HFNI Webinar

NUMBER ONE

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URAC Accreditation

- Utilization Review Accreditation Commission
  - Independent, Not-for-profit, started in 1990;
  - Education, Measurement, Accreditation;
  - Validates commitment to quality and accountability in health care organizations;
  - Exists as an industry standard;
  - 30 Programs of Accreditation;
  - HFNI is pursuing two areas:
    - Credentials Verification Organization
    - Health Network

URAC Accreditation

- HFNI has served as a Credentialing Organization historically; this will allow us to be accredited as such;
- HFNI has also served as a Health Network, and as we move towards more robust Clinical Integration, accreditation will provide a framework;
- In both instances, we are seeking nationally recognized accreditation for areas that we have been developing proficiency in for a long time

What is a QIP?

- Quality Improvement Project
  - Define an area where improvement is needed, and the population that is affected;
  - Measure current performance;
  - Develop a plan of intervention;
  - Implement the intervention, assembling whatever personnel, equipment, and material is needed;
  - Measure and compare performance after the intervention;
  - Follow up with modification if needed.

Our QIP's

- Fall risk and depression risk in the elderly;
- Both are in the ACO list of quality measures, and will affect other quality measures as well;
- Preliminary screening on both has been done on our ACO patients through the Personal Health Assessment;
- Those who failed the initial screen in either (or both) will be identified, and set up for follow up by our Care Coordinators;

Our QIP's

- Follow up eval for fall risk will be the TUG test (Timed Up and Go) to be done and recorded in PCP's office, and a care plan implemented if appropriate;
- Follow up eval for depression risk will be the PHQ-9 (Personal Health Questionnaire-9 questions), again done and recorded in PCP's office with appropriate care plan;
- We can assist at each step.

ACO Quality Benchmarks

- http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks.pdf

ACO Benchmarks

- 33 Quality Measures spread over 4 Domains
  - Patient/Caregiver experience- 7 measures;
  - Care-coordination/patient safety- 6 measures; 1 double-weighted (EHR adoption);
  - Preventive health-8 measures;
  - At-risk populations- 12 total…but there are 2 composite measures- DM with 5 related measures and you must hit all 5, and CAD with 2 related measures and you must hit both to get any points.

ACO Benchmarks

- Scoring is by Domain- (total points achieved/total points available in the Domain) x 100- that's the % score;
- %iles have been determined by CMS based on a national average of performance for each Domain;
- Max of 2 points for 90th %ile or above; 0 points for <30th %ile;
- A blended average score for each ACO will be generated which will affect savings (or losses) shared.

Wellness and Illness

- CMS has 3 “Wellness Visit” Codes:
  - G 0402- “Welcome to Medicare Preventive Visit” or “Initial Preventive Physical Exam”, IPPE- only done once and must be done during first 12 months of Medicare Part B coverage;
  - G 0438- “Annual Wellness Visit”, AWV, initial- only done once in a lifetime; if the patient didn’t get an IPPE in the first 12 months of their Part B coverage, then this is done instead;
  - G 0439- “Annual Wellness Visit”, AWV, subsequent-can be done once every 12 months after the initial;

Wellness and Illness

- The required elements for the IPPE and the AWV, initial are quite different; AWV, subsequent is an update of the AWV, initial;

- ALL require a written or printed document that is presented to the patient outlining your recommendations;

Wellness and Illness

- G 0402--- $163.84
- G 0438--- $169.02
- G 0439--- $111.91

Wellness and Illness

- For a complete description:
  - www.cms.gov/Outreach-And-Education/Medicare-Learning-Network-MLN/MLNProducts_QRI_IPPE001a.pdf
  - www.cms.gov/Outreach-And-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf
  - www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf

Wellness and Illness

- "Illness Visits" are everything else; because the Medicare Part C programs (the Medicare HMO's) have premiums that are determined by the Hierarchical Condition Category (HCC) risk score, those plans have been willing to make an incentive payment over and above the E &M code payment for a comprehensive illness visit that documents all of the patient's medical conditions and the treatment plan for each;

Wellness and Illness

- To do all of the documentation that is needed to cover both “Wellness” and “Illness” requirements, Medicare patients need two comprehensive visits a year during which all of the preventive elements are addressed at one (Wellness), and all of the disease elements are addressed at the other(Illness);
- HFNI is working on a plan to be able to offer an incentive program for the physicians based on the comprehensive Wellness and Illness visits.

Transitional Care Management

- Transitional Care is the work that is required when a patient transitions from one level of care to another; this can be from home to hospital, hospital to home or SNF, SNF to hospital or home, etc.;
- Care Transitions are intervals of significant increased risk for the patient, family/care-givers, providers, and institutions;
- Proper care and attention to detail during transitions is critical;

Transitional Care Management

- On ACO-attributed patients, we have access to the Care Coordination Nurses to facilitate Transitional Care Management (TCM);
- We are developing a method to identify ACO patients that are hospitalized, and involving the nurses as soon as possible;
- They will be in contact with patients/families AND the PCPs' offices to coordinate the necessary follow-up.

Transitional Care Management

- Because of the complexity and attention to detail that TCM requires, CMS has defined two TCM codes to bill for those services:
- 99495- moderate complexity; within 14 days
- 99496- high complexity; within 7 days
- Both require a combination of non-face-to-face contact (telephone, internet, etc) AND face-to-face contact (office or home visit), and include coordination with other providers (hospitals, SNF's HHA's, pharmacy, etc.).

Transitional Care Management

- 99495--- $163.07
- 99496--- $230.56