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State/Territory Name: Michigan

State Plan Amendment (SPA) #: 12-006

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

December 5, 2013

Stephen Fitton, Medicaid Director
Medical Services Administration
Federal Liaison Unit
Michigan Department of Community Health
400 South Pine
Lansing, Michigan 48933

ATTN: Loni Hackney

Dear Mr. Fitton:

Enclosed for your records is an approved copy of the following State Plan Amendment:

- Transmittal: #12-006 Michigan Primary Care Transformation
- Effective: January 1, 2012

If you have any questions, please contact Leslie Campbell at (312) 353-1557 or Leslie.Campbell@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12 - 06

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.204

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $ 3,571,600
b. FFY 2013 $ 5,975,100

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Pages 20, 21, 22 and Appendix A Supplement to Attachment 3.1-B, pages 40, 41 and 42

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A – New Pages

Verlon Johnson
January 3, 2012
March 29, 2012

10. SUBJECT OF AMENDMENT:
Implementation of a multi-payer demonstration project to reform primary care payment models and expand the capabilities of patient-centered medical homes (PCMH) throughout Michigan.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Stephen Fitton, Director
Medical Services Administration

12. SIGNATUE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Stephen Fitton

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
March 29, 2012

16. RETURN TO:

Medical Services Administration
Actuarial Division
Capitol Commons Center - 7th Floor
400 South Pine Street
Lansing, Michigan 48933

Attn: Loni Hackney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPE NAME:

22. TITLE:
Associate Regional Administrator

December 5, 2013

23. REMARKS:

FORM HCFA-179(07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

MiPCT Administrative Claiming Assurances

The State of Michigan assures there is an agreement in place with the University of Michigan to perform administrative functions on behalf of the State Medicaid Agency and that this agreement was in effect prior to the State Medicaid Agency claiming federal matching funds for expenditures incurred under the agreement. Also identified in the agreement is the mechanism for the University of Michigan to file a claim with the State Medicaid Agency.

The agreement identifies the administrative activities and services the University of Michigan provides and includes provisions related to Medicaid reimbursement and funding mechanisms. Oversight activities and monitoring responsibilities are defined for the State of Michigan regarding the University of Michigan. Maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are also described and defined.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

25. Integrated Care Model (ICM) Payments

Program Description:

Beginning January 1, 2012, the Michigan Department of Community Health (MDCH) will provide care coordination and performance incentive payments to eligible Physician Organizations, (POs), Physician Hospital Organizations (PHOs), and their affiliated primary care practices that serve Medicaid beneficiaries through the Michigan Primary Care Transformation project (MiPCT). MiPCT is a statewide, multi-payer collaboration aimed at reforming primary care payment models and expanding the capabilities of patient-centered medical homes (PCMH) throughout Michigan.

Primary care practices that have achieved Patient-Centered Medical Home (PCMH) designation have a model of care delivery that is patient-centered, team-based, coordinated, accessible, and focused on quality and safety. PCMH has become the widely accepted model for how primary care should be organized and delivered throughout the healthcare system.

PCMH practices deliver care coordination that provides for location, coordination and monitoring of care under the authority of 1905(t) for ICM services. These transformations in the delivery of primary care support the overall goal of MiPCT based on the Institute for Healthcare Improvement's Triple Aim: to improve patient health status; enhance patients' overall experience of care; and stabilize or decrease the cost of care. MiPCT strives to create a successful and sustainable model to improve healthcare value and transform primary care delivery in ways that can be replicated statewide.

To be eligible for MiPCT ICM payments, eligible participants must:

- Be part of an existing Physician Organization or Physician Hospital Organization (PO/PHO)
- Have achieved 2010 PCMH designation/recognition through the Physician Group Incentive Program (PGIP) or National Committee for Quality Assurance (NCQA)
- Maintain PCMH designation/recognition
- Sign a participation contract and meet specified MiPCT requirements

Medicaid will use a common approach to reimburse the additional costs for PCMH-related services and reward physicians for delivering coordinated, high-quality care in PCMH-designated practices. Payments will consist of two components:

Care coordination payments will be made quarterly as a $4.50 per member per month (PMPM) payment based on the Medicaid attributed members assigned to those primary care practices that contract with the PO/PHO for care coordination and meet the four criteria specified above.

A $3 PMPM payment will be contributed to a PO/PHO incentive pool. Incentives will be calculated and allocated using an attribution and incentive algorithm based on the multi-payer data in the data repository established for MiPCT. The semi-annual incentive award payments to PO/PHOs will be based on their

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates (Other than Inpatient Hospital and Long Term Care Facilities)

designated practices' PCMH implementation activities and performance improvement (compared to other POs/PHOs).

Performance incentive payments are designed to reward PO/PHOs and their member practices' successful implementation of effective care management practices and PCMH principles. This includes process improvements within practices and achievement of desired health outcomes. Examples include implementation and effective use of appropriate patient disease registries, effective use of care managers to track and follow-up with patients, and ongoing clinical leadership support.

Performance incentive metrics will be established by the Performance Incentive Subcommittee, subject to approval by MDCH. Performance incentive metrics will be assessed every six months of the calendar year. All funds accumulated during that 6-month period will be awarded. The Michigan Data Collaborative (MDC) will calculate a performance incentive score for each PO/PHO.

These payments will be made twice per year after each 6-month cycle.

The PO/PHO performance incentive payment methodology is effective as of February 13, 2012 and can be found at the following location: **http://mipctdemo.files.wordpress.com/2011/09/performance-incentive-program-description.pdf.**

The 2012 six-month performance incentive metrics are effective for January 1, 2012 – June 30, 2012 and published on June 21, 2012. The metrics can be found at the following location: **http://mipct.org/resources/mipct-documents-and-presentations/6-month-perf-inc-metrics-2012-1/.**

The 2012 twelve-month performance incentive metrics are effective for July 1, 2012 – December 31, 2012 and published on October 1, 2012. Metrics can be found at the following location: **http://mipct.org/resources/mipct-documents-and-presentations/12-month-metrics-final/.**

The 2013 six-month and twelve-month performance incentive metrics are effective for both six-month periods in calendar year 2013, January 1, 2013 – June 30, 2013 and July 1, 2013 – December 31, 2013. They were published on April 25, 2013 and can be found at the following location: **http://mipct.org/resources/mipct-documents-and-presentations/2013-performance-incentive-metrics/.**

The 2014 six-month and twelve-month performance incentive metrics will be effective for both six-month periods in calendar year 2014, January 1, 2014 – June 30, 2014 and July 1, 2014 – December 31, 2014. They were published on May 1, 2013 and can be found at the following location: **http://mipct.org/resources/mipct-documents-and-presentations/** >> Incentives >> 2014 Performance Incentive Metrics.

Medicaid managed care beneficiaries are attributed to a primary care practice based on the primary care provider (PCP) they choose; if they do not choose a PCP, they are assigned one by their Medicaid Health Plan.

Each month the beneficiary PCP of record is matched against the National Provider Identifiers (NPI) of eligible providers participating in MiPCT. The MiPCT-eligible NPIs are linked with identifiers for the MiPCT eligible practices and POs/PHOs. If a beneficiary changes their PCP to another participating provider, their PCP of record change is captured in the Medicaid data warehouse. The resulting list of Medicaid MiPCT-eligible beneficiaries is grouped by practice and PO. The list is provided to the MDC.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates (Other than Inpatient Hospital and Long Term Care Facilities)

On a monthly basis, the MDC posts the enrollee lists on a secure web site and notifies the PO/PHO that the enrollee lists are available.

The MDCH calculates the care coordination payment amounts quarterly for each PO/PHO by adding the enrollee counts for the applicable PO/PHO for each of the three months in the quarter and multiplying by $4.50.

MDCH transmits quarterly payments to each PO and practice through a gross adjustment payment using the Medicaid payment system. The payments are processed approximately the last month of the quarter. Overpayments and/or underpayments regarding provider and beneficiary eligibility are handled as debits or credits during the following quarter payment cycle.

POs are required to submit quarterly narrative and financial reports to assure that revenues spent are in alignment with the MiPCT Clinical Model. The report will include the progress of each practice and provide an accounting for the funds received and the distribution and use of those funds by participating Practices. The report will include an accounting of care manager activity according to the MiPCT reporting specifications.

State assurances for claiming administrative expenditures related to MiPCT can be found in Attachment 4.19-B, Appendix A, Page 1 of the State Plan.

The sunset date for MiPCT is December 31, 2014.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

29 Integrated Care Model (ICM) Services

Goals of the ICM

ICM services are provided to beneficiaries enrolled with primary care practices that meet patient-centered medical home (PCMH) designated criteria and contract with Physician Organizations or Physician Hospital Organizations (PO/PHO) that have entered into an agreement with the Michigan Department of Community Health (MDCH) to participate in the Michigan Primary Care Transformation Project (MiPCT). The PCMH is an approach to providing comprehensive primary care in a healthcare setting that facilitates partnerships between individual patients and their personal physician.

MiPCT addresses the shortcomings in the current system by enabling providers to hire care managers, implement disease registries to track and follow-up with patients (especially those with multiple chronic diseases), and develop the infrastructure and organizational changes characteristic of patient-centered medical homes. In addition, MiPCT pays physicians to expand office hours, offer same-day appointments, and offer supplemental communication with patients (e.g., via email). MiPCT rewards physicians for improving their patients' health and avoiding emergency room and inpatient use for ambulatory sensitive conditions. MiPCT provides clinical models, resources, and support to reduce fragmentation of care among providers, and involves the patient in decision-making thereby strengthening the Patient–Care Team relationship. These transformations in the delivery of primary care support the overall goal of MiPCT based on the Institute for Healthcare Improvement's Triple Aim: to improve patient health status; enhance patients' overall experience of care; and stabilize or decrease the cost of care.

Providers

Providers who will serve as primary care case managers (PCCM) may be primary care physicians, licensed physician assistants, and licensed nurses who are certified as nurse practitioners working under supervision of a physician, as defined in the Michigan Public Health Code, Act 368.

Provider Qualifications

Primary care case managers must have a PCMH designation to participate. MiPCT PCMH designation means a practice that received PCMH designation through the Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP) in 2010 and/or NCQA recognition as a Level 2 or 3 PCMH prior to July 2010. Providers who want to participate after 2010 can participate by demonstrating that they meet the criteria established as of 2010 for the Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP) and/or the criteria established as of July 2010 for NCQA recognition as a Level 2 or 3 PCMH. PCMH designation must be maintained throughout the term of the project. PCCMs must also be affiliated with a PO/PHO participating in the Physician Group Incentive Program (PGIP) of Blue Cross Blue Shield of Michigan which provides supportive services to enhance the practice's medical home capabilities and enables continuous quality improvement. These practitioners will employ or arrange with their respective PO/PHO to employ a care manager as part of a care management team (called the Care Team). Care managers must meet MiPCT education and training requirements and conform to MiPCT clinical guidelines.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

Service Descriptions

Providers of this service will provide for the location, coordination, and monitoring of primary care services through ongoing collaboration with the Care Team, consisting of a primary care case manager as defined above, care managers who meet MiPCT program requirements, and other members of the care team who may include nurses, medical assistants, and other clinical support staff who jointly participate to manage care for the entire patient panel as well as distinct subsets of patients.

Limitations

Functional tiers are used to describe the acuity levels of PCMH services provided to patients for the location, coordination, and monitoring of services. Each progressive tier includes and builds on all aspects of the previous tier(s).

- Tier 1 PCMH services focus on navigating the medical neighborhood. Services include provider-led Care Team interactions designed to optimize relationships with other providers, specialists, and hospitals; coordinate referrals and tests; and link patients to community resources.
- Tier 2 services align care transitions. Services in this tier provide for notification of admission and discharge from hospitals and other institutional care settings; PCP and/or specialist follow-up; and medication reconciliation.
- Tier 3 care management services use planned visits to optimize the care of chronic conditions; emphasize self-management support and patient education; and the informed use of advance directives.
- Tier 4 complex care management services include arrangements for a home care team; a comprehensive care plan; and palliative and end-of-life care.

The PCMH model expands access to primary care and improves care coordination. Assistance and support for practice transformation takes place through a collaborative network of POs/PHOs and shared learning opportunities facilitated by the MiPCT administrative staff. Focus areas for transformation include care management, self-management support, care coordination, and linkages to community services.

Quality Assurance

In terms of cost and efficiency, Michigan will measure overall costs, and assess both cost and utilization in areas that were shown to drive costs including hospitalizations, 30-day all-cause readmissions, and emergency department visits. Exploratory work will investigate the direction of costs in the following categories: primary care, specialty care, and high-cost radiology. Readmissions will be examined in common diagnostic categories for purposes of providing actionable feedback to participants.

Experience of care outcomes will be assessed for both patients and practices. For patients, a Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH survey will be conducted to address the following PCMH domains: access, communication, coordination, comprehensiveness, shared decision-making, whole person orientation, and self-management support.

Experiential data will be collected from program participants including patients, POs/PHOs, practices, and others. Formal surveys, as well as analysis of project documents will be the main mechanism to collect both experience and process data. Standardized tools will be selected with additional questions added to meet project specific informational needs.

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Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

Assurances

All services provided to MiPCT participants are in accordance with 1905(t) of the Social Security Act. Individuals with a favorable health status are not selectively recruited and conversely, individuals are not discriminated against based on health status. Beneficiaries that have selected or been assigned by their Medicaid Health Plan to a MiPCT eligible primary care provider will receive care coordination services. In accordance with 1932(a)(4),beneficiaries who do not wish to receive any form of care coordination may opt out. Beneficiary personal information is utilized by MiPCT providers for HIPAA permissible purposes of treatment, payment, and/or operations. The use of beneficiary information for measurement and evaluation purposes is permitted according to the Data Use Agreement between MDCH and its contracted MiPCT administrative support partners, as well as the Data Use Agreement between MDCH and CMS; and CMS and the MiPCT-participating POs and practices.