Physician Group Incentive Program
Partially Embedded Practice Model

Objective:
This document outlines standards to facilitate strong team-based care and forge an effective relationship between the care team member and the physician, *for practices that utilize a care manager who is not physically present at the practice to deliver patient care.*

Practices must adhere to the guidelines set forth in this document by 1/1/2021 in order to be considered a PDCM practice and qualify for value-based reimbursement.

Background:
The BCBSM Provider Delivered Care Management (PDCM) program was designed to foster an embedded practice model, which is supported by research.

A 2016 study by Holtrop et al. suggests that an embedded care management model was generally implemented more positively compared to centralized care management[1]. A trusting professional relationship can develop between providers, staff and care managers, when care managers have:

- Multiple, flexible opportunities for communication
- Requisite knowledge, skills, and personal characteristics
- Organizational support and resources

When any of these elements were missing, care management implementation appeared to be affected negatively.

In addition, a 2018 study found that care managers play a key role in chronic disease management and communication within the practice, as noted by other practice members. This seemed especially true for embedded care managers.[2]

Approach:
The BCBSM Provider-Delivered Care Management (PDCM) program is different from other care management programs, such as payer or vendor-based care management, because of the direct connection to the provider and point of care. Continuity of care, the ability to discuss care plans, and face-to-face connection with both the care team and patient define this care model and result in improved performance over other models.

To facilitate closely aligned care teams providing care management in the office setting, PDCM program payments are intended to support care management that is delivered at practice sites with embedded care managers. However, it is recognized that small practice size (defined as 2.0 or

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[1] Holtrop JS, Potworowski G, Fitzpatrick L, Kowalk A, Green LA. Effect of care management program structure on implementation: a normalization process theory analysis. *BMC Health Serv Res*. 2016;16(a):386. Published 2016 Aug 15. doi:10.1186/s12913-016-1613-1

[2] Holtrop JS, Ruland S, Diaz S, Morrato EH, Jones E. Using Social Network Analysis to Examine the Effect of Care Management Structure on Chronic Disease Management Communication Within Primary Care. *J Gen Intern Med*. 2018;33(5):612–620. doi:10.1007/s11606-017-4247-z

fewer full-time equivalents) may impede the ability support this model due to limited physical space and smaller patient panel.

For practices struggling with an embedded care team model, in which the care team member dedicates a significant portion of their time physically in the practice, the PDCM program has established "minimum participation" criteria for a partially embedded model. This document outlines the practice site criteria and the minimum level of interaction between the care team and the provider office that allow eligibility PDCM funding and incentive opportunities.

BCBSM will evaluate whether a practice meets the partially embedded practice criteria outlined below through the care management attestation process. If a practice does not attest to having a licensed, partially embedded care team member, then a deeper review will be conducted to determine whether the practice is meeting the minimum requirements for PDCM. Those practices not meeting the requirements will not be considered a PDCM practice, making them ineligible for associated value-based reimbursement opportunities.

Practice Site Criteria:

- Practices have fewer than two provider FTEs (the FTEs may be either advanced practice providers or primary care physicians)
- Providers commit to a practice model that promotes embedded care management, delivered in the office setting
- Technology requirements:
    - Practice must have an EMR and give full access to the care manager so that the entire care team can document in and communicate through a single patient's chart
    - Practice must have BCBSM PCMH capability 13.11[3] reported in place in the PGIP Self-Assessment Database

Timing Criteria:

- Care manager must have an average of at least sixteen hours of dedicated, scheduled patient time per month for each office; care can be delivered virtually (such as Skype face-to-face videoconferencing) or via telephone.
    - Care managers must have the ability to provide G9001 or G9002 services to patients and have been trained in accordance with the Blue Cross Blue Shield of Michigan training criteria.
- Care manager must complete at least quarterly face-to-face meetings with the provider to discuss patients and process.

Practice Activation Process:

- Duration: 4 weeks
- 3-step process

[3] Exact capability language for 13.11 reads as follows: *Practice is actively participating in the Michigan Admission, Discharge, Transfer (ADT) Initiative*

- *Step #1: Clinical services overview with physician(s) and office manager (30-45 minutes)*
  - Review care manager's role and services offered
    - Review 2-4 patients who would benefit from care management and define their care plans; practices can bill the G9007 for undertaking this review process
  - Practice/PO will share program goals such as outreach targets and clinical outcome measures, as well as sharing the financial model
- *Step #2: Establish clinic workflow (3 or more 1/2 days)*
  - Lunch and learn or other method of educating clinic staff about care manager's role.
  - Care manager to shadow clinical team (RNs/MAs) and clerical staff (check-in/check-out staff) (1/2 day)
  - Care managers shadow providers (minimum of 2 half days)
  - Finalize schedule, plus operational and billing workflows (refer to Practice Readiness Checklist, available on MICMT website).
    - Also refer to PCMH capability 4.24[4] to ensure care management workflows are established appropriately.
- *Step #3: Schedule quarterly touch-bases with physician(s) and office manager*
  - Minimum of quarterly face to face touch-bases between care manager and physician, in addition to ad hoc conversations with the physician/provider, when needed to support patient care.
  - Regular touch-bases with office manager to review workflow and billing processes

Audit Process:
Through the MICMT Scorecard, POs are required to verify several factors that confirm this partially embedded practice model has been followed.

In addition to verifying that the criteria outlined above have been satisfied if the practice unit utilizes an off-site model of care, the PO and Practice Unit will be expected to:

- Confirm payment responsibility (care team member hired by practice, time is rented by the practice; partial PO subsidy or full PO subsidy; etc.)
- Confirm amount of time care team member dedicates to the Practice Unit.

[4] Exact language for capability 4.24 reads as follows: *Physician organization and/or practice unit standardizes, develops and maintains care management processes and workflows, to ensure efficient delivery of care management services in the practices for whom they coordinate/administer care management.*

At the end of the year, MICMT will provide this documentation to BCBSM and Michigan Data Collaborative to assist with the determination of who is eligible for the BCBSM PDCM Population Management VBR and Outcomes VBR.