HEALTHTECH S3
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CEO UPDATE

August 2016

Special points of interest:

- MACRA
- Regulatory Update
- Retirement
- Population Health - Part 5 of 7

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MACRA – It is coming. Were you aware?

All across the country, physicians and other healthcare providers are scrambling to prepare for the impending implementation of MACRA, the Medicare Access and CHIP Reauthorization Act of 2015. This is the federal law that implements healthcare delivery and payment reform across the spectrum to eligible clinicians beginning on January 1, 2017.

MACRA consolidates the alphabet soup of federal reporting programs: PQRS, MU, and VBPM, under one unifying umbrella; the goal of which is to drive down fee-for-service reimbursement by shifting risk and responsibility for cost savings and cost control to providers while boosting the overall health of the population and quality of care. In other words, … "The Triple Aim."

MACRA provides a fixed annual payment update to the fee schedule based on the performance of the clinician. There are two pathways for achieving this, but the most prevalent model is MIPS (Medicare Incentive Payment System), the one most likely to affect our hospitals and clinicians.

MIPS requires data reporting for the 2019 payment adjustments to begin this coming January 2017. Clinicians will have to report their performance in four categories: Quality, Resource Use, Advancing Care Information, and Clinical Improvement. These are all weighted together on a 100-point scale and then benchmarked against all other eligible clinicians (EC's). **MIPS is revenue neutral;** those performing well will get positive incentives (additions) to their fee schedule beginning in 2019. Poor performers will have their fee schedule reduced by as much as 4%. These bonuses and penalties will extend to as much as 9% by 2022. EC's include just about every practitioner in the country who bills under Medicare Part B currently and will extend to most ancillary providers in 2019. This program is statutory, so everyone will have to participate, with a few current exceptions. In addition, as an increasing percentage of clinicians are employed by hospitals and groups, the risk of significant reimbursement changes to the employing entities is very high.

Chances are your organization has begun capturing much of the critical data already under Meaningful Use and PQRS. These measures form the backbone of much of the MACRA reporting. If you are doing well, then build upon your successes. If you have not performed as well, then you have a very short window to improve your scoring as the reporting period for the 2019 payment adjustments begins in less than 5 months. Remember, your future reimbursement hinges on your reported performance.

HealthTech can assist with the development of a performance improvement plan for meeting the new MACRA targets, educate your providers, boards and staff. Contact Mike Lieb for further information: Michael.lieb@healthtechs3.com

HealthTech will provide a more detailed Webinar on MACRA and its implications in the coming weeks. Registration information will be distributed shortly.

Regulatory Affairs

Each month an updated snapshot of regulations, proposed rules/regulations and opportunities to highlight your initiatives is provided. The list is clearly not all-inclusive, but the most applicable information is offered.

HHS News: Secretary Burwell announced that HHS will award a series of AHRQ grants to support rural primary care practices in delivering medication-assisted treatment for people addicted to opioids and to study how to overcome barriers to increasing access to treatment. AHRQ is investing $9 million over three years to help rural primary care practices provide access to more than 20,000 people with opioid addiction. Visit AHRQ's National Center for Excellence in Primary Care Research for more information.

To accelerate development of a Zika vaccine, the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response (ASPR) will begin developing a vaccine using its Center for Innovation in Advanced Development and Manufacturing (CIADM) in Baltimore, Maryland.

CMS News: CMS reverses 'two-midnight' rule in final inpatient PPS for 2017 In making final the inpatient prospective payment system rates for 2017, the Centers for Medicare & Medicaid Services (CMS) reversed a proposed payment reduction associated with the "two-midnight" rule. The final rule will increase rates by 0.95 percent compared with fiscal year 2016, after accounting for inflation and other adjustments required by law. In the rule, CMS finalizes two adjustments to reverse the effects of the 0.2 percent cut it instituted when implementing the two-midnight policy for 2014. CMS also will require hospitals to report data on eight of the available electronic clinical quality measures (eCQMs) rather than the 15 originally contemplated, reports HealthLeaders. "Today, CMS finalized a rule that is a mixed bag for hospitals and the patients they serve," said American Hospital Association Executive Vice President Tom Nickels. "On the one hand, we are pleased CMS reversed the effects of the 0.2 percent payment reduction that was part of the original 'two-midnight' policy, and restored the resources that hospitals are lawfully due. However, we are disappointed that CMS finalized an unjustified cut to reimbursement rates for hospital services." Source: AONE eNews 08/05/2016

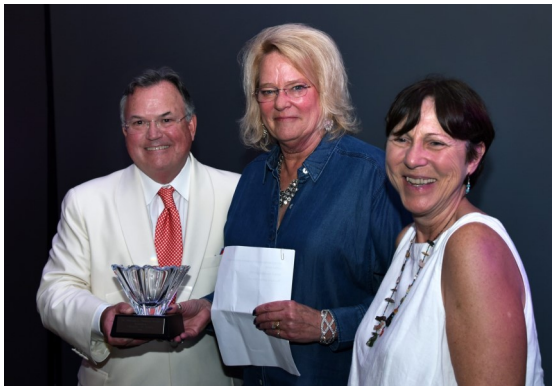
On July 25, 2016, the Department of Health & Human Services (HHS) proposed new models that continue the Administration's progress to shift Medicare payments from quantity to quality by creating strong incentives for hospitals to deliver better care at a lower cost. These models would reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions, and speed recovery. The proposal contains three new policies: (1) New bundled payment models for cardiac care and an extension of the existing bundled payment model for hip replacements to other hip surgeries, (2) A new model to increase cardiac rehabilitation utilization, and (3) A proposed pathway for physicians with significant participation in bundled payment models to qualify for payment incentives under the proposed Quality Payment Program.
Source: hhs.gov

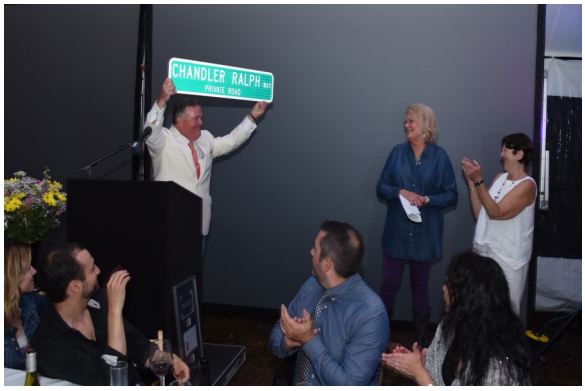
CDC News: CDC is providing $67 million to help health departments nationwide tackle antibiotic resistance and other patient safety threats, including healthcare-associated infections. The new funding for antibiotic resistance, part of the awards available through CDC's Epidemiology and Laboratory Capacity for Infectious Diseases Cooperative Agreement (ELC) supports seven new regional laboratories with specialized capabilities allowing rapid detection and identification of emerging antibiotic resistant threats. Available to jurisdictions starting August 1, the funding will dramatically expand existing capabilities to track infections in healthcare settings, protect patients through targeted prevention, and increase coordination across medical care. Source: cdc.gov

CDC has issued updated Zika guidance for providers The Centers for Disease Control and Prevention (CDC) released updated guidance for health care providers caring for pregnant women with possible exposure to Zika virus. The guidance extends to 14 days the timeframe for testing the blood of pregnant women for Zika particles. Previous guidance had set the timeframe at one week. All pregnant women in the United States and U.S. territories should be assessed for possible Zika virus exposure at each prenatal care visit. CDC recommends that pregnant women not travel to an area with active Zika virus transmission. Pregnant women who must travel to one of these areas should strictly follow steps to prevent mosquito bites during the trip however, new evidence has found that Zika virus can be present in the blood for longer after symptoms begin, and that even pregnant women without symptoms can have evidence of the virus in their blood and urine. CDC also released updated interim guidance for the prevention of sexually transmitted Zika virus based on the recent finding of female-to-male transmission of the virus in New York City. (CDC guidance, 7/25/16)

Celebrating Two Decades of Leadership

On July 9, 2016 five hundred (500) people celebrated Chandler Ralph's successful tenure as CEO of Adirondack Health. Chandler is known by many as a progressive leader, who together with her team, lifted Adirondack Health to the peak of performance in New York's North Country. During the celebration, Chandler was recognized by physicians and colleagues with the Trudeau Award which honors individuals who demonstrate the qualities of courage, compassion and generosity in their service to Adirondack Health. In addition, the road entering the Uielein nursing facility will now be known as Chandler Ralph Way.





Chandler Ralph, center, is presented with the Dr. Edward L. Trudeau Award for her distinguished career as President & CEO of Adirondack Health. Presenting the award is W. Scott McGraw, Adirondack Health Foundation Board of Trustee Chair, and Jeannie Cross, Adirondack Health Board of Trustees Chair.

Adirondack Health Foundation Board of Trustees Chair W. Scott McGraw displays the "Chandler Ralph Way" road sign that will mark the entrance to the Uihlein campus in Lake Placid to Chandler Ralph as Adirondack Health Board of Trustees Chair Jeannie Cross looks on.

In September Chandler and her husband David will be leaving on a motorcycle trip to the National Parks. Chandler officially closed this chapter of her professional journey, however knowing her, I imagine there will be more chapters to follow. Best wishes to Chandler and her family! You may be gone, but you will never be forgotten, especially by those who have worked with you.

Introducing Sylvia Getman

Sylvia Getman officially received the Adirondack Health CEO leadership baton from Chandler on July 1, 2016. She was one of the many people who celebrated Chandler's accomplishments over the last 21 years. She joins Adirondack Health from Aroostock Medical Center in Presque Isle, Maine where she was the CEO. We wish Sylvia much success at Adirondack Health since she has some big shoes to fill, and look forward to working with her and the Adirondack team.

Population Health

Part 5 of 7: Care Management & Care Coordination

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Care Management enables a multi-disciplinary care team to provide more consistent care for high-risk and rising-risk patient populations

Care Coordination is the deliberate organization of patient activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of care services. Organizing care usually involves the marshalling of personnel and other resources needed to carry out all required patient care activities along with the exchange of information.

With the inception of the Population Health model, there has been a morphing of the traditional case management model into a few different concepts that help broaden what a case manager's job description describes. As a result, a number of health care organizations have redesigned and renamed case management to reflect the increasing responsibilities being added to the role along with the changing concept of shifting care from the inpatient to the outpatient setting.

The term care management is not new. In fact, the term was coined by insurers in the early 90s when the idea of risk surfaced, especially for the high risk Medicare and Medicaid populations. Simply put, providers shared risk and were rewarded for keeping patients healthy. Providers were assisted by care managers who did home visits, scheduled appointments with primary care providers before high risk patients experienced a medical crisis, and oftentimes the care managers followed the patient using telemedicine for regular monitoring. An interdisciplinary team consisting of nurses, social workers and physician Medical Directors managed the patients in and out of the hospital.

With the implementation of Accountable Care Organizations, a further evolution has taken place called care coordination. Care coordination is an approach to healthcare in which all of a patient's needs are coordinated with the assistance of a care coordinator. The care coordinator provides information to the patient and the patient's family/caregivers, and works with the patient to make sure that the patient gets the most appropriate treatment. This process seems to be cost-effective, more efficient in that services are not duplicated, and likely improves the quality of care.

The next iteration of care coordination that organizations should design is transitional care coordination. This model eliminates the restrictive "four walls" of a building, and places transitional care coordinators and their team members where they need to be and when they need to be there, albeit the hospital, the home, the rehabilitation center the primary care provider, or anywhere that benefits the wellness of the patient.

HealthTech consultants can help with your redesign because the future is NOW!