Client Connect

Fredericksburg Area Clients

sa medical of Virginia

October '16

EMPOWERING INDEPENDENT MEDICAL PRACTICES BY PROVIDING NOT ONLY THE SERVICES BUT ALSO THE TOOLS NEEDED TO STAY TRULY INDEPENDENT.

Mary Washington On the Prowl For Primary Care Practices, Again

As a free PSA for MWHC, several physicians are reporting that MWHC is offering to buy-out and or employ primary care physicians in community practices or other options. Although not officially announced it appears that Dr. Susan Holland and Dr. Carol Voss have chosen to take MWHC up on their offer and their practice will be owned by the health system and they will be employed by MWHC. Remaining independent is proving too hard for some while others feel the grass is greener.

As MWHC is choosing to expand its tactical control of the area outpatient referral market and compete directly with the primary care members of its majority owned Alliance (which it states will help physicians remain independent), SA Medical is focused on ensuring local area medical practices have what they need to remain successfully independent as we believe that practices that are truly independent in its decision making but collaborative clinically provide "superior" care to those controlled by a health/hospital based system.

this issue

A Hard Lesson To Learn- Dana's Rant

Mary Washington and Stafford Hospital Medical Staff members were recently hit with two letters. One from MWHC announcing it is moving forward with a different adult hospitalist model, and one from the Fredericksburg Hospitalist Group (FHG) informing everyone of well, I'm not actually sure.

FHG seems to take issue (based on their letter) that the health system made the "unilateral" decision to terminate their agreement and to pursue a different hospitalist model and felt the need to garner support from the medical staff and made it clear that this was tried by MWHC in the past and it failed miserably.

First, I am sure this was a very hard decision for MWHC to make and although I legitimately gripe about the Alliance and MWHC competing with community practices, how can anyone find fault for them wanting a better inpatient care program? It's there job to do this. I simply don't believe there is any sinister plot here to upend the lives of these physicians. What I can imagine is that the Press Ganey patient satisfaction scores have taken a consistent hit with regard to care provided by the hospitalists, this fact is overwhelmingly true in most hospitals. Then add to the mix a fact that is the "third rail" and that nobody is comfortable addressing, the language barrier in some cases which impedes doctor/patient communications, along with financial considerations and the need under healthcare payment changes to be in control, its clear why MWHC made the decision to change. I can also say with a recent personal family member experience with a hospitalist that the patient discharge process was scary and truly potentially deadly so from a personal standpoint, I do hope that this change makes the discharge process better and safer for every patient.

There is truth to the point made by FHG that the hospitalist program change made a few years back was an absolute disaster and I know that many primary care physicians were happy when that train wreck was over. I feel like we all know what is going to happen next, that many. if not the majority of FHG physicians will be hired under the new group and the new employed group will struggle with the need for temps and locums. The focus for such would overtake incorporating any new initiatives towards better inpatient care or discharge management.

I do think FHG made one critical business mistake and that is to keep all their eggs in the MWHC basket, even after being ousted previously. They (and hopefully others) are now learning a hard lesson from it. Essentially the company was set up and operated only to exist so long as it had a contract with MWHC. It certainly could have expanded to cover skilled nursing facilities, provide locums services to community primary cares, struck an agreement with other local hospitals, etc…, but did not do so.

It also certainly didn't help that FHG really never worked closely with primary care physicians and clinicians. I don't believe a hospitalist from FHG has ever stepped foot in any of our practices nor met with us. They might have done this with larger primary cares but I don't think so. It's hard to garner support when the only time you speak with a primary care is when there is a problem with a particular patient's care.

I had the pleasure many years ago working with Dr. Jeff Kin, Dr. Lisa King, Dr. Barbara Newberg and others from the formation of FHG until they were well-settled, and I am hoping that MWHC truly recognizes that this group has saved them in the past and has been loyal to them for many years. I like many I know are also hoping that each physician and employee of FHG lands safely on their feet with whatever direction forward they proceed and that they and their families are going to be Okay.

Medicare Beneficiary Identification Cards and ID Numbers to Change

In March of this year, Medicare began the process of preparing to change Medicare Beneficiary Numbers and Medicare cards based on the fact that Medicare Beneficiary Numbers that are currently utilized are social security number based. With the increase of healthcare information/data being hacked, Medicare feels a new ID number is appropriate.

The new ID will contain an 11 digit alpha-numeric code. Medicare will begin updating Medicare cards in April 2018.

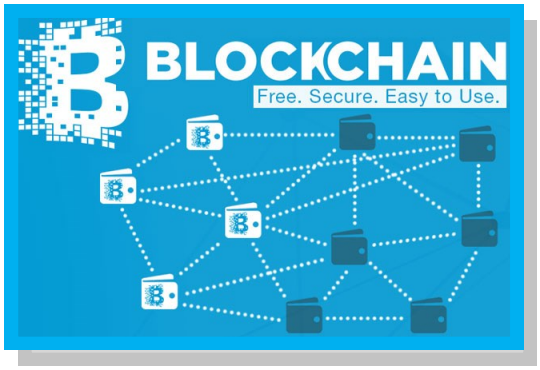
The good news is that Medicare is providing a "transition period" from April 2018 through all of 2019 during which either Medicare Beneficiary Number can be utilized. Beginning in 2020, only the new 11 digit alpha-numeric numbers can be utilized by healthcare entities.

Did you know?

1) *How many people in the United States have Medicare?* Over 60 million people

2) *How many people sign up for Medicare each day? Over 4,500 people*

We Don't Need No Stinkin' HIE



What's the newest buzz in healthcare IT?

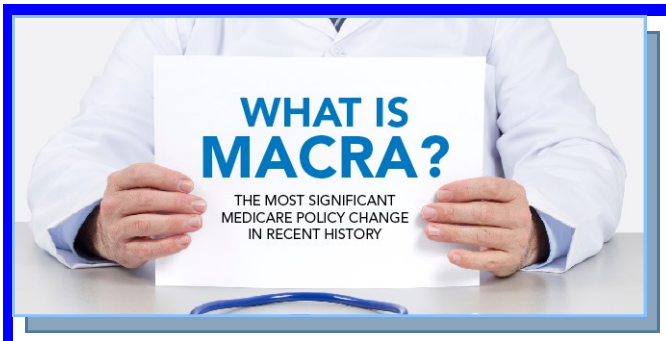
BlockChain is a technology that currently is utilized in the bitcoin industry and which is being touted as a better way than having hundreds of Health Information Exchanges (HIE's), such as the flailing Rappahannock Health Connect, and thousands of EHR patient portals.

Hundreds of healthcare IT firms are moving very swiftly in working with the federal government to begin the process of testing.

BlockChain utilizes a "distributed ledger" framework in that patients and healthcare providers, health systems have the ability to safely and securely share patient care data/information in a manner that eliminates the potential of data hacking and opens the pipeline of a database for pushing patient data in and pulling patient data out in a much more cost effective manner.

With the enormous costs charged by HIE vendors, vendors are scurrying to test and attempt to incorporate BlockChain in their software. However, based on the information coming from the ONC, if BlockChain is accepted as the national framework for patient data, the need for expensive HIE's will go away almost in their entirety.

We will continue to follow this potential ground-breaking evolution and report back to you.



MACRA—The Down & Dirty

A New Approach to Paying Clinicians For the Value and Quality of Care They Provide

MACRA—The "Medicare Access and CHIP Reauthorization Act of 2015" (MACRA) replaces current Medicare reporting initiative such as PQRS and Meaningful Use and incorporates new reporting initiatives such as "Clinical Improvement Activities" and "Costs" (also referred to as "Resource Use").

Final Rules for the MACRA program will not be announced any day and prior to November 1st, some specifics are still unknown.

MACRA provides for two different reporting/payment paths:

1) **Merit-Based Incentive Payment System (MIPS)** - An overwhelming majority of clinicians/practices will have to utilize the MIPS model as most will not qualify for the APM path (at least not in the first reporting year). As such, this article will provide and focus on a detailed breakdown of the MIPS program.

2) **Advanced Alternative Payment Models (APMs) -** Clinicians/practices who have already taken a step further towards care transformation by already participating in other advanced payments models that put reimbursements at risk for not meeting established benchmarks such Pioneer ACO's and Medicare Shared Savings Programs Track 2 and 3 (The MWHC Alliance is only on Track 1—so its members do not qualify for the APM). This model exempts participants from the MIPS reporting requirements and would allow them to qualify for a 5% additional Medicare Incentive Payment.

Why do I need to deal with this now? Medicare will begin measuring performance of doctors and other clinicians through MIPS in January 2017, with payments based on those measures in 2019. Incentive payments/payment reductions in 2019 will be reflective of year 2017 data, so you will need to ensure that you are capturing and focusing on the reporting of the 2017 data. In 2019, if you do not meet reporting/performance goals your Medicare reimbursement will decrease by 4%, in 2020 by 5%, in 2021 by 7% and in 2022 by 9%.

Remember, this program is specific ONLY to Medicare, not other insurances or Medicaid. There are a few exception to these new reporting requirements; however, if you see/treat more than a few Medicare patients, there is no exception.

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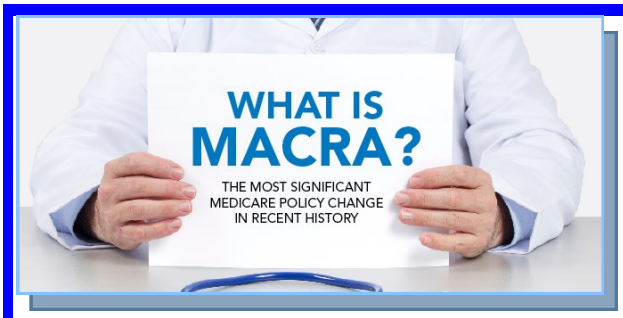

Merit-Based Incentive Payment System (MIPS)

When the final rule is announced soon it will clear up at least two questions, how many of my Medicare patients (50% or 90%) and do I have to report on and what would be the reporting period (The entire year or 3 months of 2017).

How will I be paid by Medicare in 2017, 2018 and 2019 under MIPS? Medicare will continue to pay you/your practice fee for service in 2017, 2018 and 2019. In 2017 and 2018, if you or your ACO is not reporting under Meaningful Use or PQRS, your fee for service payments from Medicare will be reduced by the appropriate penalty. Meanwhile, separately each year Medicare will increase their base fee for service payments rates to all clinicians by a half a percent (0.5%) up to and including year 2019. After 2019 Medicare reimbursement increases will only be provided through MIPS or APMS.

In 2019 under MIPS, you will have the ability to receive an extra 4% by successfully reporting or you will receive a 4% penalty for not successfully reporting.

How will I be measured under MIPS and what will I have to report? You will be measured by 4 categories:

1) **Quality (Replaces current PQRS reporting) - 50% of your total score**. Clinicians would choose to report on **6** measures versus the current PQRS reporting of 9 measures. This category will provide reporting options to choose from to accommodate different specialties and practices. This category will be reported via billing or via registry.
2) **Advancing Care Information— 25% of your total score**. Clinicians would choose to report customizable measures that reflect how they use their EMR (with an emphasis on interoperability with other systems and the exchange of information) and this replaces current “Meaningful Use” reporting. This category will be reported via attestation. Unlike with Meaningful Use, it is not an “all or nothing” and you can receive partial credit.
3) **Clinical Practice Improvement—15% of your total score.** Clinicians will be rewarded for clinical practice improvement activities such as care coordination, patient engagement, and patient safety. Medicare will provide a list of 90 reporting options that you can pick from (i.e. patient centered medical homes, participation in other alternative payment models).
4) **Cost– 10% of your total score.** Also known as “Resource Use”. No additional reporting required, this category is essentially recorded by Medicare by billing data and will focus on 40 episode specific measures to account for differences in specialty.

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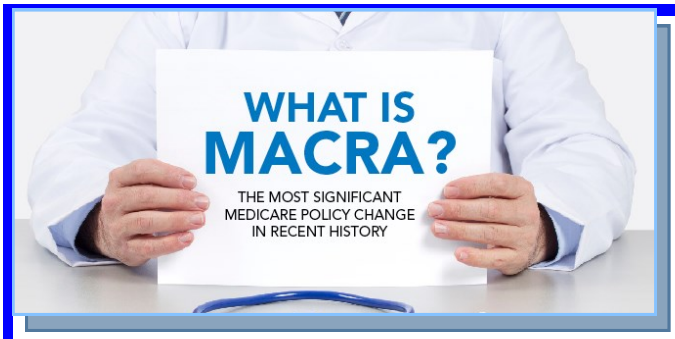

Merit-Based Incentive Payment System (MIPS)

Will I be scored by practice or by as an individual clinician? It is the choice of the practice. Additionally, **mid-level providers will also be able to participate for the first time (if the practice chooses).**

If I do not utilize an EMR, would I still be able to perform this reporting and meet the criteria under MIPS? It is absolutely possible but will be labor intensive. Your staff will have to work with your billers to coordinate and track measures. But remember the Advancing Care category(which would require an EMR of some sort) category represents 25% of your overall score.

I am a member of the MWHC Alliance, will they be handling MIPS reporting for me? I don't believe the Alliance has announced whether they will or will not as of yet. I believe that they may be choosing the 6 measures required under the Quality Reporting.

I have not been reporting via PQRS or Meaningful Use to date, should I do anything for 2017?

Yes, you will have to start at some point and Medicare has indicated that the final rule that will be announced next month will provide for some additional latitude on reporting requirements so as not to make it too difficult for smaller, independent practices.

Some Key Points to Remember:

1) If you are a client of SA Medical, we are going to help you make this happen.
2) Many of the details of this program will be provided in the final rule due to be released next month and once released we will work with every client that wishes us to.
3) This program is specific to ONLY Medicare, not Medicaid or any other insurance.
4) If you are an Alliance member, you may wish to ensure that you are actively involved in your MACRA process as now your risk of not making the grade with MACRA is bigger than just your practice, the entire Alliance membership will also decide if you make the grade or not.

MORE TO COME, ONCE ADDITIONAL INFO IS PROVIDED BY MEDICARE...

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