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Barriers primary care clinic leaders face to improving value in a consumer choice health plan design

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Abstract

Primary care clinics are a frequent focus of policy initiatives to improve the value of health care; yet, it is unclear whether they have the ability or incentive to take on the additional tasks that these initiatives ask of them. This paper reports on a qualitative study assessing barriers that clinic leaders face to reducing cost within a tiered cost-sharing commercial health insurance benefit design that gives both consumers and clinics a strong incentive to reduce cost. We conducted semi-structured interviews of clinical and operational leaders at a diverse set of 12 Minnesota primary care clinics and identified 6 barriers: insufficient information on drivers of cost; clinics controlling a portion of spending; patient preference for higher cost specialists; administrative challenges; limited resources; and misalignment of incentives. We discuss approaches to reducing these barriers and opportunities to implement them.

Key words: primary care clinic; total cost of care; cost efficiency; value-based care; value-based insurance design; tiered cost-sharing; return on investment.

Introduction

Primary care clinics ("clinics") play an important role ensuring the quality and efficiency of health care, providing nonemergent first-access care, chronic disease management, and preventive care. They are a focus of policy initiatives for improving value, such as Accountable Care Organizations and multiple primary care–focused initiatives through the Center for Medicare and Medicaid Innovation programs.[1-4] Policy makers also look to primary care clinics for specific services such as improving behavioral and mental health[5-7]; addressing social determinants of health[8,9]; and promoting healthier living such as diet and smoking or vaping cessation. In a study of Medicare beneficiaries, O'Malley et al[10] reported that patients desire more comprehensive clinic services.

Yet, despite this increased focus on clinics, what is not known is whether clinic leaders can take on these added coordinating roles that may require a significantly increased investment of time, expertise, and unreimbursed expenses. Given their connection to patients and the full scope of services, clinics are well situated to improve access and value of care, but many policy initiatives appear to be developing without adequate consideration of the barriers their leaders face in doing so. Unless policy expectations and the capabilities of clinics are better aligned, the results of these initiatives are unlikely to be successful.

To address this gap, this paper reports on semi-structured interviews with clinical and operational leaders of primary care clinics to assess barriers they face to reducing cost within a tiered total cost of care (TCOC) commercial health insurance benefit design. Tiered TCOC designs are a specific type of tiered network where costs associated with referrals, hospitalization, and prescriptions are attributed to the clinics and consumers share savings for selecting clinics with a lower TCOC. Consumers are provided with information on clinic quality to consider when making their selections. This design gives both consumers and clinics a strong incentive to reduce cost while maintaining quality.

We identify barriers and discuss approaches to reducing costs. The results of this paper can inform policy by highlighting an approach to benefit design that could enhance the role of primary care clinics in coordinating care and improving value.

Background

The goal of this paper is to understand how resources, information, and other constraints limit the ability of clinics to change health behaviors and outcomes. The setting is the Minnesota State Employee Group Insurance Program (SEGIP). In the SEGIP system, primary care clinics are assessed for TCOC (including specialist referrals, hospitalization, and prescription costs) and placed into 1 of 4 tiers with varied consumer cost-sharing. The differences in cost-sharing between each tier are significant (a sample of the benefit design is shown in Appendix A). Each year during open enrollment, the SEGIP employees select a primary care clinic. The clinic is responsible for making all referrals, and thus performs the role of coordinator and gatekeeper. The SEGIP employees are provided information about the clinics available in their area, their tier placement, and cost-sharing associated with each tier.

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Quality information is available via the website of Minnesota Community Measurement (mncm.org), a regional quality-measurement organization, enabling consumers to consider any tradeoffs of cost and quality (although high-quality clinics are available in all tiers) as well as other considerations, such as clinic location.

In the SEGIP system, clinic leaders have both short- and long-run strategies to improve their tier placement. In the short run, they can work with SEGIP to negotiate lower prices for SEGIP consumers for the coming year, resulting in a lower tier placement. In the long run, because the clinic's TCOC is based upon the previous year's spending, clinics can lower their total cost by either reducing low-value care or avoidable utilization, or substituting lower-cost personnel, including nurse practitioners and physician assistants, and referring members to more efficient specialists and hospitals.

In prior analyses of SEGIP, we found that 78% of SEGIP consumers choose clinics in the 2 tiers with the lowest cost-sharing, suggestive of consumer responsiveness to tiered cost-sharing.[11] We also found that up to 24% of primary care clinics reduce their prices for SEGIP consumers by an estimated 10%–20% to move to a lower tier, suggesting that clinic leaders are responsive to the tiering system as well.[12] We have learned from earlier interviews with clinic leaders that they consider additional price reductions unsustainable, and would prefer to find other ways to achieve placement in a lower-cost tier without sacrificing quality. Also, the program and policy objectives are not necessarily for primary care clinics to achieve lower tiers by reducing their own costs—which are a comparably small portion of total spending—but instead by exploiting the variation in cost for specialists, hospitals, and referrals, lowering cost while factoring in considerations of quality. The significant price reductions by primary care clinics in their own prices may be seen as an indicator of the strength of the incentive and motivate this paper's assessment of the barriers preventing lowering total cost.

While currently unique to a single state and program, this setting has several advantages for our analysis. First, primary care clinics are assessed and assigned their tier based upon TCOC, including referrals, hospitalization, and prescriptions, and thus have a reason to pay attention to total cost. Second, consumers are provided summary information about the cost of the clinics through the clinic tier placement and face substantial cost-sharing differentials that favor selecting clinics in lower-cost tiers. Third, the SEGIP system shares savings with consumers for choosing primary care clinics with a lower TCOC, providing an incentive for informed consumer choice, which, in turn, puts pressure on providers to reduce cost. And fourth, by providing accessible quality measures, SEGIP enables consumers to consider both the cost-sharing tier and aspects of clinic quality.

This setting has advantages over narrow networks that have been found to reduce cost, yet limit consumer choices.[13] The tiering design also combines consumer information on clinic cost with cost-sharing incentives, consistent with findings from previous analysis of reference pricing that price information alone was insufficient but, combined with incentives tied to consumer choice of provider, led to consumers choosing lower-cost care.[14]

Data and methods

We conducted semi-structured interviews with medical and operational leaders of primary care clinics participating in the SEGIP system. Qualitative methods were used to elicit the leaders' perspectives on what factors they consider when making decisions.

Data

We used administrative data including tier placement of primary care clinics, whether they agreed to a price discount in the prior 3 years, and SEGIP share of Employer Sponsored Insurance (ESI) within a Hospital Service Area (HSA) as defined by Dartmouth Atlas. Semi-structured interview data came from interviews with clinic leaders including medical and administrative managers.

Clinic sampling framework

We began by creating a sampling framework with 2 parameters: SEGIP share of employer-sponsored insurance coverage in a region (serving as a proxy for the prevalence of SEGIP consumers) and whether a clinic engaged in a price-reduction deal with the SEGIP system. The SEGIP share of ESI ranged from 0.02% to 12.64%, with the middle 50% range being a 2.48%–5.05% share. The median ESI share was 3.73% and this became the cut point for higher and lower HSA. We split the sample evenly between clinics in areas with a higher and lower prevalence of SEGIP members and established a target of interviewing 3 clinics in each of the resulting 4 categories. After sorting all eligible clinics into the framework, we used purposive sampling to achieve geographic balance across these areas. We contacted 52 clinics and received 12 acceptances, 5 denials, and 35 nonresponses. The sample is shown in Table 1.

Within each clinic we sought to interview those responsible for both clinical practice and operations including referrals. These included executive management and medical leadership positions such as CEO (chief executive officer), chief operations officer, and medical director for larger primary care clinics, groups, or health systems; or practice manager and clinic leaders for smaller clinics. A listing of the titles of key informants is also shown in Table 1. Since the main variable of interest in the analysis is TCOC, we sought participation of those responsible for decisions with respect to clinic operations (strategy, process improvement), as well as those practicing clinically who could speak to barriers implementing technology or new processes. The participation of stakeholders ultimately depended upon availability and the clinic leaders' choice.

Interviews with clinic leaders

To recruit clinic leaders, we drafted an email message that was sent from the SEGIP Director to the state's points of contact at each clinic, typically a contract manager, and the researchers followed up with emails. We stopped when we reached 12 clinics total, balanced across the 4 categories and representing a range of sizes and geographic location. We pretested the interview guide with 3 pilot interviews to ensure the questions were being understood as intended. Two researchers conducted the interviews, which typically lasted 60 minutes, although some were 30 minutes to accommodate the schedule of the participants. Multiple informants from a sight were conducted concurrently, in groups. A draft of the interview protocol is included in Appendix B.

Analysis of interview data

The interviews were recorded and transcribed, and the transcripts provided the data from which to perform thematic

Table 1. Clinic sample.

Clinic	Price deal	Geography	Tier	Share of ESI	Participants	Participant titles
1	Y	Rural	2	4.25	4	CEO, VP Services, VP Revenue, VP Finance
2	Y	Urban	2	4.49	4	CEO, VP Services, VP Revenue, VP Finance
3	Y	Urban	2	2.96	2	CEO, COO
4	N	Urban	1	N/A	2	VP Informatics, COO
5	N	Urban	3	4.08	2	Chief Administrator, CMO
6	N	Rural	4	6.13	1	Chief Administrator
7	Y	Rural	2	2.83	1	Director, contracting
8	N	Urban	2	2.22	1	Medical Director
9	N	Urban	2	2.22	3	Medical Director, Director of Primary Care, Provider
10	Y	Urban	2	3.65	1	Clinic Operations
11	N	Rural	3	4.30	2	Senior Clinic Director, Medical Director
12	Y	Rural	2	4.16	3	CEO, Clinic Director, CFO

Source: Authors' analysis of SEGIP administrative data.
Abbreviations: CEO, Chief Executive Officer; CFO, Chief Financial Officer; CMO, Chief Medical Officer; COO, Chief Operations Officer; ESI, Employer Sponsored Insurance; N, no; SEGIP, State Employee Group Insurance Program; VP, Vice President; Y, yes. N/A, data not available.

analysis using qualitative data analysis software.[15] First, 2 researchers each worked through the same initial transcript and developed a set of codes to identify responses; then they convened to compare and arrive at a single set of codes for the remainder of the analysis. Both researchers then coded the remaining 11 transcripts, adding and refining code categories. The researchers then met to organize the individual codes into code categories and convened with the rest of the research team to discuss the categories and derive themes regarding barriers identified by the interview participants. A figure depicting the analytic approach is included in Appendix C.

Results

Six key themes emerged characterizing barriers that clinic leaders face to improving efficiency in the SEGIP tiered TCOC system: (1) clinic leaders lack actionable information on the drivers of TCOC, (2) primary care clinics directly control a small portion of total spending, (3) patients prefer certain specialists and hospitals, (4) there are issues with administration of the SEGIP system, (5) some clinics have limited financial or human resources to invest in value-improving efforts, and (6) there is misalignment of incentives between clinics and individual providers. A more complete description of each theme is as follows, with sample excerpts in Appendix D.

Theme 1: Clinic leaders lack actionable information on the drivers of total cost of care

Clinic leaders reported not having accessible or actionable information on the drivers of their TCOC for the SEGIP patient population, including limited information about cost drivers of assigned tier placement, such as the degree to which their costs are a function of prices vs volume of services; the portions of total cost that are attributable to primary, specialty, or hospital care or pharmaceuticals; and what portion of care is low value or unnecessary. For example, 1 respondent commented, "I don't know that we have the data to know for sure why we're a low-cost or high-cost provider."

Primary care clinic leaders reported having little to no knowledge about the relative costs or resource use of specialty referrals, despite wide variation. As 1 respondent said, "We don't have price data for each specialist we might refer to."

The tiering process is described as a mystery: "We have no visibility into how tiering is done, or how it's developed." While the clinic leaders understood that the SEGIP system sets tiers based on TCOC, some expressed concern and frustration about a disconnect between the clinics' "own costs" (which are typically a small portion of the total cost) and those of hospitals, specialists, and pharmaceutical costs.

The lack of information leads to difficulty computing the prospective return on investment (ROI) of potential cost-reduction initiatives. Seven clinics in our sample elected to voluntarily reduce their fee schedule for SEGIP members, enabling them to enter a lower tier. All of these clinics reported that they estimated the cost of these price reductions in foregone revenue but were unsure to what degree the lower tier would increase patient volume and practice revenue. Other initiatives to improve tier placement would include referring patients to lower-cost hospitals, specialists, or pharmacies. Discovering the relative prices of other providers would involve increased costs to the clinic unless it was provided by another entity like the health plan or the government.

Improving clinic information represents perhaps the greatest opportunity for savings because—if properly informed—clinics can exploit the variation in costs of specialists and hospitals in their area.

Theme 2: Clinics have constrained resources to invest

Clinic leaders reported a few types of resource constraints. First, some lack personnel for undertaking changes to care processes. They have limited bandwidth and cited the number of national payment programs as creating too much complexity, and implementation of new technologies such as electronic medical records may be more difficult for independent clinics. This was especially a concern for small and independent clinics. Some respondents reported a lack of prospective funding to support changes to care processes, since there is no grant funding to support improvements. In addition to the need for more data described in theme 1, clinics also require skilled teams and capacity to operationalize the data to improve care processes.

The limited size of the SEGIP patient panel is a factor for clinics, ranging from 2.2% to 6.1% in the sample. While these portions are significant—especially for clinics that rely on the commercial population to offset comparatively low rates from Medicare and Medicaid populations—the SEGIP population is not large enough on its own to motivate major changes to practice. Clinics were unsure whether they would gain or

lose enough patients to justify making changes to practice. They did, however, choose to reduce prices for SEGIP consumers, which is limited to the SEGIP patient panel.

Theme 3: Primary care clinics directly control a small portion of total spending and there may be limited referral opportunities

Primary care clinics nationally account for 2%-7% of total spending,[16,17] although, within SEGIP, the range is 15%-60% because many primary care clinics are tiered as care systems. The remainder of the costs are attributed to specialists, hospitals, and pharmaceuticals—and so variance in costs of referrals represent the largest cost driver.

Clinic leaders reported multiple challenges to making more efficient referrals. First, there are limited referral opportunities in some areas, particularly rural. Leaders from all of the rural clinics in our sample mentioned few feasible alternatives. Those clinics that are part of a health system or have referral relationships with health systems reported pressures to refer within their own system regardless of cost, citing nonfinancial benefits, such as shared electronic medical records, and potential for lost information or poor coordination from referring to out-of-network specialists and hospitals.

Theme 4: Patient preferences constrain provider options

Patient preference for specialists or hospitals (citing convenience or reputation) may influence the referral decision. Multiple respondents reported facing a potential conflict between accommodating patients' preference while being cost-effective. "Even if you have the information," 1 respondent said, "it's difficult to [act on] it."

Multiple respondents mentioned that patients sometimes will self-refer, making unauthorized visits to specialists and hospitals and later request retroactive referral. Respondents said, "Hospital referrals often are patient driven and they want to go places that are familiar and have free parking." And, "oftentimes they self-refer, and then we hear about it later."

Some patients travel to warmer climates for the winter and incur costs in other states and those costs are difficult or impossible to control, although it is unclear how many of these, who tend to be older, are SEGIP consumers. Some respondents reported that there is inconvenience and potential quality implications for patients to change their specialist clinics and so prioritize continuity of care. "It's hard … especially if [the patient has] chronic conditions, to break that relationship."

Theme 5: Administrative limitations specific to the SEGIP system create challenges for primary care clinics

To increase sample sizes, SEGIP combines cost data across small, independent clinics regardless of their costs, disadvantaging the lower-cost clinics and reducing their incentive to undertake efforts to improve tier placement.

Given constraints of their own resources and staff, SEGIP has meaningful, but limited, interaction with the clinics, relying on 3 health plans to administer the system. This can lead to confusion and an impression that the program is unclear or unfair. In the SEGIP system a clinic's tier placement is relative to the performance of other clinics in the state. In the interviews some clinic leaders appeared to be unaware that competitors' activities influence the clinic's own tier placement.

Some respondents reported that they think SEGIP is not making the most of its potential to negotiate rates. One respondent said they lack the leverage to negotiate prices with specialists, and instead suggested that SEGIP do so. "If you think about a state health plan, you'd think that … use your leverage … you negotiate directly with them, which is what … other employers or health plans have to do."

Theme 6: There is misalignment of incentives between clinics and individual providers

The tiering in the SEGIP system is designed to directly affect economic incentives on consumers (cost-sharing) and clinics (gain or loss of consumer volume), but since the payments are made to the clinic it does not directly affect physicians, revealing a gap between the incentives on clinics created by the health plan design and the internal incentives of the clinic with their primary care providers. Physicians do not differentiate care unless they know that there may be large out-of-pocket costs to the patient that are appropriate to avoid. A provider responded, "I want to send them to a physician that I feel is a good physician that will give them good care and I have no idea what they charge … the payers have to decide how they reign in the expense" (reflecting theme 1).

Some respondents praised the strong alignment of the SEGIP system design with the goals of better health outcomes for less cost. Leaders from 1 integrated delivery system said that SEGIP represents a "perfect" alignment: "The SEGIP model is a nice one that tilts toward value, which is where we prefer to be as an organization, moving as much of our payment models as we can toward value." Other clinic leaders expressed that they believe the system is aligned with value in concept, although expressed limitations (cited in the prior themes) in their ability to perform in the way the system intends them to.

Discussion

By assessing primary care clinics for TCOC and placing them into tiers with varied consumer cost-sharing, the SEGIP tiered TCOC system achieves 2 important policy objectives: positioning primary care clinics as coordinators of care and engaging patients as informed and incentivized consumers. Through shifting patient volume to lower-cost clinics, the system creates incentives on clinic leaders to improve efficiency. This design has significant potential policy implications for promoting coordinated, efficient care.

These findings are consistent with analysis of challenges faced by value-based payment designs,[18-20] and it is noteworthy that these barriers also exist in the tiered TCOC model used by SEGIP where the incentive is gain or loss of patient volume. For the benefit design to work as intended, clinic leaders need to have the ability to respond to incentives by changing processes and becoming more efficient. Better understanding of the barriers they face to doing so can help inform program design and policy. One barrier that emerges is the lack of information on drivers of TCOC, and the potential for clinics to realize savings by referring to lower-cost specialists and hospitals.

Tiered TCOC network designs are an opportunity for employer purchasers of health care. Of all the primary stakeholders of health care—patients, plans, providers, purchasers—larger employers are most well positioned to care about and act on cost and quality.[21]

Table 2. Ways to reduce barriers.

No.	Barrier	Possible course of action	Responsible party(ies)	Who pays?	Likely positive ROI?
1.	Challenges of information	SEGIP provides actionable information to clinics	SEGIP, plan administrators	SEGIP; could be fee-based for clinics	Yes, for SEGIP and for clinics by leading to lower tier placement
2.	Resource constraints	Clinics estimate anticipated ROI if move to lower tier	Clinics using available information on specialist costs	Clinics	Not directly
3.	Clinics responsible for small portion of total spending	Better information on composition of TCOC; SEGIP negotiate with specialists; exception for rural clinics if they have only 1 specialist options	SEGIP; clinics	SEGIP; clinics	Yes, for SEGIP and for clinics by leading to lower tier placement
4.	Patient preferences	Improve explanation of benefit design to consumers including variance in cost of referrals; frame lower tiers as sharing savings	SEGIP	SEGIP	Yes for SEGIP and clinics, if results in selection of efficient specialists
5.	Limitations of system administration	Better communication about the program design with clinics and members; add reference pricing or tiering for referrals	SEGIP	SEGIP	Not directly
6.	Misalignment of clinic and provider incentives	Clarify relationship between responding to payment reforms and needing to practice more efficiently	Clinics	Clinics	Yes, if improved support from providers

Source: Authors' analysis of study findings.
Abbreviations: ROI, return on investment; SEGIP, State Employee Group Insurance Program; TCOC, total cost of care.

Possible actions to address barriers

We now consider how barriers identified through the interviews may be reduced or eliminated, including what action could be taken, by whom, who could pay for it, and whether there is likely to be a positive ROI. These are detailed in Table 2. While primary care clinics, the administering health plans, and SEGIP have many constraints, there is a lot they can do to address the barriers identified in this study.

To address challenges of information, SEGIP may provide actionable data on drivers of TCOC to clinics, such as risk-adjusted comparisons of their own cost and those of specialists, hospitals, or pharmaceutical costs, and specify whether variation in cost is driven by prices or utilization, and where there is excessive or low-value care. To be most impactful this information should be provided in a timely manner and in formats that aid analysis by clinic leaders and care teams. Clinics that are independent of large care systems may have an increased interest in this information. SEGIP could generate these data using member claims and present this to clinics in user-friendly formats. If clinics can use data on lower-cost referrals, it could lead to a positive ROI both for the clinics and ultimately for SEGIP if the system ends up lowering cost for its members.

To address limited referral options, SEGIP first can provide information to clinics about the availability and relative cost of feasible referral alternatives. SEGIP could also seek to negotiate fees directly with specialists, hospitals, and pharmacies, although that would require significant resources beyond SEGIP's current capacity and utilization would be difficult to monitor. By lowering costs, this could have a positive ROI for both the clinics and for the SEGIP system.

To address patient preferences for specialists SEGIP can improve the explanation of benefits, including how the costs of referrals factor into total cost. SEGIP can also re-emphasize their current efforts to frame tiering as consumers saving by paying less by going to lower-cost clinics. SEGIP could provide this information in the interest of improving the system design, and it may result in savings if consumers choose lower-cost providers.

To address SEGIP administrative constraints, program staff can further improve their explanation of the benefit design with clinics and members, so they understand the purpose of the design and how it can work to their advantage. The most cited barriers from clinic leaders are lack of information on drivers of total cost, and how tiers are set. These are linked, as the clinics understand the basis of tiering but do not understand the drivers; thus, it appears the tiering process is a "black box." Similarly, if clinic leaders do not understand the basis of tiering, they may not appreciate how their specialists lead to tier placement. By improving member education, SEGIP could make the job easier for providers making referrals. Another approach could be to make the variation in referral costs more immediate to members by incorporating reference pricing or tiered cost-sharing for the referrals, although these approaches would add complexity to the benefit design and challenge member understanding.

Resource constraints in terms of personnel and finances are real, and improving processes is challenging work. If clinics can effectively estimate the potential ROI from interventions, it may improve their ability to make investments. The ROI calculation could come through improved information on the drivers of total costs or knowledge of the most cost-effective interventions.

To address misalignment of clinic and provider incentives clinic leaders could develop new clinical processes that enable and incentivize providers to consider cost of referrals. The analysis would be done by the organization and could be communicated to primary care providers through new processes or decision tools. This would have a positive ROI if it resulted in lower cost referrals.

Limitations

This paper has important limitations. First, the sample was limited in size to 12 clinics, all within the state of Minnesota, and our conversations with leaders from each clinic were constrained by time, ranging from 30 to 60 minutes. With greater

resources we would have been able to expand the scope of the sample more widely and gone into greater depth with the interview subjects. Second, all clinics participate in a complex range of payment designs, including other value-based payments, and the SEGIP patient panel represents a relatively small portion of their overall patient panel. Therefore, the influence of these other payment models may likely contribute to the variation we observed on clinic responses. Third, while leaders at clinics were generally interested to be interviewed, 5 declined for reasons such as time or lack of awareness of the program and a larger number did not reply to the initial and follow-up email. This introduces the prospect for selection bias, as those clinics that take issue with the SEGIP system, or are especially favorable, may be most likely to reply. However, the themes we identified from the interviews were represented across multiple clinics and enable us to draw insights.

Conclusion

Primary care clinics are increasingly regarded as key actors to improve the value of health care. Tiered TCOC health plan designs are appealing because they place primary care clinics in the position of coordinating care and share savings with consumers for choosing lower-cost clinics. The movement of consumer volume to more efficient clinics aligns incentives for both consumers and clinics to improve efficiency. Prior research has found that clinics reduce prices to attain a better tier, suggesting clinic responsiveness. But these price reductions are only 1 tool to improve efficiency. For the system to work as intended clinics will also need to change processes to improve efficiency. Despite the barriers identified by this paper, employers, policy makers, and consumers may find tiered TCOC networks an appealing option to align incentives with value.

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Supplementary material

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

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