How Should Primary Care-Centric Physician Practices Choose A Path to Risk?

written by Theresa Hush | August 29, 2019



It’s an urgent question for most practices: How should physicians participate in value-based reimbursement? Traditional Medicare is moving assertively to physician payment models that include capitation and ceilings on spending, with revenue risk tied to patient care costs. Without a doubt, primary care practices are bearing the brunt of risk-based reimbursement.

With the exception of specialty-aimed Bundled Payments, most payment models are primary care-centric. Patient costs are grouped and then attributed to their primary care physicians—regardless of whether the services were provided by those physicians or by specialists and hospitals—and those PCPs are then rewarded or penalized under various risk arrangements.

Under Medicare Value-Based Health Care programs, elimination or

modification of Fee-for-Service (FFS) has become a stated priority. CMS is also rewarding physicians to participate in other plans, like Accountable Care Organizations (ACOs) that must include downside risk under CMS rules. Again, while the dollar risk may be spread throughout the ACO network, the reality is that the PCPs are compared based on cost, and those whose patients drive ACO cost overruns usually feel the brunt of criticism.

A five-year trajectory to risk-based reimbursement is likely for most physicians, whether they accept government or private insurance. Commercial health plans have been, so far, slow to readopt capitation because they can achieve savings by directing patients to network providers who negotiated lower rates. But incentive payments tied to spending are common. If Medicare succeeds in transitioning to risk-based reimbursement, Medicare Advantage and private insurance plans will undoubtedly follow suit. Capitation will be necessary under competition with traditional Medicare and other MA plan.

Let’s examine both the options and decision-making criteria that practices must weigh as they contemplate options for participating in Risk, especially primary care and multi-specialty practices with a primary care base of services.

Risk Models for Physicians Come in Many Varieties

There are five Risk models for participation in Medicare or commercial health plans. These include three options for practices and two for networks. Practices may directly participate in the following:

- Medicare's Primary Care First (PCF) model (small groups), which is a 5-year pilot that would allow physicians to "practice" for more substantial risk initiatives;
- Medicare's Direct Contracting (DC) model, also a 5-year initiative targeted to larger groups with infrastructure to manage populations;
- Health plan options like Medicare Advantage (MA), which already claims about a third of Medicare beneficiaries and is expected to grow beyond 40 percent within a decade.

Additional options can be leveraged with locally-organized physician or hospital-physician networks. These choices include:

- Accountable Care Organizations (ACOs) directed either by hospital networks, physicians, or combined, for Medicare and/or commercial health plan participation;
- Provider networks such as a Clinically Integrated Network (CIN), or Independent Practice Organization (IPA) /Physician Hospital Organization (PHO) acting as a CIN, for commercial health plan participation.

Some options are mutually exclusive, so the real range is limited. Each practice will have to make a choice between direct Medicare options, and may also decide to participate in Medicare Advantage. Depending on the size of the group, the decisions now look more limited:

- PCF or ACO/CIN, with or without MA

Or

- Direct Contracting or ACO/CIN, with or without MA

Each option also often has variations that will affect level of risk and payment type.

Decision Criteria for Risk Participation

Realistically, any primary care or multi-specialty practice cannot predict which risk arrangement will be safest or most financially viable. Why? Because the data simply won't be readily available for them to calculate how the future final metrics—cost of patient care and practice revenues—will turn out under each model. Their decision criteria will necessarily be subjective. Here are four key questions:

1. Seminal Decision: Is Practice Independence or Interdependence the "Safer" Route?

Each direct Medicare option above is a choice of independently engaging in Risk, or working with other providers in an ACO or CIN. That decision will ultimately be determined on the basis of whom the other providers are—and any history of trust issues. But there is a basic preference in every practice for independent or group action that overrides logic. Nevertheless, it pays—quite literally, under financial risk—to perform due diligence of other providers in the network.

Partnering practices should ideally share a variety of information that would demonstrate their cost status, such as Medicare scores on cost-per-beneficiary-per-year, and their cost scores relative to targets. While this type of data sharing has been rare in the past, the financial partnership under Risk creates an imperative for transparency and knowledge

based on solid data. That exercise builds trust and makes it possible for providers to create a group process of change.

2. Are Data and Infrastructure Established—with Ongoing Investment?

Every risk model will require actionable data to change the cost curve. The best practices will calculate patient risk and track costs against predicted expenses, so that intervention can be timely. There must be systematic processes to reach out to patients and to improve the knowledge of risks, barriers, and experiences of patients. Then, applications and analytics must put that data to use in a way that will be clear to physicians.

Infrastructure is expensive, and the economics of Risk help make a strong case for spreading that cost over a larger number of providers. Physicians who are engaging with ACOs or CINs should make their participation decisions based on the necessary investment in infrastructure and staff to support the practices. Otherwise, physicians will be scrambling and blindsided by questionable analytics. Data and infrastructure are logical selection criteria. If present, the organization is a safer bet. If not, participating brings a higher risk to the practice.

3. Is There a Learning Approach for Physicians and Patients?

Providers are just beginning to understand the requirements of value-based care, and how motivational conversations and joint medical decisions can help physicians and patients create a collaborative plan. But this is a departure from traditional

roles. Research is beginning to highlight good results coming from positive physician learning processes as well as use of coaches to participate in patient goal-setting.

Physicians need to feel engaged and valued in their practices and/or in larger groups like ACOs. Both in reviewing their data in patient cases, as well as in leadership of the organization and actual patient care, there must be a learning environment that contributes to building skills that will help physicians succeed at Risk. When these learning processes are coupled with changes in productivity criteria that emphasize time with patients rather than churning appointments, physicians will be more willing to engage in Risk because they find it doable.

4. Is the Commitment to Quality and Evidence-Based Medicine Evident?

With Medicare reducing requirements for quality reporting, many are concerned that Risk will usher in old problems associated with HMOs, like patient dumping, difficult pre-authorization processes, and so on.

Physicians should question how the organization is conducting its outcome and quality reviews. Sticking to Medicare's bare minimum and calculating quality only at the annual review period on a sample of patients should be a red flag. Practices and ACOs should be harvesting data from EMRs so that it does not affect workload, and use that data to populate quality information on all patients.

ACOs versus CINs and other Networks

Physician practices, in some areas, may have a choice between

ACO participation and various CINs in the community. ACOs are more structured, often better funded, and generally more mature than most CINs. But the wide range of ACOs, Risk adoption, and success levels make the distinction between the two categories somewhat arbitrary. Nevertheless, they are used here as part of a continuum of Risk-oriented networks. If ACOs mature and achieve their savings goals more universally, CINs are likely to disappear.

An ACO is the only network model that has flexibility under Medicare and Medicaid to participate as a Risk entity. The only real reason for participating in a CIN instead of, or in addition to, an ACO is if the CIN is the only network available for commercial health plan contracting.

Medicare Advantage—Competing Risk Model or Not?

While MA plans are at risk with Medicare, that risk is not directly passed on to network providers. MA negotiated rates may first appear to practices as non-risk-based. MA plans often pay physicians on rates synced with traditional Medicare. However, in FFS under Medicare Advantage, claims may be denied for lack of medical necessity (more common in MA HMO plans). Therefore, physician revenues are at risk but the criteria are different—they are assessed at the level of individual medical decisions, rather than global cost targets.

Medicare Advantage participation also does not compete with Medicare programs offered directly to providers, such as Direct Contracting—for now. Because patients enroll in MA plans and thereby remove themselves from the traditional Medicare structure, providers can participate in a direct program from both Medicare and Medicare Advantage. Over time, however, MA

will attract patients that would otherwise be attributed to the provider ACO, or the provider may be part of a Direct Contracting organization and decide that the dual processes are not sustainable. Ultimately, the models will compete for patients and for revenue.

To sum up, to navigate Value-Based Health Care, physicians should apply criteria that are already within their assessment capabilities. In a contest between independence and interdependence, physicians can investigate four key parameters to determine how well they can integrate their practice into a group like an ACO, or whether they have the resources to benefit more by going it alone.

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.

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