WHY CHC CODING MATTERS & THE IMPACT ON FUTURE COMPENSATION

Agenda

- Introduction
- Healthcare Vernacular & National Landscape
- CR 7038… Lost Opportunity
- MACRA, MIPS, & QPP
- Massachusetts CHC Learning
- California Modeling
- Change in care delivery model
- Medicare FQHC PPS G Codes
- Triangle of Communication
- Summary

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Ray is a nationally prominent speaker whose motivational style and unique perspective afford audiences unusual and thought-provoking insight around healthcare financial issues. Having personally trained thousands of providers and financial/billing professionals in all 50 states on coding, billing, and reimbursement, he has also authored several books and dozens of articles.

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Disclaimer

1. The guidelines, interpretations, and recommendations set forth as part of this training session are presented as a guide only. Attendees understand and recognize that actual coding and/or business decisions are the sole liability and responsibility of the provider(s), respective billing staff, and financial professionals. PMG, Inc. does not accept any liability or responsibility in this regard.

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PMG's CHC Mantra

Get paid when you can as much as you can so you can give it away when you want to.

Healthcare Vernacular

- HCPCS: **H**ealthcare **C**ommon **P**rocedure **C**oding **S**ystem
  - Visits, procedures, diagnostic tests
- ICD: International Classification of Diseases
  - Diseases, signs/symptoms, reasons for visit
- FFS: Fee for Service
  - Medicare Professional Fee Schedule (PFS) or
- Capitation or Fixed Payments
  - Fixed payments timeframes vary & covered areas vary
  - PMPM, PMPY, Total risk vs. partial
- PPS: Prospective Payment System
- Actuaries, insurance industry
  - Numbers' folks who decide insured worth/payments

Healthcare Vernacular (Con.)

- Rate Setting
  - Determination of dollars paid by payers
- PCMH: Patient Centered Medical Home
  - CHCs doing this long before it was popular
- PCHH: Patient Centered Health Home
  - A.K.A. PCMH
- MSSP: Medicare Shared Savings Program
- ACO: Accountable Care Organization
- ACA: Affordable Care Act
- MACRA: Medicare Access & CHIP Reauthorization Act
- MIPS: Merit-based Incentive Payment System
- APM: Alternate Payment Methodologies
- QPP: Quality Payment Program

National Landscape

Health Care Payment Learning & Action Network

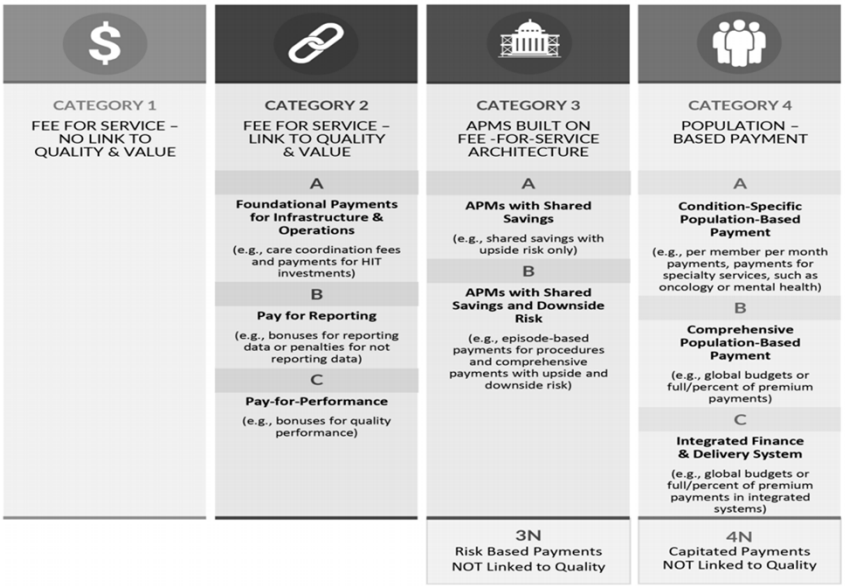
Accelerate shift towards value based care

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

https://hcp-lan.org/

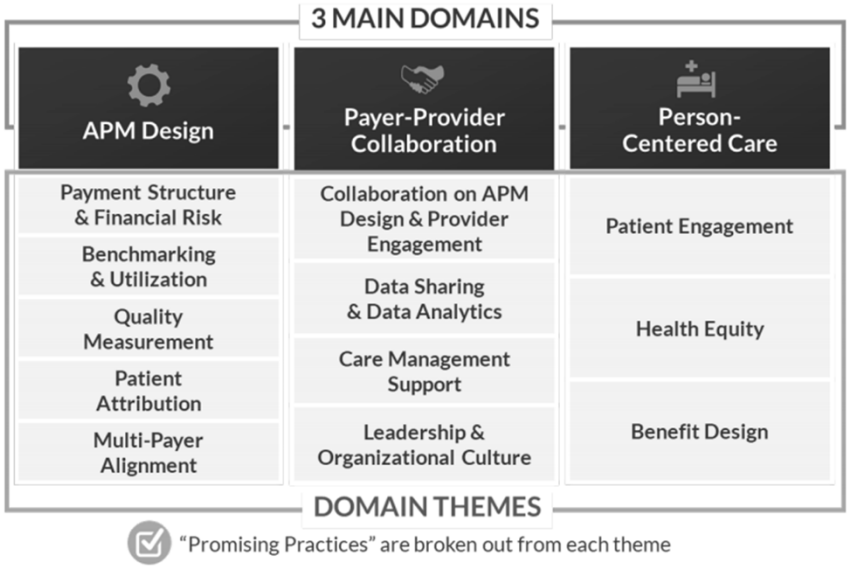
Partial Population Based Payments for Primary Care

Alternate **P**ayment **M**ethodology



https://hcp-lan.org/

HCP-LAN Themes



https://hcp-lan.org/

HCP-LAN Recommendations

Primary Care Payment Models should be:

1. Team-based, population-focused, patient-centered
2. Take into account patient case mix
3. Dominated by prospective population-based payment (per member per month, PMPM)
4. Multi-payer (and most patients in practice should be in same payment model)
5. Greater than historical PC payment to support additional expectations
6. Incentivize infrastructure investments
7. Have a limited role for FFS

HCP-LAN Recommendations

Primary Care Payment Models should be (con.):

8. Be contingent on ability of care teams to coordinate care
9. Have transparent financial incentives
10. Have performance measurement designed to eliminate unintended consequences
11. Use aligned sets of comprehensive performance measures focused on outcomes measures
12. Hold care teams responsible for BH management
13. Allow flexibility to establish linkages with community services (e.g., addressing SDOH)

CR 7038… Lost Opportunity

- Jan 2011
- CMS mandated HCPCS
- Why?
  - CMS “Just curious”
  - Evaluating cost-based to PPS… actual services rendered?
- Mayhem at CHCs
  - PM systems not configured to do this
  - Provider coding substandard
- Questionable data capture
- Result: Lost $$
  - ***< .5% of Medicare beneficiaries see > 1 provider at TOS***

Lesson #1

CHC Coding matters…

The payers are watching & learning.

MACRA, MIPS, & QPP

MIPS: Merit-Based Incentive Payment System

MACRA: Medicare Access & CHIP Reauthorization Act, 2015

QPP: Quality Payment Program*

- Adjustment factor for each MIPS EP*/year
- Result of composite performance score vs. threshold
- Scoring is either positive, negative, or zero
- More money for exceptional performance
- Scaling Factor assures budget neutrality requirement
- Percent of FFS at Risk (Negative adjustment… ***2 year lag***)
  - 2020 = 5%
  - 2021 = 7%
  - 2022+ = 9%
- ***CHCs eligible yet not required to report!!***

*EP = Eligible Provider

**Resource: https://qpp.cms.gov/measures/performance*

Performance Threshold & Payment Adjustments

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment
2017	3 Points	70 Points	Up to +4%
2018	15 Points	70 Points	Up to +5%
2019	30 Points	75 Points	Up to +7%
2020	45 Points	85 Points	Up to +9%

Used with permission of Patient360, Inc. (www.patient360.com)

MIPS Scoring

- QPP* combines:
  - Meaningful Use, PQRS, & Value Based Modifiers
- QPP scoring breakdown:
  - 45% Quality (actual provider clinical activities)
  - 15% Improvement Activities (demonstrable change in behavior)
  - 25% Promoting Interoperability (was Advancing Care Information)
  - 10% Cost
- QPP Submission options:
  - Registry (up to 250 unique measures… primary care focused)
  - Qualified Clinical Data Registry (QCDR), unique non-QPP measures
  - Certified Electronic Health Record Technology
    - Not all EMRs are CEHRT (now, Promoting Interoperability)
    - Limited measure options

**Resource: https://qpp.cms.gov/measures/performance*

Participation Requirements

Must Report MIPS

Bill $90,000 in covered professional services under the Physician Fee Schedule (PFS)

AND

See more than 200 Medicare Beneficiaries

AND

Provide more than 200 Covered professional services under the PFS

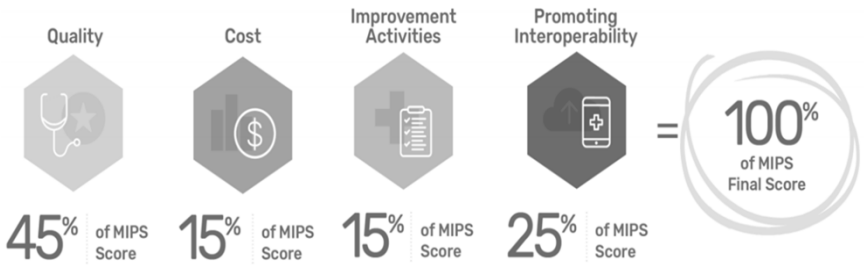
Choose to Opt-In

MIPS eligible clinicians that meet or exceed at least 1 (but not all) of the low-volume threshold criteria

Opted-In clinicians will be subject to all MIPS performance requirements, MIPS payment adjustments, etc.

Used with permission from Patient360, Inc. (www.Patient360.com)

MIPS Categories



Category weights in 2019 and 2020 Reporting Years

Used with permission from Patient360, Inc. (www.Patient360.com)

Performance Threshold & Payment Adjustments

MIPS from Then to Now

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment
2017	3 Points	70 Points	Up to +4%
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Performance Threshold & Payment Adjustments

Practice 1	Practice 2	Practice 3
150 Providers	25 Providers	5 Providers
$12,043, 651 in Part B Claims in 2019	$2,672,866 in Part B Claims in 2019	$481,746 in Part B Claims in 2019
MIPS Impact= +/-$843,055.57	MIPS Impact = +/- $187,100.62	MIPS Impact = +/- $33,722.22

These figures are based on 2019 +/- 7% adjustment.
2020 adjustment is +/- 9%.

Used with permission from Patient360, Inc. (www.Patient360.com)

Looking Ahead: MIPS Categories

	Category Weights	Changes in 2020
COST	15%	No significant changes
Quality	45%	In 2020, 70% of all MIPS eligible data must be submitted
Promoting Interoperability	25%	No significant changes
Improvement Activities	15%	50% of clinicians in a group practice must report

Used with permission from Patient360, Inc. (www.Patient360.com)

QPP: Quality Measure Examples

- 50% of total score
- 6 measures required
- >50% of patients, all payers, not just Medicare
- Registry/QCDR or…
  - Claims, web interface (≥ 25 providers), or EMR (60+ measures)
- Outcomes & High Priority preferred… more value & money

#1: Diabetics 18-75 years with diabetes HGB A1c > 9.0%

#24: Communication with Ortho by PCP, patients >50 years post fracture & evaluation for osteoporosis

#46: Rx reconciliation post discharge, seen < 30 days post discharge

#47: Advance care plan and surrogate decision maker

#50: Female ≥ 65 years with plan or urinary incontinence

#236: Patients 18-65 years with controlled BP (< 140/90 mmHg)

QPP: Improvement Activity (IA) Examples

- 15% of total score
- Most providers need 40 points
- "High" weighted item = 20 points, medium = 10

Two "High" Examples to hit 40 points:

1. IA_**AHE**_1: Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. Timely manner = within 10 business. Medicaid & Medicare (Medi-Medi).

2. IA_ **BE**_ 6: Collection & follow-up on patient experience & satisfaction data on beneficiary engagement, including development of improvement plan.

AHE = Achieving Health Engagement
BE = Beneficiary Engagement

QPP Promoting Interoperability (PI) Examples

- 25% of total score (Can earn up to 10 points)
- CEHRT 2015

Performance Based Example:

PI_EP_1; General Description:
At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.

Cost

- 15% of total score
- Replaces Value Based Payment Method
- Based on attribution group
- Overall patient expense, not just your NPI
- Still seeking objective info on cost determination

Lesson #2

FQHC PPS is presently immune to QPP…

This won't last forever.

A Mass CHC Example

- Romney Care ahead of the curve
  - Several programs… none delivered promises of shared $
- FFS + Quality Bonus
- Targeted disease (e.g., DM, pulmonary, cardiac)
- Inability to demonstrate breadth and scope
  - Sit in the lobby for ten minutes
- Mean = 1 (average patient score)
- CHC Medical Director Expectation: 1.2-1.3
  - Actual score… .85 (15% less complex)
  - Patient Example
- Poor coding = Lesser share of $$

NOTE: Version 5010 allows up to 8 ICD codes!

Lesson #3

Relevant ICD capture is essential…

Future payment decisions depend on it.

California Learning

- CP3: Capitation Payment Preparedness Program
  - Rachel Toby: JSI in California
- Limited Risk… made whole to Medicaid PPS
- Visit threshold… 3 PMPY
- Managing PPS & Capitation simultaneously
  - 2 different healthcare delivery models
  - 2 different accounting methodologies gauging "success"
- Considered progressive state…
  - In actuality, still lagging with no "at risk" program

Washington State Example (1 of 2)

- Started 2000: “Delink” payment from patient volume
- Optional Participation (16 of 27 as of Jul-2017)

https://www.healthmanagement.com/blog/washington-fqhc-alternative-payment-methodology/

Washington State Example (2 of 2)

- PMPM- Capitation
- Maximizing visit volume BEFORE calculation starts

$$\text{APM4 RATE} = \frac{\text{CY2015 Encounter Rate } (\$150) \times (1 + \text{CY2016 MEI}) (101.1\%) \times (1 + \text{CY2017 MEI}) (101.2\%) \times \text{CY2015 Encounters } (20{,}000)}{\text{CY2015 Member Months } (60{,}000)} = \text{Per Member, Per Month } (\$51.16)$$

https://www.healthmanagement.com/blog/washington-fqhc-alternative-payment-methodology/

Lesson #4

A^{2}PM & other options for CHCs…

WIP so get involved to influence outcome.

Change in Care Delivery Model

- FFS/PPS
  - More encounters, more profit
  - Constant provider productivity conversation
  - Increasing visits and $/visit = success
- Capitation or Risk, More profit if fewer encounters
  - Manage patients remotely
  - Minimum threshold (e.g., CA, 3+ encounters)
  - Managing patient populations; outcomes vs. production

Lesson #5

Not better or worse care…

Just different.

Blended Encounter Rate… What is it?

- Average payment per visit/encounter
- How to calculate:

Total Payments ÷ Total Visits = Blended Encounter Rate*

vs. (different than knowing) Medicaid or Medicare Rate

*Visits = Encounters = Single patient face-to-face service with core provider

Blended Encounter Rate BER… 2018 UDS Data

- Average payment per visit/encounter
- How to calculate:
  - 2018 National UDS 5, Lines 15,19,20-22, & 22d (Visits) 109,305,803
  - 2018 National UDS 9, Line 14B Collection $19,516,245,728
  - **2018 National Blended Encounter Rate: $178.55/visit**

  - 2018 SC UDS 5, Lines 15,19,20-22, & 22d (Visits) 1,523,963
  - 2018 SC UDS 9D, Line 14 Collection $313,373,122
  - **2018 SC Blended Encounter Rate: $205.63**

NOTE: Visits = Encounters = Totals excluding "Enabling Services"

Source: https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=
& https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=SC

Blended Encounter Rate BER… 2018 UDS Data

- Average payment per visit/encounter
- How to calculate:
  - 2018 National UDS 5, Lines 15,19,20-22, & 22d (Visits) 109,305,803
  - 2018 National UDS 9, Line 14B Collection $19,516,245,728
  - **2018 National Blended Encounter Rate: $178.55/visit**

  - 2018 NC UDS 5, Lines 15,19,20-22, & 22d (Visits) 1,833,991
  - 2018 NC UDS 9D, Line 14 Collection $265,557,581
  - **2018 NC Blended Encounter Rate: $144.80**

NOTE: Visits = Encounters = Totals excluding "Enabling Services"

Source: https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=
& https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=NC

Payment P^4Y… What is it?

- Average payment per patient per year ***(PPPPY… P^4Y)***
- How to calculate:

Total Payments ÷ Total Patients = Payments P^4Y*

NOTE: Patients = Total UDS Patients, excluding "Enabling Services"

Blended P^4Y… 2018 UDS Data

- Average payment per PATIENT per year (P^4Y)
- How to calculate:
  - 2018 National UDS 5, Lines 15,19,20-22, & 22d (Patients) 34,256,142
  - 2018 National UDS 9, Line 14B Collection $19,516,245,728
  - **2018 National Payments P^4Y: $569.72***

  - 2018 SC UDS 5, Lines 15,19, 20-22, & 22d (Patients) 462,625
  - 2018 SC UDS 9D, Line 14 Collection $313,373,122
  - **2018 SC Payments P^4Y: $677.38**

NOTE: Patients = Total UDS Patients, excluding "Enabling Services"

Source: https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=
& https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=SC

Blended P⁴Y… 2018 UDS Data

- Average payment per PATIENT per year (P⁴Y)
- How to calculate:
  - 2018 National UDS 5, Lines 15,19,20-22, & 22d (Patients) 34,256,142
  - 2018 National UDS 9, Line 14B Collection $19,516,245,728
  - **2018 National Payments P⁴Y: $569.72***

  - 2018 NC UDS 5, Lines 15,19, 20-22, & 22d (Patients) 630,662
  - 2018 NC UDS 9D, Line 14 Collection $313,373,122
  - **2018 NC Payments P⁴Y: $421.08**

NOTE: Patients = Total UDS Patients, excluding "Enabling Services"

Source: https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=
& https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state=NC

Lesson #6

Different reimbursement opportunity…

Creates new definition of "success."

The G Codes for FQHC Visit

- G0466: General medical, new patient
- G0467: General medical, established patient
- G0468: IPPE or AWV
- G0469: Mental health, new patient
- G0470: Mental health, established, patient

G Code Payment Rates

- FQHC encounter-based payment
  - 2016: $160.60
  - 2017: $163.49
  - 2018: $166.60
  - **2019: $169.77**
- Geographic Adjustment Factor (GAF)
  - Puerto Rico 1.003
  - Oklahoma .949
  - DC, MD/VA suburbs 1.120
  - Alaska 1.321
- New/Initial Patient Adjustment: **1.3416 (2019 = $227.76)**

Medicare PPS GAF

Region	GAF	Base PPS	New Patient PPS
NORTH CAROLINA	0.968	$ 164.34	$ 220.48
SOUTH CAROLINA	0.959	$ 162.81	$ 218.43
ATLANTA, GA	0.999	$ 169.60	$ 227.54
REST OF GEORGIA	0.953	$ 161.79	$ 217.06

Lesson #7

Big money in growing Medicare population…

Expand your Medicare base now or lose $$.

CMS New Patient Definition

A New patient is someone who has not received ***any professional*** medical or mental health services from any site or from any practitioner within the FQHC organization within the past 3 years from the date of service

"The 3-year rule"

Yet NOT CPT Rule…

https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-06-25-FQHC.pdf; Slide 10

Medicare FQHC (PPS) Acceptable Provider

Medicare's FQHC services may be covered if rendered by:

- Physician
  - Medical Doctor or Osteopath
  - Optometrist
  - Podiatrist
  - Chiropractor
- Nurse Practitioner (NP)
- Physician's Assistant (PA)
- Certified Midwife (CNM)
- Clinical Psychologist (CP)
- Licensed Clinical Social Worker (LCSW)
- Certified Diabetic Educator
- Medical Nutrition Therapist

Note: Some Medicaid programs also include Registered Nurses as Core Providers AND Medicaid provider list varies

New or Established Patient, FAQs

#1 Within past 3 years, Medicare patient saw dentist?

New…because dental not CMS covered.

#2 Newly hired physician sees patient from previous private practice?

*New…because they are new to your FQHC**

* *Inconsistent with historic/traditional guidelines but CMS says "OK."*

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-FAQs.pdf

Lesson #8

New patient "rule" confusing…

Create for your CHC a single definition.

Triangle of Communication

Summary

- Corporate wide educational effort
  - Never-ending
- Clinical activity drives financial success or failure
- Coding matters… always
- Clinical leadership at table for fiscal review/future
- Commit to Educate (Top down)
- Update Constantly

Questions?