

Private Sector Cost Containment Strategies

Blue Cross Blue Shield of Michigan Value Partnerships Program

**Presentation to:
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Thomas Leyden, MBA
Director, Value Partnerships
Blue Cross Blue Shield of Michigan



Presentation Objectives

- 1 • BCBSM and the Value Partnerships Program
- 2 • Hospital Initiatives (Collaborative Quality Initiatives)
- 3 • Ambulatory Initiatives (PGIP, PCMH Designation and Tiered Payments)
- 4 • Organized Systems of Care/Accountable Care Organizations
- 5 • Aligning Hospital and Physician Incentives
- 6 • Overview of the Move from Fee for Service to Fee for Value /Reimbursement Transformation



About the Blue System

Blue Cross Blue Shield Association (BCBSA) is a national federation of BCBS Plans in all 50 states and U.S. territories

**38 independent,
locally based and
community
operated Blue
Plans**

**Collectively covering nearly 100
million – one in three – Americans**

**Networks with 90% of hospitals and
80% of physicians in every zip code**

**83 years' experience providing health
benefits in local communities**



Overview of BCBSM



- BCBSM is the largest single state non-profit Blues plan
- Serving **4.7 million** Michigan members (45% in-state market share) and over **1 million** out of state members
- 7,000 employees state-wide
- Michigan Blues have largest network in the state
 - More than 150 hospitals (100% of all MI hospitals)
 - Over 30,000 physicians (95% of all MI physicians)
- In 2010, BCBSM processed over 80 million claims and paid out over \$17 billion in benefits
- Fulfilling a unique, nonprofit mission for more than 70 years and insurer of last resort for Michigan members
- Maintaining collaborative partnerships with providers committed to improving health of all Michigan residents and advancing quality of care they receive

Root Causes of High Cost Health Care System

Poorly aligned incentives: Fee-for-service drives increased delivery of services and members lack benefit incentives to promote better health.

Lack of population focus: Provider delivers services that are demanded and paid for, instead of focusing on the health of the overall population.

Fragmented healthcare delivery: Physicians and hospitals lack information infrastructure and integration of care processes across the care continuum.

Lack of focus on process excellence: Creates variation and re-work, not clinical process improvement.

Weak primary care foundation: Missed opportunities for care coordination and lower cost approaches.



Our Approach to Payer/Provider Roles

Payer

- Align payment and performance
 - *Convene providers to forge future vision and plan means to achieve it*
 - *Create a payment model that supports the business case for healthcare transformation*
 - *Reward achievements measured on the population level*

Provider

- Possess care relationship with patients*
 - *Responsible for the process of care and system transformation*
 - *Improve patient care*



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
- 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



BCBSM's "All Payer" Approach

- Value Partnerships encourages providers to have an all payer focus; catalyzing all payer system development, rather than payer-specific system development
- Developing systems of care which are used for all patients helps ensure that providers don't have to alter care processes based on whether patients have insurance, or which insurance they have
- An important factor in ensuring that best practices and care processes are reliably provided to all patients, all of the time
- Patients throughout Michigan, regardless of payer, benefit from improved care processes developed through an all-payer approach to practice transformation
- Helps further BCBSM's social mission of cultivating a healthier future for all Michigan residents



BCBSM's Value Partnerships Program

Hospital Collaborative Quality Initiatives

Physicians

Physician Group Incentive Program

34 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

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

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)

12 PGIP initiatives address development of PCMH capabilities

BCBSA Best of Blue & BlueWorks 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)



Other Awards and Recognition

- 2008 - NBCH eValue8 Health Plan Innovation Award, CQI Program
- 2010 - URAC Bronze Award , PCMH

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.



Hospital Collaborative Quality Initiatives (CQIs)

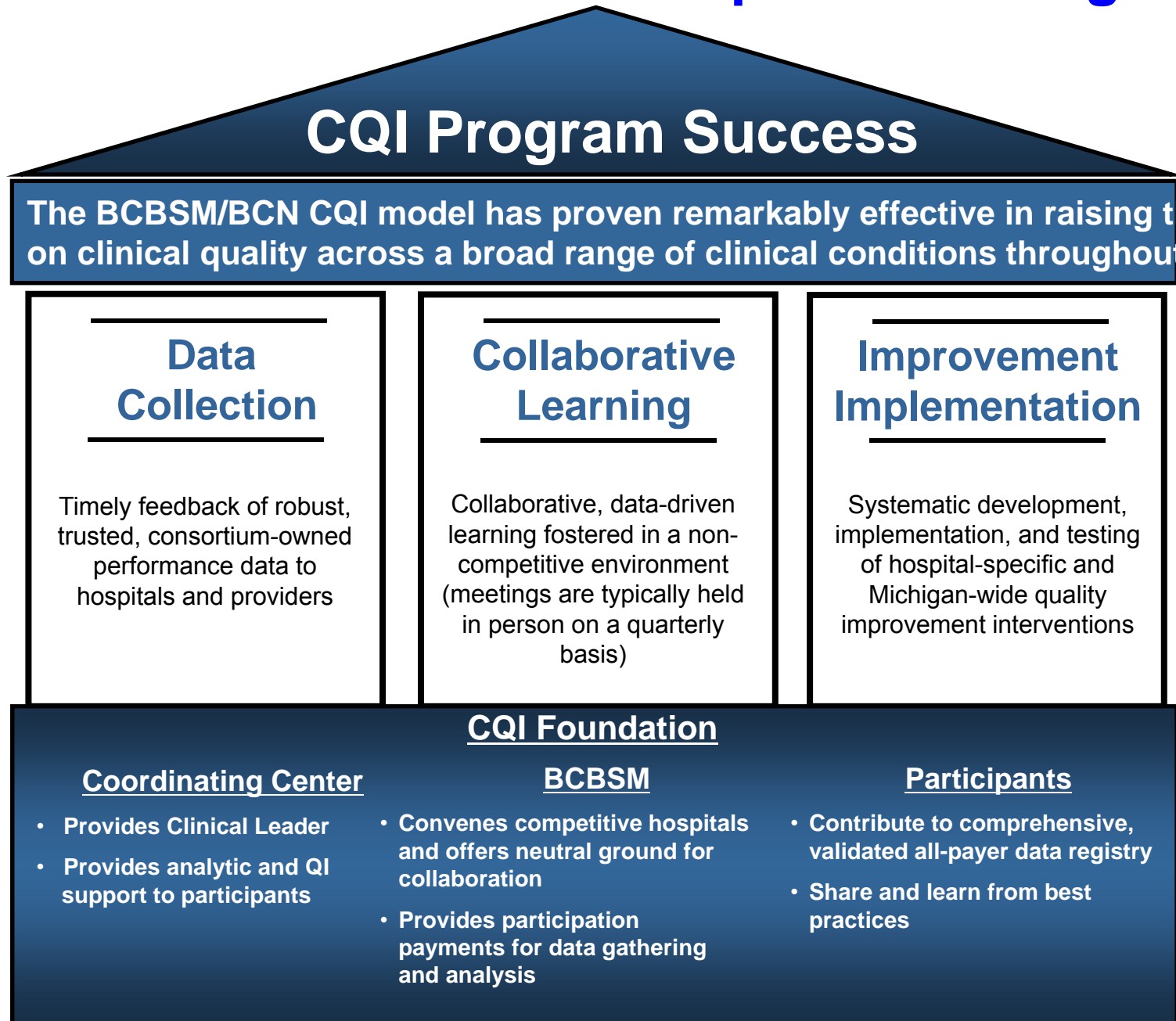


Collaborative Quality Initiatives (CQIs)

- CQIs rely on comprehensive clinical data registries and/or databases that enable physicians at each CQI to examine the links between care processes and outcomes in complex, highly technical areas of care to contribute to an understanding of which care processes lead to optimal outcomes
- Goal of CQIs is to empower providers to self-assess and optimize their care by identifying opportunities to bring care into closer alignment with best practices developed in the CQI which lead to improved quality and lower costs for selected, high cost, high frequency and highly complex procedures and conditions
- Objectives of each CQI are to:
 - address many of the key drivers of health care costs in surgical and medical care
 - improve healthcare outcomes
 - curb the increasing healthcare cost trend



Three Pillars of the Hospital CQI Program

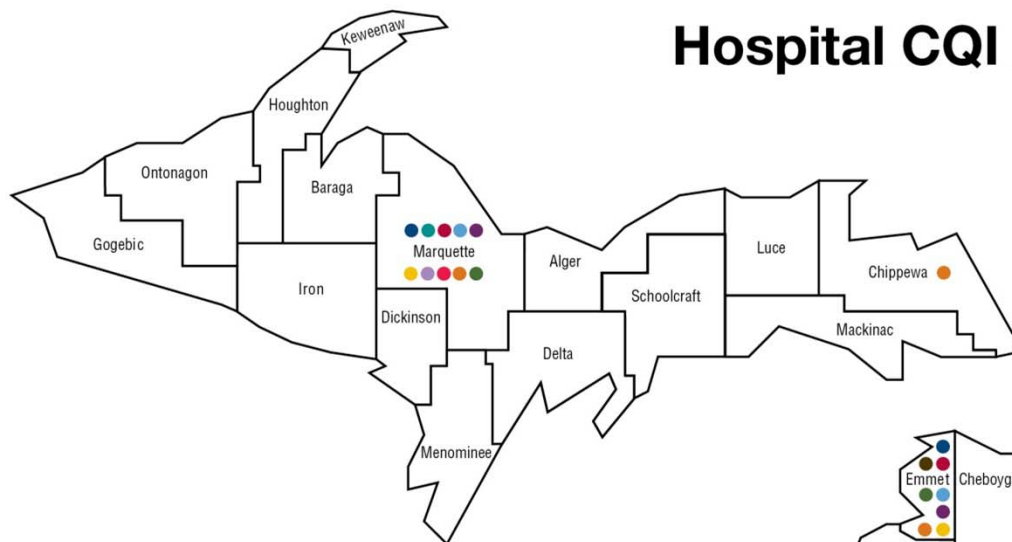


Collaborative Quality Initiatives (CQIs)

BCBSM/BCN Collaborative Quality Initiatives		Inception Date:
Hospital Based:		
Michigan Cardiovascular Consortium - Percutaneous Coronary Intervention (BMC2 - PCI)		July 1997
Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality		Sept 2005
Michigan Bariatric Surgery Consortium (MBSC)		Oct 2005
Michigan Surgical Quality Collaborative (MSQC)		Nov 2005
Michigan Breast Oncology Quality Initiative (MiBOQI)		Apr 2006
Michigan Cardiovascular Consortium - Peripheral Vascular Intervention (BMC2 - PVI)		Oct 2006
Hospital Medicine Safety (HMS) Consortium		Oct 2010
Michigan Trauma Quality Improvement Project (MTQIP)		Jan 2011
Peri-Operative Outcomes Initiative (POI)		Jan 2011
Michigan Arthroplasty Registry Collaborative for Quality Improvement (MARCQI)		Feb 2012
Michigan Radiation Oncology Quality Collaborative (MROQC)		Feb 2012
Hospital/Provider Based:		
Advanced Cardiac Imaging Consortium (ACIC)		July 2007
Also, BCBSM is expanding CQIs via Professional CQIs:		
Lean for Clinical Redesign (LEAN)		Apr 2008
Michigan Anticoagulation Quality Improvement Initiative (MAQI2)		Sept 2009
Michigan Oncology Quality Consortium (MOQC)		Jan 2010
Oncology Clinical Treatment Pathways (Pathways)		Jan 2010
Michigan Transitions of Care Collaborative (MTC2)		Jan 2010
Michigan Urological Surgery Improvement Collaborative (MUSIC)		Jan 2012

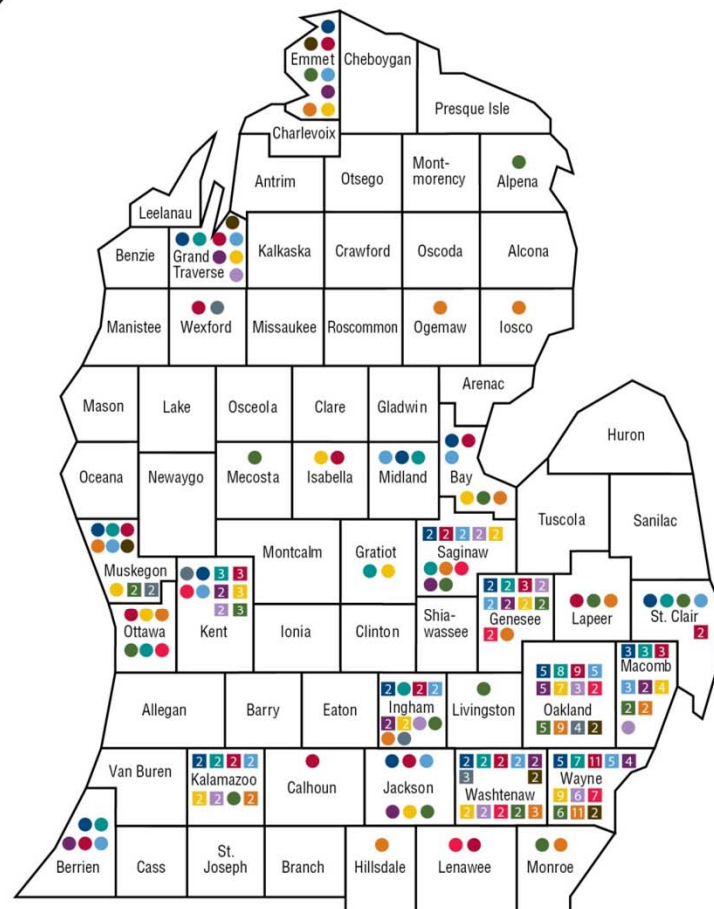
Hospital CQI Map by County

through April 2012



Single Facility Locations	Multiple Facility Locations	Total Participants 2012	Total Participants 2011	BCBSM Collaborative Quality Initiative (CQI)
●	■	33	32	Angioplasty (BMC2-PCI)
●	■	43*	46*	Advanced Cardiac Imaging Consortium (ACIC)
●	■	12	N/A	Arthroplasty (MARCQI)
●	■	37	32	Bariatric Surgery (MBSC)
●	■	25	22	Breast Oncology (MiBOQI)
●	■	33	33	Cardiac Surgery (MSTCVS)
●	■	52	52	General & Vascular Surgery (MSQC)
●	■	36	16	Hospital Medicine Safety (HMS)
●	■	18	9	Peri-Operative Outcomes (POI)
●	■	9	N/A	Radiation Oncology (MROQC)
●	■	23	18	Trauma (MTQIP)
●	■	42	38	Vascular Interventions (BMC2-VIC formerly PVI)

2012 - *38 hospitals and 5 physician locations
2011 - *41 hospitals and 5 physician locations



The CQI Foundation

- BCBSM/BCN sponsored collaboratives
- Health plans provide active leadership support of program
- Consortium identifies and disseminates best practices
- CQI program coordinated by Coordinating Centers
- Coordinating Center assures rigor, guides cross-institutional study of practice patterns and their relation to outcomes, and orchestrates QI interventions
- Multiple facilities collect and share data to improve the delivery and quality of care
- Locus of control remains with the providers – complete, accurate, risk adjusted, confidential, provider-owned data



Collaborative Quality Initiatives: Underlying Assumptions

- Cross-group/institution collaboration yields more than competition on quality
 - Improvement catalyzed by sharing best practices
 - More can be learned from variation in care processes and outcomes across groups than within groups
 - Permits more robust analyses of link between processes and outcomes of care than can be achieved by examining one group or institution
- Valid, evidence-based, nationally accepted performance measures cover a narrow slice of health care generally, and hospital care in particular
- Simple performance measures don't address areas of care which are highly technical, rapidly-evolving and associated with scientific uncertainty
- These areas best addressed through collaborative, inter-institutional, clinical data registries, with coordinated QI programs



Role of Coordinating Center

- Coordinating center primary functions:
 - Serve as data warehouse
 - Conduct data audits
 - Performs data analyses to identify best practices and opportunities for improvement
 - Convene quarterly meetings to share data
 - Guide quality improvement efforts
 - Evaluate participant's active participation



BMC2-PCI: Accomplishments to Date

- 32% reduction in hospital deaths
- 60% reduction in contrast-induced nephropathy (kidney injury from contrast dye used during angioplasty)
- 30% reduction in blood transfusions after angioplasty
- 32% reduction in vascular complications (resulting from injury to the arteries in the groin)
- 31% reduction in emergency revascularization (where angioplasty needs to be redone at the same site)
- 19% reduction in unplanned coronary artery bypass surgery
- 29% reduction in strokes or TIAs
- 19% reduction in gastrointestinal bleeding



General & Vascular Surgery (MSQC) Advances

Michigan is outperforming national improvements in surgical outcomes, including complications & surgical site infections

Overall MSQC changes in outcomes between 2006 Q2 and 2007 Q2

Time Period	Total Cases	Mean RVU	% Mortality	% Comp	% SSI
2006q2	2965	15.2	0.98	12.76	4.48
2007q2	4196	14.6	0.88	8.03	3.67
% change from 2006q2	41.5	-3.9	-9.9	-37.1	-18.1
2007 YTD	9132	14.6	0.99	8.10	3.66

Overall NSQIP changes in outcomes between 2006 Q2 and 2007 Q2

Time Period	Total Cases	Mean RVU	% Mortality	% Comp	% SSI
NSQIP 2006q2	25,573	-	2	12.1	6.5
NSQIP 207q2	46,868	-	1.8	11.6	6.2
% change from 2006q2		-	-10	-4.1	-4.6



Michigan Bariatric Surgery Collaborative (MBSC) – Quality Improvement Success

Reduced rate of pre-operative IVC filter placement

Quality Improvement Initiative Description:

Inferior vena cava (IVC) filter is a device that is inserted into inferior vena cava to prevent pulmonary emboli (PE), which are potentially fatal to patients. IVC filters are used prophylactically in patients with high risk of PE. Bariatric patients are at a higher-than-average risk of PE due to reduced mobility, compromised cardiopulmonary status, decreased venous return, and obesity-related metabolic factors.

Because PE accounts for almost 40% of perioperative deaths occurring in bariatric surgery patients, it is recommended that some form of VTE prophylaxis be used. However, effectiveness of IVC filters has never been proven.

Through analysis of data in the clinical registry, MBSC Coordinating Center leadership identified significant variations in IVC filter usage pre-operatively in an effort to prevent post-operative PE (a practice that has increased over last two decades). The MBSC Coordinating Center also discovered that IVC filter use was not always preventing blood clots, but at times was **contributing to increased complications** such as filter migration, IVC thrombosis, and IVC injury.



MBSC – Quality Improvement Success

Initial Rate (Pre-improvement status):

- During 2006-2008, IVC filter use in Gastric Bypass patients varied from 0-35% for 20 hospitals in the MBSC
 - 4 hospitals did not use any IVC filter
 - 6 hospitals used IVC filter in more than 10% of patients
- During 2006-2008, 591 (8.5%) Michigan Gastric Bypass patients underwent IVC filter placement
- Complications linked to IVC filter placement:

Postop VTE	13 (2.2%)
Deaths	5 (0.9%)
Grade I	63 (10.7%)
Grade II	36 (6.1%)
Grade III	9 (1.5%)
Any complication	207 (35.0%)

Average Cost of Complication in Gastric Bypass Patients:

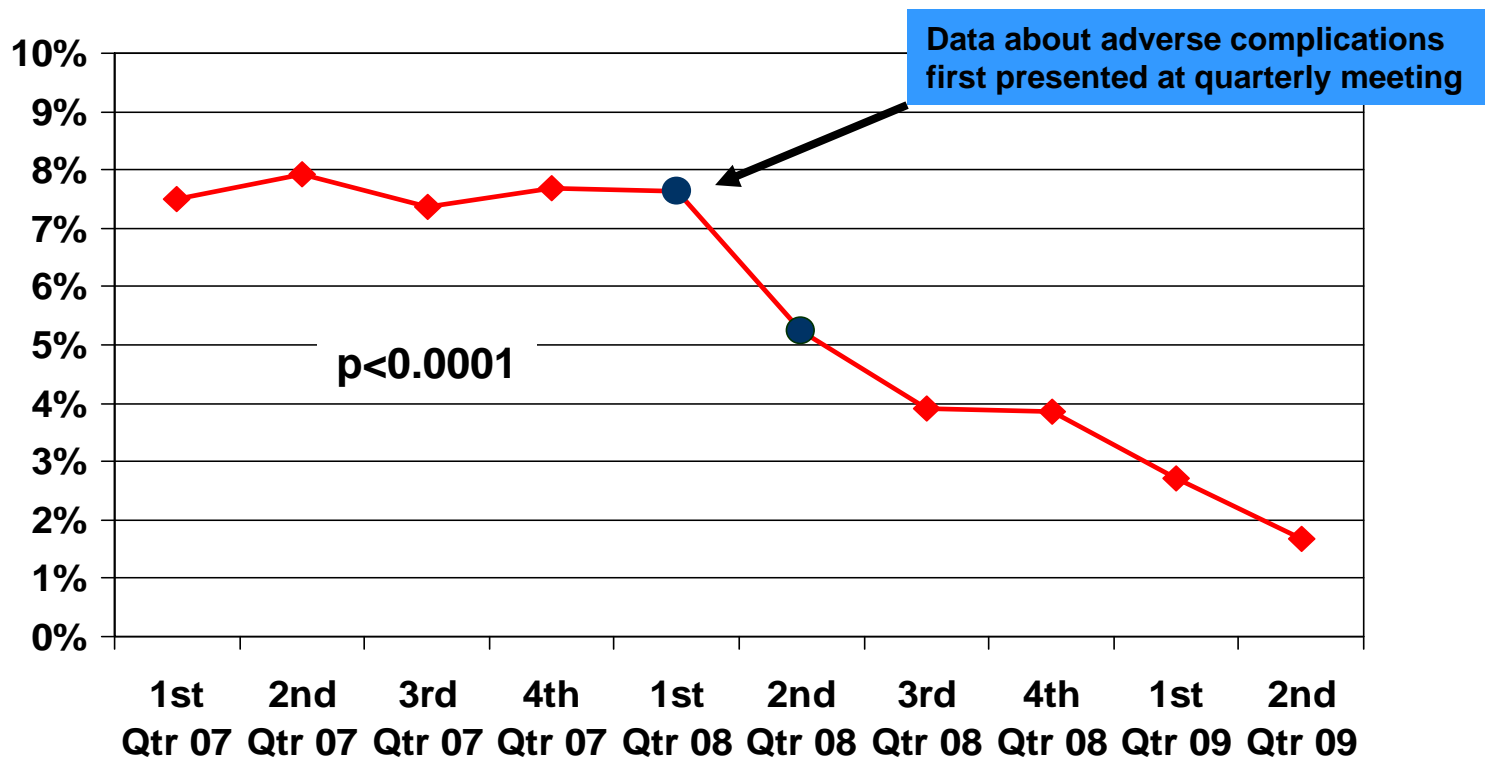
Based on 2006 claims data, payments are more than \$13,500 for IVC filter patients (it is estimated that excess costs may total \$270 million dollars in the US annually).



MBSC – Quality Improvement Success:

Reduced rate of pre-operative Inferior Vena Cava (IVC) filter placement

Use of IVC filter in 20 Michigan Hospitals
participating in MBSC



Consider: It typically takes approximately 15 years to implement evidence-based medicine



CQI Savings

BCBSM conducted a high level analysis of savings associated with improvements in quality resulting in reductions in adverse events (and cost avoidance associated with these improvements) for the past few years. To date, four CQIs have undergone this internal evaluation conducted by BCBSM Provider Performance , Innovation & Experience.

Results are as follows:

- **MSQC:**
 - From 2009-2010, saved an estimated \$49.2 for BCBSM
 - Estimated to have saved \$85.9M statewide in same time period
- **BMC2 - PCI:**
 - From 2008-2010, saved an estimated \$13.8M for BCBSM
 - Savings of \$102.0M statewide
- **MBSC:**
 - From 2008-2010, saved an estimated \$4.7 for BCBSM
 - Savings of \$14.6M statewide.
- **MSTCVS:**
 - From 2009-2010, saved an estimated \$2.5 for BCBSM
 - Savings of \$30.3M statewide.



Results of CQIs Receive National Exposure Through Peer Reviewed Publications

* denotes a professional CQI

2009	2010	2011	2012
MSQC – <i>Journal of the American College of Surgeons</i> (Jan 2009)	MSQC – <i>Medical Care</i> (Mar 2010)	BMC2-PCI – <i>American Heart Journal</i> (Jan 2011)	BMC2-PCI – <i>Journal of the American College of Cardiology</i> (Jan 2012)
MSQC – <i>Anesthesiology</i> (Mar 2009)	BMC2-PCI – <i>American Heart Journal</i> (Apr 2010)	BMC2-PCI – <i>American Heart Journal</i> (Jan 2011)	ACIC – <i>Journal of the American College of Cardiology</i> (Feb 2012)
MSTCVS – <i>Seminars in Thoracic and Cardiovascular Surgery</i> (Spring 2009)	BMC2-PCI – <i>Clinical Cardiology</i> (May 2010)	BMC2-VIC– <i>Archives of Surgery</i> (Apr 2011)	ACIC – <i>American Heart Journal</i> (March 2012)
ACIC – <i>Journal of the American Medical Association</i> (June 2009)	MBSC – <i>Journal of the American Medical Association</i> (July 2010)	MBSC – <i>Obesity Surgery</i> (2011)	MSTCVS, MSQC, HMS, MBSC, MTQIP, MAQI* - <i>Journal of Thrombosis and Thrombolysis</i> (Apr 2012)
BMC2 PCI – <i>Journal of the American College of Cardiology</i> (July 2009)	MBSC – <i>Annals of Surgery</i> (Aug 2010)	MSTCVS, MBSC, BMC2-PCI, and MSQC – <i>Health Affairs</i> (Apr 2011)	MOQC* - <i>Health Affairs</i> (Apr 2012)
MSQC – <i>Journal of the American College of Surgeons</i> (July 2009)	MSQC - <i>Annals of Surgery</i> (Sept 2010)	MTQIP – <i>Journal of Trauma</i> (March 2011)	
MSQC – <i>Journal of the American Medical Association</i> (Oct 2009)	MSTCVS – <i>Annals of Thoracic Surgery</i> (Oct 2010)	BMC2-VIC – <i>Journal of the American College of Cardiology</i> (June 2011)	
MOQC – <i>Journal of Oncology Practice</i> (Nov 2009)	MSQC – <i>Archives of Surgery</i> (Oct 2010)	BMC2-PCI – <i>Journal of the American College of Cardiology</i> (Sept 2011)	
MSQC – <i>American Journal of Surgery</i> (Nov 2009)	BMC2-PCI – <i>Journal of the American College of Cardiology</i> (Oct 2010)	MiBOQI – <i>Surgery</i> (Oct 2011)	
	BMC2-PCI – <i>Journal of Invasive Cardiology</i> (Oct 2010)		

Improving Quality of Care in Michigan Through CQIs

“The CQI Projects *effectively* put the workings of Comparative Effectiveness Research in the hands of the *Provider Community* in *real world* situations empowering them to use sophisticated scientific methods to *rigorously assess and improve* care affecting the *entire population* making hospitals self-optimizing institutions” – David Share, Assistant CMO, BCBSM



Regional collaborations between hospitals and physicians may be more effective than either selective referral or pay-for-performance in improving the quality of health care at the population level

The improvement programs target clinical conditions and procedures that are relatively common and that are associated with high costs per episode

Health Affairs, April 2011 Vol 30(4). p.1-11

By David A. Share, Darrell A. Campbell, Nancy Birkmeyer, Richard L. Prager, Hitinder S. Gurm, Mauro Moscucci, Marianne Udow-Phillips, and John D. Birkmeyer

The large sample sizes and statistical power associated with regional collaborative improvement program registries allow for more robust, rapid assessment of relationships between process and outcomes and of the effects of quality improvement interventions than can be achieved by hospitals examining their own practice in isolation

Physician Group Incentive Program (PGIP)



One of PGIP's Initial Goals: Restoring Primary Care

- Support performance transformation initiatives
- PGIP rewards based on performance and building PCMH capabilities
- Higher E & M fees for PCMH designated primary care practices
- Selective privileging of qualifying PCMH practices to deliver services not payable for other physicians, i.e., case and disease management, selected diagnostic tests, etc
- Benefit designs that encourage patients to see PCMH designated physicians



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.

BCBSM/Provider Partnership

PGIP Initiatives

Delivery of Care

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 Program Results

- The 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 cost trend fell to 3.1% in 1Q2011 with *negative* professional cost trend

Patient Centered Medical Homes (PCMH)



Patient Centered Medical Home

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



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

*POs work on Initiatives
to achieve practice transformation.*

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%)

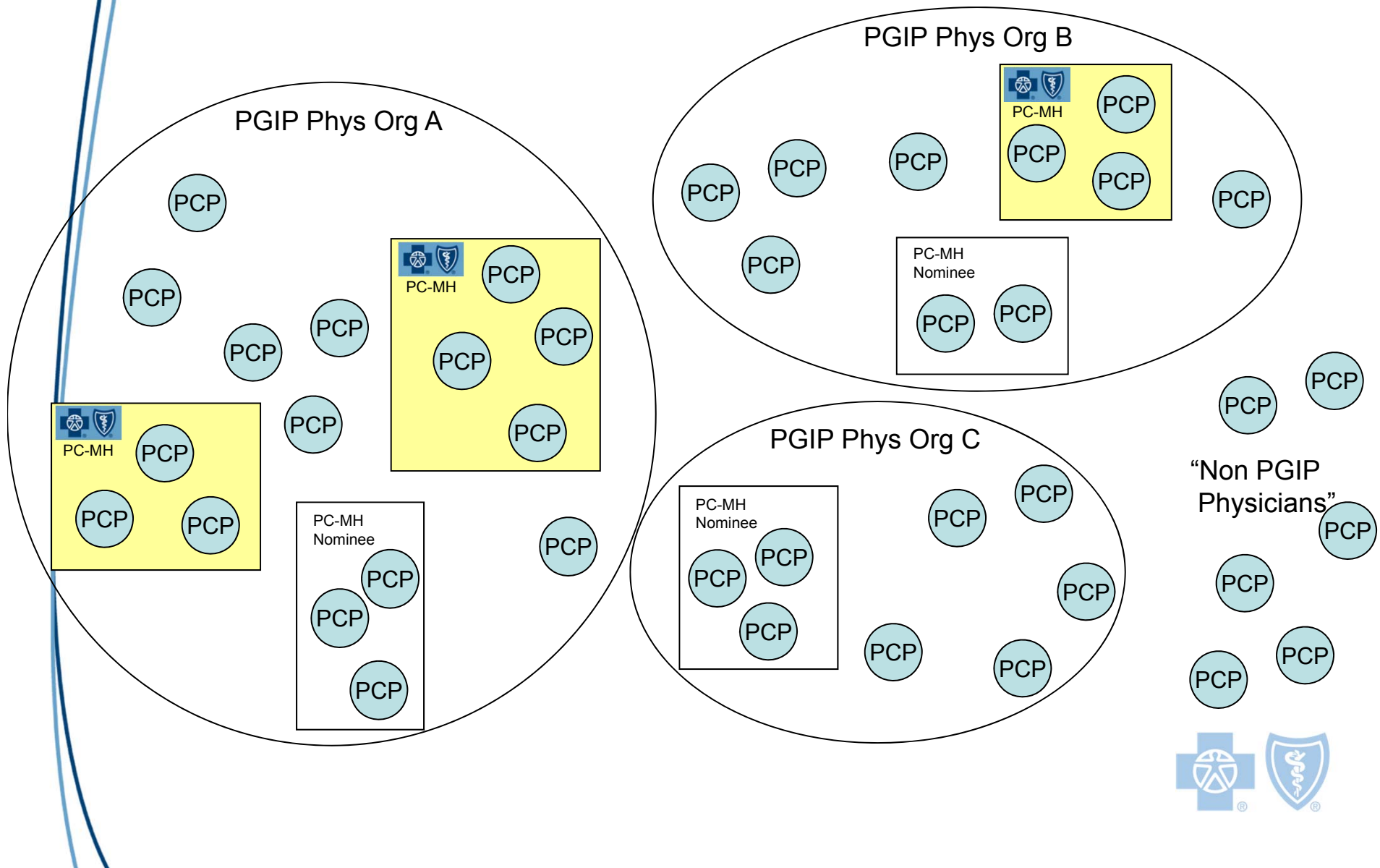
Eligibility Requirements for PCMH Designation Program

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 Designation



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 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

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%		

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

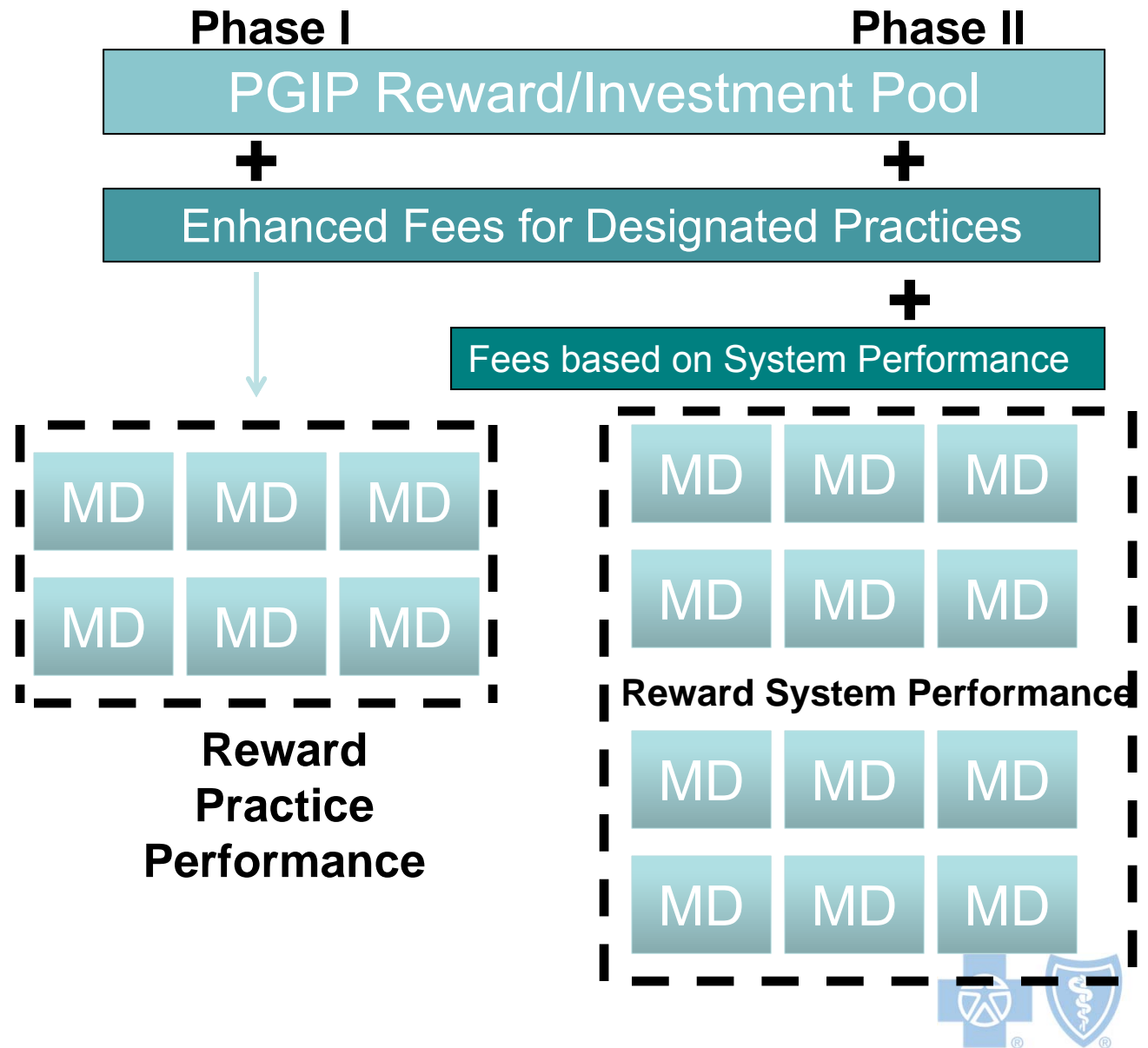


Overview of the Move from Fee for Service to Fee for Value “Reimbursement Transformation”



PGIP and its Continued Evolution

BCBSM will direct an increasing proportion of professional payment to PCMH designated practices through higher fees based on population-based practice and system performance.



Transforming Physician Reimbursement at the Physician Office Level

- Incentive payments to physicians in office practice
 - 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%)



Specialist Performance Measurement and Payment

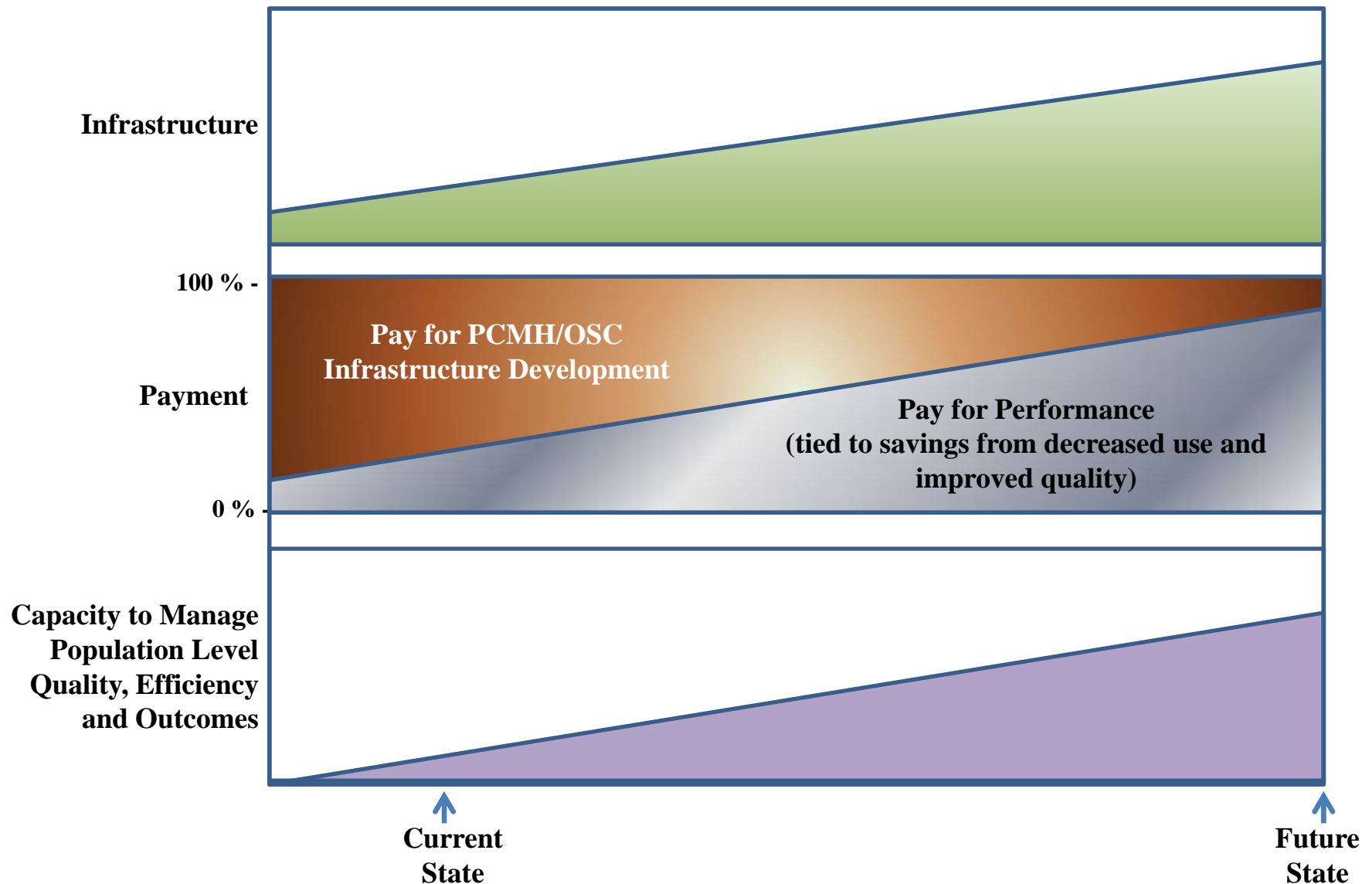
- Payment Strategy: Increase E & M fees to specialists to recognize better performance measured at the overall population level
- BCBSM will employ CAVE analytics as well as other performance measures (e.g. PMPM) as foundation for this payment strategy
- Specialists are nominated based on following criteria:
 - Is actively engaged with the PO
 - Is involved in managing the use of services
 - Is involved in optimizing quality of care
 - Works collaboratively with PCPs to develop and improve shared processes of care
 - Coordinates care across settings and over time



Strategy: Modernize Hospital Reimbursement

- Move away from traditional FFS reimbursement by linking payments to:
 - Performance measured on a population level
 - Decreases in per-member-per-month payment trends
- Align hospital and physician payment incentives
 - Create attributed populations for hospitals and physician organizations
 - Establish common measurement system and performance goals
 - Foster collaboration
- Link payment to creating population management infrastructure, improving processes of care and improving performance.

Moving towards Fee For Value



Conclusion



Value Partnerships: How Strategic Initiatives are Addressing the Root Causes of our High Cost Health Care System

Poorly aligned incentives: Tiered fees based on performance measured at the population level

Lack of population focus: All-patient registries (patient lists) and Physician Group Incentive Program rewards for performance

Fragmented healthcare delivery: Organized Systems of Care aligned incentives for primary care physicians, hospitals, and specialists

Lack of focus on process excellence: Collaborative Quality Initiatives

Weak primary care foundation: Patient-Centered Medical Home

Strengthening Providers' Ability to Improve Care



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



Contact Information

Tom Leyden, MBA

Director

Value Partnerships Program

Blue Cross Blue Shield of Michigan

600 E. Lafayette Blvd

Detroit, MI 48226-2998

tleyden@bcbsm.com

