PRIMARY CARE PHYSICIAN – PROVIDER-DELIVERED CARE MANAGEMENT OPPORTUNITY

ABOUT:

Engrained in the Blue Cross Blue Shield of Michigan (BCBSM) Patient Centered Medical Home (PCMH) program, Provider Delivered Care Management (PDCM) is a model where care management is provided within the primary care physicians' practice by trained care managers. Multi-year studies demonstrated positive outcomes with care manager engagements within the practices. For example, those patients who engaged with care managers had reductions in costs, risk scores, and readmissions.

The Physician Alliance aims to provide the necessary support to practices to ensure success in mainstreaming the integration of care managers into primary care practices, billing of the 12 PDCM codes and 3 PDCM-related codes to increase revenue and improve quality of care and patient satisfaction.

PDCM is the mechanism used by BCBSM to reimburse for care management and care coordination activities for BCBSM members through the billing of care management codes. Each PDCM patient must have a care plan- either focused or comprehensive. The practice must be able to provide sample care plans upon request. PDCM participation is available to all Patient Centered Medical Home (PCMH) designated practices and CPC+ participants.

PDCM care management billing has been available since July 1, 2015 and is the payment methodology that will be used to support the CPC+ and SIM initiatives.

- PCMH designated or CPC+ practices should have the following staff in place when participating in the PDCM program:
  - At least one physician that supports care management and understands the PDCM program (A **physician champion** should be named). The physician(s) in the practice take(s) responsibility for determining who in the practice is qualified to provide care management and can designate care management responsibilities based upon scope of practice and supported by policies and standard protocols which must be in writing.
  - The practice must choose to have one of the following two types of care managers below:
    - A **licensed care manager** (who can bill for all 12 PDCM codes including G9001) - either a registered nurse, licensed social worker, physician assistant and/or a nurse practitioner, pharmacist, LPN licensed professional counselor, or licensed mental health counselor.
      OR
    - An **unlicensed care manager** for example a certified diabetes educator, registered dietician, Master of Science - trained nutritionist, respiratory therapist, certified asthma educator, certified health educator specialist (bachelor's degree or higher in health education), Medical assistants, behavioral health workers and EMT's who receive the specified training may also bill some of the PDCM codes but are more restricted to codes billed. Unlicensed care managers are not able to bill for code G9001.
  - Training requirements:

- The **licensed care manager** must successfully complete the BCBSM approved complex care manager training within 6 months of beginning to bill the PDCM codes. The care manager must receive the designated complex care management course and complete the mandatory online BCBSM billing webinar in addition to obtaining an additional 8 hours of care management training annually.
  OR
- An **unlicensed care manager** must have successfully completed either complex care management course OR an approved self-management course and online BCBSM PDCM billing course and 8 hours of additional education annually. If unlicensed personnel are used to deliver care management services, a signed practice collaborative agreement, which delegates and enumerates which activities those members of the care team can provide in the practice, must be signed by the physicians and available on request.

- The practice should have a practice **panel manager** or clinical lead that will actively work to close gaps in care across the practice's population. A panel manager is a clinical team member trained in panel management - the primary contact person for running gaps in care in the practice.

Value Based Reimbursement Opportunities

1. PDCM Population Management VBR

- To qualify for consideration to obtain the **PDCM Population Management VBR** the practice must submit claims for a specific percentage of its attributed BCBSM commercial, FEP (federal employees) and Medicare Advantage (MA) PDCM-eligible patients annually (January 1st –December 31st).
  - In 2020: At least two paid claims for services provided on separate dates are processed during calendar year 2019 for 3% of the eligible BCBSM Michigan members to qualify a practice to be considered for the 5% PDCM VBR.
  - In 2021: At least two paid claims for services provided on separate dates are processed during calendar year 2020 for 4% of the eligible BCBSM Michigan members to qualify a practice to be considered for the 5% PDCM VBR.
- Codes included in the analysis are: HCPCS codes G9001, G9002, G9007, G9008, S0257 and CPT codes: 98961, 98962, 98966, 98967, 98968, 99487, 99489 and PDCM -related codes: 99495, 99496 and 1111F.

2. PDCM Outcomes VBR

- To qualify for consideration to obtain the **PDCM Outcomes VBR**:

  In 2020: A total of four metrics will be used to determine the additional outcome VBR. Performance will be evaluated at the **Sub-PO** level (all practices with care managers scores will be aggregated as a group); in the future there may be opportunities to measure at the practice unit level based upon the size of the practice.

  Two Quality Metrics:

- Blood pressure control (HEDIS) weighted 1.5%
- HgbA1c control in Diabetes (HEDIS) weighted 1.5%

Total Quality VBR Opportunity= 3%

Quality metrics apply to adult population only

Two Utilization Metrics:

- ED Utilization Rate - weighted 1.5%
- Inpatient Discharge Rate (non-Maternity, risk adjusted) weighted 1.5%

Total Utilization VBR Opportunity= 3%

Utilization metrics apply to both adult and pediatric populations.

Two methods to receive VBR for all four measures:

1. Performance against a national benchmark (i.e. Milliman loosely managed benchmark)

OR

2. Improvement measurement based on opportunity to improve benchmark (improvement methodology is currently under development by BCBSM).

Practices should strive to engage all high complexity patients flagged in the monthly eligible lists as Blue Cross may soon require practices to engage a specific percentage of high complexity patients.

The PDCM VBR's will be assessed annually and will continue, start, or stop based on performance and reaching the required touch rate for the year. Only PCMH designated and CPC+ participating practices are eligible for VBR consideration.

BENEFITS OF PARTICIPATION IN PDCM:

- More money – earn additional PDCM VBR's Population Management VBR (potential 5% VBR) and PDCM Outcomes VBR (potential 6% VBR) and PDCM (PCMH designated practices only).
- Increased revenue through reimbursement for care management services
- Improve quality and increase the capture of pay for performance dollars
- Reduce cost with care being provided in the lower cost settings
- Add a trained care manager to expand the practice's care team
- Prepare your practice to manage risk

Learn more about Provider Delivered Care Management, the benefits to your primary care practice and more. View the presentation.

*Training information can be located here.

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