Paying for Value

The Patient-Centered Medical Home and Organized Systems of Care

Physician Group Incentive Program

Value Partnerships

Blue Cross Blue Shield of Michigan

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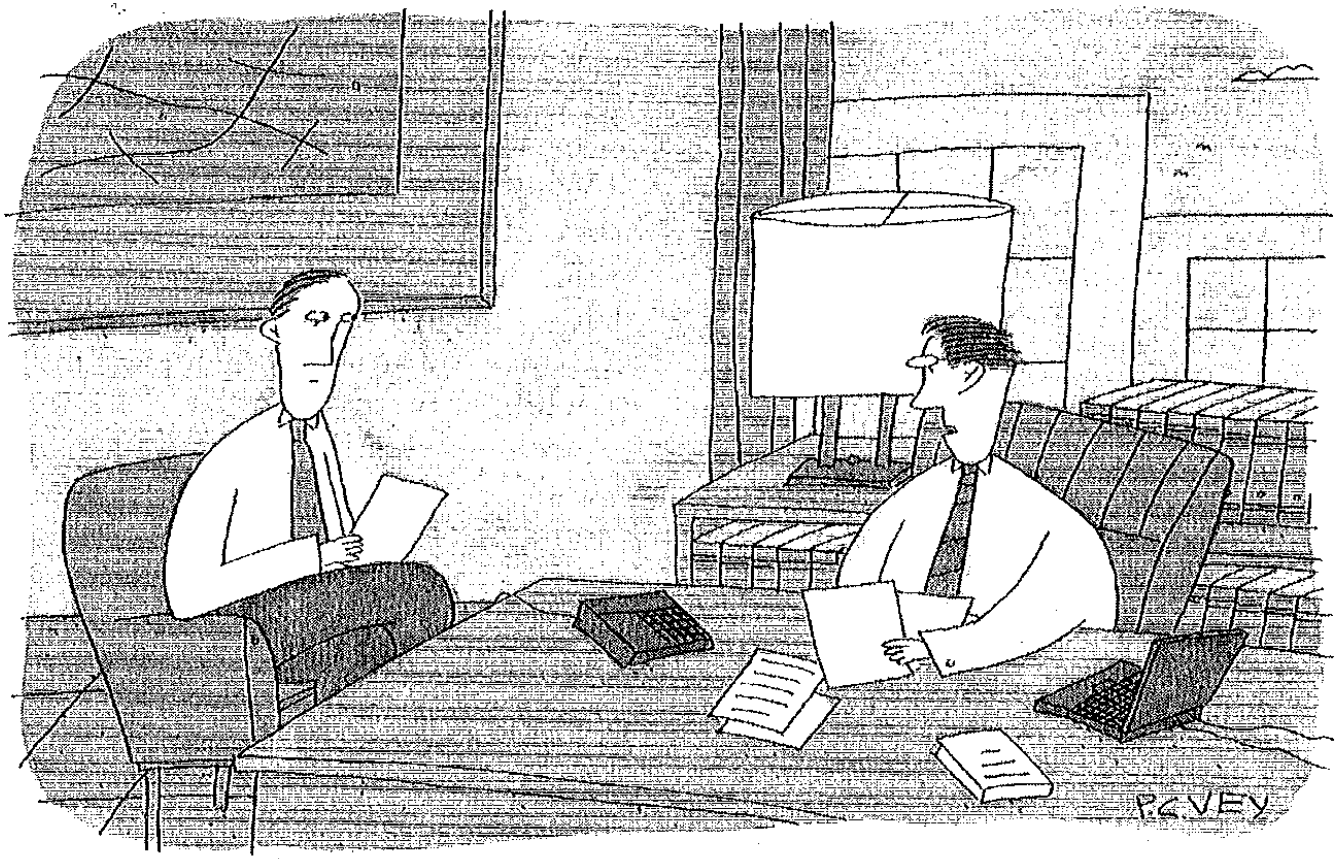
Presentation Outline

- Physician Group Incentive Program (PGIP) Overview
- Patient-Centered Medical Home (PCMH) program
- Payment Reform Vision: Fee for Value
- Organized Systems of Care (OSC) Program



"These new regulations will fundamentally change the way we get around them."

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Forging a Shared Vision & Transforming Roles: Physician Group Incentive Program (PGIP)

Patients - poorly served by health care non-system → **Active partners benefiting from organized systems of care**

Payer - controller and adversary → **Change Facilitator and Catalyst**

Providers - respond to prescribed controls → **Change Agents in Collaborative Communities of Team-Based Caregivers**

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PGIP: Catalyzing Health System Transformation in Partnership with Providers

2005 2006 2007 2008 2009 2010 2011 2012

PGIP
Chronic Care Model

- Partner with physicians to create shared vision, community, and local solutions
- Transform care processes to effectively manage chronic conditions
- Build registry and reporting capabilities to manage populations of patients
- Reward physicians for improved performance and efficiency

PCMH
Primary care transformation

- Support incremental implementation of PCMH infrastructure
- Strengthen doctor-patient partnership
- Reward practices that have made significant PCMH progress and have strong quality/use performance

OSCs
Organized Systems of Care

- Catalyze communities of caregivers to create shared care processes and information systems
- Hold OSC responsible and accountable for managing its population of patients across all locations of care

Expand PGIP to include specialists involved in chronic care

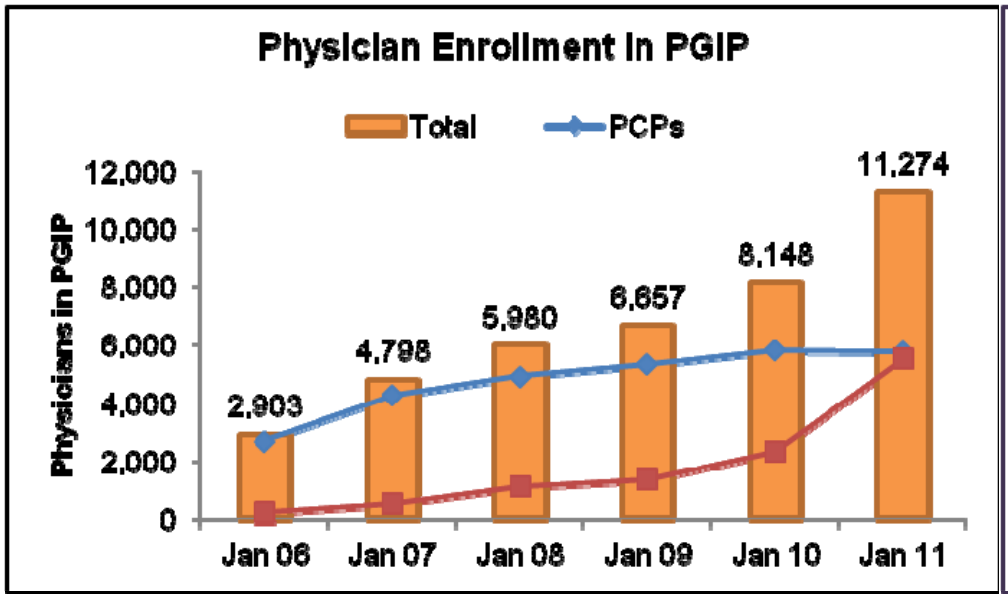
Implement PCMH and quality/use initiatives

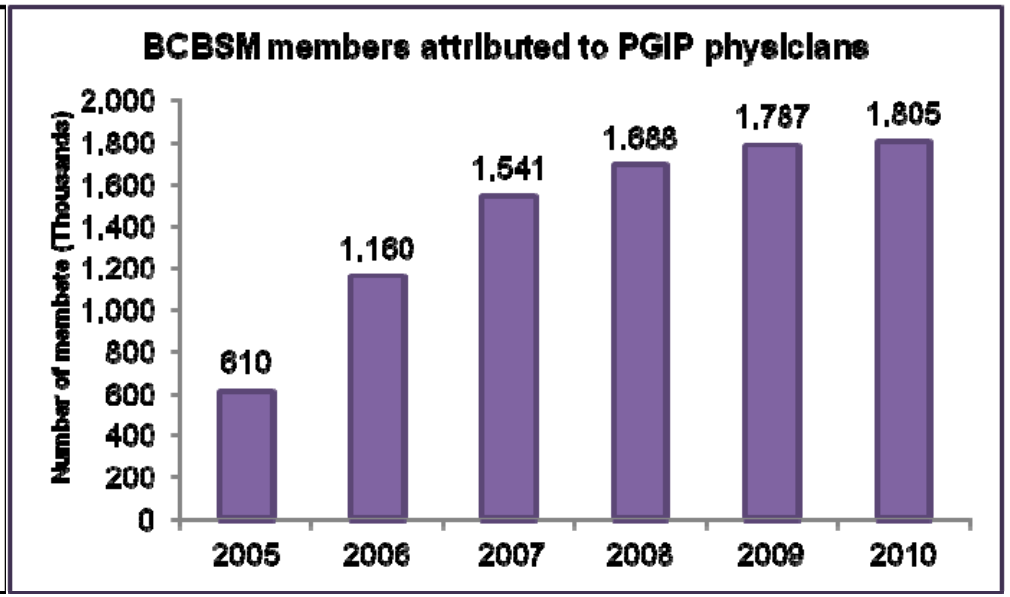
Continue to increase number of initiatives

Continue to add new specialties to PGIP

Expand provider-delivered care management with links to BCBSM for customer reporting

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)

Roughly **1.8 million members** and **5 million citizens** impacted by PGIP physicians

A PGIP presence in **81** of Michigan's 83 **counties**

33 PGIP initiatives

$100 M annual reward pool

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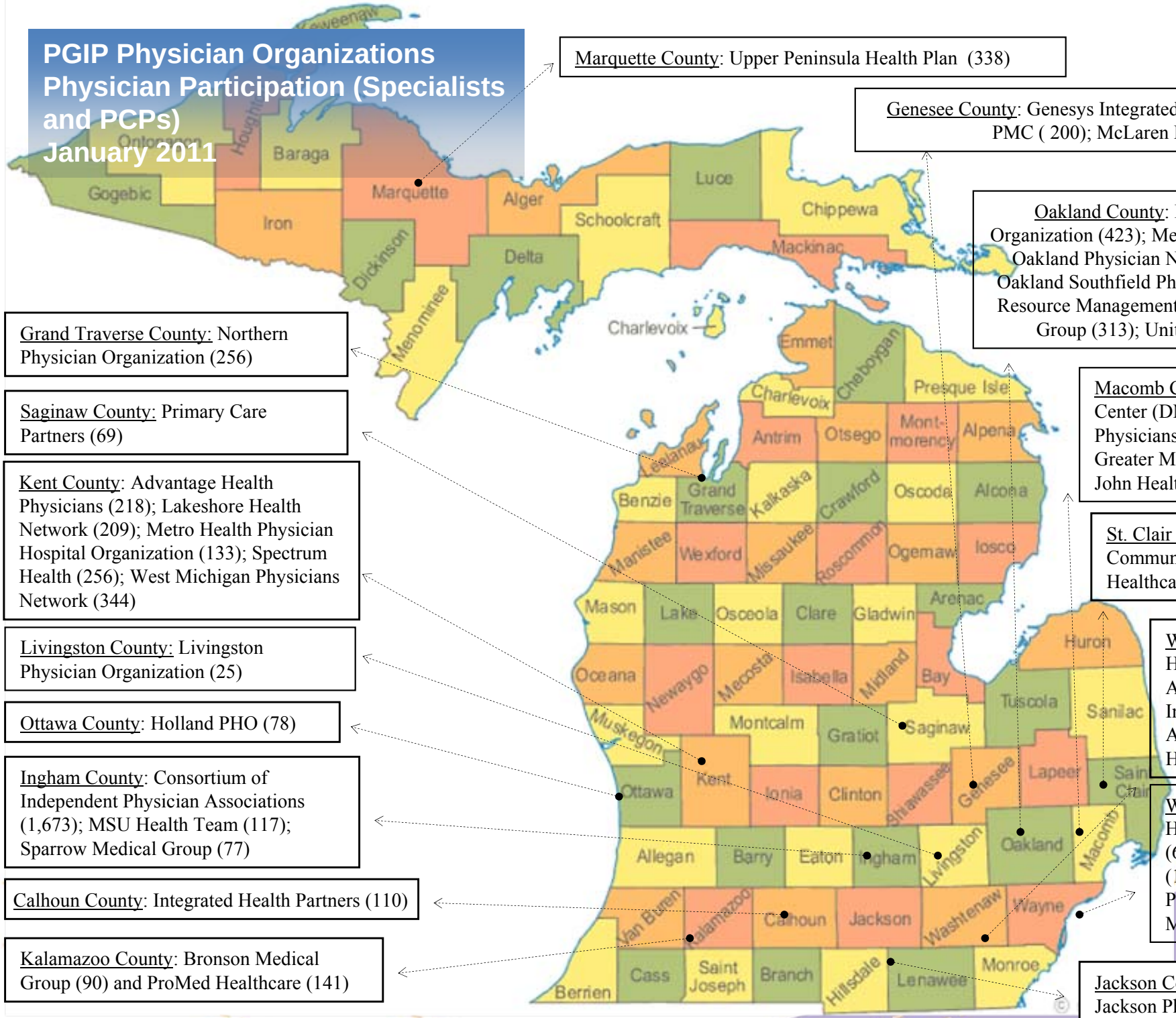
PGIP Physician Organizations Physician Participation (Specialists and PCPs) January 2011



Marquette County: Upper Peninsula Health Plan (338)

Genesee County: Genesys Integrated Group Physicians (94); PMC (200); McLaren PHO (369)

Oakland County: Beaumont Physician Organization (423); Medical Network One (573); Oakland Physician Network Services (212); Oakland Southfield Physicians (233); Physician Resource Management (103); St. John Medical Group (313); United Physicians (805)

Grand Traverse County: Northern Physician Organization (256)

Saginaw County: Primary Care Partners (69)

Kent County: Advantage Health Physicians (218); Lakeshore Health Network (209); Metro Health Physician Hospital Organization (133); Spectrum Health (256); West Michigan Physicians Network (344)

Livingston County: Livingston Physician Organization (25)

Ottawa County: Holland PHO (78)

Ingham County: Consortium of Independent Physician Associations (1,673); MSU Health Team (117); Sparrow Medical Group (77)

Calhoun County: Integrated Health Partners (110)

Kalamazoo County: Bronson Medical Group (90) and ProMed Healthcare (141)

Macomb County: Detroit Medical Center (DMC) Primary Care Physicians (109); DMC PHO (232); Greater Macomb PHO (171); St. John HealthPartners (567)

St. Clair County: Mercy Physician Community PHO (65); Physician Healthcare Network (46)

Washtenaw County: Huron Valley Physicians Association (397); Integrated Health Associates (165); U-M Health System (838)

Wayne County: Henry Ford Medical Group (652); Olympia Med Svcs (191); United Outstanding Physicians (214); Midwest Medical Ctr (103)

Jackson County: Jackson Physician Alliance (65)

PGIP Initiatives

1. **Improvement Capacity Initiatives**
   - Establishing staff dedicated to managing process improvement teams (new PGIP groups only)
   - Establishing analytics and reporting staff (new PGIP groups only)
2. **Condition-focused Initiatives**
   - Oncology/ASCO Quality Oncology Practice Initiative™ (limited participation)
3. **Service-focused Initiatives**
   - Pharmacy use and quality
   - Radiology procedures utilization
   - ER Utilization
   - Inpatient Utilization
   - Anticoagulation management (Professional CQI ~ limited participation)
   - Transition of Care Professional (CQI: SHM BOOST)
4. **Core Clinical Process-focused Initiatives**
   - Evidence based care (quality) performance
   - *Performance reporting
   - *Patient-Provider Partnership
   - *Extended access
   - *Individual care management
   - *Test tracking and follow-up
   - Lean Thinking-Clinic Re-engineering (Professional CQI)
   - *Coordination of Care
   - *Preventive Services
   - *Specialist Referral Process
   - *Linkage to Community Services
   - *Self-Management Support
5. **Clinical IT-focused Initiatives**
   - *Accelerating the Adoption and Use of Electronic prescribing
   - *Patient registry
   - *Patient Portal

** = PCMH capabilities*

PGIP Key Program Results

- The Generic Prescribing Rate has risen from 38 percent in 2004 to 74 percent in 2011
- Direct Radiology savings were $24M in 2010
- BCBSM cost trend fell to 3.1% in 1Q2011 with negative professional cost trend

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PCMH: BCBSM Incremental Approach Developed in Collaboration with PGIP Providers

PGIP PCMH Initiatives

- Opportunity for PGIP POs to participate in **12 PCMH Initiatives** (started in 2008)
- All PCPs and Specialists in PGIP may participate
- Over 6,000 physicians currently working on implementing PCMH capabilities
- ***$ to POs via PGIP incentives***

PGIP PCMH Designation Program

- Opportunity for PGIP Practice Units to be PCMH Designated by BCBSM and compensated for additional time and resources required (started in July 2009)
- Only PCPs are eligible
- ***$ to Practices via increased E&M fees***

Office visits → 99201 – 99215
Preventive → 99381 – 99397

*POs working on **initiatives** with their practices leads to Practice **designation**.*

Scoring Process for PCMH Designation Program

1. Physician offices nominated by their PGIP PO
2. PCMH Scores Based 50% on PCMH infrastructure and 50% on quality/use/efficiency metrics (adult and pediatric)
   - Self-reported PCMH capabilities data validated through site visits
   - 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

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

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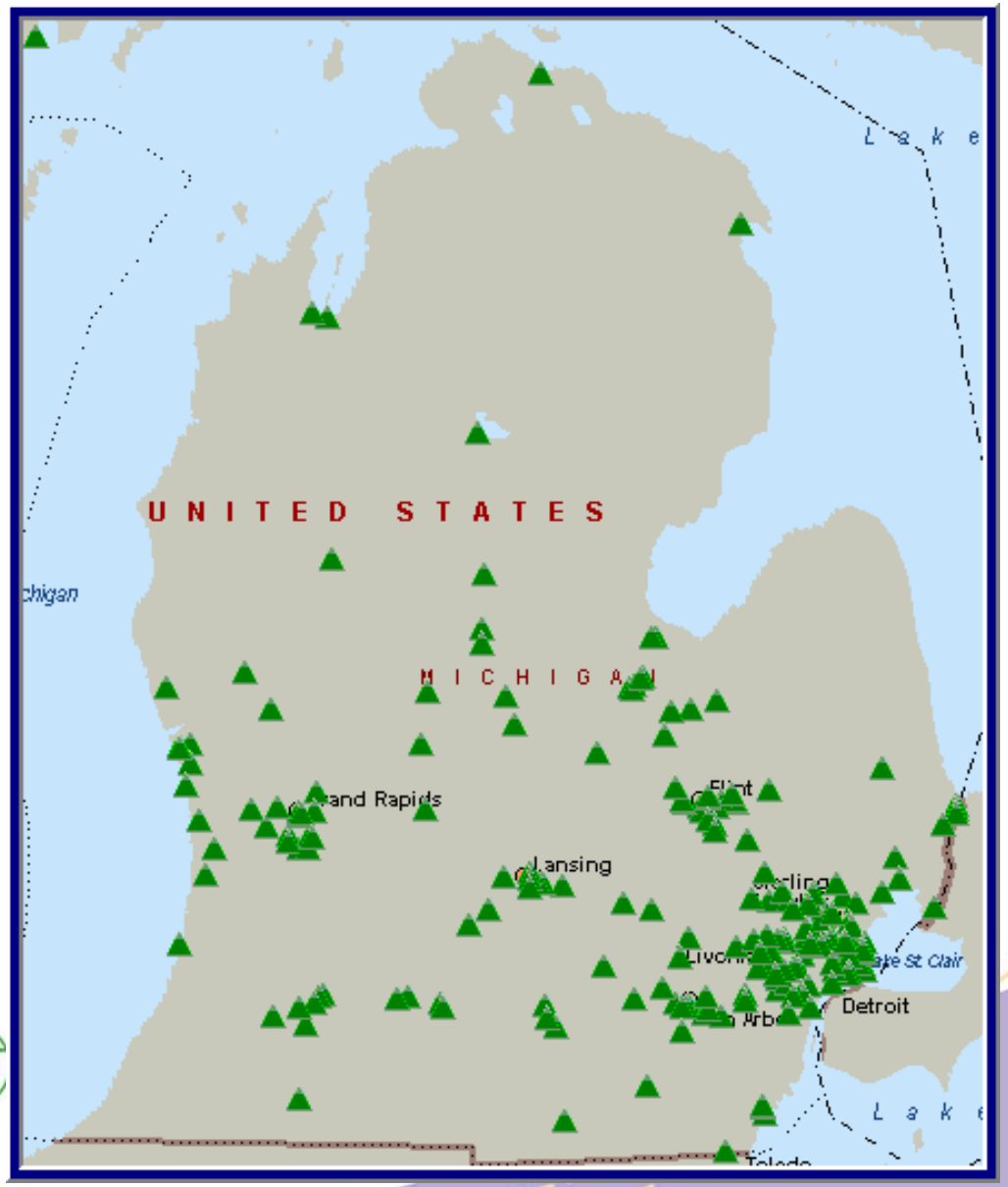
329 Validation Site Visits For 2011 PCMH Designation

POs are accountable for accurate reporting of practice unit progress



Practices are highly satisfied with site visits

	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree	Rating Average	Response Count
Overall, I was satisfied with the site visit.	3.8% (5)	0.8% (1)	0.8% (1)	9.1% (12)	**85.6% (113)**	4.72	132
The PGIP field representative explained the purpose of the visit.	3.8% (5)	0.0% (0)	0.8% (1)	3.0% (4)	**92.4% (122)**	4.80	132
The PGIP field representative presented/discussed the information clearly and effectively.	3.8% (5)	0.0% (0)	0.8% (1)	6.1% (8)	**89.4% (118)**	4.77	132
The site visit was educational and increased my knowledge of PCMH and PGIP.	3.8% (5)	0.0% (0)	3.0% (4)	9.1% (12)	**84.1% (111)**	4.70	132
The PCMH material provided by my physician organization has had a positive impact on my understanding of PCMH.	3.8% (5)	2.3% (3)	3.0% (4)	9.8% (13)	**81.1% (107)**	4.62	132
					answered question		**132**

POs provide significant support to practices

How many times during the year has your physician organization met with your practice to work on the PCMH program?

	Response Percent	Response Count
1 - 3	20.5%	27
4 - 6	**34.1%**	**45**
7 - 9	13.6%	18
10 or more	31.8%	42
answered question	132	

- Survey results show practices receive significant support from both the health plan and the physician organizations. Other processes, such as NCQA, lack programmatic support.
- Over 30 percent of practices were visited “10 or more times” by the physician organization to promote the transformation

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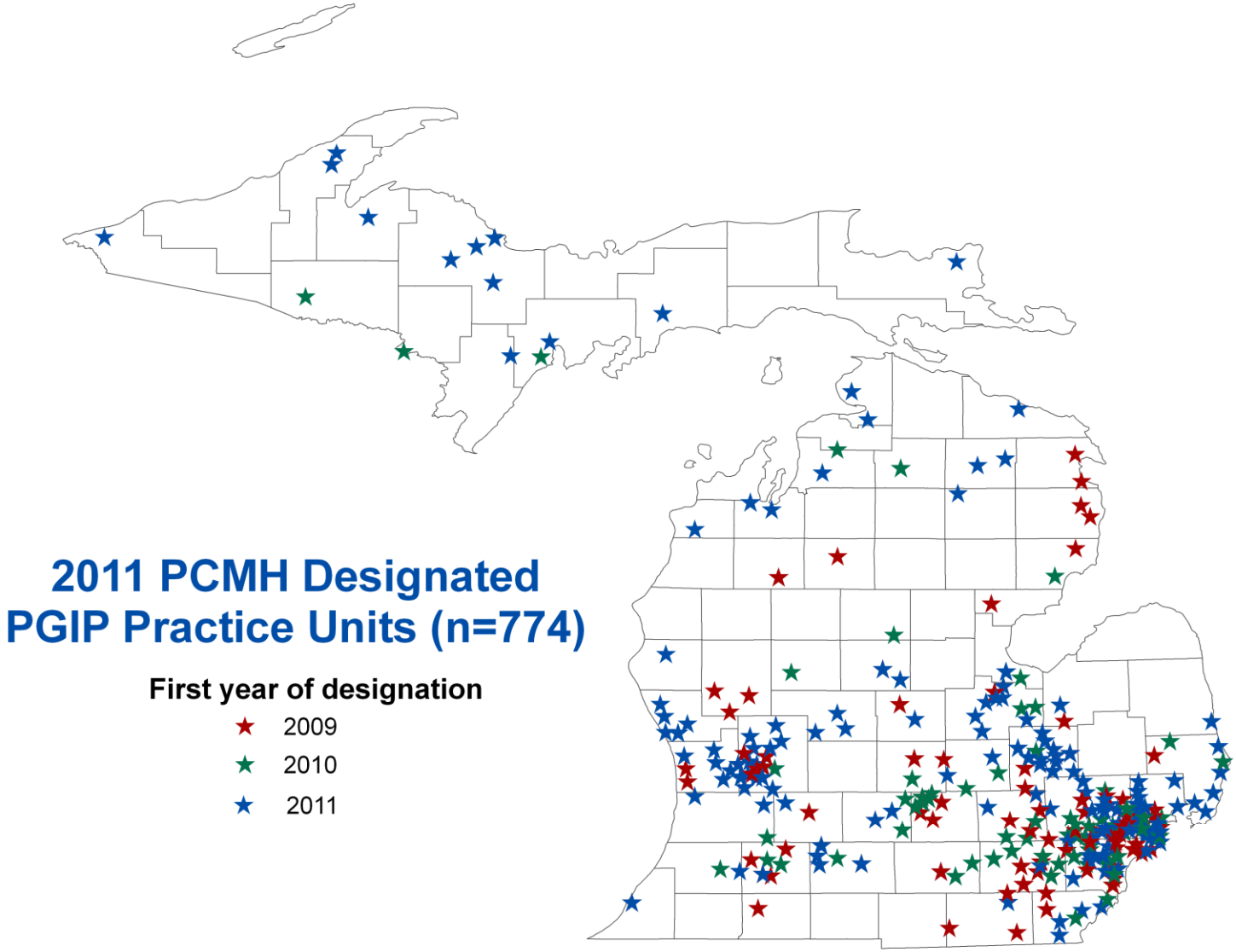

2011 PCMH Designated PGIP Practice Units (n=774)

First year of designation

- 2009
- 2010
- 2011

Created by: Amanda Markovitz,
Department of Clinical Epidemiology and Biostatistics
August 11, 2011

PCMH Progress

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

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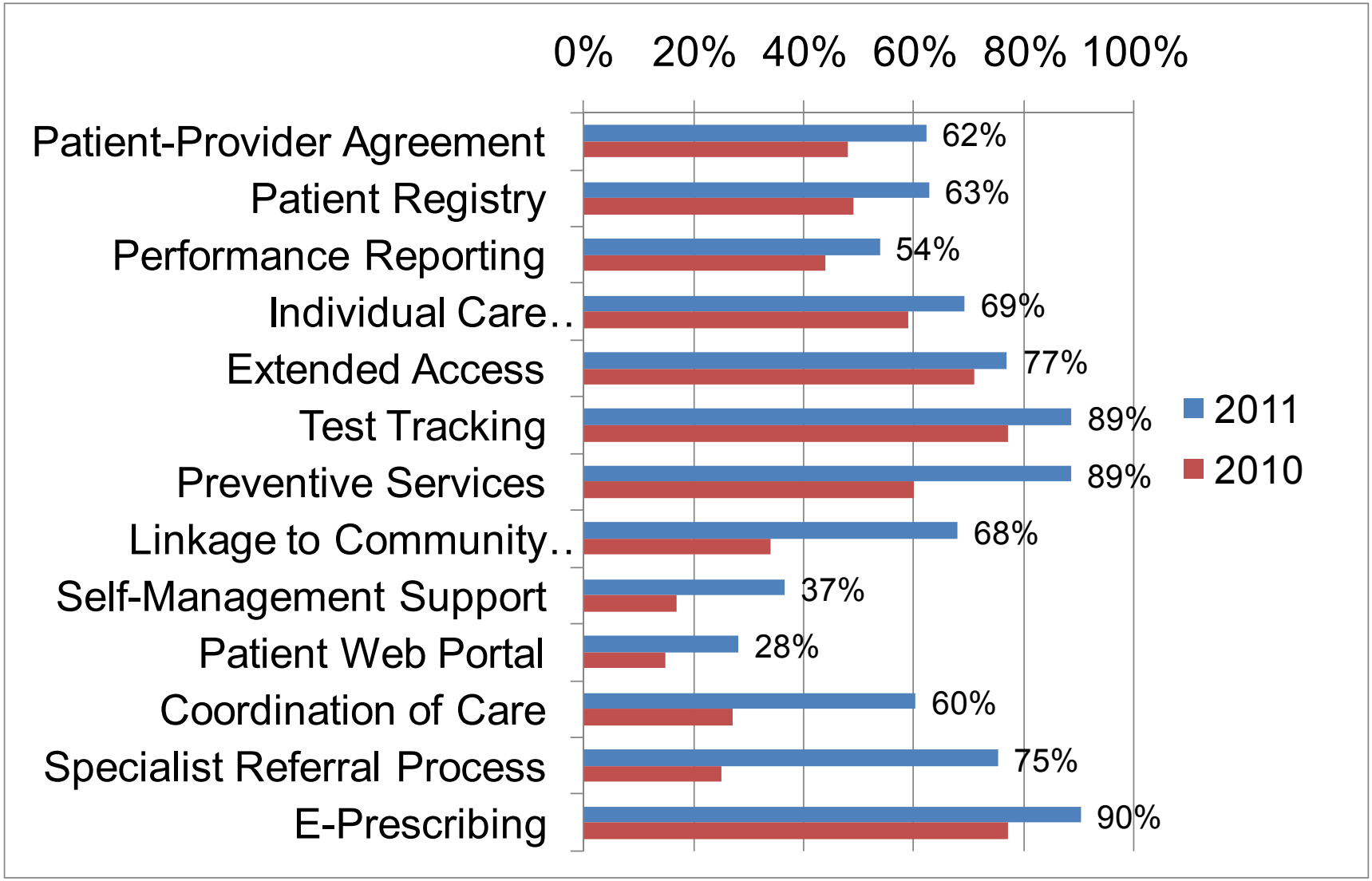
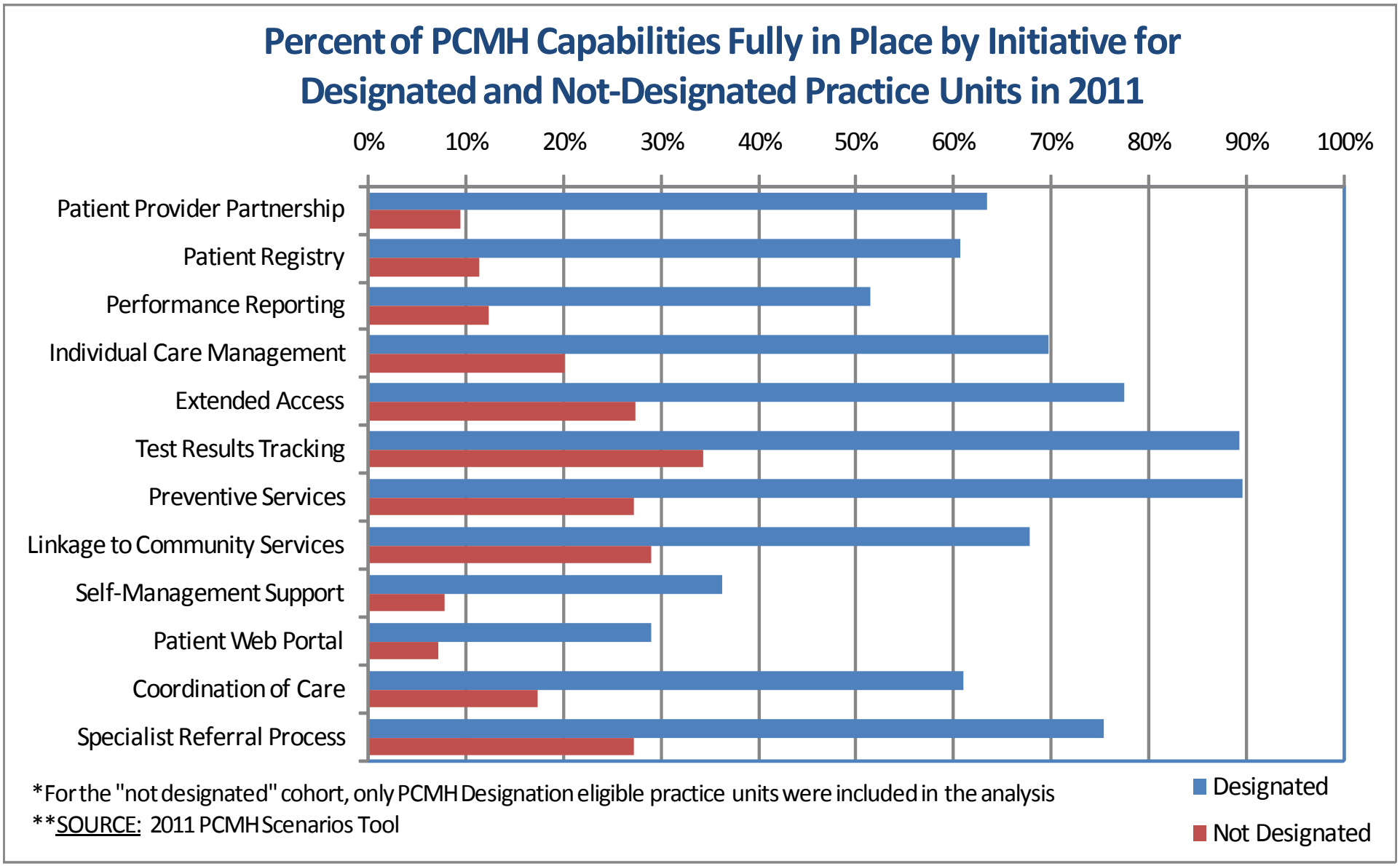
PCMH Designated Practices Continue to Implement PCMH Capabilities



PCMH Designated Practices Have Significantly More PCMH Capabilities Implemented Compared to Non-Designated



Performance of PCMH Designated Practices Continues to Improve as Program Expands

Metric	PCMH Designees Compared to non-PCMH Practices					
	Year 2 Designation*			Year 3 Designation♦		
	Jan.- Dec. 2010	2010 Designated Physicians	2010 Attributed BCBSM Members	Jan.- Dec. 2011	2011 Designated Physicians	2011 Attributed BCBSM Members
Adults (18-64)		**1,836 physicians**	**650,000**		**2,614 physicians**	**820,000**
		774 practices			**502 practices**	
Emergency department visits (per 1,000)	-6.6%			-9.9%		
Primary care sensitive emergency department visits (per 1,000)	-7.0%			-11.4%		
Ambulatory care sensitive inpatient discharges (per 1,000)	**-11.1%**			**-22%**		
High tech radiology services (per 1,000)	-6.3%			-7.5%		
High tech radiology standard cost PMPM	-3.0%			-4.9%		
Low tech radiology services (per 1,000)	-5.9%			-4.8%		
Low tech radiology standard cost PMPM	-5.9%			-5.0%		
Generic dispensing rate	3.3%			3.8%		

Differences between PCMH Designated and non-designated practices increased between 2010 and 2011, even with addition of 42% more physicians

*Year 2 Designation: July 2010 - June 2011
♦Year 3 Designation: July 2011 - June 2012

PGIP PCMH Program Year End 2011

Award-winning PGIP PCMH Program includes:

- Approximately 5,600 primary care physicians implementing PCMH capabilities
- Almost 2,000 specialists implementing PCMH capabilities
- Over 2,500 PCMH-Designated primary care physicians in more than 770 practice units
  - Approximately $27M in annual E&M uplifts for PCMH designated providers
  - Expect to further expand PCMH Designation program in July 2012

URAC

Health Care Heroes

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Why Don't We Just Use the NCQA Program?

- PGIP PCMH developed at the same time as NCQA, in collaboration with our PGIP partners
- Latest validation results demonstrate greater than 90 percent adherence to our interpretive guidelines
- We are able to assess and validate the association between the presence of specific practice capabilities and related performance measures, such as between after-hours access and ER visits
- High degree of satisfaction with site visits and support materials provided by the health plan and POs

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Payment Reform Vision

- All payment methods have inherent risks:
  - fee for service can lead to over use
  - global payment can lead to under use
  - episode payment can increase episode volume
- Must be driven by explicit purpose:
  - Improved population wellbeing at lower cost
  - Shift 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

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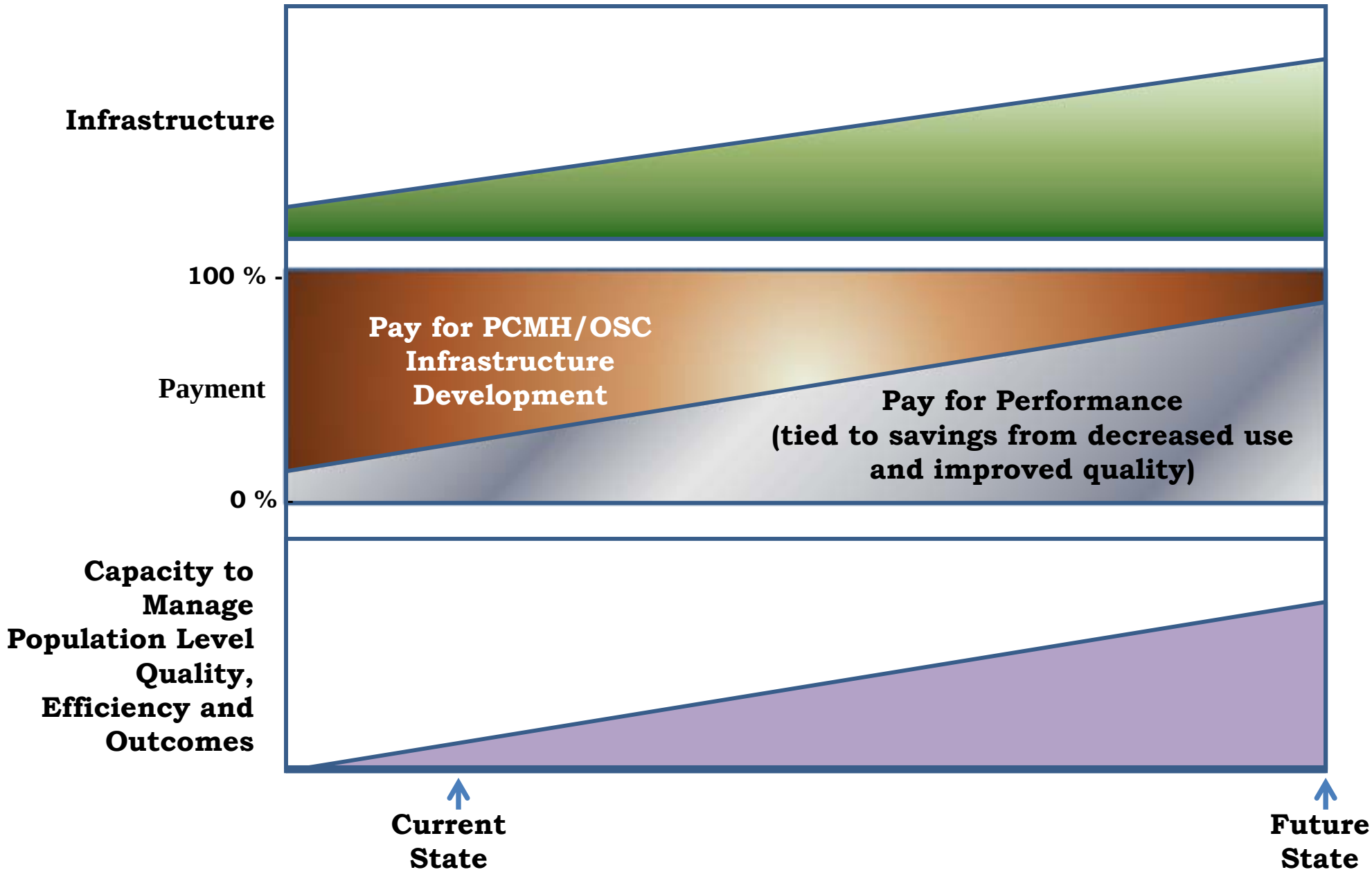
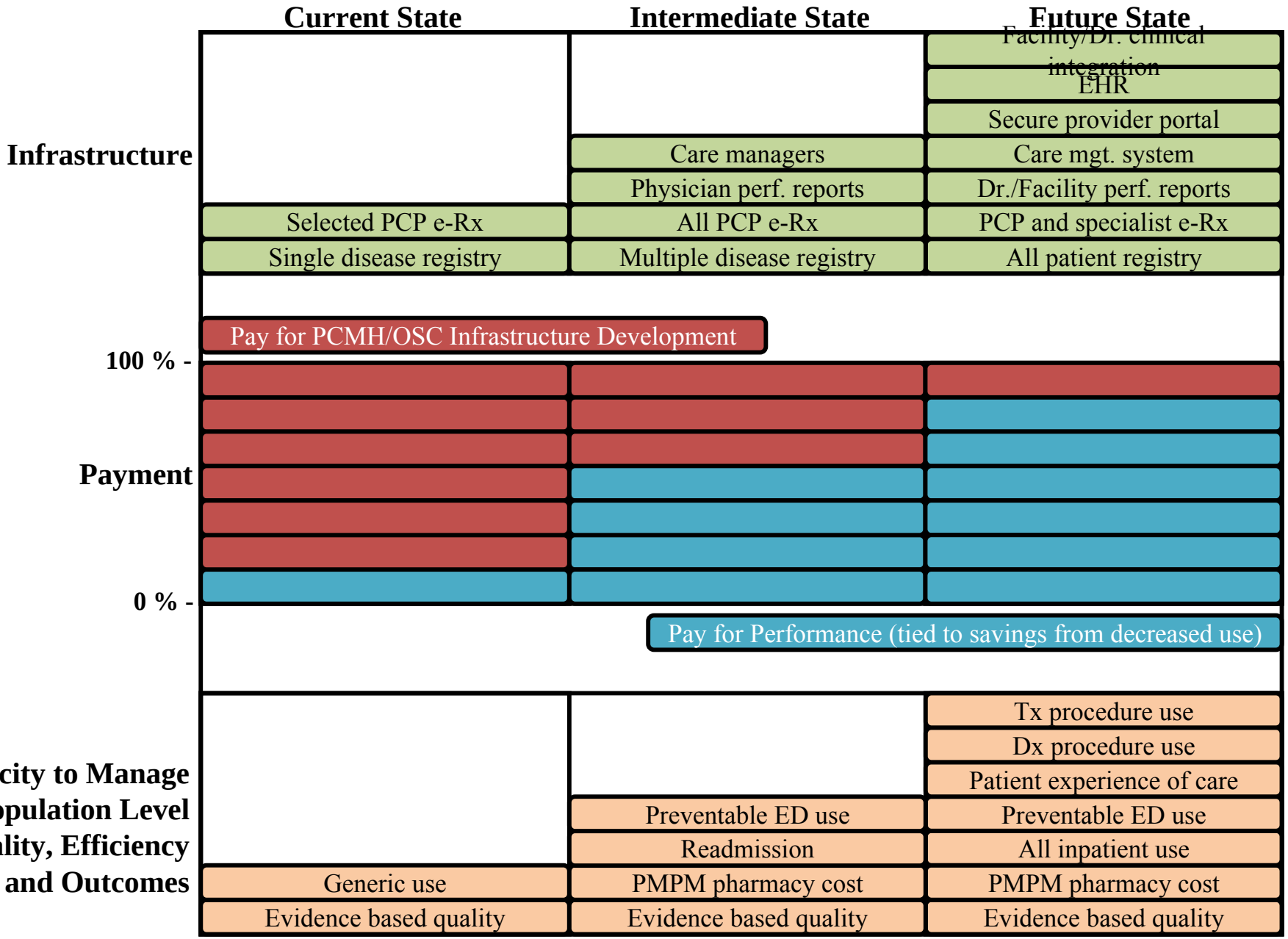
Vision: Fee For Value



David Share and Bharath Mamathambika, Blue Cross Blue Shield of Michigan

PGIP's Movement Towards Fee For Value



David Share and Bharath Mamathambika, Blue Cross Blue Shield of Michigan

Transforming Physician Reimbursement at the Physician Organization Level

- Incentive payments to Physician Organizations
  - Reward infrastructure development ($50M per year)
  - Reward improvement and optimization of population level quality and cost performance ($50M per year)
  - Lean clinic process re-engineering support
- Payments to support provider delivered care management services

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Transforming Physician Reimbursement at the Physician Office Level

- Increase office visit fees to PCMH-designated practices (+10%)
  - Additional 10% increase in office visit fees for PCMH-designated practices in POs with benchmark population level cost performance
- New codes for care management and self-management support (in person and telephonic) payable to PGIP physicians to support multi-disciplinary, team based care management
- Increase office visit fees for specialists who are contributing to benchmark population level cost performance

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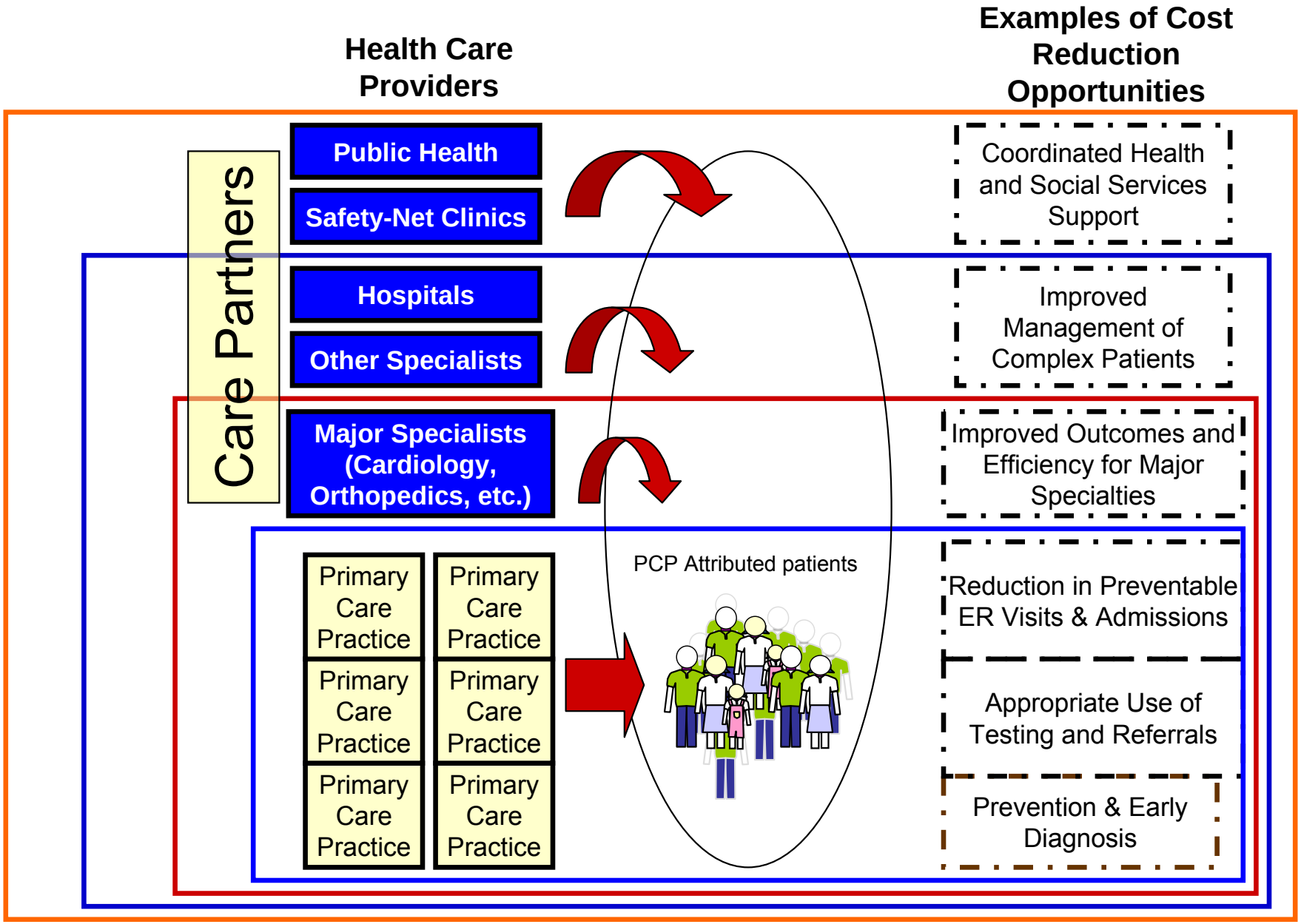
Ultimate Objective: High-Performing Systems of Care



*derived from Harold Miller's depiction of ACO models

ACOs and OSCs

- Conceptually aligned
  - Provider-based organizations responsible for the care of a population of patients
  - Goals are better care for individuals, better health for populations and slower cost growth
- ACO – requirements defined by CMS (section 3022 of the Affordable Care Act)
- OSC – capabilities defined collaboratively by BCBSM and Physicians Organizations to allow flexibility in how communities of caregivers are identified, defined and organized
  - Support incremental implementation of OSC shared information systems and care processes

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OSC Program Developed in Collaboration with PGIP Physician Organizations

- Established Core Development Team
  - Composed of 10 PO leaders selected based on interest and to ensure representation of cross-section of PGIP POs
  - Meets in person monthly, four hour meetings
  - Now adding hospital representatives

- Other interested PO leaders serve on Review Team
  - 25+ members
  - Email review of documents developed by Core Development Team
  - Phone conferences at least quarterly

Organized Systems of Care Goals

- Strengthen the primary care foundation
- Increase clinical integration among primary, specialty and facility-based care
- Decrease variation in care and fragmentation in care processes
- Improve care quality and health outcomes for patients

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OSC Guiding Principles

- The organization exists to serve the community
- Patient-Centered Medical Home-based care
- All-patient systems/solutions, not payer-specific programs
- Population defined by PCP-attributed patients
- Goal is clinical integration across provider groups (PCP, specialist, facility) in a collaborative manner: affiliation and alignment essential; co-ownership optional and may be detrimental
- Success will depend on optimizing quality and efficiency at population level: right sizing facility and specialist capacity and services; activating and engaging patients

OSC challenges

- Building OSC capacity analogous to practices building PCMH capacity
  - OSCs don't come ready-made
- IT capabilities lag behind vision
- Viability depends on optimizing value
  - OSCs must be judicious stewards of health care resources, reliably providing high quality care

OSC Development Goals

- Support incremental development of OSC shared information systems and care processes that allows OSCs to identify their population, track and assess performance
  - OSC Initiatives structured like PCMH Initiatives, with discrete capabilities to be implemented
- Develop payment model that rewards high-performing OSCs
- Align incentives for physicians, hospitals and specialists
- Elevate system transformation from practice level to population level

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OSC Structural Requirements

- Each PCP can be in only one OSC
  - One to one relationship between OSC and PCP
- Specialists and hospitals may be in more than one OSC
  - One to one, or one to many, relationship between specialists/hospitals and OSC
  - Note: specialists must join only one PGIP PO, but large specialty groups can subdivide into multiple practice units, and each practice unit can choose which PO to join based on shared patient populations
- Minimum number of 20,000 attributed BCBSM members
  - OSCs may have fewer members but may not be eligible for all incentive opportunities due to measurement challenges
- Geographic proximity of care-givers is not an OSC requirement
  - Geographically dispersed OSCs may face greater challenges meeting the essential elements of an OSC

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OSC Initiatives Support Incremental Implementation

Launched July 2011		*Launch 2012*
OSC Integrated Patient Registry	**OSC Integrated Performance Measurement**	**OSC Processes of Care**
Supports implementation of an OSC integrated health information system that will be used to collect, track, use and store patient health information and allow all OSC providers to have the right information at the right time to effectively manage patient population (23 capabilities)	Supports implementation of OSC-level integrated performance metrics, measurement, and reporting to enable providers to manage patient population at the OSC level (6 capabilities)	Supports implementation of OSC-level care processes that will enable the OSC community of caregivers to communicate, coordinate and collaborate to achieve clinical integration (31 capabilities)

OSC Integrated Patient Registry Vision

When fully implemented, the OSC Integrated Patient Registry will:

- Link all PCPs, key specialists and key hospitals
- Link labs, Rx, PBMs, community agencies, key non-hospital facilities
- Allow providers to exchange key clinical information electronically
- Incorporate claims data
- Update data via electronic feeds
- Include patient generated data (e.g., goals, HRA, functional status)
- Enable providers to identify and address disparities in care
- Allow population-level analysis
- Include all patients

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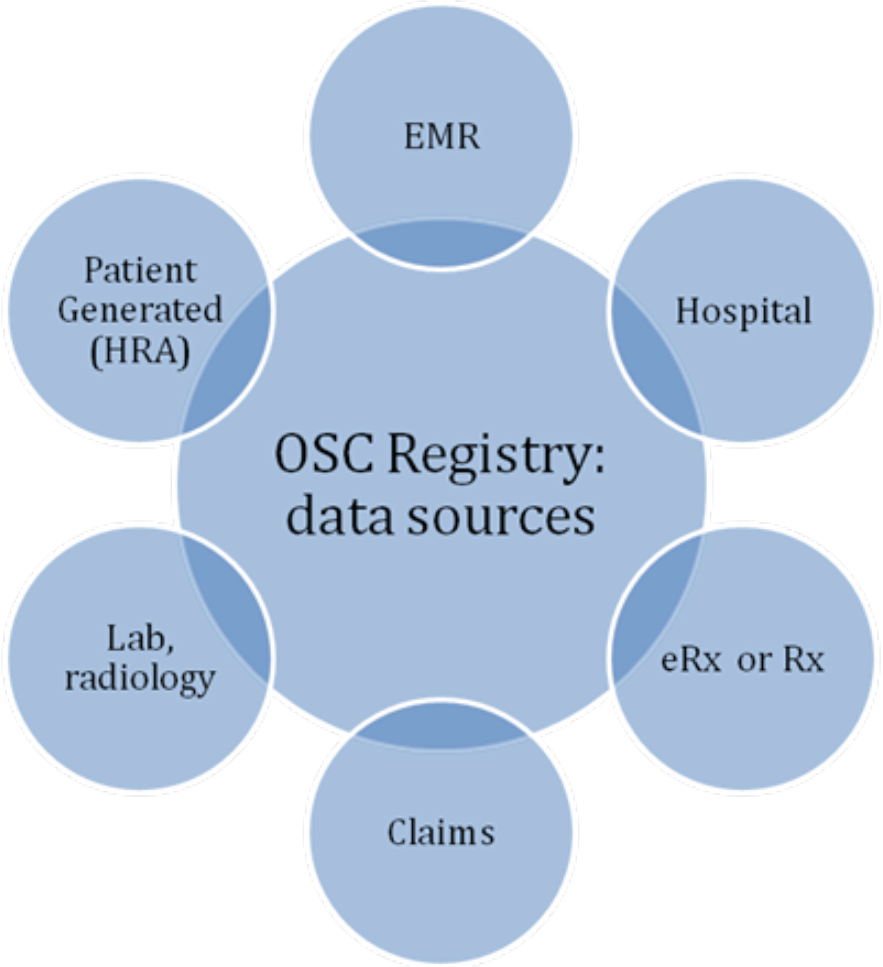
OSC Integrated Patient Registry



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OSC Integrated Performance Measurement Vision

When fully implemented, OSC Integrated Performance Measurement reports will:

- Address the full range of population segments
- Measure transitions across care settings and over time
- Measure patient experience with care
- Incorporate claims data
- Incorporate metrics relevant to key OSC stakeholders
- Measure quality and efficiency of care
- Provide clinically meaningful health information on OSC population
- Be reliable and actionable and useable for internal quality improvement
- Align with nationally /regionally recognized performance measures (e.g., CMS ACO measures, HEDIS, HITECH, PQRS)

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OSC Integrated Processes of Care Expands PCMH Domains to OSC Level

- Patient-Provider partnership
- Individual care management
- Extended access
- Test results tracking and follow-up
- Preventive services
- Linkage to community services
- Self-management support
- Patient web portal
- Coordination of care
- Specialist referral process
- Specialist access

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The PCMH Neighborhood

1. Incorporating ACP concept of “PCMH-N”
2. Expanding PCMH Interpretive Guidelines to incorporate specialist-specific expectations
   - PCMH Initiatives have always been open to participation by PGIP specialists, but new Interpretive Guidelines will explicitly address specialist role in each domain
3. Developing sample Primary Care-Specialty Care Agreement
   - POs can use sample template or develop own
   - To be considered for PGIP specialist “fee uplift” beginning 2012, specialists must complete agreement and be nominated by PO

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OSC Patient Experience with Care

- Under development
- Goal is to determine best way to measure patient experience with care
- Collaborating with other community stakeholders to avoid redundancy and patient inconvenience

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Bringing Hospitals into OSCs

- During 2011, several OSC symposiums with hospitals around the state
- Move away from traditional FFS reimbursement by linking payments to:
  - Improved patient outcomes on a population level
  - Decreases in per-member-per-month payment trends
- Align hospital and physician payment incentives
  - Establish common performance goals, foster collaboration
- Build on PGIP initiatives to establish better clinical integration through OSCs
  - Effective and timely communication across providers
  - Better alignment and decreased fragmentation
  - Reduction in duplicative and unnecessary services

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PO and Hospital Alignment

- Hospitals are expected to collaborate with any PGIP PO whose attributed patients represent at least 10% of the hospital's encounters, or for whom the hospital(s) represents at least 20% of the PGIP OSC's inpatient volume
  - Hospital performance reports will be based on the weighted average performance of all collaborating POs/Sub-POs
- Hospital performance metrics will be the same as PGIP to facilitate information sharing and analysis across hospitals and their partner POs

Performance-Based Hospital Reimbursement

- Phase 1: payments based on capability building and goal setting:
  - Developing the infrastructure needed to partner with affiliated PGIP POs in an organized system of care
  - Integrating care processes with affiliated PGIP POs
  - Establishing OSC cost and quality goals
- Phase 2: payments based on:
  - Achieving cost and quality goals at an OSC level
- Phase 3: Modernized hospital pay-for-performance:
  - Focus on alignment with physicians and population-based care

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Phase 1: Structural Framework of Hospital Agreements

- Replaces all or part of base-rate percentage increases with a defined dollar amount linked to OSC infrastructure development and performance
  - Not an ongoing percentage increase
- Additional payment amount spread over the course of the agreement
  - Payments made to one or more hospitals within each system
  - Distribution of funds to OSC partners determined by hospital system leadership
- Payments dependent upon completion of specific milestones
  - Letter of intent with PGIP POs
  - Project plan developed collaboratively with affiliated PGIP POs
  - Achievement of project milestones and goals
- All milestones subject to BCBSM approval
  - Must reflect new efforts; no payment for already completed work or efforts funded through another source

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OSC Future Development

- Patient attribution – allow PPO members to identify their primary care physician to supplement patient attribution based on claims data
- Tiered provider reimbursement - tiered payment to providers based on population level cost and quality performance
- Tiered member liability - Members' cost liability will vary based on the value of the population-level care delivered by the system from which they seek care (parallel to providers' value tiers)

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Lessons Learned

- Don’t rush to payment solutions
  - Incentives or payment reform separate from community and explicit purpose will not succeed
- 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 and right-sizing facility capacity

Website Information

Some helpful links:

- **BCBSM Value Partnerships website**
  - **http://www.valuepartnerships.com/**
- **Main PGIP section of BCBSM site:**
  - **www.bcbsm.com/provider/value_partnerships/pgip/index.shtml**
- **PGIP Initiative Fact Sheets:**
  - **www.bcbsm.com/provider/value_partnerships/pgip/initiatives.shtml**
- **PCMH Initiatives:**
  - **www.bcbsm.com/provider/value_partnerships/pgip/medical_home.shtml**
- **To subscribe to BCBSM's PGIP Matters eNewsletter:**
  - **www.bcbsm.com/provider/publications/index.shtml**

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