SIM PCMH Initiative

Intent to Continue Participation

9/13/2017

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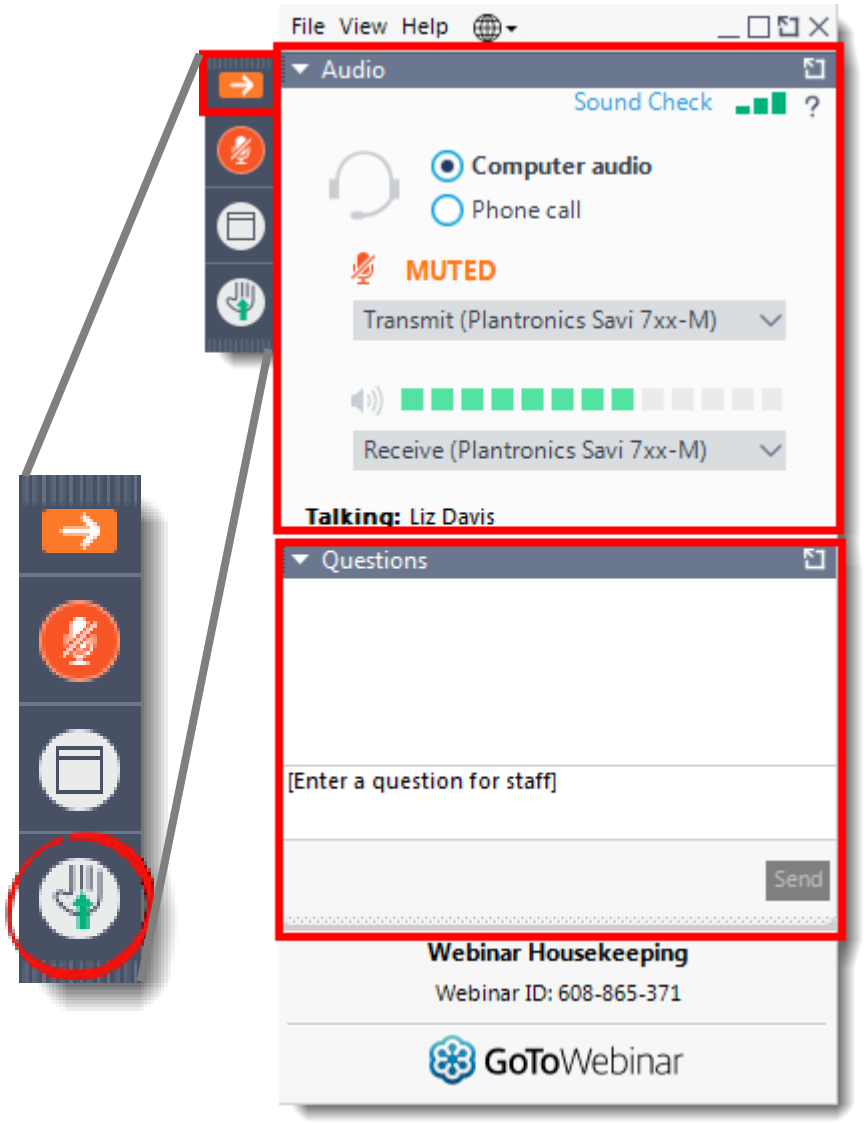

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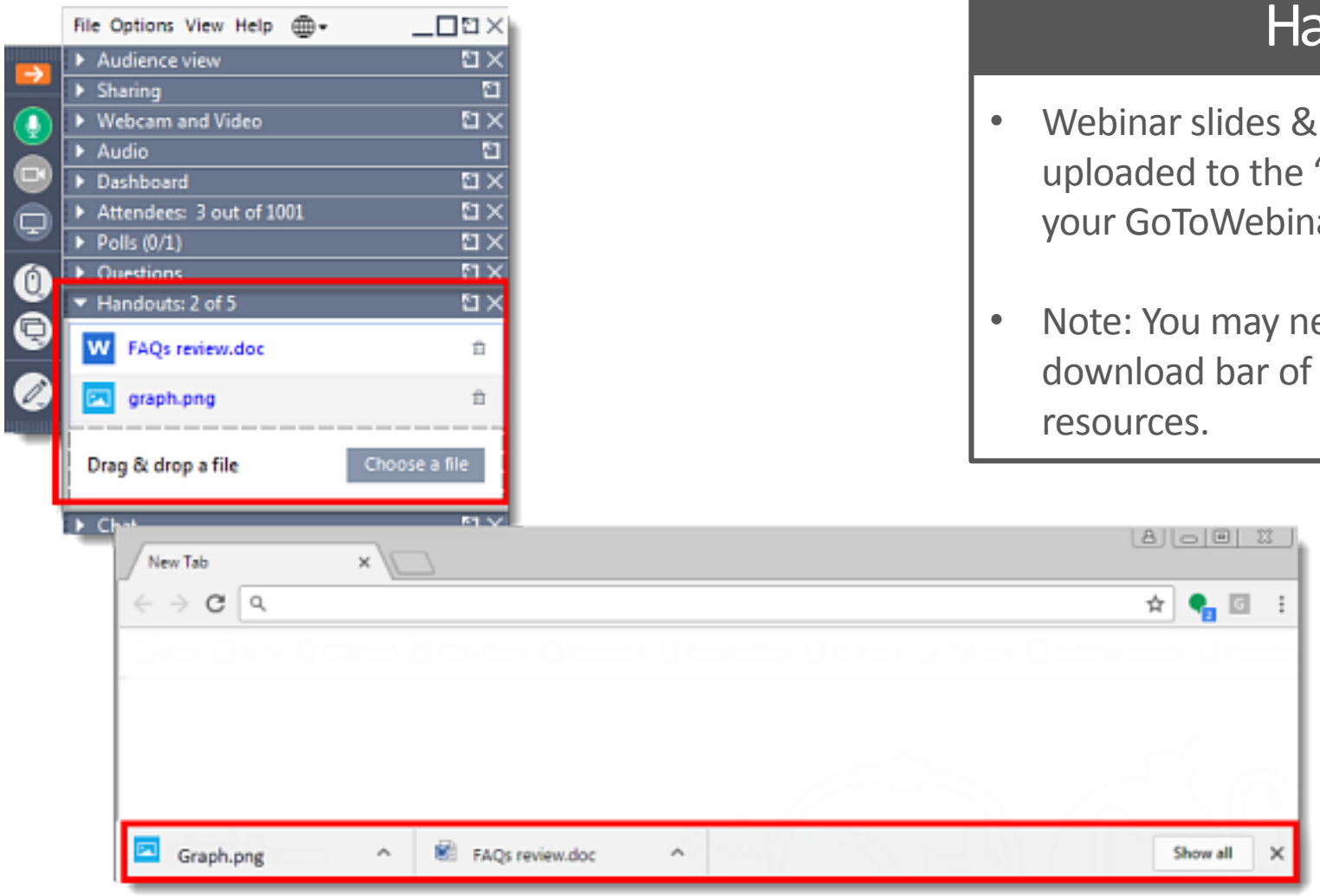


Handouts

- Webinar slides & other resources are uploaded to the “Handouts” section of your GoToWebinar Toolbar.
- Note: You may need to check the download bar of your browser to view the resources.

2018 Preview

Transition from 2017 Initiative to 2018 Initiative

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

PCMH Initiative Year 1
Accomplishment Highlights

- Application, Participant Selection and Participation Agreement Processes Established
- Completed the First Annual Participant Self-Assessment Process
- Established Performance Monitoring Measures/Reporting and Requirements Compliance Processes
- Finalized Medicaid Payment Model, Care Management and Coordination Tracking Codes and Payment Process (including MHP payment arrangements) in Partnership with MHPs
- Refined and Re-Launched the Complex Care Management Training Program for Participants
- Began Producing PCMH Patient Lists and Resolved Attribution Challenges
- Deployed Quarterly Progress Reporting and Semi-Annual Transformation Reporting Formats and Processes
- Defined Practice Transformation Objectives and Launched Learning Collaborative
- Launched New Billing and Coding Training for Participants
- Began Active Participant/Provider Data Maintenance through the Health Directory and Completed Technical Onboarding for ACRS and ADT Use Cases, began technical onboarding for the QMI Use Case
- Developed a Regular Office Hours (Participant Guidance) and Participant Meeting Cadences
- Launched a Monthly Participant Newsletter and New Participant Communications Process

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

PCMH Year 2 Preview

Core Primary Care (PCMH) Requirements

Requirement		2017	2018
Accreditation	NO CHANGE	Possess and maintain current designation from one of the following organizations/programs: • National Committee for Quality and Assurance- PCMH (NCQA) • Accreditation Association for Ambulatory Health Care- Medical Home (AAAHC) • The Joint Commission- PCMH (TJC) • Blue Cross Blue Shield of Michigan/Physician Group Incentive Program- PCMH • Utilization Review Accreditation Commission- PCMH (URAC) • Commission on Accreditation of Rehabilitation Facilities- Health Home (CARF)	
24/7 Access	UPDATED	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.	Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.
Team-Based Care	UPDATED	…encouraging team-based care and attention to other aspects of the PCMH Initiative model.	Organize care by practice identified teams responsible for a specific, identifiable panel of patients to optimize continuity.

PCMH Year 2 Preview

Core Primary Care (PCMH) Requirements, cont.

Requirement		2017	2018
Alternative to Traditional Visits	UPDATED	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.	Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.
Same Day Appointments	NC	Ensure (on average over the course of a week) 30% of available appointments are reserved for same-day care across the patient population. (Alternative Considerations Allowed)	
Care Team Meetings	UPDATED	Ensure that all Care Team(s) meet at least monthly with time dedicated to team-based management and review of reports.	Ensure that all Care Team(s) have planned meetings at least monthly (or, alternatively, team huddles more frequently) with time dedicated to reviewing practice and panel level data from payers and internal monitoring, and use this data to guide tactics to improve care and achieve practice goals.

PCMH Year 2 Preview

Clinical Practice Improvement Activities (Practice Transformation)

Requirement		2017	2018
Clinical-Community Linkages	UPDATED	Develop documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations which provide services and resources that address significant socioeconomic needs of the Practice's population following the process below: a. Assess patients' social determinants of health to better understand socioeconomic barriers using a brief screening tool with all attributed patients. b. Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and outcomes of referrals made. c. As part of the Practice's ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion.	While the base requirement will remain the same from 2017 to 2018, the Clinical-Community Linkage Requirement in the 2018 participation agreement will transition focus from establishing to maintaining CCL efforts in year 2. Additional detail will be provided in the requirements, some focused on outlining expectations for participants located within Community Health Innovation Region and those outside of Community Health Innovation Regions.
Other Objective	UPDATED	Selection of one objective from a menu of 11 practice transformation objectives	All Participants will be required to focus on Population Health, current participants which selected an objective other than population health during year one will be asked to realign their objective as an activity which corresponds with improving performance on one or more of their population health objectives.

PCMH Year 2 Preview

Care Management and Coordination Requirements

Requirement		2017	2018
Embed CM/CC Staff	NC	Embed Care Management and Coordination staff members functioning as integral, fully-involved members of every participating Care Team.	

CM/CC Team Composition	UPDATED	• Care Managers and Care Coordinators may be employed or contracted by the 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.
		• Maintain a ratio of at least 2 Care Management and Coordination staff members per 5,000 patients attributed to the Practice as part of the PCMH Initiative.
		  • At least one member of the Care Management and Coordination team must be a licensed Care Manager.
		  • Other members of the team may be a licensed Care Manager or a Care Coordinator.
			• Care Managers and Care Coordinators may be employed or contracted by the 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.
			• The Initiative encourages Practices to include a licensed Care Manager as part of the Care Management and Coordination team. However, a Practice may staff their team(s) using both licensed Care Manager(s) and/or Care Coordinators(s) as needed to meet the needs of the patient population and other programmatic/payer/administrative requirements outside the Initiative.

PCMH Year 2 Preview

Care Management and Coordination Requirements, cont.

Requirement		2017	2018
CM/CC Service Types	UPDATED	*The level of intensity of care management will vary based on the needs of the patients, as to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.*	• Provide targeted, proactive, relationship-based (longitudinal) care management and coordination to all patients identified as at increased risk, based on a defined risk stratification process, and who are likely to benefit from intensive care management. • Provide short-term (episodic) care management and coordination along with medication reconciliation to patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management/coordination. • Use a plan of care centered on patient's actions and support needs in the management of chronic conditions for patients receiving longitudinal care management.
CM/CC Population Served	UPDATED	• Assure that embedded Care Managers/Care Coordinators are serving attributed patients from all participating Payers. • 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).	Ensure at least XX%* of attributed Practice patients receive care management and coordination services (represented through billing MHPs using the Initiative's tracking codes). *While no finalized, it is likely that the required percent of patients receiving CM/CC services will be increased from the 2017 benchmark
Collaborative Care	NC	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.	

PCMH Year 2 Preview

Care Management and Coordination Requirements, cont.

Requirement		2017	2018
Self-Management Support	UPDTD	Defined as an activity or service of Care Management and Coordination	Implement self-management support for at least 1 high risk condition.
CM/CC Training	UPDATED	1. Care Management Learning Requirement a. Each Care Manager and Care Coordinator must have completed a Self-Management Support Training Program approved by the PCMH Initiative within six months of hire. b. Each Care Manager must have completed the Complex Care Management Course provided by the PCMH Initiative within six months of hire. c. Each Care Manager/Coordinator must complete a total of twelve (12) contact hours of continuing education per year. This can be satisfied through attendance at PCMH Initiative-led events, PO-led trainings, or other related continuing education credit-granting events.	Care Managers and Care Coordinators must receive care management and self-management training provided or approved by the Initiative in addition to obtaining an additional 12 hours of care management/coordination training annually.
CM/CC Other (Workspace, Provider Contact, Serving Across MHPs)	NO CHANGE	• Assure that Care Managers/Care Coordinators have a workspace, computer access, and telephone in each Practice setting served. • 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. • Assure that embedded Care Managers/Care Coordinators are serving attributed patients from all Michigan Medicaid Health Plans with beneficiaries in a Practice's patient population.	

PCMH Year 2 Preview

Health Information Technology and Exchange Requirements

Requirement		2017	2018
EHR	UPDATED	Possess and utilize a fully implemented Office of the National Coordinator for Health Information Technology (ONC) certified Electronic Health Record (EHR) system.	Added clarification to 2017 Requirement: Either 2015 Edition or 2014 Edition CEHRT
Patient Registry	UPDATED	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 (no less often than quarterly) to generate population-level performance reports, pursue population health improvement, and close gaps in care for preventive services and chronic conditions	Added clarification to 2017 requirement: Performance reports should include measures from Quality Measure Information use case
Health Information Exchange	UPDATED	Complete technical onboarding and be actively participating in the following Michigan Health Information Network Health Information Exchange use cases (by specified date): Active Care Relationship Service (ACRS); Health Provider Directory (HPD); Admissions, Discharge, Transfer Notification Service (ADT) Quality Measure Information (QMI);	Language updated to focus on maintenance and continued participation
CM/CC Documentation Tool	NC	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	
Electronic Decision Support	UPDATED	Possess and utilize an electronic system capable of providing decision support prompts and care alerts to clinicians at the point of care.	Added clarification that the decision supports should, at a minimum, encompass measures from Quality Measure Information use case

PCMH Year 2 Preview

Participant Support and Learning Activities

Requirement		2017	2018
Practice Learning Activity	UPDATED	All Participating Practices must complete eight (8) hours of Initiative led learning activities during the period of this agreement. In addition to the required hours, all Participating practices must have a representative participate in each Quarterly Update Meeting.	• Ensure a representative from the Participating Organization participates in the annual Initiative virtual launch meeting. • Ensure a representative from the Participating Organization participate in each Quarterly Update Meeting, and shares relevant information with participating practice locations. • Ensure a clinical champion and other care team members from participating practice units/locations participate in the annual Initiative virtual launch meeting. • Ensure clinical champion and other care team members from participating practice units/locations participate in PCMH Initiative hosted learning activities as appropriate and relevant to their position in the practice

Optional Participant Supports will be available through the following activities:

- Practice Transformation Collaborative (entering phase 2, will have some participation adaptions)
- Monthly Topic Focused Sessions (Office Hours)
- Care Coordination Collaborative: (New in 2018!)
- Annual Regional Summits

PCMH Year 2 Preview
Initiative Operations Requirements

- Initiative Operations Requirements encompass those requirements related to legal agreements (such as the Participation Agreement, or the MDC DSUA), payment arrangements with participating payers, maintenance of participant data, participation in program evaluation, etc.

Requirement		2017	2018
Various Operations Requirements	UPDATED	Various requirements related to general day to day operations of the Initiative, for example: *"Sign (or provide consent for a PO to sign on the Practice's behalf if applicable) a Data Use Agreement (DUA) and Business Associate Agreement (BAA) with the MDC."*	• Language has been adapted to correspond with maintaining agreements (instead of newly signing) where applicable. • Added language specifying annual self-assessment, semi-annual transformation and quarterly participation reporting.

PCMH Year 2 Preview
Payment Model

Requirement		2017	2018	
Care Management & Coordination PMPM Rates	UPDATED	PCMHs will receive care management and coordination payment to support embedded care coordination services as a PMPM rate of: a. $3.00 for General Low Income Beneficiaries (TANF) b. $5.00 for Healthy Michigan Plan Beneficiaries (HMP) c. $8.00 for Aged, Blind and Disabled Beneficiaries (ABD)	General Requirements have remained the same, but rates have been updated to differentiate between adult and pediatric populations:	
			<u>Adult :</u> a. $3.00 for TANF b. $5.00 for HMP c. $7.00 for ABAD	<u>Pediatric:</u> a. $2.75 for TANF b. $5.50 for ABAD
Practice Transformation PMPM Rates	UPDATED	PCMH Initiative Practices will receive practice transformation payment to support needed investment in practice infrastructure and capabilities at a PMPM rate of $1.25 for all Medicaid beneficiaries attributed to the Practice by the Initiative.	PMPM payment will remain at $1.25 for all Medicaid beneficiaries attributed to the Practice by the Initiative, additional detail has been included: • Practice transformation payments are intended to be made for a total of 24 months. Practices which participated during 2017 will receive transformation payments during 2018 but this payment will be discontinued in 2019 because 24 months of payment will be complete.	

PCMH Year 2 Preview
Payment Model

Requirement		2017	2018

CM/CC Tracking Codes	UPDATED	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).	• Practices must bill MHPs for Care Management and Coordination Tracking Codes developed by the Initiative to monitor CM/CC services delivered within the Practice.
			• Addition of 3 codes:
			  • Education/Training for Patient Self-Management (98961, 98962)- NEW
			  • Provider Oversight (G9008)
			  • End of Life Counseling (S0257)

ICD 10 Codes	EXPLORING	Not included as a requirement in 2017, however encouraged exploration of the use of ICD 10 Z codes	Exploring the possibility of integrating a requirement related to the inclusion of International Statistical Classification of Diseases and Related Health Problems (ICD) codes appropriate for a patient's health diagnoses (primary) and socioeconomic and psychosocial circumstances (secondary) when billing Care Management and Coordination Tracking Codes.

REMINDERS:
2018 Intent to Continue Participation

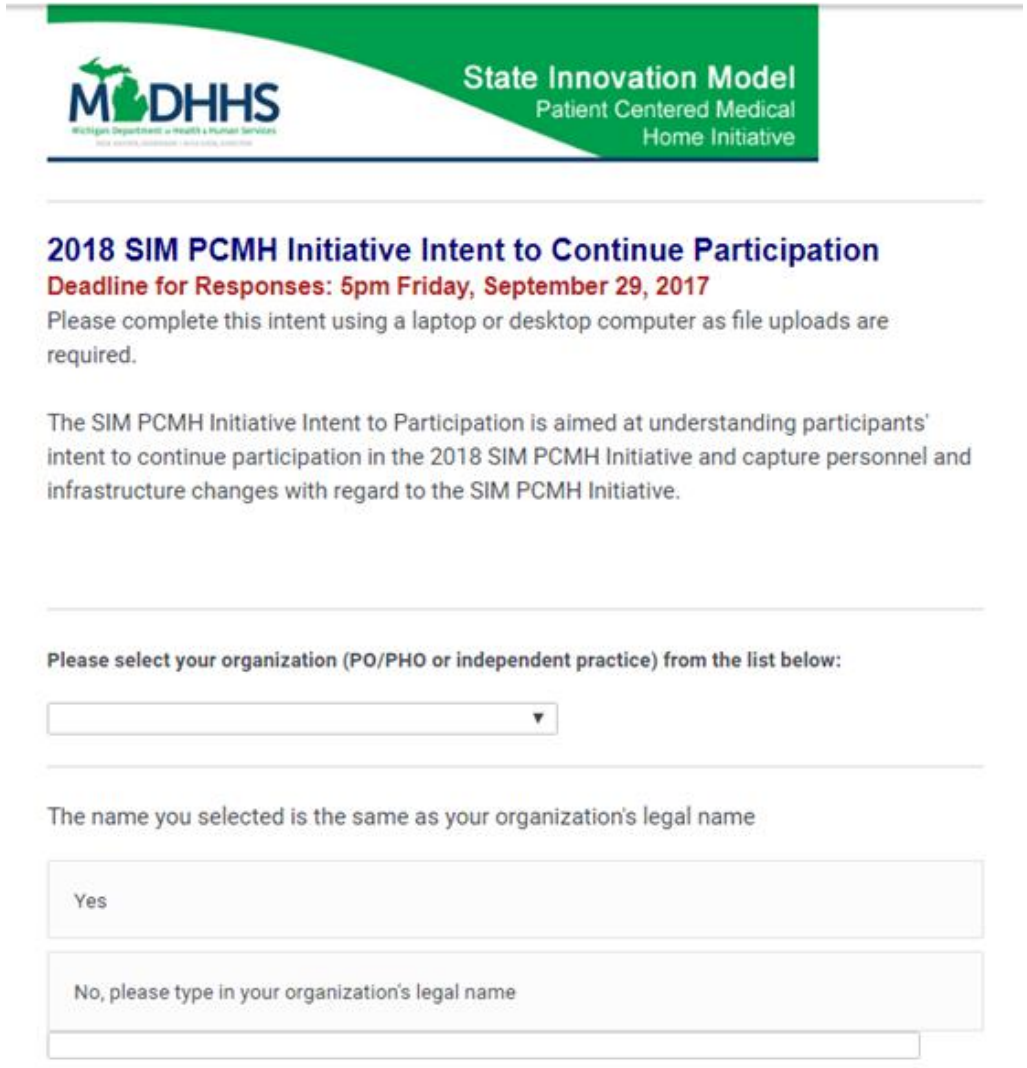
- The previous slides provided a preview to 2018, final requirements will be outlined and provided within the 2018 Participation Agreement

- 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: TODAY 9/13/2017
  - "Application" Q&A: Thursday 9/21/2017 (during Quarter 3 virtual update meeting)
  - "Application" closes: Friday 9/29/2017

Application Walkthrough

Intent to Continue Participation



MDHHS State Innovation Model Patient Centered Medical Home Initiative

2018 SIM PCMH Initiative Intent to Continue Participation

Deadline for Responses: 5pm Friday, September 29, 2017

Please complete this intent using a laptop or desktop computer as file uploads are required.

The SIM PCMH Initiative Intent to Participation is aimed at understanding participants' intent to continue participation in the 2018 SIM PCMH Initiative and capture personnel and infrastructure changes with regard to the SIM PCMH Initiative.

Please select your organization (PO/PHO or independent practice) from the list below:

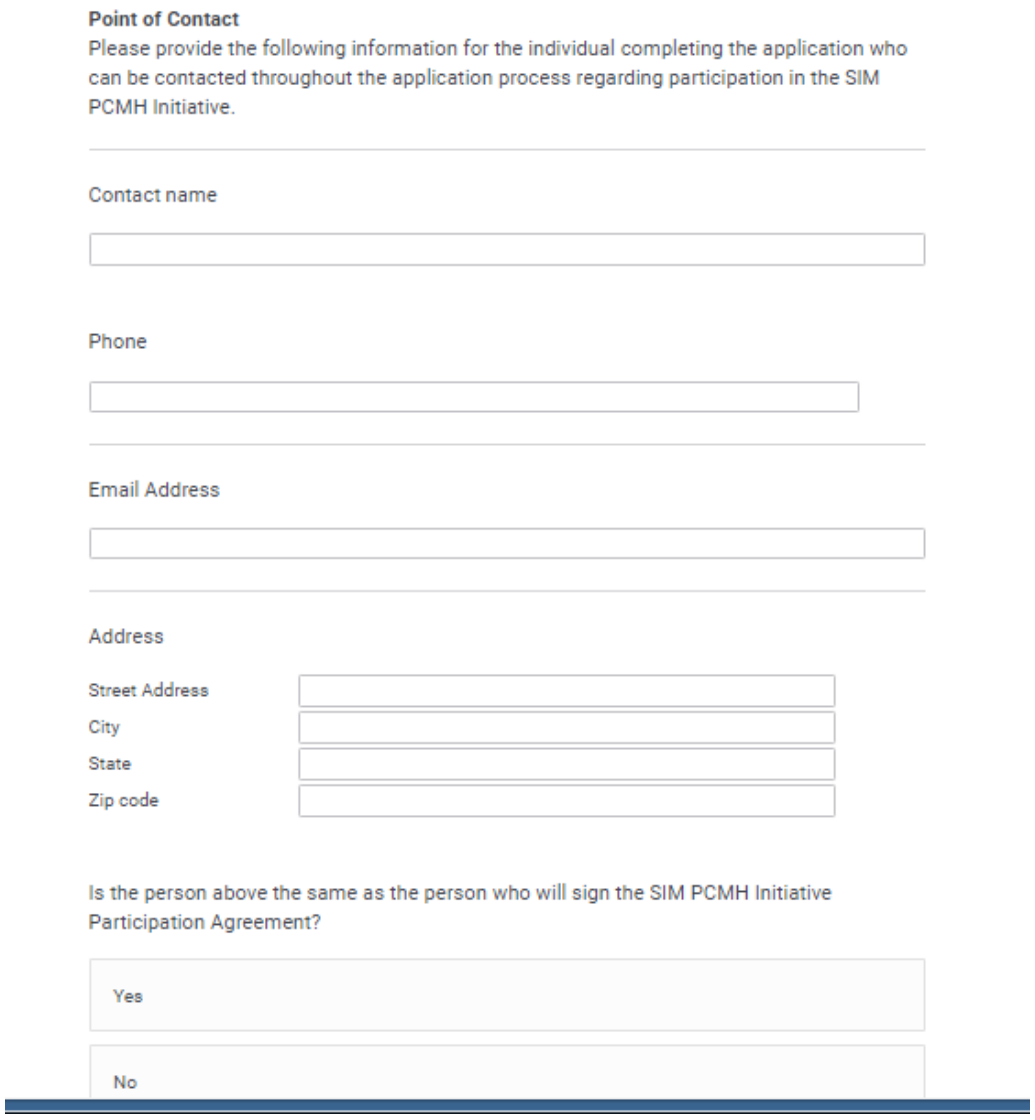
The name you selected is the same as your organization's legal name

Yes

No, please type in your organization's legal name

- Application landing page:
  - The SIM PCMH Initiative Intent to Continue Participation (ITP) is aimed at understanding participants' intent to continue participation in the 2018 SIM PCMH Initiative and capture personnel and infrastructure changes with regard to the SIM PCMH Initiative.
  - Please save the ITP link. You can access and continue the ITP by using the link. Progress is automatically saved every time you hit the “next” button.
  - Please provide the organization name on this page

Intent to Continue Participation (Cont.)



Point of Contact
Please provide the following information for the individual completing the application who can be contacted throughout the application process regarding participation in the SIM PCMH Initiative.

Contact name

Phone

Email Address

Address

Street Address
City
State
Zip code

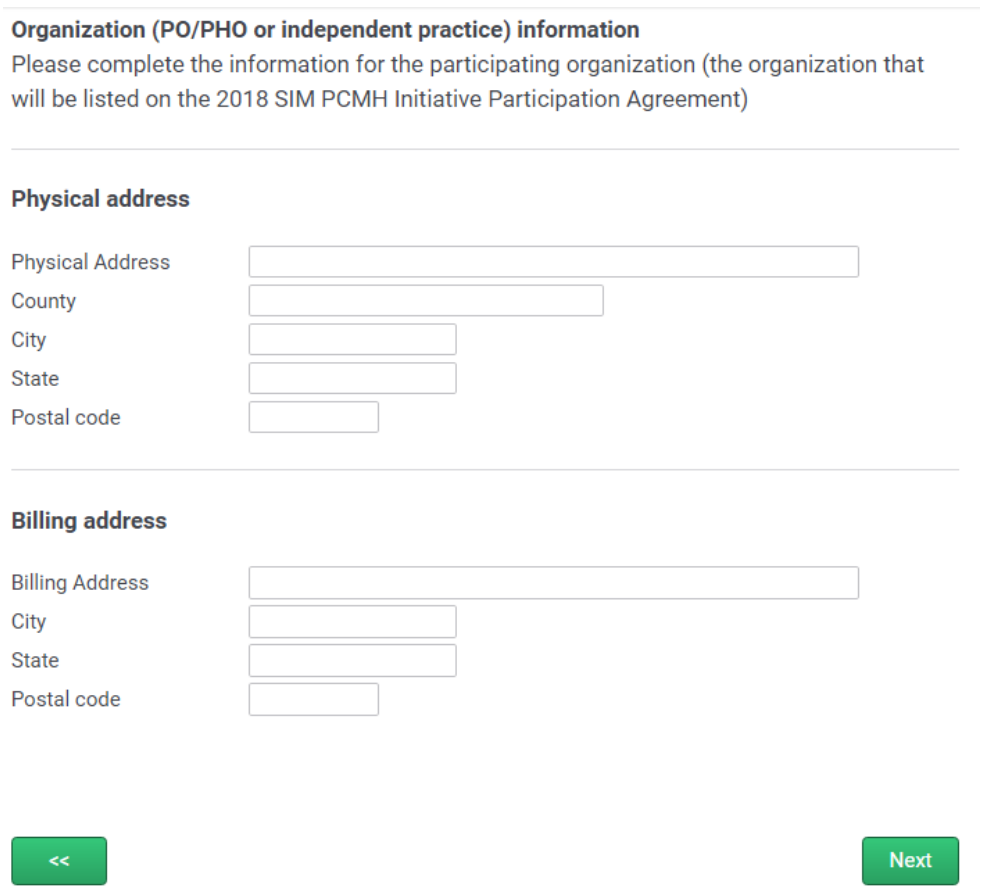
Is the person above the same as the person who will sign the SIM PCMH Initiative Participation Agreement?

Yes

No

- Point of Contact:
  - Provide the contact information for the individual that is completing the application, the one that should be contacted in the event of selection or need for further information.
  - If the contact person is not the individual who will sign the participation agreement, please fill out the signer's information on the next page.

Intent to Continue Participation (Cont.)



Organization (PO/PHO or independent practice) information

Please complete the information for the participating organization (the organization that will be listed on the 2018 SIM PCMH Initiative Participation Agreement)

Physical address

Physical Address
County
City
State
Postal code

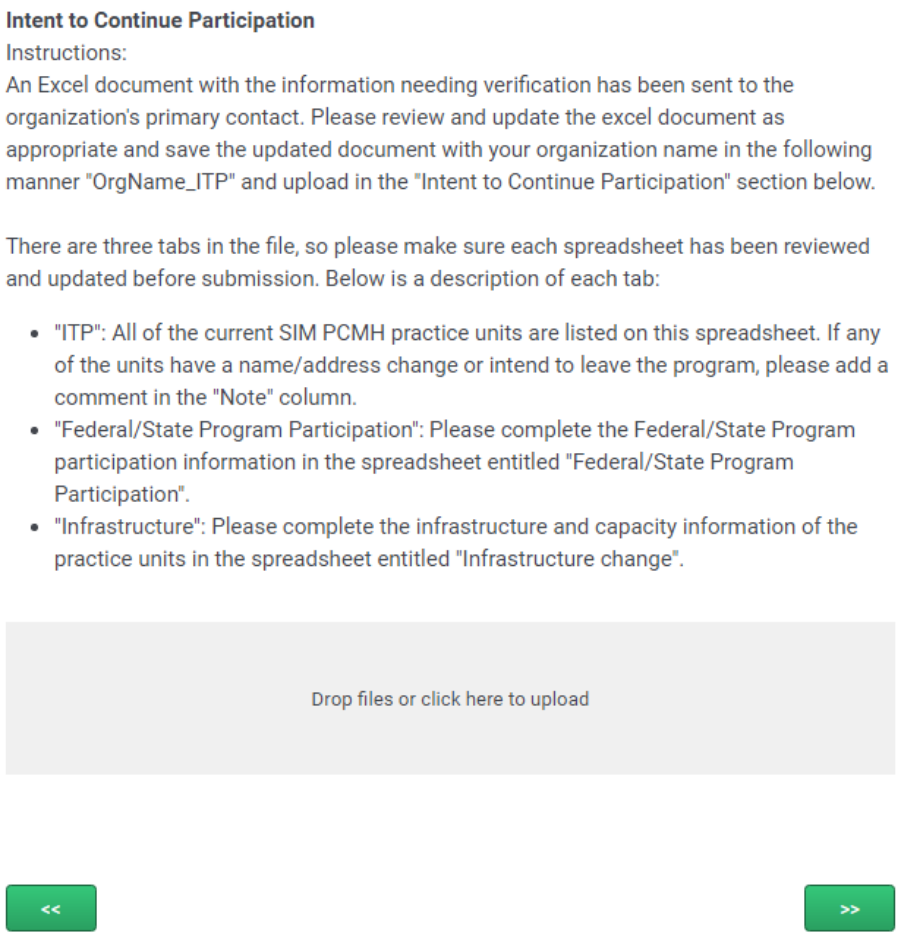
Billing address

Billing Address
City
State
Postal code

<< Next

- Organization (PO/PHO or Independent Practice) Information:
- Please provide the contracting entity information. The contracting entity refers to the organization that will sign the contract to continue the participation in SIM PCMH

Intent to Continue Participation (Cont.)



- Intent to continue participation:
- The Excel template has been sent to your organization's primary contact by email. There are three tabs in the file, so please make sure each spreadsheet has been reviewed and completed. If you have not received the document, please send a request to SIMPCMH@mail.mihealth.org.
- Upload the completed file in the "intent to continue participation" section

Intent to Continue Participation (Cont.)

Intent to Participate

- Please verify the current participating practices and physical addresses
- If any of the units have a name/address change or intend to leave the program, please add a comment in the "Note" column.

Participating Organization Name	Participating Practices	Physical Address	City	Zip Code	Billing Address	City	Zip Code	Note
A	AAA	111 Harvey St Ste A	Muskegon	49444	PO Box 19128	Belfast	49105	
A	BBB	222 Liberty Rd	Ann Arbor	48103	222 Liberty Rd	Ann Arbor	49451	This practice intends to leave the SIM PCMH Initiative
A	CCC	333Getty St.	Muskegon	49445	333 Getty St.	Muskegon	49445	Billing address changed from 6/1/2017, updated address: 100 Getty St.
A	DDD	444 Farr Rd	Fruitport	49415	444 Farr Rd	Fruitport	49415	
A	EEE	555 Ruddiman Drive	Muskegon	49445	555 Ruddiman Drive	Muskegon	49445	

ITP | Federal&StateProgram | Infrastructure

Please verify the current participating practices billing and physical addresses.

If any of the units have a name/address change or intend to leave the program, please add a comment in the "Note" column.

Federal/State Program Participation

- Please complete the Federal/State Program participation information. There is a drop down menu in each cell. Please select "yes" or "no" as appropriate for each practice.

Participating Organization Name	Participating Practices	Federal/State Program Participation										Other programs, please specify
		Medicare Shared Savings Progam	MI Care Team (Health Homes)	MI Health Link	Accountable Communities of Health	CPC+ Track 1	CPC+ Track 2	Next Generation ACO	Practice Transformation Network	Million Hearts	Community Hub Model (Pathways, CHIR, etc.)	
A	AAA	No	No	No	No	Yes	No	No	No	No	No	
A	BBB	No	No	No	No	Yes	No	No	No	No	No	
A	CCC	No	No	No	No	Yes	No	No	No	No	No	
A	DDD	No	No	No	No	Yes	No	No	No	No	No	
A	EEE	No	No	No	No	Yes	No	No	No	No	No	

ITP | Federal&StateProgram | Infrastructure

Please complete the Federal/State Program participation information. There is a drop down menu in each cell. Please select "yes" or "no" as appropriate for each practice.

Intent to Continue Participation (Cont.)

Infrastructure

- Please update effective and end date (mm/dd/yyyy) of PCMH designation program(s) for each practice as applicable .
- For other infrastructure requirements (24/7 access, team-based care, alternative to traditional visits, same day appointment, and care team meetings), please select "yes" or "no" as appropriate from the drop down menu for each practice according to the description of the requirements below.
- 24/7 Access: Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.
- Team-Based Care: Organize care by practice identified teams responsible for a specific, identifiable panel of patients to optimize continuity.
- Alternative to Traditional Visits: Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.
- Same Day Appointments: Ensure (on average over the course of a week) 30% of available appointments are reserved for same-day care across the patient population. (Alternative Considerations Allowed).
- Care Team Meetings: Ensure that all Care Team(s) have planned meetings at least monthly (or, alternatively, team huddles more frequently) with time dedicated to reviewing practice and panel level data from payers and internal monitoring,

	Participating Organization Name	Participating Practices	PCMH Designation												24/7 Access	Team-Based Care	Alternative to Traditional Visits	Same Day Appointments	Care Team Meetings	Note
			AAAHC Effective Date	AAAHC Recognition End Date	BCBSM/PGIP Effective Date	BCBSM/PGIP Recognition End Date	CARF Effective Date	CARF Recognition End Date	NCQA Effective Date	NCQA Recognition End Date	TJC Effective Date	TJC Recognition End Date	URAC Effective Date	URAC Recognition End Date						
4	A	AAA			07/01/2016	06/30/2018									Yes	Yes	Yes	Yes	Yes	
5	A	BBB			07/01/2016	06/30/2018									Yes	Yes	Yes	Yes	Yes	
6	A	CCC			07/01/2016	06/30/2018									Yes	Yes	Yes	Yes	Yes	
7	A	DDD			07/01/2016	06/30/2018									Yes	Yes	Yes	Yes	Yes	
8	A	EEE			07/01/2016	06/30/2018			04/22/2014	04/22/2017					Yes	Yes	Yes	Yes	Yes	
9																				

ITP | Federal&StateProgram | **Infrastructure**

Please update effective and end date (mm/dd/yyyy) of PCMH designation program(s) for each practice as applicable.

- Please select "yes" or "no" as appropriate from the drop down menu for each practice according to the description of the requirements below.
- 24/7 Access
- Team-Based Care
- Alternative to Traditional Visits
- Same Day Appointments
- Care Team Meetings

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

MDHHS Michigan Department of Health & Human Services

Intent to Continue Participation (Cont.)

2018 PCMH Initiative Practice Transformation Collaborative - Phase 2

The PCMH Initiative is seeking participating Patient Centered Medical Home teams interested and ready to accelerate their journey in Clinical-Community Linkages. This phase of the Practice Transformation Collaborative will be designed to accelerate your journey in linking patients to the support they need, when and where they need it. This collaborative will:

- Focus on working with practices to move from "Good" to "Great"—from having good linkages to having reliable linkages,
- Feature content on quality improvement and best practices related to Clinical-Community Linkages,
- Provide opportunities for local quality improvement coaches to support teams,
- Engage community partners and patient representatives to meaningful contribute to the design of improved linkages,
- Promote networking with and learning from colleagues and practices across Michigan.

Participation in Phase 2 of the Practice Transformation Collaborative, will be open to practice teams (additional supports will be available to Physician Organization staff, such as practice coaches), and will require a commitment to participate in collaborative meetings (virtual and in-person) as a team. If you would like to express interest in Phase 2 of the collaborative, on behalf of a practice team, please select the number of practice teams below (If there are more than 10 practices interested in Phase 2, please contact SIMPCMH@mail.mihealth.org to submit additional information):

2 ▼

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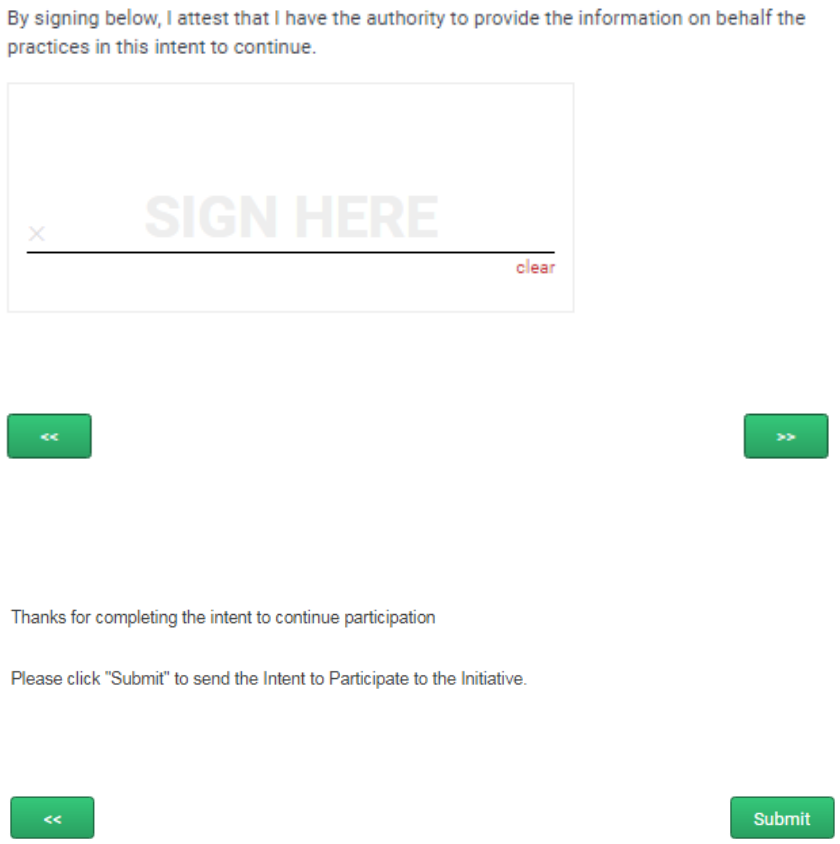
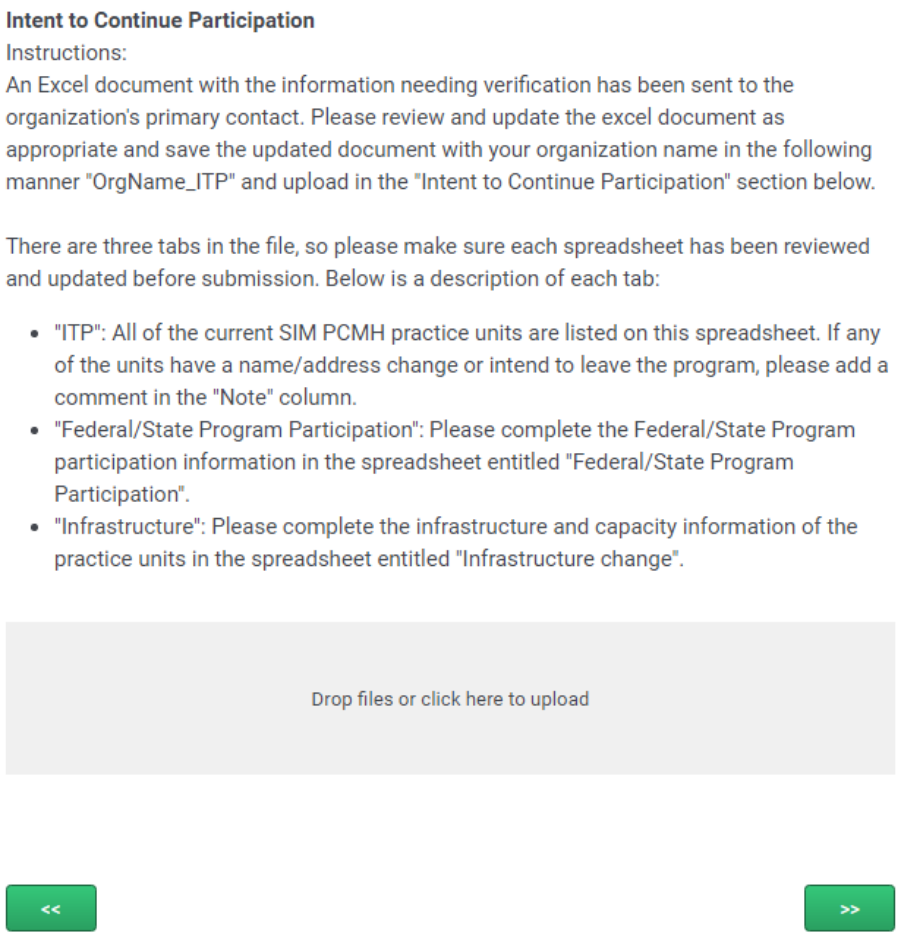
- 2018 PCMH Initiative Practice Transformation Collaborative - Phase 2:
- Please select the number of practice teams that are interested in Phase 2 of Practice Transformation Collaborative.
- Information about each practice will be collected on individual pages.
- If there are more than 10 practices interested in Phase 2, please contact SIMPCMH@mail.mihealth.org to submit additional information

Intent to Continue Participation (Cont.)



- Signature and submission:
- Please sign your name to attest that you have the authority to provide information on behalf the practices
- Click “Submit” to send the response to the Initiative. Once the response is submitted, you cannot access the application by using the saved link. If you need to make any changes after submission, please send your request to SIMPCMH@mail.mihealth.org.

Intent to Continue Participation (Cont.)



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Discussion