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Emerging health plan led primary care strategies

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Primary care* has been under significant pressure to adapt to technological advancements, shifting member preferences, and overall market changes. As the traditional method of primary care has been challenged, these pressures have acted as a catalyst for new and innovative primary care models to enter the industry and rapidly gain market share. As a result, many healthcare organizations have begun to improve their primary care functions to provide better health outcomes, lower healthcare costs, and gain a competitive advantage. Instead of viewing the emerging models as competitors, some healthcare organizations have opted to collaborate with them or have adopted their methods. For payers, there are several benefits to building ties with innovative primary care models. The ability to reduce member risk and thus lower downstream costs, increase membership, and expand the payer footprint by allowing for points of orchestration across various assets are considerable advantages. Ultimately, adoption of emerging primary care models can help payer organizations provide members with benefits such as enhanced experiences, convenient care, broader options, and most importantly, improved health.

* **Primary care** is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.[1]

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Evolving primary care landscape

Reduced access, increased expense, and evolving member preferences are all factors that continue to contribute to recent changes across the primary care landscape. These changes are most heavily influenced by member preferences or member behavior, which are driven by advances in technology and data that are increasing the available and affordable options, that impact primary health care delivery methods in the United States.

As a result, the value of a positive member experience is more important than ever before.

Payers must now adjust their approach to primary care to meet members' desires for affordable, accessible, convenient, and quality healthcare. ▶

Trends

Shifting member preferences | Surging healthcare costs
The burden of chronic care

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Shifting member preferences

Catalyzed by the COVID-19 pandemic, the primary care landscape has changed significantly as a result of increased utilization of telehealth and virtual care options. Even prior to the pandemic, member preferences were shifting for reasons including an overall decrease in loyalty in primary care patients, a reliance on ancillary services such as labs, and the desire to see a clinician quickly and close to home.[2]

Across all industries, Americans are increasingly selecting options that are the most convenient for them, including options for primary care. Other elements in the primary care sector are also encouraging members to seek out convenient care options. This evolution, created in part from the pressure the primary care landscape was facing, has resulted in a wide array of care options, such as urgent care centers and telehealth, from which members can choose.

Health leaders predict ambulatory primary care centers, like walk-in clinics, will provide routine care by 2024, indicating that member preferences will continue to evolve.[3] These choices point to a growing inclination for primary care, as well as all healthcare in general, to be more convenient and less expensive for members. The rising reliance on ancillary services demonstrates that members are focused on itemizing their healthcare in order to achieve expedient and low-cost outcomes. Member preferences for seeing a clinician swiftly and near in proximity are having a direct impact on innovative primary care models that will deliver care to members at the time and place most convenient to them.

In addition, the National Bureau of Economic Research has identified a substitution effect for different sources of care, such as retail clinics, telehealth, and urgent care centers.[3,4] These alternative care options have a common goal of providing treatment through value-based care while lowering member expenses. These solutions cater to members' desire for convenient and accessible treatment, and they address primary care deficiencies that traditional providers cannot.

154%

increase in telehealth use between March 2019 and March 2020

Decreased reliance on primary care providers is directly shifting to an increased reliance on retail health clinics. As such, it is forecasted that nearly 70 million U.S. adults will visit a retail health clinic annually by 2022, representing a 42.7% increase in visits from 2018.[3]

Every year, approximately 89 million members attend urgent care clinics, accounting for over 29% of all primary care visits in the United States. Practically all of those visits are more convenient and cost-effective than going to the emergency department. According to the Urgent Care Association's 2018 Benchmarking Report, nearly 94% of members waited less than 30 minutes to be seen by a provider at an urgent care center.[5]

Telehealth use increased by 154% between March 2019 and March 2020.[6] At the height of the COVID-19 pandemic, telehealth had around 12 million visits. By March 2021, use had dropped to approximately 9 million visits. However, this is still significantly more than the fewer than 2 million monthly visits that occurred between April 2019 and January 2020.[7]

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Surging healthcare costs and chronic underinvestment

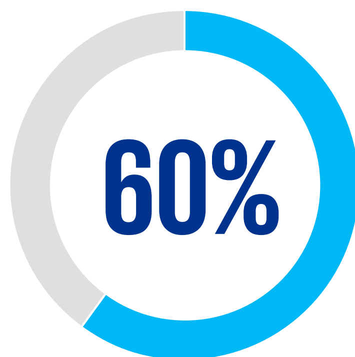
In 2020, the United States spent $4.01 trillion on health expenditures.[8] In fact, 1 of 6 dollars that Americans earn is spent on doctors, hospitals, medications, and other healthcare costs. Despite spending nearly twice as much on healthcare as a percentage of GDP, America has the lowest life expectancy among 11 similar nations.[3] This is largely due to the country underinvesting in primary care for far too long. As compared to any other developed country, America spends 50% less on primary care.[9] A December 2020 report from the Primary Care Collaborative shows that 2019 primary care spending was only 4.7% of total national commercial healthcare spending. This was a net decrease from 4.9% in 2017.[3] In order to resolve the rising cost of healthcare, primary care must be expanded and enhanced within the United States. Primary care can be described as the front door, or starting point, of a member's healthcare journey. Therefore, proactive primary care can save dollars on specialty care later on. According to studies, every $1 invested in primary care can save $13 in downstream costs. By spending closer to 12% of its healthcare dollars on primary care, the United States could reduce per-patient expenses and overall healthcare spending.[10]

The burden of chronic care

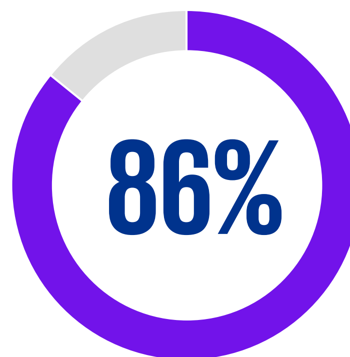
One area of focus in primary care is chronic condition management. Chronic conditions are costly and inadequately managed in the United States. Over 60% of U.S. adults have one or more chronic condition, and 86% of healthcare costs can be attributed to chronic disease.[3] Despite allocating such a high percentage to chronic disease expenditures, America has the worst chronic illness burden among 11 comparable countries.[3] This burden is jeopardizing the national healthcare system's long-term viability. Proper management of chronic care conditions requires comprehensive care coordination. Since primary care often serves as the initial touchpoint for members, it is intuitive that expanding primary care capabilities to service members with chronic conditions would aid in achieving higher quality and improved outcomes.

Increased primary care for chronic disease members would enable identification, intervention, and possible prevention of more severe health incidents as they arise. For example, having preventative care plans upfront as well as providing follow-up primary care for members who have recently been discharged on the backend could result in better member outcomes and lowered costs. If appropriate primary care is not delivered, the consequences could be observed in the form of increased and unnecessary emergency department visits downstream along with the associated expenses.[3]

The compounding effects of these disruptions has led to member dissatisfaction and frustration with the broader healthcare system, and specifically the traditional primary care model. In light of this, there are opportunities for payers to differentiate themselves in the market through strategic interactions with emerging models.



of U.S. adults have one or more chronic condition.



of healthcare costs can be attributed to chronic disease.

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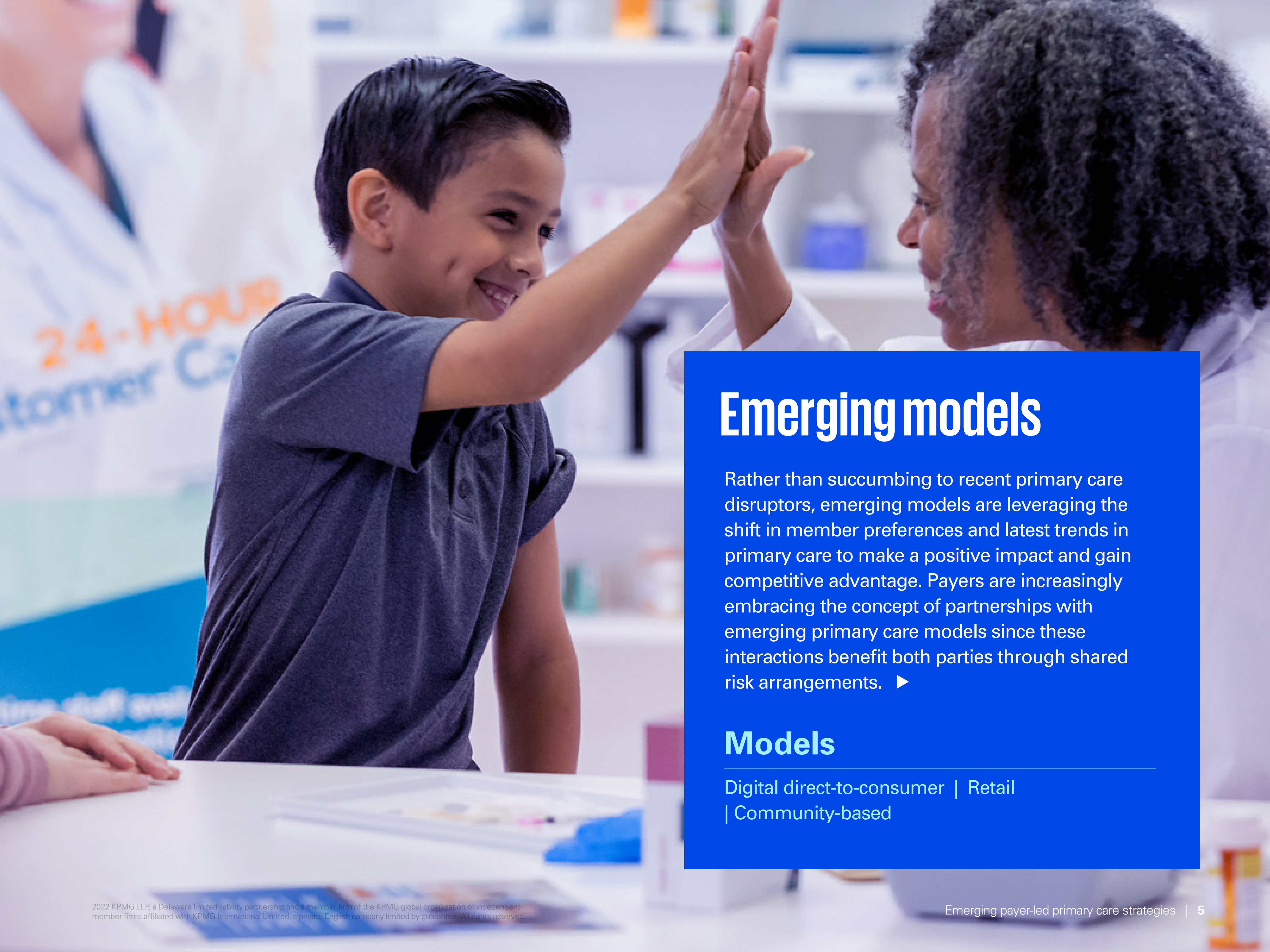

Emerging models

Rather than succumbing to recent primary care disruptors, emerging models are leveraging the shift in member preferences and latest trends in primary care to make a positive impact and gain competitive advantage. Payers are increasingly embracing the concept of partnerships with emerging primary care models since these interactions benefit both parties through shared risk arrangements. ▶

Models

Digital direct-to-consumer | Retail | Community-based

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Emerging models

To address the limitations in primary care, healthcare organizations implementing these models have become creative – modifying machine learning, data analytics, operating systems, and EHR designs. Once these deficiencies are recognized, it enables allocation of resources to members who require them the most, such as those with chronic conditions. This is especially appealing to investors as these tech-enabled companies are attempting to fix cost challenges while also improving health outcomes.

Emerging innovative models continue to challenge traditional primary care. An underpinning of these models is providing value-based care: aiming to improve patient care while also reducing costs. From our perspective, these models fit into three segments:

Digital direct-to-consumer | Retail | Community-based.

Examples

Oak Street Health's tech capabilities allow the organization to acquire vast volumes of data from claims, pharmacy, and medical records and integrate it into their clinical and operational data. This enables the organization to use data analytics to identify members who have the greatest risk and require intervention. Oak Street has been able to decrease hospital admissions, 30-day readmission rates, and emergency department visits as a result of these efforts.[3]

Carbon Health is a lucrative primary care startup that has found success through the use of machine learning software that automates time-consuming administrative healthcare labor. The company's machine learning technology enables members to scan their insurance information on its app prior to arriving for their appointment, allowing for a faster check-in process.[3]

Heal is a telehealth startup that aims to provide in-home primary care services as needed to its members via an app. Users enter their details and search for a doctor in their region. Last year, Humana invested $100 million in the company.[3]

Digital direct-to-consumer

Digital direct-to-consumer models deliver primary care straight to their members and bypass intermediaries. This can be in the form of:

Virtual care | 24/7 access | On-site

The goal of this model is to utilize technology in order to provide services that meet members when and where it is the most convenient for them. Digital Direct-to-Consumer models can help to overcome access challenges in primary care by removing specific barriers to care, such as transportation.

One Medical has been a pioneer in this field, offering its members 24-hour access to digital health services, physician texting, and same-day appointment scheduling for a $199/year membership fee. The membership fee, however, does not cover visits or services, which are still charged to the member's insurer.

To improve accessibility even further, the company has offices in primarily metropolitan areas that are intentionally close to where members live and work. More than 8,000 businesses partner with One Medical to provide health benefits to their employees, with many covering membership costs.[3, 11]

Teladoc Health uses its own proprietary cloud-based platform to provide video, audio, and asynchronous telemedicine services to its members. Teladoc's services are offered by over 50 U.S. health plans. Several small businesses, labor unions, public-sector employers, in addition to over 40% of Fortune 500 employers, extend Teladoc benefits to their employees as well.[12, 13]

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Retail

The retail primary care model is most commonly found in drugstores, supermarkets, and other retail chain locations. The focus is on treating low-acuity conditions while appealing to members' preferences for convenience and accessibility.[14, 3] These retail enterprises are expanding their offerings and breaking into the primary care industry by leveraging their existing customer bases. The idea behind this strategy is to be a full-service company that offers a wide range of products and benefits under one roof.

CVS Health, which acquired Aetna in 2018, has introduced CVS HealthHUB into the primary care market. CVS HealthHUB is a neighborhood-based store that offers members a spectrum of healthcare services, wellness products, credible guidance, and customized care with the convenience of walking into a local CVS Pharmacy. A Care Concierge will interact with and educate members, assisting them in navigating in-store services and activities, and connecting them to in-store clinicians. Members can also use health and wellness apps, health monitors, smart devices, and weight management programs.[15] Inside HealthHUB stores, members can find MinuteClinics as well. MinuteClinic provides enhanced services in which clinicians can screen, diagnose, and treat members. Members can also receive follow-up treatment for chronic conditions, minor injuries and illnesses, vaccines, and annual exams, in-store or virtually.[16]

VillageMD members can receive primary care from VillageMD and its subsidiary, Village Medical, in conventional clinics and Village Medical at Walgreens joint clinics. Their primary care services include preventive care, treatment for illness and injury, and management of chronic conditions such as diabetes and congestive heart failure. VillageMD and Village Medical have expanded to 15 markets, serving over 1.6 million members.[3]

Community-based

Community-based primary care models actively work to assist disadvantaged and underserved populations. These populations are identified through social determinants of health and medical history to comprise a targeted population. Disadvantaged and underserved populations can be greatly impacted through specific and focused primary care intervention. This model meets members' needs through a variety of tools such as accessible care.

Oak Street Health is a tech-heavy start-up that collaborates with its senior and Medicare members to construct a personally tailored health care plan. Oak Street Health's facilities are located in communities where their members live, and include community rooms, in-center pharmacies, and behavioral health specialists – amenities that are often beneficial to seniors.[17]

Similarly, ChenMed's model consists of physician-led care teams that coordinate their members' patient journey. Physicians provide care to a smaller number of patients, and patients are able to access their doctor 24/7, which in turn generates valuable relationships. ChenMed has a focus on prevention for their senior and Medicare members, many of whom often have multiple chronic conditions. 33% of ChenMed members see fewer hospitalizations and emergency room visits.[18]

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Emerging models matrix

Using new innovative models, a number of companies are gaining market share in primary care. Our Emerging Models Matrix highlights fourteen companies that provide a variety of primary care services, segmented into three emerging primary care models – digital direct-to-consumer, retail, and community-based. Each company has a distinct and specific primary care model that caters to their targeted members. Each entity's membership, size, cost structure, investment or revenue, and payer partners, have been identified to highlight their unique qualities while grouping them by the primary care model that they represent.

Company	Care delivery channel	Size	Membership	Revenue model	Investment	Selective payer partners*
Digital direct-to-consumer						
One Medical	Virtual 24/7 access On-site	124 centers in 16 markets [3]	621,000 members [3]	Membership fee model [3]	Publicly traded [3]	Aetna Cigna Humana United Healthcare Multiple BCBS plans nationwide [11]
Teladoc Health	Virtual 24/7 access	N/A	40M+ members [12]	Subscription fee model [13]	Publicly traded [20]	Aetna United Healthcare Multiple BCBS plans nationwide [13]
Amazon Pharmacy	Virtual 24/7 access	50,000 participating pharmacies [21]	310M active Amazon customers [22]	Varies based on medication requested and Prime membership	Publicly traded [23]	Unavailable
Ro	Virtual	23 states [24]	N/A	Varies based on medication requested [25]	Privately held venture-capital backed [25]	None [25]
K Health	Virtual 24/7 access	N/A	3M users [26]	Membership fee model [26]	Privately held venture-capital backed [27]	Anthem [27]
Carbon Health	Virtual In-home On-site	83 clinics across 12 states [28]	N/A	Varies based on service [29]	Privately held venture-capital backed	Aetna Cigna Humana United HealthCare Multiple BCBS plans nationwide
Heal	Virtual In-home	9 states	Services available to 134M Americans [30]	Varies based on service [31]	Privately held with promised investments by Humana [32]	Aetna Wellcare Clover United Healthcare [30] Humana [32]

*Information compiled in this matrix may not be comprehensive as information is continually evolving. The payer partners included may not be indicative of all payer partners for each company but are a representative sample.

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Emerging models matrix *continued*

Company	Care delivery channel	Size	Membership	Revenue model	Investment	Selective payer partners*
Retail						
CVS Health	On-site	650 HealthHUB locations 1,100 MinuteClinic sites [3]	N/A	Varies based on service	Publicly traded [4]	Aetna
VillageMD	On-site	1,000 clinics across 30+ markets by 2027 [33]	1.6M members [3]	Varies based on service	Privately held with promised investments by Walgreens [34]	Humana
Walgreens	On-site	Approximately 9,021 drugstores [35]	N/A	Varies based on service	Publicly traded [36]	Unavailable
Walmart	On-site	Approximately 4,756 stores [37]	N/A	Varies based on service	Publicly traded [38]	Unavailable
Community-based						
Cityblock Health	Virtual 24/7 access In-home On-site	5 states [3]	75,000 members [19]	Various capitated risk arrangements with payers [19]	Privately held venture-capital backed [19]	Emblem Health ConnectiCare Tufts Health Plan CareFirst [39]
Oak Street Health	On-site	100 centers in 24 markets across 15 states [3]	122,000 members [3]	Various capitated risk arrangements with payers [40]	Publicly traded [3]	Humana Aetna Cigna United Healthcare WellCare Health Plans MoreCare Multiple BCBS plans nationwide [17]
ChenMed	24/7 access On-site	Over 80 centers in 12 states [3]	Information not disclosed by firm	Value-based reimbursement [18]	Privately held venture-capital backed [41]	Unavailable

*Information compiled in this matrix may not be comprehensive as information is continually evolving. The payer partners included may not be indicative of all payer partners for each company but are a representative sample.

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Redefined payer strategy

Payers have the opportunity to readjust their primary care strategies to meet the needs of the evolving primary care market. The primary care market is challenged with shifting member preferences, surging healthcare costs, chronic underinvestment, and mismanaged treatment of chronic conditions in the United States. Through this, the primary care landscape has evolved to encompass new and innovative primary care models. These primary care models address a number of healthcare issues from the perspective of members, while also providing a variety of benefits to payers.

The emergence of novel primary care models has been fueled by one key motive: to reduce payers' risk by managing members' risk. This is in part due to value-based care being derived from government mandates and standards around outcomes as well as a broader understanding of how positively value-based care can be seen in future generations. In focusing on member needs and trends, payer organizations have immense opportunity to promote a healthier member population while gaining financial benefits. As a result, a growing number of payers are investing in or partnering with emerging primary care providers as a viable business strategy with a financial incentive. ▶

Strategies

Rethink risk management | Navigate members for effective access and engagement | Effectively orchestrate assets

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Rethink risk management

Through these collaborations, payers and primary care organizations have an opportunity to rethink how they can manage risk differently. Downstream, this is financially beneficial for both parties. The simplest form of value capture for payers in this landscape is to retain as much of the premium as possible. Thus, these new primary care models and collaborations have a financial justification that is two-fold:

1) **The per-member-per-month (PMPM) costs for Medicare Advantage and Medicaid groups are far greater than those of commercial populations.** Therefore, allocating a higher proportion of spending and having a greater focus on primary care for Medicare Advantage and Medicaid plans is an enticing investment for payers and provides an opportunity to better manage the care of these populations as well as reduce downstream costs.[4]

2) **Payers and primary care organizations have essentially formed risk-sharing agreements that result in increased revenue and benefits both parties.** As the health of members is managed, and positive health outcomes are seen, there is greater control of the downstream cost of care for these payers. Simply put, through managing member health and controlling the cost of care, payer organizations are seeing greater returns in shared savings, leading to increased revenue.

Example

Cityblock Health aims to serve the Medicaid market. Approximately two-thirds of Medicaid members are enrolled in Medicaid managed care, which is managed by private payer firms. Cityblock enters into agreements with payers by offering to care for members with greater healthcare needs. Cityblock's business strategy is based on a risk-sharing arrangement. The company accepts Medicaid members from its payer clients in exchange for a lump sum payment to manage their treatment. This payment depends on the complexity of the member's health needs and can range between $10,000 and $30,000 per member per year. Payers receive a portion of the savings if Cityblock provides high-quality care at a reduced cost, while Cityblock keeps the remainder. In the alternative, Cityblock is responsible for any cost overruns.[11]

Navigate members for effective access and engagement

Using this updated payer strategy and collaborating with convenient primary care models, payers can retain current members while also recruiting new ones. Member engagement in their own care can also play a role in long-term member retention from a payer perspective. Emblem Health's relationship with Cityblock Health, for example, has led to a 70% engagement rate of Emblem's Cityblock program members. Now moving forward, Emblem Health does not restrict Cityblock membership to only its Medicaid patients. Instead, the company allows select Medicare and commercial members to join its Cityblock program as well.[19]

These models allow payers to focus on quality of care provided to ensure a healthy population. In focusing on Medicare Advantage and Medicaid groups the benefits to members and payers are reshaping primary care.

In reaching additional members, the shared risk decreases, and greater population health is realized.

Effectively orchestrate assets

Payers often have a wide array of assets on hand, such as care management, utilization management, and virtual care, that can be harnessed for business improvement and enhanced member experiences. The focus has now shifted from the traditional model to one that allows for points of orchestration across existing assets resulting in an expanded footprint for payers. Payers will be better off in terms of risk management and profitability if existing assets are properly coordinated while meeting the needs of their members.

In order to implement this strategy, payers are collaborating with a variety of different primary care models, each of which has its own distinct perspective on how to improve primary care services and access.

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How KPMG can help

Rather than continuing to operate under legacy primary care, many healthcare organizations have begun to strategically modify their approach to primary care. As the primary care landscape shifts toward greater accessibility and value-based results, payer operations will need to align with progressive primary care models to effectively maintain positive health outcomes and realize increased profits. Proactive primary care provides a holistic member view that enables payer organizations to engage with and support the member journey from initial visit to discharge. As member preferences evolve, payers can strengthen existing primary care initiatives by leveraging creative technological breakthroughs, partnerships, and collaborations with, or acquisitions of, promising primary care companies gaining market share in the industry. Coupled with the implementation of a shared risk arrangement, primary care payers will see substantial benefits. Understanding the key points of strategic potential to engage with emerging primary care models will benefit payers and have the greatest impact on member satisfaction, health outcomes, and costs.

Recent client engagements

1. A leading pharmacy-owned health plan with a wide retail clinic market was looking to develop a statewide partnership with the largest health system for its members. KPMG was able to:
   a. Outline coordinated primary care pathways between the two organizations to improve access to convenient care services
   b. Develop a three-party risk-based value model for collective value to all parties involved that is payer, provider, and retail entities

2. A top 5 national health plan was seeking a clinical operating model transformation with a focus on integrating home health capabilities and pharmacy services to improve outcomes for their Medicare Advantage population. KPMG was able to:
   a. Define integrated care models incorporating expanded home health capabilities with an understanding of members to navigate to needed home services and when
   b. Identify opportunities to better integrate pharmacy distribution, education, and reconciliation with home health for a holistic model of at home primary care services

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