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Summary Page

About Quirk Healthcare Solutions

Quirk partners with healthcare systems nationwide. Our clients range from individual physician clinics to multi-state conglomerations Our healthcare consulting services and suite of products are designed to help you successfully navigate the ever-evolving government programs and industry trends that impact your business.

Adopt and keep abreast of changes with support from Quirk's world-class business, clinical, and technical support teams. Whether you require expertise and guidance with EHR strategic management, workflow optimization, systems development, or training, Quirk has a solution

2014 is a challenging year for the healthcare industry. We've all read about ICD-10 (which has unfortunately been pushed back by a year), EHR incentives, Medicare cuts disguised as "payment adjustments", and the mandatory health insurance required under the Affordable Care Act. Here is our guide on how to not only survive 2014, but confront it with confidence.

Products and Services

EHR Upgrades

If you are using NextGen Healthcare's software, you need to upgrade to version 5.8 and KBM 8.3 this year. Or do you? With ICD10 pushed back, Quirk Healthcare Solutions is offering a free short-term solution that allows you to achieve Meaningful Use in 2014 for both Stages 1 and 2 without the need to upgrade. And yes, you read it correctly, it is absolutely free!

<Include an icon for the Free MU Package and more information>

Should you choose to upgrade to KBM 8.3 to stay ahead of the curve, you can take advantage of our flat fee upgrades. This means you will know the exact upgrade cost upfront. Our proprietary gap analysis tool identifies technical gaps similar to the version available from NextGen. In addition, it enables you to work interactively with your staff, saving you hours when deciding on what to do with each template, and send the changes to our developers.

<icon> Every organization needs help to weather the storm of changes. The amount of help and level of involvement from Quirk Healthcare Solutions can be specifically tailored to fit your organization's needs for a flat fee.

Meaningful Use

CMS has stated that there will be no delays to MU deadlines in 2014. That means

providers who have never attested under the Medicare program must do so by September 30, or else be subject to penalties in the form of Medicare payment adjustments starting in 2015. Providers who have attested for Medicare in the past will have a bit longer (until December 31), but the penalties will be the same.

There is much dissatisfaction with the government's "all or nothing" approach to MU, where even the slightest misstep can invalidate an otherwise accurate attestation. While the ONC has proposed a more lenient model for EHR certification in coming years, everything will be measured against a hard deadline in 2014. CMS is offering some mitigation through hardship exemptions based on rules that are rather broadly designed at this point. Providers should consider applying for an exemption if no other options are available and they meet the established criteria.

We can help you decipher Meaningful Use, confidently meet all required criteria, and accurately report on it. Our suite of services specific to MU include flat fee or hourly guidance and support in optimizing EHR and workflows, and helping you understand, create, and analyze targeted data reports. We will even assist you in preparing for an audit just in case.

<Include an icon> Quirk Healthcare Solutions offers a full range of services for our clients who are looking to demystify MU, meet all criteria, and be able to report on it. This includes:
EHR optimization
Workflow optimization
Reporting
Attestation
Audit preparation and assistance

Decreased Reimbursement - Medicare Payment Cuts and the ACA

Medicare Sustainable Growth Rate (SGR) cuts continue to shadow Medicare providers. Enacted by Congress in 1997, the SGR was intended to control costs by cutting reimbursements to providers based on prior year expenditures. Yet every year costs continue to rise, as do SGR cut increases, - projected to be almost 24% in 2015. And every year Congress prevents the cuts via the so-called "doc fix" legislation, which affects the industry's ability to move forward as evidenced in the recent decision to defer the ICD-10 implementation for yet another year. The U.S. trails all developed countries in its adoption of ICD-10.

In early 2014, there was surprising bi-partisan agreement on a permanent doc fix, whereby Medicare reimbursements would be based on quality measures rather than overall expenditures. However, the legislation was derailed, by linking it to a little-noticed delay of the ACA's individual mandate requiring Americans to purchase health insurance or pay a penalty until at least 2016. Finally, we received a one-year reprieve from the cuts, but we still face sequestration and the looming possibility of cuts to medical research.

In addition, the introduction of the ACA has resulted in high-deductible plans becoming

more common. Media outlets focus on the impact to consumers, and argue about whether more “skin in the game” leads to better choices or less care. What we’re hearing from the front lines is much more concrete: high deductibles are having a negative impact on revenues.

Very few people understand their liabilities under a typical health insurance plan. Last year George Loewenstein, a health-care economist with Carnegie Mellon University, published a survey showing that only 14 percent of respondents understood the basics of traditional insurance policies. At the same time, hospitals are reporting that about 25 percent of bad debt originates from patients who are currently insured. With millions of new enrollees in high-deductible plans and an ongoing economic slump, the situation is definitely not improving.

The upshot is that you need to be efficient and collect all you can to survive in the current market. Make sure the continued rise of payment cuts doesn’t impede your survival in the upcoming year.

Providing assistance in reviewing and adjusting the provider revenue cycle process is one of Quirk’s specialties. We’ll sit down with you and perform a comprehensive review of your system, making suggestions for fine-tuning details, identifying crucial gaps, and helping you optimize the management process so that you know you are accurately estimating patient services, educating patients at check-in, and instituting proactive billing and collection at the point of service. We’ll teach you how to take the right steps to assure that you get paid and on time for your services.

PQRS and Its Evil Cousin – Value Based Modifier

This program has not been a worry for most providers thus far. It’s not because it won’t have an impact on revenue, but rather they don’t know about it. A little-known provision of the ACA, the Value-Based Payment Modifier mandates adjustments to Medicare reimbursement based on quality and cost measures. The program is being phased in, and so far has applied only to group practices of 100 or more Eligible Professionals (EPs). In 2014, smaller groups of 10 or more EPs will be subject to the legislation. These groups must apply and report to the program by October 1. Failure to do so will result in a 2 percent cut in Medicare reimbursements starting in 2016.

One of the most important aspects of the program is its definition of “eligible professional” when determining the size of a group practice. For the purposes of Value Modifier, eligible professionals include not only physicians, but also practitioners and therapists. This means that a practice with 8 physicians, a nurse practitioner, and a physical therapist would qualify as a practice with 10 EPs.

Value Modifier is part of the growing trend of quality-based reimbursement. Even commercial payors are considering some version of the program. The scoring calculations are complex and poorly understood, so we advise clients to get up-to-speed as soon as possible. Groups with high quality and low cost will receive incentives rather than cuts, with additional upward adjustment for services to high-risk beneficiaries. Groups that are not keeping pace with these changes may be surprised by an additional hit to revenue in 2016. In addition, quality scores will eventually be published to the

general public on the Medicare Physician Compare website. Sub-par or missing scores could have a negative financial impact on a practice.

The Physician Quality Reporting System creates heavy administrative work that may seem to outweigh its benefits, but it will ultimately help your business. To be successful, providers must look for revenue from all possible sources. Are you an eligible professional (EP)? Should your organization participate in PQRS? The need for stellar quality rating is important to the future of your practice. Don't get caught up in trying to answer these questions and iron out the details on your own. Partner with Quirk and let our PQRS subject matter experts guide you along the way. We'll help you plan your process and choose from over 200 quality measures with codes and patient data that are relevant to your specialty or practice. You'll gain a better understanding of the incentives and adjustments schedule and be able to validate your quality of care.

PCMHs, ACOs, Population Health, and Patient Engagement

Understanding the crossover between quality and revenue cycle models that demand massive transformation within care settings has practically frozen the progress of many provider organizations. Leaders and stakeholders are battling their way through complex challenges and threats to sustainability. As Fee-for-Value models impose new demands, many who have not yet committed keep a close eye on data driven studies around these new models.

A study of PCMH results published in the February 28th, 2014 issue of JAMA describes the effectiveness of quality and containing costs as "unclear". And, while over 10 percent of U.S. primary care practices (more than 35,500 clinicians at more than 7,000 practice sites) have earned NCQA PCMH Recognition, the model is unsustainable without proper financial alignment with payment reforms. Currently, many of the core principles of the PCMH are reimbursed poorly, if at all, by Medicare and commercial payors. Payment for increased patient education, care coordination, staffing for augmented practice hours and a telephone triage service, and an electronic medical record does not exist and cannot be covered by billing for evaluation and management codes alone. These upfront and continuing costs readily discourage organizations from transitioning to the PCMH model.

The types of payments associated with the ACO model should allow ACOs to increase primary care compensation through quality and cost incentives. However, Accountable Care is really about improving and maintaining the health of a population of patients and not just controlling costs. Leveraging the elements of PCMH and integrating Care Coordination is critical and several organizations are developing programs that recognize and/or accredit medical homes according to specified standard sets

Providers need to embrace the concepts and elements of transforming their practices in a judicious albeit expeditious manner. Practices that have not transformed or are not viewed as thought leaders may be left out of whatever develops in the "yet to be determined" world of Accountable Care Organizations. Organizations need to partner with and engage top-level guidance for strategic planning and integration of Health IT tools and systems to solve business problems with Decision Support, Care Transitions, optimization of Electronic Health Records and Performance Reporting.

Quirk Healthcare Solutions is actively engaged in helping organizations drive healthcare IT and in transformation from the role of supporting a traditional fee-for-service, visit-driven reimbursement model and facilitating documentation to support a billing function - to that of shifting care delivery and outcomes. We recognize the importance of a "total needs" approach to using HIT for effective change as a powerful foundation that enables workflow and process change to ultimately foster stronger teams, interoperability, and information exchange within the context of an overall medical neighborhood and within complex payor matrices.

<Include an icon for PCMH and ACO> Quirk Healthcare Solutions offers a full range of services for our clients. Those for whom transformation to a PCMH is a strategic organizational priority will benefit from our expertise in the following:
PCMH readiness self-assessment
Policies and procedures and their operationalization
Empanelment
Care teams
Continuous Quality Improvement
EHR optimization
Workflow optimization
Reporting
Preparation of application materials
Evaluation and implementation of patient portals
Client for whom becoming an ACO is a strategic organizational priority can benefit from our expertise in the following:
ACO application process
Leadership development
IT infrastructure
Provider recruitment and marketing
Process/quality improvement

Increased Competition and Consolidation

Acquisitions and mergers of healthcare facilities have slowed in some parts of the country, but remain hot in others. In 2012, healthcare mergers and acquisitions exceeded $143.3 billion, one of the highest volumes recorded in a decade, according to a report from a strategic advisory and investment banking firm, Hammond Hanlon Camp LLC. The reasons vary and include financially strained smaller organizations joining up with larger ones in order to survive. Even if your clinic is not at risk of being acquired, your hospital partners may be. After the buying sprees of the past 5 years, health systems are realizing that their new ambulatory programs aren't just referral sources, they are opportunities for financial success, failure, and even risk. The best way to survive the changing landscape is to decide: Should I be acquired (and what am I worth), should I acquire (and what does that entail?), or how do I make myself strong enough to survive?

Quirk Healthcare Solutions is at the forefront of helping you with your strategic planning goals. Our strategic consulting division was created specifically to help our clients navigate through the often challenging and seemingly constant changes in industry and

to find success. Whether you have already been acquired, are in the process, or are considering participating in an acquisition or merger, our expert consultants can help you analyze and solve even the most complex problems.

<Include an icon for strategic consulting> Our strategic consulting division was created with the end goal of positioning our clients for success by helping them meet their strategic organizational goals

Fee For Value, Medicare Advantage, Managed Medicaid, and Shared Risk

Politics aside, the biggest takeaway from HIMSS was Hillary Clinton sharing her vision for eliminating the fee for service model and switching to fee for value. This already exists in the Medicare Advantage and Shared Risk worlds where you are paid on a combination of the patients' risk factors and quality measures, with additional reimbursement available for decreased utilization.

Under the current Medicare Advantage program, CMS is required to contract with private health plans on a prospective payment basis, which in turn contract with individual medical groups and preferred provider networks to deliver care to enrolled Medicare beneficiaries. Medicare Advantage plans have shown evidence of increased care coordination and superior clinical outcomes due to their ability to measure and report quality of performance. As a result, these plans are becoming increasingly attractive to Medicare beneficiaries who are highly satisfied with outcomes. In fact, 50 percent of new Medicare enrollees choose a Medicare Advantage option and enrollment in the program has tripled in a decade, exceeding 16 million beneficiaries. Some experts predict that Medicare Advantage enrollees will represent 30 percent of all Medicare beneficiaries by 2016.

It is becoming clear is that the advantages of moving from "fee-for-service" to "pay-for-value" payment models far outweigh the negatives. Paying for value rather than volume and encouraging investments in superior quality, technology, and coordination of care is rising in popularity. The real winners are the Medicare beneficiaries and their health.

Having data from a multitude of sources at the providers' fingertips is the key to the success of these initiatives. Only by providing risk factors, diagnoses, quality metrics, and utilization data to the provider at the point of care can you make a real impact. The free Medicare Advantage templates developed by Quirk in collaboration with NextGen, provide exactly this and more.

Quirk Healthcare Solutions has teamed up with NextGen to develop a Medicare Advantage suite of templates that are built on their 8.3 platform. These templates ensure capture of HCC scores and assist in maximizing 5-star scores. Contact us today to find out how Medicare Advantage templates can work for you.

<Include an icon for Medicare Advantage templates> Our Medicare Advantage suite is built on the NextGen 8.3 platform. The suite includes features that:

Identify HCC and RxHCC codes at point of care.
Ensure HCC codes are recertified annually.

Facilitate the Medicare Health Risk
Assessment.
Code and post encounter query workflows.
Import HCC codes diagnosed by other providers and Medicare data.
Automate identification of suspect HCC codes.
Identify gaps in HEDIS measures. Project HCC scores in real time.
Provide pre-sweep HCC optimization review.
Integrate with transportation systems.

ICD10

CMS announced October 1, 2015 as the new deadline for ICD-10 implementation. This is possibly the most significant change to the healthcare industry in 35 years, affecting claims payment/billing systems, clearinghouses, and private and public software applications. Anyone who provides or receives healthcare in the US will be affected by this turn of events in some way.

In a recent poll of healthcare providers conducted by KPMG, less than half of the respondents said they had performed basic testing on ICD-10, and only a third had completed comprehensive tests. Moreover, about 3 out of 4 said they did not plan to conduct tests of any kind with entities outside their organizations.

Denial of incorrect claims will be the most likely result. CMS will not process ICD-9 Medicare/Medicaid claims after October 1, and there is a high potential for faulty ICD-10 coding or bad mapping to ICD-9 codes. Error rates of 6 to 10 percent are anticipated, compared to an average of 3 percent under ICD-9. ICD-10 will result in a 100 to 200 percent increase in denial rates, with a related increase in receivable days of 20 to 40 percent. Cash flow problems could extend up to two years following implementation. This will be a costly issue for providers, and a very visible issue for patients.

This transition to ICD-10 affects all covered by HIPAA and this hard cut off date is heating up the pressure for compliance. Let Quirk Healthcare Solutions assist you with the planning and preparation required for your transition. We offer a suite of services to prepare you that include training, customizations, and testing. Our consultants will support you through every step of the process to ensure a successful transition.

<Include an icon for ICD10 consulting> Quirk Healthcare Solutions offers a range of services to prepare clients for a successful transition to ICD-10. Our services include:
Core team training
Provider documentation training
Document customization
Template customization
Internal testing to ensure proper functioning of software, including identification and resolution of any internal system issues caused by creating or receiving transactions with ICD-10 codes
External testing to ensure transmission and receipt of ICD-10 transactions

Conclusion

Topics discussed here are only the most high profile impacts to the healthcare industry during the current year. Much else flows from them: changes to workflow, to computer systems, to financial expectations. Tremendous pressure is coming to bear within a limited timeframe. We are seeing an industry in the midst of tectonic change, with 2014 as the fault line. It' is unclear whether these disruptions will be for better or worse. But there certainly will be winners and losers, and those who plan ahead are most likely to survive.

The Future of Healthcare Is Now. Partner with Quirk Healthcare Solutions to thrive in spite of these challenges and surpass your competitors.