IMPERIUM HEALTH

Imperium Vox

Newsletter for Imperium Health clients and those invested in the ACO Industry Volume III, Issue 5 Winter 2018

Letter from Imperium Leadership

The Centers for Medicare and Medicaid Services (CMS) released the names of the new ACOs added to the Medicare Shared Savings Program (MSSP) and even among the strongest class ever of new ACOs to the market, Imperium Health excelled as the leader in new ACOs added.

Of the 124 total new ACOs announced for 2018, the most ever added in one year, Imperium led the field with 16.

The faith these organizations have shown in our company's ability to be a knowledgeable partner in the quest to become a successful ACO is humbling and inspires our entire staff to work harder than ever to show Imperium's strength within the healthcare innovation sector.

Imperium continues to show year-over-year growth since it was founded in 2011 and with the addition of these 16 new ACOs on January 1, 2018, our ACO total grows to 30 MSSP ACOs, comprised of nearly half a million lives.

We are honored by the commitment of our partner ACOs as we work to focus our efforts on continued innovation and excellence in the transition to value-based accountable care. Thank you to our partner ACOs, those who have been with us and those who are just joining us. We look forward to 2018 and continued hard work to build on our foundation of success.

Sincerely,
Imperium CEO Gary Albers and Benjie Levine, Chief of Strategy

Of the 124 total new ACOs announced for 2018... Imperium led the field with Sixteen.

- Gary Albers,
CEO, Imperium Health

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PY 2017 Quality Reporting — Don't Wait to Test EIDM Accounts

The CMS Web Interface (CMS WI) opened for PY 2017 data collection on Monday, January 22, 2018, and will close at 8:00 p.m. Eastern Time on Friday, March 16, 2018.

As announced in the CMS Spotlight Issue 38, in order to participate in CMS WI quality reporting for PY 2017, ACOs must set up the necessary Enterprise Identity Management (EIDM) accounts and roles. CMS encourages ACOs to test their access to these accounts now. ACOs can also refer to the 2017 Medicare Shared Savings Program Quality Reporting Guide: EIDM Account and Role Setup guidance document located on the MSSP ACO Portal under the Resource entitled 2017 Quality Measurement and Reporting Guides for details on how to set up accounts and roles. If PY 2017 is your ACO's first year in the Shared Savings Program, then your ACO must set up EIDM accounts and roles to be able to access the CMS WI for reporting.

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Provider Reminders: Preventive Care and Screening — Influenza Immunization

~ By Angela Farley

Time is running out to meet the **PREV-7: Preventive Care and Screening: Influenza Immunization** Quality Measure. This is a Pay-for-Performance measure for 2018.

ACO beneficiaries who have been seen for a visit between October 1, 2017 and March 31, 2018 should be offered the Influenza Immunization.

Please ensure that you have documentation for all of your ACO beneficiaries regarding either the administration of or the refusal of the Influenza Immunization during this time period.

March 31, 2018 is the last date to meet this measure for the 2018 performance period.

PY 2017 Quality Reporting, continued...

According to CMS ACOs that participated in PY 2016 quality reporting and maintained active passwords, accounts, and roles, do not need to set up new accounts or roles. If user accounts are no longer active, CMS advises ACOs to contact the Quality Payment Program (QPP) Service Center at qpp@cms.hhs.gov or 1-866-288-8292 and note you are a Shared Savings Program ACO and need assistance with your EIDM account or role.

As a reminder, QPP has posted resources regarding Excel reporting of the CMS WI. The Excel template and accompanying user guide are now available on the QPP Resource Library under the heading MIPS Group Participation. In addition, a short training video is now available on YouTube to introduce the new Excel template that can be used to upload data to the CMS Web Interface. As a reminder, CMS has altered the submission process for PY 2017 and is moving forward with Excel file uploads and downloads only for CMS WI quality reporting, and removing the Excel conversion to .xml step from the quality reporting process altogether. ACOs and group practices may also manually enter and submit data through the CMS Web Interface. ~ Reprinted from NAACOS Membership Newsletter

Timing is key to understanding the impact of diagnosis coding

~By Timothy Hollowell

For providers participating in an ACO, there is sometimes confusion around the relationship between documented diagnoses, risk scores and financial impact on MSSP.

The first thing to know is that CMS HCC risk scores are assigned based upon diagnoses from the previous calendar year.

This means that any changes in coding practices could take a year or more to be reflected. For example, any diagnoses documented in 2017 will determine risk scores for the 2018 performance year. Any financial impacts of the 2017 diagnoses won't be realized until financial reconciliation for the 2018 performance year, which occurs in late 2019.

Within the Medicare Advantage space, risk scores are a direct multiplier to the PMPM payments from CMS. For an ACO in a shared savings plan, it is the relative change in average risk scores over time that will impact the benchmark, and therefore the potential for achieving shared savings. Understanding how diagnosis coding and risk scores affect practice savings is key to the success of value-payment models.

Analysis of Final 2018 QPP Rule

Overview and Summary of Key Provisions available from CMS

On November 2, 2017 the Centers for Medicare & Medicaid Services (CMS) released the final rule outlining performance year (PY) 2018 policies for the Quality Payment Program (QPP), which corresponds with 2020 payment adjustments for Medicare Part B payments.

The rule finalizes policies related to both of the QPP tracks, one for providers in Advanced Alternative Payment Models (Advanced APMs) and the other for those in the Merit-Based Incentive Payment System (MIPS). A link to the final rule is available here along with this CMS factsheet. NAACOS issued a press release in response to the final rule, which is available here.

Contact Imperium

We welcome your inquiries and feedback! Please email Corporate Communications Director Allison Haley at: Allison.Haley@ImperiumHlth.com.

Key 2018 ACO Dates—1st Quarter

March 1: 2017 Q4 Expenditure and Utilization Report Due

April 15: 2018 Preliminary Benchmark

Hierarchical Condition Category (HCC) Coding Tips and Hints ~ By Angela Farley

Remember to get those PHQ-9 screenings and follow-ups done! Providers can bill for **subsequent** AWV's that include depression screening with HCPCS code G0444 (time-based code).

The American Psychiatric Association reports Major Depression is highly recurrent, with recurrent episodes occurring in 50% or more of patients. Patients can only experience one single depressive episode during their lifetime, after the initial single episode, further episodes are considered recurrent.[1]

Documenting to the highest specificity is crucial for the appropriate code assignment. The clinician should document the frequency (single episode or recurrent) and the severity (mild, moderate, severe with or without psychotic features, and/or the clinical status of the current episode (partial or full remission).[1] All efforts need to be made not to use an unspecified code when possible.

Major depressive disorder[2]:

•F32.0 Major depressive disorder, single episode, mild

•F32.1 Major depressive disorder, single episode, moderate

•F32.2 Major depressive disorder, single episode, severe without psychotic features

•F32.3 Major depressive disorder, single episode, severe with psychotic features

Recurrent major depression[2]

•F33.0 Major depressive episode, recurrent, mild

•F33.1 Major depressive episode, recurrent, moderate

•F33.2 Major depressive episode, recurrent, severe without psychotic features

•F33.3 Major depressive episode, recurrent, severe with psychotic features

1 American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA American Psychiatric Association, 2013

2 ICD-10-CM: Professional for Physicians 2018

Louisiana ACO Retreat Provides Lessons for 2018 Success ~By Dr. Joshua Lowentritt

Joining an ACO as a healthcare provider implies your desire to meet certain objectives in order to deliver lower-cost, higher-quality care to your patients. Imperium partner Louisiana Physicians Accountable Care Organization (LPACO) recently held an intensive retreat designed to support providers in their market as they begin working toward those objectives for 2018.

Twenty clinic and physician participants from around Louisiana, along with national speakers and participants met in a packed board room at the headquarters of the Louisiana State Medical Society in Baton Rouge for a meeting that featured several vendors with the capability to facilitate Chronic Care Management (CCM) and Comprehensive Primary Care Plus (CPC+) services to the local clinics, which include Curant Health Pharmacy Services and ThoroughCare.

LPACO pilot projects with Imperium Health vendors Innovaccer and Labcorp were reviewed. Imperium Operations Director Lloyd Wilson and Chief Strategy Officer Benjie Levine presented the 2018 work plan and strategies. LPACO Provider Dr. Joshua Lowentritt and CareJourney staff presented a lively interactive discussion reviewing an analysis of Urinary Tract Infection (UTI) admissions and Urology outpatient care.

Lessons from the retreat are summarized here in the hopes of generating conversation and interest among others in our provider community.

The January retreat focused on six major goals, chosen because they can have the greatest positive impact on ACO results. They included:

- Improve Clinic-Patient Engagement
- Increase Annual Wellness Visits (AWV)
- Improve Transitional Care Management (TCM)
- Reduce Home Health Over-Utilization
- Reduce ED Utilization
- Understand the Correlation Between UTI and Referrals to Urology

Establishing the Primary Care Physician as the uncontested leader in a patient's care and allowing them to manage the patient's plan of care at all levels serves as the cornerstone of several ACO initiatives, including CCM, CPC+, Hospital/ED Utilization and Post-Acute Care Network (PAC) Management.

By increasing AWV and improving TCM, practices can generate significant revenue while reductions in Home Health and ED Utilization can lead to substantial savings for an ACO practice. Imperium Health offers a suite of technology, tools and expertise to assist practices in reaching their full performance potential.

Along with a best practices curriculum providers were given a list of 2018 Initiatives aimed at improving the data performance feed and developing a high-performing PAC Network. Top initiatives include:

- Establishing ACO Clinic Leads
- Distributing Provider Reports
- Network Management
- Improving Care Coordination with Skilled Nursing Facilities (SNFs)

If you have questions about information presented at the retreat and ways that you can start 2018 on the best path to ACO success, contact your Imperium Operations representative or email us at: info@imperiumhlth.com.

Excerpts From: How CMS Improves Primary Care Payments Through Codes, APMs

New billing codes for non-face-to-face services and alternative payment models are key methods CMS uses to enhance primary care payments. ~ **By Jacqueline Belliveau**

New medical billing codes for non-face-to-face encounters and alternative payment models are seeking to change the way Medicare reimburses for primary care, according to researchers at the Urban Institute's Health Policy Center.

The report, supported by the Robert Wood Johnson Foundation, showed that CMS aims to find the right payment amount and structure to reimburse providers for treating high-cost, medically complex patients…

As the largest payer in the country, Medicare has leveraged this role to improve primary care payment and compensation by developing new medical billing codes and implementing alternative payment models.

Both methods showed that CMS is willing to pay more to primary care providers for treating chronically ill patients. The federal agency also demonstrated its intentions to shift primary care payments to flat monthly reimbursements to provide additional flexibility to primary care providers…

The Medicare Physician Fee Schedule (PFS) reimburses physicians primarily for providing face-to-face office visits. CMS updates the codes and corresponding rates each year.

Recently, CMS started to add PFS codes that reimburse providers for non-face-to-face activities. For example, in 2013, the federal agency began to pay physicians for care transition management for patients recently discharged from the hospital (99495 and 99496)…

By 2015, CMS added ongoing chronic care management codes for patients with multiple chronic conditions (99490). The federal agency intended for the codes to cover the costs of creating and updating care plans, reviewing results, communicating with other providers outside of the practice, and regularly adjusting treatment regimens… While the medical billing codes attempted to rectify primary care underpayment, primary care providers found the rate for chronic care management too low and the requirements for billing too burdensome… Providers also complained of excessive administrative burdens…In light of the challenges, providers did not use chronic care management codes…

Updating and adding codes is a quick way for CMS to modify provider incentives and encourage providers to engage in high-value care services. However, medical billing codes do not provide the flexibility providers may need to treat high-cost, complex patients. Alternative payment models may be a more effective method for evaluating payments for new services and testing models that do provide that flexibility.

Since the Affordable Care Act, CMS created several alternative payment demonstrations targeting primary care. The demonstrations tend to grant providers flexibility through end-of-year bonuses, supplemental monthly payments, or a combination of both reimbursement structures.

The first primary care alternative payment model was the Independence at Home (IAH)demonstration, which reimbursed primary care providers for making home visits to frail Medicare beneficiaries. Providers billed Medicare under the PFS, but they could earn shared savings payments if the practice reduced total costs of care while meeting quality standards…

The IAH demonstration significantly reduced costs, generating $13.3 million in net savings the first year and $2.7 million the second year. The bonuses offered to providers helped to produce net program savings. However, only about one-half of the participating practices earned shared savings during the two-year demonstration and the top-performing organizations saw their shared savings payments fall as the program matured.

The Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration used a different approach for primary care payments. Continues on next page

Imperium Staff Enhancement

Over the past year, Imperium Health has added a number of talented staff who bring their collective experience and proven successes to the purpose of enhanced support for our partner physicians.

In our previous issue, we introduced several outstanding staff who joined Imperium Health in 2017. As we continue to grow, we will continue to showcase the dynamic individuals who join our team.

Cameron Bisset
Director of Operations

Cameron Bisset joined Imperium Health in October, overseeing ACO markets in several states. After graduating law school from the University of Houston in 2012, he began advising healthcare organizations through business transactions and regulatory issues. Bisset continued to develop his operations experience prior to onboarding with Imperium, which included roles as a hospital performance consultant and practice administrator.

Most recently, Cameron served as the Director of Business Operations for a pediatric behavioral health practice overseeing analytics, growth strategy, and clinical operations in Austin, Texas.

Dustin Summers
Associate Director of Operations

Dustin Summers joined Imperium Health in October, covering parts of Tennessee, West Virginia and Kentucky.

Additionally, he serves as the Executive Director of the West Tennessee Physicians' Alliance (WTPA), an independent physicians' association representing over 200 health care providers.

A native of Paris, TN and graduate of the University of Tennessee-Martin, Summers also holds a master's degree in Education from Lipscomb University and a master's degree in Public Health with an emphasis in Global Health from George Washington University.

How CMS Improves Primary Care Payments Through Codes, APMs, continued...

The model promoted patient-centered medical home adoption by providing primary care practices with supplemental monthly payments on top of Medicare, Medicaid, and some private payer revenue...

The demonstration resulted in net losses and care quality was not better than that of practices outside the model... CMS responded to MAPCP criticisms by developing the Comprehensive Primary Care Initiative (CPCI). The multi-payer initiative reimbursed primary care practices a monthly payment for patient-centered medical home adoption, as well as comprehensive primary care functions, including risk-stratified care management, 24/7 care access, and care coordination activities...

CPCI generated net savings overall and more regions earned shared savings payments as the demonstration progressed. The demonstration also slightly decreased emergency department use and improved patient experience, but had little effect on care quality. CMS built on the CPCI through the Comprehensive Primary Care Plus (CPC+) model. The CPC+ model also departs from its predecessor by containing two payment tracks. Under the first track, providers receive fee-for-service payments for office visits plus a $15 Per Beneficiary Per Month (PBPM) payment on average.

The second track includes more generous PBPM payments, averaging $28 PBPM. Track 2 practices also receive reduced Evaluation and Management (E/M) fee-for-service payments for office visits, but they earn upfront quarterly payments for E/M services. Both tracks also include pay-for-performance bonuses in lieu of regional shared savings. CMS awards the incentives payments at the beginning of the year and recoups them if practices fail to meet quality targets...

Upfront incentive payments should also help practices implement the necessary practice transformation to keep, rather than gain, payments. The CPC+ demonstration launched in 2017. CMS has yet to see if the primary care alternative payment model will generate net savings and improve care quality. But the federal agency is hopeful, calling the model "the future of primary care." ~Reprinted from RevCycle Intelligence News