



 **BlueCross  
BlueShield**  
Association

# TRANSFORMING HEALTHCARE DELIVERY

A Pathway to Affordable, High-Quality Care in America

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# 1

## EXECUTIVE SUMMARY



# EXECUTIVE SUMMARY

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The U.S. healthcare system is changing rapidly, but greater efficiency, improved care and lower costs are not coming fast enough. Now is the time to establish an innovative healthcare system that provides people with high-quality, safe, coordinated, evidence-based and affordable care.

Americans need more effective, efficient and coordinated care that helps patients get healthy faster—and stay healthy longer.

Currently, healthcare spending in the United States is \$2.9 trillion per year, straining the budgets of families, businesses and taxpayers. Too much of this money is not well-spent. In fact, studies estimate that 30 cents of every healthcare dollar goes to care that is ineffective or redundant.

Despite having the most expensive healthcare system in the world, Americans' health compares poorly with the health of people in other countries.

The solution is not simply to cut costs, but to transition from a system that currently rewards doctors, hospitals and other medical professionals for the volume of services they provide to one that pays practitioners for delivering high-quality care and greater success in treating patients. This is a complex transition that requires close collaboration between public and private sector payers, hospitals, doctors and nurses to ensure that every patient receives healthcare that is of the highest quality possible.

Blue Cross and Blue Shield companies have a four-part strategy that's leading a **successful transformation** of America's healthcare system.

Blue Cross and Blue Shield (BCBS) companies collectively cover 1 in 3 Americans—and they are already leading this transformation. What started as small initiatives many years ago has grown to a BCBS portfolio of more than 570 locally-developed, quality care programs across the country, providing coverage to more than 25 million Americans. Community by community, The Blues® are working aggressively to improve quality and rein in costs, tying more than \$71 billion in medical claims (one in five dollars spent annually) to programs that focus on prevention, wellness, improving access to care, disease management and coordinated care. The programs link reimbursement to the quality of care and improved patient health, and are customized to meet local needs.

**As a result, Blue Cross and Blue Shield customers are experiencing:**

- Fewer unnecessary emergency department visits;
- Fewer hospital admissions and readmissions;
- Reduced hospital infection rates; and
- Better outcomes in key quality measures, including breast cancer screening, improved cholesterol control and adherence to best practices for treating diabetes.

Based on this experience, The Blue System has identified four key strategies that are critical to a successful transformation of America's healthcare delivery system.

**First, change the way doctors and hospitals are paid** to establish meaningful financial incentives that reward better patient health. Doctors, nurses and hospital administrators can and should collaborate with payers to establish performance-based financial incentives.

**Second, work with doctors and hospitals by providing them with the tools and data they need** to transform their practices and provide high-quality care.

**Third, help people be active partners in their own healthcare** by providing wellness incentives with educational tools that make healthcare quality and costs transparent. Innovative benefit designs also will help patients make informed healthcare decisions and promote cost-conscious behaviors.

**Fourth, promote savings** in the healthcare system. These include services that add cost without adding value, such as unnecessary or duplicative testing that results from poor communication across settings of care; rapidly escalating pharmaceutical costs that threaten patient access to new and life-saving drugs; and fraud, waste and abuse across the system.

BCBS companies also are using many of their quality-driven strategies in government programs.

For example, the Blues cover nearly four million people through Medicaid managed care. There have been measurable improvements in patients' health as a result of chronic disease prevention and treatment programs developed by BCBS companies, which include

comprehensive diabetes management services and obesity prevention strategies. Blue Cross and Blue Shield Medicaid managed care plans also deliver effective care programs to the most vulnerable.

The Blue System is **improving quality and reining** in costs, with one in five dollars spent annually in programs that provide incentives for better health outcomes.

Medicare Advantage (MA) plans offered by BCBS companies have developed care coordination systems that emphasize prevention, wellness, disease management, and the seamless delivery of services across the care continuum. These MA plans outperform traditional Medicare on a variety of quality measures while protecting patients from high out-of-pocket costs, providing strong consumer protections and maintaining high levels of consumer satisfaction.

Blue Cross and Blue Shield companies are building the pathway to a better healthcare system for a new era of quality care, but the transition can gain momentum more quickly and effectively through public-private partnerships.

The Blues' growing body of experience in improving care and reining in costs shows that these strategies can be successfully replicated in both public and private health insurance programs. Public programs are poised to make notable progress in comprehensive healthcare transformation by aligning with what is already working in the private sector. The government should leverage this experience and lessons learned to accelerate the transformation in government programs. Toward that end, this white paper lays out critical strategies for achieving high-quality and affordable care and offers specific recommendations on how the public and private sectors should partner in creating a healthier America through higher quality, more affordable healthcare.

# 2

## A PATHWAY TO AFFORDABLE, HIGH-QUALITY CARE IN AMERICA



# A PATHWAY TO AFFORDABLE, HIGH-QUALITY CARE IN AMERICA

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The Blue Cross Blue Shield Association and its 37 independent, locally based Blue Cross and Blue Shield companies are a critical link between people and the healthcare system in communities nationwide. The Blue Cross and Blue Shield System shares the goals of governments, insurers, doctors and hospitals to improve the quality of care and patient health.

With a diverse portfolio of more than 570 locally-developed quality care programs, BCBS companies are committed to a four-part, patient-oriented strategy that already is demonstrating significant results. Based on the Blues' collective experiences developing, customizing and executing high-quality care programs in communities across the country, BCBS companies offer some lessons learned and recommendations that federal and state government insurance programs can implement to amplify the impact of private-sector initiatives.



## 1. Change the Way Doctors and Hospitals are Paid

BCBS companies are moving away from fee-for-service payment models and instead are providing financial incentives for quality care and improved patient health. BCBS companies are leading this change by supporting evidence-based medicine; testing hybrid payment approaches that pay for care coordination and offer rewards for improved outcomes and lower costs; and implementing innovative approaches to support doctors in transforming their practices while paying them based on how well they care for the health of an entire population.

Blue Cross and Blue Shield works community by community, nationwide with more than **570 locally-developed, quality care programs.**

BCBS companies have a broad range of delivery system reform initiatives underway across the country, including Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs). PCMHs are proven to improve quality and reduce costs. Under these “homes,” primary care physicians are expected to help patients get the care they need, when they need it, by providing a centralized setting that facilitates partnerships between individual patients and their personal physicians and fosters improved coordination of care as a patient navigates the healthcare system. Based on the Blue System’s experiences, the government can accelerate delivery system reform by aligning with private sector initiatives that have already demonstrated positive outcomes. This will streamline change and minimize the burdens on medical professionals for activities like data collection, quality reporting and workflow redesign.

### Recommendations for our Government Partners:

- **Expedite the planned transition from fee-for-service to a system that rewards healthcare practitioners for quality over quantity.** While The Department of Health and Human Services (HHS) has announced an aggressive shift to quality-based payments over the next few years, BCBS companies believe incentives to motivate practice change should be increased to offset the costs of transformation for doctors. BCBS

companies' experience shows that substantial financial incentives are needed to motivate practice change and propel sustained improvement, often in the range of 10 to 15 percent of their existing reimbursements.

- **Allow Medicare the flexibility to tailor benefits to the needs of specific populations and subpopulations and test complementary alternative payment arrangements.** More than two-thirds of Medicare beneficiaries have at least two or more chronic conditions, and the cost of caring for these patients is increasingly driving Medicare spending. The traditional “one size fits all” benefits approach cannot address this problem. The private sector is deploying new, innovative benefit designs specific to patient needs and health conditions, such as diabetes and heart disease, as well as developing and testing alternative payment arrangements. These strategies lead to more coordinated care that better addresses chronic conditions and keeps patients healthier, reducing the need for expensive procedures or hospitalizations. This, in turn, helps to lower overall costs. By aligning with these established programs, Medicare practitioners will benefit from a lower burden for data collection, reporting and practice redesign.
- **Strengthen Medicare Advantage by encouraging the development of new, innovative delivery systems—such as ACOs—within the program.** As the Medicare and Medicaid programs encourage ACO formation and expand the types of available payer-practitioner arrangements, experience has proven that it's critical to ensure a level-playing field with existing risk-sharing programs, such as Medicare Advantage and Medicaid managed care organizations (MCOs). Partnerships between ACOs and managed care plans should be encouraged to promote coordinated care while protecting beneficiaries.
- **Enhance primary care.** Government must continue to aggressively examine the physician fee schedule so that services that are overvalued or undervalued are adjusted for appropriate reimbursement. BCBS companies also recommend that government invest more in primary care and enhance incentives for the provision of coordinated primary care.
- **Reform the care and payment model for post-acute care.** This will allow for a better measurement of quality and outcomes in those settings to improve quality and value for patients, their caregivers and their families.

## Horizon Blue Cross and Blue Shield of New Jersey

The Horizon Blue Cross and Blue Shield of New Jersey Patient Centered Medical Home reports higher rates of diabetes control, cholesterol management, and breast and colorectal cancer screenings, along with an overall 4 percent lower total cost of care.

## 2. Work with Doctors and Hospitals by Providing them with the Tools and Data they Need

The Blues are partnering with doctors in communities across the country to give them the tools they need to be successful in transforming their practices to become more patient-oriented and to help them deliver evidence-based care. This includes providing clinicians with real-time information on their own practices, their peers and patients, as well as hands-on technical assistance in redesigning workflows and adopting best practices. BCBS companies are also working with pharmacists and physicians to create tailored interventions to drive better outcomes.

### Blue Cross and Blue Shield of Massachusetts

Blue Cross and Blue Shield of Massachusetts partners with physicians on ways to improve their standard of care for their nearly 700,000 members; a New England Journal of Medicine article in 2014 reported that the quality of care is 12 percentage points higher than national averages, while costs have been reduced. Health improvements include preventive care for healthy children and adults as well as improvements in the management of serious chronic illnesses.

#### Recommendations for our Government Partners:

- **Empower healthcare practitioners with actionable data.** Physicians should be given timely access to the data, tools, funding and analytical expertise they need to effectively and efficiently manage their patients' health and deliver the most appropriate care in the most appropriate setting. Based on the Blue System's experience, it is recommended that government follow the private sector's best practices in giving healthcare professionals data that allows them to identify those most at risk and to address gaps in care. Clinicians, patients and payers all can benefit.
- **Assist with practice transformation.** The government should partner in ensuring that medical practices have access to consultative and on-site services to assist in this transformation. The recently announced Health Care Payment Learning and Action Network will assist with this transformation, but it is important that the efforts are driven through strong partnerships that develop at the local level (and not a top-down approach from the national level). Government can also expand the mission of—and provide funding for—Regional Extension Centers to educate and train practitioners, as well as offer support and funding under the Medicare program for case managers.



- **Develop a comprehensive technology roadmap and timelines for sharing information in ways that enhance care.** Work with all parties in the healthcare system to lay out clear milestones for implementing new technical standards (e.g., ICD-10, “Meaningful Use”). Healthcare professionals vary significantly in their readiness to adopt new technologies. As a result, technical assistance to support shared information systems and care processes will be necessary to achieve interoperability and meaningful use of healthcare data.
- **Obtain healthcare data from multiple payers via distributed data collection rather than costly and inefficient centralized data collection.** Collecting, storing and handling claims data is very expensive. States that have tried to do it on a centralized basis typically spend years cleaning and preparing the data before any meaningful results are available. States often do not have a clear vision of how the data will be used before embarking on a multi-year, cost-intensive process. In contrast, payers already have systems and knowledgeable experts in place and can quickly aggregate and analyze data to specification.
- **Accelerate quality improvement efforts.** Government should continue working with a wide range of payers, practitioners and other stakeholders to develop a core set of measures for alignment across public and private sectors, with an emphasis on promoting research into patient-oriented outcomes measures. Based on the Blues’ experiences, it is recommended that the government partners in developing learning collaboratives with doctors, hospitals and insurers to support medical professionals’ ability to interpret quality data. Additionally, government should foster voluntary efforts by payers to share aggregate results for practitioner measures.

### 3. Help People be Active Partners in Their Own Healthcare

BCBS companies are engaging individuals in their own healthcare by providing wellness incentives and easy-to-use tools that make healthcare quality and cost information more transparent. BCBS companies are using enhanced network and benefit designs, including wellness incentives, to customize care and encourage patients to make more informed decisions. To facilitate this, the Blues are providing patients with more information regarding higher quality doctors and hospitals, allowing them to make more educated decisions, become active partners in their health and adopt cost-conscious behaviors.

BCBS companies are also creating user-friendly platforms for patients to give them greater insight into the comparative quality and cost of healthcare practitioners. Patients can read and write reviews of medical professionals based on a standard methodology, and these reviews, as well as other data, are then integrated into doctor and hospital finders on a local level. Moreover, an expanding database of tools has been developed to help individuals estimate the range of costs for specific services and procedures across practitioners in their communities. Providing members with access to information about physician price and quality helps them to choose a high-quality physician best suited to meet their needs.

In addition, BCBS companies are continually measuring and assessing the impact of their delivery and payment models and can change product offerings, networks and benefit designs as needed to best serve their customers. Consumer segmentation approaches have also been developed to more effectively target and engage people in ways that meet their health needs.

## Health Care Service Corporation

Health Care Service Corporation (Blue Cross and Blue Shield of IL, TX, OK, NM, and MT) offers customers a transparency tool that provides cost information by physician for a wide range of procedures, such as knee replacement and heart surgery. Customers also are able to compare physicians on quality metrics, patient reviews, professional profiles and location.

### Recommendations for our Government Partners:

- **Provide individuals in traditional Medicare with meaningful transparency tools so they can make informed choices and develop cost-conscious behaviors.** Transparency is an imperative first step to addressing rising healthcare costs, especially at a time when individuals are taking on greater financial responsibility for their care. Clear, meaningful information about local price variation, cost-sharing, quality metrics and

The Blues' cutting-edge programs are **achieving clear results** and building the pathway to a system that helps patients get healthy faster—and stay healthy longer.

other factors can allow patients to choose physicians or facilities that will deliver the best care at the best price for them. Government should collaborate with health plans to identify meaningful data elements and reporting methods to accomplish the goal of greater transparency.

- **Establish rewards and incentives for patients.** Well-tailored benefit designs work to increase patient adherence, improve disease management and give individuals incentives to seek high-quality, affordable services and make cost-effective choices about their practitioners (e.g., Centers of Excellence, reference-based pricing).
- **Enable new innovative benefit designs in Medicare Advantage.** Government must allow Medicare Advantage (MA) plans the flexibility to employ evidence-based benefit designs, just as they do for private sector patients, to improve patient health and contain costs. Currently, MA plans are statutorily prohibited from providing extra benefits to certain subgroups or charging different amounts to different populations based on various factors. This restriction prevents MA plans from using innovative benefit design strategies for actions such as offering tailored cost-sharing arrangements to those with chronic conditions. Additional flexibility would allow MA plans to modernize their benefit designs, further enhance the care they are able to provide, and promote cost-conscious behaviors.
- **Promote a broad range of network options in Medicare Advantage.** The availability of tailored and tiered physician networks provides affordable options for patients and helps contain costs in the healthcare system.

## 4. Promote Savings

The Bureau of Economic Analysis found that healthcare spending during the last three months of 2014 rose nearly four percent due to higher costs and greater use of health services. Increases in the cost of care itself are the largest factor in premium growth, and two areas of significant concern are prescription drug prices and consolidation among physician practices and hospitals. These system-wide, fast-growing cost drivers threaten the ability of payers and practitioners to ensure that patient care is of the highest quality possible: safe, coordinated, and evidence-based, as well as affordable.

Prescription drugs play a critical role in helping prevent, manage and cure disease. Spending on many of the newest high-priced and specialty drug therapies is growing rapidly—driving a 13.1 percent increase in overall drug spending in 2014, according to Express Scripts. Addressing this cost trend is critically important to maintaining a workable healthcare system and safeguarding access and affordability for patients who need life-saving drugs. Aggressive pharmaceutical company campaigns in the states to remove co-pays for brand-name drugs, even when generics are available, along with other proposed restrictions on health plans' abilities to use innovative plan designs will result in unsustainable costs. Substantial reforms are needed to ensure that prescription drug costs over the long run are fair and sustainable.

Coverage should include technologies and services that result in better patient health without increasing costs; full funding for efforts to identify and isolate unwarranted variation; and a halt to waste, fraud and abuse. BCBS companies are doing innovative work in these areas, notably providing services to members via telehealth and implementing thoughtful strategies to identify and eliminate these abuses. In addition, line items that add costs devoid of value (e.g., health insurance and medical device taxes) should be eliminated.

### CareFirst BlueCross BlueShield

CareFirst's Patient Centered Medical Home (PCMH) initiative helps better coordinate patient care by assuring coordination after a hospital discharge, encouraging physician office visits to discuss patients' care plans, and providing regular web-based updates to records available to the entire care team. Over three years, the program has also demonstrated a decrease in readmissions and days in the hospital, while outcomes-based quality scores have risen, along with savings of \$267 million when measured against the projected cost of care.

## Recommendations for our Government Partners:

- **Provide greater transparency into drug valuation.** Various options include the creation of a system to review and evaluate price increases, making drug labels public throughout the FDA approval process, and the requirement that manufacturers submit drug valuation models and initial proposed list prices with their FDA applications.
- **Produce more studies on the clinical effectiveness and safety of drugs.** Greater availability and use of comparative effectiveness data is necessary for developing innovative new payment arrangements and incentive structures for drugs. Work from the National Institutes of Health (NIH) and Patient-Centered Outcomes Research Institute (PCORI) can be leveraged to make more clinical data available to researchers, policy makers and payers.
- **Shorten the exclusivity period for brand-name biological drugs to seven years.** This would promote greater price competition and earlier access to lower-cost options.
- **Ensure flexibility in formulary design.** Payers should be able to develop coverage policies and medical management techniques that ensure safe and effective use of prescriptions (e.g., tiered formularies, prior authorization, limiting at-risk patients to one pharmacy and one prescriber to avoid abuse), as every drug has benefits and risks. Health plans negotiate prices with pharmaceutical manufacturers to bring the most affordable treatment options to patients and use these tools to inform individuals about treatment alternatives that may be more clinically safe and effective, often at lower costs.
- **Repeal the health insurance tax.** The healthcare reform law imposes a new sales tax on health insurance that is larger than the medical device tax and the prescription drug tax combined. The tax increases costs for individuals, families, small businesses and public program beneficiaries with managed care plans.
- **Equalize payment across care settings.** Despite the delivery of identical services in hospital outpatient departments (HOPDs) and physician offices, with no difference in outcomes, care provided in HOPD settings is reimbursed at a higher rate. In fact, a 2013 report from the Medicare Payment Advisory Commission (MedPAC) pointed out that Medicare payments in 2011 were \$1.5 billion higher for physician office visits and echocardiograms when services were billed as hospital outpatient services. Site-neutral payment policies would ensure that healthcare payments are based on the needs of the patient and not the site of service.
- **Ensure government policies do not further anticompetitive arrangements or consolidation among physician practices and hospitals.** Policies that support higher payments to hospital outpatient departments encourage the acquisition of office-based physician practices by hospitals, resulting in increased consolidation. This, in turn, leads to community clinic closures, less competition, more expensive physician networks and increased costs over time.



- **Eliminate barriers to make telehealth part of the continuum of care.** Telehealth includes a broad range of technologies with the potential to enhance patient care by meeting patients where they are and providing necessary and appropriate services outside of costly clinical settings. Federal and state governments should eliminate barriers, such as inflexible Medicare regulations, that restrict the adoption of telehealth technologies and should encourage pilot projects with certain populations and subpopulations.
- **Work to reduce medical errors and unnecessary treatments.** Medical errors, such as misdiagnoses and adverse drug interactions, are dangerous and costly. Similarly, the unnecessary use of technologies, such as over-ordering diagnostic tests, wastes precious healthcare resources and contributes to cost growth without adding value to the patient. Enacting malpractice reforms would help to prevent defensive medicine, which increases utilization of unnecessary and potentially harmful services.
- **Fully fund efforts to combat fraud, waste, and abuse.** Fraud and abuse has an enormous adverse impact on healthcare quality and safety while also imposing higher costs on patients, employers and taxpayers. Efforts to combat fraud before it occurs should be expanded and fully funded to help guarantee that healthcare dollars are spent on patient care rather than diverted to those who commit fraud.

## **Conclusion**

The collective experience of BCBS companies over the past several years tells us the transition to higher quality, more affordable healthcare — while extraordinarily complex — is possible when insurers, doctors, hospitals, patients and the government work together. Close collaboration and cooperation are a prerequisite to success.

BCBSA and the 37 Blue Cross and Blue Shield companies look forward to partnering with government and other private sector payers on this important transition to a more effective, efficient and coordinated healthcare system that helps patients get healthy faster — and stay healthy longer.

# 3

## **APPENDIX:** CASE STUDIES

## Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan's PCMH program involves more than 4,020 primary care physicians in 1,420 Michigan practices, making it the country's largest PCMH effort of its kind. These practices implement key capabilities like developing and using patient registries to identify gaps in care and monitor patients' care over the long-term; providing self-management education and support to patients with chronic conditions; and offering 24-hour patient access to a clinical decision-maker, with a multilingual approach to care. More than 1.2 million BCBSM members are covered by PCMH-designated practices, and close to 2 million total patients are impacted by this initiative.

### Results

The program saved approximately \$155 million over its first three years. In comparing PCMH-designated practices with non-designated Michigan PCP practices' utilization trends, BCBSM has observed that PCMH-designated doctors are succeeding in managing their patients' care to keep them healthy and prevent complications that require treatment with expensive medical services. In 2014, in comparison with non-PCMH practices, the PCMH practices had:

- 9.9 percent lower rate of adult ER visits
- 27.5 percent lower rate of adult ambulatory care sensitive inpatient stays
- 11.8 percent lower rate of adult primary care sensitive ER visits
- 8.7 percent lower rate of adult high-tech radiology usage

- 14.9 percent lower rate of pediatric ER visits
- 21.3 percent lower rate of pediatric primary-care sensitive ER visits

In addition, a study published February 2015 in JAMA Internal Medicine showed Blue Cross Blue Shield of Michigan's PCMH model improved overall cancer screening rates for colon, breast and cervical cancer.<sup>1</sup>

## Horizon Blue Cross and Blue Shield of New Jersey

Horizon BCBSNJ has a number of patient-centered programs, including Accountable Care Organizations, Patient-Centered Medical Homes, and Episodes of Care programs (i.e., joint replacement, oncology, pregnancy). More than 6,000 network doctors are participating in Horizon BCBSNJ's patient-centered programs and more than 750,000 Horizon BCBSNJ commercial and Medicare Advantage members are now benefiting from Horizon BCBSNJ's patient-centered programs that are working to improve patient care while controlling costs.

### Results

Horizon BCBSNJ's PCMH program is now helping deliver better quality outcomes at lower costs. Through strong collaboration with participating practices, Horizon BCBSNJ is making great strides in keeping patients healthy and reducing complications that can drive unnecessary healthcare costs. A review of 2013 claims data demonstrate that patient-centered care works to improve the

quality of care while lowering total healthcare costs. Claims data compared outcomes for more than 200,000 Horizon BCBSNJ members using patient-centered practices with outcomes for members using traditional primary care practices and found a:

- 14 percent higher rate of improved diabetes control
- 12 percent higher rate of cholesterol management
- 8 percent higher rate of breast cancer screenings
- 6 percent higher rate of colorectal cancer screenings

Results also showed that more active care is being provided at a lower cost, as Horizon BCBSNJ members in patient-centered practices had a:

- 4 percent lower rate of emergency room visits
- 2 percent lower rate of hospital admissions
- 4 percent lower cost of care for diabetic patients
- 4 percent lower total cost of care

## Blue Cross and Blue Shield of Massachusetts

Blue Cross and Blue Shield of Massachusetts' 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, BCBSMA 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. Currently, more than 85 percent of primary care physicians and nearly 90 percent of specialists in BCBSMA's HMO network participate in the AQC. Collectively, they care for nearly 700,000 members.<sup>2</sup>

### Results

An independent evaluation of the AQC by Harvard Researchers, published in the *New England Journal of Medicine* (2014), showed that the AQC has improved the quality of patient care and lowered costs in the four years since it was first implemented. The study found the savings achieved by the AQC groups accelerated year by year.

In the initial year, savings were approximately two percent compared to the control group, while by year four, the AQC groups saved 10 percent compared to the control group. Savings were concentrated in the outpatient setting and explained by providers increasingly using lower cost settings and by reduced utilization, including discretionary procedures, imaging and testing.

The study also demonstrates significant quality improvements achieved under the AQC. While quality scores for BCBSMA members were on par with local and national averages prior to the AQC contract, the dramatic improvements in quality over the course of the contract show that members now receive quality of care that is significantly higher (12 points) than national averages. These improvements

include preventive care for healthy children and adults as well as improvements in the management of serious chronic illnesses.<sup>3</sup>

## Health Care Service Corporation

Health Care Service Corporation (Blue Cross and Blue Shield of IL, TX, OK, NM, and MT) offers customers a transparency tool that provides cost information by physician for a wide range of procedures, such as knee replacement and heart surgery. Consumers are given the information they need to make decisions before they select and schedule an appointment with a healthcare professional. The out-of-pocket cost information allows for real-time comparisons and is tailored to each customer given his or her plan benefit and cost sharing design. Customers also are able to compare physicians on quality metrics, patient reviews, professional profiles and location.

## CareFirst BlueCross BlueShield

CareFirst BlueCross BlueShield's PCMH initiative includes more than more than 4,000 primary care providers (PCPs) and nurse practitioners—more than 80 percent of all PCPs in the CareFirst service area, which includes parts of Northern Virginia, the District of Columbia and Maryland. These participating providers are coordinating care for approximately 1.1 million CareFirst members. 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 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.

### Results

CareFirst has seen the overall rate of increase in medical care spending for its members slow from an average of 7.5 percent per year, in the five years preceding the program's launch, to 3.5 percent in 2013. Beyond the encouraging overall medical care spending trends, CareFirst continues to see strong performance by its PCMH program when measured against the expected cost of care for CareFirst members covered by the program. Healthcare costs for the 1.1 million CareFirst members covered by its PCMH were \$130 million less than projected in 2013, and 3.2 percent less than the expected cost of care for this population of patients. The savings has risen from 1.5 percent in 2011 and 2.7 percent in 2012. In all, the PCMH program has accounted for \$267 million in avoided costs when measured against the projected cost of care from 2011 to 2013.

Key quality indicators suggest positive impacts on CareFirst members who

are under the care of PCMH primary care providers. The company tracks key quality indicators for those members who see participating PCMH physicians and members who see physicians who are not in the PCMH program. When compared to members under the care of non-PCMH physicians, CareFirst

members seeing PCMH providers had:

- 6.4 percent fewer hospital admissions\*
- 11.1 percent fewer days in the hospital\*
- 8.1 percent fewer hospital readmissions for all causes\*
- 1.3 percent fewer outpatient health facility visits\*

\* Per 1,000 CareFirst Members

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#### SOURCES

<sup>1</sup> <http://archinte.jamanetwork.com/article.aspx?articleid=2110999>

<sup>2</sup> <http://www.bluecrossma.com/visitor/pdf/avalere-lessons-from-aqc.pdf>

<sup>3</sup> <http://www.bluecrossma.com/visitor/newsroom/press-releases/2014/2014-10-30.html>



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