



BCBSM Physician Group Incentive Program 2012 Program Year

**Patient-Centered Medical Home
Performance Reporting**

Initiative Plan



I. Initiative Overview

The Blue Cross Blue Shield of Michigan (BCBSM) Patient-Centered Medical Home Initiatives are part of the Physician Group Incentive Program (PGIP). Since its inception in 2005, PGIP has supported and facilitated practice transformation using a wide variety of initiatives to reward physician organizations (POs) for improved performance in health care delivery. As of September 2011, PGIP includes 40 POs from across the state of Michigan, representing nearly 15,000 primary care and specialty physicians who are members of the BCBSM TRUST PPO and/or Traditional Networks. These physicians provide care to nearly two million BCBSM members.

BCBSM's Physician Group Incentive Program encourages all payer collaboration, catalyzing all payer system development, rather than payer-specific system development. Through PGIP, BCBSM is helping to improve the quality of care for all Michigan residents. Patients throughout the state, regardless of payer, benefit from the improved care processes developed through the PGIP provider community. Developing systems of care which are used for all patients helps assure that providers don't have to alter care processes based on whether patients have insurance, or which insurance they have. This is an important factor in ensuring that the best practices and care processes are reliably provided to all patients, all of the time. This all-payer approach to practice transformation is good for patients with coverage from BCBSM and BCN and helps further BCBSM's social mission of cultivating a healthier future for all Michigan residents.

BCBSM's PCMH program has provided the foundation to build Organized Systems of Care (OSCs). An Organized System of Care (OSC) is a community of caregivers consisting of primary care practices, specialists/subspecialists, hospitals and other providers that measure performance, set goals, track progress, and coordinate care across the continuum for the primary care-attributed patient population. The OSC assumes responsibility for establishing shared information systems and care processes, and accepts accountability for delivering effective and efficient patient care over time and across settings of care.

Specialty and sub-specialty practices affiliated with the OSC are expected to engage in care processes consistent with the principles of the Patient-Centered Medical Home Neighbor (PCMH-N) model¹:

- Ensure effective communication, coordination, and integration with PCMH practices
- Provide appropriate and timely consultations and referrals that complement the aims of the PCMH practice(s)
- Confirm the appropriate flow of necessary patient and care information
- Determine responsibility for all types of clinical interactions, in accordance with the definitions listed below
- Support patient-centered care, enhanced care access, and high-quality, safe care
- Recognize the PCMH practice as the provider of the patient's primary care
- Understand that the PCMH practice has overall responsibility for coordination and integration of care provided to the patient

For more information about Organized Systems of Care and the specialist role within the PCMH model, please see the Organized Systems of Care Initiative Plan.

Goals and Objectives

The goal of the Performance Reporting Initiative is to implement performance reporting technology that will allow physicians to receive feedback on their performance, which will lead to decreased gaps in care and improved patient outcomes. Ultimately, this Initiative will lead to improved patient care.

The objective of the Performance Reporting Initiative is to annually increase the percentage of PGIP practice units that have implemented the capabilities associated with this Initiative.

Summary of Results

For details on progress being made by Physician Organizations participating in this Initiative, please refer to the *Results* section of this Initiative plan.

In 2012, BCBSM will continue to engage participating POs in their efforts to implement the tasks associated with this Initiative, offering assistance as needed. BCBSM will also update the *PCMH Interpretive Guidelines* annually, based on PO feedback and clarification about the Initiative tasks.

II. Background

Health Problem and Significance

An important part of chronic care management is the ability to take a long term, comprehensive look at how care is being delivered to the individual patient, and the larger population. More than half of all Americans suffer from a chronic disease and seventy-five percent of all health care expenditures are spent treating these patients. Despite this, health care is still primarily focused on how best to treat acute conditions. Researchers report that only 56% of those with chronic disease receive clinically appropriate care, and only 27% of adults (and 12% of low-income Americans) report having full access to a well-organized source of health care.²

The most common chronic diseases cost the economy more than \$1 trillion annually, and costs are projected to rise as high as \$6 trillion by 2050. Michigan ranks 28 out of 50 in incidence of chronic disease. In 2003, chronic disease treatment cost Michigan residents \$10.6B in direct costs and \$37.9B in lost productivity.³

III. Initiative Description

To support and promote the concept of the Patient-Centered Medical Home (PCMH), and in recognition of the challenges associated with transitioning to a PCMH model,

BCBSM invites PGIP-participating POs to collaborate with us in a two-pronged PCMH approach:

1. PCMH Related PGIP Initiatives: Opportunity to participate in Initiatives that support development of competency as a PCMH.
2. PCMH Designation Program: Implementation of differential reimbursement for PGIP physicians who meet criteria for BCBSM designation as a PCMH.

Both opportunities are optional for providers. In addition, POs and their Practice Units do not have to apply for PCMH Designation to participate in the PCMH Initiatives.

POs that choose to participate in PCMH Initiatives will receive incentive rewards commensurate with their performance and participation in their selected Initiatives.

Specific Area of Focus

Participants in this Initiative will use reporting technology to improve physician performance and optimize patient care. Previous studies indicate that providing physicians with performance feedback has improved their performance.⁴ Participants will receive incentive payments for implementing the capabilities listed in Table 1 below, and for meeting the stated goals and objectives of this Initiative plan.

Consistent with the overall design of PGIP, an integral part of this Initiative is that PO-identified Practice Units will work to implement capabilities to successfully accomplish stated objectives. POs are responsible for providing leadership, support, coordination, and monitoring of Practice Unit practice transformation activity. POs are expected to maintain documentation regarding the capabilities that Practice Units implement during the course of their participation in the PCMH Initiatives, and which Practice Units identify as being “fully in place” on the PCMH self-assessment survey. Documentation may be provided to BCBSM upon request and future practice audits are possible.

TABLE 1. Performance Reporting Initiative Tasks	
3.1	Performance reports that allow tracking and comparison of results at a specific point in time across the population of patients are generated for: Diabetes
3.2	Performance reports are generated at the population level, Practice Unit, and individual provider level
3.3	Performance reports include patients with at least two other chronic conditions for which there are evidence-based guidelines and the need for ongoing population and patient management, and which are sufficiently prevalent in the practice to warrant inclusion in the registry based on the judgment of the practice leaders
3.4	Data contained in performance reports has been fully validated and reconciled to ensure accuracy
3.5	Trend reports are generated, enabling physicians and their POs/sub-POs to track, compare and manage performance results for their population of patients over time
3.6	Performance reports are generated for the population of patients with: Pediatric Obesity
3.7	Performance reports include all current patients, including well patients, and include data on preventive services.
3.8	Performance reports include patient clinical information for a substantial majority of health care services received at other sites that are necessary to manage chronic care and preventive services

TABLE 1. Performance Reporting Initiative Tasks	
	for the population
3.9	Performance reports include information on services provided by specialists
3.10	Performance reports are generated for the population of patients with: Persistent Asthma
3.11	Performance reports are generated for the population of patients with: Coronary Artery Disease <i>[not applicable to pediatric practices]</i>
3.12	Performance reports are generated for the population of patients with: Congestive Heart Failure <i>[not applicable to pediatric practices]</i>
3.13	Performance reports are generated for the population of patients with: Pediatric ADD/ADHD

Criteria for Participation

To participate in this Initiative, POs must currently participate in the Physician Group Incentive Program.

BCBSM Deliverables

BCBSM will provide PCMH Interpretive Guidelines to participating POs, and update the guidelines at least annually based on PO and practice questions and feedback. The Interpretive Guidelines provide detailed descriptions of each capability associated with each PCMH Initiative to deepen PO and practice unit understanding of program expectations and the PCMH model.

BCBSM will also conduct site visits to enrich PO and practice unit understanding of the Patient-Centered Medical Home Initiatives.

In addition, BCBSM will provide semi-annual Progress Report templates and a database for the collection of Self-Reported PCMH data, so that POs can adequately fulfill their reporting requirements.

PO Expectations

POs are expected to complete all reporting requirements, including self-reported data about practice unit performance on PCMH capabilities, twice per year. POs are also strongly encouraged to participate in workgroups and webinars related to their PCMH involvement, and to collaborate with their fellow POs to share best practices.

Incentive Model & Payment Methodology

This Initiative will have 2 Incentive Payment periods:

- January 1 – June 30 (6 months)
- July 1 – December 31 (6 months)

Physician Organizations will receive incentive payments commensurate with their performance on implementing PCMH capabilities during the six-month incentive

payment period. POs will be expected to complete the following reporting requirements in a timely manner:

- At the end of each six-month incentive payment period, update PCMH self-reported data, identifying all tasks implemented by each participating Practice Unit
- Once per year, complete the PCMH progress reports, identifying best practice accomplishments, challenges encountered, and outlining plans to overcome barriers to success

POs are encouraged to maintain high-level implementation plans to assist them in tracking progress and recording key milestones related to the PCMH Initiatives.

Performance payments will reflect the percent of the PO's total practice units that implement an Initiative capability. POs employing a phased approach to practice unit involvement in an Initiative will not be financially penalized since there is no time limit for implementation of PCMH capabilities.

Note: BCBSM reserves the right to modify its evaluative and administrative processes related to the Initiative at any time.

IV. Evaluation

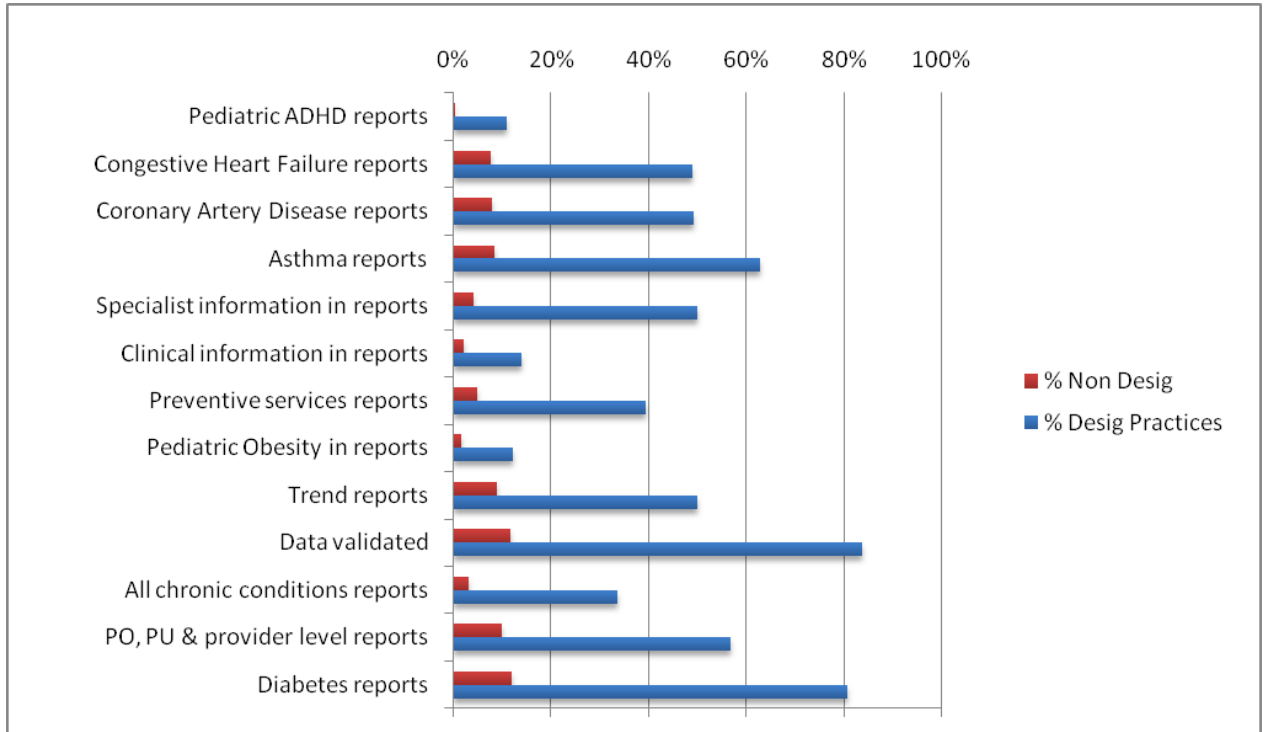
A long-term evaluation of the Patient-Centered Medical Home Program is currently underway. Objectives of the evaluation are as follows:

- Assess the rate of PCMH implementation to assist providers with understanding the level of commitment needed for long-term development of their medical home
- Determine whether the PCMH model is associated with more efficient utilization of services
- Determine whether the PCMH model is associated with improved performance in evidence-based care
- Determine whether the PCMH model is associated with lower overall medical and pharmacy costs
- Estimate savings, if any, generated from the PCMH program and its associated Initiatives
- Determine whether members who obtain care in a patient-centered medical home are more likely to have a continuous source of care than members who obtain care in practices without patient-centered medical home capabilities
- Determine stakeholder awareness of and satisfaction with the PCMH program
- Determine whether the PCMH model is associated with improved patient satisfaction with their medical care.

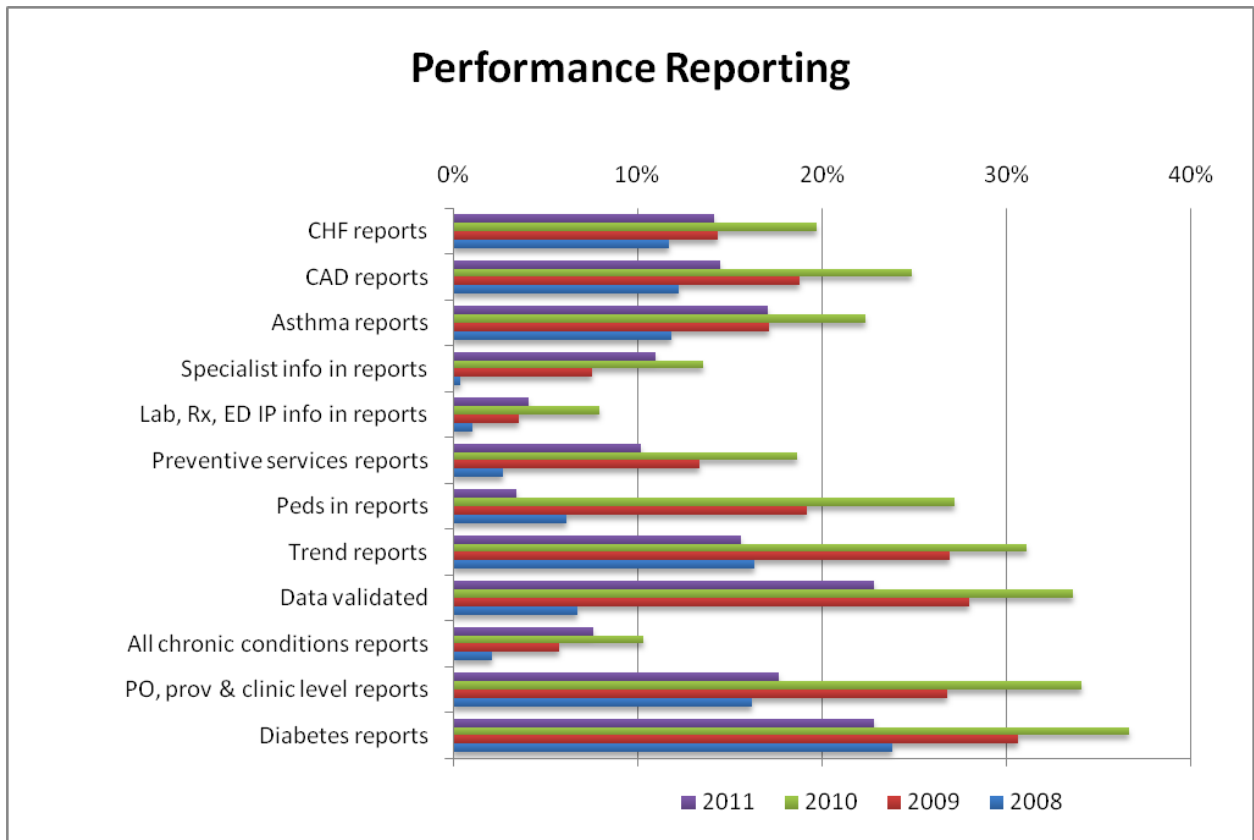
Findings from the long-term evaluation will be available on a rolling basis, beginning in the 2012 program year.

V. Results

The objective of the Performance Reporting Initiative is to annually increase the percentage of PGIP practice units that have implemented the capabilities associated with this Initiative. As our recent program results show, both designated and non-designated providers are actively implementing capabilities related to performance reporting.



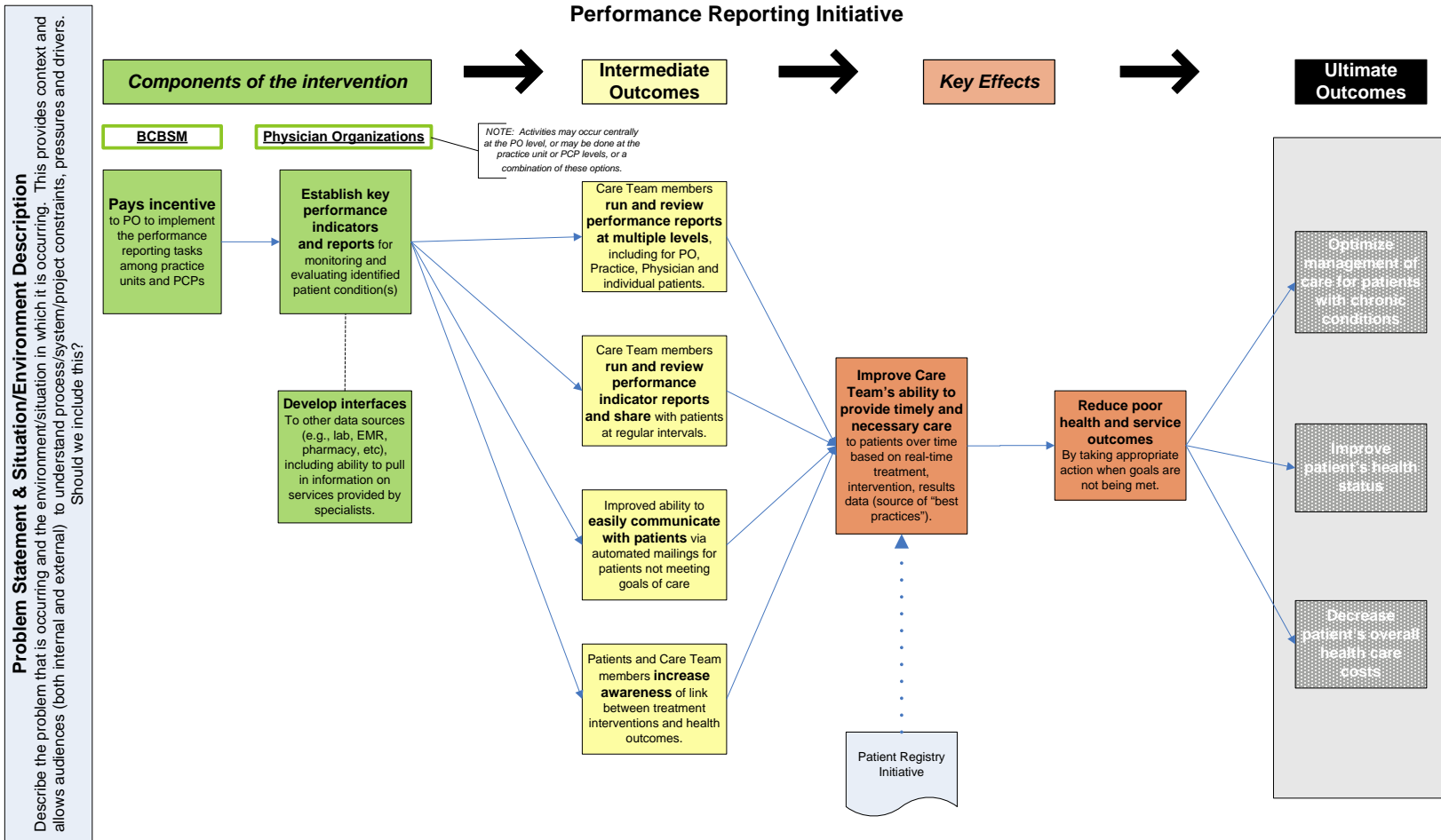
In addition, the percentage of practice units that have implemented each capability associated with this Initiative has steadily increased over time, which shows that overall, PCMH-participating providers across the state are transforming their practices to become more patient-centered.



Appendix I: Cause and Effect Diagram

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Patient Centered Medical Home Performance Reporting Initiative



Appendix II: PGIP Initiative Contacts

For more information on the PCMH Coordination of Care Initiative, please contact one of the following individuals:

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Endnotes

¹ American College of Physicians Policy Paper, “The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices”, October 2010.

²Health Care Quality Survey, Commonwealth Fund, 2006.

³DeVol R, Bedroussian A. An Unhealthy America: The Economic Burden of Chronic Disease, *Milken Institute*, October 2007.

⁴ Jamtvedt, G., J. M. Young, D. T. Kristoffersen et al. 2003. Audit and Feedback: Effects on Professional Practice and Health Care Outcomes. *Cochrane Database of Systematic Reviews* (3): CD000259.