Rewarding Hospitals for Improved Payment Trends

Implementing population-based hospital measures within a fee-for-service payment system

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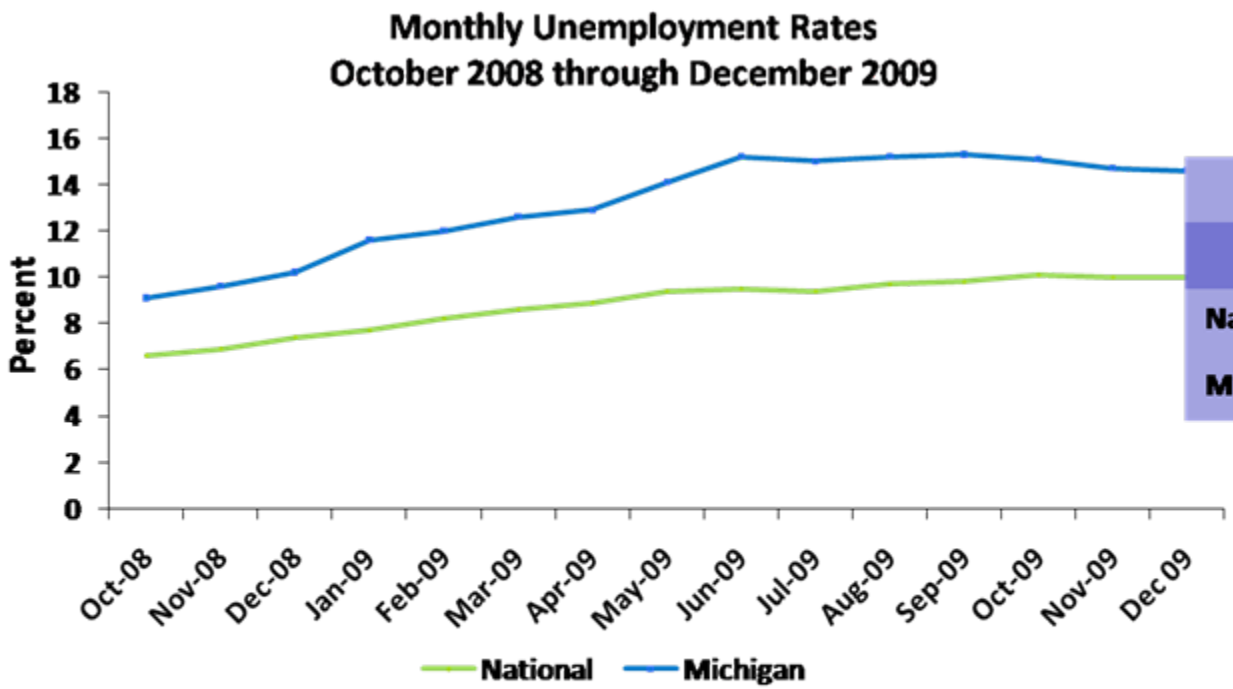
Today's presentation

- About Michigan
- About BCBSM
- Our P4P history
  - Limits of the fee-for-service system
- New P4P strategy
  - Focus on payment trends
- Success factors

About Michigan



Forecast Highs		
	2010	2011
National	10.1	9.6
Michigan	15.8	15.4

Note: rates are seasonally adjusted

Source: Michigan.gov; Labor Market Information, Data Explorer -Unemployment Statistics

About Michigan

2007 Data	Michigan	U.S. Average
Median age in years	37.5	36.6
Obesity prevalence among adults	28.2%	26.3%
Diabetes prevalence among adults	8.8%	8.1%
Smoking prevalence among adults	21.1%	19.7%

About BCBSM…

Nonprofit

Michigan's largest health care provider:

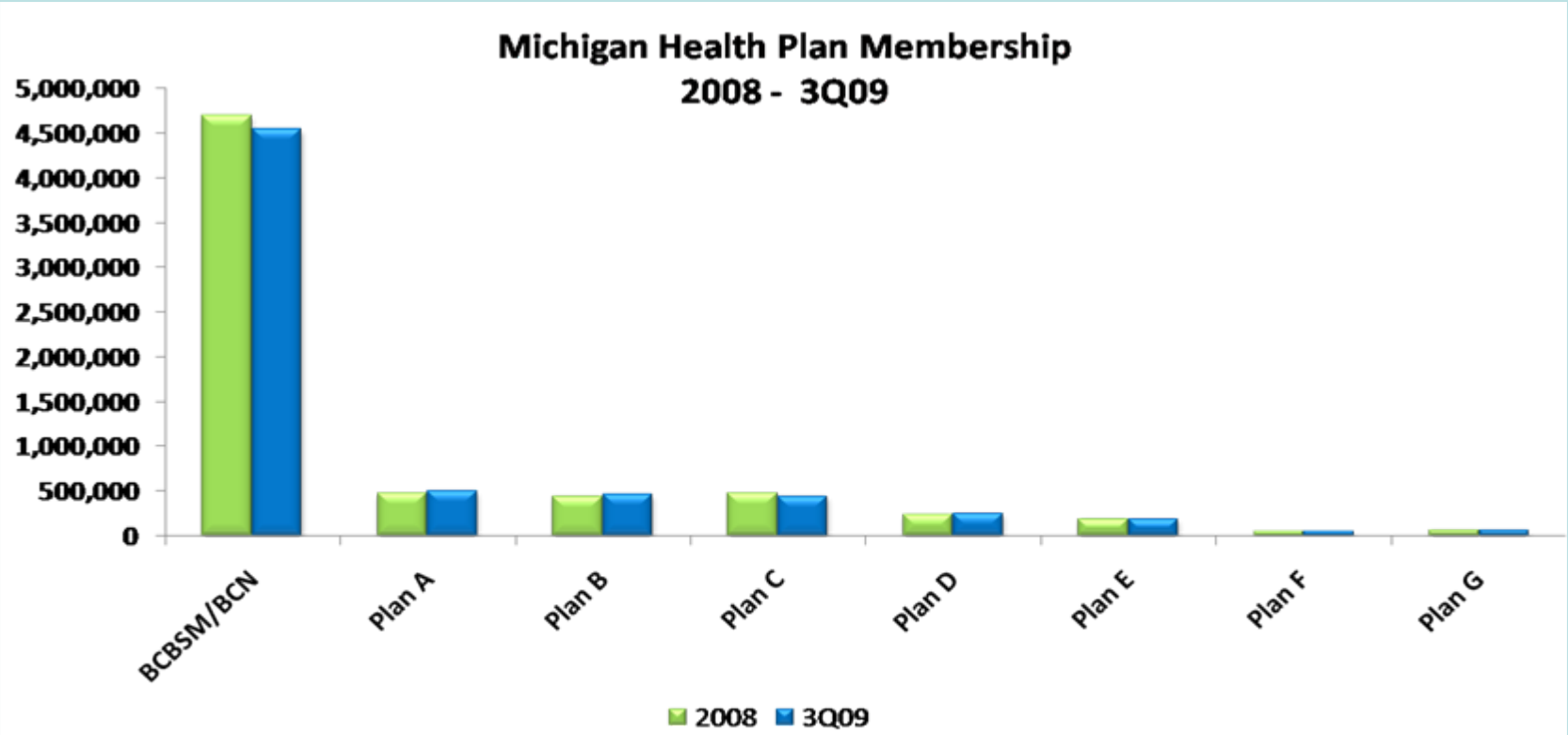
- 45% market share
- 4.5 million Michigan members
- $17.3 billion in health care benefits provided

High level of provider participation:

- 100% of hospitals (about 140 acute care hospitals)
- 95% of MDs / DOs

Social Mission

About BCBSM



Membership figures may differ from previous reports due to methodological refinements made for estimating state-level market share. In addition, multistate plans licensed as LAH have changed some of their filings.

About BCBSM

Common “model” contract for all hospitals

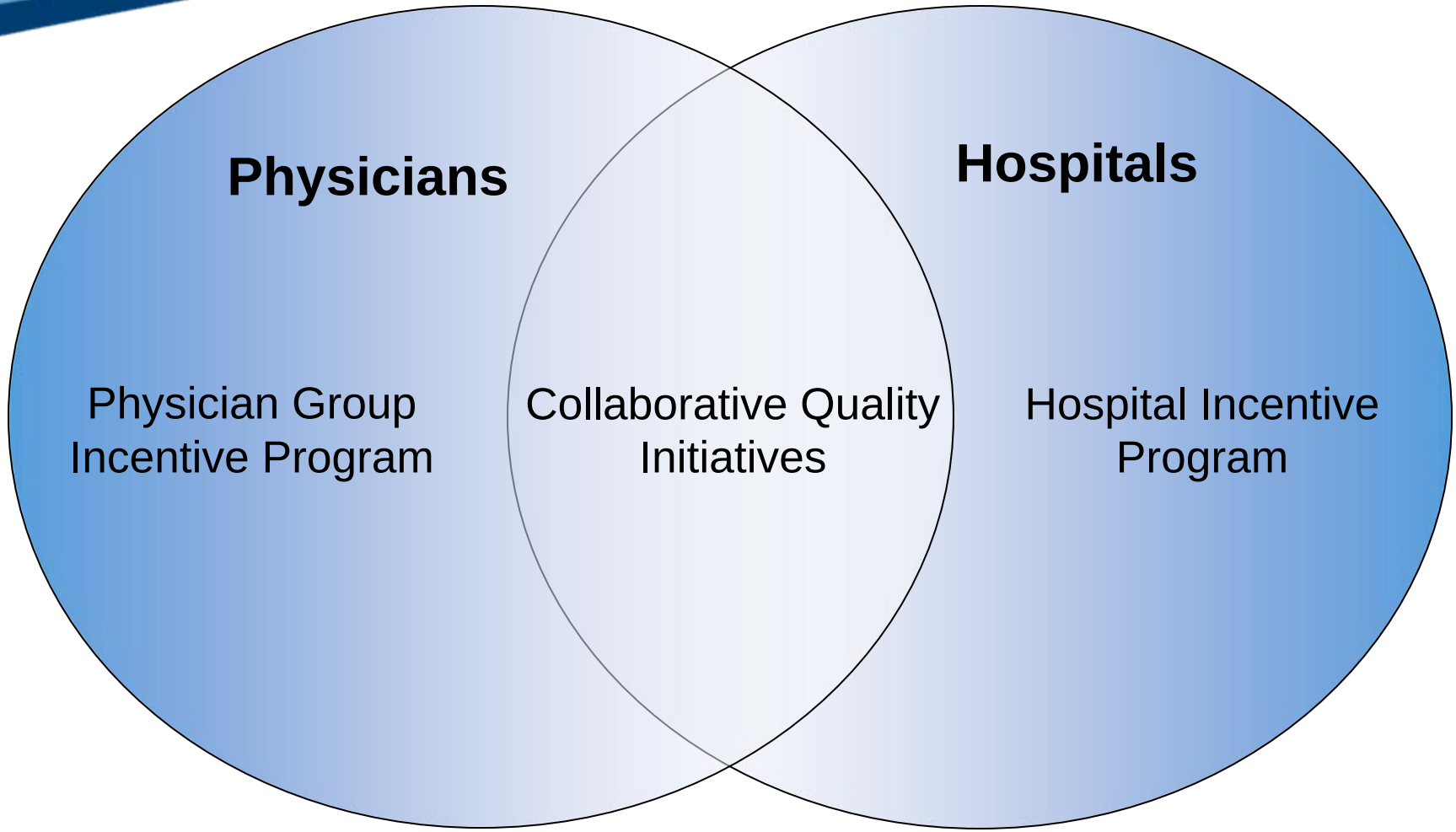
Formal contract administration process

- Joint Blue Cross/hospital committees address reimbursement, quality and administration issues
- Joint oversight by hospital CEO’s and Blue Cross board members

Partnership emphasis to improve quality and efficiency

Our Hospital P4P history

Our Hospital P4P History



Our Hospital P4P History

A component of hospital's overall reimbursement rate

- Ability earn up to an additional 5% on all inpatient and outpatient payments

Program measures:

- Pre-qualifying conditions, quality indicators, participation in quality initiatives, efficiency

Potential payout: $180M

- Actual payout: Approximately 75% ($135M)

Our Hospital P4P History

Success! Michigan hospitals:

- Demonstrate high quality on most measures
- Highly efficient on a per case basis

So why change?

Payment trends not sustainable!

Our Hospital P4P History

Limits of the fee-for-service reimbursement system

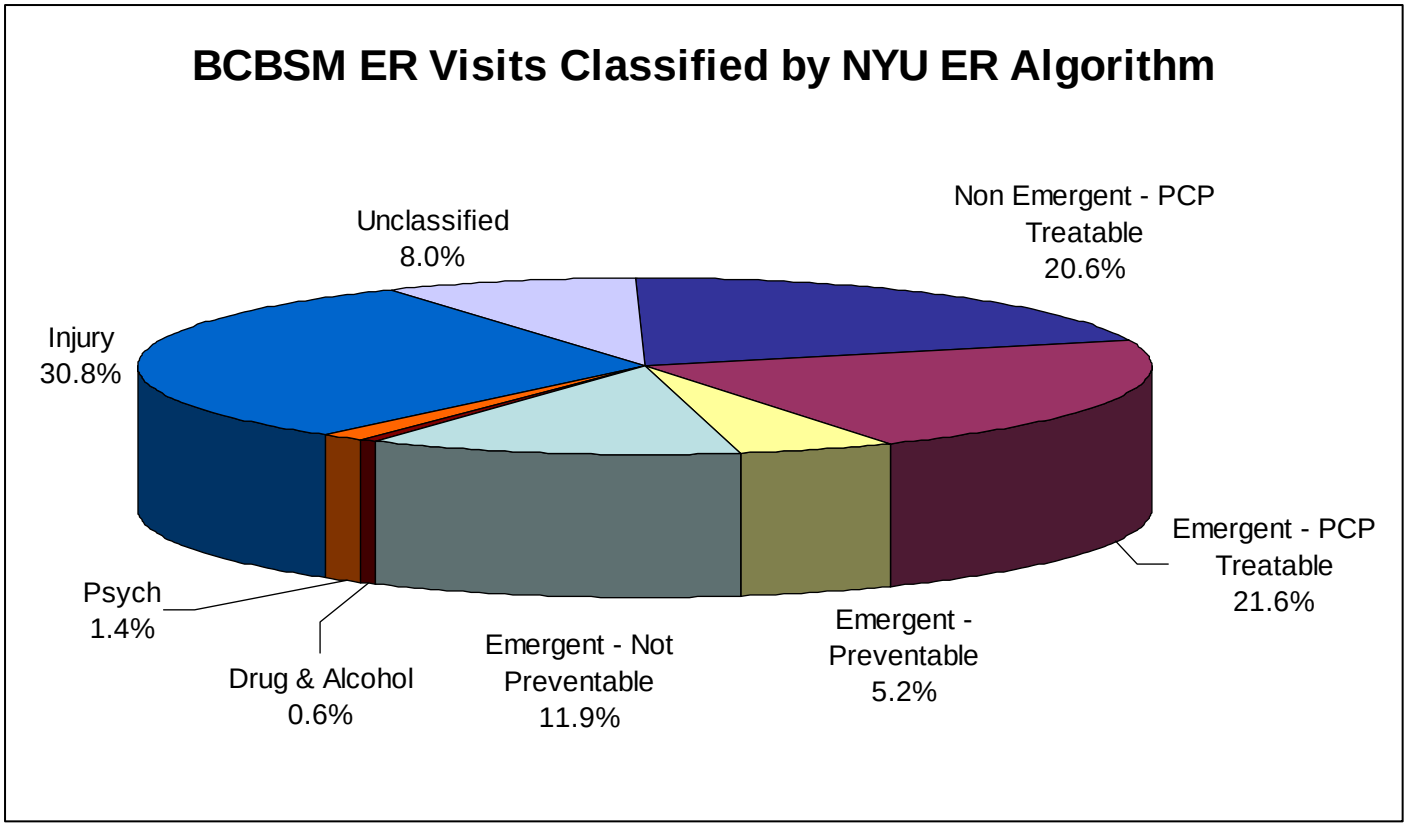
- Lack of population focus
- Fragmentation of delivery system
- Lack of focus on healthcare processes
- Weak primary care foundation
- Lack of clinical data sets
- Poorly aligned incentives

Limits of the fee-for-service system in Michigan

Outpatient	Benchmark *	BCBSM
Laboratory visits per 1000 members	610	903
Radiology visits per 1000	411	455
ER visits per 1000	180	191
Inpatient		
Total admits per 1000 members	65.28	68.42
Stent-related admits per 1000	.89	.98
C-sections as percent of deliveries	32.6%	34.7%

* - BHI Midwest Benchmark

Limits of the fee-for-service system in Michigan



42.2% of ER visits could be treated effectively in a more cost efficient setting

New P4P strategy

Focus on payment trends

New P4P Strategy – payment trends

Enhance the existing fee-for-service:

- Recognize improvement on a population basis
- Encourage the establishment of high-performance healthcare systems
  - Align incentives
- Reward quality improvement and innovation

Why payment trends?

- All-encompassing
  - Price and use
  - All settings (inpatient, outpatient, office, etc)
  - All services (facility, professional, pharmacy)
- Customer focused
  - Direct link to premium increases
- Provider flexibility
  - Hospitals choose where opportunity is greatest

Why not bundled payments or episodes?

	Trend measures with aligned Incentives	Bundled Payment or episodes
Delivery of care	Coordinated	Coordinated
Incentive to improve quality	Yes	Yes
Incentive to reduce use	Yes	After episode begins
Data sophistication	Medium to high	High to very high
Provider trust level	Medium to high	Very high
Level of new infrastructure	Medium	High
Customer understanding	Medium	High
Time to implement	Short to medium term	Long term

New P4P Strategy – payment trends

3 implementation phases

1. Introduce payment trends in a broad-based manner
2. Invest in provider infrastructure
3. Increase risks, rewards, complexity … and results

Phase 1: Introduce payment trends in a broad-based manner

Trends incorporated into existing P4P program – with some controls on hospitals and BCBSM risk

- Reward based on a comparison of the BCBSM statewide payment trend to national (Milliman HCI)
- One uniform, statewide score – no individual hospital differentiation
- Some potential for increased payment based on gain sharing

Phase 2: Invest in infrastructure

Provide funding to help hospitals build the infrastructure and relationships (e.g., LEAN processes, high-performing accountable care organizations) needed to bend the trend

Phase 3: Increase risks, rewards, complexity … and results

Distribute reward pool based on individual hospital performance

- Establish hospital-specific pmpm benchmarks
- Opportunity for additional reward through gain-sharing
- Increased potential for reward - and risk - for individual hospitals

Four success criteria

1. Member attribution
2. High-quality population-based data
3. Alignment with physician incentives
4. Provider engagement & education

Success criterion #1:

Member attribution

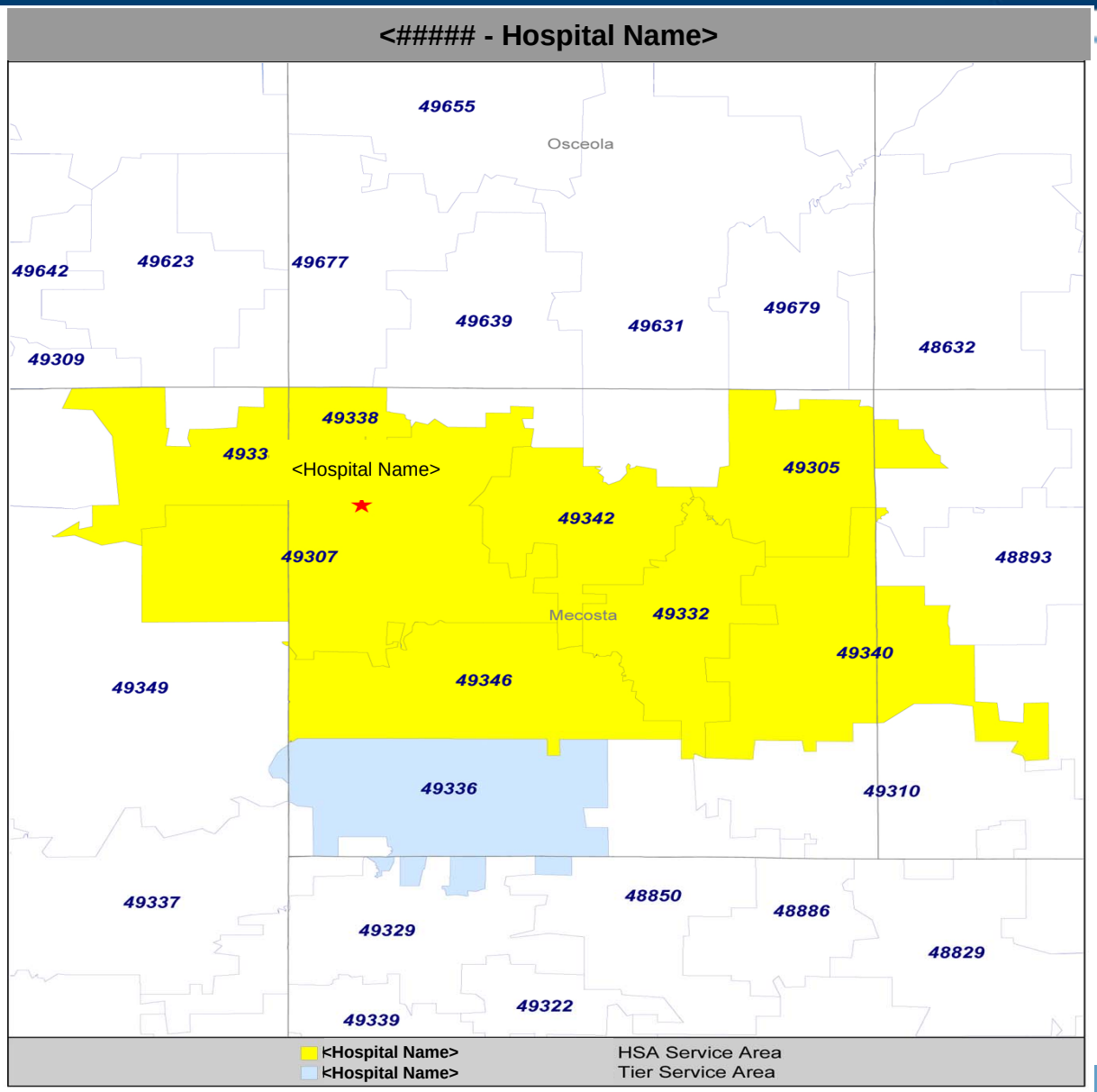
Member attribution

All members assigned to one or more hospitals based on:

- Geography (Dartmouth Atlas Hospital Service Areas)
- BCBSM claims data
- Reasonability checks
- Verification and adjustment by hospitals

Zip-code level – all members living within a zip code attributed to the same hospital(s), regardless of whether he/she received services at that hospital

Attribution map



Member attribution

Pros

- Simple and easy to understand
- All members attributed
- Overlapping service areas - promotes shared responsibility
- Hospital validation = greater hospital acceptance

Cons

- No stratification (e.g., specialty services)
- Unequal impact on a given zip code (tragedy of the commons)
- Imperfect alignment with physician attribution model

Success criterion #2:

High-quality population-based data

High-quality, population-based data

Continued, long-term effort to improve and refine

- Timeliness
- Relevance
- Reliability

New hospital performance report - *Hospital Insights*

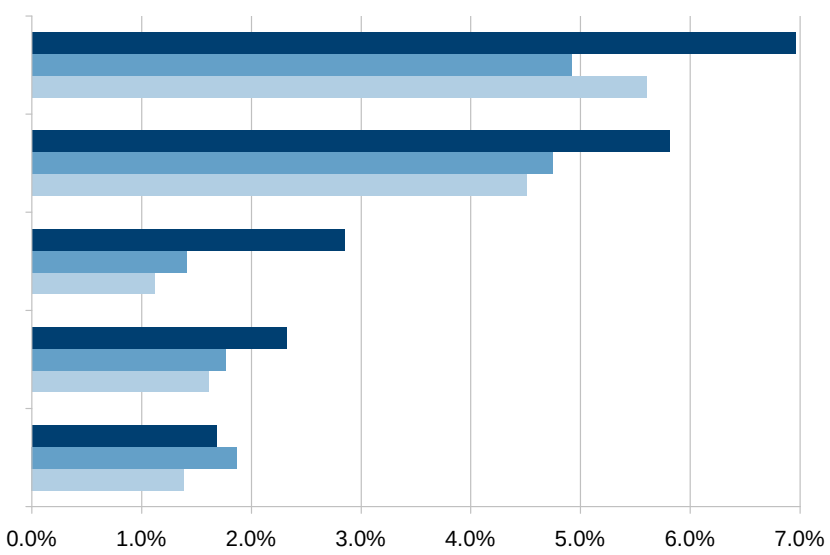
Blue Performance

<Hospital Name>
Hospital Insights

December 2009

Data – disease prevalence

Percentage of Hospital PMPM Payments



Joint Degeneration

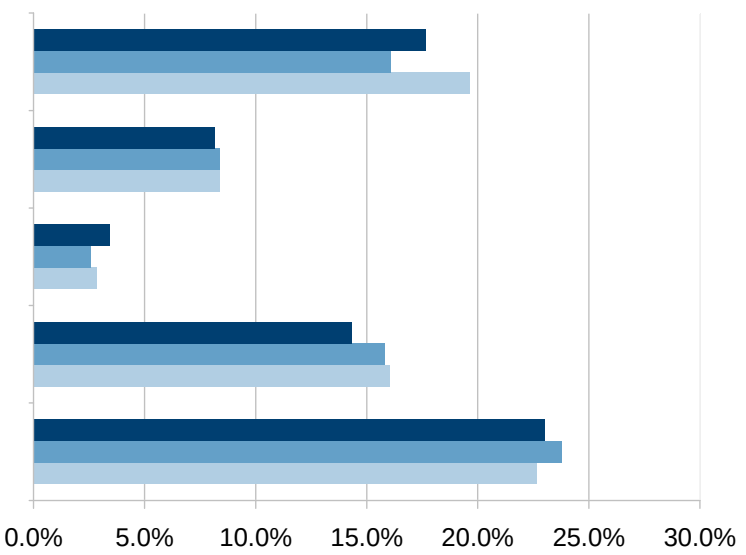
Coronary Artery Disease

Malignant Neoplasm of the Breast

Diabetes

Neonatal Management

Percentage of Total Members



Hospital Peer BCBSM Overall

Data – ambulatory care sensitive conditions

	Admissions	Admissions per 1,000*			
Ambulatory Care Sensitive Conditions	Current Year	Prior Year	Current Year	Peer Current Year	BCBSM Overall Current Year
Hypertension	693	4.85	12.00	8.33	3.86
Adult Asthma	166	2.42	2.51	2.17	0.88
Dehydration	107	1.80	1.71	1.65	0.71
Diabetes Long-term Complications	92	2.18	1.63	1.00	0.39
Angina without Procedure	72	2.33	1.92	0.69	0.32
Bacterial Pneumonia	69	1.07	1.09	1.18	0.61
Congestive Heart Failure	56	1.06	0.95	0.95	0.39
Chronic Obstructive Pulmonary Disease	55	0.62	0.66	0.65	0.44
Urinary Tract Infection	52	0.91	0.77	0.65	0.32
Diabetes Short-term Complications & Uncontrolled Diabetes	40	0.57	0.52	0.55	0.27
Low Birth Weight Rate	1	-	-	-	-

Success criterion #3:

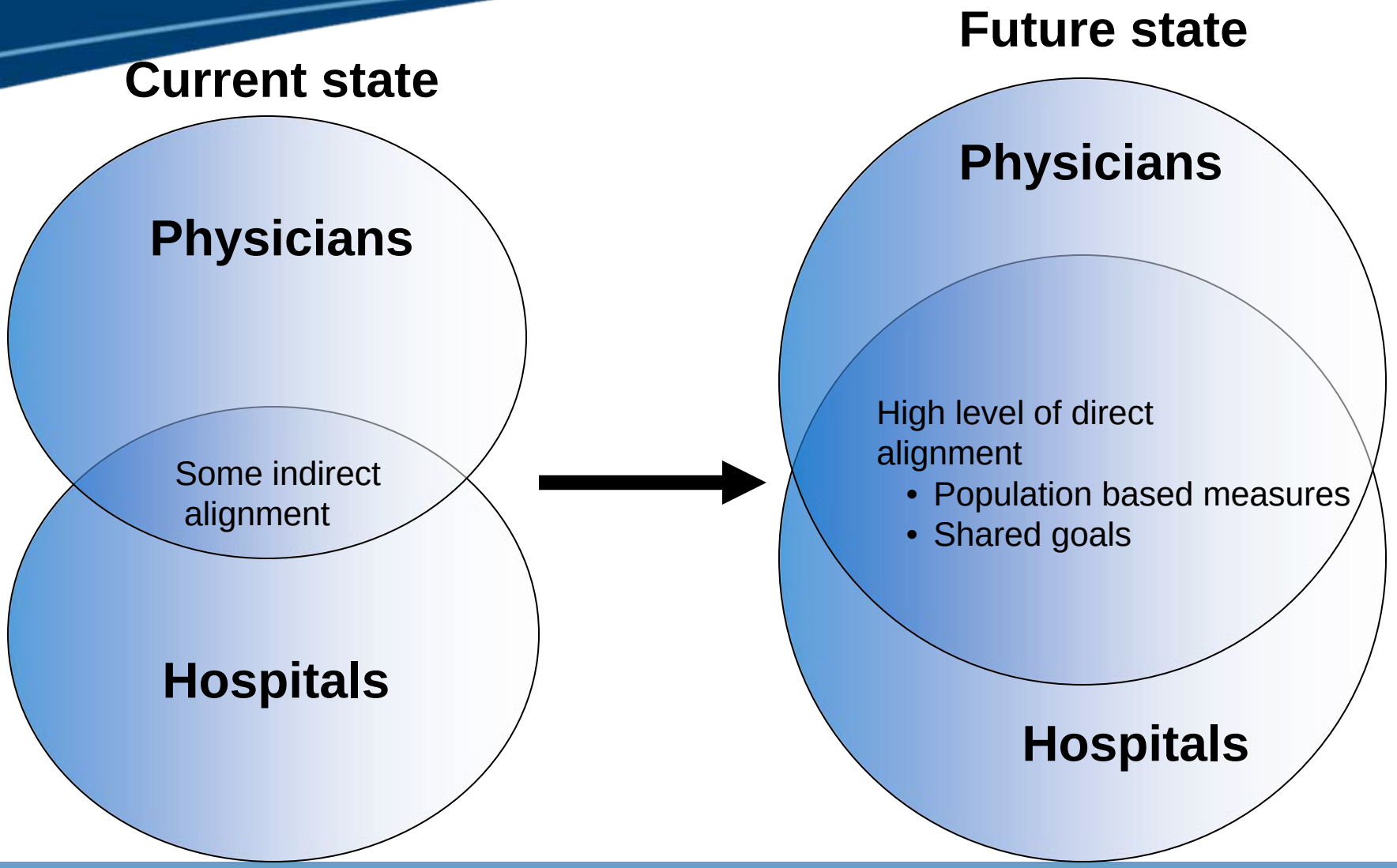
Alignment with physician incentives

Hospital-physician alignment

Alignment - the act of aligning or state of being aligned; *especially* **:** the proper positioning or state of adjustment of parts in relation to each other.

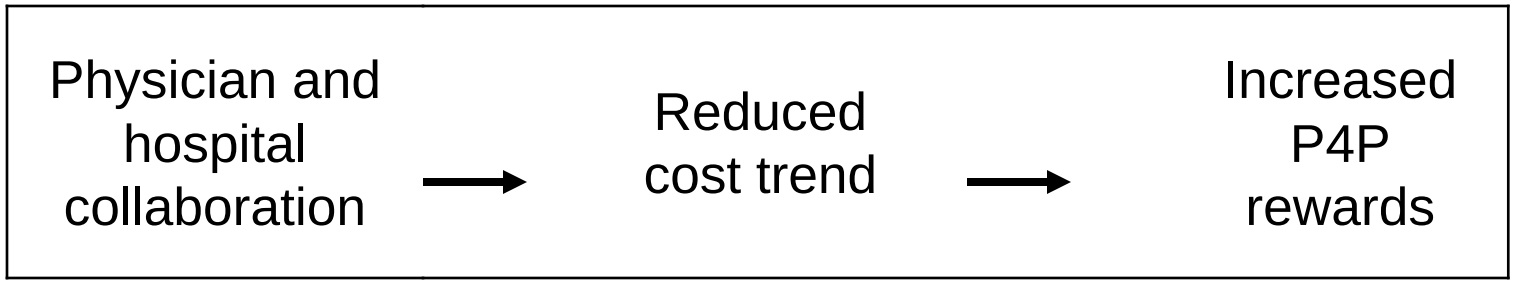
- Need to ensure we do not penalize one party for an outcome resulting from what we have rewarded another party to do.
- Need to encourage the development of accountable care organizations, including a strong foundation of high-performance primary care.
- Need to have common overall goal (e.g., reducing trends)

Hospital-physician alignment



Hospital-physician alignment

Create collective responsibility for cost trends and quality



Hospital-physician alignment

Expected result:

A high performance healthcare system, with a strong physician - primary care foundation, that supports the coordinated delivery of care.

A reward system that increases payments to facility and professional providers, through gain-sharing, based on population-based performance.

Success criterion #4:

Provider engagement & education

Provider engagement, collaboration, and education

- Overcoming fear
- Establishing expectations, defining benchmarks, distributing rewards
- Redefining relationship as a partnership

Provider engagement, collaboration, and education

Issues of readiness and acceptance

- New paradigm – collaboration vs. competition
  - Managing capacity in a community
  - Sharing best practices
- Overcoming fear - collaboration is rooted in TRUST and transparency
- Establishing expectations, defining benchmarks, distributing rewards
  - Data availability and sharing
  - Openness to input
- Redefining the payor/provider relationship as a partnership

Summary recap

- Michigan and BCBSM
- Hospital incentive programs past and present
- The need for a new direction
- Achieving success

Questions?

Thank you!

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