Blue Distinction Total Care Questions & Answers

Paying For Value

Q1: When and where have value-based programs come to market?

Blue Cross Blue Shield plans have been developing value-based programs for many years. Beginning in 2015, Blue Plans began to implement a common infrastructure for these programs to offer a solution for national customers and members. Blue Distinction Total Care (BDTC) is the culmination of these efforts, connecting more than 13 million members to 450 value based programs across the country. Independence piloted BDTC in 2016 with select customers with full rollout effective January 1, 2017.

Q2: How are you partnering with physicians to implement these programs? Do you work with all providers in the same way?

The Blues are partnering with providers to implement these programs by providing consistent communication regarding program requirements and expectations, frequent reporting to track and improve performance, and direct support needed for clinical care transformation. Independence and Blue plans have established key program attributes around patient-focused, value-based care to provide a consistent understanding of program participation requirements to providers. To deliver the best results for our customers, we work with providers to best leverage their capabilities and address the local market dynamics.

Independence and the Blues also recognize that providers are unique and have varying levels of sophistication. Therefore, we work with providers to identify the information that is most useful and actionable and tailor reporting and support accordingly. For example, a provider group with a live EMR (electronic medical record) may not need information pertaining to gaps in care but would find medical claims information useful, as this information may not be in an EMR. A practice without an EMR, on the other hand, may welcome a summary patient gap in care report. Reporting often includes utilization and cost information by provider, service line, line of business, procedure, DRG, and all other claim, member, or provider data dimensions. Predictive analytics, such as likelihood of hospitalization models, are also provided to assist practices in identifying patients who are at greatest risk for high intensity health events and would benefit from direct outreach from primary care providers to address their health needs. Independence provides a level of support to providers through a leadership team from the Provider, Actuarial, Informatics, and Medical Director areas. This team supports the efforts of each provider within our value-based programs. Support includes, but is not limited to, weekly or bi-weekly calls, monthly/quarterly on-site meetings, and the above-mentioned reporting.

Q3: How do you identify a patient's primary care provider?

PPO members are assigned to primary care offices using a review of member claims history. Through this process, referred to as attribution, doctors know which members they are responsible for and this becomes the foundation for clinical coordination incentives to providers. Attribution methodology may vary by geography (because BDTC programs are designed to reflect local provider dynamics) but are generally claims based. Independence's attribution methodology is based on where a member lives, the provider they see, and when they see the provider.

- PPO members who reside in the PA-9 county area* are eligible for attribution to a PPO QIPS provider.
- Claims data is analyzed to determine the primary care physician that an eligible member has seen most frequently in the most recent 18-month period.
- Independence members who reside outside the PA-9 county area* are eligible for attribution to the value-based program in the area in which they reside.

**Includes PA-5 (Montgomery, Philadelphia, Chester, Delaware, and Bucks) plus Lancaster, Berks, Lehigh, and Northampton counties*

Independence

Q4. How does attribution work for new customers?

Members are attributed to a provider once they meet the plan's guidelines for attribution. Eligibility requirements and claim look-back period timeframes may vary by market.

Q5: How are we attributing members in Blue Plan service areas that are overlapping?

To attribute Independence members to BDTC providers in a Plan area outside our local Plan area requires exchange of data and claims files between Plans and the BCBSA. When a member resides in a geography where there are overlapping Plan service areas (e.g., California, Idaho, Washington state) Independence has designated one Blue Plan to which the member can be attributed.

Q6: What are provider performance payments and how are they calculated?

Provider performance payments – which may include reimbursement for quality, cost efficiency, or shared savings – reward providers for successfully managing the quality and overall health care costs of our members participating in value-based programs. In terms of payment calculation, performance of BDTC providers will be measured on both quality and cost of care. Clinical quality metrics are focused on such aspects of care as managing chronic conditions and compliance with preventive health guidelines (e.g., preventive health screenings, vaccinations, etc.) while the cost evaluation examines the relative savings associated with delivering care (e.g., reducing costs for diabetic patients, fewer avoidable ER visits, fewer readmissions, etc.). Performance payments are often calculated based on providers' performance against set clinical and cost efficiency targets. These targets are developed based on peer group performance, historical norms, and/or national/regional benchmarks, and typically include high and low thresholds that dictate the amount of compensation for a given provider Shared savings payments are calculated by looking at the total amount of savings generated by a provider and splitting that savings between the provider and the plan.

Q7: How do self-funded customers pay for these programs?

There are no administrative costs to self-funded customers for participation in these programs. Provider incentive payments are a part of the overall compensation strategy for providers.

Provider incentives are invoiced to self-funded customers either through paid claims or as a Per attributed Member Per Month (PaMPM) expense.

- Paid claims: Individual Blue Plans may bill directly through paid claims through an enhanced fee schedule, supplemental factor and/or S&G code.
- Line item: The majority of Blue Plans bill a fixed PaMPM amount set by actuaries for members attributed through BDTC. The PaMPMs are updated periodically based on experience and actuarial projections. Any surplus or shortfall will be applied when setting future provider performance payment amounts. As noted above, these payments are a part of the overall provider compensation strategy - providers now must earn previously guaranteed fee for service reimbursement through quality and cost performance. PaMPM payments are already included in the medical cost forecasts.

Provider Performance

Q8: What terms must a provider group agree to in order to participate in Blue Distinction Total Care?

To qualify for BDTC designation, providers must meet consistent value-based criteria across four categories:

1. **Deliver patient-centered quality care** – providers must demonstrate expertise in delivering high quality care and patient safety, measured using evidence-based guidelines and successful achievement towards established targets
2. **Accountability across the care continuum** – demonstrate coordination across a broad range of services to improve population health from a holistic perspective, including the compliance with preventive services and management of chronic conditions

3. **Practice transformation** – with the support of the Blues, providers will have access to data, analytic tools, transformation support, and funding that allow them to effectively and efficiently manage their patient populations – these resources ensure that providers have the information they need to identify gaps in care, better manage patients with chronic conditions, reduce duplication of efforts, and improve outcomes
4. **Accept value-based reimbursement** – payments made to designated providers are paid not on the volume of services they provide, but on the value of the care they deliver – taking into account both quality outcomes and their ability to better manage costs

Q9: How will you monitor provider performance?

Nationally, Blue plans monitor the quality and cost performance of BDTC participating providers through data and reporting to ensure they are delivering high quality care and improving efficiencies. The exact metrics used to measure program outcomes will depend upon the local provider dynamics and program goals. Typically, clinical quality metrics are focused on aspects of care such as managing chronic conditions and compliance with preventive health guidelines (e.g., preventive health screenings, vaccinations, etc.) while the cost evaluation examines the relative savings associated with delivering care (e.g., reducing costs for diabetic patients, fewer avoidable ER visits, fewer readmissions, etc.). Independence distributes close to 10 reports annually to participating providers.

Q10: How will this program help maintain or improve the quality of care delivered by participating providers?

BDTC programs maintain and improve the quality of care delivered by participating providers by incenting providers to monitor, track, and enhance the quality and efficiency of care, not just the quantity of care, being delivered to Blue members. BDTC participating providers are given specific targets and goals to achieve during their agreed-upon measurement period; at the conclusion of the measurement period an assessment is done to determine the provider's performance on these metrics for their attributed member population. The exact metrics used to measure program outcomes will depend upon the local provider dynamics and program goals.

Blue Plans also make sure that providers are equipped with the tools needed to succeed in BDTC programs. These tools include reporting toolkits with the data, information, advanced analytics, and best practices to monitor, track, improve, and transform care being delivered to members. Blue plans' value-based program teams also work with practices to ensure that they are getting the maximum benefit of the resources provided by the plan.

Q11: Do clinical coordination and provider performance payments apply toward stop-loss?

When clinical coordination and provider performance payments are a claims expense, they will count towards both individual and aggregate stop-loss. If these costs are broken out as a PaMPM expense, they will not count toward stop-loss.

Reporting

Q12: What type of reports will providers receive?

Providers receive an array of data to assist with population health management, to identify opportunities for improvement, and to connect the dots between the actionable activities that tie to financial incentives.

In Independence's BDTC program, participating providers receive member level information to identify gaps in care for important preventive care metrics. Independence also provides cost and care efficiency reports on ER utilization, medical admission, follow up visits after discharge, and performance against cost targets. Other value-based program reporting includes utilization and cost information by provider, service line, line of business, procedure, DRG and all other claim, member or provider data dimensions. Predictive analytics, such as likelihood of hospitalization models, are also provided to assist practices in identifying patients who are at greatest risk for high intensity health events and would benefit from direct outreach from their primary care provider to discuss and address health care needs. In addition to reporting, Independence facilitates best practices sessions with doctors. PCPs get together to share what works best, new reports, changes to the program, and cost effective settings for care.

Employer Participation

Q13. Why do ASO customers participate in value-based contracting programs?

A key component of value-based payment strategies is to move providers from a fee for service model and toward value based care delivery. This strategy puts dollars at risk for the provider's reimbursement. Our customers expect us to develop and maintain contracts with a network of providers who promote high-quality, affordable care. This is what our customers trust us to do every day. Our provider contracts outline the health care services that providers deliver to our members and how we will pay them for those services. Value-based payment is one of the ways we compensate providers for their work. Value-based payments shifts away from today's predominant compensation model under which providers are paid solely based on the volume of services they deliver to a model where providers are paid based on the value of the services they deliver. In response to clear customer demand that the Blues move in this direction – and based on the very positive results we have seen in programs across the country – paying providers based on the value they deliver is fast becoming the standard way Blue plans contract with providers.

Q14. Do Independence's ASA agreements permit us to charge for value based programs?

Yes, both Independence's HMO and PPO ASA agreements contain language permitting the chargeback of our value-based programs to customers.

Q15: Are all customers expected to participate in Blue Distinction Total Care?

Yes. Independence and Blue Plans across the country can drive positive change in quality and cost when all of our business participates. All Independence customers will participate in national BDTC programs effective January 1, 2017 when their out-of-state employees will begin to be attributed to BDTC programs in their geography.

Member Impact

Q16: Why value-based care? How does it improve the member experience?

Independence and Blue plans across the country are strong proponents of primary care as the foundation of an optimal health care system. For that reason, value-based programs have been designed around primary care doctors managing the overall health of their patients. Through BDTC programs, including Independence's BDTC program, PPO QIPS, providers have the opportunity to earn bonus payments for delivering care to our members that is both high quality and efficient.

Q17: Do members need to select a primary care provider as part of these programs?

No. Members will be attributed to providers based on the attribution methodology of the Blue plan in their geography. Members may continue to see any provider that they choose, regardless of attribution. For additional detail on our attribution method, see question 3.

Q18. Will members be able to identify participating Blue Distinction Total Care providers in online provider finders?

Yes, to help members identify BDTC physician practices, the National Doctor and Hospital Finder (http://provider.bcbs.com/) and our local provider finder on ibxpress.com have been updated to include a designation for BDTC-participating doctors..

General Questions

Q19: In addition to PPO QIPS and BDTC what else is Independence doing to improve patient care?

Independence is working alongside other Blue plans nationwide to transform health care delivery through value-based payment programs. Independence and the Blues have embedded market-specific and value-base care models across the country and will continue to do so going forward. We will align our future Accountable Care Organization (ACO) strategies with these guiding principles:

- Shift of contracting from upside with minimal (or no) risk to contracts with both upside and downside risk
- Placement of contractual inflationary increases into value-based contracts so that provider performance ultimately drives provider payment
- Emphasis on PCPs as the focal points of patient-centered and coordinated care
- Continued development of patient-centered and coordinated care through ACOs and Patient Centered Medical Homes (PCMHs)
- Use of robust tools and technology to support ACOs and workflow changes

In addition to BDTC, Independence is working to develop several other payment models, such as:

- Episode Bundled Payments
- Shared Savings Models
- Site-of-Service Incentives
- Reduced Readmissions
- Specialty-specific programs (e.g., oncology, urology, cardiology)

Q20: I've heard of Comprehensive Primary Care Plus (CPC+), sponsored by the Centers for Medicare and Medicaid Services (CMS). Is Independence involved in this?

Yes. CMS recognizes the importance of encouraging a shift away from volume to value-based payments through PMPM payments for clinical coordination activities as well as shared savings rewards. Independence is a payer partner with CMS in Greater Philadelphia, including Bucks County, Chester County, Delaware County, Montgomery County, and Philadelphia County. CMS will select eligible practices in this area for the 5-year program.

Q21. Will Blue Distinction Total Care be available nationally, or will each state ultimately have a different Blue Distinction Total Care solution?

The goal of Blue Distinction Total Care is to design programs that meet the local market needs but at the same time meet nationally consistent selection criteria. The foundation of Blue Distinction Total Care is consistent across the country yet allows for nuances to meet local market needs. Blue plans have united to focus on improving quality and reducing the healthcare spend in each region across the U.S. Health care is never a "one size fits all" approach. The Blues focus on the needs and opportunities in each region to assess opportunities and develop strategies to improve quality and reduce costs. Each Blue plan has a unique and personal relationship with the communities and providers with which they partner.

Independence

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.