

# Moving from Fee-for-Service to Fee-for-Value: Blue Cross Blue Shield of Michigan's Value Partnership Programs

The Tenth National Pay for Performance Summit  
March 2015



Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

# Session Description

*This presentation will describe value-based primary care, specialist, and hospital programs at Blue Cross Blue Shield of Michigan, all of which are designed to transition the health care system from a fee-for-service model to an approach that is rooted in “fee-for-value.”*



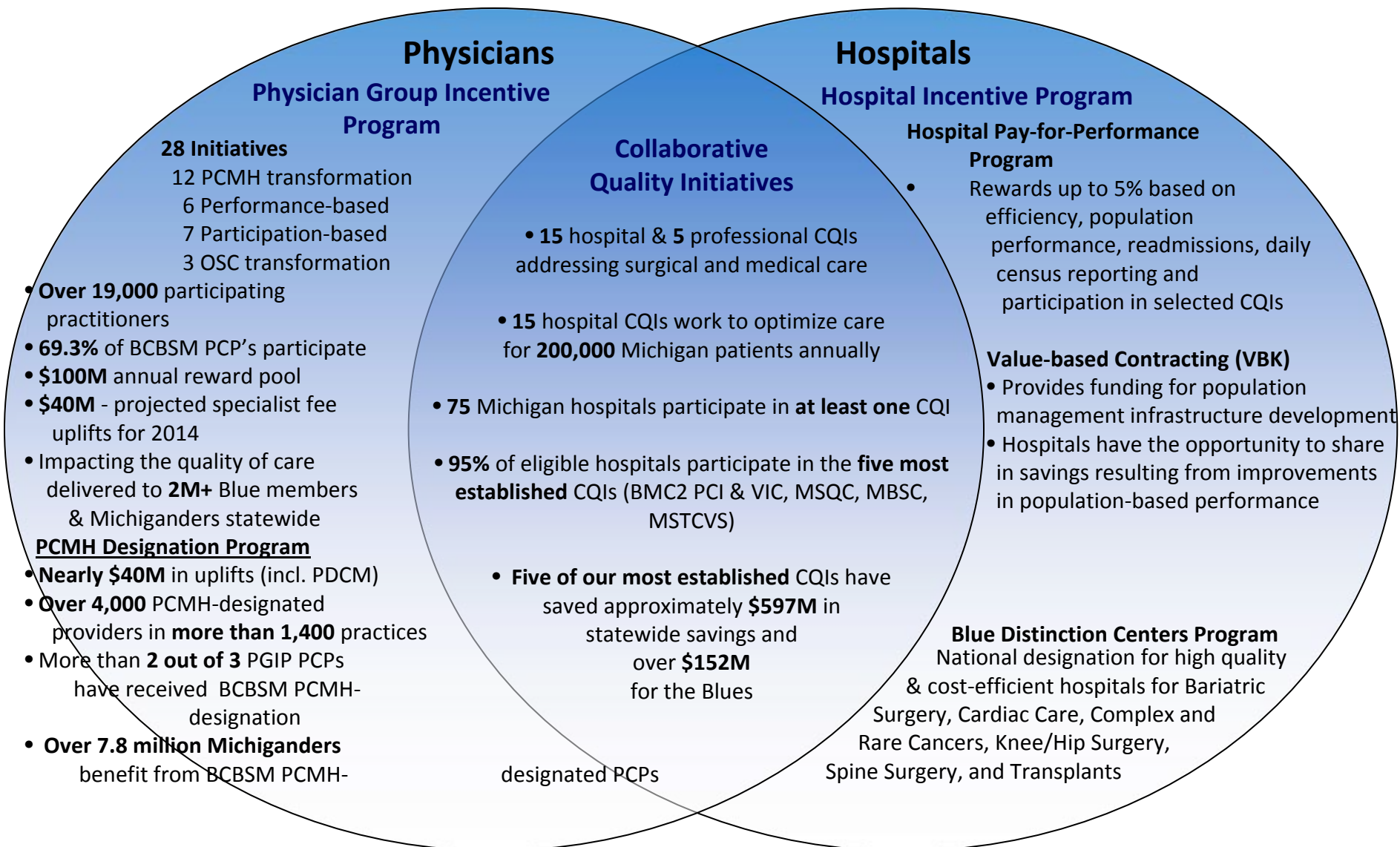
**Value Partnerships** is a diverse set of clinically oriented programs that foster collaboration among the Blues, physicians and hospitals - and it's changing the health care landscape in Michigan.



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# BCBSM's Award-Winning Value Partnerships Programs



## BCBSA "Best of Blue Awards"

- PGIP and CQIs
- PCMH (*also received BlueWorks, BCBSA's premiere award*)
- MSQC, MBSC and MOQC (*MSQC & MBSC also received BlueWorks, BCBSA's premiere award*)

## Additional recognition

- Michigan Cancer Consortium
- National Business Coalition on Health
- URAC

# Moving from “Fee for Service” to “Fee for Value”

## Volume



VS.

## Value



# BCBSM's "Partnering for Value" Philosophy

- 1 • Design and execute programs in a *customized and collaborative* manner, rather one-size-fits-all
- 2 • Recognize and reward performance of *physician organizations*, not just individual physicians
- 3 • Reward *improvement*, not just highest performance, to create meaningful incentives
- 4 • Focus on investments in *long-term changes in care processes*
- 5 • Encourage *collaboration* among participants
- 6 • Focus on *population-based* cost measures, rather than per-episode cost, to avoid stimulating overuse



# What is a “physician organization”?

- Physician organizations (a.k.a. “POs”) are a collection of provider practices – some big, some small, some geographically constrained, some not – that are affiliated with one another
- Sometimes affiliation exists for the purposes of participating in PGIP, sometimes affiliation is related to hospitals (e.g., University of Michigan Health System)
- In 2015 there will be 46 physician organizations participating in PGIP
- We use POs as the vehicle for change, instead of individual providers
  - More efficient
  - Facilitates large scale transformation
  - Makes data better
- POs receive incentive dollars for participating in nearly 30 PGIP initiatives

# Physician Group Incentive Program

*Transforming health care across Michigan*



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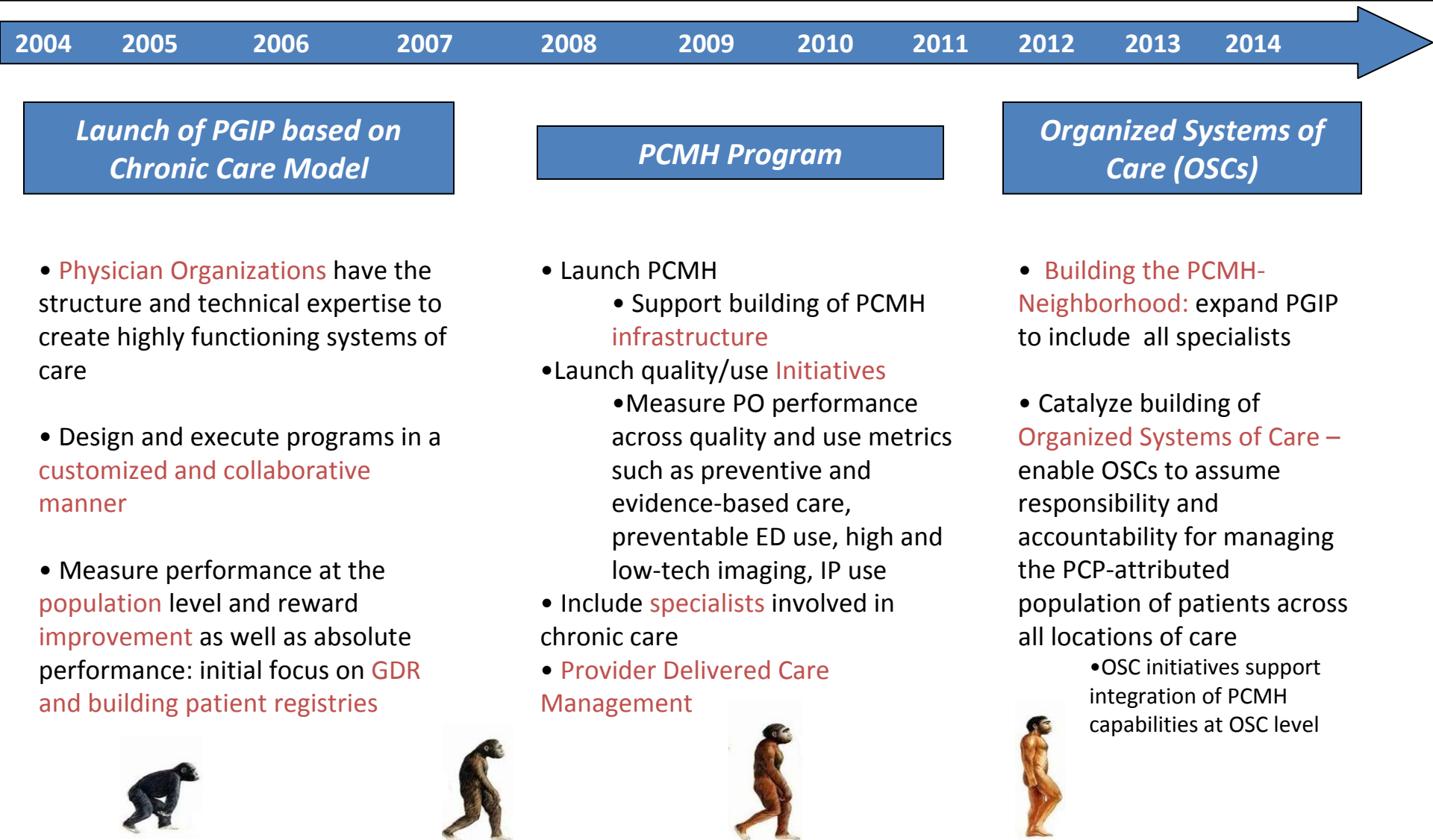
# What is the Physician Group Incentive Program?

- BCBSM partners with Physician Organizations (POs) to create high performing health care systems in Michigan
- Moving from a fee-for-service to a fee-for-value approach
- PGIP offers rewards to:
  - *POs* to assist with infrastructure improvement and practice transformation
  - *Practitioners* through fee-for-value-based fee uplifts
- Increasingly, a portion of professional reimbursement is tied to rewarding specialists for:
  - Supporting the Patient Centered Medical Home (PCMH) model as PCMH-Neighbors
  - Collaborating with their community of caregivers to optimize use, efficiency and quality in their shared patient populations

# Physician Group Incentive Program: Key Statistics

- Part of the “Value Partnerships” umbrella of programs: includes Patient Centered Medical Home + Organized Systems of Care + quality initiatives
- 46 participating physician organizations
- Over 6,500 practice units
  - 19,272 physicians (about 5,900 PCPs + 13,300 specialists)
- Physician Group Incentive Program (PGIP) has participating providers in 81 of 83 counties in MI (remaining two counties have no PCPs)
- Over two-thirds of network PCPs and just over half of network specialists currently participate in PGIP
- Providing care to approx. 2 million members and an additional 5.8 million Michiganders

# Physician Group Incentive Program: Catalyzing Health System Transformation in Partnership with Providers



David A. Share and Margaret H. Mason, *Michigan's Physician Group Incentive Program Offers A Regional Model For Incremental 'Fee For Value' Payment Reform*. Health Affairs, 31, no.9 (2012):1993-2001.

# Physician Group Incentive Program: Payment Transformation

- **PGIP Incentive Pool: Physician Organization incentives**

- 5% of professional payment = \$110M
  - 50% supports PCMH-N/OSC infrastructure development
  - 50% rewards Physician Organizations/OSCs for population level cost and quality performance

- **Variable professional payment tie-barred to population value: no fee increases after 2009**

- Payment partly dependent on modernizing systems and care processes; re-purposing assets; integrating across settings; managing populations; and optimizing cost and quality performance
- Variable reimbursement dependent on PCMH-Designation and cost/quality performance for PCPs; and PCMH-N participation and cost/quality performance for specialists

- **Provider Delivered Care Management**

- Reimbursement for team-based care management/coordination/self-management support for patients with chronic illness



# Payment Transformation/Incentive Alignment for Hospitals and Members

## Hospitals:

- Contracts are modernized
- Minimal base fee increase
- OSC infrastructure payment
- Positive margin dependent on population performance
- Initial focus on re-hospitalization, ED use, ambulatory care sensitive condition admissions

## Members:

- New products with tiered local networks
- Variable member liability linked to self-assignment to a PCMH practice
- Use of PCMH-Neighborhood specialists and OSC facility providers in the local network

# Practice Transformation

- To transform health care, we started by transforming *primary care practices*
- What does practice transformation mean?
  - Providing tools, support, and resources to do the job well
  - The best care possible for patients
  - Changing systems and care processes, making care standardized and consistent
  - Efficiencies for physicians – time-saving, allows for ideal care
  - Rewarding practices for their efforts...it's hard work!
- Began specialist practice transformation in 2012

# Patient Centered Medical Homes

*The foundation of practice transformation and fee-for-value*



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# Patient Centered Medical Homes: Key Statistics

- Patient Centered Medical Home program includes:
  - Nearly 16,000 providers across the state working to implement capabilities
    - Includes both PCPs (6,600) and specialists (9,300)
- 2014 Patient Centered Medical Home Designation
  - Over 4,000 primary care physicians in 1,422 practice units
  - Designated providers consistently show excellence on quality and utilization metrics
  - More than two-thirds of PGIP-participating PCPs are Patient Centered Medical Home designated

# 2008 Patient-Centered Medical Home Initiatives

- **Patient-Provider Partnership:** Physician, care team, and patient discussions about PCMH model and patient and provider roles and responsibilities
- **Patient Registry:** Comprehensive patient registries that enable population level management and point of care readiness
- **Performance Reporting:** Performance reporting that enables POs and providers to compare and track management of their patient population
- **Individual Care Management:** Care processes that enable patients with chronic conditions to receive organized, planned care and be empowered to take greater responsibility for their health.
- **Extended Access:** Care processes that ensure all patients have timely access to health care services that are patient-centered, culturally sensitive, and delivered in the least intensive and most appropriate setting
- **Test Tracking:** Standardized, reliable system to ensure that patients receive appropriate tests, and that test results are communicated in a timely manner.

# 2009 Patient-Centered Medical Home Initiatives

- **Preventive Services:** Patient screening and education on both primary and secondary preventive care
- **Linkage to Community Services:** Community services directories and care processes to ensure patients receive needed community services
- **Self-Management Support:** Formalized care processes to enable patients to effectively manage their chronic conditions.
- **Patient Web Portal:** Web portals giving patients ability to schedule appointments, obtain test results, enter health information, and have e-visits
- **Coordination of Care:** Care processes that avoid duplication of services and effectively manage patient care transitions across settings
- **Specialist Referral Process:** Standardized referral processes to ensure patients receive needed care and all providers have timely access to the information they need to provide optimal care to the patient.

# PCMH: Two Ways to Participate

- **Phase I:** Implementing up to 145 PCMH capabilities in 12 initiatives
  - Physician organizations receive incentive dollars for capability implementation within their practices
    - Practices can be either PCPs or specialists
  - Rewards paid twice/year
  - Incentive at PO level = differentiator. Two reasons:
    - No issues with small  $n$ , better from measurement standpoint
    - More efficient dissemination of tools and resources
- **Phase II:** Becoming PCMH Designated
  - Designation takes place at practice unit level
  - Nominated by PO
  - Occurs annually
  - PCP only
  - Providers receive enhanced fee for office-based E&M codes



# PCMH: Two Forms of Reimbursement

## 1) PGIP PCMH Initiatives

- POs and affiliated practices can implement up to 145 capabilities in 12 PCMH initiatives
- All PCPs and Specialists in PGIP may participate
- Reward payments to physician organization based on the number of PCMH capabilities implemented during each six-month payment period

*POs work on Initiatives  
to achieve practice transformation.*

## 2) PGIP PCMH Designation Program

- PGIP practice units can become PCMH- designated by BCBSM
- Only PCPs are eligible to participate
- Increased E&M fees:
  - Office visits → 99211 – 99215
  - Preventive → 99381 – 99397
  - Fee uplift to PCMH-designated practices (+10%)
  - Additional fee uplift (+10%) for those PCMH-designated practices in POs with optimal population level cost performance

# PCMH Results

- Our Patient Centered Medical Home program demonstrated savings of \$155M over first three years of program
  - 2008-2011 program years, certified by BCBSM Actuary
  - 2012 data will be certified later in 2014
  - Not *just* designated practices – all PCMH-participating practices
- For a practice that has fully implemented patient centered medical home model, expected cost savings of \$26.37 lower per member per month adult medical costs
  - *Health Services Research* article (M. Paustian, July 2013)
  - Caveat: No practice has accomplished full PCMH-ness...yet
  - At **current average level of PCMH implementation**, we project savings of \$5-\$13 per member per month in adult medical costs

# Integrating Specialists into Fee-for-Value

*Another piece of the puzzle*



# Patient Centered Medical Home Neighborhood

- What is “the neighborhood?”
  - Not a separate program...an enhancement to an existing one!
  - Integrating specialist physicians into the PCMH model
    - PCMH originally focused on PCPs – to bolster and support them
    - Recognized need for specialists to join in PCMH capability implementation, to foster growth of *Organized Systems of Care* (OSCs)
    - Specialists benefit from transforming care processes, just as PCPs do

# PCMH-N, Cont'd.

- How does PCMH-N work?
  - Just like PCMH does, except does not include a designation program
  - Specialist practices can implement PCMH capabilities in any order they choose, as applicable to their practice and patient population – same as PCPs
  - PCMH interpretive guidelines include detailed info about how capabilities apply to specialist practices
  - POs receive incentive rewards for specialist capability implementation, as they do for PCP capability implementation

# Rewarding Specialists

- We provide incentives for specialist implementation of PCMH capabilities, but rewards are disbursed to the *physician organization*
- How do we incentivize providers directly?
  - Specialist fee uplifts!
  - 36 specialty types are currently part of program
- Rewarding specialists who collaborate with PCPs and POs to:
  - Create improved systems and care processes
  - Implement evidence-based care
  - Promote efficient and effective care
- The measures for specialists fee uplifts are population-based ... rewarding those specialists who serve entire patient populations and have better overall performance
- Eligibility for fee uplifts is determined on an annual basis with an effective date of February
- Fee uplifts are applied only to PPO/Traditional Commercial claims

***“Measuring at a population level focuses on system performance, encourages system accountability and supports system improvement. Measuring at the individual practice and individual physician level is essential for focusing providers’ attention on opportunities to improve processes and outcomes of care. But, given the methodological limitations which constrain the accuracy of results, ideally it is best to hold a community of caregivers responsible for aggregate performance at a population level...”***

**- David Share, MD, MPH  
SVP, Value Partnerships**

**Testimony submitted to the House Ways and Means Committee, Health Subcommittee**

# Criteria for the Specialist Fee Uplifts

- Eligibility
  - Practitioners are listed with an eligible specialty type
  - Practitioners must be in PGIP for **at least 1 year** prior to the uplift year
- Nomination
  - Each year eligible practices must be nominated by their member PO and, if applicable, another PO with which they are affiliated
  - Nomination is based on publicly-available criteria and Patient-Centered Medical Home-Neighbor (PCMH-N) principles
  - Nomination is a necessary to receive uplift but doesn't ensure practice will receive it
- Evaluation
  - Population-based metrics are calculated for practices based on sub-PO member populations
  - BCBSM selects nominated practices based on one or more population-based metrics of cost, quality, utilization and/or efficiency
  - In 2015, BCBSM selected the top half of nominated, non-pediatric specialty practices plus all nominated pediatric specialty practices to receive a fee uplift

# Care Management

*Care management where patients want it...in their doctor's office or at home*

# Provider Delivered Care Management

- Integral part of the Blue Cross Blue Shield of Michigan Patient Centered Medical Home Program
- Care management traditionally delivered by the health plan; now also available in the office setting for select practices/patients
- WHY??
  - Patient have trusted relationship with PCP
  - Literature suggests favorable outcomes/engagement
- Expands BlueHealthConnection suite of wellness programs:
  - No diagnostic restrictions
  - Includes pediatric patients
  - Intervention includes telephonic **and** face-to-face **and** group visits



# Provider Delivered Care Management

- Phase I: Provider Delivered Care Management (PDCM) Pilot, 2010-2012
  - Five physician organizations in 50+ practices with over 250 PCPs
  - Each physician organization tested their own model
- Phase II includes approx. 1,600 physicians in 360 practices across MI
  - Michigan Primary Care Transformation project runs from 2012-2016
    - CMS-supported multi-payer demonstration project
    - Tests efficacy of PCMH model with standardized care management
    - Year 1 CMS net savings: \$227 million
  - Providers working with care managers in advanced practice settings
    - More patient centered medical home capabilities in place, strong performance on health care quality/use metrics
- Oncologists added to program in November 2013

# Provider Delivered Care Management

- Reimbursement
  - Code-based reimbursement mechanism is also our reporting mechanism
    - 12 unique codes that can only be used for delivering care management services
    - Four G-codes + One S code + Seven CPT codes
    - Presence of these codes in our claims system triggers alert that patient is engaged in PDCM
    - Fee for service...not PMPM-based (helpful in selling to customers!)
  - 5% fee uplift in addition to 10% or 20% already allotted for PCMH participation

# High Intensity Care Model (HICM)

- Addresses complex Medicare Advantage (MA) patients
- Identifies at-risk BCBSM MA members in Michigan and provides intensive care management services to increase quality of life, increase their care cost-efficiency and increase BCBSM's ability to refine risk adjustment and address STARS gaps in care.
- Team based care model based on Indiana University GRACE model
- Majority of services are home-based, delivered by teams including NP/RN, MSW, pharmacist, nutritionist, LPN, and medical director
- Consistent with Patient Centered Medical Home (PCHM), Patient Centered Medical Home-Neighbor and Organized Systems of Care principles

# HICM Reimbursement

- Phase 1
  - Reimbursement will be via PDCM codes
- Phase 2
  - Providers will begin billing a monthly chronic care management monthly code in lieu of PDCM non-face-to-face phone and care coordination codes
  - Face to face services billable fee for service
    - Two new S codes will be added to pay a higher fee in the home location for the comprehensive care management assessment and in-person care management encounters

# Organized Systems of Care

*The culmination of our fee-for-value transformation*



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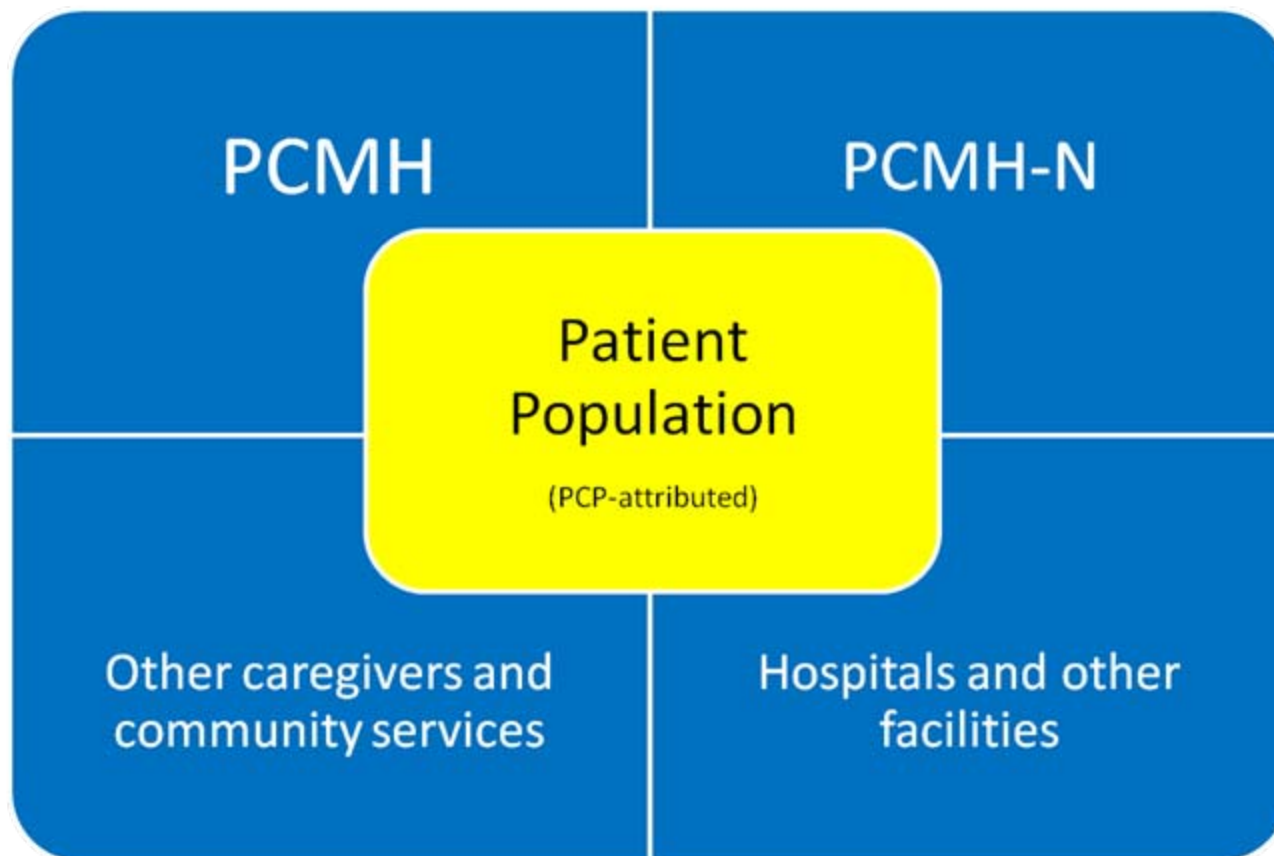
# What is an Organized System of Care?



Organized System of  
Care

- BCBSM term used to describe a **community of caregivers** with a shared commitment to quality and cost-effective health care delivery for the primary care-attributed population of patients

# What is an Organized System of Care?



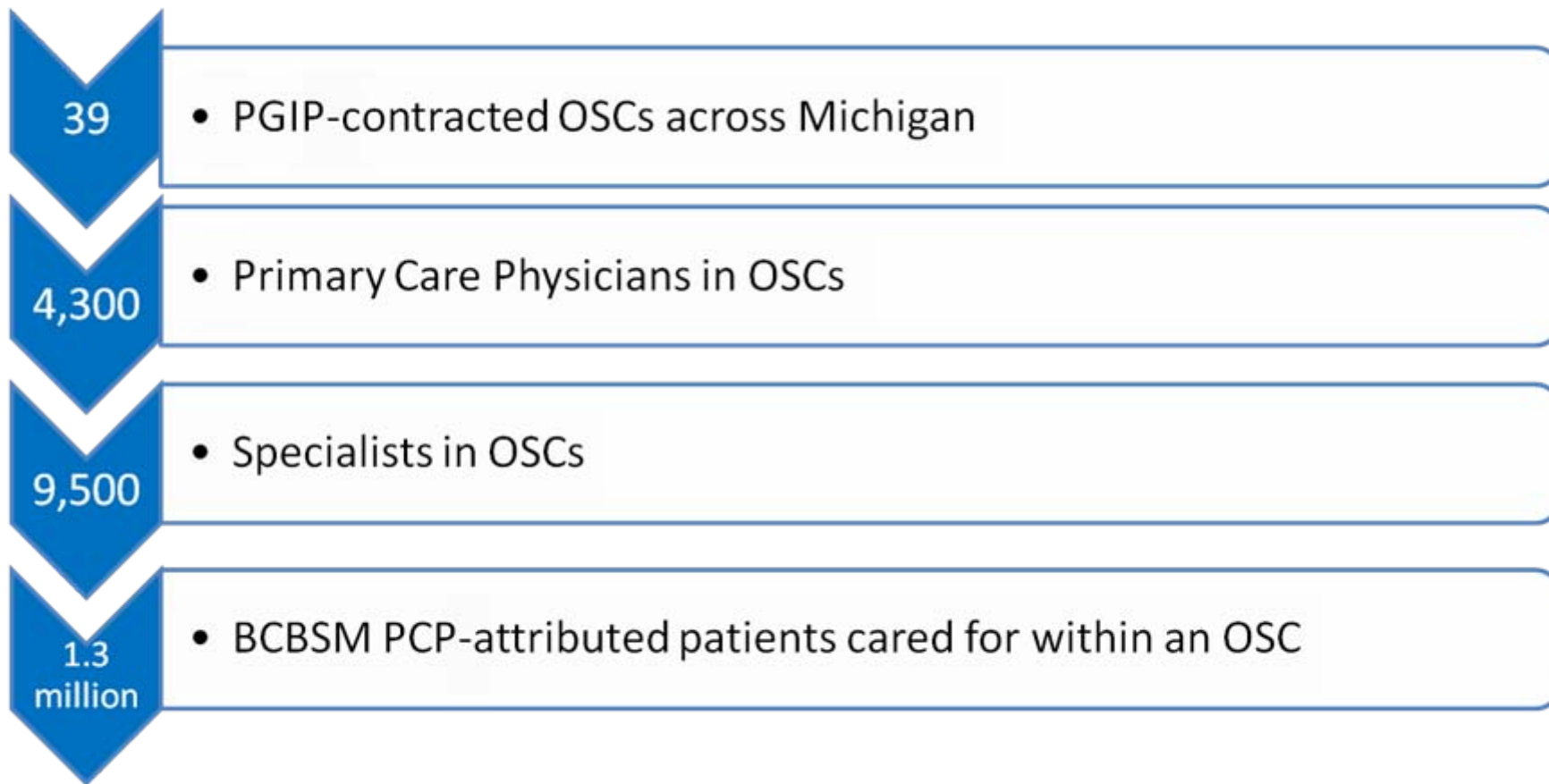


# Desired Outcomes

High-performing health systems with responsibility and accountability for collectively managing a shared population of patients

- Coordinated health and social services support
- Improved management of complex patients
- Improved outcomes and efficiency
- Reduction in preventable ER visits & admissions
- Appropriate use of testing and referrals
- Prevention and early diagnosis
- Self-management support

# Current PGIP-contracted OSCs



# OSC By County

Ontonagon County: Upper Peninsula  
Health Group

Grand Traverse County: Northern  
Michigan Health Network

**Kent County:** Advantage  
Health/Saint Mary's Care  
Network; Spectrum  
Health; Metro Health  
OSC; Physician  
Organization of Michigan;  
WMPN OSC

Ottawa County: Advantage Health/Saint Mary's Care Network; Holland OSC; Lakeshore Health Network; Metro Health OSC; Physician Organization of Michigan; Spectrum Health; WMPN OSC

Allegan County: Borgess  
Health; Holland OSC; Metro  
Health OSC; Physician  
Organization of Michigan

Calhoun County: Borgess Health; Integrated Health Partners; Jackson Health Network

Saginaw County; MidMichigan  
Collaborative Care Organization;  
Primary Care Partners Physician  
Network; Sparrow Physicians  
Health Network; St. Mary's of  
Michigan OSC; Michigan  
HealthLink

Livingston County: UofM; IHA;  
HHPA; Michigan HealthLink; The  
Physician Alliance-Partners in Care

Ingham County: Greater Washtenaw  
Area Care Partners; McLaren  
Physician Hospital Organization;  
Sparrow Medical Community;  
Sparrow Physicians Health Network;  
Jackson Health Network

Eaton County: McLaren Physician  
Hospital Organization; Sparrow  
Medical Community; Sparrow  
Physicians Health Network;  
Integrated Health Partners

St.ClairCounty:  
Accountable Healthcare  
Alliance, Mercy Physician  
Comm PHO, Physician  
Healthcare Network, The  
Physician Alliance

**Oakland County:** Accountable Healthcare Alliance, PC; DMC PHO, LLC; DMC Primary Care Physicians, P.C.; Genesys PHO, L.L.C.; Henry Ford Medical Group Organized System of Care; McLaren Physician Hospital Organization; Michigan HealthLink; Physician Direct Connection, LLC; Michcare, LLC; OMS OSC; The Physician Alliance-Partners in Care; United Physicians Integrated Care

Macomb County;; DMC PHO, LLC; DMC Primary Care Physicians, P.C.; Henry Ford Medical Group Organized System of Care; McLaren Physician Hospital Organization; Michigan HealthLink; Michcare, LLC; The Physician Alliance-Partners in Care; United Physicians Integrated Care

Wayne County:  
Accountable Healthcare  
Alliance, PC; Organized  
System of Care; DMC  
PHO, LLC; DMC  
Primary Care Physicians,  
P.C.; UofMI HVPA;  
IHA;; Henry Ford  
Medical Group  
Organized System of  
Care; Michigan  
HealthLink; Michcare,  
LLC; Oakwood  
Accountable Care  
Organization, LLC; OMS  
OSC; United Physicians  
Integrated Care; The  
Physician Alliance-  
Partners in Care

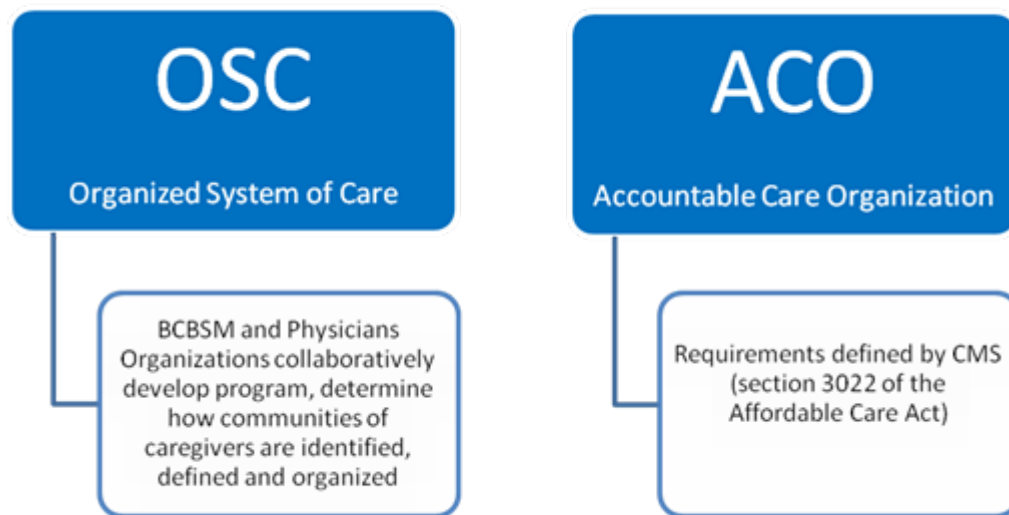
Washtenaw County:  
UofM; HVP, IHA; Henry  
Ford Medical Group  
Organized System of Care;  
Michigan HealthLink

Lenawee OSC; IHA

# How is an OSC different from an ACO?

Goals conceptually aligned – better care for individuals, better health for populations and slower cost growth

Differences – OSC focuses on infrastructure support in addition to after the fact accountability; did not use “ACO” name because of our commitment to collaborative development with Physician Organizations



# How OSCs are Aligned with Other Initiatives

- Implementation of 42 capabilities across three initiatives – similar to structure of PCMH program – results in OSC capability payments twice annually
  - Reward payments for other PGIP initiatives are disbursed to physician organizations...reward payments for OSC capability implementation is disbursed to the OSC
- Value-based Contracts (VBK) for hospitals – VBK Infrastructure component complements OSC capabilities and funding
- OSC-based product – in development, slated for 2016

# Summary

- Blue Cross Blue Shield of Michigan is using a variety of physician and hospital-based programs to transform the health care system in Michigan from fee-for-service to fee-for-value
- Our reimbursement approach includes incentives that are regularly paid to physician organizations and organized systems of care, and fee uplifts paid directly to physicians
- Keys to our success:
  - Strong collaborative relationships with the provider community
  - There is no such thing as “one size fits all”
  - Visionary leadership is critical



# Questions?

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