Follow the Pathway to PCP Success In Medicare Direct Contracting

written by Theresa Hush | June 27, 2019

Primary care physicians were sitting on the sidelines as Medicare developed financial risk models in various generations of ACOs. At best, they could only hope to participate in Medicare Advantage and/or join a larger ACO. But potential for financial gain was elusive when the physicians' success depended on the actions of others to achieve savings.

Now Medicare is offering a carrot to large primary care practices with its new Direct Contracting (DC) models, luring them with the possibility of capturing higher and more predictable revenues as well as shared savings.

CMS recently announced an initiative to test risk-based reimbursement models for primary care practices over five years:

> Primary Care First aimed at small practices, which we've reviewed in a previous post, and "Direct Contracting" (DC) models that target larger practices with infrastructure to manage services and distribution of money to other physicians.

Direct Contracting is Reminiscent of the "Good Old Days" in Managed Care

DC builds on past experiences of Independent Practice Associations (IPAs) and Physician-Hospital Organizations (PHOs), where primary care physicians played the central role in managing their patients' services, costs and referrals. Those models and DC share a philosophy that patients need a primary care home to guide their health care and avoid unnecessary use of emergency care and avoidable hospital admissions.

Payment differs under the three DC models, with a Professional Per Beneficiary Payment (PBP) option comprised of a PCP capitation plus shared savings/losses based on performance, and a Global PBP option that allows partial or full capitation plus sharing of shared savings/losses. A third DC option, not yet configured, will establish a regional geographic model.

But there are major differences from the 1980s primary care-centric model of services and capitation, the biggest being that patients are free to use other providers freely without authorization. DC lacks the restrictions on patients that were viewed as essential elements to financial success.

As a result, Direct Contracting physician groups must control the full spectrum of patient care costs to achieve savings. DC requires a considerable shift in the core expertise of most group practices. They must significantly address cost drivers, generate patient loyalty and cooperation, and make it easy for patients to choose and follow therapies.

PCP Group Structure Is Contingent upon the Choice of DC Reimbursement Model

DC practices must actively manage their patients' services—whether they are directly providing that care or not. For a Global PBP capitation model to financially succeed for primary care groups, PCPs must already be aligned with specialists and hospitals who are reliable partners and can ensure that the PCP continues to be part of the medical decision-making process. They will need to provide the benefit of shared savings to other physicians as well as to PCPs, and use strong tactics to steer patients to facilities that cooperate with their needs. Only the best situated independent primary care groups or primary care-centric groups with some specialists will have the leverage to accept Global PCP payments.

Even with partial capitation, however, DC will demand that primary care groups use their leverage to arrange a referral network that can facilitate their coordination efforts. DC groups are still subject to downside risk if they cannot manage patient utilization of services beyond

the PCP setting.

All DC groups must therefore identify and proactively manage patient risks, especially those more likely to be admitted under emergency situations. That will require analytics and data that are not typically used by PCPs, and population health and other functionality that may not be available in their current systems.

Three Guideposts for DC Success

As primary care physicians enter the fray of provider risk, they must engage in the three processes that determine their ultimate success:

Assessment of patient needs;
Adoption of a plan of care with the patient in a joint process of medical decision-making; and
Arrangement of specialized services that will help manage services beyond their walls.

Let's take a closer look at each, in turn:

Pathway to DC Success Starts with Patient Needs Assessments

A key differentiator for PCP groups cost management will be the use of pro-active rather than retroactive tools to identify and coordinate patient needs. Since events associated with chronically ill patients drive as much as 90 percent of total patient costs nationally, the focus for PCPs will naturally be to avoid hospital and emergency care.

But PCPs should not be misled by industry statistics for chronic illness to then simplify the problem. Included in chronic disease are cancers, mental illness, auto-immune disease and other genetic conditions for which the causes are unknown. Similarly, some population health efforts attempt to go after "high users" with chronic disease, on the premise that patients' poor lifestyles are the central problem. That fails to address financial and physical circumstances that must be addressed for patients to get better.

The more realistic and compassionate approach is to help patients achieve success through various supports that are targeted to their circumstances. But this requires PCP practices to gather patient data in a reliable and connected way through patient meetings or interviews, and to use this data to identify functionality issues, social determinants of health, and barriers to patient treatment.

DC provides the opportunity for practices to rebuild the primary care relationship with patients. By talking to patients and collecting the associated data, a needs assessment process can build the clinical foundation for patient care coordination while also improving patient communication, engagement and loyalty. This should recharge primary care and can help get patients and physicians on the same page for planning care and engaging in shared decision-making.

PCP practices will need to invest in technology to help them store data and connect it with the EMR patient history, and to roll out defined and customized population health initiatives.

A Pro-Active Medical Decision-Making Process Is Key to Aggregate Cost Trends

Total patient costs are aggregated by thousands of events associated with individual patients. What drives the cost of those events? Individual medical decisions made by patients and/or providers. Ultimately, reducing costs always must involve altering the decisions—not just altering the front end of the process of establishing the treatment plan.

Changing the front end of the process is the needs assessment and the development of a plan that can be achieved by the patient. But that plan, and its execution, has to stick. What makes it work? One solution is a process between the provider and patient to discuss and agree on the goals and plan of action.

PCPs who are unwilling to work with patients to understand concerns and achieve consensus will be unlikely to succeed in lowering costs long-term. Patients will simply do what they want—which could be nothing.

In addition, there will be surprise events and medical crises that occur despite best intentions of PCPs and their patients. These situations are unexpected and unavoidable, and each will undoubtedly come with options for aggressive or conservative treatment, or none at all. In each circumstance the resulting medical decision is also a cost decision, and the patient and PCP should engage in a discussion of cost and benefit based on reliable data.

Physicians are not trained in the art of motivational interviewing as applied to health, or in shared decision-making. But PCPs in DC will find that learning these skills could be as important as the plan itself. They should seek resources to educate physicians in these new skills.

Partnerships with Specialists and Hospitals Will Be Essential to Successful DC

No matter how excellent the PCP care, most patients will need specialized services at some point. Some patients will rely on specialty services more than primary care. It is unavoidable, and PCPs must ensure that the choices of specialty services align with their DC cost goals.

While PCPs are unable to strongly steer patients in Medicare and deploy prior authorization practices of the past, they are not powerless to help direct patients to good resources. They must establish preferred referral arrangements, and do so by evaluating cost and outcomes as much as possible. In short, they will need to have a different recruiting process in the future if they want to achieve savings, and to make arrangements mutually beneficial for specialists.

Specialty groups have, in the past, been averse to sharing data or episode-based cost profiles. But CMS has reinforced the need for price transparency, most recently upping the ante through an executive order. In addition, there are more initiatives that foster bundled payments for specialty procedures and medical episodes. Many specialty practices are now experimenting with creation of episodes and could be eager to engage with primary care physicians in ventures, rather than health plans or even ACOs.

PCPs should work with specialty practices that are willing to establish shared initiatives like cost per episode tracking. PCPs and specialists can share the cost of technology or outsourced vendors that will create episodic shadow pricing, and assist in tracking the results of intervention to bring the cost trend down. Over time this will enhance both PCP and patients' ability to compare costs of various specialty procedures and medical episodes.

Relationships with hospitals are more complex, because PCPs have largely given up inpatient management of patients to hospitalists, especially in populated areas. But PCPs should develop a process to establish relationships with hospitals that ensure communication upon emergency department or inpatient admission, and communication with attendings and PCPs during the event, so that the primary care practice can manage the transition back to home or post-acute settings.

In sum, coordination of care cannot, by itself, fuel the achievement of good outcomes at lower cost. Value is attained by matching patient needs with interventions that are both achievable and implemented. It's a tall order to turn the ship around and put primary care in a central role. Practices with the energy for change will do well if they work hard to rebuild the trust and engagement of their patients, and work collaboratively with specialists.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image: Thor Alvis