

# Centers of Medicare & Medicaid Services Update



2011 New Mexico Hospital Association Annual  
Pre-Conference Seminar



September 28, 2011



Kathy Maris, Dallas Regional Office

# Disclaimer

- This presentation was current at the time it was published. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.
- This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. CPT only copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS\DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

# TOPICS

- Accountable Care Organizations
- HIPAA 5010
- ICD-10
- HITECH Electronic Health Records

# Shared Savings Program Background

- Mandated by Section 3022 of the Affordable Care Act
- Establishes a Shared Savings Program using Accountable Care Organizations (ACOs)
- Must be implemented by January 1, 2012
- Notice of proposed rulemaking published (March 31<sup>st</sup> 2011)
- Slide information was taken from the proposed rule



# Medicare Shared Savings Program Goals

- The Shared Savings Program is a new approach to the delivery of health care aimed at reducing fragmentation, improving population health, and lowering overall growth in expenditures by:
  - Promoting accountability for the care of Medicare fee-for-service beneficiaries
  - Requiring coordinated care for all services provided under Medicare Parts A and B
  - Encouraging investment in infrastructure and redesigned care processes



# Medicare Shared Savings Program Vision

- ACOs will promote the delivery of seamless, coordinated care that promotes better care, better health and lower growth in expenditures by:
  - Putting the beneficiary and family at the center
  - Remembering patients over time and place
  - Attending carefully to care transitions
  - Managing resources carefully and respectfully
  - Proactively managing the beneficiary's care
  - Evaluating data to improve care and patient outcomes
  - Using innovation focused on the three-part aim
  - Investing in their workforce

# Medicare Shared Savings Program ACO Defined

- A group of health care providers and suppliers that:
  - Works together to manage and coordinate beneficiary care
  - Agrees to be held accountable for:
    - Quality
    - Cost
    - Overall care
- Invests in infrastructure and redesigned, coordinated care processes



# Eligible Organizations

- Existing and newly formed organizations are eligible to apply to participate in the program and include:
  - Group practice arrangements
  - Physician networks
  - Joint ventures/partnerships of hospitals and ACO professionals
  - Hospitals employing ACO professionals
- Secretarial discretion for other providers and suppliers of services
  - Other providers/suppliers may participate in an ACO but would not be used to directly assign patients
  - Critical Access Hospitals (CAHs) that bill under Method II

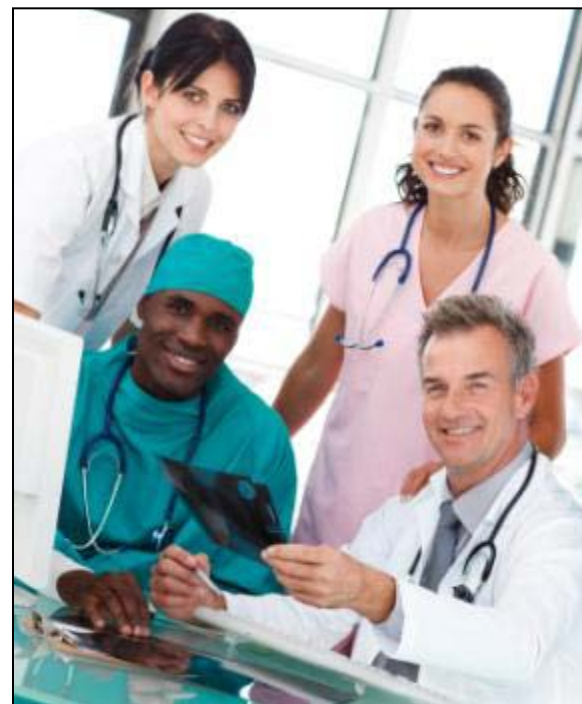
# Eligible Organizations



- FQHCs and RHC's cannot independently form an ACO but will be valued ACO participants and the ACO can qualify for additional savings for their partnerships.
- A "hospital" means only acute care hospitals paid under the hospital inpatient prospective payment system (IPPS).

# ACO Professionals Defined

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
  - Primary Care Provider:
    - general practice
    - family practice
    - internal medicine
    - geriatric medicine
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialists (CNS)



# Medicare Shared Savings Program Requirements

- By statute ACOs will have to meet the following requirements to participate:
  - Have a formal legal structure to receive and distribute payments
  - Have a sufficient number of primary care professionals
  - Agree to participate in the program for a 3-year period
  - Have a leadership and management structure that includes clinical and administrative systems
  - Define processes to (a) promote evidenced-based medicine, (b) report quality and cost measures and (c) coordinate care
  - Demonstrate it meets patient-centeredness criteria

# Put Patients First



# Required Person Centeredness Activities

1. Beneficiary experience of care survey in place and results used to improve care over time
2. Patient involvement in ACO governance
3. Evaluating and address the health needs of the population, including consideration of diversity
4. Identify high risk individuals and develop individualized care plans for targeted patient populations
5. Mechanism in place for coordinating care & a process (or plan to develop a process) to electronically exchange care information when a beneficiary transitions to another provider or setting

# Required Person Centeredness Activities (Continued)

6. Communicate clinical knowledge/evidence based medicine to beneficiaries in a way that is understandable to them.
7. Written standards for beneficiary access and communication and a process in place for beneficiaries to access their medical record.
8. Internal processes for measuring clinical and/or service performance by physician or across the practices. Results are used to improve care/service over time.

# Three Year Agreement

- ACO will enter into a 3 year agreement with an annual start date of January 1 with the exception of the first year which will also include a July 1 review date
- ACOs will be accountable for new program standards, as established by regulations, during the agreement period
- A reevaluation process has been established if significant change to an ACO structure occurs during the agreement term

# Data Sharing

- Aggregate data reports provided at the start of the agreement period, quarterly aggregate data reports thereafter
- Beneficiary identifiable data provided for patients seen by ACO primary care providers who have been notified and not opted out
- Beneficiary-identifiable data provided upon request

# Patient Population



- ACO accepts responsibility for an “assigned” patient population
- Assigned patient population is the basis for establishing and updating the financial benchmark, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs
- Patients assigned to ACOs based on the plurality of assigned charges for primary care services from primary care physicians (internal medicine, general practice, family practice, and geriatric medicine)

# Patient Population

- Primary care physicians on whom assignment is based must be exclusive to one ACO
- Primary care services are defined as a select set of HCPCS codes defined in section 5501 of the Affordable Care Act, including G-codes associated with the annual wellness visit and the Welcome to Medicare visit



# Patient Population

- Retrospective beneficiary assignment will be used to determine an ACO's eligibility to receive shared savings for two reasons:
  - It creates incentive for ACOs to standardize care processes across all Medicare patients
  - The actual population seen by a physician over the course of a year changes significantly
- Prospective assignment will be used for sharing aggregate beneficiary data at the start of the agreement period to help the ACO understand their patient population and formulate a plan

# Beneficiary Communication

- Beneficiary will be notified that their provider is participating in the program (ACO)
- Beneficiary will receive general notification about the program and what it means for their care
- Beneficiary will be informed their data may be shared with the ACO and be given the opportunity to opt out

# Beneficiary Communication (Continued)

- To prevent beneficiary steerage, inappropriate advertising and to ensure information about ACOs is consistent and accurate, CMS will provide parameters around marketing materials and clear all documents produced for beneficiary and other public use
- Beneficiary will be notified that their provider is no longer participating in the Medicare Shared Savings Program

# Quality Measurement & Performance

- Quality measures are separated into the following five key domains that will serve as the basis for assessing, benchmarking, rewarding and improving ACO quality performance:
  - Better Care
    1. Patient/Caregiver Experience
    2. Care Coordination
    3. Patient Safety
  - Better Health
    1. Preventative Health
    2. At-Risk Population/Frail Elderly Health



# Quality Measurement & Performance Continued

- ACO Quality Performance Standard made up of 65 measures intended to do the following:
  - Improve individual health and the health of populations
  - Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement and care coordination
  - Support the Shared Savings Program goals
  - Align with other incentive programs like PQRS, EHR and HIQR

# Quality Data Reporting

- Quality data collected three ways:
  - Claims data
  - GPRO tool
  - Survey
- Pay for reporting the first year
- Must meet minimum attainment level in the following years
- 100% complete reporting required
- Shared savings payments linked to quality performance based on a sliding scale that rewards both attainment and improvement
  - High performing ACOs in each domain receive higher sharing rate



# Quality Calculation

- Benchmark levels set at the start of the Medicare Shared Savings Program and at the start of each annual performance period
- Quality standards set for each measure and each domain
- ACO must meet minimum attainment levels to be eligible for shared savings
- ACOs would earn points for each measure based on a sliding scale
- Performance below the minimum attainment level would earn zero points for that measure

# Incorporation of Other Data Reporting Requirements

- Full reporting on measures through the Shared Savings Program qualifies for each ACO participant for PQRS incentive payment.
- At least 50% of an ACO's PCPs must meet criteria for meaningful use by the end of the first performance year. These providers will qualify separately for their bonus under meaningful use.



# Financial Performance

- ACO providers continue to be paid under regular Medicare fee-for-service payment systems
- For each ACO, an annual risk adjusted expenditure target is calculated based on the assigned patient population updated by national Medicare expenditures
- ACOs may share in savings if actual assigned patient population expenditures are below the established benchmark
- Minimum savings rate (MSR) based on assigned patient population size must be exceeded to share savings
- Percentage of savings shared depends on meeting quality performance standards and FQHC/RHC participation

# Shared Savings Determination

- An ACO that exceeds its MSR and meets quality standards will be eligible to share in up to 52.5% or 65% of the savings (depending on risk model)
- Shared Savings Payments for:
  - Incorporating RHCs/FQHCs
  - Performance on quality metrics



# Medicare Shared Savings Program Agreements—Initial Two Track Approach

- ACOs may choose to participate in one of two tracks:
  - A three year agreement comprised of 2 years of one-sided shared savings and transition to two-sided shared savings/losses in the final year
  - A three year agreement of two-sided shared savings/losses
- All ACOs who elect to continue in the program after the first agreement period must continue in the two-sided shared savings/losses model.
- Provides on-ramp for organizations to gain population management experience and transition to risk arrangements
- Annual performance periods subject to routine updates to program operations.

# Monitoring & Termination

- Monitoring, by a variety of methods, assures general program compliance and focuses on avoidance of at risk beneficiaries, poor quality performance
- ACO must give CMS a 60-day notice of its intention to terminate its agreement to participate in the shared savings program
- CMS is clearly defining the actions that if an ACO conducts would result in CMS terminating the agreement
- RESOURCE: <http://www.cms.gov/sharedsavingsprogram/>

# Are you Ready for HIPAA 5010 & ICD-10?

- Medical diagnosis and inpatient procedure code sets:
  - ICD-9 CM → ICD-10 CM
  - ICD-10 PCS
- HIPAA standards for electronic transactions:
  - Version 4010/4010A → Version 5010

# Who Is Affected?

Anyone who is covered by HIPAA:

- Health care providers that conduct electronic transactions
- Payers including Medicaid and Medicare
- Clearinghouses

Some non-HIPAA covered entities that use ICD-9 codes:

- Vendors and business associates of covered entities
- Worker's compensation programs
- Life insurance companies

# Version 5010

- Refers to new HIPAA standards for electronic health care transactions
- Replaces Version 4010/4010A1 standards
- Accommodates ICD-10 code sets

# ICD-10

- Refers to the diagnosis and procedure code sets
- Replaces ICD-9 code sets and includes updated medical terminology and classification of diseases.
- More logically organized, more detailed and specific, and more clinically accurate

# Why the Change?

- **ICD-10 provides more specific data than ICD-9**
  - Better reflects current medical practice
  - Structure accommodates addition of new codes
    - The current coding system is running out of capacity and cannot accommodate future state of health care
  - Expanded data capture
    - Quality measurement
    - Reduce coding errors
    - Better analysis of disease patterns
    - Track and respond to public health outbreaks
    - Make claim submission more efficient
    - Identify fraud and abuse

# More on ICD-10

- ICD-10 CM/PCS consists of two parts:
  - ICD-10-CM for **diagnosis coding** in all health care settings
    - Describes left vs. right, initial vs. subsequent encounter, routine vs. delayed healing, and nonunion vs. malunion
  - ICD-10-PCS for **inpatient procedure coding** in hospital settings
    - Provides detailed information on procedures and distinct codes for all types of devices
- **CPT coding for outpatient and office procedures is not affected by the ICD-10 transition**

# Benefits of ICD-10

- More accurate payments for new procedures
- Fewer miscoded, rejected, and improper reimbursement claims
- Improved ability to measure healthcare services
- Increased sensitivity when refining grouping and reimbursement methodologies
- Decreased need to include supporting documentation with claims

# Transitioning to ICD-10

- Identify your current systems and work processes that use ICD-9 codes
- Communicate implementation plans between providers, payers and vendors
- Identify potential changes to work flow and business processes
- Budget for time and money related to the implementation
- Allow enough time to test transactions
- Assess staff training needs

# Important Dates to Know

- **January 1, 2012: Full implementation of Version 5010**
  - All electronic claims must use Version 5010 standards
- **October 1, 2013: Full implementation of ICD-10**
  - All claims for services provided on or after this date must use ICD-10 codes

# Resources to Help You Prepare

- CMS ICD-10 Web site: <http://cms.gov/ICD10>
- CMS ICD-10 Listserv:  
[http://cms.gov/ICD10/02d\\_CMS\\_ICD-10\\_Industry\\_Email\\_Updates.asp](http://cms.gov/ICD10/02d_CMS_ICD-10_Industry_Email_Updates.asp)
- Professional, clinical, trade associations

# What is the EHR Incentive Program?

- EHR Incentive Programs were established by law
  - American Recovery & Reinvestment Act of 2009
  - Incentive programs for Medicare and Medicaid
  - Programs for hospitals and eligible professionals
  - Must use certified EHR technology AND demonstrate adoption, implementation, upgrading or meaningful use
  - Programs differ between Medicare and Medicaid
  - Medicare incentive program is federally run by CMS
  - Medicaid incentive program is run by States and is voluntary

# Eligible Professionals

**Medicare-only Eligible Professionals**

**Medicaid-only Eligible Professionals**

**Doctors of Optometry  
Doctors of Podiatric Medicine  
Chiropractor**

**Doctors of Medicine  
Doctors of Osteopathy  
Doctors of Dental Medicine  
or Surgery**

**Nurse practitioners  
Certified nurse midwives  
Physician assistants (PAs)  
when working at an FQHC  
or RHC that is so led by a  
PA**

**Could be eligible for both  
Medicare & Medicaid  
incentives**

# Which Hospitals are Eligible to Participate?

- Medicare Hospitals include:
  - Acute Care Hospitals
    - Subsection (d) hospitals that are paid under the PPS and are located in the 50 States or Washington, DC (including Maryland)
  - Critical Access Hospitals (CAHs)
- Medicare Advantage Affiliated Eligible Hospitals:
  - Will be paid under the Medicare Fee-for-service EHR incentive program
- Medicaid Hospitals include:
  - Acute Care Hospitals (now including CAHs)
    - Medicaid included critical access hospitals in its definition of “acute care hospital” (but incentive is like other acute care hospitals, not following the Medicare CAH formula)
  - Children’s Hospitals

# How Much Are the Medicare EP Incentives?

- Medicare Incentive Payments Overview
  - Incentive amounts based on Fee-for-Service allowable charges
  - Maximum incentives are \$44,000 over 5 years
  - Incentives decrease if starting after 2012
  - Must begin by 2014 to receive incentive payments. Last payment year is 2016.
  - Extra bonus amount available for practicing predominantly in a Health Professional Shortage Area
  - Only 1 incentive payment per year

# How Much Are the Medicaid EPs Incentives?

- Medicaid Incentive Payments Overview
  - Maximum incentives are \$63,750 over 6 years
  - Incentives are same regardless of start year
  - The first year payment is \$21,250
  - Must begin by 2016 to receive incentive payments
  - No extra bonus for health professional shortage areas available
  - Incentives available through 2021
  - Only 1 incentive payment per year

# How Much Are the Hospital Incentives?

- Federal Fiscal Year
- \$2M base + per discharge amount (based on Medicare/Medicaid share)
- Medicare's calculation derives a payment amount, while Medicaid's calculation derives a total amount that States may pay eligible hospitals.
- Hospitals meeting Medicare Meaningful Use requirements may be deemed eligible for Medicaid payments

# What are the Requirements/ Meaningful Use?

- Meaningful Use is using certified EHR technology to
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and families in their health care
  - Improve care coordination
  - Improve population and public health
  - All the while maintaining privacy and security
- Meaningful Use mandated in law to receive incentives

# What are the Requirements/ Meaningful Use?

- The Recovery Act specifies the following 3 components of Meaningful Use:
  1. Use of certified EHR in a meaningful manner (e.g., e-prescribing)
  2. Use of certified EHR technology for electronic exchange of health information to improve quality of health care
  3. Use of certified EHR technology to submit clinical quality measures (CQM) and other such measures selected by the Secretary

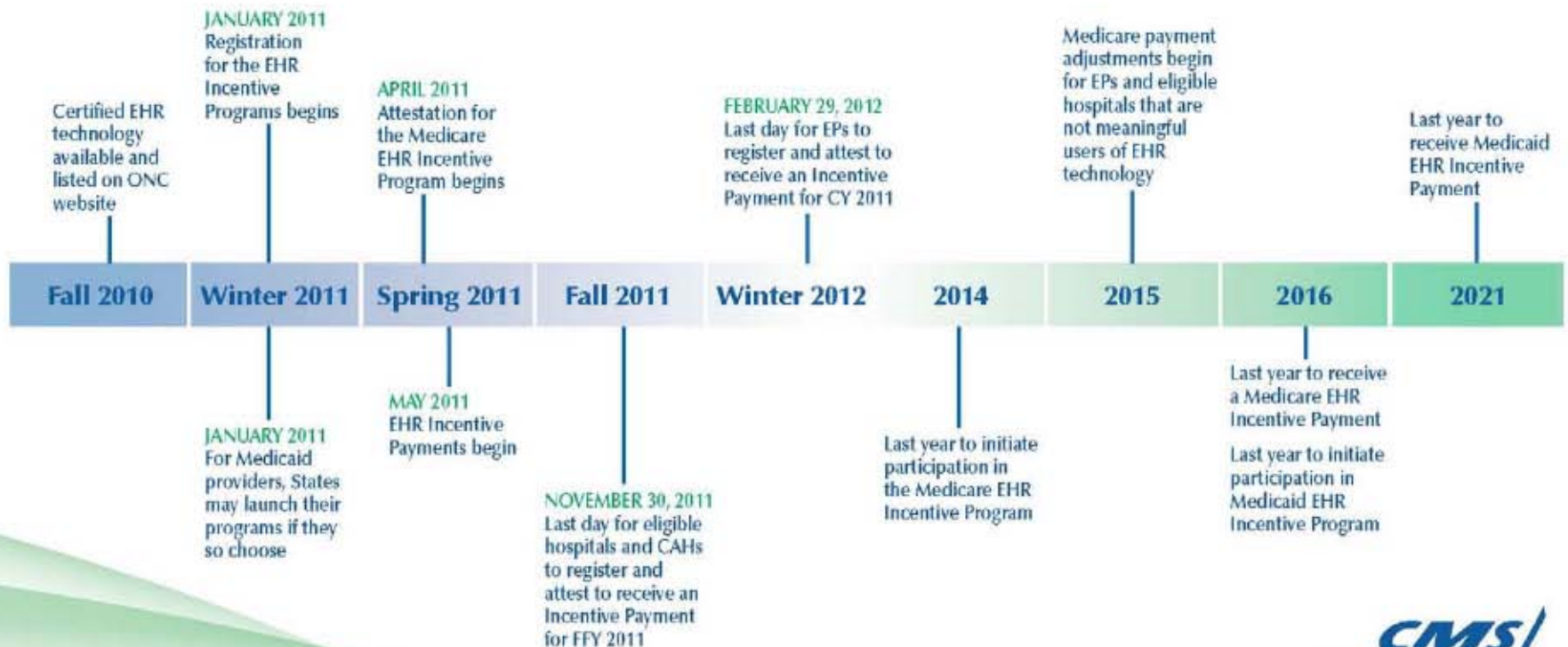
# What are the Requirements/ Adopt/Implement/Upgrade?

- MEDICAID – only for first participation year
- Adopted – Acquired and Installed
- Implemented – Commenced Utilization of
  - Staff training, data entry of patient demographic information into EHR
- Upgraded – Expanded
  - Upgraded to certified EHR technology or added new functionality to meet the definition of certified EHR technology
- Must be certified EHR technology capable of meeting meaningful use
- No EHR reporting period

# What are the Requirements/ Meaningful Use?

- Basic Overview of Stage 1 Meaningful Use:
  - Stage 1
  - Reporting period is 90 days for first year and 1 year subsequently
  - Reporting through attestation
  - Objectives and Clinical Quality Measures
  - Reporting may be yes/no or numerator/denominator attestation
  - To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology
- [http://www.cms.gov/EHRIncentivePrograms/30\\_Meaningful\\_Use.asp#TopOfPage](http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage)

# CMS Medicare and Medicaid EHR Incentive Programs Milestone Timeline





# Resources to Get Help and Learn More

- Get information, tip sheets and more at CMS' official website for the EHR incentive programs:

[www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)

*Follow the latest information about the EHR Incentive Programs on Twitter at [www.Twitter.com/CMSGov](http://www.Twitter.com/CMSGov)*

- Learn about certification and certified EHRs, as well as other ONC programs designed to support providers as they make the transition:

<http://healthit.hhs.gov>

# CMS Contact Information

- **Public Inquiry Phone Line:**
  - 214-767-6441
- **Public Email Address:**
  - [RODALFM@cms.hhs.gov](mailto:RODALFM@cms.hhs.gov)
- **EHR Information Center**
  - 1-888-734-6433

# Questions ???

