2026 | Case Study

# Closing the Gap in MSK Care: Engaging Specialists Through Condition-Based Value Models

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Musculoskeletal (or MSK) conditions affect more than 50% of U.S. adults, including nearly 75% of adults age 65 and older. These conditions are among the largest drivers of health care spending in the U.S., accounting for over $300 billion in annual expenditures. Even though conservative treatments such as physical therapy are often recommended as a first-line option for MSK conditions, many members are referred first to costly services like imaging, surgery, and other procedures. Value-based MSK care transforms member outcomes while lowering total costs. By using technology and advanced services to enable clinical best practices, Blue Cross Blue Shield of Michigan (BCBSM) intervenes earlier and guides patients to the most effective, cost-conscious care.

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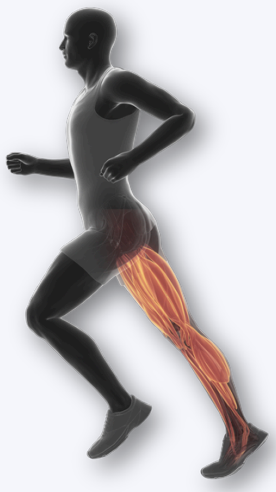
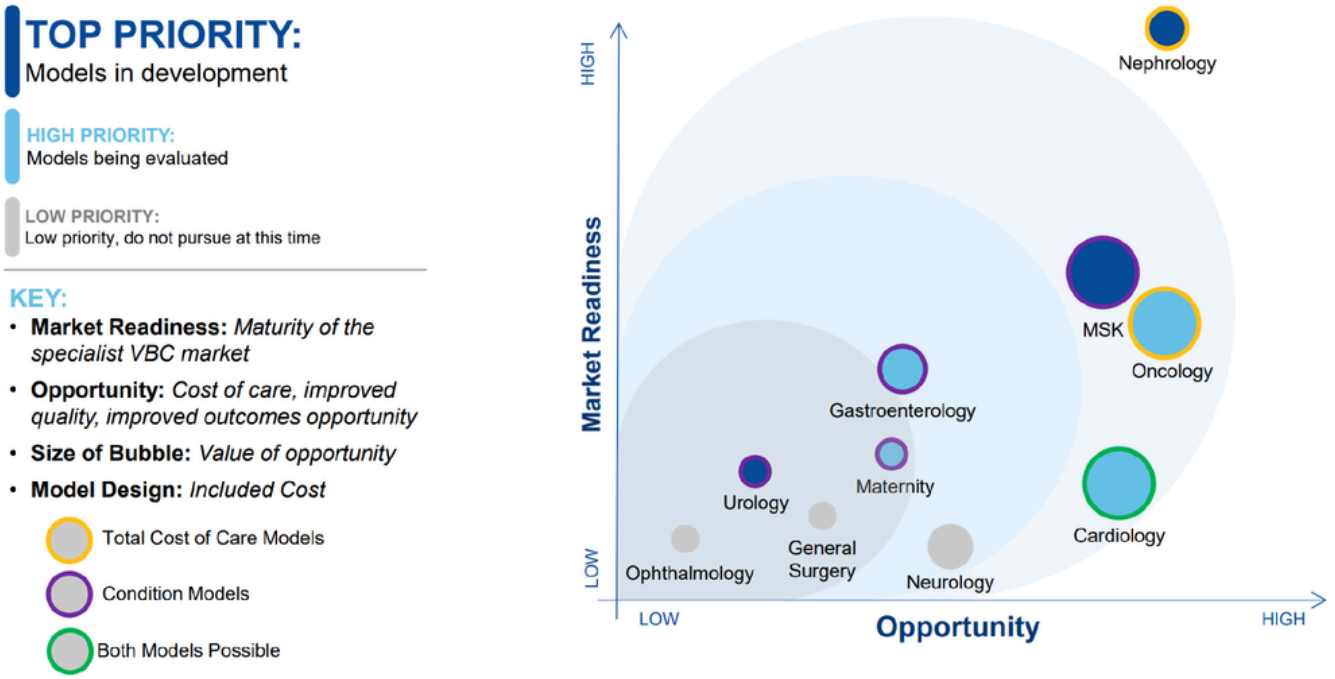


# BCBSM's Model

BCBSM has been investing in value-based care for over 20 years through their flagship Physician Group Incentive Program (PGIP) and Blueprint for Affordability Program, which offer financial incentives and varying levels of risk for physicians respectively. While these programs have led to improved outcomes and reduced costs, BCBSM sought to further engage specialists in value-based care. BCBCM assessed specialty models with high market readiness for innovation and opportunities for improved outcomes and costs.




In 2018, BCBSM began an optional orthopedic model focused on hip and knee replacement episodes in the Medicare Advantage and commercial populations. Savings were achieved in these episodes by shifting care from inpatient to ambulatory settings and creating optimal care pathways for post-acute care. However, as orthopedists adopted the care pathways into their standards of care, there were limited opportunities for additional savings. BCBSM therefore ended the commercial component of the program in 2024, moving instead to address upstream factors.

In 2025, BCBSM shifted to a condition-based MSK model which focuses on caring for patients with a given diagnosis rather than immediately following a procedure. The goal is avoiding unnecessary procedures, better managing chronic conditions, and driving members to the most appropriate care for their condition. In simple terms, an episode would address knee replacement, while a condition-based model addresses knee pain.

BCBSM co-created the model in collaboration with TRIARQ Health, a subsidiary of BCBSM, and hip-network providers. Any willing provider is eligible to participate in the model. The initial pilot was focused on commercial HMO membership in southeast Michigan.

Model interventions include:

- Referrals to high-value specialists
- Care pathway planning and adherence
- Care management / navigation
- Procedural site of care shift
- Emergency room and inpatient avoidance
- Increased member engagement

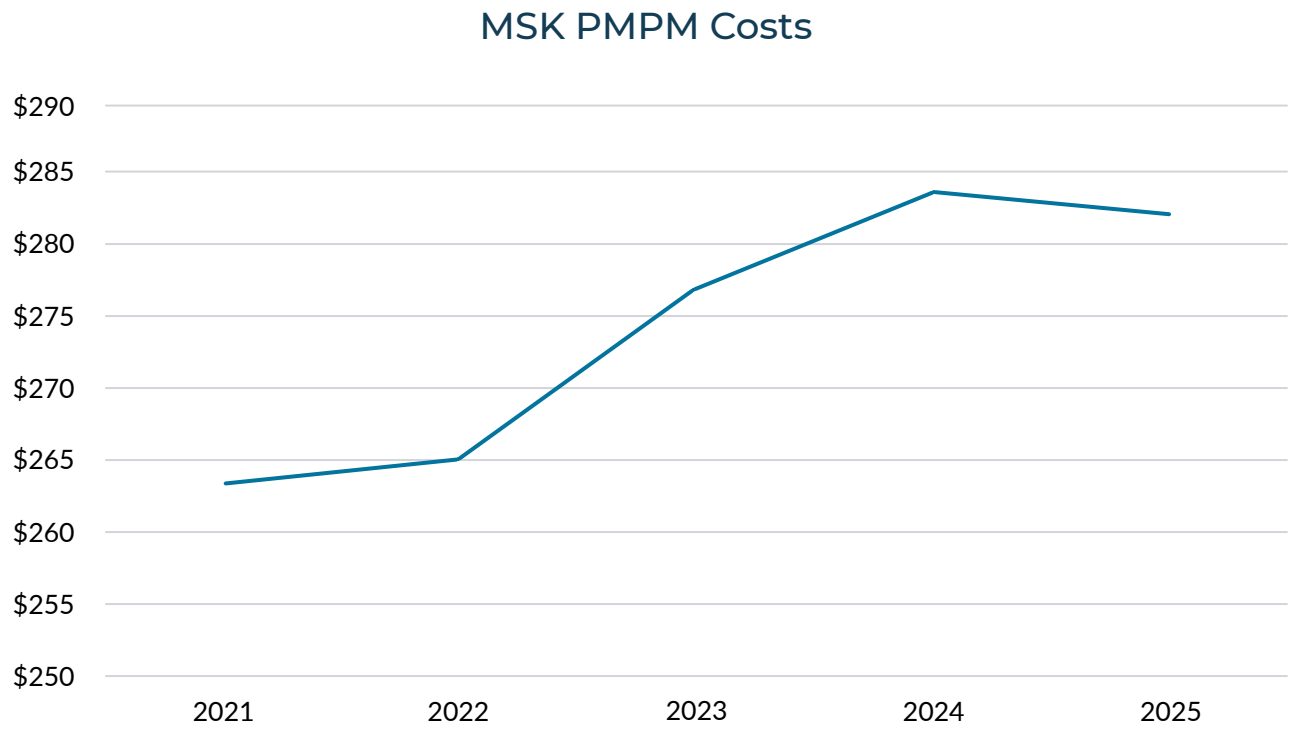
## Financial Arrangements

TRIARQ Health is a specialty value-based care enablement company that partners with in-network specialists to offer care pathway tools and wrap around services and capabilities not reimbursable under fee-for-service. TRIARQ contracts with providers to align care delivery with clinical pathways. TRIARQ receives an at-risk advance payment, and shares savings 50/50 with BCBSM, after providers exceed certain quality and cost outcomes. The majority of the 50% TRIARQ share is then shared with provider partners, rewarding them for their participation and behaviors that drove the creation of better outcomes and lower costs. BCBSM's share of the savings is used to continue efforts to offer affordable products to their customers and members.

Members are eligible for the model if they have a claim during the first 10 months of the performance period that includes an in-scope MSK condition. For eligible members, all in-scope costs are incorporated in the financial methodology for the full performance period regardless of when attribution occurs in the year. In the inaugural year of the program, BCBSM identified over 100,000 eligible members based on 35 MSK conditions. These members accounted for over $320M in MSK spend in 2025.

## Outcomes

Preliminary results show a meaningful 3.5% reduction in MSK spend for the population included in the model as compared to the market trend. Amongst the eligible membership, per member per month in-scope MSK spend decreased for the first time since 2021. The total savings for 2025 are estimated to be $10.5M, with a sizable portion being shared directly with physician partners in the market, which adds to BCBSM's goals to offer affordable products to customers and members.




*Data from BCBSM's internal analysis. HCTTF did not independently validate the results.*

## Replicating this Model

Moving from procedure-based to condition-based models creates an opportunity to intervene earlier, reduce unnecessary utilization, and better manage chronic MSK conditions over time. Success hinges on engaging specialists in new ways, building the right infrastructure to support care transformation, and designing sustainable financial models. Organizations can build on BCBSM's model by focusing on these efforts:

1. **Partner with in-network specialists** to create true long-term care transformation that leads to better outcomes and lower costs. Models who do not partner in this way are not creating durable or sustainable models.

2. **Share savings with specialists** generated through care transformation efforts to create new opportunities, essential for independent specialists to thrive.

3. **Utilize third parties** to aggregate risk and deliver necessary capabilities to specialists to enable success in value-based care models. Specialists **are often not interested in or equipped to take on significant financial risk directly** from the health plan.

4. **Implement both total cost of care and condition-based models.** Certain specialties (e.g., nephrology) lend themselves to total-cost of care models, while other specialties (e.g., MSK) require models built around condition spend.

5. **Incentivize specialists' practices for care transformation when it occurs.** Often models wait 12-18 months for a settlement to be complete to share in the value created, which can hinder or slow practice transformation.

6. **Scale successful capabilities** such as care pathways and member navigation across specialty types. What works in one specialty can often work well in another.

MSK conditions highlight the limitations of procedure-driven models and the importance of managing patients longitudinally across the full continuum of care. By aligning incentives, supporting providers with the right capabilities, and focusing on condition-based outcomes, payers and providers can build models that reduce spending and improve patient functioning and quality of life.