PROVIDER PAYMENT TRENDS AND STRATEGIES IN THE DETROIT AREA

BY ALLAN BAUMGARTEN

A key element of the Affordable Care Act has been promoting changes in the way Medicare, Medicaid, and private insurers pay hospitals, physicians, and others for the health care services they provide. When the era of managed care began more than 30 years ago, health insurers moved away from the indemnity insurance model, where a patient received care, the provider sent a bill to the patient, who paid the bill and then presented it to his/her insurance company to be reimbursed, usually 80% of the fees. Some managed care plans contracted with providers on a full risk capitation basis, though many later retreated from that arrangement. Under capitation, providers were encouraged to practice conservatively, working within the budget of the capitation payments. Other insurers entered into contracts with providers in which they paid them set discounted fees for every unit of service, that is, every procedure or test performed, and every day spent in the hospital. The patient's responsibility was limited to the amount of the annual deductible and whatever other cost-sharing was specified in their benefit plan.

This paper describes the state of provider payment in the Detroit area today and several of the key innovations and initiatives that have recently been introduced. These programs are intended to change payment to providers from a system that rewards volume to one that rewards providers for value, defined by the Institute for Healthcare Improvement as the Triple Aim: improving population health and patient experience while reducing costs.

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CURRENT PAYMENT PRACTICES AND INNOVATION: BLUE CROSS BLUE SHIELD MUTUAL INSURANCE OF MICHIGAN

Based on health insurance premium revenues, Blue Cross Blue Shield Mutual Insurance of Michigan (BCBSM) is by far the largest health insurer in the state, with 41.6% of the market in 2016. That includes revenues from its Blue Care Network HMO and its Blue Cross Complete Medicaid HMO, which compose the largest HMO in the state. (The denominator for market share does not include premium equivalents for about 1.6 million employees and retirees in self-funded employer groups in the state.)

BCBSM contracts with all hospitals in the state and a high percentage of the physicians. For both hospitals and physicians, the primary form of payment is a version of discounted fee-for-service. Hospitals receive pre-payments subject to annual reconciliation based on actual utilization. Historically, both hospitals and physicians have received annual adjustments in payment rates based on inflation.

But Blue Cross Blue Shield and some other insurers have moved away from the notion of annual increases and now require providers to "earn" increases through participation in a series of population health and pay-for-performance programs.

These programs incent providers to participate in population health initiatives and to invest in data systems, analytics and staff needed to monitor and manage population-based care for an identified group of covered patients. These "value-based contracts" can be described as limited risk arrangements in which the hospital can be rewarded in the following three ways:

- Sharing in savings resulting from year to year reductions in cost for an attributed population of patients;
- Being rewarded for "population-based performance," where better coordination of care is reflected in reductions in per member per month claims compared to the base year; and
- Receiving infrastructure payments that support information technology, analytics, and care coordination, if part of a hospital and physician organization with overlapping patients.

As of 2015, Blue Cross Blue Shield had entered into gain-sharing contracts with 69 hospitals in 18 health systems. (Note that BCBSM describes these contracts as like Accountable Care Organizations, which we will describe below.) Five of the systems earned shared savings based on their performance in 2013, when they generated $50 million in savings and shared the overage with BCBSM. A similar amount was reported saved in 2014 and shared with physicians, (Source: Blue Cross Blue Shield Mutual Insurance of Michigan, 10 Year Value Partnerships report, accessed at https://www.bcbsm.com/content/dam/public/Providers/Documents/help/documents-forms/partners-report.pdf

Blue Cross Blue Shield contracts with many independent physicians through physician organizations like United Physicians of Bingham Farms, which had more than 2,200 participating physicians in 2014, according to a *Crain's Detroit Business* list. In the past 10 years, BCBSM has introduced a series of initiatives that reward physicians with additional payments for successful participation in quality improvement programs. The most significant program has been the Patient-Centered Medical Home (PCMH), in which primary care clinics receive additional payments in exchange for playing a larger role in care coordination for their patients. That program started out slowly, with Blue Cross Blue Shield discovering that most of the clinics did not have the capability to collect and report data on physician performance. The program has now grown so that nearly two-thirds of the 30,000 active physicians in the state participate in the PCMH program.

Blue Cross Blue Shield calculates that the PCMH program resulted in savings of $512 million from July 2008 to June 2014, including $127 million in the 2013-2014 program year. The savings are from reductions in emergency room visits and in ambulatory care-sensitive inpatient hospital admissions, meaning that better treatment of conditions like asthma or congestive heart failure in ambulatory settings reduced the need for hospital admissions or emergency department visits.

A second program is the Physician Group Incentive Program, in which 46 organizations now contract with Blue Cross Blue Shield. The program started in 2005 with primary care practices and expanded in 2011 to include specialty groups. Similar to the hospital programs, physician organizations receive additional payments to build capacity for data collection, analytics, and care coordination. Note, however, that the annual payments are funded by withholding a portion of contracted fee (about 4% in 2010) that the providers have to earn back.

At this point, these programs create upside opportunities for physicians and hospitals, without downside risk. About 5% of the payment dollars are tied to these programs, although Blue Cross Blue Shield has proposed expanding this to as much as 20% in the future. Physicians still see that volume remains their primary incentive. These strategies by Blue Cross Blue Shield are similar to recent changes in the Medicare Advantage program of private health plans for seniors. The base payment rates have remained relatively flat for the past four years. To receive higher payments, health plans need to perform well so that they receive four or five stars in their ratings. Or they need to be more complete or aggressive in their coding so that they raise the Risk Adjustment Factor (RAF) scores that are applied to the base payment rate. Blue Cross Blue Shield is sending a message to providers that inflationary increases are a thing of the past and that the only sustainable way to increase payments is through full participation in these quality improvement and population health programs.

EXHIBIT 1

Medicare Bonuses and Penalties for Southeast Michigan Hospitals *(Beaumont, Tenet Detroit Medical Center)*

HOSPITAL/SYSTEM	CITY	QUALITY STAR RATING	READMISSION PENALTY		YEARS PENALIZED FOR READMISSIONS	VALUE-BASED PERFORMANCE ADJUSTMENT	HOSPITAL-ACQUIRED CONDITIONS SCORE		1% HAC PENALTY IN 2016?
			FY 2017	FY2016			2015	2016	
BEAUMONT HEALTH									
Beaumont Grosse Pointe	Grosse Pointe	3	1.18%	0.80%	5	0.42%	7.025	6.75	N
Beaumont Royal Oak	Royal Oak	3	1.58%	1.15%	5	0.23%	6.75	6.00	N
Beaumont Troy	Troy	3	1.47%	1.28%	5	0.33%	3.325	3.75	N
Oakwood	Dearborn	3	1.41%	0.89%	5	-0.22%	8.325	7.00	Y
South Shore	Trenton	3	1.07%	0.14%	5	0.17%	9.325	6.25	N
Heritage	Taylor	4	0.55%	0.70%	5	0.00%	5.25	5.25	N
Wayne	Wayne	2	2.21%	2.03%	5	-0.01%	7.00	5.25	N
Botsford General	Farmington Hills	2	1.34%	1.09%	5	-0.40%	5.75	6.00	N
TENET DETROIT MEDICAL CENTER									
Detroit Receiving	Detroit	1	1.23%	0.85%	5	-0.71%	7.075	7.50	Y
Harper - Hutzel University	Detroit	2	0.71%	0.87%	5	0.00%	7.70	8.25	Y
Huron Valley	Commerce Twp	3	0.92%	1.88%	5	0.16%	5.725	5.25	N
Sinai - Grace	Detroit	1	1.24%	0.92%	5	-0.68%	6.75	8.50	Y

EXHIBIT 1, CONTINUED

Medicare Bonuses and Penalties for Southeast Michigan Hospitals *(Henry Ford, Trinity, St. John-Providence)*

HOSPITAL/SYSTEM	CITY	QUALITY STAR RATING	READMISSION PENALTY		YEARS PENALIZED FOR READMISSIONS	VALUE-BASED PERFORMANCE ADJUSTMENT	HOSPITAL-ACQUIRED CONDITIONS SCORE		1% HAC PENALTY IN 2016?
			FY 2017	FY2016			2015	2016	
HENRY FORD HEALTH SYSTEM									
Henry Ford	Detroit	1	0.99%	0.76%	5	-0.53%	7.40	6.50	N
Henry Ford Macomb	Clinton/Mt. Clemens	2	0.68%	0.30%	5	-0.20%	7.725	7.00	Y
West Bloomfield	West Bloomfield	2	1.04%	0.44%	5	-0.03%	4.80	4.75	N
Wyandotte	Wyandotte	2	1.15%	0.46%	5	-0.56%	4.625	5.00	N
TRINITY HEALTH									
St. Mary's - Livonia	Livonia	3	1.00%	1.02%	5	0.14%	2.30	2.75	N
St. Joseph Mercy Oakland	Pontiac	3	0.94%	0.12%	3	-0.04%	6.05	7.25	Y
ST. JOHN-PROVIDENCE									
St. John	Detroit	2	0.78%	0.82%	5	-0.29%	6.675	6.25	N
Macomb	Warren/Oakland Center	2	1.17%	1.07%	5	-0.72%	5.35	4.75	N
Providence	Southfield	4	0.48%	0.83%	5	-0.05%	6.35	6.25	N
River District	East China	3	0.10%	0.02%	5	0.45%	2.40	1.25	N

EXHIBIT 1, CONTINUED

Medicare Bonuses and Penalties for Southeast Michigan Hospitals *(McLaren, Other)*

HOSPITAL/SYSTEM	CITY	QUALITY STAR RATING	READMISSION PENALTY		YEARS PENALIZED FOR READMISSIONS	VALUE-BASED PERFORMANCE ADJUSTMENT	HOSPITAL-ACQUIRED CONDITIONS SCORE		1% HAC PENALTY IN 2016?
			FY 2017	FY2016			2015	2016	
MCLAREN HEALTH									
McLaren Macomb	Mt. Clemens	2	1.43%	1.11%	5	-0.55%	7.375	7.00	Y
McLaren Oakland	Pontiac	2	0.31%	0.39%	5	-0.16%	4.40	5.75	N
Karmanos Cancer	Detroit	2	0.02%	0.00%	1	-0.07%	5.425	6.25	N
OTHER									
Garden City	Garden City	2	1.71%	1.57%	5	-0.58%	6.625	6.00	N
Crittenton	Rochester	3	1.85%	1.47%	5	-0.23%	7.05	6.00	N
Doctors Hospital	Pontiac	NA	0.25%	0.10%	5	NA	5.30	8.00	Y
Oakland Regional	Southfield	NA	0.14%	0.00%	1	0.00%	6.00	6.00	N

SOURCE: Centers for Medicare & Medicaid Services
For 2016, hospitals with a score above 6.75 are subject to the 1% Hospital Acquired Conditions penalty

CURRENT PAYMENT PRACTICES AND INNOVATION: MEDICARE

Under the Affordable Care Act, the Medicare program has introduced a series of programs through which hospitals can earn bonuses or face penalties based on their performance. Note that these programs generally do not evaluate hospitals that are excluded from the penalties and bonuses, including pediatric hospitals and small, critical access hospitals. In 2016, CMS released the first star rankings of hospitals, developed by constructing a composite ranking of a series of measures reported on the Hospital Compare website (https://www.medicare.gov/hospitalcompare/search.html).

Exhibit 1 summarizes how Detroit-area hospitals were rated on those measures and compares those hospitals on their performance on four other programs. While four hospitals in other parts of Michigan received the top five-star rating, no hospitals in the Detroit region received a five-star rating. Two hospitals, St. John Providence and Beaumont Taylor, received four stars, and 10 others received a three-star rating. Some of the major hospitals in the region received only one or two stars, including Henry Ford, St. John and DMC Harper University Hospital.

Under the Readmission Reduction Program, started four years ago, Medicare evaluates hospitals on their readmissions within 30 days for certain admission categories, such as heart failure and pneumonia. Only 2 Detroit-area hospitals will not be penalized in 2017, and 10 of them face penalties above 1%. Three hospitals face penalties of 1.5% or higher. The exhibit shows the penalties for 2016 and 2017, and also shows how many years out of the five years of the program each hospital has been subject to penalties.

Through Medicare's Value-Based Purchasing (VBP) program, hospitals can earn a modest bonus on their Medicare payments for their performance on a value-based performance index composed of outcomes, patient experience, efficiency, and clinical process. Hospitals can be rewarded for high scores but also for improvement over previous years. Seven hospitals in the Detroit area earned bonuses of up to 1% for 2016, with St. John River District and Beaumont Grosse Pointe earning the highest bonuses. However, 19 hospitals in this group will be penalized by amounts up to 1%, including 7 whose penalty will be 0.5% or more.

Hospitals can also face a 1% penalty if they have a high rate of hospital-acquired conditions. That is based on a composite score including problems like central line-associated bloodstream infections and catheter-associated urinary tract infections. Eight of these hospitals will suffer the penalty in 2016, including three Detroit Medical Center hospitals, Beaumont Dearborn and Henry Ford Macomb. Hospitals are subject to the penalty if their combined rate is above 6.75%. Based on the most recent data, six of these hospitals had a combined rate of 5% or less, with Beaumont Troy, St. Mary Mercy Livonia and St. John River District reporting the lowest rates.

Medicare has also launched a series of demonstration projects—the Bundled Payments for Care Improvement initiative—involving bundled payments for specific kinds of frequent surgeries like joint replacement and for care of conditions such as cancer. A range of Detroit-area providers are participating in those projects, including hospital systems, federally-qualified health centers, skilled nursing facilities, and providers of therapies.

CURRENT PAYMENT PRACTICES: HMO CAPITATION ARRANGEMENTS

Capitation payments were widely used in the early days of managed care and are still used extensively in California and some other states. Under a capitation payment or contract, an organization of providers agrees to accept a fixed monthly payment from an HMO. The exact amount will likely vary based on age, sex, geography, and other factors. In exchange, the provider organization agrees to provide a defined menu of health care services to all the patients who select that provider organization as their primary care provider. As negotiated between the parties, the menu of services may be limited to primary care, or it may be defined comprehensively to include virtually all services.

Michigan HMOs report on their use of capitation payments in an exhibit in their annual statements, which follow the format prescribed by the National Association of Insurance Commissioners. The form divides capitation payments into three categories based on the type of provider organization and then categorizes other payments into categories like fee-for-service or contractual fees with a bonus or withhold.

EXHIBIT 2

Capitation Payments by Detroit-Area HMOs *(Primarily Medicaid)*

PRIMARILY MEDICAID PLANS	2015 CAPITATION PAYMENTS	TOTAL PAYMENTS	% PAID THROUGH CAPITATION		
			2015	2014	2013
Aetna Better Health	$59,109,535	$184,623,245	32.0%	32.6%	33.4%
Blue Cross Complete	139,804,122	353,756,477	39.5%	52.8%	65.6%
HAP/Midwest Health Plan	106,732,044	379,102,502	28.2%	34.3%	33.9%
Harbor Health Plan	12,022,981	23,730,133	50.7%	10.4%	1.2%
McLaren Health Plan	185,709,957	757,550,363	24.5%	21.8%	18.3%
Meridian Health Plan of MI	408,790,788	1,660,254,381	24.6%	27.3%	29.9%
Molina Healthcare	312,539,330	1,076,560,418	29.0%	30.1%	28.6%
Total Health Care	90,025,987	256,926,250	35.0%	36.3%	34.1%
UnitedHealthcare Community Plan	286,773,198	942,539,898	30.4%	29.1%	31.2%
SUBTOTAL	$1,601,507,942	$5,635,043,667	28.4%	29.7%	29.6%

Exhibit 2 compares HMOs with significant operations in the Detroit area on their use of capitation payments. It further divides the HMOs into two categories: those that are primarily contracting to serve Medicaid recipients and those that primarily serve Commercial and Medicare enrollees.

The general trend in Michigan and most other states has been a decline in the percentage of dollars paid to providers through capitation arrangements in the past 10 years. (California is also seeing a decline in capitated commercially insured lives outside of the Kaiser Permanente system.) Given all the discussion about a move away from paying for volume, have Michigan HMOs and providers begun to make increased use of capitation arrangements? The answer from the Michigan HMO data is no. For Medicaid HMOs, the percentage of provider payments made through capitation has dropped, albeit only a little, from 29.6% in 2013 to 28.4% in 2015. Of the largest plans, Blue Cross Complete has the highest percentage of payments through capitation, though that has dropped from 65.6% in 2013 to 39.5% in 2015.

One small Medicaid HMO, Harbor Health Plan, reported increasing its use of capitation from less than 2% of payments in 2013 to 50.7% in 2015. Harbor Health Plan is owned by Tenet Health/Detroit Medical Center and is one of a new cohort of provider-sponsored health plans. . (In 2016, Harbor Health Plan was acquired by Trusted Health Plans, Inc, a Washington DC company. Tenet Health has been reducing its health plan operations in some of its other regions as well.)

The health plans that primarily enroll commercial and Medicare patients saw their use of capitation drop sharply, from 18% in 2013 to 8.2% in 2015. The biggest change came with provider-sponsored health plans. Health Alliance Plan, which as recently as 2009 had capitated 54% of payments, was capitating only 16.1% of provider payments in 2015. Similarly, Priority Health, whose major operations are in western Michigan, capitated 28% of provider payment in 2004 but less than 1% in 2015.

EXHIBIT 2, CONTINUED

Capitation Payments by Detroit-Area HMOs *(Primarily Medicaid)*

PRIMARILY COMMERCIAL AND MEDICARE	2015 CAPITATION PAYMENTS	TOTAL PAYMENTS	% PAID THROUGH CAPITATION		
			2015	2014	2013
Blue Care Network	$262,124,399	$2,781,117,800	9.4%	8.8%	9.3%
Health Alliance Plan	232,400,467	1,439,876,993	16.1%	19.4%	46.9%
Priority Health	3,224,844	1,850,556,183	0.2%	0.9%	1.0%
Total Health Care USA	7,253,206	120,262,005	6.0%	6.2%	6.2%
SUBTOTAL	$505,002,916	$6,191,812,981	8.2%	9.3%	18.0%

MEDICARE ACCOUNTABLE CARE ORGANIZATIONS

We noted earlier that Accountable Care Organization (ACO) is sometimes used in a generic sense to describe arrangements in which a provider organization can earn a portion of the savings resulting from better care coordination and low utilization for an identified population of patients. Medicare has entered into ACO contracts with nearly 500 provider organizations since 2011. The basic notion is that an organization of providers provides comprehensive care to seniors who are not enrolled in a Medicare Advantage plan. If the providers can meet quality requirements and are able to serve that population at a lower cost when compared to a benchmark of spending in the previous year, the ACO and its participating providers share in those savings.

In Michigan, three provider organizations contracted with Medicare to be Pioneer ACOs: the University of Michigan Health System, Genesys PHO and Michigan Pioneer ACO, composed of the Detroit Medical Center and its affiliated physicians. Only one of them remains a Pioneer ACO. The University of Michigan dropped out of the Pioneer program after the first years, but remains part of an ACO formed by other provider groups in the state. That ACO participates in the Medicare Shared Savings Program (MSSP), which was the second cohort of Medicare ACOs. The Genesys PHO ACO also dropped out of the Pioneer program and dropped into the MSSP ACO program at the beginning of 2015.

Over the next two years, new MSSP ACOs were formed across Michigan, including the following located primarily in the Detroit area: Oakwood Accountable Care Organization, Physician Organization of Michigan ACO (formed by University of Michigan plus eight physician organizations such as United Physicians), Southeast Michigan Accountable Care (United Outstanding Physicians and St. Mary's Livonia) and St. John Providence Partners in Care (a joint venture with the Physician Alliance).

Beginning in 2016, Henry Ford Physicians Partners has entered into a contract with Medicare to become a Next Generation ACO. Trinity Health, operating in Michigan and Iowa, will also become a Next Generation ACO. Nineteen others Next Generation ACOs were formed in other states, with some of them being former Pioneer ACOs transitioning to the new program.

Exhibit 3 summarizes the performance of these ACOs in 2014 and 2015. Southeast Michigan Accountable Care had by far the largest number of Medicare beneficiaries and it grew by about 13,000 in 2015 to 135,000. The others lost beneficiaries: Michigan Pioneer and Oakwood ACO both saw a decrease in beneficiaries.

EXHIBIT 3

Results for Detroit-Area Medicare Accountable Care Organizations, 2014 and 2015

EXHIBIT	ASSIGNED BENEFICIARIES		TOTAL EXPENDITURES		GENERATED SAVINGS		EARNED SHARED SAVINGS		QUALITY SCORE	
	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015
PIONEER ACOS										
Michigan Pioneer	16,540	12,213	$248,113,038	$188,469,513	$16,761,772	$2,379,268	$9,821,272	$1,420,157	85.41%	87.01%
MSSP ACOS										
Oakwood Accountable Care Organization, LLC	14,305	12,610	$150,365,095	$134,940,004	$19,074,154	$15,279,768	$8,147,793	$6,972,349	87.18%	93.13%
Southeast Michigan Accountable Care	122,032	135,455	$1,074,504,180	$1,231,085,711	$27,073,648	$0	$12,075,693	$0	91.03%	98.56%
Physicians of Michigan ACO	12,879	12,309	$155,280,782	$152,967,013	$0	$0	–	$0	77.94%	63.35%
Partners in Care St. John*	11,131	NA	$93,410,014	NA	$0	NA	–	NA	91.76%	NA
SUBTOTAL	176,887	172,587	$1,721,673,109	$1,707,462,241	$62,909,574	$17,659,036	$30,044,758	$8,392,506		

SOURCE: Analysis of CMS ACO performance data downloads for 2014 and 2015 operating years.

* Data for 2015 operations for Partners in Care was not found in the CMS downloads

In 2014, Michigan Pioneer ACO and two of the MSSP ACOs earned shared savings totaling $30 million. However, these dropped sharply in 2015. Michigan Pioneer saw its enrollment and revenues drop by about 25%, and its earned shared savings dropped to $1.4 million. Oakwood's earned shared savings dropped by about $1.2 million to $7 million. Southeast Michigan Accountable Care earned shared savings of $12.1 million in 2014 but zero in 2015. Three of the ACOs saw their composite quality scores improve in 2015, but the score for Physicians of Michigan ACO decreased.

SUMMARY

The major payers in Michigan, including Blue Cross Blue Shield, Medicare, and Medicaid, have taken significant steps to change provider payment methods from those that reward increased volume of care to those that reward greater value in improving the health of a defined population of patients. In particular, Medicare has set ambitious goals for expanded use of advanced payment methods in which a greater amount of payments are tied to provider performance.

Even so, most of the new methods are only rewarding provider organizations for shared savings or for expanded participation in population health improvement. In general, providers are not at risk if they spend more than benchmark amounts or do not achieve quality and patient satisfaction goals. Michigan providers and health plans continue to make less use of full-risk capitation contracts.