Healthcare Reimbursement: Current and Future Payment Models

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Disclosures

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	Nonfinancial Disclosures: State Advocate for Medicare Policy-Texas
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	Nonfinancial Disclosures: State Advocate for Medicare Policy-Texas

Disclosures of SPEAKERS

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Course Objectives

- Differentiate the parts of Medicare and the respective rules for service delivery of each.
- Identify government requirements, payer parameters and standards of care impacting clinical services.
- Explain the development, structure and implementation of alternative payment models.
- Identify resources for additional information and clarification

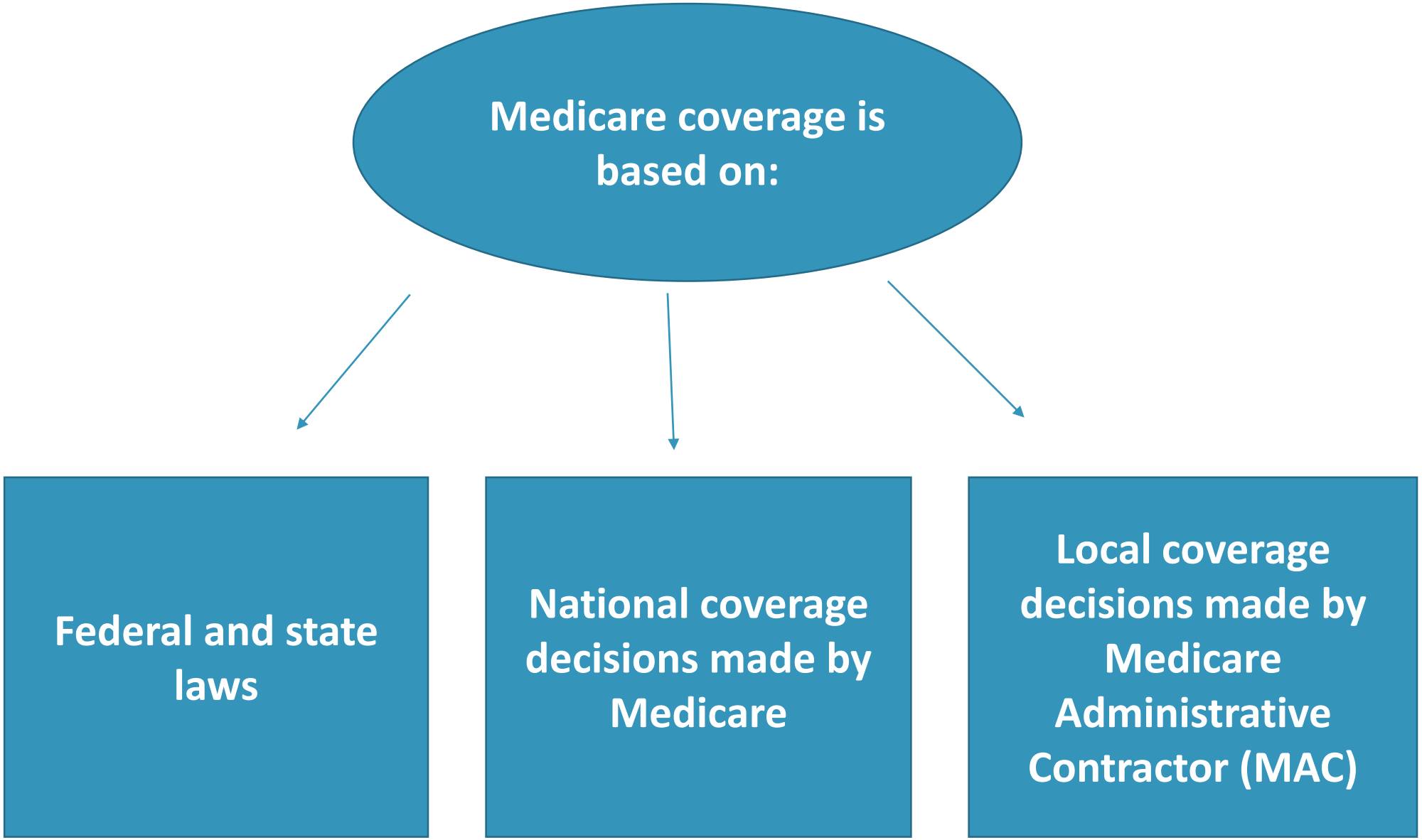
What is a State Advocate for Medicare Policy (StAMP)

- Partner with ASHA staff, volunteer leaders, and other state association members on ASHA's advocacy and objectives
- Engage in direct advocacy with lawmakers, policymakers, and external partners
- Raise awareness about relevant public policy topics within our professions
- Serve as a conduit between ASHA and state associations

What is Medicare?

- Federal health insurance program for people 65 and older or who are permanently disabled
- Comprised of four “Parts”
  - **Part A:** Inpatient services such as hospital, inpatient rehabilitation, hospice, skilled nursing and some versions of home health
  - **Part B:** Outpatient services provided in private practices, university clinics, outpatient clinics, some forms of home health and to patients who do not meet inpatient admission criteria
  - **Part C:** Medicare Advantage
  - **Part D:** Prescription Drugs

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES


Medicare coverage is based on:
Federal and state laws
National coverage decisions made by Medicare
Local coverage decisions made by Medicare Administrative Contractor (MAC)

Medicare Part A: Inpatient Rehabilitation Facility (IRF)

Criteria

- 3 hour intensive multidisciplinary therapy 5-7 days/week and meets medical necessity
- 60% must meet criteria for CMS-13 qualified diagnoses
- May require 3 day hospital stay prior to admission to IRF

Payment

- Prospective Payment System called Case Mix Groups (CMG): based on diagnosis and functional status

Medicare Part A: Skilled Nursing Facility (SNF)

Criteria

- Requires skilled intervention on daily basis
- 3 day prior hospitalization required

Payment

- Consolidated billing: daily per diem rate per level of care for each patient

- ***Clinical conditions and comorbidities drive payment*** vs. number of therapy minutes provided
- Variable per diem rates for PT, OT, and non-therapy ancillary services; ***consistent payment*** across the episode for ***SLP services***

Payment for ST based on presence of 5 case mix factors:

- Acute Neurologic
- Comorbidities
- Swallow Disorder
- Mechanically Altered Diet
- Cognitive Impairment

Who is ensuring that all altered diets are captured on the MDS?

Nursing

SLP

Dietary

Who Completes the BIMS in Your Facility?

Admissions?
MDS?

Nursing?

Social Work?

Resources for PDPM

https://www.asha.org/practice/reimbursement/medicare/medicare-patient-driven-payment-model/

- **Free ASHA Webinars and Podcast**

Webinar Part 1: Know the Facts! *(Video duration: 1 hr., 15 min.);* view transcript [PDF]

Webinar Part 2: Know Your Value! *(Video duration: 1 hr., 6 min.);* view transcript [PDF]

Podcast: ASHA Voices: **A New Payment System, Changes in SNFs**

CMS Website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM

- PDPM ICD-10 Mappings FY2020 SLP

Medicare Part A: Home Health (HH)

Criteria:

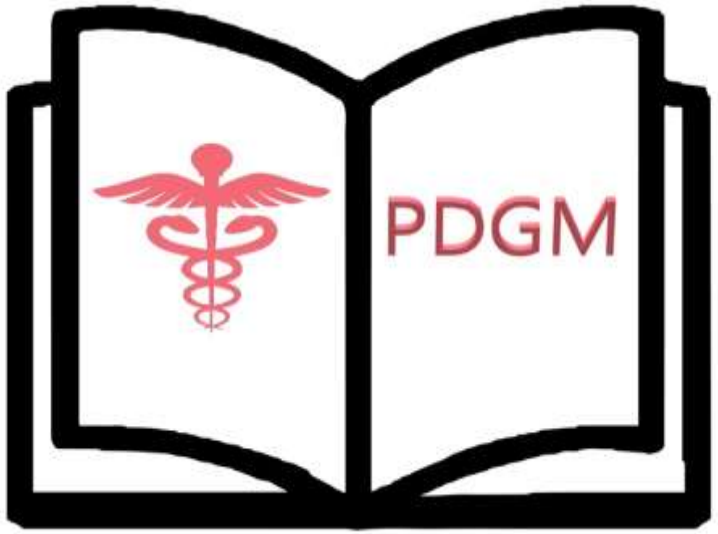
- Homebound
- Coverage in certain circumstances after you are in a hospital or SNF for at least 3 days.
- Doctor must certify HH plan every 60 days.
- Must receive HH within 14 days of hospital/SNF discharge to be covered under Part A. Any additional days past 100 are covered by Part B.

Payment:

- Consolidated billing

Patient-Driven Groupings Model (PDGM)

- Billing is reduced to **30 day periods** categorized into case mix groups for payment
- Removal of therapy threshold/number of therapy visits



Reimbursement is adjusted according to:

- Diagnosis/clinical grouping
- Timing of episode
- Admission Source
- Functional impairment level
- Comorbidities

Improving Medicare Post-Acute Transformation (IMPACT) Act

- Congress passed in 2014: better understand differences in payments and outcomes in all 4 post-acute settings
- Requires the standardization of data across the post-acute care settings; difficult to evaluate the differences in the settings
- CMS has dynamic process to change assessment tools to comply with the mandates; possibility of implementing a unified PPS

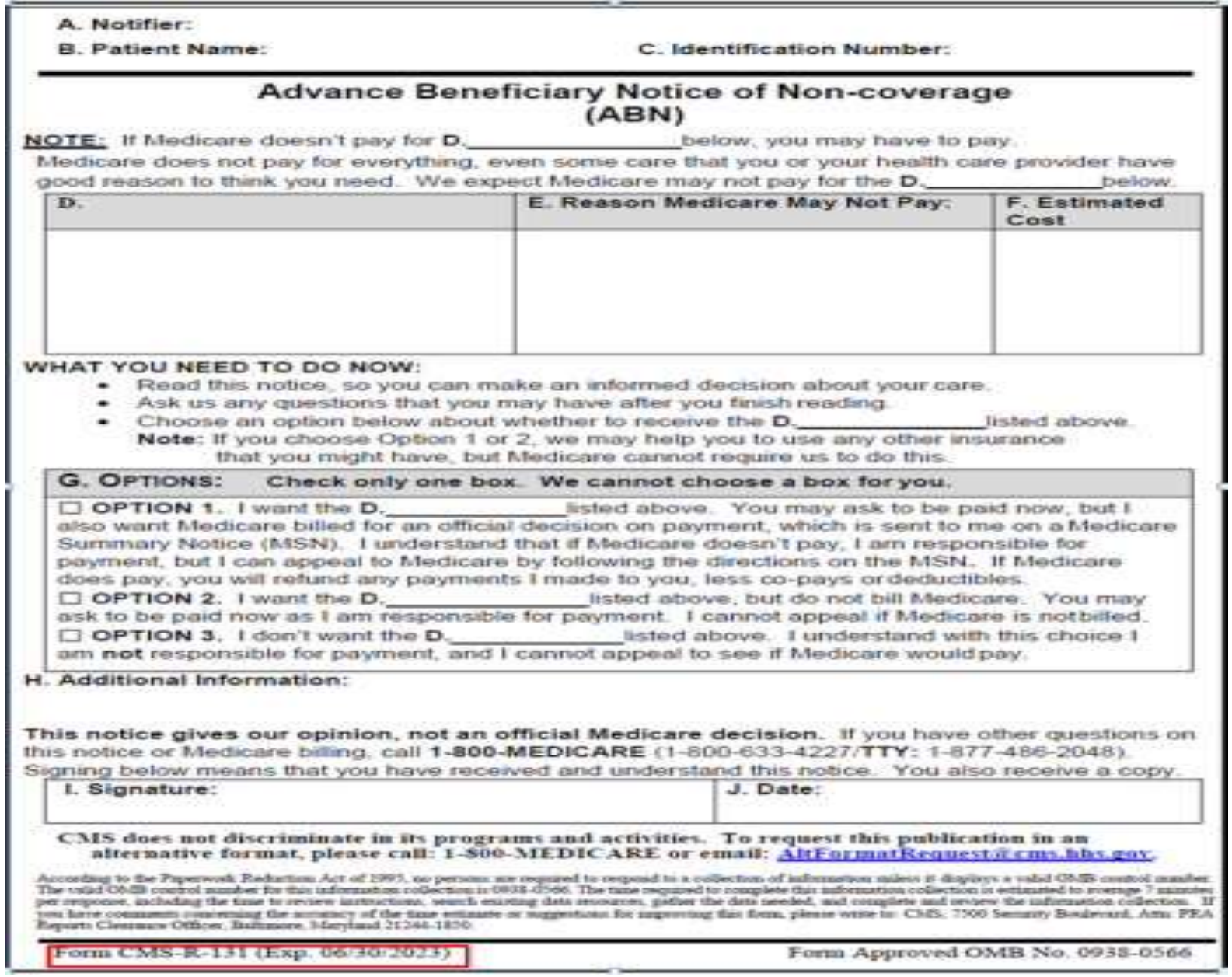
Medicare Part B

Criteria

- **Reasonable, medically necessary and skilled services**
- Physicians order required for evaluation and treatment; Recertification required every 90 days or less
- Physician must sign the plan of care in timely manner

Payment

- Fee for service **based on CPT codes billed**
- Therapy services are covered at **80% of allowable ancillary charges**. A **20% coinsurance is required** (paid by Medicaid, private insurance, or private pay)



A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D._____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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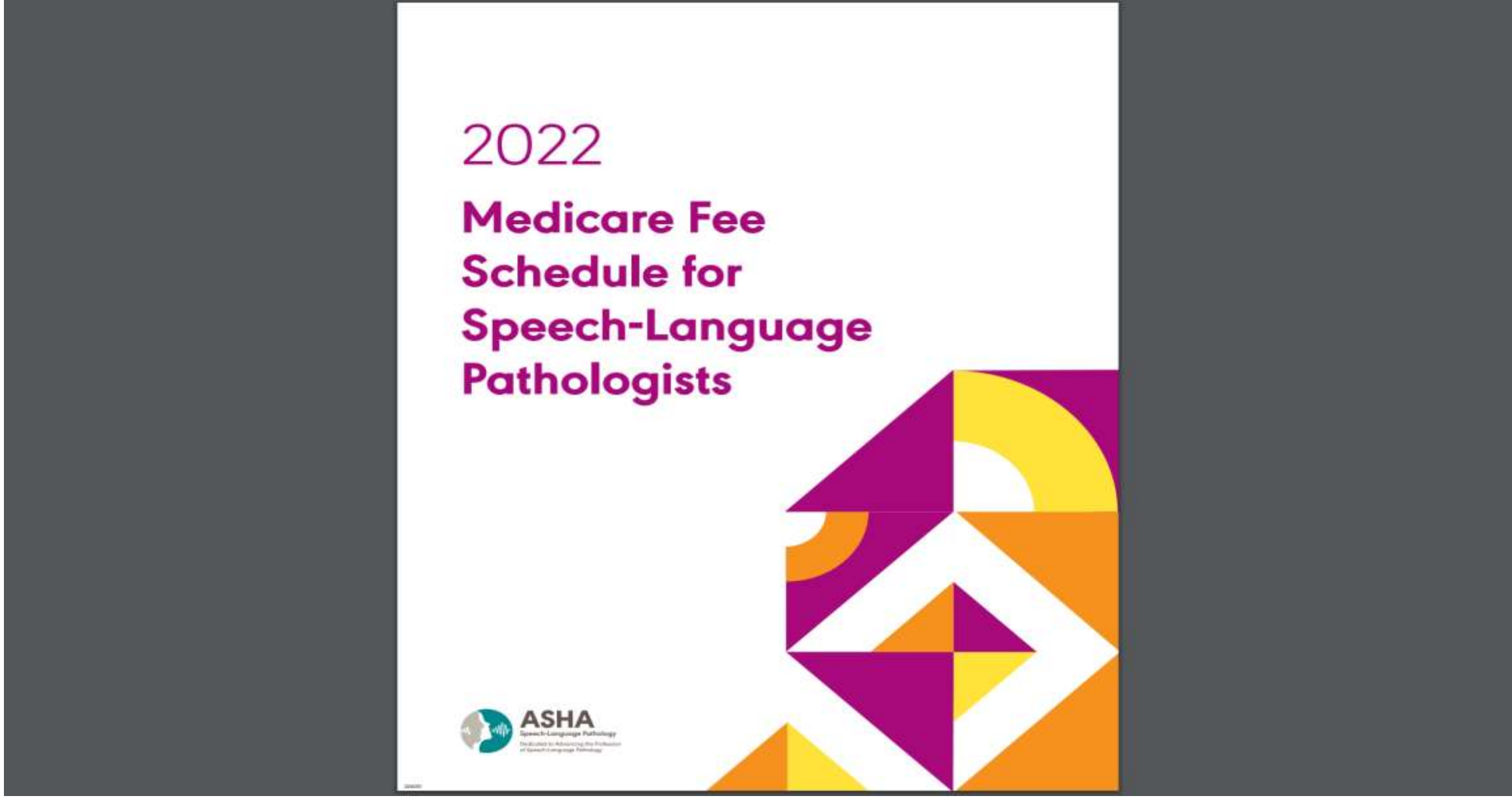
Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

Lists services that Medicare isn't expected to pay for, rationale and cost estimate



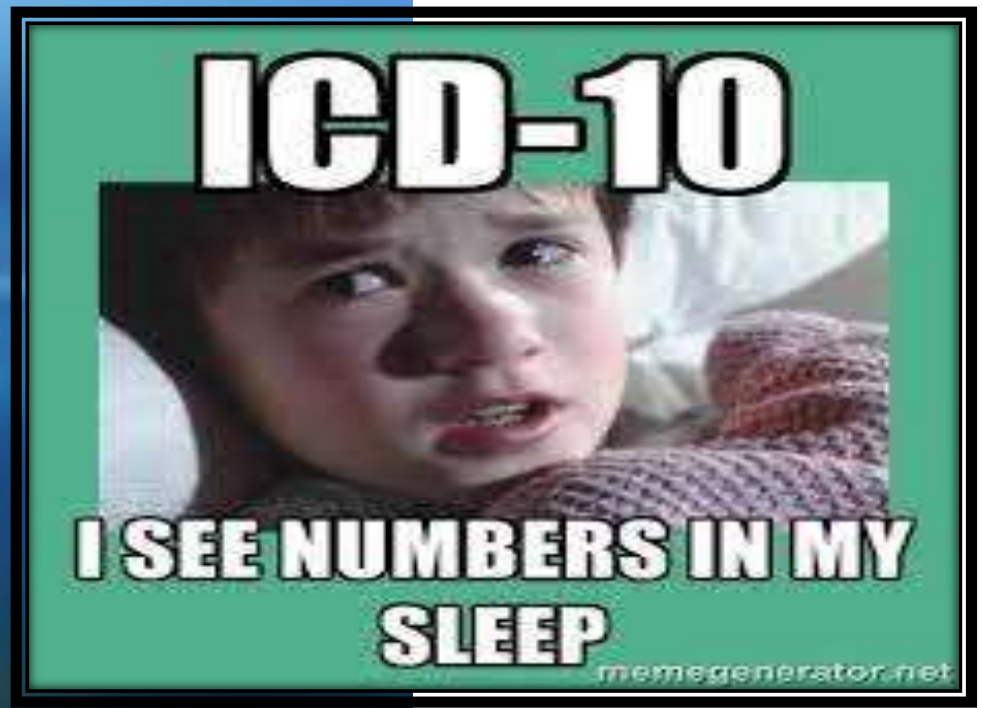
https://www.asha.org/siteassets/uploadedfiles/reimbursement/2022-medicare-fee-schedule-for-speech-language-pathologists.pdf

Annual Updated Fee Schedule

https://www.asha.org/siteassets/uploadedfiles/reimbursement/2022-medicare-fee-schedule-for-speech-language-pathologists.pdf

https://www.asha.org/siteassets/uploadedfiles/reimbursement/2022-medicare-fee-schedule-for-speech-language-pathologists.pdf

Coverage and Coding



ICD coding: diagnosis or condition that requires skilled services

Medicare Part A

- The medical diagnosis should best describe **why patient is in the SNF** setting
- Under PDPM, ICD coding is critical to **determine the overall payment** for a Part A patient's stay in SNF

Medicare Part B

- Diagnosis, condition, symptom or injury paired with your treatment diagnosis that justifies **need for skilled intervention**
- Use the Novitas Local Coverage Articles for guidance

ICD-10 Resources

https://www.cms.gov/Medicare/Coding/ICD10/ICD-10Resources

www.icd10data.com

http://www.asha.org/Practice/reimbursement/coding/ICD-10/

http://www.asha.org/uploadedFiles/ICD-10-Codes-SLP.pdf

https://www.asha.org/Practice/reimbursement/coding/ICD-10-CM-Coding-FAQs-for-Audiologists-and-SLPs/

CPT Coding: medical services and procedures

Untimed Codes

Reimbursed the same rate, regardless of time spent with the patient

Service-based

Timed Codes

Billed in per unit increments with time based on code used; uses 8 minute rule

97130 Cognitive function intervention (additional 15 minutes add on code)

96105 Assessment of aphasia per hour

96125 Cognitive performance testing per hour

92607 Eval for speech-generating device, first hour and 92608, each addit. 30 minutes

CPT Resources

https://www.asha.org/siteassets/uploadedfiles/reimbursement/2022-medicare-fee-schedule-for-speech-language-pathologists.pdf

https://www.asha.org/siteassets/uploadedfiles/reimbursement/2022-medicare-fee-schedule-for-audiologists.pdf

https://www.asha.org/practice/reimbursement/coding/slpcpt/

Medicare Administrative Contractors (MAC)

- Geographically organized
- Regionally manage policy and payment related to reimbursement and act as the fiscal intermediary for Medicare
  - Local coverage determinations (LCD)
  - Local coverage articles (LCA)
- Many insurance companies and FFP (federally funded plans) follow Medicare guidelines.

Texas MAC: Novitas Solutions, Inc

Local Coverage Determinations (LCD) policies and Local Coverage Articles (LCA) for ***communication disorders***, ***dysphagia***, **and** ***audiology services*** that list coverage limitations and codes that denote medical necessity **(must have one of listed codes on script or POC to be covered)**:

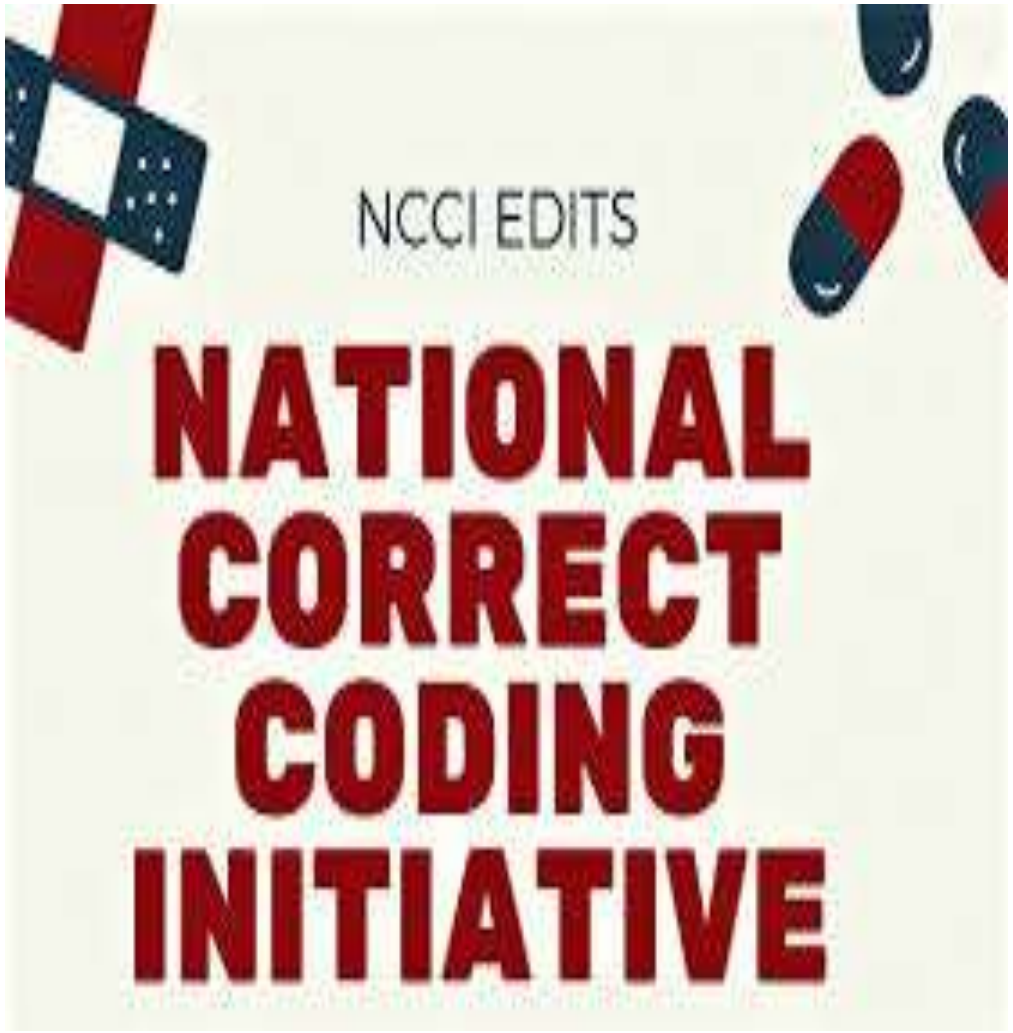
- **Barium Swallow Studies, Modified** L35433 and A56589
- **Communication Disorders** L35070 and A54111
- **Vestibular and Audiologic Function Studies** L35007 and A57434

NOVITAS SOLUTIONS

Medicare Part B Coding Rules and Edits

Medicare Part B Limitations

- Congress repealed the Medicare Part B therapy cap in 2018
- Maintained the ***KX Modifier*** threshold of ***$2150 for combined PT and ST services***
- PT and ST share the ***manual medical review amount of $3000***
  - CMS conducts a targeted review for companies who have a high denial rate or high utilization.
- We can see patients ***above the $3000*** threshold as long as services are ***medically necessary*** and demonstrate need for ***skilled intervention.***



- Automated edit system to control specific CPT code pairs that can or cannot be billed on the same day
- Used in all Medicare Part B and Medicaid claims for outpatient services.
  - **Provider-based services in outpatient settings** (clinics, private practices, and physician offices)
  - **Outpatient Code Editor (OCE) edits**—a subset of the CCI system—apply to **facility-based services** (hospital outpatient or SNF Part B services).

Coding Clarification--Edits

- **Component services: may not be reported with** CPT codes representing more comprehensive services:
  - 92523 and (speech and language evaluation) and 92522 (speech evaluation)
  - 92557 (comprehensive audiometry) and 92555 (speech threshold audiometry)
- **Mutually exclusive: may not be billed together** for the same patient on the same day:
  - 92507 (Speech,lang tx) and 97129 and 97130 (Cog tx)
  - 92508 (Speech, lang group) and 97129 and 97130 (Cog tx)
- **Medically Unlikely Edits (MUEs):** The **max number of times** that a CPT code can be reported on the same day for the same patient:
  - 92507 (Speech lang tx) may only be billed one time per day in office or hospital OP settings
  - 96125 (Cog Eval) can only be billed for 2 hours on same date of service

More Medicare Coding Rules

- 8 minute rule for timed codes
- Code modifiers:
  - **-59 modifier**: For 2 procedures **not ordinarily performed** on the same day by the same practitioner, but under **certain circumstances may be appropriate** to perform (i.e. 92508 (Group tx) & 92507 (Indiv tx)
  - **-22 modifier**: a much longer than usual procedure
  - **-52 modifier**: an abbreviated procedure: 92523 (Eval of speech, lang) if only assessed language with no mention of motor speech; 92520 (Laryngeal function studies) if perform only aerodynamic OR acoustic testing

Resources for CCI edits

- https://www.asha.org/practice/reimbursement/coding/national-correct-coding-initiative-for-audiology-and-speech-language-pathology-services/
- **Audiologists:**
- https://www.asha.org/practice/reimbursement/coding/cci-edit-tables-audiology/
- https://www.asha.org/practice/reimbursement/coding/medically-unlikely-edits-audiology/
- **Speech-Language Pathologists:**
- https://www.asha.org/practice/reimbursement/coding/cci-edit-tables-slp/
- https://www.asha.org/practice/reimbursement/coding/medically-unlikely-edits-slp/

Service Delivery Considerations

Individual Therapy

One-on-one treatment to address a patient's functional clinical needs-to help a patient **improve or maintain function.**

Documentation should support **medical necessity and the skilled nature** of the services provided.

Bill for the CPT code defined in the treatment.

Group Therapy

To help a patient **improve** or **maintain** function.

Two or more individuals actively performing the ***same or similar activities.*** Participants **do not** have to have the same or similar ***goals.***

An **adjunct to-** not a replacement for individual therapy.

The **needs of the patient and their targeted goals** should **drive the use** of group therapy.

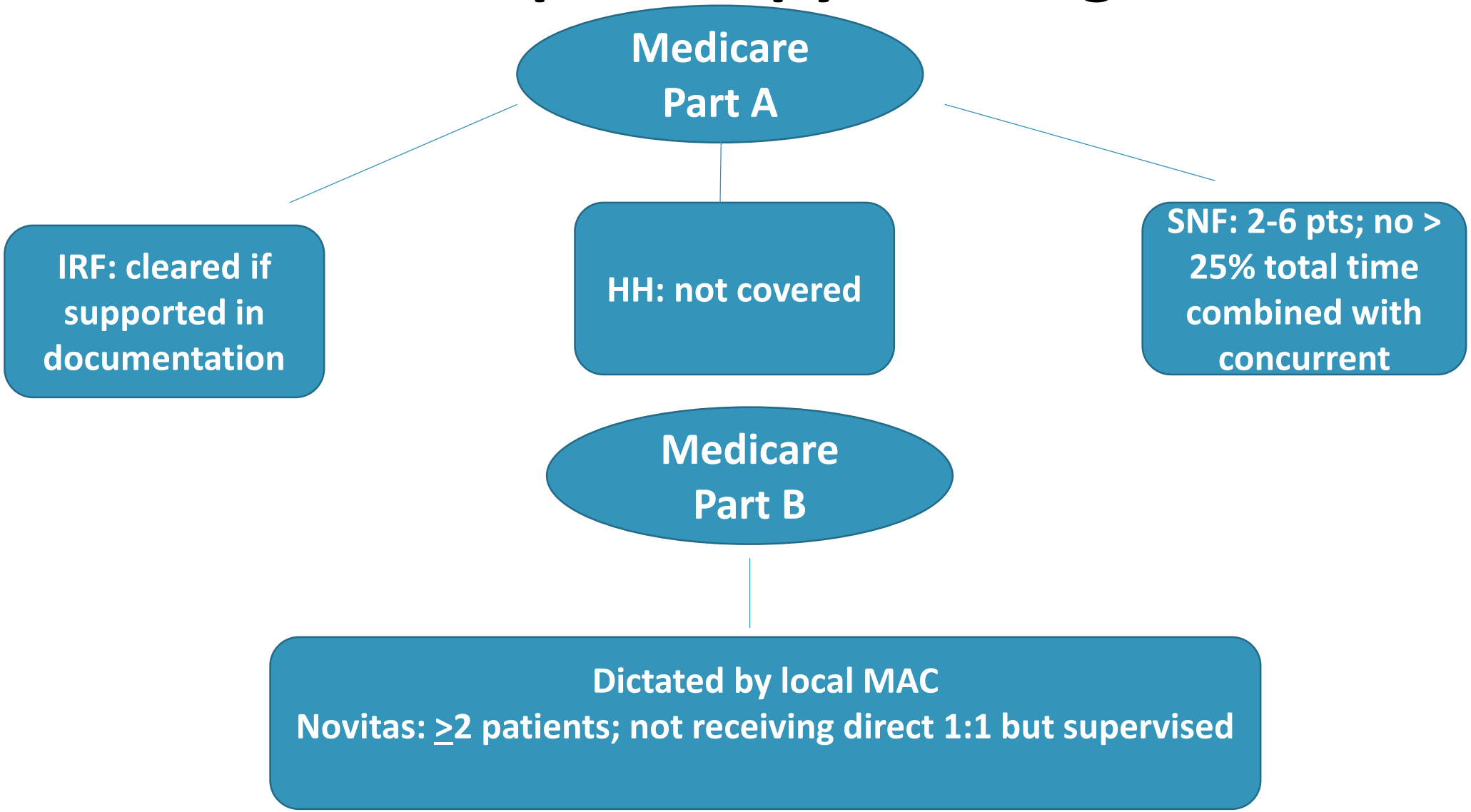
Size of group and any rules re: groups are defined in Novitas LCD and payor source.

Should **NEVER** be done for the **convenience** of the facility or the clinician.

Group Therapy Documentation to include:

- justification for a group
- goals targeted and how the group activity supports goals
- skilled interventions that were reasonable, medically necessary, and supported the patient's plan of care
- size of group

Group Therapy Coverage



Group Therapy Billing

- CPT code **92508:** *treatment of speech, language, voice, communication, and/or auditory processing disorder; group,* ***two or more individuals****.*
- **No CPT** codes describe group treatment of **swallowing or cognition**
- Payers may permit the use of **CPT code 97150** to represent group therapy not associated with speech and language but ***must check rules.***

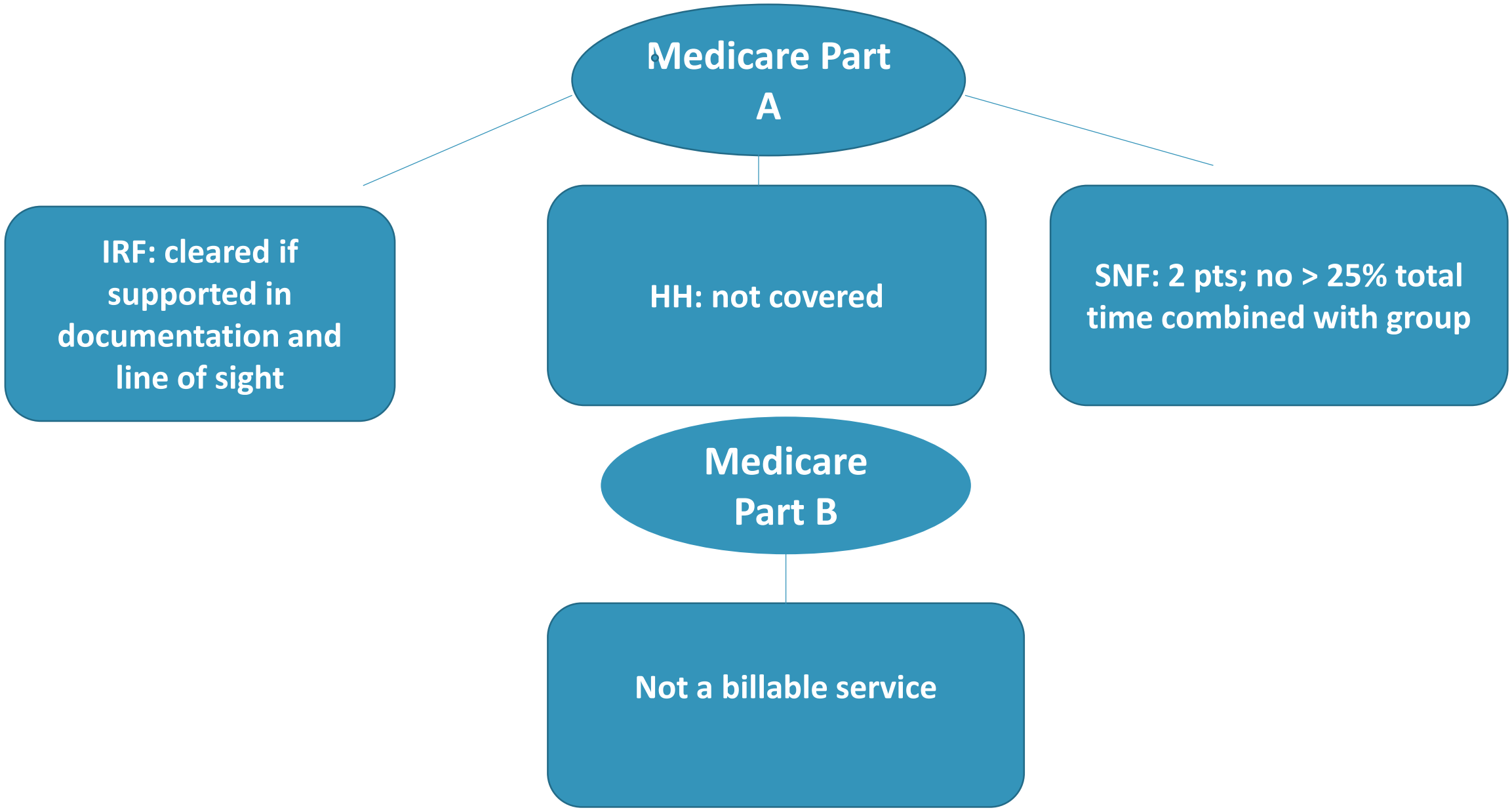
Concurrent Therapy

- Treating **two** patients **at the same time,** performing **different activities**
- Can have **varying diagnoses and levels of severity**
- **Skilled and medically necessary to improve or maintain** a level of function
- **Not** a solution to operational efficiencies
- An **adjunct** to, not a replacement for, individual therapy

Concurrent Therapy Documentation to include:

- justification for use of concurrent mode
- goals targeted and how the group activity supports goals in concurrent mode of service delivery
- skilled interventions that were reasonable, medically necessary, and supported the patient's plan of care

Concurrent Therapy Coverage



Concurrent Therapy Billing

- Use the **individual CPT** treatment code
- For timed codes (e.g., 97129, 97130), report the number of minutes spent in ***direct one-on-one treatment*** with ***each patient***.
- For untimed codes (e.g., 92507), bill once per patient. Time is an important consideration, even for untimed codes. If clinicians spend only a **short amount** of direct one-on-one time with each patient, it ***may not be appropriate*** to bill for a full therapy session.

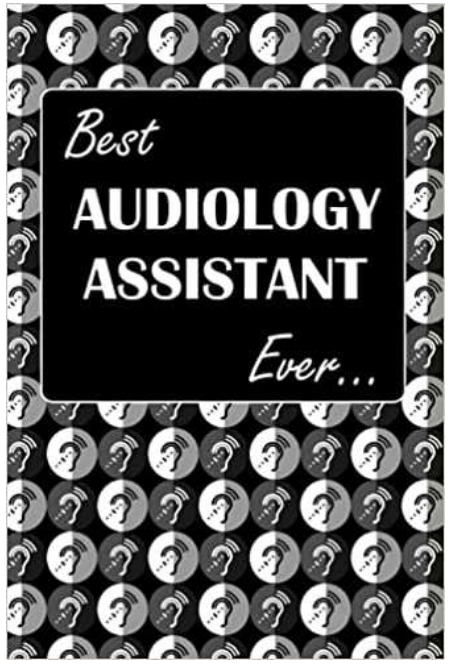
Resources for Modes of Therapy

https://www.asha.org/practice/reimbursement/modes-of-service-delivery-for-speech-language-pathology/

https://www.asha.org/practice/payer-portal/service-delivery-methods/

Services provided by Assistants

- Not currently recognized as skilled providers by Medicare Part A or B
- As most Medicare Advantage plans follow traditional Medicare rules, they also do not recognize assistants.
- Private insurance: varies; may be reimbursed at a different rate



Students

- Supervising SLPs are required to have at least **one year of practice experience**.
- Student is an **extension** of the SLP.
- Supervisor must **review and co-sign** all documentation and retain **full responsibility for the care** of the patient.
- The student's e-signature should be clearly **labeled that they are a student**.
- It is recommended that notes include a statement similar to ***"services provided by a licensed SLP with assistance from a graduate student in training".***

Services provided by students: SNF Part A

If student proves they can work **independently**

perform Rx **without** line-of-sight supervision

services will be **counted on the MDS as skilled Rx minutes**

*Students who **have not been approved** to practice independently*

*requires **line-of-sight supervision***

supervising SLP will have **direct contact with the patient**

services will then be counted on the **MDS as skilled Rx minutes**.

Services provided by students: Part B

- Supervising SLP must be **present and engaged and guiding the student** for the entire session.
  - **Cannot** be documenting, treating another patient or working on projects.
- Student may participate in therapy when the supervising SLP is **directing** the session, **making the skilled** judgment, and is **responsible for the assessment and treatment**.

Telepractice: Medicare Coverage During PHE *(extended through 4/16/22)*

Medicare has authorized SLPs and AUDs to provide a **narrow subset** of telehealth services during the **federally-declared PHE**.

- You cannot charge Medicare beneficiaries for these specific services and must **bill Medicare directly**.
- If a service is **not on** the temporarily authorized telehealth services list, you may **enter into a private pay arrangement with the Medicare beneficiary** for that specific service

Medicare Telehealth Coverage: after the PHE

Medicare: will **no longer reimburse** directly for any telehealth services.

SLPs will have two options for reimbursement:

- Enter into **private pay arrangements** with Medicare beneficiaries.
- Provide select telehealth services **"incident to" a physician**, meaning these services would be provided under the direct supervision of a physician and **billed under the physician's NPI** through the **remainder of 2023**.
  - **Physician is in the office suite** (but not necessarily in the same room) or **available through real time audio-visual** communication technology.
  - Applies to: **92507** (speech treatment), **92521** (fluency eval), **92522** (speech sound eval), **92523** (speech and language eval), and **92524** (voice eval)

Resources for telepractice

- Refer to ASHA's Telepractice Resource page for details and coverage: https://www.asha.org/about/telepractice-resources-during-covid-19/

What Are We Going With Healthcare Reimbursement?

CHANGE IS CONSTANT

Federal Laws & Regulations

- Annual “Revised Final” Rules
- Fee Schedules
- Annual Medicare Advantage Updates

State Surveys

- Irregular schedules, OSHA, AAAASF

Medicare Regulations and Policy

- Service Model Changes
- Payment Model Proposals
- Medicare Learning Network “Newsletter”
- CMS Open Door Forums with verbal revisions

State Practice Acts

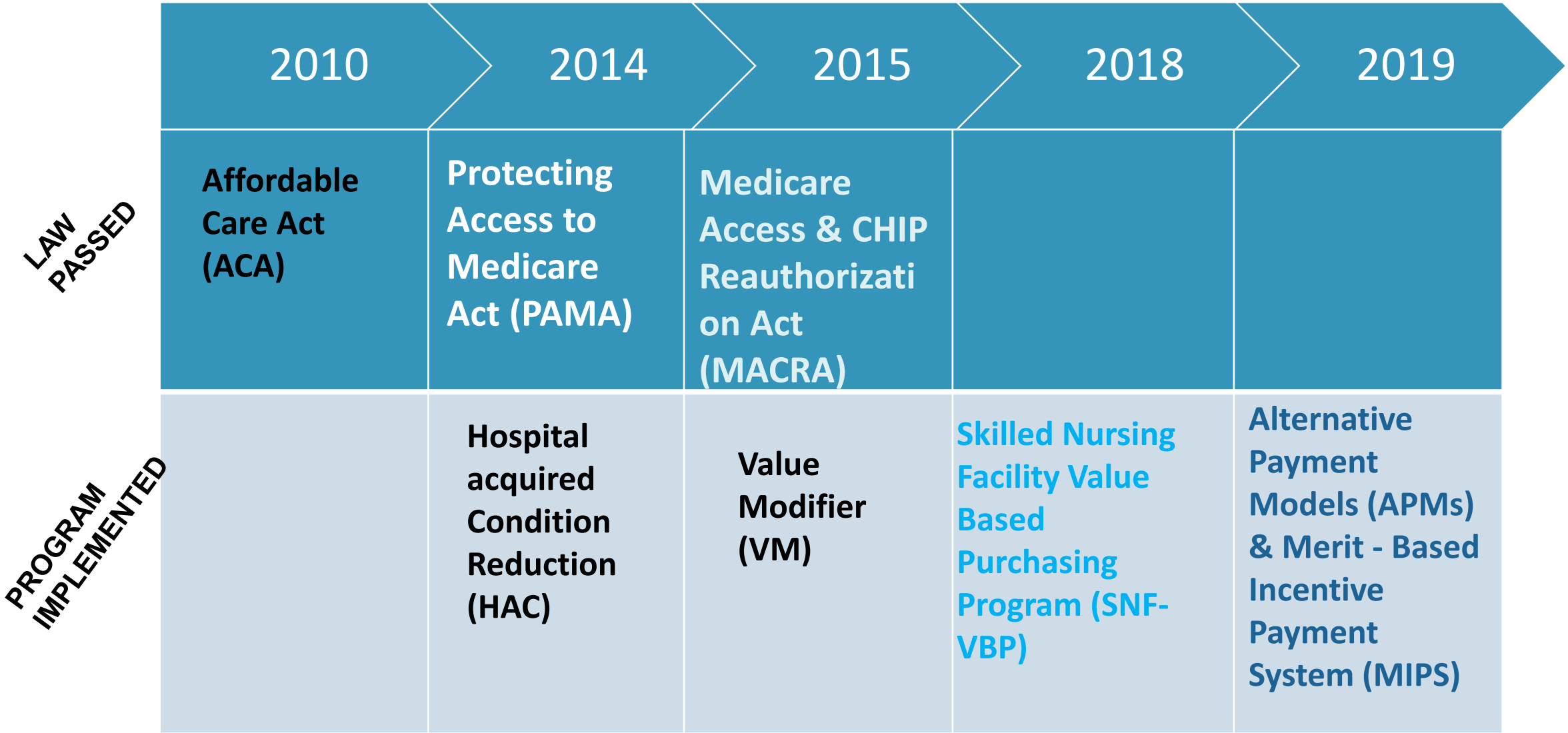
- Frequent and significant changes

HEALTHCARE SERVICE AND DELIVERY IS TRANSFORMING

- Fee-For-Service = Payment for *quantity* of care
- Value-based = Payment for *quality* of care
- The trend is moving toward value-based
  - As a result of the Affordable Care Act in 2010

Value: Improved quality at reduced cost

FEDERAL LAWS & VALUE-BASED PROGRAMS



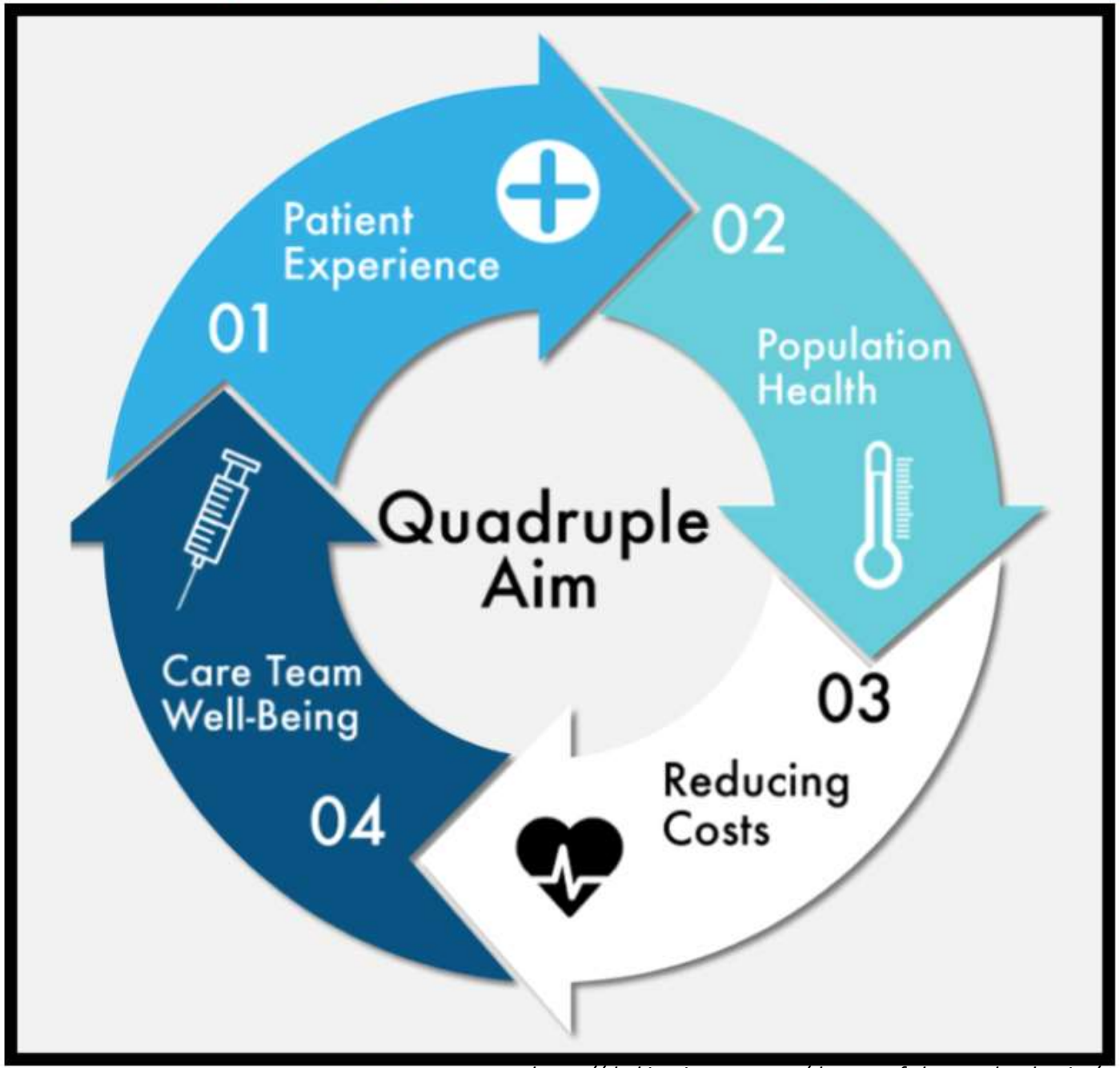
QUALITY REPORTING

IMPACT Act:

Quality Measures	Incorporated into each setting Cross-setting requirements to report on cognitive function, functional status, skin integrity, falls, medications and resource use
Requirements for standardized assessment	Across all settings facilitates information being uniform throughout the progression of care
Interoperability requirements	Enhance the ability to share patient-centered information

SLPs have a responsibility to participate in the collection and reporting of quality results through various programs

CMS QUADRUPLE AIM: THE MASTER PLAN



https://thekinetixgroup.com/the-era-of-the-quadruple-aim/

VALUE BASED CARE

A form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness

WHERE ARE WE TODAY?

VALUE BASED CARE: DEVELOPMENT, IMPLEMENTATION, EVOLUTION 2016 -2020

Skilled Nursing Homes

- Implemented Quality Measures: Revisions and development continue
- VBP implemented: Payment incentive program initiated 10/1/18
- Alternative Payment Model: Patient Driven Payment Model (PDPM) – implementation 10/1/2019

Schools and Clinics

- Medicaid Expansion - 36 states and the District of Columbia

SNF, IRF, LTCH, HH: IMPACT Act (implementation is ongoing)

- Standardized Assessment – portions integrated into SNF MDS, IRF-PAI, HH OASIS, LTCH - FIMS
- Interoperability – initiated but far from completion

VALUE BASED CARE: DEVELOPMENT, IMPLEMENTATION, EVOLUTION 2016 -2020

Home Health

- OASIS revisions – 2018
- Alternative Payment Model – Patient Driven Groupings Model (PDGM)- implementation 1/1/2020

Private Practice, Rehab Agency, Group Practice (Physician Fee Schedule)

- New Rehab (PT & OT) evaluation codes
- Reduced Fee Schedule Rates
- Ongoing and proposed re-weighting of “mis-valued” codes
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Merit Based Incentive Payment System (MIPs)

MORE TO COME FOR ALL PRACTICE SETTINGS

Alternative Payment Models

- Skilled Nursing Facilities Patient Driven Payment Model (PDPM): *implementation 10/1/2019*
- Home Health Care Patient Groupings Payment Model (PDGM): *implementation 1/1/2020*
- Private Practice Medicare Incentive Payment System (MIPS): *data collection underway for 2021 payment adjustments*

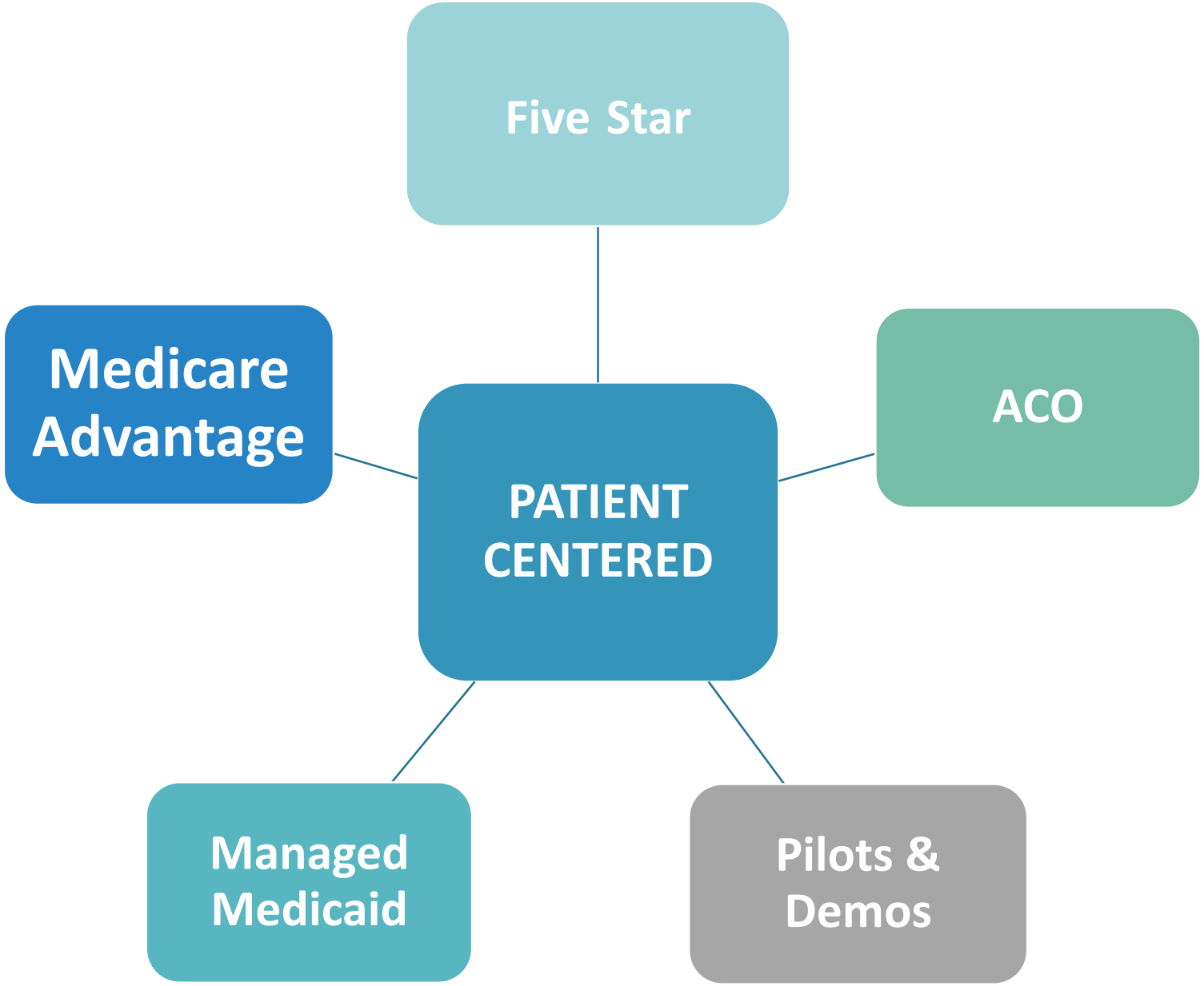
Quality Measures

- SNF, HH, IRF, LTCH, Private Practice, Rehab Agencies, Clinics - Medicare Spending Per Beneficiary- Post Acute Care (MSPB-PAC): *data collection implemented in 2017*

Clinical Care and Service Models

- SNF/Long Term Care Revised Rules Of Participation
- Agencies, Clinics, Private Practice: New Code Values and/or “Mis-valued” code revisions

VALUE BASED CARE IS EVERYWHERE…

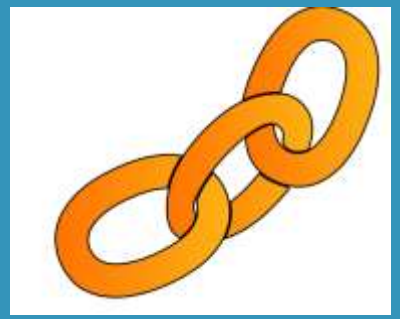


ALTERNATIVE PAYMENT MODELS

What is an Alternative Payment Model (APM)?

- An APM is a reimbursement system that incorporates quality and the total cost of care rather than paying providers a set fee for a particular service
- APMs may be government run or operated by a private insurance entity
- APMs may require the provider to give evidence of the expected patient outcome that is based on the patient's classification/diagnosis and historic resource utilization

HHS' Historic Shift to Alternative Payment Models

			
Category 1 **Fee for service- No link to Quality & Value**	**Category 2** **Fee for Service-** **Link to Quality & Value**	**Category 3** **APMs Built on Fee for service Architecture**	**Category 3** **Population-based Payment**
	A: Foundational Payments for Infrastructure and Operations **B:** Pay for Reporting **C:** Rewards for Performance **D:** Rewards and Penalties for Performance	**A:** APMs with Upside Gainsharing **B:** APMs with Upside Gainsharing/Downside Risk	**A:** Condition-Specific Population-Based Payment **B:** Comprehensive Population-Based Payment

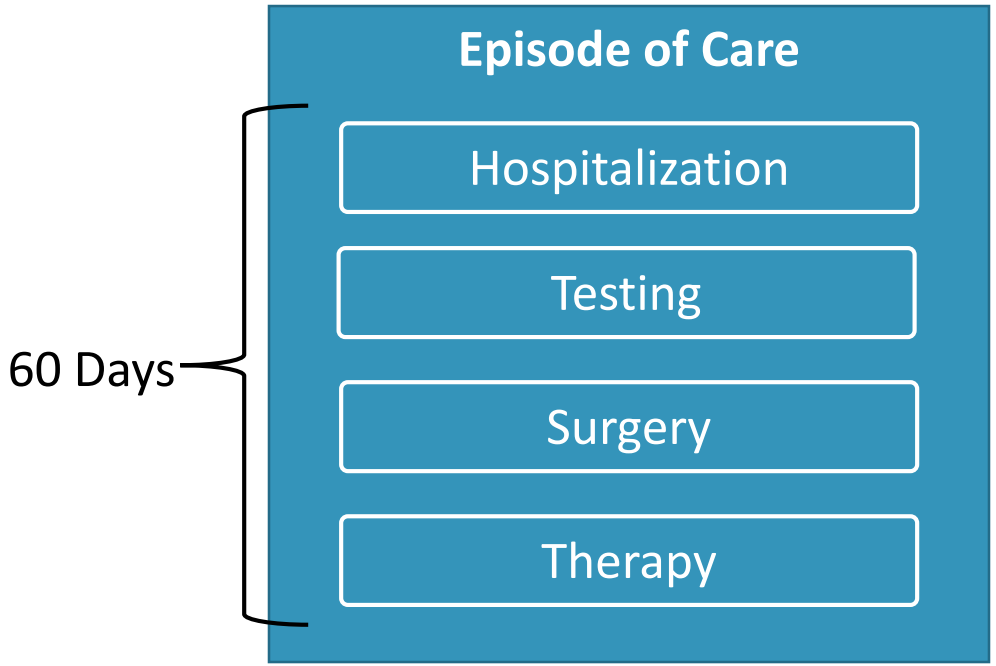
APMs & Quality Measures: What To Do?

- Encourage efficient, high quality service systems
  - Look for innovative opportunities……
- Reimbursement is dependent on:
  - Quality Measures ***AND*** Shared Savings
- Payment is impacted by:
  - Re-hospitalization ***AND*** Functional Outcomes
- Participate in personal contact to educate & collaborate
- Structure systems & processes for what will come

EPISODE OF CARE

Encompasses all services provided to a patient with an identified condition within a specific period of time across a continuum of care in an integrated healthcare system (e.g., Stroke)

Example: Home Health Patient with diagnosis of CVA (stroke)



- Did services improve outcome?
- Was spending reduced?
- Was treatment completed within the required timeframe?

BUNDLED PAYMENT

- Episodes of care are typically used to inform a bundled payment
- Represents a single fixed payment for an identified condition
- Better coordination of care for patients
- Works really well for procedures/services with a discrete stop/end time
- Can also be implemented for chronic conditions

ACCOUNTABLE CARE ORGANIZATIONS(ACOs)

- Assume accountability for the cost and quality of care for a defined population of patients
- Coordinate the services of its providers in various healthcare settings to manage patients' needs
- Health information technology is integral
- Can be hospital-driven or hospital/provider arrangements
- Medicare and private sector ACOs exist

Background Information….

http://www.beckershospitalreview.com/lists/100-accountable-care-organizations-to-know-2015.html

MEDICARE AND ACOs

- MedPAC defined an ACO as:

"A group of physicians (possibly including a hospital) that assumes responsibility for annual Medicare spending for a defined patient population"

- ACOs would be compensated through an arrangement that combines traditional fee-for-service payments with financial incentives to reduce costs, improve quality, and achieve greater information transparency

ACCOUNTABLE CARE ORGANIZATIONS

Emphasis on:

- Quality and cost savings
- Enhancing care coordination and integration
- Efficiency
- Use of performance-based incentives and bundled payments

(Accountable Care Organizations and Payment Reform: Setting a Course for Success: Bard & Nugent – www.navigant.com)

***ACCORDING TO THE AFFORDABLE CARE ACT,* Accountable Care Organizations must:**

1. Be willing to become accountable for the quality, cost, and overall care of a defined population of Medicare fee-for-service beneficiaries

1. Agree to participate in the program for at least 3 years

1. Have a formal legal structure allowing it to receive and distribute payments for shared savings

Have in place leadership and management structures that include clinical and administrative oversight systems

According to the ACA, Accountable Care Organizations must also:

5.Have a network of providers that includes enough primary care professionals to cover the Medicare beneficiaries assigned to it

5.Demonstrate to the Secretary of HHS that it meets patient-centeredness criteria for these beneficiaries

5.Define processes to promote evidence-based medicine and patient engagement

PAYMENT TO ACOs

Providers participating in ACOs can continue to receive payments under the original Medicare fee-for-service program Parts A and B

- These providers are eligible to receive additional payments for shared savings if the ACO meets the quality performance standard

If the ACO's annual expenditures are far enough below the benchmark, and the ACO meets the quality performance standard.

- The ACO shall be eligible to receive payment for a portion of the savings it has brought to the Medicare program

PATIENT-CENTERED MEDICAL HOME (PCMH)

Patient–Centered Medical Home

- A model, not a “home”
- The PCP coordinates care with other providers (“gatekeeper”)
- Enhanced care coordination and communication, particularly useful for chronic conditions
- Intended to minimize fragmentation of information between providers
- Can be integrated into ACOs

EVOLUTION OF DIAGNOSTIC PRACTICE

- ***The focus is on EFFICIENCY***
  - The diagnosis must be accurate and substantiated.
- ***We must focus on the CLINICAL QUESTIONS***
  - Reason for referral
  - Impact on function
  - Determining the problem
  - Recommending the solution
- ***PATIENTS are the CENTER***
  - What do they want/need to know?
  - What do they want/need to do?

- ***Interprofessional COLLABORATION is required***
  - Differential diagnosis needs to consider the whole person.
- ***Reporting DATA is not an option.***

WHAT DOES EVOLING PRACTICE LOOK LIKE?

Our clinical decisions are questioned and must be substantiated.

- ***Evidence based practice is expected***

Interprofessional Collaborative Practice is the expected standard

- ***Collaboration***
- ***Communication***
- ***Community***

Clinical predictions/assumptions for length of service are challenged

- ***Lengths of service are to align with historic clinical evidence***

MANAGING EVOLVING PRACTICE

Comprehensive evaluations are expected on "Day One" of service

Completion within 24-48 hours of admission

Treatment must focus on FUNCTION, FUNCTION, FUNCTION

International Classification of Function (ICF) is the foundation for most value-based rules

Quality Measurement criteria must be known

Patient outcome must reflect quality care and respect patient preferences

MANAGING EVOLVING PRACTICE

As clinically appropriate, Interprofessional Collaboration requires us to insert ourselves into the care of the patient, regardless of the "admission diagnosis"

- Are there swallow or cognitive issues post-surgery?
- Does the patient have the ability to follow directions and problem solve?

SNF Facility "short stay" patient care is still comprehensive

- Treatment must be individualized for each admission
- Care is based on the patient's discharge plans and destination.

KEYS TO SUCCESS

Collect your performance data to share it with “upstream” and “downstream” care partners/providers.
Be able to answer these questions:

- What are the provider’s rehospitalization rates?
- What are the provider’s successful “Discharge to Community” rates?
- What is your patient’s average length of service?
- Do you have Guest/Patient/Family Satisfaction Scores?
- What are you contributing to Quality Measurements for the hospital/SNF/IRF/LTCH/Agency/Clinic, etc.?
- What Functional Outcome Information can you report about your patients?

The Goal for Value Based/APMs/Bundled Plans:

The Next Level Of Care

Prior Level of Function (PLOF) is no longer the deciding factor for medical necessity

- Re-design nursing and therapy processes to increase prompt and complete communication
- Discharge management is from day of admission
- Essential to have SLP active participation

Involvement from the caregiver/family is now required

- Establish good partnerships with community resources

Strive for increased transparency with all provider partners

The Challenges

- Reimbursement Issues, Paperwork burden
- Rules – hard to keep up with frequent changes & differences across payers
- Productivity expectations – time for what??
- Work at top of professions – what does this mean & can we do it???
- Evidence Based Practice
- Customer / Patient anxiety and discontent due to economy and pressures of economy (e.g. high deductible plans, feeling rushed at appointments)
- Medical providers' understanding of what SLPs can do
- Poor understanding of healthcare economics

Reframing the Professions to Become Indispensable

- *First: Understand the Healthcare Landscape*
- *Then: Embrace Change!*

The ADULT HEALTH CARE Environment

Influence the Patient Experience:

- Short term rehab, Long term stay, HOME AND COMMUNITY SERVICES
- Managing expectations of the patient and his/her family members
- Managing other caregivers
- Educating family and caregivers about SLP services
- Functional Outcomes

Children's Hospital IP & OP

Influence the Patient Experience

- **Outcome Measures** – They should demonstrate outcomes & life impact
- **Service Delivery Models** – to increase access to care
  - Individual, Group – what we know
  - Telepractice – continue to develop
  - Consultative, Intensive, Episodic - need to get better at knowing when appropriate & using these models!
- **Family Education & Training** – developing overviews, patient experience… Computer Based Trainings, could be in multiple languages

Population Health

- Medical scholars David Kindig, M.D. & Greg Stoddart, M.D., defined population health in 2003 as:

"The health outcomes of a group of individuals, including the distribution of such outcomes within the group."

- Daniel Hyman, M.D., M.M.M., Chief Quality and Patient Safety Officer at Children's Hospital Colorado, further qualifies this definition, stating:

"Population health is about improving the health outcomes of the entire population AND reducing or eliminating disparities between groups."

Stretching our Healthcare Dollar

- Professional Time – our main expense!
  - Work at the Top of Your License – How? What does this mean for us?
  - Adequately Scheduled Workday – What does this look like for your setting?
  - Developing workflow efficiencies
- Outcomes – our main cost savings!
  - How can we: help reduce LOS, increase independence, reduce resources needed/services utilized…
  - EBP – ensuring effectiveness
- Reimbursement – how we get paid!

Professional Time

- Work at Top of our Profession (more than one answer)
  - SLPA – identify where they can be used & how
  - SLP as educator/trainer – for nursing, nursing aides, teachers, other staff, families; need to ensure that SLPs are trained in training professionals & para-professionals
  - Service Delivery Models – Consultative – develop clinical competence

Developing Workflow Efficiencies

Streamline Paperwork (advocate for, or develop a system)

Electronic Medical Record – Be a key team member in documentation and process flow development for our service

Point of Service Documentation

- A laptop or tablet enables you to document when you are with a patient
- Most patients enjoy participating in writing up their “report card”

Work with a therapy aide

- Room set up, materials preparation, cleaning

Professional Time

- Productivity – expectations, understanding
  - What is an adequately scheduled workday for your setting?
  - What to do if your agency requires an unreasonable level? How to discuss this with your leadership team
  - Billable vs. non-billable activity

Outcomes

- Search for and know EBP for your services
  - Critically appraise the research, determine the clinical bottom line, be able to discuss
- Service Delivery Models
  - Not one size fits all, be able to use & discuss with patients & families, providers & 3rd party payors
- Measure your program effectiveness
  - Not just goals met, but life impact (increased independence, reduced services/resources needed)
  - Overall cost of care impact? help reduce LOS, services needed while in hospital (did you reduce the need for a 1:1 assistant??)

Understanding Reimbursement

- **KNOW YOUR PAYOR SOURCE!!**
  - Medicare Part A
  - Medicare Part B
  - Managed Care A and B
  - Commercial Insurance
  - Private Pay
  - Medicaid

How is Speech Therapy Reimbursed?

- Bundled services vs. per unit charges
  - Defining a service-based visit (ST) vs. a time-based unit (PT & OT)
  - Comparing cost to reimbursement
  - The importance of time per visit
- Screening vs. Evaluating

Guidelines

- What is medical necessity?
  - You must be able to say that the services you are providing is at the level of complexity that it could ONLY be provided by a licensed SLP.
- The only insight into your treatment to determine medical necessity that CMS has is your documentation!!

Summarizing

Any Questions?

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