Provider-Delivered Care Management

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How to Reach Us

- Submit an issue through the Issues Log on PGIP Collaboration site
- Check out the announcements page or the Initiative pages, also on the collaboration site
- Email valuepartnerships@bcbsm.com
- Email us directly (least preferred method, unless you have so many attachments/questions it's unwieldy to use the issues log)

Patient-Centered Medical Home (PCMH)

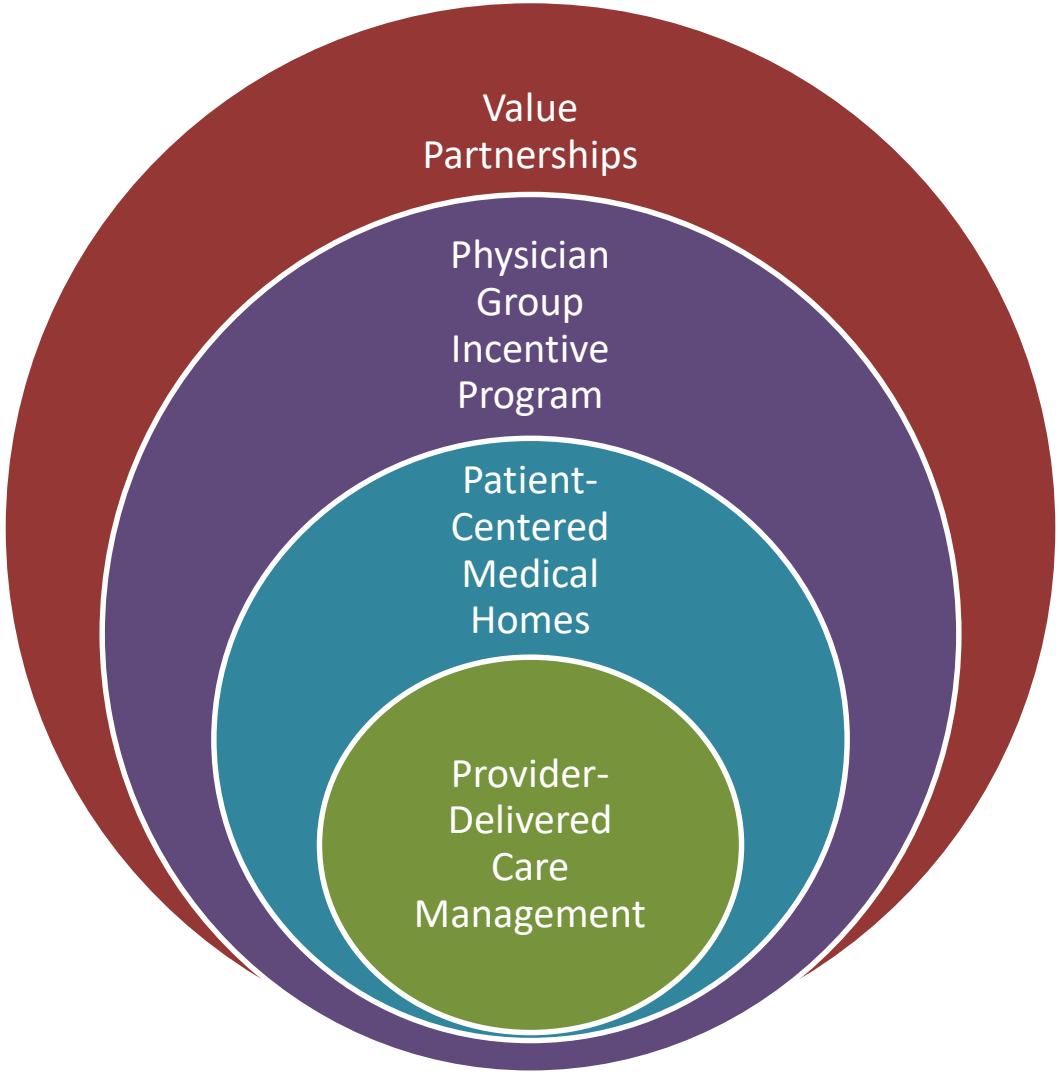
“What is a PCMH?” In 20 Words or Less

Core Features

- Personal Physician
- Physician-directed Medical Practice
- Whole Person Orientation
- Care is Coordinated and Integrated
- Quality and Safety
- Enhanced Access
- Payment Reform
- Transforming Practices

Provider-Delivered Care Management (PDCM)

How Do PCMH and PDCM Interrelate?



What is Provider-Delivered Care Management?

Primary care physicians lead multi-disciplinary care teams in the PCMH

Care managers and qualified health professionals deliver services to patients with chronic conditions

Expands traditional health-plan delivered care management; convenient for patient, maximizes existing relationships

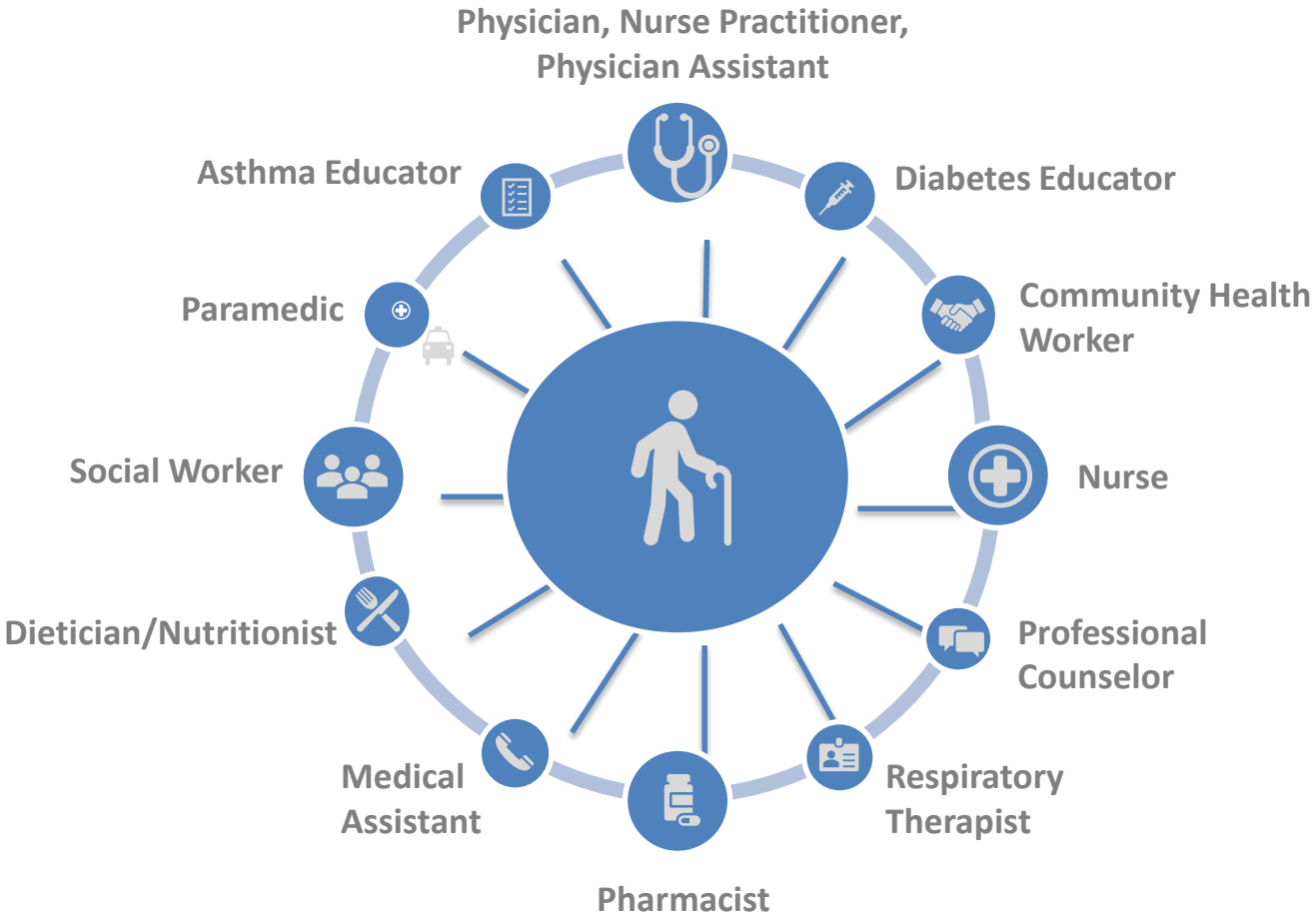
No diagnostic restrictions; available to adults and peds; intervention includes groups, face-to-face, and phone visits

PDCM expanded to specialists in July 2017, provided they meet program criteria

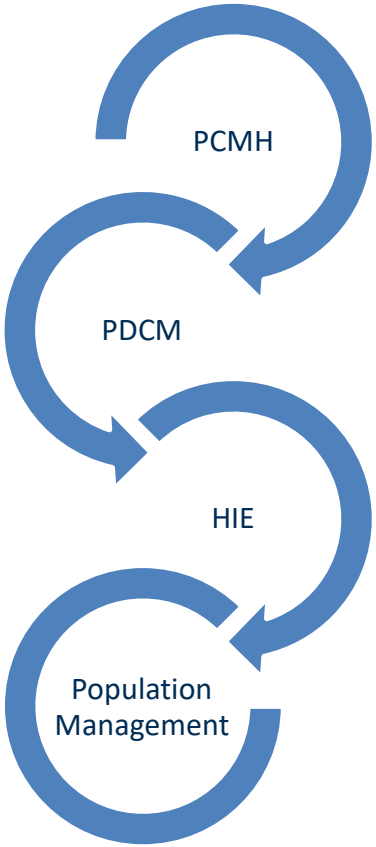
PCMH is Foundational to PDCM

- 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)

Expanded PDCM Care Team



While PCMH is Foundational, PDCM and use of HIE are Next Steps for Practice Evolution to Effectively Manage Populations and Manage Risk



- These programs work synergistically to achieve better outcomes in population health management
- PCMH providers who are performing **PDCM <u>and</u> using HIE** are showing the best outcomes on lowering ED visits

PDCM: Two Ways to Participate

Billing PDCM Codes

- PCMH designated PCPs, selected specialists, or CPC+ non-designated physicians
- Care team meets Blue Cross staffing requirements
- For training info visit https://micmt-cares.org/training-requirements-framework

Earning PDCM Value-Based Reimbursement

- Meet all criteria to bill the codes, PLUS…
- PCMH designated
- Meet PDCM claims criteria
- Care team meet training requirements

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

2021 BCBSM PDCM Training Requirements

Required Training

All care team members new to BCBSM PDCM must attend the *Introduction to Team-Based Care course* and view the *BCBSM billing webinar*.

The course covers the critical components of getting started as a care team member.

Continuing (Longitudinal) Education

Every learner has to accomplish (8) credit hours of additional training per year.

These (8) credits may include:

1. Official continuing education credits for licensure
2. Approved PO-hosted meetings
3. Webinars/learnings on the MICMT website
4. Approved other courses

For training visit: www.micmt-cares.org
Questions: micmt-requests@med.umich.edu

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)

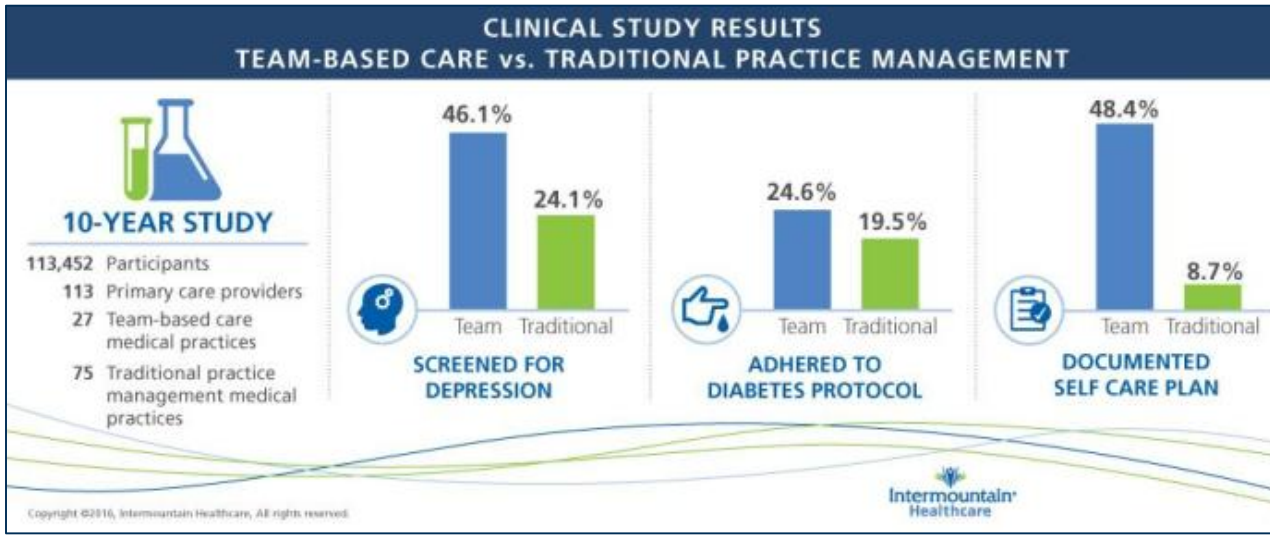
PDCM Claims Activity Reporting

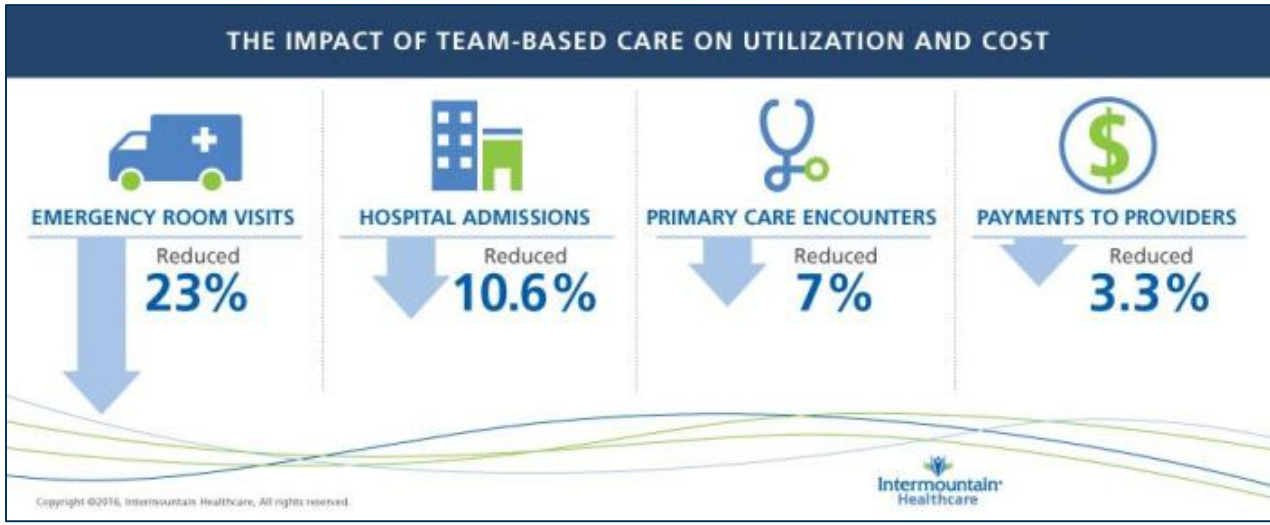
PDCM Claims Activity Reports are delivered into your EDDI folders, prepared by Michigan Data Collaborative (MDC)

- 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

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

Benefits of Team-Based Care and Collaborative Care Models

- Increased Primary Care Access
  - Frees up time for PCPs to focus on what they are uniquely qualified to do as physicians, increasing availability and access to care
- Reduced Primary Care Burnout
  - Higher levels of integrated care were associated with higher personal accomplishment and lower depersonalization for physicians, demonstrating that collaborative care may relieve PCP burnout.
- Reduced Inpatient Utilization
  - A literature review by McKinsey found that patients who receive integrated care have a 19% reduction in hospital admissions

Researchers Investigate Primary Care Professional Burnout. Root Cause: Underutilized Team Based Care
January 2018 , AAFP

Team Based Care: Saving Time and Improving Efficiency
November 2014, Family Practice Management

Associations Between Integrated Care Practice and Burnout Factors of Primary Care Physicians
2018, Family Medicine

Implementing Optimal Team Based Care to reduce Clinical Burnout
September 2018, National Academy of Medicine

Elements of Team Based Care in a PCMH are Associated with Lower PCP Burnout Among VA Primary Care Employees
April 2014, Journal of General Internal Medicine

In Closing, Michigan Providers Have Made Tremendous Strides in the Last 12 Years

As of August 2020 –

85% of the PGIP-participating primary care physicians are **PCMH designated**

- **1,696 practices**
- **4,644 PCPs**

Questions?