The Provider Tune Up is Smart, Safe & Vital

- Increase reimbursement.
- Increase billing encounters.
- Bridge compliance gaps.
- Identify/address/reduce gaps-in-care.
- Improve patient RAF scores.
- Increase shared savings.
- Improve MIPS score.
- Maximize payment adjustment under the QPP & MACRA.
- Improve patient satisfaction.
- Reduce operating costs.
- NO additional workload.
- NO staffing requirements.
- And more.

Live Well A.P.S., Inc. — Who We Are

We subscribe to the motto — In an environment of government "incentivized" regulations, superior business intelligence is the ONLY way to triumph.

We are a contracted agency and facilitator for leading experts that specialize in the processes of MIPS (QPP & MACRA), RAF Compliance, Health Information Exchange, and Patient Outreach Optimization for financial ROI.

Together we support thousands of independent and hospital-based physicians & clinicians, multi-TIN, Medicare Advantage plan providers, and ACO and Advanced APM members. And we deliver **Maximum Value** with vital CMS program guidance and the most effective and innovative clinical and non-clinical business solutions that improve compliance, patient

Most Medicare Providers are Failing to Meet Requirements on at Least One of These Categories: 1) RAF, 2) Patient Outreach, 3) Health Information Exchange, and 4) MACRA Compliance

CMS's Risk Adjustment Data Validation (RADV), Transactional Coding of Diagnoses Final Rules, the National Quality Strategy (NQS), and payment adjustments under the QPP & MACRA have begun. These have and will continue to create a significantly higher risk of an audit and could have a serious impact on reimbursement.

The ***Provider Tune Up Platform*** is a vital and proactive solution for all MIPS eligible and exempt TINs, physicians, clinicians, ACO and Advanced APM members, and all payor classes (Medicare, Medicare Advantage, Medicare Shared Savings Plans (MSSP), Medicaid, Commercial – Insured and Employer Self-Funded Plans, and other Risk Based Reimbursement Plans).

We help you properly address ***RAF Compliance, Patient Outreach, Health Information Exchange,*** your and (if you are MIPS eligible) ***MACRA Optimization*** issues *(See our website for more details on each category).*

Compliance is Now Incentivized

Though most TINs did a good job meeting compliance in the past, due to complexity and the failure of vendors and health plans to provide TINs and their providers with the proper expertise, tools, and/or training, 98% are **NOT** meeting requirement benchmarks and targets on at least one, but for some, all four categories.

Administrators even boast about their Quality scores, robust risk adjustment, abstract coding and QA audit teams, and provider education. Unfortunately, too many are still apathetic about verification and action needed, because up until now, fully meeting requirements has not amounted to any significant increase in revenue. This has now changed.

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So, now when ownership, boards, and/or stakeholders ask why your TIN's reimbursement has been reduced or why you failed to maximize reimbursement and/or the payment adjustment under the QPP & MACRA, and no one can explain why or do anything about it, ignorance or apathy will not be an accepted excuse. **Don't let this to happen to you!**

RAF Compliance Optimization

All payors view the Risk Stratification and the manner that patients are treated based on the allocated risk identified from patient RAF Scores. Just a quarter-point increase in a patient RAF Score translates into an extra $3,000 per year to a Medicare Advantage plan or ACO and higher reimbursement and/or shared savings for the provider.

In addition, providers may not be accepted into an ACO, MSSP, or be allowed within a network of commercial payors without acceptable patient RAF Scores.

To drive higher reimbursement, MA plan providers and ACOs often seek to identify diagnoses which will result in higher patient scores. But this requires focus on the coding of a patient's diagnoses, and not necessarily on how well each condition is being managed. In other words, creating an overemphasis on coding instead of on caring. This method reviews a patient's medical record, typically after the patient encounter, to identify opportunities for "upcoding" the diagnosis. For example, if a diabetes diagnosis can be coded as having neurological manifestations, the risk score will be higher, as will the reimbursement.

There are a flurry of software products coming to and on the market claiming to help identify opportunities to optimize or manage risk, but in reality, they are just a veiled way of upcoding. They do NOT provide you with tools at the point of care for the patient; that is, properly manage, evaluate, assess, and treat a patient's various conditions in accordance with the original intent of VBC: **Improved Outcomes Through Better Management of Patient Health.**

A comprehensive clinical care approach to VBC, as opposed to an approach that focuses on the transactional coding of diagnoses to maximize risk scores, requires a solution that enables you to quickly see the status of any known or suspected condition.

The platform will make the efficient management of patient care as easy as 1-2-3 and can create the increase in reimbursement you desire. It will empower you with instant access to the information and data you need to manage and code each patient's specific diagnoses – as well as create the documentation that supports the coding. In addition, allow you to act upon information immediately and satisfy potential Quality Care and CMS/MA audits.

It is an advanced system that effortlessly navigates the complexities of patient diagnostics to optimize patient RAF Scores. The exclusive, compliance-focused intelligence retrieval technology guides credentialed intake providers through an infallible step-by-step validation process.

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It Reflects the Health Status of a Patient Population Accurately and Compliantly, Which Makes It a Vital Tool for All Providers.

Patient Outreach Optimization

Increasing Quality of Care starts by directly assessing and highlighting gaps in care at the individual patient level. You are required to gather specific standardized and health risk assessments on up to 60% of your entire patient population and integrate this data into your EHR system. And this applies to all payor classes (Medicare, Medicare Advantage, Medicare Shared Savings Plans (MSSP), Medicaid, Commercial – Insured and Employer Self-Funded Plans, and other Risk Based Reimbursement Plans).

Under Value-Based Care and Standards of Care Guidelines, where a medical necessity is found, action must be taken, unless the patient declines the service. Failing to do so can result in the reduction of Quality Scores and/or the penalty of lower reimbursement. But even if you're doing Annual Wellness Visits (AWVs) and Health Risk Assessments (HRAs) for every patient, you must act on any medical necessities found within those results. And each time a patient encounter is completed, new medical necessity "next steps" must be immediately identified. And the NQS will expand this policy.

The platform provides electronic beneficiary engagement and completion of the assessments.

Specific types of assessments are sent to your entire patient population throughout the year for completion including Health Risk Assessments, Social Determinants of Health Assessments, and others. They are delivered electronically via email and/or text/SMS and designed to gather relevant health information and engage patients in between visits, as well as obtain updated contact information as part of the process. Then patients can be engaged based on their low, moderate, or elevated risk.

The gathered information is helpful at identifying elevated health risks and prompt the patient to come into the office prior to next scheduled visit. Thus, potentially helping to minimize hospital admissions and Urgent Care or ER visits. The patient is also asked to confirm and consent to the provider's review of the assessment results, which will result in a billable E-visit.

Assessments are also designed to gather the maximum relevant health information. Whether the treatment standard is MIPS, HEDIS, STAR or Quality Care Measures, the platform pivots to those measures.

Patient communications are a combination of compliance statements and rewards that creates a **45-65%** response rate, while the response rate of all other patient engagement methods is in the low to mid-single digits. The best part, in as little as 30-45 days the platform can significantly improve billing encounters.

Patient Assessments that Reflect Health Statuses Accurately and Compliantly Are the Cornerstone for Increasing MIPS, HEDIS, and Patient RAF Scores. In Addition, Increasing Billing Encounters and Reimbursement.

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HIE Optimization

The CMS NQS advances electronic health information exchange and streamlines cumbersome health care processes by establishing standardized requirements across the industry. These rules reflect the deep collaboration between CMS and ONC to ensure that providers and payers adopt common, open-industry standards to advance interoperability and industry innovation.

It develops and expands the requirements for sharing, receipt, and use of digital data, including digital Quality Measures, across CMS Quality and Value-Based programs. And to transition to all digital Quality Measures and digital data collection by 2030 to reduce burdens and enable timely availability of quality data.

You are required to share and have access to patient data and compile and collect data for use in treating patients. But what makes this difficult is the goal post is moved every year and the NQS will make it more difficult for TINs to navigate compliance, which will subject them to a penalty of lower reimbursement.

To ensure you avoid the penalty and improve reimbursement, you must make the commitment to optimize your EHR and improve your Referral Network pathways. If you don't, this oversight will cost you a lot of money. In addition, to avoid non-compliance, you must use the compliance requirements as part of your broader strategy around interoperability and patient engagement.

While the rules present significant challenges, they also provide an impetus to gather new levels of clinical data. And if you're looking to do more than check the box, it will allow you to turn your compliance into a competitive advantage by developing new services in line with Value-Based Care such as CCM, RPM, and more.

MACRA Optimization

Up until 2022, the QPP & MACRA was just a compliance checkbox issue and a nuisance. But now all MIPS eligible TINs, physicians, and clinicians receive a positive or negative payment adjustment on their Medicare Part B claims submissions. And it is estimated that up to **$3.6 billion** will be redistributed to 2022 top MIPS performers in 2024.

Though most TINs have done a good job meeting quality measures, many are being penalized or missing the opportunity to qualify for the maximum positive payment adjustment of 9%.

MACRA requirements make up of thousands of pages of regulations in the Federal Registry and are a very complicated beast and no small task to manage or optimize. And the CMS NQS is adding even more complexity.

The MACRA Optimization Cycle

Optimization consists of a 9-step process that can only be achieved with an ***Active*** or ***On-Going Program*** that follows a regiment of extract, report, analyze, plan, and act for each quarter or month. And only by taking each

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step can you earn exceptional Category Weights and a Final MIPS Score that will qualify for the maximum payment adjustment in the next PAY.

MACRA is much more than a year-end submission exercise or a periodic measure calculation. You can't improve performance by looking at your metrics after the year is over. And simply making numbers available a couple times a year only improves things a little.

At times your Category Weights and MIPS score may not be complete and/or accurate. And while some solutions can be applied retroactively, many require that coders or physicians change the way they describe things, or even change physician behavior.

Many so-called MIPS or MACRA experts (vendors) give lip service to CMS quarterly or monthly requirement of integration and feedback. They get by with a dashboard that clients can look at any time. Such a passive approach is **NOT** reliable. The fact is – a dashboard is the least reliable of all.

Payment Adjustment Remittance Verification

You need to verify the payment adjustment on each claim you submit because it will not be easy to identify and will require a bit of calculation to show if it's correct. It will show as a dollar amount on your Remittance Advices, but to determine if it is accurate you will need to convert it to a percentage and compare it to the expected percent for the submitting physician, which will not appear on your Remittance Advices.

The Payment Adjustment Remittance Verification pulls the expected percent from the CMS / QPP database and compares that value to the value calculated on your Remittance Advices.

The Provider Support You Need

All our category services are offered on a Clinic-by-Clinic basis and tailored to each clinic's specific needs, which can change from one year to the next. They require very little workload and no additional staffing requirements on your part, and for less than the cost of a single new hire.

We deliver **Maximum Value** and make the decision on whether to invest in optimization or stay the course with your ACO, vendor(s), or your own efforts, very easy.

The ***Provider Tune Up Platform*** is the empowering solution that will ensure you meet all category requirements and maximize reimbursement.

Data Analysis

Unlocking Financial Rewards starts with a ***RAF Verification Analysis***, and maximizing your payment adjustment begins with the ***MIPS Category Weights Data Analysis.***

To determine the best course of action, we must first find out exactly where you are hitting and where you are missing. We will utilize publicly available CMS data, and data you supply us from your QP P Detailed Final Report, ACO, MA Plan(s), Electronic Medical Records (EHR) system, Practice

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Management System, and/or other manual sources. The RAF Verification Analysis requires the execution of a BAA.

Take the Next Step

In a 30-minute Zoom call, we will talk more about the ***RAF Verification Analysis*** and/or ***MIPS Category Weights Data Analysis*** and how much more revenue we can help you can capture.

Log onto our **Provider Tune Up** webpage and complete our Mutual NCND and email it to: **support@livewellaps.com**. Then reserve a Zoom call with us. On our Calendly page, compete the required fields and when asked purpose of call click: ***Provider Tune Up.***