Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

December 5, 2013

Stephen Fitton, Medicaid Director
Medical Services Administration
Federal Liaison Unit
Michigan Department of Community Health
400 South Pine
Lansing, Michigan 48933

ATTN: Loni Hackney

Dear Mr. Fitton:

Enclosed for your records is an approved copy of the following State Plan Amendment:

- Transmittal: #12-006 Michigan Primary Care Transformation
- Effective: January 1, 2012

If you have any questions, please contact Leslie Campbell at (312) 353-1557 or Leslie.Campbell@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12 - 06

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.204

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $ 3,571,600
b. FFY 2013 $ 5,975,100

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Pages 20, 21, 22 and Appendix A
Supplement to Attachment 3.1-A, pages 40, 41 and 42

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A – New Pages

10. SUBJECT OF AMENDMENT:

Implementation of a multi-payer demonstration project to reform primary care payment models and expand the capabilities of patient-centered medical homes (PCMH) throughout Michigan.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Stephen Fitton, Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Stephen Fitton

13. TYPED NAME:
Stephen Fitton

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
March 29, 2012

16. RETURN TO:

Medical Services Administration
Actuarial Division
Capitol Commons Center - 7th Floor
400 South Pine Street
Lansing, Michigan 48933

Attn: Loni Hackney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 29, 2012

18. DATE APPROVED:
December 5, 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPE NAME:
Marion Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179(07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

29 Integrated Care Model (ICM) Services

Goals of the ICM

ICM services are provided to beneficiaries enrolled with primary care practices that meet patient-centered medical home (PCMH) designated criteria and contract with Physician Organizations or Physician Hospital Organizations (PO/PHO) that have entered into an agreement with the Michigan Department of Community Health (MDCH) to participate in the Michigan Primary Care Transformation Project (MiPCT). The PCMH is an approach to providing comprehensive primary care in a healthcare setting that facilitates partnerships between individual patients and their personal physician.

MiPCT addresses the shortcomings in the current system by enabling providers to hire care managers, implement disease registries to track and follow-up with patients (especially those with multiple chronic diseases), and develop the infrastructure and organizational changes characteristic of patient-centered medical homes. In addition, MiPCT pays physicians to expand office hours, offer same-day appointments, and offer supplemental communication with patients (e.g., via email). MiPCT rewards physicians for improving their patients' health and avoiding emergency room and inpatient use for ambulatory sensitive conditions. MiPCT provides clinical models, resources, and support to reduce fragmentation of care among providers, and involves the patient in decision-making thereby strengthening the Patient–Care Team relationship. These transformations in the delivery of primary care support the overall goal of MiPCT based on the Institute for Healthcare Improvement's Triple Aim: to improve patient health status; enhance patients' overall experience of care; and stabilize or decrease the cost of care.

Providers

Providers who will serve as primary care case managers (PCCM) may be primary care physicians, licensed physician assistants, and licensed nurses who are certified as nurse practitioners working under supervision of a physician, as defined in the Michigan Public Health Code, Act 368.

Provider Qualifications

Primary care case managers must have a PCMH designation to participate. MiPCT PCMH designation means a practice that received PCMH designation through the Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP) in 2010 and/or NCQA recognition as a Level 2 or 3 PCMH prior to July 2010. Providers who want to participate after 2010 can participate by demonstrating that they meet the criteria established as of 2010 for the Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP) and/or the criteria established as of July 2010 for NCQA recognition as a Level 2 or 3 PCMH. PCMH designation must be maintained throughout the term of the project. PCCMs must also be affiliated with a PO/PHO participating in the Physician Group Incentive Program (PGIP) of Blue Cross Blue Shield of Michigan which provides supportive services to enhance the practice's medical home capabilities and enables continuous quality improvement. These practitioners will employ or arrange with their respective PO/PHO to employ a care manager as part of a care management team (called the Care Team). Care managers must meet MiPCT education and training requirements and conform to MiPCT clinical guidelines.

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Service Descriptions

Providers of this service will provide for the location, coordination, and monitoring of primary care services through ongoing collaboration with the Care Team, consisting of a primary care case manager as defined above, care managers who meet MiPCT program requirements, and other members of the care team who may include nurses, medical assistants, and other clinical support staff who jointly participate to manage care for the entire patient panel as well as distinct subsets of patients.

Limitations

Functional tiers are used to describe the acuity levels of PCMH services provided to patients for the location, coordination, and monitoring of services. Each progressive tier includes and builds on all aspects of the previous tier(s).

- Tier 1 PCMH services focus on navigating the medical neighborhood. Services include provider-led Care Team interactions designed to optimize relationships with other providers, specialists, and hospitals; coordinate referrals and tests; and link patients to community resources.
- Tier 2 services align care transitions. Services in this tier provide for notification of admission and discharge from hospitals and other institutional care settings; PCP and/or specialist follow-up; and medication reconciliation.
- Tier 3 care management services use planned visits to optimize the care of chronic conditions; emphasize self-management support and patient education; and the informed use of advance directives.
- Tier 4 complex care management services include arrangements for a home care team; a comprehensive care plan; and palliative and end-of-life care.

The PCMH model expands access to primary care and improves care coordination. Assistance and support for practice transformation takes place through a collaborative network of POs/PHOs and shared learning opportunities facilitated by the MiPCT administrative staff. Focus areas for transformation include care management, self-management support, care coordination, and linkages to community services.

Quality Assurance

In terms of cost and efficiency, Michigan will measure overall costs, and assess both cost and utilization in areas that were shown to drive costs including hospitalizations, 30-day all-cause readmissions, and emergency department visits. Exploratory work will investigate the direction of costs in the following categories: primary care, specialty care, and high-cost radiology. Readmissions will be examined in common diagnostic categories for purposes of providing actionable feedback to participants.

Experience of care outcomes will be assessed for both patients and practices. For patients, a Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH survey will be conducted to address the following PCMH domains: access, communication, coordination, comprehensiveness, shared decision-making, whole person orientation, and self-management support.

Experiential data will be collected from program participants including patients, POs/PHOs, practices, and others. Formal surveys, as well as analysis of project documents will be the main mechanism to collect both experience and process data. Standardized tools will be selected with additional questions added to meet project specific informational needs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

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Assurances

All services provided to MiPCT participants are in accordance with 1905(t) of the Social Security Act. Individuals with a favorable health status are not selectively recruited and conversely, individuals are not discriminated against based on health status. Beneficiaries that have selected or been assigned by their Medicaid Health Plan to a MiPCT eligible primary care provider will receive care coordination services. In accordance with 1932(a)(4),beneficiaries who do not wish to receive any form of care coordination may opt out. Beneficiary personal information is utilized by MiPCT providers for HIPAA permissible purposes of treatment, payment, and/or operations. The use of beneficiary information for measurement and evaluation purposes is permitted according to the Data Use Agreement between MDCH and its contracted MiPCT administrative support partners, as well as the Data Use Agreement between MDCH and CMS; and CMS and the MiPCT-participating POs and practices.