Population Health for Rural Hospitals:
2. Saving Community Hospitals by Saving Primary Care

National Rural Health Resource Center
Webinar Series: Population Health for Rural Hospitals
February 11, 2015

Steve Hyde, Principal
719-338-9500
shyde@stroudwater.com

Terry Bauer, Principal
404-647-0803
tbauer@stroudwater.com
Agenda

1. Setting the Stage
2. Primary Care and Population Health
3. The Problem
4. The Need
5. The Solution
6. The Details
7. The Impact
8. Q&A and Comments
Not-for-Profit Hospital Outlook

STANDARD & POOR’S RATING SERVICES
• Outlook negative
• “$3 trillion healthcare industry is in the midst of the most far reaching changes it has seen”
• Not-for-profit hospitals exhausting methods to maintain operating margins
• Not-for-profit hospitals at a “tipping point” facing decreasing ability to offset changes and negative trends

Moody’s
• Outlook negative (since 2008)
• Low revenue growth and shrinking volumes
• Expenses growing faster than revenues

Fitch Ratings
• Outlook negative
• Uncertainty and challenges from payment reform and reduced volumes
PCPs Essential to Population Health

The future of population health depends on expanding the role of primary care physicians beyond being just the medical-provider-of-first-resort to coordinating their patients’ care throughout the medical system, with the goals of:

1. Improving medical outcomes
2. Reducing total patient costs
3. Reaping the resulting financial rewards
The Problem

- PCPs are underpaid, overworked, and in short supply.
Physician Compensation in 2011

Physician Compensation (2011)

Sources: Medscape average physician salary report via shortwhitecoats.com
Primary Care Physician Shortages

Source: http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/
## Typical Income Statement

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- PCPs are underpaid, overworked, and in short supply.
- Hospitals are increasingly hiring PCPs and losing $150,000 to $250,000 each per year.
The Changing Practice of Primary Care

% US Physicians Employed by Hospitals and Health Systems

- 2004a
- 2008a
- 2012b

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- Adding PCMH patient-coordination responsibilities means further increasing overhead by $10,000/month and reducing panel size.
Traditional Medical Care

Patients → Hospital
→ Specialists
→ Primary Care Phys.
→ Other Services
The PCMH Care Model

Patients → PCMH
- Family practitioner
- Nurse practitioner
- Health coach
- Care coordinator
- Dietary services
- Disease mgt.
- Behavioral health
- Rx management

PCMH → Hospitals
PCMH → Specialists
PCMH → Home Care
PCMH → Ancillary Services
PCMH → Outpatient Services
PCMH → Other Required Services
The Problem

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• Adding PCMH patient-coordination responsibilities means further increasing overhead by $10,000/month and reducing panel size.
• Increasing insurance deductibles add to patient collection costs/problems.
Patient OOP Changing Very, Very Rapidly

Percentage of covered workers with an annual deductible of $1000 or more (single coverage)

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2006-2013
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- Adding PCMH patient-coordination responsibilities means further increasing overhead by $10,000/month and reducing panel size.
- Increasing insurance deductibles add to patient collection costs/problems.
- Both independent PCPs and hospitals need a new, self-sustaining PCP financial and business model.
- Community and rural hospitals are in dire need of new profit-center models to replace declining utilization of their traditional high-volume, high-margin services.
The Need

A transformational primary care business model that:

• Recognizes the essential, center-of-the-universe nature of primary care in the transformation to population health to achieve the Triple Aim
• Improves primary care physician pay from <$200k/yr to $350k +
• Covers the additional costs of care coordination
• Generates sufficient direct PCP revenue-center profits to offset reduced utilization of traditional high-margin hospital services
• Provides a stable business model for independent PCP practices
The Solution

The Capitated Direct Primary Care (CDPC) Business Model
Background: Direct Primary Care (DPC)

Total of 12,000 MDs operating under this type of model nationally

- 1% of all licensed physicians
- 5% of licensed primary care physicians

**Concierge** - annual membership fee plus practice accepts all types of insurance

**Current State of This Market Sector**

- 6000 clinics nationwide
- 28% cost less than $99/month
- 57% cost between $101-$225/month

**Direct Primary Care** - lower membership fees and typically do not accept insurance

**Current State of this Market Sector**

- 82% of memberships cost less than $99/month
- 68% charge $25-$85/month

**PPACA requires that DPC be included in proposed insurance exchanges, with the caveat that these practices be paired with a wraparound insurance policy covering everything outside of primary care.**

*Source: 2015 DPC Journal Annual Report and Market Trends*
Traditional Primary Care Patient Flow

High FFS Primary Care Admin Cost Promotes Visit Volume vs. Time with Patient
Direct Primary Care (DPC) Patient Flow
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Background: Capitated Primary Care

- Replaces third-party FFS with PMPM payment
- Gradually builds to global capitation
- Provides incentive and opportunity to better coordinate care and reduce total medical costs
Potential 45% PCMH-driven Medical Cost Reduction

Care-defect costs as % of total cost by condition/procedure

- CHF
- COPD
- Diabetes
- Asthma
- Pneumonia
- Stroke
- CAD
- Hypertension
- AMI
- CABG
- Knee
- Hip
- Bariatric Surgery
- Overall

Source: Health Care Incentives Improvement Institute, Inc. Prometheus Payment 2009
Background: Capitated Primary Care

- Replaces third-party FFS with PMPM payment
- Gradually builds to global capitation
- Provides incentive and opportunity to better coordinate care and reduce total medical costs
- Allows for high level of potential profitability with reduced patient panel size
Combining Capitation and DPC: CDPC

- Payer enrolls member in CDPC benefit plan with high deductible (HDHP)
- Member chooses participating PCMH as personal PCP and care coordinator
- Each PCP limits panel size to 1400 or so patients
- Payer pays PCMH on graduated capitation basis based on covered benefits
Graduated Capitation Implementation

Provider Financial Risk/Reward

- 3rd Pty FFS
- Traditional Payments
- PCP/PCMH Care-Mgt Fees
- Quality-Based Revenue Enhancement
- Non-Savings Incentive Payments
- Shared Savings
- Shared Risk/Reward
- Risk/Reward-Based Payments
- Capitation/ % Premium

Time
Graduated Capitation Implementation

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- Payer pays PCMH on graduated capitation basis, based on covered benefits.
- HDHP allows member to establish and fund tax-advantaged HSA.
- PCMH contracts with member for DPC
  - Member pays $50-90/mo fee as prepayment (NOT premium) for all specified PCMH services.
  - Fee is payable from member’s HSA on non-taxable basis.
  - Payer applies fee to annual deductible.
  - Member pays for all non-PCMH services up to remaining deductible/coinsurance/OOP limits.
  - Payer capitation payment covers all services above deductible, less coinsurance and copayments.
- Both PCP and patient are incentivized to minimize medical costs consistent with high-quality care.
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CDPC Results

- Optimized combination of DPC and capitation
- Enables increased personnel costs for PCMH
- Reduces both payer and patient revenue cycle costs
- Accelerates cash flow
- Improves patient outcomes
- Reduces total medical costs
- Partnership with payer enables maximized market share for both
- Enables PCPs to stay independent
- Provides new hospital profit center to replace reduced revenues & margins from traditional profit centers
- Can help eliminate PCP shortages by paying them more
Physician Compensation in 2020?

Sources: Medscape average physician salary report via shortwhitecoats.com
Issues for adapting CDPD to rural hospitals

• Market size and PCP supply will dictate a hybrid CDPC approach
• Start with hospital employees if a self-funded health plan
• Offer to existing patients with high-deductible health plans
• CCO participation can accelerate adoption by payers
  • Self-funded employers
  • Commercial insurers
  • Medicare Advantage
  • Medicaid Managed care
“What we have before us are some breathtaking opportunities disguised as insoluble problems.”

- JOHN W. GARDNER
3. Patient Care Coordination and the Intensive Medical Home on 2/25/15
Questions??
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