Overview of Strategic Goals and New Initiatives

Virginia Medical Directors Association Meeting
October 28, 2017
Our Vision:

A world in which all post-acute and long-term care patients and residents receive the highest-quality, compassionate care for optimum health, function, and quality of life.
Our Values:

- We are dedicated above all to quality in PA/LTC processes and outcomes.
- We affirm that a well-trained, collaborative, interprofessional team with physician guidance is best equipped to care for PA/LTC patients.
- We strive to deliver individualized, goal-directed care in all PA/LTC settings of care.
- We are tireless advocates in all venues.
- We are committed to being a credible information resource on PA/LTC.
- We are a community – connected to and supportive of each other.
Our Mission:

We promote and enhance the development of competent, compassionate and committed medical practitioners and leaders to provide goal-centered care across all post-acute and long-term care settings.

Dedicated to defining and improving quality, we advance our mission through timely professional development, evidence-based clinical guidance and tireless advocacy on behalf of members, patients, families and staff.
Domains of Strategy Development & Execution

CONSUMERS, POLICYMAKERS & OTHER STAKEHOLDERS

POST-ACUTE & LONG-TERM CARE MEDICINE

AMDA MEMBERSHIP

AMDA – THE ORGANIZATION

VISION
VALUES
MISSION
**10 Strategic Goals for 2017**

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<th>Domain I</th>
<th>Domain II</th>
<th>Domain III</th>
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<td>Goal 1. Ensure that the Society is sustainable &amp; well governed</td>
<td>Goal 2. Grow the Society’s membership &amp; enhance member value</td>
<td>Goal 4. Promote clinical education and competency to optimize system-wide, individualized, goal-directed care</td>
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<td>Goal 3. Sustain &amp; support the Society’s Chapters and affiliates</td>
<td>Goal 5. Deliver evidence-based clinical guidance for PA/LTC</td>
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<td>Goal 6. Leverage technology &amp; innovation to advance PA/LTC</td>
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10 Strategic Goals for 2017

Domain IV

Goal 7. Advocate for AMDA’s mission of improved quality, value and patient/resident experience

Goal 8. Improve & strengthen AMDA’s external relationships

Goal 9. Support optimal patient/resident care through the appropriate definition of quality in PA/LTC

Goal 10. Support the needs of PA/LTC patients, residents and families
An Expanded Focus

• 2014:
  • Name change: AMDA – The Society for Post-Acute and Long-Term Care Medicine
  • Expanded membership: NPs and PAs are now “general members” with voting rights and may serve in the HOD and on the AMDA board

• 2016:
  • New website & domain, logo & branding
  • GAPNA joint membership agreement

• 2017:
  • Practice Management Section established for PA/LTC practices
A New Focus on Assisted Living

  - Center for Excellence in Assisted Living (CEAL) co-sponsored the 2017 summit
  - All major players in assisted living participate
  - Focus is on describing an “integrated model” in assisted living
  - Acknowledges the higher/rising health care needs of AL residents
  - Seeks more consistency in care in a highly heterogeneous setting
  - Also: quality measures, technology, readmissions all affecting AL

- A 4th summit is being planned, with CEAL, for Fall 2018 in DC area

- AL intensives at AMDA 2015, 2016 & 2017 Annual Conferences
A Better Definition of Quality in PA/LTC

• Transition from volume-based to value-based reimbursement requires appropriate quality measures for PA/LTC medicine
• We are working on MACRA/MIPS, IMPACT Act Clinical Quality Measures
• Quality Measures Committee is working to define a focused core measure set for PA/LTC medicine
  • Research group developing ACOVE measures for physicians practicing in nursing homes
• Funding opportunity through MACRA to field-test medical specialty measures to be announced this fall
• Practice management leaders working to explore a QCDR to house and report measures and an AAPM to provide reimbursement outside MIPS
Support for PA/LTC Physicians

• PA/LTC Physician Competencies
  • Physician Competencies approved by the AMDA board in March 2013
  • Training curriculum is now completed and available
  • Plans for 2017 & beyond: Distribute the training widely through partnerships

• ABPLM has completed job task analyses for the medical director and attending physician to establish the unique and specialized nature of this practice setting
  • Next – Validation: Research to show the value of the training and skills needed

• Practice Management Section
  • New section established through affiliation with a group of PA/LTC practices
  • Will pursue advocacy, education, membership goals for attending physicians, APRNs and PAs
New Directions for Clinical Tools

• Clinical Practice Guidelines improvements:
  • Developing actionable tools, pocket guides
  • New inclusion criteria for National Guidelines Clearinghouse requires systematic reviews to be completed
  • Conversion to EHR use
• Interactive versions of the Know-it-All series
• Mobile apps for clinical tools
• Embed clinical decision support/order sets into EHRs
• A key Board priority
AMDA Online Member Forum Launched

• AMDA’s online member discussion forum is now live: www.paltc.org/forum
• Opportunity to bring up questions and have your peers respond
• A popular venue for comparing processes and identifying best practices
• A National Forum as well as a State/Regional Forum are currently active; Chapter Forum in the works and more are in the planning stages.
“We Are PA/LTC” Campaign

• Launched at the Phoenix AMDA conference
• A year-long public information campaign to raise the profile of the good work being done by PA/LTC clinicians and staff, and the positive experiences of patients, residents and families
• Still looking for patient/resident/family stories as well as IDT contributions – please consider submitting to http://www.paltc.org/we-are-paltc
Advocacy: A Time of Change

• 2016: SGR Repeal
  • Put the shift from volume to value on a timetable
  • MACRA (Medicare Access and CHIP Reauthorization Act 2015) /MIPS (Merit-based Incentive Payment System) /APMs (Alternative Payment Models)

• 2016 Physician Fee Schedule
  • ACP (Advanced Care Planning) and Chronic Care Management (CCM) Codes and others
  • SNF POS 31 exemption for ACO attribution and no-cost attribution in MIPS

• 2016 Joint Replacement Surgery and Cardiac Bundling

• 2016 Nursing Home ROP (Requirements of Participation) Reform and 2017 interpretive guidance from CMS

• 2017 ACA repeal & replace initiative (not over yet!)

• 2017 Budget: Possible cuts to Medicare & Medicaid
Advocacy: Key Concerns

• MIPS/APMs
  • Focus is on quality measures appropriate to our patient population and setting, sensitive to physician intervention
  • We need to develop one or more APMs for PA/LTC

• ACA stabilization
  • Congress is still looking for ways to stop or constrain ACA implementation (e.g., block grants)
  • Mandatory bundles are off the table, but voluntary bundles still very viable

• Nursing Home ROPs
  • Interpretive guidance concerns
  • Will some components of the new rule be rolled back (e.g., arbitration clause already blocked)?
Big Takeaways - The Good News

• The Value of Post-Acute/Long-Term Care clinical experts has never been greater!
  • Caveat - you must know/learn how to leverage what you do into new contractual agreements in value-based medicine

• Health Systems/ACOs are looking to control post-acute costs but they don’t know what that entails – you do!

• Look past the regulatory confusion to leverage opportunity!
National Policy Update

AMDA Board Hill Day,
September 7, 2017
AMDA Advocacy Wins: AMA and CMS

• Each year we present HOD-passed and Board-approved resolutions to the AMA House, with remarkable success.
  • Three presented in 2017, one was adopted as AMA policy, the other two referred to the AMA Board of Trustees

• With CMS the focus has been on reducing the penalties on PA/LTC physicians that were built into the MACRA VM methodology
  • Achieved a 50% reduction in penalties (-2% from -4% for large practices, and -1% from -2% for small practices or solo practitioners)
  • Hold harmless any group/physician meeting the minimum quality reporting requirements
  • Zero out the cost category for 2017 & 2018 performance periods
MACRA
April 2016

SGR
Repealed April 2015

- CPC Plus
- ACO's (MSSP, Next Generation ACO Model)
- Comprehensive End Stage Renal Disease Care Model
- Oncology Care Program

APM

- Quality (POS)
- Advancing Care Information (MU)

MIPS

- Clinical Practice Improvement Activities (eg PCMH)
- Cost (Resource Use/VM)
More Society “Wins”

• New Improvement Activities accepted by CMS
  • Participation in the National Partnership to Improve Dementia Care
  • Physician participation in facility QAPI
  • Advance care planning
  • CDC course on antibiotic stewardship
  • CDC course on opioid prescribing
  • CME activities (such as AMDA Annual Meeting!)

• New CPT Codes for Primary Care
What to do in 2017

- Participate in MACRA!
  - Two pathways: MIPS/APMs
  - Pick-Your-Pace an Option
  - Learn from Society resources (FAQ available on-site)

- Consider new infrastructure
  - Role of EMRs/EHRs

- Learn new codes
  - New opportunities for reimbursement for the work you do in SNF/NF

- Prepare for SNF Regulatory Changes
  - Phase 1 in effect now!
  - 5-Star Rebasing and Changes

- Pay attention to the market
  - Consolidation of practices
  - Preferred post-acute networks (Narrowing of networks)
  - Value of PA/LTC medical director and clinician expertise
  - Role of Cognitive Analytics or Big Data, AKA “Healthcare Moneyball”
All Those New Codes

- Advance Care Planning codes 99497/99498 - reimbursed since January 1, 2016 (billable in SNF/NF)
- Chronic Care Management Codes 99490 – reimbursed since January 1, 2016 (billable in SNF/NF)
- Complex Chronic Care Management Codes 99487/99489 – reimbursed since January 1, 2017 (billable in SNF/NF)
- Transitional Care Management – 99495/99496 – reimbursed since January 1, 2015 – (NOT billable in SNF/NF)
- Non-Face-to-Face Prolonged Service 99358/99359 – reimbursed since January 1, 2017 (billable in SNF/NF)
All Those New Codes

- Behavioral Health Integrated Services G0502/G0503/G0504 – reimbursed since January 1, 2017 (billable in SNF/NF)
- General Behavioral Assessment G0507 – reimbursed since January 1, 2017 (billable in SNF/NF)
- Functional Assessment G0505 – reimbursed since January 1, 2017 (not billable in SNF/NF)
- More coming next year!

- Guide to PA/LTC has been revised to include information on all new codes! Available now!
Transitional Care Management

• 99495
  • communication: by end of 2nd business day
  • face-to-face by end of 14th day
  • medical decision making: moderate

• 99496
  • communication by end of 2nd business day
  • face-to-face by end of 7th day
  • medical decision making: high
Transitional Care Management: Billing

- Can only be billed by one provider
- Covers non-face-to-face physician and non-physician time/work
- Required F2F visit - if not done by physician must meet “incident to” rules; included in TCM – is not billed separately
- Other E/M medically necessary services are billed separately
- Covers 30 days, starting with discharge day and ending 29 days later (bill may be submitted when F2F is done)
- POS code is for the site of service of the required face-to-face visit
The following previously unreimbursed non-face-to-face services are now being reimbursed:

- **99358** is used to report the first hour of prolonged service on a given date regardless of the place of service.
- Prolonged service of less than 30 minutes total duration on a given date is not separately reported.
- **99359** is used to report each additional 30 minutes beyond the first hour regardless of the place of service.
- **NOTE**: According to CPT convention, the threshold is reached at the halfway point; e.g., “First hour” is reached at 31 minutes.
- **Note**: We have gotten reports of denials based on POS – there is no POS restriction!
Chronic Care Management Services (CCM)

- Two or more “significant chronic conditions”
- Non face-to-face work
- Billed no more frequently than once per month per qualified patient
- Started January 1, 2015
Chronic Care Management (CCM)

• Billing
  • The practice must have the patient’s consent
  • CPT code 99490 (avg: $43)
  • Co-pays do apply
  • Only one clinician can be paid for CCM services in a calendar month
  • The following codes cannot be billed during the same month as CCM (CPT 99490):
    • Transition Care Management (TCM) – CPT 99495 and 99496
    • Home Healthcare Supervision – HCPCS G0181
    • Hospice Care Supervision – HCPCS G9182
    • Certain ESRD services – CPT 90951-90970
Complex Chronic Care Management

CMS Recognition of CPT Codes for Primary Care Previously not Paid for Complex Chronic Care Management Codes 99487 / 89

CMS noted that in order to more accurately pay for services based on the relative resources required, that the original somewhat more stringent CCCM codes would now be paid for. These codes require the patient be at significant risk of death, acute exacerbation/decompensation or functional decline, and requires the establishment or substantial revision of a comprehensive care plan or moderate or high complexity medical decision making, 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. 99487 is for the first 60 minutes per month, 99489 is for each additional 30 minutes.
Chronic Care Management (CCM)

• Resources
  • Medicare MLN
  • Medicare MLN Connects: National Provider Call
Advance Care Planning

- Low utilization so far!
- Unclear about reasons
- CPT Codes available
- Added to list of acceptable telehealth services in 2017
- Ethics Committee White Paper won Society HOD approval

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<td>Non Facility</td>
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<td>Facility</td>
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> 15 minutes to use 99497

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<tr>
<th>CPT code 99498* - each additional 30 minutes</th>
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*> 45 minutes to use add-on code 99498*
ACP Codes

• Voluntary—get and document permission/consent
• Billed in addition to other E/M and CPT codes
• No limit on how many times can be billed
• Physician/NPP can bill (incident-to rules apply)
• Must be face-to-face (with either patient or decision-maker)
• Remember 20% copay by beneficiary or secondary insurer
  - Except when doing Annual Wellness Visit, modifier -33, no copay
• Does not require any specific template or completion of any legal documents like POLST/AHCD; document time and content
Are there minimum amounts of time to bill ACP?

- In the absence of rules otherwise, CMS defers to CPT descriptor language.
- According to CPT coding convention, the threshold for minimum time is reached after the midpoint.
- For 99497, “first 30 minutes” is reached at 16 minutes.
- For 99498, additional 30 minutes is reached at 30 + 16 minutes = 46 minutes total to bill both codes.
How do I select MACRA QPP measures?

• Look at the denominator of the measures – does it have the nursing facility CPT code? There are 51 such measures.
  • Full list with specifications available https://qpp.cms.gov/resources/education

• Benchmarking is important!

• Society list of nine “recommended” measures http://www.paltc.org/public-policy (bottom of page)
  • Do these measures actually represent quality in PA/LTC?
  • We need PA/LTC-appropriate measures
MACRA QPP Changes for 2018 Perf Period

• Public Comment closed Aug 21st
• Changes to minimum reporting threshold
• Changes to low volume threshold
• Cost category continues to be 0 – development of episode groupers for 2019
• Virtual Groups proposal
• Additional improvement activities – Advance Care Planning
• Changes to nominal risk in Advanced APM
• More APMs?
Resources/References

- CMS QPP Web Site: https://qpp.cms.gov/
- Society MACRA Web Site: http://www.paltc.org/macra
- Society developed FAQ specific for PA/LTC practices: http://www.paltc.org/sites/default/files/MACRA%20FAQs.pdf
- Society Webinars (free for members plus CME credit!): –
  • http://www.paltc.org/product-store/role-qios-new-payment-models
  • http://www.paltc.org/product-store/archived-webinar-overview-macra-paltc-practitioners
- More to come!
And there is more...

• Post-Acute Reform
  • 5-Star Rating Changes
  • Payroll Based Journaling (PBJ)
  • SNF Quality Reporting Program (IMPACT Act)
  • SNF Value-Based Purchasing Program

• Requirements of Participation
  • Final rule issued
  • Interpretive Guidance Issued
  • Society updating the Synopsis of Federal Regs to include new regs
AMDA Public Policy & Advocacy Contacts

Karl Steinberg, MD, CMD
Chair, Public Policy Committee
karlsteinberg@MAIL.com

Alex Bardakh, MPP, PLC
Director, Public Policy & Advocacy
abardakh@amda.com

David Nace, MD, MPH, CMD
Vice-Chair, Public Policy Committee
naceda@upmc.edu

Gaby Geise
Manager, Public Policy & Advocacy
ggeise@amda.com
Board Focus

• The AMDA Board met September 8-9 to discuss a number of key issues and trends:
  • Revenue generation and how to “re-invent” AMDA
  • Stronger alignment with our State Chapters
  • Clinical practice guidelines development process changes
  • Our role in the ongoing development of post-acute networks
  • How to engage PA/LTC practices, ACOs/MCOs, and CMOs of nursing home chains
    • We have an active CMO group that is evolving to include practice group CMOs and ACO medical directors
    • We presented a panel discussion at NAACOs this fall
Your voice is needed!

• Consider serving on a national committee or workgroup
  • Opportunities are plentiful in AMDA, ABPLM, and the Foundation
• Bring the next generation of PA/LTC practitioners into this setting – be a mentor
• Help shape the future for PA/LTC medical direction and medical practice
  • Engage your ACO leaders and those driving post-acute networks
  • Connect with local thought leaders, bring them to Chapter meetings, ask them to get involved – be an AMDA ambassador!
• Post on the online AMDA Forum
Your voice is needed!

• Nominate a colleague for one of our national awards:
  • Medical Director of the Year
  • James Pattee Award
  • William Dodd Award

• Talk to Geriatric Fellows, residents, and NPs about participating in the Futures program

• Consider submitting a resolution to the House of Delegates

• Send us a story for the We Are PA/LTC Campaign!

• Come to the Annual Conference in Grapevine, TX (Dallas/Ft. Worth) in March!
Thank You!

Christopher E. Laxton, CAE
claxton@paltc.org