Opinion paper

The physician-insurer dynamic must shift to successfully implement value-based payments

Roy A. Beveridge, Laura E. Happe *, Mike Funk

Humana Inc, United States

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A B S T R A C T

Decades of practice under a system that set the financial interests of physicians and insurers at odds, has resulted in physician distrust of insurers being cited a key obstacle to value-based arrangements. Insurers must work to shift the insurer-provider relationship from one that’s transactional to a partnership built on trust. Even when physicians and insurers agree philosophically on quality over quantity, there are practical challenges. Insurers can provide the data, systems and analytical insights that help inform the physician’s care strategy. Implementing value-based payments requires the two groups to build trust and work together to change long-established systems.

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1. Introduction

Paying physicians for the quality of care provided instead of the quantity of patients seen and procedures performed is a significant shift from the way insurers and physicians have interacted in the United States for decades. With a new era of healthcare ushered in by the Patient Protection and Affordable Care Act, the value-based payment arrangement piloted in Pioneer Accountable Care Organizations (ACOs) moved to the mainstream in 2015. In January of that year, U.S. Secretary of Health and Human Services Sylvia M. Burwell established a clear timeline to transition Medicare payments from traditional, fee-for-service payments to alternative payment models, including value-based care.

1 Secretary Burwell outlined a goal to shift half of fee-for-service Medicare payments to value-based payments by the end of 2018, igniting discussion, plans and speculation about the future of the American health care system.

Value-based payments are an appealing proposition. What physician would not want a system where their financial success is aligned with their patients’ improved health and where insurers are partners, not counter-parties? Yet such an idyllic proposition is anything but simple. In fact, a national survey of over 500 physicians found that 78% actually prefer traditional payment models over value-based. Further, two-thirds of primary care physicians aren’t actively pursuing value-based payments, according to a 2015 survey of 600 physician members of the American Academy of Family Physicians (AAFP). With the inevitable push towards value-based payment, these statistics beg three questions: Why are not physicians adopting the new model, what must insurers do differently, and what needs to change?

2. Why aren’t all physicians adopting value-based payments?

Value-based payment systems shift the dynamic of the relationship between physicians and insurers from counter-parties with competing interests to partners whose interests are aligned around a common goal of improving the health of the people they serve. But partnerships are built on trust and trust requires understanding. Insurers must explore and internalize physicians’ mindsets relative to value-based payment models as an important step toward achieving that understanding.

Physicians, for the most part, don’t have time to come to grips with such a fundamental and monumental change to the way their practices operate. A physician’s average work week exceeds 50 h and includes call on nights and weekends. Much of their work week is consumed by administrative work, nearly 17% by one estimate. Physicians’ time is valuable. The national time cost to practices of interactions with health insurance plans has been estimated to be as high as $31 billion annually. Beyond costs, increasing administrative burden has actually been correlated to
lower physician job satisfaction after controlling for income and other factors.5

Time and administrative burden could certainly be a barrier to implementing value-based payments, but the resistance seems to cut deeper. According to the AAFP survey, more than three-quarters of physicians believe there’s a lack of transparency between insurers and providers.3 Similarly, another survey revealed that physicians’ biggest concern with value-based payment models is insurance companies either penalizing doctors for things that are out of their control or not giving credit for improving quality.2 Perhaps these sentiments are best captured by a report that 41% of physicians not in a value-based relationship cite distrust of insurers as their biggest obstacle.7

This distrust is the product of a system that has imposed competing interests between physicians and insurers for decades.5,10 Today, doctors in a fee-for-service structure are financially rewarded for providing more care. At the same time, insurers try to limit risk and ensure the treatments they pay for are necessary, medically proven and not excessive. When insurers’ efforts are perceived to get in between patients and the care their doctor said they needed, it rankles physicians and their patients alike. Following decades of practice under a system that set the financial interests of physicians and insurers at odds, it is not surprising that some physicians are wary of embracing insurers as partners in improving health outcomes for patients.

3. What must insurers do differently?

Physicians and insurers must transition from counter-parties with competing interests to partners with a common goal of improving the health of the people they serve – a goal they cannot reach without each other. If the physician is a quarterback of care in the value-based system, calling the plays and implementing the strategies required to achieve interoperability can take root. With their scale, data and the clinical insight that can be shared across a diverse ecosystem of internal and external systems, insurers are invaluable partners for physicians transitioning to value-based payments.

The best way for insurers to earn the trust of physicians in this transition is simple: listen first, and then offer resources that make a physician’s and the practice’s work easier – not harder. Insurers have a wealth of resources that can and should be shared with physicians. Best practices to create value for physicians under value-based arrangements include setting a uniform standard for quality of care measures, advancing interoperability and data sharing, providing actionable data analytics that are transparent and relevant, reducing the administrative burden, and helping to manage risk. Value-based payments are not, and never will be, a one-size-fits-all approach. It is incumbent upon the insurers to understand the needs of each physician practice and offer resources accordingly.

4. What needs to change?

Even when physicians and insurers agree philosophically with a system that values quality over quantity and incentivizes health outcomes rather than sick-care procedures, there are practical concerns about implementation of this new payment model that need to be addressed.

Agreeing that quality of care should be a key part of how physicians and insurers are rewarded is one thing; agreeing how to define “quality” is another. Currently, there are no standard quality metrics in health care that all payers universally adopt. In fact, the opposite is true: each payer and government program may – and frequently do – have different sets of quality metrics. One survey of public and private health plans found 546 different quality measures in just 23 plans.10 Another study of 48 state and local quality measure sets found that just one-in-five of metrics were used in more than one measure set, and no one metrics was used in all sets.11 Physicians would be excused for perceiving this system of different and disparate metrics more as compliance and reporting quagmire than an clear incentive path to improved outcomes.

Recognizing that it is difficult to ask physicians to stake the financial success of their practice on a set of quality metrics that are unclear and vary by payer, insurers and government are working together to streamline and standardize quality reporting. In early 2016, the Centers for Medicare & Medicaid Services and American’s Health Insurance plans released seven sets of clinical quality measures with the goal of multi-payer alignment.12 The seven core measures sets include: cardiology, gastroenterology, HIV and hepatitis C, medical oncology, obstetrics and gynecology, orthopedics, and ACOs, patient centered medical homes and primary care.

If developing a uniform set of quality metrics is Exhibit A on the list of practices that need to change to enable value-based payments, improving data sharing is Exhibit B. Timely data and information sharing is a linchpin to establishing a new dynamic between physicians and insurers because it fosters transparency and information sharing and can lead to reforms in care.13 This is where the proof of partnership between physicians and insurers can take root. With their scale, data and the clinical insight that comes from the combination of these assets, insurers are invaluable partners for physicians transitioning to value-based payments.

Insurers can provide data and analytics required to take clinical action at a scale that will improve overall population health. But the utility of that information is not maximized if systems can’t share it. Interoperability – or the ability of myriad systems used by physicians and payers to share information – is a primary barrier to implementing value-based payments. The success of value-based payments depends in part on the ability of organizations to link different sets of data to the benefit of physicians and physician organizations.

There are several foundational steps that physician and insurance organizations can take to improve interoperability. The first is to prioritize the integration of clinical data from the physician organization’s internal systems with claims data from the health plan(s). Another opportunity is to embrace new health information standards, such as the Fast Healthcare Interoperability Resources (FHIR) specification, which enable data to be more easily shared across a diverse ecosystem of internal and external systems. Last, the time and resources spent facilitating the connections required to achieve interoperability can be daunting. Provider organizations should inquire about the population health management technology solutions available from health plans, which may be able to do the heavy lifting for them.

Many insurers offer interoperability support and solutions, such as Humana’s Transcend Insights subsidiary. And Humana is not alone in this effort. Other insurers and unaffiliated independent interoperability companies are working to make it easier for multiple systems to share data. These partnerships thrive in geographic areas with a large or dominant health system and a high concentration of members of the health plan. Further, interoperability is most effective when the shared data are useful to the clinical organizations’ systems. If the systems are volume based, are not adapted to electronic clinical workflows, or otherwise do not want or use data not already captured in their silos, then the information would not be sufficient to improve outcomes.

In addition to supporting interoperability, insurers can support physicians with analytics that identify gaps in care and work
toward population health improvements. The data and analytic tools insurers can provide identify those patients who are not currently well served by the health system and target them with additional resources (i.e., care coordination, social services, or care management) to improve population health and achieve significant reductions in total spending.14

Finally, insurers can help physicians extend care beyond the exam room. For example, Transcend is a management services organization and subsidiary of Humana Inc. that provides care coordination and staffing support in evaluating patient population panels, identifying at-risk patients and conducting regular outreach to ensure that these patients are seen and treated before serious complications can occur. Chauhan Medical Center in Florida, for example, uses Transcend for staff coding support and care navigators to follow up on missed appointments, tests or screenings. This additional support and practice structure allows patients to visit the center as often as needed to have medical conditions monitored, thereby avoiding trips to the hospital emergency room. It also allows staff to focus on disease education and management, like creating a support group for patients with diabetes.

5. A new dynamic of trust

The relationship between insurer and physician has to be redefined in this new era of healthcare. An integrated care approach, with the primary care physician at the center, is the key to change. Such an integrated approach requires interoperability. Information should be a shared asset, not a proprietary asset. There is no doubt that physicians need support to transition to value-based payments; and insurers have the capabilities to provide it. This new quality-based payment model is better aligned with our shared goal of improving patient health but can only work if the metrics are standardized, clear and reflective of evidence-based medicine.

We have to be bold leaders in changing healthcare, because patients are looking for us to change. And it’s time.

References


Conflict of interest disclosure statement

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