HEALTH MANAGEMENT ASSOCIATES

Maximizing Reimbursement and Preparing for Value Base Payment
Virtual Training Series
May 24, 2021

IDAHO PRIMARY CARE ASSOCIATION

Healthy Idahoans Living in Healthy Communities

Our Mission

To promote and support vibrant, effective community health centers in providing accessible, affordable, and high quality healthcare to all Idahoans

Our Work

Health center administration

We help health centers strengthen business operations through support in financial management, health information technology, emergency preparedness, workforce development and medical, behavioral health and dental practice integration.

Quality improvement

We assist health centers achieve the best patient outcomes through innovative quality improvement programs utilizing the highest clinical standards, fostering patient engagement and coordinating care within the larger healthcare system.

Outreach and enrollment

We help health centers provide health insurance education and enrollment assistance to community members, many of whom face barriers in accessing healthcare.

Governmental relations

We monitor the changing healthcare policy environment and connect health center leaders with elected officials on the local, state and federal levels. We engage with the Idaho Department of Health and Welfare and the Department of Insurance to create strong and lasting relationships.

Network management

We support payment reform and value based reimbursement by collaborating with insurance companies to control costs and increase quality of care.

WEBINAR HOUSEKEEPING

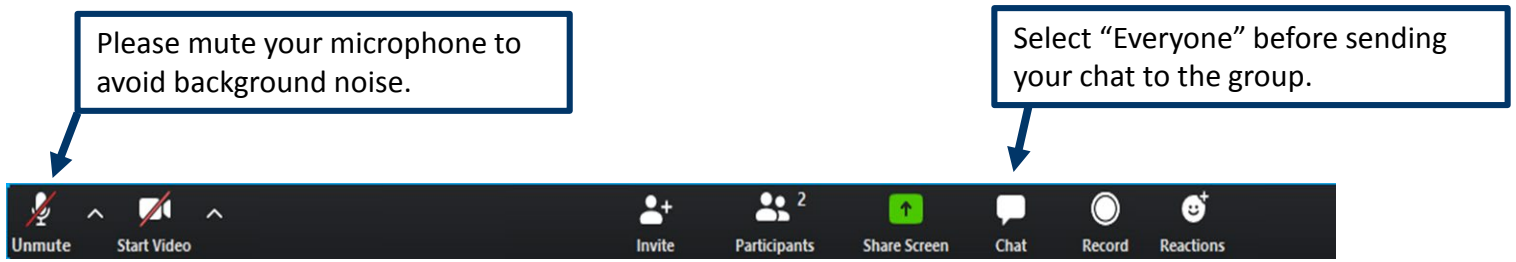
We are Recording

Mute/Unmute Mics

Asking Questions

Evaluations

- Questions?
  - Use the chat function for questions
  - Email:



VIRTUAL TRAINING SERIES

- February 22 –Care Management Best Practices and ROI
- March 22 - Population Health and Care Management – Using Data to Focus on Populations of Greatest Need
- April 26 - Virtual Care Management for Diabetes and Hypertension
- May 24 - Maximizing Fee-for-Service Care Management Revenue and Preparing for Value-Based Reimbursement

Technical Assistance/coaching offered – Complete the request form or contact the IPCA and we will call you!

THE HEALTH MANAGEMENT ASSOCIATES TEAM

Art Jones, MD
Principal

Nancy Jaeckels-Kamp, RN
Managing Director

CHATTER FALL

Type an answer into Chat but do not hit enter yet…..

- **What are your current funding sources or reimbursement sources for your care management/coordination model?**

REVIEW THE SERIES…….

- Care management models need to be analyzed and designed in the most efficient approach, with the right staff in the right roles
- Care management and coordination focus should be driven by your data and risk stratification methods
- Current reimbursement, incentives and contracts with your payers are also a driver in your CM/CC focus
- Virtual care is an efficient and effective means to team-based care for your complex patients

HOW DO WE GET THIS DONE - STEPS TO ACTION

+ Understand your costs to do care management

+ Understand current payer contracts and other sources of funding – what care management/coordination activities do you currently get reimbursed for?

+ How do you know your CM/CC is making improvements? What are your measures – both process and outcome – that you are routinely collecting? Or that your payers are looking for?

ACTION STEPS

- Understand and analyze your costs for your CM/CC:
- Program investment costs:
  - staff, salaries and benefit
  - training,
  - technology,
  - space,
  - Any other operational costs identified

ACTION STEPS

- Understand your payer environment and current contracts and payment
  - Payer mix; % Medicare, Medicaid, commercial plans
  - Medicaid (Healthy Connections) PMPM has 40-55% of the reimbursement for CM work
  - Any incentive (P4P) around CM?
  - Any shared savings contracts
- Align the focus from your payments/contracts with those patients to be engaged in some type of care management service

ACTION STEPS

Other value to CM (need to measure these!):

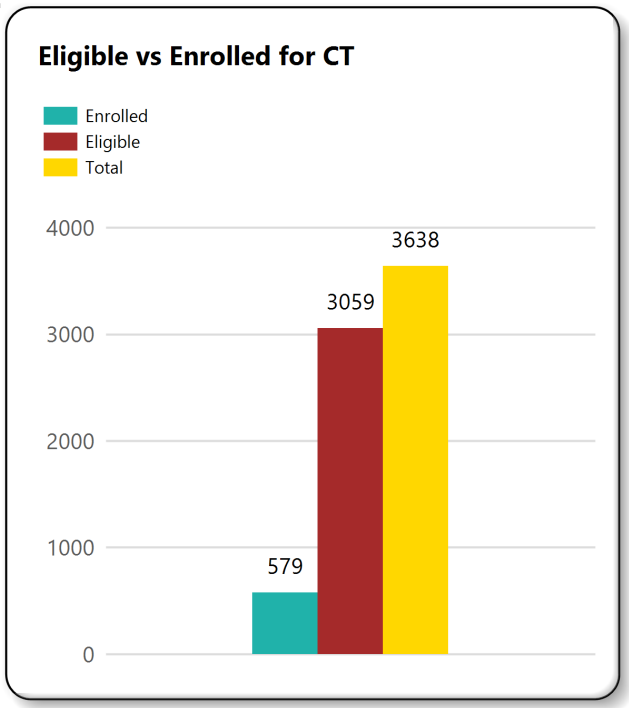
- PCPs and staff satisfaction
- Decreased PCP and staff turnover
- Patient experience, engagement and retention
- Decrease in utilization of ED and hospitalization (decrease in total cost of care)
- Increase in panel size and PCP appointments with virtual care and team-based care

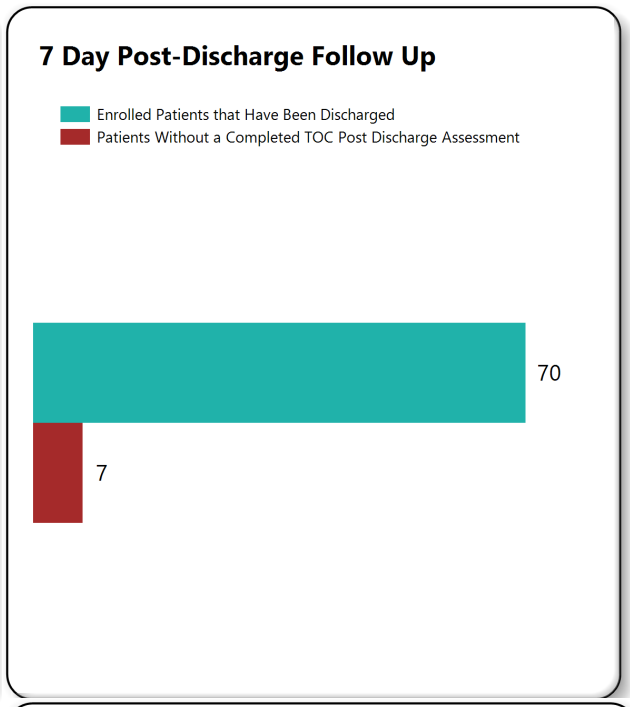
ACTION STEPS

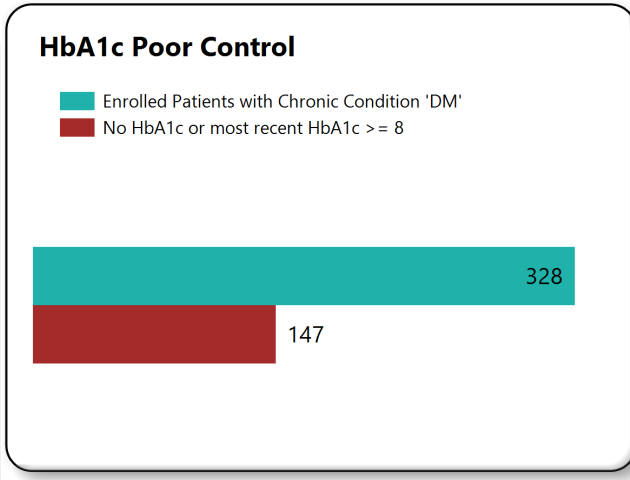
Develop measurement set and goals that align with payer contracts and your patients' identified gaps and needs :

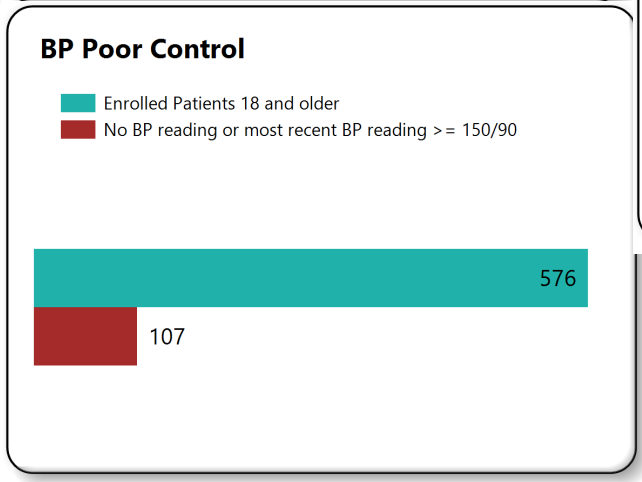
- Measurement set that tells you how your CM/CC is going:
  - **TCOC** data for your payers for your attributed patients
  - ED and hospital **utilization** data
  - **Process measures** specific to CM/CC processes put in place, i.e., patient engagement
  - **Outcomes** that specific to payer contracts and those patients enrolled in CM/CC activities
  - Patient **experience** and satisfaction specific to CM
  - **PCP and staff experience** specific to CM

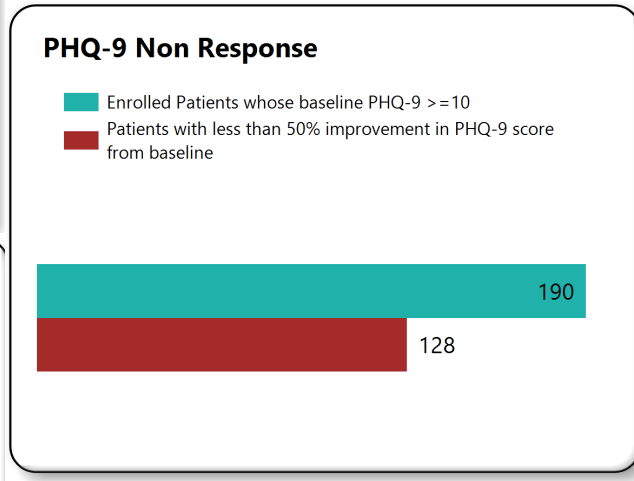
EXAMPLE MEASURES DASHBOARD



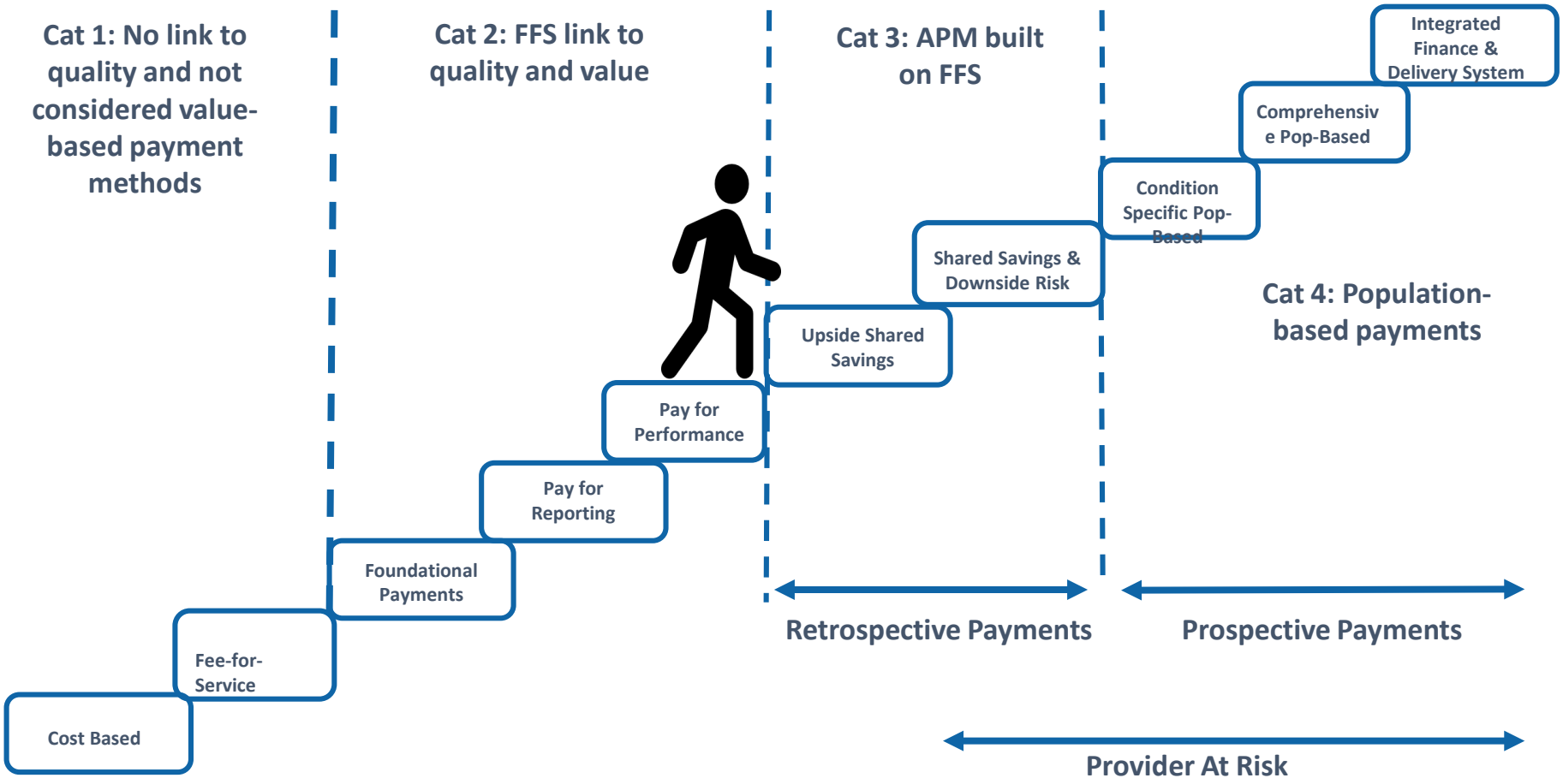








PROGRESS IN PURSUIT OF VALUE-BASED PAYMENT: LAN VBP CATEGORIES



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LAN VBP CATEGORY 1: FFS PAYMENTS WITH UNLINKED TO QUALITY AND VALUE

Cat 1: FFS unlinked to quality and value can stimulate and focus providers on quality improvement initiatives

Fee-for-Service

1: Foundational Payments: Paid on a fee-for-service basis; may be risk adjusted by member complexity; may be bundled so it can only be paid once within a defined period of time no matter the number of patient encounters

Example: Most Health Homes programs under Section 2703, Medicare CCM/TCM or Collaborative Care Model for depression.

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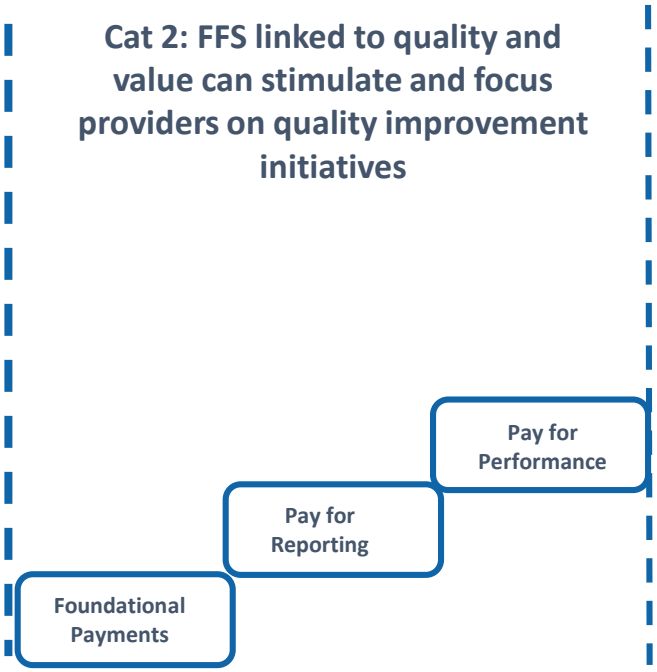
LAN VBP CATEGORY 2: FFS PAYMENTS WITH LINKS TO QUALITY AND VALUE



2-A: Foundational Payments: Often paid on a per member per month (PMPM) basis; may be risk adjusted by member complexity; tied to meeting qualifying criteria by the provider such as PCMH certification
Example: Idaho Healthy Connections Case Management Payment

2-B: Pay for Reporting: These provide positive or negative incentives to report quality data to the payer. They support providers in building internal resources to collect and report data.
Example: report service and outcomes such as primary care engagement, closing gaps in care, reduced ED visits or reduced rehospitalizations

2-C: Pay for Performance: These reward providers that perform well on quality metrics and/or penalize providers that do not perform well. These directly link payment to quality such as HEDIS scores or health service utilization
Example: similar metrics to 2-B but require reaching performance targets

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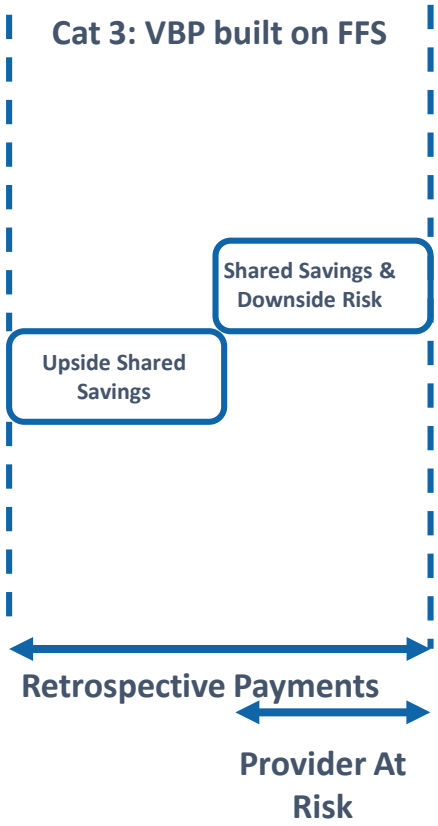
LAN VBP CATEGORY 3: VALUE-BASED PAYMENTS BASED ON FFS

Category 3 payments are based on cost (and occasionally utilization) performance against a pre-defined target.



Upside Shared Savings:

- Providers can share in a portion of the savings they generate against cost or utilization targets if quality targets are met; use a care management-related outcome as a gate to accessed shared savings or for a clinically integrated network to distribute savings among its participating providers.

Example: a minimum percentage of assigned members must have at least one primary care visit in the performance year;

Shared Savings & Downside Risk:

- Providers can share in a portion of the savings they generate against cost or utilization targets if quality targets are met.
- Payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.

Medical Homes

- 30 Day All Cause Readmissions
- CTM3* Compliance Survey Completion Rate w/in 7 days of discharge
- 7 Day Visit upon IP Discharge
- 7 Day Follow-Up on ER Admissions
- New Patient Visits within 90 Days
- Care Plan/CRA Completion
- ED Utilization/1000
- Newborn Visits within 7 Days

Medical Cost of Care MLR < Contract

Specialists & Hospitals

- **7 Day All Cause Readmissions**
- Discharge Summary/CCD Transmissions
- CTM3* Question Score (Value)
- System Uptime for HL7/IT MHNConnect
- Implementation and Maintenance of Care Transition Processes
- Repeat ED visits w/30 days; trigger @ ACO Hospitals

Medical Cost of Care MLR < Contract

50% Provider Contribution & Attainment Calculation

50% Savings Calculation Weighted by Membership

50% Provider Contribution & Attainment Calculation

50% Savings Calculation Weighted by Utilization

CHATTER FALL

Type an answer into Chat but do not hit enter yet…..

- How do you think we should allocate savings that we generate?

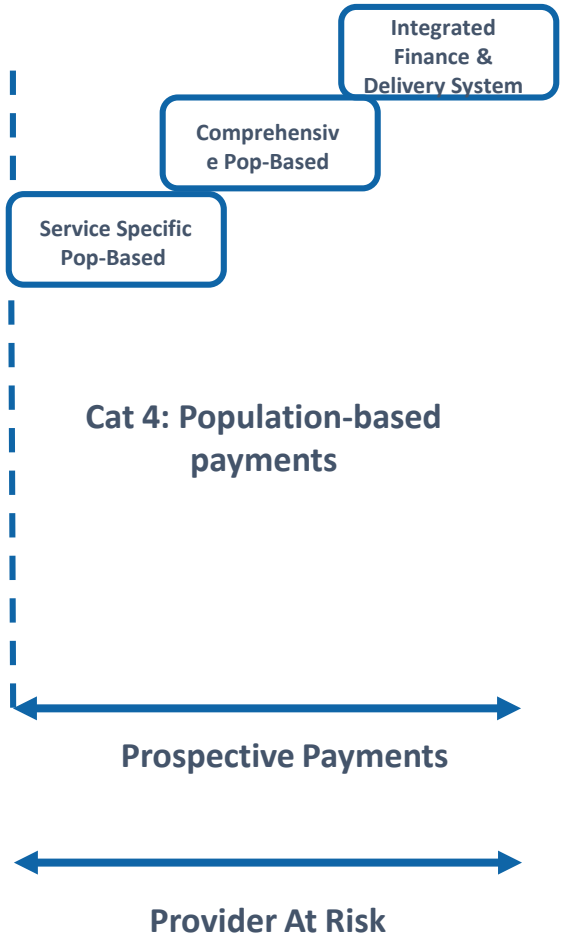
LAN VBP CATEGORY 4: POPULATION BASED PAYMENTS

Category 4 involve:

- **Prospective, population-based payments encourage the delivery of coordinated, high-quality, and person-centered care.**
- **Requires accountability for measures of appropriate care to safeguards against incentives to limit necessary care.**

4-A: Condition or Service Specific Population Based: Includes bundled payments for comprehensive treatment of specific conditions, such as cancer care, or all care delivered by specific types of clinicians such as primary care or orthopedics.

Example: Capitated FQHC alternative payment model that includes care management services



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PRIMARY CARE CAPITATION ALTERNATIVE PAYMENT METHODOLOGY

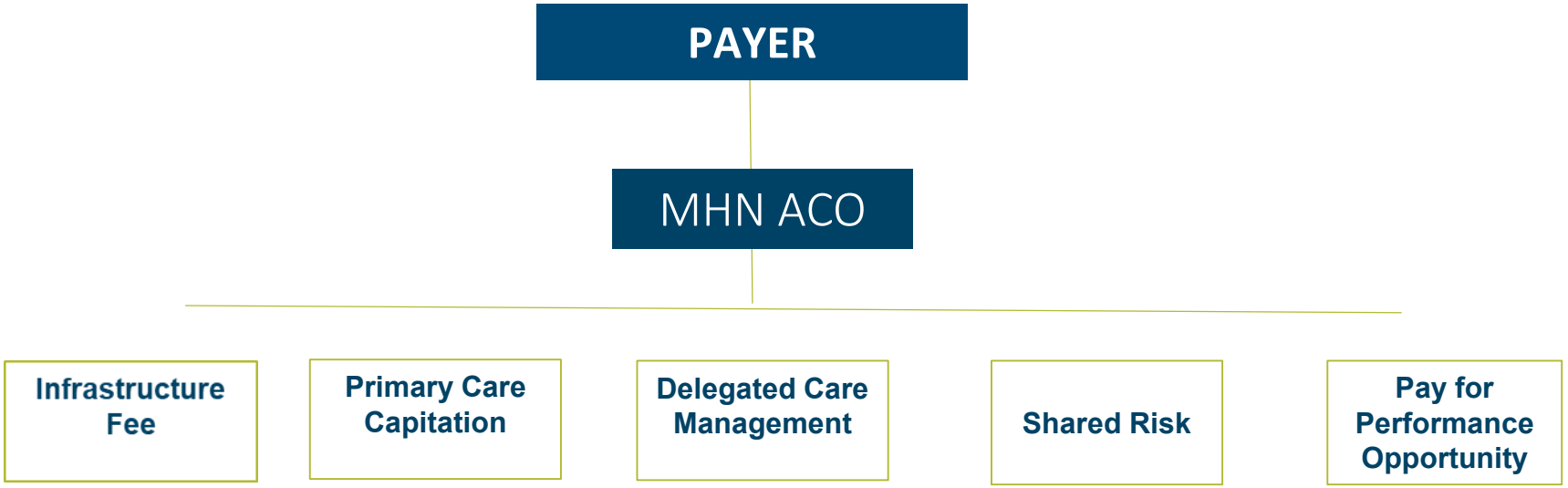
2019 Primary Care Revenue

# of empaneled Medicaid Member Months in 2019

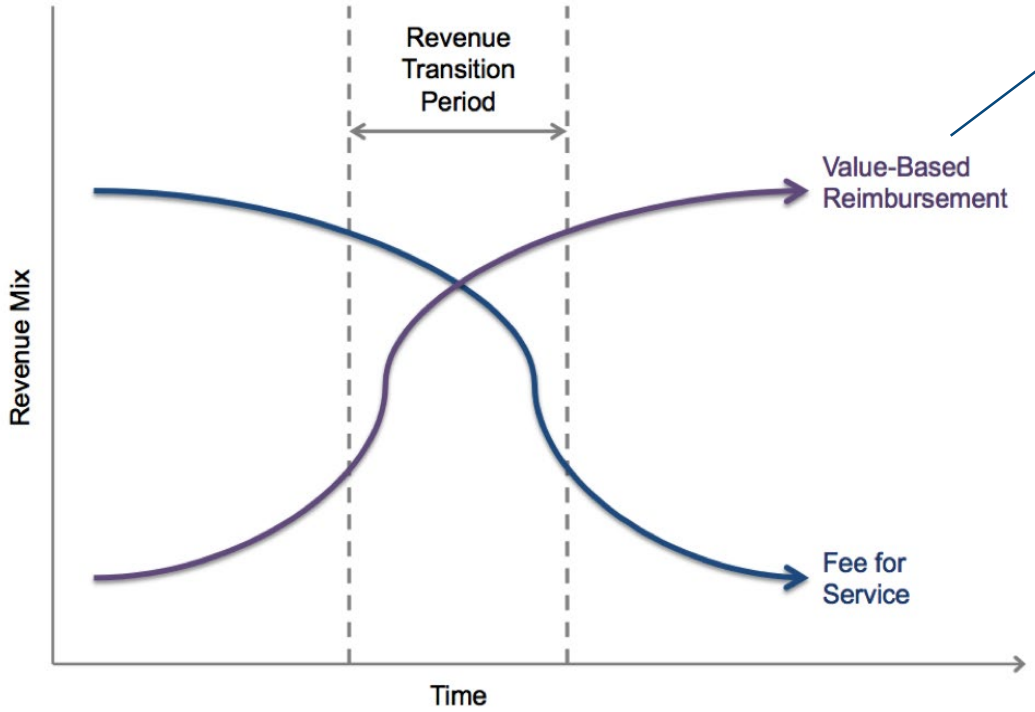
= PER MEMBER PER MONTH APM RATE*

***Rate is inflated annually**

MHN ACO: Contracting Construct for Delegated CM & Value-based Partnership



INTERSECTION OF FFS AND VBP – WHERE ARE WE AT?



IT infrastructure
EHR
Quality & PI Infrastructure
Care Management Models
Physician Alignment
New partnerships
Analytical capabilities

CURRENT REIMBURSEMENT POTENTIALS

Medicare

+ Complex care management
+ Transitions of care
+ BHI – Collaborative Care

Medicaid/Healthy Connection

+ As part of PCMH - CM, CC, BHI and transitions of care and connectivity to the HIE – are all a part of the Healthy Connections Tier level 3 and 4 payment structure

Payer Contracts

+ Care coordination/gaps in care
+ Shared savings programs (MSSP, others?)

COMPLEX CARE MANAGEMENT - CCM

+ CPT 99490 – at least 20 mins per mon - $42.23
+ 99491 – at least 30 mins per mon - $74.26
+ 99487 – complex CCM – 60 mins per month with moderate or high complexity medical decision making - $94.55
+ 99489 – used in conjunction with 99487 for any additional 30 mins per month of complex care management

Covered:

- Telephonic care management contacts and coordination of care
- Development and review of a comprehensive care plan
- Time tracking and documentation of contacts
- Billed under provider, services conducted by clinical staff under provider supervision (most typically an RN to do medication reconciliation but that could be done by provider)

TRANSITIONAL CARE MANAGEMENT - TCM

- Coordination of patient's transition after discharge from an acute setting
- Oversight of the management and coordination of the patient's medical, psychological, and daily living needs following discharge
- 30 days with one face to face visit within 7 – 14 days and non-face to face services after that
- Medication reconciliation required on or before the face-to-face visit
- Billed under provider, services conducted by clinical staff under provider supervision (most typically an RN to do medication reconciliation but that could be done by provider)

- 99495 – moderate complexity - $187.67
- 99496 – high complexity - $247.94

COLLABORATIVE CARE - COCM

+ 99492 (Initial month, CoCM) - $161
+ 99493 (Subsequent month, CoCM) - $129 Billed once a month by the PCP
+ 99494 (Add'l 30 mins, CoCM) - $69
+ 99484 – other models of BHI - $48
+ G0512 – FQHC $134

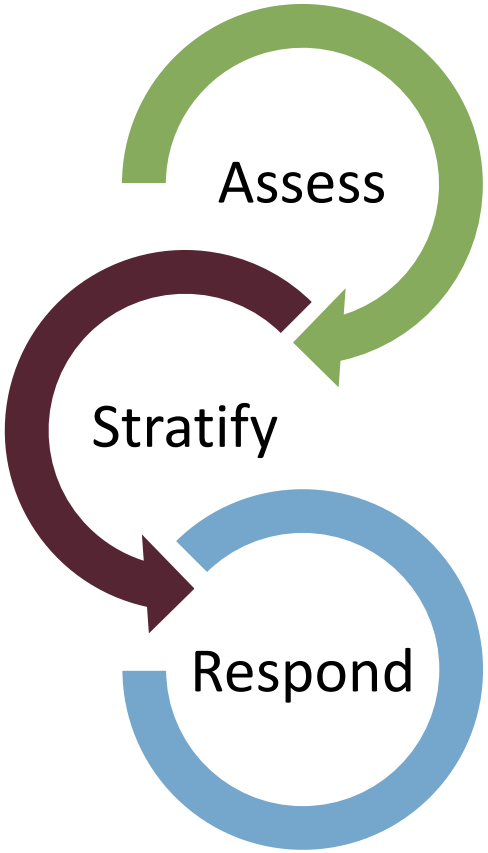
Codes cover:

- Outreach and engagement by BH Provider or Care Manager (no licensure required), Initial assessment of the patient, including administration of validated rating scales
- Entering patient data in a registry and tracking patient follow-up and progress
- Participation in weekly caseload review with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

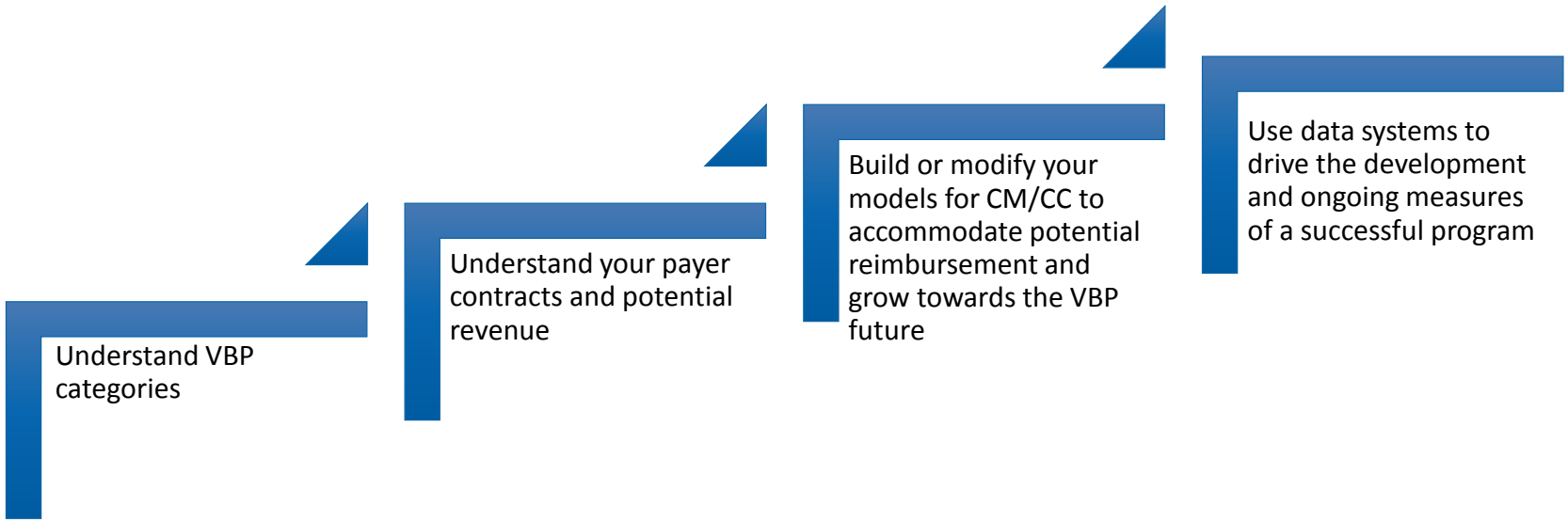
- GCCC2 – proposed new code for FQHCs $135/month starting January 1, 2017

DATA DRIVING OUR CARE MANAGEMENT MODELS AND FOCUS

- Data helps drive who in your population should be outreached to and engaged in a level of Cm/CC
- Risk stratification drives level of need and determines model of care workflows
- Risk stratification of the population will drive the staff needed for care management



IN SUMMARY



WRAP UP

- Please complete the poll for a quick evaluation of today's session
- IPCA will conduct a 3-month follow-up evaluation on implementation of take-aways from this series
- Additional questions in the chat box will be reviewed and responded to after the webinar
- Recording of the webinar will be sent out
- Technical Assistance (TA) hours are still available through IPCA – contact them for more information on how to set up coaching and TA time