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Out of the Box

Thinking.

Patient Care.

Reimbursement.

Extraordinary Strategies for Navigating Physician Group Reimbursement Conditions in 2021

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What's inside?

In this edition...

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Do as much as possible for the patient, and as little as possible to the patient.

Dr. Bernard Lown

Dose of Inspiration

“It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.”
- Charles Darwin

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Overview

Healthcare providers across the country have experienced a tremendous amount of change over the past decade from Meaningful Use (MU) initiatives to the Affordable Care Act (ACA) to the Covid-19 pandemic. It has been particularly challenging for independent private practice physicians and groups.

Healthcare reform inevitably brings new reporting requirements and learning curves for physicians who are already fatigued from serving long hours on call or in practice for quality patient care. It can be confusing to understand all the new payment models and the patient outcomes and reporting requirements that come with them. What types of incentives or penalties might I face and what if my patients refuse to comply?

While Value-Based Care can be scary, it is also an exciting opportunity as a physician to really measure your impact on population health, drive change, and be in control of your financial outcomes.

Today, we will review the various standard reimbursement models and how we achieve success for our physician groups in traditional Value-based Care (VBC) and Alternative Payment Models (APM) and some extremely out-of-the-box, progressive approaches that have helped our physicians partner with payors to target a specific hire risk patient demographic for better proven outcomes and special reimbursement provisions for taking the initiative.

"Clear and concise strategy can transform any practice."

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Ever evolving, ever improving.

94% of "Value Based Care" contracts are standard and offer little in the way of taking an aggressive approach to proactive whole patient care.

Value-based Care

Foster improved population health across communities

Physicians can earn financial rewards or avoid negative payment adjustments by meeting specific performance and quality measures tied to better long-term outcomes for patients.

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Healthcare is full of abbreviations and acronyms and it doesn't stop with patient care. The Revenue Cycle and managed care ecosystems can be some of the most complex and confusing landscapes to navigate. Today, we will cover the high level basics and dive deep into what it really should look like from a physician's perspective. Value-Based Care is the idea that physicians should be reimbursed for quality of care and patient outcomes rather than the volume of services or time spent with patients as it were in the traditional Fee For Service (FFS) Model.

This was intended to promote caring for the whole patient upon interaction to proactively keep the patient well as opposed to treating symptoms of an ill patient which may prevent or reduce costly hospital admissions and treatment of advanced chronic illnesses that may have been preventable. Physicians assigned a roster of managed lives in a geographic area for a flat fee Per Member Per Month (PMPM) can earn incentive payments, bonuses, or avoid financial penalties by meeting pre-defined quality metrics that have been linked to long-term improved population health outcomes. If the patient attends only their annual well visit and does not need any further treatment, the physician or group stands to gain financially, however, in this risk model, if the patient is extremely ill and requires frequent and extensive treatment, the PMPM rate will leave the physician at a deficit for the particular patient when calculating the per visit reimbursement equivalent.

Quality measures include the percentage of the physician's assigned population to receive well care visits, immunizations, preventative screening exams and chronic disease management such as A1C levels in diabetic patients. While some of these measures can be effective, most are pretty standard and are not customized to the specific patient demographic being treated by a physician. This is where the physician has the power to really get creative and be proactive in engaging with the payor to address specific population health trends with purposeful patient engagement for better outcomes.

Access to preventive care is the foundation of good population health management. It’s critical for chronically ill patients and for healthy patients, whether or not they routinely seek out care themselves.

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Alternative Payment Models

Merit-based Incentive Payment System (MIPS)/Quality Payment Program (QPP)

MIPS combines the EHR Incentive Programs (Meaningful Use), the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBPM) into a single structure. This single program measures the quality of care, the costs of care, health IT interoperability, and practice improvement all in one. MIPS includes financial incentives and penalties based on a set of measures.

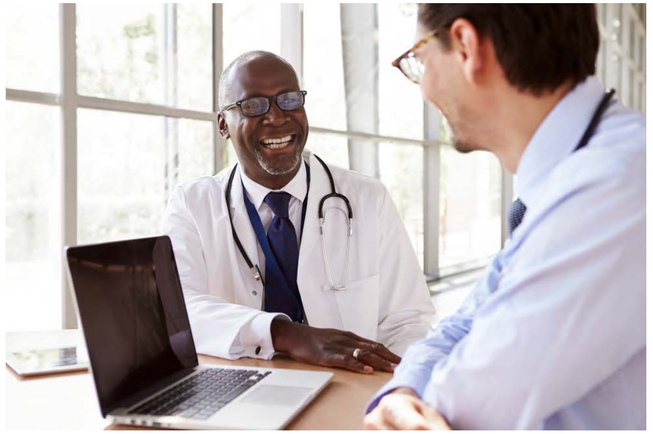
Pay for Performance (P4P)

Physicians assigned a roster of managed lives in a geographic area for a flat fee Per Member Per Month (PMPM) can earn incentive payments, bonuses, or avoid financial penalties by meeting pre-defined quality metrics that have been linked to long-term improved population health outcomes.

Advanced Alternative Payment Models (AAPM)

An Advanced APM is a track of the Quality Payment Program that offers a 5 percent incentive for achieving threshold levels of payments or patients through Advanced APMs. If you achieve these thresholds, you are excluded from the MIPS reporting requirements and payment adjustment

Managing Population Health



"The good physician treats the disease; The GREAT Physician treats the patient, who has the disease."
-William Osler

To succeed in population health management, you first need to be able to categorize patients by their health risks and unmet needs. Informatics tools and data analytics are critical for providing this deep level of visibility into the assigned population's specific preventative and chronic care needs, satisfied measures, predictive performance tiers, weighted patient outreach queues and cap equivalent reimbursement analytics per encounter. With the right digital tools, primary care practices will be able to stratify patients by risk, close gaps in care, and identify areas for performance improvement.

Understanding your unique patient population's access barriers helps you create a practice that serves your community most efficiently and effectively. Utilizing clinical resources that are most effective in a particular visit type, grouping visit types in scheduling blocks, and incentivizing patients to keep their scheduled preventative visits are all ways that providers can improve their performance and reach higher quality scores.

Analytics also play a very important role in identifying trends in patient risk factors and chronic conditions which can help navigate conversations with payors regarding an agreement for the delegation of patients with a specific set of risk factors or conditions to a new specialized clinic that is closely monitored for improved patient outcomes. Payors will often consider grants or a unique payment model to reward providers for improving the health of high risk patients and reducing hospital admissions.

How do we do it?

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"He who has **health**, has hope; and he who has hope, has **everything**."
-Thomas Carlyle

Collaborative Strategy

Partnerships between the payor and the provider where the patient is more healthy with fewer visits and hospital stays benefits the provider, the payor and the patient.

Comprehensive Analytics

Analytics that merge historical visit data, healthcare needs data, population risk factors, and data specific to your patient population and community, some really powerful direction takes place

Proactive Care Programs

Taking a proactive approach to patient outreach shows your patients that you care, builds your practice, and consistently improves quality performance scores.

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Reactive healthcare

Doing things the way we are told to do them because that is the way we were told to do it.

Proactive healthcare

Trailblazing a new path by engaging the payor, the hospitals and the patient because we, as providers, know best what our patients need.

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Escaping The Box

Case Studies with successful outcomes in *out of the box medicine.*

Translating a customized care model for a specific demographic of patients into improved patient care outcomes, reduced cost of healthcare, and increased revenue is no easy task, but with the right team establishing the outline, identifying patients through analytics, submitting encounter data, flagging patients and providing detailed clinic status reports, payors will see that patients are receiving the level of care that prevents hospital admissions and improves the health of the whole patient, especially with a population of patients with multiple chronic illnesses.

A medium sized pediatric group with offices in 4 locations felt that a high percentage of their patient population had multiple chronic conditions and consumed a lot of resources for the PMPM agreement. We ran some analytics and performed some market analysis to determine the degree to which this notion was prevalent and discovered that the practice did, in fact, have a high chronically ill population. We approached the payor and suggested that we start a Chronic Care Clinic and set aside a specific set of resources on a dedicated schedule and track and monitor progress with a very intentional set of measures to determine outcomes. The payor agreed to a fairly large grant to help fund the clinic and if the outcomes presented success, the clinic would be reimbursed for the treatment of these patients beyond the PMPM.

Patient outcomes were astonishing! Patients that frequented emergency rooms and inpatient hospital stays were no longer taking those unnecessary trips. Patient care was coordinated between 8 or more specialists and patients were able to make progress that had not been possible before. Patients' mothers sent tearful "Thank Yous". This was more rewarding than the newly negotiated agreement. This is truly managing population health by thinking outside of the box.

Execution Plan

Phase I

Write a letter of intent that showcases your abilities and appeals to payors' goals.

Phase II

Utilize analytics to identify a population health need.

Phase III

Identify and propose specifics about how you can meet that need and what your resource requirements are..

Phase IV

Implement a wholistic patient care approach and be sure to record and monitor progress and successes.

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