

Applicable to All Capabilities

Any capability reported to BCBSM as "in place" must be in place and in use by all appropriate members of the practice unit team on a routine and systematic basis, and, where applicable, patients must be able to use the capability.

Must be able to demonstrate the capability is currently in use versus "can do" at the time of the reporting and site visit

Payment for each capability that is implemented in the payment time-frame will be made for practices that are already existing practices. Payment will not be made for new practices or existing practices that are reporting capabilities for the first time.

NPO: Each year, BCBSM clarifies capability language as needed. Please review the 2024-2025 PCMH Guidelines for the capabilities the practice has in place and in use. Redline version is easiest to see changes.



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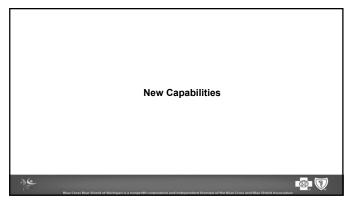
Summary of Changes

- Required Capabilities for PCMH Designation –(no additional capabilities added for 2024-2025)
 - 15 Required Capabilities (1.1, 4.1, 4.3, 4.10, 4.12, 4.13, 5.1, 6.2, 6.5, 6.6, 9.1, 9.2, 10.2, 10.4, 13.1)
- Retired Capabilities (no additional capabilities were retired for 2024-2025)
 - 20 Total Retired Capabilities (1.9, 2.5, 4.6, 4.7,4.28, 4.29, 6.3, 8.7, 8.8, 8.9, 8.11, 12.1, 12.2, 12.8, 13.8, 13.9, 14.2, 14.3, 14.5, 14.10)
- 3 New capabilities
 - 4.30, 10.9 and 14.12
- NPO: BCBSM it is no longer required to put a new capability in place each year! NPO continues to encourage practices to consider and only add what capabilities are truly valuable to the practice; this also means the practice should remove any capabilities that no longer add value.



		ure customers that every BCBSM PCMH-designated practice in Michigan ha
the foundational care pro		
	cesses th	nat they and their employees expect from a high-value PCP practice.
PCMH Domain	Capability	Description
Patient-Provider Partnership	1.1	Prepared to implement patient-provider partnership with each current patient
Individual Care Management	4.1	Practice and staff have been trained in PCMH and PCMH-N Models, Chronic Care models and practice transformation concepts
Individual Care Management		Evidence-based care guidelines are in use at the point of care by all team members of the practice unit
	4.10	Medication review and management is provided at every visit
Individual Care Management		Appointment tracking and generation of reminders for all patients
	4.13	Systematic approach to ensure follow-up for needed services
	5.1	24-hour phone access to clinical decision-maker
Test Tracking	6.2	Process in place to ensure patients receive needed tests and practice receives results
Test Tracking	6.5	Systematic approach to ensure patients receive abnormal test results
Test Tracking	6.6	Systematic approach for communicating abnormal results and receiving follow up care within defined timeframes
	9.1	Primary prevention program in place to identify and educate patients about personal health behaviors
	9.2	Systematic approach is in place to provide primary preventive services
Linkage to Community Services	10.2	PO maintains community resource database/central repository of community resources
Linkage to Community Services	10.4	Practice and staff have been trained on how to identify and refer patients to community resource appropriately
Coordination of Care	13.1	Notification of admit and discharge or other type of encounter, at facilities with which the physician has an engoing relationship

Capabilities for site visits are randomly selected from the Fall (October) Snapshot All capabilities must be verified by either demonstration or documentation POs should inform practices that demonstration will be required for certain capabilities. Examples: - If the practice is asked to show the field team how patient contacts were tracked in the practice system for abnormal test results, the practice should have patient examples identified ahead of time and be prepared to discuss them with the field team during the site visit. - 5.2 - After hours - must bare example in EHR or charl - Registries - must demonstrate active outreach via worksheets, medical record notes, contact log, tickler file, etc., conditions must be relevant to and managed by the practice reported as having fully in place Required documentation must be from the site visit practice and completed. Templates, tip sheets and training documents will not be accepted for validation NO DOCUMENTATION EXAMPLES CAN BE PROVIDED AFTER THE SITE VISIT NPO: Some capabilities require training: Must document training (staff meetings, read & sign etc.) at least oncelyr. New staff training must also be documented. BCBSM does not want to see training signed one week/month before a site visit. Engagement Opportunities: End of Monthly PCMH Requests



Practice or PO ensures that Certified Community Health Worker (CCHW) is trained, onboarded, and integrated into the practice unit effectively. PCP Guidelines (applicable to PCPs only): a. Practice or PO ensures that certification requirements have been completed. i. Accepted CHW programs are available on the collaboration site. b. Practice or PO has created a bilateral process for referrals and systematic follow-up between the CCHW and the care team. c. The Practice or PO has developed patient education resources that define the role and support as an integral part of practice staff. i. CCHW hay be employed by practice, PO, or contracted community entity. ii. CCHW is actively supporting needs of all patients/all payors. d. CCHW is collaborating with the practice care team to provide feedback on on-going interventions aimed at addressing social need and access to community resources. e. Transition of care calls do not constitute active CCHW coordinated and integrated care and would not meet the requirements of this capability. f. CCHW has dedicated time available to meet with patients face to face in the clinic (as needed) to address socials needs and assist in reducing health care disparities, improve access to health care, and improve the overall health of all patients.

Practice or PO ensures that Certified Community Health Worker (CCHW) is trained, onboarded, and integrated into the practice unit effectively.

Required for PCMH Designation: No Predicate Logic: n/a PCMH Validation Notes for Site Visits

Provide documentation of active MI CHW certification for those CCHWs working with the care team.

Provide patient education resources that support CCHW as part of the care team.

Provide patient examples of CCHW documentation that address resource needs and collaboration with the care team.

Provide evidence that the CCHW documentation that address resource needs and collaboration with the care team.

Provide evidence that the CCHW has dedicated time to meet with patients in the clinic.

Practice utilizes data to identify patients with the greatest social need (ex. ADI 8+) and outreach where disparities in health outcomes and care exist.

PCP Guidelines (applicable to PCPs only):

a. The practice screens those patients identified with potential for higher social needs in the domains of food, housing, and transportation.

b. Practice has established referral process to provide interventions when patients indicate a social need.

c. Practice uses NCOA approved screening tool to screen for Social Determinants of Health.

d. Practice staff are trained on screening and referrals processes.

e. Practice or PO provides training on A through D annually and for new staff.

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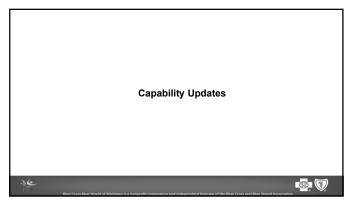
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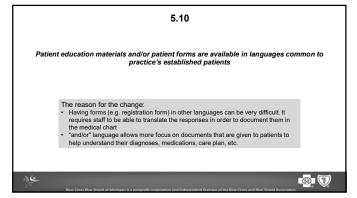
Practi	10.9 ce utilizes data to identify patients with the greatest social need (ex. ADI 8+) and outreach where disparities in health outcomes and care exist.
1	Required for PCMH Designation: No Predicate Logic: 10.5 & 10.6
	PCMH Validation Notes for Site Visits
	The practice demonstrates a process for identifying patients with the highest social needs. The practice shows documentation demonstrating how outreach is performed, spanning their attributed population. The practice provides sample of screening tool used to screen patients for social determinants of health specifically in domains that identify food, transportation, and housing resources. The practice provides patient examples of referrals and follow-up. The practice provides program information related to addressing food insecurity, transportation, and housing needs. The practice provides documentation of staff training on process.
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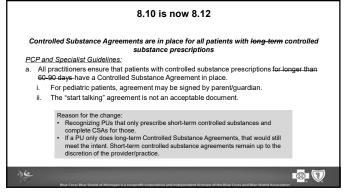
Practice unit actively promotes high-performing specialty referrals and reviews BCBSM provided data. High-performing specialty providers are identified based on their performance metrics and outcomes, ensuring patients receive the most efficient care. PCP Guidelines (applicable to PCPs only): a. PO identifies and provides PU with tier 1 and 2 specialty providers. i. The PU ensures that all PCPs and relevant staff have access to the list of high-performing specialty providers. b. PO reviews specialist BCBSM data with practice unit. c. PO and PU develop processes/protocols to support PCP referrals to tier 1 and 2 specialty providers. d. PO provides training on referral data and processes/protocols to support PCP referrals. e. PO and PU conduct a review and analysis of referral patterns at least annually. NPO: Will receive data reports mid February. Depending on the data, NPO will share the reports our to practices for opportunity with this capability.

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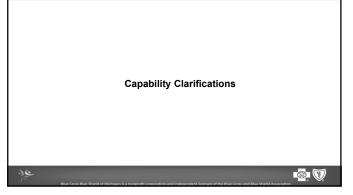
Practice unit actively promotes high-performing specialty referrals and reviews BCBSM provided data. High-performing specialty providers are identified based on their performance metrics and outcomes, ensuring patients receive the most efficient care. Required for PCMH Designation: No Predicate Logic: n/a PCMH Validation Notes for Site Visits PO provides list of liers 1 and 2 SCPs. Provide documentation of PU review of SCP referral data. Provide training documentation and process/protocol documents that support referrals to tier 1 and 2 SCPs. PU provides process/protocol documents that support referrals to tier 1 and 2 SCPs. PU provides evidence of regular review and analysis of referral patterns annually.

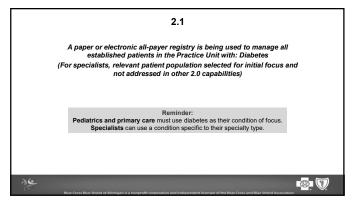






	14.4
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PU 0	or Practice Unit has developed specialist referral materials supportive of process and individual patient needs
Speci	alist Guidelines:
	ocesses are in place to ensure PCP referral materials are used appropriately by the specialist and her team members in the specialist office.
	pecialist practice must provide patient with a summary of the specialist appointment, including: Diagnosis, medication changes, plan of care.
ii	. Sub- specialist referral materials supportive of process and individual patient needs. i. Expected duration of specialist involvement.
iv	v. When the patient should return to the specialist and when the patient should return to the PCP.
c. Vis	sit information must be provided to patient in writing at time of visit.
	We've added requirements for sub-specialist referrals materials that are supportive of process and individual patient needs to the specialist quidelines.
	process and marriada, pager, research the specialist guidelines.
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<u> </u>	Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association





2.20 Clarification Registry contains advanced patient information that will all identify and address disparities in care Requirements – Collect race and ethnicity data, plus additional data elements in registry. PCP and Specialist Guidelines: a. Registry may be paper or electronic. i. Registry contains advanced patient demographics to enable practices to identify vulnerable patient populations, including Face and othnicity, and including data elements such as: primary/preferred language measures of social support (e.g., caretaker for disability, family network, isolation, single parent) disability status military status enployment status education status refuge health literacy limitations type of payer (e.g., uninsured, Medicaid) The highlighted elements align with BCBSM's health equity scorecard and other near-term initiatives. Collection of other elements should be considered by PUs to determine what is relevant to their patient population. In addition to using this data at point of care, the goal is to use this data to identify the patient population being served, along with any health or health care disparities, and opportunities for focus. treatin iteracy limitations type of payer (e.g., uninsured, Medicaid) relevant behavioral health information (e.g., date of depression screening and result) NPO: Please reach out to NPO if your practices has questions or wants to further consider any of the AT RISK VBR Capabilities. CoCM practices or and practices considering CoCM may also want to consider the additional At RSIK VBR capabilities to be eligibale for the new APC VBR. More Information on the next slide.

NPO Slide: At Risk VBR and APC VBR

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- 5% VBR awarded to providers trained on and addressing needs in the LGBTQ+ community and other at-risk
- 2024 Requirement:
- Adult Practices
 5.13, 5.14, 5.16, 9.1, 9.12, 9.13, 9.14 Pediatric Practices
 - 5.13, 5.14, 9.1, 9.11
- 2025 Requirements:
- Same as the above Plus 2.20 and 2.21
- 2026
 - At Risk VBR goes away

ACP VBR

New 5% Advanced Primary Care VBR awarded to PCMHdesignated practices that also participate in the PDCM and CoCM programs

- · 2025 Requirement:
 - PCMH Designated
 Participate in PDCM

 - And meet the initial 1% target

 - CoCM Designated
 Meet APC 2024 requirements meaning 2.20 and 2.21 are not required.

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13.11 Practice is actively participating in the Michigan statewide Admission, Discharge, Transfer (ADT) Notification Use Case d. The practice appropriately documents receipt of notification of ED and inpatient admission on the day of admission or within the following 2 calendar days. Documentation must include the date the notification was received. Reminder 13.11 and 13.12 will be used for the HIE incentives starting with the 2025 Fall PACT snapshot. The PACT reporting will replace the annual HIE survey. 13.12 Practice is actively participating in the Michigan statewide Exchange CCDA Use Case The practice appropriately documents receipt of discharge information in the patient medical record on the day of discharge or within the following 2 calendar days. Documentation must include the date the notification was received.

Domain 5 for Specialists

- 5.3 As applies to SCP-Applicable ONLY to those specialists who refer their patients to urgent cares after hours.
- 5.4 As applies to SCP-<u>Applicable ONLY to those specialists who refer their patients to</u>
 urgent cares after hours. Verblage added to capability for 2024-2025. Specialists must have an
 active role and appropriate patient population when sending patients to urgent care after-hours
- 5.5 As applies to SCP-<u>Applicable ONLY to those specialists who refer their patients to urgent cares after hours.</u>
- 5.11 and 5.12 Applicable ONLY to those practices who provide after hours URGENT CARE services WITHIN the practice



