Value-Based Contracting and Payer-Provider Collaboration

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Agenda

• Introduction and Takeaways
• Current Value-Based Programs
• BlueCross BlueShield of Tennessee Mission and Strategy – Who are we? What do we do?
• Health Care Cost Growth and Value – Perspectives of health care customers, purchasers and policymakers
• Provider – Payer Collaboration Model
Takeaways…

• BlueCross operates in a highly competitive market for health care benefits and related products. We must respond to needs and expectations of customers and consumers.

• Our large customers, both government and employer, recognize health care costs as a significant challenge. They increasingly expect us to address health care cost while promoting better quality and outcomes.

• Value-based payment and payer/provider collaboration in the PCMH and other programs are critical components of our strategy to meet these customer expectations and to achieve our mission to promote better health.
# Overview of Core Pay-for-Value Programs

**Program Objectives:** Align incentives with patient care and clinical outcomes, reward health care providers delivering higher value care, and ultimately reduce medical costs

| 1. Quality Care Partnership Initiative | Incorporates upside and downside risk sharing for performance against quality metrics; supported by Clinical Data Exchange |
| 2. BlueCare Quality Care Partnership Initiative |
| 3. Medicare Advantage Stars | Incorporates upside and downside risk for performance against quality metrics; supported by Clinical Data Exchange |
| 4. Patient-Centered Medical Homes | Transforms primary care via standardized patient-centered protocols and enhanced care coordination; supported by analytics on cost, quality, and outcomes |
| 5. BlueCare Patient-Centered Medical Homes |
| 6. Medicare Advantage Gain Share | Permits upside gain for improved performance against benchmarked cost and outcomes; supported by Clinical Data Exchange |

**Common Elements**
- Pursuit of standardized metrics
- Timely sharing of data
- Incenting improved performance
- Support of physician engagement
From Volume to Value

Fee for Service has challenges. Approximately $750 billion (30% of annual health spending in US) is considered wasted on unnecessary services, inefficiency or missed prevention opportunities.

### Fee-for-Service Payment Models:

↑ Volume of Services ➔ ↑ Payment

### Value-Based Payment Models:

Better quality, outcomes, and more efficient care ➔ ↑ Payment

**Align incentives and drive change:** Care Delivery, Care Management, Patient Engagement
Who We Are…

BlueCross BlueShield of Tennessee is an independent not-for-profit organization founded in 1945. Today, we serve more than 3.3 million people. We employ more than 5,400 people at our headquarters in Chattanooga and our regional offices in Jackson, Knoxville, Memphis, Nashville and Northeast Tennessee.

- Independent, non-profit, tax-paying Tennessee corporation
- Licensee and member of BlueCross BlueShield Association
- Tennessee Health Foundation and Community Trust

**Mission: Peace of Mind through Better Health**
What We Do…

- Benefits (Medical, Behavioral, Pharmacy)
- Networks
- Claims/Customer Service
- Marketing/Sales
- Utilization Management
- Case Management
- Disease Management
- Health Promotion/Wellness
- Population Management

Our lines of business include:
- BlueCare Tennessee, our Medicaid managed care subsidiary
- Employer-sponsored plans, serving more than 11,000 groups
- Individual and family plans
- Medicare Advantage plan
Our Strategic Goals: Cost, Quality, Value

Deliver Best Medical Value
- Accreditation excellence
- Partner with providers to improve cost and quality
- Rank in top tier of Blue Plans for medical costs

Drive Positive Change
- Drive health care system improvement
- Advocate for customers
- Create change through social responsibility
- Enhance the brand

2017 Ops Priorities:
*Improve member care by accelerating our “pay for value” efforts:*
*Change our provider networks by aggressively aligning payments – and even participation – with higher-quality performance standards.*
Health Care – Who Are Stakeholders?

AHRQ has defined "stakeholders" as persons or groups that have a vested interest in a clinical decision and the evidence that supports that decision.

- Consumers, patients, caregivers, and patient advocacy organizations
- Clinicians and their professional associations
- Health care institutions, such as hospital systems and medical clinics, and their associations
- Purchasers and payers, such as employers, and public and private insurers
- Health care policymakers at the Federal, State, and local levels
- Health care industry and industry associations
- Health care researchers and research institutions

https://www.ahrq.gov/research/findings/evidence-based-reports/stakeholderguide/chapter3.html
What Consumers Want Depends On…

Who?
- Age
- Gender
- Health Status
- Financial Status
- Family Status

What?
- Health Plan
- Primary Care
- Specialist Care
- Hospital Care
What Consumers Want…Common Themes

• Cost
• Access/Convenience
• Useful information
• Care
  o Effective
  o Personalized
  o Respectful/Humane
  o Coordinated
Purchasers and Policymakers: “Rising Medical Costs Mean More Rough Times Ahead”

“Medical costs are rising again… The issue of health care costs plays differently in the political arena than the issue of coverage. Politicians bicker endlessly about who should be covered and how generously… In contrast, there is bipartisan agreement that policy action is needed to address rising medical costs.”

David M. Cutler, PhD – JAMA, August 8, 2017
“Health care in the United States is more expensive than in other developed countries, costing $2.7 trillion in 2011, or 17.9 percent of the national gross domestic product...

Increasing costs strain budgets at all levels of government and threaten the solvency of Medicare, the nation’s largest health insurer...

At the same time, despite advances in biomedical science, medicine, and public health, health care quality remains inconsistent. In fact, underuse, misuse, and overuse of various services often put patients in danger.”

IOM Report – “Target Decision Making, Not Geography” IOM 2013
“Haslam says cost, not just coverage, needs to be addressed in health care reform”

“Haslam told the Rotary Club of Chattanooga… states which must balance their budgets will be better able to control the soaring costs of Medicaid and other government health insurance than the federal government has been. Haslam suggested that Congress block grant money for Medicaid to the states with flexibility for local solutions.”

"If health care inflation keeps going as it is now, we're sunk as a nation… When Medicare and TennCare take more of the government's budget, there is less left for anything else.”

“The cost of medical care continues to rise across the globe with no light at the end of the tunnel, according to insurers responding to the 2017 Willis Towers Watson Global Medical Trends Survey. Although the trend has slowed in some countries, it is still mostly above inflation…

Employers anticipate higher trend due to three major drivers: hospital/inpatient services and basic medical/outpatient services, including pharmacy; providers overprescribing many services and employees seeking inappropriate care; and new medical technology and higher provider profit.”

*Willis Towers Watson, 2017 Global Medical Trends Survey Report*
Employer Responses to Health Care Cost Growth

“What are employers doing in response to contain cost?

Most turn to traditional strategies — cost sharing with employees (e.g., coinsurance and deductibles), cost management strategies led by contracting with provider networks, and requiring preapprovals for scheduled inpatient services.

However, with concern growing over affordability for employees and recognition that a healthier workforce is a more productive workforce, we are beginning to see greater investment in programs that empower employees to manage their own health with strategies like offering preventive care and well-being initiatives.”

Willis Towers Watson,
2017 Global Medical Trends Survey Report
“Rising Medical Costs Mean More Rough Times Ahead” II

“…addressing costs in a meaningful way is difficult. The central difficulty is that medical spending increases apply to a mix of valuable services and less valuable ones.”

“…the steps taken will necessarily involve difficult trade-offs. Three approaches that policy makers might take are…”

- Cutting prices
- Charging people more in the form of cost sharing, or
- Value-based payment
“Rising Medical Costs Mean More Rough Times Ahead” III

“Generally, the literature shows some savings associated with value-based payments, but the savings are not enormous—5% or less—depending on the program…

To date, there has been no evidence of adverse consequences. Indeed, many measures of quality are used to determine compensation, and by those metrics, quality seems to have improved…

The literature thus supports an expansion of value-based payments, but with a caveat: we have not yet figured out how to use bundled payments to save significant money.”

David M. Cutler, PhD – JAMA, August 8, 2017
Model for Payer – Provider Collaboration in the PCMH Program

1. Identify and Understand the Target Population
2. Improve / Redesign the Delivery Model
3. Improve / Redesign Care Management Activities
4. Align Incentives in the Payment Model
5. Measure and Improve Results and Performance
6. Measure and Improve Outcomes
Summary

• BlueCross operates in a highly competitive market for health care benefits and related products.

• Our large customers expect us to address health care costs while promoting better quality and outcomes.

• Value-based payment and payer/provider collaboration, in the PCMH and other programs, are critical components of our enterprise strategy and our mission to promote better health.
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