Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

High-intensity in-home care program

Frequently asked questions for providers

For Medicare Plus Blue℠ and BCN Advantage℠

November 2022

In this document

To further serve our Medicare Advantage members and complement the capabilities of our provider partners, Blue Cross Blue Shield of Michigan and Blue Care Network are expanding their high-intensity in-home care program that serves chronically ill members. We contracted with Landmark Health, an independent company, to provide these members who have coverage through Medicare Plus Blue or BCN Advantage plans and reside in select counties in Michigan's Lower Peninsula with access to this program.

This document answers frequently asked questions about the program.

High-intensity in-home care model

Will Landmark serve as the primary care provider for patients who engage in the Landmark program?

No. The patient will still be attributed to their current primary care provider, or PCP. Landmark will work collaboratively with the primary care provider to address the patient's needs.

Will patients who are engaged with Landmark continue to see their PCP and specialists?

Yes. This is a collaborative model where patients continue to be cared for by their PCPs and specialists. Landmark offers another layer of support through in-home care visits for the most at-risk patients, but it doesn't take over as the primary care provider.

Why do patients need this type of care model?

Patients need this type of care model to provide additional assistance to primary care providers in the management of complex patients who have multiple chronic conditions and require a large number of interventions.

Landmark provides around-the-clock access to comprehensive medical care in the home that complements care provided by PCPs. Patient participation is voluntary and home visits are offered at no cost.

Do high-intensity in-home care models work?

Yes. Landmark approaches care using the patient's personal health characteristics, not historical utilization. They provide care day and night, every day of the year, including weekends and holidays.

Landmark medical care is provided in addition to care provided by a patient's regular primary care provider and other specialists. The Landmark team works with the patient's PCP and provides care to the patient with the following proven outcomes:

- 15% to 25% reduction in hospital admissions
- 26% reduction in mortality
- 20% decrease in medical costs
- 90% increase in advanced directives and quality ratings

Is the Landmark program a primary management or co-management model?

Landmark uses a collaborative practice model. This means the patient will continue to see their PCP and any specialists, but the Landmark team will provide additional support through in-home visits and care coordination.

Who are the doctors who will provide care?

Landmark employs local staff to complete their care teams.

The Landmark Complexivist® care team augments PCP office-based care as a local interdisciplinary team that consists of:

- Doctors of medicine, or M.D.s
- Doctors of osteopathy, or D.O.s
- Advanced practice providers, or A.P.P.s
- Behavioral health specialists
- Social workers
- Dietitians
- Pharmacists
- Care coordinators
- Health care ambassadors

The Complexivist care team is specially trained in caring for older adults with multiple chronic conditions, and in end-of-life care conversations and management.

Landmark's team is designed to help PCPs close quality gaps and amplify PCP care through urgent acute interventions, routine visits in collaboration with the PCP and thorough documentation — while giving patients maximum access to quality care that is aligned with their health goals.

Will the doctors in the model become part of our provider organizations if they are caring for patients who are attributed to us?

No, they will remain employees of Landmark Health.

Once a patient is enrolled with Landmark, how long will they be engaged with Landmark?

Patients will remain enrolled in the program as long as they:

- Have coverage through a Medicare Plus Blue or BCN Advantage plan
- Reside in an area that's served by the Landmark program
- Maintain need for the services

Given the complexity and chronic nature of the patients who are eligible for the program, most patients maintain the need for Landmark services and continue with the program until hospice care is required or until end of life.

Will patients enrolled in Landmark continue to use primary care office-based care management services?

Yes. Patients in this program can continue to use primary care office-based care management services.

How will the care plans and management of these members be communicated back to the PCPs?

The value of Landmark services depends on strong communication and collaboration among the PCP, the PCP's care management staff, the Landmark provider and the Landmark care team.

After Landmark's first visit to the patient's residence, the Landmark provider will reach out to the PCP's office by phone. Landmark is happy to work with the primary care provider's practice

to determine the most effective mode of communication. You can contact Landmark at 1-833-908-6733 to discuss this.

After subsequent visits, the Landmark care team will follow up by phone, direct message or secure fax — including providing a *Post Home Visit Summary* and a *Continuity of Care* document. Page 2 of these documents includes patient visit highlights.

The Landmark provider and care team notify the PCP office about any changes in a patient's status, disease progression or medication usage. Although Landmark providers may have questions or recommendations about a patient's medications or conditions, they will consult with the PCP before making changes, except in urgent situations.

How does a PCP notify Landmark of a change to a patient's status?

We will give Landmark's contact information to all PCPs who have patients that are enrolled in the Landmark program. The best collaboration occurs when the PCP and Landmark communicate with each other about patient status.

Patient-related questions

How are patients identified for this program?

We identify eligible Medicare Plus Blue or BCN Advantage members through specific criteria related to level and number of qualifying chronic conditions, age, geographic location and other factors (for example, frailty).

How will Landmark inform patients about the program?

Landmark will reach out to patients who are eligible for the program through mailings and phone calls. They'll do this after attributed primary care providers are notified of their eligible patients.

Landmark will let all patients know that they will continue to receive their primary care services through their PCP and that Landmark services are supplemental and in collaboration with the care provided by their PCPs.

What services do patients who are engaged with Landmark receive?

Patients who enroll with the Landmark program receive house call visits, including routine services in collaboration with the PCP, urgent and post-discharge visits. They also have 24/7 phone access to Landmark resources.

Landmark services include:

- Multidisciplinary care teams — Landmark's mobile care team includes doctors, advanced practice providers, behavioral health nurse practitioners, social workers, pharmacists, dietitians, nurse care managers and health care ambassadors.
- In-home urgent care services — Landmark helps to reduce avoidable emergency department visits, hospital admissions and readmissions.
- Social, lifestyle and behavioral health support — Social and behavioral challenges often accompany multiple chronic conditions. Landmark's care team addresses a wide range of needs through phone, video and in-person support.
- PCP collaboration and following the PCP's care plan — After each home visit, Landmark updates the PCP by phone, direct message or secure fax, and provides the PCP with additional insight into the patient's needs. Landmark encourages patients to follow up with their PCP and specialists for continued care.
- Help closing quality care gaps — Landmark works with PCPs to address gaps in care such as comprehensive diabetes care, colorectal cancer screening and behavioral health screening.

Do patients have the option to designate Landmark as their PCP?

No. Landmark cannot be assigned as a PCP. Landmark is a collaborative practice model where the patient continues to engage with their current PCP and specialists.

Landmark will notify the provider of any interactions that they have with the patient. At a minimum, the PCP will receive a *Post Home Visit Summary* of the visit. If any urgent needs arise, the Landmark representative will call the PCP office.

PCPs can also reach out directly to Landmark if they think an enrolled patient would benefit from a home visit due to an active risk.

When Landmark works with a patient, they will always:

- Direct the patient back to their PCP for primary care services
- Make the patient aware that Landmark services are supplemental to the PCP services and are performed in coordination with their PCP

Provider-related questions

How does Landmark communicate with PCPs about the availability of this program?

Landmark will reach out to PCPs as patients who are attributed to them are identified as eligible for the program. On the monthly panel, PCPs will receive a letter with a list of patients who are eligible.

How will the PCP be notified when their patients qualify for Landmark?

The PCP will receive a list of their patients who are eligible for the program before Landmark contacts the patients.

Landmark will notify patients that they qualify for the program only after PCPs receive these lists.

Do patients need referrals from their PCPs to participate in the Landmark program?

A patient does not need a referral to Landmark from their PCP unless the provider is in a full-risk contract with Blue Cross; in that case, a referral to Landmark would be required.

When a patient is identified as eligible, will the PCP be involved in deciding whether the patient will participate in the program?

Once a member is identified as eligible for the program, it is up to the member (or their legal caretaker) to decide whether to participate. In many cases, PCP input will be an important consideration for members.

Landmark and Blue Cross will meet with practices or care management teams to address any questions regarding eligible members during an open-forum discussion. To schedule a discussion with Blue Cross and Landmark, contact the Blue Cross Care Delivery Solutions team at caredeliverysolutionsprogrammtg@bcbsm.com.

What happens when a patient expresses interest in enrolling with Landmark?

Patients who qualify for Landmark will be notified about their eligibility for the program. If they choose to engage with Landmark, a Landmark representative will call the patient to discuss the program. During the call, Landmark will set up a time for an in-home assessment. If the patient chooses to enroll, Landmark will notify the PCP office that the patient has enrolled.

Can I refer patients to the program if they aren't identified based on claims data?

Yes, you can refer patients to the Landmark program. To do this, send either an **encrypted** email message to caredeliverysolutionsprogrammtg@bcbsm.com or a **secure** fax to 1-877-381-3621 with the patient's:

- First and last name
- Contract ID
- Date of birth
- Any pertinent medical information, including chronic conditions

For the patients you refer, we'll review the information you provide and reply to your email to let you know whether the patient will be accepted into the Landmark program.

How do PCPs know which of their patients are eligible and engaged in the program?

PCPs will receive a letter with a list of patients who are eligible.

When a patient chooses to enroll, Landmark will notify the PCP office that the patient has enrolled.

PCPs can call Landmark's provider line at 1-833-908-6733 to request an in-service for their office staff, to discuss patient care or to receive an updated list of eligible and engaged patients.

How will PCPs be informed about patient care for patients who are engaged with Landmark?

The PCP will receive a *Post Home Visit Summary* after each Landmark home visit; the patient's visit highlights will appear on the top portion of the fax. If the patient has urgent needs, Landmark will contact the PCP office immediately.

Landmark providers will consult with the PCP before making any changes in the patient's medications or health plan, unless there is an urgent situation that requires immediate action.

Please call Landmark at 1-833-908-6733 to establish who in your practice can coordinate care.

How will Landmark update me on my patient's status?

The Landmark provider and care team notify the PCP office about any changes in a patient's status, disease progression or medication usage. Although Landmark providers may have

questions or recommendations about a patient's medications or conditions, they will consult with the PCP before making changes, except in urgent situations.

What happens if a patient is currently engaged in care management through provider-delivered care management or coordinated care?

If the PCP has a care manager based in the office, Landmark will coordinate with the care manager. This collaborating is crucial, particularly when coordinating care such as home health services or long-term care planning.

The care managers in the PCP office are also a great resource for referring eligible patients to Landmark. Landmark's local outreach team will occasionally meet with care managers in a PCP office to give them more information on the program and share a list of eligible patients. The relationships care managers have with patients may make patients more comfortable with and receptive to working with Landmark.

When a patient has a need for urgent care but is unable to see their PCP, the PCP or Landmark will encourage the patient to use Landmark services instead of going to the emergency department.

These are the billing codes for provider-delivered care management:

Procedure code	Description	Delivery method	Licensed care team member	Physician	Quantity limits	Notes
G9007	Team conference	Face-to-face, video, telephone or secure web conference between physician and care team	X	X	1 per patient per practitioner per day	Team conference doesn't include the patient. Email communications don't apply. **A licensed care team member can bill this code if they have a conference call with a Landmark nurse practitioner or physician.**
G9008	Physician coordinated care oversight services	Face to face, video or telephone; physician discussion with EMT, patient or other healthcare professionals who aren't part of the care team		X	None	This is a physician-delivered service, commonly used when the physician is actively coordinating care with the team or interacting with another health care provider seeking guidance or background information to coordinate and inform the care process. **This code can be billed by the physician if they are coordinating care with Landmark.**

Procedure code	Description	Delivery method	Licensed care team member	Physician	Quantity limits	Notes
*99487	Care management services – 31 to 75 minutes per month	Non-face-to-face clinical coordination	X	X	Once per patient per calendar month	
*99489	Care management services – each additional 30 minutes per month	Non-face-to-face clinical coordination	X	X	Time-based quantity billing	After 75 minutes, this code can be quantity billed in 30-minute increments.

Will Landmark offer care management services to enrolled patients? Should practice care managers continue to engage with these patients?

Care managers, social workers, dietitians, pharmacists, care coordinators and health care ambassadors are all part of the Landmark care team. For patients enrolled in Landmark, Landmark can coordinate with practices to provide these services to patients while avoiding duplication of services and maximizing the efficiency of the care team. The office's care manager will coordinate with the Landmark care team.

Although Landmark has a care team that works with engaged patients, it's helpful for patients to also have an office-based care manager. The office-based care manager can help to coordinate care with Landmark for the patient. The provider-delivered care manager can bill for these services using provider-delivered care management codes.

Workflow-related questions

Who is responsible for follow-up care for emergency department and inpatient discharges for members enrolled in Landmark?

Members' PCPs and specialists will be the primary providers of care for these members. However, Landmark can assist with managing transitions of care for patients who are engaged with the Landmark program.

Landmark's care managers will call patients for follow-up after an emergency department or inpatient stay, and Landmark providers will see patients in their homes for post-discharge appointments after inpatient stays. Landmark will also recommend that the patient visit their

PCP after discharge. If your practice would like to coordinate a virtual visit during a Landmark visit, call 1-833-908-6733.

Is Landmark connected with MiHIN?

Landmark will receive notification of admissions, discharges and transfers of members who are engaged with the Landmark program. This process will be developed in the clinical workstream with Landmark and will use the best method for timely notification.

Landmark is reviewing Michigan Health Information Network, or MiHIN, capabilities to see how they can be leveraged for admissions, discharges and transfers and for other aspects of the program.

Is Landmark integrated with the PCP's electronic health record?

No, Landmark is not integrated with individual PCP's electronic health records at this time.