

How ACOs Can Realize the Full Potential of Primary Care to Improve Outcomes

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Disclosure

I am a part-time senior advisor at the Center for Medicare and Medicaid Innovation (CMMI).

However, I am speaking today solely on the basis of my role as a practicing physician and academic researcher.

My views do not represent any official position of CMMI or CMS.

I have no conflicts of interest to report.

Study Context

- Primary care is only part of health care system that in which investments routinely result in **longer lives** and **more equity**.
 - It is weakening in the U.S. when it is needed most.
- Changing topography of organizational arrangements:
 - >70% of primary care physicians work in practices owned by other entities; only some of which are in accountable arrangements
 - CMS goal of 100% of beneficiaries in accountable care by 2030
 - BUT...real questions about future of value-based care, and some pushback

If Primary Care Were a Pill or a Scan...

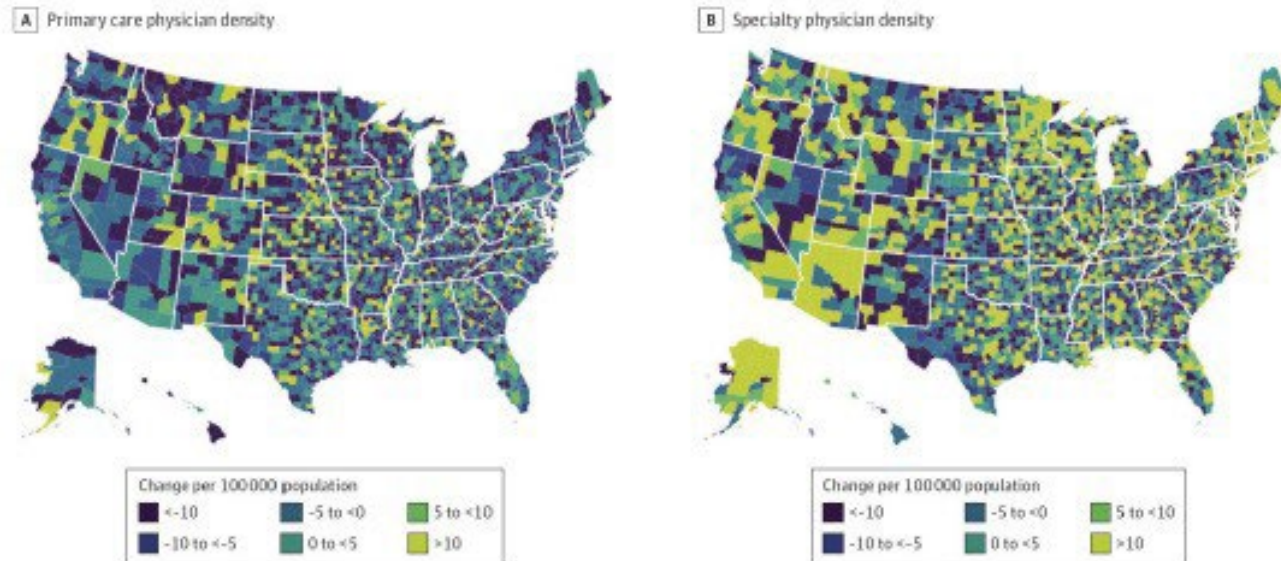
Research

JAMA Internal Medicine | Original Investigation

Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015

Sanjay Basu, MD, PhD; Seth A. Berkowitz, MD, MPH; Robert L. Phillips, MD, MSPH; Asaf Bitton, MD, MPH; Bruce E. Landon, MD, MBA; Russell S. Phillips, MD

Figure 1. Changes in Density of Primary Care and Specialist Physicians in 3142 US Counties, 2005-2015



What's Happened Over 20 years?

Annals of Internal Medicine

ORIGINAL RESEARCH

Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000 to 2019

Michael L. Barnett, MD, MS; Asaf Bitton, MD, MPH; Jeff Souza, MA; and Bruce E. Landon, MD, MBA, MSc

We looked at a huge span of Medicare claims from 2000-2019 to measure changes in primary and specialty care

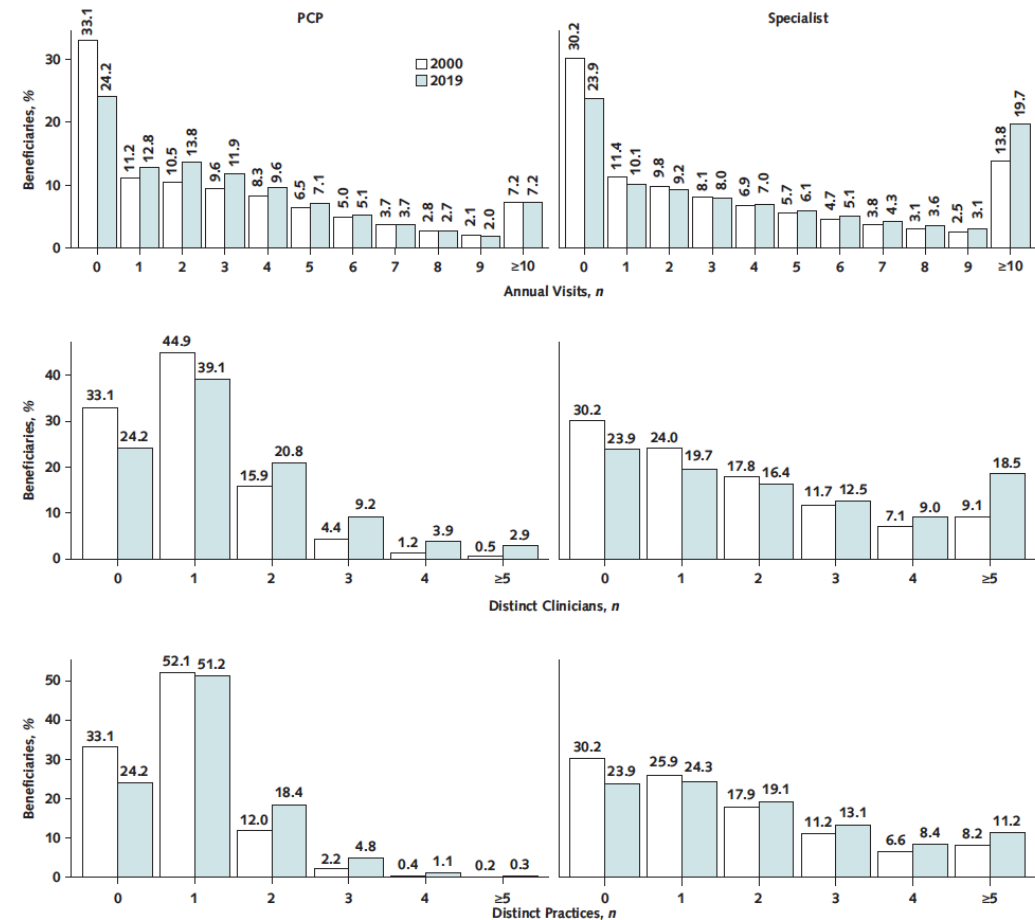
The results imply that primary care is a much harder job in 2019 than it was in 2000

Many Still Lack a Usual Source of Care

There was only a modest increase in the proportion of Medicare beneficiaries with any visit to a PCP (66% in 2000 to 76% in 2019).

Only 3/4 are empaneled with a usual source of primary care.

Figure 1. Patterns of primary and specialty outpatient care use by Medicare beneficiaries in 2000 and 2019.



PCP = primary care provider. Top. The annual mean number of office visits with either PCPs or specialist physicians per Medicare beneficiary in 2000 to 2019. Middle. The annual mean number of distinct PCP or specialist physicians per Medicare beneficiary in 2000 to 2019. Bottom. The annual mean number of distinct PCPs' or specialists' practices seen per Medicare beneficiary during the same period.

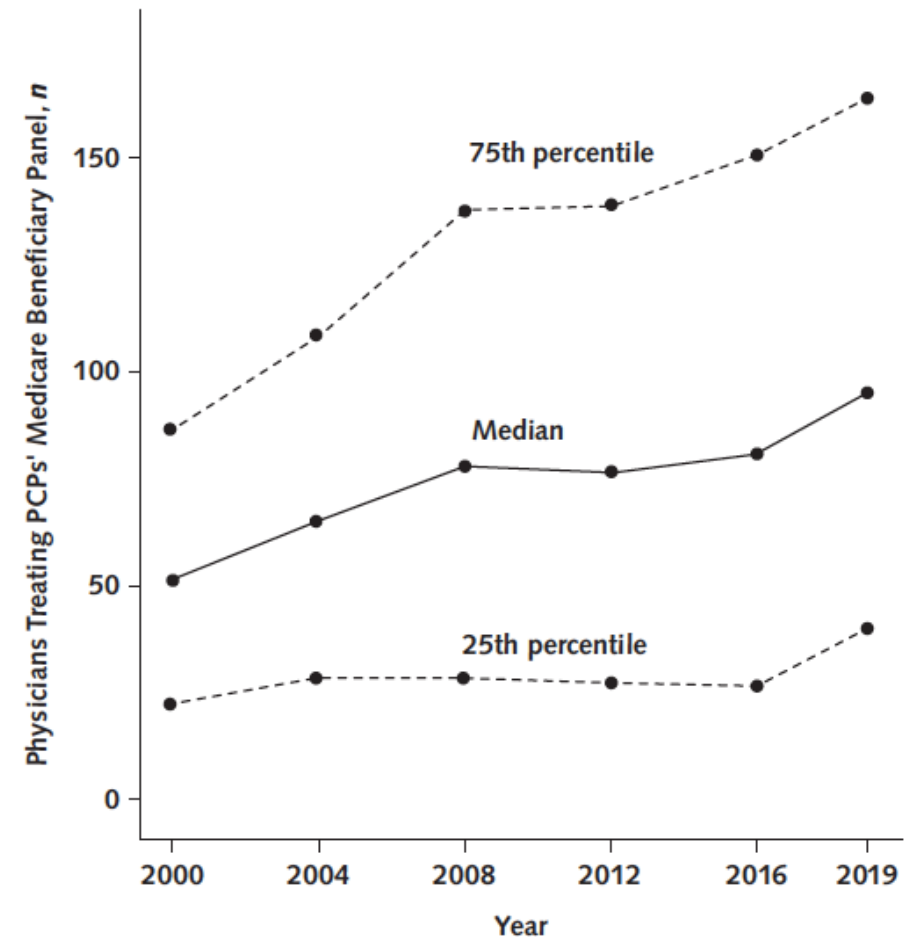
Less Coordination, More Fragmentation

The number of physicians seen by a PCP's panel of Medicare patients increased by ****83%**** from 2000-2019.

This means much more information, more drugs, more procedures, and higher costs per patient in 2019 than in 2000.

A much harder job for the entire primary care team to coordinate and integrate.

Figure 3. Trends in the number of physicians treating a PCP's panel of Medicare beneficiaries, 2000 to 2019.



Then...COVID

The implications of this failure are bad...



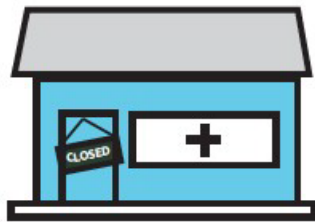
say they have had to furlough/layoff practice members.



say they have gone into debt



have experienced severe or close to severe stress for 2 months



...and will get worse:

51% are uncertain about their financial future one month from now

7% have already closed

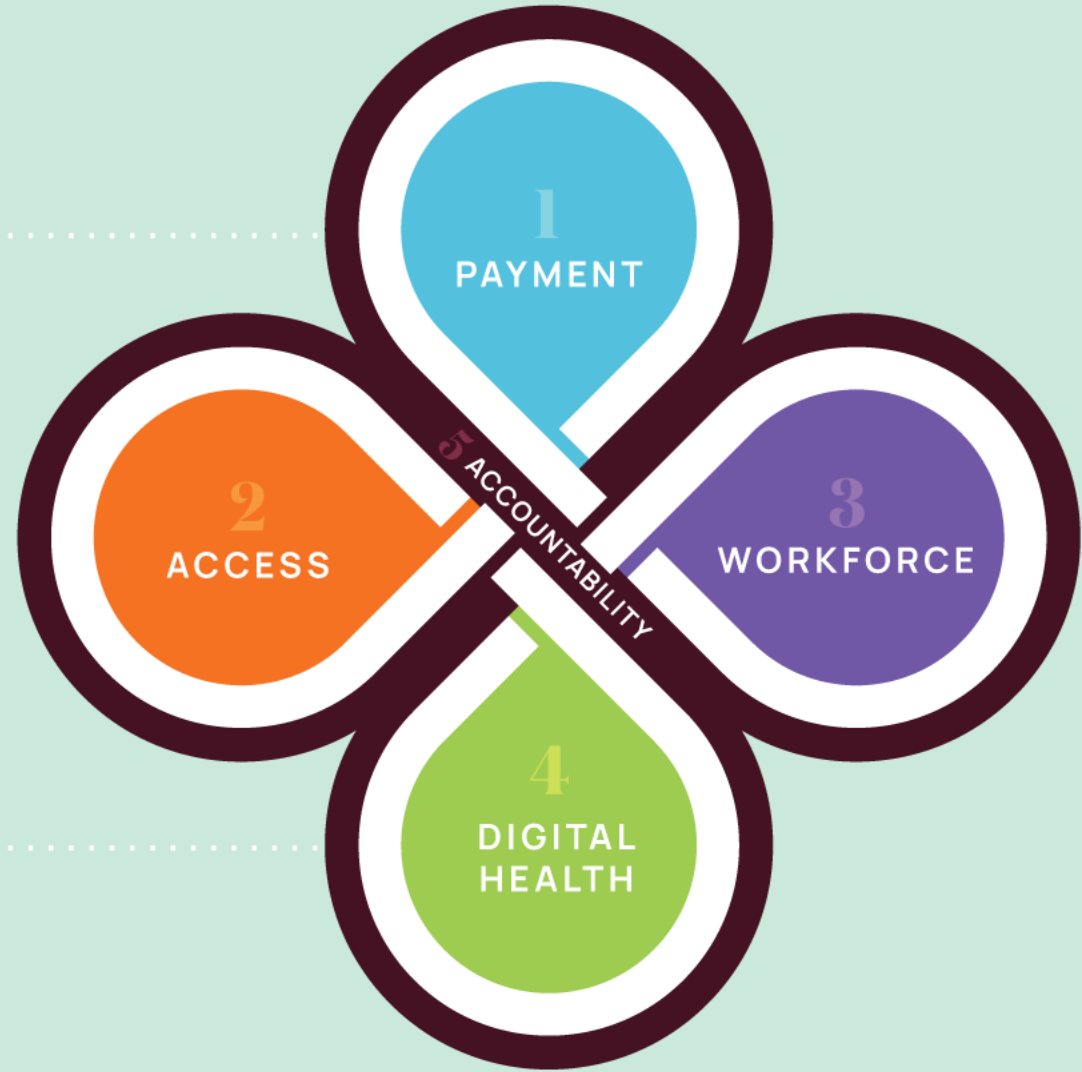
Primary care needs your urgent action because:

72% If primary care fails, so too does the health care system.

55% We are not ready for the next wave of this pandemic.

21% If my practice closes, the people in my community will have no access to care.

5 Objectives for Achieving High-Quality Primary Care



5 Objectives for Achieving High-Quality Primary Care

1

PAYMENT

Pay for primary care teams to care for people, not doctors to deliver services.

2

ACCESS

Ensure that high-quality primary care is available to every individual and family in every community.

3

WORKFORCE

Train primary care teams where people live and work.

4

DIGITAL HEALTH

Design information technology that serves the patient, family, and interprofessional care team.

5

ACCOUNTABILITY

Ensure that high-quality primary care is implemented in the United States.

Central Finding: Payment Has to Change

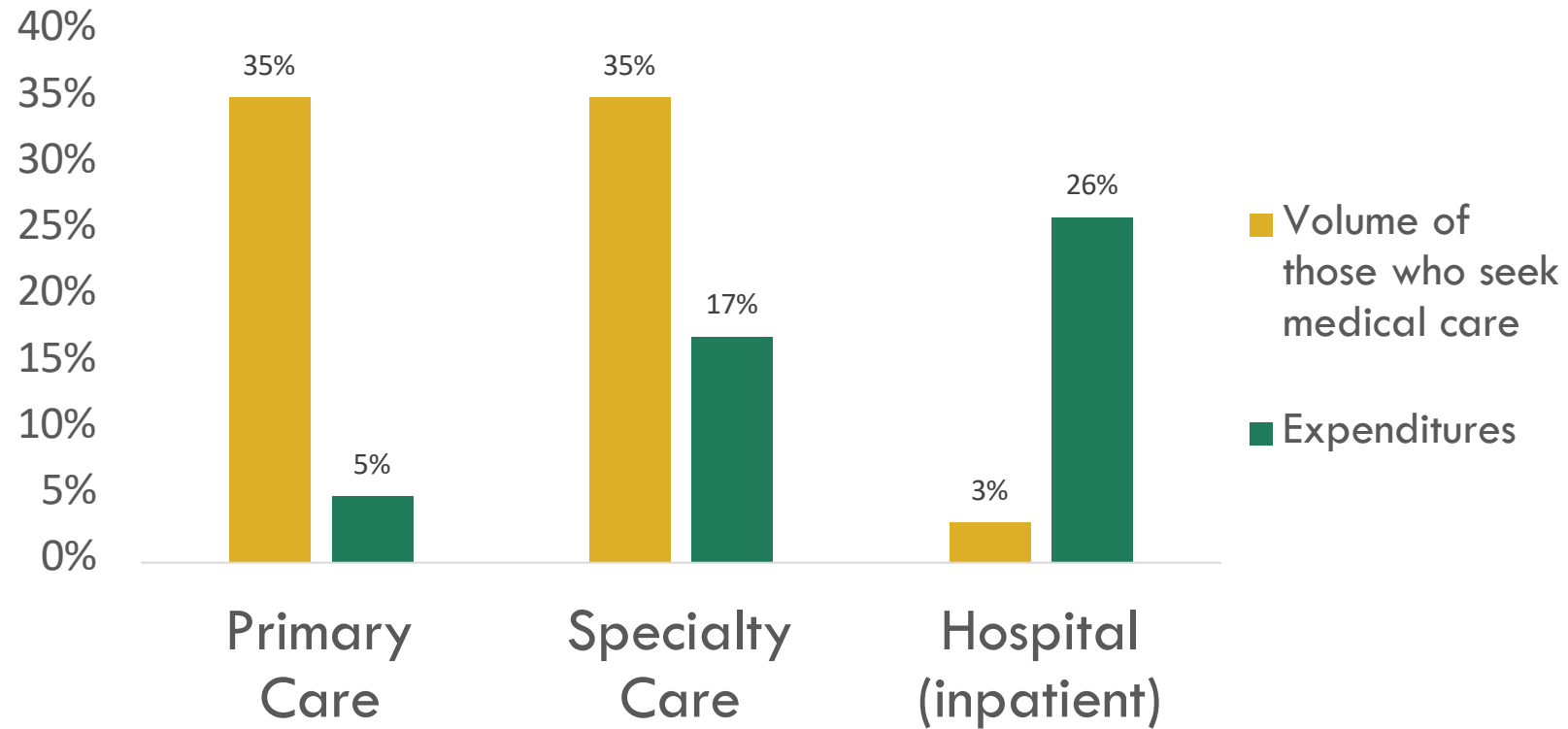


1

PAYMENT

**Pay for primary care
teams to care for
people, not doctors
to deliver services.**

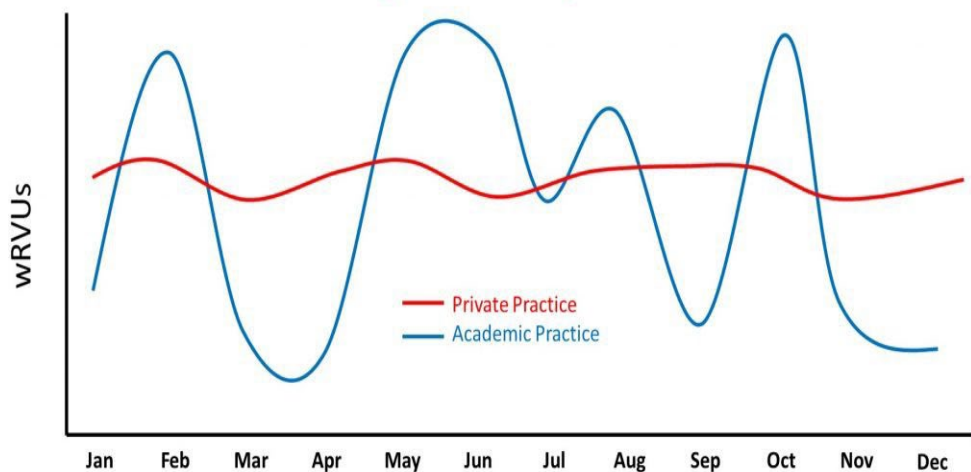
The Problem Starts (but doesn't end) with the Distribution of Money



Inside or Outside ACOs, Primary Care Practices Face a Broken Production Model

20th Century Payment

wRVU Productivity Varies By Month



21st Century Primary Care



Doing the Math: You Can't Run an Advanced Primary Care Practice on FFS

Effects of New Funding Models for Patient-Centered Medical Homes on Primary Care Practice Finances and Services: Results of a Microsimulation Model

Sanjay Basu, MD, PhD^{1,2}

Russell S. Phillips, MD^{3,4}

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ABSTRACT

PURPOSE We assess the financial implications for primary care practices of participating in patient-centered medical home (PCMH) funding initiatives.

METHODS We estimated practices' changes in net revenue under 3 PCMH funding initiatives: increased fee-for-service (FFS) payments, traditional FFS with additional per-member-per-month (PMPM) payments, or traditional FFS with PMPM and pay-for-performance (P4P) payments. Net revenue estimates were based on a validated microsimulation model utilizing national practice surveys. Simulated practices reflecting the national range of practice size, location, and patient population were examined under several potential changes in clinical services: investments in patient tracking, communications, and quality improvement; increased support staff; altered visit templates to accommodate longer visits, telephone visits or electronic visits; and extended service delivery hours.

RESULTS Under the status quo of traditional FFS payments, clinics operate near their maximum estimated possible net revenue levels, suggesting they respond strongly to existing financial incentives. Practices gained substantial additional net annual revenue per full-time physician under PMPM or PMPM plus P4P payments (\$113,300 per year, 95% CI, \$28,500 to \$198,200) but not under increased FFS payments (−\$53,500, 95% CI, −\$69,700 to −\$37,200), after accounting for costs of meeting PCMH funding requirements. Expanding services beyond minimum required levels decreased net revenue, because traditional FFS revenues decreased.

CONCLUSIONS PCMH funding through PMPM payments could substantially improve practice finances but will not offer sufficient financial incentives to expand services beyond minimum requirements for PCMH funding.



A Way Forward...That Needs Your Help

Fee-for-service (FFS):

- Phase out over time
- Interim revalue evaluation & management codes (E&M)
- Internalize the RUC's committee function within CMS

Hybrid Payment (FFS + Capitation):

- Pragmatic balancing of incentives
- Limit FFS and push toward more capitation
- Resources for transformation and health-related social needs
- Not focused on cost savings

Risk Bearing Contracts with Focus on Population Health:

- Sufficient resources and incentives for primary care teams to care for communities

Prospective Payment is Necessary

PRIMARY CARE

By Sanjay Basu, Russell S. Phillips, Zirui Song, Asaf Bitton, and Bruce E. Landon

THE PRACTICE OF MEDICINE

High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care

ABSTRACT Capitated payments in the form of fixed monthly payments to cover all of the costs associated with delivering primary care could encourage primary care practices to transform the way they deliver care. Using a microsimulation model incorporating data from 969 US practices, we sought to understand whether shifting to team- and non-visit-based care is financially sustainable for practices under traditional fee-for-service, capitated payment, or a mix of the two. Practice revenues and costs were computed for fee-for-service payments and a range of capitated payments, before and after the substitution of team- and nonvisit-based services for low-complexity in-person physician

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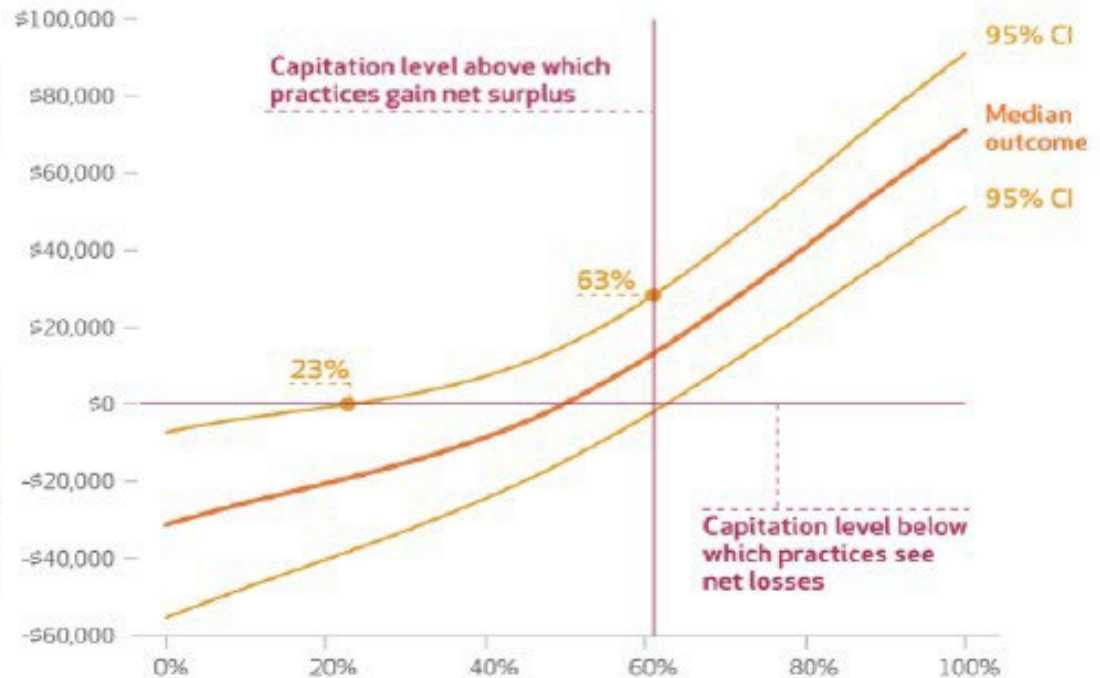
Sanjay Basu (basu@stanford.edu) is an professor of medicine, Department of Medicine, Stanford University School of Medicine, in California.

Russell S. Phillips is an professor of the Center for Health Care Delivery Research, Harvard Medical School, in Boston, Massachusetts.

Zirui Song is an assistant professor of health policy, Department of Health Policy, Harvard Medical School, in Boston, Massachusetts.

EXHIBIT 3

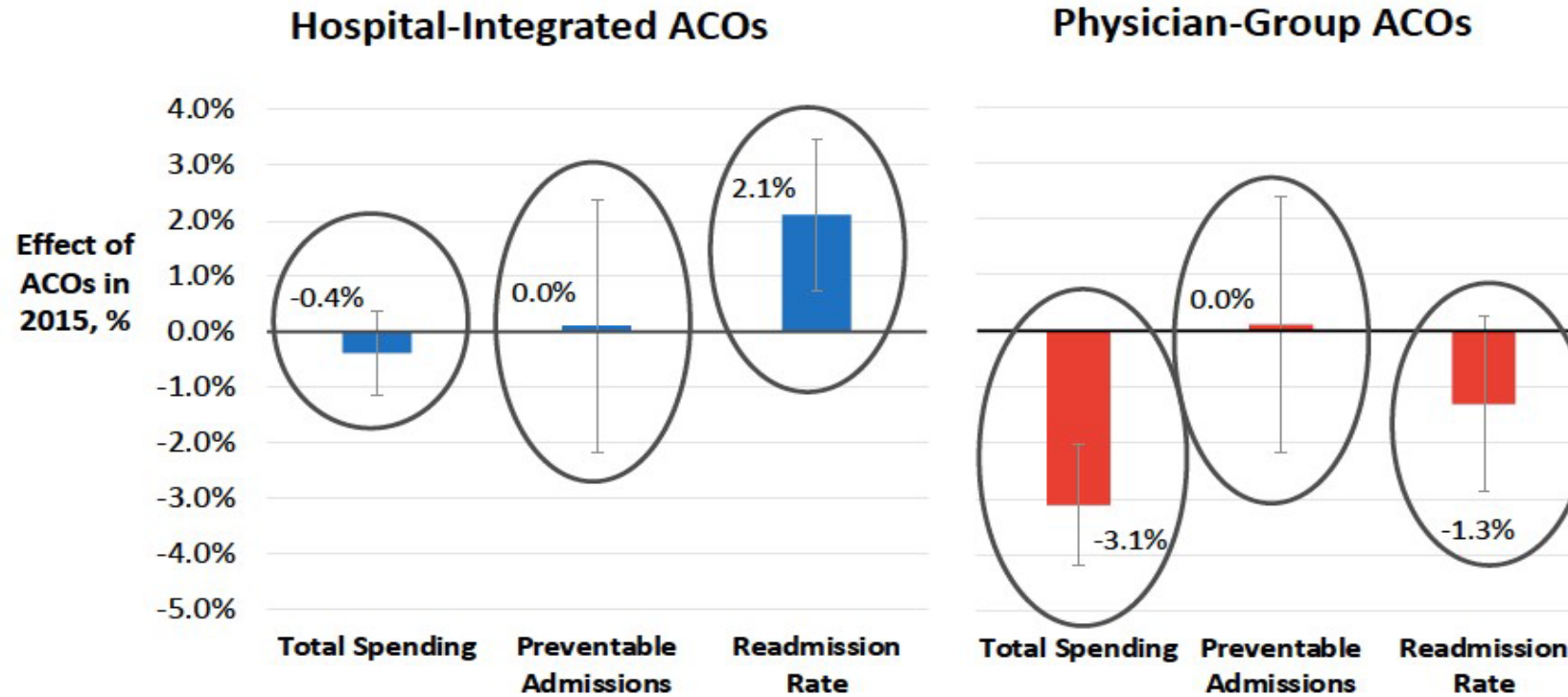
Net surplus per FTE physician per year after shifting to team- and non-visit-based care, by percentage of patients with capitated payment



SOURCE Authors' calculations. **NOTES** Net surplus per full-time-equivalent (FTE) physician per year is defined in the Notes to Exhibit 2. The minimum capitation level is the level above which 95 percent of practices would gain revenue by shifting to a team- and non-visit-based primary care delivery strategy.

How to Succeed in ACO Arrangements Requires Knowing More About the Sources of Savings

What is Not Driving Savings:
Health Systems, Preventable Admissions, Readmissions



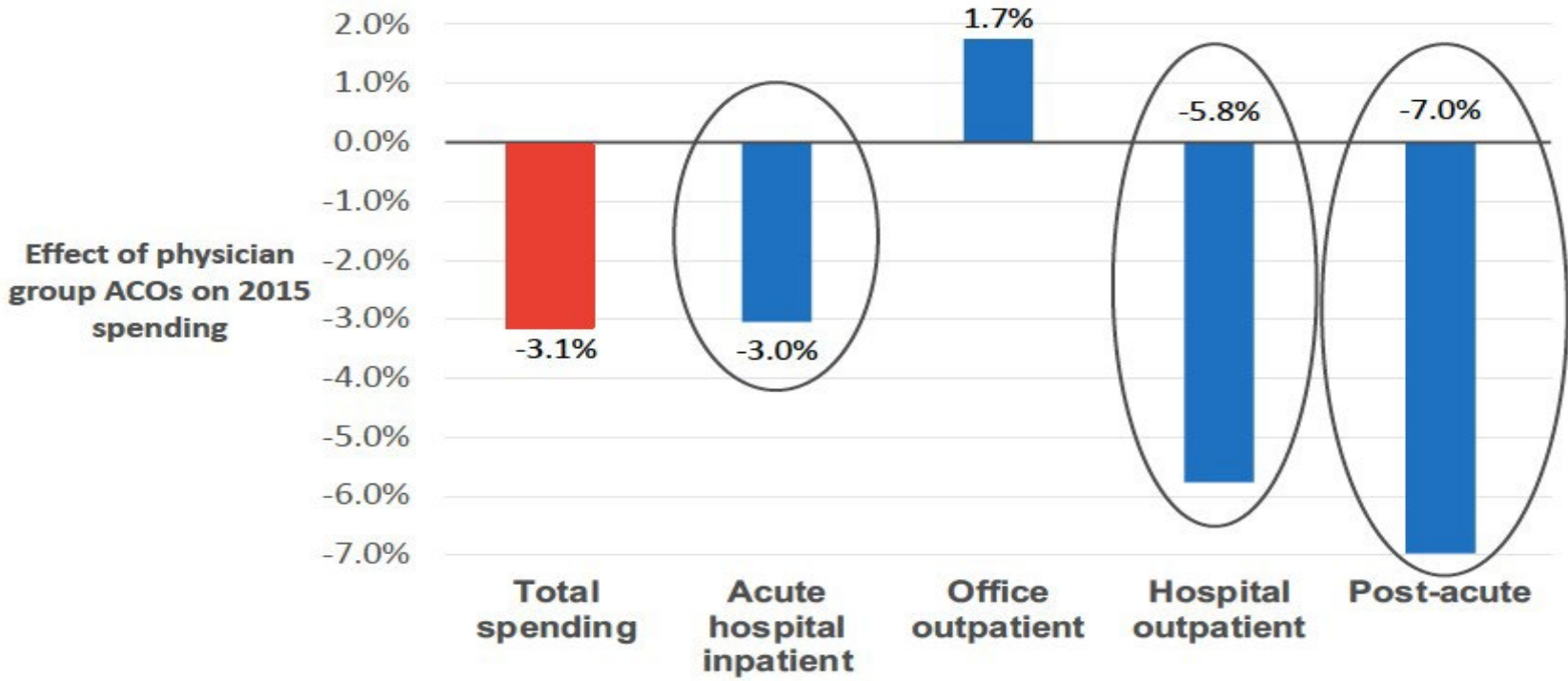
Sources of Savings from ACOs

High-risk Patients: Savings Not Greater but Patient Experiences Better

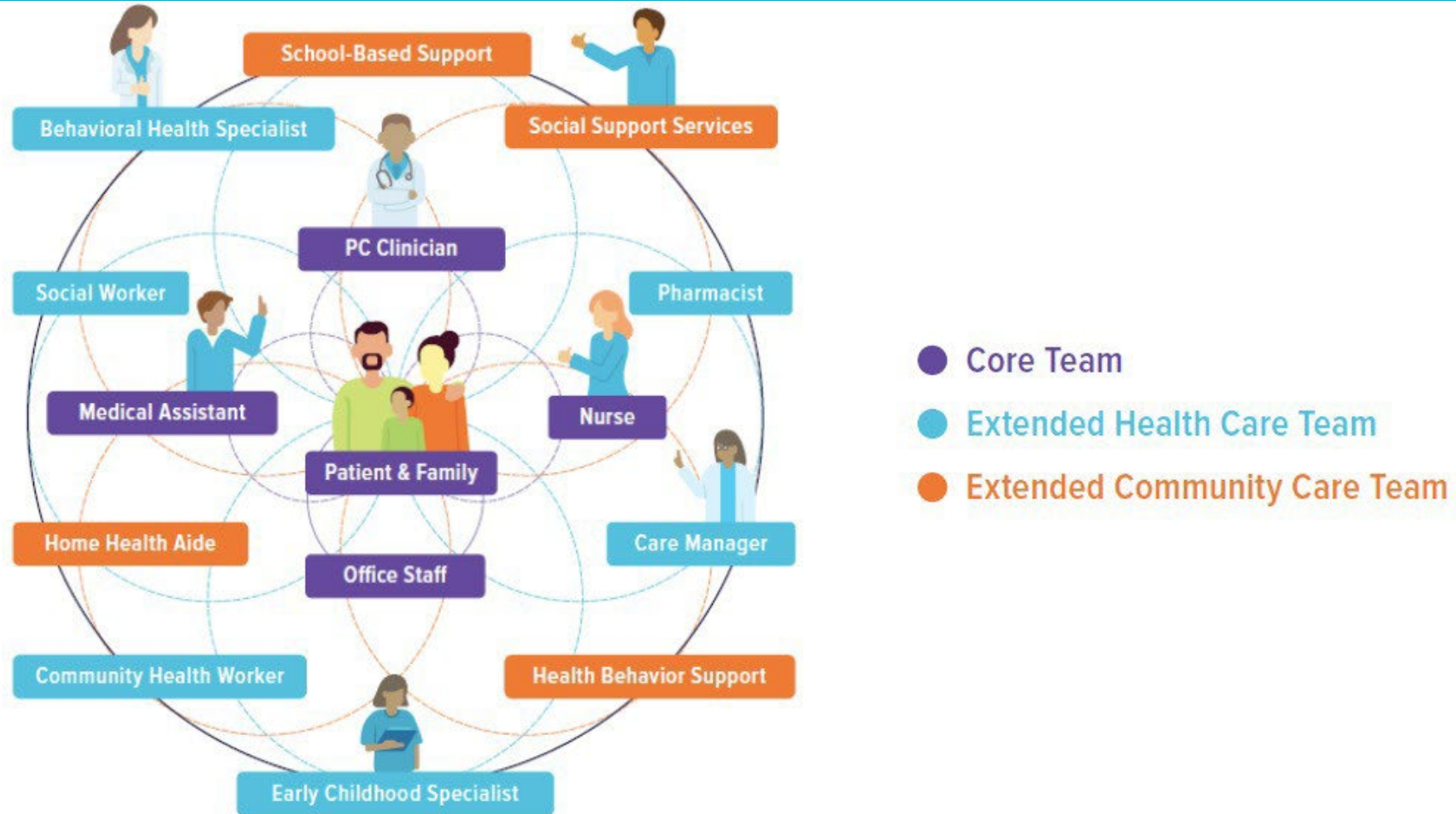


Sources of Savings from ACOs

What Is Driving ACO Savings? Apparent Waste Reduction



Primary Care Teams are Necessary for Success



3 Key Specific Investments for Advanced Primary Care

- 1. Team-Based Primary Care with a Population View (Panels)**
- 2. Primary-Specialty Care Integration (eConsults)**
- 3. Community Engagement and Navigation (CHWs)**

Success Stories in Primary Care Delivery



Alaska Native People Shaping Health Care



U.S. Department
of Veterans Affairs

What About Medicare Advantage? It's Complicated...



COMMENTARY

Making Sense of New Approaches to Primary Care Delivery: A Typology of Innovations in Primary Care

Bruce E. Landon, MD, MBA, MSc, Gabe Weinreb, BA, Asaf Bitton, MD, MPH
DOI: 10.1056/CAT.22.0032

A Typology of Innovations in Primary Care

This figure presents a classification system for primary care models, as well as care enablement models. We offer a non-exhaustive list of representative firms and practices based on the authors' understanding of the organizations' strategies at time of publication. Where no example is listed, the ellipses (...) indicate that none exists or is known to the authors.

Type of service	Scope of offering	Financial Model	Target Segments	Care Model Spectrum			Innovation Type*
				Virtual-first / home-based	Traditional	Intensive	
Care Delivery	Comprehensive: segmenters	Capitation / risk contracts	High-need Medicare	Oak Street, ChenMed, Iora	Segmented populations
			Medicaid / duals	Cityblock	
			Employer groups	Firefly, Amazon Care, NavigateNOW	Crossover	...	
	Comprehensive: fee-based	Enrollment + FFS	Employer groups and consumers	...	One Medical	...	Membership model
			Consumers	...	Direct primary care, concierge care practices	...	
			Limited: urgent care	Enrollment + FFS	Employer groups and consumers	Teladoc, 98.6	CVS (MinuteClinic), PhysicianOne
Limited: chronic care	Enrollment + risk	Employer groups	Livongo, Omada, Onduo	CVS Health Hub	...	Chronic disease focus	
Care Enablement	Wraparound services	Capitation / risk contracts	Risk-bearing providers	Landmark, Accolade	Value-based care enablers
	Management partners	Fee + risk	Risk-bearing providers	Agilon, VillageMD, Aledade			
	Patient navigation	Enrollment + FFS	Employer groups	Grand Rounds, Quantum Health			

FFS = Fee for service

The organizations listed are representative of the type, not called out for any other special reason.

*Our typology provides what might be considered modal types, but also recognizes the potential for substantial overlap among the different approaches, especially as innovative primary care organizations scale and diversify.

Source: The authors' analysis

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Take Home Messages

1. Primary care is a key route to ACO and overall health system success
- 2. You have to pay primary care differently (and prospectively) to achieve and sustain better results, even within an ACO**
3. Investments should target team-based care for populations, primary-specialty care integration, and community engagement/navigation
4. Medicare Advantage effects on primary care are complicated (and see #2)

Thank you!

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