

APPENDIX A

PCMH Initiative PAYMENT MODEL

The PCMH Initiative payment model is designed to provide financial support to Initiative participants to enable the development and ongoing advancement of patient-centered care.

PCMH Initiative payments from commercial payers (as applicable) will be made based upon payer agreements entered into by the Initiative, its vendors or contractors.

PCMH Initiative participants simultaneously selected by CMS to participate in the Comprehensive Primary Care Plus (CPC+) program will receive payment from Medicare according to the CPC+ payment model. PCMH Initiative participants not participating in CPC+ will bill Medicare for applicable services according to the Medicare Physician Fee Schedule.

PCMH Initiative payments from Medicaid health plans will be made according to the model below.

PCMH Initiative Medicaid Payment Model

- All PCMH Initiative payments from Michigan Medicaid health plans will be made on a per member per month (PMPM) basis.
- PMPM payment will be made based on the primary care provider selected by or assigned to each Medicaid beneficiary as recorded by the applicable Medicaid health plan. Participating Practices which believe the primary care provider on record with a Medicaid health plan is incorrect should initiate a primary care provider change with the beneficiary using a health plan's established process.
- Medicaid health plans will not make payments for retroactive Medicaid eligibility periods or attempt to recoup payments previously made for a beneficiary which experiences a change in eligibility type or status.
- Medicaid health plans will make payments to a Physician Organization if the PO completes the application to participate in the Initiative on behalf of its member Practices.
- Medicaid health plans will make payments to a Practice directly if the Practice completes the application to participate in the Initiative as an individual practice unit.
- Both components of the Medicaid payment model (practice transformation and care management and coordination) will be paid to the same entity.
- Medicaid health plans will make payments to either a PO or Practice (whichever is applicable) no less often than quarterly. Each Medicaid health plan will determine payment frequency within this guideline.
- Payment will be made to all Practices selected to participate during their first six months of participation in the Initiative. After six months of participation, payments will continue to be made to Practices demonstrating appropriate performance as assessed through the mechanisms defined below (i.e. semi-annual transformation progress reporting and two care coordination metrics).

(Payment model information contained herein will describe payments made to Practices for simplicity. If/when payments are made to a PO, the PO payment will represent the aggregate amount of payment due to all participating Practices which are members of the PO.)

Practice Transformation

- PCMH Initiative Practices will receive practice transformation payment to support needed investment in practice infrastructure and capabilities at a PMPM rate of \$1.50 for all Medicaid beneficiaries attributed to the Practice by the Initiative.
- To receive the PMPM practice transformation payment, Practices must complete the required practice transformation objective (as defined in the Participation Agreement), demonstrate progress toward completing the practice transformation objective selected from the Initiative's menu of objectives, and report progress in a manner defined by the Initiative on a semi-annual basis.
- Failure to report practice transformation progress, complete the required practice transformation objective, or demonstrate movement toward completing the selected transformation objective will result in corrective action defined by the Participation Agreement up to and including stoppage of PMPM transformation payment.

Care Management and Coordination

- PCMHs will receive care management and coordination payment to support embedded care coordination services as a PMPM rate of:
 - \$3.00 for Low-Income Beneficiaries (TANF)
 - \$5.00 for Healthy Michigan Plan Beneficiaries (HMP)
 - \$8.00 for Aged, Blind and Disabled Beneficiaries (ABD)
- To receive the PMPM care management and coordination payment, Practices must:
 - Maintain care management and coordination expectations defined in the Practice Responsibilities and Characteristics section of this Participation Agreement
 - Maintain care management and coordination performance above benchmarks established by the Initiative on two metrics:
 - The percentage of a Practice's attributed patients receiving care management and coordination services
 - The percentage of a Practice's attributed patients receiving a timely (within 14 days) follow-up visit with their primary care providers following a hospital inpatient or emergency discharge or transfer from one care setting to another