Can Medicare Primary Care Risk Models Work in Today's Practice Environment?

written by Theresa Hush | July 11, 2019

There's now no doubt that Medicare is eager to move forward with Value-Based Health Care and risk-based reimbursement. CMS has rolled out major changes to make Accountable Care Organizations (ACOs) risk-bearing and add attractive benefits to capitated Medicare Advantage plans. Add to that two new classes of Primary Care Risk Models that introduce risk-based reimbursement into the general provider population, which, CMS says, are designed to stimulate primary care: Primary Care First (PCF) and Direct Contracting (DC).

But we also know, from early CMS statements on direct contracting, that it intended to find other mechanisms to move physicians into Value-Based Health Care in light of tepid adoption of ACOs. At the same time, existing and future ACOs are depending on recruiting from the same dwindling pool of primary care physicians to achieve success.

Given the reality of consolidated health care organizations and primary care physician practices today, will these models actually work?

In prior articles, we've described the two programs and the variants of each model, and laid out how groups need to examine their likelihood of success. For large groups considering direct contracting, we've outlined key steps to preparing for the challenge of partial or global capitation.

Here we examine how the Medicare Primary Care Risk Models fit the evolving delivery system and the goals of Value-Based Health Care. What are the potential effects of these models on adoption and success for providers?

Can Primary Care Physicians Take on More?

Let's take a look at what is happening to physician groups, in general, and to primary care physicians, particularly.

It's a well-established fact that the capacity of primary care physicians falls short of need in the U.S., and that there is a maldistribution of physicians, to the detriment of high-need areas. Observational data links reduced capacity by county to increased mortality and specific higher causes of death. Although there has been a recent rise in number of practicing primary care physicians, the per capita benchmarks are declining.

Primary care physicians are being driven to take on more volume, while at the same time the population health processes envisioned by Medicare Primary Care Models require more work and time per patient. Physician thought leaders are asking legitimate questions about how pressure to see more and spend less time per patient can result in better care—and whether incentives to focus on primary care management of expensive chronic illness can actually result in worse outcomes.

Primary Care of Yesteryear is Not Same as Today

There is nostalgia regarding primary care that does not seem to reflect the reality for most practices and patients. In a departure from the past, less than half of physicians are in physician-owned practices, which tend to be smaller in size.

According to the American Medical Association's (AMA) Physician Practice Benchmark Survey of 2018, more than half of physicians are employees in a practice. Ownership and partnership of practices declined from 75.3 percent in 1983 to 45.9 percent in 2018. Along with this trend is a significant shift in practice size, with just over one-third of all practices having five or fewer physicians. More of the smallest-size groups tend to be physician-owned and single specialty practices. This will be a significant obstacle for ensuring the resources and technology required

to manage risk in small primary care and specialty practices.

In both Family Medicine and General Internal Medicine, the majority of physicians are employees, and in both areas the number of physicians operating in physician-owned single specialty groups is obscured by the combined total of physicians in multi-specialty practices and hospital-owned settings. The traditional small general medicine practice is fading and being replaced by larger multi-specialty groups. Primary care physicians have exited solo small practices, and practices with fewer than 5 physicians are dwindling. These smaller practices, along with the next tier of 5 to 10 physicians, are the target of Primary Care First.

Private practice is also declining, as hospitals have acquired or established joint-venture practices with physicians. The AMA Survey reveals that just 54 percent of physicians are in private practice, down from 61 percent in 2012, but the rate of decline is slowing. Hospital investment tends to produce multi-specialty groups of larger size.

A second survey of physician practice trends, morale and perspectives paints a markedly bleaker picture of the numbers, with only 31 percent of physicians as owners or partners in practice (different results due to a different mix of responding physicians, including more primary care physician responders).

Primary Care Models Favor Larger Practices and Prominent Multi-Specialty Groups

Physician practice trends will have a significant effect on the adoption and success—from both provider and patient standpoint—of Medicare Primary Care Models.

> Primary Care First will face the greatest hurdles to adoption on a large scale, and less success in achieving incentives for practices. Its focus on a waning number of small and under-resourced practices will be a natural deterrent to adoption, and perhaps this is intentional. CMS cannot exclude such primary care physicians from the game and has understandably set a low bar for incentives. But stronger and trended outcome measures are necessary to ensure that patients are improving. Rewarding practices based on reduction in hospital utilization, while depending on MIPS measures for quality, is an insufficient formula for value.
> Direct Contracting should appeal to certain larger groups, especially if they are negotiating other risk-based agreements. Targeting large groups with guaranteed per-beneficiary payments—with beneficiary alignment advantages an extra plus—creates strong incentives for groups that have invested in expansion. However, we should recognize that consolidated systems with physician practices are in the best position to

capitalize on direct contracting, since their providers can participate in a closed system of care, including ambulatory, outpatient and inpatient services, as well as post-acute arrangements. Nonetheless, note that these organizational assets will be offset by the attitudes of employed primary care physicians in such groups—being overworked, with little autonomy and power—lessening their leverage and interest in controlling costs. While the group's top hierarchy may be keenly interested in a committed patient volume, rank-and-file physicians are unlikely to be the change agents needed to generate better care or savings.

Participation of physician multi-specialty and single-specialty primary care groups is unlikely to be very advantageous to any but the most prominent multi-specialty physician groups. While partial capitation is available, there are shared savings associated with costs that are often outside the control of the primary. Medicare has established cost of care as the primary indicator of value, because the only real measure of success is savings against capitated revenues or total expenditures. Like PCF, DC lacks key trended outcome measures and safeguards to protect attributed patients from denials of care or inadequate treatment.

Capitated payments planned under Direct Contracting have worked in the private sector to produce savings, and Medicare Advantage plans have also been successful. But all capitated arrangements benefit groups by the influx of younger, healthier patients that balance the costs of older and more ill patients. Medicare Advantage plans have already siphoned off many lower cost patients from traditional Medicare, and those who remain will represent more difficult and expensive patients to serve and still generate returns for providers.

We have presented a rather pessimistic forecast of Medicare's Primary Care Models, but not because of their inherent design. There is little doubt that stimulating primary care relationships may be helpful for many patients, and could result in better outcomes and lower costs. The question is whether this result could take place on a large scale in the current health care environment. We may have passed the stage where existing vertical organizations can reimagine and reinvigorate primary care and specialty care to become a real continuum of accountable care. In fact, is not that vision what ACOs are intended to do?

The question of ACOs and the competition for primary care physicians we will leave for another post. CMS seems to be indicating that where ACOs have failed to achieve the goals of value, a less cumbersome regulatory structure for providers may succeed. Or, the larger CMS goal may be simply to steer physicians toward fixed or capitated fees, rather than to remodel the delivery system. Stimulating the supply of primary care physicians could be better accomplished through a payment system other than capitation or risk-based incentives.

In either case, there is a nascent but growing group of providers who recognize the potential for fulfilling the CMS goals: private-equity-backed physician practices. Lacking the history and baggage of physician-owned as well as hospital-owned practices, these companies are eager to fill the void and make health care a business.

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