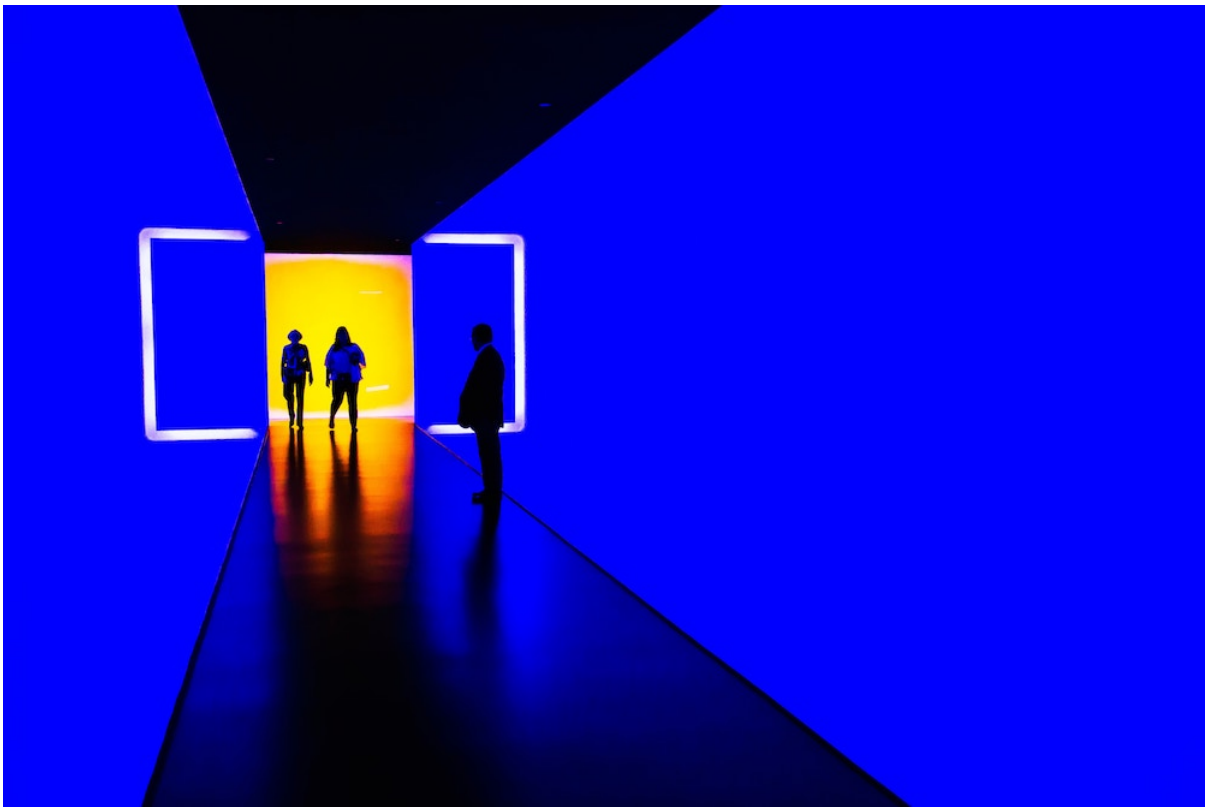
How Will New Primary Care Models Affect Providers in VBHC?

written by Theresa Hush | May 9, 2019



Embraced by some provider groups and disparaged by others, CMS's five new payment models for practices focused on primary care include much to consider. All reflect a key departure of Medicare's Value-Based Health Care (VBHC) efforts to date: they are direct efforts by Medicare to transition physician practice revenues to risk without the necessity of ACO participation.

The primary care models will affect both providers and patients. In this article, we'll address the provider issues. How patient choice of care and outcomes for patients and patient populations will be affected deserves dedicated scrutiny in a future post.

No Surprise that CMS Actions May Sidestep ACOs

The non-ACO models should not be a surprise to providers. We predicted in a June 2018 blog post that CMS signals to ACOs should be taken seriously. CMS made its plan to move forward with financial risk very clear, pushing for more growth of ACOs, higher provider participation, and more savings. They raised the possibility of direct contracting and showcased Medicare

Advantage as a better deal. The agency repeatedly stressed the problems and incentives with Fee for Service (FFS).

Aside from the limited savings that many ACOs were able to achieve, CMS may have been influenced by ACOs to create the primary care models. When ACOs threatened to drop out of the program in reaction to the CMS downside risk, it was abundantly clear that ACOs' ability to convince their providers to adapt to financial risk had hit a limit.

How will Primary Care Models Affect Physician Practices?

Primary Care First

All five primary care models represent options that move practices in a step-wise fashion toward accepting financial risk for delivering care more efficiently, with adherence to quality standards (not yet specified).

The two payment models under Primary Care First (PCF and PCF High Needs) are very reminiscent of what existed under PQRS and the Value-Based Payment Modifier (VPM), and, most recently, CPC+ (which targets groups having infrastructure, so small practices will not be as familiar with this model). PCF and PCF High Needs are FFS models with some retrospective shared savings (incentive) and downside risk, calculated by an algorithm that targets metrics similar to the VPM. But these models, which are intended for smaller primary care practices, also provide additional payments for the extra work involved, such as coordination of care.

PCF Models recognize that many small practices have neither the infrastructure nor the comfort level with risk that an ACO needs to meet its savings. So instead, CMS created a method to integrate them into VBHC and make it a positive step for practices. This new payment system enables CMS to incorporate a small amount of risk and provide practices with additional support, in the interests of leveraging primary care physicians. However, apart from the payments, how that primary care focus will be defined is currently somewhat vague..

Direct Contracting

The three Direct Contracting (DC) models are a much bigger departure from the current system than PCF. Aimed at large groups with existing infrastructure and experience in financial risk, the DC models recognize that many large multispecialty groups—especially in academic centers—can effectively participate in risk.

Clinically integrated networks or academic groups that have substantial technology and infrastructure have avoided expensive ACO architecture because of higher risk populations or provider attitudes. Under the DC models, because the groups will include primaries and multiple specialties under single governance, the capitated payment mechanism may be less a deterrent.

Academic groups with high concentration of Medicaid and dual eligible patients, in addition to more complex health issues, perceive the extra cost of upfront ACO investment and the downside risk potential as too financially dangerous. But capitation can fix this perception by providing a stream of predictable revenues. The models' incentives to motivate patients to stay inside the group are beneficial financially to the group.

Are ACOs Hurt by the Primary Care Models?

Some ACOs have reacted with alarm to the models because ACOs depend on the motivation of primary care physicians to join their efforts. The models appear to be competing for primary care physicians at a time when there is scarcity of PCPs.

Confounding that issue are rule provisions that require physicians to make either/or decisions on joining an ACO. This is based on assignment of the physician practice Tax Identification Number (TIN) to the ACO along with the attribution of their patients—and costs, making it easier to account for costs, and upside /downside risk.

CMS will have to respond to two questions that affect the ACO bottom line and its ability to attract primary care physicians:

> Can primary care physicians participate in both a primary care model and in an ACO? If yes, how does this affect the incentive payments to primaries and the calculation of savings for ACOs?

The technical obstacle—dedication of the physician group's TIN to the ACO—is a simple fix, but leveling the playing field through incentive adjustments is not. And, the answers to these are likely to be different for PCF models and Direct Contracting.

PCF Can Help Both Primary Care Groups and ACOs

For small PCF physician groups, it is easier to blend the models and allow dual participation by primaries because both remain under FFS. The payment structure for PCF could actually benefit ACOs greatly by lowering primary care physicians' resistance to risk—and directly tying their

actions to patient care costs and incentives.

There is a mutual benefit to both physician practices and ACOs by making it possible for PCF practices to participate. If small groups were concerned about their good efforts being offset by less efficient practices in an ACO network, CMS brings these primaries directly into the fold. They also get the infrastructure they need from the ACO to achieve their goals. For PCF, CMS could maintain separate incentive schemes for these primaries, adjust ACO shared savings and downside risk potential, or find a mechanism that blends the two accounting mechanisms.

Direct Contracting Will Compete with ACOs but Not Necessarily Disadvantage Them

Direct Contracting is an entirely different matter, yet from an ACO perspective it is hard to see a huge disadvantage. Such groups often already have the infrastructure to perform as accountable care practices or can afford them. Some have already used their market presence to establish ACOs that have drawn in other providers. But more are resistant and find the ACO model not to be nimble enough to address their unique needs.

Direct Contracting groups will be multi-specialty and, by CMS design, large. The capitation payment is advantageous for them and will result in a stronger alignment within the group to get all providers onboard with improvements, from better data collection to adoption of interventions.

But the groups that will be directly contracting with CMS were never going to be part of an ACO, unless it was their own. Except for one model—the geographic attribution of patients within a region to the group, yet to be configured in detail—the patients are already likely to represent distinct populations. Even the geographic model is likely to be focused on patients that are dual-eligible and highly concentrated geographically.

ACOs Can Use the Opportunity Presented by Primary Care Models to Create Advantage

There is little doubt that if capitation models succeed and ACO risk mechanisms do not, capitation will find its way into the ACO arena. We should expect all of the models to morph along a continuum toward capitation with extra incentives and savings pools. A global capitation model like Medicare Advantage is easily imagined for ACOs.

But ACOs have the perfect opportunity to create the necessary sense of urgency in their groups to achieve better performance, and to distinguish their model by more innovation. Since the

specter of capitation is now clearly in play, along with bundled payments, ACOs should move quickly to focus on their downstream patient costs, starting with specialty services. They can work with specialists now to create virtual episodes to examine variations in cost. They can focus on the collection of better data that will help them predict high-risk patients and create interventions to change the arc of pre-diabetes and early hypertension.

The threat to ACOs is not external payment models; rather, the threat is underfunding of initiatives and a slow pace of change. Building internal strengths through better funding and infrastructure will create the opportunity for ACOs to achieve what a multi-specialty group can't.

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