Quarterly Update(Q3)

State Innovation Model

Patient Centered Medical Home Initiative

9/21/2017

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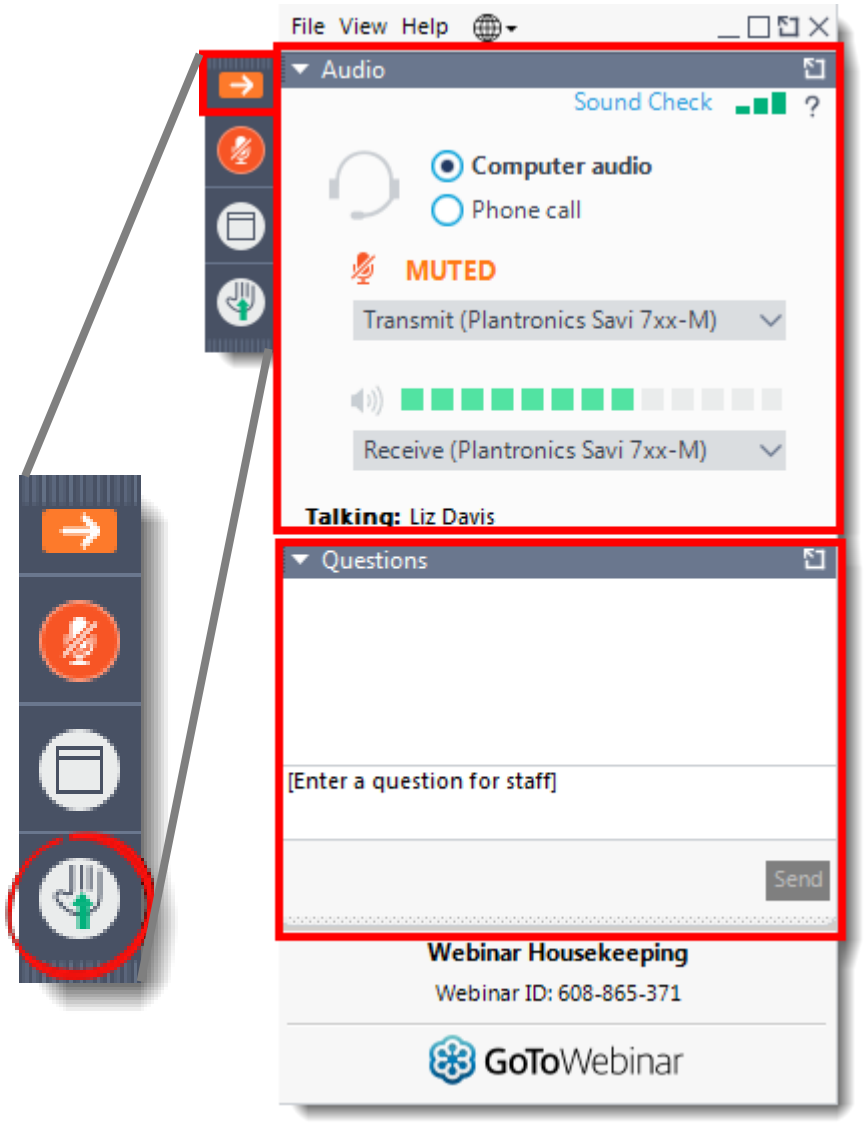
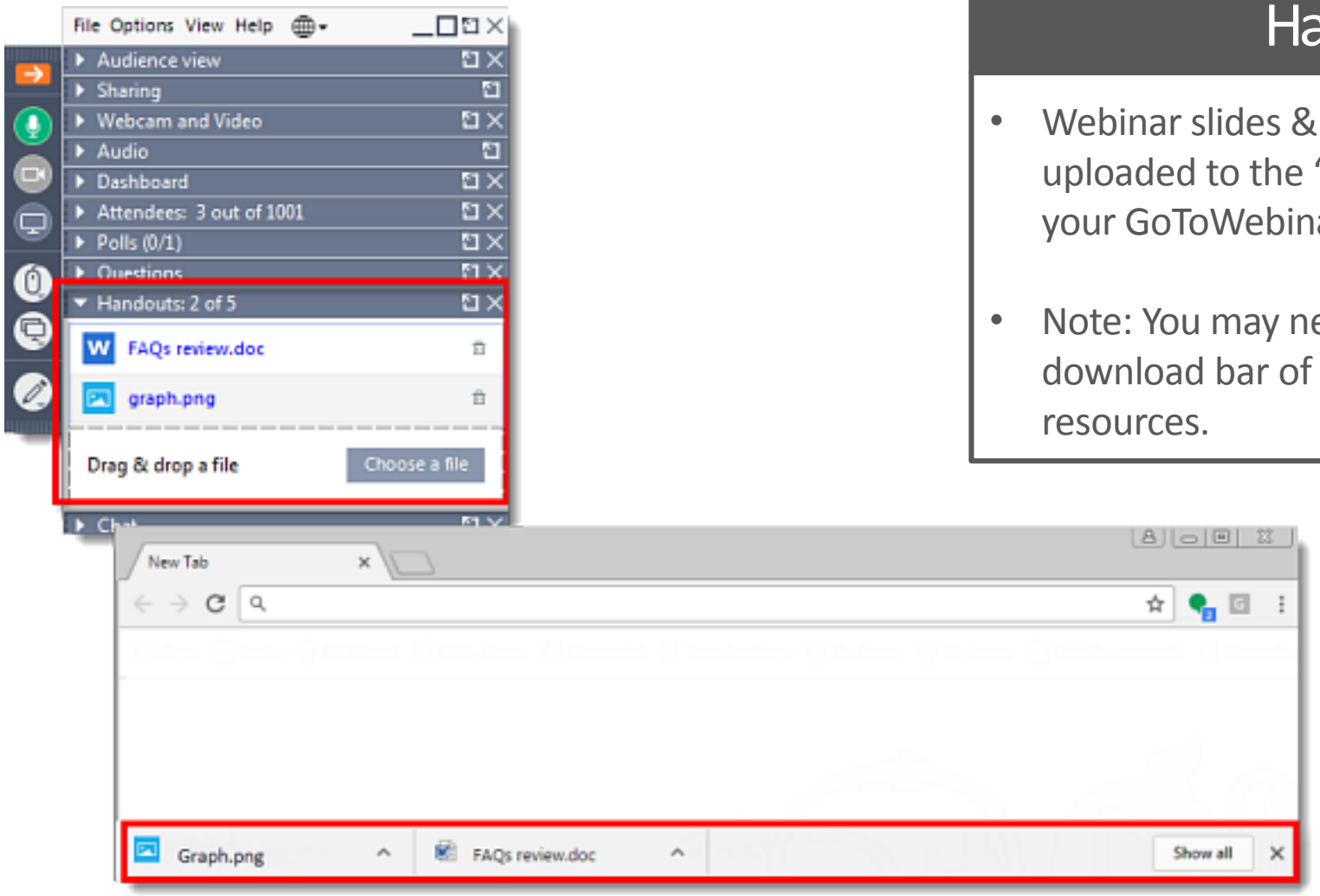
Submit questions and comments via the Questions panel

Note: If time allows, we will unmute participants to ask questions verbally.

- Please raise your hand to be unmuted for verbal questions.



Housekeeping - Webinar Resources / Handouts



Handouts

- Webinar slides & other resources are uploaded to the “Handouts” section of your GoToWebinar Toolbar.
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Overview / Webinar Agenda

- Initiative Overview → How are we doing?
  - Quality and Utilization
  - HIE Use Case onboarding
  - Practice Transformation Progress
- Upcoming Learning Activities & Support
  - CM/CC Affinity Groups
  - PCMH Initiative Dashboard Release 2
- Upcoming Compliance Expectations
  - Audits – underway
  - Reporting
- Quarter 3 Payment Update
- Care Management and Coordination Metrics
- Q&A Session: Intent to Continue Participation in 2018 Initiative

Initiative Overview

HOW ARE WE DOING?

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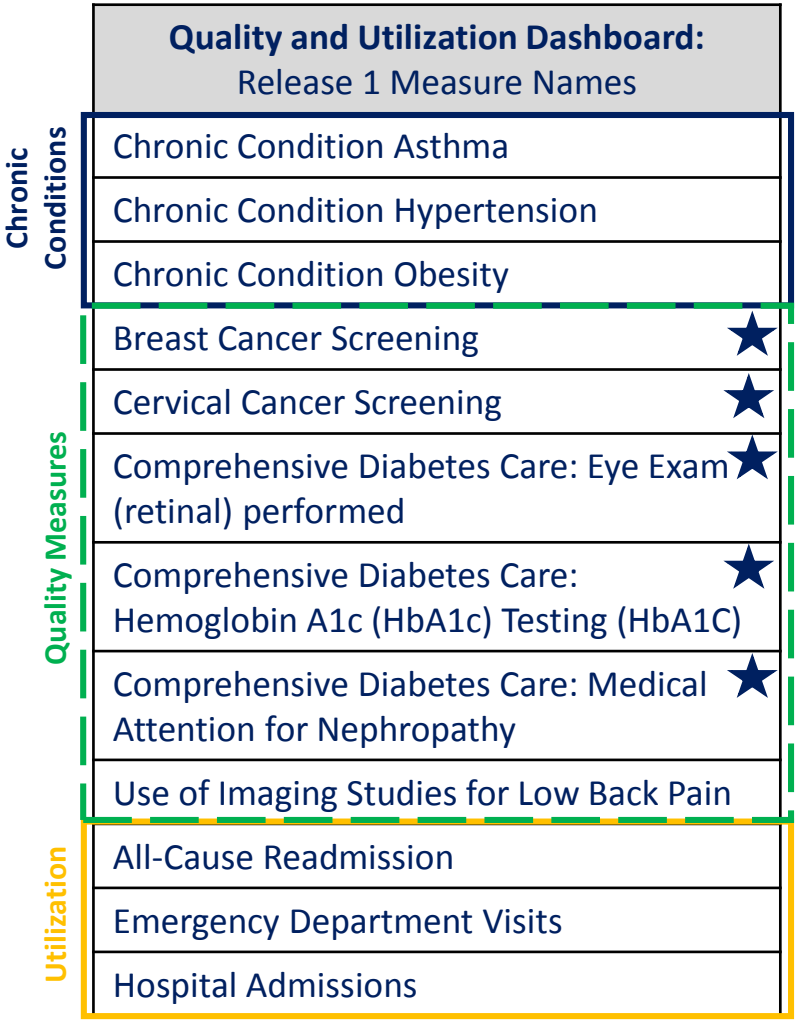
PCMH Initiative Quality & Utilization Dashboard

- Patient Lists:
  - Includes attributed Medicaid Beneficiaries eligible for CM/CC Services
- Care Management and Coordination Metric Reports
  - Identifies performance on each CM/CC metric
- Quality and Utilization Dashboard:
  - Allows Quality and Utilization Measure Review at multiple levels
  - Includes Visualization and Charts of Medicaid eligibility, medical and drug claims as well as January attribution utilized to calculate measure results
    - Release 1 Reporting Period: 1/2016 – 12/2016 (Baseline)
    - Functions on January 2017 Attribution
  - Supports Participants in:
    - Evaluating overall performance
    - Compare to benchmarks and other participating organizations
    - Identify areas for improvement



*Clinical Data is not expected in the first few releases. Measures will be supplemented when data is available.

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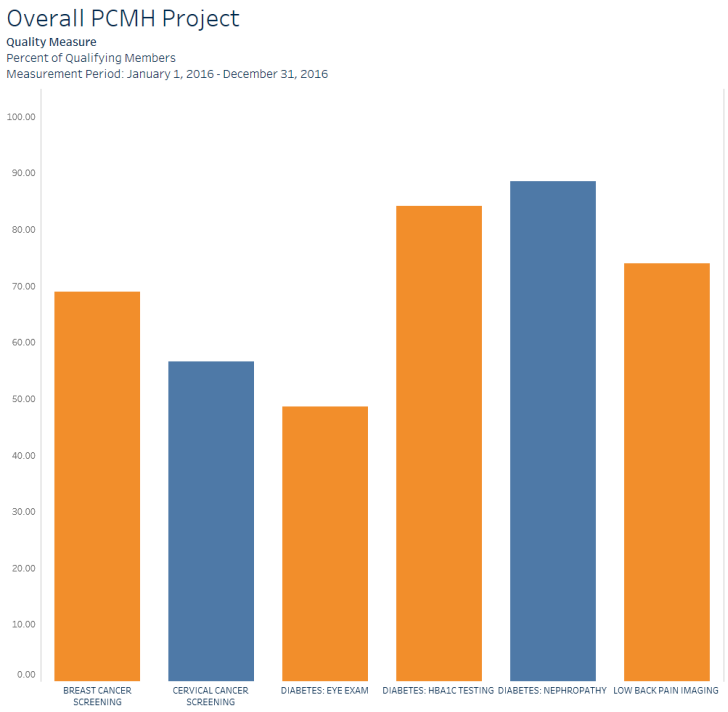
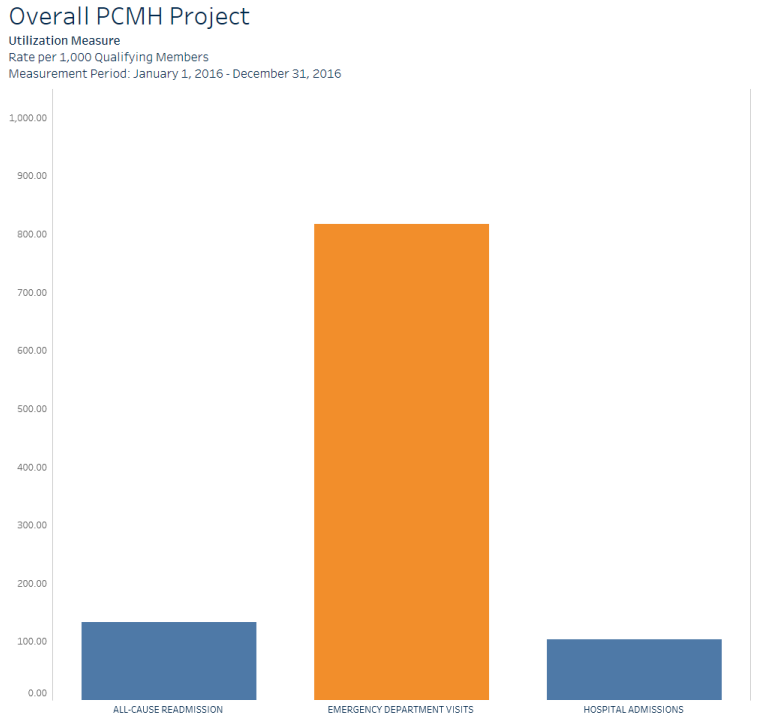
Quality and Utilization:
Highlights from Dashboard Release 1

POs/MSOs	Practices	Providers	Patients
34	344	2,122	343,859

Attribution: January 2017

Total Patients	343,859	
Average Age	22	
Patients by Sex		
Female	184,435	54%
Male	159,424	46%
Patients by Race		
Black	86,288	25%
White	199,925	58%
Other/Unknown	57,937	17%
Chronic Condition	105,289	31%
Asthma	26,726	8%
Hypertension	35,264	10%
Obesity	71,808	21%
Overweight	24,546	7%
Moderate	11,122	3%
Severe	45,532	13%





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SIM PCMH Initiative Participants

General HIE Update

Managing Organizations:

- 29 Physician Organizations
- 5 Multi-Site Practices

Practices:

- 337 Total Practices
  - Includes 9 Independent Practices

Providers:

- 2153 Physicians

SIM PCMH Initiative Participants
MiHIN Legal Agreement Status

SIM PCMH Initiative Participants	MUCA/SDOA/QDSOA	ADT	ACRS	HD	QMI	CKS
Medicaid Health Plans	100%	100%	100%	100%	100%	100%
Managing Organizations	100%	100%	100%	100%	100%	100%
Multi-site Practices	100%	100%	100%	100%	100%	100%
Independent Practice Units	100%	100%	100%	100%	100%	100%

SIM PCMH Initiative Participants

HIE Use Case Onboarding Status: Overall Participation

SIM PCMH Initiative Participants	TOTAL (OF 43)	PERCENTAGE
In ACRS Service	41	95%
In Health Directory	41	95%
Receiving ADTs	35	81%

SIM PCMH Initiative Participants

HIE Use Case Onboarding Status: Org Type Breakdown

SIM PCMH Initiative Participants	ACRS	ADT	HD
29 Managing Organizations	42 of 43 98% In Production	39 of 43 91% In Production	42 of 43 98% In Production
5 Multi-Site Practices	100% In Production	100% In Production	100% In Production
9 Independent Practice Units	8 of 9 89% In Production	5 of 9 56% In Production	8 of 9 89% In Production

MiHIN and the PCMH Initiative Team are working with participants that need assistance with technical onboarding

SIM PCMH Initiative Participants

MHP Use Case Onboarding Status

Medicaid Health Plan	ACRS	ADT	HD
Aetna	In Production	In Production	In Production
Blue Cross Complete	In Production	In Production	In Production
HAP Midwest Health Plan	In Production	In Production	In Production
Harbor Health Plan	In Production	In Production	In Production
McLaren Health Plan	In Production	In Production	In Production
Meridian Health Plan	In Production	In Production	In Production
Molina Healthcare	In Production	In Process	In Production
Priority Health	In Production	In Process	In Production
Total Health Care	In Production	In Production*	In Production
United Healthcare Community Plan	In Production	In Production	In Production
Upper Peninsula Health Plan	In Production	In Production	In Production

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SIM PCMH Initiative Participants

Quality Measure Use Case Onboarding Status

SIM PCMH Initiative Participants	TOTAL (OF 43)	PERCENTAGE
Kick Off Call Complete	43	100%
SFTP Accounts Created	41	95%
PPQC Files Received	35	81%

Practice Transformation:
Clinical-Community Linkage Design and Implementation

Highlights:

- 43% of Participants have started the screening process
- 86% of the Participants submitted a screening plan
- Most Participants will be initiating screening as part of the annual wellness exam or care management visit
- Almost 90% of Participants have a staff training approach in place
- Participants working collaboratively with CHIRs to support screening/linking processes

Opportunities

- Few Participants specifically mentioned plans for patient follow-up after the linkage is made
- Few Participants mentioned **how** they would follow up with patient after a linkage is made
- Some Participants relying solely on Care Management staff member(s) to implement CCL design as opposed to supporting team-based nature of the activities
- Some participants still unclear on the CCL requirements and ultimate purpose

Quality Improvement Activities

Screening QI Activities:

- Analyze variation in screening rates
- Compare feedback of different screening approach (paper, phone, etc.)
- Discuss where screening is more effective (who is with patient at the time of screening

Linkage QI Activities:

- Identify high volume community needs
- Plan community resource event to see if all needs are met
- Interview clinical sites to understand barriers and opportunities
- CHIR: Electronic screening and Pathways reporting

Partnership Approaches

76% of Participants have identified their partnership approach

- Meet CHW and PATHWAY organizations to optimize relationship
- Annual review and contact with community resources
- New local services are invited to present
- Regular touch base meetings
- Information contacts
- Donate funds to community organizations
- Volunteer on-site labor services such as local Soup Kitchen
- Formal MOU
- Community care management collaborative

Upcoming Compliance

SEPTEMBER/OCTOBER

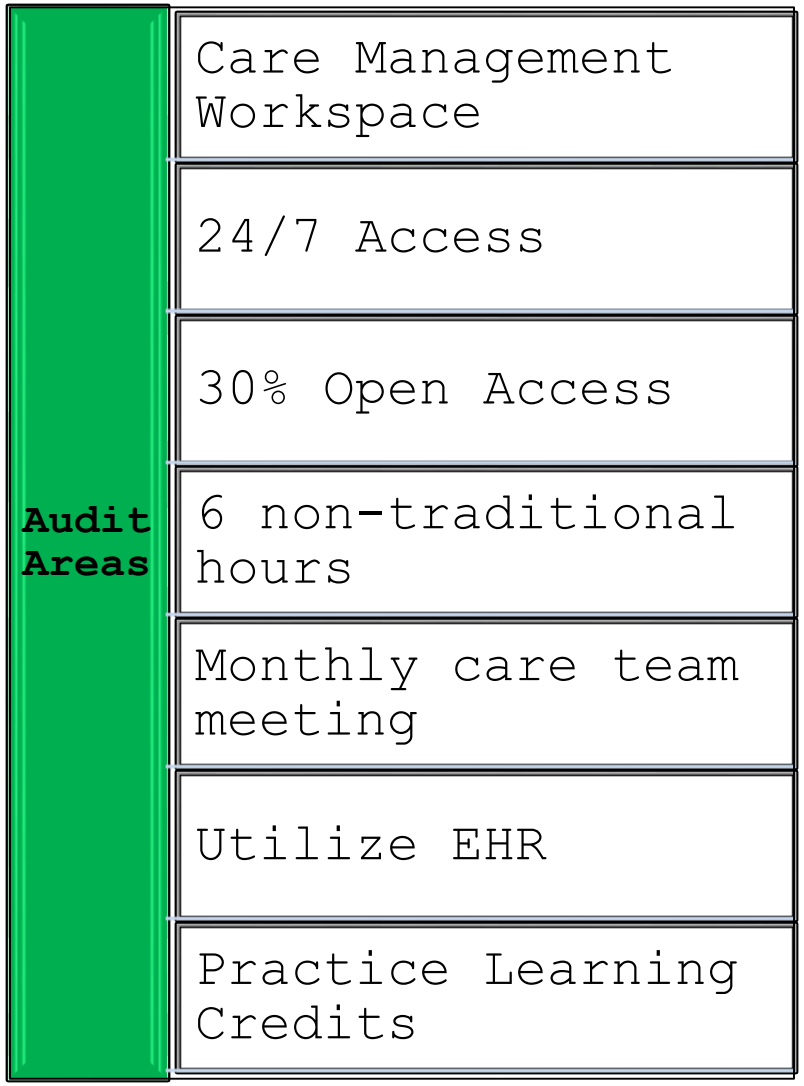
Upcoming Compliance

Q3 Participant Audits

Timing: September 1 - 30

Status:

- Outreach complete for audits
  - Emails sent to care managers at sites requesting participation in an online survey about their workspace **[6 responses received so far, due 9/22]**
  - Calls made to practices during business hours to verify hours open **[2 practices did not pass]**
  - Calls made to practices after hours to verify a decision-maker could be reached **[Results TBD]**
  - Emails sent asking for notes/agenda from care team meetings, or masked patient note from EHR **[1 response, due 9/22]**
  - Sample of practices sent to BCBSM to verify compliance with BCBSM measure 5.7 (30% open access) **[100% pass]**



Upcoming Compliance
Quarterly Progress Report (Q3)

Release: first week of October

Due: October 31, 2017

Content:

- PO contacts and clinical champion, practice contacts and clinical champions
- Care Manager and Coordinator information
- MHP contracting information
- Infrastructure, practice, provider changes
- Practice Registry
- High Level Practice Transformation check in
- Participation Experience, Strengths and Challenges

Note:

Report will be formatted so that the PO can complete on behalf of all participating practices

Participant Key Contact will receive an email with supplemental excel document (similar to Q2 report)

Upcoming Compliance
Semi-Annual Practice Transformation Report

Release: early November

Due: December 22, 2017

Content:

- Clinical Community Linkages
  - Focus on submission of finalized tools, screening & linking plans
  - If a plan previously submitted, report on progress or indicate any updates to the plan
- Elected Practice Transformation Objective

Note:

Report will be formatted so that the PO can complete on behalf of all participating practices, but variance between individual practices will be noted.

Learning Activities & Support

Learning Activity
Annual Regional Summits

Taking Michigan Forward with Team-Based Care

Purpose:
Each interactive regional summit will facilitate collaboration and shared learning focused on efficient team- based care in the primary care setting. Together physicians, practice team members, Physician Organization leaders and partners will address clinical and office operations aimed at meeting the diverse needs of the Michigan patient population.

Intended Audience:
The summits are intended for Michigan State Innovation Model (SIM) Patient Centered Medical Home (PCMH) Initiative participants and partners including physicians, practice teams, care managers, care coordinators, Physician Organization leaders, Community Health Innovation Region (CHIR) partners, and health plans.

Contact Hours:
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Michigan State Medical Society (MSMS) through the joint providership of Practice Transformation Institute and Michigan Department of Health and Human Services. Practice Transformation Institute is accredited by the MSMS to provide continuing medical education for physicians.

Practice Transformation Institute designates this live activity for a maximum of (6) *AMA PRA Category 1 Credit(*s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Practice Transformation Institute is accredited by the International Association for Continuing Education and Training (IACET) and is authorized to issue the IACET CEU. Practice Transformation Institute is authorized by IACET to offer .6 CEUs for this program.

This activity provides 6 Social Work Continuing Education Contact Hours. "Michigan Care Management Resource Center is an approved provider with the Michigan Social Work Continuing Education Collaborative". Approved Provider Number: MICEC 1102160

West
October 10, 2017
Frederik Meijer Gardens & Sculpture Park
1000 East Beltline Ave NE
Grand Rapids, MI 49525
REGISTER HERE

Southeast
October 17, 2017
University of Michigan North Campus Research Center
2800 Plymouth Rd, Bldg. 18
Ann Arbor, MI 48105
REGISTER HERE

North
October 24, 2017
Crystal Mountain Resort & Conference Center
12500 Crystal Mountain Dr.
Thompsonville, MI 49683
REGISTER HERE

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Participant Support

Required Training: Care Managers and Coordinators

Initial Required Training	Care Coordinator	Care Manager
MiCMRC Approved Self-Management Support Course	X	X*
MiCMRC Complex Care Management Course		X
SIM Overview Recorded Webinar	X	X
PCMH, Chronic Care Model, and ACOs Recorded Webinar	X	X**
Team Based Care Recorded Webinar	X	X**
Introduction to Social Determinants of Health Recorded Webinar	X	X***
The Role of Care Managers & Care Coordinators in Developing and Maintaining Community Linkages Recorded Webinar	X	X***
Social Determinants of Health and the Implications for Care Management eLearning Module	X	X***
Social Determinants of Health Case Study eLearning Module	X	X***

*Care managers are strongly encouraged to complete this course prior to registering in the MiCMRC CCM Course.
**Recorded webinar content is included in the CCM course. If a care manager attends the CCM course after January 2017, they do not need to complete the PCMH, Chronic Care Model, and ACO or the Team Based Care recorded webinars. However, Care Coordinators do need to complete
***SDOH recorded webinars and eLearning modules are included in the CCM course content. If the care manager attends the CCM course after July 2017, they do not need to complete the recorded webinar or eLearning Modules. However, Care Coordinators do need to complete.

Participant Support

Care Manager and Coordinator Affinity Groups

Benefits of Participation:
The Participants of the Affinity Groups identify the focus/topics for each Affinity Group meeting.
Meetings are interactive with participants sharing experiences, challenges, lessons learned and successes.
Networking opportunities.
Affinity Groups are offered quarterly via one hour virtual meetings.
Care Managers and Care Coordinators who participate in an Affinity Group will receive a maximum of *four longitudinal learning activity hours* each calendar year.*
Care Manager & Care Coordinator Participant Commitment:
Attendees will participate in a variety of ways during the interactive virtual meeting; posting questions, sharing experiences and lessons learned, and responding to polls.
Completion of post meeting evaluation.
Post meeting information sharing. Attendee contact information will be shared with the group to promote networking. Example: in addition to the contact information, sharing information such as area of expertise.
Completion of a brief survey to identify future high priority Affinity Group meeting topics.

Purpose:

Affinity Groups are designed for SIM PCMH Care Managers and Care Coordinators to facilitate networking, peer to peer learning, and best practice sharing across the state. We will have two types of Affinity Groups—an Adult Affinity Group and a Pediatric Affinity Group

Who:

Open to all PCMH Initiative Care Managers and Care Coordinators. *Participation is voluntary*

When: November 2017

Participant Support

Care Manager and Coordinator Affinity Groups

SIM PCMH Initiative Care Manager and Care Coordinator Affinity Groups: All Sessions Take Place From: 2:00 PM – 3:00 PM EST				
Date	**Patient Population**	**Topic**	**Registration**	**Other Information**
November 28, 2017	Pediatric	Kids Health – Overweight and Obesity	Register Here	Submit your questions in advance on the registration link.
November 30, 2017	Adult	Population Health Management	Register Here	Submit your questions in advance on the registration link.

Registration and Flyer for Affinity Group:
http://www.michigan.gov/documents/mdhhs/Affinity_Group_Flyer_FINAL_572275_7.pdf

SIM PCMH Dashboard

Release 2

Release 2 Dashboard targeted for end of October

- Reporting Period: 6/2016 - 5/2017
- May 2017 Attribution
- Medicaid eligibility, medical and drug claims utilized to calculate measure results

New Measures

- Adolescent Well-Care Visits
- Childhood Immunization Status
- Chlamydia Screening
- Immunization Status for Adolescents
- Lead Screening in Children
- Well-Child Visits in First 15 months of Life
- Well-Child Visits in Third, Fourth, Fifth and Sixth years of life

New Functionality

- Managing Organization, Practice and Provider Comparisons
- Provider view for Executive Summary, Utilization and Quality visualizations and data

User Access Security Update

Michigan Department of Health & Human Services

Payment Update

Quarter 3 (July, August, September)

Reminder
Q1 Technical Setback

A technical setback was uncovered during the Quarter 1 payment process, MDHHS has been investigating. This setback impacted deliverables related to patient attribution, including the following items:

- Q2 PCMH Initiative Patient Lists
- The Initial Release of Quality Measure Dashboards
- Quarter 2 Payment Timing

This technical setback has an additional impact on Quarter 3 payments

Q3 Payments
What does the Q1 Setback Mean?

Some patients were included in Q1 attribution and payment inadvertently

- Some MHPs identified the attribution issue internally and did not make inappropriate payment to providers
- Some MHPs did make the full payment, including for beneficiaries that should have been excluded.
- This does not impact all providers/practices; concentrated on those providers that practice out of multiple locations

Q3 payment will include a reconciliation/offset in payment to adjust for any overpayment

- In some cases the MHP did not make the overpayment in Q1 and payment for Q3 will not be impacted
- MDC has developer a 1Q17 Aggregate difference report to support this process, will be released on October 12, 2017

Payments are expected to go to Participants in middle to late October*

CM/CC Metrics

MONITORING DETAILS/2017 EXPECTATIONS

Care Management and Coordination Metrics
Background

To receive the PMPM care management and coordination payment, Practices must:

- Maintain care management and coordination expectations as defined in Appendix C (of the 2017 Participation Agreement). **Reported during Quarterly Reports**
- Maintain care management and coordination performance above benchmarks established by the Initiative no later than June 30, 2017, on the following two metrics:
    - The percentage of a Practice's attributed patients receiving care management and coordination services; and
    - The percentage of a Practice's attributed patients receiving a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient or emergency discharge or transfer from one care setting to another.

Care Management and Coordination Metrics

Metrics & Benchmarks

	2017 BENCHMARK	2018 BENCHMARK
Any patient who has had a claim with one of the applicable codes during the reporting period / Eligible Population	2.0%	↑↑%
Any patient who sees a PCP, within 14 days of the last discharge date on a room and board claim in the measurement period. / Eligible Population with an inpatient claim*	XX%	XX%

*Exclude any member who had an inpatient stay in a psychiatric facility, or inpatient stays related to delivery

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Care Management and Coordination Metrics
% of Patients Receiving CM/CC Services

2017 BENCHMARK **2018 BENCHMARK**

Any patient who has had a claim with one of the applicable codes during the reporting period

Eligible Population

→ **2.0%** → ↑↑%

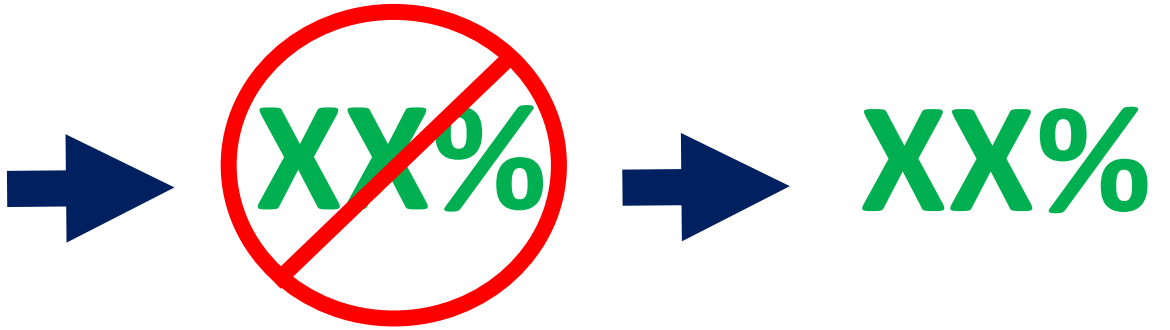
What is the Measurement Period?	Quarterly. Monthly reports will be aggregated and de-duplicated to generate quarterly totals.
Is the metric assessed at Practice or PO level?	The metric will be assessed at a practice level, FQHCs participating independently will be treated as a single practice.
When does the monitoring take effect?	For dates of service in Q4 (Oct., Nov., Dec. 2017). Reports to support monitoring will be available in April 2018.
What is the impact if benchmark not met?	Participants will be required to execute a process improvement plan, allowing a re-measurement period. In addition, they may be required to complete Initiative led technical assistance
How do participants know how they are doing?	The Michigan Data Collaborative generates monthly Care_Coordination_Percent reports, and will soon provide quarterly reports to Participants.

Care Management and Coordination Metrics
Follow-up after Discharge

2017 BENCHMARK **2018 BENCHMARK**

Any patient who sees a PCP, within 14 days of the last discharge date on a room and board claim in the measurement period.

Eligible Population with an inpatient claim*



WILL BE SHARED SOON

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How do participants know how they are doing?	The Michigan Data Collaborative generates monthly Care_Coordination_IP reports, and will soon provide quarterly reports to Participants.

2018 PCMH Initiative

INTENT TO CONTINUE PARTICIPATION Q&A

PCMH Year 2 Preview
Overview of Transition

PCMH Initiative Year 2 Participation Requirements:

- Core Primary Care (PCMH) Requirements
- Clinical Practice Improvement Activities (Practice Transformation)
- Care Management and Coordination Requirements
- Health Information Technology and Exchange Requirements
- Participant Support and Learning Activities
- Initiative Operations Requirements
- Payment Model and Payment Budget

Details of 2018 updates included in release webinar (recording and slides posted here)

REMINDERS:
2018 Intent to Continue Participation

- The Intent to Continue Participation "Application":
  - Is required for all practices that wish to continue participation in 2018
  - Is open to current participants only (not currently accepting new practices)
  - Can be completed by PO representatives on behalf of participating practice locations
  - FQHCs with multiple practice locations will complete a single "application"
  - Participant key contacts were sent individualized excel templates to edit (as necessary) and upload within the online "application"

- Key Dates:
  - "Application" open: 9/13/2017 (webinar recording and slides posted here)
  - "Application" Q&A: Thursday 9/21/2017 (during Quarter 3 virtual update meeting)
  - "Application" closes: Friday 9/29/2017

2018 PCMH Initiative
FAQs

Question	Answer
Is the Initiative expanding/accepting new practices in 2018?	The PCMH Initiative will be maintaining the current participation. No new regions or practices will be added at this time.
Will the commercial or Medicare Patient Population be included in Y2?	While the State Innovation Model and the PCMH Initiative support multi-payer alignment, the patient population in 2018 will remain focused on Medicaid beneficiaries with the same inclusion/exclusion criteria as used in 2017.
Can Alternative Considerations be submitted in Y2?	Alternative Considerations will be accepted for the requirement detailed below: *Ensure (on average over the course of a week) 30% of available appointments are reserved for same-day care across the patient population.*
Will additional HIE Use Cases be required in Y2?	The 2018 PCMH Initiative is focusing on the maintenance and active use of the HIE Use Cases that have been established in 2017.
Is the Practice Transformation Collaborative: Phase 2 required?	The Practice Transformation Collaborative: Phase 2 is an optional Learning Community for participating practices teams focused on supporting them in the implementation and strengthening of Clinical-Community Linkages. While not required for Initiative participants, those that express interest and plan to participate must make a commitment to actively participate in the Learning Network events, data collection, and information sharing.

Discussion