

State Innovation Model

# SIM Update



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# SIM Update

- Michigan Blueprint for Health Innovation developed in 2013
- Model Test proposal submitted July 2014
- Proposal presentation at Center for Medicare and Medicaid Innovation: October 2014
- \$70 Million award announcement: December 2014
- Pre-implementation year started February 1, 2015
- Medicaid managed care procurement: May to October 2015
- No-cost extension filed December 2015; pre-implementation year end date extended to July 31, 2016
- SIM Operational Plan due to CMS May 31, 2016

## SIM Model Overview

- Sustain and broaden Patient Centered Medical Home
- Define and support Accountable Systems of Care development
- Develop and test Community Health Innovation Region model
- Leverage existing efforts to support providers (PPQC)
- Support expansion of health information exchange use cases
- Work with Medicaid health plans and other payers to develop and test payment models for PCMH and ASC to achieve high quality at a lower cost
- Support collaborative learning environment to develop and test interfaces between PCMHs, ASCs, CHIRs, MHPs, and other payers

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# Patient Centered Medical Homes



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## Our Foundation and Objectives

- Patient Centered Medical Homes are the foundation for coordinated care delivery strategies
- PCMH efforts are intentionally building upon the Michigan Primary Care Transformation Project (MiPCT) including sustaining involvement of MiPCT providers and multi-payer participation, leveraging the project's existing infrastructure and advancing the project model
- PCMH-specific objectives (in addition to SIM's overall goals) include:
  - Increasing the percentage of active primary care providers practicing in PCMH settings
  - Increasing the percentage of Michigan residents receiving primary care services in a PCMH setting
  - Increasing the percentage of active primary care providers participating in Category 3A or higher Alternative Payment Methodologies
  - Continuing measurable improvements in quality of care, health outcomes and patient satisfaction measures
  - Making a positive impact on total cost of care, including better equipping PCMHs to understand and manage their patients' healthcare costs

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## PCMH Focus

- Development of personalized, patient-centered care plans
- Implementation of comprehensive, team-based care delivery and coordination/management activities
- 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 and self-care
- Utilization of registry functionality and quality improvement strategies to support population health improvement

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## Scaling Up

- The 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
- Based on what we know today, we've initiated the following scale-up strategy to get us there:
  - Year One: PCMHs meeting participation requirements within SIM's 5 regional test locations **and** existing MiPCT practices meeting participation requirements outside SIM's regional test locations will be offered an opportunity to participate
  - Year Two: The PCMH Initiative will expand to 5 Michigan prosperity regions chosen by SIM's governing body in consultation with PCMH stakeholders
  - Year Three: The PCMH Initiative will expand the remaining 5 Michigan prosperity regions

## Accreditation Requirements

- 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 being considered include, but are not limited to, NCQA, AAAHC, TJC and BCBSM/PGIP
  - 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



## 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)

## Patient Population

- Patients included in the PCMH Initiative will represent a broad array of individuals including healthy individuals, those with single or multiple chronic diseases etc.
  - A sustentative portion of the Initiative’s performance metrics and payment methodologies will be targeted toward patients with more significant healthcare needs and costs including Michigan’s SIM target populations (high utilizers of emergency department services, patients with multiple chronic diseases etc.)
- Several Medicaid and Medicare beneficiary populations will be excluded from the PCMH Initiative 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 during year one
- Private payers participating in the Initiative will make decisions regarding beneficiary population inclusion/exclusion as well

## Patient Attribution

- The PCMH Initiative continues to be multi-payer in nature with the intent of maintaining and growing MiPCT payer participation
- For the Medicaid managed care population, patients will be attributed to PCMHs based on their selected/assigned primary care provider
- For the Medicare population, the PCMH Initiative will apply the attribution algorithm used by MiPCT and approved by CMS
- Private payers participating in the Initiative will be encouraged to use one or both of these approaches for their beneficiary populations
- Only patients served by participating payers that do not fall into an excluded beneficiary population will be attributed to PCMHs for the purposes of the PCMH Initiative

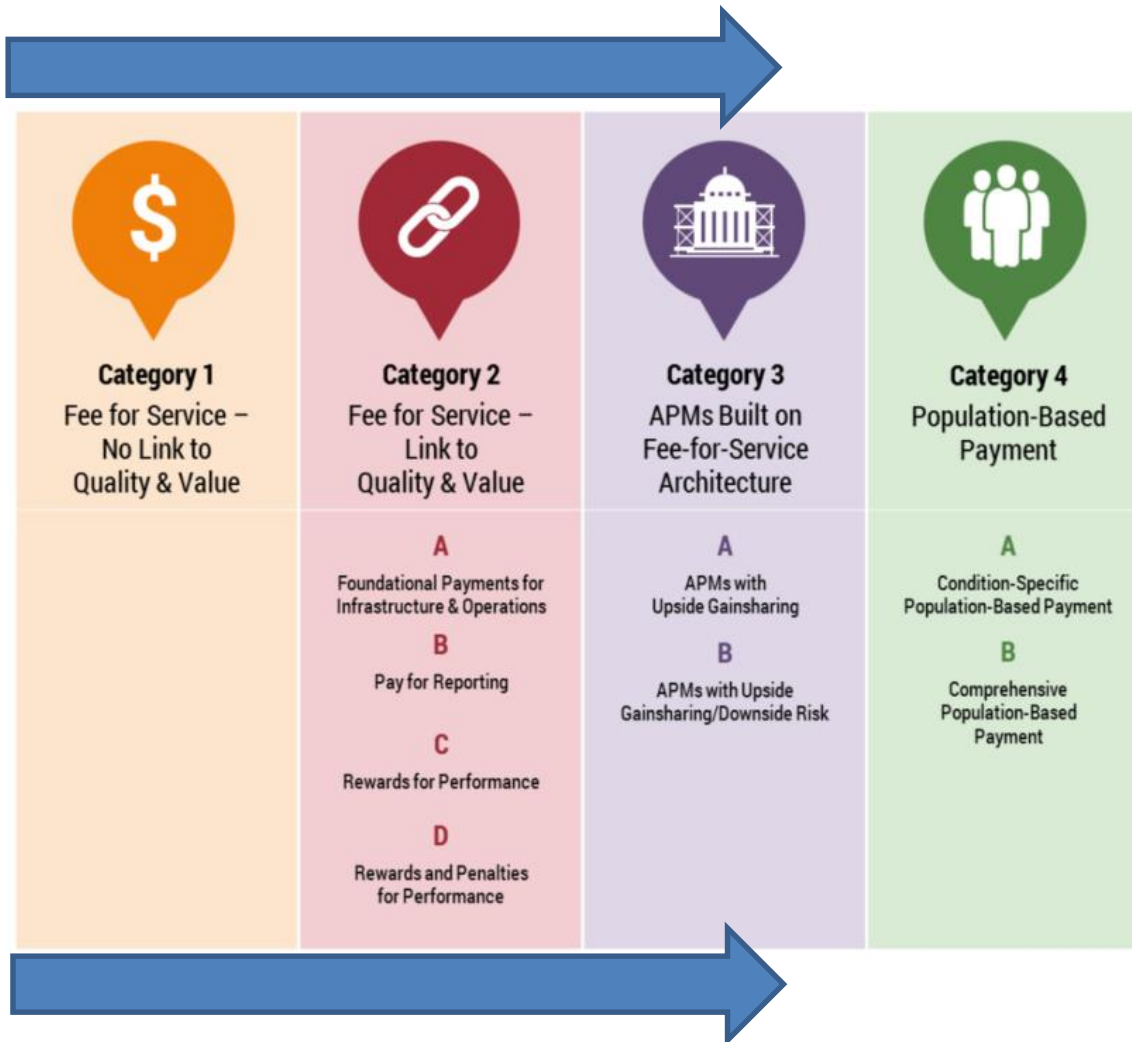
# Participation Requirements

- The following practice requirements are being considered for PCMH participation in the Initiative:
  - PCMH accreditation from an Initiative approved recognizing body
  - An ONC certified Electronic Health Record (EHR) with stage 1 meaningful use attainment
  - 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 and Medicare provider in compliance with all standard provider policies
  - Embedded care coordination staff meeting professional, training and population ratio standards set by the Initiative
  - 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)
  - A patient registry or EHR registry functionality
- The Initiative is also evaluating use of a grace period for PCMHs to fully comply with certain requirements during the first 6-12 months of participation

## Participation Requirements and Agreement

- PCMHs entering the Initiative will attest to required characteristics and agree to participation requirements through an application process which will be opened in annual waves
  - The initial application process targeted to begin Fall 2016 will include a participation agreement outlining responsibilities and expectations in addition to the payment structure
  - The initial application process will be streamlined for existing MiPCT practices
  - Following a PCMH's initial application process and agreement, PCMHs will complete an abbreviated annual renewal process to continue program participation including amendment(s) to the participation agreement as applicable
- Participating payers may require an amendment to a PCMH's provider contract (or PO/PHO/IPA contract) with the payer in addition to the participation agreement

# Payment Model Direction



- Practice Transformation Payment
- Care Coordination Payment
- Shared Savings

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# Payment Model Components

- Practice Transformation Payments
  - PCMHs will receive practice transformation payments to support required 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 as part of their participation application process
  - The Initiative will monitor PCMH progress toward meeting their transformation objectives through a reporting process

# Payment Model Components

- Care Coordination Payments
  - 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 the first six month period they are engaged in the SIM PCMH Initiative
  - PCMHs will be required to demonstrate performance on care coordination linked metrics and meet a minimum ratio (of care coordinators to patients) to continue to receive care coordination payments in subsequent semi-annual periods
  - For the Medicaid managed care population, care coordination payments will be adjusted using a Medicaid eligibility category differential during year one
    - We will be working to implement care coordination payment risk adjustment using a more advanced methodology over the course of the next few years



# Payment Model Components

- Shared Savings
  - Details of the PCMH shared savings model and calculation parameters will be forthcoming, mirroring the model used for ASCs
    - It's very likely the first TCOC performance period will not begin in January 2017 to allow more time for the model to be developed, operationalized and receive stakeholder input
    - The Initiative is still determining the scale at which shared savings can/will be deployed during the first year
  - In general, total cost of care (TCOC) savings will be calculated and shared savings payments made (if applicable) in a lump sum payment on an annual basis

## Performance Approach and Monitoring

- PCMH practice transformation performance will be measured based upon whether or not a PCMH is making progress toward and ultimately meets its identified practice transformation objective(s)
  - Performance will largely be based upon 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
  - Care coordination performance metrics being considered include (but are not limited to):
    - Number/percentage of attributed patient population receiving care coordination services
    - Timely, comprehensive care transition process completion
    - PCMH referral tracking and receipt of a summary of care report
    - Level of patient activation
- The Initiative will identify and set targets for a subset of the quality/utilization metric set to be used as the eligibility threshold for receipt of shared savings

## Participant Support and Assistance

- 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 Initiative will continue to be operated in partnership between MDHHS and key administration/operations partners that MiPCT uses today
- 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 outside of SIM to stimulate alignment

## Governance and Stakeholder Processes

- The PCMH Initiative will be directed by SIM's three part governance structure which includes governing bodies at the tactical, strategic and executive levels in addition to an overall SIM advisory body/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
  - PCMH Advisory Committee (comprised of PCMH stakeholders and MDHHS staff, providing guidance to the implementation effort)
    - The PCMH Advisory Committee will likely employ both standing and temporary sub-committees, examples could include a Clinical Leadership Sub-Committee and/or Provider Organization Sub-Committee
  - PCMH Core Team (working group comprised of MDHHS staff and key contractual partners, focused on implementation)
- MiPCT's current advisory members will be invited to join PCMH governance to ensure leadership and knowledge continuity

## Coming Next

- Further SIM test location specificity
- April SIM update webinar(s)
- Broad Stakeholder survey
- Operational Plan public comment
- Regional and statewide stakeholder engagement opportunities
- Advisory committees and implementation workgroups development
- PCMH participation application and agreement process
- January 1, 2017 launch date for new PCMH payment model

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