Healthcare 7 (2019) 60–61

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/healthcare

Interview

Building a model health insurer: An Interview with Blue Cross North Carolina CEO Patrick Conway

Adam L. Beckman[a,b,*], Sanchay Gupta[a]

[a] Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, United States
[b] Aledade, Bethesda, MD, United States

Patrick Conway is President and CEO of Blue Cross and Blue Shield of North Carolina (Blue Cross NC) and a practicing pediatric hospitalist. He was formerly the Acting Administrator, Principal Deputy Administrator and Deputy Administrator for Innovation and Quality and Chief Medical Officer for the U.S. Centers for Medicare and Medicaid Services (CMS). In these roles, Dr. Conway was responsible for overseeing the programs that serve over 130 million Americans that access health care services through Medicare, Medicaid, Children's Health Insurance Program (CHIP) and the Marketplace. He and the CMS team focused on improving health outcomes, access and affordability, while reducing health disparities and combating health care fraud. He holds an MD from Baylor College of Medicine and MSc from University of Pennsylvania. This interview was condensed and edited for clarity.

Adam Beckman (AB): Why did you want to lead Blue Cross NC?

Patrick Conway (PC): Blue Cross NC can be a model of what is possible for a health plan–because I don't think that exists yet today. I have been talking about becoming a Model Blue for the country. We can excel at better care, lower costs, best in class service experience. We can push the envelope on what a health plan can be. The challenges and potential that exists in North Carolina brought me to this role.

I'll give at least two tangible examples. First, we can move a health outcome at scale. We are looking at partnering on diabetes care with a company to cure 10,000 patients with diabetes. Their complex intervention helps people lose so much weight and keep it off that they no longer need medicines. For hepatitis C, we are thinking about partnering with one pharmaceutical company and saying, "We are going to pay you X, which might be about what we pay today for the drug we are using today–but you are going to treat every single person we find with hepatitis C." We are going to try to eradicate hepatitis C in a whole state.

Second, we can excel at customer service experience. Our net promoter scores (NPS) are in the teens, which for a non-provider health plan–which are usually negative–is really good. We want to be better than anyone in the country and eventually have an NPS in the 50 s, 60 s or 70 s, like a great consumer company. To achieve that, we are thinking about how to treat every customer like family. We are trying to create systems that reduce friction with customers and really delight them.

A recent story illustrates this point. We had a 3-year-old with a rare genetic disorder who was not getting a life-saving medicine. I found out about it through social media. The good news is we fixed it in less than 60 minutes and did a lean process review to prevent it from happening in the future. But I called the parents right after we fixed it. It was painful to hear how they had bounced through our system. The customer service representative wanted to help, as I heard when listening to the phone call. Unfortunately, the doctor had accidentally filled out the wrong date on the form, so it was getting denied. This situation almost produced a bad outcome. We now have a system where a frontline customer service representative can escalate something to a special team who fixes it.

On the provider side, we have also been talking about turning off prior authorization for providers who are in a full-risk relationship with us. We are thinking creatively about ways to make a system that is better for patients and providers.

Sanchay Gupta (SG): What will be the biggest barrier to curing hepatitis C for your beneficiaries?

PC: We will have to find a willing pharmaceutical partner. There are three major companies in this space, so I think we can achieve this goal.

The other challenge will be navigating Medicaid best price. I would argue that we are not actually paying a “price” because we do not know how many people we are going to treat. Rather, this program will be closer to the ultimate population health bundle. Still, the pharmaceutical company will not want the payment to get in the way of Medicaid best price, as that would lower the rest of their prices.

AB: How have you continued to pursue payment reform since coming to Blue Cross NC?

PC: I am very excited about our work on provider partnerships and paying for value. At Blue Cross NC, we have over 80% of payments that are value-based today. However, most of them are more traditional pay-for-performance programs, with some low percentage at risk based on quality and costs. We have some ACOs and bundles that are saving money. Our most exciting goal is to have over 50% of our payments in Advanced Alternative Payment Models (AAPMs)–where the providers experience both upside and downside risk for total cost of care–over the

* Corresponding author at: Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, United States.
E-mail address: adam_beckman@hms.harvard.edu (A.L. Beckman).

https://doi.org/10.1016/j.hjdsi.2018.08.005
Received 14 June 2018; Accepted 26 August 2018
Available online 31 August 2018
2213-0764/

next 12–24 months.

I am not aware of any payer in the country that has over 50% AAPMs. Many payers will quote value-based numbers that include pay-for-performance programs with small incentives. But we are talking about shifting the entire system.

At Blue Cross NC, we are uniquely positioned to lead this transition. We insure the majority of people in North Carolina, many of them for the majority of their lives. I met a 75-year-old the other day, who we have insured for all 75 years of her life. When we shift the market, it is shifting the entire health system of a large state.

SG: If you still had your prior job at CMS, what is an initiative that you would be pushing forward?

PC: I would focus on a few initiatives. First, we know enough about bundled payments that they can and should be tested in a mandatory geographic matter. Second, we started advancing consumer-oriented models around transparency and consumer behavior. That's still a gap in the portfolio and fortunately the current administration is planning to work on this area. Third, I would like to see more innovation in health plan design. Lastly, we tried but could not launch novel ways of paying for pharmaceuticals. We need to address drug costs.

We need to move to a value-based payment mechanism for drugs in this country. The Center for Medicare and Medicaid Innovation (CMMI) is the best tool to achieve this reality. We had a Part B demo that was stopped at the end of the day. Fortunately, the new secretary in the administration is talking about paying-for-value in drugs, so hopefully that will occur.

AB: What is one disagreement you had with one of your colleagues while you were at CMS?

PC: We had a robust discussion about paying for advanced care planning at the end of life. Some people were concerned it could be spun as death panel rhetoric. We did end up putting into Medicare policy paying for advanced care planning. I pushed hard because I think it is the right thing to do for patients. It reflects patient-centered care. It was a good example where, despite disagreement, we ultimately landed in the right place.

AB: Christina Farr recently tweeted that “a lot of the health innovation money seems to have shifted from wealthy/healthy to chronically sick, low-income, elderly populations.” As an example of this trend, investor and former CMS Administrator Andy Slavitt recently announced his venture's investment in Cityblock Health. Cityblock is a spinout of Alphabet that aims to provide Medicaid and lower-income Medicare beneficiaries with access to high-value, readily available personalized health services. What will be the greatest challenge for organizations in this space?

PC: I am excited about Cityblock Health. Full disclosure: I am a small investor in them. That said, we have a great need for more innovation in delivering care to lower-income populations. It is terrific to see for-profit capital going into dual-eligible and Medicaid care, which can help address high costs in the system and nonoptimal outcomes.

When I was at CMS with Andy Slavitt, we updated the risk model for Medicare Advantage. Doing so literally shifted billions of dollars towards low-income populations including dual-eligibles. It turned out the old risk model was not appropriately adjusting risk for the low-income individuals.

This gets to the one thing we need to watch: the unintended negative consequences of cherry picking and lemon dropping. Even in low-income populations, organizations can target so that they are not taking care of the sickest of the sick. We need to be careful with the way we design population attribution, risk adjustment and patient protections.

SG: Some argue that by bringing people who have historically been locked out of the healthcare system deeper into it–for example, by providing more intensive chronic care management–that healthcare costs will go up and ruin the business model of generating savings. How do you respond to that?

PC: Over the long-term, these models will no doubt take costs out of the system. However, in the short-term, I do think this argument may translate into reality. That does not concern me, though.

North Carolina is the last big market to go to Managed Care in Medicaid, and we are going to compete for that business. We told our board that we plan to lose money for the first several years if we are awarded the contract; the population is going to need care, and we want to deliver that care because we are mission-driven. In early years of caring for the chronically ill, especially low-income populations, we and Cityblock alike will see losses for several years. But over time, we will see dramatically improved quality and lower costs.

SG: Much of your work has focused on improving value in healthcare. Earlier this year, Brigham physician and *NEJM* correspondant Dr. Lisa Rosenbaum wrote a controversial piece, “The Less-Is-More Crusade — Are We Overmedicalizing or Oversimplifying?” In it, she argued, “Mitigating waste is imperative. But doing so effectively means grappling with a greed that may more often reflect a hunger for information than a desire for financial gain. Until we learn how to better manage the uncomfortable uncertainties inherent in clinical care, ‘less is more’ may be an aphorism better suited to telling coherent stories than to the complex decisions faced by doctors and patients.” How would you respond to this claim?

PC: In some areas, we do not have the evidence on quality and cost outcomes. In those situations, this claim is true; a large amount of uncertainty leads to more testing and costs. We have an obligation to be honest about this and communicate it to patients. In my patient care, I am very honest with families. When the evidence is unclear whether your child needs this major surgery, doctors need to be saying, “Here's what we think are the risks and benefits.” They need to engage in shared decision making with the family.

However, there are other areas where this thinking is used as an excuse. For example, folks say, “I must order X scan because of medical liability.” Yet if a scan or antibiotic is not indicated, it is against evidence-based care to order it. We still have a lot of progress to make in reducing unnecessary and wasteful care. A huge percentage of people in this country still die in ICUs. We have a large percentage who get surgery or chemotherapy in the last month of life.

Why are we as physicians making decisions that patients are not making? Is it because we are not fully informing patients and their families about all their choices? A great study showed that doctors' decisions at the end of life were very different than those made by patients they served. That should make us all question our clinical care model.

AB: You notoriously work as a pediatric hospitalist on the weekends. How do you manage your career with your family life and numerous children at home?

PC: It is always a challenge. We have four children, so family life is busy. I like to coach as well. I still practice medicine because I love it and think it is an honor. When practicing, I also learn things that apply to the rest of my work. We are one of the ten largest health plans in the country, and no physician leads a health plan of this size. When I talk with providers or speak about our health system, it can come from a place informed by direct patient care. That matters.