VIEWPOINT

Value-Based Payment and Vanishing Small Independent Practices

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An estimated 80% of physicians are now employed by hospitals, health systems, and corporations.[1] Many factors have contributed to this shift away from independent practices, including rising administrative burdens, changing employment preferences, greater capital demands for health information technology, and favorable financial incentives (eg, site-differential payments). However, underappreciated among these factors is another important accelerant of corporate consolidation: the shift from fee-for-service to value-based payment models. These models, which require clinicians to manage a budget or spending target for subgroups of their patients, include global budget contracts, like accountable care organization (ACO) contracts, as well as bundled or episode-based payment models. For small independent practices in particular, these payment models require significant support and resources. The pursuit of the capital investments, analytic tools, technology platforms, and regulatory expertise needed to enter value-based payment models risks further corporate alignment and consolidation. This inadvertent consequence warrants attention as policymakers seek to widen adoption of value-based payment models across the health care system.

> These demands on smaller independent practices create a buyer's market for corporate owners who can leverage capital, management, and scale.

Directly owned by clinicians, independent practices are often well positioned to deliver high-quality, lower-cost care.[2,3] Evidence suggests that, on average, they exhibit lower per-patient spending, fewer preventable admissions, and lower readmissions compared with their hospital-owned counterparts.[2-4] Physician-led ACOs have demonstrated more savings than other types of ACOs.[5] However, independent practices are often less equipped to participate in value-based contracts because participation requires technology infrastructure (eg, electronic health records), human expertise in population health management (eg, coding practices, quality measures, and reporting), and relationships with delivery system segments (eg, post–acute care providers). Under value-based financial incentives, these levers of control can be contained within the (often risk-bearing) organization. An independent practice without such infrastructure or relationships has less ability to manage total spending, generate savings, or manage the quality measures for their attributed patients.

Thus, intended or not, value-based payment models tend to favor consolidated organizations, which are more likely to have organizational capacity for data collection and monitoring, including analytics, reporting, and patient engagement or outreach. These tools facilitate guideline-concordant screening and tests, which yield quality-based bonuses under these models. They are more likely to have software or backroom support to maximize the capture of diagnosis codes and boost risk-adjusted spending targets. Moreover, Medicare ACOs require participating providers to have 5000 attributed traditional Medicare beneficiaries—an onerous threshold for smaller independent practices, particularly as more beneficiaries shift to Medicare Advantage. Practices with fewer attributed patients are often reluctant to assume financial risk, making corporate partners who will backstop or fully mitigate potential losses more attractive. Indeed, ACOs that are larger, affiliated with a supporting organization, and are not physician-owned are more likely to move to 2-sided risk.[6]

These demands on smaller independent practices create a buyer's market for corporate owners who can leverage capital, management, and scale. For example, insurers, retail chains, and private equity firms have rapidly acquired or affiliated with provider groups expressly to participate in value-based contracts. UnitedHealth's Optum is a market leader in value-based contracting, with nearly 5 million people in such arrangements. Humana is now the largest provider of primary care focused on older adults, partnering with private equity firm Welsh Carson to build risk-based primary care practices. Last year, CVS Health purchased the Medicare Advantage–focused primary care chain, Oak Street Health, and plans to scale these practices nationwide with private equity backing. In April, Elevance Health (formerly Anthem) announced a joint venture with private equity firm CD&R to expand value-based primary care practices.

"Softer" forms of corporatization have also emerged. Most well-known is the clinically integrated network or the ACO network, in which independent practices affiliate with a health system but do not change ownership. Insurance companies are building analogous forms of aggregation. Optum now owns and operates clinically integrated networks, ACO networks, and independent practice associations, although CVS' Accountable Care and Humana's CenterWell Care Solutions are establishing their own risk-contracting networks. Furthermore, risk- and value-based care management companies like Cano Health, Privia, agilon health, and Aledade increasingly partner with practices and form risk-contracting networks. From 2019 to 2021 alone, private capital invested in value-based care companies increased 4-fold.[7]

Such capital infusions might increase the chances of success under value-based payment through newer technology, intensified population health management,

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or improved management of the spending target. However, they also carry potential risks, including aggressive and potentially fraudulent coding practices and other forms of gaming that increase spending or are untethered to clinical outcomes. Medicare Advantage beneficiaries now cost substantially more in this program than they would in traditional Medicare, with 1 estimate indicating that diagnostic coding—a core competency of risk-based corporate primary care companies—accounts for $54 billion of the $88 billion in Medicare Advantage overspending annually.[8] More broadly, lawsuits have alleged that insurer-led vertical consolidation may enable collusion to squeeze out independent providers,[9] whereas hospital consolidation and private equity ownership have increased prices without convincing evidence of quality improvement.

If policymakers believe the delivery system should maintain some independent practices, then a key challenge is to sustain these practices through value-based payment without requisite corporate backing or ownership. Public and private payers could subsidize these practices directly (through additional payments analogous to those for rural or critical access hospitals) or indirectly through the fee schedule (raising fees for independent sites of care). Payers could continue to promote "low-revenue," physician-led ACOs by supplying them with more up-front capital, as Medicare plans to do in its recently announced Primary Care Flex Model. Payers could also reduce the threshold of minimum covered beneficiaries to participate, provided practices are able to manage these populations, to promote more equitable access to value-based payment models. Efforts are needed to lower other participation barriers that disproportionately affect smaller, independent practices, including simplifying the significant administrative complexity of the value-based payment landscape and shoring up technical assistance.

Furthermore, policymakers could consider additional models focused on population health. For example, certain primary care case management programs in Medicaid have successfully deployed community-based care managers and other population health tools to support high-risk patients across practices. Medicare's Quality Improvement Organizations, some of which focus on social determinants of health, provide another model that could assist practices. The Primary Care Extension Program, which was codified in the Affordable Care Act yet never funded, could be a model to build local extension agencies that facilitate practice improvement and integrate with community-based organizations.

A more ambitious approach could deemphasize risk-bearing as the centerpiece of mature value-based payment models. The paradigm of "physician-as-insurer" may always tend toward corporatization, given the nature of actuarial risk and factors described above. As evidence suggests, it is also a challenging way to contain health care spending, as waste stemming from high prices, administrative costs, profits, and fraud remains largely unaddressed—often "baked in" to the spending target. Along these lines, reforms like greater fraud enforcement and site-neutral payments could further dampen incentives to consolidate, saving Medicare substantial amounts.[10]

Small independent practices are rapidly vanishing. Value-based payment models, despite their intended benefits, may present a different reality to those remaining independent practices compared with their corporate-consolidated counterparts—most notably as an additional threat to independence in a modern practice landscape. Policy attention is warranted to ensure that efforts to improve the value of care do not unintentionally make independent practices a casualty in this era of payment reform.

ARTICLE INFORMATION

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REFERENCES

1. Physicians Advocacy Institute. Physician employment-practice ownership trends 2019-2023. Accessed May 13, 2024. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023

2. Casalino LP, Pesko MF, Ryan AM, et al. Small primary care physician practices have low rates of preventable hospital admissions. *Health Aff (Millwood)*. 2014;33(9):1680-1688. doi:10.1377/hlthaff.2014.0434

3. Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. *JAMA*. 2014;312(16):1663-1669. doi:10.1001/jama.2014.14072

4. McWilliams JM, Chernew ME, Zaslavsky AM, Hamed P, Landon BE. Delivery system integration and health care spending and quality for Medicare beneficiaries. *JAMA Intern Med*. 2013;173(15):1447-1456. doi:10.1001/jamainternmed.2013.6886

5. Medicare ACO. Past performance and future directions. Congressional Budget Office. Published online April 16, 2024. Accessed June 11, 2024. https://www.cbo.gov/publication/59879

6. Peck KA, Usadi B, Mainor AJ, Fisher ES, Colla CH. ACO contracts with downside financial risk growing, but still in the minority. *Health Aff (Millwood)*. 2019;38(7):1201-1206. doi:10.1377/hlthaff.2018.05386

7. Investing in the new era of value-based care. McKinsey & Company. Published online December 26, 2022. Accessed June 10, 2024. https://www.mckinsey.com/industries/healthcare/our-insights/investing-in-the-new-era-of-value-based-care

8. Chapter 12: the Medicare Advantage program: status report. MedPAC. Published online March 15, 2024. Accessed June 10, 2024. https://www.medpac.gov/document/chapter-12-the-medicare-advantage-program-status-report-march-2024-report/

9. Emanate Health et al v Optum Health et al. Justia Dockets Filings. 2024. Accessed June 10, 2024. https://dockets.justia.com/docket/california/cacdce/2:2023cv09872/906267

10. An analysis of the president's 2021 budget. Congressional Budget Office. March 2020. Accessed June 10, 2024. https://www.cbo.gov/publication/56301