Value: CMS Means Business

Implications for Gastroenterology

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CMS Means Business

Value instead of fee-for-service

MACRA legislation implications

CPT changes: some new opportunities for GI?

Reading the tea leaves

- Sylvia Says
- How is she gonna’ get there?
  (Fast Track task force….)
- Congress Says
- In the meanwhile
- Preview of 2016 fee schedule
- New E/M codes with opportunities for GI
Triple Aim: changing payment, healthcare delivery

CMS pumps the accelerator

- Better healthcare outcomes
- Better healthcare experience
- Lower cost/better outcomes (= value)
- Requires accountability (quality reporting) & transparency
Setting Value-Based Payment Goals—HHS 2015

- Incentives to motivate higher-value care, increasingly tying payments to value through alternative payment models (APMs)
- Changing care delivery through greater teamwork & integration...population health
- Power of information to improve care
- Majority of Medicare FFS payments already have link to quality or value

S.Burwell NEJM mar 5 2015 372;10:897-819
Setting Value-Based Payment Goals-2

• Goal to have 85% of all Medicare FFS payments tied to quality or value by 2016, 90% by 2018
• Target to have 30% Medicare payments tied to quality or value through APMs by end of 2016, 50% by end of 2018
• Includes ACOs, bundled payment arrangements…engaging Medicaid, private payers
Setting Value-Based Payment Goals-3

• Three strategies
  – 1st strategy: Incentives:
    • New institutions, pay arrangements eg ACO, bundles, medical homes, episodes of care, dual eligibles integrated care
    • “we plan to develop & test new payment models for specialty care, starting with oncology care”; chronic care coordination…today such payments approx 20% of Medicare payments
    • Consensus on quality measures…risk adjustment
Setting Value-Based Payment Goals-4

• 2\textsuperscript{nd} strategy: incent greater integration within practice sites, provider coordination, attention to population health
  – eg hospital readmission programs, Transforming Clinical Practice Initiative ($800M)…medical homes

• 3\textsuperscript{rd} strategy: accelerate availability of information to guide decision making…advance interoperability through alignment of health IT standards with payment policy
Changing employment dynamics:
Private versus hospital-owned practices, 2002-2011

Source: Physician Compensation and Production Survey, Medical Group Management Association, 2011 Survey
Transitioning from Fee-for-service to Value-based Reimbursements

Notice how there’s no specific unit of time to mark the transition from fee-for-service to value-based reimbursement. Nobody knows yet how long this process will take.

B Brown, J Crapo  HealthCatalyst 2015
https://www.healthcatalyst.com/hospital-transitioning-fee-for-service-value-based-reimbursements
State of the current physician fee for GI

Had >120 GI endoscopy codes revalued by CPT → RUC → CMS

- EGD, EUS and ERCP **professional fees fell 8-40%** 2014, finalized 2015
- Colonoscopy fees revalued by CPT → RUC process 2014
  - DELAY of one year by CMS
  - Demands that CMS show more transparency, ie tell us earlier and give us time to comment and adjust
  - Removal of moderate sedation value from endoscopy…pays it back if we do it, NOT NOT
- COLONOSCOPY FEES PROPOSED RULES DUE OUT ANY TIME NOW
  - No reason to think they will be spared similar reductions
  - Project **potentially $20-$50,000 revenue loss per GI doc**

6/11/2015
# CMS Penalties Adjustments for Non-participation in Quality Programs

<table>
<thead>
<tr>
<th>Year</th>
<th>eRx</th>
<th>EMR (MU)</th>
<th>PQRS</th>
<th>Total Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>-1.5%</td>
<td>No penalty</td>
<td>No penalty</td>
<td>-1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>-2.0%</td>
<td>No penalty</td>
<td>No penalty</td>
<td>-2.0%</td>
</tr>
<tr>
<td>2015</td>
<td>No penalty</td>
<td>-1.0%</td>
<td>-1.5%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>2016</td>
<td>No penalty</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-4.0%</td>
</tr>
<tr>
<td>2017</td>
<td>No penalty</td>
<td>-3.0%</td>
<td>-2.0%</td>
<td>-5.0%</td>
</tr>
<tr>
<td>2018</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td></td>
<td>-6.0%</td>
</tr>
<tr>
<td>2019</td>
<td>-5.0%</td>
<td>-2.0%</td>
<td></td>
<td>-7.0%</td>
</tr>
</tbody>
</table>

**ADDED TO VB modifier? -4%**

**And your -2.0% sequester “bonus”**
Value-Based Modifier Scoring

- Clinical care
- Patient experience
- Patient Safety
- Care Coordination
- Efficiency
- Total overall costs
- Total costs for beneficiaries with specific conditions

Quality of Care Composite Score

Cost Composite Score

VALUE-BASED PAYMENT MODIFIER AMOUNT

2017 ADJUSTMENTS +4% vs zero vs -4% based on 2015 reporting
2016: groups of 10+    2017: all of us
The Health IT Policy Committee emphasized 4 areas of EHR technology in their recommendations:

- Clinical Decision Support (CDS) –
- Patient Engagement –
- Care Coordination –
- Population Management –
- Slated to take effect in 2017 (deferred a year)
More than 25% of patients seen by an EP or discharged from a hospital or emergency department (ED) must "actively engage" with their electronic records.

For more than 35% of patients seen by an EP or discharged from a hospital or ED, a secure message must be sent using the EHR's secure messaging function or in response to a secure message sent by the patient.

Patient-generated data from a nonclinical setting must be incorporated into the EHR for more than 15% of patients seen by the EP or discharged from a hospital or ED.

EPs and hospitals must use their EHR to create a summary of care and electronically exchange it with other providers for more than 50% of transitions of care and referrals.

In more than 40% of these transitions of care, the provider has to incorporate in its EHR a summary of care from an EHR used by a different provider.

In more than 80% of transitions of care, the provider has to perform a "clinical information reconciliation" that includes not only medications and allergies, but also problem lists.
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MU 3  what are they smoking?

We’ll know this year (we sent LOTS of comments)

Implementation 2017?

ONC White Paper on meeting interoperability goals….2024??

Pipe dream?
Sylvia’s way March 2015

Health Care Payment Learning & Action Network

(?? HCPLAN)

- Contractor-led multi-stakeholder /observer public-private entity
- Tasked with pressing the accelerator, pushing/pulling everyone along
  - eg private payers
    - Medicaid
    - providers
- The Agenda? They’ll tell when they’re ready
- The Conclusions? They’ll reveal when they’re ready
Starting in 2019, physicians will choose from one of two paths: MIPS or APMs?

Merit-based Incentive Payment System

Alternative Payment Model

Medicare Access & CHIP Reauthorization Act  MACRA  P.L.114-10
MACRA (HR 2)  SGR repeal 2015 (YEAH!)

- "Positive" updates 0.5% 2015 - 2019; 0% 2020-2025. Beyond 2025 0.75% for eligible alternative payment model (APM) participants, 0.25% for others.
- "Merit-based Incentive Payment System" (MIPS) quality program:
  Max bonuses and penalties 4% 2019;
  5% 2020; 7% 2021; > 2021 9%
  $0.5 B for bonuses up to 10% “exceptional performance”
- PQRS, MU and VBM penalties end in 2019.
- Adjustable for individuals or groups

- APM participant: >25% of income by 2019 from APMs → 5% bonus 2020-2024 then 0.75%
By 2019 There will be 2 Options to Satisfy Value Based Reimbursement Mandates

**OPTION 1:** Merit Based Incentive Payment System (MIPS)

**OPTION 2:** Alternative Payment Models (APM)

4 years 0.5% +9 to -9%

5% Bonus Maybe
Two pathways: MIPS versus APMs

MIPS

- Point scale, threshold ?mean or median, penalty funds feed high performers
- Measurement categories:
  - Clinical quality (by year 3 will be 30% of total composite score)
  - Meaningful use (25%--but could be adjusted down to 15% if 75% of eligible professionals are meaningful users)
  - Resource Use (10% in year 1, 15% in year 2, and 30% in year 3 and subsequent years)
  - Practice improvement (15%)
- Additional weighting will be applied based on achievement, improvement, and the applicability of each category to the type of EP

APM

- 5% annual bonus FFS payments for physicians with substantial revenue from alternative payment models that
  - Involve upside and downsize financial risk, e.g. ACOs or bundled payments
  - OR
  - PCMHs, if shown to improve quality w/o increasing costs, or lower costs w/o decreasing quality <no financial risk>
APMs: required revenue thresholds

• Two options available for eligible professionals to qualify for the annual 5% FFS bonus:
  – First option: 2019-2020, 25% of Medicare payments must be attributable to the APM; increasing to 50% in 2021
  – Second option: starting in 2021, 50% of combined payments from Medicare and other payers must be attributable to the APM
What else does the MACRA legislation do? *Strong incentives for PCMHs*

- Certified PCMHs and PCMH specialty practices will get highest possible scores for clinical practice improvement under MIPS (15% of total)
- PCMHs can potentially qualify as an APM without having to take financial risk (not clear if specialty PCMHs would be eligible).
APMs for Gastroenterologists

What, me worry?

- Colonoscopy bundled payment
- Financial risk subcontracting within ACOs?
- What if our current contracts are with capitated organizations (IPAs, contracting medical groups, PHOs etc)
- GI subcapitation
- Episodes of care eg
  - IBD
  - Chronic hepatitis, cirrhosis
- Specialty medical homes /garages
FOR SCREENING or FOBT positive…not for high risk patients, diagnostic or complex therapeutic exams
SO, IS THERE ANY GOOD NEWS?
- ASC facility fees up modestly, yearly, since 2012 (after falling 40%)
- Many GI groups internalized pathology, anesthesia and some imaging & other services
- Many GI practices in good shape for doing bundled fees for colonoscopy
  - Could this qualify for APM threshold if we do nearly all colonoscopy as bundled?
- There are some new E/M codes that GI MAYBE can take advantage of

6/11/2015
Requirements for billing Transitional Care Management services

<table>
<thead>
<tr>
<th>CPT code 99495</th>
<th>CPT code 99496</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Face-to-face visit within 14 days of discharge from inpatient setting</td>
<td>■ Face-to-face visit within 7 days of discharge from inpatient setting</td>
</tr>
<tr>
<td>■ Medical decision-making of at least moderate complexity</td>
<td>■ Medical decision-making of high complexity</td>
</tr>
<tr>
<td>■ Communication (defined as phone call, e-mail exchange, or face-to-face) with patient or caregiver within two business days of discharge</td>
<td>■ Communication with patient or caregiver within two business days of discharge</td>
</tr>
</tbody>
</table>

2.11 wRVU  approx $160   40 min intraservice   3.05 wRVU  approx $230

The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient setting and continues for the next 29 days. The reported date of service should be on the 30th day.

Source: Centers for Medicare and Medicaid Services, Medicare Learning Network
Transitional Care Management Services (TCM)

- The transition in care is **from:**
  - Inpatient, ED
  - Observation status
  - Skilled nursing/nursing facility

NEW OR ESTABLISHED PATIENT

- **To** the patient’s community setting:
  - Home
  - Dom., assisted living
  - NOT TO SNF
  - NOT A HOSPITALIST SERVICE
Services Furnished by Licensed Clinical Staff Under the Direction of a Physician or NPP/PA  (1)(2)

- Communicate with community services used by the beneficiary;
- Provide education to patient/family, caretaker to support self-management, independent living, and ADLs;
- Assess and support treatment regimen adherence and medication management;
- Identify available community and health resources; and
- Assist the beneficiary and/or family in accessing needed care and services.

(1) i.e. incident to… (2) can be contracted for
Needed, to provide TCM

• Identify eligible patients while inpatient and prepare staff to implement TCM process
• Staff team carries out contact, arranges followup
• New EHR templates to document team contributions, billing submitted at 30 days
Transitional Care Management Services

This publication provides the following information:
- Transitional Care Management (TCM) services;
- Health care professionals who may furnish TCM services;
- TCM services settings;
- Components included in TCM;
- Billing TCM services;
- Frequently Asked Questions; and
- Resources.

TCM SERVICES

The requirements for TCM services include:
- The services are required during the beneficiary’s transition to the community setting following particular kinds of discharges;
- The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap; and
- The beneficiary has medical and/or psychosocial problems that require moderate or high-complexity medical decision making.

Chronic Care Management

From CMS ICN 909188
January 2015
PAYS $42 per month if provided within the month
Practitioner Eligibility

Physicians and the following non-physician practitioners may bill the new CCM service:

- Certified Nurse Midwives;
- Clinical Nurse Specialists;
- Nurse Practitioners; and
- Physician Assistants.

Only one practitioner may be paid for the CCM service for a given calendar month.

Source: http://www.cdc.gov/pcd/issues/2013/13_0137.htm
“...may use individuals outside the practice to provide CCM services, subject to the Medicare PFS “incident to” rules and regulations and all other applicable Medicare rules.

**Supervision** CMS provided an exception under Medicare’s “incident to” rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the *general supervision* (rather than direct supervision) of a physician (or other appropriate practitioner).
“CMS requires the billing practitioner to furnish an Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), or comprehensive evaluation and management visit to the patient prior to billing the CCM service, and to initiate the CCM service as part of this Patient Agreement exam/visit.”

MAIN HURDLE TO SPECIALISTS FURNISHING CCM...

comprehensive in-patient or office visit then SAME DAY “enroll” patient for CCM
Patient consent requirements include:
--Inform
--obtain written agreement …
--including written authorization for the electronic communication of medical information with other treating practitioners and providers
<one time requirement>
--What the CCM service is;
--How to access the elements of the service;
--How the patient’s information will be shared among practitioners and providers;
--How cost-sharing (co-insurance and deductibles) applies to these services; and
--How to revoke the service.

WOULD YOU BE OK WITH A CO-PAY FOR WHAT YOU NOW GET FREE?
“The CCM service is extensive...”

**Structured Data Recording**
- Record the patient’s demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.

**Care Plan**
- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues).
- Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record.
- Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.
- Share the care plan electronically outside the practice as appropriate.
Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.
Access &

• Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services.....practitioners in the practice who have access to the patient’s health record

• Ensure continuity of care with a designated practitioner or member of the care team

• HIPAA compliant communication i.e. no Yahoo emails
...Management...such as

- Systematic assessment of the patient’s medical, functional, and psychosocial needs;
- System-based approaches to ensure timely receipt of all recommended preventive care services;
- Medication reconciliation with review of adherence and potential interactions; and
- Oversight of patient self-management of medications.
- Manage care transitions between and among health care providers and settings, including referrals to other providers, including:
  - Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.
  - Coordinate care with home and community based clinical service providers.
<table>
<thead>
<tr>
<th>CCM Scope of Service Element/Billing Requirement</th>
<th>Certified EHR or Other Electronic Technology Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation during an AWV, IPPE, or comprehensive E/M visit (billed separately).</td>
<td>None</td>
</tr>
<tr>
<td>Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record.</td>
<td>Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.</td>
</tr>
<tr>
<td>Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with health care practitioners in the practice who have access to the patient's health record to address his or her urgent chronic care needs regardless of the time of day or day of the week).</td>
<td>None</td>
</tr>
<tr>
<td>Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.</td>
<td>None</td>
</tr>
<tr>
<td>Care management for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.</td>
<td>None</td>
</tr>
<tr>
<td>Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all the plan as appropriate with other practitioners and providers.</td>
<td>Must at least include: the plan for care towards the following: an agreement with the practitioner and other practitioners and providers.</td>
</tr>
<tr>
<td>Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.</td>
<td></td>
</tr>
<tr>
<td>Management of care transitions between and among CCM certified care providers and settings, including referrals to CCM certified care providers; follow-up after an emergency department visit and follow-up after discharge from hospital facilities or other health care facilities for care provided by other providers.</td>
<td></td>
</tr>
<tr>
<td>Coordination with home and community based service providers.</td>
<td></td>
</tr>
<tr>
<td>Enhanced opportunity for the caregiver to continue; but also the other as available.</td>
<td></td>
</tr>
<tr>
<td>Beneficiary consent - written agreement among the beneficiary and the provider regarding authorization of his or her medical records.</td>
<td>Document the beneficiary's written consent and authorization in the EHR using CCM certified technology.</td>
</tr>
<tr>
<td>Document that all of the CCM services were performed, and note the beneficiary's written authorization and decline these services.</td>
<td>None</td>
</tr>
<tr>
<td>Beneficiary of the right to stop the CCM at any time (effective at the end of the calendar month) the effect of a revocation of the agreement on the services.</td>
<td>None</td>
</tr>
<tr>
<td>Beneficiary consent—inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.</td>
<td>None</td>
</tr>
</tbody>
</table>

For more information, contact: [CASE MANAGERS SOURCE & CCM] 800-000-000. 500 patients in CCM for an average of 90.0 months/year.
Needed, to provide CCM

- Team, templates, EHR templates to include the consent, problem list, care plan
- EHR to accommodate the team documentation including time spent
- Deferred billing until >20 min staff time per month threshold met
- In conjunction with comprehensive visit
Who should have what tests?

Cost efficiency, choices with incentives

Increase population uptake of the testing

Efficient high quality colonoscopy
  - Bundled payment as incentive
  - Quality means fewer future cancers

Adhere to guidelines: surveillance when appropriate
• More hospital consolidation/market power
  – 20% more costly than independent MD practices for same patient population (1)
• More complex “MU” with interoperability way behind
• More complex quality reporting with less $$ incentive but larger “adjustments”
• More incentive to delegate care to people we can’t afford to hire

(1) J Robinson JAMA 2014
CONCLUSIONS

• Multiple methods of payment for GI services
  – All are evolving
  – Standard Fee for service payments mostly all gone

• VALUE (Outcomes / Costs) is the present MANTRA

• Provider risk, accountability, transparency
  – But more consumer/beneficiary “skin in the game”

• AFFILIATION or INCORPORATION of PHYSICIAN PRACTICES into HOSPITAL SYSTEMS
  – Good or bad?
  – Can model provide value or just more market power?

• Need to focus on care provision as teams
• Need to learn to do more with less