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# From Volume to Value: Transforming How We Pay for Healthcare

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At Blue Cross & Blue Shield of Rhode Island (BCBSRI), we are driving toward a modern model of health care focused on raising quality and lowering costs. We understand that the traditional fee-for-service model is unsustainable. In keeping with our 75+ year heritage of local and national healthcare leadership, we and all Blue Cross and Blue Shield (BCBS) Plans are collaborating with key stakeholders to design and implement a better healthcare system for our nation, one based on value not volume.

**Already today, nearly \$71 billion**, approximately **20 percent**, of the medical claims paid by BCBS Plans is tied to new value-based care programs, in which provider incentives must be earned and are not automatically given in fee schedule increases.<sup>1</sup>

This far outpaces the impact of other health plans and demonstrates the significant commitment that BCBS Plans have made to employers and their employees to promote value-based payment and healthcare. As we continue to measure and evaluate the impact of these programs, our national footprint will expand accordingly.

We've developed this FAQ to help you better understand Blue Cross value-based care programs and how self-funded employers and members will benefit from these arrangements.

## **UNDERSTANDING VALUE-BASED CARE PROGRAMS**

### **Q. What is a value-based care program?**

A. A value-based care program is a term generally used to describe an outcomes-based payment arrangement and/or a coordinated care model contracted with one or more local providers. They are designed to reduce unnecessary care and claims costs, while improving the quality of care. Typically a portion of total provider reimbursement is based on cost-efficiency (cost management) and improved patient and/or population outcomes (better quality). These programs are similar to industry terms such as “care delivery innovation,” “value-based contracting,” “payment reform,” and “payment innovation.”

At the center of a value-based care program are incentive payments that motivate providers to deliver cost-efficient, high-quality, coordinated healthcare. Providers receive rewards for the quality of services they deliver as well as patient outcomes.

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<sup>1</sup> 2014 BCBSA Value-based Programs Master Survey

This contrasts with traditional fee-for-service payment programs, which compensate providers on the quantity of services provided.

**Q. How do fee-for-service and value-based payment models differ?**

- A. In a **fee-for-service model**, providers are reimbursed for each service they provide to a patient. The more services they provide, the more reimbursement they receive. Value, quality and improved outcomes are not part of the reimbursement equation.

With a **value-based payment model**, quality is a key component of the equation. How providers are compensated is linked to how they perform in a variety of areas, such as patient experience and outcomes, and how they use cost-efficient tools such as electronic medical records. Provider focus is on:

- Delivering care in the most clinically and cost-appropriate settings
- Using evidence-based guidelines and quality outcomes data
- Improving the patients' experience and including them in the decision-making process
- Identifying gaps in care

**Q. What are some types of value-based care programs?**

- A. Various Blue Cross and Blue Shield Plans currently offer—or will offer in the near future—a variety of value-based care programs depending on the unique market dynamics and needs of the community.

Today, BCBS Plans have four primary value-based care models:

- **Accountable Care Organization (ACO)**—A group of healthcare providers that agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their patient (member) populations. ACOs are often hospital-based, but may include groups of physicians, hospitals, and other healthcare providers.
- **Patient-Centered Medical Homes (PCMH)**—A model of care in which each patient has an ongoing relationship with a primary care physician (PCP) who coordinates a team that has collective responsibility for patient care. When appropriate, this PCP arranges for care with other qualified physicians as defined within the program. The PCMH model is intended to offer patients accessible, continuous, coordinated, and comprehensive patient-centered care, managed centrally by a primary care team.
- **Pay-for-Performance / Quality-Based Incentive Program**—This payment model rewards physicians, hospitals, and other healthcare providers for

achieving improvements in multiple areas including process, efficiency, clinical quality outcomes, infrastructure, and patient safety performance measures.

- **Episode-Based Payment (including Bundled Payment)**—Episode-based payment bundles services as an “episode of care” and pays providers with a single negotiated payment for all clinically related services of the specific episode delivered by various providers over a period of time.

**Q. How much experience do Blue Cross and Blue Shield Plans have in value-based care programs?**

- A. With insights gained from collaborating with providers in each community for more than eight decades and serving more than 106 million members, Blue Cross and Blue Shield Plans are uniquely positioned to lead the transformation of healthcare from one based on volume to one based on value.

BCBS members represent a significant share of physician and hospital consumers, making BCBS Plans better able to bring more data, on more patients, across a broader population to those providers so that they can better manage care. This equates to more informed decisions and deeper collaboration between BCBS Plans and providers to control costs and improve care delivery.

Local presence has enabled BCBS Plans to work with local providers in developing advances in healthcare payment models for well over 20 years, working to transform fee-for-service structures to value-based agreements.

**Q. What is “patient-centered, value-based care”?**

- A. Patient-centered, value-based care is an approach to healthcare delivery that focuses on ensuring employees receive the right care at the right time—the first time. By emphasizing care coordination and giving providers incentives and rewards for better health outcomes, these programs are designed to lower cost trend over time, ultimately lowering healthcare costs for all stakeholders, including employers and their employees.

As the industry leaders, Blue Cross and Blue Shield Plans look to engage providers in these programs with patient-centered, value-based care as the “new standard” in healthcare.

## THE INNER WORKINGS OF VALUE-BASED CARE PROGRAMS

### **Q. How are value-based payments made to providers?**

- A. While the financial incentives paid to providers will vary based on the specifics of the local program, the payments generally fall into the following two categories:

Providers may be paid **care coordination fees/incentives**, which are negotiated amounts typically paid on a per attributed member per month (PaMPM) basis to reimburse providers for the additional services such as the inclusion of pharmacists, nurse case managers, and physician champions located in primary care physician offices. Payments may also be used to implement tools and systems, such as electronic health records, that promote quality improvements and cost savings.

**Shared savings incentives** are negotiated with providers and typically are paid annually. They are retrospective payments made outside of the fees associated with specific services and are based on defined quality and cost targets.

### **Q. How committed are the Blue Cross and Blue Shield (BCBS) Plans and BCBSRI to value-based reimbursement models?**

- A. As indicated above, nationally, the BCBS Plans are fully committed to the transition to a value-based payment system. We have over 576 programs in market today or in development, representing 229,000 participating providers. Our programs extend to more than 25 million members!

Locally, more than 90% of BCBSRI's reimbursement models will have evolved beyond fee-for-service and will include value-based elements by 2018. That evolution is well underway and is already producing cost and quality benefits within our Primary Care Physician (PCP) networks and Patient-Centered Medical Homes (PCMH).

Our value-based models currently extend to all fully-insured and most self-funded clients. As we move into 2016, all customers will fully participate in value-based contracting and have the ability to maximize all of the benefits of these programs.

### **Q. Do all members participate in value-based care programs?**

- A. While our goal is to have as many members as possible enrolled in value-based care programs, membership is determined by attribution to a provider associated with one of the value-based programs. Blue Cross and Blue Shield Plans currently have over 25 million members attributed to value-based care programs.

**Q. What is “attribution” and how are employees attributed?**

A. Attribution is the process of using defined methodologies to assign patients (members) to providers for the purposes of identifying the population for which the provider is accountable, as well as to measure the provider performance measurement and incentive/shared savings calculations. Local Plan attribution methodologies will apply. The specific attribution criteria used by Blue Cross and Blue Shield Plans varies, but they are based on previous services received by that member. Attribution is a key element in determining provider incentives.

**Q. What is the role of primary care physicians (PCPs) in programs using a value-based payment structure?**

A. PCPs are a key to the success of value-based care programs because they create the foundation on which quality care is provided. PCPs are in a unique position to coordinate care and guide patients to the right treatment, in the right setting, at the right time. This reduces the chances for unnecessary and costly care and improves the possibility for the best outcomes.

**Q. How do you set medical cost targets for providers?**

A. Provider medical cost targets are developed in one of two ways. Some targets are established by projecting utilization and cost based on historical claims utilization trends and expected reimbursement. Other targets are established by comparing the trend of the provider group to the trend of the network in totality. The goal is to set reasonable targets that provide the proper balance of potential financial rewards to providers and savings to employers, while promoting superior quality of care.

**Q. How are provider and program performances measured?**

A. Program performance is measured based on quality, utilization, and total cost of care. Quality measures focus on aspects of care such as managing chronic conditions and offering preventive care services. Quality metrics may include adult BMI assessment, diabetes care – HbA1c testing and nephropathy screening, breast cancer screening, blood pressure monitoring, hypertension and cholesterol medication adherence, and childhood immunization status.

Utilization and total cost of care are measured in relation to the performance of providers not enrolled in value-based programs. Metrics may include readmission and emergency room practice management.

**Q. As you develop new payment models, will you eliminate old ones?**

- A. The transformation of the healthcare delivery system is a huge undertaking. As we transition from traditional payment models to newer, more effective models, we will be sensitive to the size and capabilities of our various contracted providers. Since smaller practices may need more time and assistance to transition to a newer payment model, we may need to keep older models—or some version of them—in place for some time.

## **VALUE-BASED CARE PROGRAM BENEFITS**

**Q. How do employers benefit from Blue Cross and Blue Shield’s (BCBS) value-based care models?**

- A. Employers benefit from BCBS Plans’ leadership in redefining how to pay for healthcare and from programs designed specifically to address local care delivery dynamics. Our programs (many certified by the Blue Cross and Blue Shield Association as Blue Distinction Total Care <sup>2</sup>) optimize alignment of healthcare payments with improved member health from BCBS Plans across the country – improving and/or maintaining quality of care while lowering overall total cost of care over time. Our programs encourage a more collaborative, coordinated approach across the care spectrum – helping to ensure that employees and their families are receiving the right care.

Our integrated solution provides employees access to locally developed value-based care programs on a national scale. Employees are attributed to providers who are held accountable for managing their care. Employers benefit from this attribution process because providers have access to more information on their attributed patients and can more easily identify gaps in care, develop comprehensive care plans, and prevent unnecessary care and avoidable adverse events.

Among those certified programs reporting results, savings have averaged **\$10 PMPM**<sup>3</sup>.

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<sup>2</sup> Blue Distinction Total Care (BDTC) recognizes physicians, group practices, and hospitals participating in locally tailored value-based programs designed to lower cost trend through better coordinated care and performance-based payments. Using nationally consistent criteria, BDTC recognizes programs that promote patient-centered, value-based care including healthcare payments aligned with improved member health outcomes and lower costs to deliver maximum value to employers and their employees.

<sup>3</sup> Savings averaged across subset of BDTC programs, based on members attributed



**Q. How does the implementation of these programs affect employees?**

A. Since employees are attributed to value-based programs based on previously received medical services, employees do not need to take any action to be enrolled in these programs. Once enrolled in a value-based care program, employees will benefit from the enhanced care coordination and best practices available at these practices. They will develop ongoing relationships with their primary care physicians and truly “own” their care. As a result, the member will receive care in the most appropriate setting and avoid unnecessary procedures often associated with disjointed care. Many of our value-based programs have extended and weekend office hours to allow patients access to quality care and avoid long waits in costly emergency room settings.

**Q. What benefits do providers get from a value-based care program?**

A. Providers acknowledge that responsibility for the quality and cost of healthcare is best placed in their practices and hospitals. They want to provide superior care, and they want to provide it cost-efficiently. A value-based care program provides them with the opportunity for greater financial and professional rewards when they reach those goals. As they are given the freedom to move their focus from volume to value, their experience and expertise actually become more valuable than ever. They gain more control over their patients’ health and their own financial potential.

## **VALUE-BASED CARE PROGRAMS AND SELF-FUNDED CUSTOMERS**

**Q. How do value-based care programs benefit self-funded employers?**

A. Self-funded clients benefit from value-based care programs in a manner similar to fully insured clients. However, instead of a reduction to premium rates, self-funded clients may benefit from reduced claims costs as providers practice under these arrangements.

Provider reimbursement and incentives have been structured to target cost trends below fee-for-service levels, thereby reducing overall claims cost.

**Q. Will self-funded employers be charged when their employees access Blue Cross and Blue Shield (BCBS) value-based programs?**

A. Yes, participating employers that have employees attributed to BCBS value-based care programs will be responsible for the cost of their employees’ portion of the provider incentives (including care coordination fees) related to these programs in exchange for the value they deliver, including better coordinated patient care that is designed to lower cost trends over time.

When applicable, per attributed member per month (PaMPM) payments will be included as part of the employer's weekly claims charges. These payments are only made for value-based payments or incentives earned by participating providers who have treated the employer's attributed employees.

There are no administrative fees associated with these payment programs and claims are processed and paid just as they have been in the past.

**Q. How do self-funded employers know if they are saving money and providers are cutting costs?**

- A. Blue Cross and Blue Shield (BCBS) value-based care programs represent advanced provider contracts that incorporate the measurement of provider performance against both cost and quality outcome targets when determining total payment or incentives. Providers do NOT earn incentives if they do not satisfy contracted criteria and generate aggregate savings for employers.

**Q. Can self-funded employers opt out later if their costs increase?**

- A. No. An employer is responsible for value-based payments for their employees who are attributed to value-based programs. As the healthcare system transitions from a fee-for-service reimbursement methodology to a fee-for-value system, we anticipate continued increases in value-based care program membership. Increased membership in these programs drives increased cost savings for employers as these programs continue to reduce medical claim cost trends.

Across the industry, healthcare cost trends are anticipated to increase over time. However, the inclusion of value-based care programs is expected to moderate the increased claims cost trend. To date, Blue Cross and Blue Shield (BCBS) value-based programs have resulted in an average PMPM savings of \$10. Locally, BCBSRI programs have produced an average ROI of 2:1.

**Q. What if an employer doesn't have any employees going to providers in a value-based program?**

- A. The employer is not responsible for any value-based payments or bonuses.

**Q. Will stop-loss premiums be affected?**

- A. Self-funded clients who purchase stop loss insurance may see a slight decrease in premium increases as a result of value-based care programs as those programs dampen medical cost trends.

## **GOING FORWARD**

### **Q. What can employers do to support value-based payment programs?**

A. When employers talk, insurers and providers listen. Let BCBSRI and providers know you believe in the power of value-based payment programs and that you want to offer a health plan that uses this model. Also, embrace opportunities to educate your employees about value-based payment programs and how they can improve quality and reduce costs.

### **Q. How can I learn more about value-based payment programs?**

A. Simply contact your BCBSRI representative. They will answer any questions you have.

*Please look for information on value-based programs that have earned the Blue Distinction Total Care (BDTC) designation in the September issue of our Broker Brief.*



Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.