Direct Primary Care (DPC):

Potential Impact on Cost, Quality, Health Outcomes, and Provider Workforce Capacity

A Review of Existing Experience & Questions for Evaluation

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Purpose of this Presentation

- Not about whether the DPC model should or should not be available as a choice or option for consumers.
- Focuses on whether and what financial and health benefits the DPC model might provide.
- Specifically relevant to whether Medicaid or other public funds invested in the DPC model deliver overall savings.
- Does not discuss impact on:
  - Physician job satisfaction/retention
  - Patient satisfaction

The Overall Logic Model

Inputs

- Expansive access to primary care services
- Longer visit times with their health care provider
- Removing health insurance from many transactions

Outputs

- Improve the health care experience
- Reduce other health care use and costs (such as specialty, lab, prescription drug and hospitalization)
- Improve health outcomes

Evaluations and Case Studies

- Existing literature on DPCs provides descriptive and survey information.
- Generally lacks rigorous studies on cost, quality, and outcomes.
- Two studies for discussion
  - MD-Value in Prevention (MDVIP)
  - Qliance Medical Group

Evaluations and Case Studies

MD-Value in Prevention (MDVIP)

- DPC group with practices in 43 states and the District of Columbia
- 2012 study reported substantial savings, mostly due to reduced hospitalizations
- Did not adjust for baseline health or socioeconomic factors of its members relative to comparison population – factors that would affect health care use.
- Does not allow for conclusion about the impact of the DPC model

Evaluations and Case Studies

Qliance Medical Group

- Founded in 2007 in Seattle, served individuals, employers, Medicaid, and ACA plan members
- By 2015, served 35,000 patients, half Medicaid covered
- In 2015, Qliance reported that its model “delivers 20% lower overall healthcare costs, increases patient satisfaction, and delivers better care.”
- Attributed savings to reduced ER visits, inpatient days, specialist visits, advanced radiology visits

Evaluations and Case Studies

Qliance Medical Group

- Literature includes descriptive reports of Qliance early operations, but offers no independent evaluations.
- External evaluators did not conduct the Qliance study.
- Does not specify whether Qliance patients' underlying health status differed relative to a comparison group
- For these reasons, Qliance's reported results may not be attributable to the DPC as a delivery model.
- ***Closed all clinics by 2017, and filed for chapter 7 bankruptcy in 2018***

Questions Raised by these Experiences

- Are the subscription rates sufficient to cover the cost of services to the enrolled population?
- Do such practices provide, for individuals in generally good health, more care than may be necessary?
- Do DPCs promote evidence-based services that improve health?

DPC “Value Proposition”

1. **For Consumers:** Savings in out-of-pocket health care costs, improve patient experience and satisfaction, improve health care quality and value, improve health outcomes.
2. **For Purchasers:** Reduce unnecessary health care use and costs, improve health care quality and value, improve health outcomes
3. **For Providers**: Improved professional satisfaction, better revenue flow, improve retention of primary care physicians.

DPC and Return on Investment

Value-Added Calculation for Consumers

+ DPC subscription fee

+ Wrap-around insurance premium

+ Out-of-pocket for non-DPC services

= Total Payments

<Other medical service costs averted>

= Total cost of care

VS.

+ Standard Insurance Premium

+ Out-of-pocket payment for cost-sharing

= Total Payments

< Reduced out-of-pocket by applying primary care cost-sharing to deductible>

= Total cost of care

DPC and Return on Investment

- A consumer within a DPC agreement would presumably also purchase a complementary "wrap-around" health plan to cover the services not provided by the DPC contract.
- All health plans cover required preventive services at no direct cost to the consumer
- Standard insurance generally partially covers other office visits pre-deductible, with any cost-sharing applied to meeting the deductible.
- If an individual has a wrap-around plan, does DPC add value beyond the preventive services already built into any other coverage that includes mandated preventive services?
- Depends on consumer's risk profile and pre-existing conditions.

DPC and Return on Investment

Wisconsin 2018: Monthly Premiums for ACA-Compliant Plans, Before and After Federal Subsidy				
	Overall	Bronze Plan	Silver Plan	Gold Plan
Average Premium (monthly)	$750	$626	$833	$759
Average Premium after Subsidy among consumers receiving APTC (monthly)	**$106**	**$74**	**$105**	**$193**

Average annual Wisconsin Medicaid per member per month cost, 2015-16		
	Average Annual Per Member Cost	**Average Per Member Per Month**
Children	$1,762	**$147**
Parents	$4,128	**$344**
Childless Adults	$5,770	**$481**
BadgerCare Plus Total	$3,228	**$269**

DPC and Return on Investment

Cost-exposure across the range of services

- DPC, in order to deliver a return on investment, would need to result in cost-savings from other services that exceed the monthly or annual DPC subscription fee.
- Such savings would likely need to occur at the point of pre-deductible specialist, lab, imaging, prescriptive, and emergency department services.

DPC and Return on Investment

Costs and Benefits

+ DPC contracts subscription fee

+ Premium for wrap-around coverage

+ out-of-pocket for non-DPC services, pre-deductible and OOP maximum

= Total Payments

<Other medical service costs averted>

= Total cost of care

+ 0 Subscription Fee

+ Standard Insurance Premium

+ out-of-pocket payment for cost-sharing, pre-deductible and OOP maximum

= Total Payments

< reduced out-of-pocket by applying primary care cost-sharing to deductible>

= Total cost of care

Questions to consider

- Does the DPC model avert other specialty, lab, imaging, referral, and hospital costs that would otherwise accrue?
- How much does the DPC provider rely on laboratory, imaging, and specialist referrals?
- Do the health plans continue to price in the required preventive services into their premiums, apart from the DPC, or carve out these services and rely on the DPC to provide them?
- Does DPC provide and participate in after-hours care, or do their enrolled patients rely on other sources of care for after-hours services?

DPC and Health Care Cost/Quality

Volume of Care and Utilization

- Most health care costs are concentrated in a small proportion of high-cost, high need patients – often referred to as super-utilizers.
- Costliest five percent of patients account for half of all health care spending.
- Generally have complex chronic and acute needs.
- Not clear whether this population, their health care needs, and their costs can be managed within a primary care office setting, as many of their needs require significant and intensive specialist management and care coordination.

DPC and Health Care Cost/Quality

Most consumers use relatively few services

- In 2015, U.S. residents incurred 1.6 visits per year with primary care physicians, and 1.5 visits per year to medical and surgical specialists
- Including all visits – for primary and specialty care services:
  - About half of all U.S. residents visit the physician three or fewer times in a year, while another quarter incur 4-9 visits annually.

Average Number of Physician Office Visits Annually				
	None	1-3	4-9	10 or more
Total Population	15.0%	48.4%	23.7%	12.8%
Medicaid	12.4%	43.4%	25.4%	18.8%

DPC and Health Care Cost/Quality

Will enrollment in a DPC reduce or avert other costs that would otherwise occur?

- Under existing utilization patterns: The other half of consumers' office visits, along with the lab, imaging, and pharmacy services may fall outside of the DPC contract.

→ The DPC model will need to avert use of non-primary care visits in order to show cost savings to the consumer and to health care purchasers.

DPC and Health Care Cost/Quality

- How might DPC affect volume of care provided?
- Proponents of DPC point to this decreased panel size, and increased time a provider can spend with each patient, as one of the primary benefits of this model.
- The evidence remains unclear whether extra time and additional visits improve health outcomes and avert other specialty and referral services that would otherwise occur.

Office Visit Length: Does DPC Offer Better Quality, and Outcomes?

- U.S. office visits
  - About half last fewer than 15 minutes
  - 42% last up to 30 minutes
  - 15% last up to an hour
  - Will vary by specialty
  - Primary care specialties averaging about 20 minutes overall
- DPC physicians spend an average of 35 minutes with each patient visit, and patients in the practice average four visits annually.
- U.S. primary care physicians maintain a practice panel of about 2,300 patients, while DPCs typically limit their patient panels to several hundred patients.

Cost/Quality: Does DPC Office Visit Length Offer Better Quality, and Outcomes?

- Comparison between the overall U.S. average and the DPC average does not necessarily reflect an actual upgrade in service for each patient.
- The existing system triages care needs, such that high need patients incur more visits, with longer visit times, while lower need patients incur fewer visits with shorter visits times.
- DPC visit average includes only the limited population of patients enrolled in the DPC subscription model.

For Evaluation: Need to assure random assignment of various risk status patients between the two models and compare health care use and outcomes – assuring that observed outcomes do not reflect potential that healthier patients select DPC providers.

Cost/Quality: Does DPC offer longer visits to those who need it?

- All users, including a generally well population, may appreciate DPC practice amenities and a stronger relationship with their physician.
- Evidence does not yet exist to show that, for generally well patients, more time with the physician or more visits improve outcomes, or whether this population in fact needs these visits.
- The extra time and visits provided by the DPC may or may not, for most consumers, avert other specialty or referral costs that would otherwise have been incurred.

“Retainer practices note that they are able to see their patients more often throughout the year. Once again, there is no evidence to suggest that this is always necessary or effective. With all of the “amenities” offered by these practices, it is important to do a cost–benefit analysis to understand the true effect of the “extras” in a practice. At this time, no research or data are available to indicate that many of these amenities in a practice yield better clinical outcomes. It is important to be aware of the potential for overutilization of physician time and medical services.”

American College of Physicians. Policy Position, 2015.

Published in Ann Intern Med. 2015;163(2):949–952.

Questions to consider

- Does DPC avert additional care needs for lab, prescription drug costs, or hospitalizations?
- Do these savings exceed the subscription fee payment?
- Can the DPC model sufficiently manage the care of high needs patients that currently incur most of health care costs generally and within Medicaid?
- Given existing and projected primary care provider shortages, what effect would DPC expansion have on access to care?

Specifically for Medicaid

- Would DPC affect the types of services needed by Medicaid enrollees, and would the DPC model generate total savings?
- How would DPC affect current managed care contracts?
  - Would they be able to carve out required preventive services, and primary care, from those contracts, and would this reduce Medicaid's payments to managed care providers?
  - Would DPCs (when they do not submit insurance claims), submit other data to allow for care coordination and/or quality measurement? How would this affect administrative costs?

DPC and Medicaid

- Michigan Pilot Program
  - 400 enrollees from each of various eligibility categories
  - Average $70 per enrollee for DPC services
  - Required quarterly report from Health Department
- Implementation delayed from October 2017, with timeframe "contingent on negotiations between Medicaid Health Plans and any potential contracted providers"
- Most recent (April 2018) quarterly report noted an anticipated implementation start date of July 1, 2018.

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