

Applying Upstream Problem-Solving to Value-Based Payment Reform in Specialty Care: Blue Cross Blue Shield of North Carolina's Approach

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You are walking along a riverbank and spot a baby floating helplessly down the river. You immediately jump in and pull the baby to safety. But what if, after you have rescued that first baby, you see another baby, then another, and then another, all floating down the river? By now you have exhausted yourself trying to pull each baby out of the water and realize that it is not possible to save them all. You may even be thinking, “Why are there so many babies floating down this river in the first place?” After going upstream to investigate, you see someone is putting babies into the water.

This classic parable shifts the focus from downstream problem-solving (saving the babies already floating in the river) to upstream problem-solving (preventing the babies from being placed into the water). Upstream problem-solving, or implementing preemptive actions to avoid subsequent adverse outcomes, is a powerful strategy to promote both individual and population health. Yet the majority of upstream problem-solving efforts in the health care community to date have revolved around reducing health disparities¹ by addressing social determinants of health.²

This article will discuss both how to apply an upstream problem-solving approach specific to value-based payment reform and its challenges as a way of addressing the suboptimal quality and soaring costs of health care. Facilitated by federal legislation, payers and providers are realigning financial incentives with outcomes that matter to patients through alternative payment models (APMs).³ These arrangements fundamentally change the business case of clinical care delivery by decoupling revenue generation from discrete services or activities. Rather, financial success in APMs depends on effectively moving clinical care upstream by rewarding optimal health and avoiding undesirable and costly events. To use the earlier

parable as an example, value-based payments aim to reward those who successfully keep the babies out of the river.

Successful models of population-based, primary care-centric APMs are gaining traction across a broad swath of payers. However, specialty care accounts for more than 90% of commercial claims payments⁴ and remains largely entrenched in downstream activities⁵ (Table). Although multiple specialty care models in high-priority specialty areas are planned or under way at the federal level,⁶ the pace of commercial value-based payment transformation in the specialty care arena is lagging.

Barriers to Moving Specialty Care Upstream

In the recent book *Upstream: The Quest to Solve Problems Before They Happen*, Dan Heath identifies several major barriers to achieving upstream transformation.⁷ This article will examine how these barriers apply to specialty care value transformation and discuss how a large commercial payer, Blue Cross and Blue Shield of North Carolina (Blue Cross NC), is actively working to overcome these challenges.

1. Problem blindness

Problem blindness, or failure to recognize there is a problem, is among the first barriers to moving specialty care upstream. The health care community must first accept the reality that a purely transaction-based reimbursement system is problematic and creates misaligned incentives among health care providers, patients, and payers. The coronavirus disease 2019 pandemic exposed the vulnerabilities and inadequacies of the care delivery created around a system of fee-for-service reimbursement. The health care community must also collectively reject that notion that our entrenched system of downstream specialty care is inevitable and there is no path

toward improving patient outcomes and affordability through payment reform. The challenge is that many health systems and providers rely on revenues from downstream services to maintain financial solvency, so it is imperative to offer a viable alternative to the fee-for-service system that adequately rewards upstream and preventive care. Until this happens, specialty providers will have no impetus to shift their focus away from fixing problems as they occur.

Value-based payment reform alone is not the panacea for all that ails our health care system, but Blue Cross NC considers this a fundamental element to systematically improve quality, affordability, and member experience. To that end, Blue Cross NC has committed to provide each of our members with an accountable health care provider by the end of 2023.⁸ Specialty APMs build on this foundation of accountable primary care by expanding the scope of accountable providers and aligning specialists' incentives around value. Specifically, we are focusing our attention on high-impact specialty care areas including oncology, maternity, chronic kidney disease, orthopedics, and cardiology (Table), which cumulatively account for nearly 22% of Blue Cross NC's overall spend.

Upstream payment transformation requires specialty providers to rethink their business models. Provider organizations that have traditionally focused on maximizing fee-for-service revenue through market consolidation or restrictive certificate of need laws must now compete with high-value provider groups and innovative built-for-purpose value-based care entities for network eligibility and preferred provider status. Specialists affiliated with accountable care organizations are also beginning to take note of these value-based incentive payments.⁹

The Center for Medicare & Medicaid Innovation's growing portfolio of specialty-oriented APMs, particularly those that are mandatory, has substantially reduced provider-side problem blindness.⁶ Blue Cross NC is actively creating synergies with its commercial APM strategy to minimize the marginal effort and administrative burden of making a holistic value transition. APMs are an opportunity for payers and providers to collaboratively address inefficiencies, pain points, and sources of clinician abrasion, dissatisfaction, and burnout.

It is neither desirable nor possible to eliminate downstream services. Skilled specialists will always be needed to jump into the river when necessary. Rather, Blue Cross NC challenges the belief that high-quality specialty care is defined solely on the proclivity for and efficiency of managing problems with no consideration of their role in maintaining health.

2. Lack of ownership

A second barrier to moving specialty care upstream is lack of ownership. The invested stakeholder must feel both

Table. Downstream Services vs Upstream Services

Downstream services	Upstream services
Total joint replacement of arthritic knee	<ul style="list-style-type: none"> • Weight loss/exercise programs • Physical therapy
Rescuing preterm infant in the neonatal intensive care unit	<ul style="list-style-type: none"> • Augmented prenatal health services • Tobacco cessation/substance abuse programs • Mental health support • Nutrition support
Immunotherapy for advanced lung cancer	<ul style="list-style-type: none"> • Tobacco cessation programs • Targeted lung cancer screening
Leg amputation necessary because of peripheral vascular disease	<ul style="list-style-type: none"> • Better management of hypertension, cholesterol, and diabetes • Nutrition support • Tobacco cessation programs
Dialysis and/or kidney transplant resulting from kidney failure	
Coronary artery bypass surgery for clogged arteries	
Repeated emergency department visits for mental health crises, homelessness, food insecurity, etc	<ul style="list-style-type: none"> • Adequate mental and behavioral health programs • Substance abuse disorder resources • Social services

responsible and empowered to effect systems change in order to take ownership and engage in upstream problem-solving. However, many stakeholders are extremely reluctant to take ownership of specialty care transformation. This is due to the systematic misalignment of incentives that entrenches self-interest and ties financial viability to the status quo. Although this has begun to change in recent years,¹⁰ payers have not felt obligated or possessed the capabilities to redesign specialty care reimbursement to both incentivize health promotion and avoid illness.

Health systems and specialty provider groups have also deferred ownership of upstream transformation in favor of responding rationally to fee-for-service incentives. The primary factors leaving patients floating farther and farther downstream are that health systems and groups are gaining market share and negotiation power through consolidation, expanding capacity for lucrative downstream services, and redesigning clinical care processes to maximize revenue.

Blue Cross NC recognizes the critical nature of engaging its health systems partners, provider organizations, and clinical leaders throughout the entire life course of each specialty APM initiative—from concept to design to implementation. As such, Blue Cross NC regularly collaborates with clinicians,

academicians, and subject matter experts from across its statewide provider network to define high-value specialty care. Blue Cross NC and its design partners also work to identify improvement opportunities and jointly design reimbursement models for high-impact specialty conditions and episodes that align incentives to support the transition to this new model of care. This partnership facilitates a greater sense of ownership for those best suited to effect upstream change in specialty care.

3. Tunneling

Tunneling, or the inability to deal with a problem at the present moment, is a third barrier to moving specialty care upstream. This is due to the lack of bandwidth and resources that allow a bunch of little problems to crowd out bigger ones. A finite supply of financial and human resources is constantly allocated to address short-term problems within the status quo reimbursement system. Legacy payers employ the myopic approach to address the skyrocketing costs of care by increasing premiums, cutting reimbursement, and aggressively managing utilization. Payers stuck in this traditional fee-for-service tunnel are unable to allocate the necessary time, money, and expertise to upstream specialty APM design.

The typical health care provider also spends an exorbitant amount of time addressing the complexities of billing, coding, and documentation required to secure reimbursement from a number of payers, insurance products, and pharmacy formularies. This administrative burden not only siphons limited resources away from delivering a high-quality care experience but also forces health systems and providers to pivot toward offering downstream, reactive solutions—as opposed to upstream, proactive ones—to stay afloat. Frontline providers remain stuck in the fee-for-service revenue tunnel, and they consequently lack the time or resources to dedicate to education, counseling, and shared decision-making, which also poses challenges to participating in an upstream system redesign. To address these challenges, Blue Cross NC has a multidisciplinary team with many stakeholders in health care strategy, actuarial services, clinical quality, development and program management, data analytics, sales and marketing, research and evaluation, and clinical operations who are dedicated to moving specialty care upstream through reimbursement reform. Through its APM design partnerships, Blue Cross NC hopes to facilitate the “slack” necessary for clinicians and researchers to collaborate with the payer side to develop a fair, sustainable reimbursement mechanism for specialty care that aligns financial incentives with positive patient outcomes.

4. Appropriately measuring and paying for success

Although success in specialty APMs looks different for each stakeholder, mutual benefit for all parties is possible by aligning financial incentives with value. First and foremost, we must reward necessary downstream care. Rigorous quality standards, formal shared decision-making, and patient-reported outcomes are keys to this. Clinicians must inform the quality component for specialty APMs such that financial gain and subpar quality are mutually exclusive. Longitudinal evaluations of cost, quality, and patient experience metrics are necessary to measure the effectiveness of moving upstream.

Shifting reimbursement upstream in specialty care must be appropriate, fair, and sustainable. To accomplish this, Blue Cross NC is actively tackling the existential question of how to adequately compensate providers for reducing the occurrence of undesirable events and avoiding the need for downstream care. Specialty APM design requires that we measure what does not occur, quantify the value of preventing those events, and fairly allocate accountability across multiple providers, health systems, and payment arrangements. This is no easy task.

Conclusions

There is a significant opportunity to improve our nation’s health care system by moving from a downstream to an upstream problem-solving approach. To date, upstream efforts have largely focused on identifying and addressing social factors that are indisputably tied to poor health outcomes.¹¹ Although these efforts must remain a top priority, value-based payment transformation, including for specialty care, is an essential component that shows great benefit from shifting from a downstream to an upstream problem-solving approach. Blue Cross NC is an example of a large payer that is making this shift upstream and serves as a good example to other large payers and organizations on how to address these challenges in their transitions toward upstream problem-solving.

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