PARTICIPATION AGREEMENT

Between

PRACTICE

and the
Michigan Department of Health and Human Services (MDHHS)
for the
2019 Patient Centered Medical Home Initiative

The PCMH Initiative, a key component of the State Innovation Model, involves collaboration among the Michigan Department of Health and Human Services (MDHHS); the University of Michigan (U of M); public and private Michigan health insurance providers (Payers); Michigan's Physician Organizations (POs); and Michigan Primary Care Practices that have been designated as a Patient-Centered Medical Homes (PCMH).

Patient-Centered Medical Homes are the foundation for coordinated care delivery strategies for Michigan's State Innovation Model (SIM). Michigan's PCMH Initiative efforts are centered on further spreading the PCMH model of care, continuing measurable improvements in quality, health outcomes and patient satisfaction, and increasing opportunities for primary care providers to participate in alternative payment methodologies. PCMH Initiative participants serve as a patients' primary touch point with the healthcare system and will focus on the development of personalized, patient-centered care plans as a means of delivering high quality and affordable care. Initiative participants will provide comprehensive, team-based care delivery and coordination activities including collaboration and intentional interfacing with other providers to create an integrated approach.

The purposes of the PCMH Initiative are to: (1) foster the transformation of participating PCMH primary care practices to enable interventions that impact all persons served by the Practice in a cost-effective manner using evidence-based guidelines and practices; and (2) support a premier model for advanced primary care in Michigan leveraging experience gained from the Michigan Primary Care Transformation demonstration; and (3) improve health outcomes, improve patient experience of care, and reduce preventable healthcare costs.

The major objectives of the PCMH Initiative include:

1. Create a Sustainable PCMH Model – Implement payment models that provide meaningful incentives to Primary Care Providers for advancing health outcomes and delivery system transformation through public/private Payer and Practice collaborations to improve health care value and transform primary care in ways that are sustainable and can be replicated statewide.

2. Improve Quality and Outcomes – Maintain and expand measurable improvements in quality of care, total cost of care, and patient satisfaction through continuous quality

improvement of participating PCMH Practices.

3. Lower Overall Health Care Costs – Reduce unnecessary or avoidable costs through the timely and effective transformation of care delivery by the PCMH Practice and stronger coordination of care in other settings.

A. DEFINITIONS

"Agreement" means this Participation Agreement between the Participating Physician Organization (if applicable), Participating Practice, and MDHHS, for the PCMH Initiative.

"Billing Code" refers to Healthcare Common Procedure Coding System (HCPCS) Care Management G and CPT codes and modifiers submitted to participating Payers by practices or POs for care management and coordination services.

"Care Coordinator" means an individual member of the Care Team, who is not required to be licensed, who provides patients assistance with self-management support, accessing medical services, making linkages to community services, and other related patient supports as appropriate. The following types of professionals are eligible to serve as a Care Coordinator: Bachelor's Social Worker, Social Services Technician, Certified Community Health Worker, Certified or Registered Medical Assistant, or other similar types of health professionals determined by MDHHS.

"Care Management and Coordination Payment" means the payment made by a participating Payer to support Care Management and Coordination activities. See Appendix A.

"Base Incentive Payment" means the payment made by a participating Payer as a result of the Participant meeting or exceeding the defined benchmark on the Initiative identified Performance Incentive Program measures for which the participant is eligible.

"Bonus Incentive Payment" means the payment made by a participating Payer as a result of meeting or exceeding the Initiative defined benchmark for 75% or more of the Performance Incentive Program measures for which the participant is eligible.

"Care Management and Coordination" means the application of systems, science, incentives, and information to improve clinical practice and assist patients and their support system to become engaged in a collaborative process designed to manage medical, social, and/or behavioral health needs more effectively. It includes services such as:

a. Comprehensive assessment of the patient's medical, functional, and psychosocial needs;
b. System-based approaches to ensure timely receipt of all recommended preventive care services;
c. Medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications;

d. Management of care transitions between and among health care providers and settings, including referrals to other providers, follow-up after emergency department visits, and discharges from inpatient settings; and
e. Coordination of care with home- and community-based service providers.

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.

"Care Manager" means a licensed individual assigned to provide care management services, including targeted interventions to avoid hospitalizations and emergency department visits, ensure standards of care, coordinate care across settings, and help patients understand options. The following types of professionals are eligible to serve as a Care Manager: Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Licensed Master Social Worker, Licensed Professional Counselor, Licensed Pharmacist, Registered Dietician, Physician's Assistant, or other similar types of licensed health professionals determined by MDHHS.

"Care Management Improvement Reserve" A reserved portion of the SIM PCMH Initiative Care Management and Coordination Per Member Per Month (PMPM) payment (see Appendix A), due to Participant poor performance on established Initiative metric (see Appendix C). Participants have the opportunity for payment recovery, should they exhibit satisfactory performance in future measurement periods.

"Care Team" means a Participating Practice-based team consisting of an eligible provider, one or more Care Managers or Care Coordinators, and/or other clinical support or allied professional staff within the Participating Practice who jointly manage care for the entire patient panel as well as distinct subsets of patients.

"CHEAR" is Child Health Evaluation and Research (CHEAR), a unit of the University of Michigan's Board of Regents, selected by MDHHS to conduct all data acquisition and merging tasks related to Medicaid administrative data.

"Clinical-Community Linkage" or "CCL" refers to processes to support patient linkage and coordination between clinical care and community-based social services to improve population health.

"Community Health Innovation Region" or "CHIR" refers to a small number of regional governing bodies launched by the SIM program to define regional health priorities, support regional planning, increase awareness of community-based services, and increase linkages between community and health entities in Michigan.

"CMS" is the Centers for Medicare & Medicaid Services, a branch of the U.S. Department of Health and Human Services.

"Eligible Provider" means one of the following provider types practicing within an Eligible

Practice:

- Family physicians
- General practitioners
- Pediatricians
- Geriatricians
- Physician Assistants
- Advance Practice Registered Nurses
- Nurse Practitioners
- Internal medicine physicians
- Obstetricians / Gynecologists

"Eligible Practice" means primary care practice that has a current PCMH Designation and

a. Has successfully completed the PCMH Initiative Intent to Participate process;
b. Has been invited to apply to participate in the PCMH Initiative;
c. Meets all requirements in this Participation Agreement, and
d. Is formally selected by MDHHS to participate in the PCMH Initiative.

"Financial Sanction" means the reduction of an amount paid to a PO or Practice (without the opportunity for payment recovery).

"Member List" means the list of all beneficiaries of a Participating Payer that have been attributed to the PCMH Initiative. See Appendix B and Appendix D.

"Medicaid Health Plan 4275 file" or "4275" refers to a standard file that Medicaid Health Plans submit to the Michigan Department of Health and Human Services and the enrollment broker to provide information on the Medicaid Health Plan's provider network.

"MDHHS" is the Michigan Department of Health and Human Services, the agency of state government designated by the Governor of Michigan as the lead agency for the State Innovation Model, and the entity required by CMS to be responsible for oversight and monitoring.

"Michigan Data Collaborative" (MDC) is the central entity that houses the claims and eligibility data from Michigan Payers, and produces regular reports for POs, Practices, and PCMH Initiative. MDHHS provides oversight for the MDC as related to the PCMH Initiative.

"MiPCT Demonstration Project" is the statewide Michigan Primary Care Transformation Demonstration Project involving public and private Payers, Physician Organizations, and PCMH-designated Practices that expired December 31, 2016.

"Participating Practice" or "Practice" means a primary care practice that is an Eligible Practice and is also a PCMH Initiative Participant as indicated through signature of this Participation Agreement.

"Participating Payer" or "Payer" means a public or private insurer, health service corporation, or health maintenance organization that has entered into an agreement with MDHHS to participate in PCMH Initiative.

"Participation Agreement" means this document that outlines the parameters and

expectations of participating stakeholders in the PCMH Initiative.

"Patient Registry" or "Registry" means an electronic database that contains demographic and clinical data (in data fields accessible for tabulation and population management) on all patients served by the Practice to enable Primary Care Providers and staff to manage their populations of patients.

"Payment Correction" refers to the process to correct previous payments in such instances where a payment was made in error, or updated details regarding a beneficiary's enrollment has resulted in identifying a previous payment was made where one should not have been made. Payment Correction will occur in instances in which beneficiaries were found to be incarcerated, within a nursing facility or deceased.

"Performance Incentive Program" or "PIP" refers to the opportunity for Participants to earn an incentive payment relative to Participant performance on a set of Initiative quality and utilization metrics as presented on the SIM PCMH Initiative dashboard developed by the Michigan Data Collaborative. Metrics and performance measurement detailed in Appendix D.

"PCMH Designation" refers to designation, certification, recognition, or accreditation by an approved organization according to a set of approved standards, as determined by SIM PCMH Governance. Acceptable bodies/standards are detailed in Appendix C.

"PCMH Initiative" or "Initiative" refers to the MDHHS-led program intended to advance the purposes described in the preface of this document. This agreement defines roles and responsibilities for Practices, Physician Organizations, and Payers participating in the PCMH Initiative.

"Physician Organization" or "PO" means a Physician Organization, Physician/Hospital Organization, Independent Practice Association, or similar organization that has affiliations with PCMH-designated Practices. POs provide supportive services to enhance the Practice's medical home capabilities and enable continuous quality improvement.

"Practice Transformation" or "PCMH Transformation" refers to the result of enabling a primary care Practice to use both educational and financial support to develop the 1) infrastructure, 2) organizational, and 3) cultural changes characteristic of PCMHs, i.e., primary care provider-led; prepared and proactive care teams providing comprehensive, whole person care; coordination of care across healthcare settings; enhanced patient access; use of electronic technology; and development of a culture that encourages striving for continual improvement in patients' experience of care and health outcomes for the entire Practice panel, while reducing preventable costs.

"Primary Care Provider" means a primary care physician, and also includes licensed physician assistants and licensed nurses certified as advanced practice registered nurses, who are working under supervision of a physician, as defined in the Michigan Public Health Code, Act 368. Unless the context suggests otherwise, the term "Provider" or "Participating

Provider" refers to a PCP practicing in a Participating Practice.

"PCMH Initiative Participant" means any Payer, Physician Organization, or Primary Care Practice that has signed an Agreement with MDHHS and participates in PCMH Initiative.

"Social Determinants of Health" or "SDoH" refers to conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

"UMHS" refers to the University of Michigan Health System, the entity with which MDHHS has contracted to provide operational support for PCMH Initiative.

B. PERIOD OF AGREEMENT

This Agreement will be in effect beginning January 1, 2019 through December 31, 2019, with the potential for additional extensions at the sole discretion of MDHHS.

C. MDHHS RESPONSIBILITIES

1. MDHHS is responsible for overall direction and control of the PCMH Initiative. Assisted by PCMH Initiative advisors, contractors, and vendors, MDHHS will assure that programmatic standards are met, provisions in agreements are adhered to, and program objectives are achieved.

2. MDHHS and affiliated PMCH Initiative vendors, contractors or subcontractors will provide technical assistance (TA) on the implementation of the SIM PCMH Initiative; as requested, contingent upon resources, and as deemed necessary by the Initiative. This may include issues related to: Care Management, Quality Improvement, Clinical-Community Linkages, Practice Transformation, Billing and Coding, or other activities related to carrying out SIM PCMH Initiative activities. TA may come in the form of required activities as outlined in Appendix C.

3. MDHHS shall enter into and maintain Business Associate and Data Use Agreements with the University of Michigan on behalf of its sub-units, including CHEAR and MDC, to protect Personal Health Information as required by HIPAA.

4. MDHHS and PCMH Initiative advisors, contractors, and vendors will monitor PMCH Initiative Participant performance throughout the contract period, which may include a review of quality and utilization data/metrics, review of claims and encounter data, authorization data, patient input, Provider surveys and clinical outcomes data, and review of PCMH Initiative Participant reports, including self-assessment data. MDHHS and PCMH Initiative advisors, contractors, and vendors will utilize data and participant reports to assess performance and compliance with the SIM PCMH Initiative model, including the following actions:

    a. MDHHS requires the PCMH Initiative Participant to complete and submit Quality

Improvement Plans (QIP) or Corrective Actions Plans (CAP) and to demonstrate improvement (see 2019 PCMH Initiative Participation Guide for more details).

b. MDHHS will monitor the PCMH Initiative Participant's completion of the QIP or CAP items and provide written documentation when all items have been successfully fulfilled
c. MDHHS may in its sole discretion make a determination regarding continued participation, continued participation but with a financial sanction, or termination of the participant from PCMH Initiative if non-compliance is a continuing issue.

5. MDHHS and the PCMH Initiative advisors, contractors, and vendors will track PCMH Initiative Participant engagements in required Initiative activities.

6. MDHHS shall monitor participating Payers to assure that provisions of participation are being met.

7. MDHHS shall oversee all vendors, contractors and subcontractors affiliated with the PCMH Initiative.

D. PHYSICIAN ORGANIZATION (PO) RESPONSIBILITIES

Appendix C details the responsibilities of the participating Physician Organization.

E. PCMH-DESIGNATED PRACTICE RESPONSIBILITIES

Each participating PCMH Practice is responsible for ensuring specific capabilities throughout the PCMH Initiative that lead to improved health outcomes, improved patient experience of care, and reduced healthcare costs.

Appendix C details the responsibilities of the participating practices.

F. DISPUTES AND REMEDIES

1. Representatives of POs and/or Practices and MDHHS shall discuss any dispute issues and negotiate in good faith in an effort to resolve a dispute without the necessity of any formal proceeding. During the course of dispute resolution, all reasonable requests made by one party to another for non-privileged information reasonably related to the Agreement will be honored in order that each of the parties may be fully advised of the other's position. Each party agrees to continue performing its obligations under the Agreement while a dispute is being resolved, except to the extent the issue in dispute precludes performance (dispute over payment must not be deemed to preclude performance) and without limiting either party's right to terminate the Agreement as provided elsewhere in this Agreement.

2. The following issues are not subject to the dispute resolution process described in Section F.1:
   a. The Physician Organization and Practice Requirements (see Appendix C).

b. Required Business Associate and Data Use Agreements.
c. Training and Education Requirements for PCMH Initiative Care Managers, Care Coordinators, and Practice Care Teams (see Section A (Definitions)) and Appendix C).
d. MDHHS decision to terminate a PO, Practice or Provider from the Project.

G. MISCELLANEOUS PROVISIONS

1. Governing law: This Agreement shall be governed by and construed according to the laws of the State of Michigan.

2. Amendments: This Agreement cannot be amended without the consent of MDHHS.

3. Access to Information and Records: All Project Participants shall provide MDHHS with access to such information and records consistent with relevant federal and state law as may be necessary to assess appropriate reimbursement levels and to otherwise monitor and evaluate the Project.

4. Record Maintenance/Retention: This agreement requires that all participating parties maintain adequate program and financial records and files, include source documentation to support program activities and all expenditures made under the terms of this agreement, as required. Participating parties must ensure that all terms of the agreement will be appropriately adhered to and that records and detailed documentation for the Project identified in this Agreement will be maintained for a period of not less than three (3) years from the date of termination, the date of submission of the final expenditure or until litigation and audit findings have been resolved.

5. Authorized Access and Audit: Permit upon reasonable notification and at reasonable times, access by representatives of the MDHHS, CMS, Comptroller General of the United States, and State Auditor General, any Participating Payer, or any of their duly authorized representatives, upon presentation of documentation to PO or Practice which verifies such representatives' authorization, to records, files and documentation related to this agreement, to the extent authorized by applicable state or federal law, rule, or regulation.

6. Agreement Termination: MDHHS may suspend or terminate this Agreement with a PO or a Practice or a Provider under any of following circumstances:
   a. The PO and/or Practice no longer complies with the requirements set forth in this Agreement, subsequent to written notice and opportunity to comply.
   b. The PO and/or Practice fails to provide reasonable and necessary services in accordance with professional standards.
   c. A Practice is convicted of fraud or a felony.
   d. A Provider within a Practice is convicted of fraud or a felony.
   e. A Practice is sanctioned by Medicare or Medicaid.
   f. A Provider within a Practice is sanctioned by Medicare or Medicaid.
   g. Revocation of a Provider's medical license.

h. Other reasonable causes determined by the sole discretion of MDHHS.

7. Procedure for Termination by PCMH Initiative: A termination will be effective after written notice from MDHHS to the PO or Practice.
   a. If the Practice is unable to maintain provisions in this Agreement, MDHHS has sole authority to make a final determination regarding continued participation status or termination of the Practice from the Project.
   b. If a Practice is terminated, MDHHS will inform the Practice and the PO, and will notify all Payers to suspend any future payments under the PCMH Initiative.

8. Procedure for PO/Practice Withdrawal from Project: A PO or Practice may end its participation in the Project by providing sixty (60) days written notice of its intent to withdraw to MDHHS, and by completing a PCMH Initiative Practice Change Form. Providers are obligated to continue to provide all PCMH services through the end of the effective date of their elected termination.
   a. A Payer shall be responsible for paying the Practice for Care Management and Coordination Payment obligations incurred prior to the termination date.
   b. A Payer providing reimbursement to the Practice shall not be required to pay any Care Coordination payments for services rendered after the termination date.

9. Termination by Payer: Nothing in this Agreement shall be construed to disallow a Payer from terminating its relationship with a clinician, subject to the contractual terms of an independent agreement with that clinician. Nothing in this Agreement shall prevent a Payer from seeking recovery of payments made after the effective date of termination.

10. Insurance Coverage: Participating Practices shall maintain the types and amounts of insurance coverage as they deem necessary for their protection. Nothing contained herein shall constitute an agreement by the State of Michigan to provide legal representation or liability coverage to Participating Practices.

SPECIAL CERTIFICATION

The individual or officer signing this 2019 Participation Agreement, effective January 1, 2019 through December 31, 2019, certifies by his or her signature that he or she is authorized to sign this agreement on behalf of the Participating Practices, responsible governing board, official and/or contractor(s), and agrees to abide by the specific responsibilities outlined herein.

SIGNATURE SECTION

For the Michigan Department of Health and Human Services:

Name Title

Signature Date

PRACTICE

Name Title

Signature Date

APPENDIX A
PCMH INITIATIVE PAYMENT MODEL

The PCMH Initiative payment model is designed to provide financial support to Initiative participants to enable the development and ongoing advancement of patient-centered care.

PCMH Initiative participants simultaneously selected by CMS to participate in the Comprehensive Primary Care Plus (CPC+) program will receive payment from Medicare according to the CPC+ payment model. PCMH Initiative participants not participating in CPC+ will bill Medicare for applicable services according to the Medicare Physician Fee Schedule.

PCMH Initiative payments from Medicaid Health Plans will be made according to the model below.

A. PCMH INITIATIVE MEDICAID PAYMENT MODEL

1. All PCMH Initiative Care Management and Coordination payments from Michigan Medicaid Health Plans will be made on a per member per month (PMPM) basis. Appendix E provides further detail on Medicaid health plan members included in the PCMH Initiative.

2. PMPM payment will be made based on the primary care provider selected by or assigned to each Medicaid beneficiary as recorded by the applicable Medicaid Health Plan. Participating Practices which believe the primary care provider on record with a Medicaid Health Plan is incorrect should initiate a primary care provider change with the beneficiary using a health plan's established process.

3. Medicaid Health Plans will make payments for beneficiaries that are included in the attributed population as defined by the Initiative (some Medicaid beneficiaries will be excluded, see Appendix E).

4. Medicaid Health Plans will not make payments for retroactive Medicaid eligibility periods or attempt to recoup payments or work through payment corrections previously made for a beneficiary which experiences a change in eligibility type or status, with the exception of beneficiary incarceration, the beneficiary was found to be in a nursing facility or deceased.

5. Medicaid Health Plans will make payments to a Physician Organization if the PO completes the application to participate in the Initiative and signs this participation agreement on behalf of its member Practices. (Medicaid Health Plans may choose to make these payments using a contract, payment agreement or an alternative means of payment).

6. Medicaid Health Plans will make payments to a Practice directly if the Practice completes the application to participate in the Initiative and signs this participation agreement as an individual Practice.

7. Both components of the Medicaid payment model (Performance Incentive Program Payments and Care Management and Coordination PMPM) will be paid to the same entity.

8. Medicaid Health Plans will make payments to either a PO or Practice (whichever is applicable) no less often than quarterly.

9. Payments are contingent upon satisfactory performance as assessed through the mechanisms defined

below (i.e., quality and utilization measure performance and a care coordination linked performance measure).

10. Payment model information described in this appendix refers to payments made to Practices for simplicity. If/when payments are made to a PO, the PO payment will represent the aggregate amount of payment due to all participating Practices which are members of the PO.

B. PCMH INITIATIVE MEDICAID PAYMENT MODEL: CARE MANAGEMENT AND COORDINATION

1. PCMH Initiative Participants will receive care management and coordination payment to support embedded care coordination services as a PMPM rate according to their performance during the 4Q17-2Q18 performance period:
    a. Participants that met the required 2.5% benchmark for the defined performance period will receive PMPM rates of:
        i. Adult Beneficiaries (19 years and above)
            1. $3.00 for Adult General Low Income Beneficiaries (TANF)
            2. $5.00 for Healthy Michigan Plan Beneficiaries (HMP)
            3. $7.00 for Aged, Blind and Disabled Beneficiaries (ABD)
        ii. Pediatric Beneficiaries (18 years and under)
            1. $2.75 for Pediatric General Low Income Beneficiaries (TANF)
            2. $7.00 for Aged, Blind and Disabled Beneficiaries (ABD)
    b. Participants that fell below the required 2.5% benchmark for the defined performance period will be subject to a Care Management Improvement Reserve that will adjust their 2019 PMPM rates as outlined below:
        i. Adult Beneficiaries (19 years and above)
            1. $2.85 for Adult General Low Income Beneficiaries (TANF)
            2. $4.85 for Healthy Michigan Plan Beneficiaries (HMP)
            3. $6.85 for Aged, Blind and Disabled Beneficiaries (ABD)
        ii. Pediatric Beneficiaries (18 years and under)
            1. $2.60 for Pediatric General Low Income Beneficiaries (TANF)
            2. $6.85 for Aged, Blind and Disabled Beneficiaries (ABD)

2. To maintain the full PMPM care management and coordination payment, Participants must:
    a. Maintain care management and coordination expectations as defined in Appendix C.
    b. Maintain care management and coordination performance above the Initiative defined benchmark (see Appendix C) on the following metric:
        i. The percentage of a Practice's attributed patients receiving care management and coordination services
            1. Participants will receive formal notice of their performance and payment status prior to the disbursement of the first payment for the 2019 participation year.
            2. MDHHS reserves the right to update the benchmark outlined in Appendix C based on overall participant performance, regular metric specification maintenance or other applicable events. In the event that the benchmarks must be updated, MDHHS will provide sixty (60) days written notice to participants.

3. PCMH Initiative Participants will have their performance related to care management and

coordination services assessed 4Q18-2Q19 to inform final PCMH Initiative CM/CC payment.

a. Participants who were assessed the CMIR based on 2018 performance period (4Q17-2Q18) who:
    i. perform at or over the 2.5% benchmark will receive the full withheld CMIR during the final payment of the PCMH Initiative.
    ii. perform below the 2.5% benchmark will forfeit the CMIR and will have an additional sanction of $0.05 PMPM assessed on the final payment of the PCMH Initiative.
b. Participants who were not assessed a sanction for the 2018 performance period (4Q17-2Q18) who:
    i. perform at or over the 2.5% benchmark will receive full final payment of the PCMH Initiative payment.
    ii. perform below the 2.5% benchmark will receive an additional sanction of $0.05 PMPM assessed on the final payment of the PCMH Initiative.

C. PCMH INITIATIVE MEDICAID PAYMENT MODEL: PERFORMANCE INCENTIVE PROGRAM

1. PCMH Initiative Participants may receive a year end performance incentive payment relative to their performance on Initiative defined benchmarks for a specified set of quality and utilization measures outlined in Appendix C.

a. Base Incentive Payment: Participants will receive a base incentive payment when their performance is at or above the initiative defined benchmarks (see Appendix D) for the measures for which they are eligible.
    i. The maximum base incentive payment to any organization would be calculated at a rate of $21.00 per member across the average membership for the 2019 participation year.
    ii. The base incentive earned by a participating organization would be adjusted based on the number of measures for which they meet the minimum volume criteria (denominator), and the portion of these for which they exceed the measure benchmark (numerator).
b. Bonus Incentive Payment: Participants will receive a bonus incentive payment when their performance meets or exceeds the defined benchmark on 75% or more of the measures for which they are eligible.
    i. Funds remaining in the incentive pool following the calculation of the base incentive payments will be used to generate the bonus incentive payments.
    ii. Total funds left in the incentive pool will be divided among all organizations that reached the 75% or above on their performance score based on the number of attributed SIM PCMH Initiative beneficiaries in each organization over the participation year.

APPENDIX B
PCMH INITIATIVE MEDICAID ATTRIBUTION MODEL

Overview

A Medicaid beneficiary must be both eligible (see Appendix C) to be attributed and have a selected/assigned primary care provider (PCP) that is participating in the PCMH Initiative to be considered part of the PCMH Initiative population. Care Management and Coordination payment(s) made as part of the PCMH Initiative payment model will be made based on this attribution process.

1. The State of Michigan has identified exclusion criteria to determine beneficiaries eligible to be attributed in the PCMH Initiative. In general, beneficiaries must be enrolled in a Medicaid Health Plan, receive the full scope of Medicaid services and not be attributed to another Medicaid program/initiative which possess a potentially duplicative service set or payment model. (See Appendix E for more details).
2. The beneficiary's attributed provider is determined based on the selected/assigned primary care provider (PCP) reported to the State of Michigan by each Medicaid Health Plan.
3. Beneficiaries are considered part of the PCMH Initiative population if the selected/assigned PCP is employed or contracted by a PCMH Initiative participating practice (participating practices are selected by MDHHS and execute a formal Participation Agreement).
4. The PCMH Initiative Operations Contractor is responsible for maintaining participating provider and practice information within the Statewide Health Provider Directory for the PCMH Initiative.
5. All eligible Medicaid Health Plan members whose PCP is employed or contracted by a participating practice will be considered a part of the PCMH Initiative population.
    a. A provider may only select a single participating organization for which they are employed or contracted by to prevent any potential duplicative payments.

PCMH Initiative Provider Participation Determination

Practice participation is determined through the PCMH Initiative application process.

1. Practices (or their Physician Organization) complete an intent to participate process which is evaluated against baseline eligibility criteria and requirements by the PCMH Initiative Operations Contractor. Practices meeting baseline eligibility criteria and requirements were invited to complete a full application for participation.
2. Practices invited to apply completed (or were directed by their Physician Organization to complete) the PCMH Initiative application in the Statewide Healthcare Provider Directory (HPD). During this process practice unit and PCP details including applicable Tax Identification Numbers (TIN) and National Provider Identifiers (NPI) are collected by the PCMH Initiative.
3. Upon acceptance of a practice's application or Practice Change Form (see 2019 PCMH Initiative Participation Guide for details) the PCMH Initiative Operations Contractor will update the HPD portal to indicate which practices are participating in the PCMH Initiative. This determination will be noted at the each of the following levels:
    a. Provider Organization (PO)
    b. Practice Unit (PU)
    c. National Provider Identifier (NPI)

PCMH Initiative Population Determination, Payment and Communication[1]

1. The State of Michigan will:
    a. Generate an ACRS 2.1 file containing the full Medicaid population and associated Medicaid Health Plan and PCP attributes.
    b. Populate the SIM eligibility fields in the Medicaid beneficiary weekly ACRS file generated the first Monday of each month.
    c. Determination will be based on beneficiary eligibility at the point in time the report is generated.
    d. Set "SIM Eligible Flag" (Y/N) based on approved exclusion criteria
        i. Beneficiaries in only the following Medicaid plan types shall be considered SIM eligible:
            1. MA-HMP-MC
            2. MA-MC
        ii. Beneficiaries in the following Medicaid plan types shall be explicitly excluded from SIM eligibility, even if they are also in another eligible plan type.
            1. HHMICARE
            2. HHBH
        iii. Beneficiaries with an "OtherInsuranceCode" of "89" or above shall be excluded from SIM eligibility, regardless of any other eligible criteria.
    e. Populate "SIM Program Code" (e.g., TANF, ABAD, HMP) conveying the type of beneficiary eligibility, which corresponds with PCMH Initiative payment model rates.
    f. Transmit the ACRS 2.1 file to MiHIN
2. MiHIN will:
    a. Determine the Medicaid PCMH Initiative population:
        i. Based on the information contained in the ACRS 2.1 file from the State of Michigan and the HPD portal (maintained by the PCMH Initiative Operations Contractor), MiHIN will identify which PCPs are associated with PCMH Initiative participating practices and denote them as PCMH Initiative participating PCPs.
        ii. Beneficiaries attributed to PCMH Initiative participating PCPs will be identified as part of the PCMH Initiative attributed population.
            1. SIM Participating Flay set to Y
        iii. PCMH Initiative participating practices will be eligible for Care Management and Coordination payment(s) based on their attributed beneficiary population.
            1. PCMH Payment Type – CC, PT, Both or None
    b. Generate an ACRS 2.1 file populating the following information:
        i. SIM Program Code – returning the values from the State ACRS 2.1 file.
        ii. SIM Participant – indicating participation at the beneficiary level.
        iii. PCMH Payment Type - indicating payment type (CC - Care Coordination, PT - Practice Transformation, Both, None) at the beneficiary level.
        iv. PCP NPI - returning the values from the State ACRS 2.1 file.
        v. Tax Id Number – Will be used for determining where to send payment
        vi. Payment Name – Name associated with the Tax ID Number for Payment

[1] The State of Michigan and MiHIN will perform reconciliation testing with the Medicaid Health Plan specific ACRS 2.1 and the monthly SIM participation file. Upon successful completion of testing and Medicaid Health Plan onboarding, the continued use of the monthly SIM participation report will be reevaluated.

vii. Payment Address – Address associated with the Tax ID Number for Payment

c. Transmit the full Medicaid ACRS 2.1 to the State of Michigan
d. Transmit the provider specific ACRS 2.1 Patients to the appropriate provider organization as identified in the HPD.
e. Transmit the full Medicaid ACRS 2.1 to the SIM Data Aggregator

3. The State of Michigan will:
    a. Receive the ACRS 2.1 file from MiHIN and store in the Data Warehouse.
    b. Review the ACRS 2.1 file received from MiHIN and evaluate against Medicaid Health Plan 4275 files, and PCMH Initiative participant contract details.
    c. Initiate SIM payment process.
        i. Payments will be made to Medicaid Health Plans on a quarterly basis through a Gross Adjustment.
        ii. A quarterly reconciliation report will be provided to the Medicaid Health Plans to facilitate the disbursement of funds.
        iii. The quarterly report will include the following information for each month of the quarter.
            1. Month of Eligibility
            2. Beneficiary ID
            3. Beneficiary First Name
            4. Beneficiary Last Name
            5. Beneficiary Program Code
            6. PCMH Payment Type {CC | PT | Both}
            7. CC Payment Amount
            8. PT Payment Amount
            9. Provider NPI
            10. Provider First Name
            11. Provider Last Name
            12. Tax ID Number
            13. Payment Name
            14. Payment Address

APPENDIX C
REQUIREMENTS FOR PRACTICES PARTICIPATING INDEPENDENT OF A PO

The PCMH designated practice that is participating in the PCMH Initiative independent of a Physician Organization must ensure that the following designation, activity, infrastructure, and practice characteristic requirements are met. Requirements have been organized into the following sections:

- Initiative Operations 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
- Performance Monitoring and Initiative-Provided Feedback

INITIATIVE OPERATIONS REQUIREMENTS:

1. Sign the 2019 Participation Agreement and return the signed Agreement to MDHHS.

2. Maintain an executed Data Sharing and Use Agreement with the Michigan Data Collaborative.

3. Maintain enrollment as a Michigan Medicaid provider in compliance with all provider policies and requirements.

4. Inform the PCMH Initiative within seven days of learning about a change in provider employment or status within a participating Practice by completing a PCMH Initiative Provider and Practice Change Form.

5. Regularly participate in PCMH Initiative conference calls, webinars, and events.

6. Utilize PCMH Initiative newsletters and other communications in staff meetings, team discussions, etc. as appropriate.

7. Cooperate with PCMH Initiative operations, program monitoring, and evaluation activities as requested by the Initiative including but not limited to assisting and/or participating in patient and Practice/care team surveys, focus groups, thought leader interviews, Practice site visits, and periodic narrative progress/status reporting.

8. Cooperate with the Initiative led self-assessment process, semi-annual practice transformation reporting process and quarterly participation reporting process described below in the Performance Monitoring and Initiative Feedback section.

9. Provide additional practice-level information including, but not be limited to, payer mix and contracting status, and electronic clinical quality data as requested by the Initiative.

CORE PRIMARY CARE (PCMH) REQUIREMENTS:

1. Possess and maintain current designation from one of the following organizations/programs:
   a. National Committee for Quality and Assurance- PCMH (NCQA)
   b. Accreditation Association for Ambulatory Health Care- Medical Home (AAAHC)
   c. The Joint Commission- PCMH (TJC)
   d. Blue Cross Blue Shield of Michigan/Physician Group Incentive Program (PGIP)- PCMH
   e. Utilization Review Accreditation Commission- PCMH (URAC)
   f. Commission on Accreditation of Rehabilitation Facilities- Health Home (CARF)

2. Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.

3. Organize care by practice identified teams responsible for a specific, identifiable panel of patients to optimize continuity.

4. 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.

5. Ensure (on average over the course of a week) 30% of available appointments are reserved for same-day care across the patient population.
   a. Alternative Consideration: A Practice accepted to participate in the PCMH Initiative can, by submitting the request for alternative consideration request form (see Appendix F, indicate why 30% same day appointment availability is not operationally feasible for the Practice and describe how the Practice will ensure access to services through an alternative mechanism. MDHHS has full discretion in granting this request for alternative consideration.

6. 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.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES (PRACTICE TRANSFORMATION):

Clinical-Community Linkages

All Participating Practices were required to develop a plan to support Clinical-Community Linkages during 2017 Initiative Participation. During 2019 participation, all participants must continue their investment in these plans, maintain established partnerships, and refine processes as applicable. The details below describe the expectations of all Participants in the execution of CCLs:

1. For Participants Outside CHIR Regions: Develop, maintain and enhance partnerships between a Practice) and community-based organizations which provide services and resources that address socioeconomic needs of the Practice's population.

2. For Participants Within CHIR Regions: Participate directly as an active partner in a CHIR, including collaborating as a key stakeholder in the development, operations and continuous improvement of Clinical-Community Linkages and other population health improvement strategies.
   a. The Initiative specifically requires participants to work with the CHIR in their community(s) to participate in the creation of and use shared CCL tools and supports.

b. Shared tools and supports may include a brief screening tool, screening process(es), CCL methodology(s), CCL documentation/data storage approach, partnerships with community organizations, training in community resource utilization, quality improvement etc. (Note: The specific shared tools and supports developed within each CHIR will vary.)
c. Where requirements below require participants to implement specific processes, tools, and methodologies, the Initiative anticipates that in many cases the shared tools and supports above (not uniquely developed by the participant) will be used to meet these requirements.

3. All Participants: Assess patients' Social Determinants of Health (SDoH) to better understand socioeconomic barriers using a brief screening tool administered with all patients of the practice. (Note: SDoH screening cannot be limited to only the population receiving Care Management and Coordination services. In addition, a CHIR may focus efforts on a subpopulation but a practice should conduct screening and linkages with all patients.)
    a. The screening tool must, at a minimum, assess needs related to the domains of healthcare, food, employment/income, housing/shelter, utilities, family (e.g. children, elders) care, education, personal/environmental safety (e.g. domestic violence) and transportation.
        i. Adaptations to current tools to include personal/environmental safety (e.g. domestic violence) and family (e.g. children, elders) domain requirements described above must be completed on or before November 1, 2018.
    b. Questions (or other inputs) utilized in the screening tool must illicit patient assessment responses consistent with the purpose and intent of each topic as defined by the Initiative. However, question (or other input) phrasing, order and the format for administering screening is flexible.
    c. The practice must also maintain a screening plan and screening procedure which document brief screening processes.

4. All Participants: 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 linkages made.
    a. The practice must also maintain a linkage methodology which documents a Practice's linkage preparation, initiation and follow-up processes.

5. All Participants: Periodically review common linkages made and the outcome of those linkages to determine the effectiveness of the Practice's processes and community partnerships as well as opportunities for process improvement and partnership expansion.
    a. A practice's review should include monitoring screening completion, revealing screening gaps and circumstances/visits where screening is more and less effective, ensuring the screening procedure is operationally efficient and being implemented consistently, analyzing the effectiveness of partnerships and revealing the need (as applicable) for additional resource partnerships or collaboration.

Population Health Management

All Participating practices must engage in the Clinical Practice Improvement Activities to support Population Health Management as outlined below. Participants which selected a Practice Transformation Objective other than Population Health Management in 2017 may continue to pursue that objective (e.g. telehealth adoption) but are required to realign their objective as an activity which corresponds with improving performance on one or more of their population health objectives.

1. Ensure engagement of clinical and administrative leadership in practice improvement by ensuring responsibility for guidance of practice change (i.e. a Champion) is a component of clinical and administrative leadership roles.

2. Empanel (assign responsibility for) at least 95% of the Practice's patient population, linking each patient to a clinician or care team. Use the resultant patient panels as a foundation for individual patient and population health management.

3. Use feedback reports provided by MDHHS, other payers and/or practice systems at least quarterly to implement strategies to improve population health on at least 2 utilization measures and 3 clinical process/quality/satisfaction measures at both practice and panel levels.

CARE MANAGEMENT AND COORDINATION REQUIREMENTS:

1. Embed Care Management and Coordination staff members functioning as integral, fully-involved members of every participating Care Team.
    a. Care Managers and Care Coordinators may be employed or contracted by the 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.
    b. 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.

2. 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.

3. 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.

4. 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.

5. Ensure at least 2.5% of attributed Practice patients receive care management and coordination services, as measured on aggregated quarterly reports. (represented through billing MHPs using the Initiative's tracking codes, outlined in the 2019 PCMH Initiative Participation Guide).
    a. MDHHS reserves the right to update this benchmark based on overall participant performance, regular metric specification maintenance or other applicable events. In the event that the benchmark must be updated, MDHHS will provide sixty (60) days written notice to participants.

6. 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.

7. Implement self-management support for at least 1 high risk condition.

8. 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 (see 2019 PCMH Initiative Participation Guide for more details).

9. Assure that Care Managers/Care Coordinators have a workspace, computer access, and telephone in each Practice setting served.

10. 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.

11. 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.

12. Ensure participating payers are billed for Care Management and Coordination services provided, as represented by the Care Management and Coordination Tracking Codes identified by the Initiative to monitor CM/CC services delivered within the practice. CM/CC tracking codes included below (further detail about the identified codes can be found in the 2019 PCMH Initiative Participation Guide)
    a. Comprehensive Assessment (G9001)
    b. In-Person CM/CC Encounter(s) (G9002)
    c. Telephone CM/CC Services (98966-98968)
    d. Education/Training for Patient Self-Management (98961, 98962)
    e. Care Transitions (99495, 99496)
    f. Care Team Conferences (G9007)
    g. Provider Oversight (G9008)
    h. End of Life Counseling (S0257)

HEALTH INFORMATION TECHNOLOGY REQUIREMENTS:

1. Possess and utilize a fully implemented Office of the National Coordinator for Health Information Technology (ONC) certified Electronic Health Record (EHR) system (either 2015 Edition or 2014 Edition CEHRT).

2. 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. Performance reports should include measures from Quality Measure Information Use Case.

3. Maintain all necessary legal documents and be actively participating in the following Michigan Health Information Network Health Information Exchange Use Cases:
    a. Active Care Relationship Service (ACRS);
    b. Health Provider Directory (HPD);
    c. Admissions, Discharge, Transfer Notification Service (ADT)
    d. Quality Measure Information (QMI);

4. 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.

5. Possess and utilize an electronic system capable of providing decision support prompts and care alerts to clinicians at the point of care. The decision supports should, at a minimum, encompass measures from Quality Measure Information use case.

PRACTICE SUPPORT AND LEARNING ACTIVITY REQUIREMENTS:

1. Ensure a clinical champion and other care team members participate in the annual Initiative virtual launch meeting.

2. Ensure clinical champion and other care team members participate in PCMH Initiative hosted learning activities (outlined in Table C1 below) as appropriate and relevant to their position in the practice.

Table C1: Initiative Hosted Practice Support and Learning Activities

Activity	Purpose	Occurrence	Who Should Attend
Annual Initiative Launch Meeting	Gather participants to kick off the new year of participation, discuss direction for the year	Required Annually: held virtually in January	PO representatives, and practice clinical champions
Quarterly Update Meetings	Provide participants with important Initiative updates and resources for successful participation.	Required Quarterly: schedule to be outlined in communications to Participants	PO representatives and key practice staff for practices participating independently
Topic Focused Sessions (Office Hours)	Gather participants to engage in resource sharing and Initiative learning opportunities including review of tools and/or Initiative requirements.	Monthly: virtual opportunities throughout the year	Varies: depending on topic; Initiative communications will provide suggested attendees
Care Coordination Collaborative	Designed to support collaboration and coordination between Participants and their shared beneficiaries.	As Identified: Schedule to be outlined in communications to Participants	Participating Practice Care Management and Coordination staff and Medicaid Health Plan Care Management and Coordination staff.
Annual Summit	Gather participants to engage in networking and opportunities to build on the foundation of regular learning opportunities.	Annual: schedule to be outlined in communications to Participants	Participating practices, POs and associated staff
Technical Assistance	Provide participants with needed assistance to achieve the goals of the PCMH Initiative	As Requested: contingent upon resources, and as deemed necessary by the Initiative	Participating practices, POs and associated staff

PERFORMANCE MONITORING AND INITIATIVE FEEDBACK REQUIREMENTS:

1. Complete the PCMH Initiative's required Annual Practice Self-Assessment.

2. Complete the required Semi-Annual Progress Reports

3. Complete the required Semi-Annual Practice Transformation Progress Reports.

APPENDIX D
PERFORMANCE INCENTIVE PROGRAM

A. BACKGROUND

Participating Organizations will have the opportunity to earn incentive payments calculated based on quality and utilization performance as measured in the Michigan Data Collaborative (MDC) dashboards. A subset of high-volume, clinically important claims-based MDC dashboard measures form the base of the measurement approach. All measures and benchmarks are claims based only. Each measure has a minimum volume requirement, if the denominator does not meet this level, that measure will be excluded from the percentage calculation for the organization

B. MEASURES

MEASURE TYPE	AGE GROUP	MEASURE NAME	2019 BENCHMARK
Quality	Pediatric	Adolescent Well-Care Visits	48.54
		Childhood Immunization Status	45.00
		Lead Screening	78.67
	Adult	Diabetes Nephropathy	86.67
		Diabetes HbA1c Testing	85.63
		Cervical Cancer Screening	59.61
Utilization	Adult	Prevention Quality Indicator Chronic Composite 92 (PQI 92)	8.77
	Both	Acute Hospital Admissions	67.78
		Emergency Department Visits	606.01

C. BENCHMARKS

The dashboard uses best-in-class methodology for benchmark rates. Quality benchmarks are calculated at 5 percentage points below the 75th percentile across the participants on a given measure. Benchmarks for Acute Hospital Admissions and Emergency Department Visits are calculated at 50 points above the 75th percentile. This rate keeps it in line with the quality measures of 5% per 1000. For the Prevention Quality Chronic Composite (PQI 92) measure, the latest benchmark published by AHRQ will be used. This benchmark is a nationwide comparative rate based on an analysis of discharge data from forty states from the 2013 AHRQ Healthcare Cost and Utilization Project (HCUP) State Inpatient Database (SID). While the MDC dashboard re-calculates the benchmark with each release to correspond to the reporting year used for the data included in the current Dashboard, the 2019 PIP benchmark will be static based on the best-in-class methodology applied to Dashboard release 6.01 (a reporting period of July 1, 2017 to June 30, 2018), the benchmark is noted in the table above.

D. CALCULATION

Performance will be calculated at the Participant level. Overall performance and payments will be based on the percentage of measure benchmarks met by the organization. For example, if all benchmarks are met, the

organization would receive 100% of the base incentive payment. If seven out of nine benchmarks are met, the organization would receive 7/9ths or 78% of the base incentive payment. In addition to the base incentive payment, an additional bonus payment may be available to those organizations who have met the benchmark for at least 75% of measures for which they are eligible. The bonus pool will be derived from unallocated funds resulting from participants not meeting their defined benchmarks. For example, an organization who received 72% of their base incentive payment, would not qualify to receive a portion of the bonus payment, should one be available.

For example, if $1,000,000 were available once the initial incentives were calculated, and the following five organizations met the 75% threshold, the additional funds would be apportioned as follows, with each receiving approximately $12.35 per member, or an additional $1.03 PMPM.

Organization meeting 75% threshold	**Attributed SIM members (average over 12 months)**	**Bonus Payment Amount**
Organization 1	8,000	$98,765.43
Organization 2	30,000	$370,370.37
Organization 3	11,000	$135,802.47
Organization 4	7,000	$86,419.75
Organization 5	25,000	$308,641.98

Release 10 of the MDC Dashboard, containing the reporting period of July 2018 through June 2019 dashboard data will be used for the final performance period calculation.

APPENDIX E
CRITERIA FOR INCLUSION/EXCLUSION OF MEDICAID BENEFICIARIES

A Medicaid beneficiary must have full Medicaid coverage and be served through a Medicaid managed care organization (Medicaid health plan) to be attributed to a participating Practice. For purposes of the PCMH Initiative, the benefit plans listed under "included" below are full Medicaid coverage.

Included Benefit Plans		**Excluded Benefit Plans**		
BMP	Benefits Monitoring Program	APS	Ambulatory Prenatal Services	Not Full Coverage
MA-HMP-MC	Healthy Michigan Plan – Managed Care	CSHCS	Children's Special Health Care Services (FFS)	Not Medicaid Health Plan
MA-MC	Medicaid – Managed Care	CSHCS-MC	Children's Special Health Care Services – Managed Care	Existing and/or Potentially Duplicative Payment Structure
TCMF	Targeted Case Management Flint	HHMICARE	Primary Care Health Homes	Existing and/or Potentially Duplicative Payment Structure
		HHBH	Health Home Behavioral Health	Existing and/or Potentially Duplicative Payment Structure
		Hospice	Hospice	Not Medicaid Health Plan
		ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	Not Medicaid Health Plan
		ICO-MC	Integrated Care - MI Health Link	Existing and/or Potentially Duplicative Payment Structure
		INCAR-ESO	Incarceration – Emergency Services Only	Not Full Coverage
		INCAR-MA	Incarceration - MA	Not Medicaid Health Plan
		INCAR-MA-E	Incarceration – MA Emergency Services Only	Not Full Coverage
		MA	Full Fee-for-Service Medicaid	Not Medicaid Health Plan
		MA-ESO	Medical Assistance Emergency Services Only	Not Full Coverage
		MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only	Not Full Coverage
		MA-HMP	Healthy Michigan Plan (FFS)	Not Medicaid Health Plan
		MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only	Not Full Coverage
		MA-HMP-INC	Healthy Michigan Plan Incarceration	Not Medicaid Health Plan
		MME-MC	Medicaid – Medicare Dually Eligible – Managed Care	Existing and/or Potentially Duplicative Payment Structure (Medicare)
		MIChild - ESO	MIChild Program – Emergency Services Only	Not Full Coverage

		MI Choice-MC	Home and Community Based Services – Managed Care	Existing and/or Potentially Duplicative Payment Structure
		MOMS	Maternity Outpatient Medical Services	Not Full Coverage
		NH	Nursing Home	Not Medicaid Health Plan
		PACE	Program of All-Inclusive Care for Elderly	Not Medicaid Health Plan
		Plan First!	Family Planning Waiver	Not Full Coverage
		QMB	Qualified Medicare Beneficiary – All Inclusive	Not Medicaid Health Plan
		Spend-down	Medical Spend-down	Not Full Coverage
		SPF	State Psychiatric Hospital	Not Medicaid Health Plan
		QDWI	Qualified Disabled Working Individual	Not Full Coverage / Not Medicaid Health Plan
		SLMB	Specified Low Income Medicare Beneficiary	Not Full Coverage / Not Medicaid Health Plan
		ALMB	Additional Low Income Medicare Beneficiary	Not Full Coverage / Not Medicaid Health Plan

Not Applicable for Inclusion/Exclusion Decisions

The following benefit plans are either not directly relevant to deciding whether or not a beneficiary can be included in the population (dental, mental health etc.) or represent services that are additions/enhancements to the standard Medicaid state plan benefit (waivers etc.).

HK-Dental Healthy Kids Dental
HK-EXP Full Fee-for-Service Healthy Kids Expansion
HK-EXP-ESO Healthy Kids Expansion Emergency Services Only
NEMT Non-Emergency Medical Transportation
PIHP Prepaid Inpatient Health Plan
PIHP-HMP PIHP Healthy Michigan Plan
DHIP Foster Care and CPS Incentive Payment
AUT Autism Related Services
CWP Children's Home and Community Based Services Waiver
HSW Habilitation Supports Waiver Program
SED Children's Serious Emotional Disturbance Waiver Program
SED-DHS Children's Serious Emotional Disturbance Waiver Program – DHS

APPENDIX F ALTERNATIVE CONSIDERATION FORM

2019 PATIENT CENTERED MEDICAL HOME INITIATIVE ALTERNATIVE CONSIDERATION REQUEST FORM	
DIRECTIONS: Please complete one form for each Practice Unit requesting Alternative Consideration. Attach supplemental materials and information as appropriate. Submit electronically per the directions below	
Practice Name: Click here to enter text.	**Date of Request:** Click here to enter a date.
Contact Person: Click here to enter text.	**Phone:** Click here to enter text.
Email Address: Click here to enter text.	
Associated Physician Organization (if applicable): Click here to enter text.	
Request for Alternative for: ☐ Ensuring (on average over the course of a week) 30% of available appointments are reserved for same-day care across the patient population.	
Use the space below to detail the Request for Consideration Be sure to describe how the Practice will ensure access to services through an alternative mechanism	
Barriers to Meeting Requirement(s): Click here to enter text.	
Alternative Mechanism(s) for Consideration: Click here to enter text.	

Please complete and return form via email to:

MDHHS-SIMPCMH@michigan.gov

2019 Alternative Consideration Requests must be received by February 28, 2019

FOR SIM PCMH INITIATIVE USE ONLY	
Date Received: Click here to enter a date.	**Date Reviewed:** Click here to enter a date.
Request Disposition: ☐Accepted ☐Denied **Date Response Sent:** Click here to enter a date.	**If Denied, provide rationale:** Click here to enter text.
Additional Comments: Click here to enter text.	