VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

Population Health and Management of Complex Patients

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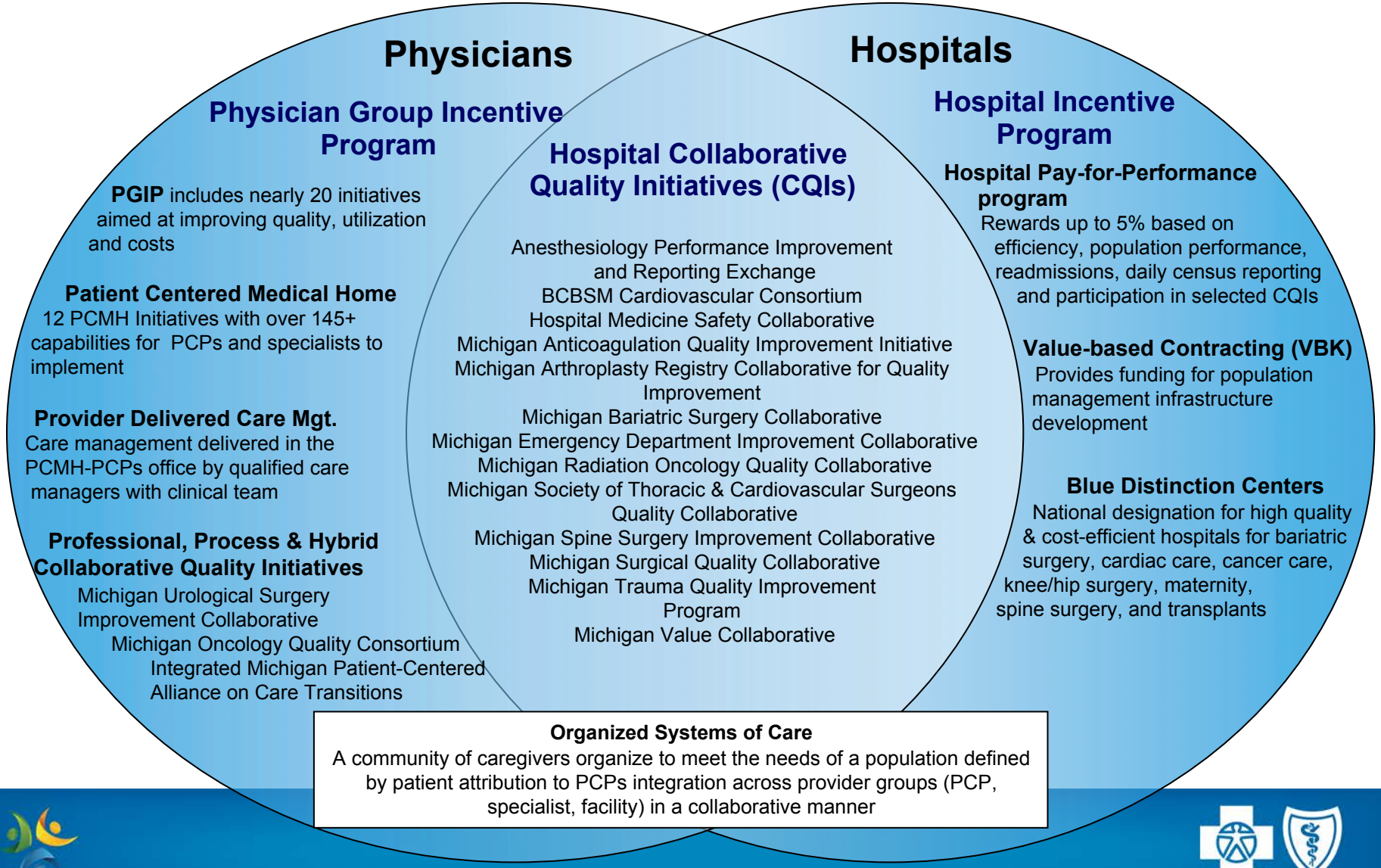
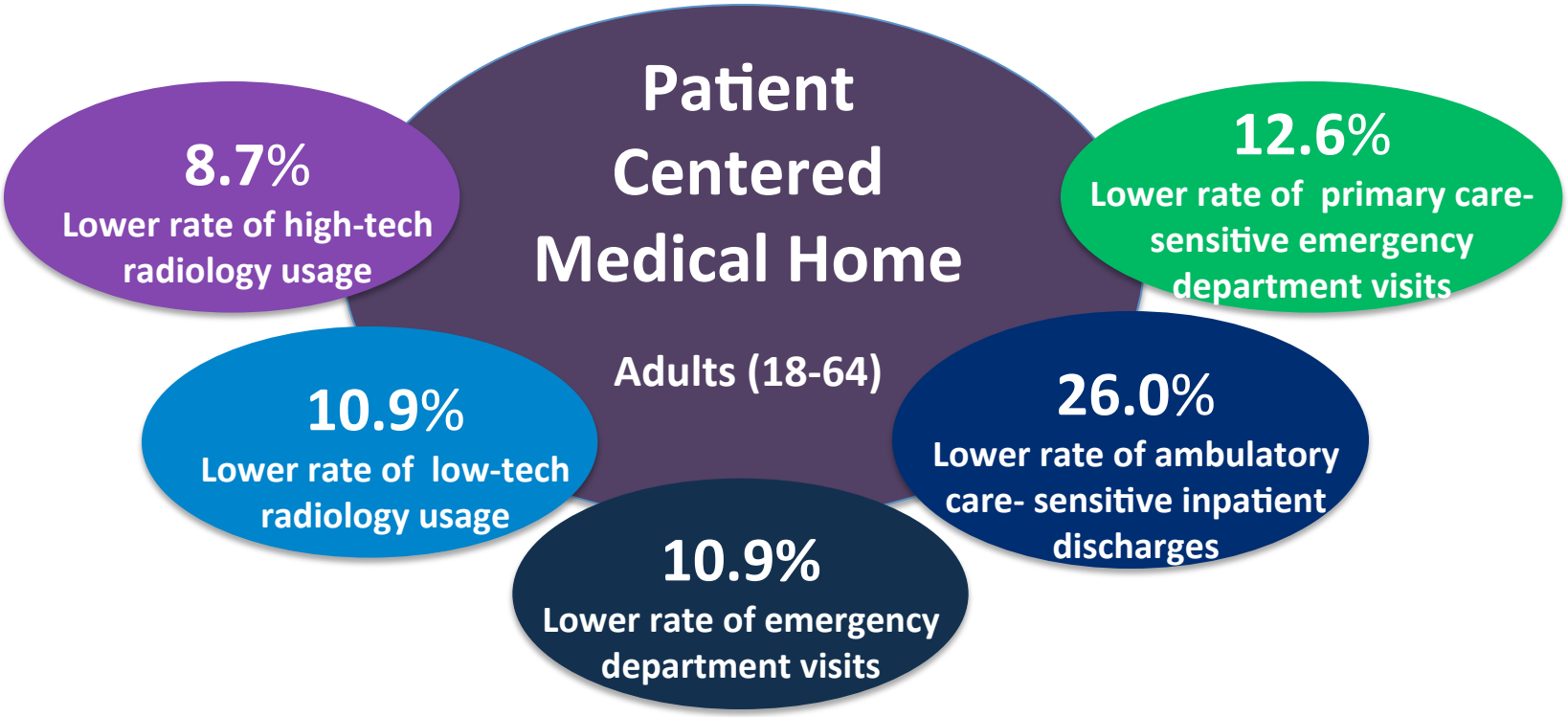
May 19, 2017

BCBSM Value Partnerships Programs

Moving from *Fee for Service* to Fee For Value

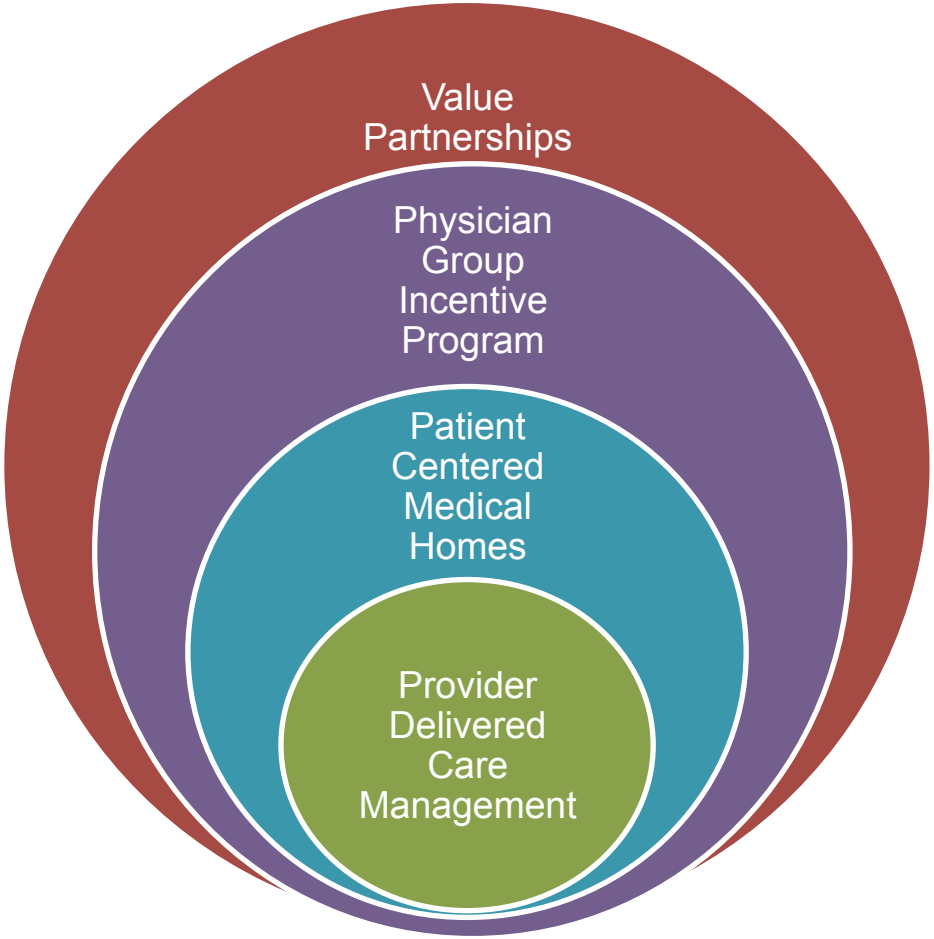


2015 Performance comparisons, for PCMH-designated practices compared to non-PCMH designated PGIP practices



Provider Delivered Care Management

Part of our Value Partnerships Programs



What is Provider Delivered Care Management?

Primary care physicians lead multi-disciplinary care teams in the patient-centered medical home

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

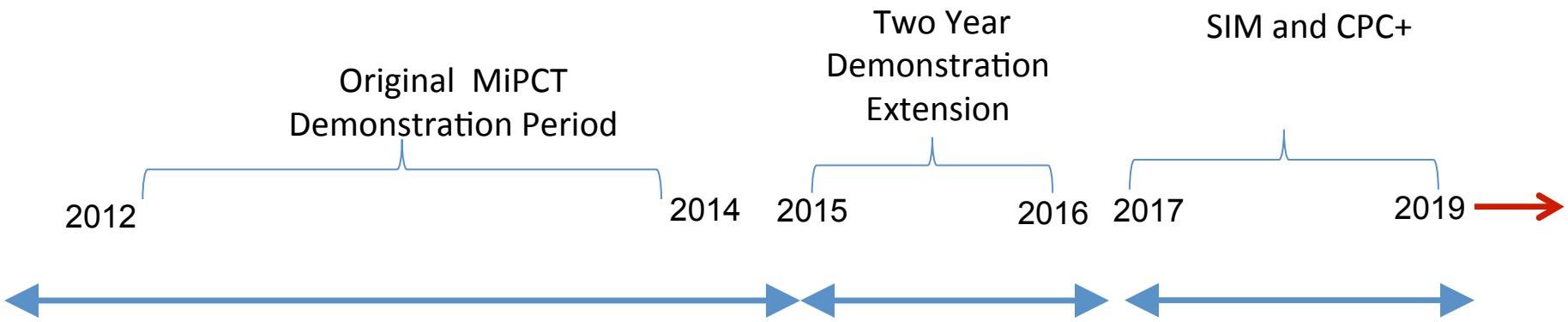
No diagnostic restrictions; available to adults and peds; intervention includes groups, face-to-face, and phone visits

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

Provider Delivered Care Management: History

2010-2012	2012-2016	2015-Present
• PDCM Pilot • 5 regions across Michigan; 5 physician organizations; 50+ practices with 258 PCPs • Tested reimbursement, intervention, data exchange, effective models	• Michigan Primary Care Transformation Project (MiPCT); Michigan one of eight states in the Multipayer Advanced Primary Care Practice (MAPCP) demonstration Project • Over 1,900 physicians in 350 practices across MI, plus over 300 nurse practitioners and PAs • Ended on 12/31/16; practices then were "absorbed" into PDCM	• All PCMH designated physicians eligible to deliver care management and bill PDCM codes, effective 7/1/15 (ongoing process). • Practices meeting additional criteria may qualify for value-based reimbursement for PDCM (annual process) • Expanding to key specialists on 7/1/17

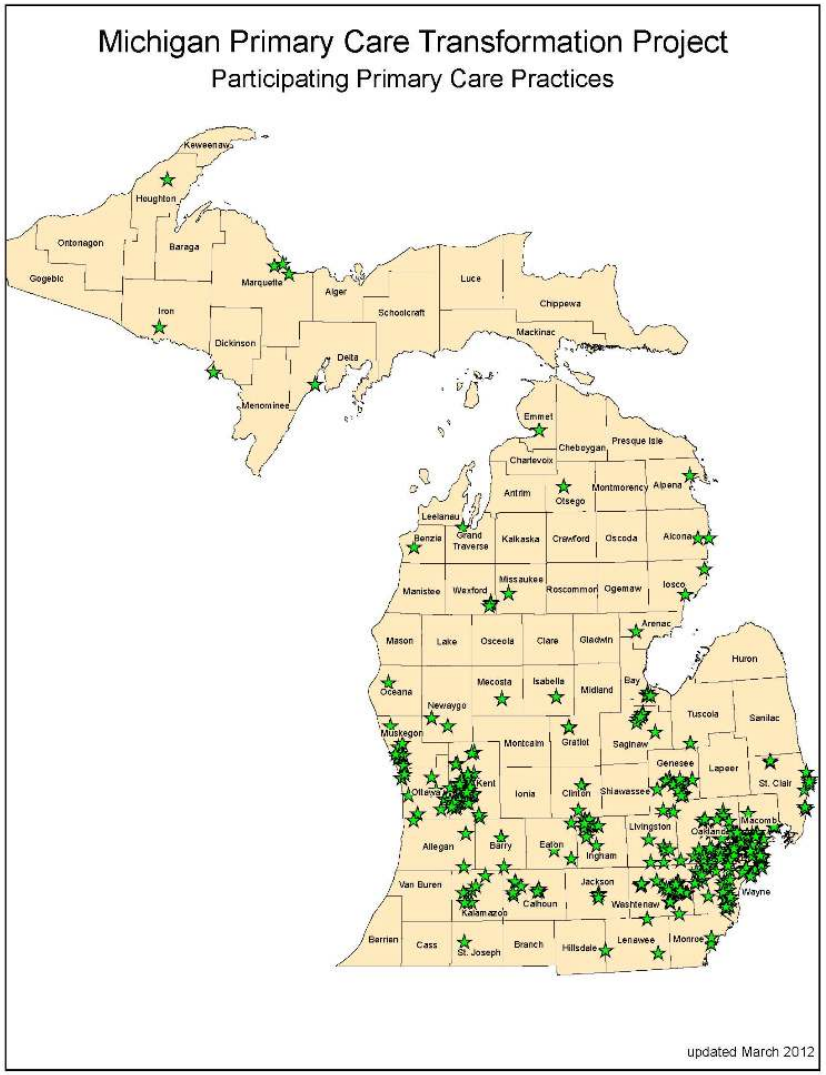
BCBSM's Participation in Multi-Payer Initiatives



- Michigan Primary Care Transformation Project (2012-2016)
- State Innovation Model PCMH Pillar (2017-2019)
- Comprehensive Primary Care Plus (2017-2021)

MiPCT Participants

- 350 practices
- 37 Physician Organizations (POs)
- 1,953 PCPs
  - 303 are NPs and PAs
- 1.2 million patients
  - Medicare (16%)
  - Medicaid managed care plans (19%)
  - BCBSM (35%)
  - BCN (20%)
  - Priority Health (11%)



Michigan Primary Care Transformation Project
Advancing Population Management

PCMH Services

Complex Care Management ***Functional Tier 4***	All Tier 1-2-3 services plus: ▪ Home care team ▪ Comprehensive care plan ▪ Palliative and end-of life care
Care Management ***Functional Tier 3***	All Tier 1-2 services plus: ▪ Planned visits to optimize chronic conditions ▪ Self-management support ▪ Patient education ▪ Advance directives
Transition Care ***Functional Tier 2***	All Tier 1 services plus: ▪ Notification of admit/discharge ▪ PCP and/or specialist follow-up ▪ Medication reconciliation
Navigating the Medical Neighborhood ***Functional Tier 1***	▪ Optimize relationships with specialists and hospitals ▪ Coordinate referrals and tests ▪ Link to community resources

Prepared Proactive Healthcare Team
Engaging, Informing and Activating Patients

PCMH Infrastructure

Health IT
- Registry / EHR registry functionality *
- Care management documentation *
- E-prescribing (optional)
- Patient portal (advanced/optional)
- Community portal/HIE (adv/optional)
- Home monitoring (advanced/optional)

Patient Access
- 24/7 access to decision-maker *
- 30% open access slots *
- Extended hours *
- Group visits (advanced/optional)
- Electronic visits (advanced/optional)

Infrastructure Support
- PO/PHO and practice determine optimal balance of shared support
- Patient risk assessment
- Population stratification
- Clinical metrics reporting

*denotes requirement by end of year 1

P O P U L A T I O N M A N A G E M E N T

Emphasis on Care Management Features Associated With Positive Outcomes

- Care delivery by multidisciplinary teams
- Care delivery in collaboration with PCP
- Attention to care transitions
- Medication reconciliation
- Both in-person visits and telephonic encounters
- Patient selection important - Risk stratification plus PCP input

Provider Delivered Care Management: Patient Selection and Engagement

- **Patient selection:**
  - Participating practices are provided with a claims-based patient list which includes risk score and utilization (inpatient, ED, etc.) information
  - Patients with "very high" risk score are flagged
  - Patients are selected for care management based on a combination of claims and clinical data, with PCP and team input

- **Patient engagement:**
  - Most successful if PCP encourages patient to participate in the program
  - Care management can be tailored to the member's specific needs:
    - Registered Nurse, Social Worker, or Nurse Practitioner/Physician Assistant acts as "lead" care manager
    - Other team members include PharmDs, behavioral health, registered dieticians
  - Emphasis on patient goal-setting and self management support
  - Frequent communication between care team members and PCP

Michigan Care Management Resource Center (MiCMRC)

- Collaboration between BCBSM and University of Michigan
  - Additional funding from other payers through multi-payer projects
- Foundational curriculum, ongoing webinars, in-person sessions
- Mentoring system for care managers
- "Care Management Connection" monthly newsletter
- Facilitate "best practice" presentations
- Additional curriculum and toolkits:
  - Integrating Behavioral Health
  - Palliative care
  - Addressing Social Determinants of Health
- Over 800 care managers trained to date
- www.micmrc.org

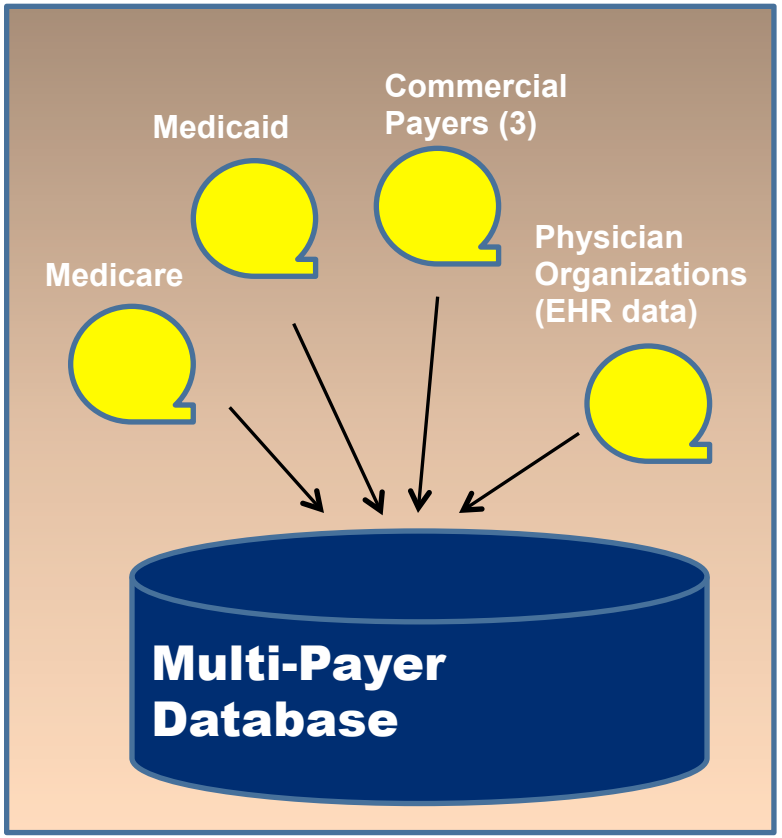
Complex Care Management Training Curriculum

- Fundamentals of Complex Care Management
- Care Management – 5 Step Process
  - Screen, enroll, assess, manage, case closure
- Community resources
- Care transitions
- Care coordination
- Medication reconciliation
- Identification of High Risk Patients
- Specific Assessment Tools
- Health Plan Payment Policy
- Evidence based care
- Care Manager visit documentation tools

Michigan Data Collaborative (MDC): Multi-Payer Database

Collect data from multiple Payers and aggregate it in one database

- Creates a more complete picture of a patient's information when they:
  - Receive benefits from multiple insurance carriers
  - Visit physicians from different Practices, Physician Organizations or Hospitals
- Phase 1 – claims data
- Phase 2 - claims and clinical data



MAPCP Program Results: BCBSM

- BCBSM conducted a recent study on the PDCM program (January 2017). Practices included those participating in MAPCP.

- When examining a treatment group of 3,799 members versus a matched comparison group that also had 3,799 members, found the following results for 2014:
  - The treatment group had **$144.17 lower PMPM medical costs** than the comparison group
  - The treatment group had **37.9 fewer emergency department visits per 1,000 members** than the comparison group
  - The treatment group had **40 fewer inpatient admits per 1,000 members** than the comparison group

MAPCP National Results: Medicare

State	MAPCP Demonstration states		Total MAPCP Demonstration fees	Net savings in Years One and Two	Return on fee investment
	Eligible beneficiary quarters in Years One and Two	Gross savings in Years One and Two			
New York	157,032	$12,637,119*	$3,258,078	$9,379,041	3.88
Rhode Island	60,214	$5,795,880	$1,009,374	$4,786,506	5.74
Maine	247,558	-$32,518,083	$7,238,571	-$39,756,696	-4.49
Minnesota	106,616	-$19,553,595	$1,258,309	-$20,811,903	-15.54
North Carolina	152,322	$9,955,916	$4,166,490	$5,789,426	2.39
Michigan	1,518,542	$380,069,806*	$43,964,835	$336,104,971*	8.64
Pennsylvania	217,997	$4,906,765	$3,916,170	$990,594	1.25
Vermont	381,814	$35,699,155	$8,603,828	$27,095,327	4.15
Total	2,842,095	$396,992,963	73,415,655	$323,577,266	5.41

Savings are for Medicare patients attributed to providers in the Michigan Primary Care Transformation Project (MiPCT) for 2012 and 2013. Study conducted as part of the national Multi-Payer Advanced Primary Care evaluation, of which Michigan was a participant from 2012-2016.
Source: Research Triangle Institute

New BCBSM Program - High Intensity Care Model

- BCBSM program designed to target high cost Medicare Advantage members
  - To date, implemented by 8 physician organizations (6 in SE MI, 2 in W MI)
- Builds on PCMH, PDCM and other population health strategies
- Clinical model based on Indiana University program: Geriatric Resources & Assessment for Care of Elders (GRACE)
  - Majority of services are home-based, delivered by dedicated teams composed of NP/RN & MSW
  - Additional team members include pharmacist, nutritionist, LPN, and medical director
  - Team has access to patient's electronic health record and regularly confers with PCP
  - Comprehensive care plans include valuable information gathered from visits to the patient's home, including family/caregiver input, that enhances PCP's ability to manage patient
- Standardized Care Team training provided through MiCMRC

HICM Targeting Criteria

Targeting method component 1: chronic disease comorbidity

- Determine the number of chronic conditions each member has from a list of 35 chronic diseases.

Targeting method component 2: indicators of high utilization or poor care management::

- Number of acute inpatient hospital stays in 12 months
- Number of emergency department visits in 12 months, 0-30 days after which ≥1 of the following occurred:
  - Another emergency department visit OR an acute inpatient hospital stay
- Number of visits to a specialist in12 months
- Number of distinct generic class numbers (GCNs) dispensed in 12 months
- Information from Medicare Advantage Health Assessment:
  - Member responded 'fair' or 'poor' to "In general, would you say your health is:")
  - Member reported needing help with activities of daily living
  - Member reported losing weight without trying over 6 months
- Facility + professional PMPM costs 24 months

The two components are combined to develop a weighted risk score

Early Evidence of Positive HICM Impact on Patients and Providers

- Participating Physician Organizations (POs) report HICM is having very positive impact:
  - Significantly improved medication adherence and management
  - Avoided repeat use of the ER
  - Avoided admissions and readmissions
    - One PO reported decrease in admissions among HICM engaged members from over 130/1000 to 20/1000, and decrease in ER admissions from 17/1000 to zero.
  - Strengthening patients' relationship with PCP
  - Guiding patients into palliative care at an earlier point
- POs report high patient satisfaction and often dramatic impact on patients' health and quality of life
- Care managers love HICM - very dedicated to patients
- Average program cost: $235 PEPM
- More data needed in order to perform robust evaluation