Partnering for Value: Blue Cross Blue Shield of Michigan's Physician Group Incentive Program

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Key Messages

- **Current state = non-system**
- **Preferred future state = Organized System of Care**
- **Measurement and change efforts should focus on communities of caregivers, not individual practitioners**
- **Third parties should be partners and catalysts, not adversaries and controllers**
- **Harness physician creativity by giving their *organizations* responsibility for system change, not by prescribing change**
- **Modest reimbursement reform can drive system change, which can be achieved by relentless incrementalism**

Transformed Roles

- Payer: Change Facilitator and Catalyst
  - Provoke thought and action
  - Convene providers to forge future vision and plan means to achieve it
  - Devote resources and dedicate relationships to catalyzing change
- Provider: Change Agent
  - Locus of control in providers' organizations
  - Physicians and Hospitals must lead system transformation

The Case for Transformation

- The current system is ineffective
- Huge gap between actual and optimal performance
  - Quality Chasm is trivial compared to the gap between the current health care system and an optimal, coherent health care system
  - Excess cost, inadequate quality, inadequate access
  - Patients are passive
- Care complexity exceeds capacity of traditional approaches
    - » Insufficient hours in the day for individuals to perform all essential functions

Insane Responses to Health System Inadequacy

- Trying to improve health care value by exhorting individual behavior change in a poorly designed system

Sane Responses to Health System Inadequacy

- **Change the System**
  - Team-based, not physician-centric, system designed to reliably provide care of high fidelity with what is known about optimal quality in an efficient way
  - In an effective system of care, practitioners are free to engage patients in setting and acting on goals pertinent to patients' conditions and preferences
  - Absent system transformation, performance improvements will be trivial
- **Locus of Control of System Change Should be Local**
  - If physicians don't craft the vision, they won't own it
  - Absent physicians' control of system change, it won't happen
  - BCBSM partnered with the physician community to create the Physician Group Incentive Program

Future State: ***Communities of Caregivers in Organized Systems of Care***

- Shared processes of care
- Shared information systems
- Shared responsibility for a community of patients
  - Includes stewardship of health care cost and quality
- Active partnerships with patients yielding care customized to individuals' values and needs
- Proactive management of population wellbeing
- Providers share responsibility for system transformation

BCBSM's Incentive Strategy

- Inertia results from:
  - Market unreceptive to substantial benefit and/or reimbursement changes or expansion
  - Benefit and payment overhaul requires massive re-tooling
- Overcoming health system inertia via:
  - Relentless incrementalism
  - Re-directing existing benefit/reimbursement dollars to catalyze provider practice transformation

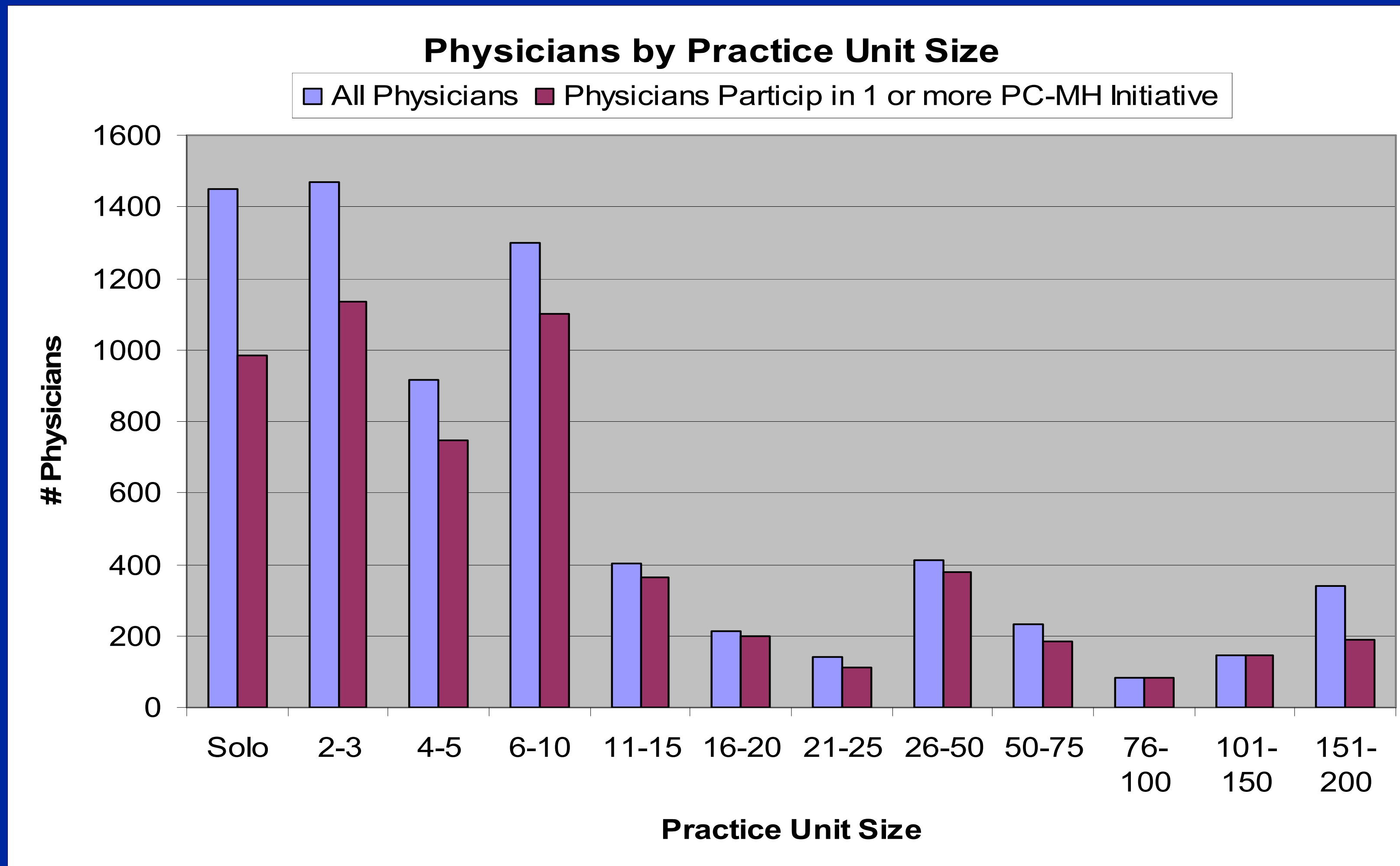
Partnering for Value: underlying assumptions

- **Physicians practice in groups (actual or virtual)**
  - **Whether physicians practices are solo, small office or large groups:**
    - **Physicians don't practice in isolation**
    - **Cross coverage is standard**
    - **PCP's rely on specialists, hospitalists, the ER**
    - **Specialists sub-specialize**
    - **Physicians don't independently manage care**

Partnering for Value: underlying assumptions

- **Advantages of measuring group performance**
  - **Stimulates assessment and improvement of systems**
  - **Less likely to:**
    - » **reward past achievements**
    - » **encourage adverse selection**
  - **More valid than individual level measurement (low ‘n’, patient clustering, patient attribution)**
  - **Physicians’ creative energies are focused on improving systems not defending personal practice**

Most Practice Units have 1-10 physicians; larger Practice Units more likely to participate in PC-MH Initiatives



Optimizing Value in Physicians' Practices

- Health plan can catalyze system transformation:
  - first partner with physician groups
  - then foster development of high-functioning, integrated systems of care
  - then support system-based care management efforts
- Physician groups can amass sufficient resources to optimize systems of care; individuals can't
- One size doesn't fit all: Physician group sophistication varies, from vertically integrated, highly functioning systems to cottage industries

BCBSM's Value Partnership Physician Group Incentive Program (PGIP)

- Planned in collaboration with State medical society
- Early adopters in 2005: 10 physician organizations/2,179 doctors
- 2008: 35 groups; 6,415 doctors (80% are PCP's; comprise 63% of PPO PCPs); 1,900,000 members; $50,000,000 per year in incentive payments
- Rewards collaboration across groups
- Rewards high quality and cost effective care and proactive management of populations of patients
- Supports implementing the domains of function in the Patient Centered Medical Home model
- Includes specialists (e.g., oncologists, cardiologists, etc.); focus on care coordination among primary care providers and specialists
- Incentive pool filled with 2.5% of professional payments; started with 0.5% and increases annually

[note: BCBSM members = 50% of the population in Michigan]

PGIP frame of reference: Physician Organizations (POs)

- POs
  - comprise between 30-1,200 physicians representing a community of caregivers with shared responsibility for a population of patients
  - accept incentive payments on behalf of member physicians
  - Have discretion to use resources for infrastructure development and reward payment as they see fit
  - provide leadership, organizational structure and technical support in implementing system transformation
  - are accountable for performance on cost, quality and system transformation at the PO (population) level
  - receive data at the Practice Unit (office) and individual physician level to support internal self-assessment and improvement

PO Evolution

- PO structure and purpose pre-PGIP
  - Of 35: 33 IPAs; 2 employed staff of vertically integrated system
  - Only one new group formed: Medical Society practice management entity became umbrella organization for 43 small POs which include many new physicians
  - Primarily limited to single signature managed care contracts
- PGIP Initiatives and incentive payments dramatically expanded POs' size and focus:
  - shared accountability for cost and quality
  - leadership responsibility for implementing PCMH core capabilities
  - Focus on creating an organized system of care
  - POs grow by attracting unaffiliated physicians

PO Accountability and Member Attribution

- Patients attributed to individual physicians (PCP or selected specialist categories) based on frequency of E and M services
- Physicians linked to Practice Units (usually physicians' offices) and aggregated into Physician Organization population
- PO is responsible for interacting with Practice Units and individual doctors; data provided at level of Practice Units and individual doctors
- Accountability to the health plan is at the PO level

Physician Group Engagement: They are *energized*!

- Intra-group leadership: at PO, regional and Practice Unit (office) levels
- PGIP leadership: partnership between BCBSM and PO leaders
  - Primary Care Leadership Committee comprised of PO leaders
  - Each Initiative has a Leadership Team
  - POs are paid to support effort of leadership participants
- Cross-PO Interest Groups: context for ongoing sharing of knowledge and experience regarding best practices and challenges in practice transformation

Interest Groups Accelerate Pace of Change

- PGIP quarterly meetings: active working sessions among PGIP partners
- PGIP Interest Groups developed out of need for more opportunity to collaborate
- An example: One Interest Group grappled with inertia in physicians' offices, spawning a new approach to facilitated change management
- The result was the Lean Thinking Clinic Re-engineering Collaborate Quality Initiative
  - PGIP now supports POs in structured office re-design, including training of PO change management facilitators

BCBSM's Physician Group Incentive Program Initiatives

- Rewards earned by successful participation in change "Initiatives"
- Attempt to strike balance between structured expectations and PO latitude
- Initiatives are focused approaches to transforming the delivery of health care (quality and efficiency).
  - Organizational capacity building for newly formed Physician Organizations (e.g., leadership, analytics)
  - Core clinical process or capability (e.g., PCMH domains of function)
  - Type of service or procedure (e.g., radiology, cardiology, ER, inpatient use)

Initiatives to develop capabilities for collaborative improvement

- Establishing staff dedicated to managing or coaching process improvement teams
- Establishing analytics and reporting staff
- *Performance reporting
- Lean Thinking-Clinic Re-engineering CQI

Service-specific Initiatives

- Increase the use of generic drugs
- Radiology procedures utilization (e.g., overall, high tech, office-based, condition specific)
- Improve Oncology Practice Performance (ASCO QOPI)
- Anticoagulation management CQI (in development for early 2008)

Core clinical process Initiatives

- *Evidence based care tracking/patient registry
- *Patient-Provider agreement
- *Extended access
- *Individual care management
- *Test tracking and follow-up
- Developing automated self-management support systems

Clinical information technology Initiatives

- *Accelerating the Adoption and Use of Electronic prescribing

*Components of the Patient Centered Medical Home Model (PCMH)

PGIP Approach to PCMH implementation

PCMH Related PGIP Initiatives

Opportunity for PGIP Physician Organizations (POs) to participate in Initiatives that support implementation of domains of function of the PCMH model, beginning in 2008

PCMH Designation Program

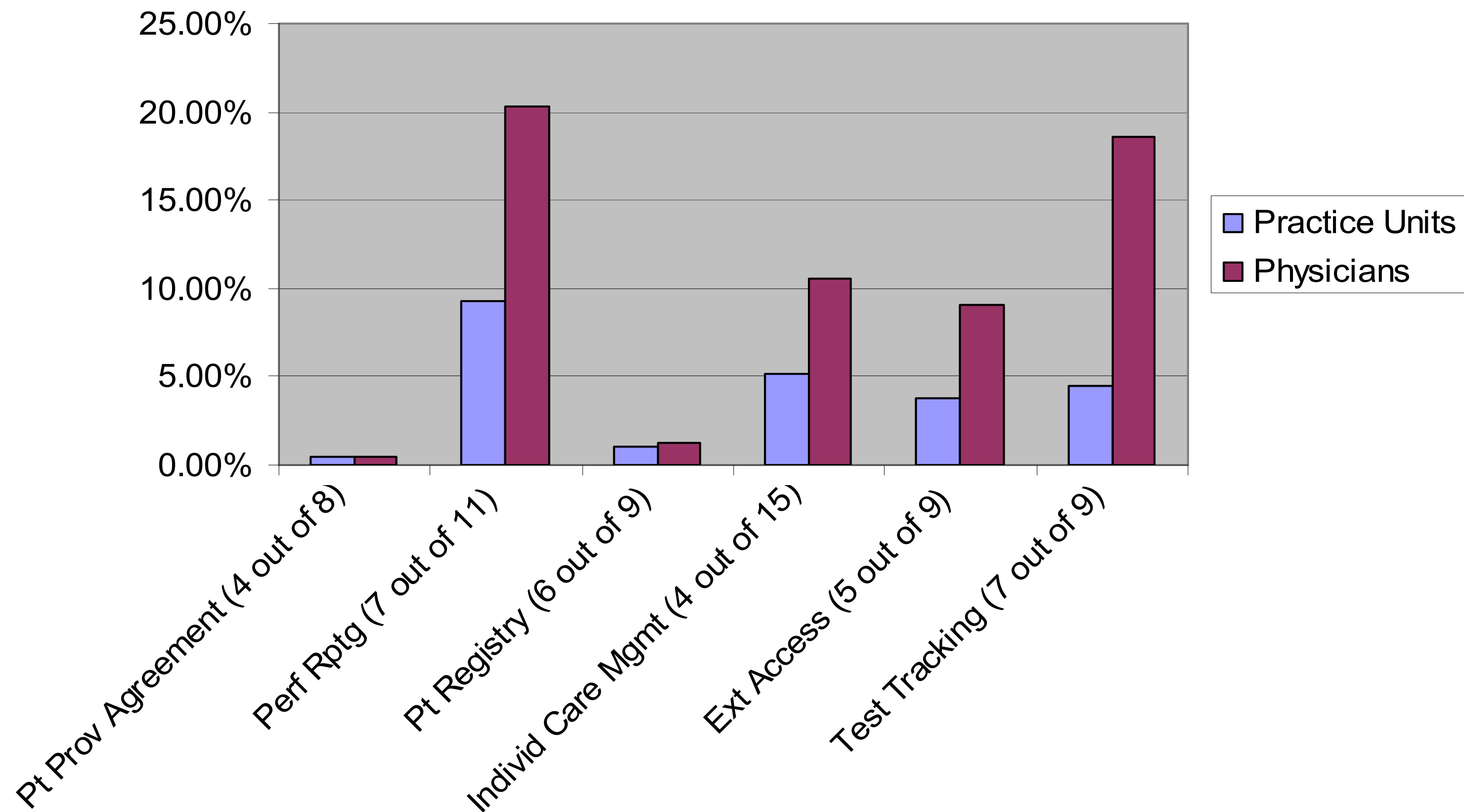
Implementation of differential reimbursement for PGIP physicians who meet criteria for BCBSM designation as a PCMH, beginning mid-2009

The gap between PCMH vision and reality dwarfs the Quality Chasm

Current state of PCMH implementation: adrift in a sea of rhetoric and models

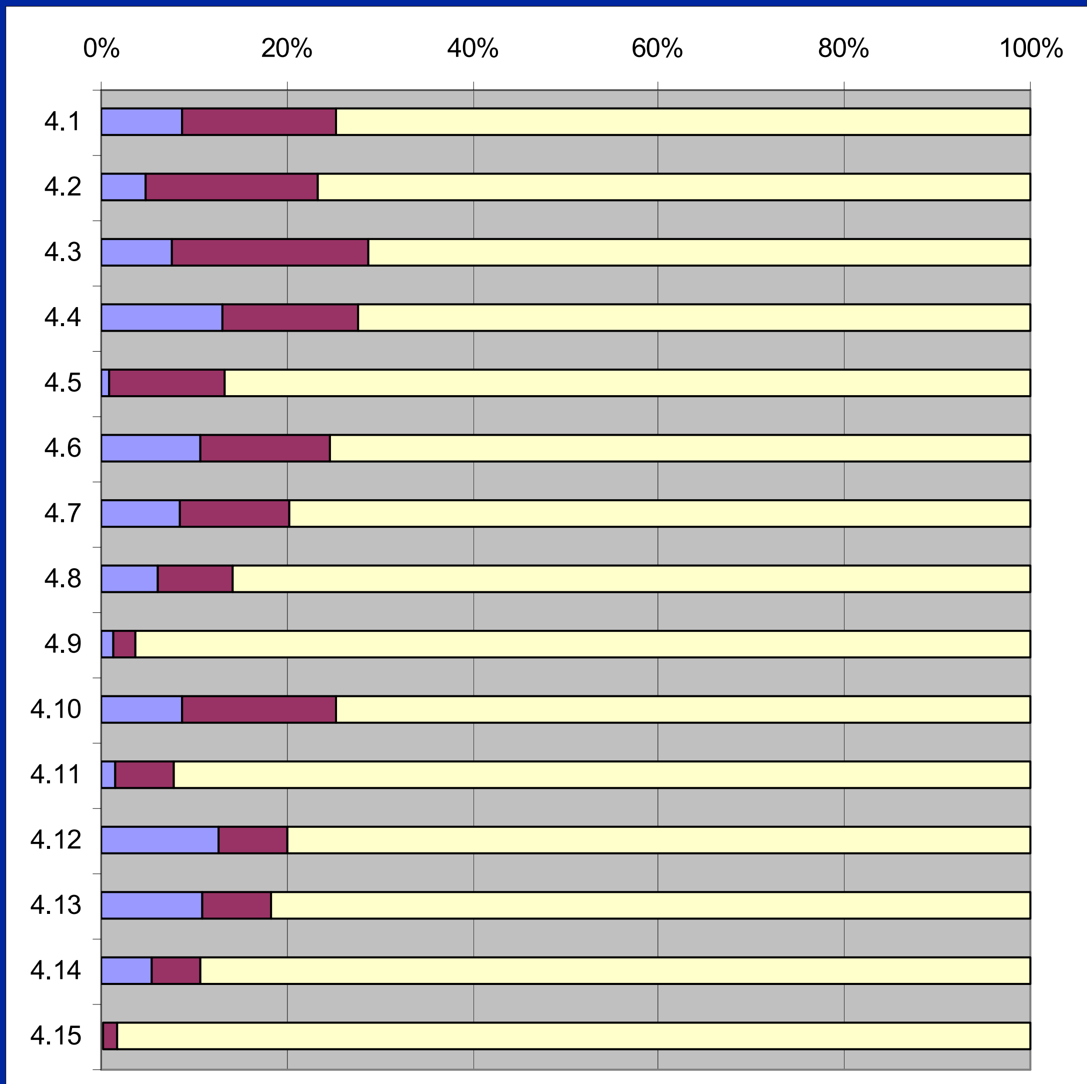
- Quality Chasm is trivial compared to the gap between the PCMH reality and vision
- Increased organizational structure (robust clinical and administrative leadership at the group, regional and clinic levels) correlates with implementation of PC-MH domains of function
- Structured expectations and incentives regarding PCMH implementation, with substantial latitude in implementation by communities of caregivers, may accelerate adoption of PCMH-based practice models

PCMH topography



Percent of physicians' offices and physicians with care management capabilities in place

INDIVIDUAL CARE MANAGEMENT INITIATIVE
Practice Unit leaders and staff have comprehensive knowledge of the Patient Centered-Medical Home model & the Chronic Care model
Practice has teams of multi-disciplinary providers and a systematic approach is in place to deliver comprehensive care
Systematic approach is in place to ensure that established care guidelines (e.g., MQIC Guidelines) are followed by all members of the Practice Unit
At least one chronic condition has been identified for initial focus
Action plan development and goal-setting is systematically offered to all patients with the chronic condition selected for initial focus
A systematic approach is in place for appointment tracking & reminders for all patients with the chronic condition selected for initial focus
A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus
Planned visits are offered to all patients with the chronic condition selected for initial focus
Group visit option is available for all patients with the chronic condition selected for initial focus
Medication review and management is provided at every visit for all patients with chronic conditions
Action plan development and goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs.
A systematic approach is in place for appointment tracking and generation of reminders for all patients
A systematic approach is in place to ensure follow-up for needed services for all patients
Planned visits are offered to all patients with chronic conditions
Group visit option is available to all patients with chronic conditions (may be done in collaboration with other Practice Units)



PCMH Designation Program

Goal - **To compensate physicians in Physician Organizations (POs) for the additional time and resources required to function as a Patient Centered Medical Home**

Mechanism - **Higher level of reimbursement for office-based E&M codes to physicians who are designated by BCBSM as a Patient Centered Medical Home.**

Eligibility Requirements for PCMH Designation Program

1. Physicians nominated by their PGIP PO
2. Acceptable Evidence Based Care Report scores (quality measures) and patient satisfaction performance
3. Have no outlier cost/use experience or pattern of excessive use of health care resources
4. Meet BCBSM's PCMH criteria
   - Initially, to facilitate a phased approach, Practice Units that meet criteria for only a subset of the Domains of Function will be eligible for PCMH Designation

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

Evaluation of PCMH Effectiveness

- Increased access to care/decreased fragmentation of care
  - Patients who have and use 24-hour phone access to PC-MH
  - Patients who have access to and use non-ED after-hours care (with communications link to PC-MH) for non-emergent conditions
- Reduced cost and use
  - ED use for non-emergent conditions
  - IP admissions for ACSCs
  - Specialist visits for conditions that can be managed by PCP-patient partnership
- Improved health care processes and outcomes
  - Reduced gaps in care for chronic conditions
  - Reduction in progression and complications of chronic conditions
  - Reduced incidence of chronic conditions
  - Increased use of preventive screening
- Increased satisfaction
  - Higher patient satisfaction
  - Greater provider satisfaction

PGIP Physician Reimbursement

- *It is not necessary to wait for reimbursement system reformation to incorporate positive incentives into professional payment*
- Transforming reimbursement
  - Payments to physician organizations
    - Payments reward infrastructure development and participation in collaborative efforts
    - Payment based on reaching goals of specific PCMH Initiatives and demonstrated improvement in quality and efficiency
  - Increase of existing fees to support PCMH practice (E and M fee boost)
  - New codes for care management and self-management training (T-code payments)
  - Payments to offices which provide comprehensive disease management services

Multiple Sources of Financial Compensation for Providers with PCMH Competencies

<table>
<tr><th>Time-Limited</th><th colspan="4">Ongoing</th></tr>
<tr><th>Implementation of PCMH Capabilities</th><th>Improved Results</th><th colspan="2">New PCMH Activities</th><th>PCMH Designation</th></tr>
<tr><td>PGIP PCMH Initiatives Incentive payments</td><td>PGIP Service-Specific Initiatives</td><td>T-Codes for Care Management & Self-Management Training</td><td>Disease Management Fees</td><td>Differential Reimbursement</td></tr>
<tr><td>•Performance
•Participation</td><td>•EBCR
•Radiology
•ED Use (new in 2009)
•IP Admits for ACSCs (new in 2009)
•Cardiology use (new in 2009)</td><td>•Services by RN, dietitian, diabetes educator, MSW, clinical pharmacist, or respiratory therapist
•Patients with care plan in medical record and diagnosis of chronic illness</td><td>•Disease Management for patients with specific chronic disease(s) delegated from BCBSM BlueHealth Connection program</td><td>Higher reimbursement for office-based E&M codes</td></tr>
</table>

Physicians’ Administrative Barriers to Embracing Transformed Reimbursement

- Physician Organizations are challenged by different fee schedules for PCMH and non-PCMH physicians
- Adding care management and self-management support staff when only one (albeit major) payer reimburses for their services

PGIP Physician Organization Activities

- Care process transformation
  - Development of chronic care travel teams which visit physicians' offices
    - RNs, Mental Health Specialists, Exercise Physiologists, Registered Dieticians, Certified Diabetes Educators available to small offices to expand expertise available for engaging patients in self-management and to provide care management services
  - Physician Organization Staffing Increases
    - Clinical pharmacists, care-managers and analytic staff
  - Implementing planned care visits/group medical visits
    - Customized, point of service care guided by PCMH model
  - Automated, Proactive outreach to patients with gaps in timely receipt of essential services
  - IT Implementation: e.g., EMR with embedded clinical decision support, E-Rx, Chronic Disease Registries, e-Laboratory access and management

PGIP Physician Organization Activities

- Care process transformation
  - Lean Thinking – System Transformation
    - » Multi-organization, collaborative, office re-design aimed at implementing streamlined, PCMH-based care processes
  - PO extends access via centralized after-hours urgent care w/ information link to PCP offices
- Community health system transformation
  - Calhoun County Pathways to Health
    - » Transforming the County's health care delivery system to improve chronic disease outcome; initial focus on diabetes; involves employer groups, community health, hospitals, insurers, physicians, community support network
- Early evidence of impact
  - Increased generic use: absolute 4% increased use rate compared to control; PGIP quality scores: absolute 4% higher than control

Keys to success

- The top 10% of performers on quality and cost measures includes both employed providers (staff model) AND loose federations of private practices (IPAs)
  - much easier for the vertically integrated systems
  - but IPAs are successful as well
- Attributes in common
  - strong clinical and administrative organizational structure (at group, region and clinic level)
  - proactive, assertive clinical and administrative leadership
  - organizational accountability for achieving explicit system transformation goals
  - investment in infrastructure and focus on transforming core clinical processes, not playing to the quiz

Hallmarks of the laggards

- Few in number
- Federations of private practices with focus on success in managed care contracts
- Weak organizational structure
- Leaders lack vision
  - limited investment in infrastructure and core clinical processes transformation
  - play to the quiz; attract physicians with short term rewards
  - cherry picking of physicians to improve results

Development for 2009

- Hospitalist Initiative
- ER utilization
- Inpatient care utilization (e.g., rates of inpatient admissions for ambulatory care sensitive conditions; rates of all other IP admissions)
- Specialty referrals
- Integration of health plan and Physician-practice-based Care Management programs
- Patient Centered Medical Home designation
- Cardiology: community-wide management of cost and quality
- Automated telephonic patient and informal care-giver self-management support

Conclusion

- Value Partnerships:
  - Foster partnerships between BCBSM and providers, and across provider groups/hospitals
  - Focus on groups, not individuals, and on measuring to improve
    - » Small offices can effectively participate in large groups
  - Strengthen the identity and capabilities of communities of caregivers
  - Locus of control of clinical information and improvement efforts in providers' hands
  - Facilitate system transformation: movement toward shared information and shared processes of care: the PCMH Chasm dwarfs the Quality Chasm
  - Increase attention on population management, including shared responsibility for a population of patients
    - » Support implementation of Patient Centered Medical Home model
    - » This is difficult and disruptive but is better than the status quo
  - Support hospitals' in continuously improving systems of care

Website Information

We are continually updating the PGIP and Value Partnerships sections of the www.bcbsm.com website with current information about the program. Some links:

- **Main PGIP section of site under Value Partnerships**:

  http://www.bcbsm.com/provider/value_partnerships/pgip/index.shtml

- **Presentations from our most recent PGIP quarterly meeting can be found at:**

  http://www.bcbsm.com/provider/value_partnerships/pgip/quarterly_meeting_march_2008.shtml

- **2008 PGIP Initiatives, Initiative Fact Sheets, BCBSM Initiative subject matter experts email addresses, etc. can be found at:**

  http://www.bcbsm.com/provider/value_partnerships/pgip/pgip_initiatives_registration.shtml

If you experience difficulties with the links, you can access the PGIP website as follows:

1) **Go to www.BCBSM.com**
2) **Select "I Am a Provider“ (upper right hand corner of page), then click on “Provider area”**
3) **Select "Value Partnerships"**
4) **Select "Physician Group Incentive Program"**
5) **You will then be on the PGIP Home Page (i.e., first bulleted item above)**