hci HealthCare CONSULTING
ebs Employee Benefits SERVICES

New HCI-EBS Website

HCI – EBS recently updated its web site. The address remains the same. However, you will find an improved layout and easier navigation to the information you want. Login pages for payroll and retirement access, as well as our Client Portal, are strategically located on our site so you may access them by clicking the top right menu button, which is displayed as three horizontal lines on the home page. After clicking this button, you can click the "Logins" button to access payroll and retirement login pages, or click the "Client Portal" button to access our client portal. We believe you will find this new website to be informative and user-friendly to navigate. As you browse the website, please contact us if any assistance is required.

EHR Incentive Hardship Application Released

CMS has released a new 2017 Medicare EHR incentive program payment adjustment hardship exception application. It can be found at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipApplication.pdf. The accompanying application instructions can be found at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipInstructions.pdf.

CMS has noted that due to the late announcement of the rule changes which impacted the meaningful use reporting for 2015, a blanket exception is included for providers on the 2107 hardship application. Those who wish to take advantage of this exception should check box 2.2.d (electronic health record certification/vendor issues) on the application.

Also the application will accept multiple providers and provider types who wish to apply as a single group on the application. Eligible providers should be listed in section 4 along with their NPI numbers. For larger organizations an electronic file containing this data may be submitted in conjunction with the application.

Five specialties are not required to submit the application. These include anesthesiology, diagnostic radiology, interventional radiology, nuclear medicine and pathology. Any hospital based eligible professional is also automatically exempt and would not be required to submit this form. In addition, any new eligible professionals who began to submit claims to Medicare in 2015 for the first time are exempt from the payment adjustments in 2016 and 2017.

This application must be submitted by March 15th. Although faxed applications will be accepted, it is strongly recommended that the application be submitted electronically to ehrhardship@provider-resources.com.

If you have questions , please contact your consultant or you can reach Bryan Burke at bburke@hci-ebs.com or 1-800-572-5275.

Alternate Payment Models

CMS has announced that it is supporting the shift away from the current fee for service reimbursement model and towards a value based system which rewards shared risk and is grounded on the concepts of quality, cost effectiveness and patient engagement. CMS has outlined a three year timeline in which it intends to boost payments to Alternative Payment Models from the current level of 20% to 30% by the end of 2016 and to 50% by the end of 2018. Alternative payment models currently include Medicare's existing accountable care organizations, both the Medicare Shared Savings Program and the Pioneer ACO Program, patient centered medical home models, and bundled payment arrangements. It will continue to promote payment systems which are linked to quality and value and will continue to work with states and private payers to explore additional alternative payment models.

Last month a white paper was released by the Health Care Payment Learning & Action Network, a policy group convened by HHS, which provides additional insights into future APMs. The paper can be accessed at https://hcp-lan.org/workproducts/apm-whitepaper.pdf and the accompanying addendum containing case studies here: https://hcp-lan.org/workproducts/apm-whitepaper-addendum.pdf.

The work group provides seven principles for an APM framework:

1. Changing providers' financial incentives is not sufficient to achieve person centered care, so it will be essential to empower patients to be partners in health care transformation.
2. The goal for payment reform is to shift U.S. health care spending significantly towards population based (and more person focused) payments.
3. Value based incentives should ideally reach the providers that deliver care.
4. Payment models that do not take quality into account are not considered APMs in the APM framework, and do not count as progress toward payment reform.
5. Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.
6. APMs will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of excellence, accountable care organizations, and patient centered medical homes are examples, rather than categories, in the APM framework because they are delivery systems that can be applied to and supported by a variety of payment models.

The work group envisions a process of moving away from fee for service towards a payment scheme which is initially built upon a fee for service architecture but includes both upside gainsharing and downside risk adjustments. Beyond this, the intention would be to move towards a payment system for condition specific services that hold providers accountable for the total cost of care for that condition. Ultimately, the goal would be to have an entirely capitated payment system for entire populations of patients.

If you have any questions or want additional information, please contact your consultant:
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