BlueCross BlueShield Minnesota

Innovations in Health Care

EVOLUTION AND SUCCESS IN VALUE-BASED CARE

September 2021

BETTER OUTCOMES AT LOWER COSTS

Providing health care benefits has become an increasingly complex and expensive proposition for employers and health care providers. Currently, the U.S. spends $3 trillion annually on health care with an estimated $1 trillion wasted.[1] According to the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS), U.S. health care costs are projected to grow at an annual rate of 5.4 percent in this decade, with a whopping price tag of $6.2 trillion by 2028.[2] Fueling this profligate spending is the traditional fee-for-service (FFS) model of health care payment, in which insurers and employers pay for the quantity of services provided rather than on outcomes and overall patient health.

To shift this paradigm, Blue Cross and Blue Shield of Minnesota has become a pioneer in value-based payments (VBPs), which pay health care providers based on the outcome of services and overall patient health rather than on the volume of services provided. Our approach evolves payments along a continuum from FFS to population-based models, measures their effectiveness with leading-edge analytics, and helps providers transition seamlessly to a value-based care system. This evolution is essential to controlling health care costs and improving outcomes. In the value-based model, the economics align with what patients, providers, employers, and insurers all want to achieve: better health care at an affordable price.

Annual health care in U.S.

$3 TRILLION SPENT

$1 TRILLION WASTED

Our goal

BETTER HEALTH CARE AT AN AFFORDABLE PRICE

[1]Modern Healthcare, Value-based agreements: Driving a healthcare system shift to improve patient outcomes and reduce cost of care
[2]https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

GROWTH OF VALUE-BASED PAYMENTS

The passage of the Affordable Care Act (ACA) in 2010 and the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 increased focus on the need for quality affordable health care. A goal of these acts was to improve the way health care providers are reimbursed. The ACA places more emphasis on quality care and authorizes several value-based programs that reward providers based on quality rather than on quantity.[3]

While some commercial payers were testing value-based models before the passage of the ACA, its passage has seen both payers and policymakers increasingly pursue value-based care to correct the flawed incentives in the FFS model that reward volume of services over value. The birth of these alternative payment models (APMs) ties provider reimbursement to health and quality outcomes rather than reimbursing providers based on FFS.

APMs require health care providers to assume some level of financial risk and reward them for improving patient care and population health, reducing health care costs, and increasing provider satisfaction.[4] Today, CMS reports over forty different APMs that tie payment to quality performance rather than total billable services.[5]

The growth of APMs has led to an increased use of value-based payment models that reward better outcomes at lower costs. This shift from volume to value is an opportunity to align cost-effective medications with care, optimize patient outcomes, and improve access. Innovative value-based agreements must be considered as a meaningful approach to address these unmet needs of our health care system.

Blue Cross is a historical leader in value-based agreements.

VBP models reward better outcomes at lower costs.

BLUE CROSS: AT THE FOREFRONT OF VALUE-BASED CARE

Today, many large commercial payers have made substantial progress towards achieving these value-based goals. Since commercial payers cannot require value-based care participation through mandatory programs the way CMS can, many commercial models encourage adoption by delivering more data and analytics to inform care decisions as well as the product and network structures that support shared or full risk.

Blue Cross has been at the forefront of this approach. We introduced our first commercial value-based programs in 2011 and our first government programs in 2015. Today, our payment approaches fall along a continuum from traditional FFS models to "population-based" payment models that move accountability for outcomes to the providers (see chart on next page).

Blue Cross has been offering VBPs since 2011.

Blue Cross is moving toward the most advanced population-based payment models.

[3]https://www.elationhealth.com/healthcare-innovation-policy-news-blog/history-value/
[4]https://digital.ahrq.gov/acts/quadruple-aim
[5]https://healthpayerintelligence.com/news/the-defining-features-of-current-value-based-care-models




CATEGORY 1 Fee for service No link to quality and value	CATEGORY 2 Fee for service No link to quality and value	CATEGORY 3 APMs Built on fee-for-service architecture	CATEGORY 4 Population-based payment
	A	A	A
	Foundational payments for infrastructure and operations (e.g., care coordination fees and payments for HIT investments)	**APMs with shared savings** (e.g., shared savings with upside risk only)	**Condition-specific population-based payment** (e.g., member per month payments, payments for specialty services, such as oncology or mental health)
	B	B	B
	Pay for reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**APMs with shared savings and downside risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**Comprehensive population-based payment** (e.g., global budgets or full/percent of premium payments)
	C		C
	Pay-for-performance (e.g., bonuses for quality performance)		**Integrated finance and delivery system** (e.g., global budgets or full/percent of premium payments in integrated systems)

The alternative payment model (APM) continuum is from the LAN (Learning Action Network).[6]

Over the last decade, Blue Cross has implemented value-based models primarily in FFS with quality and value links (category 2) and APMs built on FFS architecture (category 3). In the past several years, we have increasingly moved meaningful dollars away from FFS and into the most advanced population-based payment models (category 4). We work to demonstrate the cost value of VBPs to employers vs. the historical measure of network value, discount from billed charge, which doesn't capture the true total cost of care.

HOW VALUE-BASED CARE WORKS

Value-based payment models incent and enable providers to deliver effective care while avoiding excess or unnecessary procedures and their resulting high costs. With VBPs, insurers are not adding more dollars to the system; they are simply shifting dollars into better designed, more effective, and less costly care.

Providers participating in value-based agreements with Blue Cross are given a base rate for each service, with additional revenue opportunities tied to lower costs and improved quality. Multiple shared savings and risk models are available depending on the provider's cost per member per month (PMPM) compared to our market PMPM. Providers earn shared savings if they either meet PMPM targets or deliver annual PMPM costs below market trends.

[6]https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

In exchange for lower FFS increases, some providers receive lump-sum population health payments to invest in value-based care: Developing telehealth capabilities, building ambulatory centers, and developing systems to identify at-risk patients. Providers have significant dollars at risk to encourage them to keep their PMPM costs below market.

Our guided and phased approach helps providers transition seamlessly into a value-based system. Here's how it works:

- In the first phase of a VBP agreement (typically the first one or two years), providers receive the same number of dollars they would in an FFS arrangement, but those dollars are distributed between value and population health payments.
- In the second phase, providers begin reinvesting those value payments to reinvent care models that deliver quality care at a lower cost to reduce overall spending.
- In the third phase, providers are increasingly accountable for managing costs. New systems allow them to redesign health care models that address patient needs, provide more value, and deliver more cost-effective care — all of which notably improves provider margins while reducing member and employer costs.

In terms of health care quality, however, one size does not fit all. Flexible approaches to quality measurement are often appropriate for certain providers. At Blue Cross, our medical and quality improvement professionals work with providers to develop and implement quality care programs, exchange performance data, and collaborate to meet or exceed improvement targets. Our value-based models demonstrate significant cost savings driven by higher quality and better managed care, lower utilization, and efficient coordination that lowers utilization of high-cost services. We also reward primary care, prevention, and wellness services that reduce overall costs.

Most providers are as interested as payers in building a sustainable health care model. They support value-based care because it delivers what employers are asking for: Widespread and lasting improvements in health care cost, quality, and trends.

VBPs at Blue Cross demonstrate significant cost savings driven by higher quality and better managed care, lower utilization, and efficient coordination that lowers utilization of high-cost services.

VBPs deliver widespread improvements in health care cost, quality and trends.

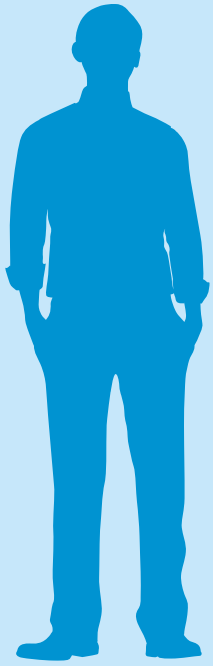
A DATA-BASED APPROACH TO VBPS

Because provider arrangements and memberships change year to year, measuring the impact of VBPs on the cost of care can be a complex proposition. VBPs and cost-of-care relationships can be assessed at two different levels: The global impact of VBP arrangements on patient cost of care; and provider-level measures of success against peers.

Simple comparisons of annual growth rates or overall PMPM often fail to account for underlying differences between VBP populations and those seen in FFS providers. Member-level variables such as age, gender, county of residence, zip code, and population risk scores can all influence cost of care and should be considered in potential cost models. To account for this complexity, Blue Cross has developed sophisticated predictive models to estimate the comprehensive cost benefit from VBPs. Our models incorporate member-level demographics, risk scores, and socioeconomic information to adjust our cost predictions. We apply our estimates to the average PMPM of attributed members to predict the impact of these variables on cost (see the chart below).

Member moves from a non-VBP provider

6.3% PROJECTED REDUCTION IN PMPM COST



- Lives in Metro County: decrease PMPM by 11.8%
- Is male: PMPM decreases 7.5%
- Age 35: PMPM decreases 16.2%
- Diabetes increases risk score by 0.4: PMPM increase by 37.5%

At a provider level, our data-based approach to measuring the VBP impact allows us to reward providers for reducing their total cost of care. To measure a provider's success in reducing costs, we can perform multiple comparisons:

- Provider year-end PMPM against prior year-end PMPM
- Year-end PMPM against a predetermined target
- Annual PMPM trend to a standardized compare group's trend
- Annual PMPM trend against community measurement trends

Our flexible data-based approach to measurement gives providers the confidence to know that we are accurately rewarding them for reducing their overall cost of care.

RETURN-ON-INVESTMENT AND IMPACT

How do value-based payments help providers succeed? Here are just a few of the ways providers can measure the return-on-investment (ROI) and impact of VBPs.

VBPs deliver demonstrable impact on provider margins.

In a well-constructed VBP arrangement, providers can maintain or increase margins while reducing revenue and reducing fee-for-service charges. In traditional FFS models, providers can increase margin only by performing more services. If those services are reduced or done in a lower cost setting, revenue is reduced and so is the corresponding margin. In contrast, with a well-constructed VBP, providers can earn enough non-FFS revenue (by reducing unnecessary services or moving services to lower cost settings) that the non-FFS revenue adds directly to operating margin because there are no variable costs associated with this source of revenue. The more care systems manage costs — for example, by performing surgeries in ambulatory centers rather than in hospitals — the greater the value payments, and the greater the margin. VBPs contribute to the provider financial viability without forcing them to attract additional business. The care system, plan sponsors, and patients all win.

Historically, VBPs in the market may not have been seen as sustainable because the reward did not offset the lost revenue from FFS models. Blue Cross is committed to have sustainable payment models that allows for a glide-path off FFS to VBP. We believe these new VBPs do that.

VBPs drive improvement in quality of care.

Value-based payments infuse providers with the funds required to reinvent their care models. They might use these funds to increase care coordination capabilities, to design virtual platforms, or to construct lower-cost sites. As cost transparency becomes more common and competition increases, providers are increasingly interested in this transformation. In addition, VBPs allow providers to focus on patient needs rather than prioritizing services they can bill for.

Members benefit from VBPs.

Value-based payments make member health care more affordable and accessible. VBP models support home care delivery, virtual care, additional care coordination, and other services to achieve better outcomes at lower billing volume. With economic incentives aligned with better and lower-cost care, members are less likely to become stuck in the middle between payers and providers over care authorization. Health care becomes easier to use and more aligned with patient values.

CASE STUDY: ALLINA HEALTH

Providers in value-based agreements have a different working relationship with Blue Cross. We partner with these providers to identify areas of readiness where they can efficiently and effectively meet the health care needs of patients and be held accountable for outcomes. For example, a six-year agreement between Blue Cross and Allina Health aims to significantly improve health care affordability, while maintaining high standards for quality and experience. Provisions of this agreement include:

- A new level of shared accountability to deliver costs **10 percent below** the current market trend over six years. If Allina does not meet the below-market trend targets, Allina will reimburse Blue Cross; these savings are passed back to plan sponsors.
- Uncoupling of a significant portion of annual claim payments to support **population health-driven** approaches.
- Dollars tied to value that are **five to ten times greater** than typical risk arrangements.

Our six-year agreement with Allina Health will enable expanded care coordination, increase the number of affordable care settings, continue the expansion of virtual care offerings, and support the development of innovative service offerings, such as Allina Health's Home Hospital Care program and additional ambulatory surgery centers (ASCs).

The agreement also addresses societal factors that impact health disparities, simplifies administrative requirements, and maximizes time available for building doctor/patient relationships. Our value-based agreement with Allina Health will enable our organizations to provide high quality care at an affordable price for our communities.

Allina Health is an independent company that provides network access to health care services. Allina Health Network is a subsidiary of Allina Health.

CONCLUSION: DEEPER VALUE-BASED CARE

The health care industry has long understood that the fee-for-service model is outdated. Both payers and providers recognize that a shift to value-based payments is the most effective way to deliver better health outcomes at a lower cost. However, while payers often promote their value-based models, the percentage of health care dollars impacted by them is small.

By entering into deeper value-based arrangements that shift health care dollars away from volume of care to value of care, Blue Cross aims to change this paradigm. Our bold approach leverages VBP data to develop the next generation of payment models — models that move providers beyond FFS to incentive-based systems that impact all aspects of health care.

These changes will require close collaboration with providers. Purchasers committed to payment reform must be willing to challenge the traditional evaluation of health plan value on the discounts rather than on total cost-of-care. Blue Cross pledges to work hand-in-glove with purchasers to guide this transition. Fortunately, this shift means a greater emphasis on initiatives on which Blue Cross has already been focused: Preventive rather than responsive treatment, care delivered at the right time and location, and reduction of unnecessary care.

Case studies such as our collaboration with Allina Health are a testament to our partners' eagerness to move in this direction. We will continue to leverage performance data to improve member health and outcomes, incentivize providers to lower costs, and improve quality of care. Doing so will deliver what employers, providers, and patients have long demanded: Transformation of our current broken system and the reinvention of managed care.

For more information, connect with your Blue Cross Sales Representative or Account Manager today.

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