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

2004 2005 2006 2007 2008 2009 2010 2011 2012 2013

Physician Group Incentive Program
Chronic Care Model

- **Physician Organizations (POs)** have the structure and technical expertise to create highly functioning systems of care
- Design and execute programs in a **customized and collaborative manner**
- Measure performance at the **population** level and reward **improvement,** as well as absolute performance: initial focus on **generic drug rate and building patient registries**

Patient-Centered Medical Homes
Primary Care Transformation

- Launch PCMH and **quality and use initiatives**
  - Support building of PCMH **infrastructure**
  - In addition to the generic drug rate, measure preventive and evidence-based care, preventable emergency department use, high and low-tech imaging, inpatient use
- Include **specialists** involved in chronic care

Organized Systems of Care

- **Build PCMH-Neighbor model:** expand PGIP to include specialists
- Catalyze building of **Organized Systems of Care** that assume responsibility and accountability for managing the primary care physician attributed population of patients across all locations of care

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 performanc**e
  - 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

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

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 PGIP 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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