



RHC Billing and Value-Based Payments

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Value Based Payments (VBP)

- ✓ What are Value Based Payments (VBP)?
- ✓ Why Value-Based Payment Programs?
- ✓ How do they relate to my RHC, FQHC, or physician practice?
- ✓ Where does Telehealth fit?
- ✓ Why would we consider this?



What are Value-Based Payments?

According to the American Academy of Family Practice:

“...a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care.”

Value Based Payment. www.aafp.org/about/policies/all/value-based-payment.html. American Academy of Family Practice. 2016 COD. Accessed 10.15.2019.



What are Value-Based Payment programs?

According to the Centers for Medicare and Medicaid Services (CMS):

“Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of our larger quality strategy to reform how health care is delivered and paid for”

“What are Value Based Payment Programs”. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html. Centers for Medicare and Medicaid Services. 07/16/2019. Accessed 10.15.2019.



CMS Value-Based Goals

“Value-based programs also support our three-part aim:

- ✓ Better care for individuals
- ✓ Better health for populations
- ✓ Lower cost”

“What are Value Based Payment Programs”. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html. Centers for Medicare and Medicaid Services. 07/16/2019. Accessed 10.15.2019.



Value Based Contracting

Value-Based Contracting: “VBP uses alternative payment models (APMs) or pay-for-performance (PFP) arrangements to create a combination of incentives and disincentives intended to encourage better health care decision making by tying compensation to certain performance measures.”

Value Based Payment. www.aafp.org/about/policies/all/value-based-payment.html. American Academy of Family Practice. 2016 COD. Accessed 10.15.2019.



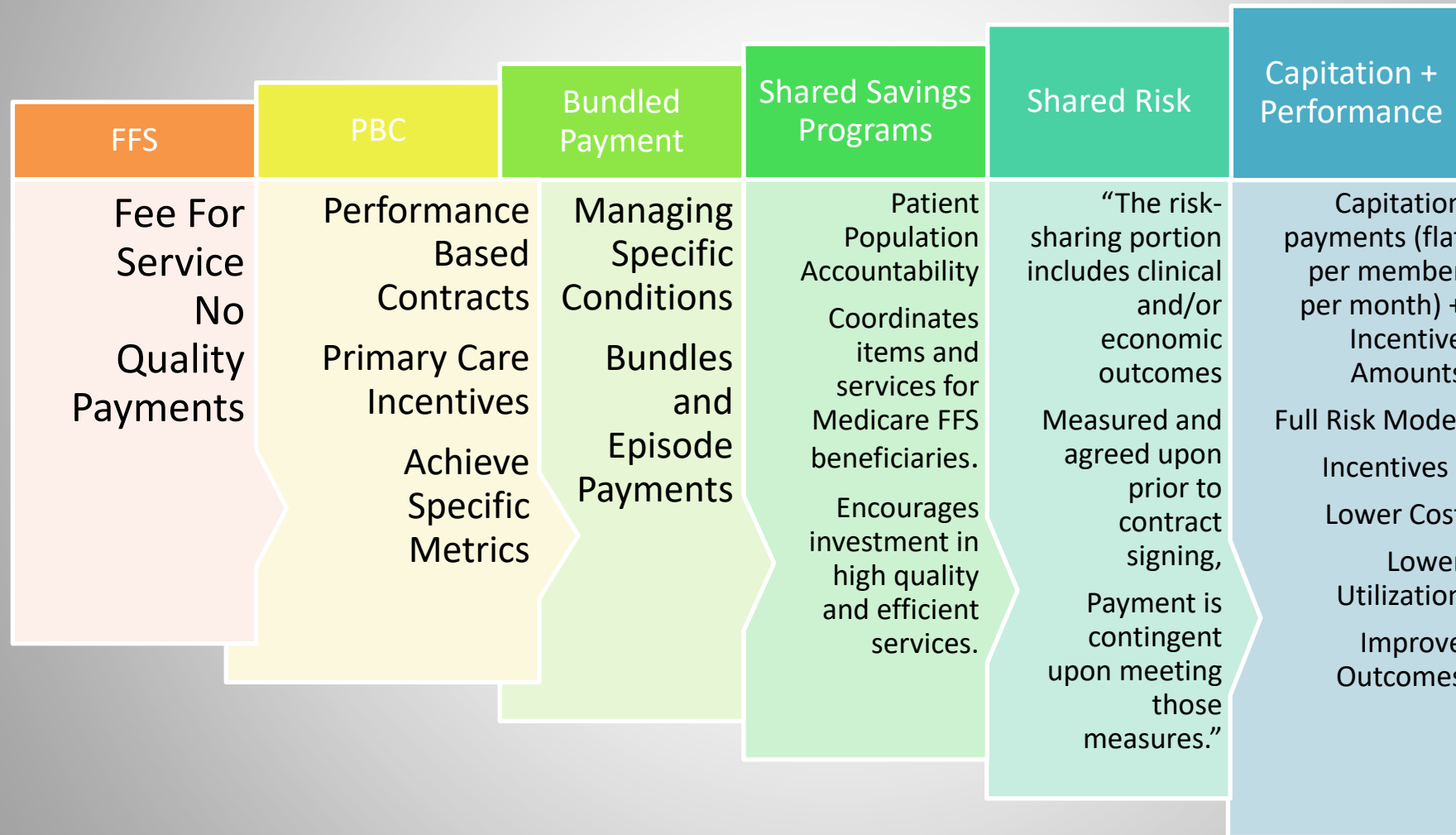
CMS Quality Payment Program

1. Support care improvement by focusing on better outcomes for patients, decreased provider burden, and preservation of independent clinical practice;
2. Promote adoption of Alternative Payment Models that align incentives across healthcare stakeholders; and
3. Advance existing efforts of Delivery System Reform, including ensuring a smooth transition to a new system that promotes high-quality, efficient care through unification of CMS legacy programs.

(CMS MIPS Final Rule)



The Spectrum of Quality Payment Programs





CMS Quality Payment Programs

“The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the [Sustainable Growth Rate](#) (SGR) formula, which would have significantly cut payment rates for participating Medicare clinicians. MACRA requires us to implement an incentive program, the Quality Payment Program.”

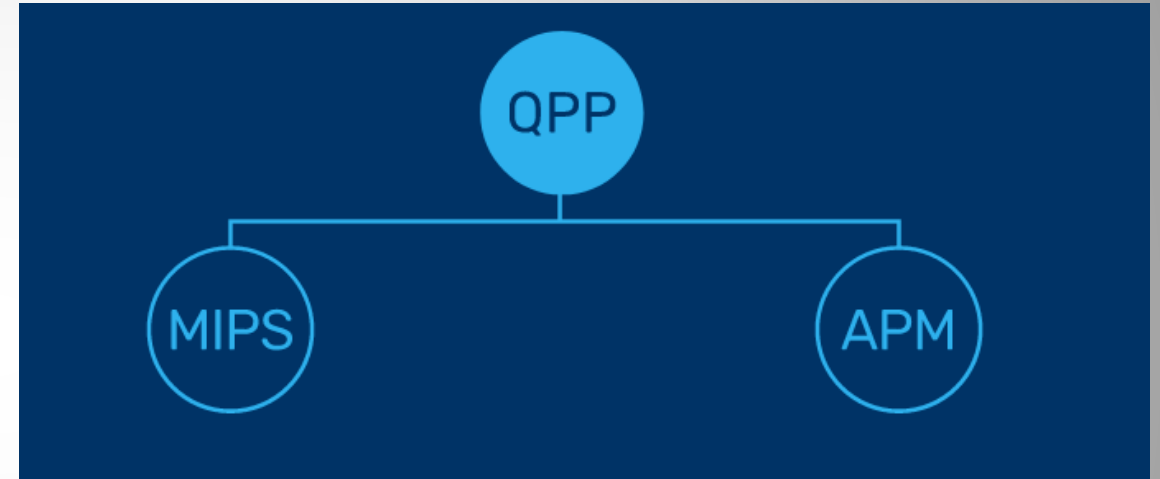
There are 2 ways clinicians can choose to participate in the Quality Payment Program:

- ✓ Medicare Incentive Payment Programs (MIPS)
- ✓ Alternate Payment Mechanisms (APM)



CMS Quality Payment Programs

An APM is a customized payment approach developed by CMS, often designed to provide incentives to clinicians who are providing high-quality, high-value care. APMs can focus on specific clinical conditions, care episodes, or populations.

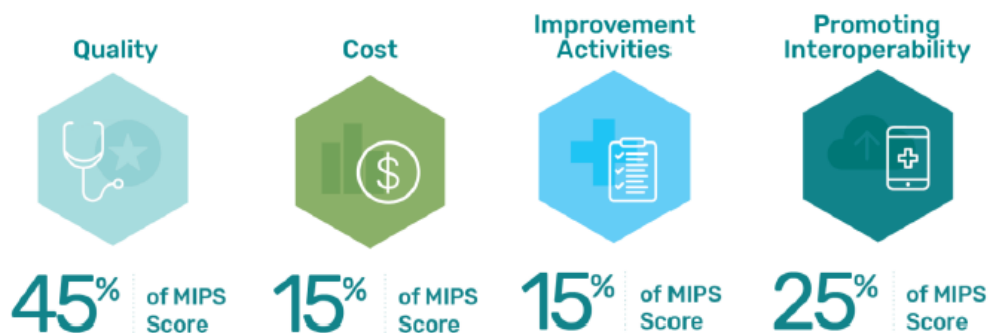




What is the Merit-based Incentive Payment System (MIPS)?

Under MIPS, there are 4 performance categories that could affect your future Medicare payments. Each performance category is scored by itself and has a specific weight that is part of the MIPS Final Score. The payment adjustment determined for each MIPS eligible clinician is based on the Final Score. These are the performance category weights for the 2019 MIPS Performance Year:

MIPS performance category weights in 2019:



Please note that for MIPS APM participants, scored under the APM scoring standard, the performance categories have the following weights:



What is MIPS?

To learn more about how to participate in MIPS:

- Visit the *MIPS Eligibility and Individual or Group Participation* web pages on the *Quality Payment Program* website.
- View the *2020 MIPS Participation and Eligibility Fact Sheet*.
- Check your current participation status using the *QPP Participation Status Tool*.





Low-Volume Threshold: MIPS Requirements 2021

You ***must participate*** in MIPS if, in both 12-month segments, you:

- Bill more than \$90,000 for Part B covered professional services , AND
- See more than 200 Part B patients, AND
- Provide 200 or more covered professional services to Part B patients **(NEW)**.

If you're not required to participate as an individual, you may still be required to participate. See Virtual Groups and "Opt-In".

From QPP.CMS.GOV:

[Low Volume Threshold](#)



Advanced APM

Advanced Alternative Payment Models (APMS) are a track of the Quality Payment Program that offer a 5 percent incentive for achieving threshold levels of payments or patients through Advanced APMs. If you achieve these thresholds, you become a (QP) and ***you are excluded from the MIPS*** reporting requirements and payment adjustment.

- ✓ Requires participants to use certified technology;
- ✓ Provides payment for based on quality measures comparable to those used in the MIPS quality performance category; and either



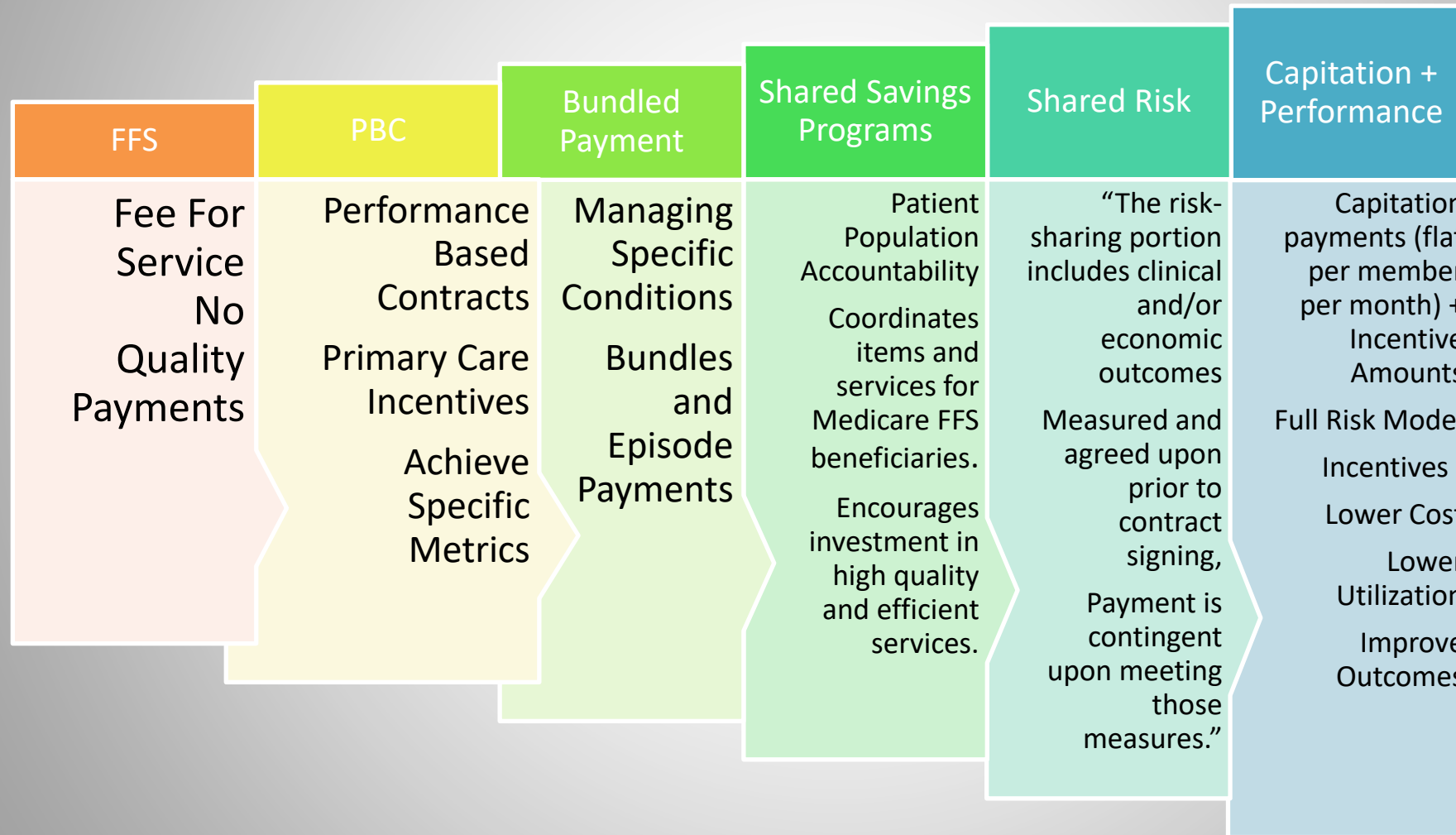
Where do RHC/FQHCs fit in?

RHCs and FQHCs are not **currently** eligible for most **Medicare** Quality Payment Programs because we are not paid on the Physician Fee Schedule.

- ✓ Most RHCs and FQHCs do not have significant PFS payments and do not meet MIPS low-threshold participation requirements.
- ✓ Many of us are participating with ACOs as part of provider-based organizations or larger Medical Group (which exempts us from MIPS).
- ✓ *Commercial payers are starting to recognize and pay quality measures.*



The Spectrum of Quality Payment Programs





Medicare Shared Savings Program: ACO

The Medicare Shared Savings Program (Shared Savings Program) offers providers and suppliers (e.g., physicians, hospitals, and others involved in patient care) an opportunity to create an Accountable Care Organization (ACO). An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population. The Shared Savings Program has different tracks that allow ACOs to select an arrangement that makes the most sense for their organization.



Medicare Shared Savings Program: ACO

The Shared Savings Program is an important innovation for moving the Centers for Medicare & Medicaid Services' (CMS') payment system away from volume and toward value and outcomes. It is an alternative payment model that:

- Promotes accountability for a patient population.
- Coordinates items and services for Medicare FFS beneficiaries.
- Encourages investment in high quality and efficient services.



Typical Mechanics

Care Management Services

Annual Wellness Visits

Transitional Care Management

Preventive Screenings

Reduce hospitalizations



Patient Centered Medical Home

- ✓ High-risk patients benefit from PCMH pro-active coordination and follow-up communication by their Care Team. Having their ongoing needs addressed, prevents trips to the hospital and saves them (and their families) both time and money and reduces unscheduled health emergencies.
- ✓ Providers report deep satisfaction by keeping their most vulnerable patients out of the hospital and maintaining their highest level of independence.
- ✓ Care Teams work smarter, not harder by developing customized patient-centered health improvement plans for high-risk patients, using electronic health technology effectively and by communicating patient updates through huddles/communication boards. Everyone functions at the top of their licenses.
- ✓ PCMH meets MIPS guidelines for CMS reimbursement and can result in increased payments from CMS ***and other payors.***



Medicare Advantage / Commercial Payers

Medicare Advantage and Commercial health plans contracts with CMS are based upon pay for performance. Provider contracts align with payer incentives.

STARS 5 components include:

- ✓ quality/HEDIS measures data,
- ✓ member CAHPS surveys,
- ✓ member HOS surveys,
- ✓ Pharmacy/Part D measures data,
- ✓ health plan operations data.

Commercial Payers are increasingly paying for performance!



Commercial Payment Example

Fee for Service

plus 5% incentive on
quality measures based
on preventive screenings





Common Performance Measures

- ✓ CAHPS: Consumer Assessment of Healthcare Providers and Systems (Patient Survey)
- ✓ HEDIS: Healthcare Effectiveness Data and Information Set
- ✓ HOS: Medicare Health Outcome Survey
- ✓ Pharma Part D Measures
- ✓ Health Operations – Cost
- ✓ Patient Centered Medical Home Status



Reporting Quality Data

Use a Certified EHR Technology. You must capture your patients' clinical data using a certified EHR technology. Not only can this make you eligible for MIPS bonus points, but most certified EHR technologies automatically capture quality measure data for you as you enter information into each patient's record.

Electronically Calculate Clinical Quality Measures. If you have a certified EHR technology, it may already include a number of electronic clinical quality measures that can be calculated. You may also use the assistance of a third party, like a specialty society registry or qualified clinical data registry (QCDR), to calculate the electronic clinical quality measure data captured within your certified EHR technology.

Submit Quality Measure Reports Electronically. You must submit an electronic file of your electronic clinical quality measure data to CMS. You may use a certified EHR technology with the ability to create an electronic submission file or use the assistance of a third party, like a specialty society registry or QCDR, to submit an electronic file on your behalf.

Quality Measures Reporting. www.healthit.gov/topic/federal-incentive-programs/MACRA/MIPS/quality-measures-reporting. 2.12.2019. Accessed 10.15.2019





State Medicaid Plans – Illinois and Missouri

Illinois: “Beginning January 1st, 2018, Illinois transitioned their managed care program into a more streamlined, accountable, and integrated program. The goal of the member-centric Health Choice Illinois Program is to provide enhanced quality and improved outcomes, all while managing cost.

Statewide, providers have an opportunity to contract with each of the 4 (6 in Cook County) qualified, experienced, and financially sound managed care plans that have been chosen to provide services.”



Illinois – Integrated Health Homes

The Integrated Health Home is a care coordination model which would create a comprehensive system of care coordination services for Medicaid individuals with chronic conditions. Health homes will integrate and coordinate all services for physical health, behavioral health and social care needs. The coordination of a member's care is done through a dedicated care coordinator who oversees and coordinates access to all the services a member requires.

“Proposed Changes In Methods And Standards for Establishing Medical Assistance Payment Rates.” January 24, 2020. Integrated Health Home. www.illinois.gov/hfs/MedicalProviders/cc/Pages/defaultnew.aspx. Illinois Department of Healthcare and Family Services. Accessed 5.27.2020.





Missouri: Primary Care Health Home (PCHH)

MO HealthNet's Primary Care Health Home (PCHH) initiative strives to provide intensive care coordination and care management as well as address social determinants of health for a medically complex population. One aspect of the program includes the implementation and evaluation of the Patient Centered Medical Home (PCMH) model as a means to:

- ✓ achieve accessible, high quality primary care;
- ✓ demonstrate cost-effectiveness in order to validate and support the sustainability and spread of the model, and
- ✓ support primary care practices by increasing available resources and improving care coordination thus improving the quality of clinician work life and patient outcomes.

MO HealthNet Primary Care Health Home Initiative. Missouri Department of Social Services. <https://dss.mo.gov/mhd/cs/health-homes/>. Accessed 5.27.2020.





Missouri: Primary Care Health Home (PCHH)

The MO HealthNet PCHH initiative currently has more than 40 participating organizations with over 160 clinic sites. A complete list of Primary Care Health Home providers and sites can be found in the Featured Links section.

MO HealthNet Primary Care Health Home Initiative. Missouri Department of Social Services. <https://dss.mo.gov/mhd/cs/health-homes/>. Accessed 5.27.2020.

MO HealthNet PRIMARY CARE HEALTH HOME PER-MEMBER-PER-MONTH RATE

RATE	EFFECTIVE DATE OF SERVICE
\$64.68	07/01/2019
\$63.72	01/01/2016
\$62.47	01/01/2015
\$61.25	01/01/2014
\$60.05	03/01/2013
\$58.87	01/01/2012

MO HealthNet Primary Care Health Home Initiative. MO Healthnet Primary Care Health Home Per-member-per-month Rate. Missouri Department of Social Services. <https://dss.mo.gov/mhd/cs/health-homes/>. Accessed 5.27.2020.



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- ✓ Most RHCs and FQHCs do not have significant PFS payments and do not meet MIPS low-threshold participation requirements.
- ✓ Many of us are participating with ACOs as part of provider-based organizations or larger Medical Group (which exempts us from MIPS).
- ✓ The Patient-Centered Medical Home model offers one route for many facilities to participate in quality payments.
- ✓ *Commercial payers are starting to recognize and pay quality measures.*



Resources

“What are Value Based Payment Programs”. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html. Centers for Medicare and Medicaid Services. 07/16/2021. Accessed 10.15.2019.

Value Based Payment. www.aafp.org/about/policies/all/value-based-payment.html. American Academy of Family Practice. 2016 COD. Accessed 10.15.2019.

“New Healthcare Model Reframes Relationships, Risk-Sharing, Between Providers And Companies”
<https://www.forbes.com/sites/siemenshealthineers/2017/02/10/new-healthcare-model-reframes-relationships-risk-sharing-between-providers-and-companies/#38151f303243>. Sourabh Pagaria. Forbes.com. 2.10.2017.
Accessed 10.15.2019.





Resources

Dyrda, Laura. Becker's Hospital Review. "The genie's out of the bottle on this one': Seema Verma hints at the future of telehealth for CMS beneficiaries." COVID-19 Coverage. Tuesday, April 28th, 2020.

Accessed 5.27.2020.

Quality Measures Reporting. www.healthit.gov/topic/federal-incentive-programs/MACRA/MIPS/quality-measures-reporting. 2.12.2019. Accessed 10.15.2019.

Care Coordination Home. www.illinois.gov/hfs/MedicalProviders/cc/Pages/defaultnew.aspx. Illinois Department of Healthcare and Family Services. Accessed 10.15.2019.

Integrated Health Home. www.illinois.gov/hfs/MedicalProviders/cc/Pages/defaultnew.aspx. Illinois Department of Healthcare and Family Services. Accessed 10.15.2019.





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