

APPENDIX C

REQUIREMENTS FOR PRACTICES PARTICIPATING INDEPENDENT OF A PO

The PCMH designated practice that is participating in the PCMH Initiative independent of a Physician Organization must ensure that the following designation, activity, infrastructure, and practice characteristic requirements are met. Requirements have been grouped based on the timing of MDHHS' expectation that a Practice be in compliance with each requirement. While applicable to the participating Practice environment:

BY NOVEMBER 18, 2016 PRACTICES MUST:

1. Sign the 2017 Participation Agreement and return the signed Agreement to MDHHS.
2. Sign a Data Use Agreement (DUA) with the MDC.
3. Complete all necessary legal onboarding documents for the following Michigan Health Information Network Health Information Exchange use cases:
 - a. Active Care Relationship Service (ACRS);
 - b. Health Provider Directory (HPD);
 - c. Quality Measure Information (QMI);
 - d. Admissions, Discharge, Transfer Notification Service (ADT); and
 - e. Common Key Service (CKS).

BY JANUARY 1, 2017 PRACTICES MUST:

1. Possess current designation from one of the following organizations/programs:
 - a. National Committee for Quality and Assurance- PCMH (NCQA)
 - b. Accreditation Association for Ambulatory Health Care- Medical Home (AAAHC)
 - c. The Joint Commission- PCMH (TJC)
 - d. Blue Cross Blue Shield of Michigan/Physician Group Incentive Program- PCMH (BCBSM)
 - e. Utilization Review Accreditation Commission- PCMH (URAC)
 - f. Commission on Accreditation of Rehabilitation Facilities- Health Home (CARF)
2. Possess and utilize a fully implemented Office of the National Coordinator for Health Information Technology (ONC) certified Electronic Health Record (EHR) system.
3. Demonstrate a collaborative relationship with specialty and behavioral health providers in addition to one or more hospitals which accept patient referrals and cooperate with PCMH coordination activities.
4. Possess and utilize an All-Patient Registry or Registry Functionality. The Registry may be a separate technology/system or be a component of an EHR. The Registry must be used on a consistent basis to generate population-level performance reports, identify subsets of patients requiring active management, pursue population health improvement, and close gaps in care for preventive services and chronic conditions.

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5. Possess and utilize an electronic care management and coordination documentation tool accessible to all members of a Care Team. The tool must be either a component of an EHR, or able to communicate with an EHR, to ensure pertinent care management and coordination information is visible to care team members at the point of care.
6. Ensure 24-hour access to a clinical decision maker (i.e., physician, advanced practice registered nurse, or physician assistant) for all patients of the Practice.
7. Provide clinical care for patients of the Practice beyond normal business hours (i.e., 8:30 am to 5:00 pm) for a minimum of 6 hours per week.
 - a. *Alternative Consideration: A Practice accepted to participate in the PCMH Initiative can, by attaching a request for alternative consideration to this Agreement, indicate why a minimum of 6 non-traditional business hours is not operationally feasible for the Practice and describe how the Practice will ensure access to services through an alternative mechanism. MDHHS has full discretion in granting this request for alternative consideration.*
8. Ensure (on average over the course of a week) 30% of available appointments are reserved for same-day care across the patient population.
 - a. *Alternative Consideration: A Practice accepted to participate in the PCMH Initiative can, by attaching a request for alternative consideration to this Agreement, indicate why 30% same day appointment availability is not operationally feasible for the Practice and describe how the Practice will ensure access to services through an alternative mechanism. MDHHS has full discretion in granting this request for alternative consideration.*

BY MARCH 1, 2017 PRACTICES MUST:

1. Complete technical onboarding and be actively participating in the following Michigan Health Information Network Health Information Exchange use cases:
 - a. Active Care Relationship Service (ACRS),
 - b. Health Provider Directory (HPD), and
 - c. Common Key Service (CKS).

BY MAY 1, 2017 PRACTICES MUST:

1. Complete technical onboarding and be actively participating in the following Michigan Health Information Network Health Information Exchange use cases:
 - a. Admissions, Discharge, Transfer Notification Service (ADT).

BY JULY 1, 2017 PRACTICES MUST:

1. Possess and utilize an electronic system capable of providing decision support prompts and care alerts, at a minimum related to the quality of care indicators used by the PCMH Initiative, to clinicians at the point of care.

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BY SEPTEMBER 1, 2017 PRACTICES MUST:

1. Complete technical onboarding and be actively participating in the following Michigan Health Information Network Health Information Exchange use cases:
 - a. Quality Measure Information (QMI).

BY NOVEMBER 1, 2017 PRACTICES MUST:

1. Complete the PCMH Initiative's required Practice Transformation Objective (clinical-community linkage), including submitting practice transformation progress reporting on a semi-annual basis. See also Appendix [F](#).

AT ALL TIMES DURING THE PCMH INITIATIVE PRACTICES MUST:

1. Maintain enrollment as a Michigan Medicaid provider in compliance with all provider policies and requirements.
2. Maintain PCMH designation as detailed above.
3. Accept reimbursements from all PCMH Initiative participating Payers, except for Practices which do not serve patients from a specific Payer's population.
4. Inform the PCMH Initiative within seven days of learning about a change in provider employment or status within a participating Practice.
 - a. For providers joining or leaving a Practice, the Practice must specify the effective date and key identification numbers (NPI, PIN, TIN) by completing a PCMH Initiative Practice Change Form. Failure to provide this information may result in a payment lapse or delay for new providers, or the need to reimburse payments made for providers who have left the Practice.
5. Provide additional requested practice-level information including, but not be limited to, payer mix and contracting status, and quality data in accordance with the Data Use Agreement.
6. Alert the PCMH Initiative of concerns about the capacity of the Practice to meet the requirements of this agreement in order to enable PCMH Initiative leadership to respond with assistance whenever possible and to assure reasonable oversight.
7. Ensure that all Care Team(s) meet at least monthly with time dedicated to team-based management and review of reports.
8. Abide by the Practice Learning Requirements described in Appendix D.
9. Embed Care Management and Coordination staff members functioning as integral, fully-involved members of every participating Care Team.
 - a. Care Managers and Care Coordinators may be employed or contracted by the

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- Practice, a Physician Organization, or another entity, but regardless of who employs the Care Management and Coordination staff, these individuals must function as an integral part of the Care Team.
- i. If Care Managers and/or Care Coordinators are employed by a PO, the ratio below will be measured at the PO level.
 - ii. If Care Managers and/or Care Coordinators are employed by a Practice, the ratio below will be measured at the individual Practice or Practice Organization level (whichever is most appropriate for the composition of the Practice).
- b. Maintain a ratio of at least 2 Care Management and Coordination staff members per 5,000 patients attributed (see Appendix B) to the Practice as part of the PCMH Initiative.
- i. At least one member of the Care Management and Coordination team must be a licensed Care Manager.
 - ii. Other members of the team may be a licensed Care Manager or a Care Coordinator.
 - iii. All Care Managers and Care Coordinators must complete training provided and/or approved by the PCMH Initiative as well as take part in continuing education as described in Appendix D.
 - iv. *Alternative Consideration: A Practice accepted to participate in the PCMH Initiative can, by attaching a request for alternative consideration to this Agreement, indicate why a ratio of 2 per 5,000 attributed patients is not appropriate for the Practice's population (evidenced with data about the Practice population's health risks and complexity). Requests should describe how the Practice will ensure access to care management and coordination services at a lower ratio, or by applying the ratio to a subset of the Practice's total population. MDHHS has full discretion in granting this request for alternation.*
- c. Notify the PCMH Initiative if a vacant Care Management or Care Coordination position is not filled within 30 days.
- d. Assure that Care Managers/Care Coordinators have a workspace, computer access, and telephone in each Practice setting served.
- e. Assure that every provider has frequent contact with the Practice's Care Manager(s)/Care Coordinator(s), no less often than weekly, regarding those patients receiving active Care Management and Coordination services.
- f. Assure that embedded Care Managers/Care Coordinators are serving attributed patients from all participating Payers.
- g. Assure that Billing Codes for Care Management and Coordination services delivered within the Practice are submitted to participating Payers as requested by the Payer(s).

10. Complete the required Practice Transformation Objective (as defined in the Participation Agreement), demonstrate progress toward completing the Practice Transformation

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Objective selected from the Initiative's menu of objectives, and report progress in a manner defined by the Initiative on a semi-annual basis. See also Appendix F.

11. Regularly participate in PCMH Initiative conference calls, webinars, and in-person events.
12. Identify a Champion who will communicate with all clinicians in the Participating Practice, encouraging team-based care and attention to other aspects of the PCMH Initiative model.
13. Utilize PCMH Initiative attributed patient population information on a monthly basis.
14. Utilize PCMH Initiative performance measure dashboards/reports for quality improvement no less often than quarterly.
15. Utilize PCMH Initiative newsletters and other communications in staff meetings, team discussions, etc. as appropriate.
16. Cooperate with PCMH Initiative operations, program monitoring, and evaluation activities as requested by the Initiative including but not limited to assisting and/or participating in surveys, focus groups, through leader interviews, Practice site visits, and periodic narrative progress/status reporting.
17. Ensure and assure that the Practice Initiative is meeting and maintaining all provisions in this Participation Agreement.
 - a. If unable to maintain one or more PCMH Initiative requirements, the Practice must notify the PCMH Initiative at the earliest opportunity in order to enable PCMH Initiative leadership to respond with assistance whenever possible and to assure oversight.
 - b. The Practice may be contacted by the PCMH Initiative, including onsite visits, to discuss the area(s) of deficiency, obtain additional information and (if deemed necessary by the Initiative) institute a corrective action plan.
 - c. Failure to notify the PCMH Initiative regarding known Practice non-compliance with this agreement is grounds for corrective action up to and including removal from the Initiative.
 - d. Practice failure to complete corrective action plan steps may subject the Practice in question to payment suspension or removal from the Initiative.

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