

BCBSM
Physician Group Incentive Program
June 11, 2010 Quarterly Meeting

PGIP and the
Journey to Organized Systems of Care

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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*

Providers



Improve Patient Care

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



- Key Themes
 - Patient Centered Medical Home / Chronic Care Model
 - Organized Systems of Care

The Patient Centered Medical Home: Foundation of the Organized System of Care



- Each patient has a care relationship with a physician-led practice team that accepts responsibility for supporting the patient **over time and across settings of care.**
- This relationship strengthens the patient's active role in maintaining health and the commitment of the clinical team to support the patient's use of the healthcare system. The primary care team makes referral recommendations, communicates with other care givers, facilitates and coordinates services across the system of care.
- The OCS conducts population-level performance measurement and improvement, and establishes the infrastructure for communication, and coordination of services across settings of care.



- Medicare identifies possible ACO's as serving at least 5000 of their beneficiaries. BCBSM may require 10,000 members with flexibility in rural areas.
- A Collaborative team facilitated by David Share and Margaret Mason will create further definition of the Organized Systems of Care.

- In 2009, BCBSM designated 304 Primary Care Practices as Patient-Centered Medical Homes
- On July 1, 2010, 500 practices across Michigan will receive this designation.



Enhanced Fees Based on System Performance

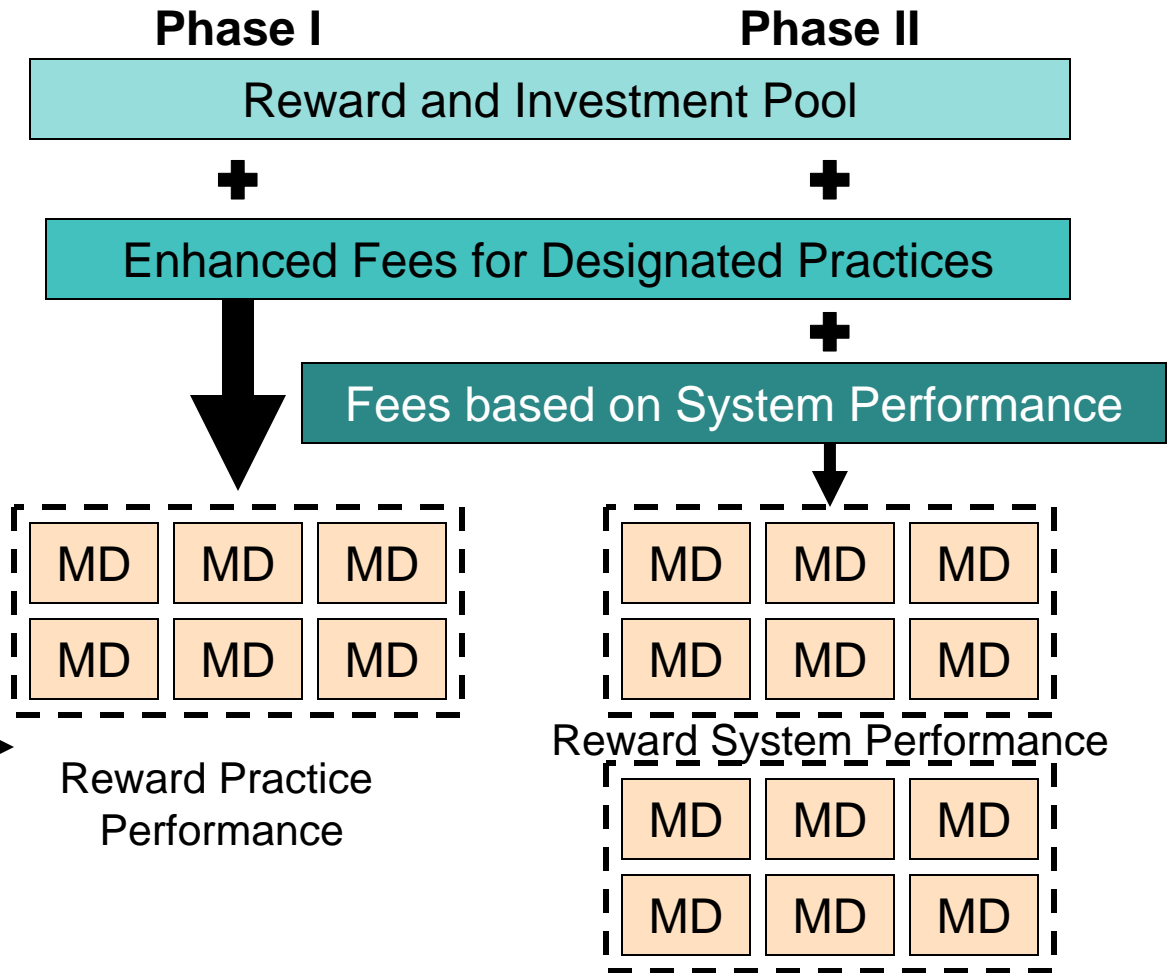


- Beginning July 1, 2010, all designated PCMH practices within benchmark-performing PGIP Groups or defined Sub-Groups will have E & M fees of 120 percent of TRUST.
- Benchmark performance is measured for the entire “system” population, not just the attributed population of the PCMH practice unit.
- The 2010 “system” measures are:
 - 2009 PMPM Total Cost for (Standard Price / Risk-Adjusted)
 - 2009 PMPM Cost Trend (Non-standard price)

BCBSM Physician Group Incentive Program



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





- In 2010, BCBSM will pay ~ \$100 M in performance-based payments
- Transition from pure fee-for-service to a model that:
 - Recognizes performance through higher fees,
 - Guides patients to PCMH designated practices
 - limits payment for selected services to designated providers (privileging)
 - rewards physician organizations based on population-based performance metrics, and
 - shares PMPM savings
- Distinct from capitation: physicians accept performance risk, but not insurance risk



- A high performance healthcare system relies on the care relationship between a patient and a primary care practice team whose responsibility extends **over time and across settings of care**.
- Systems of Care begin with primary care practices joining together with other practices as a “community of care givers.” The population for the system of care is comprised of all patients who have an ongoing care relationship with these physicians.
- Organized Systems of Care support patients and primary care physicians in communication, coordination, and care transitions across settings of care. This includes identifying the population served, measuring performance, and actively improving the care for the population.