



Cashing in on Value-based Reimbursement

The Obama administration wants to dramatically change how doctors are paid



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27

By **Jason Millman** January 26 at 12:33 PM Follow @jasonmillman



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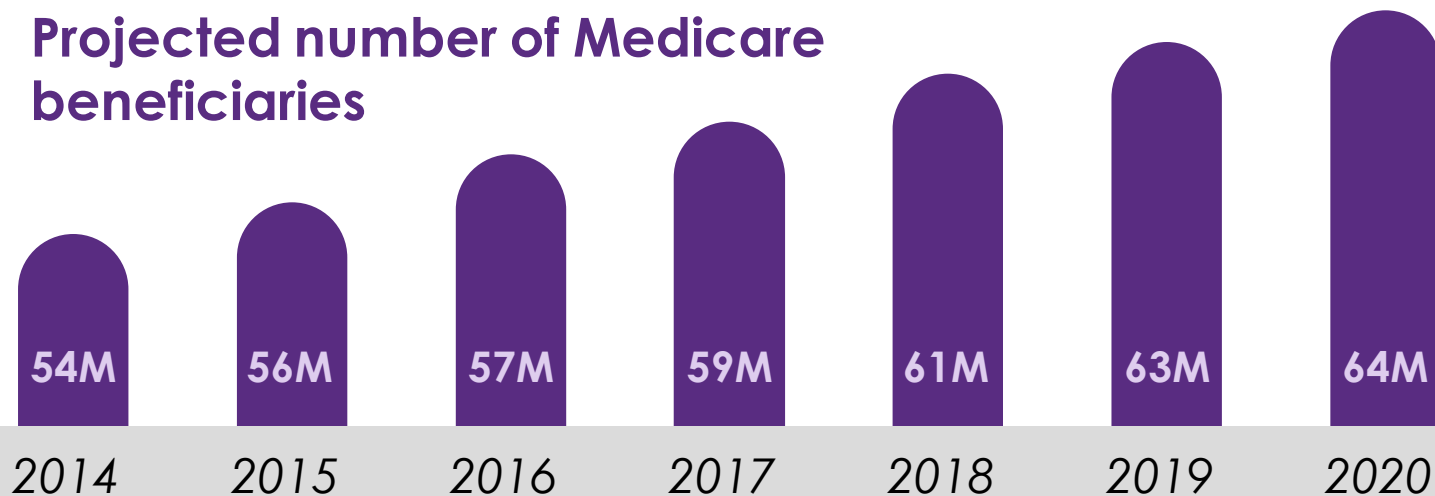
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Projected number of Medicare beneficiaries



Projected Medicare Fee-for-service Payment Cuts per the ACA



Source: CMS, "2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," May 31, 2013, available at: <http://downloads.cms.gov/files/TR2013.pdf>

FFS versus FFV

Fee-for-service

Fees billed per units of service

Income maximized through volume

No penalty for poor quality

Providers lose money if they reduce unnecessary services

Value-based payments

Eliminates incentive to increase volume

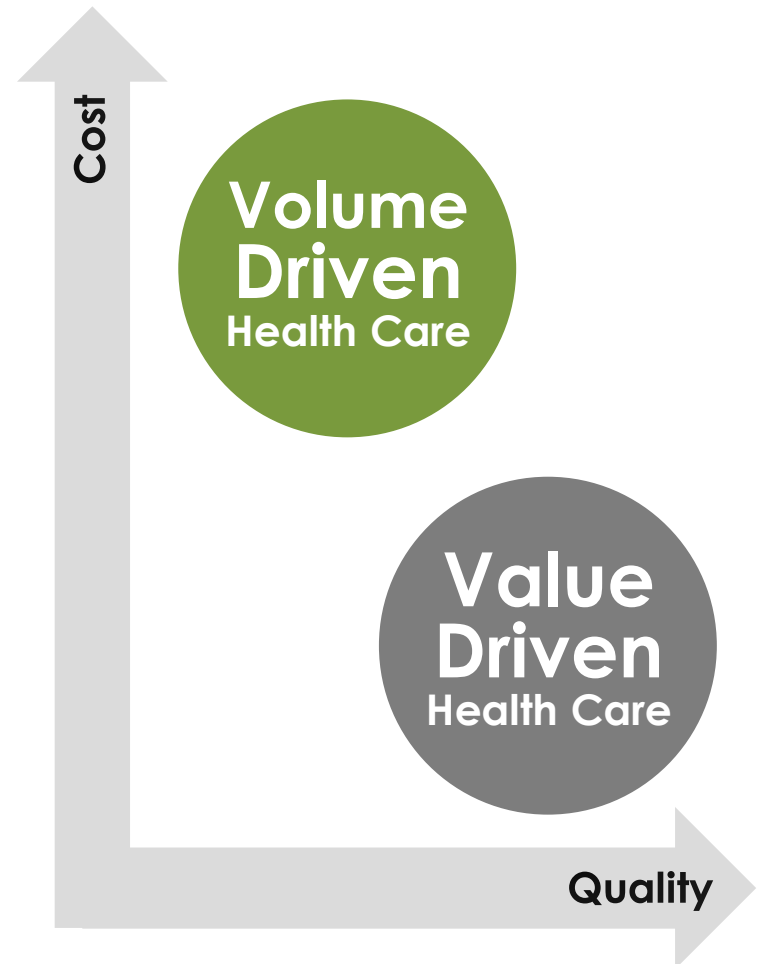
Eliminates incentive to provide high-cost services over equally effective low-cost services

Quality-based incentives

Shared risk

Emphasizes the role of primary care providers

Encourages coordination of care



2018: **90%**
of Medicare
payments
tied to quality.

2020: **75% of**
commercial
plans will be
value-based.



Jan 2015. <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>



END OF MAINTAINED
TRAIL



PAYERS



HOSPITALS



PATIENTS



GOVERNMENT



2013

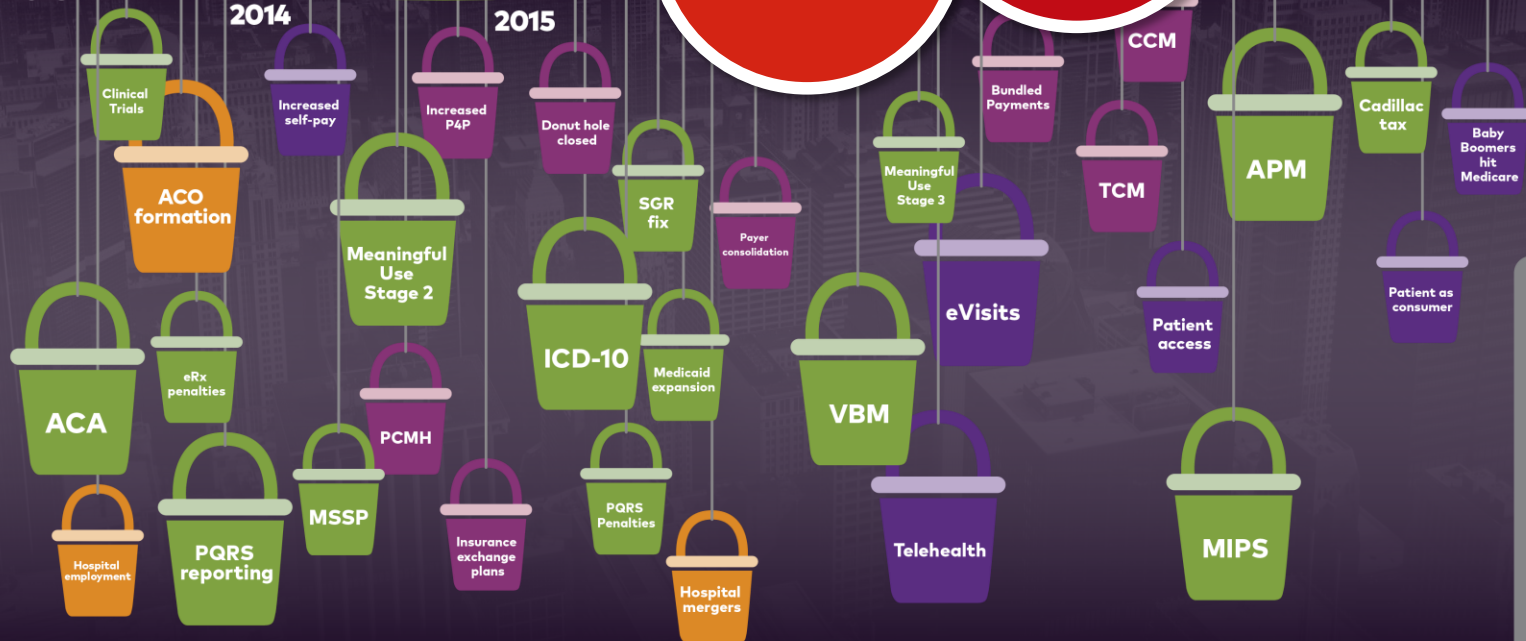
2014

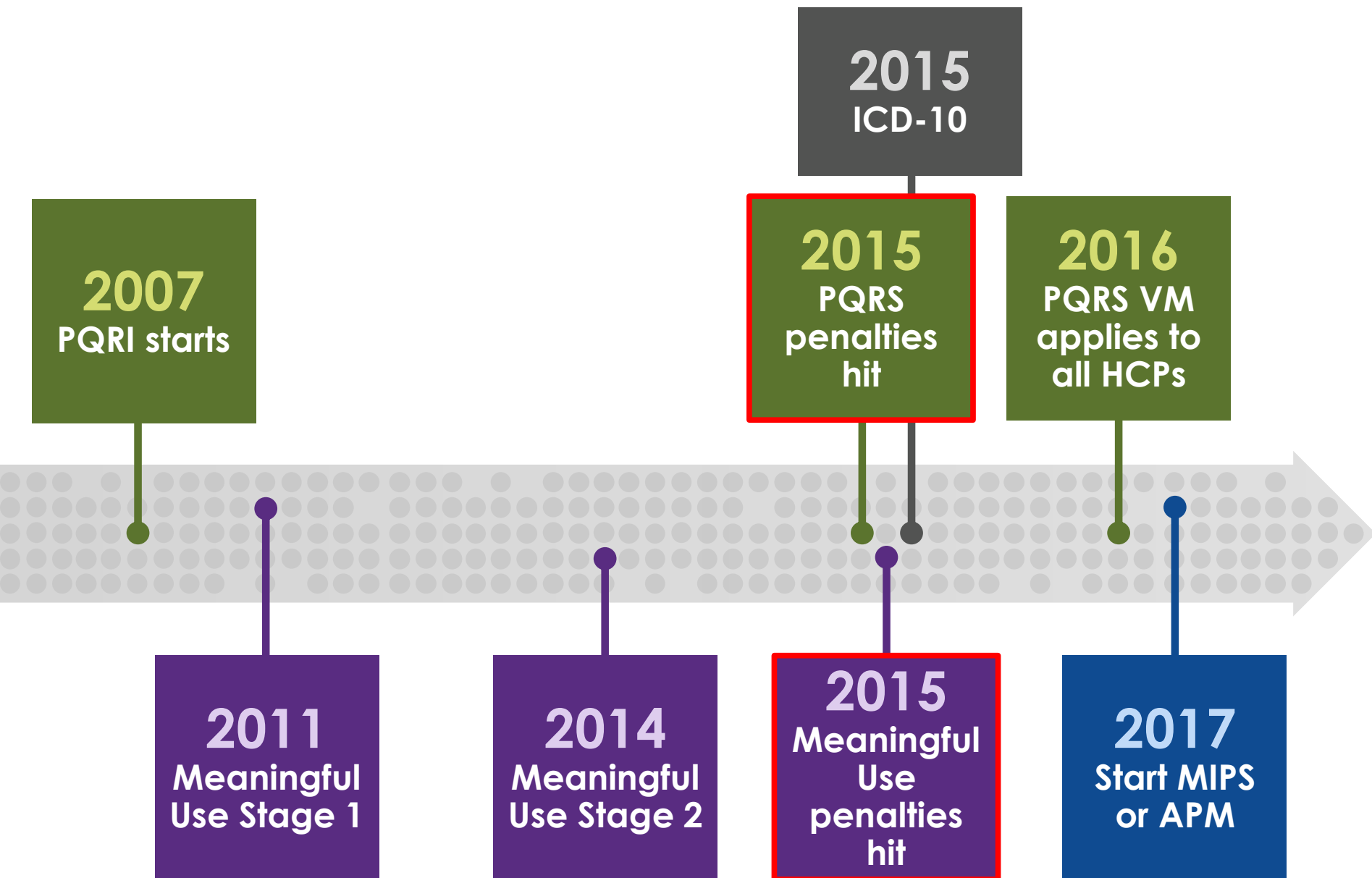
2015

2015
-4.5%

2016
-6%

2017
-9%







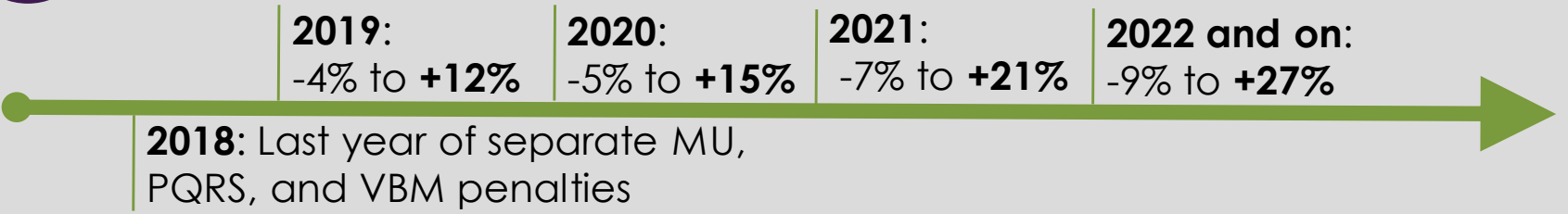
SGR Repeal bill



Two options to demonstrate value

1

Merit-Based Incentive Payment System¹



A horizontal timeline with a green arrow pointing right. The timeline is divided into four segments by vertical lines. The first segment is labeled '2018: Last year of separate MU, PQRS, and VBM penalties'. The second segment is labeled '2019: -4% to +12%'. The third segment is labeled '2020: -5% to +15%'. The fourth segment is labeled '2021: -7% to +21%'. The fifth segment is labeled '2022 and on: -9% to +27%'.

Year	Adjustment Range
2019	-4% to +12%
2020	-5% to +15%
2021	-7% to +21%
2022 and on	-9% to +27%

2018: Last year of separate MU, PQRS, and VBM penalties

1. Positive adjustments may be scaled by a factor of up to 3 times the negative adjustment to ensure budget neutrality. Actual positive adjustments may be lower than numbers shown here. In addition, top performers may earn additional adjustments of up to 10 percent.

2

Advanced Alternative Payment Models²



A horizontal timeline with a purple arrow pointing right. The timeline is divided into two segments by a vertical line. The first segment is labeled '2019 - 2020: 25% Medicare revenue requirement'. The second segment is labeled '2021 and on: Ramped up Medicare or all-payer revenue requirements'.

Year	Requirement
2019 - 2020	25% Medicare revenue requirement
2021 and on	Ramped up Medicare or all-payer revenue requirements

2019 - 2020: 25% Medicare revenue requirement

2021 and on: Ramped up Medicare or all-payer revenue requirements

2. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives or can decline to participate in MIPS.

**Cashing in on
VBR today.**

Revenue Threats

MU
+
PQRS
+
VM

Revenue Opportunities

CCM

TCM

PCMH

New Models for Reimbursement

MSSP

Bundles

ACO



1 MD

Solo Family Practice



1,410
Patients
per year



\$909,322
Annual
revenue

\$119,144 AT STAKE



	\$35,532 CCM (1 month)
MU \$7,247	\$42,540 TCM (avg. complexity)
PQRS & VM \$7,247	\$26,578 VM & HCC
PENALTY \$14,494	\$104,650 REWARD

12%

OF TOTAL 2016
ANNUAL REVENUE



5 MDs

Group Family Practice



4,078
Patients
per year



\$3,299,569
Annual
revenue

\$426,542 AT STAKE



	\$102,766 CCM (1 month)**
MU \$35,420	\$123,033 TCM (avg. complexity) ¹
PQRS & VM \$35,420	\$129,903 VM & HCC*
PENALTY \$70,840	\$355,702 REWARD

13%

OF TOTAL 2016
ANNUAL REVENUE



10 MDs

Orthopedic Practice



5,920
Patients
per year



\$11,621,454
Annual
revenue

\$1,094,736 AT STAKE



	\$178,606 TCM (avg. complexity) [†]
MU \$105,792	\$5,000 Bundles
PQRS & VM \$158,687	\$646,651 VM & HCC*
PENALTY \$264,479	\$830,257 REWARD

9%

OF TOTAL 2016
ANNUAL REVENUE



30 MDs

Multi-Specialty Practice



14,876
Patients
per year



\$11,196,511
Annual
revenue

\$2,021,573 AT STAKE



	\$374,863 CCM (1 month)**
	\$448,794 TCM (avg. complexity)†
MU \$138,945	\$1,250 Bundles
PQRS & VM \$208,418	\$849,303 VM & HCC*
PENALTY \$347,363	\$1,674,210 REWARD

18%

OF TOTAL 2016
ANNUAL REVENUE



**AVOID
THE AX**

PQRS and Meaningful Use

MU versus PQRS

Eligible providers

	PQRS	Meaningful Use
MEDICARE PHYSICIANS		
Doctor of Medicine	X	X
Doctor of Osteopathy	X	X
Doctor of Podiatric Medicine	X	X
Doctor of Optometry	X	X
Doctor of Oral Surgery	X	X
Doctor of Dental Medicine	X	X
Doctor of Chiropractic	X	X
PRACTITIONERS		
Physician Assistant	X	
Nurse Practitioner	X	
Clinical Nurse Specialist	X	
Certified Registered Nurse Anesthetist	X	
Certified Nurse Midwife	X	
Clinical Social Worker	X	
Clinical Psychologist	X	
Registered Dietician	X	
Nutrition Professional	X	
Audiologists	X	
THERAPISTS		
Physical Therapist	X	
Occupational Therapist	X	
Qualified Speech-Language Therapist	X	

PQRS versus MU

Number of measures

PQRS

9

out of

287

measures

Meaningful Use

20

out of

23

measures

PQRS versus MU

Measurement style

PQRS

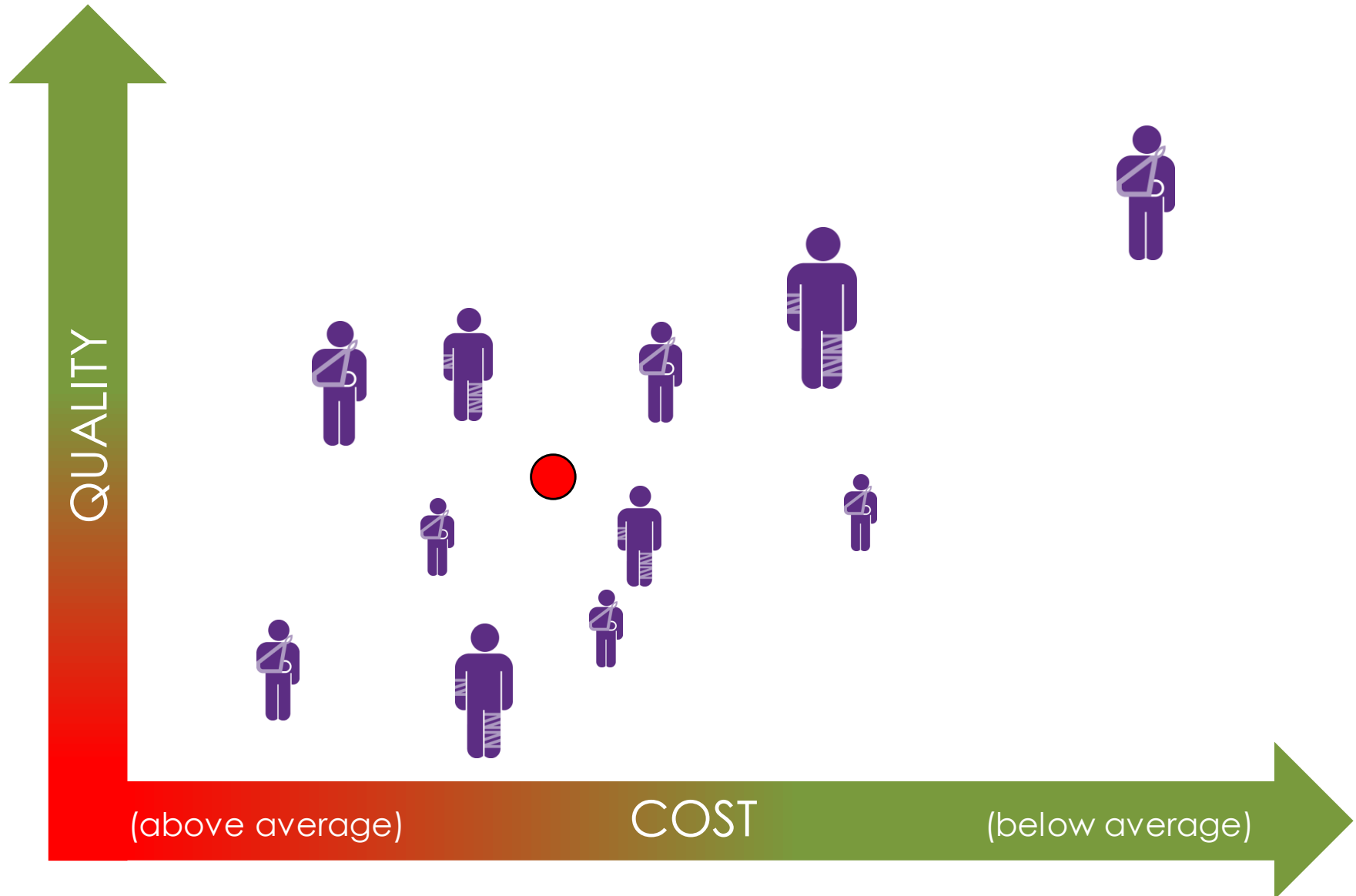
Report first.

Then,
performance
against your
peers.

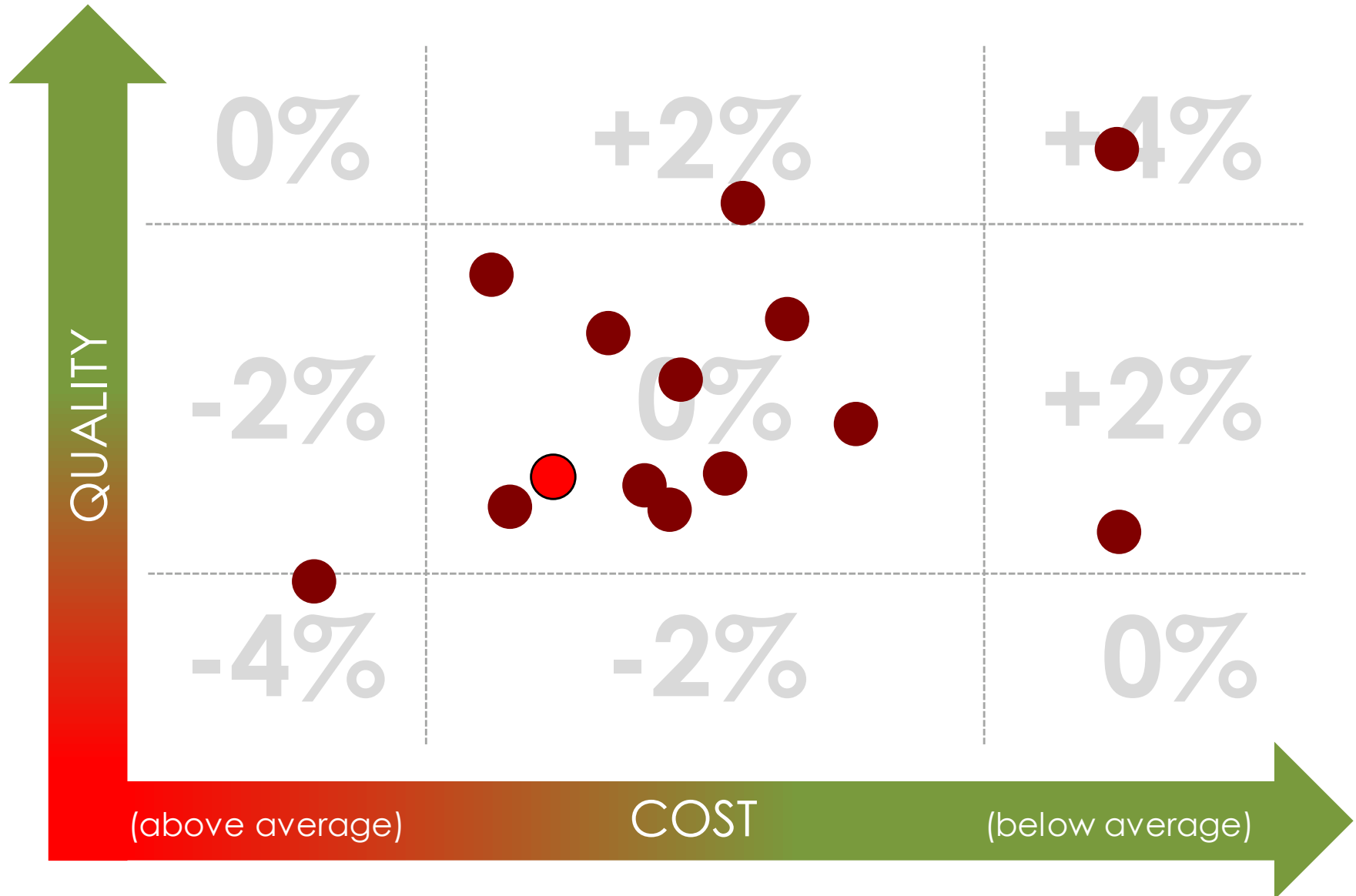
Meaningful Use

Measure
thresholds.

Value-Based Payment Program uses data in PQRS to rate practices on cost & quality



Rewards and penalties are based on how practices perform relative to the nation



PQRS versus MU

Practices facing penalties in 2015

PQRS

Nearly **40%** of eligible providers face a payment reduction for not reporting in 2013.

Meaningful Use

More than **30%** will be penalized for not meeting requirements in 2013 and 2014.

Collecting incentives

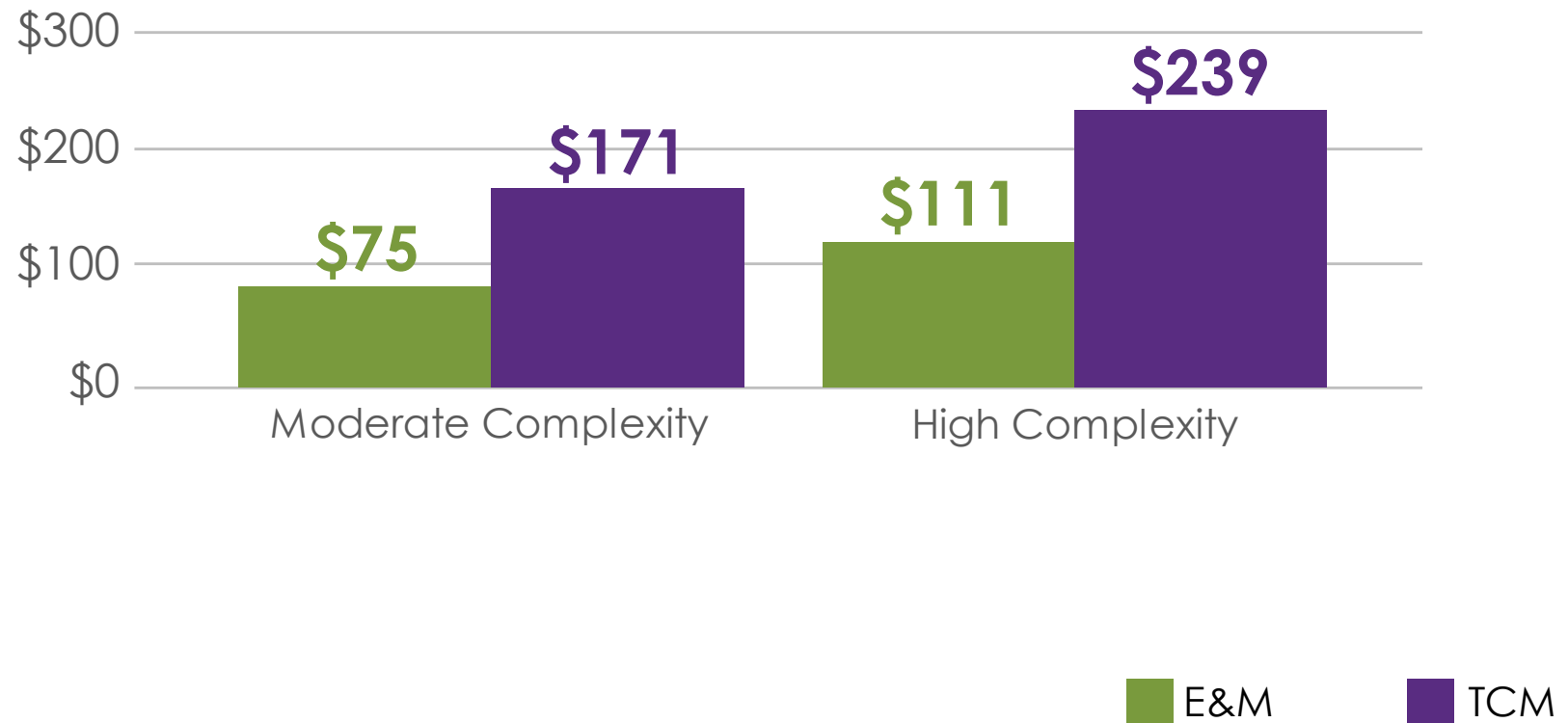


Transitional Care Management

Transitional Care Management

pays for the work of reducing re-hospitalization

Medicare Physician Reimbursement:
Evaluation & Management versus TCM



During the first 30 days after discharge...

- Interactive communication between patient and caregiver within **2 business days of discharge**
- **Non-face-to-face** services, such as reviewing discharge information or assisting in follow-up with other providers
- **A face-to-face** visit within either 7 or 14 calendar days of discharge

Chronic Care Management



2/3 of Medicare beneficiaries had **2 or more** chronic conditions

About **1/3** had **4 or more** chronic conditions



Source: http://www.cdc.gov/pcd/issues/2013/12_0137.htm

Chronic care management pays for care between visits for chronic conditions

Patients with **2 or more** Chronic Conditions

Aimed at **PCPs**, open to any specialty

20+ Minutes per month

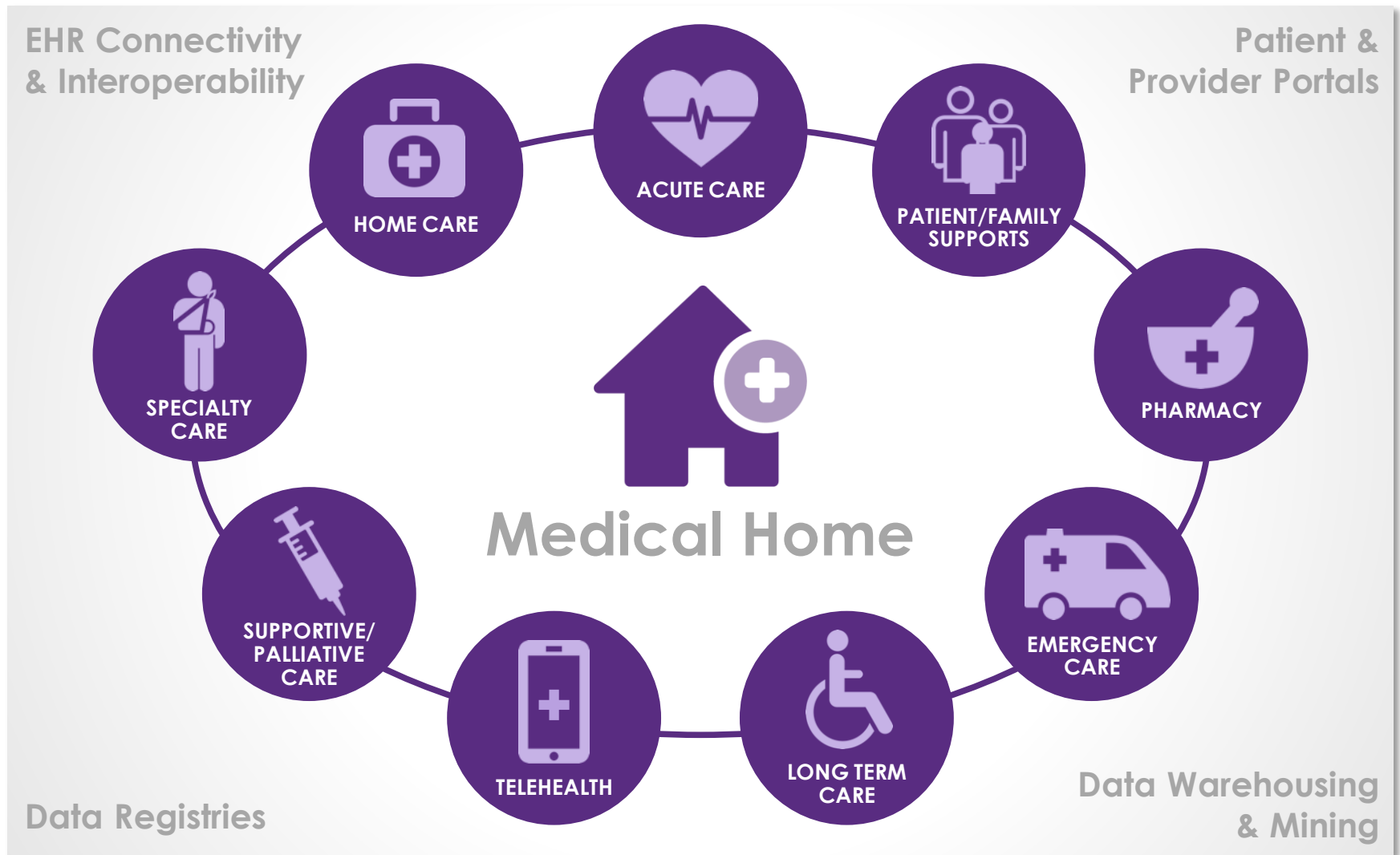
\$42.60 Medicare Payment

Examples of eligible Chronic Conditions

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart failure
- Hypertension
- Ischemic heart disease
- Osteoporosis

Patient-Centered Medical Home (PCMH)

PCMH helps provide better access to and more coordinated primary care



PCMH Recognition Through NCQA

Three Levels of Recognition

- ✓ Level 1: 35-59 points
- ✓ Level 2: 60-84 points
- ✓ Level 3: 85-100 points

A partner for VBR:
athenahealth's
Full Value Program



Government Affairs Team
4 People



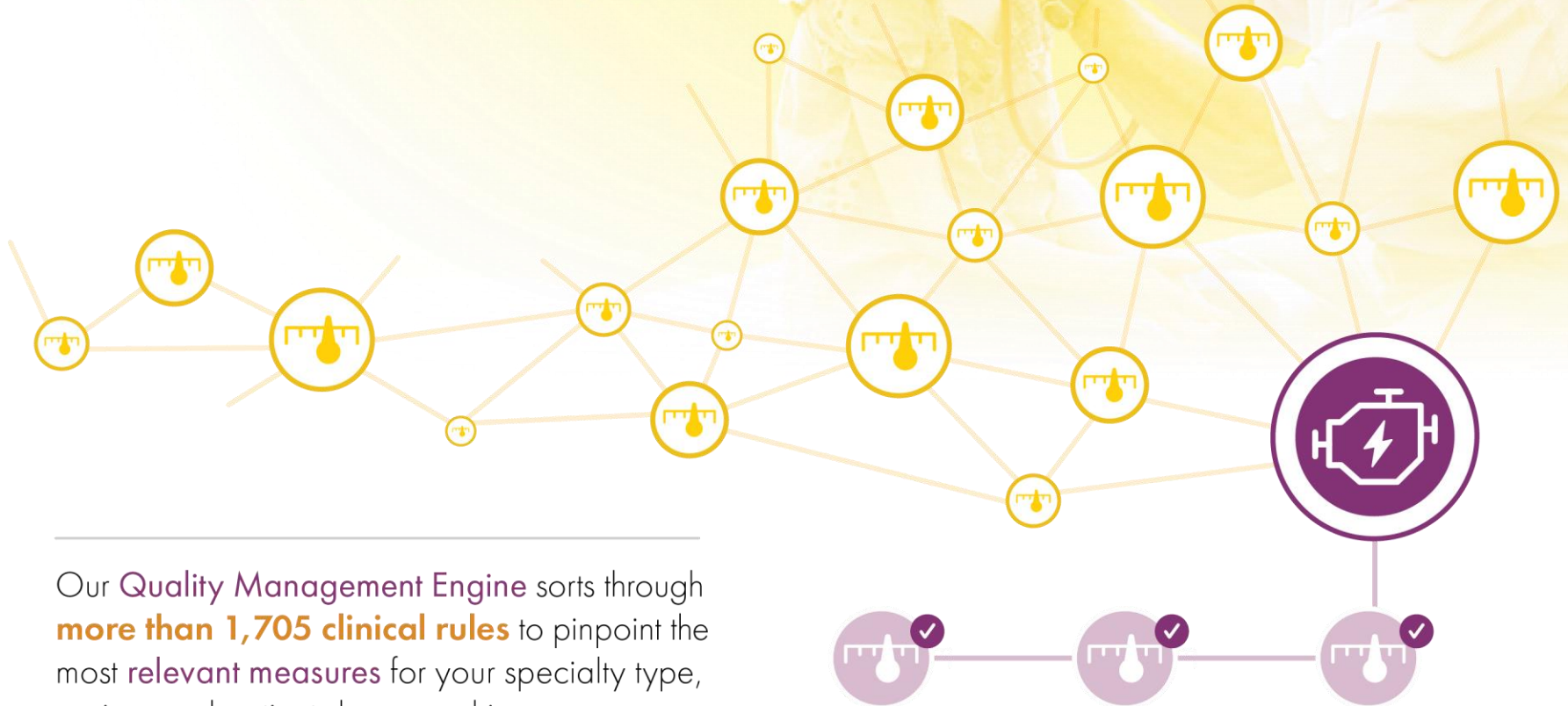
Quality Management Team
21 People



Payer Performance Team
51 People

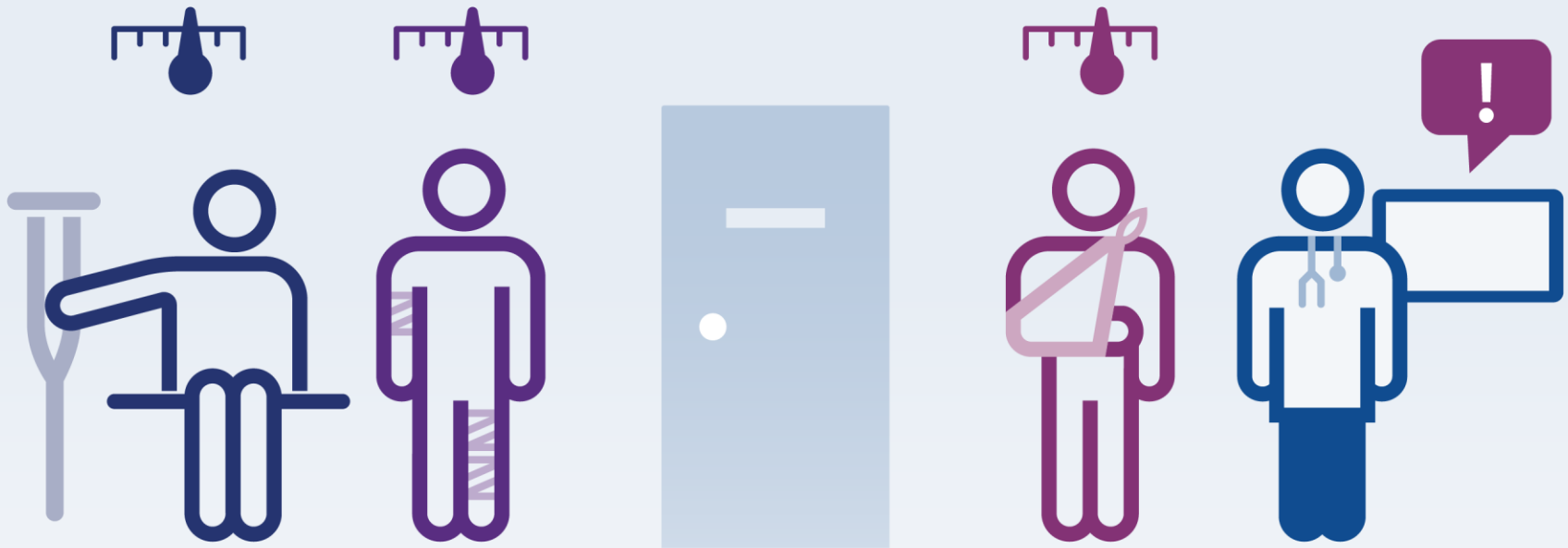
3 teams tracking **103+ different programs**

Charting an easy course to value



Our **Quality Management Engine** sorts through **more than 1,705 clinical rules** to pinpoint the most **relevant measures** for your specialty type, region, and patient demographics.

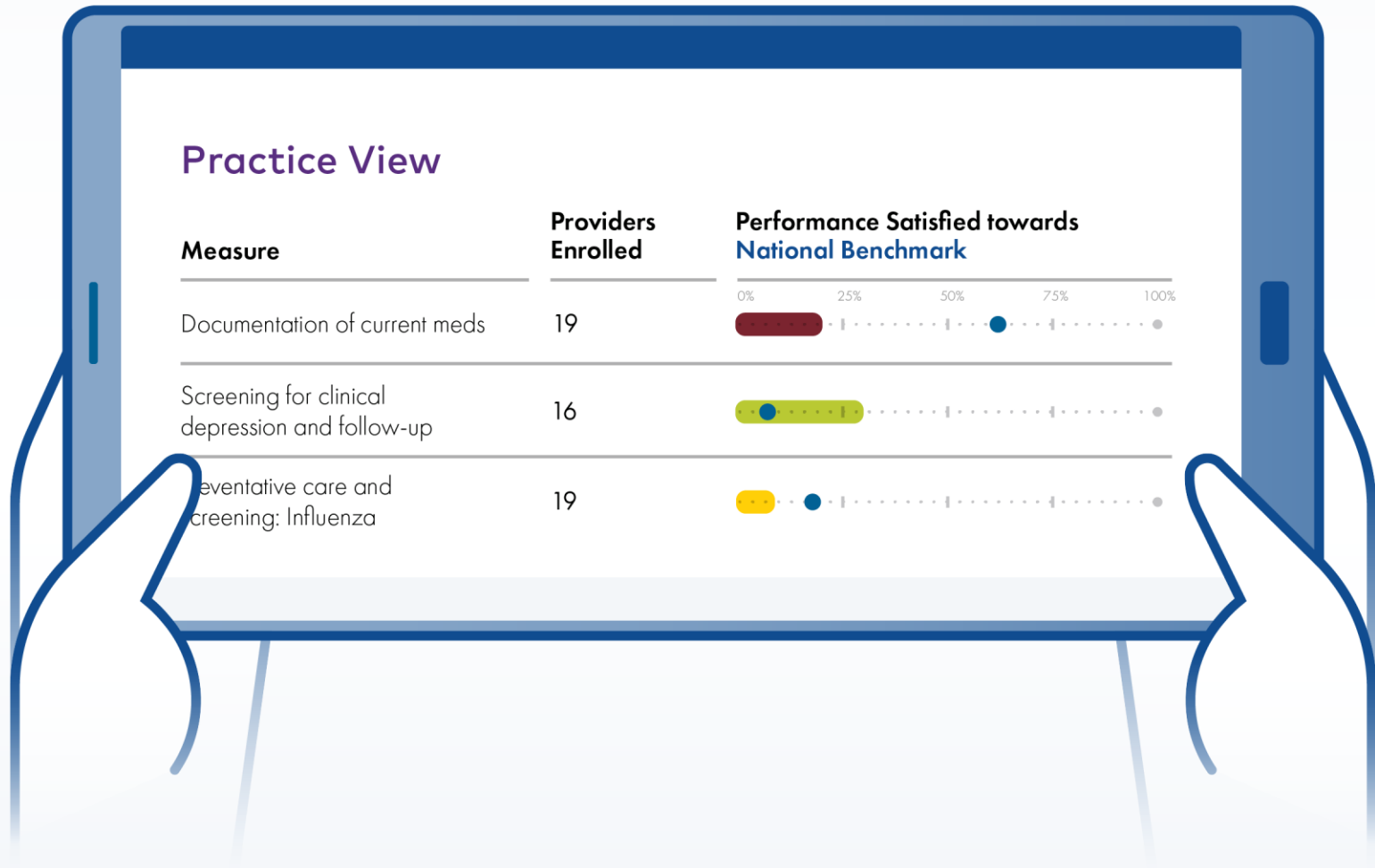
Satisfy measures easily while staying focused on your patients



Clinical rules are triggered
specific to each patient.

Providers are notified
and can satisfy measures
in the moment of care.

Real-time performance visibility



We leverage the power of our network to guide providers to success by:



Identifying
performance gaps.

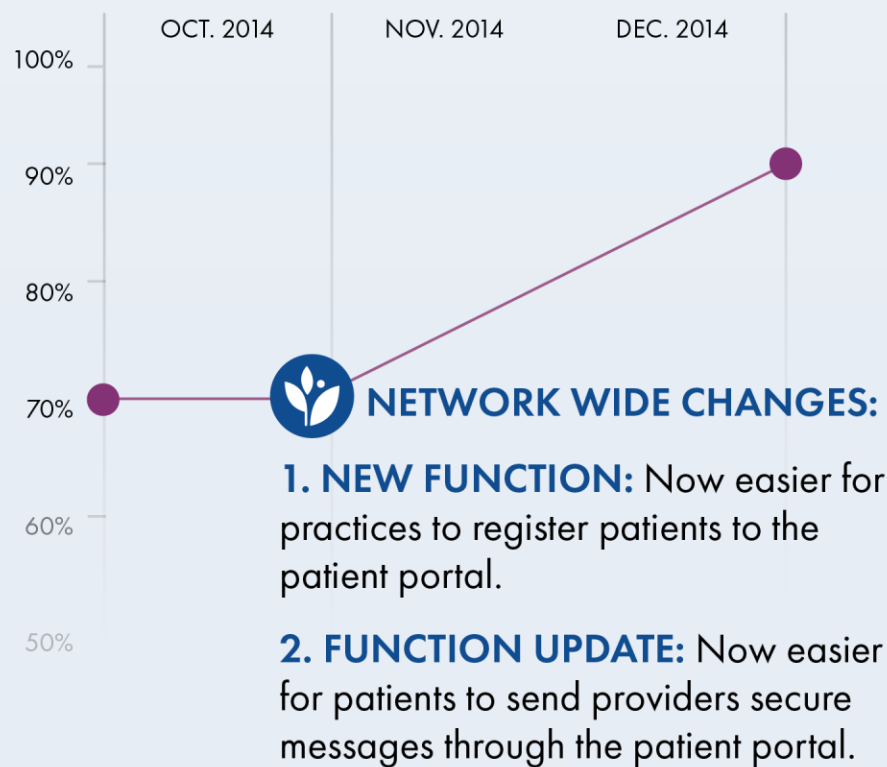


Surfacing
requirements
in the workflow.



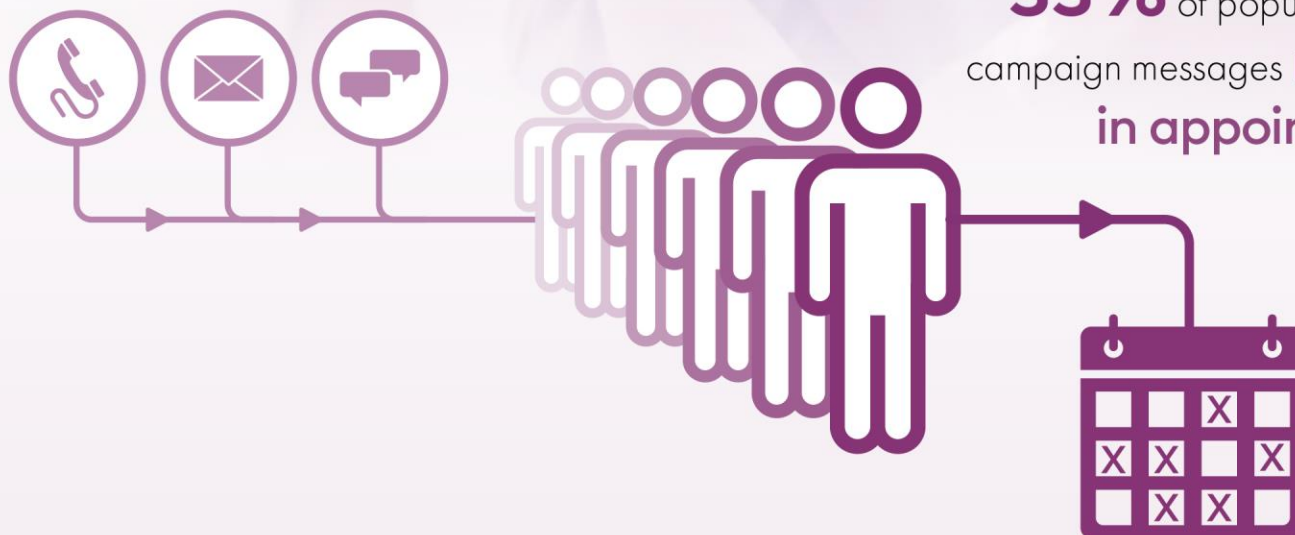
Driving
improvements
across the network.

athenaNet provider performance on Meaningful Use Stage 2
measure: Use Secure Electronic Messaging



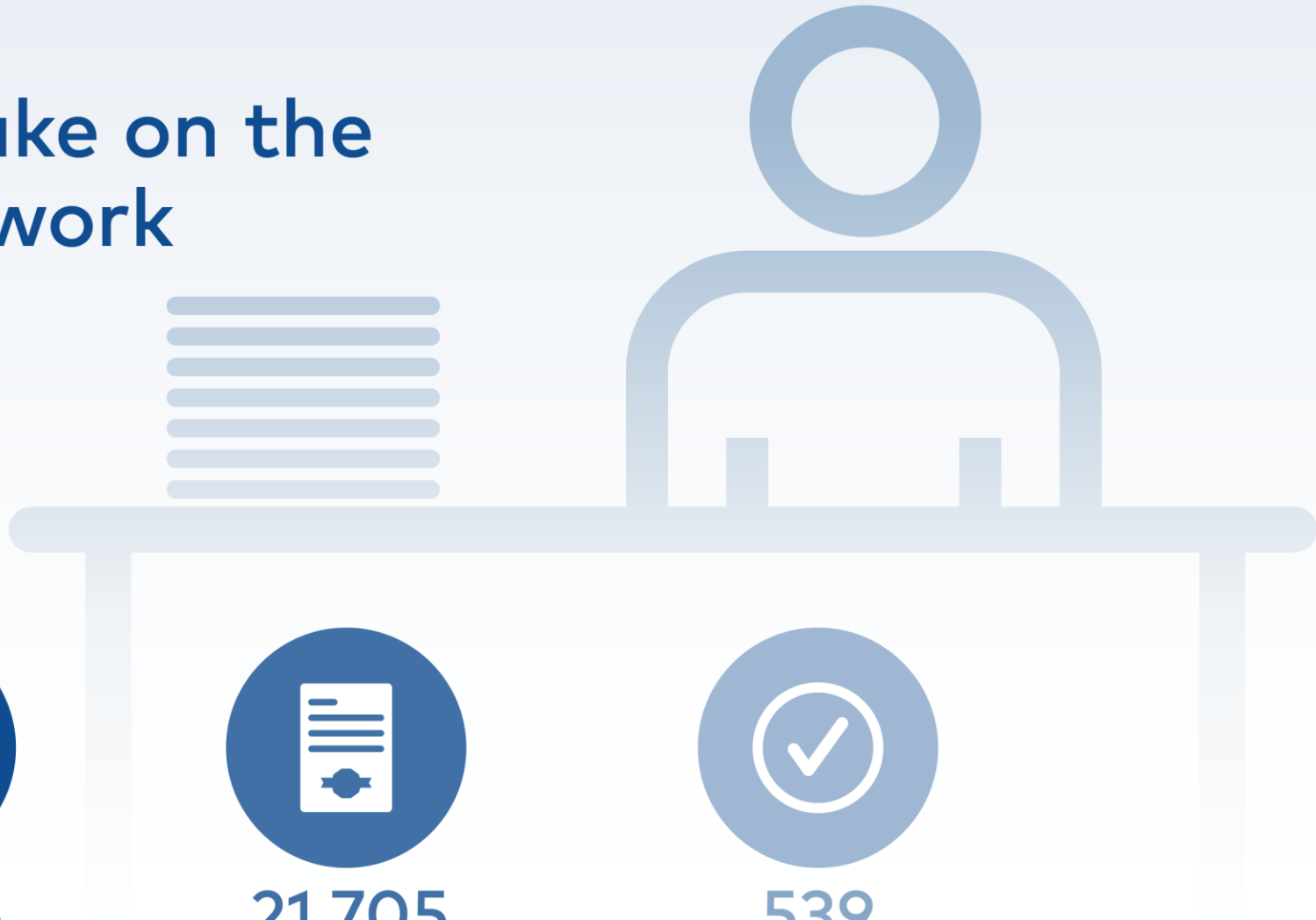
Engaging and activating patients

200 million
automated messages
were delivered in 2014.



33% of population health
campaign messages **resulted**
in appointments

We take on the busy work



169,635

hours of work saved
across the network



21,705

completed attestations



539

audits supported

Proven success



\$424 million

in incentive payments
were made across the
network since 2011.

\$192 million

was saved across
the network from
2012–2015.

15.8 million

claims processed from
January–June 2015
were tied to VBR.

Our clients are already performing better...

Meaningful Use Stage 2 attestation

NATIONAL
AVERAGE

33%

ATHENAHEALTH
CLIENTS

98.2%

% of HCPs avoiding PQRS penalties in 2015

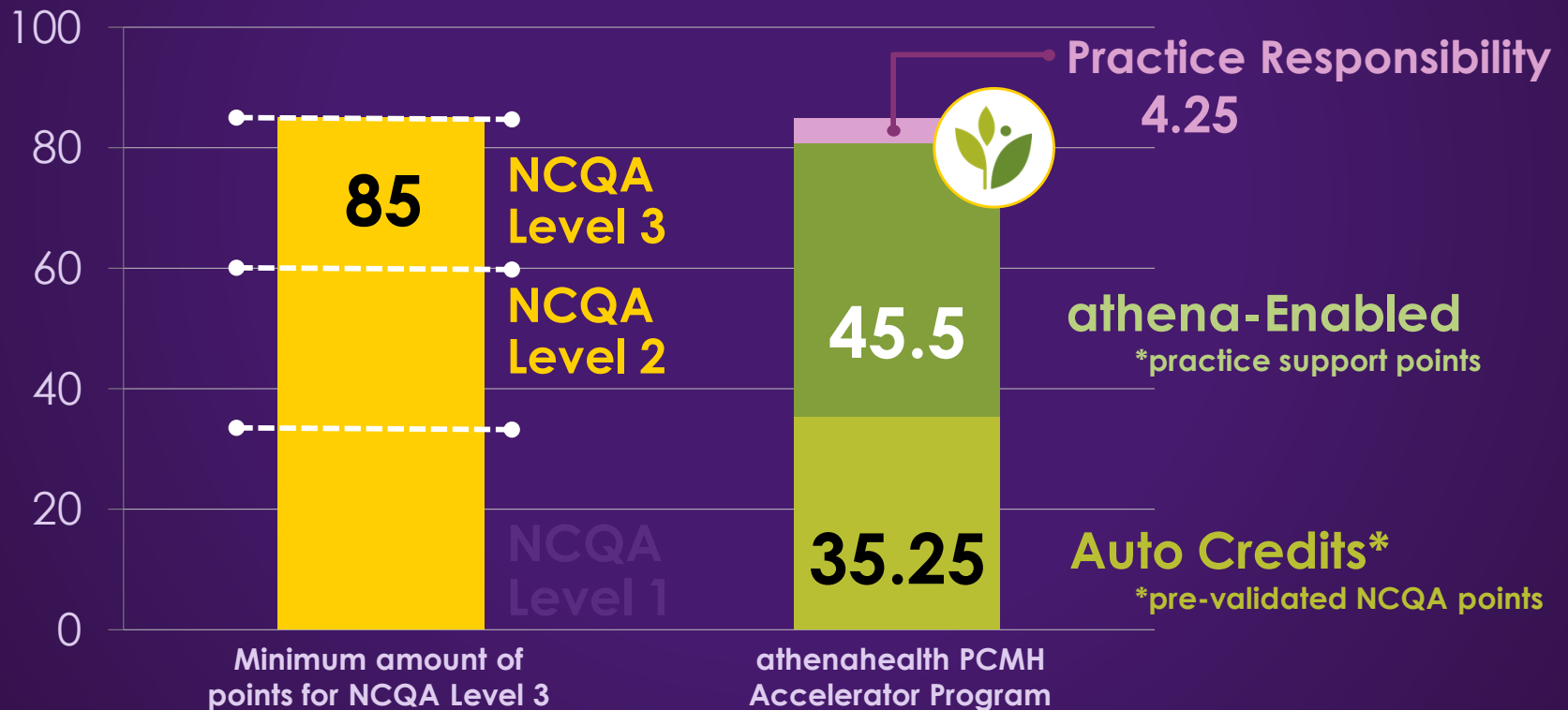
NATIONAL
AVERAGE

60%

ATHENAHEALTH
CLIENTS

93.6%

Our PCMH program was the first of its type, and remains the best in the business



athenaOne

CLOUD-BASED SERVICES



Practice
Management

Patient
Engagement

Electronic
Health
Records

Care
Coordination



SOFTWARE



KNOWLEDGE



WORK

RESULTS

OUR VISION:

Build the health
information backbone
that makes health care
work as it should.



#1 Practice
management
system

#1 Patient
Portal (ambulatory)

#1 Most usable
EHR





A stylized, abstract illustration of a plant with large, rounded leaves and a circular flower-like shape at the top, rendered in a lighter shade of purple against a darker purple background.

Questions?