VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

Provider Delivered Care Management

How to Reach Us

- Submit an issue through the Issues Log on PGIP Collaboration site
- Check out the announcements page or the PDCM Initiative page, also on the collaboration site
- Email valuepartnerships@bcbsm.com
- Email the group (least preferred method – but please, if you email one of us, email all of us at the same time and not individually! We are a team ☺).

Supporting Documents

All are available on the PDCM Initiative page on Sharepoint. When we update these documents, we will post an announcement about it

- PDCM FAQ – High-level overview document with frequently asked questions
- Billing Guidelines
- PDCM Analysis cheat sheet – to be updated shortly
- Groups Not Participating in PDCM list
- MICMT Training Table

Patient Lists

- Patient lists are distributed to all Physician Organizations (PO's) monthly in their EDDI mailbox.
- PO's should then disseminate to their practices.
- The Patient Lists **are not a guarantee of eligibility for members**. **This list is a guide to suggest who might be a candidate for care management.** You will need to confirm that the member has an active contract since the attribution is not real time.
- There are a number of fields available on the Patient List to assist you in identifying potential patients for care management. An example is a field called "Potential High Risk Indicator".

How to Use the Patient List

- Patient lists are delivered the last week of the month into your EDDI folders, prepared by Michigan Data Collaborative
- We're often asked how best to use the monthly patient list, if not to check eligibility. Here are some ideas:
  - Filter by "potential high risk" field to target highest risk members. You can also create your own filters that are meaningful, e.g., if you want to focus on diabetic members, filter by fields related to diabetes
  - Bump the filtered list against the list of people coming for appointments in the next few days/weeks, then arrange for a care team member to piggy-back on existing appointment or for physician to do "warm handoff"
    - May include creation of care team introductory materials, such as fliers, brochures or business cards describing care team member and their role in helping the patient
  - List can also be bumped against practice patient registry to help close gaps in care and be proactive about appointment scheduling (e.g., if a patient has a lot of ED visits, have care manager reach out to check health status and see if care management is appropriate)

Eligibility

- BCBSM has two systems where we house benefit information for our Commercial members. One is MOS and the other is NASCO. On our collaboration site we do include a list of Commercial groups that are excluded from the PDCM program. Additionally, you can find the powerpoint on how to check in benefits on our collaboration site.

- What is MOS? MOS stands for Michigan Operating System . This eligibility system houses our Local BCBSM groups such as the State of Michigan, BCBSM employees, and the majority of our school and government systems just to name a few. When checking WebDenis for a MOS group, you will be directed to Explainer, then you have to click on topic and key in the HCPCS code and then search to determine if the member has the PDCM benefit.

- What is NASCO? NASCO eligibility houses our National NASCO groups such as General Motors, Ford Motor Company and Lear Corporation, just to name a few. When checking WebDenis for a NASCO group, you will not be directed to Explainer, rather under the “Message” section it will indicate if the member is participating in the PDCM program.

- BCBSM’s Medicare Advantage population is included in the PDCM program; however, there are four groups which are excluded and they are MPSERS, URMBT, BCBSM retiree’s and Accident Fund retiree’s.

PDCM Claims Activity Reporting

Report: There are 3 tabs in the report

- Legend
  - Describes each field of the Practice Level tab and the Member Level tab
- Practice level details
  - Report by PO of the PCP practices and their PDCM activity
  - High level summary
  - PCMH-designated PUs, CPC+ PUs, and specialist PUs can bill PDCM claims, but only PCMH-designated PUs can potentially qualify for the PDCM VBR
- Member level details
  - Details of each unique member and each unique encounter that may count towards the PDCM VBR calculations if all criteria are met

Claims Activity Report Legend

Field Name	On PU Level Summary tab?	On Member Level Detail tab?	Field Description	Notes
PO ID	Yes	Yes	Physician Organization Unique Identifier	
PO Name	Yes	Yes	Physician Organization Name	
PU ID	Yes	Yes	Practice Unit Unique Identifier	
PU Name	Yes	Yes	Practice Unit Name	
PU Type	Yes	No	Practice Unit Type	Mixed or PCP
# of Providers in PU	Yes	No	# of providers in the practice unit	
# Providers with Paid Claims	Yes	No	# providers in the practice unit who have paid claims	
CPC+ PU	Yes	No	Is the practice a CPC+ practice?	Yes or No
Designated 2017	Yes	No	Was the practice unit PCMH-designated in 2017?	Yes or No
PDCM VBR 2017	Yes	No	Did the PCPs in practice receive PDCM VBR in 2017?	Yes or No
Newly PCMH Desig in 2017	Yes	No	Was the practice unit newly PCMH-designated in 2017?	Yes or No
Does the PU have at least 1 Paid PDCM Claim? This is required to count members towards engagement	Yes	No	Does the practice have at lest 1 Paid PDCM claim (1 of the 12 PDCM codes)	Yes or No
# PDCM Claims	Yes	No	# of PDCM paid claims in the practice	
# Medication Reconciliation Claims	Yes	No	# of medication reconciliation paid claims in the practice	
# of Transitions of Care Claims	Yes	No	# of transition of care paid claims in the practice	
Total # of Claims	Yes	No	Total number of paid claims	
# of Unique Members with 1 or More Claims (PDCM/TOC/Med Rec)	Yes	No	# of unique members with 2 or more paid claims	
# of Unique Members with 2 or More Claims diff Service Date	Yes	No	# of unique members with 2+ paid claims – diff dates	
PDCM Eligible Attribution	Yes	No	# of PDCM-eligible members attributed to the practice	
% Engagement	Yes	No	% of PDCM-eligible members with at least 2 Paid claims	
Provider NPI #	No	Yes	Provider NPI number	
Provider First Name	No	Yes	Provider First Name	
Provider Last Name	No	Yes	Provider Last Name	
Patient First Initial	No	Yes	Patient First Initial	
Patient Last Name	No	Yes	Patient Last Name	
Patient DoB	No	Yes	Patient Date of Birth	
Service Date	No	Yes	Date of service for the paid claim	
Claim Unique Identifier	No	Yes	Claim line unique identifier	
HCPCS Code for the claim line	No	Yes	HCPCS code related to the claim line	

Practice Level Sample Report

PO ID	PO Name	PU ID	PU Name	PU Type	# of Providers in PU	# Providers with Paid Claims	CPC+ PU	Safety Net PU	Designated 2018	PDCM VBR 2018	Newly PCMH Desig in 2018	Does the PU have at least 1 Paid PDCM Claim? *This is required to count members towards engagement*	# of PDCM Claims	# of Transitions of Care Claims	# of Medication Reconciliation Claims	# of HICM Claims	# of CM Claims for RHCs/FQHCs	Total # of Claims	# of Unique Members with 1 or More Paid Claims (PDCM/TOC/MedRec/HICM/CM)	# of Unique Members with 2 or More Paid Claims with different Service Date (PDCM/TOC/MedRec/HICM/CM)	PDCM Eligible Attribution	% Engagement
PO ID Y	PO Y	PU ID 1	PU NAME 1	PCP	7	1	Yes	No	No	No	No	Yes	2	5	0	3	0	10	4	2	0	-
PO ID Y	PO Y	PU ID 2	PU NAME 2	PCP	4	1	Yes	No	Yes	Yes	No	Yes	7	9	1	7	0	24	5	3	63	4.76%

Tips on the PDCM Claims Reports

- The claims reports have been provided thrice annually and will soon be provided monthly
- They are a guide, not a definitive answer on who is getting PDCM VBR
- Hosted members are not included
- The data is approx. 3 months old or more – so if a member had a visit last week, they won't be included
- Patient level data is included because POs said it would be helpful. **We do not use the patient-level data in our PDCM VBR analysis**
- The numbers will vary from report to report. This is normal and to be expected, given flux in a practice – don't panic!
  - We analyze **the average number of attributed patients over 12 months** to account for this flux. Patient movement is not a factor in our analysis

PDCM Procedure Codes

- G9001* - Coordinated Care Fee – Initial Assessment
- G9002* - Coordinated Care Fee – Maintenance (can be quantity billed)
- 98961* - Group Education 2–4 patients for 30 minutes (can be quantity billed)
- 98962* - Group Education 5–8 patients for 30 minutes (can be quantity billed)
- 98966* - Phone Services 5-10 minutes
- 98967* - Phone Services 11-20 minutes
- 98968* - Phone Services 21-30 minutes
- 99487* - Care Management Services 31-75 minutes per month
- 99489* - Care Management Services, every additional 30 minutes per month (can be quantity billed)
- G9007* - Team Conference
- G9008* - Physician Coordinated Care Oversight Services (Enrollment Fee)
- S0257* - End of Life Counseling

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Changes to the PDCM Program in 2019

- The onus is now on the provider to assess the types of health care professionals best suited for their care team and to ensure health care professionals are working within their scope of practice.
- There is no longer a distinction between lead care managers and qualified health professionals; both are part of the care team. Licensed professionals who want to bill the G9001 code must attend complex care management training to do so.
- Both community health workers and medical assistants can bill the *98966, along with *99487 and *99489. These professionals must now also complete the same training requirements as other care team members who are billing the non-G9001 codes.
- Quantity limits on G9001 have been removed.
- Quantity limits on G9008 have been removed; the rendering provider may use that code for patient engagement into care management, coordinating care with a paramedic for emergency department diversion, or coordinating care with other physician specialties.
- Paramedics are now able to bill the G9001, G9002, *98966, *98967 and *98968 codes when working in conjunction with a PDCM physician to prevent patients from being transported to the emergency room.
- If you are providing the TCM codes (99495/99496) and also the PDCM codes, both can be billed if the services being performed are separate and distinct, meet the nomenclature of the code and your physician is in agreement.

Expansion of G9008

- The service describes physician performed care coordination or active oversight of care coordination services. Examples of appropriate use:
  - Physician speaks to a patient and initiates care management services delivered by another team member.
  - Physician speaks with an external consultant, such as a pathologist, to determine which genetic test is appropriate for the patient's medical condition
  - Physician speaks with an ED physician while the patient is in the ED to inform the delivery of services there and coordinate a follow-up care plan

- A description of the care coordination or active oversight should be documented in the medical record when billing G9008.

Reducing ED Visits

- PDCM Strategies:
  - Proactive patient education to consider the PCMH practice first for acute healthcare needs, suggesting nearby urgent care or ED for true emergency.
  - Follow up each ED visit with a call to identify issues, coordinate follow up care and encourage seeking care through the practice rather than the ED when appropriate. Often, this can be performed by a medical assistant.
  - Medical assistants, operating under a protocol, may call patients, ask if the ED physician recommended follow up care, coordinate the needed care, transfer to clinician for issues requiring immediate medical assessment or guidance, encourage the patient to bring in all medications, etc.
  - Billing code: 98966 (5-10 minute phone encounter)

PDCM Training: Billing G9001?

- Care team members that deliver the G9001 code need to meet **all three training requirements:**
  - Complex care management training (once)
  - PDCM online billing course (once, currently being revised)
  - 8 hours of continuing education per year, pro-rated based on when care team member started billing PDCM services (annually)

- Note: Self-management support used to be required for this group, but no longer is
- This training opportunity is only appropriate for those licensed care team members that the provider feels can conduct comprehensive assessments within their scope of practice

PDCM Training: Billing the other 11 Codes?

- Care team members that deliver the other 11 PDCM codes need to meet **all three training requirements:**
  - Complex care management training **OR** self-management support training (once - selection is at PO/provider/care team discretion and should be based on preference, interest, role in the practice, etc.)
  - PDCM online billing course (once, currently being revised)
  - 8 hours of continuing education per year, pro-rated based on when care team member started billing PDCM services (annually)

- This training opportunity is for both licensed and unlicensed care team members (such as MAs, CHWs)

Training FAQs

- If I'm doing the same job I've always done, do I need to be re-trained?
  - No, if you were trained previously and maintain the same role as before, you do not need to repeat one-time trainings.
  - If your role changed, you DO need to complete the required trainings
  - Everyone must complete the 8 continuing ed hours annually

- Do MAs have to be trained? Or community health workers?
  - Yes, if those provider types are considered part of the care team, they need to be trained just like other care team members

- Can I use the self-management support training to count towards the 8 hours of continuing education?
  - No, those are separate training categories and must be fulfilled independent of one another

PDCM Training FAQ, cont'd.

- Does all the continuing ed have to be through MiCMRC?
  - The continuing education for both groups does not have to be completed by MiCMRC, but we expect training will be robust, related to their role as a care manager, and conducted by a legitimate training body and/or program eligible for CE/CME credits. *(Note about MiCMRC: It will soon be rolled into MICMT and will be referred to as such)*
  - CCM and Self Management training still needs to be through MiCMRC or an approved entity

- Does the training cost money?
  - Blue Cross, via the Michigan Institute for Care Management and Transformation, will reimburse up to $500 for complex care management and self-management support training. This amount will be capped by PO, and will only be provided if care team members pass a post-test. Details TBD.

- Do specialist practices have to be trained?
  - Yes, specialist training requirements are now identical to primary care training requirements.

PDCM Providers

- BCBSM is refining the definition of who is considered a PDCM provider for employer groups to direct their members to PDCM providers
  - Previously defined as those who met the requirements to obtain PDCM VBR
  - As PDCM VBR requirements change, we think it's important to recognize those who are providing PDCM, but may not meet the VBR threshold
  - PDCM providers will be eligible for outcomes based VBR (as defined on the next slide)
  - PDCM providers will also be identified on the BCBSM provider search tool
- 2019 - PDCM definition is >=1% of their patients with 2 or more PDCM codes billed
  - TCM codes will not count for the first 1% of the population. This can only be achieved using the twelve PDCM billable codes.
- 2020 – Definition will further evolve to include requirements around the relationship with care managers

PDCM Value Based Reimbursement: New Approach

		Measurement Criteria	
Measurement Year	**Payment Period**	**PDCM Population Management VBR (5%)** *replaces current 5% PDCM VBR*	**PDCM Outcomes VBR (6%)** *replaces current 5% Advanced Practice VBR*
2019	**9/1/2020-8/31/2021**	**3% + 2 Touches***	**Quality and Utilization**
2020	**9/1/2021-8/31/2022**	**4% + 2 Touches***	**Quality and Utilization**

- PCMH designation required to receive PDCM VBR
- All PDCM PUs are eligible to receive the Outcomes VBR based on performance or improvement; does not require Population Management VBR
- Performance for the 2019 measurement year will be evaluated at the SubPO level; in the future, there may be an opportunity to measure at the PU level for larger practices (smaller practices would still roll up to the sub-PO level)
  - If a SubPO has too few cases, the analysis will roll up to the PO level

* *TCM codes will only count toward population management VBR when there are PDCM codes for >=1% of the population*

Questions?