IMPACT
MEDICAL CONSULTING

Strategies to Secure, Manage and Optimize the Newer Revenue Streams:

Value Based Compensation

FACULTY and PLANNERS' DISCLOSURE

Debbie Goodman, Pamela Miller, Sheila Sylvan

IMPACT! Medical Consulting

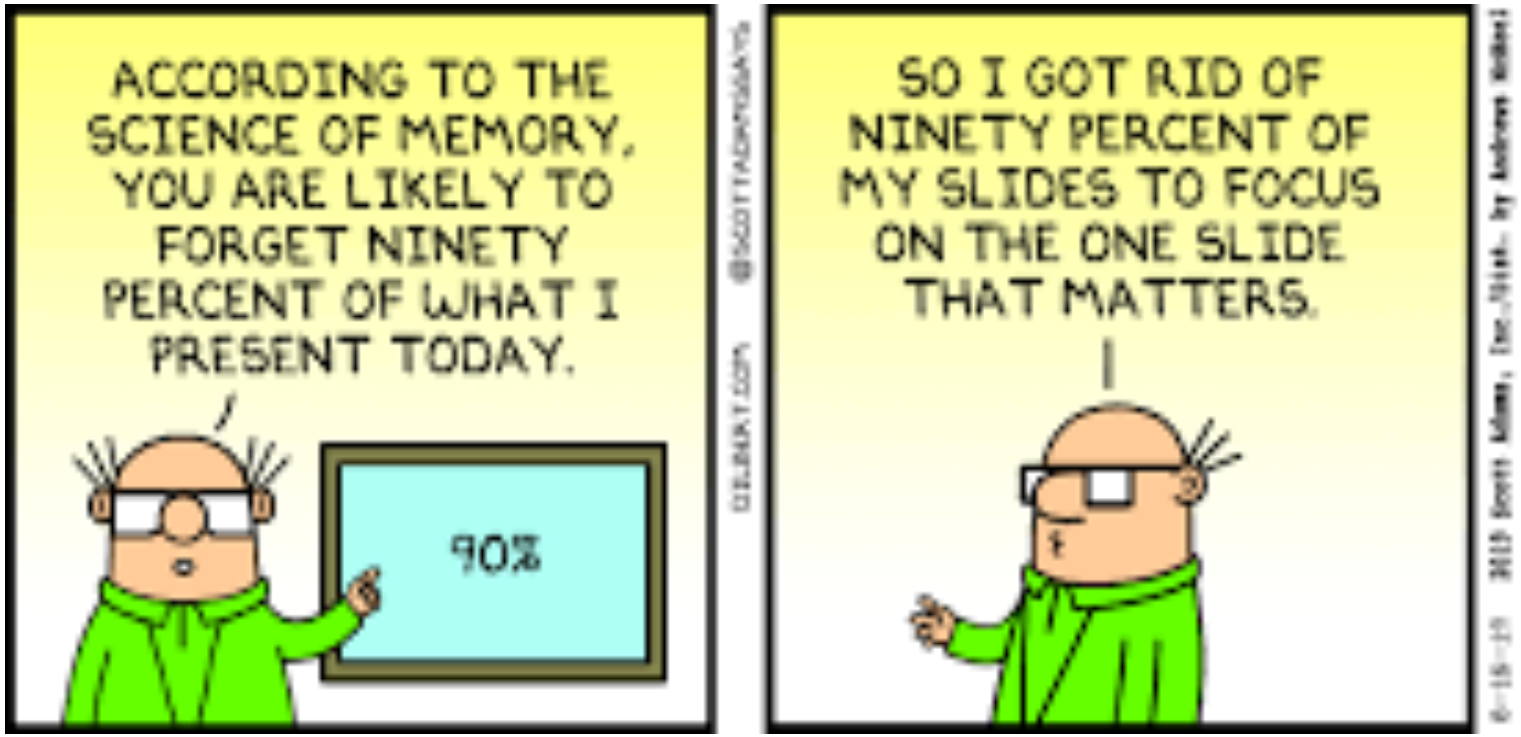
Have no relevant financial relationships with commercial interests

Business As Usual

Fee For Service (FFS) World:

- Co-Pays and Co-Insurance
  - Collect at check-in
  - Collect at check-out
- Bill the payor
  - Pursue unpaid / denied claims as needed
- Statement the balance
  - Payment plans if needed
  - Attention to small balances & indigent write off if / as needed on a case by case basis.

Business As Usual



New Value Based Models Have Varying Components in Which to Engage and Monitor

The new payment models are ever evolving and are here to stay. They will continue to increase, becoming a notable portion of income to the practice.

One must understand the model for each value based carrier agreement in order to plan and update internal operations.

Plan - Train – Monitor - Adjust as needed

Revenue Opportunities Through Value-Based Agreements

- **Enhanced Fee-for-Service Rate** for Overall Population Health Management.
- **Fee-for-Service Payment for Cost-Containment Services** – reimbursement for special services, such as for "after hours" service codes.
- **Additional revenue for Health Status Information / Required Health F**orms -- may include submission timeline or volume benchmarks.
- **Care Management Fee** -- usually in the form of a "per member per month" (PMPM) amount, sometimes adjusted based on patient health status (HCC score/value).
- **Pay for Performance Bonus** -- bonus program for meeting select Healthcare Effectiveness Data and Information Set (HEDIS measures),or assisting in closing care gaps (Gap Closure).
- **Bundled Payments** – procedure / disease specific
- **Patient-Centered Medical Home (PCMH) Incentive** -- if a practice is PCMH, additional monies can be available depending on level of certification. May apply just to practice or to group as a whole.
- **Shared Savings**

Tracking Each Agreement

- Are there outside reports from other sources?
  - How often should you receive these, and from whom?
- Should you create internal tracking reports?
  - What kind – who runs them – how often?

- Are there special CPT or HCPCS codes?
- Are there special ICD-10-CM codes?

- How can I track incomplete information or errors to be corrected?
- Does your EHR have a dashboard? Have you updated it to meet the measures that matter to your practice?

- Who is checking weekly, or monthly for errors? How?

- If outsourcing your billing – how are you checking that extra codes are used?
- If outsourcing your billing – what additional reports, if any, are you requesting?

Make Sure You Know What You Are Entitled To!

Some programs have 4 different revenue streams:

- Regular FFS
- Additional $$ for accurately completed form submission
- Additional $$ for meeting volume benchmarks for completed form submissions
- Additional $$ for HEDIS measure completion

Case Management PMPM Payments

PMPM - Per Member Per Month

- You may be receiving a PMPM for more than one agreement model.
  - **Part of a bonusing program** - Its intended purpose is to assist practices with the overhead cost of administering the cost savings program. The PMPM will potentially be eliminated if the practice does not meet certain performance standards over a period of time.
  - **Fully capitated agreement** – CMS has proposed some new payment models to be considered in the near future that are capitated agreements.

Low Hanging Fruit

Value Based Agreements (VBAs) tend to have a "carrier version" of HEDIS (**H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et) measures built into their programs - often referred to as:

- Care Gaps
- Quality Measures
- Star Measures

This is an important component of the "Triple Aim:"

- Improving the health of the population
- Reducing the per capita cost of care
- Improving the patient experience of care

Use of HEDIS Measures Vary Between Carriers

Some carriers pay for completion of measures at a fixed (additional) reimbursement rate per service, such as the Medicaid Care Management Organization Wellcare, for services such as:

- Annual preventive Exam
- Colon CA screening
- Flu Vaccine
- Controlled High Blood Pressure
- Controlled A1c

These are disbursed on a monthly basis with an increase incentive for completing certain percentages throughout the calendar year reconciled annually.

Varied Use of HEDIS Measures Continued …

Medicare has linked successful performance in completing their defined Quality Measures to its FFS provider fee schedule.

- Under the Quality Payment Program (QPP), the Merit-Based Incentive Payment System (MIPS) requires reporting for qualified clinicians in order to avoid a reduction in the overall practice fee schedule. The process includes a small reward system by experiencing no reduction in FFS payment, and a possible increase based on overall performance, which is evaluated and scored annually.

Varied Use of HEDIS Measures Continued …

- Under the Quality Payment Program, if the practice does not report under MIPS it may choose to report under an Alternative Payment Model (APM). Examples are:
  - MIPS APM
    - (i.e., Medicare Shared Savings Program (MSSP)
  - Advanced APM
  - All Payor Advanced APM
  - Other models – such as Next Generation & Pioneer

Varied Use of HEDIS Measures Continued …

APMs such as the Medicare Shared Savings Program (MSSP) use the program quality score as part of the formula to calculate the earned bonus – only after shared savings are achieved. While quality measures are extremely important - program cost savings must be earned.

(That bears repeating!)

Why Let Low Hanging Fruit Die on the Vine?

Easy to implement operational tasks can assist in capturing some revenue streams.

- Access web portal reports no less than monthly to evaluate plan identified care that's needed, and part of the program. (This is your HEDIS measures, Quality Measures, Care Gaps.)
- If a patient is on YOUR list, he/she is more than likely NOT on another practice's list, based on how most commercial programs assign attribution.
- Actively engage in contacting the patients to encourage an office visit with the correct provider.
  - Most people work during the day and are not at home to receive a call - USE the computerized re-call system – this is not an appointment reminder. This function is for services identified yet there is no appointment scheduled.

BCBS / Anthem

- Their Enhanced Personal Health Care (EPHC) program uses HEDIS measures selected for their program as a “Quality Gate.”
- The organization must meet certain % of each quality metric to pass the established “Quality Gate” before being considered for a payout under the program.

BCBS / Anthem Continued…

Access web portal hospital admission and ER reports weekly.

- If an ER or hospital event occurred, contact the patient and schedule a follow up appointment.

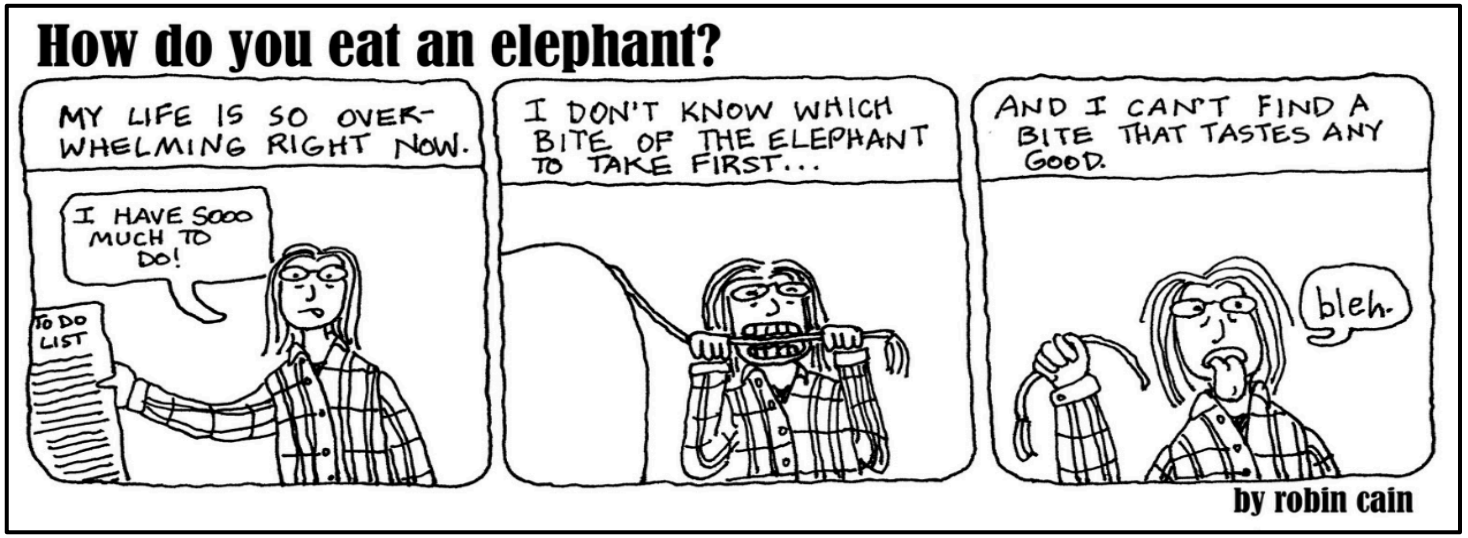
Should a provider office wait for the patient to call, or contact you if a follow-up is needed? It depends on the reason for the ER or hospital event.

- If the patient was seen for one or more chronic conditions it adds to the patient's risk score. Providing care for the patient more frequently in the office potentially drives down cost, increases patient compliance, while also increasing overall patient satisfaction. Reduction in readmission rates have a significant impact on cost savings in many programs.

More Low Hanging Fruit - Ensure Your Patients Are Properly Risk Adjusted!

- Your patients may not be risk adjusted properly, and therefore appear more expensive than others.
- The provider subsequently appears more expensive in the management of a patient. Remember, one of the categories under MIPS and within other programs is “Cost”.
- Many payors use this data within their STARS / HEDIS Programs. Cost effective providers are highlighted in various ways within the plans’ marketing strategies. Bonusing opportunities may be available.
- Each provider enrolled in one or more of the programs through an ACO or large group affects the overall score - individual activity impacts the performance score of colleagues in other practices who are also enrolled if in an ACO.
- Possible missed higher revenue stream opportunities.
- High performance results in possible opportunities to participate in other programs.
- Performance scores are factored into the formula used by plans to determine when shared savings are achieved.

One Bite At A Time!



- Run a list of your ICD-10-CM codes used for the last year.
- Sort them by frequency.
- Examine which ones you may wish to target for a given time frame.
- Pull out or tab the HCC pages for those codes, allowing easy reference during the day.
- Master coding more accurately for those code categories.
- Move on to the next set!

Data Capture & Reporting

- **Claims-based?**
  - Which carriers are these?
  - Are there additional codes?
- **Data extraction?**
  - Are there fields to capture the HEDIS measures?
  - Are you using a form?
  - What are the naming conventions for scanning to the patient file?
  - Do they need to be expanded/updated?
  - Have you designated the same location for everyone?
- **Faxed forms required?**
  - Who monitors for completeness?

Review Clinical and Administrative Activities

- Check your patient data in each carrier portal on a regular basis.
  - Gap Reports – Monthly
  - ER Reports – Weekly
  - Admission Reports – Weekly

- Define action items / duties for administrative and clinical work flow. (Staff recall expectations better, and are more accountable, when responsibilities are added to their formal job description.)

- Update Job descriptions for key employees when evaluating work flow and volume for both clinical and administrative staff.

Don't Over Think It – Just Get Started!

Small Changes = Big Results!

Pre-visit planning avoids many of the stumbling blocks. Have you considered?

- Integrating your GAP reports into part of your chart prep (or E H R prep) when preparing for a scheduled appointment?
- If no appointment on the books – add to recall system immediately.
- Have you considered clinical and administrative staff huddles?
- Have you considered early shift / late shift overlap by at least 30 minutes to create protected time for clinical and administrative duties?
- Increased focus on data review – tracking / reporting
  - The more data that is completed accurately in the process creates efficiencies throughout the patient encounter.

Hidden Treasure

Cost reduction at the core of every program. Small efforts can make a difference to the bottom line.

- Are you ensuring patients are referred to the correct preferred lab? I.e. BCBS has designated Labcorp as their preferred vendor; however, many HMO patients are accidentally being sent to other labs.
- Recheck Pharmacy Brand Formulary per carrier.
- Are you occasionally sorting your report by risk score to ensure high risk patients are being seen on a regular basis?
- Have you refreshed your internal campaign efforts to remind patients to contact you first BEFORE going to the ER after hours?

Common Pitfalls

- Waiting for the patient's next visit.
- If you are a Primary Care Provider – #1 pitfall is to wait until the patient comes in for their annual physical.
- Inconsistently accessing gap & other reports.
- Not establishing practice protocols to reach out to non-compliant patients.
- Not using the practice management system recall function.
- Not integrating adjustments within the practice work flow. Add to formal job descriptions.

Initial Plans Don't Always Work Don't Be Discouraged!

Conclusion

Thank you for participating!

dgoodman@impactmed.com

800-252-9094