

Blue Cross Blue Shield of Michigan Value Partnerships and Physician Group Incentive Programs

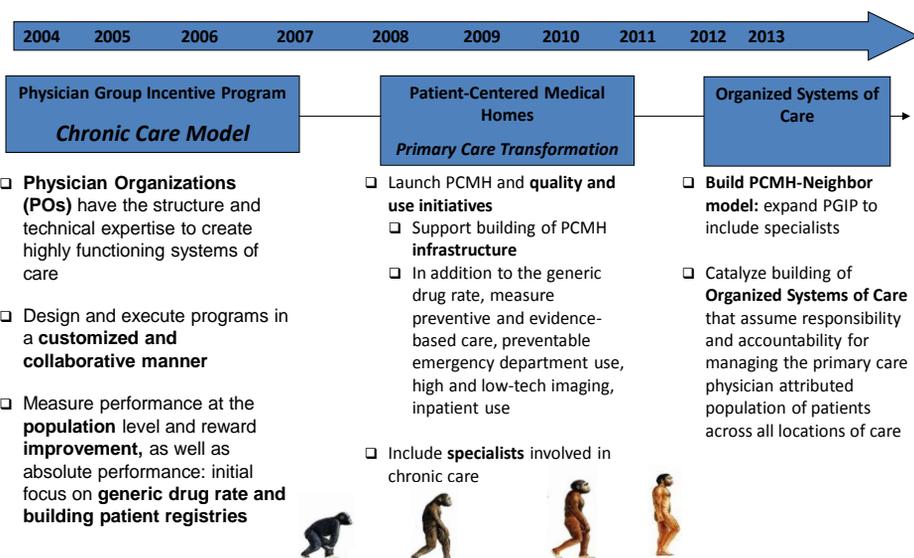
Transforming Care Systems;

Transforming Payment from Fixed Fee for Service to
Variable Fee for Value

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David Share, M.D., M.P.H.
Senior Vice President, Value Partnerships
dshare@bcbsm.com

Physician Group Incentive Program: catalyzing health system transformation in partnership with providers



Physician Group Incentive Program Root Causes

- **Lack of System**
 - Within and across physicians' practices
 - Between practices and facilities
- **No locus of control for creating a system or its results**
- **Focus on individual performance not community performance**
 - Diverts attention from system transformation and population results
 - Methodology limitations of individual physician accountability:
 - Low "n" and patient clustering
 - Specialization (e.g., interventional cardiologist vs. imaging cardiologist)
 - Fosters fragmentation and cherry picking
 - Inadequate resources, leadership, technical and administrative support to implement new systems and care processes at practice level

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Physician Group Incentive Program Catalyzing System Development and Performance

- **PCMH-Neighborhood Model as the foundation for Organized Systems of Care**
- **Explicit goals:**
 - **Shore up primary care**
 - **Population accountability based on members attributed to PCMH practices**
 - **Achieve clinical integration across settings of care**
 - Shared information systems and care management systems
 - Support proactive population management
 - Measure and reward performance at population level
 - Provide information so communities of caregivers can assess and improve at the practice and individual physician level

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Physician Group Incentive Program Payment Transformation

- PGIP Incentive Pool: Physician Organization incentives: Infrastructure/system development and population performance**
- Variable professional payment tie-barred to population value: no fee increases after 2009: Infrastructure/system development and population performance**
- Provider Delivered Care Management:** Reimbursement for team-based care management/coordination/self-management support
- Hospitals: Infrastructure/system development and population performance**
- Members:** Variable member liability linked to self-assignment to a PCMH practice ; Use of PCMH-Neighborhood primary care, specialists and OSC facility providers in the local network

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Physician Group Incentive Program Exponential Growth

- 2005:
 - 10 Physician Organizations; 3,000 physicians
- 2013:
 - 45 Physician Organizations with over 100 sub-physician organizations
 - 18,000 physicians; 6,000 PCPs (most in 1-3 physician practices)
 - 2,000,000 members (5,000,000 citizens)
 - 39 Organized Systems of Care: PCP, specialists and facilities developing integrated systems and sharing collective responsibility for population performance [note: 20 ACOs]
 - Building PCMH foundation:
 - PCMH Designated practices:
 - 2009: 300;
 - 2012: 995;
 - 2013: 1,243
 - Additional 2,000 practices working toward PCMH Designation

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Physician Group Incentive Program Population and PCMH Cost Impact

- **Since 2011 commercial underwritten PPO group trend < or = 1.9% for 10 quarters**
- **Professional use trend *negative* for 10 quarters**
- **Overall PGIIP annual savings in 2011: 1.5%** (Lemak, et al)
- **PCMH annual savings 5-6%, and 4-12% improvement in quality performance** (Paustian, et al)
 - **Example: 20% decrease in ambulatory care sensitive condition admissions**

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Physician Group Incentive Program Lessons Learned

- **Health care is local: Harnessing professionalism and intrinsic motivation** catalyzes doing the most possible; extrinsic motivation the least necessary; requires long term policy commitment
- **Use wide guard rails to promote creativity and foster innovation;** avoid being prescriptive or using narrowly framed incentive structures
- The problem is a fragmented system: **explicitly focus reimbursement on catalyzing system transformation** as well as population level results
- Best accomplished with **frame of reference on Physician Organizations/Organized Systems of Care, not individual providers**
- Using **Physician Organizations as an organizing construct guards against hegemony of large health systems and physician employment:** allows independent physicians to be full participants
- **Align incentives (all responsible for same population performance) to catalyze clinical integration** among primary care, specialist and facility providers: **fostering interdependence best serves populations**

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