VALUEPartnerships
Better Care. Better Outcomes. Better Value.

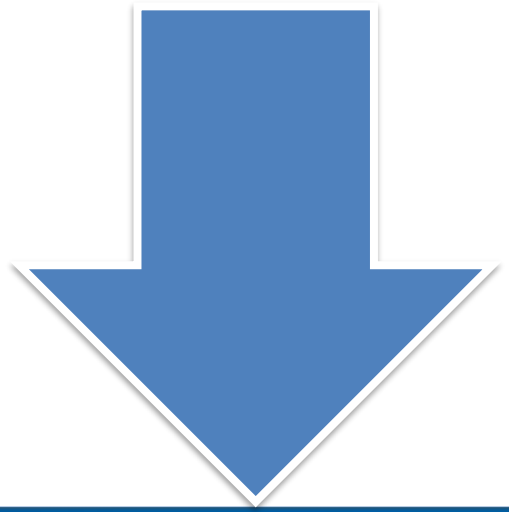
BCBSM Vision for Team-Based Care

Karolina Skrzypek MD
Medical Director
BCBSM

What is the goal of team-based care?

BETTER

- Measurable outcomes
- Patient experience
- Support for physicians to manage growing patient panels



LOWER

- Cost
- Unnecessary utilization of ED
- In-patient admissions resulting from unmanaged chronic conditions

PCPs are being pulled in every direction

- Physicians are constantly pulled in every direction
- An average PCP's panel size is 2,300, making delivering high-quality care very difficult
- Estimates suggest that patients receive only 55% of recommended chronic and preventive services
- Care teams are vital to supporting physicians and their patients.
  - **The team-based model can help distribute patient care among the interdisciplinary team to allow for high quality care and better management of the entire patient panel**
- Ensuring care managers are functioning at the top of their licensure and fully utilized, such as managing schedules as supported by the BCBSM scheduling initiative and the scorecard

Offices utilizing care teams significantly impact cost and quality

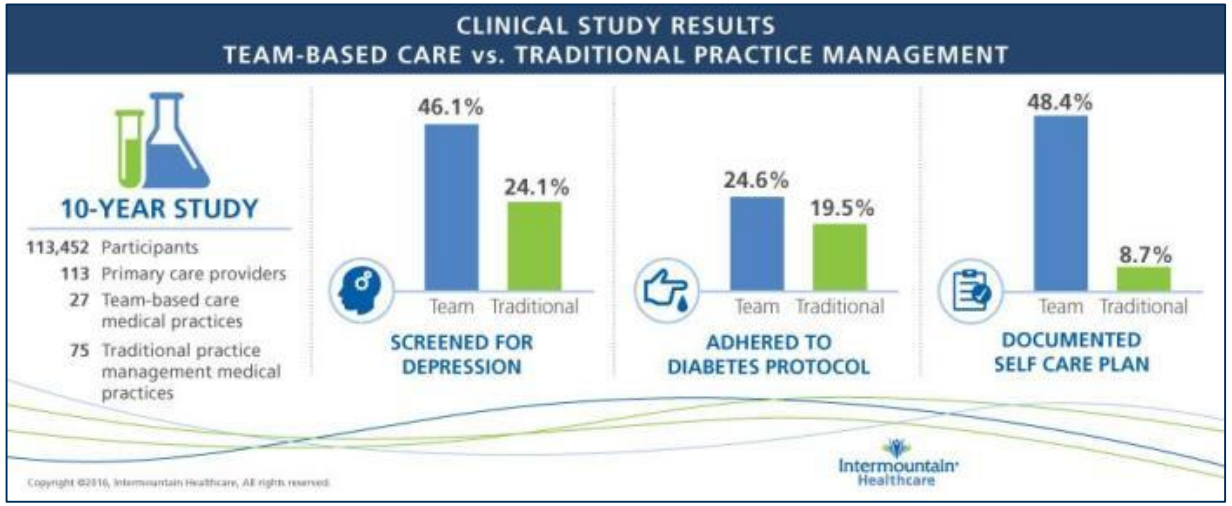
The Department of Health and Human Services (HHS) states that “by 2030, 25 percent of the U.S. population will be 60 and older, and 19 percent of the population will be 65 years of age and older. At least 90 percent of those 65 and older now have one or more chronic conditions.”

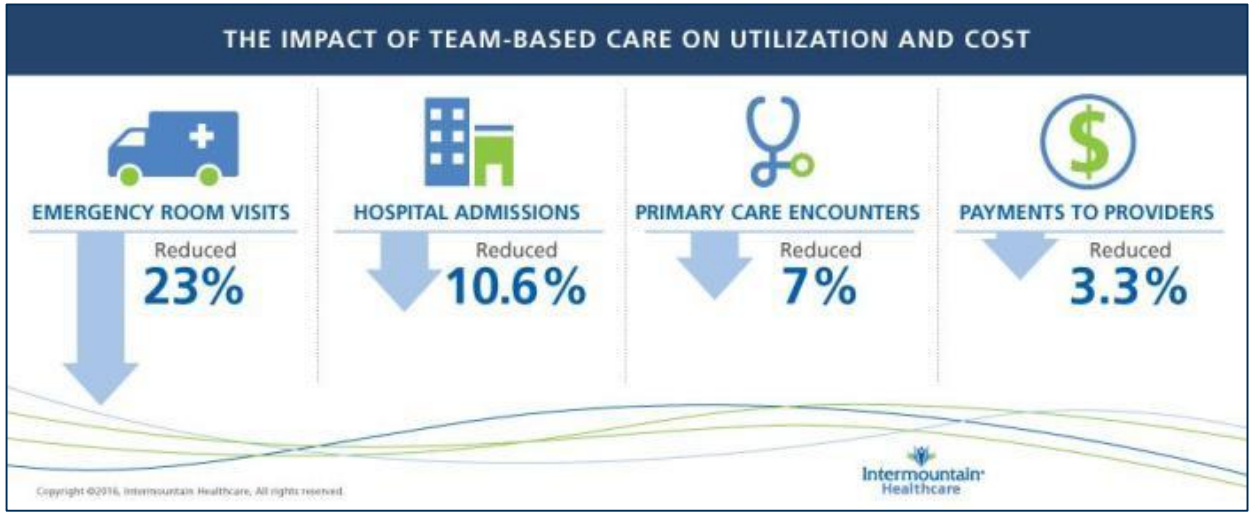
Care management delivers benefits to the aging population and those patients with chronic conditions by:

- Reducing treatment costs
- Reducing the rate of hospitalizations
- Eliminating unnecessary and redundant testing
- Managing medications to prevent adverse interactions
- Involving the patient’s family and community to boost emotional well-being
- Ensuring the primary care physician maintains a complete picture of the patient’s overall health
- Enabling the provider to properly manage all care, improving outcomes for the patient

National outcomes of team-based care vs traditional practice management

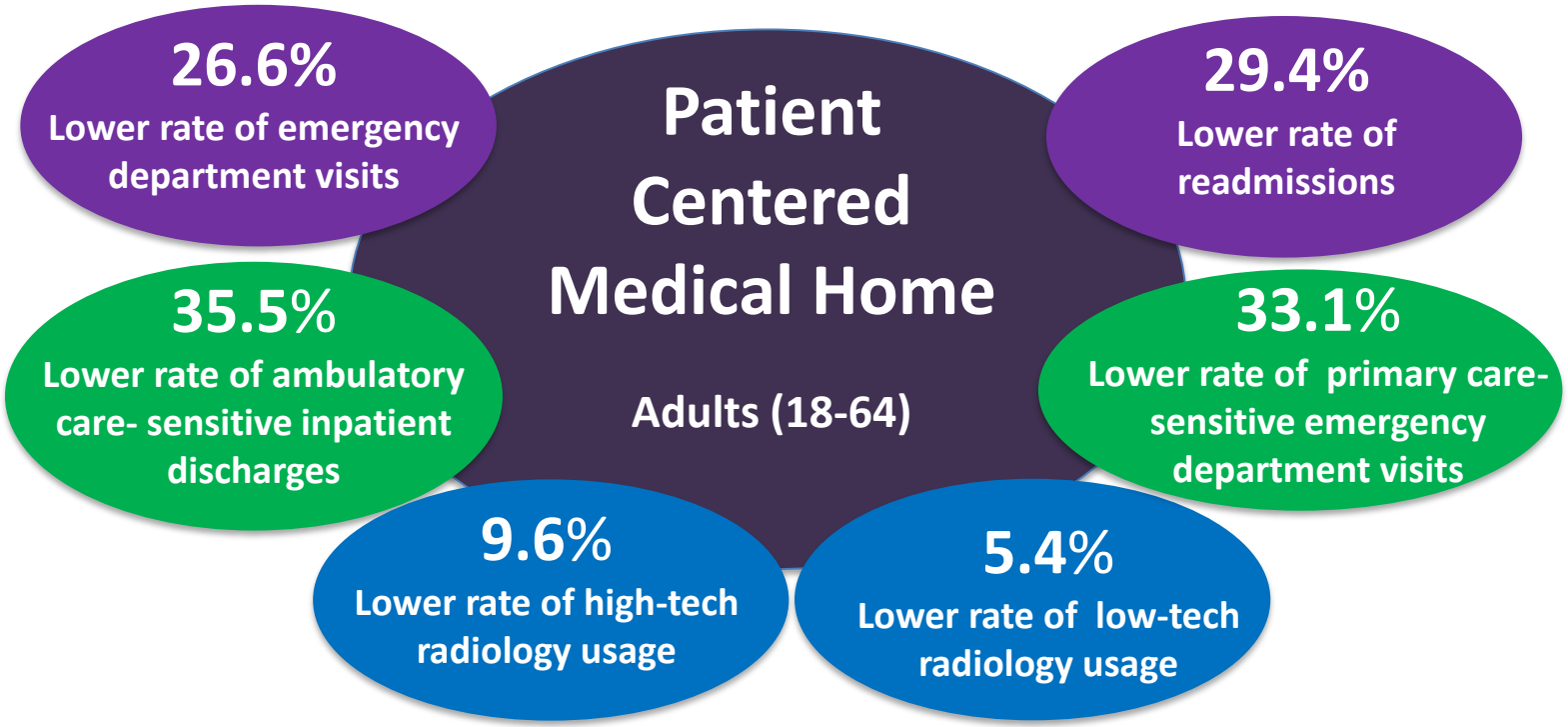
Study conclusion and results: Receipt of primary care at team-based care practices compared with traditional practice model practices was associated with higher rates of some measures of quality of care, lower rates for some measures of acute care utilization, and lower actual payments received by the delivery system



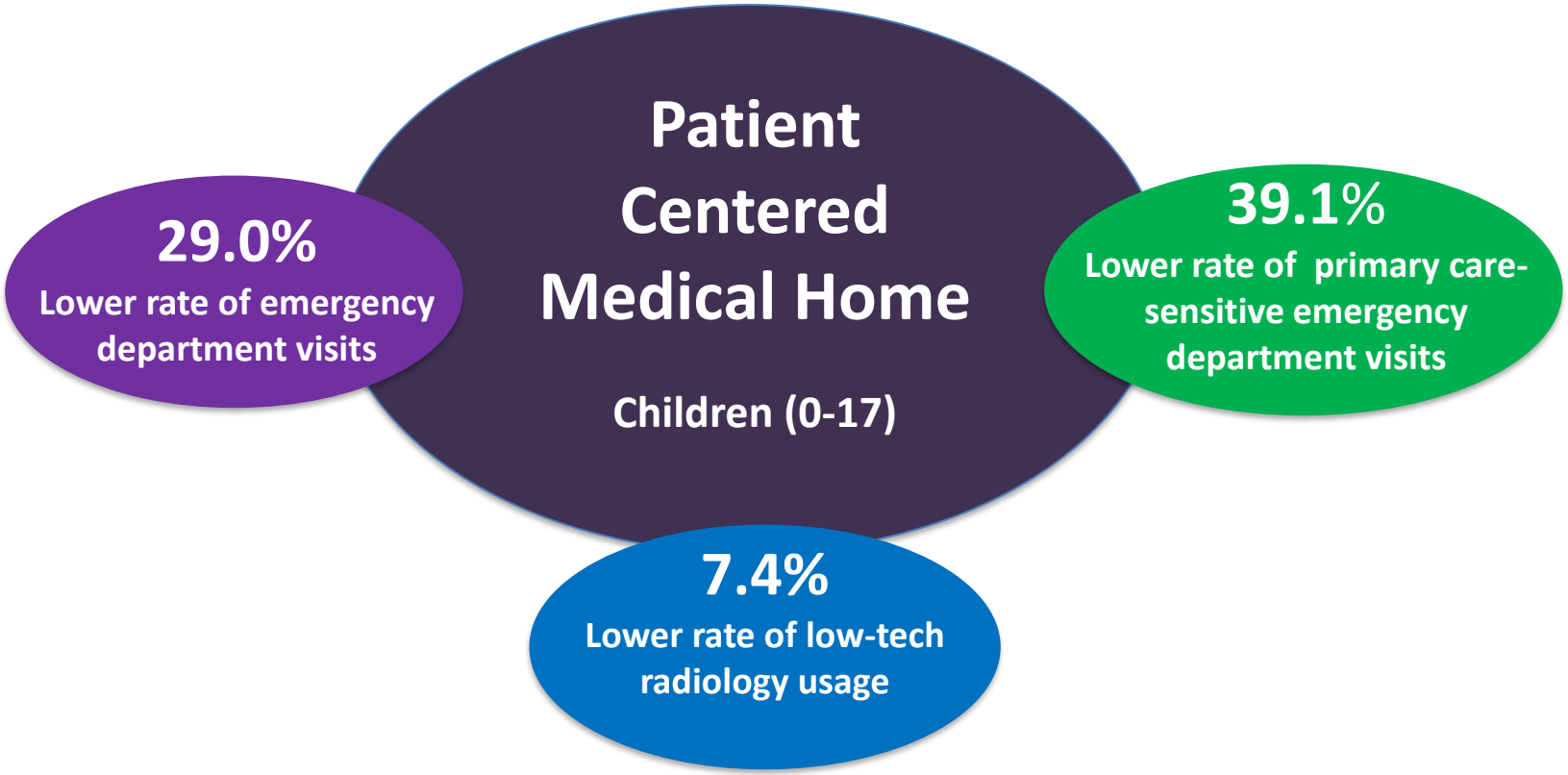


https://intermountainhealthcare.org/blogs/topics/research/2016/08/new-jama-study/
https://jamanetwork.com/journals/jama/fullarticle/2545685

2020 Performance, for PCMH designated practices compared to non-PCMH designated PGIP practices



2020 Performance, for PCMH-designated practices compared to non-PCMH designated PGIP practices

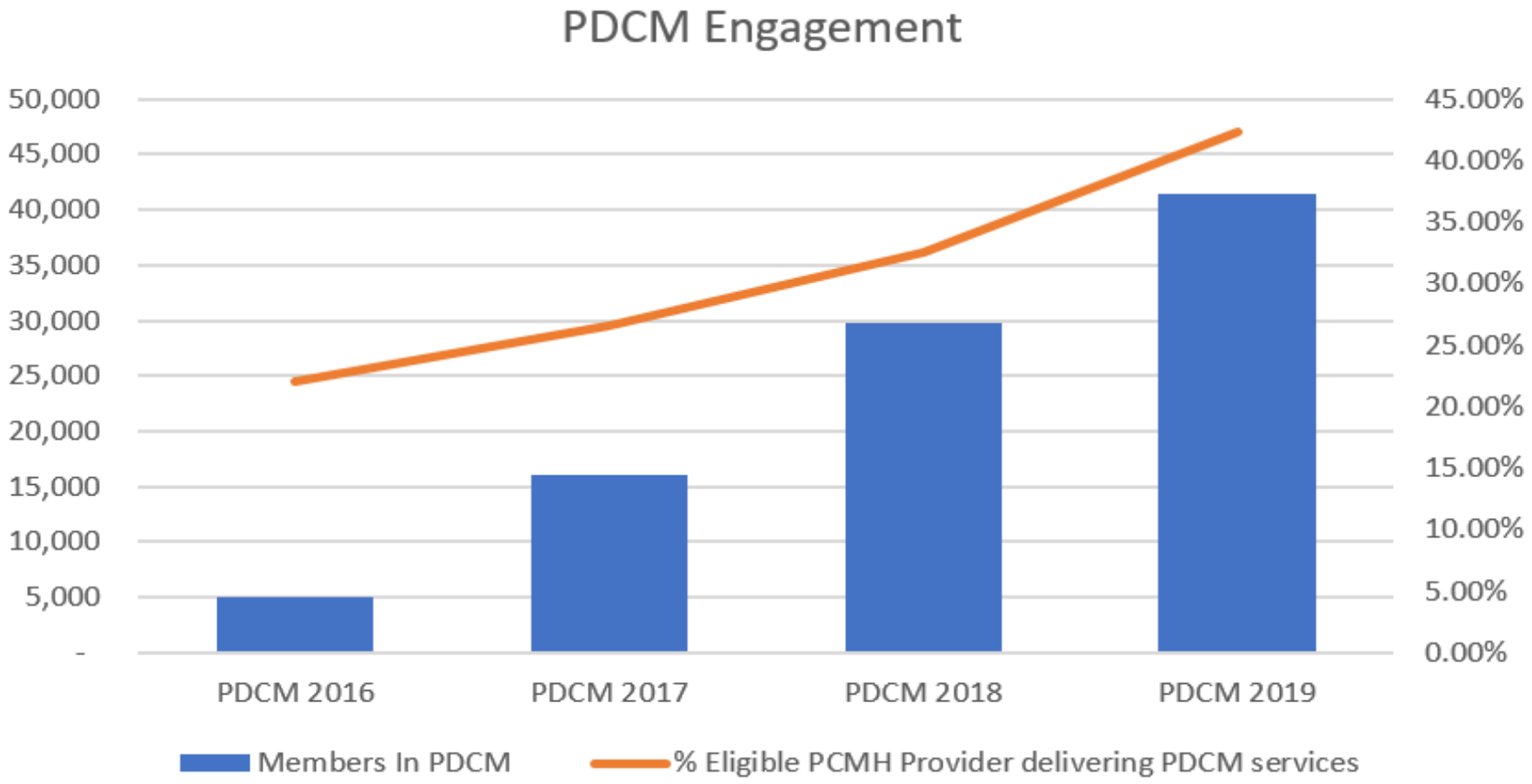


PCMH is foundational to PDCM

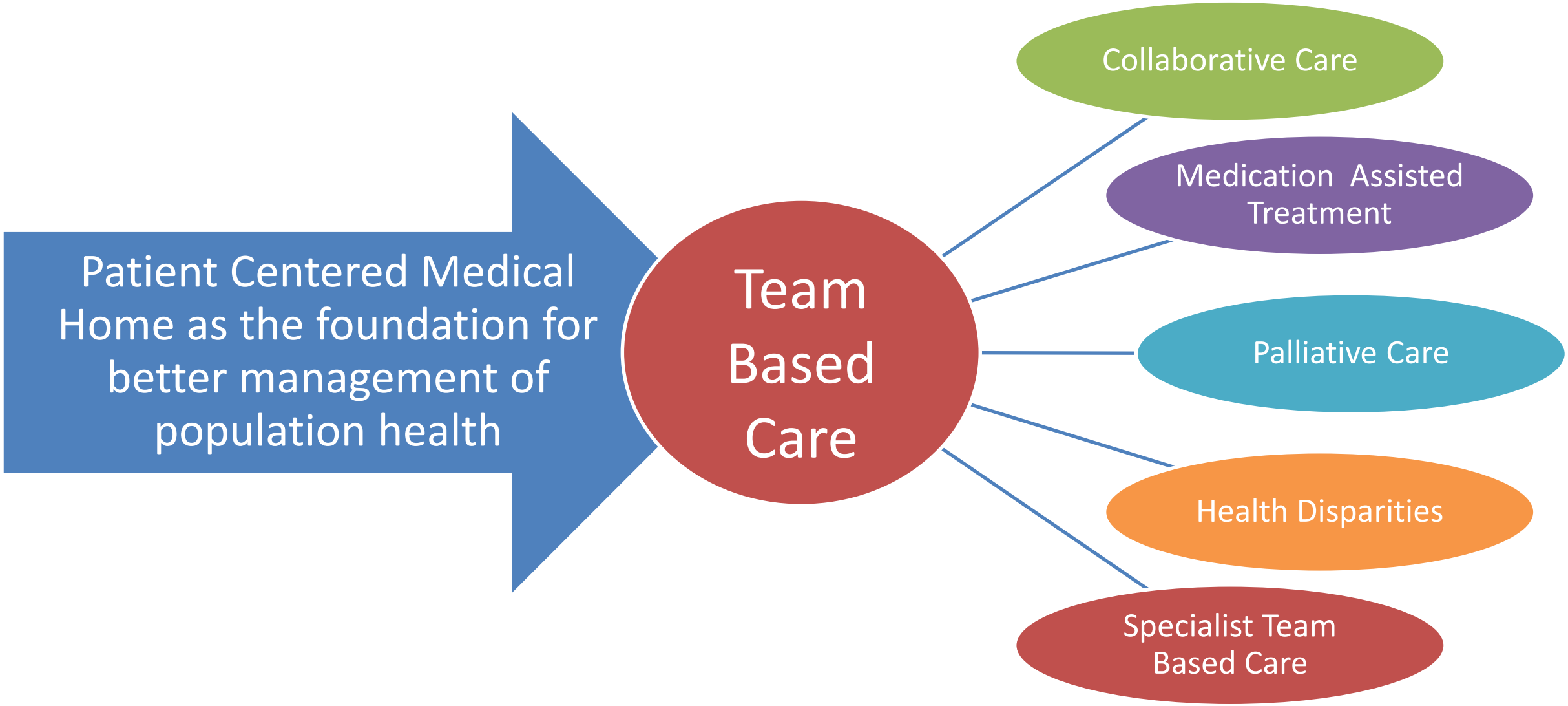
- Patient-Centered Medical Home model is the foundation of Provider-Delivered Care Management
  - PCMH specifically addresses implementation of care management tools/resources/ capabilities
    - Multi-disciplinary care team; coordination between specialists and PCPs; self-management support for chronic condition patients; individual care management
  - Providers must be PCMH designated or CPC+ recognized to deliver PDCM (or a specialist who meets training and capability requirements)

Efforts to grow PDCM services are paying off!

The number of members engaged in PDCM has steadily increased year over year



PCMH supports PDCM which enables better care in many areas



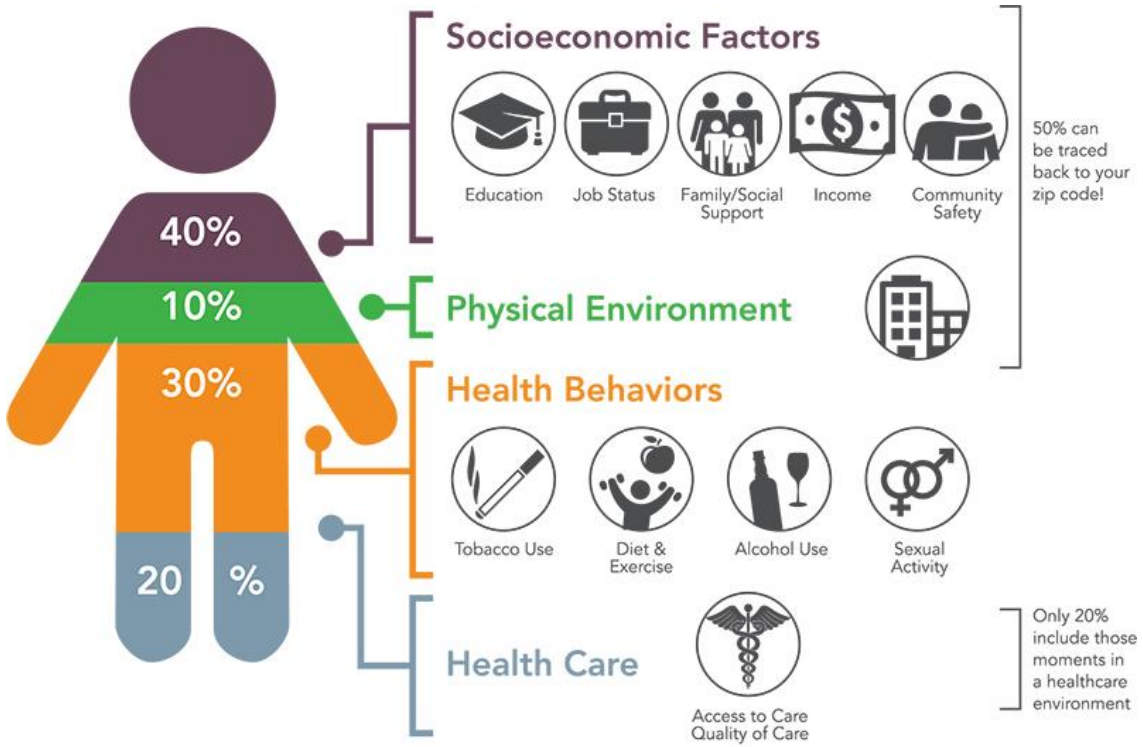
Cost and utilization savings attributed to PDCM

PCMH practices utilizing PDCM as compared to PCMH only practices have demonstrated

- 7.2% lower primary care sensitive ED utilization and 5.8% lower for pediatric population
- 11.5% lower ambulatory care sensitive inpatient utilization
- 2.1% lower rate of high-tech radiology services
- 2.5% lower rate of low-tech radiology services
- 1.9% lower rate of low-tech radiology services in the pediatric population

Estimated PDCM Cost Savings, Commercial Population, 2018

Social determinants of health



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

- It’s estimated that as much as 80% of a person's health can be attributed to factors other than heath care
- Care teams bridge the gaps of disparities which affect health and health care by
  - creating vital linkages to community resources
  - support the appropriate sharing of information to identify needs and build resources to address them

PDCM flexibility to accommodate COVID-19

In response to the COVID-19 pandemic, Blue Cross Blue Shield of Michigan has extended the following changes for PDCM:

The following professional provider fee increases have been extended through November 30, 2020 :

- G9001
- G9002
- G9008

Updated amounts for all services listed above may be found in web-DENIS under the "Fee Changes" page.

Care coordination services that typically must be delivered in a face-to-face setting can be delivered via telemedicine (audiovisual or telephone). PDCM procedure codes *98961, *98962, G9001 and G9002 are affected by this temporary change.

Guidelines for telehealth services

- CMS expanded telemedicine services under the 1135 waiver authority and for Coronavirus Preparedness and Response Supplemental Appropriations Act for the duration of the public health emergency for COVID-19
- Allowed the use any audio-visual functionality including mobile phones using video chat applications including FaceTime, Zoom for Healthcare and Skype.
- Facebook Live, Twitch, or TikTok not allowed.
- Documentation requirements have also been temporarily relaxed during the COVID-19 public health emergency.

PGIP is making it easier to deliver care management services

Enhanced Provider-Delivered Care Management (PDCM) fees by temporarily increasing the fee schedule on PDCM codes by 20%

Relaxed criteria to allow all PDCM services to be delivered virtually, through video-audio or telephone-only delivery methods

Encouraged providers to conduct outreach and engage chronically ill patients in virtual care management

Many of these members would typically be completing in-person visits to address their chronic conditions

Connected hospitalized patients, in isolation, with their families to promote care coordination and assessed the need connecting members to behavioral health resources

2020 Metric scoring results by measure

Total Practices	PDCM Practices	PDCM / PCMH Practices
2047	549	541

Measure Description	Total Practices Eligible	Practices Earning VBR Count	% Eligible Practices Earning VBR	Earned Performance VBR	Earned Improvement VBR	Practitioners Earning VBR Count
IP Discharges (per 1000 members per year)	538	499	92.8%	494	387	1872
ED Visits (per 1000 members per year)	541	317	58.6%	176	281	1091
High Blood Pressure	541	541	100%	541	0	1954
Comprehensive Diabetes Control: HbA1c < 8%	540	513	95.0%	493	263	1897

2020 Metric scoring results by VBR earned

% VBR Earned	Practice Unit Count	Practitioner Count
2	7	19
4	51	92
6	171	761
8	312	1082
Total	**541**	**1954**

Changes for 2021

- Adult Category High Blood Pressure Measure will be scored on Performance and Improvement
- Addition of 3 Pediatric Category Measures
  - ED Visits
  - IP Visits
  - Pediatric Composite including:
    - Medication Management for People with Asthma age 5-11
    - Medication Management for People with Asthma age12-18
    - Follow-Up After Emergency Department Visit for Mental Illness
    - Follow-Up Care for Children Prescribed ADHD Medication - Initiation
- Performance Thresholds are based on internal modeling rather than industry benchmarks
- Measures will be both age category and practice type specific

PDCM outcomes VBR for 2022

- To allow practices to focus on their performance and improvement on the current measures in the PDCM Outcomes program, Value Partnerships will NOT be making any changes to the metrics or analytic methods for the 2022 payment cycle (based on CY 2021 claims).

Metric	Age	Performance Threshold	Lowest/Highest Potential Rate	Improvement
ED Encounters (per 1000 members per year)	Adult	175 encounters (per 1000 members per year)	55	10%
ED Encounters (per 1000 members per year)	Pediatric	164 encounters (per 1000 members per year)	55	10%
IP Encounters (per 1000 members per year)	Adult	45 encounters (per 1000 members per year)	15	8%
IP Encounters (per 1000 members per year)	Pediatric	13.5 encounters (per 1000 members per year)	1	9%
HbA1c Control < 8%	Adult	70%	0.98	10%
High Blood Pressure	Adult	70%	0.98	10%
MMA; ED for MH; ADHD C&M	Pediatric	To Be Determined	To Be Determined	N/A

Questions