Blue Plans Improving Healthcare Quality and Affordability through Innovative Partnerships with Clinicians

**Issue:** U.S. healthcare spending exceeds $2.8 trillion annually.¹ With studies estimating that nearly 30 cents of every healthcare dollar goes to care that is ineffective or redundant, many of those dollars are not well spent.

**Position:** The Blue Cross and Blue Shield Association (BCBSA) and BCBS Plans are spearheading initiatives to assure our 100 million members receive safe, high-quality, coordinated, and affordable care. Blue initiatives use an interconnected approach involving:

- **Changing payment incentives** by moving away from fee-for-service – which rewards volume – and linking reimbursement to quality and outcomes.
- **Partnering with clinicians** so they have the individualized support, data, and tools they need to be successful.
- **Engaging patients** with wellness programs, transparency tools, and information on how to keep healthy and manage chronic conditions.
- Blue Cross and Blue Shield Plans are leading the market in developing and executing value-based care programs for our members. With more than 350 programs in market across 49 states, Washington DC, and Puerto Rico, these programs focus on shifting provider payment away from volume to value. The Blues are engaging with more than 215,000 physicians – 155,000 primary care physicians and nearly 60,000 specialty physicians – to increase quality and value in healthcare spending. More than 24 million Blue Cross and Blue Shield members are currently accessing care through value-based programs such as Accountable Care Organizations, Patient-centered Medical Homes, Pay-for-Performance programs and Episode-based Payment programs.

**Patient Centered Medical Homes**

Blue Plans collectively support the nation’s largest network of PCMHs currently covering nearly eight million Blue members under arrangements where the patient and primary care practice are at the center of care.

**CareFirst BCBS**

- **CareFirst BCBS**’s PCMH initiative includes 3,600 primary care providers (PCPs) and nurse practitioners caring for 1 million CareFirst members in MD, DC, and parts of Northern VA. PCPs can practice in established groups or “virtual” panels that help enable accurate quality and financial measurement and provider “peer-review” of one another’s performance. The model includes an immediate double-digit

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¹ CMS. National Health Expenditures 2012 Highlights. (link)
increase in the primary care fee schedule and new payments for care plans for chronically ill members. Participating providers are eligible for additional fee increases based on performance. CareFirst local care coordinators partner with PCMH practices to help coordinate care, such as assuring post-discharge coordination, making physician office visits to discuss patients’ care plans, and providing regular web-based updates to a record available to the entire care team.

In its second year, CareFirst’s PCMH program has trimmed expected healthcare costs in 2012 for PCMH-covered members by 2.7 percent (representing $98 million in savings), an improvement over the 1.5 percent savings in the program’s first year. In 2012, 66 percent of participating primary care panels in the PCMH earned Outcome Incentive Awards (OIA) (up from 60 percent in 2011). Panels earning OIAAs achieved an average 4.7 percent savings against expected 2012 care costs. Panels that did not earn OIAs registered costs averaged 3.6 percent higher than expected in 2012, but this is an improvement over the 4 percent registered in 2011. Quality scores for Panels that earned OIAs were 3.7 percent higher than for panels that did not earn OIAs in 2012. Overall, quality scores for PCMH panels rose by 9.3 percent from 2011 to 2012.

BCBS of MI

- **BCBS of MI’s** PCMH program involves 1,243 physician practices containing more than 3,770 physicians, making it the country’s largest PCMH effort of its kind for the fifth consecutive year. The number of physicians earning PCMH designation from Blue Cross Blue Shield of Michigan has tripled since Blue Cross Blue Shield of Michigan first launched the program in 2009. These practices implement key capabilities like offering after-hours access to care, implementing processes for following up on test results, and using registries that flag care gaps. More than 1.1 million Blue Cross Blue Shield of Michigan members, and close to 2 million patients across the state, have access to a Blues’ PCMH-designated practice. The program has saved approximately $155 million over its first three years.

According to 2013 data, compared with non-designated practices, PCMHs experienced 19.1 percent lower adult hospital admission rate for ambulatory-care sensitive conditions, 8.8 and 17.7 percent lower ER visit rates (for adults and children respectively), 7.3 percent lower adult use of high-tech radiology services, and 11.2 and 23.8 percent lower adult and children (respectively) primary-care sensitive emergency department visit rates.

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2 July 22, 2013. Blue Cross Blue Shield of Michigan. PCMH Fact Sheet. (link)
3 2013 BCBSA Care Delivery/Payment Innovations Survey.
4 July 22, 2013. Blue Cross Blue Shield of Michigan. PCMH Fact Sheet. (link)
Horizon BCBSNJ

- Horizon BCBSNJ has a number of patient-centered programs, including Accountable Care Organizations, Patient-Centered Medical Homes, and programs focused on Episodes of Care (i.e. joint replacement, pregnancy). More than 500,000 Horizon BCBSNJ members are now benefiting from Horizon BCBSNJ’s patient-centered programs that are working to improve patient care while controlling costs. Over 2,800 doctors at more than 900 practice locations are participating in these innovative programs.

Horizon BCBSNJ’s PCMH Program is now helping deliver better quality outcomes at lower costs for over 330,000 Horizon BCBSNJ members. More than 1,300 primary care doctors at over 450 office locations are participating in this state-wide program. Horizon BCBSNJ’s PCMH Program is making great strides in keeping patients’ healthy and reducing complications that can drive unnecessary health care health care costs. 2012 results include:

**Cost and Utilization Indicators**

- **23 percent lower rate** in hospital inpatient admissions
- **12 percent lower rate** in Emergency Room (ER) visits
- **9 percent lower cost** of care for diabetic patients
- Quality Measures
- **5 percent higher rate** in improved diabetes control (HbA1c)
- **3 percent higher rate** in breast cancer screenings
- **11 percent higher rate** in pneumonia vaccinations

In addition, Horizon BCBSNJ also launched a new Patient-Centered Pediatric Program in January 2014. The Pediatric Program, which is a patient-centered program for pediatric members, will benefit an additional 100,000 Horizon BCBSNJ pediatric members. More than 630 pediatricians and family practice doctors at over 110 practice locations throughout New Jersey are participating in this family-focused program to improve the health of children.5

BCBSND

- **BCBSND**’s MediQHome Quality Program – involving more than 84 percent of eligible Plan members – provides IT-driven care coordination for chronically ill patients while benefiting all patients through enhanced preventive care outreach. Seventy-four percent of eligible providers statewide submit their patient data, including progress notes and lab results, to the Plan’s health information and care coordination technology platform, which creates actionable reports identifying gaps in care. BCBSND also rewards providers through a targeted care management fee and outcomes-based incentives. In 2012, building on the MediQHome model, the Plan launched an Accountable Care Model that now includes more than 70 percent of MediQHome participants.

5 January 24, 2014, BCBSA Outreach. Horizon Blue Cross Blue Shield New Jersey, contact: Carl Rathjen.
MediQHome has led to a 19 percent reduction in ER use among MediQHome patients with a diagnosis of Coronary Artery Disease (CAD) compared with non-participating BCBSND members with CAD. From 2009 through 2012, inpatient hospital admission rates among CAD patients in MediQHome were 38 percent lower than those not participating in the MediQHome program.

Anthem Blue Cross and Blue Shield

- **Anthem Blue Cross and Blue Shield** has launched an Enhanced Personal Health Care Program for Primary Care (formally known as Patient-Centered Primary Care): a singular, consistent, and scalable framework designed to drive the migration from volume-based, episodic and fragmented care to value-based, patient-centered, care. All of Anthem’s primary care, value-based arrangements will operate under this framework. The program rewards participants for improvements in quality and affordability and gives PCPs the tools they need to successfully manage patients’ health. Participating PCPs receive a clinical care coordination Per Member Per Month (PMPM) payment for “non-visit” services – focusing initially on care planning for medically complex patients – and have the opportunity to share in any achieved savings if they meet threshold performance on nationally recognized quality and efficiency measures that are part of the program. Performance on these measures not only determine eligibility to share in savings, but also determine the level of shared savings earned.

Today, the program encompasses nearly 18,000 providers, including more than 9,900 primary care physicians who represent more than 1 million attributed members across CA, CO, CT, IN, KY, ME, MO, NH, NY, OH, VA and WI. Additional growth is expected with the program continuing to rollout in all Anthem markets through 2013. In early 2014, the program will be available in all 14 Anthem markets.

**Enhanced Personal Health Care** incorporates best practices from Anthem’s PCMH pilots, such as an initiative in New York, practices participating in Anthem’s PCMH pilot demonstrated 15 percent lower medical and pharmaceutical costs than control practices. In Connecticut, Anthem’s PCMH pilot practices had 18 percent fewer hospital admissions and a 29 percent lower rate of readmissions than non-participating practices. Anthem’s New Hampshire ACO pilot had similarly positive results – participating providers’ costs increased at less than half the rate of non-participating practices. In addition, Anthem saw 18 percent fewer hospital admissions and 15 percent fewer emergency room visits in a PCMH pilot in Colorado than in non-participating practices, along with improvements in diabetes measures in the participating patient population. Quality of care was maintained or improved in all of the cases described above.6

Accountable Care Organizations

Under Plans’ ACO-type arrangements, providers take overall responsibility for the quality and costs of care for a defined patient population – supported by data, analytics, and technical assistance from the Plan.

**BCBSIL**

- **BCBSIL**’s four-year agreement with the 10-hospital Advocate Health Care system covers 320,000 BCBSIL members who receive care from Advocate and its 4,000 physicians. The arrangement is that if the ACO medical cost trend is better than the network—and if the ACO meets patient quality, safety and satisfaction metrics — then Advocate shares in savings. To help guide improvement, BCBSIL provides Advocate with actionable data, including daily communication of attributed members who have been hospitalized, enabling Advocate to proactively manage patients’ care.

This ACO is driving compelling quality and cost impact including a decline of 4.7 percent in the inpatient admission rate per 1000 for Advocate facilities versus an increase of 2.2 percent for the control facilities; a decline of 0.9 percent for length of stay for Advocate facilities versus an increase of 2.7 percent for the control facilities and better results for outpatient utilization: lower ED cases/1000, OP surgery/1000 and advance imaging.

The outcomes achieved included outperforming the adjusted cost trend by approximately 2.5 percent, and maintaining the targeted high-level performance on clinical quality and service metrics as shown here.⁷

**Blue Cross Blue Shield of Minnesota**

- **Blue Cross Blue Shield of Minnesota’s (BCBSMN)** Aligned Incentive Contracting (AIC) model is a three-year partnership with providers in which increases to the fee-for-service component decrease over time and are replaced by growing performance incentives tied to measurable improvements in quality outcomes and to managing total cost of care (TCOC). Health systems assume full responsibility for the total cost of care related to approximately 370,000 attributed Blue members.⁸ BCBSMN provides a risk-adjusted per member per month payment along with an allowed trend for attributed members’ TCOC. If the provider’s actual PMPM for those attributed members is below the PMPM target, the provider is eligible to receive a share of those savings.

BCBSMN’s AIC model demonstrated in 2011 that the trend for AIC care systems was approximately 34% lower than comparable care systems. Seventy-five percent of AIC providers were successful in earning incentives, and the Plan estimates $13 million in net savings against expected claims costs after paying incentives. Members reached optimal treatment goals for diabetes, blood pressure, cardiovascular disease and hypertension.

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⁷ 2012 BCBSA Care Delivery/Payment Innovations Survey

⁸ 2013 BCBSA Care Delivery/Payment Innovations Survey
BCBSMA

- BCBSMA’s Alternative Quality Contract (AQC) moves away from fee-for-service by using a population-based global budget that is adjusted annually for health status and inflation, combined with performance incentives tied to nationally accepted quality measures. Twice annually, the Plan provides AQC-participating physician groups with practice pattern variation analyses on more than a dozen conditions that allow clinicians to drill down to patient-level detail, understand underlying reasons for differences in practice patterns, and identify improvement opportunities. AQC now includes more than 18,000 doctors and nearly 700,000 BCBSMA members.

An independent evaluation of the AQC, published in the New England Journal of Medicine (2011) and Health Affairs (2012), showed that the AQC was associated a two percent slower growth in medical spending in 2009 and a 3% slower growth in medical spending in 2010. Please note that this percentage reflects savings in medical spending, not total costs. In most of the contracts, total payments made to the providers including savings shared, quality, and infrastructure investments exceeded the medical spending savings they achieved to date; Doctors with the alternative contract spent 3.3% less in 2010 than doctors not in the program, an average savings of about $107 per patient. A previous study had reported more modest savings during the program’s first year. The same researchers found that doctors participating in 2009 spent 1.9% less than doctors, who were not participating, an average savings of $62 per patient. Those savings not only expanded in 2010, but some doctors groups spent as much as 10% less than colleagues paid under the traditional FFS system.

10 2013 BCBSA Care Delivery/Payment Innovations Survey