

What Role for Payers in Centers of Excellence?



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Several environmental factors and healthcare trends should drive clinicians to include payers and consumers in the development and ongoing management of centers of excellence, including bariatric surgery centers of excellence.

Healthcare reform was born out of frustration of patients, payers, politicians and policy makers that the United States healthcare system does not provide equitable access to care or a particularly good value for the money spent. Especially in the context of the recent recession, the American public and employers will not (and cannot) tolerate current medical expense trends, nor the perception that care is not uniformly safe or effective.

The trends of import are consumerism, health plan steerage to higher performing providers, and a significant migration from employer-sponsored to individual-purchased health insurance coverage.

Consumers are seeking (demanding) better information regarding the cost, quality and safety

About Article

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In this issue of the Bariatric News Viewpoint column, Dr. Don Bradley, Senior Vice President for Healthcare and Chief Medical Officer of Blue Cross and Blue Shield of North Carolina, provides an experienced U.S. payer's perspective on the business strategy associated with insurance coverage of bariatric/metabolic surgery and long-term patient care. While a payer representative on the Surgical Review Corporation (SRC), Dr. Bradley shared the payer's definition of the relationship between value, volume, and quality in the context of a center of excellence. He advises that clinicians should not only seek the participation and input of patients (consumers) in developing models of medical care, but also that of insurance payers, recognizing them as integral to effective and affordable delivery of treatment and follow-up in the United States. In order to flourish while navigating an increasingly regulated medical environment, bariatric clinicians, patients, employers, and payers are challenged to work together *as a successful metabolism*.

of care available to them, especially as their out-of-pocket costs for care escalate. They may have traditionally trusted physicians to provide appropriate referral information, but the continued public (and to some extent provider) perception that the safety and effectiveness of care have not improved, has led them to seek information from other sources, including the internet, government agencies, and yes, even health plans.

BCBS of North Carolina, an early adopter of the Bariatric Surgery Centers of Excellence (COEs), began their foray into the arena because of safety concerns related to the procedure. Other payers simply stopped covering bariatric surgery, largely because of safety concerns, but also because of costs.

As providers look to re-establish their credibility, and to compete in a marketplace that is more and more willing to incent patients to choose higher performing (and sometimes more distant) providers, it is critical for physicians and hospitals to understand what "quality" and "value" mean to the consumers and payers of healthcare. In particular, "quality," to a consumer, includes more than technical quality of a procedure. It also includes informed decision support, adequate interpersonal communications from initial contact through ongoing follow up, and a reasonable assurance that the provider of care will deliver the outcomes promised. "Value," from a patient's perspective, relates to out-of-pocket cost, while value to a payer relates to both the cost of an

episode of care (e.g. 30 days prior, and 180 days post, procedure) and the overall cost of healthcare, including treatment of comorbid conditions.

These perspectives are not generally innate to providers, and frankly, will change over time. Including payers and patients allows their concerns and recommendations to be integrated into COE processes and metrics; and improves transparency, which ultimately enhances trust and even advocacy.

During my tenure on the Surgical Review Corporation (SRC), as a payer representative, I believe I was able to express my perspectives and concerns, and I believe SRC listened to and incorporated many of them. I also suggest that the SRC's efforts to advocate for coverage of bariatric surgery was enhanced by listening to and understanding how a payer thinks about coverage decisions.

Our organization utilized SRC COE status as a key requirement for our health plan's COE program. We saw providers who dabbled in bariatric surgery leave the field or invest the resources needed to meet COE standards. I also know that bariatric surgery safety has improved significantly and that the value proposition for covering surgery has been confirmed.

Going forward, providers will see that bariatric surgery will be steered to higher performing centers, and we as payers (and consumers) are happy to share with you what "higher performing" means. Having

a payer on the SRC board expedites that process, can foreshadow the future, and actually provides prospective input into health plan coverage, metrics, and standards.

The day of guild mentality – specialized craftsmen maintaining a shroud of secrecy around their work and assuming that consumers must accept their terms is over. The future lies with those who collaborate, who share information, who share ideas, concerns and intentions. We may or may not like it, but our survival is dependent upon it.

About the Author

Dr. Don Bradley, Senior Vice President for Healthcare and Chief Medical Officer for Blue Cross and Blue Shield of North Carolina (BCBSNC), holds faculty appointments at Duke University School of Medicine and the University of North Carolina (UNC) School of Medicine, and is a member of the North Carolina Institute of Medicine. He was appointed by Governor Easley to the North Carolina State Health Coordinating Council (SHCC), where he chairs the SHCC Committee on Quality, Access, and Value. A family physician by training and demeanor, he completed his medical degree at the Medical College of Virginia, a family medicine residency in Harrisburg, Pennsylvania, and a Kellogg fellowship, biostatistics work and a Masters in Clinical Leadership at Duke. He practiced in rural Virginia before joining the Duke Family Medicine Residency faculty in 1981. Over the last 20+ years at BCBSNC, Dr. Bradley led implementation of open access online medical policy, extensive primary care provider performance feedback, annual State of Preventive Health forum, comprehensive benefits and programs for the medical assessment and treatment of obesity (Healthy Lifestyle Choices), and creation of one of the nation's first Bariatric Surgery Centers of Excellence programs and performance-based provider reimbursement. He regularly teaches in the Duke Clinical Leadership Program, the Duke Physician Assistant and Physical Therapy Programs, and the UNC School of Public Health.