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BCBSA Recommendations for Delivery System Reform

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Overview: Recommendations to move Medicare away from a system based on fee-for-service design to one that pays based on quality, coordinated and outcome-driven care.

We recommend Congress enact a three-tiered strategy that phases in a range of recommendations that would move the system away from paying for volume and, instead, pay for high-quality, coordinated care as follows:

- **Tier I** – Reforms that could be started immediately and would lay the groundwork for major changes in the structure of the healthcare delivery system by moving away from fee-for-service care to reward quality and outcomes. This includes expanding successful pay-for-performance programs based on Plan experience to all of Medicare.
- **Tier II** – Reforms that could be planned now and implemented within the next two years to build on Tier I reforms and further advance quality and outcomes. This includes promoting wellness through benefit design changes, and creating an environment of professional accountability for providers.
- **Tier III** – Major reforms in the structure of the healthcare delivery system that could be planned now, tested through public-private demonstrations over the next couple years, and implemented thereafter. This includes piloting approaches that move the entire system away from fee-for-service and into new payment models that will more closely align outcomes with reimbursement.

Tier I Reforms: We recommend that Medicare start these reforms now, but phase them into completion at different rates.

1. **Expand pay-for-quality incentive programs and require participation by all Medicare providers.**
   - Start with primary care physicians and hospitals in 2010 because extensive performance measures are available.
   - Accelerate efforts to develop performance measures for specialists.
   - Expand to specialists in 2011.
   - Incorporate lessons learned from successful Blue program (for example, incentives must be in the range of 10 percent to 15 percent to motivate practice changes).
   - Explore potential for incorporating med-mal insurance discounts into incentive programs.
   - Streamline quality reporting requirements to reduce providers' administrative burden.
2. **Increase reporting and transparency.**
   - CMS should continue to partner with the private sector to provide quality information on individual physicians and hospitals.
3. **Increase Medicare fee schedules for primary care relative to those for other services.**
   - Adjust payments through the Resource Based Relative Value Scale (RBRVS) to give primary care providers a 5 percent relative increase in 2010; 10 percent in 2011; and 15 percent thereafter.
   - Pay for this primarily by reducing payments for imaging services to providers who rely heavily on costly imaging machines.
   - Change the membership of the RVS Update Committee — which is sponsored by the AMA and makes recommendations that CMS uses to set payment rates — so that primary care physicians make up at least 35 percent of the medical professionals, and add private payers as non-voting members of the Committee.

Tier I Reforms (cont.)

4. **Create clinical pathways to help physicians provide compassionate and cost-effective end-of-life care.**
   - Fund a pilot starting in 2009 to identify extent of overuse errors in treatment of cancer patients, for example by measuring non-palliative chemotherapy use in the last two weeks of life, and to establish best use of palliative care.
   - Develop pathways based on the pilot and incorporate into future pay-for-quality program for specialists treating cancer patients.

5. **Increase educational subsidies for primary care providers (physicians, physician assistants, nurse practitioners).**
   - Modify current Graduate Medical Education (GME) payments to provide greater subsidies for primary care training.
   - Augment current loan forgiveness programs by forgiving loans for primary care providers who work in medically underserved areas and who are not part of the National Health Service Corps.
   - For primary care positions only, Congress should lift the cap introduced under the Balanced Budget Act of 1997 so that additional primary care residency programs could be funded.
   - Remove the Medicare limitation on supporting allied (non-physician) health practitioner clinical training not directly operated by a hospital so that more professionals can receive training.

Tier II Reforms: We recommend that Medicare start planning for these reforms now and implement them within the next two years.

1. **Create an environment of "professional accountability" that empowers provider organizations to drive quality care.**
   - Engage and fund medical specialty boards with determining standards for appropriateness of care that would be used by all practicing providers.
   - Mechanisms to reach out to non board-certified physicians also must be funded and developed so that reforms also can have an impact in rural or underserved communities.
   - Require that such standards used in pay-for-quality programs be vetted and endorsed by the National Quality Forum.

2. **Modernize benefit design to promote prevention, wellness and management of chronic conditions.**
   - Give beneficiaries incentives to participate in wellness activities, such as financial incentives for participating in a personalized online health promotion program and meeting targeted health goals.
   - Identify and test relevant value-based insurance designs — where the more clinically beneficial the service is to a beneficiary, the lower that beneficiary's cost sharing for the service — in 2010 demonstrations, and implement in 2011.

3. **Advance administrative efficiencies that can lower costs and free up provider time for patient care.**
   - Require providers (with rare exceptions) to use the standard HIPAA electronic transactions for submitting claims, getting eligibility and benefits information, etc.

Tier III Reforms: We recommend that Medicare start planning for these fundamental delivery system reforms now, test them in demonstrations in 2010 and implement lessons learned thereafter.

Each of these recommendations would fundamentally change the delivery system to pay for quality, integration, and coordination of care (e.g. among primary care practitioners, specialists, hospitals). Since these would be new approaches, we recommend each be pilot tested to fully understand impact before broader implementation. Medicare could partner with the private sector on these pilots.

Tier III Reforms (cont.)

1. **Expand the scope of care coordination in the medical home model.**
   - Establish public-private pilots with CMS that integrate specialists and hospitals into the medical home model.
   - Create incentives (such as expanded fee schedules or other additional payments) for specialists and hospitals to share information and improve coordination.

2. **Encourage greater integration of providers through "virtual" arrangements.**
   - Establish public-private pilot programs that give providers incentives to participate in what are known as "Accountable Care Organizations" (ACOs), which emulate such fully integrated delivery systems. These models are expected to greatly improve care coordination as well as lower costs by allowing participating providers a share of savings gained through efficiency.
     - Incentivize coordination through group-level quality reporting and payments that tie a provider's performance rating to that of all other providers involved in the patient's care.
     - Set spending targets for care with opportunities for providers to receive a share of any savings, as long as quality benchmarks also are met.
     - Pilots should be structured to determine who best to serve as the primary recipient of shared savings and under what method those savings should be allocated to providers involved in the patient's care.

3. **Encourage greater integration of providers through bundled episodic payments for a targeted patient population.**
   - Establish public-private pilot programs where CMS and private payers use bundled payment arrangements for patients with CHF/coronary disease.
     - Rather than separate payments for the hospital, post-acute providers and physicians involved in treatment of a patient hospitalized for a cardiac procedure, only a single payment will be made by the payer for a defined episode of care.
     - Because the predetermined payment will be split between the hospital, post-acute providers and physicians, it is hoped they will collaborate more closely to avoid complications and unnecessary procedures and re-admissions, thus preserving more of the payment for themselves.
     - Pilots should be structured to determine who best to serve as primary recipient of the payment, and under what method it should be allocated to the rest of the providers involved in the patient's care.
   - Establish reduced hospital readmission rates as one overall performance objective to which payments are tied to encourage better care and follow-up of patients after discharge from acute care.

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