Value-Based Primary Care Practices Are Positioned for Growth

Part 1 of a study exploring how PCPs are positioned to deliver against a value-based care mandate

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It's hard to keep track of the flurry of activity surrounding primary care. Core to the investment thesis for private equity and health plans alike is, of course, value-based care. The theory of value-based care remains commonly appreciated—pay providers differently to align their economic interests with activities that should improve patient outcomes and reduce unnecessary spending. But how to effectively deploy value-based care remains elusive. Understanding what differentiates value-based care practices from a traditional fee-for-service practice is not straightforward, yet it is critical to successful results and returns.

Despite the proliferation of activity, identifying a standard of practice, industry-standard competencies, or common compensation arrangements is more of an art than a science. Existing research is hazy at best in answering critical questions around characteristics, behavior, and infrastructure of established and aspiring value-based practices. Our research attempts to fill that gap through data and analyses that can provide a new level of depth and objectivity to this opaque and evolving sector.

To understand what enables primary care providers to deliver against their mandate to provide value-based care in comparison to physicians who do not, we conducted a national survey of primary care physicians (PCPs). The goal of this survey was to understand the degree of value alignment across the PCP landscape, how PCPs make decisions that impact care, and what infrastructure and capabilities have been put into place to support these new practice demands. The survey used to draw these insights was a national sampling of 307 PCPs representing a cross-section of the PCP landscape. The survey was administered by our partner ROI Rocket, a survey administration firm, in August 2022. See the appendix for details about the survey methodology and respondent sample.

Integral to our analysis is a presumption that all PCPs act in the best interest of patients and seek to improve the patient experience, improve outcomes, and reduce costs where possible. Similarly, "value" can be defined many ways and is open to interpretation. For the purposes of our research, we define value-based care participation based on the contractual models under which the physician operates. Given the limitations of this data, we are not making an assessment of the quality of care received or the patient's satisfaction. Instead, our analysis focuses on the participation in various types of financial contracts to compare PCPs across a variety of activities and capabilities intended to impact the cost of care.

Key Takeaways From This Analysis:

01 **Participation in value-based care models is common, as is taking risk.** Overall, 69% of PCPs are in some form of value-based care arrangement, with accountable care organizations (ACOs) being the most prevalent (41%). 40% of PCPs are at some level of financial risk for their panel. On average, 24% of their patient panels are within a financial risk arrangement.

02 **The degree of value-based care participation creates different cohorts of PCPs.** Three cohorts of PCPs were identified among the respondents. Those in capitation contracts ("Leaders") make up 21% of the population, while nearly one-third of PCPs do not participate in value-based care arrangements at all or are unaware if they do ("Abstainers"). The remaining 48% participate in some other value-based payment model that is not capitation ("Experimenters").

03 **PCP panel size, throughput, and growth capacity are correlated with value-based care alignment.** On average, Leaders have larger, more mature panels, see more patients each day, and are more open to growth than Experimenters and Abstainers.

04 **PCPs believe there is a focus on cost and expect that focus to continue to grow.** 71% of PCPs believe that the focus on financial costs is going to increase over the next 5 years, with perceptions of this increased impact growing across all 3 PCP cohorts.

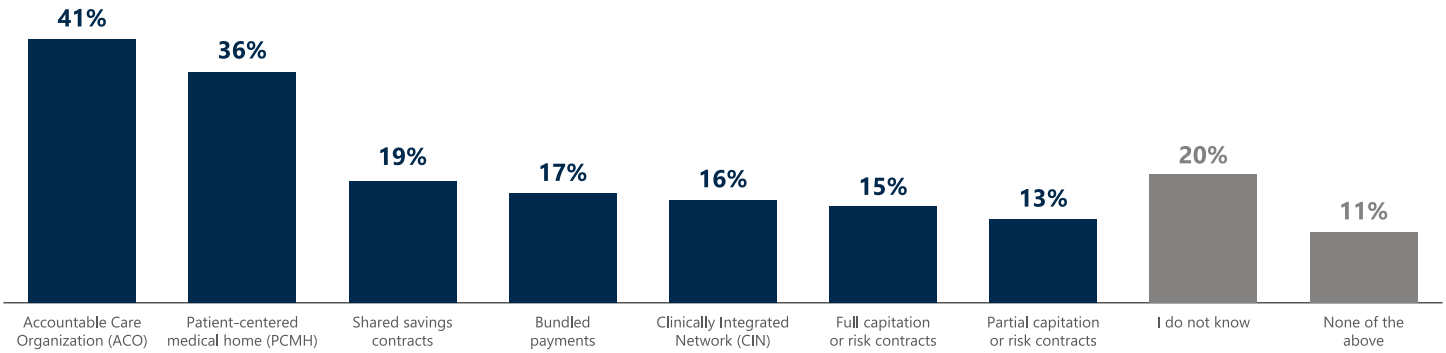
01 KEY TAKEAWAY

Participation in Value-Based Models Is Common, as Is Taking Risk

Responses show that participation in value-based payment models is robust but variable. Overall, 69% of PCPs acknowledge being in some type of value-based payment arrangement. Shown below are the types of models PCPs report participating in. PCPs were allowed to select multiple models.

The 2 most prevalent models were ACOs and patient-centered medical homes (PCMHs), with 41% and 36% prevalence, respectively. Only 21% of PCPs participate in some form of a capitation agreement (our definition of a "Leader" PCP, further defined later), with 15% of PCPs reporting that they participate in full capitation contracts. Of note, 1 in 5 PCPs were unaware of what payment models they participate in.

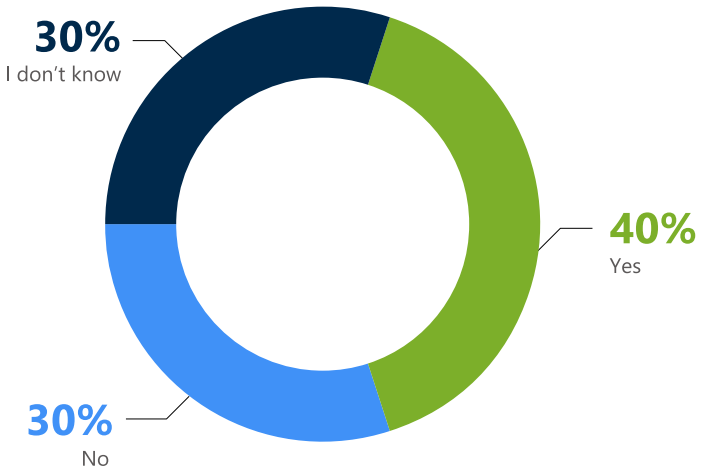
Prevalence of Value-Based Payment Models



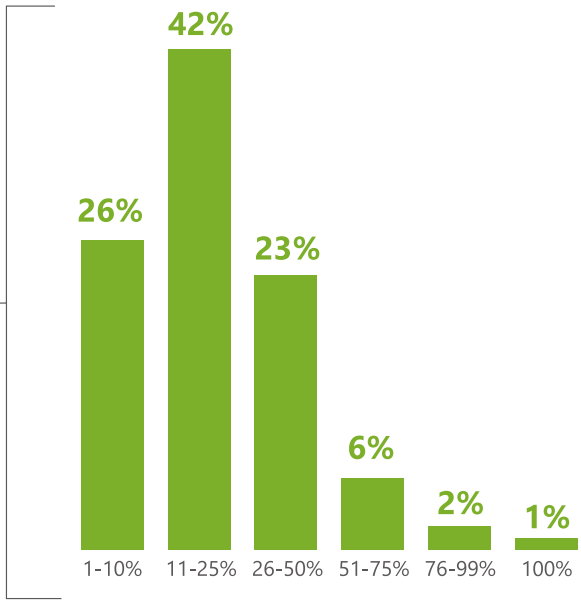
Within these models, 4 in 10 PCPs report taking some level of financial risk on their patient panel, 3 in 10 are unaware whether they do or do not take financial risk, and the remaining 3 in 10 are not taking any financial risk. There are 2 important takeaways within these data:

- First, while 40% of PCPs report taking financial risk on some portion of their panel, only 21% of PCPs are in models that explicitly involve taking risk (partial or full capitation contracts). There are 2 explanations for this: Either there is a misunderstanding among PCPs between the perception of taking risk and the reality of taking risk, or financial risk is prevalent in non-capitation value-based payment models.
- Secondly, the fact that 30% of PCPs are unaware as to whether their practice takes financial risk itself is a meaningful takeaway because it shows a disconnect between the practice economics and the physician's role in managing them. If the PCP does not understand the financial risk within their panel, they cannot be expected to manage the financial performance accordingly.

Distribution of PCPs Who Take Financial Risk



Percent of Panel at Financial Risk



Finally, it is worth noting the penetration of financial risk in the average risk-taking physician's panel. As mentioned earlier, 40% of PCPs report taking financial risk on their patients. Among those PCPs, 24% of the patients on their panel are at financial risk. Only 9% of these PCPs reported having more than half of their panel as at-risk. While fully at-risk practice models continue to capture the industry's attention, they are still nascent.

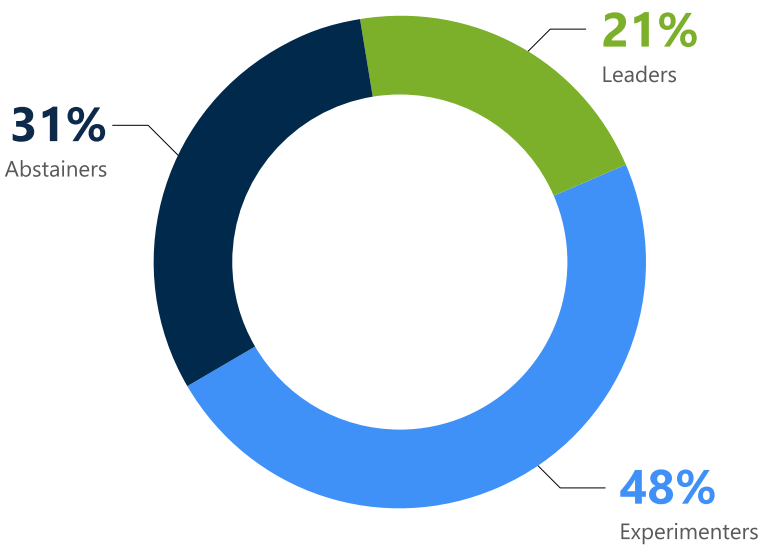
02 KEY TAKEAWAY

The Degree of Value-Based Care Participation Creates Different Cohorts of PCPs

When looking across the nearly 240,000 PCPs in the U.S. today, it's hard to draw a clear distinction between those who practice value-based care and those who do not.[1] Health system practices could have several commercial shared savings contracts. A private practice in Southern California may have professional fee capitation contracts across Medicare Advantage, Medicaid, and commercial populations. Practices in Florida may only accept Medicare Advantage patients for which they are at full financial risk. Accordingly, for further analysis and comparison, we categorized physicians by their level of "value alignment" into 3 cohorts based on the contracts in which they participate:

- **Value-Based Care Leaders ("Leaders"):** 21% of PCPs report having one or both of partial- or full-risk capitation agreements in their practice.
- **Value-Based Care Experimenters ("Experimenters"):** 48% of PCPs acknowledge having another value-based agreement, such as participating in ACOs, clinically integrated networks (CINs), shared savings, or bundled payment agreements.
- **Value-Based Care Abstainers ("Abstainers"):** The remaining 31% of PCPs reported not participating in any of these agreements or were unaware of the agreements they had altogether. Our assumption for this analysis is that physicians who are unaware of their value-based contracts are not positioned to manage to any specific value-based contracting outcome.

Market Distribution of Value-Based Care Focus



This stratification allows us to explore the differences in practice composition, capabilities, incentives, and more, depending on the level of contractual participation and financial risk and opportunity available to the practice.

03 KEY TAKEAWAY

PCP panel size, throughput, and growth capacity are correlated with value-based care alignment.

Several compelling findings emerge through a simple analysis of the baseline panel and practice composition among the 3 PCP cohorts.

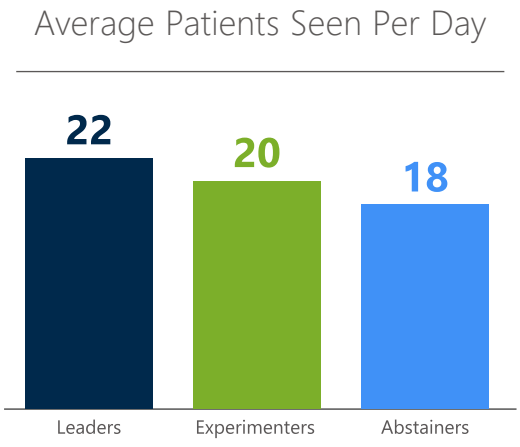
LEADERS ARE MORE EXPERIENCED, WITH LARGER AND MORE SENIOR PATIENT PANELS

Leaders have a longer tenure in their roles as PCPs and have a correspondingly larger panel than Experimenters or Abstainers. What's more, Leaders have a disproportionately higher Medicare-eligible panel. This is counterintuitive since more seniors on a panel typically translates to smaller panels, given their greater health needs.

COHORT	AVERAGE PCP TENURE	AVERAGE (MEDIAN) PANEL SIZE	AVERAGE MEDICARE %
Leaders	19 years	1,700 (1,500)	37%
Experimenters	15 years	1,500 (1,200)	32%
Abstainers	16 years	1,000 (800)	32%

LEADERS SEE A HIGHER VOLUME OF PATIENTS THAN THEIR PEERS

Patient throughput grows with value-based care alignment. Leaders see an average of 22 patients per day, which is +2 over Experimenters and +4 over Abstainers. Conventional wisdom is that capitated providers (Leaders) can see fewer patients per day and fund the lower productivity through risk margin. However, the data show that daily patient volume progressively grows with degree of value-based care alignment. This throughput explains how Leaders can manage comparatively larger and more senior panels.



LEADERS ARE MORE LIKELY TO SEEK PANEL GROWTH

Finally, all 3 cohorts have significant panel capacity. However, only 5% of Leaders reported not accepting new patients, compared with 10% and 13% of Experimenters and Abstainers, respectively. This is noteworthy because Leaders have larger existing panels than Experimenters or Abstainers yet are more open to accepting new patients.

New Patient Capacity

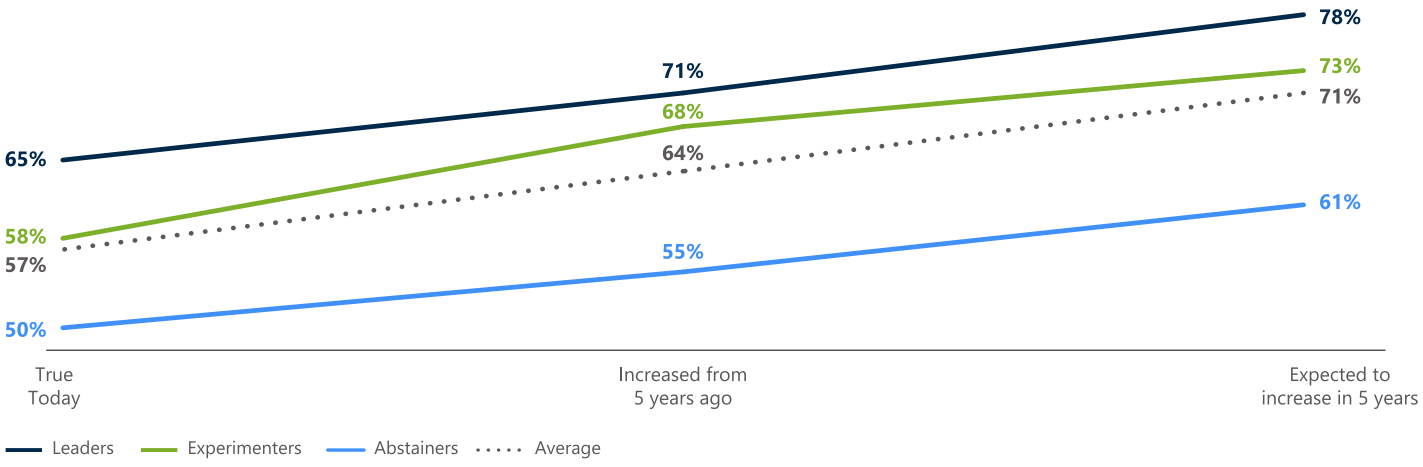
The differences in panel composition, throughput, and capacity between the 3 cohorts are meaningful in that they generally track the level of value-based care alignment. Many tools enable a PCP to operate with a larger panel, see more patients, and accept growth, such as advanced practice provider (APP) utilization or practice infrastructure, which we will explore in greater detail in subsequent pieces.

04 KEY TAKEAWAY

PCPs Believe There Is a Focus on Cost and Expect That Focus to Continue to Grow

The difference between the cohorts becomes further evident when asked about the trajectory of the industry on its value-based care journey.

Focus on Panel Financial Costs (% Somewhat or Strongly Agree)



The majority (57%) of PCPs agree there is an organizational focus on financial costs for their panel, a core tenet of value-based care. What's more, PCPs broadly believe that this focus will grow over the next 5 years. The forward momentum of this trend persists across cohorts, with all believing today's focus exceeds the focus 5 years ago and that the focus will continue to increase over the next 5 years.

Unsurprisingly, value-alignment today influences the perceived level of focus and focus trajectory. 65% of Leaders agree there is a focus on financial costs today, and 78% of them agree it will continue to increase, as compared to 50% and 61% of Abstainers for current and future state, respectively.

Implications and Opportunities

Value-based care models are highly prevalent, but those that involve explicit risk-taking are less so. The physicians who are aligned with these payment models stand out from their peers, as measured by several key metrics. They are more experienced, with larger and more productive practices, which are more positioned for growth.

The Leader PCP archetype is highly aligned with private capital's goals around growth and value-based care alignment when investing in primary care. As the presence of value-based primary care continues to expand, this physician archetype will be increasingly favored. Accordingly, Experimenters and Abstainers have an opportunity to align the characteristics of their practice more closely to those of Leaders in this high-growth sector.

We will further explore differences between these cohorts in our next report focused on PCP decision-making. That report outlines how referrals are managed, how compensation is aligned to value participation, and whether PCPs can influence which products or plans their panel enrolls in to consolidate lives in value-based products.

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ACKNOWLEDGMENTS

This survey was informed by leaders from both our Private Equity Advisory and Strategy practices, including Bret Anderson, Todd Fitz, and Roger Ray, MD. Special thanks to Jun Chen, Ben Kelty, and Christopher Lu for supporting the development and evaluation of the survey findings.

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SOURCES

1. AAMC 2020 Physician Specialty Data Report, published January 2021

About the Survey Data

SOURCE

We partnered with our survey administration firm ROI Rocket to field this survey in August 2022 with a target n=300 (n=307 achieved). We surveyed a representative sample of self-identified primary care physicians throughout the United States. Individuals captured in these data must have been a primary care physician who actively practices medicine and whose patient panel is at least 10% seniors. Those not meeting these criteria were not included in the results.

QUALIFICATIONS

Respondents to this survey must have met the following qualifications to be included in the n=307 sample used for our analysis:

QUESTIONS	ACCEPTABLE RESPONSES
What best describes your profession?	• Physician
What is your primary specialty as a physician?	• Primary Care • Family Medicine • Internal Medicine • Geriatric Care
Do you actively practice medicine today?	• Yes
In your estimation, what % of your patient panel is 65 years of age or older?	• 10-25% • 26%-50% • 51-75% • 76-90% • Over 90%

RESPONDENT PROFILE

	TOTAL	LEADERS	EXPERIMENTERS	ABSTAINERS
Total Responses	**307**	**65**	**146**	**96**
Reported Physician Specialty (Question: What is your primary specialty as a physician?)				
Family Medicine	59%	58%	60%	59%
Geriatric Care	2%	2%	2%	1%
Internal Medicine	18%	17%	15%	23%
Primary Care	21%	23%	23%	17%
Years Practicing (Question: How many years have you been practicing in your current specialty?)				
1-5	23%	12%	21%	33%
6-10	16%	17%	18%	11%
11-20	27%	26%	32%	20%
21-30	25%	34%	24%	20%
>30	10%	11%	5%	16%
Geographic Distribution (Question: In what state do you practice?)				
Midwest	26%	31%	25%	23%
Northeast	18%	15%	20%	18%
South	35%	28%	36%	38%
West	21%	26%	19%	22%
Employment Model (Question: What is the best way to describe your physician practice?)				
Employed by a single hospital or a multi-hospital health system	48%	32%	57%	46%
Independent physician practice not employed by a hospital or health system	50%	68%	42%	52%
I don't know	1%	0%	1%	2%
Payer Mix (Question: In your estimation, what is the health insurance mix of your practice?)				
Commercial	41%	39%	44%	36%
Medicaid (including Managed Medicaid)	16%	17%	15%	16%
Medicare (including Medicare Advantage)	33%	37%	32%	32%
Self-Pay, Uninsured, or Other	11%	6%	9%	16%

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