



# State Innovation Model

Patient Centered Medical Home Webinar  
May 11, 2016

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## Agenda

- SIM Overview & Updates
- Patient Centered Medical Home Overview
- Questions

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# SIM Overview & Updates

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## SIM Overview & Updates

- Overview and Vision
- Goals and Objectives
- Update

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## Overview and Vision

- Michigan received a State Innovation Model grant from Centers for Medicaid and Medicare Services (CMS) to test delivery and payment system changes.
- Strategies focus on moving towards cost-effective use of healthcare dollars overall in terms of patient experience and quality outcomes.
- Our vision is a system that coordinates care within the medical system to improve disease management and utilization; and out into the community to address social determinants of health.
- Developing a project structure, strategy, and timeline to support our goals.

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## Overview and Vision

- With the Blueprint for Health Innovation as our vision, we developed strategies and priorities that would account for our partners and move Michigan towards that vision
- Michigan's State Innovation Model (SIM) project will be a simultaneous effort of:
  - Putting payment policies, measurement infrastructure, and key investments into place.
  - Developing a coordinated communication and committee process that assesses these policies and investments with our partners on an ongoing basis.

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## Strategies

- Patient Centered Medical Home
- Accountable System of Care
- Community Health Innovation Region
- Health Information Exchange/Health Information Technology
- Collaborative Learning Network
- Stakeholder Engagement Committee Structure

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## Goals and Objectives

### **Patient Centered Medical Home (PCMH)**

- Our goals are to support the existing PCMH foundation in our State; and support the increase of PCMH adoption.
- Introducing and testing more performance-based measurement and payment.
- Developing policies to broaden elements such as the level of flexibility for PCMH eligibility and staffing for their medical or community-based teams for providing care.

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## Goals and Objectives

### Accountable Systems of Care (ASC)

- We are aiming to support these performance-based PCMH teams by introducing and testing payment models for ASCs.
- ASCs are a group of primary care providers and other key providers that agree to work together to improve health outcomes and contain costs by leveraging the PCMH effort to coordinate care across patient populations.
- Testing the benefits of supporting ASC providers in sharing information, understanding their patient population, and providing the right team-based and community-based care to address their patients' needs.

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## Goals and Objectives

### Community Health Innovation Region (CHIR)

- Leverage well-developed, existing capacity in communities to bring partners together in a local area to identify and address community health needs.
- CHIRs will develop and implement linkages between healthcare and community-based agencies to address social determinants of health.
- CHIRs will pursue local policy and built environment efforts; and other services to encourage health and wellness.
- Our vision is to achieve a high level of organization and sophistication in terms of governance, partnership, data collection and information sharing, and integrated service delivery.

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## Regional Roll Out

- Starting with 5 regions:
  1. Jackson
  2. Muskegon
  3. Washtenaw & Livingston
  4. Genesee
  5. Northern Michigan
- We will be exploring resource needs and feasibility to expand, including:
  - Determining the unit cost of Community Health Innovation Region
  - Determining the timeline and cost for Accountable System of Care
  - Determining cost of collaborative learning and other supports

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## Strategic Approach

### Strategic Supports

- Health Information Exchange/Health Information Technology
  - Foundational use cases
  - Build upon existing efforts
- Collaborative Learning Network
  - Continuous improvement approach
  - Accountability
- Stakeholder Engagement and Committees
  - Efficiency: limited number of committees
  - Effectiveness: membership, inputs, and topics

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## Updates

- No Cost Extension
- Status of Year-One Activities
- Finalizing the Operational Plan (Due May 31)

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## Update: No Cost Extension

- \$70 million, 4-year grant began February 1, 2015
  - First year planning
  - Three years of implementation
- Medicaid managed care procurement May—October 2015
  - Overlap between new managed care contract and State Innovation Model objectives
  - Similarities between managed care contract bidders and State Innovation Model participants
  - No external communication about State Innovation Model
- No cost extension for planning year 1 approved to July 31, 2016

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Update: Year One Activities

### Regional Selection

- Self-report Capacity Assessment Surveys
  - 50+ Accountable System of Care responses
  - 20+ Community Health Innovation Region responses
- Evaluated and scored responses to narrow possibilities to 29 Accountable Systems of Care and 14 Community Health Innovation Region backbone organizations
- One-on-one interviews with each organization scoring well enough to move on
- Combined both Accountable System of Care and Community Health Innovation Region capacity and scoring to prioritize regions

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Update: Year One Activities

### Design

- Established the vision, goals, and objectives of each State Innovation Model strategy
- Assessed the degree of alignment and impact of these strategies across the MDHHS and with our partners
- Determined the types of supporting infrastructure these strategies would need to be successful (staffing, funding, assistance, etc.)
- Began development of execution-level detail for each strategy
  - Different stages of this development depending on the maturity and traditional role of the MDHHS for each strategy
  - Details will need to be developed in partnership with our regional participants and payers

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Update: Year One Activities

### Operational Planning

- Drafted a strategy-level operational plan, built our project management structure, and put together implementation approaches for our strategies.
- Improving our strategies and implementation approaches with input from our partners before submitting operational plan to CMS May 31, 2016.
- Webinar series will be followed by publication of sections of our operational plan for comments and feedback.

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## Patient Centered Medical Homes (PCMH)

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## Foundation

- Patient Centered Medical Homes are the foundation for all coordinated care delivery strategies and play a critical role in health system transformation
- Aggregate outcomes from multiple peer-reviewed studies, state government program evaluations, and industry reports demonstrate significant PCMH achievements in cost, utilization, quality and more:

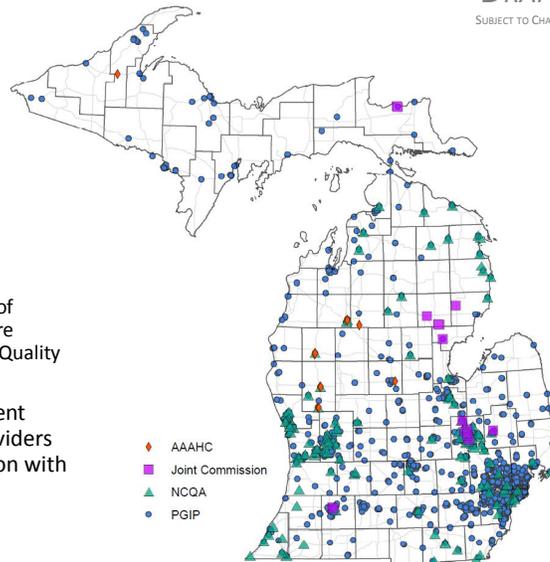


- Michigan’s SIM PCMH efforts are centered on further spreading the PCMH model of care, continuing measurable improvements in quality, health outcomes and patient satisfaction, and increasing PCMH participation in alternative payment methodologies

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## PCMH in Michigan

- Approximately 5,200 providers are already choosing to practice in a PCMH accredited settings in Michigan
  - The majority of Michigan’s current PCMH providers (approximately 88%) have been accredited through Blue Cross Blue Shield of Michigan’s PCMH program, another 10% are recognized by the National Committee for Quality Assurance
- Michigan’s current PCMH providers represent about 32% of total active primary care providers in the state, a significant base to build upon with great opportunity for growth



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## Experience to Build From

- The Michigan Primary Care Transformation Project (MiPCT) is the largest Multi-Payer Advanced Primary Care Practice demonstration in the country
  - MiPCT serves over 1.2 million patients with 350 primary care practices, 37 physician organizations, 1,800 primary care providers and over 400 specially-trained Care Managers participating
- SIM PCMH efforts are intentionally building upon MiPCT including sustaining the involvement of MiPCT providers and multi-payer partners, leveraging the project's existing infrastructure and learning from the project model to further PCMH advancement

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## SIM PCMH Focus

- Development of personalized, patient-centered care plans
- Team-based delivery of comprehensive, highly accessible healthcare and care management services
- Coordination and support for effective transitions of care
- Provision of referral decision support, scheduling and follow-up
- Collaboration and intentional interfacing with other providers to promote an integrated treatment approach
- Engagement of supportive services through community-clinical linkages
- Leadership in patient education, self-care and caregiver engagement
- Utilization of registry functionality and technology-enabled quality improvement strategies to support population health

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Environmental Context  
Comprehensive Primary Care Plus

Merit-based Incentive Payment System

Advanced Alternative Payment Models

Chronic and Transitional Care Management

Medicare Shared Savings Program

State Innovation Models

Mental Health and Substance Abuse Parity Requirements

**Health Systems Transformation Is Influenced By Many Factors!**

Accountable Care Organizations

Bundled Payments for Care Improvement

Transforming Clinical Practice Initiative

Accountable Health Communities

Medicaid/CHIP Managed Care Final Rule

Health Care Payment Learning and Action Network

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SIM PCMH Strategy Overview

Strategy Component	Motivation
Achieving Statewide Scale	Spread PCMH support infrastructure and payment reform across Michigan by 2019
Inclusive Accreditation Approach	Provide flexibility to leverage a variety of PCMH accreditation programs as a foundation
Broad Attributed Population	Reflect the diversity of practice patient populations through attribution methodology
Participation Requirements	Ensure needed capabilities for practice success and advance those capabilities over time
Advanced Care Management	Extend care management, coordination and community linkages capabilities
Multi-Payer Participation	Growing alternative payment model scale within practices to drive transformation
Performance-Driven Payment	Clear rewards for implementing impactful processes and achieving outcomes
Consistent Metrics	Leverage metrics utilized by other programs where possible to simplify measurement
Sustainable Financing	Position Michigan's PCMH infrastructure for lasting innovation and financial stability
PCMH Support and Learning	Provide a collaborative learning context for expert and peer connections

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## Achieving Statewide Scale

- Our goal (contingent upon budgetary capacity not only within SIM, but within the state Medicaid budget as well) is to spread the PCMH Initiative statewide by 2019
- Beginning January 1, 2017, PCMHs meeting participation requirements within SIM's 5 regional test locations **and** existing MiPCT practices meeting participation requirements across Michigan will be invited to join the Initiative
  - MDHHS will launch an intent to participate process later this month for practices to indicate their interest in being part of the Initiative
  - The intent to participate will not be binding (i.e. a PCMH can choose not to apply after the submitting their intent), but only those PCMHs that participate in the intent process will be able to complete the full application
  - The Initiative's full application will be open in late summer / early fall
  - Subsequent annual application periods will be opened to facilitate spread

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## Inclusive Accreditation Approach

- The PCMH initiative will take an inclusive approach to PCMH accreditation (also called recognition and/or certification) by leveraging existing PCMH accreditation programs rather than developing a unique accreditation requirement
  - Accrediting body programs considered acceptable for participation include, but are not limited to, BCBSM/PGIP, NCQA, AAAHC, TJC
  - Some accrediting programs may have non-mandatory components that the Initiative determines are required for participation
- Practices wishing to participate in the Initiative will be required to possess PCMH accreditation from one of the approved programs

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## Eligible Providers

- Provider types eligible to participate in the PCMH Initiative will include:
  - Family Physicians
  - General Practitioners
  - Pediatricians
  - Geriatricians
  - Internal Medicine Physicians
  - Obstetricians
  - Gynecologists
  - Advanced Practice Registered Nurses
  - Physician Assistants
  - Safety Net Providers (e.g. federally qualified health centers, rural health clinics, child and adolescent health centers, local public health departments, and Indian health services)

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## Broad Attributed Population

- Patients included in the PCMH Initiative will represent a broad array of individuals including healthy patients and those with single or multiple chronic diseases
  - A substantive portion of the Initiative's performance metrics will be targeted toward patients with more significant needs including Michigan's SIM target populations (high utilizers of emergency department services, patients with multiple chronic diseases etc.)
- Several Medicaid populations will be excluded from the population
  - The excluded populations will be those where beneficiaries are already receiving significant care management services to avoid potentially duplicative payment/services
  - In addition, the FFS Medicaid population will not be included initially
- Medicaid managed care beneficiaries will be attributed to PCMHs based on their selected/assigned primary care provider

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## Participation Requirements

- The following practice requirements will be required upfront for PCMH participation in the Initiative:
  - PCMH accreditation from an Initiative approved recognizing body
  - Implementation of an ONC certified Electronic Health Record (EHR)
  - Advanced patient access (e.g. 24/7 access to clinician, open access slots, extended hours)
  - A relationship with specialty and behavioral health providers in addition to one or more hospitals which accept patient referrals and cooperate with PCMH coordination activities
  - Enrollment as a Michigan Medicaid provider in compliance with all provider policies
  - Embedded care management / coordination staff meeting standards set by the Initiative
  - A patient registry or EHR registry functionality
- We are evaluating the use of time bound implementation periods for PCMHs to meet the following practice requirements during the first 6-12 months of participation:
  - Connection to a Health Information Exchange (HIE) Qualified Organization (QO), also known as sub-state HIEs
  - Participation in MiHIN use cases applicable to SIM (e.g. HPD, ACRS, ADT, SCD)
  - Stage 1 / modified Stage 2 Meaningful Use achievement

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## Advanced Care Management

- Practices participating in the PCMH Initiative will be expected to meet care coordination requirements
  - A participating practice's care team(s) must include embedded care management and care coordination staff members functioning as integral, fully-involved members of the team
  - At least one member of the team will be required to be a licensed Care Manager
    - The following types of professionals will be eligible to serve as a Care Manager: Registered Nurse, Licensed Practical Nurse, Licensed Master's Social Worker, Licensed Professional Counselor, Licensed Pharmacist
  - Other members of the team may be a licensed Care Manager (defined above) or a Care Coordinator for Medicaid reimbursement
    - The following types of professionals will be eligible to serve as a Care Coordinator : Licensed Bachelor's Social Worker, Certified Community Health Worker, Registered Dietician, Social Service Technician
  - All Care Managers and Care Coordinators will be expected to complete training provided and/or approved by the Initiative as well as take part in continuing education
  - We are following the collaborative work currently underway with MiPCT care managers and Medicaid health plans to further define roles and partnership expectations for PCMHs

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### Multi-Payer Participation

- The Initiative continues to work toward sustentative multi-payer participation
- Medicaid managed care organization participation is a significant and exciting component of the PCMH Initiative
  - Michigan’s Medicaid health plans are critical partners in the implementation of the Initiative
- Medicare participation in the PCMH Initiative is key, and we are working toward an approach which engages Medicare as a payer
  - We have discussed CPC+ program participation and the custom Medicare participation option available to SIM states with many stakeholders over the course of the last few weeks
  - To date, there has been considerable support to pursue a custom Medicare participation path but MDHHS is still considering all available options and continuing conversation with CMS
  - The custom Medicare participation option would involve a set of negotiations between MDHHS/SIM and CMS to develop an agreement which incorporates a set of Medicare principles for participation in care delivery and payment models
- Discussions with currently participating commercial MiPCT payers are in process and looking positive for continued participation
  - The Initiative is interested in recruiting additional commercial and self-funded employer payers and will be launching a formal payer engagement plan soon

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### Payment Model Evolution and Growth

A Potential Path using the Custom Medicare Participation Option

	<b>Initiative Year 1</b> Beginning January 2017	<b>Initiative Year 2</b> Beginning January 2018	<b>Initiative Year 3</b> Beginning January 2019
Medicaid	Initial payment model implementation	Payment model alignment (to the extent possible) with custom Medicare approach	Payment model refinement and growth
Medicare	Interim chronic and transitional care management payments	Custom approach payment model implementation	
Commercial	Sustaining current commercial payer participation	Commercial payer participation growth	

*Please note that timelines are approximate.*

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## Payment Model Evolution and Growth

A Potential Path Combining CPC+ and the Custom Medicare Participation Option

	<b>Initiative Year 1</b> Beginning January 2017	<b>Initiative Year 2</b> Beginning January 2018	<b>Initiative Year 3</b> Beginning January 2019
<b>Medicaid</b>	Payment model implementation	Payment model refinement and alignment (to the extent possible) with custom Medicare approach	
<b>Medicare</b>	CPC+ payment model for a limited/specific group of practices in Michigan approved to participate in the program		
	Interim chronic and transitional care management payments	Custom approach payment model implementation	
<b>Commercial</b>	Sustaining current commercial payer participation	Commercial payer participation growth	

*Please note that timelines are approximate.*

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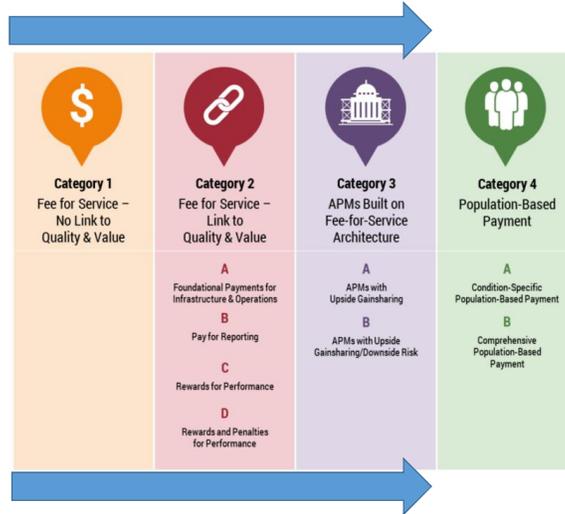
## Comparing the Options

<b>Positive Aspects- Flexibility</b>	<b>Potential Challenges- Time Horizon</b>
<ul style="list-style-type: none"> <li>The custom approach provides the greatest amount of flexibility in designing how payment reform and delivery system transformation are pursued in Michigan</li> <li>We believe we will have the opportunity to continue to grow the size of our PCMH program, allowing for practice expansion (within a negotiated framework) in Michigan over time</li> </ul>	<ul style="list-style-type: none"> <li>CMS considers the custom approach a new demonstration which will take an estimated 18 months to complete negotiations and implement</li> <li>Custom Medicare participation needs to have one or more new/unique components, we cannot use it to implement models which have been previously demonstrated</li> <li>Stakeholder engagement/input surrounding the custom Medicare approach would need to be substantial and likely be time-intensive</li> </ul>
<b>Positive Aspects- Potential for Balance</b>	<b>Potential Challenges- Complexity</b>
<ul style="list-style-type: none"> <li>Blending the CPC+ and custom Medicare participation approaches balances need for a near term path to Medicare participation with development of a custom participation approach that will likely be a better fit for Michigan long term</li> </ul>	<ul style="list-style-type: none"> <li>CPC+ and the custom Medicare approach will likely have different program requirements and payment model variations which could be complicated</li> <li>Michigan will have to navigate and manage an additional layer of programmatic complexity for several years while two PCMH programs are underway</li> <li>CPC+ exclusion of some practices would remain an issue in addition to constraints in program scale and a competitive selection process</li> </ul>

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Payment Model Direction



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Performance-Driven Payment

A Potential Model using the Custom Medicare Participation Option

**Initiative Year One**

- **Medicaid:** Practice Transformation and Care Management PMPM Payments, Continued Medicaid Health Plan Incentive Structures
- **Medicare:** [Chronic Care Management](#) and [Transitional Care Management](#) Payments
- **Commercial:** Payment aligned with the goals of the initiative, with some anticipated payment structure variation across payers

**Initiative Year Two and Beyond**

- Aligned (to the extent possible) payment model for both Medicaid and Medicare, commercial payment structure may still vary across payers
- Alignment payment model structural focus:
  - Based on quality measures that are evidence-based, reliable, and valid
  - Reasonable financial accountability for total cost of care
  - More advanced EHR/HIT requirements
  - Demonstration of tangible practice improvement
- The aligned payment model will be developed and finalized with significant stakeholder involvement

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## Performance-Drive Payment

- **Medicaid Practice Transformation**

- PCMHs will receive practice transformation payments to support needed investment in practice changes
- These payments will be made on a per member per month basis for the first 24 months a PCMH is engaged in the Initiative
- The Initiative will provide a menu of practice transformation objectives targeted toward differing levels of PCMH maturity for PMCHs to select from
- PCMHs will be required to describe how they will invest practice transformation payments to meet their objective(s) and set clear, measurable milestones for their work
- The Initiative will monitor PCMH progress toward meeting their transformation objectives through a reporting process

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## Performance-Drive Payment

- **Medicaid Care Coordination**

- PCMHs will receive care coordination payments on a per member per month basis while engaged in the Initiative
- Care coordination payments will be linked to performance metrics reflecting the successful provision of care coordination activities
- All PCMHs will receive care coordination payments for an set period of time beginning when they are engaged in the Initiative
- PCMHs will be required to demonstrate performance on care coordination linked metrics and meet care coordination requirements to continue to receive care coordination payments in subsequent periods

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## Performance-Drive Payment

- Medicare Chronic Care Management (CCM) Services and Transitional Care Management (TCM) Services

- CCM: Patients with multiple (two or more) chronic conditions expected to last at least 12 months are eligible for the service
- CCM: Service encompasses at least 20 minutes of clinical staff time per month and includes structured data recording, a patient-centered care plan, ensuring access to care and care management services (assessment, medication reconciliation, self-management support, care transitions, coordination with home and community services etc.)
- TCM: Patients being discharged from an inpatient setting (hospital, skilled nursing etc.) are eligible for the service
- TCM: Service encompasses an interactive contact within 2 business days following discharge, some non face-to-face services (reviewing discharge information, patient education, access to services etc.) and a face-to-face visit

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## Performance-Drive Payment

- Custom Medicare Payment Approach

- CMS has put forward a set of principles for states to design a proposal for Medicare participation in a SIM test
  - Patient centered
  - Accountable for the total cost of care
  - Transformative
  - Broad-based
  - Feasible to implement
  - Feasible to evaluate
- This custom approach would involve significant negotiations between MDHHS and CMS to develop an agreement with Medicare
- The approach would likely feature new and/or modified payment components which move toward a more advanced alternative payment methodology construct
- The custom approach is functionally treated as a new demonstration, requiring a strong value proposition for Medicare to pursue

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## Consistent Metrics

- PCMH practice transformation performance will be measured on whether or not a PCMH is making progress toward and ultimately meets its identified practice transformation objective(s)
  - Performance monitoring will largely be based upon streamlined self-reporting by PCMHs
- A small number of metrics reflecting the process and/or outcome of care coordination will be used to assess PCMH care coordination performance
  - Number/percentage of attributed patient population receiving care coordination services
  - Timely follow-up after discharge
- The Initiative will monitor performance on 19 quality metrics and 4 utilization metrics on a consistent basis during the first year
  - Quality metrics were adopted from the [Physician Payer Quality Collaborative](#) core measure set, which was developed using practice and physician organization feedback
  - Eight additional measures which are part of the PPQC core set will be added as the Initiative progresses

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## Sustainable Financing

- The PCMH Initiative will have a lasting, sustainable role in the Michigan primary care ecosystem
- Funding available through the SIM cooperative agreement with CMS is being utilized to make investments in infrastructure, model development and payment reform acceleration
- A sustainable infrastructure financing mechanism will provide funding for the Initiative on an ongoing basis after the SIM model test period
- Revenue associated with administrative payment component will grow over time as the number of participating practices/patients expands

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## PCMH Support, Learning and Engagement

- All PCMHs participating in the Initiative will complete a standardized self-assessment process on an annual basis to measure PCMH implementation maturity over time and guide support activities
- PCMHs participating in the Initiative will be invited to join peer practices in a set of Initiative-sponsored collaborative learning activities
- The PCMH Initiative will also work to generate multi-stakeholder (payers, provider associations, continuing education providers etc.) collaboration surrounding the types of practice support provided to stimulate alignment
- The PCMH Initiative will be directed by the SIM governance structure in addition to a SIM advisory commission
- The PCMH Initiative will maintain a strong working group and advisory process as a compliment to SIM's overall governance structure to ensure stakeholders are consistently engaged and guidance is acted upon

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## Patient Centered Medical Homes (PCMH)

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