Michigan Multipayer CPC+ Monthly Briefing

December 2017

This update is distributed to PO and ACN leaders to provide multipayer CPC+ information. This is intended to supplement, but not replace, information from CMS and its contractors about their upcoming events and CPC+ CMS requirements and expectations. The Michigan payers view POs and ACNs as important intermediaries in CPC+ success and are working with CMS and its contractors to leverage PCMH developments made to date in Michigan.

Michigan Multipayer CPC+ Steering Committee Holds First Meetings

The multistakeholder Michigan CPC+ Steering Committee has begun convening and held sessions on November 9th and December 14th in Lansing. The committee meets monthly to advance multipayer CPC+ success in Michigan. Topics discussed at the November 9th session included a review of the operational infrastructure that will support our multipayer work including regional convening, a multipayer data base and reporting, and coordination with training partners and CPC+ leadership. The December 14th meeting focused on gleaning lessons from the CPC Classic demonstration and regional vision brainstorming.

Commercial Payer Revenue Reporting to CMS

In the last edition, we provided information about commercial payer revenue reporting. Following is an update to this language (in yellow highlight) to further clarify reporting of BCBSM and Priority Health revenue:

> CPC+ practices receive revenue for the program from both currently participating CPC+ commercial payers. In the CPC+ Financial Reporting Guide, CMS requests that you report these as well as payment from CMS. Three types of payments are referenced: 1) Care management fees; 2) Medicare Fee for Service (FFS) applicable to CMS payment only; and 3) Alternative to FFS or FFS alternative payments. Since BCBSM and Priority Health began participation effective 1/1/17, any CPC+ payments received in the time period pertaining to the CMS request should be recorded. HealthScope Benefits will begin participating on 1/1/18 and thus has not yet generated payments for CPC+ services.
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> *For BCBSM*, the CPC+ Value-Based-Reimbursement (or VBR) payments you receive for CPC+ members (*this includes the PCMH VBR, Cost VBR, Clinical Quality VBR, PDCM VBR and PCMH3 VBR*) should be recorded as "Alternative to FFS or FFS alternative payments". If you have questions about these payments for your CPC+ members, please contact your Field Representative.
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> *For Priority, you receive a care management fee for CPC+ members. Under CMS' CPC+ payment terminology this care management fee encompasses both FFS reimbursement for billing care management codes, and the PMPM care management incentive. Please note that certain care management code claims submitted for services delivered are batched and paid by Priority every 60 days to allow for the claim to be processed and for any member liability to be removed. This important step allows for care management services to be delivered without members incurring financial liability, reducing barriers to engaging patients in care management. This batching/delayed payment process affects the following care management codes: G codes, telephonic CPT, and collaborative care management CPT codes. If you have questions about any of this information, please contact your Provider Performance Specialist.*

Optimizing Risk-Adjusted Reimbursement: Understanding Your Role
(one in a series of resource articles for CPC+ practices from Priority Health)

Risk adjustment is a process for using health data, such as a patient's specific diagnoses and demographics, to help predict and explain future health outcomes and care expenditures.

Health plans, Centers for Medicare and Medicaid Services (CMS), and provider groups use risk adjustment to monitor patient populations, improve quality of care, and increase the accuracy and completeness of health data.

Risk adjustment is also closely tied to reimbursement under CPC+ programs. CMS guidelines require a patient's full burden of illness be documented each calendar year for risk adjustment purposes.

It's important to use every face-to-face encounter with a patient as an opportunity to optimize risk adjustment, so be sure you and your team:

- Assess all relevant conditions and document the entire patient encounter.
- Document all acute, chronic, and status conditions every year.
- Note specific, rather than general, conditions (e.g., 'major depression single episode mild', rather than 'depression') if applicable.
- Bill all addressed conditions on the claim.
- Confirm all diagnoses make it to the medical billing clearinghouse/superbill.

Accurately identifying, documenting and managing a patient's full burden of illness helps to ensure the appropriate compensation is received to cover the cost of care for patients with above-average risk.

How Can We Help? Supporting CPC+ POs and Practices in Michigan

The joint commercial CPC+ payers in Michigan are working together to support multipayer alignment with the University of Michigan. In 2017 thus far, we have advocated with CMS for better recognition of POs as partners in CPC+, created a multipayer briefing for Michigan POs, begun planning for a CPC+ multipayer dashboard and reporting system, updated a multipayer billing, coding and documentation G and CPT code grid, and coordinated with CPC+ partners including CMS and their subcontractors. We are interested in your experience of what is going well and what your find challenging. **Please contact the CPC+ Michigan Regional Convener, Diane Marriot (dbechel@umich.edu or 734 998 0390) at any time to share your ideas and experiences.**