OPTUM®

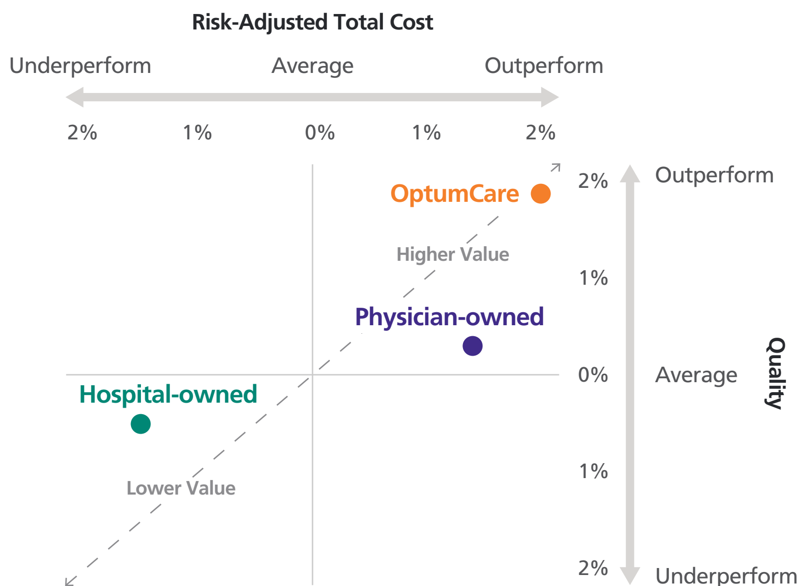
OptumCare Primary Care Physician Practices Deliver More Value to Patients, Outperforming Hospital-Owned Practices on Quality and Cost

The ownership of primary care physician practices has important implications for health care quality and costs.

Hospitals acquired over 40,000 physician practices between 2012 and 2018.[1] Nearly half of U.S. doctors are hospital employees,[2] and fewer than half of primary care doctors work in physician-owned practices.[3] As physicians continue selling ownership of their medical practices to larger provider organizations in order to reduce their financial risks and administrative burdens, **OptumCare partnerships represent a high-value alternative to hospital ownership.**

OptumCare primary care physician practices outperform hospital-owned practices by 2.4 percentage points on quality and 3.5 percentage points on risk-adjusted total cost of care, delivering more value to privately insured patients, employers, and the health care system.

Performance of Primary Care Physician Practices on Quality and Cost, 2018



For privately insured patients, relative to the average:

- OptumCare practices **outperform** by 1.9 percent on quality and 2.0 percent on cost.
- Physician-owned practices **outperform** by 0.3 percent on quality and 1.4 percent on cost.
- Hospital-owned practices **underperform** by 0.5 percent on quality and 1.5 percent on cost.

The Importance of Who Owns Primary Care Physician Practices

Hospital-owned primary care physician practices typically do not have clear incentives to lower their patients' total health care costs because, even when a hospital-owned primary care practice can earn bonuses by keeping patients out of the hospital, the hospital that owns the practice can earn more from additional inpatient admissions and outpatient procedures.

OptumCare's physician-led primary care practices earn more when they keep patients healthy and lower their total health care costs, helping primary care doctors focus on:

- Delivering preventive services
- Managing chronic conditions
- Making referrals to high-quality specialists
- Avoiding unnecessary and costly interventions
- Keeping patients out of the hospital

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Methodology

This analysis of quality and cost was conducted internally by UnitedHealthcare using its own claims data.

Defining Primary Care Practices

A primary care physician (PCP) practice is a contracted entity with at least one UnitedHealthcare member attributed to a PCP (family practice, internal medicine, or pediatrics) in the entity in 2018. A practice can have more than one tax identification number and/ or physical address. Multi-specialty practices that include PCPs are included. Practices owned by health plans that in turn are owned by hospitals are assigned to the hospital ownership category. Practices with incomplete or conflicting information regarding hospital vs. physician ownership are assigned to the physician ownership category; these practices together account for 2 percent of spending in the sample. The physician ownership category may include a small number of practices owned by health plans or private-equity firms that were not identified. OptumCare practices include owned and affiliated practices and owned management services organizations.

Attributing Patients

Members are attributed to a PCP under contract with UnitedHealthcare using the member's most recent PCP visit or, if a member does not have a PCP office visit, through an algorithm that uses additional claims data (i.e., most recent prescription). Nineteen percent of members could not be attributed to a PCP and are not included. The following categories of attributed members are excluded from the study: members enrolled for fewer than 7 months during the study year; members without a valid retrospective risk score; and outliers, defined as members with total costs in the top or bottom 2.5 percent of patients in each treatment set. A treatment set is defined for each combination of PCP specialty (family practice, internal medicine, pediatrics); insured coverage (medical only, medical and pharmacy); risk score cohort; geography; and insured product type.

Initial Screen

An initial quality screen was applied using UnitedHealthcare commercial, Medicare Advantage, and Medicaid managed care claims for services provided between January 2016 and February 2019. Quality was evaluated using national standardized clinical measures endorsed by the National Quality Forum when available. Additional measures were selected or developed from measures published by the National Committee on Quality Assurance (NCQA), the American Medical Association Physician Consortium for Performance Improvement, primary care specialty societies, and the federal government. Patients receiving hospice care or who had benefits administered under a coordination of benefits process were excluded. Practices with insufficient quality measurement data to achieve statistically significant results were excluded; these practices accounted for 10 percent of total spending for physician-owned practices and 0 percent for OptumCare and hospital-owned practices. To limit the cost comparison to practices meeting the target quality benchmark, practices whose quality performance were statistically less than the target benchmark (using the chi-squared goodness of fit test and phi coefficient with 98 percent confidence) were excluded; these practices accounted for 10 percent of total spending for physician-owned practices, 5 percent for OptumCare practices, and 3 percent for hospital-owned practices. Following the initial quality screen, the shares of total spending that remain included in the comparisons of quality and cost are 80 percent for physician-owned practices, 95 percent for OptumCare practices, and 97 percent for hospital-owned practices.

When a sufficient number of quality measures is attributed, the practice's quality performance is compared to the target benchmark. The practice's quality performance is the sum of all attributed measures where the quality measure criteria are met. To establish the target benchmark, the number of measures expected to be compliant at the 50th percentile compliance level is determined. This is accomplished by first calculating the national compliance rate for each measure by unique combinations of: the attributed physician's specialty; the patient population (commercial, Medicare, Medicaid); the condition or procedure; and the severity level (when applicable). A minimum of 50 instances of each unique measure combination is required to calculate the national compliance rate. For the NCQA all-cause readmission measure, the NCQA-specified method to calculate the risk-adjusted expected rate of readmission, based on prior and current health of the patient among other factors, is used rather than calculating the national compliance rate. Once the national compliance (or expected) rate for each measure is calculated, the rate is multiplied by the number of applicable measures attributed to the practice. This adjusts for case-mix. A minimum of 50 measures across ten patients is required to evaluate a practice for quality. The chi-square goodness of fit test and the phi coefficient are used to determine if the practice's performance is not statistically less than the target benchmark with 98 percent confidence. The practice meets the quality criteria when the practice's performance is not statistically less than the target benchmark.

Quality Comparison

Following the initial screen, observed and expected values for quality are calculated for each practice using 2018 commercial claims. Observed values represent the number of quality measures attributed to the practice where the measure result is compliant. Expected values represent the national compliance rate for each measure multiplied by the number of applicable measures attributed to the practice (to adjust for practice's case-mix). A practice's PCP quality observed-to-expected ratio is the sum of all attributed measures where the quality measure is met (observed) divided by the case-mix adjusted target benchmark (expected).

Cost Comparison

Following the initial screen, observed and expected values for total costs – which include all allowed spending, including patient cost sharing, under the medical and pharmacy benefits – are calculated for each included PCP-attributed member using 2018 commercial claims. Observed values represent the risk-adjusted total cost of care for the member during the study period. Expected values represent the risk-adjusted total cost of care per PCP-attributed member per month across all PCP-attributed members in the observed member's treatment set, multiplied by the number of months of eligibility for the observed member during the study period. Observed and expected values are then summed by ownership category across all members and observed-to-expected ratios are calculated for all included OptumCare practices, physician-owned practices, and hospital-owned practices. Percentage difference to the 1.00 average observed-to-expected ratio was calculated for each ownership category. An observed-to-expected total cost ratio of 0.980 represents risk-adjusted costs of 2 percent lower than average, which is represented as 2.0 percent outperformance relative to the average.

Citations

[1] Physicians Advocacy Institute. "Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment, 2012-2018," 2019.

[2] Physicians Advocacy Institute. 2019.

[3] American Medical Association. "Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees," 2019.

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