Blue Cross Blue Shield of Michigan
Advancing to the Next Generation of
Value Based Pay for Performance

Physician Group Incentive Program, Patient Centered Medical Homes,
and Moving From Fee for Service to Fee for Value

Presentation to:
Integrated Healthcare Association
7th National Pay for Performance Summit

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Overarching Principles

Health care is local: natural communities of caregivers taking responsibility for creating systems serving community need

– Build community first; don’t rush to payment solutions
– Organized Systems of Care (OSC)/Accountable Care Organizations (ACO) must be grounded in self-defined communities, not third party defined communities
– Harness intrinsic motivation of providers by ceding control: Purpose, autonomy and mastery must drive system development and performance, not short term gain
– Incentives, or payment reform, separate from community, and explicit purpose, will not succeed
What is Value Partnerships?

BCBSM’s innovative, quality-based approach to:

– “Partnering for value” with physicians, physician organizations (POs) and hospitals
– Rewarding the transformation of health care
– Working with the majority of the acute care hospitals in the state and nearly 15,000 primary care and specialty physicians
– Collaborating and sharing data to enhance clinical quality, decrease complications, manage costs, eliminate errors and improve health outcomes
BCBSM Value Partnerships Philosophy

1. Design and execute programs in a **customized and collaborative** manner rather than using a one-size-fits-all approach.

2. Recognize and reward performance of **hospitals** and **physician organizations**, not only individual physicians.

3. Reward **improvement**, not just highest performance, to create meaningful incentives for all physician organizations.

4. Focus on investments in **long-term changes in care processes**, rather than just “top of mind” behavior.

5. Encourages **all-payer approach**, rather than payer-specific system development.

6. Focus on **population-based** cost measures, rather than per-episode cost, to avoid stimulating overuse.
BCBSM’s Value Partnerships Program

Physicians
Physician Group Incentive Program

33 Initiatives aimed at Capability Building, Improving Quality of Care Delivery, and Appropriate Utilization of Services – Types of Initiatives Include:

- Improvement Capacity
- Condition-Focused
- Service-Focused
- Core-Clinical Process-Focused
- Clinical Information Technology-Focused

Hospitals
Hospital P4P Incentive Program

BCBSM Cardiovascular Consortium – Percutaneous Coronary Intervention and Peripheral Vascular Intervention CQIs
- Michigan Society of Thoracic & Cardiovascular Surgeons Quality Collaborative
- Michigan Bariatric Surgery Collaborative
- Michigan Breast Oncology Quality Initiative
- Advanced Cardiac Imaging Consortium
- Michigan Surgical Quality Collaborative
- Peri-Operative Outcomes Initiative
- Hospital Medicine Safety Collaborative
- Michigan Trauma Quality Improvement Program
- Michigan Arthroplasty Registry Collaborative for Quality Improvement (1Q12)
- Michigan Radiation Oncology Quality Collaborative (1Q12)

P4P program consists of
- Quality Measures
  - CQIs
  - Quality Indicators
- Efficiency Measures
  - Cost-per-Case
  - Hospital per member per month trends

Michigan Health & Hospital Association:
Keystone Center for Patient Safety & Quality

BCBSA “Best of Blue” Awards

2006 - PGIP and CQIs

2010 – PCMH
(also received BlueWorks – the premiere BCBSA award)

2011 – MSQC, MBSC and MOQC
(also received BlueWorks Awards for MSQC and MBSC)
**PGIP: Catalyzing Health System Transformation in Partnership with Providers**

- **PGIP Chronic Care Model**
  - Transform care processes to effectively manage chronic conditions
  - Build registry and reporting capabilities to manage populations of patients
  - Achieve savings in specified areas
  - Reward physicians for improved performance and efficiency
  - Share savings

- **PCMH Primary care transformation**
  - Build PCMH infrastructure
  - Strengthen doctor-patient relationship
  - Support PCPs and their team’s ability to effectively manage care
  - Coordinate care across the continuum for a defined patient population
  - Establish linkages with community services

- **OSCs Organized Systems of Care**
  - Support establishment of systems of care that assume responsibility and accountability for managing a defined population of patients across all locations of care

**Expansion Strategies**

- Expand PGIP to include specialists involved in chronic care
- Implement PCMH and quality/use initiatives
- Continue to increase number of initiatives
- Continue to add new specialties to PGIP
- Extend provider-delivered care management with links to BCBSM for customer reporting statewide
PGIP At 5,000 Feet

PGIP incentivizes providers to alter the delivery of care by encouraging responsible and proactive physician behavior, ultimately driving better health outcomes and financial impact.

BCBSM provides the financing, tools and support...

...so physicians can engage in specific initiatives...

...that change the way healthcare is delivered...

...and drive meaningful impacts for our customers and our members.

Efficient Utilization of Resources

Improved Quality of Care

Enhanced Member Experience
PGIP: Health Plan Role

- Convene and catalyze; not engineer and control
- Provide resources and structure reimbursement to reward infrastructure development and process transformation
- Reward quality and cost results (improvement and optimal performance) at the population level
- Share data at organization, practice unit/office and physician level
- Leave management of individual patient care to practices and of physician practices to PO
PGIP: PO Role

• Collaborate on crafting future vision
• Collaborate on implementation
  – PGIP quarterly meetings
  – Common interest groups
  – Regional learning collaboratives
• Animate physician members
• Develop and deploy new systems of care
• Work with organization members to examine and optimize performance
PGIP: Shared Vision

• POs take responsibility for developing systems of care
  – Shared information systems
  – Shared processes of care
  – Shared accountability for population level performance

• Organizing concepts
  – Lack of a system is the root cause: structure incentives to catalyze system development and system performance
  – Patient Centered Medical Home Model
  – Systems designed to respond to patients’ and community’s needs
PGIP: Key Statistics

- **14,778 Physicians** (6,686 Primary Care and 8,092 Specialists)
- **40 physician organizations**, representing over 100 physician groups statewide
- **4,190 physician practices** (most 1-3 physicians)
- **A PGIP presence in 81 of Michigan’s 83 counties**
- **Roughly 1.8 million members** and **5 million citizens** impacted by PGIP physicians
- **33 PGIP initiatives**
- **$100 M annual reward pool**

**Physician Enrollment in PGIP**

- Total physicians in PGIP:
  - Jan 06: 2,903
  - Jan 07: 4,798
  - Jan 08: 5,980
  - Jan 09: 6,567
  - Jan 10: 8,148
  - Jan 11: 11,274

- PCPs in PGIP:
  - Jan 06: 1,070
  - Jan 07: 1,909
  - Jan 08: 2,480
  - Jan 09: 2,978
  - Jan 10: 3,772
  - Jan 11: 5,088

**BCBSM members attributed to PGIP physicians**

- 2005: 610
- 2006: 1,160
- 2007: 1,541
- 2008: 1,688
- 2009: 1,787
- 2010: 1,805
PGIP Key Program Results

• Generic Prescribing Rate has risen from 38 percent in 2004 to 74 percent in 2011
• PCMH practices demonstrate lower rates of hospitalization, radiology utilization and lower ED visits
• Direct Radiology savings were $24M in 2010
• BCBSM has a 2.2% cost trend for 12 months for PPO business ending 3rd quarter 2011 with negative professional cost trend for that quarter
Patient Centered Medical Home (PCMH)

With the PCMH model, the primary care physician leads a professional health care team that tracks and monitors the patient’s overall health, working collaboratively to ensure a patient’s health care needs are being met, from lifestyle and nutrition counseling to testing and monitoring health outcomes.

In 2011, of the nearly 1,000 practices that were nominated for PCMH designation, 776 practices throughout the state were designated, representing more than 2,500 primary care physicians.
PCMH Initiatives

In 2007, the Joint Principles of the PCMH were released by four primary care physician societies – American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. Principles have since been endorsed by 19 additional physician organizations, including American Medical Association, among others.

In 2008 and 2009, BCBSM developed 12 PGIP initiatives designed to help Michigan PCP and specialty practices develop the capabilities associated with the Joint Principles.

<table>
<thead>
<tr>
<th>BCBSM’s PGIP PCMH Initiatives</th>
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<tbody>
<tr>
<td>• Extended Access</td>
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<tr>
<td>• Coordination of Care</td>
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<td>• Individual Care Mgt</td>
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<td>• Linkage to Community Svcs</td>
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<td>• Patient Provider Partnership</td>
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<td>• Patient Web Portal</td>
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<td>• Patient Registry</td>
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<td>• Preventive Services</td>
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<td>• Performance Reporting</td>
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<td>• Self-Management Support</td>
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<td>• Test Tracking</td>
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<td>• Specialist Referral Process</td>
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## BCBSM Approach to PCMH

Model developed in Collaboration with PGIP Providers

### PGIP PCMH Initiatives
- Opportunity for PGIP POs to participate in 12 PCMH-focused PGIP Initiatives that support implementation of 129 specific PCMH capabilities
- Targeted assistance offered through collaboratively developed “Interpretive Guidelines”
- All PCPs and Specialists in PGIP may participate
- More than 5,500 PCPs are currently working on implementing PCMH capabilities
- Incentives for the obtainment of PCMH capabilities

### PGIP PCMH Designation Program
- Opportunity for PGIP Practice Units to be PCMH-designated by BCBSM and rewarded for additional time and resources required (started in July 2009)
- Only PCPs are eligible to participate
- Additional reward monies available via increased E&M fees:
  - Office visits → 99201 – 99215
  - Preventive → 99381 – 99397
- Increase office visit fees to PCMH-designated practices (+10%)
- New codes for care management and self-management support (in person and telephonic) payable to PGIP physicians: supports multi-disciplinary, team based care/care management
- Increase office visit fees for offices in PCMH-designated practices in POs with optimal population level cost performance (+10%)

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POs work on Initiatives to achieve practice transformation.
Eligibility Requirements for PCMH Designation Program

1. Physician offices nominated by their PGIP PO
2. Commendable performance on quality/use/efficiency measures (adult and pediatric)
   - Quality: Evidence Based Care and Preventive measures
   - Use: ED use for primary care treatable conditions and high-tech and low-tech radiology rates
   - Efficiency: Generic Dispensing Rate and trend
3. Critical mass of PCMH capabilities in place
   - Self-reported data validated through site visits

Practice Units that achieve PCMH Designation continue to participate in PCMH Initiatives and are expected to demonstrate ongoing progress towards fully implementing PCMH domains of function
BCBSM PCMH Nomination

PGIP Phys Org A

PGIP Phys Org B

PGIP Phys Org C

“Non PGIP Physicians”
BCBSM PCMH Designation

PGIP Phys Org A

PGIP Phys Org B

PGIP Phys Org C

“Non PGIP Physicians”
PCMH: Key Statistics

- Patient Centered Medical Home program includes:
  - Approximately 5,600 primary care physicians working towards implementing PCMH capabilities
  - Almost 2,000 specialists working towards implementing PCMH capabilities
  - Number of participating providers increases each year

- 2011 BCBSM PCMH Designation includes:
  - Over 2,500 primary care physicians and specialists in more than 770 practice units
  - Over $25M in annual E&M uplifts for PCMH designated providers
PCMH Designation Continues to Expand Across Michigan

2011 PCMH Designated PGIP Practice Units (n=774)

First year of designation
- 2009
- 2010
- 2011

Created by: Amanda Markovitz,
Department of Clinical Epidemiology and Biostatistics
August 11, 2011
PGIP PCMH Infrastructure in 2011

Percent of PCMH Capabilities Fully in Place by Initiative for Designated and Not-Designated Practice Units in 2011

*For the "not designated" cohort, only PCMH Designation eligible practice units were included in the analysis

**SOURCE: 2011 PCMH Scenarios Tool
PCMH Capabilities in Place

Among those practices that were designated as patient-centered medical homes in 2011:

Over 95% of PCMH-designated primary care physicians have:
• 24 hour phone access to a clinical decision-maker
• Patients who are fully informed about after-hours care options
• Medication review & management for all chronic patients
• A system in place for tracking abnormal test results

Over 90% of PCMH-designated primary care physicians have:
• Primary prevention program to reduce patient risk of disease and injury
• Patient registry with evidence-based care guidelines
• Written procedure and staff training in place for referring patients to specialists
**Performance of PCMH Designated Practices Continues to Improve as Program Expands**

<table>
<thead>
<tr>
<th>Metric</th>
<th>PCMH Designees Compared to non-PCMH Practices</th>
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<tr>
<td></td>
<td>Year 2 Designation*</td>
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<tr>
<td></td>
<td>2010 Attributed BCBSM Members</td>
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<tr>
<td>Adults (18-64)</td>
<td>1,836 physicians 650,000</td>
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<tr>
<td></td>
<td>774 practices</td>
</tr>
<tr>
<td>Emergency department visits (per 1,000)</td>
<td>-6.6%</td>
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<tr>
<td>Primary care sensitive emergency department visits (per 1,000)</td>
<td>-7.0%</td>
</tr>
<tr>
<td>Ambulatory care sensitive inpatient discharges (per 1,000)</td>
<td>-11.1%</td>
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<tr>
<td>High tech radiology services (per 1,000)</td>
<td>-6.3%</td>
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<tr>
<td>High tech radiology standard cost PMPM</td>
<td>-3.0%</td>
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<tr>
<td>Low tech radiology services (per 1,000)</td>
<td>-5.9%</td>
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<tr>
<td>Low tech radiology standard cost PMPM</td>
<td>-5.9%</td>
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<tr>
<td>Generic dispensing rate</td>
<td>3.3%</td>
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Despite adding 42% more physicians in 2011, there were significant increases in differentiation between PCMH and non designated physicians.

*Year 2 Designation: July 2010 - June 2011
†Year 3 Designation: July 2011 - June 2012
Moving towards Fee For Value

David Share and Bharath Mamathambika, Blue Cross Blue Shield of Michigan
## PGIP’s Movement Towards Fee For Value

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<tr>
<th>Current State</th>
<th>Intermediate State</th>
<th>Future State</th>
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<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
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<tr>
<td>Single disease registry</td>
<td>Multiple disease registry</td>
<td>All patient registry</td>
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<tr>
<td>Selected PCP e-Rx</td>
<td>All PCP e-Rx</td>
<td>PCP and specialist e-Rx</td>
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<tr>
<td>Care managers</td>
<td></td>
<td>Care mgmt. system</td>
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<tr>
<td>Physician perf. reports</td>
<td>Dr./Facility perf. reports</td>
<td>Secure provider portal</td>
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<tr>
<td><strong>Payment</strong></td>
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<tr>
<td><strong>Capacity to Manage</strong></td>
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<tr>
<td><strong>Population Level Quality, Efficiency and Outcomes</strong></td>
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<tr>
<td><strong>0 % -</strong></td>
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<tr>
<td>Pay for PCMH/OSC Infrastructure Development</td>
<td></td>
<td>Pay for Performance (tied to savings from decreased use)</td>
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<tr>
<td><strong>100 % -</strong></td>
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<tr>
<td>Pay for PCMH/OSC Infrastructure Development</td>
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<tr>
<td><strong>Generic use</strong></td>
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<td>Evidence based quality</td>
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<td><strong>Evidence based quality</strong></td>
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<td>Evidence based quality</td>
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<tr>
<td><strong>PMPM pharmacy cost</strong></td>
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<td>Evidence based quality</td>
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<tr>
<td><strong>Preventable ED use</strong></td>
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<td>Evidence based quality</td>
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<tr>
<td><strong>Readmission</strong></td>
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<td>Evidence based quality</td>
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<tr>
<td><strong>All inpatient use</strong></td>
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<td>Evidence based quality</td>
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<tr>
<td><strong>Preventable ED use</strong></td>
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<td>Evidence based quality</td>
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<tr>
<td><strong>Dx procedure use</strong></td>
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<td>Evidence based quality</td>
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<tr>
<td><strong>Tx procedure use</strong></td>
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<td>Evidence based quality</td>
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<tr>
<td><strong>Patient experience of care</strong></td>
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<td>Evidence based quality</td>
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David Share and Bharath Mamathambika, Blue Cross Blue Shield of Michigan
Lessons Learned

• Health care is local: Intrinsic motivation catalyzes doing the most possible; extrinsic motivation the least necessary
• The problem is a fragmented system: focus reimbursement on catalyzing system transformation and population level results, not narrow P4P goals
• Best accomplished with frame of reference on Physician Organizations/OSCs not individual providers
• Population level accountability: improves accuracy of measurement; discourages cherry picking of patients and providers
Lessons Learned

• All payment methods have inherent risks: e.g., fee for service-over use; global payment-under use; episode payment- episode volume

• An incentive system must be driven by explicit purpose: BCBSM’s is
  – Improved population wellbeing at lower cost
  – Moving from volume to value
    • from procedure-based care to relationship-based care for both PCPs and specialists

• Fee for Value: retains granular detail on diagnosis and service provision; no expensive system overhaul; enhanced population level performance
Lessons Learned

• Making a substantial portion of FFV reimbursement dependent on system development and performance can move the needle on cost and quality

• Collaboration among providers is essential: align incentives for PCPs, specialists and facilities so they create clinically integrated systems which best serve the community, rather than compete for declining resources through technology wars

• Savings will come from moderating procedure, ED and inpatient use; right-sizing facility capacity is necessary and requires a glide path for facilities
Conclusion

Patient-Centered Medical Home

- **7.5%**
  - Lower rate of high-tech radiology usage

- **4.8%**
  - Lower rate of low-tech radiology usage

- **11.4%**
  - Lower rate of primary care-sensitive emergency department visits

- **22.0%**
  - Lower rate of ambulatory care-sensitive inpatient discharges

- **9.9%**
  - Lower rate of emergency department visits

- **2,552 designated physicians**
- **776 practices**
- **~ 820,000 members**
Contact Information

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