Primary Care: Strategy & Performance

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Discussion Topics

- Securing Market Share
- Meeting Patient Expectations
- Quality/Value-Based Payment
- Patient Centered Medical Home
- Clinical Integration/Population Health
Primary Care:
Securing Market Share
Physician Integration Economics - Fee for Service

- Capture & Retain Market Share
- Potential Capital Loss
- Hospital Capital Generator

- Referral Path

- Primary Care
- Potential Capital Drain

- Market Manager

- Potential Capital Drain

- Subspecialty Physicians

- Capital Preservation & Investment

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Physician Integration Economics - Risk Payment Model

Panel Size
Access
Time & Materials

Potential Capital Loss
Referral Path

Hospital Risk Pool
Capital Potential

Potential Capital Drain

Primary Care

Market Manager

Potential Capital Drain

Potential Capital Drain

Capital Preservation & Investment

Subspecialty Physicians

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Securing Market Share

➢ Primary Care Provider of Choice
➢ Specialist of Choice
➢ Independent Providers
Primary Care: Meeting Patient Expectations
Access

- Same Day Acute/Routine Visits
- New patient visits
- Communication
- Alternative Delivery Models
Alternative Primary Care Delivery Models

- Retail Clinics
- Concierge Medicine
- Direct Primary Care
- Hybrid: Concierge/Direct Primary Care
- Tele-Health
Retail Clinics

- Mainly primary care
- Free-standing or embedded
- Walk-in access
- Advanced Practice Providers (APPs)
- Accept most insurance products or cash
- Convenience, lower cost
- Potential fragmentation
- Links with health systems
Concierge Medicine

- Started in the 1990s
- Same day appointments
- 24/7 phone access and e-mail service
- Telemedicine
- House calls (occasionally)
- Fee range $200/month - $30,000/month
- Limited MD panel sizes
- Most bill Medicare and commercial insurance
Direct Primary Care

- Started in the 2000s
- Smaller panels, improved access
- Most do not accept payment from or bill third party payers
- Monthly patient fee with a defined list of services (lower than concierge)
- Fee range estimated $50-$150/month (AAFP) - could be higher based on scope of services
- Varied services
- Modest per visit fee
Hybrid: Concierge/Direct

- Allows for two revenue streams
- Can transition from private practice
- Increased complexity
Tele-Health

- Increasing patient demand for convenient services
- Expanded hours, eliminates travel costs and wait times
- Insurance Companies starting to embrace
- Medicare reimbursement slow to come, keeping adoption low overall
  - Seniors in rural areas
  - Concerns of being an add-on service
- Most common service lines
  - Behavioral health, dermatology, radiology, infectious disease, stroke
Self-Directed Care

- Care incorporates patients' preferences, functioning, and lifestyle goals
- Goal-driven treatment plans with strategies to address barriers
- Transparency and communication
- Listening to understand
- Education/Resources
Coordinated Care

- Knowledge about all points of service
- Follow-up communication and care
- Clinical information exchange
- Referral Communication
Primary Care: Quality/Value-Based Payment
# Quality *Practice* of Medicine: Overlapping Core Measures

<table>
<thead>
<tr>
<th>Quality Requirements/ Source</th>
<th>CMS165v1 Controlling High Blood Pressure</th>
<th>CMS138v1 Tobacco Use Screening and Cessation Intervention</th>
<th>CMS125v1 Breast Cancer Screening</th>
<th>CMS130v1 Colon Cancer Screening</th>
<th>CMS126v1 Use of Appropriate Medications for Asthma</th>
<th>CMS117v1 Childhood Immunization Status</th>
<th>CMS147v1 Influenza Immunization</th>
<th>CMS17v1 Pneumonia Vaccination</th>
<th>CMS122v1 Diabetes: Hemoglobin A1c Poor Control</th>
<th>CMS3v2 Screening for Clinical Depression and Follow-up Plan</th>
<th>CMS68v2 Documentation of Current Medications in the Medical Record</th>
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Uniform Quality Measures

- Core Quality Measures Collaborative
- Uniform Measures
  - ACOs/PCMH/Primary Care
  - Cardiology
  - HIV/Hepatitis
  - Medical Oncology
  - Obstetrics/Gynecology
  - Orthopedics
Value-Based Payment

- Medicare Access Reauthorization Act (MACRA) - April, 2015
  - Replaced the Sustainable Growth Rate (SGR)
  - Separates FFS vs. all other “pay for value” methodologies, e.g. bundled payments, shared savings, PMPM, etc.

- Pay for Value
  - Merit-Based Payment System (MIPS)
  - Alternative Payment Models (APMs)
Value-Based Payment

What will change

- MIPS
  - Combines PQRS, VM, MU, adds Clinical Practice Improvement Activities (CPIA)
  - Focused on quality, resource use, clinical practice improvements, meaningful use of EHR technology
  - Pay for value incentive methodology

- APMs
  - If qualify and participating, can opt out of MIPS
  - Implement in 2019 - HHS goal to move 30% of Medicare payments to APMs by 2016, 50% by 2018

Patient Centered Medical Home (PCMH)
What is PCMH?

- A model of care that emphasizes care coordination and communication to transform primary care into "what patients want it to be."

*NCQA Website*
What is PCMH

- **Patient-Centered** - Self directed care based on preferences
- **Comprehensive** - Whole person care with a team of providers
- **Coordinated** - Across all elements of the health system
- **Accessible** - Shorter wait times, better hours, 24/7 electronic or phone access, alternate methods of communication
- **Committed to Quality & Safety** - Quality initiatives using data and health information technology

*The Agency for Healthcare Research and Quality*
PCMH - Impact on Cost and Quality

- Controls costs by providing the right care
  - 21 of 23 Studies on cost measures showed reductions in one or more measure
  - 23 of 25 studies found reductions in one or more measures of utilization

- Payment and Performance both must be aligned
  - Payment reform
  - Alignment of performance measures

- Assessing and promoting the value of PCMH is needed
  - Variation exists
  - Need alignment with value as defined by patients

*The Patient-Centered Medical Home’s Impact on Cost and Quality - PCPCC*
As of 2013, despite the large number PCMH practices, 87% have not received payment for their status.

Currently, Humana Medicare, Central Ohio, Providence Medical, Cleveland Clinic offer care coordination fees in select markets.

By December, 2018, the Ohio Office of Health Transformation (OHT) anticipates that at least 80% of the state’s 11.5 million population across all payers including Medicaid, will be participating in a PCMH.
Primary Care: Clinical Integration/Population Health
Moving UP the Integration Pyramid

Population-Centered Care
• Personal accountability for healthy behaviors and lifestyle
• Population health management (PHM)
• Chronic disease prevention & management
• Access and information = value
• Risk-based payment

Collaborative Care (Trust)
• PCMH & “Choice” Initiatives
• Vital behaviors (“we”/”our”)
• Service quality extension of referring provider’s office
• Information lubricates the referral path
• Referral management

Choreographed Care (Accountability)
• Improving process and outcomes
• Clinical quality commitments
• Transparent flow of clinical information across care continuum
• Managing an episode of care or chronic disease using clinical metrics
• Individual and joint accountability to live by established metrics

Coordinated Care (Silos)
• Basic form of integration
• Legal structure/organization chart
• Payroll silos (“me”/”you”)
• Referral leakage

The Role of Primary Care

- Patient Engagement
- Care coordination
- Quality discussion
- PCMH
- Service line leadership