Value-Based Payments and Family Physicians

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Disclosures

I have nothing to disclose.

Learning Objectives

- Discuss the evolution of health insurance in the US.
- Name and compare the different reimbursement payment types.
- Describe the HEDIS measures family physicians are most likely to be measured against.

Health Insurance in the US

- Workers' Compensation insurance began around 1915
- Hospital insurance began in the 1930s during the Depression
  - Blue Cross started as insurance for hospitalizations
  - Blue Shield started a few years later for physician coverage
- The AMA opposed national health insurance in the 1930s and 1940s
- Employee-sponsored insurance started as a benefit after WWII
- Medicare and Medicaid signed into law in 1965

Health Insurance in the US

- The Direct Primary Care Model was developed in the late 1990s
- Medicare Part C started 1/1/1999
- Medicare Part D followed 1/1/2006
- Patient Protection and Affordable Care Act ("Obamacare") became effective in 2014

Reimbursement Types

- Fee for Service (FFS)
- Pay for Performance (P4P)
- Value-Based Payments including Shared Savings
- Bundled Payments
- Capitation
- Prospective Payments
- Direct Primary Care
- Concierge Care

Center for Medicare and Medicaid Innovation (CMMI)

- Also known as the CMS Innovation Center
- Established by Congress in 2010 to:
  - Improve patient care
  - Lower costs
  - Better align payment systems to promote patient-centered practices
- Alternative Payment Models (APMs) are developed and tested by CMMI
  - Merit-based Payment Incentive System (MIPS)
  - Bundled Payments
  - Programs for specific health conditions like ESRD

Health Care Payment Learning & Action Network (HCP LAN)

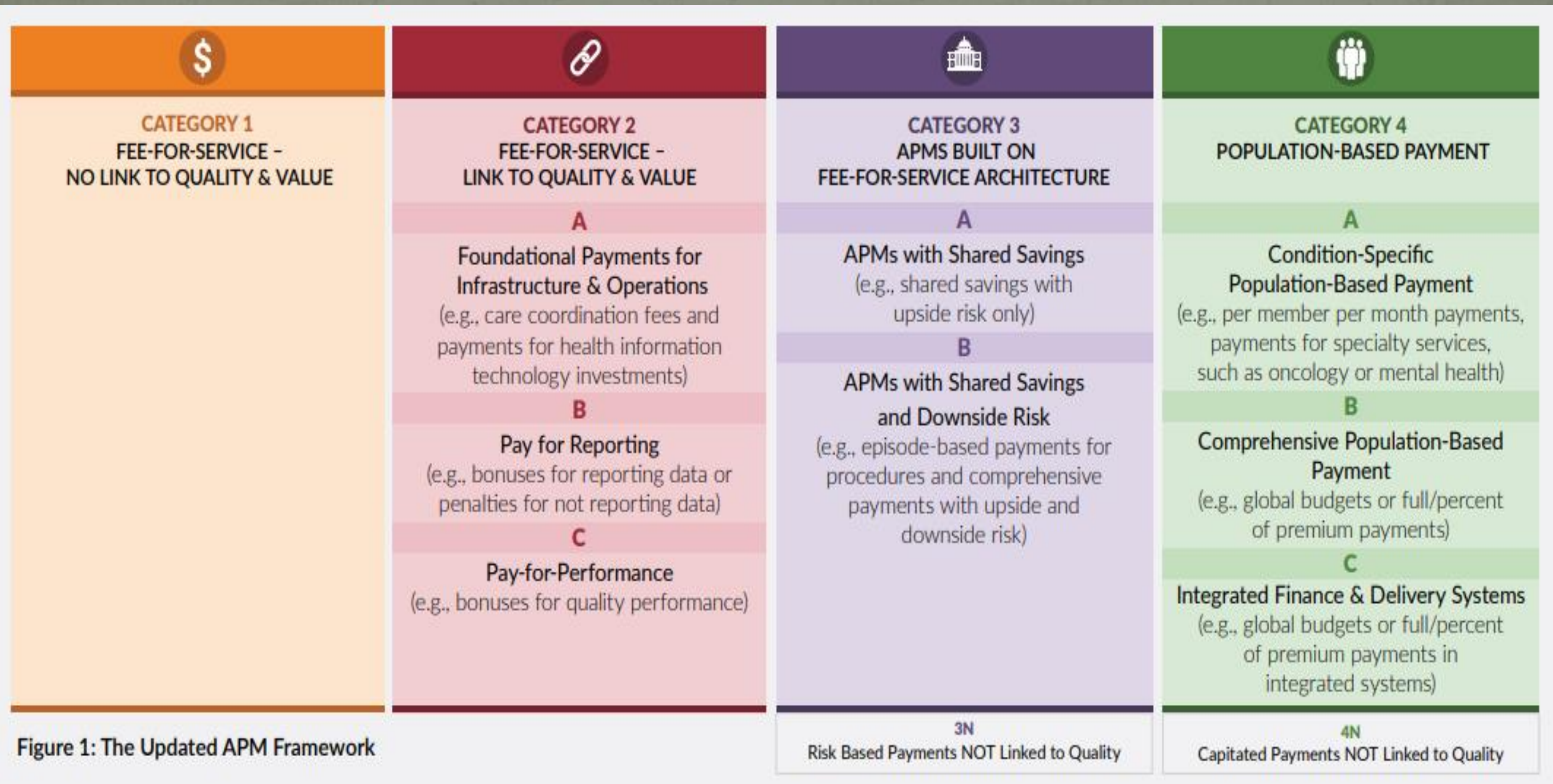

Figure 1: The Updated APM Framework

Health Care Payment Learning & Action Network (HCP LAN)

Goal: Percentage of patients in a Category 3B or Category 4 program by the following dates:

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

Medical Loss Ratio

- The percentage of premium that an insurer spends on medical care and performance improvement activities
- Commonly used in value-based programs for Medicare Advantage and Medicaid
  - If 80 cents of every premium dollar is spent on those activities, the MLR would be 80%
  - May work to beat a set target or make an improvement year over year

Quality Measures

- Healthcare Effectiveness Data and Information Set (HEDIS) from the National Committee for Quality Assurance (NCQA)
- More than 90 measures across 6 domains
  - Effectiveness of Care
  - Access/Availability of Care
  - Experience of Care
  - Utilization and Risk Adjusted Utilization
  - Health Plan Descriptive Information
  - Measures Reported Using Electronic Clinical Data Systems

Quality Measures

- HEDIS data help calculate national performance statistics and benchmarks and set standards for measures in NCQA Accreditation
- Commercial data are also included in Quality Compass (with health plan permission)
  - Health plans, purchasers, consultants, and the media use Quality Compass data for comparative health plan performance analyses

Quality Measures

- Core Quality Measures Collaborative (CMQC)
  - Coalition of health care leaders working to facilitate cross-payer measure alignment through the development of core sets of measures
  - AAFP participates
- Getting Payers to adopt has been a challenge

Common Quality Measures

- Breast, Cervical, and Colorectal Cancer Screening
- Child and Adolescent Immunizations (composite measures)
- Asthma Medication Ratio
- Controlling High Blood Pressure
- Eye Exam for Patients with Diabetes
- Hemoglobin A1C Control
- Kidney Health Evaluation for Patients with Diabetes
- Osteoporosis Testing and Management in Older Women
- Prenatal and Postpartum Care
- Chlamydia Screening in Women

Overuse/Inappropriate Use Measures

- Non-Recommended Cervical Cancer Screening in Adolescent Females
- Non-Recommended PSA Screening in Older Men
- Appropriate Treatment for URIs
- Use of Imaging Studies for Low Back Pain
- Use of Opioids at High Doses
- Use of Opioids from Multiple Providers
- Medication Management in Older Adults

Quality Measures

- Cut-points are updated each October and reflect the prior year's performance
- Programs may true-up scores when the new cut-points are released
  - Often delays pay-outs
- Health plans may derive their own cut-points
- There may be measures on a scorecard that are information only
- Measures may change year over year

Population Health Teams

- Larger physician groups and hospital-owned physician groups often have entire departments devoted to managing their value-based contracts
- The team may include nurse managers, care coordinators, patient navigators, health coaches, data analysts, quality improvement specialists, and pharmacists in addition to a physician champion

How can small practices participate in these programs with limited staff?

Aggregators

- Aledade
- Privia
- Agilon
- Main Street Health
- Diverge Health

References

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