 years
- Focused regions - 67 Metropolitan Statistical Areas (MSAs) only
  - List of participants can be viewed on the innovation.cms.gov website
  - Hospitals paid under Inpatient Prospective Payment System (IPPS) and located in the proposed MSAs are required to participate in CCJR

- First 90 days post procedure (inpatient, outpatient, facilities - will need to coordinate care)!!!!

- All providers will be paid under the normal Medicare payment system throughout the year.

- Compile results at end of each year from initial pilot group
How can you prepare?

• Analyze current post-acute spending
• Standardize protocols
• Evaluate existing staff
• Assess the technological capabilities of your organization.

Technology

• Analyze risk
• Customize care plans
• Alerts for patients falling off-plan
• Communicate with partners no matter what EHR they use
• Engage patients
• Reporting
QUALITY MEASURE PROGRAMS

- Medicare CCM
- PQRS
- MU
- HEDIS
Medicare CCM - What is it?

- Started in 2015
  - **Non-face-to-face** care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.
  - CPT 99490 is defined as follows:
    - At least **20 minutes, per calendar month**
    - **Multiple (two or more) chronic conditions** expected to last at least 12 months, or until the death of the patient
    - Chronic conditions pose significant risk to patient
    - Comprehensive care plan established, implemented, revised, or monitored.
Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart failure
- Hypertension
- Ischemic heart disease
- Osteoporosis
Chronic Care Management (CCM)

Who is eligible to participate in CCM?

- Physicians
- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

2/3 of Medicare beneficiaries had 2 or more chronic conditions

About 1/3 had 4 or more chronic conditions

Source: [http://www.cdc.gov/pcd/issues/2013/12_0137.htm](http://www.cdc.gov/pcd/issues/2013/12_0137.htm)
Chronic Care Management (CCM)

Comprehensive Care Plans Typically Include:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice will be directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan
Chronic Care Management (CCM)

Key Things to Know

• CPT code 99490 reimbursement averaged $42.60
• Must have patient’s written consent
• Only **one** clinician can furnish and be paid for CCM services during a calendar month.
• Copayments (coinsurance and deductibles) **DO** apply.
• Certain codes **cannot** be billed during the same month as CCM:
  • Transition Care Management (TCM) – CPT 99495 and 99496
  • Home Healthcare Supervision – HCPCS G0181
  • Hospice Care Supervision – HCPCS G9182
  • Certain ESRD services – CPT 90951-90970
• Time for other E&M/procedural services can **NOT** be counted toward the 20 minutes.
Healthcare Effectiveness Data and Information Set (HEDIS) – What is it?

- Originated in the late 1980s and entrusted to NCQA in the early 1990s
- NCQA – National Committee for Quality Assurance
- Utilized by more than 90% of America’s health plans
- HEDIS allows for the performance of health plans to be compared
How does it work/Key things to know

• Consists of 81 measures across 5 domains of care:
  • Effectiveness of Care
  • Access/Availability of Care
  • Experience of Care
  • Utilization and Relative Resource Use
  • Health Plan Descriptive Information

• Measures are added, deleted and revised annually

• All HEDIS results must be audited by an NCQA approved firm for public reporting

• NCQA utilizes Quality Compass for on-line reporting
Physician Quality Reporting System (PQRS)

Physician Quality Reporting System (PQRS) – What is it?

• Quality reporting program that encourages individual eligible professionals and group practices to report information on the quality of care to Medicare

• Formerly known as PQRI

• Starting in 2015, PQRS moved from an incentive program to a penalty one
  • **Negative** payment adjustment to individual eligible professionals (EPs) and PQRS group practices now in effect
Physician Quality Reporting System (PQRS)

How does it work?

- Individual Eligible Providers choose at least
  - 9 individual measures
  - Across 3 National Quality Strategy domains
    - Communication and Care Coordination
    - Community/Population Health
    - Effective Clinical Care
    - Efficiency and Cost Reduction
    - Patient Safety
    - Person & Caregiver-Centered Experience and Outcomes
  - For at least 50% of Medicare Part B patients
  - Also required to report one cross-cutting measure if they have at least one Medicare patient with a face-to-face encounter
Meaningful Use (MU)

Meaningful Use – What is it?

- Health Information Technology for Economic and Clinical Health (HITECH) Act
- Led by CMS and the ONC
- The concept of meaningful use rested on the '5 pillars' of health outcomes policy priorities
  - Improving quality, safety, efficiency, and reducing health disparities
  - Engage patients and families in their health
  - Improve care coordination
  - Improve population and public health
  - Ensure adequate privacy and security protection for personal health information
What is new?

- Now possible to be **penalized** for failure to demonstrate meaningful use
- 90-day reporting period for MU 2015, both Core and Clinical Quality Measures
- Patient Access – Only one patient is required to view, download, or transmit his/her information during the reporting period. Previously, it was 5% of patients
- Secure Messaging – Clinicians only need to demonstrate the ability to generate secure messaging
- Single set of ten (10) objectives for all EPs regardless of Stage
- No Menu objectives to select from in the Modified Stage 2 objectives
Meaningful Use (MU)

What goes?
- Record demographics
- Capture vitals
- Smoking status
- Provide clinical summaries
- Lab Results
- Generate patient list
- Patient reminders

** Some of these may still be need to be reported on for PQRS and/or MU Clinical Quality Measures**
What stays?

- Protect Patient Health
- Clinical Decision Support
- Computerized Provider Order Entry
- Electronic Prescribing
- Health Information Exchange
- Patient Education
- Medication Reconciliation
- Patient Electronic Access
- Secure Messaging
- Public Health Reporting
HOW CAN GALEN HELP?
How Galen Can Help?

• Professional Services
  • Assessing which payment reform model is best for you
  • Configuration of quality measures
  • Training/education of team and end-users
  • Staff utilization assessments
  • Development of care teams

• Technical Services
  • Custom reporting
  • Integration
  • Data warehouse development for quality reporting

• Products
  • Pinpoint
  • Noteform reporting
  • eCalcs
References

Accountable Care Organizations
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-in-Your-State.html
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html

Patient Centered Medical Homes
http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
https://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home
https://www.pcpcc.org/resource/infographic-why-medical-home-works#sthash.j4FDQmPR.dpuf

CCJR
https://innovation.cms.gov/initiatives/cjr

CCM

Galen Resources
Questions/Comments?

Email: transformation@galenhealthcare.com
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