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On the topic:

Managing Value in a Fee-for-Service World

Jan Hailey, CMC, CMIS, CMOM, CMCO
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Managing Value in a Fee for Service World

Jan Hailey, CMCO, CMC, CMIS, CMOM

Agenda

- Current State for Reimbursement
- Fee-for-Service Payment Model
- Value-based Payment Model
- Transitioning from Fee-for-Service to Value-Based
- Upside / downside risk
- Effective communication between payers and providers
- Importance of comprehensive care coordination
- Coordination between primary care, specialists, hospitals and other health care entities
- Billing for care coordination services
- Patient engagement
- Risk Scoring
- Quality measures
Current State

- Most providers are paid on a fee-for-service basis by Medicare, Medicaid, and other 3rd party payers
- The current volume-based model pays for each individual service, procedure, and hospitalization
- Fee-for-service model is inefficient, unsustainable and is driving the trend toward value based reimbursement

Fee for Service Payment Model

Definition:
Separate payment to a health-care provider for each medical service rendered to a patient—often used attributively (Meriam Webster)

- Inefficient and overly expensive
- Incentivizes to provide more treatments because payment is dependent on the quantity of care, rather than quality of care
- Does not encourage a comprehensive “team care” approach
Fee for Service Payment Model

- Does not recognize or pay for virtual interactions with provider/staff
  - Care through electronic patient portals
  - Secure email
  - Nurse triage
- Without reimbursement, providers are reluctant to provide these types of service
- Does not provide incentive to change the way medicine is practiced
- Providers are penalized for providing lower cost or fewer services

Value-Based Payment Model

Definition:

- Value-based payment model is a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness.

Value-based programs reward health care providers with incentive payments for the quality of care they provide while reducing healthcare costs.

Value-based care programs center on patient outcomes and how well healthcare providers can improve quality of care while reducing costs.

- Improve hospital readmission rates
- Improve preventative care and reduce gaps in care
- Use of certified EHR, shared data
Value-Based Payment Model

- Triple Aim
  - Improve Patient Satisfaction
  - Improve Health
  - Reduce Costs

- Quadruple Aim
  - Address workforce burnout

Transitioning from Fee-for-Service to Value-Based Reimbursement
Yesterday
- Productivity / RVUs
- Revenue Based on Quantity of Services

Today
- Productivity / RVUs
- Quality / HEDIS Based Bonuses
- Revenue Based on Quantity of Services with Performance Bonus

Tomorrow
- Quality Reporting and Expanded Measure Set
- Quality / HEDIS Based Bonuses
- Productivity Based Pay with Performance Bonuses
- Performance Based Payment Through Risk Sharing Contracts

Day after Tomorrow
- Quality Reporting and Expanded Measure Set
- Total Cost for Managing Populations
- Base Pay with Increasing Income from Population Based Performance
- Revenue from Base Pay and Population Performance

(MacLellan, n.d.)

Challenges
- Provider Readiness
  - Providers are often not in a position to take on financial risk
  - Lack of infrastructure
  - No way to automatically report quality measures
  - Outdated EMR, lack funds to update technology
  - Limited knowledge / experience on how to succeed
- Lack of alignment between payers
- Lack of patient engagement / understanding
- **Upside Risk**
  - **One-sided Risk**
  - Providers are eligible to earn all or a percentage of any healthcare savings achieved.
  - Payers typically set a benchmark for how much care should cost for a patient.
  - If the providers perform services at costs below the benchmark, they share in the savings.
  - If costs exceed the benchmark, no shared savings, no financial penalty.
  - Provider prefer upside risk since they are not liable to repay losses if the cost of care goes over benchmark.

- **Downside Risk**
  - **Two-Sided Risk**
  - Providers are eligible to earn all or a percentage of any healthcare savings achieved.
  - Payers typically set a benchmark for how much care should cost for a patient.
  - If the providers perform services at costs below the benchmark, then they share in the savings.
  - If the providers perform services at costs above the benchmark, then the provider must refund the payer for all or some of the losses.
Types of Value Based Payment Models

- Medicare Quality Incentive Programs
- Pay for Performance
- Accountable Care Organizations (ACO)
- Bundled Payments
- Patient Centered Medical Home
- Payment for Coordination

Effective Communication Between Providers and Payers

- Effective communication requires an integrated system that allows payers and providers to collaborate without barriers
- Payers can play a role in improving education and awareness to help providers understand how to manage clinical and financial risk
- Payers can provide resources for data collection
- Payers and providers should keep lines of communication open
  - Data sharing
    - Claims and cost data
Effective Communication Between Providers and Payers

- Transparency is critical
- Cultural change; traditionally providers and payers have not collaborated
- Quality measures that providers are performing against must be made available timely
- Transparency builds trust, takes down silos creating a collaborative effort to improve health outcomes for the patient

Comprehensive Care Coordination

![Diagram of care coordination with roles such as Primary Care Provider, Nurses, Behavior Health, Pharmacist, Specialists, Insurance Plan, and Care Manager interconnected]
Care Management

Care management is a set of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions.

The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost-effective, non-duplicative services.

Goodell, S (n.d.)

- Engage the patient (or caregiver) in the development of a care plan that reflects the patient’s needs and goals
- Ensure the patient (or caregiver) understands their role in the care plan and feels they can be successful fulfilling their responsibilities
- Identify any barriers the patient has to their healthcare (social, financial, environmental)
- Enlist the appropriate members of the healthcare team to address the patient’s needs (specialists, community resources, etc.)
- Facilitate communication between healthcare team
- Assist the patient (or caregiver) with navigation through the healthcare system
- Follow the patient to ensure their needs and goals are being met
Billing for Chronic Care Management

CPT 99490

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

[CMS.gov](https://www.cms.gov)

CPT 99487

Complex chronic care management services, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Establishment or substantial revision of a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

CPT 99489 Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

[CMS.gov](https://www.cms.gov)
Billing for Chronic Care Management

- Only one practitioner may be paid for CCM services for a given calendar month
  - Must only report either complex or non-complex CCM for a given patient for the month (not both)
- CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an “incident to” basis (as an integral part of services provided by the billing practitioner), subject to applicable State law, licensure, and scope of practice
- The clinical staff are either employees or working under contract to the billing practitioner whom Medicare directly pays for CCM
  - Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month in order to bill CCM services
  - Non-clinical staff time cannot be counted toward the threshold

Supervision

- The CCM codes (CPT 99487, 99489, and 99490) are assigned general supervision under the Medicare PFS
- General supervision means when the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not required.

For more information:
Patient Engagement

- Patient engagement is one of the keys to success with value-based payments
- CMS has added patient engagement to MIPS through Advancing Care Information
- CMS emphasizes patient centered care through APM incentive payments
- Health technology use is necessary to support patient engagement
- Shared decision making and partners in care

Risk Scoring

- Risk adjustment and HCC coding is a payment model that uses a patient’s health status and demographic information to calculate a risk score in order to establish a baseline for how much it will cost to provide care to that patient
- Providers need greater understanding how risk adjustment affects reimbursement
- In the past, under fee-for-service, diagnosis codes were required to support medical necessity for the CPT (procedure) code
- Accurate and specific diagnosis coding is becoming increasingly important
- As we shift to value-based reimbursement, fee-for-service continues; however, there are many other reporting avenues that will now use diagnosis codes
Risk Scoring

- Most practices will encounter value-based reimbursement through MIPS
- Any attempt to measure and provide financial incentives based on quality and cost will require risk adjustment
- Both quality and cost measures under MIPS are risk adjusted
- The preferred methodology for risk adjustment is Hierarchical Condition Coding (HCC)
- Over the years, HCC scores have become very accurate in predicting future healthcare expenses for patient populations
- The patient’s health conditions are identified via ICD-10 codes submitted on claims

How is Risk Adjustment Calculated

- 69,832 ICD 10 Codes
- Approximately 8,600 qualifying ICD 10 codes
- 79 HCCs
Calculations

A risk score is calculated as the sum of demographic and health factors weighted by their marginal contributions to total risk.

For example: Average = $1,000
Female, age 57 = $500
Condition A = $700
Risk Score = 0.5 + 0.7 = 1.2

Calculated relative to average expenditures.

Documentation

- CMS requires documentation in the patient’s medical record to support the submitted diagnosis.
- Documentation must support the presence of the condition and indicate the provider’s assessment and/or plan for management of the condition.
- Must occur at least once each calendar year in order to recognize the individual continues to have the condition.
Documentation

- Document on each condition the patient has that influences the provider's ability to evaluate or treat the patient:
  - Pertinent Conditions
  - Chronic Conditions
  - Active Status
  - History of or Past Conditions
  - Conditions that require a combination code or require two codes billed together

Remember the acronym MEAT!

- Document all conditions being:
  - Monitored (signs, symptoms, disease progression or regression)
  - Evaluated (test results, medication effectiveness, response to treatment)
  - Assessed / Addressed (tests ordered, discussions, record review, counseling)
  - Treated (medications, therapies, other modalities)
Documentation

- Document and code for conditions that are:
  - Present but stable
  - Managed on therapy
  - Requires observation
  - Requires referral to another provider
  - Influences medical decision making
- Avoid documenting “history of” when the condition currently exists
  (in ICD-10 coding language, “history of” means that the patient no longer has
  the condition, in which case it cannot be coded as an active disease)

Documentation

**Chronic Conditions**
- Document chronic conditions annually, even if stable with treatment
- Document that the condition is chronic
- Document severity / stage of condition (i.e. stage IV chronic kidney
  disease)
- Document associated conditions or complications and relationship to the
  underlying chronic condition
Documentation

Active Status
- Conditions that are present and unresolved need to be documented annually.
- CMS considers the condition resolved if not evaluated and coded at least once in a calendar year, in which case the risk factor score for the patient is lowered.

Forever Codes
- Forever codes are conditions that do not go away and the patient is expected to have the condition forever.
  - Amputation
  - Transplant
  - Alcoholism in remission
  - CHF (compensated)

Annual Evaluation
- All relevant diagnosis codes should be reported at least once a year.
- On January 1st of each year, the patient’s diagnosis code information is reset in preparation for a new year of data.
- 12 Diagnosis codes on CMS - 1500
- Important for:
  - Promoting quality patient care
  - Ensuring appropriate preventative screening tests are received
  - Ongoing assessment of chronic conditions
  - Accurate patient risk score calculation
### CMS Measures Inventory

The CMS Quality Measures Inventory is a compilation of measures used by CMS in various quality, reporting and payment programs. The Inventory lists each measure by:

- **program**
- **reporting measure specifications including, but not limited to:**
  - numerator
  - denominator
  - exclusion criteria
  - National Quality Strategy (NQS) domain
  - measure type
  - National Quality Forum (NQF) endorsement status


### Program ID | CMS ID | Reference | Measure Groups | Program | Title | Description | Numerator | Denominator | Exclusions |
<table>
<thead>
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<tr>
<td>65</td>
<td>5775</td>
<td>CMS117v5</td>
<td>qpp quality id: 240</td>
<td>Merit-Based Incentive Payment System (MIPS)</td>
<td>Childhood Immunization Status (eCQM)</td>
<td>Percentage of children 2 years of age who had Childhood Immunization Status</td>
<td>Old children who have evidence showing they</td>
<td>Old children turn 2 years of age during the</td>
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<td>CMS123v5</td>
<td>qpp quality id: 001; GPRO: DM2</td>
<td>Merit-Based Incentive Payment System (MIPS)</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (eCQM)</td>
<td>Percentage of patients 18-75 years of age with diabetes who had Hemoglobin A1c Poor Control</td>
<td>Patients whose most recent HbA1c level</td>
<td>Patients 18-75 years of age with diabetes</td>
<td>None</td>
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<td>5777</td>
<td>CMS123v5</td>
<td>qpp quality id: 016</td>
<td>Merit-Based Incentive Payment System (MIPS)</td>
<td>Diabetes: Foot Exam (eCQM)</td>
<td>The percentage of patients 18-75 years of age with diabetes who received Foot Exam</td>
<td>Patients who received visual, pulse and sensory</td>
<td>Patients 18-75 years of age with diabetes</td>
<td>Patients who have had either a unilateral</td>
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<td>65</td>
<td>5778</td>
<td>CMS124v5</td>
<td>qpp quality id: 089</td>
<td>Merit-Based Incentive Payment System (MIPS)</td>
<td>Cervical Cancer Screening (eCQM)</td>
<td>Percentage of women 21-64 years of age who were screened for Cervical Cancer</td>
<td>Women who had one or more screenings for</td>
<td>Women 21-64 years of age with a valid dating</td>
<td>Women who had a hysterectomy with no</td>
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<td>5779</td>
<td>CMS125v5</td>
<td>qpp quality id: 113; GPRO: RAB5</td>
<td>Merit-Based Incentive Payment System (MIPS)</td>
<td>Breast Cancer Screening (eCQM)</td>
<td>Percentage of women 50-74 years of age who had Breast Cancer Screening</td>
<td>Women who had one or more mammograms for</td>
<td>Women 50-74 years of age with a valid dating</td>
<td>Women who had a bilateral mastectomy or</td>
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Quality Measures

- HEDIS
  - Healthcare Effectiveness Data and Information Set
  - Used by more than 90% of health plans to measure performance
  - Consists of 81 measures across 5 domains of care
  - Health plans are easily compared because of HEDIS data collection and the specificity of the measures
  - [http://www.ncqa.org/hedis-quality-measurement](http://www.ncqa.org/hedis-quality-measurement)

Tips to Improve Quality Scores

- Well care visits
  - Well Child Checks
  - Medicare Wellness Visits

- Patient Satisfaction
- Standardization
- Chart Preparation
- Attribution
- Correct Coding and Documentation

- **Make Every Visit Count!**
References

- https://www.familiesusa.org/sites/default/files/product_documents/Care-Coordination.pdf

Questions