“GATEKEEPERS OF HEALTHCARE”
Primary Care in a Quality-Measured World

Presented by:
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What is Primary Care?

Wikipedia describes Primary Care as “the day-to-day healthcare given by a health care provider” who “acts as the first contact and principal point of continuing care for patients... and coordinates other specialist care...”

Primary Care Professionals:
- General Practitioner or Family Physician
- Nurse Practitioner (adult-gerontology, family, pediatric)
- Physician Assistant
Primary Care

Primary Care Providers often collaborate with other health professionals via consultation or referral.

AAFP – “Primary Care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in healthcare.”
Primary Care

Primary Care is usually the first contact and continuing care for patients with any undiagnosed sign, symptom, or health condition or diagnosis.

ROLE:
- Health promotion
- Disease prevention
- Health maintenance
- Counseling
- Patient education
- Diagnosis and treatment of acute/chronic illnesses if a variety of settings
Primary Care

• PHYSICIANS (M.D. or D.O.): Family Medicine, Internal Medicine, Pediatrics

• NON-PHYSICIAN PRIMARY CARE PROVIDERS: Nurse Practitioners, Physician Assistants, and some other health care providers

  ṭ Serve as part of the collaborative team
Terminology - Quality

- **Quality measures** – tools to “measure” healthcare processes, outcomes, patient perceptions, and organizational structure associated with the ability to provide high-quality health care that relates to one or more quality goals
- **Quality measurements** – using data to evaluate performance of health plans and health care providers against recognized quality standards
- **Quality health care** - “the right care for the right person at the right time, the first time” that is safe, timely, effective, efficient, equitable, and patient-centered (AHRQ, Institute of Medicine Domains)
Terminology - Value

**Value-Based Payment Models** – Aim is to reduce the growth spending rate while improving patient satisfaction and outcomes.

- Built to transition from a fee-for-service payment methodology
Terminology is changing

“FEE-FOR-SERVICE”

“PAY-FOR- PERFORMANCE”
Quality Measures

“VALUE-BASED”
Reimbursement
Quality Healthcare?

Å Institute of Medicine (IOM) Domains

- **Effectiveness** – Supported scientific evidence of care processes and achieving outcomes
- **Efficiency** – Maximizing quality health care delivery or health benefit achieved
- **Equity** – Equal quality of health care to patients who may differ in personal characteristics other than their clinical condition or preferences for care
- **Patient centeredness** – Meeting patient needs and preferences; providing education and support
- **Safety** – Actual or potential bodily harm
- **Timeliness** – Minimizing delays for obtaining needed care
Patient Responsibility?

- Institute of Medicine’s Framework of Consumer’s Perspectives
- Reporting categories were developed based on Foundation for Accountability (FACCT) research showing how consumers think about their care:
  - Staying Healthy – Getting help to avoid illness and remain well
  - Getting Better – Getting help to recover from an illness or injury
  - Living with Illness or Disability - Getting help with managing an ongoing, chronic condition or dealing with a disability that affects function
  - Coping with the End of Life – Getting help to deal with a terminal illness
How did we get here?

Â 1965 Congress passed legislation which established the Medicare and the Medicaid programs

Â 1965 Congress established a set of conditions called “Conditions of Participation” for hospitals

Â 1972 Medicare pilot projects called “Professional Standards Review Organizations (PSROs) set into motion the goal of high-quality care

Â 1983 PSROs were placed by the utilization and quality control Peer Review Organizations (PROs)
How did we get here?

Å 1989  Creation of Agency for Health Care policy and Research (currently, Agency for Healthcare Research and Quality [AHRQ])

Å 1990  Establishment of National Committee for Quality Assurance (NCQA) – measured accreditation performance through *HEDIS and *CAHPS

Å 1995-2000  Several quality improvement initiatives, task forces, and sentinel reports were initiated and published

Å 1999  The National Quality Forum (NQF) (nonprofit organization) was established with the mission of improving quality of healthcare

*HEDIS = Healthcare Effectiveness Data and Information Set
*CAHPS = Consumer Assessment of Healthcare Providers and Systems
How did we get here?  HMO’s

- It’s interesting to note that group managed care did not exist prior to the 1970’s
- The “network model” by HMO’s began in the 1990’s
  - HMO’s contracted with combination of groups and individual physicians
  - Most HMO’s were managed care organizations with other lines of business (such as PPO, POS, and indemnity)
How did we get here?  HMO’s

Å HMO’s require(d) members to select a Primary Care Physician (PCP) who would act as a “gatekeeper” for direct access to medical services

ï Their list of PCP’s included internists, pediatricians, family doctors, geriatricians, and general practitioners

Å The financial benefits

ï Fee-for-service payments to PCP’s
ï Capitation to Specialists
How did we get here? HMO’s

Å The purpose of the HMO model was cost containment
  • Control utilization
  • Patient cost sharing (Co-pay)
  • Case management – assigning a case manager to the patient or a group of patients with certain chronic disease (i.e. diabetes, asthma, some forms of cancer)

Å HMO’s often have a negative public image due to their restrictions
  • Many have been the target of lawsuits claiming HMO prevented necessary care
How did we get here? HEDIS

Â HEDIS was originally titled the “HMO Employer Data and Information Set) in 1991
Â Changed in 1993 to “Health Plan Employer Data and Information Set”
Â The purpose of HEDIS was not intended for trending but for consumers to compare health plans performance to other plans
Â In 2007, NCQA changed it to “Healthcare Effectiveness Data and Information Set”
How did we get here?  HEDIS

Å HEDIS data are collected through surveys, medical records, and insurance claims for hospitalizations, office visits, and procedures

Å “Measures” are updated yearly

Å Unfortunately, a disadvantage of HEDIS is that measures do not account for many important aspects of health care quality

ï They count only a select set of healthcare interventions for specific at-risk patient populations and report if institutions and providers are giving adequate care
How did we get here? HEDIS

HEDIS 2017 Measures (highlights) – Applicable to Commercial, Medicaid, and Medicare

- **Adult:**
  - BMI Assessment
  - Cancer Screenings (Breast, Cervical, Colorectal)
  - Chlamydia Screening in Women

- **Children/Adolescents:**
  - Weight Assessment, Counseling for Nutrition and Physical Activity
  - Immunization Status
  - Lead Screening
  - Follow-up care for Children prescribed ADHD medication
How did we get here?  HEDIS

Å HEDIS 2017 Measures (highlights) – Applicable to Commercial, Medicaid, and Medicare

ï Chronic Conditions
   Å Pharmacotherapy Management of COPD Exacerbation
   Å Asthma Medication Management
   Å Controlling High Blood Pressure
   Å Statin Therapy for patients with Cardiovascular Disease
   Å Disease Modification for Rheumatoid Arthritis
   Å Osteoporosis Management in Women who have had a fracture
   Å Anti-depression medication management
How did we get here?  HEDIS

To get the entire list of HEDIS 2017 Measures, NCQA Website: http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017

11 pages of changes and list of measures by categories:
- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems
How did we get here?

2003 Surgical Care Improvement Program (SCIP) was created to reduce surgical complications and mortality—targeted measures were related to (1) infection prevention or (2) reducing surgical complications (venous thromboembolism)

2003 Hospital Inpatient Quality Reporting (IQR) – intention to guide hospitals and providers toward improving inpatient care through an incentive. Publicly available through the Hospital Compare website

2006 Physician Quality Reporting Initiative (PQRI), changed to PQRS in 2011, a voluntary pay-for-reporting program— incentive payments for successfully reporting on a minimum of 3 quality measures- reporting period CY2007

2010 With the passage of the Patient Protection and Accountable Care Act (PPACA), the law’s central objective was to improve quality while lowering healthcare costs and expanding access
How did we get here?  PQRS

- PQRS was formerly known as PQRI (Physician Quality Reporting Initiative) – a “voluntary” quality reporting program
- Incentive program initiated by CMS in 2006
  - Also called “Pay for Performance” which financially rewards providers for reporting health care quality data
- “EP’s” (Eligible Professionals) are defined as Medicare physicians, practitioners, and therapists (PT, OT, SLT)
- EP’s can report as an individual or group practice (GPRO)
- Subject to negative payment adjustments due to not satisfactorily report quality measures
How did we get here?    PQRS

Â CMS updates quality measures yearly
Â Specialty Measure Sets (17 different specialties) are not required measures but are suggested measures
Â Complicated system with prerequisite denominator-numerator criteria
  ï Denominator – intended patient population for the measures groups
  ï Numerator – each individual measure defines the quality actions available
    Â Performance Met
    Â Performance Exclusion
    Â Performance Not Met
    Â Not Reported
How did we get here? PQRS

- Registry-based submission
  - Minimum sample of 20 patients
    - Majority (11 of 20) must be Medicare Part B FSS patients
  - Reporting Period: January 1 through December 31
    - Applicable measures must be reported at least once for each patient

- Feedback Reports to EP’s and PQRS group practices
  - Usually in the Fall of the following year
  - Reports indicate satisfactory or unsatisfactory reporting

- PQRS transitioning into MIPS beginning January 2017
### How did we get here?

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td><strong>2010</strong></td>
<td>Patient-Centered Outcomes Research Institute conducted research and compared clinical effectiveness of medical treatments – findings produced treatment algorithms that support patient-centered, evidence-based, high quality care</td>
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<td><strong>2012</strong></td>
<td>Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing Program, and Hospital-Acquired Condition (HAC) Reduction Program were rolled out</td>
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<td><strong>2015-2016</strong></td>
<td>All providers eligible for the incentive payments become subject to penalties for failing to participate – began with 1.5% reduction in reimbursement but increased to a 2% reduction in 2016 and beyond</td>
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<td><strong>2017</strong></td>
<td>PQRS moving to MACRA, MIPS, APM’s...</td>
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The Transition from Quality to Value-Based

On October 14, 2016, CMS released the final rule for “Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)”

MACRA repeals the Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula and replaces it with a new value-based reimbursement system called “Quality Payment Program (QPP)"

Two Tracks
- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advances APMs)
The Transition from Quality to Value-Based

MIPS will impact the management and reporting of performance measures inherited from Meaningful Use (MU), Physician Quality Reporting System (PQRS), and Value-Based Modifier (VBM)

- MIPS will consolidate the financial impacts of these programs
- MIPS payment adjustments will be applied to Medicare Part B payments two years after this performance year (CY2019)
Value Based Programs – Time Line

LEGISLATION
- ACA: Affordable Care Act
- MIPPA: Medicare Improvements for Patients & Providers Act
- PAMA: Protecting Access to Medicare Act

PROGRAM
- ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
- HACRP: Hospital-Acquired Condition Reduction Program
- HRRP: Hospital Readmissions Reduction Program
- HVB: Hospital Value-Based Purchasing Program
- MIPS: Merit-Based Incentive Payment System
- VM: Value Modifier or Physician Value-Based Modifier (PVBM)
- SNFVB: Skilled Nursing Facility Value-Based Purchasing Program
Back to Primary Care as Gatekeepers

Considering the new payment models, the question is how will the value-based care delivery work?

Value-based care will transform the care delivery model to groups of peers treating similar patients in a shared setting and using agreed upon clinical guidelines and disease management protocols.

Physicians will be required to work as part of the team.

WHO WILL MANAGE THE TEAM??????
PROS – Primary Care as Gatekeepers

If we go back to the definition of Primary Care, we understand that the PCP (Primary Care Provider) coordinates care.

They regulate patient access to specialists.

Help in early detection of preventable illnesses and diseases.

Provides valuable medical history to other specialists, thus increasing communication among physicians, allowing for quicker diagnosis, and lessens the patients burden of deciding their own health care path.
CONS – Primary Care as Gatekeepers

- Public perceptions – PCP’s do not know have sufficient medical knowledge to make a diagnosis for their condition – “I need to go to a specialist”
- Lack of access to PCP’s (number of PCP’s)
- Lack of insurance coverage, not eligible for Medicare or Medicaid, or can’t pay for out-of-pocket expenses
Primary Care - Gatekeepers

Who is going to manage the health care team?

The new value-based care delivery model will significantly increase the demand for PCP’s and extenders to do what they do best.
In 2012, CMS rolled out a new initiative, the Comprehensive Primary Care (CPC) Initiative and described it “will strengthen primary care”

It is a four-year, multi-payer initiative

Since the CPC’s launch, CMS collaborated with commercial and State health insurance plans in seven regions that offered population-based care management fees and shared savings to participating PCP’s

The initial testing regions were to determine if this model can achieve improved care, better health for populations, and lower costs, and can inform future Medicare and Medicaid policy
Comprehensive Primary Care: 2016 Fast Facts

Primary care transformation occurred in 441 practices across the 7 CPC regions

(number of participating practices in bold)
Comprehensive Primary Care Initiative

- Five core primary care functions
  - Risk-stratified Care Management;
  - Access and Continuity;
  - Planned Care for Chronic Conditions and Preventive Care
  - Patient and Caregiver Engagement
  - Coordination of Care across the Medical Neighborhood
Comprehensive Primary Care Plus

CMS launched a newer initiative in January 2017

Five-year advanced primary care medical home model called Comprehensive Primary Care Plus (CPC+)

14 regions including the original 7 CPC regions
Arkansas • Colorado • Hawaii • Greater Kansas City Region of Kansas and Missouri • Michigan • Montana • North Hudson-Capital Region of New York • New Jersey • Ohio and Northern Kentucky Region • Oklahoma • Oregon • Greater Philadelphia Region of Pennsylvania • Rhode Island • Tennessee
CPC+

Practices in both CPC and CPC+ will make changes in the way they deliver care centered on the key CPC Functions:
1. Access and Continuity;
2. Care Management;
3. Comprehensiveness and Coordination;
4. Patient and Caregiver Engagement; and
5. Planned Care and Population Health

PAYMENT ELEMENTS:

1. Care Management Fee
2. Performance-Based Incentive Payment
3. Medicare Physician Fee Schedule
CPC+ Care Management Fee

- Both CPC and CPC+ provide a non-visit-based payment per beneficiary per month.
- The amount is risk-adjusted for each practice to account for the intensity of care management services required for the practice’s specific population.
- Paid on a quarterly basis.
CPC+ Performance-Based Initiative

CPC+ will prospectively pay and retrospectively reconcile a performance-based incentive based on how well the practice performs on:

- Patient experience measures;
- Clinical quality measures; and
- Utilization measures that drive total cost of care
CPC+ Physician Fee Schedule

Track 1 continues to bill and receive payment from Medicare FFS as usual.

Track 2 practices also continue to bill as usual but the FFS payment will be reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which will be paid in a lump sum on a quarterly basis absent a claim.

- It is anticipated that CPCP amounts will be larger than the FFS payment.
CPC+ More to come – Round 2

Å CMS opened solicitations for payers and practices between February 17 and April 3, 2017
Å The next model should being January 1, 2018
Å Practices located in up to 10 new regions will be eligible to apply in summer 2017
   ï Practices located in the 14 (Round 1) regions are not eligible to apply to CPC+ Round 2
Å CMS will accept a maximum of 5,500 practices across Round 1 and Round 2
CPC+ Practice Eligibility – Tracks 1 & 2
CPC+ Practice Eligibility – Tracks 1 & 2

**TRACK 1**
- Must have at least 150 attributed Medicare beneficiaries
- Must have support from CPC+ payer partners
- Must use CEHRT
- Existing care delivery activities must include:
  - Assigning patients to provider panel
  - Providing 24/7 access for patients
  - Supporting quality improvement activities

**TRACK 2**
- All of Track 1 plus:
  - Developing and recording care plans
  - Following up with patients after ED or hospital discharge
  - Implementing a process to link patients to community-based resources
  - Must apply with a letter of support from health IT vendor that outlines the vendor’s commitment to support the practice in optimizing health IT
CPC+ Five Functions

Access & Continuity

Comprehensiveness & Coordination

Care Management

Planned Care & Population Health

Patient & Caregiver Engagement
## CPC+ Access & Continuity

<table>
<thead>
<tr>
<th>TRACK 1</th>
<th>TRACK 2</th>
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<tbody>
<tr>
<td>Å Empanelment</td>
<td>Å Same as Track 1, plus</td>
</tr>
<tr>
<td>Å 24/7 patient access</td>
<td>Å Alternative to traditional office visits (e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours)</td>
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<tr>
<td>Å Assigned care teams</td>
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## CPC+ Care Management

**TRACK 1**
- Risk stratified patient population
- Short-term and targets, proactive, relationship-based care management
- ED visit and hospital follow-up

**TRACK 2**
- Same as Track 1, plus
- Two-step risk stratification process for all empaneled patients
- Care plans for high-risk chronic disease patients
## CPC+ Comprehensive & Coordination

### TRACK 1
- Identification of high volume/cost specialists
- Improved timeliness of notification and information transfer from ED’s and hospitals

### TRACK 2
- Same as Track 1, plus
- Behavioral health integration
- Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs
- Collaborative care agreements
- Development of practice capability to meet needs of high-risk populations
<table>
<thead>
<tr>
<th>TRACK 1</th>
<th>TRACK 2</th>
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<tbody>
<tr>
<td>At least annual Patient and Family Advisory Council</td>
<td>Same as Track 1, plus</td>
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<tr>
<td>Assessment of practice capabilities to support patient self-management</td>
<td>At least bi-annual Patient and Family Advisory Council</td>
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<tr>
<td></td>
<td>Patient self-management support for at least three high-risk conditions</td>
</tr>
<tr>
<td>TRACK 1</td>
<td>TRACK 2</td>
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<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>À At least quarterly review of payer</td>
<td>À Same as Track 1, plus</td>
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<tr>
<td>utilization reports and practice cCQM</td>
<td>À At least weekly care</td>
</tr>
<tr>
<td>data to inform improvement strategy</td>
<td>team review of all population health</td>
</tr>
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<td></td>
<td>data</td>
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## CPC+ Three Payment Structures

<table>
<thead>
<tr>
<th>Objective</th>
<th>Care Management Fee</th>
<th>Performance-Based Incentive Payment</th>
<th>Payment Structure Redesign</th>
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<tbody>
<tr>
<td>Support augmented staffing and training for delivering CPC</td>
<td>Support augmented staffing and training for delivering CPC</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting</td>
</tr>
<tr>
<td>Track 1</td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>N/A (Standard FFS)</td>
</tr>
<tr>
<td>Track 2</td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective CPC payment</td>
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CPC+ Ineligible Practice Types

**Pediatric Practices**
CPC+ practices must include at least 150 eligible Medicare fee-for-service beneficiaries and pediatricians generally do not treat Medicare patients.

**Concierge Practices**
Retainer fees usually replace traditional co-insurance under Medicare fee-for-service and/or conflict with CPC+ Care Management Fees.

**Rural Health Clinics**
RHCs do not submit claims on a Medicare Physician/Supplier claim form and are not paid according to the Medicare Physician Fee Schedule for routine office visits.

**Federally Qualified Health Centers**
FQHCs do not submit claims on a Medicare Physician/Supplier claim form and are not paid according to the Medicare Physician Fee Schedule for routine office visits.
CMS Innovations Website:
Summary

Primary Care will continue to be the “gatekeepers” of healthcare as part of a Patient-Centered Medical Home to include a team of healthcare providers.

Next Step: Solve the shortage of Primary Care physicians.
QUESTIONS?

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