Is Patient Lock-In the Next Step in Value-Based Care?

written by Theresa Hush | October 31, 2019

Hoping to safeguard survival under financial risk, health care providers are courting a contentious issue: how patients select primary providers. During the HMO heyday , health care risk economics depended on patient selection of primary providers as part of coverage selection that “locked” them into those PCPs and their referral networks. PCPs operated as gatekeepers to the rest of the health care system, authorizing services (or not) for specialists and other care.

It’s well known that the HMO’s Primary Care gatekeeper model generated a backlash among private sector consumers. In fact, the gatekeeper was so unpopular with patients that it was partly responsible for the demise of the HMO model in favor of more open-ended PPO networks. Patients complained about the bureaucracy and constraints on resolving their health issues, and refused to choose HMO coverage when there were options. Their employers listened.

Despite that history, the language of “patient attribution” in governmental Value-Based Health Care is now morphing into “patient alignment.” Along with care coordination and other changes

in both ACO and Direct Contracting models, VBHC is moving toward active choice of provider. In the private sector, this means that employers and health plans are narrowing networks that automatically exclude providers from the menu for consumers.

Do these efforts signal that a return to restricted patient choices is the next step in Value-Based Health Care? Providers and ACOs are converging on the position that primary care physician selection by the patient is key to making risk work and to engaging patients in care. Depending on how and where provider selection becomes a reality, this transition could significantly affect the Value that patients derive from their health care. As discussed in our prior article on Patient Experience, providers aren't uniformly ready to work with consumer needs and patient realities.

Let's examine how ideas about patient choice are changing, and what safeguards must be present in order to have a fair choice process that contributes to health care Value.

How Free Patient Choice Is Quietly Changing

In the private sector, patient selection of primary providers is already being constrained, with coverage restricted to narrow, selective networks that are developed by direct employer-to-provider contracts or by exclusive health plan networks. Some employers are creating on-site clinics to manage care costs.

In governmental programs, Medicare and Medicaid programs are implementing methods to create more affirmative connections between beneficiaries and primary care providers while maintaining that patient alignment is voluntary. CMS Rules now require ACOs to inform patients that they have been included in an ACO after seeing an ACO primary provider, and CMS also enables choice of primary physician on the MyMedicare.gov website. Primary care models such as Direct Contracting include voluntary alignment provisions that are augmented by incentives that may be paid to Medicare beneficiaries for visits within the Direct Contracting network.

Implications for Patients Under Alignment Efforts

Under competitive risk programs without valid outcome and patient experience standards, there is a danger that patients lose their consumer rights as purchasers of health care. They become, instead, the owned assets of the risk-bearing entity that will determine what health care they need.

While Voluntary Alignment may be a far reach from patient lock-in to a provider risk organization, the presence of private sector plans with limited or no choice should alert

consumers to restrictions on choice of provider.

Whether there is a real danger to patients depends, of course, on “valid outcome and patient experience standards.” Although Value-Based Health Care Programs have quality and some outcome measures, these measures are not enough to protect consumers. Here’s why:

> Most of the measures are related to the most basic requirements for medical processes—preventive checks for chronic disease patients, for example, or capture and advice on smoking—but aren’t enough for consumers to make choices of providers.
> Measurement and publication of key outcomes for providers—including mortality standards—is largely voluntary, so consumers can’t assess where they may get the best care before choosing a provider. In addition, results for how providers improve outcomes in the long-term, across the spectrum, is either not measured at all or measured inconsistently and without validation by outside auditors.
> The lack of transparency in costs, quality, and other patient experience factors put consumers at a disadvantage in choosing providers. They literally cannot determine who will be responsive to them prior to an actual experience—after which time they are already “aligned.”
> There currently exists no process to adjudicate patient complaints or cases, outside the provider’s own reach.
> Providers move frequently now between “in” and “out” of network status by virtue of negotiations and personal change of practice/insurance decisions. Patients have no way of knowing whether their provider will remain or not within their coverage choice.

Trust and Transparency Criteria for Mutually Beneficial Patient-Provider Alignment

All purchasing arrangements—the underlying premise for Value-Based Health Care—are based on a set of defined purchasing factors, plus additional factors that influence the purchasing decision itself. With patient alignment or selection, patients are asked to make a semi-exclusive and long-term purchasing arrangement that will involve repeat purchases of services.

If we want consumers to shoulder the burden of health care costs and better engage in their outcomes, these direct and indirect factors must be satisfied so that patients are not endangered by the incentives under provider financial risk—denial of access based on risk, or refusal of treatments based on cost.

So let’s take a moment to review how consumers make purchasing decisions. The elements are pretty standard across all industries and include key product features as well as comparative

information.

For any product or service, consumers need to know:

- Product detail;
- Quality information related to the product (in the case of routine services, consumers regularly consult Yelp and Amazon ratings);
- Cost of the product;
- Similar information about comparable products or services.

The purchasing decision itself, which in this case is a long-term alignment with a provider, assumes acceptance of the product information, but then adds:

- Confidence in the seller;
- Customer service;
- Other experiences of friends and family with the provider.

When it comes to selecting a PCP, patient alignment with providers must be a positive and shared arrangement based on trust. That trust is borne by meeting reasonable expectations of services and outcomes, inclusion of other trust agents in the care process, and transparency of value of services. A body of research from various Robert Wood Johnson grants in collaboration with AcademyHealth reveals important findings as to how to achieve positive patient improvements and experiences, while building trust.

In particular, as providers transform their patient operations to meet Value-Based Health Care Goals, they should concentrate on meeting the tests for Trust and Transparency. These include:

1. Increase Physician Time and Resources/Support for Patient Care during Scheduled Visits

Physician burnout is a known obstacle to Value, and nearly 80 percent of providers say they are overextended. Ensuring physician time for exams as well as questions is essential, and the inclusion of patient support networks in communication and appointments are key. Before patients can be expected to commit to providers, they must be able to perceive the respect of providers and receive input from their supportive family members or friends. Physicians must be supported by other staff who gather patient preferences and risk details so that clinical time is optimized. Patients will be quick to recognize the sufficiency of the process and should provide feedback that is subsequently used for improvement.

2. Ensure Medical Decision-making Process for Chronic Conditions and Major Surgical Procedures

Providers should actively take into account patient goals and preferences as well as barriers to treatment, and ensure transparency around cost, clinical effectiveness, and outcomes history. While many parts of a care team must be involved in such a process—not only the physician—this will save significant time in later coordination activities. Patients' ability to gain knowledge and actually make decisions with their providers will forge a bond that is personal and inspirational, and will help them achieve outcomes.

3. Ensure Clinical Responsiveness Outside of Visit Time

Centralized call centers (purportedly to help focus clinicians on their patients)—coupled with no means for patients to message their providers or any clinical staff—sends a clear signal to patients that they are unmoored from a physician-patient relationship. There must mechanisms set up for responding to patients, and made clear to patients and their support network, whether via telemedicine, secure messaging or emails, or covering provider options (that do not involve hospital emergency rooms).

4. Publication of Quality, Outcomes, and Patient Responsiveness Data

Patients should be able to assess the quality and performance of an institution, specialty group, or primary physician before a commitment. Rather than marketing clinical specialty or "patient-centric" prowess, providers should give consumers their performance information and details about how they are measuring their clinical performance.

5. Cost Transparency

The only understandable way for consumers to accept cost transparency is through episodic costs. Price lists assume that the consumer can identify and obtain costs for the additional components of care that go beyond physician services, which are impossible for them to obtain in an insurance environment. But it's not impossible for providers to create such a resource; they know who and what will be included in an episode, and they also have benefit and allowed cost information (or can get it).

Without argument, this is an ambitious list of transformative items that can't be completed in one year or even two. But if ACOs and providers believe this is too much to do, then it's a sure

sign that they are also not prepared to fully commit to ensure what patients need in a mutual long-term relationship with its guaranteed repurchase of services. Unless we are working to achieve the Trust and Transparency required to make Value-Based Health Care a reality, we will also miss the opportunity to make health care work for both providers and patients.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image: Sharon McCutcheon