



Blue Cross Blue Shield of Michigan Physician Group Incentive Program

PGIP Summary Document



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Executive summary

The goal of Blue Cross Blue Shield of Michigan's Physician Group Incentive Program is to transform systems of care to more effectively manage populations of patients, and build the necessary infrastructure to measure, monitor and optimize the quality of care.

Blue Cross Blue Shield of Michigan collaborates directly with physicians and key stakeholders to develop quality health care initiatives that provide incentives to physician organizations that engage in this work. The ultimate goal is to improve the quality and safety of care provided to Michigan residents while controlling health care costs.

To participate in PGIP, physician organizations may select up to 27 initiatives in which to participate. They then should show meaningful progress in implementing patient-centered medical home capabilities while improving quality-and-use performance.

In the future, the Michigan Blues anticipate increasing levels of participation among primary care physicians and specialists enrolled in PGIP; with a focus on establishing more robust collaboration with hospitals and other providers in building organized systems of care.

I. Background

Blue Cross Blue Shield of Michigan collaborated with Michigan physician organizations in 2004 to establish the Physician Group Incentive Program (PGIP). The initial focus of PGIP was on chronic disease management and promotion of generic drugs. A PGIP reward pool was established based on a fixed percentage of professional fees and Blue Cross commitment to allocating 100 percent of the reward pool to PGIP-participating physician organizations, based on performance.

PGIP was designed to encourage the provision of high-quality chronic disease management. It addresses many of the *Chronic Care Model* elements as developed by Ed Wagner, M.D., M.P.H., and colleagues of the Improving Chronic Illness Care program, which was developed with support from The Robert Wood Johnson Foundation. PGIP physician organizations are encouraged to develop productive interactions between patients who take an active part in their care and providers backed by resources and expertise.¹

Subsequent to the implementation of PGIP, the Physician Organization Gain Sharing (POGS) program was implemented in 2006. The POGS program focused on reducing cost in various service categories such as pharmacy, diagnostic imaging and acute care, while promoting in-network referrals. The incentive approach included a participation component and provisions for “gain sharing” cost savings that were achieved through temporary fee increases for evaluation and management services.

In 2007, the PGIP and POGS programs combined, and in the past three years PGIP has experienced tremendous growth — both in the number of physicians and specialties participating and with a notable increase in the number of initiatives available for a PO to choose. In addition, PGIP embraced the Joint Principles of the Patient-Centered Medical Home, developed by the professional primary care physician societies in 2007. PGIP created its own PCMH Program in 2008, followed by the inception of the PCMH Designation Program in 2009. Currently the Michigan Blues’ PCMH program is the largest of its kind in the country, with more than 1,800 designated physicians.

The fundamental work of PGIP – to develop incentive initiatives that assist providers in improving the quality of care to ultimately transform the health care delivery system - is based on the following objectives:

- Transform systems of care to effectively manage populations of patients, and build the infrastructure needed to robustly measure, monitor and optimize quality of care.
- Strengthen the performance-improvement infrastructure available to clinicians.
- Promote collaborative relationships with physicians and among physician organizations to support improved care outcomes.
- Achieve measurable savings in specified areas including (but not limited to) pharmacy costs, diagnostic imaging and other domains of resource use.
- Reward physicians for improved performance and cost-effective care delivery.
- Share savings from improved performance outcomes with physicians.

As of June 2010, the PGIP program included 100 physician groups from across Michigan, including more than 8,000 physicians who are members of the Blues' TRUST PPO network. PGIP-participating primary care physicians (PCPs) and specialists currently provide care for approximately 1.8 million Michigan Blues' members.

To get the most from their participation in PGIP, physician organizations must select initiatives in which they would like to participate. Then they must show meaningful progress in implementing patient-centered medical home capabilities and improving quality and use performance. Today, the Physician Group Incentive Program offers an array of initiatives designed to improve multiple aspects of the health care system.

Fundamentally, an "initiative" is a focused approach to transforming the delivery of health care. Each PGIP initiative fits into one of the following categories:

- *Capacity improvement:* These initiatives help physicians develop the fundamental capabilities needed for practice improvement.
- *Condition-focused:* For these initiatives, physicians address conditions that present significant opportunities for standardizing treatment to improve outcomes, such as breast cancer or diabetes.
- *Service-focused:* These initiatives address services that are associated with wide variation in practice patterns, such as high tech radiology or emergency room visits.
- *Core clinical processes:* These initiatives, such as extending after-hours access, tracking test results and providing self-management support services, are designed to improve patient care. Most initiatives related to developing core clinical processes are part of the Blues' *Patient-Centered Medical Home program*, the largest of its kind in the country.

- *Clinical information technology*: Initiatives in this category support IT infrastructure, such as developing a chronic disease registry and accelerating the adoption and use of electronic prescribing.

Each PGIP initiative has an incentive design that includes clearly defined metrics to measure success.

II. Program philosophy

The following core philosophies provide a foundation for each of the PGIP initiatives and shape the way in which we develop those initiatives and collaborate with our physician and physician organization partners.

- Focus on **improving systems of care**, as well as short-term savings. PGIP provides the infrastructure needed to fundamentally change care processes, which often improves care for Blues' and non-Blues' patients alike. This approach will ultimately result in real improvements in the health of all Michigan residents, not just those who are Blue Cross members.
- **Be respectful of providers' role** as the primary owners of the care-relationship with their patients. Providers are capable innovators; they are trustworthy, hard-working and evidence-driven.
- Focus on **measureable improvements** in structure, process, outcomes and performance.
- Focus on **measures of performance on a population basis**. This approach recognizes that the overall cost of care is based on frequency of procedures and episodes of care, as well as the cost per procedure and the cost per episode. Care-responsibility data should be defined at a member level, not only to support population-based measures, but also to enable patient-centered improvements to the health care system and population-oriented redesign of the health care reimbursement model.
- **Reward performance of physician organizations**. Recognize that the most effective care is delivered by prepared, proactive teams, and that the investment in capabilities and infrastructure needed to transform systems of care is unlikely to occur on a physician-by-physician basis.
- Focus on **value, not just cost-savings**. Value includes quality of care, health and economic outcomes and the member experience.
- **Reward improvement and collaboration**, not just highest performance. This ensures that the incentives are relevant to physician organizations across the performance spectrum, recognizing that different physician organizations have different strengths and weaknesses. This approach also acknowledges that

improving health care in Michigan is facilitated by sharing best practices, exchanging health information and collaborating to build shared resources.

- **Be flexible.** An approach that is not proscriptive, and that recognizes the diversity of PGIP participants relative to their size, geographic location and patient population, results in program participants who are successful and engaged.

III. Initiatives

Because of the complexity of health care processes and the diversity of physician organizations, it has long been recognized that better health care requires improvements in care across a variety of settings. Success in practice improvement requires that each physician organization focus on opportunities that are most important within their environment, in a time frame that reflects their unique capabilities and limitations. Therefore, PGIP recognizes that a “one size fits all” program design is less than optimal. Physician organizations in PGIP choose which opportunities to pursue and are supported by an incentive program tailored to meet the needs of Blue Cross members who look to those organizations for their care.

The PGIP approach includes a process for ongoing development of a wide variety of initiatives, each focused on improving different aspects of the health care system. Each PGIP initiative includes the following elements:

- **Eligibility criteria** to define the characteristics of physician organizations for which the initiative is relevant.
- **A description of the scope, focus and objectives of the initiative.** These are based on improvement capabilities, health conditions, health care services, core clinical processes or clinical information technologies
- **Data, metrics and reports designed to serve the following functions:**
 - a. Describe the size of the improvement opportunity, to assist the physician organization in deciding which initiatives are most relevant to their needs.
 - b. Improve physician organization processes and assist them in tracking their implementation efforts.
 - c. Measure improvements to determine which physician organization process changes are most effective, and to support Blue Cross decisions regarding incentive rewards.
- **An incentive design** appropriate to the parameters of each initiative.
 - a. Some incentives are based on the participation of the physician organization and the extent to which care provided by the physician organization incorporates relevant technology and processes.
 - b. Other incentive components are based on the level of performance or the rate of performance improvement of the physician organization.
 - c. The incentive design may change over the course of each physician organization’s enrollment in the initiative, to better reflect the stages of a physician organization’s improvement efforts.

As described in Table 1 below, there are currently 25 initiatives available in 2010 for PGIP physicians. Using a menu-based approach, physician organizations may participate in as many or as few initiatives as they choose within a calendar year, based on their organization's need and physicians' interest.

Table 1: PGIP Initiatives

Initiative name	Initiative category	Description
Accelerating the Adoption and Use of Electronic Prescribing	Clinical information technology	Improve the safety, quality and cost-effectiveness of the prescription process through widespread adoption and increased use of electronic prescribing and clinical decision support tools.
Chronic Kidney Disease — PCP Management	Condition-focused	Improve PCP identification and management of individuals with Chronic Kidney Disease, while strengthening the PCP-specialist relationship.
Chronic Kidney Disease — Nephrologist Management	Condition-focused	Improve management of patients with CKD by nephrologists, while strengthening the specialist-PCP relationship.
Coordination of Care — PCMH*	Core clinical processes	Coordinate patient care across the health system, through active collaboration and communication between providers, caregivers and patients.
Emergency Department Utilization	Service-focused	Use relevant data to reduce primary care sensitive emergency department use.
Evidence Based Care to Reduce Gaps in Care	Core clinical processes	Implement effective systems of care designed to support outreach to populations of patients with identified primary and secondary prevention needs, and chronic illness management needs.
Extended Access — PCMH*	Core clinical processes	Ensure that all patients have comprehensive and timely access to health care services that are patient-centered, culturally sensitive, and delivered in the least intensive and most appropriate setting based on patient needs.
Increase the Use of Generic Drugs	Service-focused	Reduce pharmacy drug costs by increasing the use of generic and over-the-counter drugs.
Individual Care Management — PCMH	Core clinical processes	Ensure that patients with chronic conditions receive organized, planned care that empowers patients to take greater responsibility for their health.
Inpatient Utilization	Service-focused	Patients will have access to timely and effective primary care with an emphasis on disease-state management, which can ward off disease progression, reduce preventable complications, and avoid unnecessary hospitalizations and emergency department visits.
Lean Clinical Redesign for PCMH	Core clinical processes	A professional Collaborative Quality Initiative* to support and facilitate PGIP physician organizations to use lean thinking principles when developing strategies to implement

Initiative name	Initiative category	Description
		components of the patient-centered medical home model.
Linkage to Community Services — PCMH*	Core clinical processes	Connect patients with community resources through a process of active coordination between the health system, community service agencies, family, caregivers and the patient.
Michigan Anticoagulation Quality Improvement (MAQI2)	Service-focused	A professional CQI to improve the quality of care for patients receiving maintenance anticoagulation under the guidance of anticoagulation services.
Michigan Oncology Clinical Treatment Pathways	Condition-focused	Establish and define evidence-based oncology treatment pathways for lung, breast and colon cancer, via a partnership between Blue Cross, the Michigan oncology community and P4Healthcare.
Oncology/ASCO Quality Oncology Practice Initiative	Condition-focused	Promote high-quality, cost-effective care for cancer patients, facilitated by participation in the American Society of Clinical Oncology's Quality Oncology Practice Initiative Health Plan Program.
Patient-Provider Partnership — PCMH*	Core clinical processes	Expand physician, health care team and patient awareness of and commitment to the patient-centered medical home model, and strengthen the bond between patients and their care-giving teams.
Patient Registry — PCMH*	Clinical information technology	Establish a comprehensive patient registry that can be used to optimally manage a population of patients.
Patient Web Portal — PCMH*	Clinical information technology	Support optimal management of patients by using a web portal for electronic communication among patients and physicians, and provide greater access to medical information and technical tools.
Performance Reporting — PCMH*	Core clinical processes	Implement performance-reporting technology that will allow physicians to receive feedback on their performance.
Preventive Services — PCMH*	Core clinical processes	Create a process of actively counseling, screening and educating patients on preventive care.
Radiology Utilization	Service-focused	Moderate the increase in diagnostic imaging costs by reducing inappropriate use of diagnostic radiology procedures.
Self-Management Support — PCMH*	Core clinical processes	Offer support to patients as they learn to assume responsibility for daily management of their chronic conditions.
Specialist Referral Process — PCMH*	Core clinical processes	Seamlessly coordinate the process of referring patients from primary care to specialty care, with both providers receiving timely access to the information they need to provide optimal care to the patient.
Test Tracking — PCMH*	Core clinical processes	Implement a standardized, reliable system to ensure that patients receive appropriate tests, and that test results are communicated in a

Initiative name	Initiative category	Description
		timely manner. Additionally, ensure that every step in the test-tracking process is properly documented.
Transitions of Care	Core clinical processes	Develop processes of care at discharge (from inpatient to outpatient care) to improve and systematize the discharge process.

** Those initiatives marked as PCMH in the table above are part of PGIP's Patient-Centered Medical Home suite of initiatives. To read more about our PCMH initiatives and PCMH designation program, please refer to the PCMH overall plan or the individual PCMH initiative plans.*

In addition, Blue Cross has developed two initiatives for physician organizations new to PGIP. The purpose of these “new group” initiatives is to assist the new groups in assessing their current improvement capacity as well as to assist them in gaining the needed skills so they can provide the most value to their member physicians.

Initiative Name	Initiative Category	Description
Establish Analytics and Reporting Staff (required for new groups)	Improvement capacity	Assist physician organizations new to PGIP in establishing the capacities needed to achieve sustained improvement in health care delivery and patient outcomes.
Establish Process Improvement Teams (required for new groups)	Improvement capacity	Assist physician organizations new to PGIP in establishing the capacities needed to achieve sustained improvement in health care delivery and patient outcomes.

IV. Organizational model

Because collaboration is an integral part of the philosophy that guides PGIP, both Blue Cross and our participating physician organizations have unique roles that contribute to the success of the program.

Role of Blue Cross Blue Shield of Michigan

Funding the pool and distributing payment

For services subject to the Traditional, Program 52 and TRUST PPO fee schedules, Blue Cross funds the physician incentive reward by reserving a percent of the physician fee for most procedure codes (3.7 percent as of July 2010).

Physician organizations' share of the reward is adjusted based on participation and performance. Payment distributions occur two times per year, in January and July. The size of the overall reward pool is based on the money accrued to the pool during the previous six months. For example, the July distribution is based on the money accrued to the pool beginning in January of the current year through June of the current year.

Attributing patients to physicians

Performance improvement at the physician organization level is based on management of an attributed population.

Each physician organization provides Blue Cross with a list of the physicians participating in the program. Blue Cross uses the list to determine the population of Blue Cross members that the physician organization is serving and to confirm the relationship between the member and the physician. Physician organizations have an opportunity to update the physician list two times per year.

When attributing patients to physicians, each member is assigned to only one physician's panel, except for selected specialties (oncology, for example), for which a patient may also be assigned to a specialist.

Designing the initiative and monitoring performance

PGIP staff design and implement the initiatives in which physician organizations elect to participate. Included in each incentive design is the incentive structure. Incentive payments are based primarily on performance, but there are some initiatives that have an initial participation component.

- Where relevant, the *participation payment* is intended to support infrastructure development and catalyze system transformation by offsetting costs incurred by groups to achieve program goals.
- The *performance payment* is intended to reward success in achieving measurable goals as defined in the initiatives that the physician organization elects to participate in for that year.
 - a. Each initiative has an explicit set of metrics that is used to measure performance improvement.
 - b. Blue Cross supplies performance reports to each participating physician organization, generally summarizing data at a physician organization, practice unit and individual physician level for peer comparison and improvement purposes.
 - c. The metrics contained within each performance report are used by Blue Cross to gauge the level and rate of performance for each physician organization.

In general, payment is based on attributed population, the number of physicians participating or other methods as deemed appropriate. Blue Cross attempts to reward physician organizations commensurate with their contribution to the overall success of PGIP.

Providing performance reports and data

Performance reports and data provided by Blue Cross to the physician organizations vary by initiative. The reports and data periods covered may change during the course of the year.

Role of the physician organization

Providing leadership

Physician organizations must provide clinical and administrative leadership, organizational structure and technical support to their affiliated providers, so they may implement system-wide transformation. Physician organizations are accountable for performance as it relates to cost, quality and system transformation at the population level.

Being collaborative

Collaboration is critical to the success of PGIP. Participants are expected to actively work with representatives of Blue Cross and other physician organizations, become involved in interest groups, and engage in one-on-one meetings and site visits to share experiences regarding what works and what doesn't work. In addition, physician organizations are expected to attend and participate in the quarterly PGIP meetings.

Updating physician lists

Twice a year, physician organizations provide to Blue Cross lists of physicians who participate in the program.

For incentive payment purposes, physicians on these lists must be grouped into practice units. Practice units are defined as one or more physicians within a PGIP physician organization who share clinical responsibility for a group of patients and are formally organized to provide medical care, consultation, diagnosis and treatment through joint use of clinical information and care processes. In the vast majority of practice units, this collaboration occurs in the context of shared facilities, equipment or personnel.

Selecting areas of focus and setting annual goals

Physician organizations should select goals that expand their capacity to comprehensively address the health care needs of their patients. Goals should support the development of systems that reliably provide care and meet the highest standards possible for quality and efficiency.

Physician organizations select the initiatives that they will participate in and the respective performance goals for the subsequent year each fall.

Reporting progress

Physician organizations participating in PGIP are expected to provide the following reports, so that Blue Cross may assess their performance:

- Semiannual progress report
- Implementation plan (required only for the first period in which a physician organization participates in an initiative)
- Semi-annual self-assessment database for PCMH initiatives

These reports should specify investments, achievements, progress towards goals and measurable results of initiatives selected as compared to the previous year. Blue Cross then evaluates progress and performance improvement at the physician organization level, provides feedback and uses the reports as supportive material to determine the size of the physician organization's incentive payment.

Physician organization participation requirements

To form an independent PGIP physician organization, the following is required:

- Physician organizations must have at least 100 Blue Cross TRUST PPO network physicians; at least two-thirds of those physicians must have a primary care focus.
- Physician organizations must be considered a partnership, association, corporation, individual practice association or other legal entity that has its own tax ID and can receive and distribute income among members of the physician organization.
- Participating physicians must be board-certified in one of the defined specialties.
- All physicians participating in PGIP through the physician organization must participate with Blue Cross TRUST PPO and be in good standing with the network.
- Physicians are limited to participation with only one physician organization, for purposes of the incentive program.

To learn more about current PGIP initiatives please visit the Michigan Blues' website at bcbsm.com.

ⁱ Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? **Effective Clinical Practice**. 1998;1(1):2-4