2026 Value-Based Care Report

Delivering Better Outcomes and Lower Cost

How Blue Cross Blue Shield of Michigan's value-based care model creates measurable employer value



Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

Table of contents

04 Executive Summary

06 The Case for Change: Why Traditional Models Fall Short

07 Scale and Reach: Value-Based Care as the Standard

08 A Model Designed for Performance

09 A Proven Concept: Blue Cross' Value-Based Care Approach

- **09** Capability Layering: A Unique Differentiator
- **10** 1: Primary Care Transformation
- **12** 2: Team-Based Care
- **13** 3: Behavioral Health Integration
- **14** 4: Advanced Primary Care
- **14** 5: Accountability Through Blueprint

16 Chronic Disease Management: Addressing the Largest Cost Drivers

18 Member Experience: Accountability Behind the Journey

20 Delivering Measurable Employer Savings

22 Why Blue Cross is Different

23 Looking Ahead: Expanding Value-Based Care



Executive Summary

Employers today face a fundamental challenge: Healthcare costs continue to rise, yet improvements in quality and employee outcomes can be difficult to determine. Traditional healthcare models reward volume — the number of services delivered — rather than outcomes, leaving employers with limited control over both cost and performance.

Blue Cross has spent more than 20 years building a different model — one that aligns care delivery, provider incentives and patient outcomes through value-based care.

When care is designed around outcomes, cost and quality improve together.

The results are measurable, sustained and delivered at scale.

Consider these examples:

$6.3 billion in healthcare costs avoided
over 20 years

Increases in cancer screenings
breast (7%) and colorectal (9%) with provider-delivered care management*

2.5% lower commercial cost trend
for accountable provider groups

Significant reductions
in hospitalizations, emergency visits and readmissions

~$90 million
in annual commercial savings

*BCN Advantage claims data, 2021

Impact Snapshot: Why Early Screenings Matter

Screening and early detection have significant cost and outcome implications
In the year after diagnosis, average allowed costs per patient with breast cancer were $60,637 for stage 0 and more than double, at $134,682 for stage IV.[1]

Five-year survival rates for women with breast cancer are also heavily dependent on early diagnosis, typically before the cancer has had a chance to spread. Localized breast cancer, which has not spread outside the breast, is survivable nearly 100% of the time. Metastasized breast cancer, which has spread to other parts of the body such as the lungs or bones that are away from the breast, have a 33% survival rate.[2]

1. Blumen H, Fitch K, Polkus V. Comparison of Treatment Costs for Breast Cancer, by Tumor Stage and Type of Service. Am Health Drug Benefits. 2016 Feb; 9(1):23-32. PMID: 27066193; PMCID: PMC4822976.
2. Breastcancer.org



The Case for Change: Why Traditional Models Fall Short

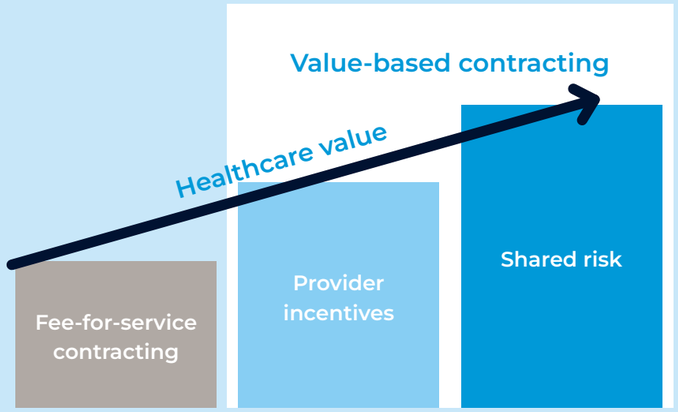
Employers are navigating an increasingly complex healthcare landscape characterized by:

- **Rising and unpredictable cost trends**
- **Significant variation in provider performance**
- **Limited visibility into the drivers of healthcare spend**

Under traditional fee-for-service models, providers are reimbursed based on the quantity of services delivered rather than their effectiveness. This structure can lead to care fragmentation if providers and specialists are working separately and incentivize more treatment, not necessarily better outcomes — leading to avoidable hospitalizations, unnecessary procedures and higher total cost of care.

Value-based care fundamentally changes this equation by aligning financial incentives with outcomes — rewarding providers for keeping patients healthy, managing chronic conditions effectively and reducing avoidable complications.

Blue Cross's experience demonstrates that this alignment produces both **higher-quality care and improved affordability.**



Blue Cross's commercial value-based care programs include two primary contracting models: provider incentives (upside only) and shared accountability (upside and downside)

Scale and Reach: Value-Based Care as the Standard

Unlike many health plans, Blue Cross's value-based care approach isn't limited to pilot programs or select markets — it is the dominant model and available for providers to engage in across all counties in Michigan.

~3 million Blue Cross members
aligned to Patient-Centered Medical Home providers

More than 65% of commercial members
in value-based arrangements

Coverage across
94% of Michigan counties

25K+ physicians & 100+ hospitals
participating

This scale enables Blue Cross to deliver consistent, measurable performance improvements across large populations.

Nationally, more than 81 million Blue Cross Blue Shield members have access to value-based care providers and programs. This represents approximately 71% of total Blue Cross Blue Shield membership nationwide.

Citation: Blue Cross Blue Shield Association. Total Care: The Total Care Difference. March 2024

A Model Designed for Performance

Blue Cross prioritizes high-performing providers engaged in value-based care. Across key measures, value-based providers demonstrate:



Higher screening and preventive care rates



Better chronic disease management



Stronger gap closure performance

This creates a model that actively manages both quality and cost, providing meaningful value to employers.



A Proven Concept: Blue Cross' Value-Based Care Approach

Capability Layering: A Unique Differentiator

One of Blue Cross's most distinctive advantages is its **capability layering model**, where outcomes improve as additional care delivery capabilities are added:

The foundation:
Coordinated primary care

A team-based, proactive model of efficient, cost-effective care centered around the patient helps prevent disease, reduce hospitalizations and keep patients healthy while avoiding costs.

The next level:
Team-Based Care adds care management

Patient care teams are assembled according to each patient's needs. These teams may include nurses, medical assistants, nutritionists, counselors, psychologists and others to better serve patients with chronic or multiple, ongoing health needs.

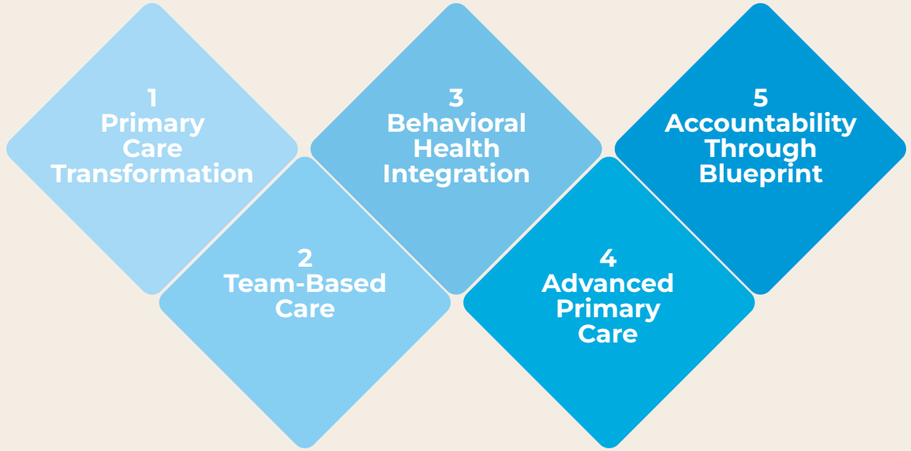
Bringing it all together:
Health Information Exchange (HIE) enhances data connectivity

By sharing patient data like emergency room and inpatient admission, discharge, transfer alerts and medication information for their entire patient population, PCPs and specialists can work in sync. This enables physicians to follow up with their patients sooner, better coordinate care transitions, and reduce duplication of medications and therapies.

Each layer produces incremental improvements in utilization and outcomes, demonstrating a clear progression of value.

This level of measurable progression across care models is a unique differentiator not commonly demonstrated by other health plans.

Blue Cross has built a comprehensive value-based care ecosystem built on these five core components:



1 Primary Care Transformation

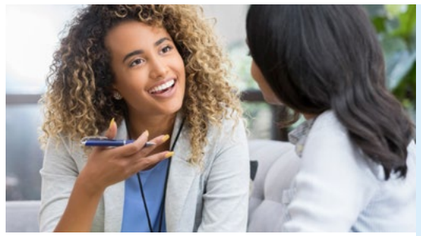
When primary care providers are empowered to lead a patient's care management, they can reduce fragmented care that leads to the avoidable complications and hospitalizations that occur under traditional models.

The Physician Group Incentive Program (PGIP) aims to improve quality, utilization and costs by providing financial incentives to providers for transforming healthcare delivery.

And it works:



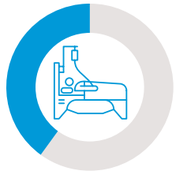
75% care gap closure rate
achieved by PGIP providers for key clinical quality metrics in 2025 compared to 63% for non-PGIP providers



Patient-Centered Medical Home (PCMH), the foundation of Blue Cross' primary care transformation strategy, puts the provider at the helm, leading a team of professionals committed to improving the member's overall health. They connect the dots between visits, doctors and healthcare settings.

Primary Care Transformation: The Foundation of Savings

Primary care is the most important lever for improving health outcomes and controlling costs. Blue Cross' PCMH model has demonstrated substantial improvements in utilization.



40% fewer inpatient stays



34% fewer hospital readmissions



29% fewer emergency department visits*



8% lower
high-tech radiology utilization

These reductions reflect fewer avoidable complications and better management of patient health — direct drivers of lower healthcare costs.

*Ambulatory care-sensitive conditions are those that shouldn't require inpatient hospitalization if appropriately managed by a primary care provider. Does not include pediatrics.

Cumulative savings from PCMH alone total $813.5 million,
underscoring the impact of sustained primary care transformation.

2 Team-Based Care

Team-based care expands the primary care model by surrounding the patient with support for managing chronic conditions or emerging risks.

Metric	Data point
Team-Based Care practices	835
Cumulative Team-Based Care savings	$1.25 billion
Adult inpatient discharge rate	.5% lower
Adult emergency room visit rate	9% lower
Pediatric emergency room visit rate	10.5% lower

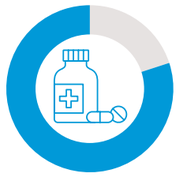
Blue Cross analyses show

$4 to $16 PMPM savings for each member engaged in Team-Based Care.

3 Behavioral Health Integration

The Collaborative Care Model embeds behavioral health services into primary care settings, improving access and supporting whole-person health.

One study found that collaborative care implementation was associated with significant reductions in mental health hospitalizations, leading to substantial cost savings of about $1.70 for every dollar spent for implementation, among research participants.



80% of antidepressants
are prescribed by PCPs



20% of PCP visits
are related to mental health

Source: PubMed Central

Behavioral Health Integration: Whole-Person Health

Behavioral health plays a critical role in overall health outcomes and cost management. Blue Cross' Collaborative Care Model embeds behavioral health services in primary care settings, improving both access and outcomes.



The model is currently deployed in
419 primary care and OB-GYN practices statewide
supporting more comprehensive care delivery.

Solutions across the continuum of behavioral health needs:



Wellness and resiliency tools
Readily accessible digital resources that support lifelong wellness habits



Therapy and coaching
Convenient care options for a range of behavioral needs



Specialty services
Support for members with complex needs



Intensive and crisis services
Higher level of care for members with acute needs

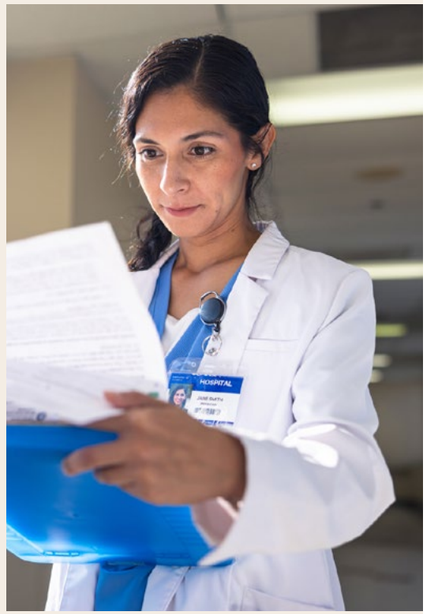
4 Advanced Primary Care

Combining PCMH, Team-Based Care and integrated behavioral health creates a proactive primary care model that's **focused on prevention, care coordination, access, and better outcomes while reducing avoidable costs**.

When patients have a primary care provider, they have 33% lower healthcare costs and 19% lower odds of dying prematurely than U.S. adults who only see a specialist.*

Investing in an advanced primary care model means focusing on population health management and creating a more modern payment approach that makes healthcare spend less sensitive to increases in utilization. With an aging population and ever-increasing utilization across the U.S., moving beyond fee-for-service payment models and focusing on prevention is critical to reducing avoidable costs.

Source: The Commonwealth Fund



5 Accountability Through Blueprint

Blueprint represents Blue Cross's advanced performance model, linking provider reimbursement to quality, cost, and outcomes. Providers participating in Blueprint for Affordability are closely aligned and coordinated with Blue Cross Blue Shield of Michigan. They put a portion of their payment at risk, which drives significant benefits to members and customers.

They can earn that portion — and more — based on how well they manage their patients' overall health and lower their total cost of care. When physicians are successful, they receive higher reimbursement.



When physicians don't meet care and cost goals, they forego some portion of reimbursement.

Across all 12 quality measures in the Commercial PPO Blueprint contract, Blueprint providers outperform every other cohort. The gaps are most pronounced against non-attributed members and are consistent across preventive screenings, chronic disease management and medication adherence measures.

Quality measure	Blueprint	PGIP (non-Blueprint)	Non-PGIP
Breast cancer screening	**87%**	84%	75%
Cervical cancer screening	**85%**	81%	73%
Colorectal cancer screening	**82%**	78%	66%
Controlling high blood pressure	**79%**	75%	53%
Glycemic status assessment (HbA1c < 8%)	**75%**	73%	58%
Kidney health evaluation (diabetes)	**65%**	60%	45%
Eye exam (diabetes)	**64%**	60%	48%
Statin therapy for cardiovascular disease	**83%**	83%	78%
Statin therapy for patients with diabetes	**67%**	64%	59%
Childhood immunization status (Combo 10)	**47%**	35%	30%
Immunizations for adolescents (Combo 2)	**41%**	35%	28%

Accountability Drives Performance

Blue Cross' Blueprint model ties provider reimbursement directly to performance, creating strong incentives for high-quality, efficient care.



Results include:



79% care gap closure
compared to 42% for non-attributed members

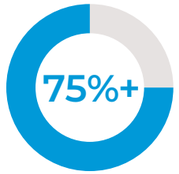


$300 million
in performance-based incentives paid to physicians through value-based reimbursement

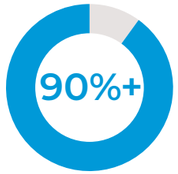
Chronic Disease Management: Addressing the Largest Cost Drivers

Chronic conditions represent a significant portion of employer healthcare spend. Primary care providers help prevent and manage these conditions. In a value-based care arrangement, we reimburse providers based on patient outcomes. When your employees are attributed to providers compensated for the value and quality of care they deliver, their chronic conditions are better controlled. That's a win for their overall health and for your business.

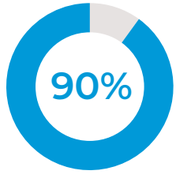
People who have at least one chronic condition (Source: CDC)**:**



age 35–64



age 65+

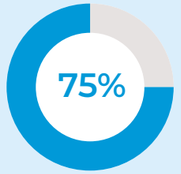


of healthcare spend is for people with chronic physical and mental health conditions (Source: CDC)



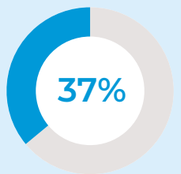
Blue Cross' value-based care model delivers measurable improvements in chronic disease outcomes.

Diabetes control (HbA1c) for:



of adults
with a provider who participates in value-based care arrangements

versus



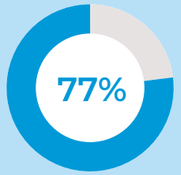
of adults
with a provider who is in a non-participating practice

Beyond reducing the risk of other health complications, controlled diabetes is also less costly.

Uncontrolled diabetes that requires an emergency department visit, hospital admission or home health services means patients may pay hundreds of dollars in annual expenses in addition to regular healthcare expenses for medication, doctor visits and other costs related to diabetes management. (Source: GoodRx)

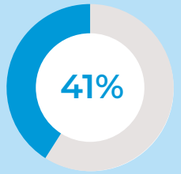
These large performance gaps demonstrate that value-based care isn't a marginal improvement — it fundamentally changes how chronic conditions are managed. Improved chronic disease control reduces long-term complications, hospitalizations and associated costs.

Blood pressure control for:



of adults
with a provider who participates in value-based care arrangements

versus



of adults
with a provider who is in a nonparticipating practice

Controlling high blood pressure is one of the most important ways to reduce risk of stroke, which is a leading cause of serious long-term disability. While the risk of a stroke increases with age, one study demonstrated that nearly 40% of people hospitalized for stroke in the U.S. were under the age of 65. (Source: CDC)

Member Experience: Accountability Behind the Journey

More connected capabilities create a more proactive member experience. This example of Anna's story shows how primary care support can expand from coordinated care to whole-person care.



Anna

Age 58

- **Diabetes**
- **Hypertension**
- **Depression**

Triggering event:

Anna returns home after a hospitalization related to complications from diabetes.

She needs follow-up care, medication support and help preventing another avoidable hospital visit.

	Hospital discharge	First week at home	Ongoing recovery	Long-term health
Patient-Centered Medical Home Coordinated primary care	**1** **Practice receives hospital information**	**2** **Follow-up scheduled and medications reviewed**	**3** **Care gaps and chronic conditions tracked**	**4** **Primary care provider remains central point of contact**
Team-Based Care Personalized support between visits	**1** **Identified added care management support**	**2** **Care team outreach and discharge plan clarified**	**3** **Individual care plan and ongoing condition support**	**4** **Check-ins between visits and barriers addressed**
Advanced Primary Care Proactive, whole-person care	**1** **Physical behavioral and social needs considered**	**2** **Broader team support, including behavioral health**	**3** **Proactive monitoring and outreach before escalation**	**4** **Ongoing team-based support for health and quality of life**

How Anna should feel:

Patient-Centered Medical Home

"My primary care team knows my health history and helps me stay on top of the care I need."

Team-Based Care

"Someone is checking on me, helping me follow my care plan and addressing problems early."

Advanced Primary Care

"My care team supports my whole health and helps me stay well, not just recover when I become sick."

What Anna doesn't see

Blueprint for Affordability

Blueprint isn't a separate step in Anna's care journey.

Behind the scenes, Blueprint creates accountability for:

- **Quality and outcomes**
- **Patient experience**
- **Affordability**
- **Responsible management of care**

Members may never see the program itself. They experience the intended result through care that is more coordinated, accountable and focused on better outcomes.

Delivering Measurable Employer Savings

The impact of value-based care is reflected directly in employer-facing financial metrics:

2.5% lower medical cost trend
for accountable providers

~$90 million
in commercial PPO savings



More than 65% of commercial members
receive care through PCP-focused value-based arrangements, including 34% in downside risk.

More than $2 billion total cumulative savings
across programs from Team-Based Care and PCMH alone

Blue Cross Blueprint Results (2022–2024) vs. non-Blueprint providers:

Better Quality HEDIS and Medicare Star Scores
Blueprint providers outperform non-Blueprint providers

~$47–77 million
MA PPO Savings
~$16–26 million annually

1.7% Lower Cost Trend
MA PPO Annually

National Evidence (MSSP)

2X Savings Rate
Two-sided Accountable Care Organizations (ACOs): ~$488 per member per year vs. $242 PMPY for upside-only[1]

4.2% Greater Generated Savings
ACOs switching to two-sided risk vs. staying one-sided[2]

79% Generated Savings
of two-sided risk ACOs generated savings vs. only 41% of one-sided ACOs[3]

Blue Cross Blueprint results are consistent with national MSSP findings:

1. Two-sided risk drives stronger savings and quality outcomes.
2. Blueprint providers outperform non-Blueprint peers across cost, quality and savings, mirroring what happens nationally when ACOs take on full risk.

These savings aren't derived from reducing access or limiting care. Instead they result from **preventing avoidable events**, including:

- Hospital admissions
- Readmissions
- Emergency department visits
- Complication

Sources: [1]MSSP longitudinal study, 2013–2022, ScienceDirect 2025, [2]2022 MSSP Performance Data, Lumeris, [3]2022 MSSP

Why Blue Cross is Different

Blue Cross' value-based care model stands apart through several key differentiators:

Scale and sustainability
More than 20 years of experience and statewide reach

Integrated capability layering
Measurable, incremental improvements across care models

Deep provider accountability
Financial incentives tied directly to quality and cost outcomes

Together, these elements create a system that delivers consistent, measurable results.

Looking Ahead: Expanding Value-Based Care

Blue Cross continues to build on its foundation through:

Expansion of Advanced Primary Care models

Growth into specialty value-based programs

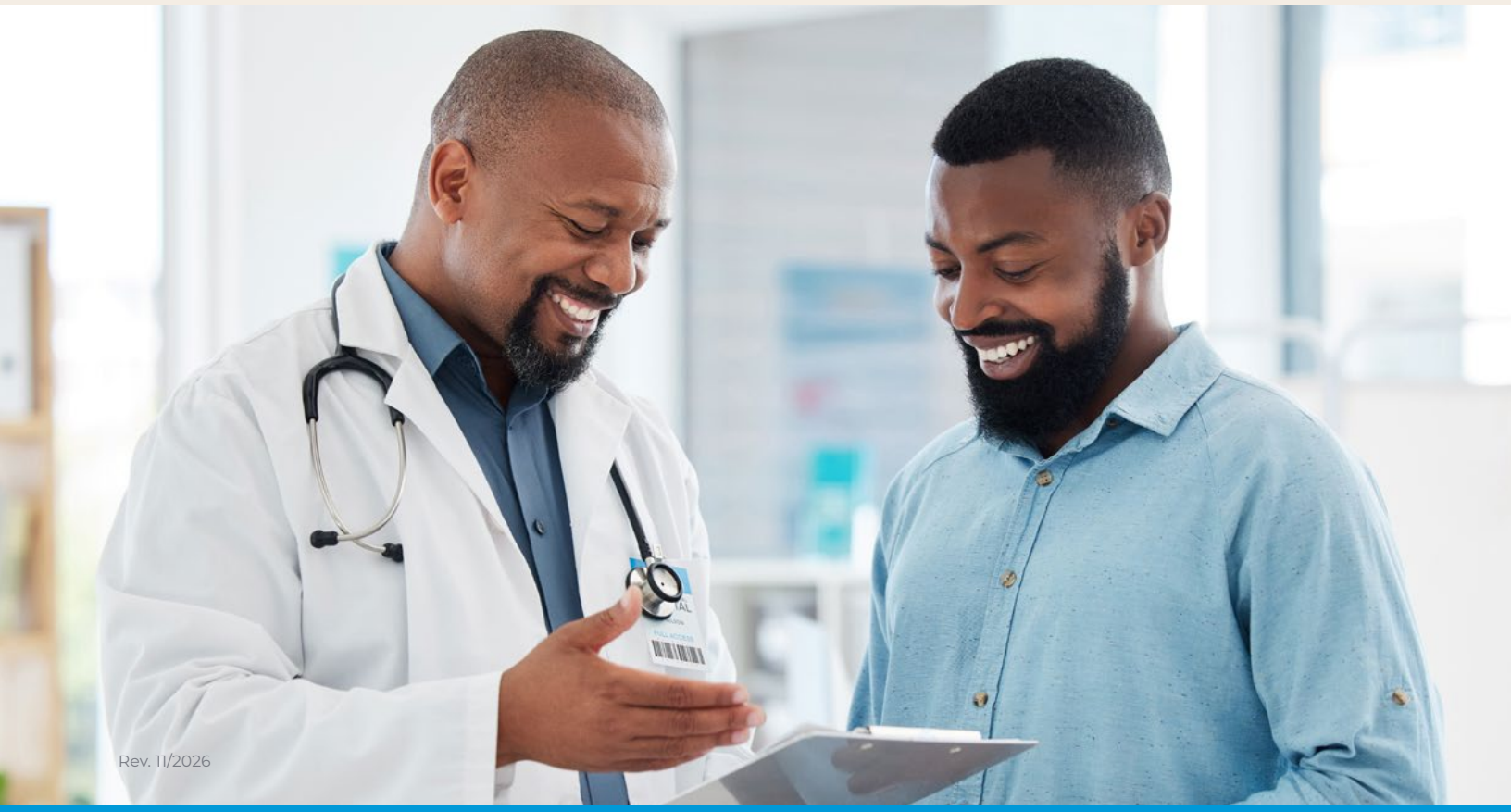
Increased adoption of accountability-based provider arrangements, such as Blueprint

These efforts will further strengthen outcomes, expand access and enhance affordability.

Healthcare is undergoing a fundamental shift from volume to value.
Blue Cross' value-based care model demonstrates that it's possible to achieve:

- **Active physician engagement**
- **Better health outcomes**
- **Lower total cost of care**
- **Sustained performance at scale**

For employers, this represents a meaningful opportunity to move beyond managing healthcare costs to actively improving the performance of the healthcare system itself.



Rev. 11/2026

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.