Behavioral Health Collaborative Care Model (CoCM) PGIP Initiatives and Opportunities.

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Etiquette

- You have not been muted on entry, so please mute your phones!
- When asking questions:
  - Send questions in the chat feature
  - Our team will moderate the session
- When speaking:
  - Please minimize background noise
  - Use either phone or computer audio, but not both
- The session is being recorded

Agenda and Objectives

- Review the collaborative care model (CoCM)
- Review rewards/incentives available to PGIP POs and practices implementing the model
- Review the expectations of POs and practices

Disclosure

- The Michigan Center for Clinical Systems Improvement (MiCCSI), Michigan Institute for Care Management and Transformation (MICMT), and Michigan Collaborative Care Implementation Support Team (MCCIST) have been contracted by Blue Cross Blue Shield of Michigan for this project.

Mi-CCSI Center for Clinical Systems Improvement

Michigan Collaborative Care IMPLEMENTATION SUPPORT TEAM

MICMT Michigan Institute for Care Management & Transformation

Blue Cross Blue Shield of Michigan

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Overview of the Collaborative Care Model (CoCM)

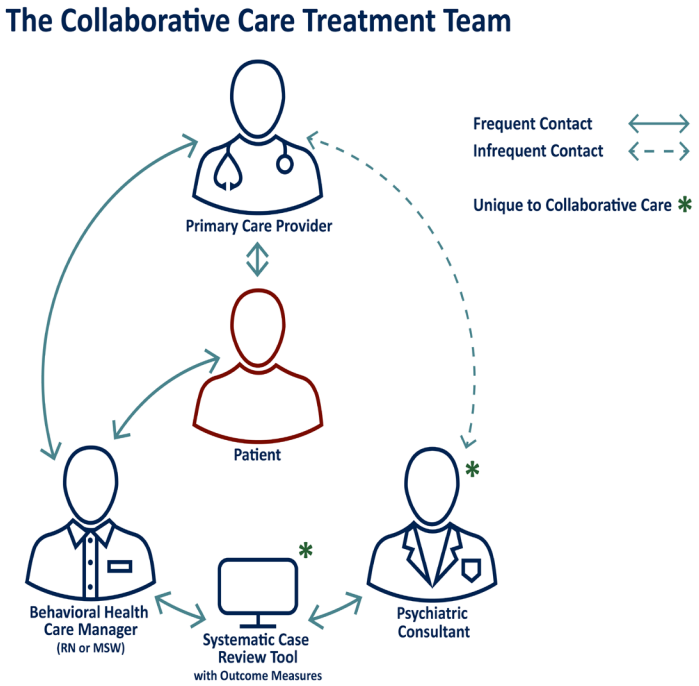
CoCM: An Overview

- Most evidence-based integrated behavioral health model
  - 80+ randomized controlled trials prove Collaborative Care provides significantly better behavioral health outcomes than “usual care”
  - 2002: First big trial was published (IMPACT study out of the University of Washington)
- Primary care-based: Meets behavioral heath need in patient’s medical home
- Patient improvements compare to those achieved in specialty care for mild-moderate conditions

Target population

- Highly evidence-based for adults with depression and anxiety
  - Depression and/or anxiety population served by primary care
  - Increasing evidence for adolescent depression, PTSD, and co-morbid medical conditions
  - More complex patients should be served in high-need clinics
- Defining the target population:
  - PHQ-9 and/or GAD-7 of 10 or more
  - Diagnosis of depression and/or anxiety
  - Just started on a new antidepressant, regimen was changed, or PCP could use prescribing guidance

The Collaborative Care team



- Operates through a patient-centered care team that shares a registry
- Team includes a PCP, behavioral health care manager (BHCM), and a consulting/advising psychiatrist
- The psychiatrist and care manager meet weekly – typically by phone – for 1-2 hours to review the BHCM's caseload of 60-80 patients with behavioral health issues identified through screening in the primary care office

- The PCP office bills the Collaborative Care codes and reimburses the psychiatrist; *the psychiatrist does not bill the insurer for his/her time*
- The psychiatrist's role is to advise the PCP and BHCM
- *The psychiatrist rarely sees the patient*; if they do, they will bill according to the member's behavioral health benefits

Components of the Evidence-Based Model

- Patient Centered Care
  - Effective collaboration between BHCMs and PCPs, incorporating patient goals into the treatment plan
- Measurement-Based Treatment to Target
  - Measurable treatment goals and outcomes defined and tracked for each patient (PHQ-9/GAD-7)
  - Treatments are actively changed until the clinical goals are achieved
- Population-Based Care
  - Defined and tracked patient population to ensure no one falls through the cracks
- Evidence-Based Care
  - Treatments are based on evidence
- Accountable Care
  - Providers are accountable and reimbursed for quality of care and clinical outcomes

Summary: What sets CoCM apart?

- Population health approach
  - Use of a systematic case review tool to ensure no one falls through the cracks
  - Proactive, tailored outreach, allowing for monitoring and updates in-between PCP visits
  - Treatments are adjusted until patients achieve remission or maximum improvement
  - Data evaluates key process measures and patient outcomes
- Maximizes access to limited psychiatry time
  - Multiple patients reviewed per hour as opposed to one patient
  - Helps reserve specialty psychiatry time for higher level cases
- Typically, a short wait time from referral to receiving an expert psychiatric recommendation (often within one week)

How Is Blue Cross supporting CoCM?

1. PGIP reward to POs
2. PGIP rewards to PCP practices
3. PGIP value-based reimbursement to PCPs
4. Blue Care Network (BHIP) rewards to psychiatrists participating in CoCM
5. PGIP support for CoCM training and ongoing practice support

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PGIP Rewards to Physician Organizations

POs Play a Vital Role in CoCM

PO incentives in first year:

- Base reward: $50,000
- Data/Tech reward: $10,000
- Per practice reward: $4,000 per practice

PO incentives in second year:

- Base reward: $25,000 **
- Data/Tech reward: $10,000
- Per practice reward: $4,000 per *new* practice

** *New reward: Based on PO feedback*

2 PGIP rewards to PCP practices

New practices

- $1,000 base reward
- Variable rewards based on training participation.

Fidelity practices

- $2,500 reward per practice deemed to be using the model with fidelity
- Variable rewards based on training participation.

3 CoCM Value-Based Reimbursement opportunities

105% VBR to PCMH-designated practices who deliver CoCM and meet VBR criteria.

- Available in addition to any other VBR the PCP is receiving
- CoCM cohorts will follow PCP VBR cycles beginning Sept. 1, 2021

3 What are the changes to CoCM PCP VBR?

Effective Sept.1, 2021 the following changes to the following will be implemented:

- Eligibility
- Criteria
- Timeline

3 What are the changes to CoCM VBR?

Updated eligibility criteria

For the 9/1/2021 through 8/31/2022 cycle, VBR will be available to practices who meet the following **by 8/31/2021**:

- Completed readiness assessments with their training partner and are found to be ready for training and implementation.
- Completed all required pre-work identified by the training partner.
- Scheduled to participate in the upcoming training offered by the training partner.

If a practice either doesn't go through training, or doesn't implement, VBR will be terminated.

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What are the changes to CoCM VBR?

Setting a progressive path to yield results

Focus by year

Year 1 – *Implementation/Training*
Year 2 – *Developing billing capabilities*
Year 3 – *Advanced billing/shifting focus to outcomes*
Year 4 – *Outcomes*

Regardless of when a practice begins training and implementation, criteria progress in years one through four.

This means that:

- Cohorts will overlap and have different VBR requirements during the same time period.
- Performance expectations are higher as a cohort gains knowledge, experience, and matures in CoCM delivery.

See the Behavioral Health initiative page of the PGIP Collaboration Site for full details.

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What are the changes to CoCM VBR?

Year 1 – Implementation and training

Criteria by year	
Year 1 Implementation/ Training	Training partner confirms the following and reports to Blue Cross: • Readiness assessments complete and practice found to be ready for training and implementation • Practice has completed all required prework identified by the training partner • Practice is scheduled to participate in a training offered by the training partner

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What are the changes to CoCM VBR?

Year 2 – Developing billing capabilities

Criteria by year	
Year 2 Developing billing capabilities	Practices must bill: • Ten paid CoCM claims. Must be a combination of initial and subsequent month services which include 99492, 99493 or G2214. 99494 is not included, as it is an add-on code.

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What are the changes to CoCM VBR?

Year 3 – Advanced billing and shifting focus to outcomes

Criteria by year	
Year 3 Advanced billing/shifting focus to outcomes	Practices must bill: • 48 paid CoCM claims Must be a combination of initial and subsequent month services which include 99492, 99493 or G2214. 99494 is not included, as it is an add-on code. Must demonstrate ability to track outcomes.

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What are the changes to CoCM VBR?

Year 4 – Outcomes

Criteria by year	
Year 4 Outcomes	Must meet billing requirements and 50% of those patients must meet one of the outcomes requirements Billing • Bill 60 paid CoCM claims. Must be a combination of initial and subsequent month services which include 99492, 99493 or G2214. 99494 is not included, as it is an add-on code. Outcomes • 5-point improvement in PHQ-9 and/or GAD-7 OR • 50% improvement in PHQ-9 and/or GAD-7 OR • PHQ-9 and/or GAD-7 less than 5 points

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What are the changes to CoCM VBR?

Which cohort is my practice in?

We have revised the Cohorts to align with the VBR cycle. This means that ramp-up and training activities generally starting between 9/1 of one year and 8/31 of the next year are in the same cohort. Cohort 1 started with an off-cycle VBR, so the dates are:

- Cohort 1 – Began training and implementation before 10/16/2020.
  - Year 1 VBR: 12/1/2020 through 8/31/2021. (This cohort had an off-cycle VBR period).
- Cohort 2 – Any practice that begins training and implementation between 10/17/2020 and 8/31/2021. (Start date impacted by previous off-cycle VBR period).
  - Year 1 VBR: 9/1/2021 through 8/31/2022
- Cohort 3 – Any practice that begins training and implementation 9/1/2022 through 8/31/2023
  - Year 1 VBR: 9/1/2022 through 8/31/2023
- Cohort 4 – Any practice that begins training and implementation 9/1/2023 through 8/31/2024
  - Year 1 VBR: 9/1/2023 through 8/31/2024

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What are the changes to CoCM VBR?

Timeline description

Measurement periods run 12 months, then allow an additional three months for **claim run out**. Blue Cross then requires three months to process performance on measurements and to **setup the next VBR cycle**.

These three months of Blue Cross processing time overlap with a new measurement period, ensuring that the practices will have continuous measurement periods with no gap between them.

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What are the changes to CoCM VBR?

VBR timeline

	2020	2021												2022												2023											
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cohort 1																																					
Year 1 (implementation/Ramp up)	VBR Year 1																																				
Year 2	VBR			Run-out			Processing			VBR Year 2																												
Year 3				VBR measurement year												Run-out			Processing			VBR Year 3															
Year 4																VBR measurement year										Run-out			Processing			VBR Year 4				
Year 5																										VBR measurement year											
Year 6																																					
Year 7																																					
Cohort 2																																					
Year 1 (Implementation/Training)	Implementation and training									VBR Year 1																												
Year 2				VBR measurement year												Run-out			Processing			VBR Year 2															
Year 3																VBR measurement year										Run-out			Processing			VBR Year 3				
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Year 3																																					
Year 4																																					

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Rewards to Psychiatrists

Blue Care Network's Behavioral Health Incentive Program

Blue Care Network will be providing a reward of $2,500 to BCN-contracted consulting psychiatrists

- Psychiatrists can receive multiple rewards if they consult with multiple practices, however we will reward no more than one psychiatrist for each practice

POs should provide name and NPI of psychiatrists who have been supporting the CoCM model for at least 60 days

- POs should indicate the names of the practices that are supported by the psychiatrist
- We will collect psychiatrist information in July and November
- This reward will be distributed to the psychiatrist's remittance address.

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Partners provide support for CoCM training and implementation

Who is involved and what do they do?

- **Michigan Institute for Care Management** and Training (MICMT):
  - Support training development
  - Ensure training and program is aligned with other care management programs
  - Help administer through hosting content on their website, conducting surveys, etc.
- **Michigan Center for Clinical Systems Improvement** (Mi-CCSI)
  - Training partner
- **Michigan Collaborative Care Implementation Support Team** (MCCIST)
  - Training partner
- Collaborating on curriculum, content, training development and support activities. Each training partner is working with assigned POs to provide the following to their practices:
  - Clinical training
  - Technical assistance
  - Tailored approaches to successfully implement and sustain CoCM services

MICMT
Michigan Institute for Care Management & Transformation

Mi-CCSI
Center for Clinical Systems Improvement

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

5 Upcoming opportunities – Introductory PO Webinar Series

This webinar series has been developed to give physician organizations an understanding of what CoCM is and what is needed to support your practices.

PO webinars	
CoCM: Data and Technology	June 15, noon-1 p.m.
CoCM: Organizing an Excellent Care Team	June 22, noon-1 p.m.
CoCM: Monitoring and Sustainability	June 29, noon-1 p.m.

Register at: https://micmt-cares.org/collaborative-care-model-cocm

5 Ongoing learning webinars for practices

These webinars have been developed for post-training practices to give them an opportunity to gain more information on a variety of topics.

Here is a sample of webinars that have been available.

Upcoming sessions and registrations are at:

https://micmt-cares.org/collaborative-care-model-going

https://www.miccsi.org/collaborative-care-model-training/

Motivational Interviewing
Behavioral Activation & Problem Solving
Building an Effective Systematic Case Review Process
BHCM Strategies for Running a Systematic Case Review
Patient Identification Process
Time Management and Caseload Tracking
Optimizing CoCM Data for Program Review
Advanced Topics in Psychopharmacology
Substance Use Disorder: Assessment and Brief Interventions
Billing Strategies
PCP Roundtables
Psychiatrist Roundtables

PO Expectations

How to help your practices

Be ready

- Learn about CoCM
- Complete readiness activities
- Identify champions
- Attend practice site visits
- Participate in CoCM training

Develop care team

- Consider workflows among practices
- facilitate shared care teams when appropriate
- Help identify or contracting with psychiatrist
- Help identify or hiring a BHCM

Promote tools and skills

- Develop systematic case review tool
- Establish workflows for routine and ongoing screening and evaluation
- Sponsor or promote quality improvement activities

Other PO expectations – related to reporting and review

Report	Used for	Frequency	Dates
Practice touch-base results – Excel spreadsheet that verifies that each practice is using CoCM *(new requirement)*	Ensuring appropriate practices are receiving VBR	Monthly	To training partners on the 1st of each month
Site visits – Two practice site visits with training partners and strongly recommend that practice's SCR is shadowed at least once by their training partner.	Ensures practices on track, to answers questions or address challenges. To offer planned opportunities for support.	Between 3 and 6 months post training. Between 9 and 12 months post training.	Varies
Psychiatrist reward information – Email NPI and name of consulting psychiatrist along with practices the psychiatrist supports	Calculating and rewarding consulting psychiatrists	Twice yearly	To PGIP via email July 31 and Jan. 31
Outcomes data tracking – Complete Excel template and upload to EDDI (contains PHI) Outcomes tracking template is posted on the PGIP Collaboration site.	Reviewing practice-level progress and reporting program progress	Twice yearly	To PGIP via EDDI July 31 and Nov 30

Outcomes data tracking tool

On PGIP Collaboration site

These elements would also be in the SCR tool. To access this template on the *PGIP Collaboration site*:

- Go to the *Behavioral Health* initiative page of the collaboration site
- *BCBSM Documentation* section on the left side of the screen
- Click *Outcomes data tracking tool*

Collaborative Care (CoCM) Outcomes Tracking Tool - Insert PO Name and data submission date

	Patient information						Plan information								CoCM entry information			Required PHQ information				
	Practice Name	First Name	Last Name	Birthdate	Gender	DUMMY IDENTIFIER	Comm PPO	MAPPO	BCN	BCNA	Other	NON-BCBS			Date of Referral to CoCM (DD/MM/YY)	Date of Enrollment in CoCM (DD/MM/YY)	If No, Reason (Refusal, No Response, Other)	Baseline PHQ 9 Score (0-27)	Date of Baseline PHQ-9 Score (DD/MM/YY)	Most Recent PHQ 9 Score (0-27)	Date of Most Recent PHQ-9 Score (DD/MM/YY)	Baselin GAD-7 S (0-21)
Blue Cross patients																						
Non-Blue Cross patients																						

- Use this spreadsheet to provide data that show practice outcomes as they use the Collaborative Care Model. Blue Cross is collecting data on both Blue and non-Blue patients to evaluate how a practice's whole population. Please add rows as applicable.
- We are not collecting patient demographic information for non-Blue members, but ask that you assign them a "dummy identifier" for tracking.
- This information *will not be used to determine value-based reimbursement eligiblity at this time* . Blue Cross is working with partners thoroughout the state to automate outcomes data as part of health information exchage work.
- Data submission is due each July 31st and January 31th.

Questions