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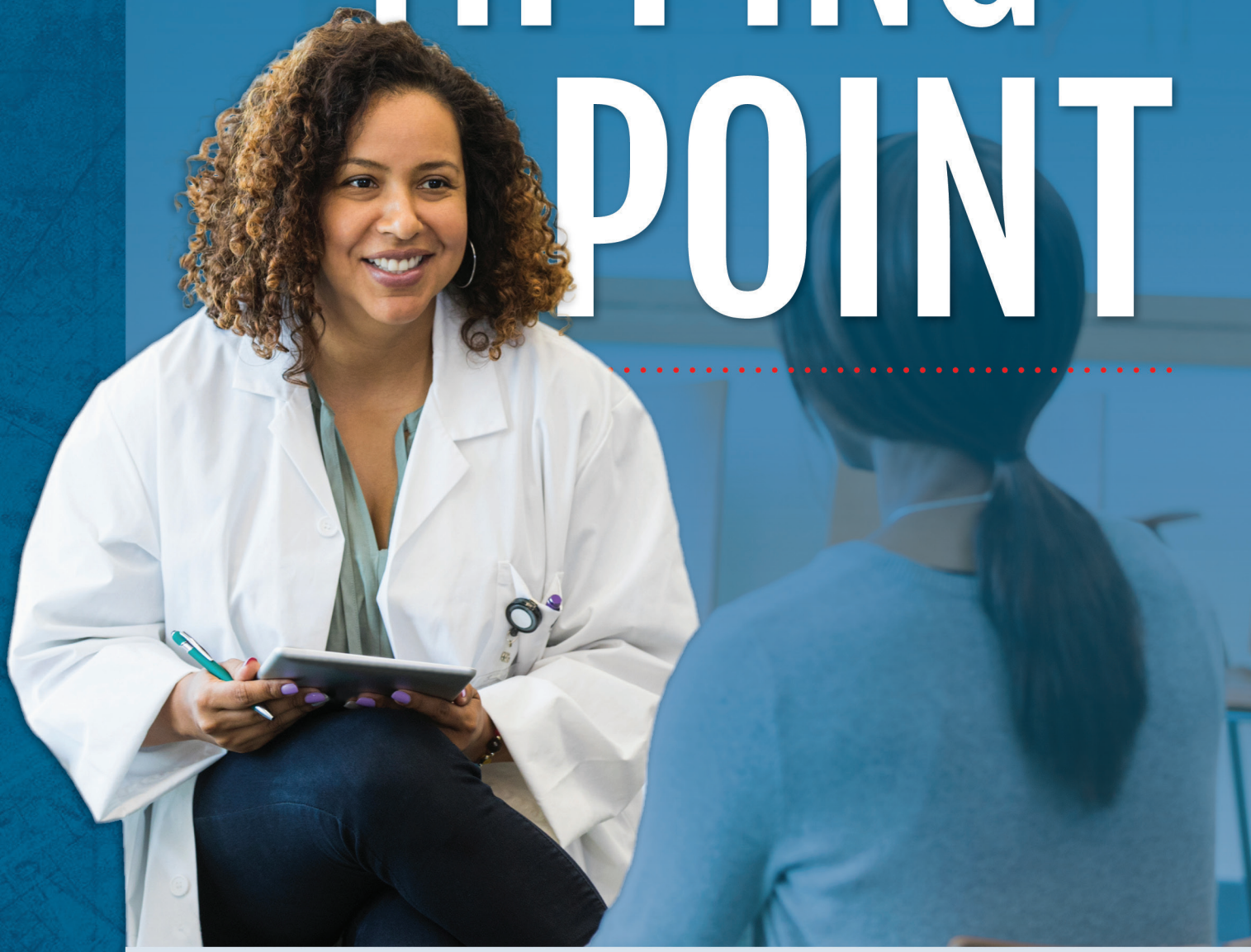

5 Challenges Pushing Primary Care Toward Value-Based Models

Aledade

Introduction

Three years after the height of the pandemic, the U.S. health care system is still finding its footing. Patients are back in the doctor's office, but many are unhealthier than they were before, and COVID still casts a shadow over operations. As we look to the future, one thing's for certain: we can't fully recover without primary care.

Established in 2014, Aledade's network of independent primary care practices and community health centers (CHCs) has grown to include more than 1,500 members across 45 states. In that time, we've seen shifting federal and state policies, the advent of countless technology solutions, and the emergence of competition in retail markets. We've also seen private primary care practices struggling to find staff, and CHCs being called to do more under already-strapped budgets.

The one constant: the resounding resilience of primary care teams committed to meeting patients' needs.

The health care industry is in flux post-pandemic, but then again, it always has been. And history has shown us that practices and health centers that are able to find the right resources and allies can not only survive but thrive.

In the following pages, you'll find out how primary care leaders must adapt to overcome the threats of today's health care landscape. Discover how economic pressure and funding changes are impacting primary care's bottom line; why today's tech solutions are overselling themselves; how savvy leaders are overcoming staffing shortages; the forces accelerating the move to value-based care - and the opportunity for independent primary care to prevail amidst it all.

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1. The State of Primary Care

There have never been more options for primary care organizations to improve patient care and remain financially independent.

Primary care practices and community health centers (CHCs) are key to the health of America's communities, and have consistently proven their value in generating improved outcomes for patients while also reducing costs. And yet, they continue to represent a small piece of the $4.3 trillion spent on health care in the U.S. each year.[1]

This is not surprising given the current landscape of the health care system, which does not bolster primary care; rather, it promotes acute care over all else, leaving primary care physicians wondering whether they should align themselves with large health systems that thrive on acute care delivery, emergency department (ED) utilization and in-patient hospitalization.

Likewise, CHCs approaching their financial ceiling can be tempted to enter a vicious cycle of grant applications. Although grants can supply much-needed funds, they often include administrative requirements and dilute a CHC's ability to set their own organizational priorities and adapt care to meet their community's unique needs.

Primary care represents:

5–7%
of the $4.3 trillion spent on health care

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The shift to value-based payment is also enabling primary care organizations that have previously struggled with low and falling payment rates and lack of leverage during negotiations with insurers to band together and access similar resources currently available to hospitals and health systems, further leveling the playing field.

These positive effects filter through to patients as well. Continued access to private and community-based primary care options enables continuity of care in a familiar and personalized clinical setting. It also helps keep health care costs down, as research has shown that patients pay substantially more for

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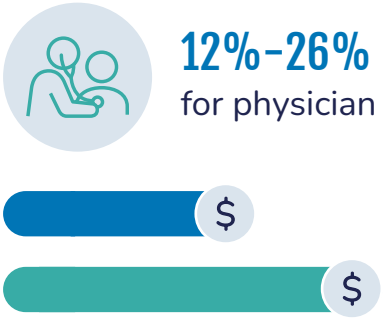

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the same services rendered by hospital- and health system-affiliated physicians.[2]

The implementation of value-based care models across the system will also create a higher demand for primary care, leading to an influx of patients seeking the services that private practices and CHCs provide. For practices and CHCs that cling to antiquated volume-based models, further strain will be put on their limited resources.

But for those who adopt value-based care, the services they provide can improve patient outcomes and lead to additional revenue streams. This could in turn fund initiatives such as infrastructure improvements, mobile clinics, food pantries, and more to further address patient needs outside of clinics' four walls.

The incentives provided by value-based care models align perfectly with the mission of primary care: to keep patients healthy. Practices and health centers who commit to adopting these models are making the right choice, for themselves and the health of their communities, taking control of their future.

Related Resources:

- Value-Based Care Glossary
- What Is Value-Based Care?

[1]https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet
[2]https://jamanetwork.com/journals/jama/article-abstract/2800656

2. Workforce

Workforce shortages won't improve without changes to the workplace.

The face of the health care crisis has been frontline workers carrying the burden of rising hospitalizations and utilization of emergency services. But one of the main drivers of this crisis is a chronic underinvestment and acute workforce shortage in primary care. Put another way, primary care is like oxygen: you really only begin to notice it when you don't have enough.

The air has never been thinner than it is today. One in four physicians plan to leave primary care by 2025,[1] and from the exam room to the front desk, primary care practices and community health centers (CHCs) are struggling to recruit and retain the employees that keep their organizations running.

Competitive wages from other industries have made it apparent that the compensation packages being offered in health care today are insufficient. This is particularly the case in primary care, where, under the traditional fee-for-service model, physicians make 29% less than their specialty counterparts.[2] This has led many physicians entering the profession to choose a specialty track over primary care.[3]

One in four

physicians plan to leave primary care by 2025

Under the traditional fee-for-service model, primary care physicians make:

29% less

than their specialty counterparts.

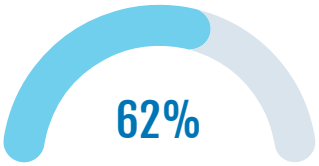
Private primary care practices, in particular, have felt the pains of physician recruitment, with 40% of physicians opting to work directly for hospitals or hospital-owned practices.[4] Likewise, it's left private practices and CHCs without the funds to offer more attractive compensation when vying for both clinical and nonclinical talent.

But the issue goes beyond compensation. Americans' priorities are changing. Today's job seekers place a high value on work-life balance,[5] which has been notoriously elusive for health care workers and a contributing factor of the industry's recent exodus.

So, how can primary care compete with the flexibilities, pay and work-life balance being offered by other industries?

Change needs to happen in both the public and private sector, in the long term and the short term. There is bipartisan agreement that the health care staffing shortage is a pressing issue, and increased

of primary care practices report being fully staffed



have personal knowledge of clinicians who have retired early or quit during the pandemic

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investments in training and funding are needed to ensure the sustainability of primary care.[6]

At the same time, primary care practices and CHCs need to shift their perspective in solving workforce challenges. This begins with examining not only who does the work but also what needs to be done and how. For some, it might mean reconfiguring workers' schedules to accommodate better work-life balance or partnering with local learning institutions to serve as a site for clinical rotations. For others, like those practicing value-based care, it could involve redesigning workflows or adopting new technologies to free up staff for more mission-driven work.

Now is the time for primary care leaders to take a holistic approach to staffing. Only by creating a fulfilling workplace can organizations recruit and maintain a stable workforce.

Related Resources:

- White Paper: Addressing Primary Care Workforce Challenges: Practical Solutions and a Way Forward
- Physician Recruitment Checklist: Crafting the Physician Job Description

[1]https://static1.squarespace.com/static/5d7ff8184cf0e01e4566cb02/t/623c7b7e7ece36771ff92adf/1648130942725/C19_Series_35_National_Executive_Summary.pdf
[2]https://www.medscape.com/slideshow/2022-compensation-overview-6015043?icd=login_success_gg_match_norm&isSocialFTC=true#2
[3]https://link.springer.com/article/10.1186/s12909-022-03244-7
[4]https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf
[5]https://www.forbes.com/health/mind/work-life-balance-survey/
[6]https://resources.aledade.com/policy-regulation/addressing-primary-care-workforce-challenges-practical-solutions-and-a-way-forward

3. Technology

Your technology is only as good as the insights you are able to draw from it.

As the digitization of health care continues to accelerate and the amount of technologies to choose from grows exponentially, adoption of these tools and platforms depends on the benefits they provide practices and community health centers (CHCs). Motivated by the desire to improve clinical outcomes and streamline workflows, physicians now use an average of 3.8 digital tools in practice, a nearly 75% increase since 2016.[1]

The uptick in technology has also been expedited as practices and CHCs transition away from volume-based payments to value-based care models, with these organizations reporting the uptake of data analytics/reporting platforms (90 percent), population health management systems (60 percent), and upgraded electronic health records (42 percent).[2] And yet, even with all these tools at their disposal, obtaining longitudinal insights into whole-person health remains elusive for physicians.

Incomplete data and limited interoperability between systems makes it difficult to identify gaps in care, opportunities for preventive screenings, and other patient needs outside of clinics' four walls, severely limiting physicians' abilities to make informed decisions at the point of care. This not only negatively impacts workflows, often leading to burnout and stress among physicians, but also potentially increases health care spend when physicians have an incomplete picture of care. For primary care organizations in value-based care arrangements, this goes against the main objective to deliver better care at lower costs.

Success in value-based care hinges on primary care physicians' ability to align patients with the appropriate clinical initiatives according to their clinical complexity. When done properly, quality of care outcomes improve for patients, leading to shared savings revenues for value-based care-enrolled practices and CHCs – thus contributing to their long-term financial sustainability.

As such, physicians need to ensure that they are adopting technologies that integrate data from disparate sources and deliver high-impact analytics necessary for survival in the value-based care landscape. Without these insights, practices and health centers will not thrive in value-based care models, which continue to scale across all payers.

Of practices that implemented new value-based care technology:

90%
added data analytics/ reporting platforms

60%
added a system for population health management

42%
upgraded their EHR

[1]https://www.ama-assn.org/system/files/ama-digital-health-study.pdf
[2]https://mgma.com/data/data-stories/getting-a-handle-on-quality-and-value-based-analyt

4. Funding & Finances

Practices and community health centers must prepare for the economy's next test.

A third of primary care physicians have reported that they have not recovered from the financial impact of the pandemic,[1] and unfortunately, many will face an uphill climb.

While some relief has come from the infusion of federal funding and expanded telehealth reimbursements, these were stopgap policies. The Public Health Emergency and its provisions are expiring in the midst of persistent inflation and a challenging labor market. Meanwhile, practices continue to struggle with insurers to receive payment and grapple with insufficient reimbursement rates when treating patients with low incomes. Patient volume is rebounding - but will it be enough?

The fee-for-service model was tested during the pandemic, and many private primary care practices paid the cost. Even those that managed to sustain operations face lasting effects. Unless primary care teams could quickly adapt their workflows and/or deliver services via telehealth, it often meant permanently losing patients to another physician, urgent care center or hospital.

1 out of 3

primary care physicians have not yet recovered financially from the pandemic.

Many CHCs rely upon the 340B Drug Pricing Program as a financial buffer, using these savings to:

provide free care to uninsured patients

offer vaccines at no cost

implement community health programs

Likewise, community health centers (CHCs) were vulnerable under the prospective payment system (PPS). Although the PPS was designed to help account for the additional services CHCs provide to patients, the pandemic demonstrated that it is no longer enough. CHCs are being called upon to expand their services to meet patients' behavioral health and social needs. Meanwhile, PPS payments only cover in-person clinician visits, and rates are failing to keep pace with CHCs' operating costs.[2]

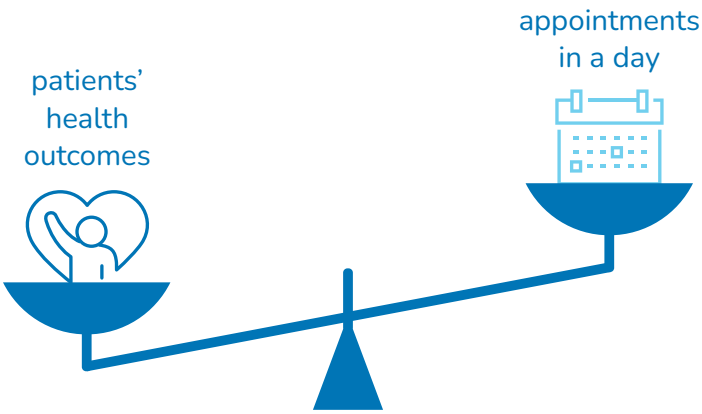
Many CHCs historically closed this gap through federal and Health Resources and Services Administration (HRSA) grant funds; however, their use is restricted - meaning, the dollars cannot be used for capital

[1]https://www.green-center.org/covid-survey
[2]https://www.commonwealthfund.org/publications/2022/jan/perils-and-payoffs-alternate-payment-models-community-health-centers
[3]https://www.nachc.org/nachc-statement-regarding-hhs-dismissal-of-adr-resolution-on-340b/

improvements and expansions. Instead, many CHCs rely upon the 340B Drug Pricing Program as a financial buffer, using these savings to provide free care to uninsured patients, offer vaccines at no cost, and implement community health programs. But despite the program's long history of expanding access to care, some stakeholders want to scale it back and reduce the benefits to eligible organizations and their patients.[3] If successful, this would be a devastating financial blow to many CHCs that are already struggling to meet the needs of their communities.

These threats loom as funds infused into community health during the Public Health Emergency reach their expiration date. The Families First Coronavirus Response Act, enacted at the start of the pandemic, required that Medicaid programs keep individuals continuously enrolled through the end of the Public Health Emergency (PHE) (May 2023). In December 2022, Congress passed its year-end omnibus bill spending bill, which delinked the Medicaid continuous coverage requirement from the PHE and established the date of April 1, 2023, for allowing states to begin ending coverage. With the end of this provision, millions could lose insurance coverage – also a relied-upon source of revenue for CHCs and private practices.[4] Simultaneously, temporary federal COVID-19 grant funding for CHCs terminates, and programs that helped the uninsured and provided free COVID testing and treatment face an uncertain future.[4]

Primary care practices that are part of an accountable care organization have a revenue stream dependent on the numbers that really matter:



The instability of volume-driven payment models will extend well beyond the Public Health Emergency period, and primary care leaders who rely on federal protections and service-based reimbursement risk their ability to pass the economy's next test.

While the pandemic illuminated the vulnerability of a volume-driven payment system, it also demonstrated that practices and CHCs that participate in value-based payment models, such as the Medicare Shared Savings Program, are well positioned to tackle patient care in a health crisis - and to remain financially resilient as a result.[5]

Primary care practices that were part of an accountable care organization benefited from having the support and financial means to quickly implement telemedicine technology if they had not already.[5] They were also better prepared to adapt workflows to meet patients' needs.[5] Already accustomed to leveraging data to identify people at risk of poor health outcomes and conduct proactive outreach, value-based care teams used these same technologies and workflow tools to support and prevent COVID-19 infection and transmission as well as to ensure patients' continuity of care when they could not visit the office. Not only did this mean better patient care, it also meant a revenue stream dependent on the numbers that really matter: patients' health outcomes, not appointments in a day.

The instability of volume-driven payment models will extend well beyond the Public Health Emergency period, and primary care leaders who rely on federal protections and service-based reimbursement risk their ability to pass the economy's next test.

Related Resource:

Investing in Primary Care Is Critical to Improving the Health of Communities

[4]https://www.kff.org/medicaid/issue-brief/how-community-health-centers-are-serving-low-income-communities-during-the-covid-19-pandemic-amid-new-and-continuing-challenges/
[5]https://www.cms.gov/newsroom/press-releases/affordable-care-acts-shared-savings-program-continues-improve-quality-care-while-saving-medicare

5. Value-Based Care

Value-based care models are proliferating across all payers, signaling the demise of volume-based payments.

Fee-for service and prospective payment system reimbursements have long been unreliable sources of revenue for primary care, and the pandemic only served to further highlight the shortcomings of relying on volume alone. Practices and community health centers (CHCs) that depended solely on these payments struggled to survive, while those in value-based care arrangements thrived, resulting in a continued acceleration of value-based care model proliferation across all payers.

As of early 2023, 13.2 million Traditional Medicare beneficiaries were in an accountable care relationship, showing signs of steady growth to achieve the CMS goal to have all Traditional Medicare beneficiaries in an accountable care program by 2030.[1]

In addition, Medicaid has been an area of development for alternative payment models (APMs), with states like California, New York, Oregon and Texas forging ahead with their own Medicaid APMs in pursuit of the ultimate goal to improve patient outcomes. These payment models have been especially advantageous for the country's 1,400 federally qualified health centers, which care for one in six Medicaid beneficiaries.[2]

Although it has historically represented the smallest subset of APMs, commercial payers are increasingly committing to the growth of value-based care models. For example, 68% of Humana Medicare Advantage members were treated by a primary care physician in a value-based agreement in 2021,[3] and Aetna has named value-based care a key focus for its future growth strategy.[4] This comes at a time when consumers, employers and other stakeholders are also looking for creative solutions to combat inflationary health care costs.

Government-based and private insurers are also using value-based programs as a platform to improve health equity. Plans are leveraging these arrangements to incentivize providers to collect standardized race, ethnicity, and language data, participate in quality improvement collaboratives, and measure clinical outcome inequities, among other strategies.[5] This will equip practices and CHCs to better address social determinants of health, enabling improved health outcomes and supporting the goals of value-based care arrangements.

The demand for value-based care extends well beyond payers and care teams - consumers are now clamoring for more personalized, high-quality care from their physicians, a direct result of increasing dissatisfaction with the lack of transparency they are receiving from health systems regarding their care and the costs associated with it.[6]

The extinction of volume-based payment is imminent as consumers and payers alike further the advancement of value-based care models across the health care system. Inaction is not an option. Denying the shift to value-based care models will put the future of primary care organizations at risk.

[1]https://www.healthcaredive.com/news/accountable-care-mssp-reach-people/640538/
[2]https://www.hhs.texas.gov/sites/default/files/documents/mco-quality-meeting-feb-16-2022.pdf
[3]https://www.humana.com/provider/news/value-based-care/value-based-care-report
[4]https://www.healthcarefinancenews.com/news/partnerships-value-based-care-key-aetnas-growth-strategy
[5]https://hcp-lan.org/apm-measurement-effort/2022-apm/2022-infographic/
[6]https://www.commonwealthfund.org/publications/2022/jan/perils-and-payoffs-alternate-payment-models-community-health-centers

Take Action

Primary care is one of the most impactful components of our health care system - and one of the most vulnerable. In today's dynamic health care landscape, there are many challenges facing practices and health centers, but there are also advances to be made and rewards to be realized. Primary care organizations must look beyond the status quo in order to succeed. Here's our advice for this year and beyond:

1. Seize the financial rewards of delivering better patient care.

The future has never been brighter for private and community-based primary care. The personalized, patient-focused care you're already delivering is perfectly aligned with emerging payment models that reward better patient outcomes.

2. Foster a fulfilling workplace.

Don't wait on policy changes to alleviate the workforce shortage. Recruit and retain a committed staff by investing in solutions that make your team feel less stressed and more appreciated.

3. Say yes to the *right* technology (and no to everything else).

A majority of today's health care applications don't play nice together. Don't bloat your system and tax your staff unless you're getting something special from the solution at hand.

4. Diversify your revenue.

Patient volume is trending up, but with economic pressures increasing, pandemic-related funding expiring, and continuing restrictions on the use of grant funds, don't count on it being enough.

5. Evolve with value-based care.

From the Medicare Shared Savings Program to state-based Medicaid to programs from commercial payers, the health care system's shift to value-based care is well underway. Don't get left behind - prepare your team to practice the primary care of tomorrow while enabling new revenue streams today.

Preserve your organization's autonomy.
Commit to the future of health care now.

Community health centers:

or visit
https://qrco.de/challenges-health-center-meeting.

Private practices:

or visit
https://qrco.de/challenges-primary-care-meeting.

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