Do You Know the Alphabet for Medicare Payments?

MACRA: Medicare Access and CHIP Reauthorization Act of 2015
CMS: Centers for Medicare and Medicaid Services
MIPS: Merit-Based Incentive Payment System
APM: Advanced Alternative Payment Models
QPP: Quality Payment Program

Cyril Spann, MD
President

Dr. Cyril Spann accepted the role of Society President at this year’s Annual Meeting in Sea Island, GA. Dr. Spann received his medical degree at Meharry Medical College, completed his residency at Emory University, a fellowship at the University of North Carolina, and a master’s degree in health care management at Harvard University School of Public Health. He has provided services in gynecologic oncology since 1992, specializing in gynecological malignancies and ovarian cancer. He is a professor of medicine at Emory University. He currently practices in Decatur, GA at the DeKalb Medical Physician Group – Gynecologic Oncology Specialists of Atlanta.

Two months ago, HHS implemented the QPP (under the MACRA) in hopes to shift Medicare reimbursement payment from a quantity-based to a quality-based model. The ultimate goal is to make patients healthier. The sustainable Growth Rate formula that Medicare and its providers have struggled with for years will end. The QPP will start to transition by January 2017 when data collection will commence. Medicare Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier will also be eliminated. The QPP has two tracks – MIPS or APM. It behooves those who care for Medicare patients and meet the requirements to participate, as there is a negative financial incentive for those who do not. Data collection for both tracks will start in Jan. 2017.

Track 1 MIPS

This track is for those who prefer to participate in traditional Medicare, rather than an Advanced APM.

The eligibility threshold for physicians, physician assistants, and nurse practitioners is billing Medicare more than $30K per year and providing care for more than 100 Medicare patients in a year. Those not meeting the threshold may elect not to participate. Participants will need to have an electronic health record (EHR) system that is certified by the Office of the National Coordinator for Health Information Technology that is able to capture information for analysis by CMS. The data will be derived from four performance categories – quality (replaces PGRS), improvement activities (new), advancing care information (replaces meaningful use) and cost (replaces value-based modifier). Those participating in this track will see a positive neutral or negative adjustment of up to 4% to Medicare payments for covered professional services furnished in 2019. Those who meet the threshold criteria and do not report will be subject to a negative 4% Medicare payment adjustment.

Track 2 APM

Advanced APM is an alternative payment approach that provides added incentives to clinicians to provide quality care. APMs can apply to a specific clinical condition, a care episode or a population. APM allow practices to earn more for taking on some risks (financial) related to patients’ outcomes. A practitioner can earn a 5% Medicare incentive payment starting in 2019 and be exempt from MIPS reporting requirements if he/she has sufficient participation in an APM. An APM requires 1) the use of an EHR, 2) base payments for services on quality measures comparable to those in MIPS, 3) be a medical home under CMS Innovation Center authority or bear more than nominal financial risk for losses. The exact calculation for financial risks is still under debate and clarification.

The QPP will phase in during 2017. Practicing Ob/Gyns who care for Medicare patients will have to make strategic decisions soon. If a practitioner does not meet the Medicare threshold outlined above, then he/she will be exempt. It is abundantly clear, though, we should all use EHR and be certain they will be compatible with CMS requirements for data transfer. Please refer to the references listed below. From my readings, it is apparent CMS would prefer that practitioners caring for Medicare patients use the APM vs. the MIPS track. Here is hoping you have a fruitful and productive 2017.

New Administration: Now What Happens to Healthcare Repeal And Replace?

A week before the Presidential election, I was tasked by a dear friend to write an article describing what the new president would bring to the healthcare table. It seemed like a bit sordid. It is filled with political backroom deals. The death of Senator Nancy Pelosi. Then, the measure was transformed into a budgetary bill enabling the use of the reconciliation process. When it returns to the Senate for approval, only 51 votes, rather than 60, were required for passage. Friendishly clever. The bill was signed into law by President Obama March 3, 2010. The bill itself consisted of a mere 2,700 pages. Yet, The Patient Protection and Affordable Care Act (PPACA), aka ACA, aka Obamacare, to prop up the system. Although wonder, 20,000 stacked pages attains a height in excess of six feet. (Although an alphabet soup of odious interventions that consist of a mere 2,700 pages. Although it seems like a simple enough endeavor. Hillary Clinton’s plan would be more, (possibly much more) of the same. I suggest that those who cannot afford coverage. Most ACA premiums at a critical campaign juncture helped to propel him into office. Trump. It seems likely the drastic rise in healthcare table. It seemed as if the new president would bring a consensus on a replacement for the ACA. Just in time. The devil however, was in the details. The bill was signed into law by President Obama March 3, 2010. The bill itself consisted of a mere 2,700 pages. Although it is filled with political backroom deals. The death of Senator Nancy Pelosi. Then, the measure was transformed into a budgetary bill enabling the use of the reconciliation process. When it returns to the Senate for approval, only 51 votes, rather than 60, were required for passage. Friendishly clever. The bill was signed into law by President Obama March 3, 2010. The bill itself consisted of a mere 2,700 pages.
Georgia Given Poor Grade for Premature Birth

The health of babies in the United States has taken a step backward as the nation’s preterm birth rate worsened for the first time in eight years. The U.S. earned a “C” grade on the latest March of Dimes Premature Birth Report Card amidst widening differences in prematurity rates across different races and ethnicities. The U.S. preterm birth rate went up from 9.57 to 9.63 in 2015, according to final data from the National Center for Health Statistics (NCHS). Across the country, preterm birth rates were nearly 48 percent higher among black women and more than 15 percent higher among American Indian/Alaska Native women compared to white women.

Georgia has a preterm birth rate of 10.8, which earned a grade of “D” on the latest March of Dimes Premature Birth Report Card. Georgia earned a score of 27 on the disparity index and ranked 32 amongst other states. In Georgia, the preterm birth rate among black women is 46% higher than the rate among all other women. The March of Dimes uses a Disparity Index score to measure and track progress towards the elimination of racial/ethnic disparities in preterm birth. The score represents the average percent difference in the preterm birth rate across all groups compared to the group with the lowest rate in the state.

Premature birth (before 37 weeks of pregnancy) is the leading cause of death of babies in the U.S. Babies who survive an early birth often face serious and lifelong health problems, including breathing problems, jaundice, vision loss, cerebral palsy and intellectual delays. In addition to the human toll, preterm birth accounts for more than $26 billion annually in avoidable medical and societal costs, according to the National Academy of Medicine.

We encourage people to visit www.marchofdimes.org to learn more about the National Academy of Medicine.

Online Shopping Gives to Georgia OBGYN

Did you know that the Georgia OBGYN Foundation is on Amazon Smile? Next time you shop on the online store Amazon, go to www.smile.amazon.com first and create a Smile account. Select Georgia Obstetrical and Gynecological Foundation, Inc. as your charity of choice. Any time you shop for items on Amazon, be sure you are logged in to Amazon Smile, and .5% of the money spent on purchases will go to the foundation. It’s a win-win!
Amerigroup’s Quality and P4HB Partnerships

Quality measures for pregnancy care

To keep Amerigroup Community Care accountable to you and your patients, we compare our health plan performance to the Healthcare Effectiveness Data and Information Set (HEDIS®) benchmarks developed by the National Committee for Quality Assurance (NCQA) and to performance targets established by the Georgia Department of Community Health (DCH). These assessments indicate if patients have received the pregnancy care they need.

Timeliness of prenatal care

This HEDIS measure identifies the percentage of women that received a prenatal care visit during the first trimester or within 42 days of enrollment in Amerigroup. Our 2014 performance rate was 79.02 percent. This rate was 10.7 percentage points below the state target of 89.72 percent.

Postpartum care

The postpartum HEDIS measure identifies the percentage of women that had live births and a postpartum visit 21-56 days after delivery. Amerigroup had a 2014 rate of 62.94 percent and was 7.26 percentage points below the Amerigroup ID card enrollment rate for women under age 45 who were enrolled in Amerigroup.

Agency for Healthcare Research and Quality (AHRQ)

Amerigroup also strives to reach state targets for the AHRQ measures:
- Cesarean delivery rate less than 28.70 percent
- Live births weighing less than 2,500 grams less than 7.99 percent

How you can help

We need your assistance to help us improve all of these performance measures. Please consider implementing these helpful tips into your practice:
- If your patient misses an appointment, pro-actively reach out to the patient to reschedule and confirm the date and time of their next appointment.
- When your patient comes in for their surgical check-up after a C-section, be sure to schedule her for a postpartum visit and explain the importance of coming back for this visit in 21-56 days.
- Consider text and/or email appointment reminders.
- Place the correct dates of service on your claims.
- Make sure your medical records reflect the details of each visit, details of your evaluation and notifications of the visit (e.g., prenatal or postpartum).

Planning for Healthy Babies® (P4HB)

The Georgia P4HB program was implemented in January of 2011. The program enrolls women of child-bearing age (18-44) who are able to become pregnant and who would otherwise not be eligible for Medicaid services. The program is designed to assist the state in reducing the low birth weight rate. The program provides family planning counseling and services and promotes the consistent use of effective contraceptive methods. We ask that you encourage your patients who meet the enrollment criteria to apply to the program. We are hopeful that family planning counseling and access to effective contraceptive methods leads to fewer unintended pregnancies and adverse birth outcomes in the enrolled population.

Goals of the P4HB program
- Reduce Georgia’s low birth weight and very low birth weight (VLBW) rates.
- Reduce the number of unintended pregnancies in Georgia.
- Reduce Georgia’s Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid.

THE P4HB PROGRAM CONSISTS OF THREE COMPONENTS:

Family Planning (FP)
Card: Pink
Benefits: Covers family planning and family planning-related services only for eligible participants for the duration of the program. Family planning services and supplies include:
- Family planning initial or annual exams (one per year)
- Contraceptive services and supplies
- Follow-up family planning or family planning-related service visits
- Treatment of major complications related to family planning services
- Counseling and referrals for social services such as Women, Infants, and Children (WIC)
- Tubal ligation (sterilization)
- Multi-vitamins with folic acid
- Hepatitis B and tetanus diphtheria vaccines for P4HB participants 18-20 years old

Inter-pregnancy care (IPC)
Card: Purple
Benefits: Covers family planning and family planning-related services for women who have delivered a VLBW baby. In addition to the family planning and family planning-related services described above, women enrolled in the IPC program are eligible for the following benefits:
- Limited primary care: primary care provider coordinates care for the participant and makes referrals to care management organization (CMO) and non-CMO specialty care, as needed
- Management and treatment of chronic disease by primary care provider
- Substance abuse treatment (detoxification and intensive outpatient rehabilitation). Participants can self-referral to an in-network provider for an initial mental health or substance abuse visit, but prior authorization may be required for subsequent visits. Participants may also receive detoxification and intensive outpatient rehabilitation services only.
- Limited dental
- Prescription drugs (nonfamily planning): medications to treat chronic conditions
- Nonemergency transportation (NET Transportation)
- Resource mother outreach (RMD): see below

Resource Mother Outreach (RMD) Card: Yellow
Benefits: Women enrolled in this program component are Medicaid-eligible and have delivered a VLBW baby. Under the program, they will have access to a resource mother, who will assist with the following:
- Increase the woman’s adoption of healthy behaviors, such as healthy eating and smoking cessation
- Support the woman’s compliance with primary care medical appointments, including assisting with arranging nonemergency medical transportation to and from medical appointments
- Support the woman’s compliance with nonemergency hospital visits
- Support the woman’s compliance with medications to treat her chronic health conditions
- Assist with coordination of social services support
- Assist women in obtaining regular preventive health visits and appropriate immunizations for their child
- Assist with linking women to community resources, such as the Special Supplemental Nutrition program for WIC

Amerigroup member who had a VLBW baby will keep their current Amerigroup ID card and their current medical benefits, but will also have access to a Resource Mother. This group will not have a P4HB logo on their card.

Georgia cAARds Online Training

A health care provider’s advice to quit tobacco use is an important motivator for tobacco users. In five minutes or fewer, you can execute the Georgia cAARds (Ask, Advise, and Refer with Follow-up form attached on next page) program and ensure your patients receive evidence-based, best practice tobacco cessation counseling. Georgia cAARds is an abbreviated program of the 5As model for treating tobacco use and dependence. The strategies were designed to be brief. The two As in cAARds represent asking all patients about tobacco use and advising patients on the benefits of quitting tobacco use. The R represents referring with follow-up to tobacco cessation counseling program, such as the GTQL. The GTQL also provides the remaining As of assessing the tobacco user’s willingness to make a quit attempt and using motivational counseling to do so, assisting in the quit attempt, and arranging follow-ups after the set quit date.

- Ask all patients about tobacco use during each visit
- Advise them about the benefits of tobacco cessation
- Refer them to the Georgia Tobacco Quit Line for a free “Quit KIT,” individualized plan and behavioral counseling: 1-877-270-STOP

• Complete the Georgia Tobacco Quit Line fax referral form with the patient GTQL Fax Referral Form can be downloaded from DPH’s website
• Inform the patient they will be contacted by a Georgia Tobacco Quit Line staff member within 48 hours or sooner

Free training on Asking, Advising and Referring:
Engaging Tobacco Users: Tips for Health Care Providers in Georgia www.GAtobacointervention.org

A VLBW baby is required and as the member’s obstetric provider, you will need to fill out a form confirming this. If a member does not have one of these required forms, they can obtain a copy by calling us toll free at 1-877-744-2101 or by visiting www.p4hb.org.
Prenatal transmission of hepatitis B virus (HBV) infection is highly efficient and generally occurs from exposure to maternal blood during labor and delivery. If appropriate and timely treatment is not initiated, perinatal infection occurs in 70%–90% of infants born to mothers who are both hepatitis B surface antigen (HBsAg) positive and hepatitis B little “e” antigen (HBeAg) positive. More than 90% of infants who are infected perinatally will develop chronic HBV infection. It is important to test pregnant women for HBsAg, as mother-to-baby transmission can be prevented if the mother’s HBV status is known at the time of delivery.

HBSAg-positive tests are reportable to public health in all states, but pregnancy status is rarely reported. To address this issue, the Centers for Disease Control and Prevention (CDC) and partners from health departments, commercial laboratories, the American College of Obstetricians and Gynecologists (ACOG) and other professional organizations have worked together to include pregnancy status in laboratory test reports sent to health departments. These efforts were guided by recommendations of the Council of State and Territorial Epidemiologists (CSTE) to improve identification of HBsAg-positive pregnant women.

Four major commercial laboratories are participating in this effort: ARUP Laboratories, LabCorp, Mayo Medical Laboratories, and Quest Diagnostics. Each laboratory now offers designated HBsAg tests for pregnant women as a stand-alone assay and/or as part of a prenatal/obstetric panel to facilitate reporting HBsAg-positive women to health departments. A summary of the available prenatal HBsAg tests can be found in the table below.

**When ordering an HBsAg screening test for a pregnant or postpartum patient from ARUP Laboratories, LabCorp, Mayo Medical Laboratories, or Quest Diagnostics, please choose a test designated as “Prenatal.” The success of timely identification and confirmatory testing for HBsAg-positive pregnant women is dependent on physician and hospital uptake of the designated prenatal HBsAg tests ordered from these laboratories.**

HBsAg-positive pregnant women should be reported to the Georgia Department of Public Health within 7 days of laboratory confirmation. Reports can be made via the State Electronic Notifiable Disease Surveillance System (SendSS) or by phone at 404-651-5196. A laboratory test code/ID table can be found at: [http://immunizationforwomen.org/uploads/Prenatal%20HBsAg%20Testing%20Guide%20and%20Algorithm_Final.pdf](http://immunizationforwomen.org/uploads/Prenatal%20HBsAg%20Testing%20Guide%20and%20Algorithm_Final.pdf)
that they are leaking urine. Some of complaints. Some women recognize added to our list. Women experiencing issues, and incontinence needs to be caring about their most intimate personal and embarrassing problems. in asking patients about many deeply addressing this problem. Considering the social stigma and diaper-market-is-about-to-take-off.) news/articles/2016-02-11/the-adult-billion was spent on incontinence

• SIGNIFICANT SAVINGS
10,000 private practices nationwide. Join Today!

866-348-9780

An Unpopular Problem

Lillian Schapiro, MD
Gynecologist, Ideal Gynecology, Atlanta, GA

Your patient may just need to be given permission to take time to take care of herself. Dietary modifications, such as cutting out or reducing caffeine can make a significant impact on more than one type of urinary incontinence. Time voiding may also help.

The next steps involve muscle training, such as Kegel exercises. This training may start postpartum or later in life. In several European countries, such as France and Belgium, women get postpartum home visits for several months and patient education often includes special attention to the pelvic floor muscles.

Pelvic floor muscles can be hard to identify and visual biofeedback can be essential in helping women do their Kegels correctly. Specialized equipment and staff well versed in the anatomy of the pelvic floor and challenges of childbirth are needed for this phase of intervention for urinary incontinence. The initial visit often takes well over an hour, as women have been keeping this to themselves for years and are greatly relieved to have someone with whom to discuss this.

While we may think of incontinence as an issue of aging, the problem often starts while they are our obstetric patients. Early intra or postpartum education may help reduce problems later. Once those problems develop, as always emptying the bladder before driving home, or before any lengthy period of time when a toilet won’t be available, is good simple advice. Teachers and nurses are busy the entire day and are notorious for not taking time to empty their bladders.

Hillary’s National Association for Continence (NACF) found that women wait an average of 6.5 years before bringing up incontinence to a physician, so most women are hoping that you will bring it up. It is a complicated socio-sexual issue, connected to women’s fear of aging, declining self-worth and sexual attractiveness. Women are somewhat socially acceptable to talk about bleeding through your clothing, it is not seen as appropriate to talk about yourself as an adult.

The initial evaluation for incontinence lasts an hour. A history can be very helpful in identifying the type of incontinence. The NACF has an extensive list of questions on their website to fully assess a woman’s incontinence. If she only leaks when she coughs, sneezes, runs or jumps, that is indicative of stress urinary incontinence. This is due to the lack of support in the pelvic floor, often caused by previous pregnancies and childbirths, but women who have never been pregnant can also experience pelvic floor muscle weakness. Patients who complain of difficulty making it to the bathroom or losing urine when they get home before they can get to the bathroom are likely to have urge incontinence or overactive bladder. Frequency and urgency with negative urine cultures may be an indication of interstitial cystitis.

Pharmacological and nonsurgical interventions are the first line of treatment. Modifying behaviors, such as always emptying the bladder before driving home, or before any lengthy period of time when a toilet won’t be available, is good simple advice. Teachers and nurses are busy the entire day and are notorious for not taking time to empty their bladders.

The Maternal/Obstetrical Outreach Coordinator

As many of you are aware, the Georgia Department of Public Health has divided the state into six perinatal regions, with one DPH-designated Regional Perinatal Center (RPC) serving each of those regions. Do you know which RPC is in place to serve you? Besides providing comprehensive perinatal health services for pregnant women, their fetuses and neonates of all nine risk categories, the RPCs provide several other services.

Among the services your Regional Perinatal Center (RPC) provides, let’s consider the role of the “Outreach Coordinator.” There is an Obstetrical and Neonatal Outreach Coordinator representing each of the six states. My name is Kathy Brinson, and I am the Maternal (Obstetrical) Outreach Coordinator for the southwestern part of the state. My ‘home base’ is Phoebe Putney Memorial Hospital, located in Albany, I want to tell you a little of what my role entails. As the OB Outreach Coordinator, I provide and maintain open lines of communication between the RPC and the referral hospitals, and community health providers) by several means of communication—including facility visits. With my neonatal counterpart, I help coordinate “neonatal needs assessment” in each hospital in our region that offers obstetric services. The “needs assessment” includes the identification of each facility’s needs and the subsequent needs each facility might have. Conducting these assessments gives me a better idea of what the needs of each facility are. Assuring the latest evidence-based practice and most up-to-date information is my primary goal.

In addition to conducting the annual “needs assessment,” my role entails planning the curriculum and teaching the courses. As Outreach Educator, I also serve as a resource to those who call and need answers to questions. Collecting and using perinatal data, writing reports and maintaining informative working relationships between community personnel and the outreach team members is also part of my job. As Outreach Educator, I also have a role in following up with the maternal transport services received at Phoebe Putney Memorial Hospital.

My primary job is to coordinate staff education in the Albany region, to teach a variety of classes and ‘run’ simulation drills in all seven of the hospitals with OB services, and teach some classes in the facilities that do not offer OB services. The list of classes I teach include (but is not limited to) the following:

1. Fetal Monitoring courses— I am certified in Electronic Fetal Monitoring, and interpretation of fetal heart monitoring strips is one of my most conducted courses. I teach a 4-hour Basic Fetal Monitoring course for new OB nurses and staff, and teach a “thumb-nail sketch” of basic fetal monitoring as a review. An Antepartum Fetal Surveillance class is another fetal monitoring course option. I have taught the Basic Fetal Monitoring course in a physician’s office, to the staff to work as a non-obstetric stress test there, so my service is not limited solely to the hospital. Besides the Basic Fetal Monitoring courses, I am an instructor of the Association of Women’s Health, Obstetric & Neonatal Nurses (AWHONN) Intermediate and Advanced Fetal Monitoring courses, and I teach a Neonatal Simulator (Sim-Newbee®) course as well.

2. Postpartum Hemorrhage & Shoulder Dystocia Drills are conducted with the high-fidelity birthing simulator, Noelle®. I make these drills as ‘real’ as possible, involving the blood bank and pharmacy in the hospitals where we ‘run’ the drills. Scenarios are presented, and the staff responds. Scenarios are presented, and the staff responds appropriately. The drills are most beneficial when all disciplines participate. Please feel free to let me know if you see an opportunity for improvement!
Winter Symposium

Saturday, February 11th, 2017

Atlanta Marriott, Buckhead

Topics include zika, NAS, perinatal depression and STIs from the obstetric and pediatric perspectives