



PRIMARY ADVANTAGE

*Advanced primary care emerging
as the engine for value-based care*

Written By Bruce Shutan

Decades of mounting dissatisfaction with fee-for-service medicine and fragmented care have laid the groundwork for a more coordinated, value-focused approach known as advanced primary care (APC), which is turbocharging self-insured health plans.

A Bain & Co. study suggests that APCs will be among the disruptors that could take over up to one-third of the traditional primary care market in the coming years. APC adoption is rapidly accelerating, with 76% of purchasers offering it or considering doing so within the next 1 to 3 years, according to the National Alliance of Healthcare Purchaser Coalitions.

Fortune 500 companies from JPMorgan Chase to 7-Eleven have turned to this model, which is credited with saving up to 30% of healthcare costs with the shift to value-based care. Organizations like the Primary Care Collaborative and the National Alliance of Healthcare Purchaser Coalitions have advocated for greater investment in comprehensive APC.

At the heart of this movement is a recommendation from leading researchers that primary care spending should roughly double, to 10% to 12% of total health spending, from about 5% to 7%. This thinking reinforces the old axiom that an ounce of prevention is worth a pound of cure, as patients schedule more regular checkups to ward off serious health problems.

MAXIMIZING OUTCOMES

APC began to take shape over the past decade amid a shift beyond traditional, volume-based care, according to Ed McNamara, executive vice president, business development strategy for Premise Health. He says this approach was built on comprehensive, team-based and value-based models and increased recognition of the role that primary care plays in improving health outcomes and reducing expenses.

“We know that investing in high-quality, accessible primary care leads to healthier populations and lower total cost of care, and APC allows us to maximize outcomes and cost savings for the organizations we work with,” he says.

It’s easy to understand why APC has emerged in recent years. As much as 80% of primary care is owned by big entities such as insurance companies and hospital systems that answer to Wall Street rather than Main Street or local communities, notes William H. “Bill” Bestermann, M.D., president and chief medical officer for Epigenex Health, Inc.

As a result, he says PCPs are under pressure to see about 30 patients a day for 10 minutes

at a time because they’re paid based on patient volume. “The financial motivations are completely misaligned,” he adds.

Doctors, no doubt, are drawn to the APC model in hopes of establishing more meaningful patient relationships and helping improve outcomes without having to deal with care barriers and administrative matters involving insurance companies.

For physicians who practice APC, “it’s not just about the transactional visit that happens when a patient is in the health center,” explains Krista Beckwith, vice president of population health with APC provider Marathon Health. “It’s more about that proactive management that happens before, after and in between that visit.”

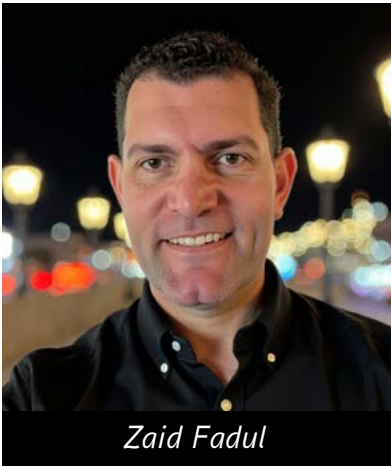
APC is rooted in the patient-centered medical home model in the early to mid-2000s, which originated in pediatrics, and both emphasized quality. However, “it never saved any money or improved care in adult medicine because it was mostly structural and administrative,” Bestermann explains.

He says nearly half the patients had few medical needs because they were younger and healthier, while about 60% had a chronic condition and accounted for 85% of the overall health spend. Mindful of these facts, he explains that the American College of Physicians created a concept called the advanced medical home whose focus was on the needs of patients with a particular condition. The best example of that in the U.S. was Kaiser Permanente in Colorado, where a collaborative coronary care service grew out of the HMO’s cardiac rehab program.



Like direct primary care and concierge care, both of which involve a membership-based model wherein they pay a monthly subscription for direct access to their own provider in lieu of traditional health insurance, APC offers more time with providers and increased access through both in-person and virtual visits.

“Where it differs is in its comprehensive, multidisciplinary care team and focus on population health and total cost of care,” McNamara says. “It brings together primary care, behavioral health, pharmacy, care management, care navigation and virtual primary care services to proactively care for members.”



APC goes further than the medical home concept by prioritizing digital access, better use of data analytics and technology, and an increased emphasis on behavioral health and pharmacy access, he explains.

But there’s also a larger swath for improvement. Employers are trying to implement more APC metrics into their wellness plans, observes Zaid Fadul, CEO of Bespoke Concierge MD. Flagging serious illnesses at a younger age and preventing disease progression “makes it much easier to mitigate the downstream negative impacts of eye damage, kidney disease, erectile dysfunction or anything else like that if you intervene early,” he says, noting that those steps typically save about \$1,200 to \$1,500 a year per employee.

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In APC, Bestermann says systems of care become standardized. He has come to believe over the past 30 years that all cardio-metabolic conditions and chronic diseases are related, driven by excess oxidant production and decreased antioxidant defense that happens as people age. “If we’re fat and smoking, it’s worse – so it all ties together,” he says.



William Bestermann M.D.

Bestermann also points to the need for a population health tool and patient-engagement resources and education programs to help them understand their disease and what can be done about it, along with evidence-based care processes that are consistent with best practices. “Then you have to have the IT infrastructure to support providing and measuring that care,” he explains, noting that these elements are missing from the direct primary care model.

WIDENING ACCESS

Self-insured employers can build APC into their plan design by focusing on access, affordability and engagement, McNamara suggests. Those steps include making APC low- or no-cost for members or integrating it into their network as a preferred provider. When members can easily access primary care, he says their healthcare shifts from reactive, episodic care to proactive care management. “Early detection and prevention methods are essential to avoiding costly complications, saving out-of-pocket expenses for both employees and employers,” he adds.

More organizations are exploring primary care-centered health plans to drive even greater engagement with APC and further improve overall outcomes, according to McNamara. In these plans, he says employers steer members to easily accessible primary care providers and incentivize preventive care like annual exams and vaccines, often at low or no cost. Members benefit from a seamless, coordinated experience, even when they do need to seek care from a specialist.

One example is Premise and Centivo partnering last year to launch a primary care-centered health plan for self-insured employers. A mutual client, which offered an alternative health plan for more than four years, noted that more than 70% of its population has enrolled. “Those receiving care from Premise providers are driving a 32% lower per member per month healthcare spend,” McNamara notes. “They’re also making 16% fewer emergency room visits and experiencing 28% fewer hospital admissions.”

With benefits such as same-day and next-day appointments, lower costs for both members and organizations, integrated behavioral and pharmacy services, and streamlined referrals, he says more employers are recognizing that APC can drive meaningful health outcomes and long-term savings.

In 2024, Premise Health reviewed claims data for more than 207,000 of its members using a methodology validated by Milliman that showed APC leads to better health and lower costs, with an average 30% reduction in total cost of care. “That’s about \$2,434 savings per member each year,” McNamara reports. “And when organizations add more services like pharmacy or behavioral health, those savings nearly double for attributed patients.”

These results stem from the increased emphasis on preventive and primary care, with members being seen earlier. They show that members made 20% more routine, preventive and mental health office visits, visited the emergency room 17% fewer times and were admitted to the hospital 52% less often.

ON-SITE MEDICAL CLINICS

Bestermann has been collaborating for five years on an effort to create the infrastructure necessary to support APC teams in cardio metabolic disease, noting that the same model could be applied to other conditions.

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“The ideal place to do this is in a worksite clinic that a self-insured employer has serving their employees because generally that is run by a nurse practitioner or PA who is supervised by one physician,” he says.

The problem is that too many self-insured employers can’t afford a worksite clinic, and even large employers often don’t have one in place, he cautions. Also, many large employers have their employees scattered all over the country, but even within the same town, patients may be seeing multiple doctors, which makes it extremely difficult to manage.

However, he says medical problems can be managed remotely, noting that “you can measure your blood pressure at home, and that measurement is more accurate than the office measurement. You can also measure your blood sugar at home.”

Across half the U.S., Bestermann notes that nurse practitioners can practice on their own. Explaining that they’re trained in care paths and best practices, and are used to protocols and algorithms, he says, “they do fantastic work on advanced primary care and the systematic application of optimal medical therapy for cardio metabolic disease.”

One approach that has proven to be effective is giving specially trained nurses or pharmacists, under appropriate supervision, the authority to make medication changes without consulting the physician as long as the changes fall within approved treatment algorithms, he says.

“It will remain difficult to improve diabetes outcomes very much unless the current medical care system can change to facilitate more frequent interactions with knowledgeable providers,” he explains.


Beckwith is sanguine about the prospect of expanding this model. “We are going to see more employers lean into not just value-based care, but also advanced primary care,” she predicts. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for nearly 40 years.


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“We drink our own Kool Aid,” quips Krista Beckwith, vice president of population health with Marathon Health, noting that the company’s employees and dependents are incentivized to use their in-house services to become healthier, which also has a positive impact on the bottom line.

More than 70% of the at-risk employee population who engaged in this APC offering reduced their overall healthcare risk in just one year. That buoyant participation has paid considerable dividends internally and externally.

One telling metric is that Marathon Health has generated an average net savings on claims trend that exceeds program costs with a 1.2 times return on investment after the first year that grows to 3.7 times by year five. ROI was driven by an 82% increase in primary care utilization from more engaged members who use more preventive services and less acute care, as well as 15% fewer ER visits, 31% fewer urgent care visits and 41% fewer inpatient admissions. The result is more than \$1,100 in savings per member per year and nearly \$1,300 per engaged member with a chronic condition.

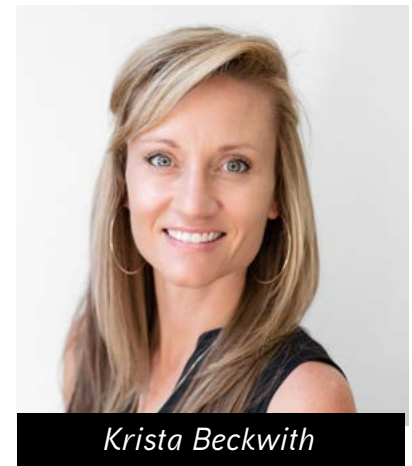
Marathon Health partners with Garner Health, whose analytics are overlaid on top of payer data, so that the patient is always being referred in network. Then, within that network, those analytics and algorithms are used to drive patients to the highest quality, lowest cost provider in the network. “Our special sauce is that we partner with patients every step of the way so that they’re never taking on the burden of having to figure out things on their own or understanding what they need to do for follow-up,” she says.

Her company’s value-based care model features three key components: substantially quicker access, greater time commitment and proactive management of employee populations. Same-day and next-day appointments are available compared with 30, 60 and even 90-day lags with the traditional fee-for-service model. In addition, patient visits last 30 to 45 minutes on average, which is two to three times a standard primary care visit.

In a departure from fee-for-service medicine, Marathon Health doctors are compensated based on the value provided to patients vs. volume. “We take more risk with managing populations and managing them to outcomes and performance guarantees,” Beckwith explains.

“It’s not about how many patients you can see in a day, how quickly you can see them, and how we can get them more services to bill,” Beckwith says. “It’s about let’s make populations healthier and make sure we’ve got that right relationship.”

– Bruce Shutan.



Krista Beckwith