THE REVOLUTION IN PRIMARY CARE

POSITIONING HEALTH SYSTEMS FOR THE FUTURE
About The Chartis Group

The Chartis Group is an advisory services firm that provides management consulting and applied research to leading healthcare organizations. The firm is comprised of uniquely experienced senior healthcare professionals and consultants who apply a distinctive knowledge of healthcare economics, markets, and organizational dynamics to help clients achieve unequaled results.

For additional information or further discussion related to this report, please contact the author:

Peter Shorett
Senior Consultant
The Chartis Group
617.538.4255
pshorett@chartis.com

For more information about The Chartis Group, please visit our website at www.chartis.com.

Disclaimer:
The views and interpretations in this paper are not intended to provide legal, valuation or other advice or guidance with respect to the matters covered. As always, be sure to contact a qualified advisor or professional before making any decision or taking any action that may affect your business.
Across the United States, alignment with primary care is re-emerging as a top strategic imperative for hospitals and health systems. As care delivery and profitability shift from inpatient to outpatient settings, primary care physicians exert increasing influence over ambulatory referrals and related diagnostic and ancillary services. Primary care plays an even more critical role in markets transitioning to value-based reimbursement. Within an accountable care model, primary care physicians (and supported allied health professionals) serve as the lynchpin of the organized delivery system – coordinating the continuum of services for their patients, and taking clinical and financial accountability for total healthcare expenditures and outcomes.

These changes are driving up the value of primary care physicians to health systems and changing the way in which the value of each practice should be estimated. The historical rule of thumb is that each primary care physician provides approximately $1 million of downstream referral revenue for hospitals. However, the same primary care physician managing the health of 2,000 patients controls $12-14 million of total healthcare expenditures. This dramatic difference in economic importance helps explain the increased centrality of primary care within value-based reimbursement models.

In addition, the nature of primary care practice is changing in ways which should make the discipline more attractive for physicians. Over the past twenty years, primary care providers have typically focused on maximizing RVU production and accessing ancillary revenue to offset inadequate reimbursement for evaluation and management services. New primary care models position primary care physicians as managers of teams of allied health professionals, organizing care across the continuum. These new models enable primary care physicians to care for larger numbers of patients and to play a broader role in health management.

Leading health systems recognize that a fully-aligned primary care network that can successfully acquire, aggregate and manage the health of populations provides significant strategic advantage.
This paper explores the changing role of primary care and the approaches to determining its value; the paper then discusses the strategies health systems should pursue to create a large, effective, aligned network of primary care practices and how these strategies may vary in different kinds of markets.

The Changing Practice of Primary Care

Nearly four in five primary care physicians worked in small, independent practices less than a decade ago.¹ Today, approximately 40% of all primary care physicians are employed by large delivery systems (defined in this paper as hospitals, health systems, and academic faculty practices)² with many healthcare markets at 70-80% primary care employment. A 2010 survey of hospital executives suggests that three-quarters of hospitals are actively investing in acquisition and recruitment of primary care practices.³ According to Merritt Hawkins, the nation’s largest physician search firm, approximately two-thirds of newly hired physicians – and an even higher proportion of primary care physicians – are being placed into hospital-owned practices.⁴

Certain regions have evolved quickly to a predominantly employed physician model. The Greater Cincinnati primary care market, for example, has shifted from 57% independent in 2006 to only 20% independent in 2012, due to a series of acquisitions by the three major competing health systems.⁵ Even in markets where a significant proportion of primary care physicians remain independent, most have become economically aligned with health systems through joint contracting. In Boston, for example, while the majority of PCPs remain in independent group practices, 77% are now participating in one of five major joint contracting networks.

FIG. 1 The Changing Practice of Primary Care

% U.S. Physicians Employed by Hospitals and Health Systems

2004ᵃ 2008ᵇ 2012ᵇ

The trend toward employment of primary care physicians by hospitals and health systems is expected to expand. Market forces and the changing nature of office practice have combined to make employment a more desirable alternative to independent practice for many primary care physicians. Increasing administrative and IT support requirements have made many solo or small group practices too costly and complex to manage. The evolving primary care model is more leveraged (requiring greater direct support staff) and technology-driven (requiring investments in EMR and related capabilities), making participation in a larger health system more attractive. In more advanced markets, the infrastructure required to successfully manage population health and succeed under new contracting models will outstrip the capabilities of most solo and small group practices.

For health systems, a mix of traditional and new imperatives is driving primary care expansion. In the Cincinnati area, intense competition to hire primary care physicians is fueled by the desire to grow downstream referrals and control market share. In regions with primary care shortages, such as Houston and Dallas, health systems are maneuvering to secure scarce physician resources. For health systems in most fee-for-service dominated markets, primary care is the key to capturing greater outpatient revenue (the key driver of profitability for many health systems) generated through referrals, office-based diagnostics and other ancillary services. In more advanced markets, such as Minnesota and Southeastern Michigan, providers are actively positioning themselves to take on greater risk and accountability for population health by growing the size of their primary care networks.

Prior periods of hospital aggregation of physicians were followed by major divestment. However, there are multiple reasons why that dynamic is unlikely to repeat itself today. First, reverting to private practice is now harder and less attractive given the infrastructure requirements to support effective primary care delivery. Second, the economic sustainability of private practice is being challenged on multiple fronts, including limited contracting leverage with payors, the inability to support major capital investments, and the inability to participate in new payment and patient care models absent sufficient patient scale. Third, as an older generation of cottage-industry physicians reaches retirement, they are being quickly replaced by a younger generation of physicians predisposed toward a new model of practice – more than willing to trade practice autonomy for the greater work-life balance, improved infrastructure, and administrative simplicity.

The Strategic and Economic Value of Primary Care

Health systems have long recognized the instrumental role of primary care in delivering high quality, cost effective care to the communities they serve. Numerous studies have shown that a greater supply of primary care physicians leads to better access, lower unmet care needs, fewer inpatient admissions and emergency room visits, and lower aggregate healthcare spending. Despite these benefits, the core economic contribution of primary care to health systems has traditionally been viewed through the lens of downstream referral generation.
In some regions, the traditional role of primary care remains important as inpatient volumes soften for various reasons and patients shift to freestanding imaging centers, ASCs, and other lower cost providers. As a result, most health systems seek to align more closely with primary care providers to stem leakage, access additional patients, and diversify their service models with a broader set of outpatient service lines. Health systems in these markets will remain focused on securing downstream volume and revenue for the foreseeable future. In Illinois, for example, where HMO penetration remains low and most providers remain solidly enmeshed in fee-for-service healthcare, all of the major systems – including Advocate Health Care, Northwestern Memorial, and NorthShore University Health System – are aggressively competing to add primary care physicians, as referral channels tighten amidst growing market consolidation.

In more advanced markets – ones that are evolving toward new payment models based on accountability for the total cost and outcomes of care – the strategic calculus for primary care is changing. Primary care is the cornerstone of the clinical delivery model under accountable care – by providing “accessible, comprehensive, longitudinal, and coordinated care” which brings together the diverse services a patient may need. In markets where payment is shifting toward population-based or episode-based reimbursement, primary care plays an increasing strategic role within the broader health system to acquire and aggregate populations and manage global medical expenditures.

To better understand how the equation is shifting, a concrete example may be illustrative. Under the Blue Cross Alternative Quality Contract (AQC) in Massachusetts, delivery systems are assigned a “global budget” based on a risk-adjusted benchmark of total medical expenditures (TME) for patients assigned to primary care physicians within their network. While providers continue to be paid on a fee-for-service basis throughout the year, the global budget serves as a target to reconcile those payments against broader efficiency objectives. To the extent that providers achieve TME levels below the AQC benchmark for their assigned patients, they share in a large proportion of the associated global surplus.

**FIG. 2** The Strategic Role of Primary Care in Different Markets

<table>
<thead>
<tr>
<th>Predominant Payment Model</th>
<th>Role of Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-Service (FFS) Markets: Volume-Based Reimbursement</td>
<td>• Downstream referral generation (inpatient admissions, outpatient ancillary services)</td>
</tr>
<tr>
<td>Mixed Markets: Hybrid – FFS with Risk-based or Shared Savings Contracts</td>
<td>• Increasing coordination of care and services for defined panel of patients • Securing referral channels</td>
</tr>
<tr>
<td>Advanced Markets: Global Budget</td>
<td>• Growth of covered or attributable lives • Coordination of care across the continuum • Management of total medical expenditures</td>
</tr>
</tbody>
</table>
Under this model, primary care physicians – as the principal basis of patient attribution, either through explicit assignment (e.g., AQC in Massachusetts) or prospective/retrospective attribution – determine the scale of achievable surplus. For example, a health system with a network of 1,000 primary care physicians can expect to garner a global budget of as much as $6-7 billion per year (assuming all patients are converted to the new payment model), while a system with 300 affiliated primary care physicians can expect to secure $1.8-2.1 billion in total medical expenditures under management.

A wide range of alternative reimbursement models are driving primary care to the center of the value equation. As a result, for providers participating in risk and shared savings contracts, primary care physicians (supported by appropriate care management infrastructure) have become principal players in coordinating and managing the total healthcare needs of their covered or attributed patients, and hold substantial accountability for clinical and financial outcomes. Primary care is becoming a centerpiece of the provider business model as the domain of competition shifts from securing volume-based market share to securing the largest covered or attributable population and effectively managing that population’s health.

The economic implications to the system are significant. For example, within the physician organization of a representative Massachusetts health system, 40% of the total patient population of 400,000 is managed by their 250-member primary care network under global risk contracts. The downstream economic value to the health system of primary care physicians is thus partly based on the historical referral generation model and partly based on the physicians’ ability to generate surpluses on a global budget of approximately $1.0 billion. Under its current payor arrangements, the potential value generation to the health system from a 5% decrease in total medical expenditures relative to budget is nearly $30 million.

All of these factors are driving up the competition for primary care physicians among health systems, group practices, and even health plans (in some markets). Competition for the allegiance of primary care physicians makes it imperative that health systems have a strong value proposition tied to a winning strategy for how they will partner with primary care physicians to care for patients, maintain or improve their incomes, and enable them to help lead health system transformation for those physicians seeking a broader leadership role. Health systems risk their primary care physicians joining competitors either at the outset or after a few years unless they can provide a clear and compelling description of how alignment will benefit the physicians both over the short and long-term. Primary care physicians need to feel that their role is greater than “pieces on the chess board” of the major health systems and that they will have a permanent voice in setting the organizations’ direction. Our experience is that alignment is best achieved by having agreement and collaboration on governance, management roles, economics and a shared strategy. These features are difficult for many health systems to achieve due to the differences in management models between large, hierarchical organizations and professional services organizations.
“First Mover” Advantage

In a transitioning market, those providers with inadequate scale and alignment within their primary care platform risk erosion of their competitive position. In numerous regions, tertiary referral hospitals with leading specialty programs are facing significant pressure on their historical referral channels as they struggle to build an employed primary care base while many of their formerly loyal primary care physicians are acquired by competing systems. In Boston, for example, many of the top specialty hospitals (e.g., orthopaedics, pediatrics and ENT) that lack a significant adult primary care network have been relegated to a position of “referral provider” in the region’s growing accountable care contracts, with limited control over global budgets.

In contrast, many of the health systems that were “first movers” in building large, integrated primary care networks are now gaining significant leverage in their markets. Aurora Health Care – an integrated healthcare provider with 15 hospitals and 200 clinics, serving 1.2 million patients in Wisconsin and Illinois – is a good example. Over the past decade, Aurora’s two employed physician groups, Aurora Medical Group and Aurora Advanced Healthcare, together have grown to include approximately 1,500 physicians, 800 of which are primary care physicians. With much of the primary care labor market within their employed physician group, Aurora has been able to dictate the terms of the region’s transition toward new payment models. In the summer of 2012, Aurora announced the formation of a direct-to-employer accountable care solution in partnership with multiple payors that will offer a “price guarantee” to small and mid-sized employers thereby ensuring stable or declining employer and employee healthcare costs, depending on prior claims experience.

Optimizing Primary Care as a Strategic Priority

While specific strategies will vary depending on local market dynamics, all providers should take stock of their current primary care investments and determine how best to leverage those investments for success in the current and projected future environment. Through honest assessment and clarification of strategic goals, leadership must define a path forward that will enhance interdependence between primary care and the broader delivery system.

Fee-for-Service Markets

For providers operating in less advanced markets, developing a broad primary care network will continue to be essential to secure referral channels and position providers for future negotiations with payers. In this scenario, hospitals and health systems would be well-suited to support a practice model characterized by high visit productivity and patient throughput to generate the broadest number of referrals. This framework typically implies an efficient primary care practice operating model that keeps the subsidy from the hospital within manageable limits. Primary care physician compensation can take a variety of forms, but should be geared toward volume generation and cost efficiency. The number of markets in which this approach remains viable is likely to decline rapidly making it a potentially short-lived strategy. In addition, this model may not optimize patient satisfaction due to
physician inability to spend significant time with patients. As new practice models (such as Patient-Centered Medical Homes and other approaches which increase patient access to physicians or other allied health professionals) become available, traditional practices are at risk of patient loss to competitors.

**Advanced Markets**

Providers in more advanced markets will need to rapidly build out their primary care network to achieve scale of attributable lives and invest in supporting infrastructure to successfully manage total medical expenditures. While a new model of expanded primary care holds the potential for greater returns, it does require significant investment. In our experience, the providers most successful at leveraging their investment have succeeded in part by surrounding their growing primary care base with the following **four core elements:**

1 | **Infrastructure for care management and care coordination:** Enhanced practice-based resources (e.g., case management nurses embedded in practices serving as a hub for managing high-risk patients) and centralized support (e.g., care coordinators to smooth transitions of care across settings) will be required to keep more care in the community, closer to home, and at a more affordable cost.

2 | **New primary care delivery models that leverage greater direct support staff:** Many providers will need to create an enhanced primary care delivery model with additional MA, RN, and/or LPN support to better leverage physician resources, expand patient access and panel size, and enhance the sustainability of physician work life.

3 | **Enhanced IT connectivity between the physician office, hospitals and ambulatory sites of care:** Effectively managing the health of a population will require seamless information system inter-operability across a wide range of settings, enabling physicians to apply evidence-based guidelines, identify and follow high-risk patients across transitions of care, and measure and manage longitudinal health outcomes.

4 | **New finance, budgeting and risk management capabilities:** Most providers currently lack the administrative, finance and actuarial/underwriting functions to assume a significant share of the responsibility for the total cost of care for the patients they serve. Building these capabilities will be essential to support primary care-driven global risk arrangements.

All of these factors require significant scale and efficiency so that the costs of new capabilities do not disrupt the delicate economics of primary care. Health systems need to be clear as to how they will benefit from these investments, including a detailed business case and an operational plan that enables value to be realized. However, the benefits from more effective management of population health and episodes of care should pay for these investments if they can be realized and accessed by the health system.

Leadership must define a path forward that will enhance interdependence between primary care and the broader delivery system.
Mixed Markets

For the majority of healthcare providers who are operating within hybrid markets – in which fee-for-service remains prevalent but alternative payment models are also present – the best course is to pursue a primary care strategy that is both effective within the current environment and well positioned for the possible growth of population-based reimbursement. Far from being passive observers, providers are instrumental in shaping their market outcomes – with the actions they take significantly accelerating or slowing the pace of evolution. To support these investments, providers should take an intermediate path that includes shoring up supporting infrastructure and incenting physicians through a mix of volume-driven and value-driven compensation. As outlined below, an honest and thorough assessment of market dynamics, investment opportunities and alternatives, and broader system goals is essential to identifying the “right” primary care strategy for an individual health system:

1 | Size the opportunity and establish ambitious goals: Conduct an in-depth current state assessment of the regional market environment – including the patient populations served, key physician dynamics, physician-hospital alignment trends (including contracting arrangements), and payor-provider relationships – to assess the opportunity to leverage primary care development to achieve competitive advantage. In our experience, every market is different; providers who understand their market’s unique characteristics and stage of evolution can tailor the most effective approach.

2 | Identify what value primary care can – and cannot – deliver in your market: Use scenario analysis to align the leadership team around a primary care strategy geared toward a range of plausible potential market end-states. How is the provider reimbursement environment likely to evolve, and what moves are competitors expected to make? Given a set of future potential scenarios, what is the ideal scale, geographic distribution and capabilities of your primary care physician platform? How will it function within both a fee-for-service and value-based environment? How will it differentiate your health system from key competitors making yours the most attractive option for primary care physicians seeking to join a larger organization?

3 | Know what you’re trying to create before taking the dive: Explore a range of possible alternatives to full primary care physician employment including clinical integration, risk contracting and MSO services. Define the potential role and value of primary care within the health system’s future care delivery model. What strategic objectives will it be designed to achieve? How will the primary care model function in relation to the hospitals and other care delivery assets and what infrastructure is required to support its intended role? Identify the optimal physician compensation and related financial incentive models that align with these objectives. In addition, governance and organizational models need to be designed that will be attractive to physicians and provide them with a meaningful role in the health system’s strategic and operational decision making. For example, one northeastern health system has merged numerous independent primary care practices into a unique for-profit, physician-governed affiliate corporation. The physicians have the opportunity to sell their shares back to the corporation when they retire; these shares can increase in value if the group continues to grow.

An honest and thorough assessment of market dynamics, investment opportunities and alternatives, and broader system goals is essential to identifying the “right” primary care strategy for an individual health system.
4 | Don’t sit on your investments – convert them into competitive advantage:
Identify the go-to-market approach to leverage primary care for competitive advantage – including potential payor collaborations (e.g., narrow network or accountable care contracts), targeting of defined geographic and demographic segments through acquisition, and the optimal practice operating model. Define the unique value proposition that the growing primary care platform will present to physicians in the market – why will this be the most attractive place to practice medicine?

In the face of heightened market uncertainty and in the midst of varying dynamics in different regions, no single course for primary care will be optimal for all health systems. Providers will need to define the right scale and infrastructure for primary care to achieve the unique role they seek within the unique healthcare delivery environment they face. Today more than ever, the ability to leverage primary care networks to maximum value will be a defining strategic advantage for all providers – an increasingly essential path to successfully navigating a turbulent future.

References