DS Medical Holdings

QUESTIONS AND ANSWERS

WHAT IS VALUE BASED MEDICINE AND HOW DOES IT AFFECT ME? WHAT ARE MY RESPONSIBILITIES UNDER IT?

Value-based healthcare is a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health **outcomes**. Value-based care differs from a fee-for-service (in which providers were paid based on the amount of healthcare services they deliver.) **Every physician needs to be doing this now … this is the new norm of how they are reimbursed. 2019 is the first year of penalties and rewards.**

Physicians who serve patients with complex conditions are more vulnerable to financial losses in value-based payment models, largely because they lack the technological infrastructure to report the necessary data.

The report, published in JAMA, found that physician practices were likely to receive a penalty in the CMS' Physician Value-based Payment Modifier program because they reported low quality outcomes and higher costs.

The study analyzed payment data from the CMS' Physician Value-based Payment Modifier program made to 899 physician practices who treat 5.2 million Medicare beneficiaries. The **mandatory pay-for-performance program penalized, or rewarded physicians based on their quality outcomes and cost of care.** The program was a precursor to and was replaced by the Medicare Access and CHIP Reauthorization Act (MACRA).

To evaluate the level of patient risk among practices, the authors used the Hierarchical Condition Category, a risk-coding model that adjusts for different demographics and conditions and whether patients were dually eligible for Medicare and Medicaid. This is tied to the RAF scores.

The study found that practices will receive a penalty because they didn't provide the necessary performance data for the program during its first year. The study shows about 45.9% of high medical and social risk practices were penalized for not reporting the data.

In total, only 122 physician practices reported the data necessary for performance payments in the first year of the CMS program. The biggest hurdle to reporting the data was likely lack of technical support.

But even if more of the high-risk practices had reported the necessary performance data, they likely would have suffered a penalty based on their low quality and high cost scores, the authors said.

A better understanding has become increasingly important under MACRA and its quality reporting system, the Merit-based Incentive Payment System, or MIPS, the authors wrote.

The MIPS track, which began this year, reimburses doctors based on their performance in four performance categories: quality, resource use, clinical practice improvement and health information

technology. Practices that serve a high population of socially and medically complex patients will "fare poorly" under the MIPS track based on these reporting requirements.

WHAT IS MACRA AND MIPS?

MACRA is the Medicare Access and CHIP Reauthorization Act. MACRA does many things but most importantly it establishes new ways to pay physicians for caring for Medicare patients. MACRA combines parts of the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VBM), and the Medicare Electronic Health Record (EHR) incentive program into one single program called the Merit-based Incentive Payment System, or "MIPS.

HOW WILL I BE SCORED UNDER MIPS?

Scores for each performance category will be weighted and rolled up into the MIPS final score. The weights of each category shift over the course of the program.

PERFORMANCE CATEGORY	2019	2020	2021
Quality	45%	40%*	35%*
Cost	15%	20%*	25%*
Promoting Interoperability	25%	25%	25%
Improvement Activities	15%	15%	15%

*Estimated weights

MIPS final scores will be published by the Centers for Medicare & Medicaid (CMS) on the Physician Compare website(www.medicare.gov).

WHO AM I COMPARED TO?

All MIPS-eligible clinicians (ECs), regardless of specialty, will be compared to each other and against a performance threshold.

WHAT ARE THE REPORTING REQUIREMENTS UNDER MIPS?

Quality

In the quality performance category, you must report at least six measures, including one outcome measure. ECs must report on at least 60% of patients eligible for the measure, regardless of payer. This is referred to as "data completeness criteria."

In addition to the six measures reported by ECs, CMS will calculate the all-cause hospital readmission measure for groups of 16 or more ECs.

Cost

CMS will calculate the clinician's performance using claims data. Cost accounts for 15% of the MIPS final score for the 2019 performance period. Clinicians will be assessed on their performance of Total per

Capita Cost, Medicare Spending per Beneficiary (MSPB), and applicable episode-based measures. CMS is currently developing additional episode-based cost measures for use in future program years.

Improvement Activities

Certified or recognized patient-centered medical homes (PCMH) will receive full credit in the improvement activities category. Organizations which currently offer approved PCMH accreditation include:

The National Committee for Quality Assurance (NCQA) Accreditation

Association for Ambulatory Health Care (AAAHC)

The Joint Commission (previously called the Joint Commission on Accreditation of Healthcare Organizations)

URAC (previously called the Utilization Review Accreditation Commission)

State-based, regional, private payers, or other entities that administer PCMH accreditation to at least 500 practices

Additionally, if at least 50% of practice sites under the TIN have PCMH recognition, the entire TIN will qualify for full points in the improvement activities performance category.

Clinicians who do not qualify for the full credit must attest to two high-weighted (20 points each) or four medium-weighted (10 points each) activities, or a combination of both to achieve a total of 40 points. An activity must be performed for at least 90 consecutive days during the performance period to receive credit.

For MIPS APMs, CMS will assign a score in the improvement activities performance category based on improvement activity requirements under the terms of the particular MIPS APM. If CMS assigns the maximum score, then MIPS APM participants would not need to submit additional activities. If the MIPS APM does not receive the maximum score, the participants would have the opportunity to submit additional activities to be added to the baseline score assigned to CMS. All other APMs will automatically receive half the credit for the improvement activities performance category.

Promoting Interoperability (PI)*

CMS redesigned the PI performance category. Scores for this category are based on an EC or group's performance on a set of required measures. An EC cannot earn more than 100 points (100%) in the PI performance category. ECs must report a minimum 90 consecutive days for the PI category.

The objectives and measures are based on the 2015 EHR Incentive Program requirements. Beginning in 2019, ECs must have 2015 Edition certified electronic health record technology (CEHRT) in place for the PI performance period.

*This category was formerly called advancing care information (ACI).

HOW WILL I BE PAID UNDER MIPS?

Physicians participating in MIPS will be eligible for positive or negative Medicare Part B payment adjustments of up to 7%. Distribution of payment adjustments will be made on a sliding scale and will be budget neutral. Payment adjustments will be based on the following:

Physicians with a final score at the threshold (30) will receive a neutral payment adjustment.

Physicians with a final score above the threshold (>30) will receive a positive payment adjustment on each Medicare Part B claim in the payment year.

Physicians with a final score below the threshold (7.51-29.99) will receive a negative payment adjustment on each Medicare Part B claim in the payment year.

Physicians with a final score in the lowest quartile (≤7.5) will automatically be adjusted to the maximum negative adjustment on each Medicare Part B claim in the payment year.

HOW ARE CARE EPISODE GROUPS RELEVANT TO THE MACRA?

MACRA requires CMS to establish "care episode groups" and "patient condition groups." The creation of these groups is intended to help CMS measure **resource use** more effectively. These groups will also play a part in determining payments to providers (under the MACRA, care episode groups will account for at least 50% of expenditures under Medicare Parts A and B).

Care Episode Groups: CMS must consider a patient's clinical problems at time of a service during an episode of care (e.g., clinical condition or diagnosis), whether hospitalization occurs, and principal services furnished.

Patient Condition Groups: CMS must consider the patient's clinical history at the time of a medical visit, current health status, and recent significant history.

WHAT DOES IT MEAN TO HAVE THESE PROGRAMS MANDATED? HOW IS THIS NEW REIMBURSEMENT MANDATED?

Mandating in this sense means that if you want to get paid now, you need to change the way you care for your patient. **All the chronic conditions management – which is the biggest expenditure to CMS – must now be lumped together and managed. No longer can these services be fragmented – or siloed – on how they are being managed.** Now OUTCOMES must be tracked and reported. Every action produces an outcome. If a physician cannot document that something was done, in the eyes of CMS – it wasn't. Now all these outcomes are being folded into value based and different payment methods and payers know through claims data what the risks are to chronically ill populations. The number now reflect in scoring – like Risk Adjustment Factor (or RAF.) The Center for Medicare & Medicaid Services' Hierarchical Condition Category (HCC) risk adjustment model assigns a risk score, also called the Risk Adjustment Factor or RAF score, to each eligible beneficiary.

The more accurately and completely you represent the disease burden of your patient in your documentation, the greater your monthly capitation and the lower the chance of clawbacks.

The relative RAF adjustments for different disease burdens are not necessarily intuitive.

Physicians must make sure they see their patients at least once every 12 months to keep them healthy and address all their chronic illnesses. Otherwise, CMS won't know their disease burden while calculating their capitation—they wipe the disease burden slate clean each year, so you'll be covering their healthcare costs with less money. It is important to remember that once medical necessity is identified, the action remains an "open item" until resolved, fulfilled, completed and/or documented properly. Our platform is integrated and intuitive so it will "pick up" and act on medical necessity, alerts and other components ensuring full patient compliance.

A patient's disease burden is solely based on the ICD-10 diagnostic codes CMS receives when bills are submitted. That's why everyone must have an EMR and watches how codes are submitted. Codes mean revenue. See this CMS fact sheet on more details - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downl oads/2015-RiskAdj-FactSheet.pdf

HOW ARE THESE PROGRAMS INCENTIVIZED? AND WHY?

By placing your patient in a chronic disease management program, all of the extraneous work of coordinating care, monitoring values daily etc. -- all of the additional work that is done to manage this patient needs to be documented and coded. A physician must identify, engage, treat and manage the patients disease state. It is far too much work to handle alone. But if these disease states are not managed properly, the reimbursement will suffer. CMS has come up with programs such as CCM, RPM, TCM to help incentivize the physicians. Problem is – it is overwhelming to the practice from an administrative perspective. That said, physicians cannot afford NOT to do what the government is now mandating they do. It is not enough to say this work was done, it must be provable and documentable.

WHY DO PATIENTS NEED CHRONIC CONDITIONS MANAGEMENT?

Chronic diseases account for 90% of the claims paid by CMS. If not properly managed, chronic diseases exacerbate and are too costly to the system.

WHAT ARE THE CONSEQUENCES IF I DO NOT FOLLOW THESE MANDATES?

Plain and simple -- Far lower reimbursement and scores resulting in penalties. Lower ranking on Physician Compare found on CMS website.

HOW DO THESE PROGRAMS DRIVE MEDICAL NECESSITY? HOW DOES THIS HELP MY PRACTICE?

By monitoring the patient through medical necessity – ancillary services such as lab, PT etc. drive the patient back to the doctor's office instead of to the hospital.

HOW DO I KNOW THE PATIENTS WILL ENGAGE?

Our partner VBurchett is one of the primary individuals who built and operationalized value-based medicine codes based on detailed regulatory compliance. Currently our partner has 20 million users on their platform and over the last several decades they have built systems to fit and meet requirements using their vast experience and proprietary workflows. The technologies are compliant

across all programs – telemedicine, RPM, BHI and so forth. With each state having different regulations, they are experienced in collaborating alongside Centers for Medicare and Medicaid (CMS) to ensure regulatory compliance across the US and Europe. The technologies are also integrated and interoperable with clinic operations, EMRs and Hospital Systems. This allows us to manage the patient's care across the continuum of care, track it and bill for it.

HOW DO YOU COMMUNICATE WITH THE PATIENTS TO ENSURE ENGAGEMENT?

Reporting is highly detailed to drill down to each patient for each value-based medicine program. Unified communications allow our clients to see each patient across the program continuum. This detail confirms they meet the time and deliverable criteria and other regulatory requirements.

Communication is key with the patients and this is made possible because of their integrated technologies. Furthermore, the patient engagement process is different. They do not employ a "call center and patient scripts with questions" like most vendors.

Their award-winning program specifically selects, trains and employs Clinical Behavior Change Specialists who work with the patient as a whole – from chronic diseases to social determinants which manage the patient in their entirety and not just the illness they suffer. When the patient is empowered the whole process and game is changed.

Additionally, techniques that drive better engagement drive revenue and improved health outcomes. Patients are assigned to one clinical patient engagement expert and that individual works with the patient with a dynamic compliant care plan **solely**. This allows for better patient engagement, better continuity of care across all programs, episodes of care and chronic conditions management across the continuum. It is a true patient centric delivery system. This person is routinely available to engage with the physician practice care team.