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Framework For Specialty Value Transformation: Perspectives From A Commercial Payer

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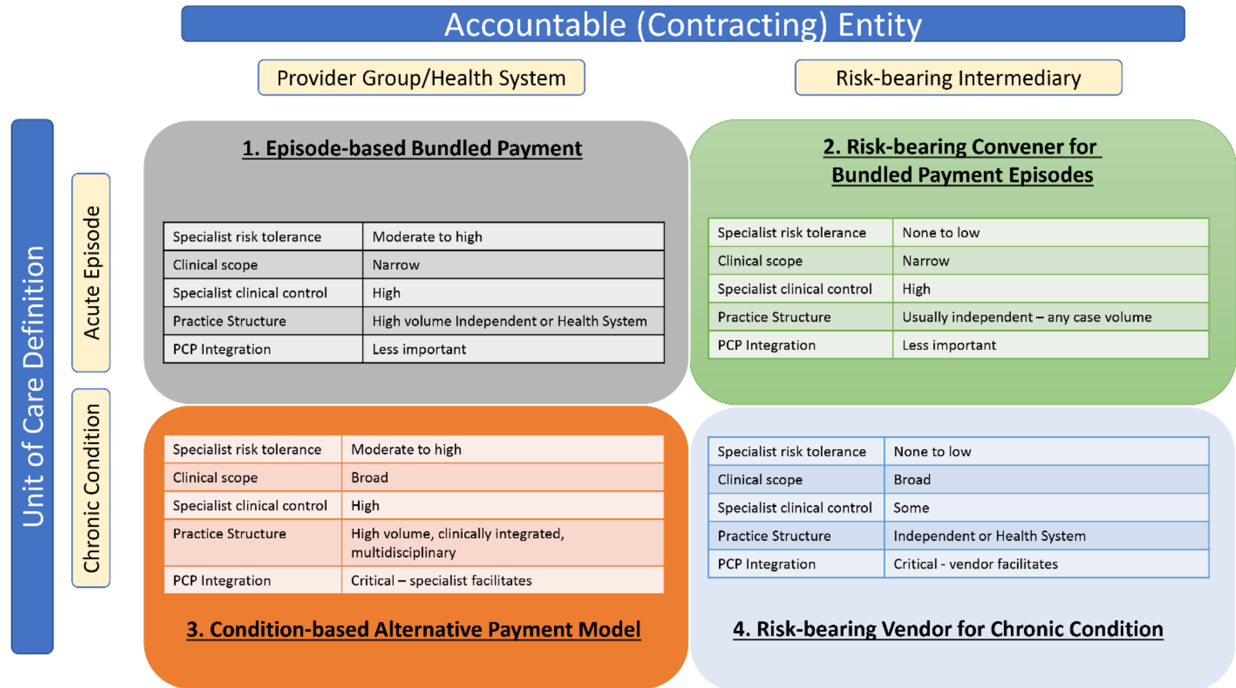
The value movement in health care continues to progress, despite, and perhaps accelerated by, the COVID-19 pandemic. Primary care practices are steadily gaining necessary tools, capabilities, and experience to manage the health of populations and accept broad accountability for cost and quality. However, the roughly 90 percent of commercial health care spending controlled by specialists remains almost entirely entrenched in volume-based, fee-for-service reimbursement models. While a strong foundation of value-based primary care accountability is essential, we cannot expect sustained success in value transformation without similarly aligning specialists' incentives to reward affordable, high-quality, appropriate, patient-centered care.

Beyond reference pricing, benefit design, and pay-for-performance initiatives, the mechanisms for driving value in specialty care for commercially insured populations are limited. Outside of select surgical bundles, there is a dearth of evidence and experience with specialty-focused, value-based payment models for privately insured patients, particularly models with downside risk. Commercial payers and self-insured groups won't be overly encouraged by the early results of Medicare's Bundled Payment for Care Improvement Advanced program, which demonstrated a net 2.5 percent increase in Medicare expenditures (after accounting for reconciliation payments) for predominantly specialty-focused episodes relative to a comparison group. Whether flawed target-setting or incentive payment methodology or premature evaluation partially explain these disappointing results, it's quite likely that this model fails to adequately incentivize specialists to fundamentally change care delivery to achieve value-based goals.

In this post, we define four viable mechanisms by which commercial payers can move specialty services into value-based arrangements, along with specific examples from a large, statewide commercial payer (exhibit 1). These four mechanisms arise from different combinations of two critical features: the clinical unit of care and the characteristics of the accountable (contracting) entity. We discuss pros and cons of each mechanism in the context of provider and market factors that determine the most appropriate avenue to pursue. These factors include specialty

providers' appetite and capability to assume accountability and financial risk, specialty practices' structure, affiliation, and relationships with accountable primary care entities, and the market availability of non-provider, risk-bearing entities.

Exhibit 1: Value-based mechanisms for specialty care



Source: Authors' analysis.

Episode-Based Bundled Payments

Episode-based bundled payments are a viable value mechanism for providers to accept direct accountability for finite, self-limited, and well-defined specialist-driven units of care. Under this model, payment is made as a lump sum at episode initiation (prospectively) or throughout the episode with a reconciliation process at the end of the performance or contract period (retrospectively). Prospective bundles incentivize providers to deliver efficient, high-quality care, as no additional payments are made for additional services rendered, and hold them accountable for complications and undesirable outcomes. Retrospective bundled payments similarly create direct financial incentives for the practice or provider to reduce costs and improve quality through shared savings (upside opportunity) with or without shared losses (downside risk).

Some providers already participate in episode-based payment models under Medicare, which may lower the threshold to accept analogous commercial models. Value-based contract terms can easily modulate the degree of financial downside to accommodate a range of provider appetites and preparedness to assume financial risk.

While episodic bundles are an important value mechanism for specialists, their limited scope also limits their potential impact. For example, an episode initiated at the time of joint replacement surgery misses the opportunity to incentive the appropriate use of conservative therapy to avoid the surgery altogether. In addition, despite the limited scope, providers still often lack necessary analytical, administrative, and care delivery redesign capabilities to successfully participate and sustain performance in a bundled payment—particularly in prospective models and retrospective arrangements with downside risk.

At Blue Cross of North Carolina (Blue Cross NC), savings from our prospective joint replacement bundle increased from roughly 20–27 percent in 2016, to 35–40 percent in 2020. Uptake is increasing yet remains limited (5.0 percent in 2016, and 7.5 percent in 2020, of all joint replacements) by restrictive inclusion criteria, low contract penetration, and patient enrollment challenges (unpublished data). While addressing these limitations to increase uptake, we are rolling out retrospective bundled payments for maternity and radiation oncology episodes.

Overall, episodic bundled payments are an essential, yet incomplete mechanism for specialty value transformation. Despite being the most operationally simplistic opportunity, the limited scope of services and restrictive clinical inclusion criteria required to gain acceptance from specialists proportionally limit their impact.

Risk-Based Convener For Episode-Based Bundled Payment

Most specialty practices remain reticent to adopt even the most narrow, episodic, value-based payment models. Insufficient episode volume may preclude an actuarially viable financial risk model. Practices may lack the administrative or clinical capability to evaluate the financial opportunity, drive high-value care redesign, and operationalize the alternative payment mechanism. Intermediary entities have thus emerged to assume financial accountability on behalf of provider groups and health systems, while supplying the necessary capabilities (technological, analytical, administrative, care management/coordination, network services) to succeed in bundled payment arrangements. These "conveners" are typically reimbursed purely as a portion of the shared savings they generate with provider partners. In Medicare's Bundled Payment for Care Improvement Advanced Model, most episodes were initiated under a convener, despite such conveners accounting for only 13.3 percent of participating entities. This concept is being successfully scaled in the commercial market for primary care arena by entities such as Aledade and Caravan Health, among others, that aggregate provider organizations to facilitate participation in population-based value arrangements across multiple payers. Despite being conceptually viable for specialty episodic bundles, this approach has yet to scale in commercial markets.

This mechanism facilitates engagement in value by providers with less (or no) downside risk tolerance. However, as specialists gain more familiarity with value-based risk arrangements and develop more sophisticated analytics and innovative care delivery models, this incremental step may ultimately accelerate direct participation in risk-based arrangements.

Introducing an additional entity into the patient-provider dyad has potential downsides. As this entity extracts revenue from value creation, it dampens the impact of value-based incentives for

the entity trusted most by patients and most in control of clinical care decisions—the provider. Furthermore, successful integration of the aggregator may place additional time and administrative burden on providers. While the accountable entity may subsequently create a value-based subcontract with its participating providers to facilitate buy-in, this is not a requirement.

In parallel with our direct-to-provider bundled payment efforts, Blue Cross NC is exploring a maternity aggregator model with an innovative, technology-based care coordination organization and a medical oncology episode aggregator model for episodes of systemic cancer therapy. Significant work remains to design a sustainable financial and operating model to support this type of arrangement.

When providers are unwilling or unable to adopt bundled payment contracts, engaging a risk-bearing convener or aggregator entity is a viable alternative mechanism. However, there is a clear tradeoff between the scalability of this approach, the complexity to design, and the potential lost opportunity to directly incentivize providers.

Condition-Based Alternative Payment Model

Expanding the scope of accountable services from a limited care episode to a longitudinal, chronic condition model shifts the focus on value generation further "upstream" in the care continuum. Rather than holding a provider entity accountable for selected services within a defined time frame, a condition-based payment model holds the provider entity accountable for all condition-related services. Continuing the joint replacement example, a condition-based alternative payment model for chronic osteoarthritis creates incentives for specialists (orthopedic surgeons) to avoid unnecessary or low-value surgeries by deploying higher-value, guideline-based, conservative therapies.

This broader scope drastically increases the incentive to fundamentally redesign clinical care pathways to support value-based care goals. Not only does this definition increase the sheer magnitude of services provided under value-based models, it also expands the range of opportunities for clinicians to deliver higher-value services that may not be adequately reimbursed in fee-for-service. As the scope of services expands even more broadly to encompass an entire clinical service line, such as all musculoskeletal care (that is, inclusive of, but not limited to osteoarthritis), global capitation reimbursement models become a possibility.

While this is a promising mechanism to align specialists with primary care population-based accountable care models, they require advanced value-based capabilities that few specialty providers currently possess—outside the context of fully integrated delivery systems. First, the contracting provider must have substantial control over the entire scope of services to effectively deliver optimal care along the entire continuum, which likely requires multiple provider types and capabilities. Second, the specialty provider entity must effectively engage primary care physicians to help manage referrals, prevent leakage, and ensure care is escalated at the appropriate time. Third, specialists must develop the capability to effectively monitor and maintain the health of a population, rather than focusing on their traditional role of addressing acute or complex downstream ailments.

At Blue Cross NC, we are designing a condition-based alternative payment approach for musculoskeletal disorders—including degeneration, deformity, and minor inflammation and injuries. The model will hold providers accountable for the longitudinal care journey, including pain, acute and chronic disease, and covering appropriate surgeries and procedures. Chronic cardiology conditions are on deck.

This avenue has enormous potential to redefine specialty care and provider incentives around managing chronic conditions yet requires significant resources and deep payer-provider collaboration to enable a sustainable, effective alternative to the status quo.

Risk-Bearing Vendor Arrangement For Chronic Conditions

An entire industry of risk-bearing entities has emerged to fill the wide chasm between payers' desire to accelerate specialty value transformation and specialty providers' limited appetite, capacity, and readiness to assume financial risk. These entities (often materializing as venture-backed startups) are built for purpose to wrap around existing provider networks and help achieve high-value outcomes for patients with specific conditions. Rather than delivering traditional reimbursable health care services, they generate revenue through value-based arrangements by keeping a portion of savings they help their provider partners achieve. By aggregating lives across multiple providers, these entities can take accountability, including downside risk, for high-cost, high-variability conditions with relatively low prevalence. Specialty provider groups, even the very largest and most progressive, are unlikely to accept substantial risk on these patients. Furthermore, this approach allows payers to create an expansive accountability model for high-impact clinical conditions without requiring execution of multiple value-based provider contracts.

Here again, providers themselves are not directly incentivized by this value-based payment arrangement. Therefore, success hinges on the risk-bearing vendor's ability to successfully engage the existing provider network and patients, identify specific value-based care opportunities, and deploy interventions to effectively drive behavior change and value improvements.

In January 2021, Blue Cross NC launched the Advanced Kidney Care program with two risk-bearing entities. These value partners assumed accountability for total cost of care and kidney disease-related quality for the majority of our commercial and Medicare Advantage members with late-stage kidney disease and end-stage renal disease.

Overall, this mechanism is the broadest and most efficient approach to moving high-cost, highly variable specialty spend into value-based arrangements. However, since the risk-bearing entity dampens value-based incentives to providers, by design, it must rely on other mechanisms to improve value. These entities are playing an increasingly important role in specialty value transformation in the immediate term, but their longer-term impact on the practice of medicine remains unclear.

Conclusion

This framework provides several archetypes for thinking about value-based payment reform for specialty care. The appropriate timing, prioritization, and mixture of approaches depends heavily on the local provider landscape, the degree of primary care accountability, and the readiness and resource availability for commercial payers to engage in specialty value transformation. Finally, payers must additionally consider the required capabilities to fund these arrangements, whether through claims configuration or value-based payment mechanisms outside of the claims system. These operational approaches to funding ultimately have implications for self-funded employer groups, medical and administrative expense accounting, and product pricing.

Authors' Note

This work was done when all authors were employed by Blue Cross Blue Shield of North Carolina.