VIEWPOINT

Primary Care Selection
A Building Block for Value-Based Health Care

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Over the past 10 years, the US health care system has undergone a significant shift in the structure of health care delivery. Many hospitals and physician groups have organized themselves to address the most pressing national priorities in health care: controlling increases in the cost of care and improving the quality of care that US residents receive. Payers, both public and private, have supported this shift by implementing new alternative models of payment that incent the delivery of cost-efficient, high-quality care. The most promising alternative payment model to fee-for-service payment is the accountable care organization (ACO) model. Some available evidence suggests that ACOs, both for Medicare beneficiaries and for commercially insured patients, reduce total cost of care and improve quality.[1-3] Although there are different ways to construct ACO models, at its core, an ACO is a contract between clinicians and the payer to meet rigorous clinical quality and experience goals and lower spending.

The first and most foundational element of any ACO model is attribution. Attribution refers to the algorithm used to identify the patients for whose total care and quality an ACO will be accountable. Beyond this technical purpose, attribution also enables other important clinical functions. For clinicians in an ACO, an attribution list allows them to prioritize engaging these patients, focusing on their transition of care, and closing gaps in their quality of care. Most ACO models apply one of a variety of claims-based approaches to attribution using the patterns of primary care service use seen in claims history over some predefined period.

Yet, in using primary care service utilization to link patients to primary care clinicians, claims-based attribution has a major limitation. Many patients (as much as 40% of commercially insured populations) do not have an observable pattern in claims commonly used for attribution. For these patients, there is an "attribution gap" because they cannot be attributed to any clinician.

Second, claims-based attribution obscures a more important dynamic that should be fostered in how patients contact the health care delivery system. Patients should choose their primary care physician or other clinicians (PCP) knowing that this choice has consequences for who is responsible for managing their care. Payers and clinicians should honor these choices and seek to involve patients in critical decisions about their health and treatment options. There is strong theoretical and empirical evidence to support the importance of the patient-clinician relationship and robust investment in primary care. This Viewpoint describes an approach that could help address the attribution gap.

Origins of Claims-Based Attribution

Researchers first established that both physician referral and patient visit patterns formed a natural network ("the extended medical hospital staff") observed in claims data. Therefore, a payment construct (eg, ACO models) could be developed to hold this network accountable for outcomes.[4]

The first Centers for Medicare & Medicaid Services (CMS) ACO models, relied on claims-based methods (**Table**). This is understandable given that fee-for-service Medicare does not contain a mechanism for PCP selection. This policy decision also was attributed to a philosophical question hiding in the background of the debate regarding the best method for deriving accountable clinicians: is the patient-clinician relationship—and thus ACO performance—best assessed by the patient's actual visit pattern or by their affirmative selection of a clinician? Some thought it was preferable for patients to have no knowledge of the ACO initiative. Unsurprisingly, the annual focus groups organized by the Medicare Payment Advisory Commission found "almost no beneficiaries are familiar with ACOs."[5] Patients are less likely to engage in important activities such as medication adherence or closing open care gaps if the ACO program and all of its clinician-focused incentives remain invisible to them.

While Medicare has experimented with PCP selection ("voluntary alignment") in 3 programs, it remains somewhat limited in scope. CMS has limited PCP selection because of concerns about patient protection that prohibit mass marketing and tightly manage the use of financial inducements to motivate patients to affiliate with particular clinicians. In the CMS programs, ACOs may communicate with Medicare patients about PCP selection, but only with those patients who have a history of seeing the ACO's clinicians. If the policy goal is to ensure that every patient has an accountable clinician, these limitations make PCP selection less effective.

Core Infrastructure for Value-Based Payment

Based on the last decade of experience with ACO models, CMS should revisit and reprioritize PCP selection. PCP selection should be viewed as part of the basic operating system for value-based care and a core piece of health information to be collected by payers that is critical to effective patient care.

Both CMS and commercial payers will need to grapple with how to incorporate PCP selection if they are to evolve these models beyond the early methods. Four policy recommendations may help advance the current state of value-based care.

First, Congress or CMS should require PCP selection among all beneficiaries enrolled in traditional Medicare. Until that happens, the Center for Medicare and Medicaid Innovation could explore a model test using required PCP selection under its authority to test new payment and health care delivery models. Such a model

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Table. Attribution Methods in Accountable Care Organization (ACO) Payment Models

Effective Dates	Payer	Alternative Payment Model	Attribution Methodology	PCP Selection Availability
2005-2009	CMS	Physician Group Practice Demonstration	Retrospective claims	No
2012-present	CMS	Medicare Shared Savings Program	2012-2018: Tracks 1-2, plurality determination based on retrospective claims; Track 3, prospective claims and voluntary alignment 2019: ACO option to select retrospective or prospective claims, voluntary alignment	Via voluntary alignment starting in 2016
2012-2016	CMS	Pioneer ACO Model	2012-2014: "Cohort" methodology using retrospective claims to track same patients over time 2015-2016: Prospective claims, voluntary alignment	Via voluntary alignment starting in 2015
2015-present	CMS	Comprehensive ESRD Model	Preliminary prospective claims, retrospective monthly true-up	No
2016-present	CMS	Next Generation ACO Model	Prospective claims, voluntary alignment	Via voluntary alignment
2009-present	BCBS of Massachusetts	Alternative Quality Contract	Retrospective claims with PCP selection where available on product	If available on product
2019-present	BCBS of North Carolina	Blue Premier	Year 1: Retrospective claims with PCP selection where available on product Years 2+: Prospective claims with universal PCP selection capability across all products	If available on product

Abbreviations: BCBS, Blue Cross Blue Shield; CMS; Centers for Medicare & Medicaid Services; ESRD, end-stage renal disease; PCP, primary care physician.

could enable a genuine test across Medicare Advantage and traditional Medicare whereby patients would actively enroll in either ACOs or in Medicare Advantage plans under a common payment method and covered benefit package. This could be done in combination with revisions to the benefit design and other beneficiary incentives for those who see their designated PCP (eg, a reduced or eliminated copayment or Part B deductible).

Second, to promote the use of PCP selection for the purposes of value-based care, CMS should also pursue a technical change to ensure that federally facilitated marketplaces can accept PCP selection data on enrollment, a current barrier to adoption. Capturing PCP selection when a member enrolls in a health plan is the best opportunity to convey the importance of this relationship as well as any associated incentives.

Third, the Office of the National Coordinator for Health Information Technology should explore whether a data standard could enable the collection, storage, and sharing of the PCP selection data of all US patients across the continuum of care. The same way that data standards were created for the admission, discharge, and transfer data that is now proposed to be a requirement of participation in Medicare, so too should be the capture and dissemination of PCP selection data.[6] This would further ensure that the often-repeated maxim of "right care, right place, right time" can actually occur if the PCP of record can be identified at any point in the delivery of care.

Fourth, commercial plans implementing risk contracts should consider PCP selection as a basic input akin to other enrollee characteristics such as name, address, or date of birth. National convening bodies of payers should come together to establish standards for the capture and exchange of PCP selection data. Delivery systems must also reorient their systems and payment arrangements with payers to ensure PCP selection data are accessible and actionable.

There are trade-offs in the use of PCP selection data for attribution, some of which led to variations in claims-based logic. The main concern is the potential for manipulation by ACO clinicians or affiliates. There may be incentives for ACOs to attempt to game their patient panels by attempting to induce or avoid PCP selection among certain types of patients. This would have the effect of either differentially including or excluding patients based on perceived likelihood of incurring significant future costs, knowledge of their health conditions, or social challenges. As a result, an ACO might earn ill-gained shared savings.

These concerns are serious, and a robust monitoring and enforcement regime must exist to ensure any selection process has integrity. PCP selection should create true, lasting relationships between patients and their PCP, not distort ACO benchmarks. "Cherry picking" (attracting healthier, lower-cost patients) and "lemon dropping" (deterring higher-need, higher-cost patients) would undermine the core premise of the ACO, which is to make gains on cost, quality, and experience. This should not be denied to any patient, regardless of risk factors.

PCP selection is not a panacea—it will not remove waste from national health expenditures. However, PCP selection is fundamental to the entire strategy of value-based care. Without comprehensive action regarding PCP selection, confusion about who is really in charge of delivering and coordinating care will continue.

ARTICLE INFORMATION

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