VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield Blue Care Network of Michigan

2024-2025 PCMH Interpretive Guidelines Updates

With NPO Comments 2025

PGIP Field Team, Value Partnerships

Blue Cross Blue Shield of Michigan

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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.

Annually is defined as within the last 12 months.

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.**

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Required Capabilities

As of April 2021, practices must have fifteen core capabilities implemented to qualify for PCMH designation.

Requiring them enables us to assure customers that every BCBSM PCMH-designated practice in Michigan has the foundational care processes that 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	4.3	Evidence-based care guidelines are in use at the point of care by all team members of the practice unit
Individual Care Management	4.10	Medication review and management is provided at every visit
Individual Care Management	4.12	Appointment tracking and generation of reminders for all patients
Individual Care Management	4.13	Systematic approach to ensure follow-up for needed services
Extended Access	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
Preventive Services	9.1	Primary prevention program in place to identify and educate patients about personal health behaviors
Preventive Services	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 resources appropriately
Coordination of Care	13.1	Notification of admit and discharge or other type of encounter, at facilities with which the physician has an ongoing relationship

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Capability Demonstration

- 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 have example in EHR or chart
  - 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 once/yr. 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!

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New Capabilities

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4.30

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 may 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.

NPO:Not applicable to NPO Practices at this time due not no CCHWs

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4.30

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 documentation of referral process and tracking mechanism to ensure follow up is communicated and resource needs are met. • Provide patient examples of 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.	

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10.9

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 NCQA 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.

NPO: practices screen for food, housing and transportation

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10.9

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

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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14.12

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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14.12

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 tiers 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.	

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Capability Updates

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5.10

Patient education materials and/or patient forms are available in languages common to practice's established patients

The reason for the change:
- Having forms (e.g. registration form) in other languages can be very difficult. It requires staff to be able to translate the responses in order to document them in the medical chart
- "and/or" language allows more focus on documents that are given to patients to help understand their diagnoses, medications, care plan, etc.

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8.10 is now 8.12

Controlled Substance Agreements are in place for all patients with ~~long-term~~ controlled substance prescriptions

PCP and Specialist Guidelines:

a. All practitioners ensure that patients with controlled substance prescriptions ~~for longer than 60-90 days~~ have a Controlled Substance Agreement in place.
   i. For pediatric patients, agreement may be signed by parent/guardian.
   ii. The "start talking" agreement is not an acceptable document.

Reason for the change:
- Recognizing PUs that only prescribe short-term controlled substances and complete CSAs for those.
- If a PU only does long-term Controlled Substance Agreements, that would still meet the intent. Short-term controlled substance agreements remain up to the discretion of the provider/practice.

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14.4

PO or Practice Unit has developed specialist referral materials supportive of process and individual patient needs

Specialist Guidelines:

a. Processes are in place to ensure PCP referral materials are used appropriately by the specialist and other team members in the specialist office.
b. Specialist practice must provide patient with a summary of the specialist appointment, including:
   i. Diagnosis, medication changes, plan of care.
   ii. Sub- specialist referral materials supportive of process and individual patient needs.
   iii. Expected duration of specialist involvement.
   iv. When the patient should return to the specialist and when the patient should return to the PCP.
c. Visit 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 guidelines.

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Capability Clarifications

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2.1

A paper or electronic all-payer registry is being used to manage all established patients in the Practice Unit with: Diabetes

(For specialists, relevant patient population selected for initial focus and not addressed in other 2.0 capabilities)

Reminder:
Pediatrics and primary care must use diabetes as their condition of focus.
Specialists can use a condition specific to their specialty type.

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2.20

Registry contains advanced patient information that will allow the practice to identify and address disparities in care

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 **race and ethnicity**, 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
      - employment status
      - education status
      - refugee
      - health literacy limitations
      - type of payer (e.g., uninsured, Medicaid)
      - relevant behavioral health information (e.g., date of depression screening and result)

Clarification

Requirements – Collect race and ethnicity data, plus additional data elements in registry.

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.

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.

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NPO Slide: At Risk VBR and APC VBR

- **At Risk VBR:**
  5% VBR awarded to providers trained on and addressing needs in the LGBTQ+ community and other at-risk populations
  - **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 PCMH-designated 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.

13.12

Practice is actively participating in the Michigan statewide Exchange CCDA Use Case

c. 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.

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.

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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-*Applicable ONLY to those specialists who refer their patients to urgent cares after hours. Verbiage 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-*Applicable ONLY to those specialists who refer their patients to urgent cares after hours.*
- **5.11 and 5.12** - *Applicable ONLY to those practices who provide after hours URGENT CARE services WITHIN the practice*

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