TMGIPA
A CLINICALLY INTEGRATED NETWORK OF PRIMARY CARE PHYSICIANS

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FUTURE FOR PRIMARY CARE an Opinion
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We are already seeing a growing trend in this market that will eventually minimize or even eliminate fee-for-service. I feel it is important that we convince the healthcare community how they pay primary care is a critical to ensuring a cost-effective high-quality healthcare system Each year in the U.S. there are over 1 billion physician office visits. Over 55% of those are to primary care physicians. Decisions made by primary care providers can influence almost 90% of total healthcare costs especially factoring in referrals to other physicians, labs, radiological studies, hospitalizations and other procedures and testing. However our current healthcare system does not seem to value this crucial component of healthcare as primary care comprises just a very small portion of our total health care costs.

Primary care is the entry point for most patients needing treatment into our healthcare system. Primary care has to serve as the foundation for all medical care as the decisions made by primary care physicians are directly related to a very large proportion of our healthcare outcomes. At some point our healthcare system has to recognize that primary care controls such an overwhelming part of downstream costs that we have to devise reimbursement models that reward primary care for their interventions that lead to cost savings and improved quality.

The primary care physician should be and must be the center of the healthcare system by developing trust with their patients and other providers while taking charge of controlling appropriate healthcare expenditures to allow for the delivery of high quality, patient-centered, and cost-effective care.

Primary care cannot assume this position without the support of CMS and commercial payers. Currently benefit designs do not encourage funneling care through primary care physicians. Payments for healthcare instead stimulate fragmented and uncoordinated care. In addition there are increasing administrative burdens which further complicate a primary care provider's role and many times lead directly to physician burn-out. Fee-for-service payments for specialists , hospitals and other care providers have misplaced incentives that further complicate any hope for a more cost-effective healthcare system.

Primary care providers need to continue to work together and put pressure on CMS and commercial payers to realize the importance of independent primary care providers. Value-based incentives are a critical component for needed change. Benefit design must have a complete overhaul to incentivize patient's to take responsibility for their healthcare and seek out advice from their primary care providers. With the correct incentives as well as support, primary care providers can and will take their proper place as the most important part of healthcare transformation.

Future payment models must provide primary care providers with better control over downstream costs including unneeded specialty visits, testing and procedures. In order to accomplish this primary care providers will need to increase their access, increase the comprehensiveness of services including digital and web-based, and be ready to adapt to ever changing patient's needs. But these models must also empower primary care to realize their important role of taking ownership in controlling overall medical costs while improving quality metrics.

Payers must continue to realize the importance of primary care and design payment models that are not only achievable but sustainable. Primary care and payers must work together to achieve this outcome rather than becoming adversaries and self-centered focusing only on rewards that benefit each other. Payers must also understand that there will be associated infrastructure costs with these new demands and must ensure that compensation includes monies to allow for this infrastructure to be maintained.

Full-risk for primary care may never be appropriate even with radical changes that allow primary care providers better control of downstream costs . There are other ways. Models with some fixed risk like capitation and some minimal down-side with upside risk sharing may bridge the gap and align goals for most cost-effective outcomes.. It is imperative that independent primary care providers continue to work together to achieve the recognition and compensation they deserve.

HEDIS TIP OF MONTH-STATIN USE IN DIABETICS

Measure - This measure looks at the % of members age 40-75 who were dispensed at least two diabetes medications and also received a statin medication fill during the measurement year
Exclusions- Patients with End stage Renal disease Of note, unlike the Part C HEDIS measure, statin use for patients with cardiovascular disease, this measure does not allow for exclusions for myalgia, myositis or rhabdomyolysis.
Calculation- Numerator -the number of patients in the denominator who received a prescription fill for a statin/statin combination during the measurement year. Denominator- The eligible population—age 40-75 by December 31 of the measurement year — who were dispensed two or more prescription fills for hypoglycemic agent (oral hypoglycemic, insulin,incretin mimetic) during the measurement year.

Related Measure -Medication Adherence for Cholesterol Meds – The denominator includes members >18 years old who have two fills for a statin. The numerator is met if the Proportion of Days Covered (PDC) is 80% or higher. Statin Therapy for Patients with Cardiovascular Disease It is similar to diabetes, but requires the statin be a moderate to high intensity statin. If a patient qualifies for both measures (cardiovascular disease and diabetes), they should meet the requirements of both measures by receiving a moderate to high intensity statin

In 2013, the American College of Cardiology and the American Heart Association published the Guideline on the Treatment to Reduce Atherosclerotic Cardiovascular Risk in Adults to address reducing cardiovascular disease. The guideline identified adult patients with diabetes mellitus as a population where evidence is strong supporting the use of moderate intensity statin. The expert panel indicates high intensity statin as reasonable when the estimated ASCVD 10-year risk is > 7.5%. The panel suggests the focus is on the maximally tolerated statin intensity, rather than LDL. Recognizing statin-associated side effects may preclude a member from receiving a moderate to high intensity statin, diabetes and statin measure guidelines allow for low intensity statin.

CONGESTIVE HEART FAILURE –IV LASIX CLINIC

Reminder if you have an Alignment patient that meets the following parameters the IV Lasix clinic is operational. 1. Target patients with 2lb weight gain overnight or 5lbs in one week IV Lasix is available at Alignment Center (New Bern Avenue) M-F from 8am-4:00PM

RAF TIP of the Month- DM with Complications

Currently you should be aware that DM with complications including renal disease, retinopathy , peripheral vascular disease, oral manifestations, foot ulcers, and neuropathy have specific ICD-10 codes which provide a higher RAF score than a patient with DM (E11.9) (HCC19) without complications. The difference in RAF score results in about $2400 additional dollars being attributed to that treated patient population's baseline costs. In fact there are almost 120 specific ICD-10 codes for DM (E11.xx)with complications. In determining RAF values CMS reviewed claims for patients with specific complications from DM. They did not include every complication . They included those that were associated with a much higher cost compared to those with DM patients without complications. They lumped all these complications into a single RAF value and category (HCC 18) . We all know that certain complications will incur higher costs but this was done to average it out and to not incentivize up-coding of complications.. CMS does audit charts and if you are found to be using inappropriate codes that result in up-coding of your patients illness burden there can be fines for you and the MA plan or ACO in which you are participating.

Some of the EMR's especially EPIC currently suggests users that if a patient has DM with HTN that you should use E11.59 which is defined by CMS as diabetes with other circulatory complications. It is common in each thread of codes E11.5x, E11.2x , E11.3x to have a catch-all for that complication that is less specific and just says other. (E11.39 DM with other eye complications, E11.29 DM with other renal complication, etc) . E11.5 is DM with circulatory complications. The category is subdivided into E11.51 DM with circulatory without gangrened and E11.52 DM with gangrene. E11.59 is for DM with other circulatory conditions. A creative coding expert (not a physician) has interpreted this as HTN is an "OTHER" circulatory condition. TMG currently does not support that conclusion and is in discussions with CMS right now to get a final answer as the use of E11.59 for DM with HTN. Using this code inappropriately can result in overpayments by MSSP, NEXT-GEN for shared savings and to MA plans . The results could be in the 10's to even 100's of millions in overpayments if this code (E11.59) is determined not to be appropriate for DM with HTN,especially given the new HTN definition.

Here are the reasons why TMG does not support using E11.59 for DM with HTN. First there are over 80,000 ICD-10 codes and CMS already listed 120 with DM with complications they found to increase expense of a diabetic patient. Over 95% of the patients with DM ICD-10 codes also have I10 or HTN. So why even come up with a differential categories of DM with and without complications if they intended to include HTN as a complication. With that many codes and the prevalence of HTN they surely could have added a specific code. Almost all DM patients are on an ACE so HTN is being treated. Therefore would you expect that a DM without HTN would cost $2400 more than a DM with HTN and no other complications? Most DM patients have HTN before they are diagnosed with DM so you cannot argue DM caused the HTN. With the high prevalence of essential HTN it would hard to argue that DM was the cause of HTN. Would you not think that having a high cholesterol with DM would also be a higher complication rate as patients would be more likely to develop other complications? So then you would have to follow the same argument. The bottom line is TMG believes currently that using E11.59 for DM with HTN is wrong and should only be reserved for DM with other forms of peripheral vascular disease specifically complicated by DM. We will update in the next newsletter.

HIGH VALUE SPECIALISTS – In Focus

TMG and Alignment have identified Triangle Vascular Associates as high value specialist. They are able to perform many of the routine vascular studies in the outpatient setting resulting in same or higher quality with significant cost savings. Triangle Vascular Associates is a nationally and JACHO Accredited independent outpatient vascular practice and lab specializing in the latest vascular surgical techniques and minimally invasive treatments under image guidance. They utilize state-of-the-art equipment in an outpatient setting eliminating the higher facility fees of hospitals.

They provide treatment for Peripheral Arterial Disease including; Arteriography, Angioplasty, Atherectomy and Stenting. Other treatments include Varicose and Spider Vein Ablations, Uterine Fibroid Embolizations, May-Thurner Syndrome, Pelvic Congestion Syndrome, Varicocele Embolization, Vascular Access including Port and PICC Implantations and Removals, Pain Management Treatments including Vertebral Augmentation and Spine and Joint Injections, Oncology Treatments, Dialysis Access Management and Intervention, biopsies and tube changes.

OPIOID CRISIS

Given the prevalence of the opiate crisis reported in our country, it is extremely important for providers to learn about the North Carolina's Strengthen Opioid Misuse Prevention (STOP) Act of 2017. Employing safety measures such as Opiate Contracts, careful documentation and accurate coding are ways in which one can prescribe responsibly controlled medications while prospering in health care. Please see the attached excellent summary provided by Dr. Ken Holt.

Most providers are also aware of the potential for abuse, overuse or the potentially fatal outcomes in combing benzodiazepines But some may overlook the dangers of prescribing other non-opioids. Carisoprodol (SOMA- Schedule IV controlled) is one such drug that causes muscle relaxation, sedation, and decreased anxiety. However, muscle relaxants like carisoprodol can also cause various unintended side effects. These side effects can become more severe, and even dangerous, when the drug is misused. Severe overdose on carisoprodol can lead to death or permanent brain damage. Risk of overdose is much higher if the drug is overused or used other than how it is prescribed. Repeated abuse of this drug can lead to an unintentional overdose.
Overdose risk is also increased among individuals who have been through detox. Repeated use of carisoprodol can lead to increased tolerance, meaning that a higher dose of the drug is needed in order to achieve effects once felt after a smaller dose. Tolerance decreases quickly after use of the drug is lessened or stopped, so a dose that was previously well tolerated may become too large and cause an overdose. Soma treatment should be limited to 14 of 21 days.