

# Patient Centered Medical Home (PCMH) Initiative

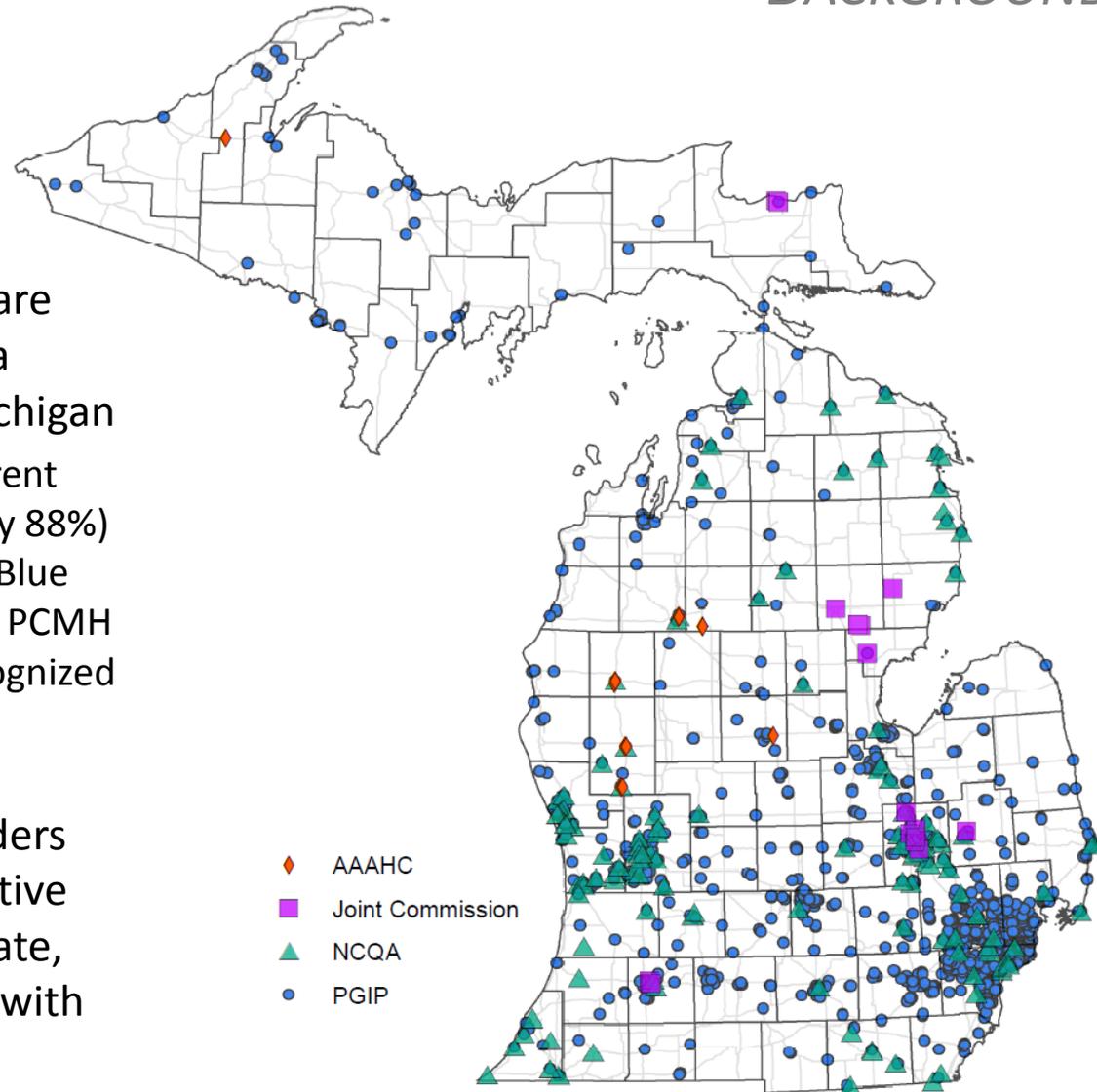
A Michigan Primary Care Transformation (MiPCT) Partnership with the State Innovation Model



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## PCMH in Michigan

- Approximately 5,200 providers are already choosing to practice in a PCMH accredited settings in Michigan
  - The majority of Michigan's current PCMH providers (approximately 88%) have been accredited through Blue Cross Blue Shield of Michigan's PCMH program, another 10% are recognized by the National Committee for Quality Assurance
- Michigan's current PCMH providers represent about 32% of total active primary care providers in the state, a significant base to build upon with great opportunity for growth



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## Experience to Build From

- The Michigan Primary Care Transformation Project (MiPCT) is the largest Multi-Payer Advanced Primary Care Practice demonstration in the country
  - MiPCT serves over 1.2 million patients with 350 primary care practices, 37 physician organizations, 1,800 primary care providers and over 400 specially-trained Care Managers participating
- The PCMH Initiative builds upon the MiPCT demonstration including sustaining the involvement of current MiPCT providers and multi-payer partners, leveraging the project's existing infrastructure and learning from the project model
  - The PCMH Initiative will advance and adapt several components of the MiPCT demonstration approach based on evaluation results, practical lessons learned and results from other state models

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## PCMH Initiative Focus

The PCMH Initiative will center practice supports, payment approaches and performance metrics on the following key focus areas:

- Development of personalized, patient-centered care plans
- Team-based delivery of comprehensive, highly accessible healthcare and care management services
- Coordination and support for effective transitions of care
- Provision of referral decision support, scheduling and follow-up
- Collaboration and intentional interfacing with other providers to promote an integrated treatment approach
- Engagement of supportive services through community-clinical linkages
- Leadership in patient education, self-care and caregiver engagement
- Utilization of registry functionality and technology-enabled quality improvement strategies to support population health

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## PCMH Strategy

The Initiative will employ multiple strategies to engage, strengthen and spread PCMHs throughout the state. Further details on a select group of these strategies are included in subsequent pages.

Strategy Component	Motivation
Achieving Statewide Scale	Spread PCMH support infrastructure and payment reform across Michigan by 2019
Inclusive Accreditation Approach	Provide flexibility to leverage a variety of PCMH accreditation programs
Broad Attributed Population	Reflect the diversity of practice patient populations through attribution methodology
Participation Requirements	Ensure needed capabilities for practice success and advance those capabilities over time
Advanced Care Management	Extend care management, coordination and community linkages capabilities
Multi-Payer Participation	Grow alternative payment model scale within practices to drive transformation
Performance-Driven Payment	Create clear rewards for implementing impactful processes and achieving outcomes
Consistent Metrics	Leverage metrics utilized by other programs where possible to simplify measurement
Sustainable Financing	Position Michigan's PCMH infrastructure for lasting innovation and financial stability
PCMH Support and Learning	Provide a collaborative learning context for expert and peer connections

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# Accreditation Approach

- The PCMH initiative will take an inclusive approach to PCMH accreditation (also called recognition and/or certification) by recognizing existing PCMH accreditation programs rather than developing a unique accreditation requirement or program
  - Accrediting body programs considered acceptable for participation include, but are not limited to, BCBSM/PGIP, NCQA, AAAHC, TJC, URAC
  - Some accrediting programs may have non-mandatory components that the Initiative determines are required for participation
- Practices wishing to participate in the Initiative will be required to possess PCMH accreditation from one of the approved programs

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## Eligible Providers

- Provider types eligible to participate in the PCMH Initiative will include:
  - Family Physicians
  - General Practitioners
  - Pediatricians
  - Geriatricians
  - Internal Medicine Physicians
  - Obstetricians
  - Gynecologists
  - Advanced Practice Registered Nurses
  - Physician Assistants
  - Safety Net Providers (e.g. federally qualified health centers, rural health clinics, child and adolescent health centers, local public health departments, and Indian health services)

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# Participation Requirements

- The following practice characteristics and capabilities will be required for PCMH participation in the Initiative on January 1, 2017.

(These characteristics and capabilities do not need to be in place to complete the Intent to Participate process, but will be required in the participation agreement prior to participation.)

- PCMH accreditation from an Initiative approved recognizing body
- Implementation of an ONC certified Electronic Health Record (EHR)
- Advanced patient access
  - 24/7 access to clinician decision maker
  - Same-day scheduling availability for at least 30% of appointments
  - Access to a provider other than the Emergency Department for at least 8 non-standard business hours per week
- A relationship with specialty and behavioral health providers in addition to one or more hospitals which accept patient referrals and cooperate with PCMH activities
- Enrollment as a Michigan Medicaid provider in compliance with all provider policies
- Embedded care management / coordination staff meeting standards set by the Initiative
- A patient registry or EHR registry functionality

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# Participation Requirements

- The following practice characteristics and capabilities will be required for PCMH participation in the Initiative, but the requirements will be phased in during the first year of participation (i.e. not required on January 1, 2017):
  - Connection to a Health Information Exchange (HIE) Qualified Organization (QO), also known as sub-state HIEs
  - Participation in MiHIN use cases applicable to the Initiative (e.g. HPD, ACRS, ADT, SCD)
  - Stage 1 / modified Stage 2 Meaningful Use achievement

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# Performance-Driven Payment

Participating PCMHs can expect the following types of payment during the first year of participation:

- **Medicaid:** Practice Transformation and Care Management PMPM Payments
- **Medicare:** FFS [Chronic Care Management](#) and [Transitional Care Management](#) Payments
- **Commercial:** Payment aligned with the goals of the Initiative from participating commercial payers, with anticipated payment structure variation across payers

Payment models for the second year of the PCMH Initiative and beyond are still in development and will involve considerable stakeholder engagement, especially with participating PCMHs.

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## Consistent Metrics

- PCMH practice transformation performance will be measured on whether or not a PCMH is making progress toward and ultimately meets its identified practice transformation objective(s)
  - Performance will be based upon streamlined self-reporting by participating PCMHs
- A small number of metrics reflecting the process and/or outcome of care coordination will be used to assess PCMH care coordination performance
  - Number/percentage of attributed patient population receiving care coordination services
  - Timely follow-up after discharge
- The Initiative will monitor performance on 19 quality metrics and 4 utilization metrics on a consistent basis during the first year
  - Quality metrics were adopted from the [Physician Payer Quality Collaborative](#) core measure set, which was developed using practice and physician organization feedback

## PCMH Support, Learning and Engagement

- All PCMHs participating in the Initiative will complete a standardized self-assessment process on an annual basis to measure PCMH implementation maturity over time and guide support activities
- PCMHs participating in the Initiative will be invited to join peer practices in a set of Initiative-sponsored collaborative learning activities
- The PCMH Initiative will also work to generate multi-stakeholder (payers, provider associations, continuing education providers etc.) collaboration surrounding the types of practice support provided to stimulate alignment
- The PCMH Initiative will be directed by the SIM governance structure in addition to a SIM advisory commission
- The PCMH Initiative will maintain a strong working group and advisory process as a compliment to SIM's overall governance structure to ensure stakeholders are consistently engaged and guidance is acted upon

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## More Information

A series of statewide webinars was conducted in April and May 2016 which shared additional details about the PCMH Initiative and other components of the State Innovation Model including the Community Health Innovation Region.

Recordings of those webinars in addition to a listing of Frequently Asked Questions are available online at: <http://1.usa.gov/22AVerQ>

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