



# Engineering a rapid shift to value in North Carolina

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# Agenda

1. What makes North Carolina so special?
2. Evidence from early ACO initiatives
3. Blue Premier Overview
4. COVID-19 Impacts + Response
5. Future Challenges

# What makes North Carolina so special?

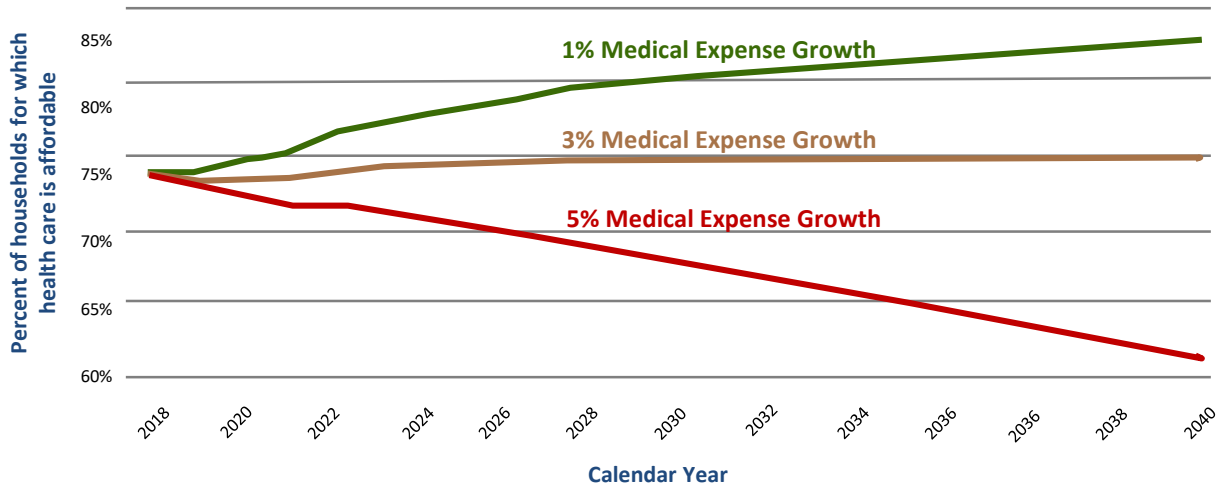
*Lessons learned from the front lines*

## **Three primary factors**

1. Aggressive goal setting and clear theory of change
2. Organizational will to push network providers
3. Application of best available science

# Our ultimate goal is to make health care affordable

Impact of medical expense growth on how many households can afford health care, assuming 3% average wage growth



# Evidence from early ACO initiatives



## Overview

1. Financial risk is necessary, but not sufficient
2. “Prospectivity” is essential, but may break in abnormal times
3. Flexibility to re-engineer care in the right place at right time
4. Need a valid clinical theory of action
5. Model overlaps are complex
6. ACO composition is important – not all ACOs types are the same

# 1. Financial risk is necessary, but not sufficient



Market-level CMS Office of the Actuary analysis found ~2% slower growth in denser Pioneer ACO markets, compared to non-ACO markets. Presence of financial risk plausible accelerant.

Inclusion of 2-sided risk not just about making program balance. Must transfer risk responsibly, at appropriate speed for given provider.

Summary of Combined HRR Market Trend Analysis

Criteria for Grouping HRRs→	HRRs with ACO Activity				Non-ACO HRRs	
	>10% MSSP 2012	>10% MSSP 2013	>10% Pioneer 2012	>10% Pioneer 2014	<10% Comb'd 2013	<10% Comb'd 2014
<b>Baseline Characteristics</b>						
Number of HRRs	48	113	26	21	171	111
HRR Percent of Total FFS Population	18%	43%	12%	7%	49%	27%
Medicare Advantage Penetration (2013)	29%	31%	42%	37%	29%	29%
Percent FFS Assigned to MSSP	17%	18%	4%	14%	3%	3%
Percent FFS Assigned to Pioneer	1%	2%	18%	22%	0%	0%
A&B FFS Per Capita Cost (Nominal 2011)	\$10,012	\$10,054	\$10,507	\$9,972	\$9,094	\$8,739
Risk Adjusted and Price Standardized	\$9,340	\$9,283	\$8,947	\$8,971	\$9,189	\$9,064
2007-2011 Avg Cost Trend (Adj & Std)	3.1%	3.0%	3.0%	3.0%	2.7%	2.6%
<b>Comparison from Final Base Year Prior to Pioneer and MSSP (2011)</b>						
Combined Adj Trend '11→'12	2.0%	2.2%	2.1%	1.9%	2.5%	2.6%
Combined Adj Trend '12→'13	-0.5%	-0.5%	-0.8%	-0.8%	-0.5%	-0.4%
Combined Raw Trend '13→'14	0.5%	0.3%	-0.3%	0.0%	0.7%	0.9%
Total Change 2011→2014	1.9%	2.0%	1.0%	1.2%	2.7%	3.1%
<i>Difference from "&lt;10% 2014" HRRs</i>	-1.2%	-1.1%	-2.1%	-1.9%	-0.3%	—

## 2. “Prospectivity” is essential, but may break in abnormal times



If you cannot know for whom you are accountable, or against what benchmark you will be measured, it will be difficult to succeed

- + PGP Demo, MSSP, and Pioneer all relied on benchmarking methods that privileged accuracy over timeliness or actionable information
  - Retrospective attribution raises uncertainty about defined population for whom the ACO is accountable
  - Retrospective trend method raises uncertainty about current performance relative to what trend will be applied at settlement
  
- + NGACO introduced novel prospective methodology
  
- + However, COVID-19 has challenged the validity of a prospective benchmark
  - Likely invalid trend projection between base/performance year
  - COVID-influenced baselines + risk adjustment

# 3. Flexibility to re-engineer care in the right place at right time



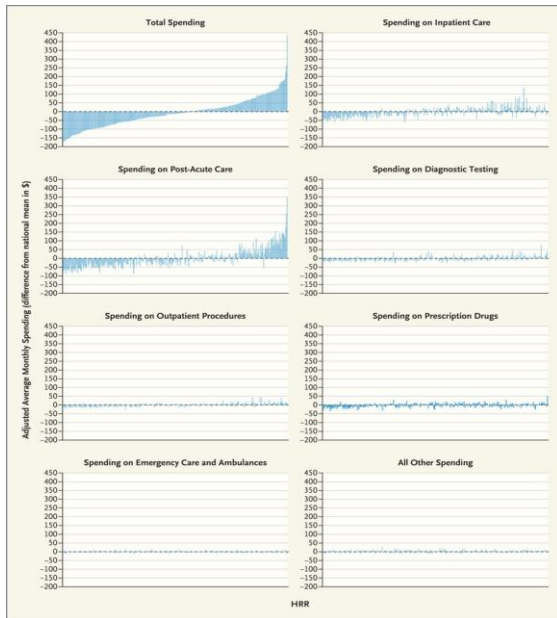
Fee-for-service guardrails designed to fight inappropriate utilization are less necessary with a global budget framework in place

Payer ought to be agnostic about where care is delivered if cost/quality are maintained or improved

- + NGACO developed payment waivers to remove the 3-day hospital stay required for discharge to a skilled nursing facility, how/where telehealth is delivered, and post-discharge home care
- + In conjunction with payment mechanisms, ACOs have developed high value referral networks and re-designed care transitions to be safer and more efficient

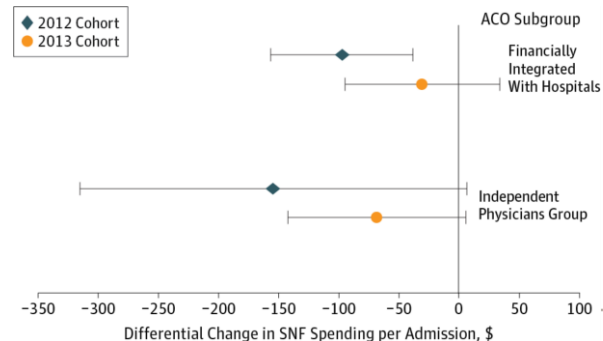
# 4. Need a valid clinical theory of action

- Medicare ACOs: opportunity around rationalizing post-acute/acute care
- Commercial ACOs: opportunity around site-of-service to lower cost settings, more efficient use of specialty care and pharmacy services



- IOM: 73% of variation in total Medicare spending concentrated in post-acute
- ACOs logically targeting this area as source of potential savings

- McWilliams, et. al show significant reductions in PAC use and spending in MSSP

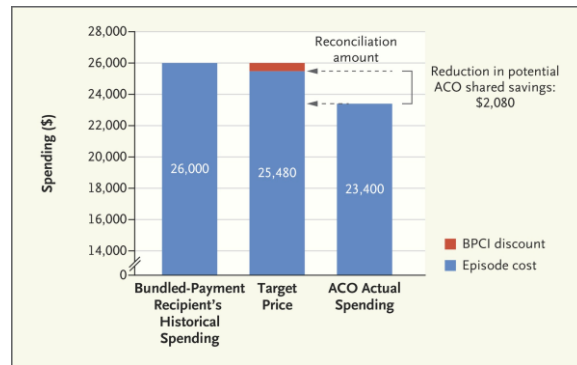


# 5. Model overlaps are complex

When payment reforms such as bundles and ACOs overlap in a market, some patients are likely to participate in both

Which entity holds the risk in such overlap is all-important – privileging episode-based models with first cut of savings reduces opportunity for ACOs in the area they are likely to focus: post-acute variation

- + Need a principled approach to avoid overlaps in first place
  - Solution: assign “risk/reward” to highest risk-bearing provider, which forces collaboration between the overlapping entities





# Blue Premier Overview: Value-Based Reimbursement

## *Foundational Elements of Payment Transformation*

### **Five Principles We Used to Develop the Model**

1. Fee schedules are flat unless providers are accountable for cost + quality
2. Health care providers must have some skin in the game.
3. Over time, we can stand down operational barriers to care that we have in place.
4. Must make the path viable for rural and independent providers.
5. Measure and reward quality as clearly and simply as possible.

# Value-Based Contracts

*There are three layers to the Blue Premier provider network*



Major  
Health  
Systems

60%  
of membership



Independent  
and Rural  
Providers

40%  
of membership



Advanced  
Primary  
Care

<1% of  
membership - growing

By 2023, **100%** of our members will have an accountable provider.

# Blue Premier: Value-Based Reimbursement

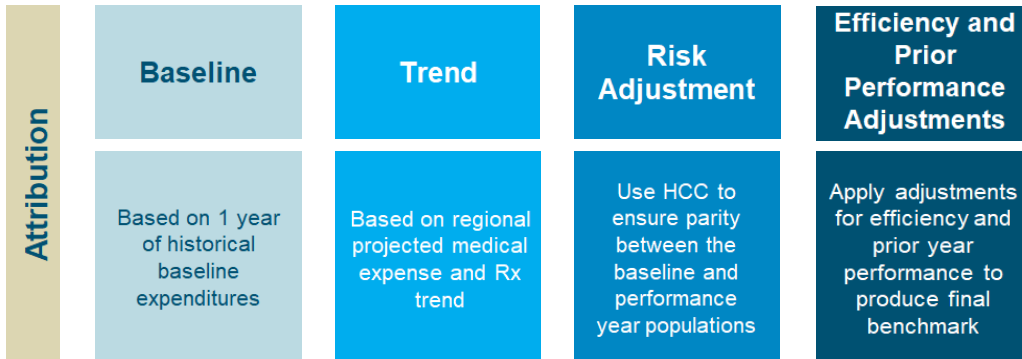
*Illustrative Terms based on CMS, AQC and other National Models*

	Year 1	Year 2	Year 3	Year 4	Year 5
<b>Risk structure</b>	Upside Only		Two-sided Symmetrical Risk Options		
<b>Gain Share Rates</b>	Up to 50% (based on quality performance)		Symmetrical sharing: 50%, 75% or 100% (based on quality performance)		
<b>Provider Risk Exposure</b>	N/A		Symmetric risk options: 50%, 75% or 100% (based on quality performance)		
<b>Benchmark Terms</b>	Savings will not be paid unless they exceed 1% of benchmark			N/A	
<b>Gross Savings/Losses</b>	Capped at 10% of gross savings		+/-5-20% of gross savings		
<b>High Cost Claimants</b>	Capped at \$250K		Capped at \$250K		
<b>Commercial Benchmark</b>	Historical performance (i.e. prior year's savings added to subsequent year's benchmarks), annually re-based up to +/- 1% adjustment based on regional efficiency				

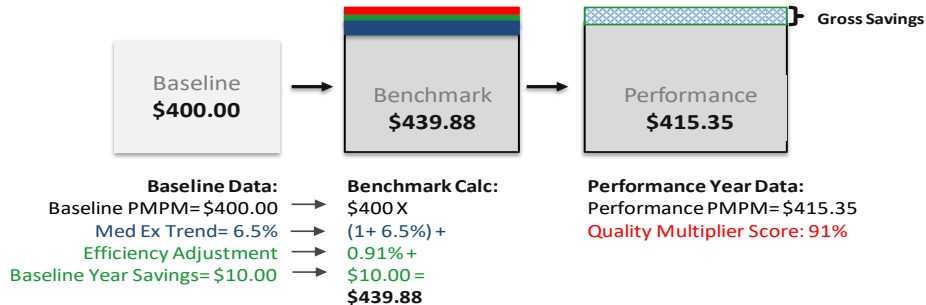


# Blue Premier Mechanics

## Benchmark and Payout



### Sample Benchmark Development & Payout Calculation



**Cost of Care Savings:** \$440 - \$415 = \$25



NC

# Blue Premier is a value-based program that includes 8 systems, of which 7 are the 10 largest health systems in North Carolina.

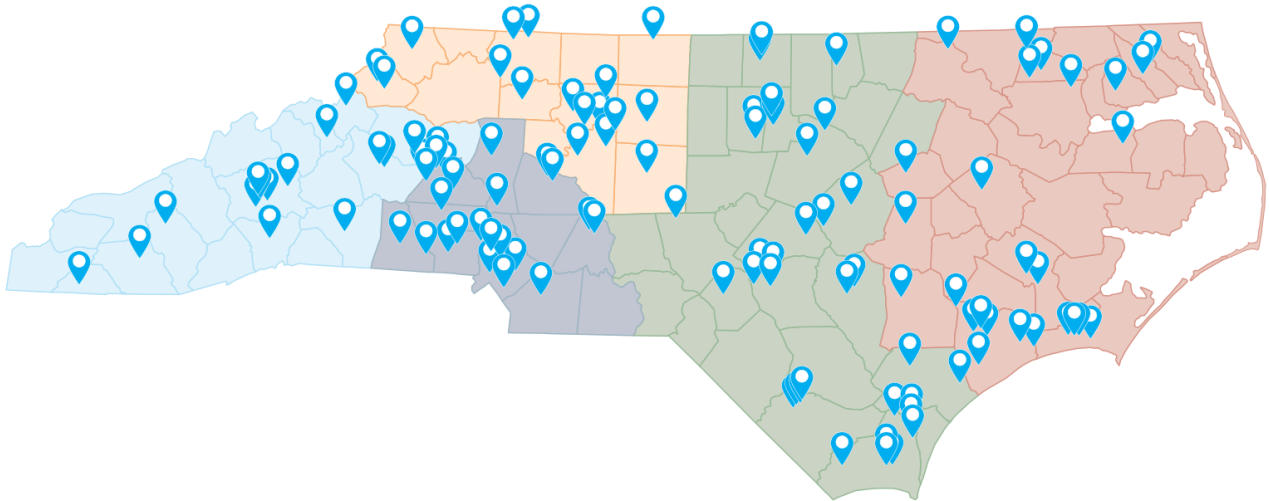
Top 10 Health Systems by \$ Allowed	Allowed Amount (\$ Millions)
Atrium Health	\$2,111
Novant Health	\$1,634
Duke Health	\$1,520
UNC Health Alliance (UNC Only)	\$1,474
Wake Forest Baptist Health	\$750
Vidant Health	\$570
WakeMed WKCC	\$553
Triad Health Care Network (Cone)	\$531
Mission Health	\$474
New Hanover Regional Medical Center	\$278



Blue Premier systems in boxes. FirstHealth is the 8<sup>th</sup> Blue Premier system. FirstHealth is the 13<sup>th</sup> largest health system by allowed amount.

# Blue Premier

*Independent Primary Care Practices through Aledade*



**2019/2020 ACO Totals:**  
**177** primary care practices  
**146,295** commercial members  
**7,562** MA members

**2021 ACO Totals:**  
**27** primary care practices  
**26,010** commercial members  
**710** MA members

SOURCE: Internal BCBSNC data, August 2020

# Blue Premier 2019 Performance Update



	2019 Performance Year	
Gross Savings from Blue Premier ACOs	\$	62.8m
Shared Savings Payments to ACOs	\$	44.3m
Quality Payments to ACOs	\$	30.9m
Payments from ACOs to BCBSNC <sup>1</sup>	\$	-
Discount Value <sup>2</sup>	\$	-
Fee-For-Service Savings <sup>3</sup>	\$	90.0m
Total Net Impact	\$	77.6m

1. In PY1, there will be no payment inflows to BCBSNC from ACOs as all Blue Premier ACOs are in upside only risk

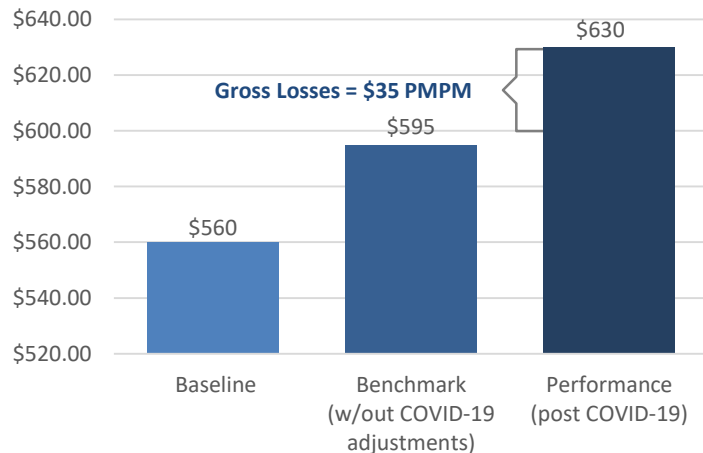
2. In PY1, no discount is applied and so this value remains zero.

3. The fee-for-service savings are estimated as a function of the average historical FFS increases at the Blue Premier ACO systems and compared to the difference in the observed FFS increases at the Blue Premier ACOs, expressed in dollars

# Blue Premier: Value-Based Reimbursement

*COVID-19 will make transition to downside risk harder*

**Key Challenge:** Uncertainty of COVID-19 impact could result in significantly underestimating ACO benchmarks leaving ACOs accountable for significant losses in 2021



6 – 18%

Estimated PMPM range of gross losses for an ACO as result of COVID-19\*

**Solution:** Introducing COVID Relief Package for Blue Premier Providers. Move out transition to downside risk in exchange for contract extension to stay in Blue Premier.

## Blue Premier COVID-19 Relief Package

1. Provide short-term relief/cash flow to providers through early payment of savings
2. Extended Blue Premier agreements
3. Waive downside risk next year
4. Technical adjustments to account for trend distortions created by COVID-19:
  - Switch to retrospective trend for 2020
  - Adjustments to attribution for 2021
  - Shift to cost trend methodology for ACA
  - Quality performance adjustment

\* Recent Study by NAACOS suggests a 6-18% increase in spend for Medicare beneficiaries. <https://www.naacos.com/potential-impact-of-covid-19-on-medicare-spending--implications-for-acos>

# Primary Care in Crisis

*Accelerate to Value seeks to help bridge post-COVID*

There are four key parts to the program:



**Stabilize practice  
revenue**



**High-quality care +  
care coordination  
during crisis**



**Rapid transition to value-  
based care through Blue  
Premier  
(Required)**



**Pathway to PCP  
capitation  
(Not Required)**



# Future challenges

*Payment reform may only go so far*

- **Specialty care**
  - Mutually exclusive primary care-derived attribution presents a challenge to reforming payments to specialists
  - Model overlap difficult
- **Addressing unit prices in commercial markets**
  - RAND: Average US private insurance rate 2.5x what Medicare pays
- **Fixing the underlying fee schedules**
  - Changing how we value physician time to rebalance cognitive v. procedural services