Advanced Primary Care-MACRA-ABFM

MAY 3—2017

What’s happening, what’s new, and what should the NYSAFP do-a map to QPP so that we can plan to support primary care and the public’s health

Introduction

Before we start, let me point out that if you are reading this, you belong on the Task Force on Advanced Primary Care. Sign up with …. [me? Donna? Kelly? Sarah? Not at all?]

Under our NYSAFP president Bob Ostrander’s direction, we were asked to assemble a task force to map out the landscape of what was then called Value Based Payments [VBP]. Our original effort was to discover the attitudes and plans at the major insurance carriers. The Medicare program, which flows from MACRA rules [The Medicare Access and CHIP Reauthorization Act of 2015], is now called QPP or the Quality Payment Program.

I want to state clearly that our goal is to promote true Advanced Primary Care (judged and defined by desirable outcomes achieved). Our interactions with the payers are to #1 encourage QPPs that do that, and #2 and perhaps more importantly right now, to figure out how to limit the damage of poorly designed QPPs.

Where do we state the precept: Any approach that requires a small independent practice to use a complex toolkit from the AAFP or hire consultant is misguided. It diverts resources from patient care and true CQI (or current collection of letters for this.)

Many payers still cling to the name Value Based Payment, which presumptively stands for ‘quality over quantity.’ Although all data points to insufficient QUANTITY of primary care, we seem to be at the focus of this demonstration from a practical point of view.

These QPP programs sprang from a bipartisan federal law to shift Medicare payments. The two programs under QPP are the Merit-based Incentive Payment System-MIPS, and advanced Alternative Payment Models-APM.

It gets more complex.

VBP is focused on controlling health costs and improving health through a focus on payment for value rather than quantity. While this idea works somewhat for issues such as too many imaging studies and too little care coordination, it becomes somewhat demeaning for us in primary care. Now we will create VALUE! Before, maybe we were the problem. (in fact, good primary care, as exemplified in typical small private practices not “big boxes” is the biggest bargain in health care today. Put less politely we are woefully underpaid.)

As mentioned above, the issue is clearly defined-from a health systems view-as too little primary care leading to higher inappropriate use of high cost services by health systems

The context is that 6% or so of the health budget goes to primary care services.

According to the NY Times of 4/23/17, [quoting a report by the Organization for Economic Cooperation and Development, attached] about 8% [or almost 150% of primary care expenses] goes for administration, billing, and payment coding services. A dramatic increase in coders has recently occurred in the US. After all, tracking down the last colonoscopy 9 years ago isn’t easy for a patient who changes plans. Not to mention the difficulties of attributing patient lives to a provider, assigning risk values to maximize pay to medicare advantage plans through up-coding, or requiring prior authorization for common medications and procedures.

All advanced countries on the planet find it sensible to train adequate primary care physicians, pay them close to the pay of proceduralists, support their work, and provide the occasional incentive bonus. This subject has become far more complex, and costly in the US than it should be, and the political situation nationally is unsettled.

Regardless, we must understand that situation and have a plan to respond. We have both an opportunity and an obligation to the health of the public and ourselves.

Since so many materials are being generated regularly, this report will try to reflect mainly the major actors-and our place in the theater.

For your convenience, a list of resources from Medicare are at <https://qpp.cms.gov/>

and at the AAFP site

<http://www.aafp.org/practice-management/payment/medicare-payment/ready-qpp.html>

and at the ABFM: <http://primenavigator.org/>

Questions of Context

* Is primary care central to the health of the public, as we believe
* Does the US currently do well in the health outcomes of the public
* Does the current QPP and other structural routes we are travelling [DSRIP, pay for performance, PCMH] improve this situation
* Can we understand or engineer a plan, and educate our members and others to follow such an evidence-based plan
* A subset of this discussion—can independent practice produce good outcomes, or must we rely on integrated health systems to produce optimal health of our patients and the public This is framed in a biased way. Do independent primary care practices have the potential to produce better outcomes than integrated health systems because of their culture and freedom from cost centers, or does the value of full integration outweigh this?
* Can we collaborate with public health projects and communities to solve problems not amenable to for-profit medicine, which monetizes all activities and uses a manufacturing-based paradigm

The Players

This is a long list, which can be summarized:

* AAFP-American Academy of Family Physicians
* ABFM-PRIME SAN-American Board of Family Medicine’s transformation and maintenance of certification product
* CMS/CMMI—Centers for Medicare and Medicaid Services, and Center for Medicare and Medicaid Improvement
* NYS PTN-NYS Practice Transformation Networks [also SAN-support and Alignment Networks]
* DSRIP/PPSs/Medicaid
* Regional and local Health Systems
* NYSDOH
* NYCDOH-PCIP/NYC REACH
* IPRO
* Commercial Payers
* NCQA/PCMH-National Committee for Quality Assurance/Patient Centered Medical Homes
* Managed Medicare [commercial Medicare as opposed to traditional Medicare]
* Managed Medicaid
* MSSNY-Medical Society of the State of NY]
* Other medical and osteopathic Societies-NYSACP, NYSAAP, ets
* Professional societies such as the nurses, pa’s, np’s
* Sundry community organizations
* Groups such as the United Hospital Fund and Pharma
* Local and regional businesses, who we presume are buyers of health care
* The public-although mostly around saving the Affordable Care Act aka Obamacare
* Healthcare unions

What to expect:

* A certainty of uncertainty, a move away from patient centered medical home by payers [except for the DSRIP PPS’s] and towards risk sharing, in which the payers in essence offload risk to providers. Most health plans wish to share risk with us [that is, not always pay us].
* A broad need to integrate practices and data sources. One cannot make statistically valid decisions on payments for results, and certainly not valid payments in a contractual sense, from small sample sizes with large confidence intervals, in the context of determining payments and modifiers of payments. [In gambling talk, the house pays for winners, but the players cannot really tell who the winners are]
* Integration of analytic and behavioral health services, as well as tech support for the above integration
* Attempts from several different arenas [federal, state, Medicaid, health plans] to simplify (Do you really believe this?) and homologate standard measures, and so far to date contributing accidentally through these efforts to complexity
* The inevitability of aggregating data in a way that can be shared and used as a negotiating tool with payers.
* A continued assault on independent practices, which otherwise take ‘attributed lives’ from health systems. Health systems may negotiate unequal payments for equal work.

It is key to recall—under QPP etc, whoever controls the data in this context controls the payments.

We’ve attached the slides that explain the MACRA law and what we likely can expect this year. [insert link to 2017-1-10 APC] Will this survive the political tumult? Seems likely at the moment, according to most health system analysts, and so we therefore need as an organization and individuals to be prepared.

Recommendations for the NYSAFP:

Our early task force should expand, meet, and develop educational tools for our events and for chapter meetings. We can call our local chapters together, with CME credit, to discuss:

* Local initiatives to make informal and formal networks of practices to meet MACRA’s targets, particularly by sharing patient data
* Concrete strategies, such as meetings with payers, joining a PTN , and using the ABFM PRIME program
* Responses by our State chapter and the AAFP to the challenges to primary care.
* In NYC, connect with the NYCDOH’s REACH program, as well as other state-wide and local support initiatives

Now more than ever the public needs strong primary care. We have many allies, and together we can use the current environment to press forward with our case to support the future of family medicine.

Bob Morrow, Chair-Advanced Primary Care Task Force

“In the past quarter century, the American medical system has stopped focusing on health or even science. Instead it attends more or less single-mindedly to its own profits.” Rosenthal, Elisabeth. An American Sickness: How Healthcare Became Big Business and How You Can Take It Back (p. 1). Penguin Publishing Group. Kindle Edition.”

Coming soon to your part of NYS: NYSDOH Appoints Northeast Business Group on Primary Care to run the Regional Oversight and Management Committees as part of the NY State Health Improvement Project- SHIP.