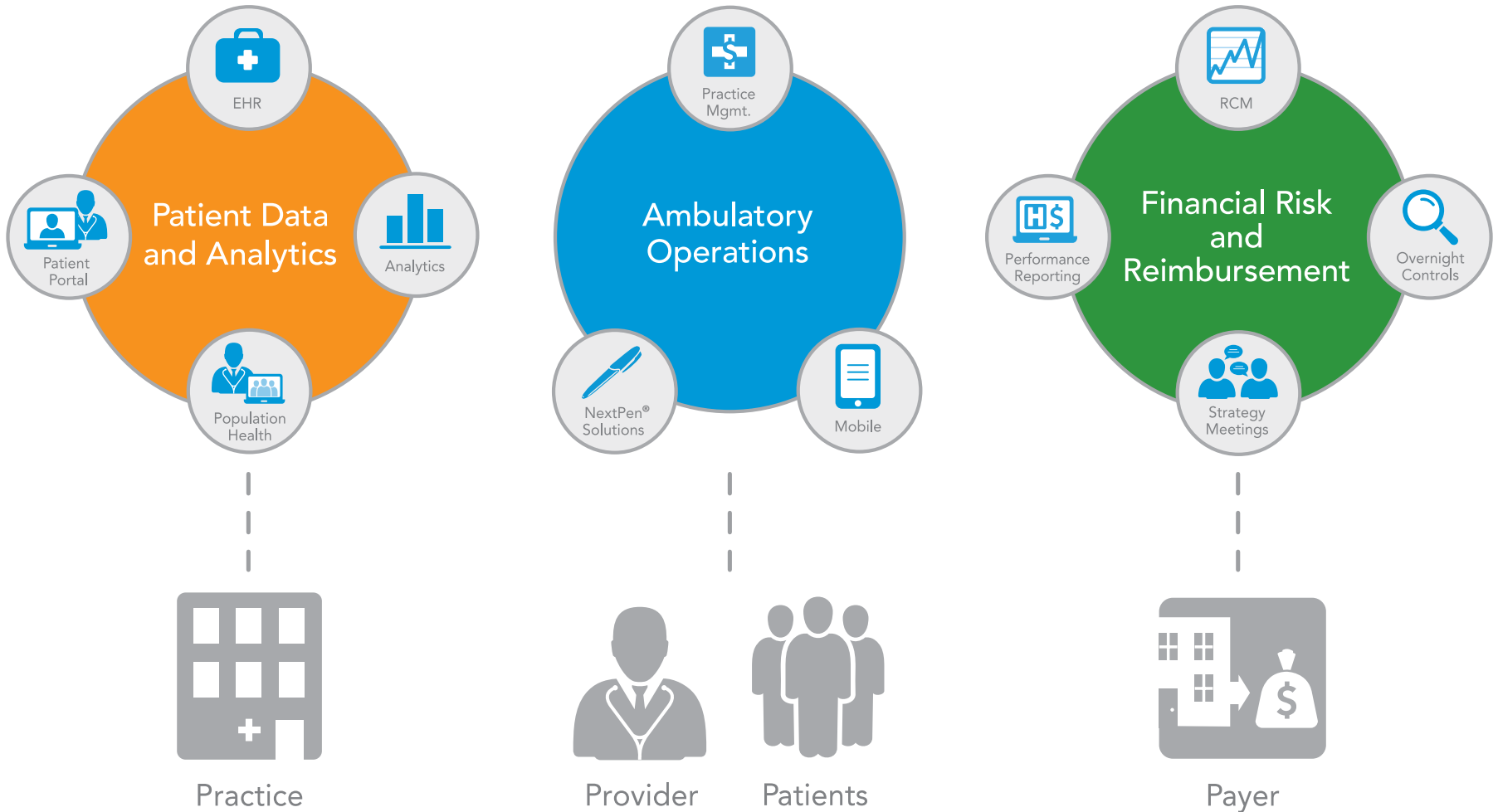


What you need to know to realize value-based revenue

- 1 Making sense of value-based care
- 2 Why the change to P4P is needed
- 3 Pick the value-based model that works for you
- 4 A new paradigm for patient care
- 5 How meaningful is Meaningful Use?
- 6 Reforming "payment reform"
- 7 A renewed focus on improved clinical outcomes
- 8 Getting the most value from value-based care

Impacting every aspect of the healthcare ecosystem





Making sense of
value-based care.

New rules governing healthcare are taking providers by storm. One area that is quickly changing is the fee-for-service payment model. This system, one we understand well and are comfortable with, will become virtually obsolete over the next decade according to analysts. The reason is simple. Payers can no longer afford to cover the cost of care, particularly for patients with chronic illnesses.

Outcomes and cost containment will drive incomes.

Value-based payment models are associated with improving patient outcomes and reducing the cost of care delivery. The term “value-based care,” can mean numerous things, including:

- Pay for performance (P4P)
- Risk-sharing
- Incentivized payments
- Capitation arrangements
- Gain sharing
- Value-based purchasing
- Risk-adjusted care
- Population-based payments

Fee-for-service is unsustainable.

Business as usual is over. Maintaining the fee-for-service model for patient care is absolutely unsustainable, especially within publicly funded models such as Medicare and Medicaid.

As fee-for-service reimbursement models vanish from the healthcare landscape, pay for performance (P4P) models are already taking their place. Turning the traditional model of reimbursement upside down, P4P offers a value-based payment premium for providers who are able to foster proactive, population-based care management, enabling them to drive better outcomes.

“The bottom line: payers can no longer afford to cover the costs of treatment for an aging population coupled with the prevalence of chronic disease.”

Core objectives of value-based care.

Delivering preventative care earlier, in lower cost settings, is the key to value-based care success. Providers must focus on improving individual and population health, reducing the number of avoidable emergency room visits and hospitalizations, reducing hospital readmissions, and significantly improving patient outcomes at an earlier point across their patient population. In turn, providers will see financial benefits based on their results.

Value-based Goals from the Centers for Medicare & Medicaid Services

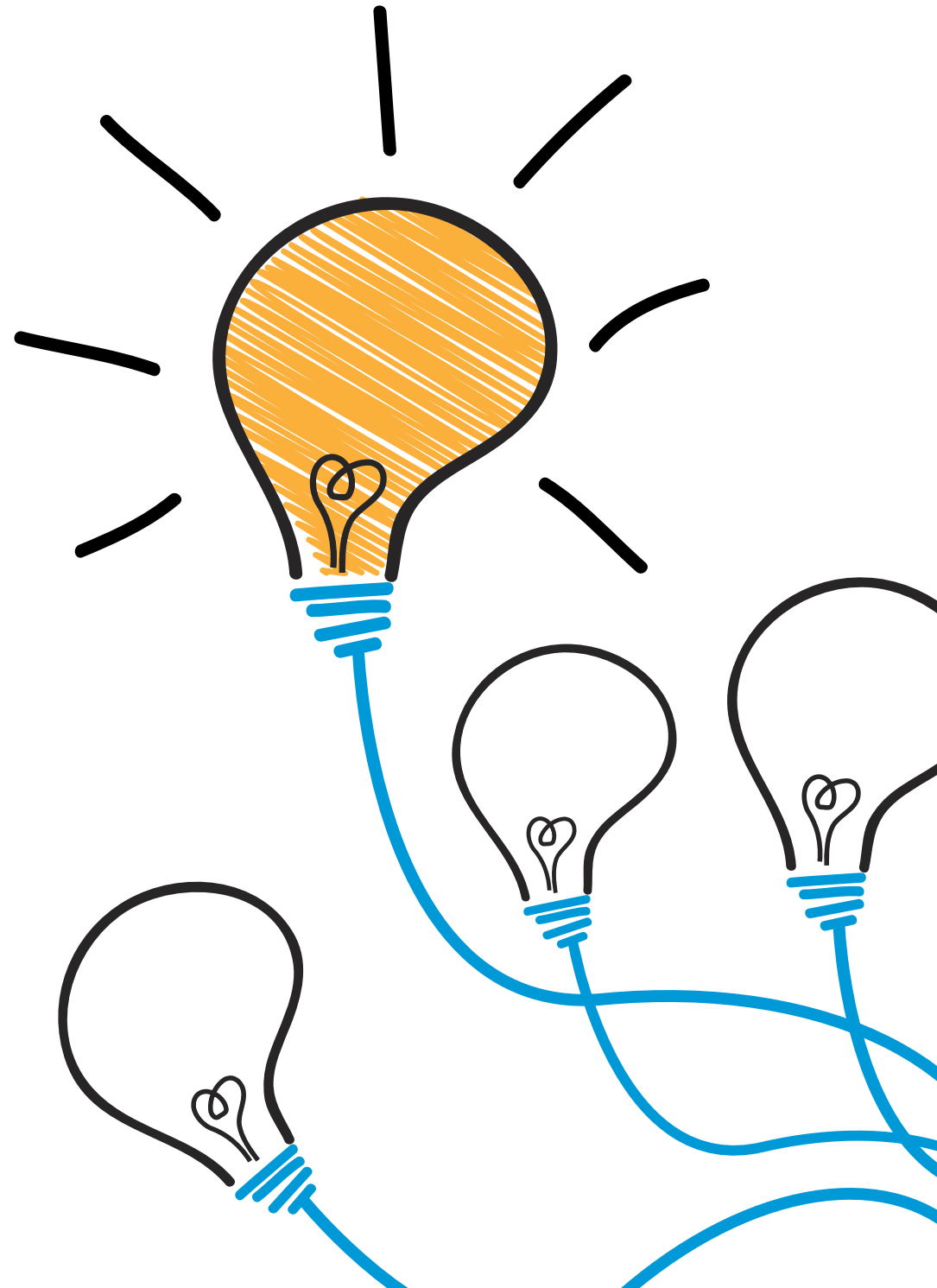
- Improve clinical quality
- Address misuse of services
- Deliver patient-centered care
- Improve patient safety
- Avoid unnecessary costs
- Reengineer care processes and system-wide workflows
- Make performance results transparent
- Reduce existing care disparities



Why the change
to P4P is needed.

Fresh ideas for treating an aging population.

Providers are seeing increasing numbers of chronic diseases and comorbid conditions such as obesity, heart disease, and diabetes. Add an aging population of Baby Boomers who become frequent utilizers of healthcare, particularly when they are living longer, and end-of-life care expenses are increasingly exorbitant. It's projected by the year 2050 that 88.5 million will be aged 65 or older and eight of 10 seniors will suffer from at least one chronic/comorbid condition.



Chronic illness drives 75% of healthcare spending...

According to the Centers for Disease Control and Prevention (CDC), chronic disease accounts for more than 75% of the nation's total healthcare spending. The overarching goal of population health and care management is to identify, as early as possible, those at-risk patients with chronic diseases. This particular patient population sees the most providers and is the greatest utilizer of medical services, incurring the most cost. This is currently what the government, as well as payers, are concerned with – the overarching cost of care for chronically ill patients.

And the amount keeps getting higher.

\$1.5 trillion dollars annually, actually; that's how much is spent treating patients with chronic diseases. And, it's increasing at an alarming rate. The figures associated with treating heart disease and stroke, diabetes, lung disease, and Alzheimer's are in the billions, and a lot of this has to do with the fact that patients don't always comply with their treatment.

Chronic diseases increasing healthcare costs at an alarming annual rate:

1

Heart Disease & Stroke
\$432 billion

2

Diabetes
\$174 billion

3

Lung Disease
\$154 billion

4

Alzheimer's Disease
\$148 billion

How about a \$2,100 average for one ER visit?

Studies show the average cost of a single ER visit across the US was more than \$2,100 dollars. Many times and for real health emergencies, that number will be the low end of a visit. Considering there were more than 136 million ER visits in 2014, total costs for ER visits represents a large portion of healthcare expenses. The goals of value-based treatment models are to reduce avoidable ER visits, hospitalizations, and readmissions by significantly improving health outcomes earlier. Meet these quality measures and, as a provider, you'll have leverage to negotiate better and more favorable risk-sharing terms with the payers you deal with.

The **goals** of value-based treatment models are to **reduce avoidable ER visits, hospitalizations, and readmissions** by significantly **improving health outcomes** earlier.

TIP

To be successful, healthcare organizations must grasp the importance of expeditious patient care coordination processes. This is essential for collaborative care delivery models such as ACOs, PCMHs, and other value-based models and is only possible through automation and data sharing.

Pick the value-based model that works for you.

Model your practice by risk managing.

Depending on an organization's readiness to accept risk, there are different models that can potentially be integrated into their health system. The most widely known is Shared Savings, which rewards providers who effectively manage costs and meet care quality measures and targets, with a portion of the savings. Conversely, if a provider delivers inefficient, high-cost care, they may be responsible for additional costs incurred or penalties. There are several other options that may dovetail with your risk level including:

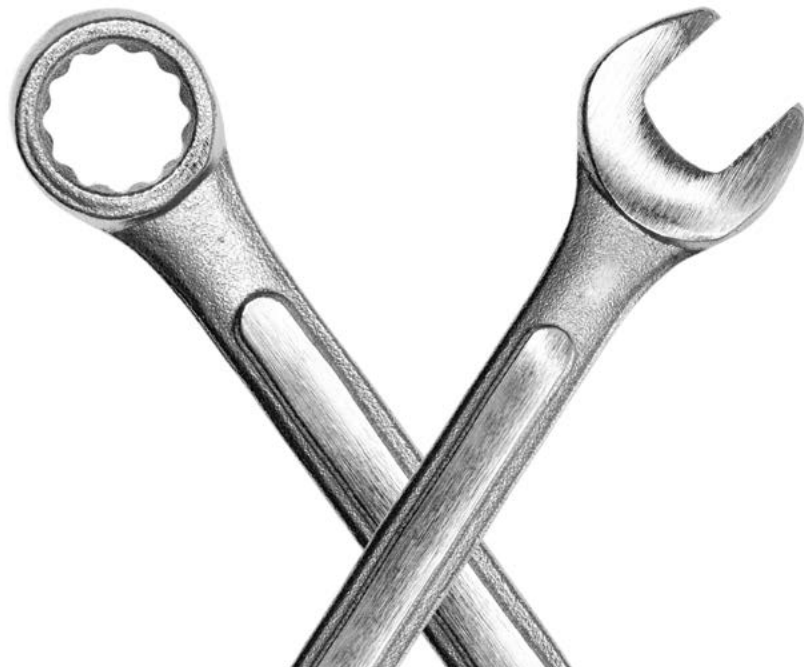
- Pay-for-Care Coordination
- Bundled Payments
- Shared Risk
- Capitation
- Provider-Sponsored Health Plan

Care payment models, defined.

- 1 Fee-for-Service:** Provider receives payment for each procedure or service performed, accepting no risk in provision of care and no accountability for the quality of care delivered
- 2 Fee-for-Service linked to value:** Provider payment is triggered by service delivery but between 5%-10% of final payment depends on procedure quality or cost
- 3 Alternative Value-based Payments Models:** Provider payment is still triggered by service delivery, but varies based on managing a population or episode of care
- 4 Population-based Payments:** Payment is not triggered by service delivery; rather providers are paid for the care of a beneficiary over a period of time

Some assembly required.

All value-based care models require clinical integration to be successful. With this integration, clinical information will help drive coordination of services across a delivery system, including everything from preventive care to outpatient, inpatient, post-acute care, skilled nursing, rehab, home health, and palliative care.



Five criteria for choosing the right model

1. **Understand your patient population** - Who they are and who you will be measured against
2. **Establish your baseline population** - Understand your population risk and opportunities
3. **Determine measurement targets** - What will you be measured against?
4. **Institute cash flow and interim payments** - Assess reimbursement models and how payments will be disseminated to provider groups
5. **Define care coordination capabilities** - How are your providers integrated and do you coordinate care and/or provide care management capabilities?

Ready to move to a value-based model?

The triple aim of healthcare reform is to improve the health of a population, deliver better quality healthcare services, and lower the cost of care delivery. The endgame of all the pay for performance programs, various risk-sharing and capitation arrangements, gain-sharing programs, and risk-adjusted care is aligned with these goals and drives effective Population Health Management.

Here's what you can expect to achieve after you move to a value-based revenue model:

1. **Improved financial performance** - Revenue cycle management, operational efficiencies
2. **Enhanced patient experience** - Patient access, patient engagement and communication
3. **Clinical integration** - Alignment of hospitals and physicians, network design/management, and performance measurements
4. **Improved clinical outcomes** - Population health management, care coordination, and care management
5. **Organizational structure** - Change management and leadership





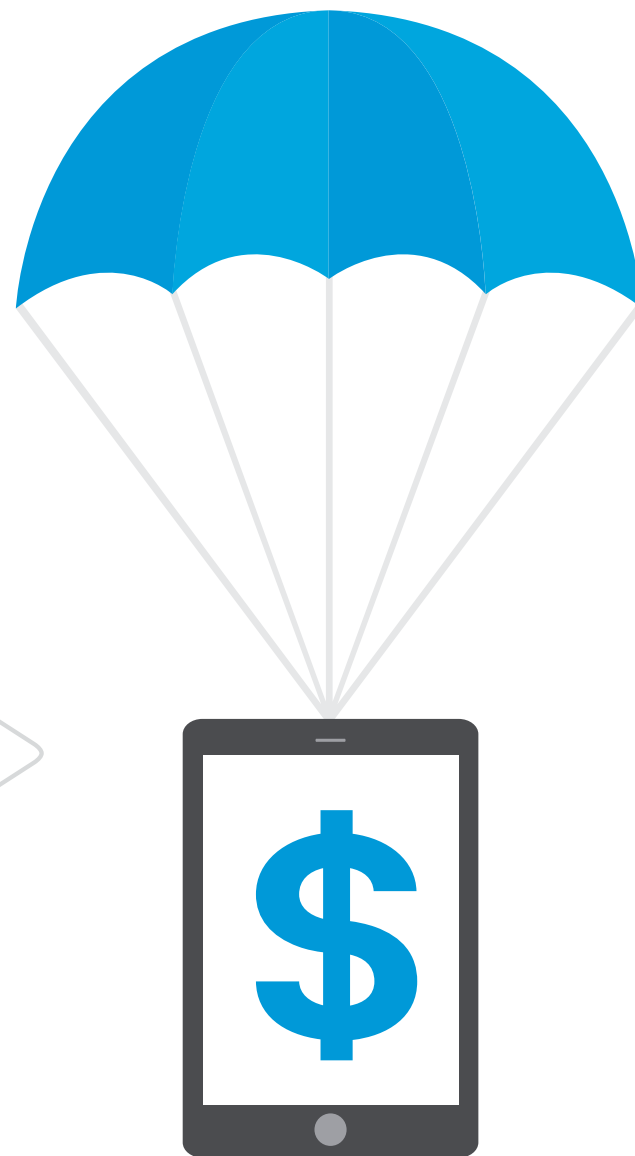
A new paradigm for
patient care.

A shared-risk model.

Insurance companies traditionally have managed the risk in the overall healthcare delivery system. Today, many of them are creating an entirely new delivery system they're willing to assume risk for. This new model features a shared-risk method between deliverers of care and the actual financing of care.

What started out as an initiative through the Centers for Medicare & Medicaid Services (CMS) is now quite common with payers. Moreover, payers continue to work with providers to reduce healthcare spending as we transition to value-based care.

In fact, the responsibility for a patient's health is now shifting more to providers. So as providers, when you contract with these individual programs, you'll see different requirements for different risk management measures and different quality measures, as well as different kinds of reimbursement incentives.



Value-based revenue... decoding the opportunities.

Given today's increasingly challenging reimbursement environment, providers need to maximize every possible reimbursement dollar. It's crucial to understand the application and impact of value-based programs and ensure you have the tools and strategy to comply with the various reimbursement program requirements.

To help providers transition from fee-for-service to value-based care, Congress created three programs to link Medicare payments to physicians to value/quality:

- Meaningful Use EHR Incentive Program (MU)
- Physician Quality Reporting System (PQRS)
- Physician Value-Based Payment Modifier (VBM)

Using a carrot-and-stick approach, CMS offers front-end incentives for participating Medicare physician compliance, followed by back-end penalties for non-compliance. While you are probably familiar with the incentive programs for complying with these programs, you may not grasp the exact impact of the penalties for failing to comply. These penalties are taking effect for the first time in 2015, based on past performance.

“The two-year lag between your performance and your payment means what you did or didn't do in MU or PQRS in 2013 is directly impacting your payment today in 2015. Penalties could add up to 4.5%”



How meaningful is Meaningful Use?



Big carrot, bigger stick for MU.

MU, program one, offers incentive payments and imposes penalties to encourage providers to adopt certified electronic health record technology (CEHRT). Effective January 1, 2015, Medicare began penalizing providers who failed to comply with the program. It gets a bit more complicated since the penalties lag two years behind. That means compliance or non-compliance in 2015 will impact payments in 2017, not 2015. Penalties also are set to increase by 1% yearly for the next several years, ultimately capping at 4% (3% if more than 75% of eligible professionals achieve MU in 2018). After 2018, MU penalties will sunset and be folded into the new merit-based incentive payment system.

Get specific with a Physician Quality Reporting System.

PQRS, program 2, uses a combination of incentive payments and adjustments to promote specific quality measure tracking and reporting. Each year, CMS releases an updated set of quality measures from which providers choose to report.

Generally, to satisfy PQRS reporting requirements, physicians need to report nine quality measures across three National Quality Strategy (NQS) domains. The year 2014 was the final year to receive an incentive payment, and as with the MU program, 2015 is the first year PQRS penalties apply (based on past performance.) For 2015, there are five different options for reporting PQRS measures for individual and group providers:

The PQRS **penalty for the 2015** payment period is **1.5%** and for the **2016-2018** payment periods it will be **2.0%**. As with the meaningful use penalties, **following the 2018** payment period, PQRS penalties will sunset and be folded into the **new merit-based incentive payment system**.

Individual Eligible Provider reporting options

1. Qualified registry
2. Qualified clinical data registry
3. Medicare Part B claims
4. Certified electronic health record technology (CEHRT) via Data Submission Vendor
5. Direct EHR using certified electronic health record technology (CEHRT)

Group Eligible Provider reporting options

1. Qualified registry
2. Certified electronic health record technology (CEHRT) via Data Submission Vendor
3. Direct EHR using certified electronic health record technology (CEHRT)
4. Web-interface (groups of 25 or more EPs only)
5. CMS-certified survey vendor (groups of 25 or more EPs only)



Get value from your Value-Based Payment Modifier.

The newest of the three programs, the Value-Based Payment Modifier (VBM), program 3, is based on PQRS reporting and creates two groups of eligible providers—providers who satisfy PQRS reporting requirements and providers who fail to satisfy PQRS reporting requirements.

Providers who do not meet PQRS measures

Providers who do not meet PQRS reporting requirements will have an additional penalty under the VBM; however, the impact of the penalty is being phased in by year and practice size, as reflected in chart below:

Performance Year	Payment Year	Application	VBM Penalty for Non-PQRS Reporters
2013	2015	Practices of 100 +	1%
2014	2016	Practices of 10 +	2%
2015	2017	All physicians	<ul style="list-style-type: none"> • 4% for practices of 10+ • 2% for practices of 1-9

Providers who meet PQRS measures

Providers who satisfy PQRS reporting requirements will be subject to a quality-tiering system, which evaluates individual physicians based on their performance relative to their peers. The quality-tiering system is being phased in by year and practice size, as reflected in the following chart:

Performance Year	Payment Year	Practices of 1-9	Practices of 10 +	Practices of 100 +
2013	2015	No application	No application	Optional: +, neutral, or -
2014	2016	No application	+ or neutral	+, neutral, or -
2015	2017	+ or neutral	+ or neutral, or -	+, neutral, or -

So what does this mean for me?

2015 marks the first year that penalties from all three programs will apply to payments. Penalties are based on a previous year's performance and increase each year. The below chart may help to clarify the financial impact and application of these programs:

Performance Year	Payment Year	MU Penalty	PQRS Penalty	VBM Penalty	Total Penalties
2013	2015	1-2%*	1.5%	1%**	3.5-4.5%
2014	2016	2%	2%	2%**	6%
2015	2017	3%	2%	4%**	9%
2016	2018	3-4%***	2%	TBD by CMS	TBD by CMS

*The 2015 MU penalty will be 2% for EPs who were subject to 2014 e-Rx payment adjustment. Also, EPs who demonstrate MU for the first time in 2014 will avoid both the 2015 and 2016 MU penalties.

**The 2015 VBM penalty will only apply to physicians in group practices of 100 or more; the 2016 VBM penalty will only apply to physicians in group practices of 10 or more; the 2017 VBM penalty will apply to ALL physicians but the penalty for physicians in practices with fewer than 10 physicians will be 2%.



It's important to note that while the PQRS penalties **apply to all eligible professionals (EPs)**, and are **required by law to remain at 2% per year through 2018**, to date the VBM penalties apply only to physicians. An annual increase or decrease in percentage is at the discretion of CMS, until 2019, when, as with MU and PQRS penalties, **VBM adjustments will sunset** and **be rolled into the new merit-based incentive payment system.**

There is no turning back.

The wheels are already in motion and these programs are now mandatory for any size physician practice participating in Medicare. Given the extremely challenging reimbursement environment, this nearly 10% adjustment can really define success in the Medicare program. We encourage all providers to participate in these value-adjusted, fee-for-service programs. Your success there will be vital to continue participation in Medicare. For more information on CMS incentive programs [click here.](#)





Reforming “payment reform.”

A hybrid model for reimbursement – another possible choice.

Another category of Payment Reform is a hybrid of value-based payments and fee-for-service, also known as alternative value-based payments on a fee-for-service architecture. Payment is still triggered by patient encounter/service, so the Physician Fee Schedule is still used as the primary billing service. But now there's an opportunity for either shared savings or two-way risk. These arrangements are based on how well providers manage the patient or episode of care.

Future Alternative Payments on Fee-for-Service Architecture

1

Payment is still triggered by service delivery but with the opportunity for shared savings or with two-way risk

2

Shared savings or two-way risk arrangements are based on managing a population or an episode of care

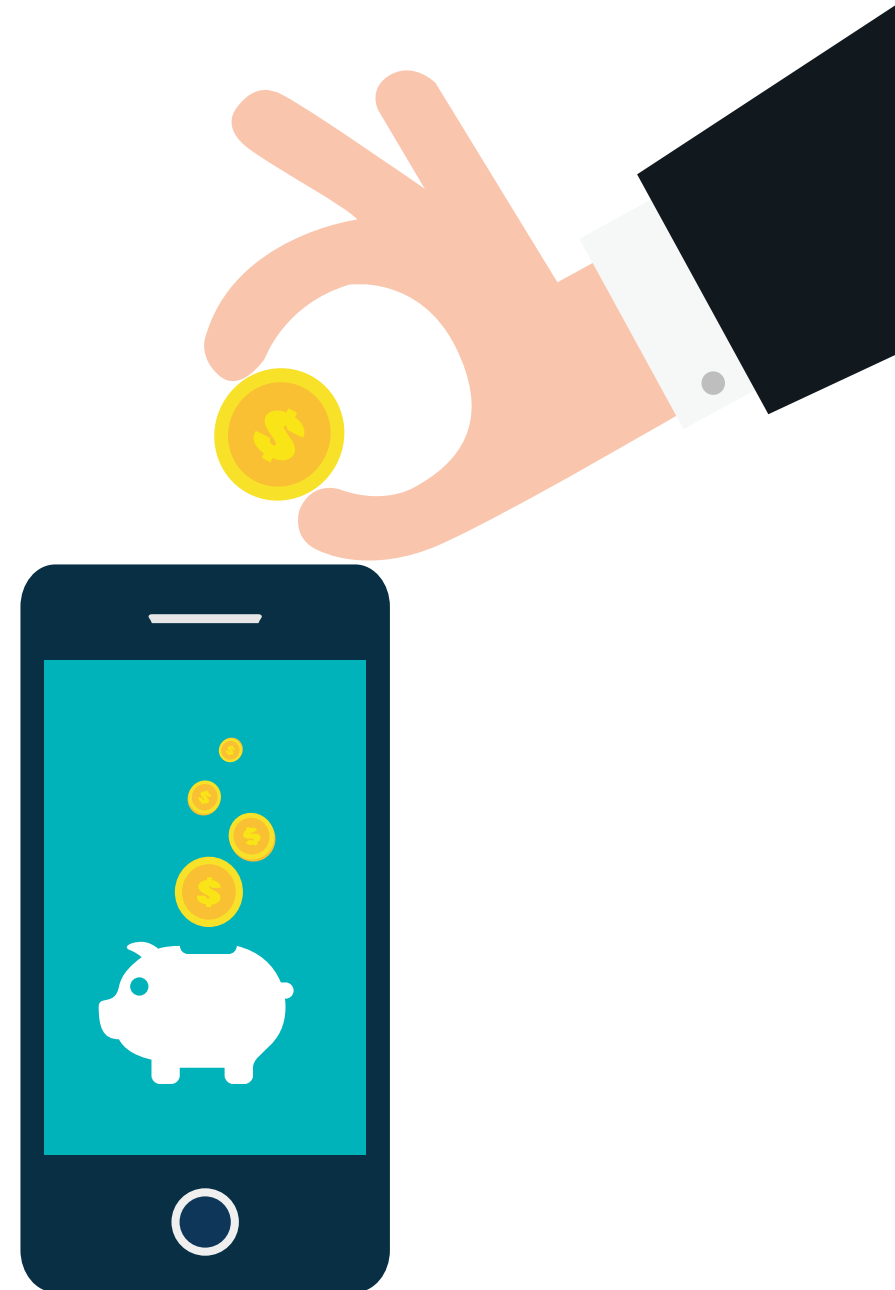
3

CMS is currently testing different payment models at the Center for Medicare & Medicaid Innovation

Get paid for Chronic Care Management.

Under the 2015 Medicare Physician Fee Schedule, providers now have the opportunity to bill approximately \$42 per patient per month for chronic care management (CCM) services using code 99490. At about \$4,000 per month for every 100 qualified patients, this is a great opportunity for providers to get reimbursed for many of the services they already provide for their chronically ill patients.

CMS has outlined very specific requirements for providers who wish to bill for CCM services. In addition to using an MU-certified EHR system, participating providers must address a set of elements identified in CMS rules and document at least 20 minutes per month spent delivering CCM services for each patient they bill out to Medicare. Patients must have at least two chronic conditions requiring close management and must sign a written consent notifying them of their copay obligation and other program rules.



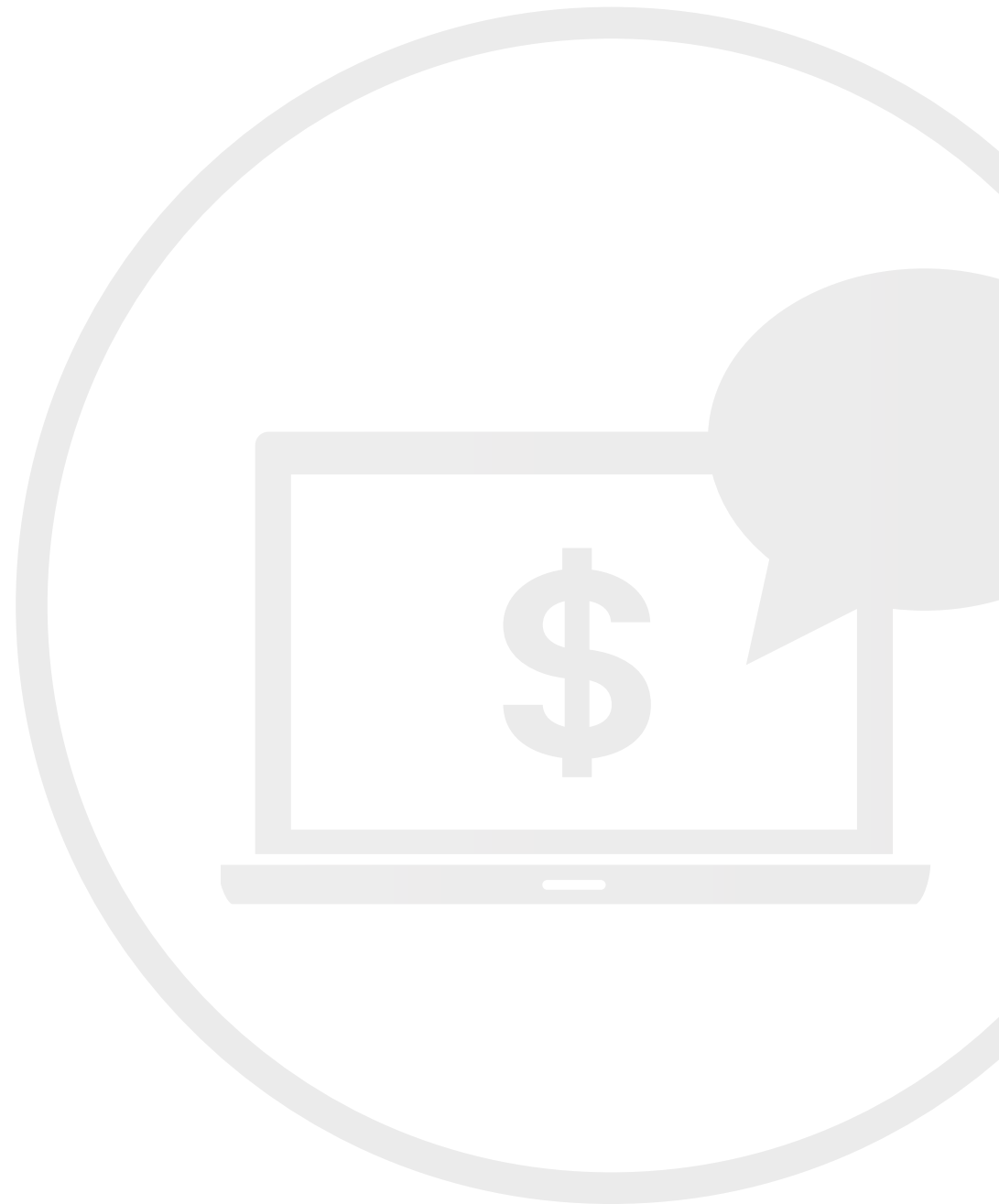
Innovative cost-based CMS models.

CMS is researching models designed to reduce program expenditures while preserving or even enhancing care quality. The CMS vision is to move payment models, which are still mostly based in a fee-for-service structure, into a strictly value-based payment structure. The CMS Innovations Portfolio includes different models that they're currently testing.

Primary Care Transformation.

The Comprehensive Primary Care Initiative and Multi-Payer Advanced Primary Care Practice are delivery models that will align with private payers and Medicaid to pay providers a set fee per month for managing a population of patients.

In these models, the primary care doctor is responsible for the patient's total care and is incentivized by collaborative care coordination and sharing patient information among providers. By improving patient health earlier, providers can decrease costs, as patients are less likely to require hospitalizations.



One or two-way for your risk?

In a one-way risk arrangement, there is no chance that you will be receiving a negative payment adjustment or penalty for performing poorly, but you do have the chance, if you perform well, to share in some savings with the Medicare program.

In a two-way risk arrangement you accept more risk and you'll be getting paid less on the lower-risk scale with a chance for greater returns as you accept more risk.

Alternative payment models

1

Physicians who receive a certain percentage of payments through alternative payment models will be exempt from MIPS adjustments

2019 & 2020:

25% threshold

2020 & 2021:

50% threshold

2022 & +:

75% threshold

2

These physicians will receive other financial incentives:

2019 & 2024:

5% bonus incentive payment for each year

2025:

.75% annual increase vs a .25% increase for MIPS participants

The background is a solid green color. In the center, there is a faint, semi-transparent graphic consisting of a bar chart with four bars of increasing height from left to right, and a line graph with an upward-pointing arrow that starts above the first bar and ends above the fourth bar.

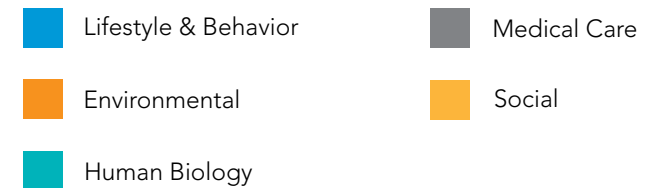
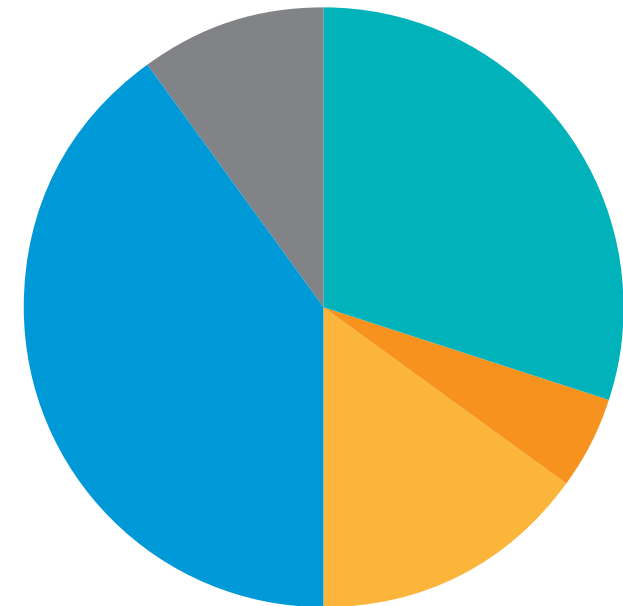
A renewed focus on
improved clinical
outcomes.

The Lifestyle Impact.

Today, almost 90% of our healthcare dollars are spent on medical care – access to physicians, hospitals, procedures, drugs, etc. The truth is, however, medical care only accounts for approximately 10% of a person’s health. The other determinants of a person’s health – their lifestyle and behavior choices, genetics, human biology, social determinants, and environmental determinants – account for approximately 90% of our healthcare spending.

In the future, healthcare resources and dollars will be dedicated to improving lifestyle and behavior earlier. The overall goal of population health management centers around patient wellness. As such, provider incentives are aligned with keeping patients healthy, resulting in a decreased use of healthcare services.

What drives the health of a population?





Getting the most value
from value-based care.

Value-adjusted fee-for-service is the new normal for Medicare.

- Fee-for-service adjustments will total ~10% of provider payment
- Movement into alternative models such as ACOs, bundled payments, and PCMHs will be incentivized, but not required
- CMS has the power to, and will scale up, successful demonstration programs, while the incentives in the MACRA legislation will force providers to take another look at participating in these new models
- Those who succeed in population health and capitated arrangements will be at the forefront of the industry
- Demonstrating early success in population health management = big financial rewards
- Predictive analytics help empower advanced risk-adjustment accuracy, quality improvement, care coordination, regulatory compliance, and utilization management

Accountable, value-based care is here to stay.

- 1 Value-based payer options will likely increase based on provider incentives to better manage patient populations
- 2 Payers will offer financial models that incentivize physicians to focus on improving health, affordability, and the overall patient experience
- 3 Opting out of value-based systems will be unlikely unless providers are willing to accept lower reimbursements and/or penalties
- 4 Providers require data access and insight into performance metrics that are critical to practice success, including:
 - Population health management
 - Risk scores
 - Utilization
 - Patient compliance
 - Provider/practice performance
- 5 Financial forecasting and resource management through predictive analytics help empower advanced risk-adjustment accuracy, quality improvement, care coordination, regulatory compliance, and utilization management



One size does not fit all.

The requirements are the same for all these models, no matter which category you've selected in the new value-based landscape. The tools you'll need are the same and depend on how little or how much risk you will accept. Remember, you'll need to track, measure, and report on quality initiatives; proactively engage your patients; integrate clinical data; and revamp your organizational structure as you adapt to these new models.

- **Understand your patient population** - who they are and who you will be measured against
- **Baseline population** - understand population risk and opportunities
- **Measurement targets** - what you will be measured against
- **Cash flow and interim payments** - assess reimbursement models and how payments will be disseminated to provider groups
- **Care coordination capabilities** - how integrated your providers are and how you coordinate care and/or provide care management capabilities

What you'll need to enable value-based transformation.

- Improved financial performance, revenue cycle management, operational efficiencies
- Enhanced patient experience, patient access, patient engagement, and communication
- Clinical integration alignment of hospitals and physicians, network design/management, performance measurements

TIP

Keep in mind the overall goal of a value-based delivery model is to improve key performance indicators across the care spectrum. This is achieved by payers changing how providers are compensated, with the ultimate goal to deliver better, timelier, quality care at a lower cost.

The cost equation aside, automation also allows providers to focus their energy where it belongs — on patient care. By easing the data gathering, analysis, and paperwork burdens, automation frees providers to spend more time offering better patient care and driving better outcomes. In the end, that is the true value gained by value-based purchasing.

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