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**FROM PARTISANSHIP TO PARTNERSHIP: THE PAYOR-PROVIDER  
PARTNERSHIP PATH TO PRACTICE TRANSFORMATION**

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*"These new regulations will fundamentally change the way we get around them."  
-The New Yorker March 9, 2009, by P.C. Vey*

**Blue Cross Blue Shield of Michigan's Physician Group Incentive Program: Building  
a Shared Vision of a High Performing Health System**

Thank you Chairman Herger, Congressman Stark and members of the Subcommittee on Health for inviting me to participate in a discussion about how private payers are rewarding physicians who deliver high quality, efficient care. I am Dr. David Share, Vice President of Value Partnerships at Blue Cross Blue Shield of Michigan. BCBSM is a non-profit health plan providing healthcare benefits to 4.3 million people in Michigan. It is one of 38 Blue Cross Blue Shield Plans covering nearly 100 million people, in every county and zip code in the US.

I appreciate the opportunity to share our experience at BCBSM partnering with the provider community to transform the health care system and to assure that care is of high quality, accessible and affordable.

Decades of government and commercial payor efforts, including cost containment, utilization management, disease management and managed care -- all of which initially appeared to hold great promise -- have fallen short of ensuring that people have ready access to affordable, effective, high quality care.

Blue Cross Blue Shield of Michigan postulates that the problem is not that physicians are inherently incapable of creating effective organizations and substantially improving value in health care, but that the relationship between payors/purchasers and providers is characterized by control and competition. Providers' creative efforts are, in large part, directed at obviating controls and maintaining the status quo to the extent possible. The quote, above, from the cartoon by P.C. Vey, captures the essence of this longstanding dynamic in the health care community.

In addition, payers' and purchasers' efforts to influence provider behavior have focused on managing the behavior of individual providers in the context of a highly fragmented system of care rather than being focused on catalyzing the development of systems designed to yield optimal value from the hard work of providers and their patients.

In 2004, Blue Cross Blue Shield of Michigan embarked on a mission to redirect the nature and tenor of its relationship with providers. The goal was to establish an active partnership, predicated on harnessing the full measure of physicians' creative efforts and forging a common vision of an optimal future state of health care in Michigan. In conversations with state health care leaders at the Michigan State Medical Society, Physician Organizations, and other healthcare organizations, Blue Cross Blue Shield of Michigan's approach was not to tell providers what to do, but to ask what we could do together.

As a result of extensive discussion over the course of twelve months, a vision emerged:

- Lack of system-ness is the root cause of poor cost and quality performance and an explicit focus on **system development** and **transformation** is needed to achieve good results for individual patients and at a population level
- Achieving substantive and sustainable system transformation depends on **physicians collectively owning the responsibility to change the systems** in which they practice.
- The locus of control of such change efforts should be in the hands of **natural communities of caregivers** who have shared responsibility for caring for a population of patients (through cross-coverage, referral relationships, and shared responsibility in a variety of clinical contexts, including office, emergency department, inpatient, and long term care settings)
- To create highly functioning systems which reliably produce high quality, efficient care, **physicians need to create "Physician Organizations" with sufficient leadership, structure and technical expertise to support the development of shared information systems and shared processes of care.** Physician Organizations are legal entities with physician leadership, and administrative and technical infrastructure, comprised of groups of physicians in a geographic area which can accept money on behalf of their members and use it to support transforming the structure and processes of the systems they use and to measure and reward physicians for improving and optimizing cost and quality performance. Physicians themselves determine who constitutes the community of providers in a Physician Organization. Independent physicians can retain their identities as private practices when they join a Physician Organization.
- **Exhorting individual physicians to improve the quality and efficiency of their practice is unlikely to succeed.** One provider, acting independently, simply doesn't have enough time in the day to provide all of the preventive, acute care and chronic illness management services patients need without the support of a multi-disciplinary team (Landon 2003; Moore 2003; Sandy 2003; Yarnell 2003).

- **Performance should be measured at the Physician Organization level.** Measuring performance at the individual physician level is fraught with methodological limitations (e.g., low “n”, non-random distribution of patients, variability in case mix which can’t be fully accounted for by current adjustment methods). Measuring at a population level focuses on system performance, encourages system accountability and supports system improvement. Measuring at the individual practice and individual physician level is essential for focusing providers’ attention on opportunities to improve processes and outcomes of care. But, given the methodological limitations which constrain the accuracy of results, ideally it is best to hold a community of caregivers responsible for aggregate performance at a population level and leave the management of individual cases, and individual performance, to the community of providers in the Physician Organization. Importantly, this reduces the incentive for Physician Organizations to cherry-pick doctors and for doctors to cherry-pick patients.

### **Launch of the Physician Group Incentive Program**

Based on these tenets, and the concepts of the Chronic Care Model, Blue Cross Blue Shield of Michigan launched an incremental yet ambitious approach to health care reimbursement reform: the Physician Group Incentive Program. The Physician Group Incentive Program, known as “PGIP”, has the goal of catalyzing health system transformation in partnership with Physician Organizations across the state of Michigan.

Including Physician Organization leaders as active partners has been vital to the success of PGIP, helping harness the full measure of physicians’ creative energy in the hard work of system transformation. PGIP began by offering incentive payments to communities of physicians to organize into Physician Organizations where they didn’t exist, or to redirect existing Physician Organizations toward the challenge of system reform. Physicians were encouraged to create and join Physician Organizations based on their own assessment of factors such as cross-coverage and referral patterns, hospital affiliation and geography. From the outset, there has been an explicit expectation that physicians in these Physician Organizations will develop and use shared information systems and processes of care, and that they will collectively be accountable for aggregate, population level quality and efficiency outcomes.

Measuring at the Physician Organization level keeps the focus on catalyzing system improvement rather than on individual physician performance on a narrow set of performance measures in pay for performance programs. By catalyzing system transformation, providers can develop systems which support them in reliably delivering high quality, efficient care. This is something that a community of physicians’ practices can do more successfully by aggregating resources than can an individual practice.

An important benefit of measuring at the population level is that individual providers who choose to serve patients with particularly complex conditions, or who are especially burdened by socioeconomic challenges, will not be discouraged from doing so because of

a concern that measurement to judge and reimburse is focused on their individual performance.

Blue Cross Blue Shield of Michigan provides relevant, aggregate data to support Physician Organization accountability. Data are also provided to the Physician Organization to support its own efforts to assess and improve performance at the practice and individual physician level. This leaves the responsibility to monitor and improve the performance of doctors' practices and of individual physicians up to their peers, with the group being collectively responsible to the payer for the net result on cost and quality measures at a population level.

Incentive payments take into account both absolute performance and rate of improvement, and are paid to the Physician Organization. The incentive pool is funded through a percentage of all professional payments (beginning with 0.5% and now at 4.2%, creating a total annual pool of \$110M); all of the money is paid out in the year in which it is accrued.

At its inception, in January, 2005, PGIP consisted of 10 Physician Organizations and about 3,000 physicians. Initially, specialist participation was limited to those involved in chronic condition management, care transitions, and high cost diseases (e.g., cardiologists, oncologists, pulmonologists, and endocrinologists). In 2011, PGIP was opened to all specialists. As of late 2011, PGIP had increased in size to 40 Physician Organizations (representing 92 sub-Physician Organizations) and 14,776 physicians, including 5,631 primary care physicians (about 67% of those actively practicing in the state) and 9,145 specialists (about 44% of those in the state). Physician Organization size ranges from 25 physicians to 1,600. There are two integrated delivery systems in PGIP; the vast majority of PGIP physicians are in small practices (consisting of one to four physicians), with most of those being in private practice. Approximately 2 million members are attributed to these physicians through analysis of health care claims, and these practices care for approximately 5 million Michigan residents.

A key principle of PGIP is that all new systems and processes of care should be designed as "all-patient" system improvements, not health plan-focused changes. This is to maximize impact on community wellbeing and ensure that overall cost and quality performance improvements are deep and durable.

Most of the 92 sub-Physician Organizations in PGIP started out as independent practice associations focused on contracting with health plans on behalf of individual physicians or small groups of physicians, with some attention paid to helping physicians succeed at earning incentive payments from insurers for good scores on selected quality and cost measures. Physician Organizations vary widely in how they are organized and in their level of sophistication regarding information systems and care management capabilities. An explicit PGIP goal is to help Physician Organizations evolve from loose federations of physicians in independent practice associations to highly functioning inter-dependent groups of physicians capable of affiliating with specialists and facility-based provider

organizations to create what we call Organized Systems of Care, to collectively manage their shared population of patients.

PGIP performance measurement initially focused on efficient use of health care resources (generic drug dispensing rate) and on chronic disease management (evidence-based care rates, based on HEDIS quality measures). The program has expanded to include a variety of “Initiatives” focused on multiple performance measures, developed in collaboration with provider partners, including, for example:

- ambulatory care sensitive condition admission rates
- emergency department use rates for primary care sensitive conditions
- high technology and low technology imaging rates
- cost and quality of cardiac care
- identification and management of chronic kidney disease patients
- re-hospitalization rates

A list of PGIP Initiatives follows:

Initiative name	Initiative category	Description
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.
Coordination of Care — PCMH	Core clinical processes	Coordinate patient care across the health system, through active collaboration and communication between providers, caregivers and patients.
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.
Environmental Cancer	Core clinical processes	Identify patients with exposure to environmental toxins, correctly diagnose related illnesses, and treat or refer for treatment patients with conditions associated with exposure to these toxins.
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.
Performance Reporting — PCMH	Core clinical processes	Implement performance-reporting technology that will allow physicians to receive feedback on their performance.
Lean Clinical Redesign for PCMH	Core clinical processes	A professional Collaborative Quality Initiative* to support and facilitate PGIP physician

Initiative name	Initiative category	Description
		organizations to use lean thinking principles when developing strategies to implement components of the patient-centered medical home model.
Preventive Services — PCMH	Core clinical processes	Create a process of actively counseling, screening and educating patients on preventive care.
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.
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.
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 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.
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.
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.
Patient Registry — PCMH	Clinical information technology	Establish a comprehensive patient registry that can be used to optimally manage a population of patients.
Radiology Management	Service-focused	Moderate the increase in diagnostic imaging costs by reducing inappropriate use of diagnostic radiology procedures.
Emergency Department Utilization	Service-focused	Use relevant data to reduce primary care sensitive emergency department use.
Increase the Use of Generic Drugs	Service-focused	Reduce pharmacy drug costs by increasing the use of generic and over-the-counter drugs.

Initiative name	Initiative category	Description
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.
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.
Encouraging evidence-based utilization of labor induction	Condition-focused	An opportunity for Ob-Gyn physicians to use available data and improved care processes, as well as existing quality improvement efforts, to encourage evidence-based utilization of labor induction.
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.
Encouraging evidence-based utilization of hysterectomy	Condition-focused	An opportunity for Ob-Gyn physicians to use available data and improved care processes, as well as existing quality improvement efforts, to encourage evidence-based utilization of hysterectomy.
Cardiac Care	Condition-focused	Reduce the use of unnecessary cardiac diagnostic procedures, limit the associated cost trend, and enhance the quality of ambulatory cardiac care.
Chronic Kidney Disease — PCP Management	Condition-focused	Improve PCP identification and management of individuals with Chronic Kidney Disease, while strengthening the PCP-specialist relationship.
Encouraging evidence-based utilization of labor induction	Condition-focused	An opportunity for Ob-Gyn physicians to use available data and improved care processes, as well as existing quality improvement efforts, to encourage evidence-based utilization of labor induction.

Physician Organizations can choose which Initiatives to engage in based on their current interests and capacities. This allows us to devote resources to supporting infrastructure building at the edges of the Physician Organizations' current capabilities and to reward improvement as well as net achievement. In this way we are using reimbursement to catalyze system transformation, moving physicians toward the creation of Organized Systems of Care. This incentive strategy motivates Physician Organizations to take on the most ambitious system transformation agenda possible rather than to do the least necessary as they have done in response to highly prescriptive and narrowly focused pay

for performance programs. The more PGIP Initiatives in which they participate, the more PCMH capabilities which they implement and the more they improve population level results, the more incentive payments they receive.

Physician Organizations have full latitude regarding how to spend the incentive money, but it is clear that success in PGIP is dependent in the long run on building effective systems and infrastructure, and on collectively taking responsibility for quality and efficiency at the population level, not on buying loyalty of physicians by paying bonuses directly to them.

### **Building Patient-Centered Medical Homes**

As the concept of modernizing health care systems broadened to include well patients in addition to those who have chronic illness management and secondary prevention needs, the Chronic Care Model evolved into the Advanced Medical Home model and finally into the Patient Centered Medical Home (PCMH) Model. In 2007, in the wake of the growing interest in the Patient Centered Medical Home model, and in response to PGIP provider requests for more direction and structure, Blue Cross Blue Shield of Michigan collaborated with providers to develop a set of 12 PCMH Initiatives. Each Initiative focuses on a PCMH “domain of function”, such as performance reporting or extended access, and provides incentive payments for the incremental implementation of PCMH infrastructure and care processes. Rather than trying to find (non-)existing full-fledged PCMH practices, pay them for care management on a per member per month basis, and hope to be able to prove the value of the model, the PGIP approach recognizes that achieving a fully transformed health care system informed and guided by the PCMH model will take years of “relentless incrementalism.” Systems of care, including PCMH-based medical practices, have to be built before we can expect to see dramatic improvement in cost and quality performance at the practice and population levels. Recognizing this, approximately half of the incentive pool is allocated to support implementation of PCMH infrastructure and care processes.

In partnership with the provider community we have explicitly articulated 128 core capabilities within the 12 domains of the PCMH model. By tracking the development of these granular medical home capabilities in over 3,000 practices over time we have observed that very few have implemented more than 100 of these capabilities, and in the most advanced PCMH-based practices the average number of capabilities fully in place in 2011 was 88 (compared to an average of 56 capabilities in those practices which were nominated for recognition as PCMH-based practices but have not yet achieved it).

Practices which begin to implement PCMH capabilities quickly realize improvements in their level of engagement with patients and in their performance. But in the vast majority of practices the full potential of the PCMH model is yet to be fully realized, which is why we are committed to continued investment in supporting practice transformation at the same time as we reward population level performance on cost and quality measures.

In July 2009, with PGIP practices having made rapid strides in implementing PCMH capabilities, the PGIP PCMH Designation Program was initiated to provide additional financial support to those practices that have made the most progress in incorporating PCMH capabilities into routine practice and achieved acceptable results on quality and efficiency measures. Information about the PCMH designated physicians, who receive a 10% increase in their Evaluation and Management office visit fees, is disseminated to BCBSM members. By focusing payment increases on office visit services, we are intentionally directing an increasing proportion of physician payment toward relationship-based care and away from procedure-based care. Funding for the fee increases comes through the claims payment system, not from the PGIP incentive pool. The number of PCMH-designated practices has grown from 300 in 2009 to 780 in 2011, and the number of physicians in those practices has increased from 1300 to over 2500, as more Physician Organizations and their physician members have responded to incentives to transform systems of care.

Of the 780 PCMH Designated practices in PGIP, approximately 480 are participating in the CMS Advanced Medical Home demonstration project, called the Michigan Primary Care Transformation project in Michigan. These PCMH-based Michigan practices represent over half of all practices participating in the program in the 8 states accepted into the program. We expect this partnership between CMS, the State of Michigan, Physician Organizations and BCBSM to measurably increase the impact of PCMH-based practice on the cost and quality of care in Michigan.

### **Incremental Reimbursement Reform**

Without having to eliminate the fee for service payment system, at great cost, against substantial inertia, and at the risk of losing access to granular data from claims regarding patients' conditions and services received, we are using PGIP as a mechanism for incremental reimbursement reform, redirecting a meaningful proportion of overall payment to physicians, and considerable physician effort, toward practice transformation and population level performance and away from volume-based practice. This approach, which can be thought of as Fee for Value-based payment (FFV), is practically and politically feasible: it does not require massive investment in claims systems overhaul or radical restructuring of health care benefits, and has the potential to contribute meaningfully to the viability of PCMH-based primary care practice and to practice transformation across the health care system. We recognize the negative aspects of the fee for service system, but don't want to wait for its downfall before we begin to transform how we pay.

In addition to the 10% increase in office visit fees for PCMH-designated practices, those designated practices that are members of Physician Organizations delivering optimally efficient care at a population level (based on per member per month cost and cost trend data) receive another 10% increase in their office visit fees, for a total increase of 20%.

We also reimburse PGIP participating practices for in-person or telephonic care management, care coordination, and self-management training/support provided by ancillary providers, including nurses, social workers, respiratory therapists and nutritionists who have received care management training through PGIP-approved programs. Physicians themselves do not typically have the time, or the skills, to provide care management services on their own, and, absent this payment, most practices could not afford to provide these essential PCMH team-based services.

Taken together, the incentive dollars, the care management payments and the PCMH Designation program provide substantial support for physicians who are devoted to transforming their practices and optimizing population level outcomes. This mixed-method reimbursement strategy also has the advantage of allowing us to retain access to granular detail about patients' diagnoses and service provision, which is necessary to evaluate performance (including detail about resource inputs), and to help assure that quality of care isn't short-changed. We intend to devote proportionately more reimbursement to communities of caregivers that offer high-value, system-based care and less to individual physicians on a service-specific basis. The net result we anticipate is that providers who come together to transform and modernize their own practices and the systems in which they work and integrate their systems and care processes with others in their community of caregivers will thrive, while those who don't, choosing to rely only on base fees without earning substantial incentive payments, will see their practices wither.

Beginning in February of 2012, starting with cardiologists, BCBSM will begin increasing office visit fees for specialists who are part of communities of caregivers which achieve benchmark performance on cost and quality measures at a population level. To be eligible for such fee increases, the specialists will have to be nominated by Physician Organizations whose attributed members represent at least 20% of the specialists' practice. This nomination will depend on the Physician Organization attesting to the active engagement of the specialist in system transformation efforts and in enhancing the coordination and management of care in concert with the primary care community. Eligibility for fee increases will depend on improvement in and optimization of cost and quality performance in the population of patients attributed to the primary care physicians with whom the specialists collaborate. In this way, incentives for specialists, and the future viability of specialists' practices, will be fully aligned with the incentives of primary care physicians and dependent on delivering high value at a population level. As with primary care physicians, this movement from Fee for Service to Fee for Value reimbursement serves as an incentive for specialists to move from a focus on volume-based practice toward a focus on collaborating with their primary care peers to achieve high value at a population level.

### **Practice Transformation Assistance**

To accelerate the pace of change, Blue Cross Blue Shield of Michigan convenes about 350 PGIP Physician Organization leaders from across Michigan four times a year to

exchange information, collaborate on developing innovative solutions, and share best practices. Between these meetings, the Physician Organization community actively uses regional and statewide collaboratives to optimize mutual learning and accelerate dissemination of best practices.

Blue Cross Blue Shield of Michigan also supports specific projects aimed at fostering practice transformation. One example is a Lean Thinking Clinic-Reengineering Collaborative Quality Initiative, involving Physician Organizations across Michigan in a structured approach to office practice transformation which includes embedding Lean Thinking-trained change management facilitators into Physician Organizations. This approach has proven essential to enabling physicians' practices to implement new systems, re-organize practice teams and modernize care processes guided by the PCMH model, while still caring for their patients, which is a daunting challenge.

### **The Role of Hospitals**

Beginning in 2012, hospital contracts, at the time of renewal, will be modernized to include very modest inflation increases to base payment, plus a component in support of building Organized Systems of Care infrastructure (clinically integrated information systems and care management processes) closely aligned with the systems of care being developed by the Physician Organizations whose physicians use their facilities. In addition, any substantial increase in payment rate, and in the long run the hope of achieving a positive margin, will depend on delivering high value (meaning moderation of the use of hospital services) at a population level, with the population measures based on the same population for which the primary care and specialist physicians are responsible. Special attention will be paid to performance on emergency department use rates, ambulatory care sensitive condition admission rates, readmission rates, discretionary procedure use rates and overall population payment trends. This will effectively align hospital incentives with those of physicians.

### **Organized Systems of Care**

In 2011, PGIP launched two Organized Systems of Care Initiatives focused on catalyzing the development of clinically integrated information systems and performance measurement at a population level across all settings of care. These will be followed by additional Organized Systems of Care Initiatives in 2012 focused on clinically integrated care processes (care management, care coordination and systematized transitions of care) and on measuring and assuring optimal patient experience of care. To be eligible for participation in these Initiatives, communities of physician and facility providers must commit to actively partnering to deliver efficient, effective care to their population of patients. We are using the same incremental approach we've used for our PCMH program, beginning with initiatives that will support nascent OSCs in building shared information systems and care processes and working toward robust expectations regarding population level performance.

Relying on integrated information systems and care processes, wherever and whenever a patient seeks care across the continuum of care settings, providers will have access to the same, accurate clinical information in real time, helping to avoid redundancy in service provision and to assure safe, reliable and timely care.

There is no expectation that OSCs need to have common ownership. Affiliation agreements between independent entities (e.g., hospitals, physician organizations, other facilities) are all that is required to begin developing an Organized System of Care.

To date, 40 Physician Organizations have initiated 33 nascent OSCs in response to the Organized Systems of Care program. In contrast, 3 Physician Organizations and/or hospitals in Michigan have expressed intent to apply for the CMS Pioneer ACO program.

### **Progress to Date**

The rapid growth of the PGIP program and the rising interest in the PCMH Initiatives and Designation Program are a testament both to the engagement of providers across the state in this experimental partnership, and to the recognition that health care, and primary care in particular, is in a period of crisis.

The Commonwealth Fund is supporting a comprehensive evaluation of PGIP led by Christy Harris Lemak, PhD at the University Of Michigan School Of Public Health. The quantitative portion of this evaluation is not finished, but the qualitative portion, based on stakeholder interviews across Michigan, is in draft form. The following is an excerpt of her findings from stakeholder interviews:

“We describe respondent perspectives on the role of PGIP in Michigan’s health care economy and its perceived impact on health care costs and quality.... The vast majority of respondents were generally positive in their remarks about PGIP. Nearly every stakeholder, Physician Organization leader, practicing physicians and even other payers (BCBSM competitors) expressed the view that PGIP is a very successful program that is working to improve primary care and health outcomes in the State of Michigan.

Many respondents were proud of their specific, individual involvement in the program, even describing how they felt as if they were part of the program’s development and success. With very few exceptions, respondents gave credit to BCBSM for its leadership to develop and implement PGIP and its role in the creation and support of a vibrant community of practice that now exists in many regions of the State. The best evidence of this community of practice can be observed in the quarterly PGIP meetings, where hundreds of primary care physicians, physician organization leaders, purchasers, and others come together to share best practices and work on solving the practice challenges.

Most importantly, however, the vast majority of physicians we interviewed were energetic and motivated to improve their practice, to fully embrace patient centered medical home concepts, and to improve the health of their patients – respondents specifically tied many (though not all) of these changes to their active participation in PGIP.”

Interview responses yielded numerous quotes such as these:

*“PGIP is the driving force for health care quality change in Michigan.”*

*“Offices in the community help each other; we have group meetings. I used to [feel like I was competing with them] but not anymore. We’re all moving in the same direction and we’re helping each other get there”*

*“PGIP has challenged us to develop a broad population-focused model for clinical improvement for our patients.”*

*“PGIP has added value by helping to be the ignition piece. We had a culture of quality that pre-dated PGIP but PGIP did come in to push and cajole us to push that quality focus across the whole patient population.”*

With its intentional focus on harnessing physicians’ intrinsic motivation, and recognizing the importance of fostering autonomy as an essential ingredient in inspiring full engagement in system change and outcome improvement efforts, BCBSM has encouraged a culture of collaboration among Physician Organizations, and between them and BCBSM. This is evidenced in the quarterly PGIP meetings, in regional clinic process re-engineering collaboratives, and in community-wide workgroups focused on challenges faced in common, such as registry implementation, data management and performance measurement. A unique effort known as the Care Management Resource Center emerged from collaborative discussions about the need for a central source of expertise and guidance for Physician Organizations engaged in implementing structured care management systems. PGIP serves as fertile ground for the development of such community-wide efforts which accelerate the pace of change, and elevate physicians’ aspirations while providing practical support for realizing them. The sense of ownership and excitement among the PGIP participants is palpable and contagious.

Over 85% of PGIP providers are actively engaged in implementing PCMH capabilities, and significant progress has been made in transforming practices. For example, among PCMH-designated practices, over 95% now provide patients with 24 hour phone access to a clinical decision-maker, conduct medication review and management for all chronic condition patients, and have established a patient registry that incorporates evidence-based care guidelines.

As measured by available efficiency and quality metrics, this practice transformation work is leading to improved results: evidence-based care rates (quality measures) and generic drug dispensing rates are increasing at a faster rate for PGIP providers than for

non-PGIP providers, and the performance of PCMH-designated practices (selected in part based on quality and use performance) compared to non-designated primary care practices has grown stronger over time, even as we've expanded the program, including thousands of additional physicians. According to an analysis of 2010 BCBSM administrative claims data, adult members who received care from 2011 PCMH designees had 11.4% lower emergency department visits rates for primary care sensitive conditions (7.0% for 2010 designees), and 7.5% lower high tech radiology rates (6.3% for 2010 designees). PCMH designated practices also had 22% lower discharge rates for ambulatory care sensitive conditions, which was not a metric used in the selection process. (Table 1).

**Table 1:** 2010 Performance Statistics\* for PCMH Designated Practices Compared to PGIP Primary Care non-Designated Practices -Adults

Metric	PCMH Designees Compared to PGIP non-PCMH Practices	
	2010 Designees** (n=502)	2011 Designees (n=774)
Jan-Dec 2010		
<b>Adults (18-64)</b>		
Primary care sensitive emergency department visits (per 1,000)*	-7.0%	-11.4%
Ambulatory care sensitive inpatient discharges (per 1,000)	-11.1%	-22.0%
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%

\*Adjusted for age, gender, and risk score. Statistics based on members attributed to Primary Care Practitioners.

\*\*Data source for the 2010 Designees: 201001 P

\*Metric used in selecting PCMH designees

For the twelve months ending in the third quarter of 2011, the overall cost trend for BCBSM PPO and Traditional business was 2.2%. This compares to an average of 4.3% for other Blue Plans nationally and to a similar rate of increase in cost for government programs. During this time period the professional cost trend (for physician payments) was 1.4%, with, remarkably, a negative 0.9% trend in the third quarter.

## Conclusion

Like all important human endeavors, practice transformation is difficult, exhausting work. The underlying sense of urgency has only strengthened, however, as providers have taken ownership of these challenges as full, collaborative partners in PGIP and have begun to experience the fruits of their efforts: the beneficial impact on their patients of improved care management, group visits, increased access -- and on their practices from greater teamwork, increased efficiency, and a shared mission.

PGIP represents the kind of regional collaboration and experimentation which we hope Medicare delivery and payment reform will encourage, not hinder, given how little we know at this time about “what works” in regard to creating systems of care and payment mechanisms which yield optimal value.

Regional and local experimentation in system and performance transformation, and in incentivizing this work, will be essential in identifying and understanding best practices in payment reform. It is likely that in different communities, with different cultures and resources, the specific answers will vary, as do the circumstances which drive performance.

Through the PGIP payer-provider partnership, we are transforming the role of the payer from controller to catalyst, the role of the provider from responder to change agent, and the role of the patient from recipient to active partner. Imbued with energy and purpose, the PGIP approach represents incremental reform with dramatic impact.

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