Michigan

Advancing the Medical Home Model for Children and Youth
Created in Collaboration with the National Academy for State Health Policy

The National Center for Medical Home Implementation (NCMHI) and the National Academy for State Health Policy (NASHP) are collaborating on the development of state profiles designed to highlight public programs implementing and advancing the medical home model in pediatric populations. These updates are part of a formal partnership between NASHP and the NCMHI that focuses on exchanging information to improve medical home access for children and youth in medically underserved populations. If you have any questions about the information included in the updates, contact medical_home@aap.org .
The NCMHI is a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau of the Health Resources and Services Administration.

The Michigan Primary Care Transformation (MiPCT) project is the largest multi-payer patient-centered medical home (PCMH) program in the country, with 346 PCMH practices serving over 1.1 million members, including over 100,000 children and youth.

MiPCT was established in 2010 after Michigan was selected to participate in the Centers for Medicare and Medicaid Services Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. Consistent with the goals of MAPCP, MiPCT strives to improve the quality and coordination of health care services delivered in the PCMH setting while reducing or stabilizing costs.

Although the MiPCT was initially designed for adults with chronic illnesses, a substantial number of pediatric practices (58 pediatric practices in total) currently participate in the project. As such, the project has adapted several core program elements to better serve children.

PROGRAM COMPONENTS

Practices participating in MiPCT are required to meet several criteria including achieving and sustaining PCMH designation from either the National Committee for Quality Assurance (NCQA) or Blue Cross Blue Shield of Michigan's Physician Group Incentive Program. As such, practices are expected to uphold the central components of the medical home model, including the following:

- expanding access to care through extended hours
- accommodating same day scheduling
- using disease registries for population health management

Practices must also agree to address four selected focus initiatives of MiPCT, including the following:

- care management
- self-management support
- care coordination
- linkage to community services

The core component of the MiPCT model is delivering and paying for care management services. Participating providers are required to embed care managers in primary care practices and, once embedded, practices receive supplemental payments to support the care manager position.

Care managers work closely with the primary care team to manage patients with complex and costly conditions. Essential care manager responsibilities are evidence-based and include activities that support services such as medication reconciliation, care transitions, and developing comprehensive and coordinated care plans.

MiPCT has tailored the care manager position to serve pediatric populations by providing pediatric specific trainings through in-person meetings and webinars. The Pediatric Care Coordination Curriculum was presented to care managers at the first pediatric care managers MiPCT conference in 2012. Family leaders are invited to present at care manager trainings and facilitate group discussions to enhance implementation of family-centered and coordinated care.

Participating providers have access to an array of clinical tools and resources pertaining to care management and other key areas through the Michigan Care Management Resource Center. The resource center maintains a page for pediatric care managers that includes webinars, assessment tools, training work, and links to resources on best practices for delivering pediatric care.

Participating providers also have access to robust data sets on patient populations, quality measures, and utilization measures through a multipayer data warehouse that allows for retrospective, prospective, and incentive payment reports.

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PAYMENT MODEL

MiPCT was formed in 2010 and payments to practices began January 1, 2012. There are five public and private payers currently participating, including Blue Care Network, Blue Cross Blue Shield of Michigan, Michigan Medicaid, Priority Health, and Medicare. Participating PCMH practices receive four types of per-member per-month (PMPM) payments in addition to standard reimbursements, including the following:

- practice transformation payment
- care coordination payment
- performance incentives
- administrative fee

PMPM amounts for Medicaid managed care and commercial insurers include the following:

- Practice Transformation: $1.50 PMPM
- Care Coordination: $3.00 PMPM
- Retrospective Incentives: $3.00 PMPM
- Upfront Administrative Fee: $0.26 PMPM

The retrospective incentive payments are based on how providers perform on the selected MiPCT incentive metrics. Metrics cover utilization, clinical quality, and capability. Of 18 total incentive measures, 10 apply to children. Examples of pediatric measures include well child visits, immunizations, weight assessment, depression screening, and emergency department visits.

OUTCOMES

The only preliminary findings available from MiPCT evaluations focus on adult populations. Currently, available results from the state evaluation focus on the role of the care manager and suggest physicians and other practice staff largely support the position and would like to see the care management model continue in their practices.

FAST FACTS:

1,278,297: Children enrolled in Medicaid and CHIP in Michigan in FY 2012 (1,174,170 Medicaid; 104,127 CHIP)

92.7% : The participation rate for those eligible for the Michigan CHIP program

88.3%: The national participation rate for those eligible for the CHIP program

For more information on state public health initiatives related to pediatric medical home, visit www.medicalhomeinfo.org.