

Understanding Quality Improvement Is More Important Now Than Ever Before

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With provider payments being adjusted for performance and emphasis being placed on value-based care, large health care systems are already developing the resources necessary to pursue quality improvement (QI) in their practices. This article explains why smaller and/or rural practices also need to learn about and implement QI.

In 2001 the Institute of Medicine of the National Academies published a landmark report titled *Crossing the Quality Chasm: A New Health System for the 21st Century* [1]. This report forced us to take a closer look at significant deficiencies in the quality of our nation's health care. Now, more than a decade later, US health care providers are starting to be held accountable for the care they deliver, as health care payers are refusing to shoulder the burden of increasing costs with no improvement in quality or patient satisfaction. Echoing a definition of quality provided by the Agency for Healthcare Research and Quality (AHRQ), Community Care of North Carolina (CCNC) has long promulgated the idea that its networks should deliver the right care, to the right patient, at the right time, in the right way to achieve the best possible results. That sentiment has now become a clarion call for quality.

The current fee-for-service paradigm, which rewards quantity above quality, is dying as health care payers increasingly cannot and will not pay for care that is not accountable. So where does this leave North Carolina's health care providers? What changes can we expect in the future?

Penalties for Failing to Adopt QI

The federal government has taken the lead in promoting quality of care with certain provisions of the Patient Protection and Affordable Care Act of 2010 that emphasize wellness and prevention. In conjunction with these changes, physician practices are being challenged to learn and apply principles of quality improvement (QI); those who do so will receive incentives for good performance, or they will be penalized if they choose not to participate [2]. Over the next 3-5 years, more and more provider payments will be "at risk" as more emphasis is placed on value-based care.

One federal guideline that promotes quality is the Physician Quality Reporting System (PQRS), which offers incentive payments to eligible providers who report data

on quality measures for professional services covered by Medicare Part B. Eligible providers who satisfactorily submit PQRS quality measures for 2014 will qualify to receive an incentive payment of 0.5% for covered services provided during the reporting period; those who do not satisfactorily report these quality measures for 2014 services will be subject to a 2% payment adjustment in 2016 [3].

Second, beginning in 2015, payment rates under the Medicare physician fee schedule will be subject to a value-based payment modifier (VBPM) for groups of 100 or more eligible professionals who submit claims to Medicare under a single tax identification number. By 2017, this modifier will be implemented for all physicians participating in fee-for-service Medicare. The VBPM is based on the physician's performance 2 years earlier (eg, application of the VBPM in 2015 will be based on performance in 2013). Eligible professionals may avoid a 1% reduction in Medicare reimbursement payments by successfully participating in the PQRS [4].

Third, on October 1, 2014, the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) is scheduled to become the code set mandated by the Health Insurance Portability and Accountability Act (HIPAA) for reporting diagnoses and conditions. For dates of service on or after October 1, 2014, providers will have to code all claims using ICD-10-CM in order to receive payment from Medicare, Medicaid, or any private payer, and failure to do so may result in denial of claims [5]. [Editor's note: At the time of publication, the Senate had passed legislation that would delay the transition to ICD-10-CM; if signed into law, it would postpone implementation of ICD-10-CM by at least 1 year.]

Fourth, practices that begin to participate in Medicare's electronic health record (EHR) incentive program in 2014 can still earn up to \$23,520 per physician in cumulative payments over 3 years [6]. In 2015, there will be a 1% payment penalty for providers who are eligible but who decide not

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to participate, and the penalty will increase to 2% in 2016. This penalty will continue to increase by an additional 1% per year, to a maximum of 5%, until at least 75% of eligible professionals have achieved meaningful use [7].

Fifth, the Centers for Medicare & Medicaid Services (CMS) is encouraging electronic prescribing through its electronic prescribing incentive program. In 2014 eligible professionals participating in the program who do not successfully use electronic prescriptions for their Medicare Part B services are subject to a penalty equal to 2% of payment [8]. The incentive program is ending, but electronic prescribing will still be a requirement of meaningful use.

Rewards for QI Compliance

Although penalties for noncompliance can add up, physicians and practices can also earn rewards for meeting certain goals. For example, the SGR [Sustainable Growth Rate] Repeal and Medicare Beneficiary Access Improvement Act of 2013, also introduced in the House as the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 [9-11], seeks to repeal the Medicare SGR and to encourage physicians to move from a fee-for-service system to a more value-based system. The legislation, which is currently undergoing review by the US Congress and by a number of stakeholders in primary care, proposes to replace the meaningful use, PQRS, and VBPM programs by rolling those incentives into a value-based performance (VBP) payment program. Beginning in 2017, health professionals would receive payment adjustments based on a composite score that encompasses 4 performance categories: quality (outcomes-based measures); resource use (cost and utilization); clinical practice improvement activities; and meaningful use. It is worth noting that many of the performance criteria in the "clinical practice improvement activities" category are requirements for certification as a patient-centered medical home (PCMH), so a primary care physician or specialist practicing in a PCMH would receive the highest possible score for this category.

Section IV of the proposed legislation would establish payment beginning in 2015 for one or more codes for complex chronic care management services. In order to receive payment for these codes, a health care provider would have to be practicing in a PCMH or in a comparable specialty practice that is providing care management services, and this practice would need to be certified by an organization recognized by the Secretary of Health and Human Services (such as the National Committee for Quality Assurance [NCQA] or The Joint Commission).

Section III of the legislation recognizes that practice changes and proper alignment of incentives are necessary to support successful participation in an Advanced Payment Model (APM). To encourage participation, the legislation provides a 5% fee-for-service bonus each year from 2016-2021 for practices that have a "significant" share of their revenues in an APM that involves 2-sided financial risk and

has a quality measurement component. In addition, the legislative committee that is putting forth the bill clearly recognizes the valuable role of PCMHs. As part of the process of qualifying as an APM, PCMHs that demonstrate to CMS that they can improve quality without increasing costs, or can decrease costs without decreasing quality, can receive a 5% annual bonus payment without having to take direct financial risk (2-sided risk).

Implementing QI in Practice

Currently, CCNC is being called upon to participate in payment reform initiatives for Medicaid. CCNC is looking to incentivize physician participation with CCNC care management programs and to align with other payer initiatives. These initiatives include PCMH recognition, successfully navigating meaningful use, and the Blue Quality Physician Program (BQPP) of Blue Cross and Blue Shield of North Carolina. CCNC also plans to incentivize enhanced quality activities, such as working with care managers and QI teams on projects involving key performance indicators and/or quality measurement and feedback data.

Commercial payers and hospital systems are also encouraging physicians and providers to participate in quality programs that mandate working with management and quality teams in order to improve care, decrease costs, and improve patient satisfaction. Many are also requiring providers to participate in value-based care programs in which at least a portion of their compensation will be through per-member-per-month payments or a portion of their salary will be withheld until certain quality metrics are met.

Some of the larger accountable care organizations (ACOs) in North Carolina are moving rapidly over the next 3-5 years toward a goal of having 40%-50% of provider's salaries contingent on quality, and many ACOs are already making the shift to value-based care and shared-savings contracts. A cultural shift is also occurring in these organizations: Instead of solo practitioners focusing on their own performance and claiming that they do not have to be worried about quality, providers in larger organizations now recognize that they rise or fall based on their collective performance. Also, employed physicians in larger organizations will need to comply with organizational goals or face possible consequences, and most hospitals and ACOs have QI teams that work with the practices within the organization to define and improve quality metrics.

Where does this leave independent physician groups, particularly small groups of 1 to 4 providers who practice in rural areas? The same forces that are driving larger practices and systems to focus on quality are beginning to affect smaller practices as well. Some smaller practices may believe that they have more time to decide whether they are willing to learn how to assess quality metrics, or they may have feelings of "warning fatigue," because physicians have been hearing for years about the coming wave of accountability but have not yet seen much proof of it. Although

these smaller practices can keep QI at arm's length for now, all will eventually have to join the quality movement.

Providers can refuse to see this coming change, allow practice performance to languish, and pay financial penalties. Or providers can embrace the coming changes—with the help of people like the members of CCNC's quality teams, working in collaboration with groups such as the North Carolina Area Health Education Centers (AHECs)—and they can work to incorporate these changes into their daily work flows.

Providers may be asking themselves whether now is the time to become recognized as a PCMH or as a patient-centered specialty practice (PCSP). A recent article in the *Journal of the American Medical Association* by Friedberg and colleagues [12] casts doubt on the effectiveness of PCMHs in reducing utilization and costs. However, it should be noted that the PCMHs in this study met the 2008 NCQA standards rather than the newer standards; NCQA updated its standards in 2011 and again in March 2014. As PCMH standards continue to evolve, more emphasis is being placed on alignment with meaningful use, outcomes, and integrated care.

Evidence for the validity of the PCMH model continues to mount and to be codified in research. A recent NCQA white paper [13] summarized several studies that found that the PCMH model improves quality of care, continuity of care, and the patient experience, and that it can lower costs through better prevention and disease management. Likewise, the most recent annual report of the Patient-Centered Primary Care Collaborative [14] analyzed 13 peer-reviewed studies and 7 industry studies and found cost savings and use reductions in about 60% of 20 PCMH evaluations. In an even more recent article by Higgins and colleagues [15], the PCMH model was associated with significantly reduced costs and utilization for those members at highest risk, particularly with respect to inpatient care.

The magnitude of savings and quality improvements in these PCMH pilot programs and initiatives depends on a range of factors, including the program design, enrollment numbers, payer mix, target population, and implementation strategies. In addition, one of the hallmarks of successful PCMH projects is the provision of financial and/or technical assistance to the practices involved. Making sure that patients are risk-stratified contributes to cost savings by giving practices the ability to target certain populations, such as those who are the most seriously ill or are high utilizers of care. The inclusion of patients as advisers or navigators is another feature of the best PCMH models, as is the presence of QI systems that include personnel educated in QI techniques and theory.

Future medical home initiatives will need to continue to be refined to produce better results and to further delineate the specific metrics and practice interventions that have the greatest impact on patient care. From my experience with a multipayer initiative in the western part of North Carolina,

I found that this is particularly true for smaller, rural practices. In such settings, spending time and resources on initiatives that do not improve care comes at a very high premium. Aiming for PCMH recognition and/or starting a quality project might be a practice's first step.

I predict that both the private and public sectors will continue to see growing value in the PCMH model. This model has been shown to play a foundational role in the development and spread of the ACO model, and with the advent of PCSPs, the PCMH model has also shown its value in the growth of the medical neighborhood, as specialty practices begin to understand their part in cost-containment and quality. Success for specialists must begin with a strong connection to their primary care colleagues. Recent research has borne out the idea that the nation's leading and highest-performing ACOs find primary care and the PCMH model to be integral to their success. Thus the PCMH model is seen as a starting point from which to move toward broader application of the Pioneer ACO Model [16].

My abiding hope is that Congress will continue to address the flawed SGR method and the other aspects of the Medicare payment system that reward quantity, waste, redundancy, and lack of accountability. We are rapidly moving toward a payment system that rewards quality, innovation, and efficiency, and that incentivizes physicians and their care teams to transform their practices to become PCMHs. This will become even more important as providers begin to enter into more gain-sharing contracts and risk-sharing practice arrangements such as ACOs. Organizations such as CCNC and the AHECs will be identifying the practices that want to work in these areas, those that are interested in becoming recognized as PCMHs, and those that are willing to meet and discuss their data and see where they need to improve. These organizations will then work with the QI practice team to move the needle toward improved outcomes, better care, higher patient satisfaction, and lower cost. **NCMJ**

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