No Outcome, No Income
The Role of Primary Care in the Healthcare Value Revolution

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Thomas Jefferson University
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November 15, 2017
Mandatory Slide For Talks Like This
Although the United States spends more on healthcare than other developed countries, its health outcomes are generally no better.

**Health Status**
- **Life Expectancy at Birth**
  - Worst: South Africa
  - Best: Switzerland
  - U.S.

- **Infant Mortality**
  - Worst: India
  - Best: Iceland
  - U.S.

**Quality of Primary Care**
- **Unmanaged Asthma**
  - Worst: Slovak Republic
  - Best: Italy
  - U.S.

- **Unmanaged Diabetes**
  - Worst: Hungary
  - Best: Italy
  - U.S.

**Quality of Acute Care**
- **Safety During Childbirth**
  - Worst: Switzerland
  - Best: Poland
  - U.S.

- **Heart Attack Mortality**
  - Worst: Mexico
  - Best: Australia
  - U.S.

**NOTE:** Data are not available for all countries for all metrics; all published data are shown. Data are for 2013 or latest available. 
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What Makes Us Healthy

Genetics 20%
Environment 20%
Healthy Behaviors 50%
Access to Care 10%

What We Spend On Being Healthy

Medical Services 88%
Healthy Behaviors 4%
Other 8%

Source: Bipartisan Policy Center, “F” as in Fat: How Obesity Threatens America’s Future (TFAH/RWJF, Aug. 2013)
The U.S. is an anomaly in health and social spending patterns

- Health expenditures as % of GDP
- Social service expenditures as % of GDP

Source: OECD
http://www.vox.com/2014/7/7/5877227/the-giant-problem-american-health-care-ignores
Your ZIP Code May Be More Important to Your Health Than Your Genetic Code
05 DAYS SINCE LAST PARADIGM SHIFT
Payers moving towards risk

Providers need data, analytics, tools and new care models to succeed in risk models.
Healthcare in transition...
Hospitals look to profit by keeping patients away

Facilities rewarded in host of ways to keep more people healthy

Jayne O'Donnell
@jayneodonnell
USA TODAY

 Asked about his health issues, Anthony Tramonte of New Castle, Del., says, "Do you have about an hour?"

It's no wonder: The former postal worker, 72, is on dialysis, has diabetes, heart disease, high blood pressure and eye problems. He's been hospitalized three times for heart failure in the past few years and was blind for a while due to his diabetes.

Tramonte's wife of 50 years, Phyllis, is his full-time caregiver, but she's got help in high places — the Christiana Care health system near their home. There, pharmacist Kelly Ann Steeves is his "care coordinator" after Tramonte is hospitalized to make sure he gets all the medical and social support he needs to avoid a return visit. A monitor checks his heart beat at home and notifies his doctor if it's irregular, which Phyllis says has saved his life twice.

"I sleep easier knowing he's got that care," she says.

Tramonte is one of about 75,000 patients in a Christiana program called Care Link that's funded by a variety of federal grants through the Centers for Medicare and Medicaid Services. Patients have care coordinators such as Steeves who link them with a nurse, pharmacist and social worker. Similar projects around the U.S. are federally funded and share the goal of keeping people healthy and out of the hospital, at least for preventable reasons.

Under the Affordable Care Act, hospitals now get penalized when Medicare patients are re-admitted within 30 days of a visit, but there are a host of other ways they get rewarded when they keep people healthy. Some are funded through CMS' innovation center, such as a reimbursement plan that gives hospitals a set amount for, say, a knee replacement. They get more if they treat the patient for less and lose mon-
Figure 2. Transitions to value-based payment models will likely vary by market\textsuperscript{17}

- **High Market pressure—Dominant provider**
  - Gain sharing
  - P4P* (includes payment for episode of care)
- **Low Market-balking—Hold the line**
  - Fee for service

**Optimize:**
- Outcome and value
- Rate and volume

**Market-innovating**
- Condition or population-focused ACO
- Global ACO

**Bubble size = savings opportunity**

*Source: Deloitte analysis of models.*

Graphic: Deloitte University Press | DUPress.com

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Jefferson Health.
<table>
<thead>
<tr>
<th>Payment model</th>
<th>Plan capabilities</th>
<th>Provider capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IT infrastructure/information services</td>
<td>IT infrastructure/information services</td>
</tr>
<tr>
<td>FFS</td>
<td>Business operations/administrative (RCM, claims mgmt. &amp; processing)</td>
<td>Business operations/administrative (RCM, claims mgmt. &amp; processing)</td>
</tr>
<tr>
<td></td>
<td>Data collection, sharing, and analysis</td>
<td>Data collection, sharing, and analysis</td>
</tr>
<tr>
<td></td>
<td>Analytics (for population health, cost, and care coordination analysis)</td>
<td>Analytics (for population health, cost, and care coordination analysis)</td>
</tr>
<tr>
<td></td>
<td>Planning/understanding market/population needs</td>
<td>Planning/understanding market/population needs</td>
</tr>
</tbody>
</table>

| Source: Deloitte synthesis of literature and subject matter expert interviews. See appendix for definitions of each capability. |

| Note: Tables are intended to be a representation, not exhaustive. |

| Basic capability required | Intermediate capability required | Advanced capability required |
Phases of Change

Patient-Centered Care 2010-2017

Provider-centric & Focused on sickness
Team-based care
Align resources
Target high utilizers
Wellness
Reduced use of hospitals & ED
Appropriate specialty and radiology
Transparency based on performance

Patient Engagement 2015-2020

Compete on value
Engage with non-health
Health kiosks
Personal genomics
Mobile apps
Home-based monitoring
Real-time access to services

Oliver Wyman: The Volume to Value revolution
The Value of Primary Care

Total cost of healthcare vs availability of Primary Care

- Spending per beneficiary (dollars)
  - 8,000
  - 7,000
  - 6,000
  - 5,000
  - 4,000

- General practitioners per 10,000
The Value of Primary Care

- Key to patient attribution
- Lower cost care
- Appropriate referrals to subspecialists and imaging
  - “downstream”
- Fulfill quality measures
- Patient satisfier
HRSA: Projected Demand for Primary Care Physicians

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total primary care physician demand (FTE)</td>
<td>212,500&lt;sup&gt;a&lt;/sup&gt;</td>
<td>241,200</td>
</tr>
<tr>
<td>General&lt;sup&gt;b&lt;/sup&gt;</td>
<td>164,400</td>
<td>187,300</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>44,800</td>
<td>49,600</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>3,300</td>
<td>4,300</td>
</tr>
<tr>
<td>Primary care physician supply</td>
<td>205,000</td>
<td>220,800</td>
</tr>
<tr>
<td>Supply and demand</td>
<td>(7,500)</td>
<td>(20,400)</td>
</tr>
</tbody>
</table>

<sup>a</sup> National demand projections presented in this report assume that in 2010 the national supply of primary care physicians was adequate except for the approximately 7,500 FTEs needed to de-designate the primary care HPSAs.

<sup>b</sup> This category includes general and family practice, and general internal medicine.
Primary Care at a Crossroads

48% plan to reduce hours or take other steps to cut back on the number of patients they see.

- Direct Primary Care
- Leave Clinical Care
- Retire
- Reduced Hours
- Retainer/Concierge Medicine
- Plow Ahead

Physicians Foundation, 2016
Fully Embrace the Quadruple Aim
Primary Care at a Crossroads

Value based care starting to make impact

- Increasing financial risks in contracts
- MIPS/APM/MACRA impact
- Risk stratification of patients
- Movement beyond the PCMH (i.e. CPC+)
- Team based care
  - Every hour spent clinically = 2 hours administrative
  - Increasing quality metrics and other responsibilities

## Value-Based Reimbursement: It’s Complex

Hospital & Ambulatory Quality Master Grid Requires Strategic Focus

### Table: Value-Based Reimbursement Indicators

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Wt</th>
<th>CY-1</th>
<th>CY-2</th>
<th>Updated Semiannually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma: Medication</td>
<td>25%</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension: Blood Pressure</td>
<td>20%</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes: HbA1c</td>
<td>15%</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDI: Hospital-acquired infections</td>
<td>10%</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAUTI: Catheter-associated urinary tract infections</td>
<td>5%</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Remarks
- For Quality Bonus
- “POD” = Physician Opportunity Bonus
- “ACO-18” = ACO-18 Bonus
- “CMS ACO MSSP” = CMS ACO MSSP Bonus

### Ambulatory

- **N=143+**

### Hospital

- **N=85+**

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**Additional Information:**
- **CMS Stars:**
  - Medicare
  - Medicaid
  - Commercial

**Updated Annually:**
- **Measures:**
  - CMS ACO MSSP GPRO
  - Amb. Quality Measures
  - HMO

**Value Based Purchasing Federal:**
- FFY2017
- FFY18
- Oct 2017 - Sept 2018

**Clinical Care - Outcomes:**
- **wt 25%...**
- **MRI Lumbar...**
- **OP-10 Abdomen CT use...**
- **OP-11 Thorax CT...**
- **OP-13 Use of Cardiac Imaging...**
- **OP-14 Simultaneous use of CT/Sinus CT...**
Embrace Team-Based Care

Physician Leader
Advanced Practice Provider
Advanced Practice Provider

Medical Assistant
Medical Assistant
Medical Assistant

Registered Nurse
Care Coordinator
Support Staff
CPC+: Program Overview

5-year CMMI/CMS program.

“Payment redesign by payers, both public and private, will offer the ability for greater cash flow and flexibility for primary care practices to deliver high quality, whole-person, patient-centered care and lower the use of unnecessary services that drive total costs of care.”

Began on January 1, 2017
- 2,983 primary care practices accepted with 13,090 clinicians
- serving 1.76 Million Medicare beneficiaries
- individual practices apply
- must have 150 Medicare beneficiaries

Both CMS and private insurers participating
Practices split into 2 Tracks (Basic and Advanced)
$10M+/year program at Jefferson Health
# Three Payment Innovations Support CPC+ Practice Transformation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Payment Structure Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>Support augmented staffing and training for delivering comprehensive primary care</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting</td>
</tr>
<tr>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>N/A (Standard FFS)</td>
<td></td>
</tr>
<tr>
<td><strong>Track 2</strong></td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>

- **Not at Risk**
- **At Risk**
- **Not at Risk**
# PBPM Care Management Fees Determined by Patient Risk Levels

Payments Support Practice Capabilities to Better Manage Care

## Track 1: Four Risk Tiers (Average $15)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Fee</th>
<th>Risk Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$6</td>
<td>0.117-0.503</td>
</tr>
<tr>
<td>2</td>
<td>$8</td>
<td>0.504-0.727</td>
</tr>
<tr>
<td>3</td>
<td>$16</td>
<td>0.766-1.247</td>
</tr>
<tr>
<td>4</td>
<td>$30</td>
<td>1.248 and over</td>
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</tbody>
</table>

## Track 2: Five Risk Tiers (Average $28)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Fee</th>
</tr>
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<tbody>
<tr>
<td>1st risk quartile</td>
<td>$9</td>
</tr>
<tr>
<td>2nd risk quartile</td>
<td>$11</td>
</tr>
<tr>
<td>3rd risk quartile</td>
<td>$19</td>
</tr>
<tr>
<td>4th risk quartile</td>
<td>$33</td>
</tr>
</tbody>
</table>

### Complex Tier: $100

- Top 10% of risk
- dementia diagnosis
- 1.992+ and Dementia

- Risk adjusted, PBPM (non-visit-based) payment
- Designed to augment staffing and training, according to specific needs of patient population
- No beneficiary cost sharing
- Risk tiers relative to regional population
CPCP Payment Explained

- 2015 Medicare Billings
- 2017 Medicare Billings
- FFS reduced compared to prior rate
- Non Face-to-Face & Less reliance on volume

10% up front
+10%
10%
25%
40% or 65% by 2019

Medicare Billings
FFS reduced compared to prior rate
Non Face-to-Face & Less reliance on volume

Medicare Billings

10% up front

10%

25%

40% or 65% by 2019
CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

Track 2 capabilities are inclusive of and build upon Track 1 requirements.

**Access and Continuity**

- Empanelment
- 24/7 patient access
- Assigned care teams

**Care Management**

- Risk stratified patient population
- Short-term and targeted, proactive, relationship-based care management
- ED visit and hospital follow-up

- Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.
- Two-step risk stratification process for all empanelled patients
- Care plans for high-risk chronic disease patients

**Online Resources:** Care Delivery Transformation Brief, Video, and Practice Requirements

**Upcoming Open Door Forums:** Care Delivery Overview and Q&A: Fri, Aug 12, 9:30-10:30am ET

Much aligns with PCMH
CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

**Comprehensiveness and Coordination**
- Much aligns with PCMH
- Identification of high volume/cost specialists
- Improved timeliness of notification and information transfer from EDs and hospitals
- Behavioral health integration
- Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs
- Collaborative care agreements
- Development of practice capability to meet needs of high-risk populations

**Patient and Caregiver Engagement**
- At least annual Patient and Family Advisory Council
- Assessment of practice capabilities to support patient self-management
- At least biannual Patient and Family Advisory Council
- Patient self-management support for at least three high-risk conditions

**Planned Care and Population Health**
- At least quarterly review of payer utilization reports and practice eCQM data to inform improvement strategy
- At least weekly care team review of all population health data
Keys For Success in CPC+

1. Embedded Mental Health
2. Time to review data and meet with Teams
3. Patient-Family Advisory Council
4. Care Coordination
   • Develop care plans
   • Acute and long term care management
   • Referral to community resources
5. Risk Stratification
6. Non-traditional office visits
   • Minimum 40% non-face-to-face by 2019
Population Health Risk Stratification

80% “Low” Risk

- Loyalty
- Access, Access, Access, Access
- Wellness Benefits
- Preventive Care
- Touch points

15%

- Needs Assessment
- Chronic conditions
- Gaps in Care
- Outreach
- Patient Education
- Care Coordination
- Self management plan

5%

- 40% of Spend
- Risk Assessment:
  - Clinical
  - Socio-economic
  - Environmental
- Behavioral Health
- Care coordination
- End of Life planning
Succeeding on Value

- Focus on top 1%, then top 5% then top 10%
- Early Interventions (ie Home-based monitoring)
- Easier Access
- Embrace Informatics
- Engage patients

Oliver Wyman: The Volume to Value revolution
What Does This All Mean?

Major Themes Moving Forward

1. Using data to strategically deploy resources
2. Accountability/Feedback
3. Team-based care
4. No outcome, No income
How Might We Get There?

Change the Culture in Primary Care

1. Make practices patient-focused and across the continuum of care
2. Practice based on evidence
3. Reduce unexplained clinical variation
4. Embrace team-based care
5. Continuously measure and improve
Questions?

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