MICMT Annual Meeting: Q&A Summary
October 8, 2021

PO Spotlight Q&A

PO Question	LPO	United Physicians	Integrated Health Partners	Holland PHO	MedNetOne
Are your CM's employed by the PO?	No	Yes	Integrated Health Partners (IHP) currently employs three RN Care Managers and one RN Population Health Manager responsible for supervising CM. The RNs are deployed in practices based on contractual agreements between the practices and IHP. The remaining CMs cited on the attestation are employed within the practices.	Currently, only 1 is - the vast majority are employed by each practice. In the medical group, specialized care managers (Behavioral Health Specialists & Diabetes Educators) are actually "leased" to primary care from Holland Hospital Behavioral Health & Healthy Life Programs.	PO
How do you collaborate with health systems and/or employed medical groups in your regions?	We have long term-built relationships with the health systems and individual specialists employed by larger medical groups.	N/A	While IHP is primarily comprised of independent practices, we do actively work with two groups of hospital-employed practices to deliver CM services. With the health systems, we have implemented joint efforts around practice improvement and collaborative care management projects to address ED use and improved transitions of care communication. IHP has deployed CMs in two hospital-based practices, working closely with hospital and ambulatory care leadership throughout planning and implementation. IHP and the hospital systems have established joint administrative committees to ensure necessary opportunities for communication and action.	Holland Hospital Medical Group accounts for roughly half of our network, otherwise the PHO collaborates with other networks through a group called "West Michigan Clinical Sharing Group" which includes Spectrum, Metro, Affinia, Wexford/Crawford, Cherry Health and Holland PHO.	We have a relationship with a hospital system downriver where we work collaboratively with their team on preventing readmissions for patients that belong to physicians in our PO.

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Are you taking all payer approach or provide CM services to patients with BCBSM (or payers that reimburse for PDCM)?	Our offices that have just started focused mainly on BCBSM while starting their program.	For CPC+ practices we do offer services to all payers.	In general, focusing on payers incentivizing or reimbursing for CM services is necessary to sustain CM programs. IHP practices actively use care management eligibility and priority lists to identify patients for CM. However, if a patient is identified who would benefit from CM and whose payer does not cover CM, the patient may be enrolled depending upon individual practice policies.	Majority is all payer (CPC+) however there is a strong focus on payer care management initiatives (BCBS PDCM & PH, SIM in the past)	All patient all payer. We try to prioritize proactive outreach to PDCM eligible members and provide more longitudinal care for eligible members. For acute care, we provide baseline intervention and then refer elsewhere for continued care when it makes sense to do so.
Do any of your care managers provide Chronic Care Management services/billing along with PDCM?	N/A	No	IHP has one practice that provides chronic care management services in scope based on FQHC/RHC rules.	Yes	Not currently
For those of you that use centralized CMs, how do they document their interactions? Is there a central EMR or do they all have access to each individual practice's system - if they are different	N/A	N/A	IHP does not use centralized CMs.	For our one PHO Care Manager, she has access to the medical record but still uses a PDF assessment for her encounters that gets faxed to practice for billing/reconciliation purposes, and they scan to chart.	Our centralized care managers document in our EHR. However, many have remote EHR access to the practices they support to review patient's charts prior to the visit/outreach.

PO Spotlight Q&A

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How did you get initial physician engagement and how do you finance your program?	We started to get initial physician engagement when we had personalized meetings with them and their staff and discussed their specific patients and how they could start small and gave exact examples of what they are already doing that is considered billable PDCM services. We did offer a $3000 incentive for any office that met PDCM eligibility for 2020.	Highlighted during the meeting (see recording)	When care management was initially rolled out, the Executive Director met with each individual practice to discuss the program and benefits. Subsequently, IHP engages providers in care management through physician-led meetings targeting clinical and cost performance improvement, data reporting, PCMH, care management, and best practice sharing. Care management is discussed (and unblinded data shared) at these meetings, with the overall goal to improve performance. Physicians are encouraged to share their experiences and care management programs with other physicians and practices. IHP also engages physicians through a practice coach model. Every affiliated practice is assigned a practice coach with expertise in data analysis and process improvement. Working in partnership with IHP clinical staff, the coaches identify practices with opportunities for care management implementation. Ongoing data sharing with physicians and practices demonstrates impact of care management on practice revenue. Care management is financed through billable encounters and payer incentives/VBR. Practices entering into care management agreements for embedded IHP care manager pay an hourly rate for services.	We charge a Care Management Assessment fee for targeted payer attribution; the fee varies whether the site employs their own care management (to cover PHO support) or they lease our care manager. We essentially "tax" their incentive earnings on CM. When you are careful to right-size your program (# FTE), include targeting based on risk, and prioritize payer incentive targets, Care Management can improve both revenue to the practice and quality performance.	Payer incentives and billing care management codes; Education and understanding team-based care is crucial to initial physician engagement. Guiding this process and setting actionable achievable goals to implementation is key. It does not happen overnight!

PO Spotlight: United Physicians

Is your model centralized? How much time do care managers spend onsite?	We utilize a hybrid model
Do your dietitians bill PDCM vs NMT codes?	PDCM
Are those care team member numbers FTEs or individuals?	FTE's
Are all of the care team members employed by the PO or are some employed by the individual practices?	Yes. Additionally, some practices have employed their own care managers.
Do each of your practices utilize different EMRs? I think you mentioned Athena, is that the EMR you use at the PO level? how do your care managers document their interactions?	Yes, we use Athena at the PO level, all of our care managers document within our EMR. Some of our practices do use different EMR's as well.
Do your lead CM have a case load? How do you prioritize the work for your CM, especially with COVID?	Yes, they have a case load. Work is completed as a team based on patient needs.

PO Spotlight: Integrated Health Partners

Do the practices employ all those nurses?	Integrated Health Partners (IHP) currently employs three RN Care Managers and one RN Population Health Manager responsible for supervising CM. The RNs are deployed in practices based on contractual agreements between the practices and IHP. The remaining CMs cited on the attestation are employed within the practices.
How are you measuring outcomes at the practice level? What outcomes are you tracking and how are you able to relate the outcomes to the impact of care management v. other work going on at the practice?	We appreciate the question regarding ability to relate outcomes to care management interventions. Without controlled studies, we are unable to establish a causal relationship between care management interventions and improved outcomes. However, we can examine trends pre- and post-care management implementation. While this is not scientific, we believe it reflects the overall care management process in the practices, including team-based care and enhanced processes. We are excited to learn about the work MICMT is conducting to understand the impact of CM interventions (frequency and type) on population and patient outcomes.
You have 33 nurses over how many sites? Are these care managers, triage nurses- are they all focused on CM or are they doing other work?	The CMs are deployed over 24 practice sites. Models and CM assignments and scope vary by site.
What CM metrics are you tracking?	See Appendix A

PO Spotlight: MedNetOne

For some of the smaller groups: it looks like you have some large teams: how do you determine the FTE of CM for each site?	We initially followed the staffing model that was suggested for MIPCT. We adjusted days/hours of staff based on patient and practice engagement and utilization of care management. We start conservatively and increase as necessary to avoid having to "scale back" staff. We are all patient/all payer.
I heard doing G9001 on same day as 99495/99496, I thought billing TOC codes encompassed all care management codes during the 30-day TOC period and that CM codes should not be billed during this time, please clarify.	Our care managers are PO employed. The providers render and bill TOC visit and care managers often scheduled initial face to face appointments following these visits, often on the same DOS. I know the TOC codes encompass the medication reconciliation code and initial post discharge call, but this is the first I have heard that care management codes, including the G9001 could not be billed within a 30-day window. To my knowledge, there is no discrepancy billing these codes on the same DOS.
I would like to hear about how you are utilizing MA to support this work.	We have had a handful of medical assistants and community health workers complete the required care management training. We utilize the unlicensed care team members for care coordination and linkages to community resources. We also have unlicensed care team members provide coaching calls to check in on patient's goals/action plans between care management appointments and ensure patients are getting required services and understand how services relate to their condition/overall health.

BCBSM Specialty Team-Based Care Program Q&A

Will there eventually be an expectation of Outcomes for STBC?	There is an expectation of outcomes to earn VBR. Following the first round of participating in the program, specialists are expected to have a specific amount of PDCM billing for their BCBSM population. So, the pilot providers (Cohort 1), who started in 2020, to be eligible for the 3/1/22 STBC VBR, a practice must bill PDCM codes for at least 4% of a predetermined population during the measurement period (November 1, 2020 through July 31, 2021). The population includes all BCBSM PGIP Attributed Commercial and MA members determined using Care Relationships that align to the claims service dates used for analysis. As of now, incentives are based on the population receiving PDCM touches. At this point we do not plan to expand this to an Outcomes VBR.
As you are not adding specialties in 2022, is there any thought about adding OB/GYNs in the future, particularly high-risk pregnancies?	We do not anticipate adding any additional types of specialists for 2022. When we revisit this for 2023, we can consider OB/GYNs.

Presenter Contacts

Presentation	Presenter	Organization	Contact
PO Spotlight	Mary Ellen Turk Ashley Sumara	United Physicians	mturk@updoctors.com asumara@updoctors.com
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BCBSM Specialty Team-Based Care	Sheri Lee	BCBSM	SLee2@bcbsm.com
Pharmacist Optimizing Oncology Care Excellence in Michigan (POEM)	Emily Mackler	MICMT and MOQC	estunteb@med.umich.edu https://www.moqc.org/poem
Integrated Michigan Patient-Centered Alliance in Care Transitions (I-MPACT)	Grace Jenq	I-MPACT	Gjenq@med.umich.edu
Michigan Collaborative for Type 2 Diabetes (MCT2D)	Caroline Richardson	MCT2D	https://www.mct2d.org/

Appendix A

IHP Reporting Metrics	IHP-level	Practice-level
# of billed CM codes and status to VBR (by payer)		X
# and % of practices qualifying for VBR (by payer)	X	
# of CM codes billed and breakout (%) by code	X	X
Average number of CM touches (billed CM codes) per eligible patient	X	X
Number of unique patients by number of touches (1, 2, 3, 4, 5-9, 10+)	X	X
# and % of patients with >= 3 conditions with no CM codes billed (patient list also provided)	X	X
Number of patients with specific conditions with CM codes billed	X	X
# and % of G9001 billed for patients with >= 3 CM codes billed	X	X
# and % of G9002 billed for patients with >= 3 CM codes billed	X	X
ED utilization	X	X
IP utilization	X	X
HbA1c control	X	X
BP control	X	X
Office visit within the past 12 months (related drill-down to above)	X	X
CM revenue generated (VBR and billable codes)	X	X