



# 2018 PCMH Initiative Participation Guide

December 19, 2017

**Special Note:** This guide is an iterative document which will be added to and amended as the PCMH Initiative continues implementation. The Department strongly encourages users to access this guide and associated materials through the SIM PCMH Care Delivery website rather than downloading and/or printing local copies to ensure that the most up-to-date information is always used.

State of Michigan  
Department of Health and Human Services

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## Introduction

This guide was written to support Physician Organizations (POs) and Practices who are participating in the 2018 State Innovation Model (SIM) Patient Centered Medical Home (PCMH) Initiative. State Innovation Models are Centers for Medicare and Medicaid Services (CMS) initiatives awarded to states to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.

Reinventing Michigan's health care system is one of the State's top priorities. The ambitious vision is shared by individuals and organizations across the State who desire to both improve the health of all Michiganders and have a health care system that provides better quality and experience at lower cost.

The Patient Centered Medical Home (PCMH) Initiative is the core component of the SIM strategy for coordinated care delivery, focusing on the development and testing service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. This focus is aligned with the overall SIM Care Delivery goals of:

Championing models of care which engage patients using comprehensive, whole person-oriented, coordinated, accessible and high-quality services centered on an individual's health and social well-being.

Supporting and creating clear accountability for quantifiable improvements in the process and quality of care, as well as health outcome performance measures.

Creating opportunities for Michigan primary care providers to participate in increasingly higher level Alternative Payment Methodologies.

## Initiative Operations

To ensure continuity in the 2018 PCMH Initiative, a set of operational requirements were defined in the 2018 Participation Agreement. These requirements support daily functions across the initiative and facilitate regular data maintenance, participant monitoring and compliance, and information sharing.

## Participation Agreements

The PCMH Initiative legal parameters, program requirements, attribution model, and payment model details have been outlined within the 2018 PCMH Initiative Participation Agreement. The PCMH Initiative has developed two versions of the Participation Agreement, designed to support the various ways participants are engaging in this program. While the Initiative is designed for individual practice transformation, each

participating practice has the ability to choose if they will engage in the Initiative independently or via a Physician Organization/Physician Hospital Organization (PO/PHO). Therefore, there is both a [PO Participation Agreement](#) which is signed by the PO/PHO on behalf of all participating practices in their membership, and a [Practice Agreement](#) for individual practices participating without a PO/PHO. Throughout this guide the 2018 agreement is referenced, for continuity it is linked to the PO version of the agreement, although the practice agreement is also available on the MDHHS SIM Care Delivery website.

#### Amendments to Participation Agreement

Amendments to the participation agreement may take place in the event that a participating practice or PO/PHO undergoes any legal name changes, chooses to leave the PCMH Initiative, or is terminated from the Initiative in accordance to the circumstances outlined within the executed agreement.

To amend an agreement for practice or PO/PHO legal name changes or in the event that a practice is choosing to leave the Initiative, the participant should communicate with the Initiative team by completing the [online change form](#).

#### Initiative Payment Model

Participating payers in the 2018 PCMH Initiative include 11 Michigan Medicaid Health Plans (managed care organizations). Additionally, the Initiative team is working with Blue Cross Blue Shield of Michigan and Priority Health to finalize participation which will be centered on multi-payer data sharing in addition to shared care delivery model and HIT/HIE priorities. Additional payers may be added over time as well. Payment for SIM PCMH Initiative beneficiaries attributed to practices will be provided to the participant (the entity that signed the Participation Agreement; PO or practice) via the Michigan Data Collaborative SIM PCMH portal, but is limited to currently participating payers.

Participants will receive payments for attributed [eligible Medicaid beneficiaries](#); these payments will be made directly by each applicable MHP on a quarterly basis. PCMH Initiative participants will receive two types of Per Member Per Month payments:

The Practice Transformation: payment is designed to support needed investment in practice infrastructure and capabilities at a PMPM rate of \$1.25 for all attributed eligible Medicaid beneficiaries.

The Care Management and Coordination: payment is designed to support embedded care coordination services as a PMPM rate of:

Adult Beneficiaries (19 years and above)

\$3.00 for Adult General Low Income Beneficiaries (TANF)

\$5.00 for Healthy Michigan Plan Beneficiaries (HMP)

\$7.00 for Aged, Blind and Disabled Beneficiaries (ABD)

Pediatric Beneficiaries (18 years and under)

\$2.75 for Pediatric General Low Income Beneficiaries (TANF)

\$7.00 for Aged, Blind and Disabled Beneficiaries (ABD)

Even though Medicaid funding is structured as a PMPM, practices are required to submit care management and coordination [G and CPT tracking codes](#) to provide insight into the type and intensity of Medicaid member services. Additionally, participating practices are required to maintain specific benchmarks for the two Care Management and Coordination [benchmarks](#) within the [2018 Participation Agreement](#) in order to maintain consistent payment of the PMPM without potential for payment sanctions.

### PCMH Practice and Provider Participation Updates

An accurate list of participating practices and providers is essential to the PCMH Initiative attribution and payment process. Attribution is run monthly and incorporates updates submitted by POs and practices in the previous month. Updates can be made to the following fields:

Practice participation status, name, TIN, practice address, billing address, phone number

Provider participation status, name and NPI

PO name, TIN, billing address

Changes can be made using the online [Provider and Practice Change Form](#).

Multiple changes can be submitted at once by submitting a form at the above link and uploading an excel document with changes highlighted.

The Initiative requires participating organizations to update changes on a rolling basis. In general, changes submitted by the 25<sup>th</sup> of the month will be incorporated in the patient attribution the following month. For example, if updates are submitted via the online change form on January 23<sup>rd</sup>, changes will go into effect on February 1<sup>st</sup>. To verify that changes have been incorporated, a snapshot of the practice and provider data will be sent every quarter. In the future, this step may be replaced with a similar snapshot uploaded monthly to the SIM Initiative dashboards. As a reminder participants must inform the PCMH Initiative of any changes in accordance with the [2018 Participation Agreement](#).

Questions regarding PO, practice, or provider changes can be sent to the SIM mailbox at [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov).

Please note that changes sent to SIM PCMH Initiative are for Initiative purposes only and cannot be used to communicate changes directly to the Medicaid Health Plans.

### Core Primary Care (PCMH)

The [2018 PCMH Initiative Participation Agreement](#) outlines six (6) Core Primary Care Requirements for all participating practices. Please reference the 2018 agreement to understand more about these requirements, which have been selected to align with many Patient Centered Medical Home accreditation/designation requirements, and

compliment other current initiative, demonstrations, or programs participants may be a part of. One of the requirements does allow the submission of an Alternative Consideration with the return of the signed [2018 Participation Agreement](#).

## Clinical Practice Improvement Activities

The purpose of the PCMH Initiative's practice transformation objectives and aligned [PMPM payment model](#) are to support the advancement of infrastructure within (or accessible to) PCMH practice environments. Practice transformation in this context is not focused on (or funded to support) the act of delivering a service to an individual patient. Rather, practice transformation support in the PCMH Initiative is geared toward building capability and developing structures which make the work of a PCMH participating practice more effective in the required focus areas.

### Practice Transformation Objectives

All SIM PCMH Initiative practices must fulfill the **Clinical-Community Linkage** and **Population Health Management** practice transformation requirements. While both practice transformation elements are required for all participants, the Clinical-Community Linkage requirement particularly will support the continued development of synergies with Community Health Innovation Regions (CHIR) for those practices in SIM regions, which will foster relationships between primary care practices and community resources.

### Clinical Community Linkages

The Clinical-Community Linkage requirement can be satisfied by maintaining documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations (such as a CHIR hub, or community case management organizations) which provide services and resources that address significant socioeconomic needs of the practice's population. Refer to the [2018 SIM PCMH Initiative Participation Agreement](#) which includes the required elements of the Clinical Community Linkage for all participants, however the general elements of the Clinical-Community Linkage are described in the process below:

Assess patients' social needs to better understand socioeconomic barriers using a brief screening tool with all attributed patients (all patients within the practice).

**Note:** to support Participants, MDHHS has developed a [template of a brief screening tool](#) that can be used as is, or adapted to meet the needs of the practice environment and the community being served. Questions (or other inputs) utilized in the screening tool must illicit patient assessment responses consistent with the purpose and intent of each topic in the template developed by MDHHS. However, question (or other input) phrasing, order and the format for administering screening is flexible.

Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and



outcomes of referrals made.

As part of the Practice's ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion.

## Population Health Management

All Participating practices must engage in the Clinical Practice Improvement Activities to support Population Health Management as outlined below. Participants which selected a Practice Transformation Objective other than Population Health Management in 2017 may continue to pursue that objective (e.g. telehealth adoption) but are required to realign their objective as an activity which corresponds with improving performance on one or more of their population health objectives. The elements of Population Health Management are described below:

Ensure engagement of clinical and administrative leadership in practice improvement by ensuring responsibility for guidance of practice change (i.e. a Champion) is a component of clinical and administrative leadership roles.

Empanel (assign responsibility for) at least 95% of the Practice's patient population, linking each patient to a clinician or care team. Use the resultant patient panels as a foundation for individual patient and population health management.

Use feedback reports provided by MDHHS, other payers and/or practice systems at least quarterly to implement strategies to improve population health on at least 2 utilization measures and 3 clinical process/quality/satisfaction measures at both practice and panel levels.

## Practice Transformation Reporting

Practice Transformation Reporting is a requirement that happens semi-annually. This reporting exercise provides insight to the SIM PCMH Initiative team on how each participant is approaching this important task, and also allows for the practice to reach out and request support in achieving their required objectives. Practice Transformation reporting requirements will be released four to six weeks in advance of the report submission date. Further detail on these dates can be found in the [PCMH Initiative Progress Reporting Section](#) in this guide. To get answers to questions, or to provide feedback on any Practice Transformation Reporting related topics, please send an email to [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov).

## Care Management and Coordination

The PCMH Initiative is built upon the joint principles of a Patient Centered Medical Home, agnostic across designating bodies. Particular value is placed in core functions of a medical home such as enhanced access, whole person care, and expanded care teams that focus on comprehensive coordinated care. The 2018 Participation Agreement outlines requirements around enhanced access, and care team composition, while this section provides an overview of Care Management and

Coordination staffing and services. The definitions for Care Management and Coordination Services, Care Manager, Care Coordinator, Care Team, etc. as provided within the [2018 PCMH Initiative Participation Agreement](#), will be referenced and provides additional context.

### **Goals of Care Management and Coordination**

Improve patient's functional health status

Enhance coordination of care

Eliminate duplication of services

Reduce the need for unnecessary, costly medical services

### **Attributes of Successful Care Models**

Successful care management and coordination programs to date have some common key elements: 1) The care manager(s) and coordinators are located in close proximity to the PCP and 2) The care manager(s) and coordinators are considered an integral part of the health care team. Care managers and coordinators working remotely, in isolation of the team; have not been shown to be as effective. For additional details see the archived [2017 Participant Guide](#).

### **Models of Care Management and Coordination**

Care Management and Care Coordination means the application of systems, science, incentives, and information to improve clinical practice and assist patients and their support system to become engaged in a collaborative process designed to manage medical, social, and/or behavioral health needs more effectively. The level of intensity of care management will vary based on the needs of the patients, as to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.

Care management and coordination provides individualized services to patients at the highest risk, based on defined risk stratification process, and who are likely to benefit from care management interventions. Prioritizing patients who will benefit from care management is a key step. Building care management capability for your practice team includes: addressing the needs of patients who may benefit from longer term care management (longitudinal) and those at increased risk due to emergency department (ED) visit or hospital admission/discharge/transfer (short term or episodic care management).

Longitudinal care management and coordination: focuses on patients identified as high risk or rising risk by your practices stratification approach, who are likely to benefit from ongoing proactive care management. This includes the use of an individualized care plan, centered on the patient's actions and support needs in the management of chronic

conditions for care management and care coordination interventions. Building a relationship over time with the patient and their support system and delivery of intensive care management services, are elements of longitudinal care management and coordination.

Episodic care management and care coordination: focuses on provision of short-term care management services, related to acute events such as ED visits, hospitalizations, and new diagnoses. Episodic care management and care coordination services help to address cost savings and patient engagement. Examples of episodic care management and coordination interventions include: medication reconciliation, ensuring patients have timely follow up visits with PCP or Specialist as indicated following hospital admission, discharge, and/or transfer.

### Collaboration and Coordination

Both internal team collaboration and coordination with various partners is imperative to support improved patient outcomes. There are various examples in how the Care Management and Coordination staff team can support both internal collaboration between all members of the Patient Centered Medical Home Team, and external coordination with other clinical providers and community partners.

### PCMH and Team Based Care

The practice team's aim is to meet the majority of the patient population's medical, behavioral, and health-related social needs to support each patient's health goals. Some examples could include:

Team Communication: The practice providers have frequent contact with the practice's Care Managers and Care Coordinators regarding patients receiving active care management and care coordination services. This contact occurs weekly or more frequently as needed to address patient needs. Regular communication supports the providers, care managers and care coordinators efforts to optimally deliver care management services for patients and their support systems. Team huddles at the start of the day when possible, or the use of technology to allow for frequent communication between team members.

Closing gaps in care: A patient registry or registry function within the EHR can be used to generate routine, systematic communication to patients regarding gaps in care. Practice team members have clearly defined responsibilities to operationalize outreach to patients who are either due or overdue for preventive services and/or tests for their chronic condition.

Longitudinal care management: A patient-specific action plan and patient's individual goals are documented in the EHR or electronic care management documentation tool, enabling providers and the practice team members to monitor and follow-up with the patient during subsequent visits.

PCMH Practice Collaboration with Specialists, Behavioral Health Providers and Community Resources (external to the practice)

Collaborative relationships are established and maintained with entities external to the PCMH such as, Specialists, Behavioral Health Providers, and Community Resource agencies to ensure patient linkages to needed resources are effective and appropriate with the exchange of information both initially and ongoing. The expected outcome of these linkages should be the resolution of the patient's identified needs. The PCMH practice, Specialist, Behavioral Health Specialists, and Community Resource agencies work together to deliver coordinated care and address identified barriers, social needs, for patients and their support systems. This can be accomplished through documenting and implementing care agreements with Specialists or other partners to foster interactions which promote effective and efficient delivery of patient care and coordination.

The PCMH practice should establish collaborative relationships with appropriate community-based agencies and organizations relevant to their patient population needs. The relationship(s) involve ongoing telephonic, face to face or other modalities for direct dialogue. An area of focus may be to improve the process of linking patients with the community resource and subsequent follow up to assess the patient's outcome and experience.

#### Shared Care Plan Development

A shared care plan is a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers. Rather than relying on separate care or treatment plans from each provider, or organization supporting the patient, a shared plan of care combines all aspects to encourage a team approach to care.

Engaging patients to participate in developing their shared care plan and gaining an understanding of their preferences leads to an increase in shared decision making between patients and providers. Engaging patients in the development of their plan requires participation of multiple members of the care team both internal to the PCMH and with external partners. Depending on the concerns, goals, and needs of the patient, many team members may work with the patient and family member(s) or support system, to identify the health and overall wellness goals. Development of a shared care plan occurs over time and requires multiple interactions with the patient, support system, and extended team. (reference: J. van Dongen, et al. 2016)

Four elements of a shared care plan include:

Current State: Current state includes the patients background, demographics, functioning, use of medication and usual treatment. The current state element may be continuously adjusted by the health care team.

Goals and Concerns: This involves the patient's goals and concerns and includes information related to the care requirements and goals identified by the patient and the professionals within the extended care team. These goals are in line with the individual's preferences, values, needs and expectations, which is the central focus of the plan.

Actions and Interventions: The actions and interventions are based on the established goals and concerns, and are individualized and tailored per the patient's perspective. Additionally, the plan needs to be kept up to date, ideally is documented using lay terms, and includes aspects to support the patient's emotional, social, and physical needs. Redundancy can be minimized if the interventions are specific, time based, and correspond to the extended care team members involved in supporting the patient.

Evaluation: Evaluation includes the care team members documenting a patient's progress to include successes and struggles and level of participation in goal setting. This also involves revising the plan of care based on the patient's response and current status. The plan should be up to date and address the patients emotional, physical, and social needs.

The shared care plan is a living document utilized by members of the care team and includes updates which reflect the patient's current goals and preferences. For additional details regarding development of shared care plans using an electronic health record, engaging patients in their care plan, and to view examples of shared care plans [click here](#).

### Optimizing Care Management and Coordination Staff Teams

Due to a variety of factors including financial and resource limitations, the practice may have Care Manager (CM) and/or Care Coordinator (CC) staff responsible for "day to day clinic work" as well as fulfilling the role of CM and CC. Inherently, this creates challenges for the CM, CC, and the practice team. The CC and CM are tasked with balancing "day to day clinic work" and the care management and coordination services; i.e. delivering episodic and longitudinal care management services. To address this challenge, some practices have utilized the following strategies:

Establish schedules and block a consistent day of the week, or consistent times of day for the CM or CC staff to dedicate to performing key care management and coordination activities. This creates protected time which allows the CM and/or CC staff to focus their efforts on episodic and longitudinal care management.

Review the current duties and responsibilities of each practice team member. Consider if there is potential to utilize the team members time/resources differently, in order to best meet the needs of the practice's patient population. As part of this review, assess if every team member works to the highest level of their scope of practice, licensure, training, and capabilities. This requires support from the practice leaders and champions. The outcome of this review may include: increased awareness of work which provides minimal value, insight about work which may allow a shift in responsibilities for a team member to optimize patient care. An example may be to decrease the administrative non clinical work of the CM or CC, so they have more time to focus on clinical work.

Efforts to optimize the Care Management and Coordination team and how they function within the broader care team is a continuous effort, which can result in greater team efficiencies, potential for cost reduction, and overall increased patient satisfaction.

### Embedded Care Management and Coordination Staff

The PCMH Initiative requires Care Management and Coordination staff to be embedded within the participating practice in which they are serving. While POs or multi-site practices can hire care management and coordination staff across participating practice locations, the requirement for care management and coordination staff to be embedded remains. The use of the term "embedded" means the care management and coordination staff spends some portion of their time in the physical participating practice location. Face to face time with patients and the practice team is known to contribute to increased success for positive care management outcomes. The care manager should be physically located in the practice and have a work station for the allotted FTE identified for that practice. Due to the variation of population needs for each participating practice, there is no set minimum amount of time for the care management and coordination staff to be physically located in the participating practice.

Participants may allocate the care manager and care coordinator staff FTE for each participating practice based on the need of the patient population. It is expected that needs of the patient will guide the staffing model and allocation of FTE for the care manager and care coordinator staff.

### PCMH Initiative Care Management and Coordination Learning Requirements

The [2018 Participation Agreement](#) indicates that Care Managers and Care Coordinators supporting the PCMH Initiative patient population must receive initial care management and self-management training provided or approved by the Initiative in addition to obtaining an additional 12 hours of care management/coordination training

(longitudinal training) annually. The initial and longitudinal training requirements are described below.

### Initial Training Requirements

Both Care Coordinators and Care Managers are required to complete a MiCMRC approved Self-Management Training course within the first six months of hire. The MiCMRC has identified a number of approved Self-Management training programs; however, if this course is completed through one of the approved vendors, Michigan Center for Clinical Systems Improvement (MICCSI), Practice Transformation Institute (PTI), or Integrated Health Partners (IHP), then the PCMH Initiative will cover the cost of the course. Care Managers are additionally required to complete the MiCMRC led Complex Care Management Training course within the first six months of hire. The cost of this course for new Care Managers will also be covered by the PCMH Initiative. The table below provides an illustration of the training requirements for Care Managers and Coordinators.

### Initial Learning Requirements for Care Managers and Care Coordinators

Initial Required Training	Care Coordinator	Care Manager	Time
<b>MiCMRC Approved Self-Management Support Course</b>	X	X*	<a href="#">Click here</a> for details (details of each course)
<b>MiCMRC CCM Course</b>		X	<a href="#">Click here</a> for details
<b>SIM Overview Recorded Webinar</b>	X	X	30 minutes
<b>PCMH, Chronic Care Model, and ACOs Recorded Webinar</b>	X	X**	20 minutes
<b>Team Based Care Recorded Webinar</b>	X	X**	45 minutes
<b>Introduction to Social Determinants of Health Recorded eLearning Module</b>	X	X***	25 minutes
<b>The Role of Care Managers &amp; Care Coordinators in Developing and Maintaining Community Linkages eLearning Module</b>	X	X***	30 minutes
<b>Social Determinants of Health and the Implications for Care Management eLearning Module</b>	X	X***	20 minutes
<b>Social Determinants of Health Case Study eLearning Module</b>	X	X***	20 minutes

\*Care managers are strongly encouraged to complete this course prior to registering in the MiCMRC CCM Course.

\*\*Recorded webinar content is included in the CCM course. If a care manager attends the CCM course after January 2017, they do not need to complete the PCMH, Chronic Care Model, and ACO or the Team Based Care recorded webinars. However, Care Coordinators do need to complete.

\*\*\*SDOH eLearning modules are included in the CCM course content. If the care manager attends the CCM course after July 2017, they do not need to complete the eLearning Modules. However, Care Coordinators do need to complete.

To access the above initial learning requirements, [click here](#).

Existing Care Coordinators and Care Managers that have completed the Initial Training requirements as outlined above will not be required to attend the courses again.

Example: If the CM has completed the MiCMRC Complex Care Management in the past, there is no need to repeat this course.

### Longitudinal Learning Requirements

The PCMH Initiative maintains the expectation that all Care Managers and Coordinators will maintain their current licensure/certification, including the requirements to seek continuing education approved by the appropriate professional organization/association. To support this expectation, the Initiative requires each Care Manager and Care Coordinator must complete a total of twelve (12) hours of education per year. The requirement of training throughout the year is termed “longitudinal learning activity.” This can be satisfied by either:

Twelve (12) hours of MiCMRC webinars/sessions (e.g., topic based live webinars and recorded webinars that offer CE certificates, web based interactive self-study eLearning modules – Basic Care Management, in person Summit attendance, etc.), OR  
Six (6) hours of MiCMRC webinars/sessions PLUS six (6) hours of PO-led, or other related learning activity events. No preapproval is necessary for PO-led or other CE granting care manager, care coordinator training sessions. However, a certificate of completion should be maintained for audit purposes.

The MiCMRC hosts live, topic-based webinars and trainings throughout the year, many of which provide continuing education credits. In 2018, MiCMRC will host webinars addressing topics relevant to delivery of care management and coordination for the adult and pediatric population. Additionally, MiCMRC maintains a library of recorded trainings (many offering continuing education credits) and various resources ranging from sample tools, articles and resources that can be accessed on demand. Access [live and recorded trainings](#), and [resources](#) can be accessed by following the links provided.

Please note, the completion of the initial required training, as stated above, is not included as part of the hours for the required longitudinal training per year. For example, the Complex Care Management course is not counted as part of the twelve (12) hours of longitudinal training. If a Care Coordinator and/or Care Manager is hired during the calendar year, the twelve (12) hours of longitudinal training requirement is



prorated based on the date of hire. A general guide for prorating the longitudinal learning requirements will be completion of one hour of longitudinal training per month, using hire date within the calendar year.

### Care Management and Coordination Service Tracking

The PCMH Initiative utilizes a set of Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's Current Procedural Terminology (CPT) codes to facilitate tracking the provision of Care Management and Coordination Services within the Patient Centered Medical Home. These codes were selected to represent common Care Management and Coordination services relevant to the SIM PCMH Initiative population. A draft code set was shared with providers across Michigan in the fall of 2016 during an open comment period, and the set was finalized based on feedback. In 2018 four additional codes were introduced to meet additional feedback from providers and support learnings from the 2017 PCMH Initiative, and alignment with the expectations of the 2018 Initiative. To review the set of codes used within the 2018 PCMH Initiative, please reference [Appendix C: Care Management and Coordination Tracking Quick Reference](#).

The Care Management and Coordination services outlined by the HCPCS and CPT codes must be provided under the general supervision of a primary care provider. However, many of the services themselves or activities to support the service can be accomplished through coordinated team efforts, maximizing Care Manager and Coordinator skills to engage patients efficiently. While many team members may be involved in the provision of a single service (such as a care transition), the service may only be billed using the National Provider Identifier (NPI) of the primary care provider. Additionally, the date of service reported should be the date the care management and coordination service took place. In some cases, a service may take place over the course of more than one day, in such an event the date of service reported should be the date the service was completed.

### Care Management and Coordination Service Documentation

Appropriate documentation of Care Management and Coordination services is imperative, not only to support continuity of care between care team members and external partners, but to ensure accuracy in claims submission. PCMH Initiative participants must have a care management and coordination documentation tool, either as a component of an EHR or able to communicate with an EHR to ensure pertinent care management and coordination information is visible to care team members at the point of care. At a minimum, documentation in the care management and coordination documentation tool should include:

- Date of Contact
- Duration of Contact

## Method of Contact

Name(s) of Care Team Member(s) Involved in Service

Nature of Discussion and Pertinent Details

For G9001- Comprehensive assessment results and detailed, individualized care plan

For G9007- Update(s) and/or additions made to individualized care plan

## Care Management and Coordination Claim Submission

All Care Management and Coordination services provided to eligible SIM PCMH Initiative patients (as identified within the [PCMH Patient Lists](#) produced by the Michigan Data Collaborative), must be submitted to the appropriate participating payers (Michigan's Medicaid Health Plans), to be recognized for Initiative tracking purposes. When submitting these claims, all diagnoses relevant to the care management and coordination encounter should be reported, with diagnosis codes reported in the appropriate order to indicate primary diagnosis.

While the HCPCS and CPT codes are being utilized for tracking purposes, supporting participant [compliance and monitoring](#) and as a part of the [Initiative payment model](#), some participating payers may reimburse specific services, and all payers must reimburse for the provision of transition of care (99495 and 99496) services. Therefore, when participants are submitting claims, they should attach their customary charge to the service in the event the payer will reimburse (according to contractual agreements, and specified fee schedule). If the service is not a reimbursable service (used for tracking purposes only) the participating payer may adjudicate the claim and pay at \$0.00, providing a reason code or explanation indicating that the claim is being accepted for informational purposes only. If a participant should experience any claims rejections, they should [contact the PCMH Initiative](#) with specific examples of the rejections including any reason codes provided by the payer.

## Health Information Technology

The PCMH Initiative has focused efforts on leveraging existing infrastructure to facilitate continued transformation and the testing of promising practices within primary care and more specifically Patient Centered Medical Home settings. As a foundation, the Initiative has required all participants to possess and utilize a 2014 or 2015 Office of the National Coordination (ONC) Certified Electronic Health Record Technology (CEHRT), to support the testing of the Relationship and Attribution Management Platform (RAMP).

### [About the Relationship and Attribution Management Platform \(RAMP\)](#)

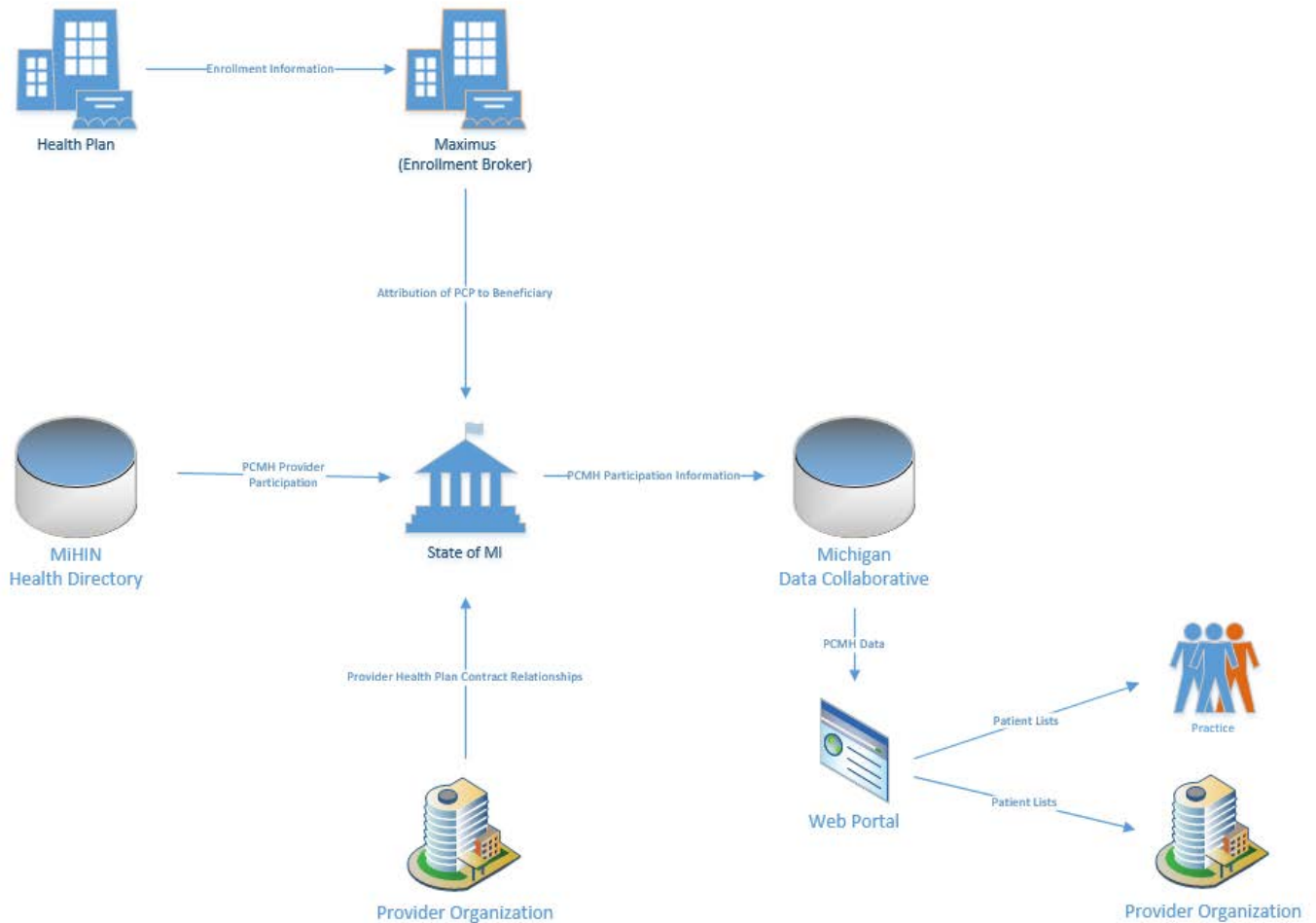
The Relationship and Attribution Management Platform has been created to support the identification and capture of relationships between patients/consumers and their healthcare delivery team members, to facilitate the active exchange of necessary

information between these identified individuals and organizations, and to provide an infrastructure that is necessary for the PCMH Initiative to be effective.

The Michigan Health Information Network Shared Services (MiHIN), the state-designated entity for health information exchange in Michigan, has been engaged in the RAMP project to leverage the widespread interoperability network MiHIN has established in the State of Michigan, along with multiple tools and services to support the goals of this large undertaking.

The State Innovation Model utilizes the RAMP as the foundation for the PCMH Initiative monthly attribution process. Technical details on the attribution process are included in Appendix B: PCMH Initiative Medicaid Attribution Model, of the [2018 Participation Agreement](#). A diagram of the attribution process has been included below to support participant understanding and review of the process. The information transmitted through RAMP for the purposes of attribution supports the development of monthly patient lists as described in the [SIM PCMH Dashboards](#) section of this guide.

## PCMH Initiative Attribution (RAMP)



### Summary of Use Cases

The work described above includes a number of “use cases” created by MiHIN to facilitate statewide exchange of health information. These use cases supporting the State Innovation Model, and the PCMH Initiative are described below.

#### Active Care Relationship Service

The Active Care Relationship Service tracks patient-provider attributions by identifying which healthcare providers have “active care relationships” with patients/consumers. This service acts as the basis of the RAMP by allowing RAMP to match patients/consumers with their attributed care team members. This use case enables organizations to submit data files which record the care team relationships attributing a particular patient with health professionals at that organization. These attributions are then utilized to accurately route information for a patient to all members of their care team. The Active Care Relationship Service also captures key physician organization,

practice unit, and additional provider information to support the hierarchical relationships within the Health Directory (discussed below).

The ACRS use case is the foundation for several other use cases, including HPD, ADT and QMI. Therefore participation is crucial, as the ACRS file is used for routing of information for ADT messages and QMI files.

#### Health Directory

While multiple organizations track physicians and information on how to contact them (name, address, specialty, national provider identifier, or specific credentialing information), the MiHIN Health Directory also includes the electronic service information required to know how and where health information is to be delivered electronically for each healthcare provider.

#### Quality Measure Information

The Quality Measure Information use case enables providers and payers to consolidate and standardize the electronic exchange of quality-related data and performance results. With this use case, providers gain the ability to send one supplemental clinical quality data file in one format and have it distributed to multiple locations, if and as needed.

#### Admission-Discharge-Transfer Notifications

Admission-Discharge-Transfer (ADT) notifications can be leveraged to improve patient care coordination through exchange of health information. ADT messages are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. These alerts are sent to update physicians, care management teams, and payers on a patient's status; to improve post-discharge transitions; to prompt follow-up; to improve communication among providers; and to support patients with multiple or chronic conditions. The use of the ADT feeds and alerts are crucial in supporting active care coordination processes.

#### Active Participation in RAMP

PCMH Initiative Participants are required to actively participate in RAMP and the corresponding use cases (described above). To be considered actively participating in the RAMP the following must occur:

All legal onboarding (execution of all requisite legal documents) must be completed and maintained.

All technical onboarding must be complete and maintained

Consistent submission of valid files (as appropriate to each use case – ACRS, QMI), or continuous connect and receipt of notifications (ADT use case).

Should a PCMH Initiative Participant experience a change (such as merger/legal name change, change in EMR, etc.), then it is the responsibility of the participant to maintain active participation in the RAMP. This includes maintenance of all appropriate legal documents, and ensuring smooth transition to new system to limit the potential for disrupted submission (or receipt) of necessary information for any of the required use cases (HD, ACRS, ADT, QMI) within the PCMH Initiative.

### MiHIN Additional Resources

For all support issues: via <https://mihin.org/requesthelp/>

Legal onboarding: [legal@mihin.org](mailto:legal@mihin.org)

For more information: [www.mihin.org](http://www.mihin.org)

Technical onboarding contact information:

Lindsey Weeks	Megan Herbst	Maureen John
Production Manager	Onboarding Coordinator	Onboarding Coordinator
517-588-8373	586-549-1674	517-944-1786
<a href="mailto:lindsey.weeks@mihin.org">lindsey.weeks@mihin.org</a>	<a href="mailto:megan.herbst@mihin.org">megan.herbst@mihin.org</a>	<a href="mailto:maureen.john@mihin.org">maureen.john@mihin.org</a>

### MiHIN Use Case Implementation Guides

The published MiHIN use case implementation guides for the identified SIM use cases may be accessed via following web pages on MiHIN.org:

[Active Care Relationships](#)

[Health Directory](#)

[ADT Notifications](#)

[Quality Measures Information](#)

### Performance Monitoring and Initiative Feedback

The PCMH Initiative utilizes a number of mechanisms to monitor participants and to provide feedback across the Initiative performance. Each mechanisms serves a purpose to facilitate Initiative operations, in addition to providing participants with a mechanism to access important quality and utilization data, or provide the Initiative with valuable feedback. The following section of this guide outline the mechanisms used to support participant monitoring and feedback, these mechanisms have been broken into two focus areas:

Performance Monitoring: Supports the monitoring of quality of care, health outcome, utilization, and cost performance metrics to report progress/successes and enable quality and process improvement for Initiative participants.

Compliance: Ensure PCMH Initiative participants operate in accordance with the requirements of the Initiative upon selection and on a continuous basis during their participation.

## Participant Monitoring

The PCMH Initiative utilizes aggregated data from the participating payers across medical claims, pharmacy claims, and eligibility files to monitor participant performance and compliance. The PCMH Initiative has leveraged the efforts of existing infrastructure and collaborative partnerships as experienced within the [Physician Payer Quality Collaborative \(PPQC\)](#). The PPQC has identified a set of 27 quality measures that had overlap between national and local quality reporting programs.

In order to support participant monitoring, and participants' internal quality efforts, a subset of the PPQC measures were selected for use within quality reporting through the Michigan Data Collaborative SIM PCMH dashboards. Metrics were selected based on multiple considerations, including:

The population being served within the PCMH Initiative.

Whether a particular metric is a CMMI priority metric for SIM.

The ease with which a data aggregator could collect, store, and disseminate the data.

## Performance Monitoring

To facilitate participant performance monitoring, the PCMH Initiative partners with Michigan Data Collaborative (MDC), a non-profit healthcare data organization at the University of Michigan. MDC supports care delivery transformation initiatives across the state of Michigan by providing solutions for data collection, aggregation and visualization, measure calculation, and reporting.

## Claims Database

MDC developed a claims database to collect the following types of data for the PCMH Initiative:

Claims, eligibility, immunization, and lead screening data

Clinical/EHR

Patient population

Provider hierarchy (Provider NPI and associated practice and Managing Organization relationship)

**Note:** The database initially includes Medicaid claims data and will include commercial payer claims data and clinical EMR data in the future.

## The SIM PCMH Dashboard

MDC uses the information collected in their database to calculate quality, utilization and cost, and chronic condition measures, which are displayed on the SIM PCMH Dashboard in table and graph formats.

The Dashboard includes pages for each data analysis area: overview (executive summary), tile, quality of care, utilization, comparisons, and reports. From these pages, participants can view demographic information, view chronic condition prevalence, compare measure performance against other entities and published benchmarks, and download reports.

Using the Dashboard, Initiative participants can analyze the data and access reports for their organization.

You can find descriptions for the Dashboard components, instructions for using the Dashboard features, and detailed information about the data in the [SIM PCMH Dashboard User Guide](#).

### *Dashboard Releases*

Throughout the duration of the SIM PCMH Initiative, MDC will provide regular data updates (releases) to the SIM PCMH Dashboard.

The following releases are targeted for the Dashboard in 2018.

Release	Reporting Period	Target Date
3	October 2016 – September 2017	End of January 2018
4	January 2017 – December 2017	End of April 2018
5	April 2017 – March 2018	End of July 2018
6	July 2017 – June 2018	End of October 2018

### *Measures Included in the SIM PCMH Dashboard*

The release of measures on the SIM PCMH Dashboard follows a progressive continuum from claims-based measures to those that are reliant on clinical data. Some quality measures support the QMI use case and goal to report once. As a result:

The SIM PCMH Dashboard releases began in 2017 with Medicaid claims data. Clinical data (through the QMI Use Case) will be added as soon as it is available.



2017

The following measures were the focus of the PCMH Initiative for performance monitoring in 2017. The *Dashboard Release* column indicates the release in which the measure was initially included.

Measure Group	Measure Name	Dashboard Release
Quality of Care	Adolescent Immunization	2
	Adolescent Well-Care	2
	Breast Cancer Screening	1
	Cervical Cancer Screening	1
	Childhood Immunization Status	2
	Chlamydia Screening	2
	Diabetes Eye Exam	1
	Diabetes HbA1c Testing	1
	Diabetes Nephropathy	1
	Lead Screening	2
	Low Back Pain Imaging <b>Note:</b> This measure will be removed with the Release 3 HEDIS 2018 update	1
	Well Child Visit: 3-6 Years	2
	Well Child Visit First 15 Months	2
	Utilization	All-Cause Readmission
Emergency Department Visits		1
Hospital Admissions		1
Chronic Condition Prevalence	Asthma	1
	Hypertension	1
	Obesity Overall	1
	Obesity – Overweight	1
	Obesity – Moderate	1
	Obesity – Severe	1

2018

The following additional performance monitoring measures are targeted for addition to the Dashboard in 2018. The *Dashboard Release* column includes the release in which the measure is scheduled to be added.

Measure Group	Measure Name	Dashboard Release
Prevalence	Diabetes Chronic Condition	4
Quality of Care	Adult BMI <b>Note:</b> This measure is dependent upon receipt of clinical EMR data.	4
	Diabetes Blood Pressure Control <b>Note:</b> This measure is dependent upon receipt of clinical EMR data.	4
	Diabetes HbA1c Control <b>Note:</b> This measure is dependent upon receipt of clinical EMR data.	4
	Controlling High Blood Pressure <b>Note:</b> This measure is dependent upon receipt of clinical EMR data.	4
	Screening for Depression and Follow-Up <b>Note:</b> This measure is dependent upon receipt of clinical EMR data.	4
	Appropriate Testing for Children with Pharyngitis	5
	Appropriate Treatment for Children with URI	5
	Tobacco Use Screening and Cessation <b>Note:</b> This measure is dependent upon receipt of clinical EMR data.	5
	Weight Assessment and Counseling <b>Note:</b> This measure is dependent upon receipt of clinical EMR data.	5
Utilization and Cost	Total PMPM Cost	4
	Preventable ED Visits	4
	Ambulatory Care Sensitive Condition Hospitalizations	4

## HEDIS

SIM PCMH Dashboard Release 1 and 2 measures were calculated with HEDIS 2015 specifications. Release 3 will update to HEDIS 2018 specifications. Detailed definitions for the measures are available in the [SIM PCMH Dashboard Technical Guide](#) on the [MDC website](#).

### *MDC Dashboard Reports*

To further support Initiative participants, MDC provides practice-level and managing organization-level reports on the Dashboard. The following reports are included (along with their target delivery timeframes):

<b>Report Name</b>	<b>Description</b>	<b>Target Delivery Timeframe</b>
PCMH Patient Lists (PPLs)	<p>Each month, MDC creates a current list of patients who are attributed to a practice participating in the SIM PCMH project. Both Practice-level and MO-level reports are available as applicable. The patient list includes additional helpful information such as the number of hospitalizations and emergency department visits a patient has had for the last dashboard release reporting period.</p> <p>For more information, see the <a href="#">PCMH Patient List Information Guide</a>.</p>	End of the month
Aggregated Patient Reports	<p>MDC generates quarterly aggregate patient reports to assist organizations in reconciling their Medicaid Health Plan payments. The reports contain counts of patients attributed to a provider for each practice for the quarter.</p> <p>For more information, see the <a href="#">PCMH Aggregated Patient Report Reference Document</a>.</p>	Beginning of the month following the close of the quarter
Care Coordination Reports	<p>These reports provide a view of both the frequency of care management services and appropriate follow-up care for members with inpatient encounters. The following reports are included with each monthly and quarterly release:</p> <p><i>Percentage of Patients Receiving Care Management Service Report</i></p> <p>This report shows the unique number of patients who received a care management service in the measurement month or quarter based on medical claims data.</p> <p><i>PCP Follow-Up after Inpatient Discharge Report</i></p> <p>This report includes the percentage of patients with an inpatient stay who had a follow-up visit with a SIM primary</p>	Monthly - Early in the month  Quarterly - Middle of the month

Report Name	Description	Target Delivery Timeframe
	<p>care physician within 14 days of the last discharge date in the measurement month or quarter.</p> <p><a href="#">For more information, see the PCMH Care Coordination Reports Reference document.</a></p>	

*Official Deliverables Calendar*

MDC maintains the target dates for upcoming deliverables on the [SIM PCMH page](#) of the MDC website. Adjustments due to holidays, etc. will be communicated in the target dates provided here.

MDC Deliverables Notification

When MDC posts a deliverable that is ready to be viewed/downloaded, an email notification is sent directly to participants who have an active MDC account. Additionally, they will post an announcement on the [SIM PCMH News page](#) of the MDC website.

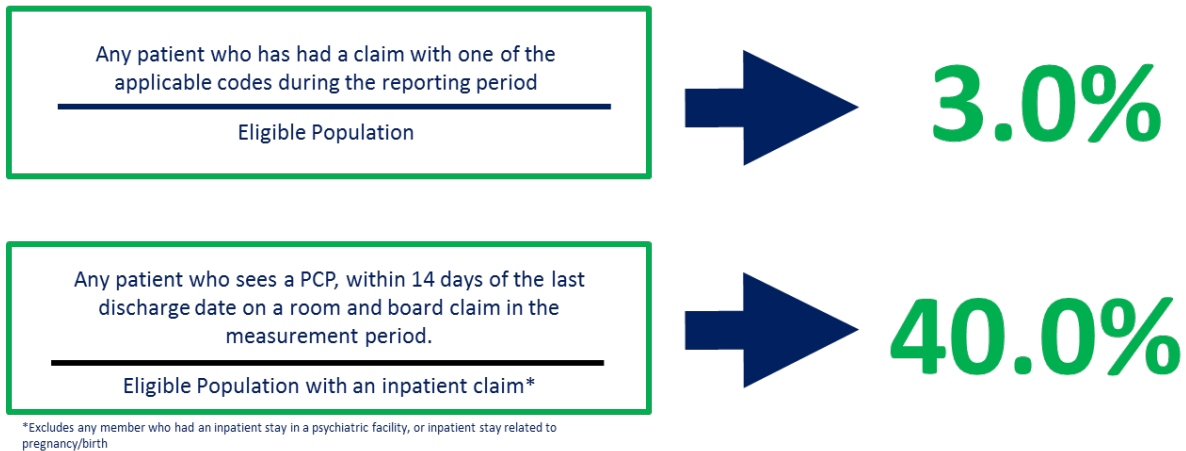
Care Management and Coordination Metric Benchmarks

As outlined in the 2018 PCMH Initiative Participation Agreement, all participants are required to maintain care management and coordination performance above benchmarks established by the Initiative on the following two metrics:

The percentage of a Practice’s attributed patients receiving care management and coordination services

The percentage of a Practice’s attributed patients receiving a timely (within 14 days) follow-up visit with a Primary Care Provider following a hospital inpatient discharge

## 2018 BENCHMARK



With support from the Michigan Data Collaborative, the PCMH Initiative has created monthly reports to support participants in monitoring their progress in achieving these benchmarks. Participant performance related to the benchmarks will be measured quarterly, through reports developed by MDC and placed on the MDC SIM PCMH dashboard for download. These Care Management and Coordination Reports are described above.

### Access to the Dashboard and Reports

MDC maintains access control for participants to view the SIM PCMH Dashboard and to download appropriate reports and lists for their Managing Organization (MO) or practice.

If an organization leaves the SIM PCMH Initiative, the provider hierarchy drives the continued access rights. For example, if the organization is part of the project during a report timeframe, they will still have access to that report. Additionally, the organization will continue to be included in the data and have Dashboard access as long as the provider hierarchy indicates that they are part of the project during the reporting period.

The process for requesting and maintaining access is documented in the [SIM PCMH Dashboard Account Maintenance Guide](#).

### Support Documentation

You can find all support documents on the [SIM PCMH Support page](#) of the MDC Website. The following list provides a short description of each support document:

#### *Dashboard documentation*

[User Guide](#) – Includes descriptions of the Dashboard components, instructions for using the features, and detailed information about the data.

[Technical Guide](#) – Provides detailed information about each measure included in the Dashboard.

[Timeline](#) – Visual graphic that displays date-specific information about the data included in the Dashboard.

[Release Notes](#) – Provides details about each dashboard release.

#### *Dashboard Access documentation*

[Accessing the SIM PCMH Dashboard](#) – Provides information and detailed instructions for accessing the Dashboard.

[Accessing SIM PCMH Dashboard Using the Previous Method](#) – Provides instructions for accessing the Dashboard with the VPN login method (which is available for only a limited time).

[Installing Duo to Use Two Factor Authentication](#) – Provides instructions for installing Duo, a two-factor authentication system that must be used to access the Dashboard.

[SIM PCMH Dashboard Account Maintenance Guide](#) – Information about the account process for Dashboard Users and Acknowledgers.

#### *Report documentation*

[PCMH Patient List: Information Guide](#)

[Aggregated Patient Report: Quick Reference](#)

[PCMH Care Coordination Reports: Quick Reference](#)

#### Additional Information

Use the following MDC resources to find out additional information or make inquiries.

Website: <https://michigandatacollaborative.org/>

General Inquiries: [MichiganDataCollaborative@med.umich.edu](mailto:MichiganDataCollaborative@med.umich.edu)

Account Inquiries: [MDC-Accounts@med.umich.edu](mailto:MDC-Accounts@med.umich.edu)

## Participant Compliance

To support continued progress within the PCMH Initiative and ensure participant compliance with requirements as outlined in the participation agreement, a series of reports, audits and other compliance mechanisms have been developed to facilitate Initiative understanding of how participants are meeting program expectations. Each report has been focused to capture information that will allow for participant requirements attestation, as well as provision of information imperative to program implementation and evaluation. The following section outlines the various mechanisms

used to gain information about participants and how they continue to execute participation requirements.

### PCMH Initiative Progress Reporting

The PCMH Initiative Data will track participant progress towards achieving relevant milestones in healthcare delivery transformation and to ensure fidelity to the Initiative model. The Initiative will use several types of PCMH Initiative participant reporting (described below) to accomplish these tasks.

PCMH Initiative participant reporting will be collected through the Qualtrics system using a combination of survey response style questions and spreadsheet uploads. Reports will be due at different intervals depending on the report type:

<b>Report Title:</b>	<b>Frequency:</b>	<b>Release:</b>	<b>Due Date (s):</b>	<b>Contents</b>
Practice Self-Assessment	Annually	4-6 weeks prior to due date	2/6/18	Standardized scale and multi-select survey questions for the purposes of assessing overall PCMH practice capability/maturity and how PCMH capability changes over time
Quarterly Progress Report	Quarterly	4-6 weeks prior to due date	Quarter 1 Report: 4/30/18, Quarter 2 Report: 7/31/18, Quarter 3 Report: 10/31/18	Participating Organization Contacts Care Management and Coordination Staffing Details Participation Requirements Information, Updates and Attestation Participation Experience, Strengths and Challenges
Practice Transformation	Every Six Months	6-8 weeks prior to due date	7/31/18 and 12/21/18	Includes some survey response style transformation progress questions for response on behalf of multiple practices (if applicable) and a small amount of progress narrative specific to each participating practice's transformation activity to track completion of required/selected objectives.

#### *Quarterly Progress Report:*

The quarterly progress report is intended to be a brief report utilized to assess the progress participants are making across multiple areas of the Initiative. The quarterly report will feature spreadsheet-based templates for participating organizations to use in uploading both participating organization contacts. Once completed, the spreadsheets can be saved between quarterly due dates to expedite subsequent reporting cycles (the spreadsheets will only need to be updated with changes that occurred during the quarter). The participation requirements section of the quarterly report is attestation-based, providing survey style questions which confirm a participating organization is following all Initiative requirements for compliance purposes. The participation experience section of the quarterly report will feature a small number of short narrative response and survey questions geared toward understanding how elements of the Initiative are impacting participating practices as well as ascertain participant challenges and opportunities for improvement.

#### *Semi-Annual Practice Transformation Report:*

The semi-annual practice transformation report is intended to assess the progress participants are making in implementing the required practice transformation objectives: Clinical-Community Linkages, and Population Health Management. The semi-annual report will feature survey style questions with either multiple choice response options or request detailed narrative on progress. Practices may be requested to upload appropriate documentation to substantiate their reports. Provisions will be made for POs to report on behalf of multiple practices.

#### *Annual Self-Assessment:*

Self-assessment reporting will capture details on existing practice capabilities across a number of domains related to care management and coordination, team-based care, quality improvement, patient engagement, leadership, etc. This annual assessment will provide the Initiative the ability to assess what the technical assistance and practice support needs are for participants, while also allowing a standardized system for capturing participant growth. The assessment tool is must be completed at the practice level, therefore in the case of Physician Organizations, or multi-site organizations (such as a Federally Qualified Health Center) each site should complete a separate PCMH Initiative Self-Assessment Tool. Practice transformation, even when directed and supported by consistent organizational leaders, happens differently at the site level. Organizational leaders can compare PCMH Initiative Self-Assessment Tool scores and use this information to share knowledge and cross-pollinate improvement ideas.

It is strongly recommended that the PCMH Initiative Self-Assessment Tool be completed by a multidisciplinary group (e.g., providers, nurses, medical assistants, care managers, other operations and administrative staff) in order to capture the



perspectives of individuals with different roles within the practice and to portray the most representative viewpoint of current capabilities. It is additionally recommended that staff members complete the assessment individually, and then meet together to discuss the results and produce a consensus version for final submission via Qualtrics. This discussion is a great opportunity to identify opportunities and priorities for PCMH transformation

### Participant Input Opportunities

The PCMH Initiative will provide participants with input opportunities via surveys and committees, along with feedback mechanisms after webinars and in person events. Surveys will be specifically designed to be as concise and simple as possible, while providing targeted feedback to shape technical assistance, reporting or other aspects of the Initiative. The PCMH Initiative is also seeking volunteers to serve on committees (for example the Care Coordination Collaborative Planning Committee and the Summit Planning Committee) to help to make these events as beneficial as possible for all involved. Event evaluations will be included in all events within the year, and participants are encouraged to complete post webinar and event evaluation forms to provide the Initiative with real time feedback on areas of improvement. Finally, the PCMH Initiative email [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov) is available to all participants for questions and other input.

### Practice Support and Learning Activities

The PCMH Initiative will facilitate a number of opportunities for participants to engage in collaborative learning, technical assistance, and peer to peer learning. Many of these opportunities/activities are optional; however, participation in the Initiative Quarterly Updates detailed below is required of all participants. To view a calendar of all of the learning opportunities currently being offered, the calendar in the [appendix of this guide](#).

#### Quarterly Update Meetings:

The PCMH Initiative will conduct virtual update meetings each calendar quarter. While many opportunities/activities available through the PCMH Initiative are optional; participation in the Initiative Quarterly Updates is mandatory for Physician Organization representatives and key practice staff for practices participating independently. These meetings will provide participants with important Initiative updates and resources for successful participation.

#### Practice Transformation Collaborative

The optional Practice Transformation Collaborative will provide participants with an opportunity to engage in learning activities to support continued transformation related to Clinical-Community Linkages

The Practice Transformation Collaborative will provide a forum for participant engagement, learning and continuous improvement around the identification, development and strengthening of practices to improve team based whole person care. This Collaborative will be built upon the principles of peer learning and promising practice sharing and will seek to discover ways to improve patient centered services that embody the PCMH Initiative. While voluntary, this Collaborative will require regular attendance and active participation in order to ensure the best possible learning environment.

### Annual Summit

The PCMH Initiative will support three regional Annual Summits to accommodate participants across the state of Michigan. The annual summit will be geared towards engaging in networking and opportunities to build on the foundation of regular learning opportunities. These regional summits will be open to participant staff including but not limited to administrative staff, care managers and coordinators, quality improvement staff, and other leaders within participating organizations. General regions for the annual summit include the Northern Lower Peninsula, Western Lower Peninsula, and South East or Mid-Michigan. The summits will be held in the fall.

### Care Coordination Collaborative

The State Innovation Model will host a Care Coordination Collaborative in 2018 to support participants in the PCMH Initiative, Medicaid Health Plans, and community partners that are involved in Care Management and Coordination processes (such as Community Health Innovation Region). These events will serve as opportunities to support networking and facilitate exercises to align efforts, reduce duplication, and identify methods of collaboration on shared patients.

### Office Hour Sessions

The PCMH Initiative will offer monthly office hour sessions to provide operational, technical, topic based and current health care policy information in a timely and concise manner. Using a webinar format, PCMH Initiative participants will be able to access sessions that will both inform and allow for peer learning. Topics will be determined based on Initiative current happenings, trends throughout the Initiative and through feedback from PCMH Initiative participants. Sessions will be about 1 hour in length

### PCMH Initiative Communications

The PCMH Initiative currently maintains a general public facing web presence on the [SIM PCMH Care Delivery website](#). The website will include resources for implementing the PCMH Initiative, including information on upcoming events and learning opportunities, Summits, archives of newsletters and webinars, guides to billing, coding and payment and contact information should project participants have questions.

Official PCMH Initiative communications will be facilitated via the MDHHS “Gov Delivery” system. The “Gov Delivery” system is designed as a “send only” system. This system is utilized to send PCMH Initiative monthly newsletters. Additionally, the PCMH Initiative also utilizes the [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov) mailbox to receive participant questions and other communications.

### PCMH Initiative Monthly Newsletters

The PCMH Initiative will send monthly newsletters to all participants to ensure up to date and timely communication of events, technical assistance opportunities, reporting requirements, data distributions, resource ideas and other current happenings. The monthly newsletter will also include a calendar of events for easy reference of upcoming events and report due dates. Initiative participants are encouraged to provide newsletter ideas via [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov).

### PCMH Initiative Contacts

The PCMH Initiative is possible through a number of partnerships between the Michigan Department of Health and Human Services and various stakeholders, therefore participants may receive communications from these partners in order to support the overall goals and efforts of the Initiative. These partners include:

- The Michigan Health Information Network: for information regarding use cases
- The Michigan Data Collaborative: for information regarding the impact of clinical data on measure results, dashboard access and member list questions
- The University of Michigan: for information regarding project operations
- The Michigan Care Management Resource Center: for information regarding Care Manager and Care Coordinator training and education opportunities
- The Institute for Health Care Improvement: for information and coaching around the Practice Transformation Collaborative and change management

The PCMH Initiative is grateful for your continued work on behalf of patients and families. We recognize that this work is incredibly difficult and a team is available to assist you. Below are the best contacts for the various questions you may have throughout the Initiative.

#### **General Questions:**

SIM PCMH Initiative Mailbox ([MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov))

#### **Program Requirements:**

Katie Commey ([CommeyK@michigan.gov](mailto:CommeyK@michigan.gov))

Laura Kilfoyle ([KilfoyleL@michigan.gov](mailto:KilfoyleL@michigan.gov))

#### **Care Management and Coordination:**

CMRC mailbox ([micmrc-requests@med.umich.edu](mailto:micmrc-requests@med.umich.edu))

Marie Beisel ([mbeisel@med.umich.edu](mailto:mbeisel@med.umich.edu))

#### **Participant Reporting, Compliance and Updates:**

Amanda First Kallus ([afirst@med.umich.edu](mailto:afirst@med.umich.edu))  
Yi Mao ([yimao@med.umich.edu](mailto:yimao@med.umich.edu))

**Technology Requirements (Specific to HIE Use Cases):**

MiHIN ([help@mihin.org](mailto:help@mihin.org))

**Performance Dashboards and Downloadable Performance Reports:**

Michigan Data Collaborative ([MichiganDataCollaborative@med.umich.edu](mailto:MichiganDataCollaborative@med.umich.edu))

## Appendices

### Appendix A: SIM PCMH Acronym Dictionary

	Acronym	
•	ABD	Aged, Blind and Disabled Medicaid
•	ACRS	Active Care Relationship Service
•	ADT	Admission, Discharge, Transfer Notifications
•	CAP	Corrective Action Plan
•	CCL	Clinical-Community Linkage
•	CCSI	Center for Clinical Systems Improvement
•	CCM	Complex Care Management
•	CHAP	Community Health Accreditation Partner
•	CHIR	Community Health Innovative Region
•	CHW	Community Health Worker
•	CM/CC	Care Management and Care Coordination
•	MiCMRC	Michigan Care Management Resource Center
•	CKS	Common Key Service
•	CPC+	Comprehensive Primary Care Plus
•	FFS	Fee-For-Service
•	FQHC	Federal Qualified Health Center
•	HIE	Health Information Exchange
•	HMP	Healthy Michigan Plan
•	HPD	Health Provider Directory
•	IHI	Institute for Healthcare Improvement
•	MHP	Medicaid Health Plans
•	MiCHWA	Michigan Community Health Worker Alliance
•	MiHIN	Michigan Health Information Network Shared Services
•	MPI	Master Patient Index
•	MSA	Medical Services Administration
•	MU	Meaningful Use
•	PMPM	Per Member Per Month
•	PPL	PCMH Patient List
•	PPQC	Physician Payer Quality Collaboration
•	PT	Practice Transformation
•	PTO	Practice Transformation Objectives
•	QMI	Quality Measure Information
•	QO	Qualified Organization
•	RAMP	Relationship and Attribution Management Plan
•	RHC	Rural Health Clinics
•	SDoH	Social Determinants of Health
•	SIM-PCMH	State Innovation Model-Patient Centered Medical Home
•	SNF	Skilled Nursing Facility
•	TANF	Temporary Assistance for Needy Families
•	TCM	Transitional Care Management

## Legend

• Personnel/Population • Organizations • Reform and Innovation • Sites of Care • Payment and Insurance

## A

### ABD •

Aged, Blind and Disabled Medicaid

ABD Medicaid is for adults 65 and older or anyone who is disabled according to Social Security.

### ACRS •

Active Care Relationship Service

ACRS provides the ability to link patients with their care team members (providers who have declared an active care relationship with that patient).

[Learn more](#)

### ADT •

Admission, Discharge, Transfer Notifications

Patients transition from one provider or healthcare setting to another as the patients' health care needs require. These transitions trigger Electronic Health Records to generate ADT notifications that identify the patient along with important details that provide insight to an extremely complex set of care decisions being made by care teams, families and the patient.

[Learn more](#)

## C

### CAP •

Corrective Action Plan

A response to a compliance warning notification from MDHHS. CAP describes exactly how a SIM PCMH participant will resolve the issue in order to meet the PCMH-SIM compliance.

### CCL •

Clinical-Community Linkage

CCLs support referral processes and coordination between clinical care and community-based social services to improve population health.

### CCSI •

Center for Clinical Systems Improvement

Also known as Mi-CCSI. CCSI is an organization supports its stakeholders and their communities to deploy models that deliver better care for individuals, improved population health and lower cost, promote initiatives supporting clinical integration, and develop and provide care management training.

[Learn more](#)

### CCM •

Complex Care Management

CCM is a set of activities designed to more effectively assist patients and their caregivers in managing medical conditions and co-occurring psychosocial factors.

[Learn more](#)

**CHAP •**

Community Health Accreditation Partner

CHAP is an independent, nonprofit accrediting body for home and community-based health care organizations.

[Learn more](#)

**CHIR •**

Community Health Innovative Region

CHIRs are small number of regional governing bodies launched by the SIM program to define regional health priorities, support regional planning, increase awareness of community-based services, and increase linkages between community and health entities in Michigan.

**CHW •**

Community Health Worker

CHW is front-line public health worker has a close understanding of the community served, serves as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery, and builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

[Learn more](#)

**CM/CC •**

Care Management and Care Coordination

CM/CC are activities that care manager and care coordinator partner with the practice care team to; effectively empower patients and their families, engage patients in self-management and health behavior change, positively affect patient self-care practices and decision-making, provide comprehensive assessment and care planning using shared decision making, implement evidence based interventions and advocate for the right care, at the right time and in the right place.

**MiCMRC •**

Michigan Care Management Resource Center

MiCMRC provides training and support for the statewide Care Management initiatives.

[Learn more](#)

**CKS •**

Common Key Service

The Common Key Service use case provides a consistent and reliable way to match patients across multiple organizations, applications and services, ensuring patient safety and high data integrity when data is shared.

[Learn more](#)

**CPC+** •

**Comprehensive Primary Care Plus**

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the US.

[Learn more](#)

**F**

**FFS** •

**Fee-For-Service**

System of payment in which providers receive reimbursement for each service they perform.

**FQHC** •

**Federal Qualified Health Center**

Clinics offering comprehensive health care to an underserved population and receive Medicare and Medicaid payment.

**H**

**HIE** •

**Health Information Exchange**

Electronic infrastructure that allows health care professionals and patients to appropriately access and securely transmit a patient's vital medical information across sites of care in many geographic regions of the country.

[Learn more](#)

**HMP** •

**Healthy Michigan Plan**

The HMP is a new category of eligibility authorized under the ACA. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors.

**HPD**•

**Health Provider Directory**

HPD is a foundational service within MiHIN's road map to standardize electronic communications among providers and anyone empowered to access protected health information.

[Learn more](#)

**I**

**IHI** •

**Institute for Healthcare Improvement**



HIH is an independent not-for-profit organization which promotes care improvement worldwide.

[Learn more](#)

## **M**

MHP •

Medicaid Health Plans

MiCHWA •

Michigan Community Health Worker Alliance

MiCHWA is the CHW information hub for the state of Michigan.

[Learn more](#)

MiHIN •

Michigan Health Information Network Shared Services

MiHIN is Michigan's initiative to continuously improve health care quality, efficiency, and patient safety by promoting secure, electronic exchange of health information.

[Learn more](#)

MPI •

Master Patient Index

MPI is an electronic medical database that holds information on every patient registered at a healthcare organization. It may also include data on physicians, other medical staff and facility employees.

MSA •

Medical Services Administration

MSA oversees the operation of Medicaid plans in Michigan.

MU •

Meaningful Use

MU is a CMS Medicare and Medicaid program that awards incentives for using certified electronic health records to improve patient care.

## **P**

PMPM •

Per Member Per Month

PMPM is a capitation payment that payers provide to providers.

PPL •

PCMH Patient List

PPL provides a current list of patients who are attributed to a practice and participating in the SIM PCMH project.

## PPQC •

### Physician Payer Quality Collaboration

The PPQC is a physician-led activity that engages government and commercial payers in an effort to focus quality improvement efforts around a core set of measures and standardize performance report and feedback with health plans.

## PT •

### Practice Transformation

PT in the SIM-PCMH context refers to building capability and developing structures which make the work of a PCMH participating practice more effective in the required and selected objective focus areas.

## PTO •

### Practice Transformation Objectives

PTO refers to the Clinical-Community Linkage requirement and one selected PT requirement in the SIM-PCMH context.

## Q

### QMI •

#### Quality Measure Information

QMI use case contains multiple scenarios for sending, receiving, finding and using quality measure information for different quality reporting programs.

[Learn more](#)

## QO •

### Qualified Organization

## R

### RAMP •

#### Relationship and Attribution Management Plan

RAMP has been created to support the identification and capture of relationships between patients/consumers and their healthcare delivery team members, to facilitate the active exchange of necessary information between these identified individuals and organizations.

## RHC •

### Rural Health Clinics

RHCs are clinics located in rural areas that provide outpatient primary care services and basic laboratory services for Medicaid and Medicare patients.

## S

### SDoH •

#### Social Determinants of Health

SDoH are conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

**SIM-PCMH •**

**State Innovation Model-Patient Centered Medical Home**

SIM focuses on the development and testing of multi-payer health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. The SIM-PCMH Initiative is the core component of the SIM strategy for coordinated care delivery, focusing on the development and testing of multi-payer health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders.

**SNF •**

**Skilled Nursing Facility**

SNF is a type of nursing home recognized by the Medicare and Medicaid systems as meeting long term health care needs for individuals who have the potential to function independently after a limited period of care.

**T**

**TANF •**

**Temporary Assistance for Needy Families**

TANF program provides temporary financial assistance for pregnant women and families with one or more dependent children. TANF provides financial assistance to help pay for food, shelter, utilities, and expenses other than medical.

**TCM •**

**Transitional Care Management**

TCM includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting

## Appendix B: Social Determinants of Health Brief Screening Tool

The intent of brief social determinants of health screening is to establish a routinized process through which providers identify (in an actionable manner) social barriers their attributed patient population is facing. Accordingly, the brief screening will not take the place of deeper, more comprehensive assessment processes utilized as part of care management or mandated by other programs, but it should inform those processes

The State Innovation Model is providing this template screening tool to participants, however this tool can be altered to match local needs (e.g. changing how questions are phrased, varying how questions are categorized in domains, choosing different formats to administer the screening such as an EHR template or incorporating into existing patient questionnaires etc.)

Participants cannot completely remove one or more of the topics/domains contained in the template, although combining and/or rearranging domains is permitted

PCMHs located in SIM/CHIR regions should work with their CHIRs (typically through a PO) to use the brief screening tool the CHIR in your area has/is developing.

**Note:** that the tool provided below is representative of the tool provided during the 2017 calendar year to promote participant development of their own tool (or adaptation of the template). The requirements for the 2018 PCMH Initiative have been updated, expanding the childcare domain to family care (inclusive of child and elder care), removed the clothing and household domain, and added the personal and environmental safety domain. Participants, while allowed to alter the questions used within the screening tool, must ensure that the questions used remain consistent with the intent of the domain as defined by MDHHS. To support participants in ensuring consistency MDHHS is developing guidance on the intent of each domain which will be included in the next release of this guide, intended for release in early February 2018.

Domain	Question	Response	
<b>Healthcare</b>	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school or a hobby?	Yes	No
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	Yes	No
<b>Food</b>	Do you ever eat less than you feel you should because there is not enough food?	Yes	No
<b>Employment &amp; Income</b>	Do you have a job or other steady source of income?	Yes	No
<b>Housing &amp; Shelter</b>	Are you worried that in the next few months, you may not have safe housing that you own, rent, or share?	Yes	No
<b>Utilities</b>	In the past year, have you had a hard time paying your utility company bills?	Yes	No

<b>Domain</b>	<b>Question</b>	<b>Response</b>	
<b><i>Childcare</i></b>	Does getting child care make it hard for you to work, go to school or study?	Yes	No
<b><i>Education</i></b>	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	Yes	No
<b><i>Transportation</i></b>	Do you have a dependable way to get to work or school and your appointments?	Yes	No
<b><i>Clothing &amp; Household</i></b>	Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.	Yes	No
<b><i>General</i></b>	Would you like to receive assistance with any of these needs?	Yes	No
	Are any of your needs urgent?	Yes	No

# Appendix C: Care Management and Coordination Tracking Quick Reference

## 2018 PCMH Initiative Care Management and Coordination Tracking Codes Quick Guide

Code	Quick Description	Formal Description	Code Purpose	Provider	Method	Max Frequency (/Beneficiary)	Length (minutes, quantity)	PCP Signature Required	Associated Fee Schedule*	Note
G9001	Comprehensive Assessment	Coordinated Care Fee Initial Rate	Document a comprehensive assessment and development of a care plan with a beneficiary	CM	In-person	Once/year	> 30 minutes	Yes	No	Date of service should be the date the assessment is completed for patients entering into care management. If patient does not agree to enter into care management, the date of service should be the date of the face-to-face component. All active dx should be reported on the claim.
G9002	In-person Encounter	Coordinated Care Fee Maintenance Rate	Document any care management or coordination service provided	CM/CC	In-person	Once/day	1-45 minutes, quantity of one; 46-75 minutes, quantity of two; 76-105 minutes, quantity of three; 106-135 minutes, quantity of four.	No	No	Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided.
98966	Telephone Services	Telephone assessment and management service to an established patient, parent or guardian	Document any care management or coordination service provided over the telephone or by other real-time interactive electronic communication.	CM/CC	Phone OR Real-time interactive electronic communication	Once/day	5-10 minutes	No	No	Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided. Should not be used to report routine provider communication such as appointment reminders or test results.
98967	Telephone Services	Same as above	Same as above	CM/CC	Same as above	Once/day	11-20 minutes	No	No	Same as above
98968	Telephone Services	Same as above	Same as above	CM/CC	Same as above	Once/day	21-30 minutes	No	No	Same as above
99495	Care Transition	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; AND Medical decision making of at least moderate complexity during the service period; AND Face to face visit within 14 calendar days of discharge	Document supportive services for patients experiencing discharge from an inpatient, long term care, skilled nursing, rehabilitation or emergency department environment to a home or community setting.	CM/CC	Direct contact, telephone, or electronic communication within 2 business days of discharge; AND Face to face visit within 14 calendar days of discharge	Once/transitional care management period	N/A	No	Yes	Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided. Reasonable and necessary evaluation and management services (other than the required face-to-face visit) to manage the beneficiary may be reported separately. Other care management and coordination service(s) may be reported during the transitional care management period.
99496	Care Transition	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; AND Medical decision making of high complexity during the service period; AND Face to face visit within 7 calendar days of discharge	Same as above	CM/CC	Direct contact, telephone, or electronic communication within 2 business days of discharge; AND Face to face visit within 7 calendar days of discharge	Once/transitional care management period	N/A	No	Yes	Same as above
G9007	Team Conference	Coordinated Care Fee Scheduled Team Conference	Document meetings between, at minimum, a beneficiary's primary care provider and care manager or coordinator during which formal discussion of a patient's care plan occurs.	1.PCP+CM/CC;OR 2.Primary CM/CC+Specialty CM/CC; OR 3.PCP+SCP+CM/CC	Face-to-face, via secure live video conference OR telephone	Once/day	N/A	No	No	Communication should include substantive, focused conversation pertinent to each patient's individualized care plan and goal achievement.
G9008	Physician Coordinated Care Oversight Services	Coordinated care fee Physician coordinated care oversight services	Document physician engagement at the initiation of care management	Physician	In-person	N/a	N/A	No	No	E&M visit performed by the physician must be simultaneously or previously billed for the patient (for Priority Health: in close proximity to the visit date) Patient/care giver understanding and agreement to care plan 3. Service must include completion of patient assessment. 4. Bill code after the patient enrolls in a care management program.
98961	Group Education and Training	Formalized educational sessions led by qualified non-physician personnel for patient self-management for 2-4 patients	Document educational sessions for patient self-management in a group setting	CM+Other Care Team Members	In-person	None	30 minutes; May be quantity billed.	No	No	There must be some level of individualized interaction included in the session. Must use a standardized curriculum
98962	Group Education and Training	Formalized educational sessions led by qualified non-physician personnel for patient self-management for 5-8 patients	Document educational sessions for patient self-management in a group setting	CM+Other Care Team Members	In-person	None	30 minutes; May be quantity billed.	No	No	Same as above
S0257	End-of-life Counseling	Face to face or telephonic counseling and discussion regarding advance directives or end of life care planning and decisions	Document counseling and discussion regarding advance directives or end of life care planning and decisions	CM+PCP+Other care team members	In-person OR telephone	None	N/A	No	No	

\*Associated Fee Schedule is determined individually by each Medicaid Health Plan, additionally, MHPs may choose to include codes beyond 99495 and 99496 on their fee schedule

CM: Care Manager  
CC: Care Coordinator

PCP: Primary Care Provider  
SCP: Specialty Care Provider

## Appendix D: Medicaid Beneficiary Inclusion-Exclusion

A Medicaid beneficiary must have full Medicaid coverage and be served through a Medicaid managed care organization (Medicaid health plan) to be attributed to a participating Practice. For purposes of the PCMH Initiative, the benefit plans listed under “included” below are full Medicaid coverage.

Included Benefit Plans		Excluded Benefit Plans		
BMP	Benefits Monitoring Program	APS	Ambulatory Prenatal Services	Not Full Coverage
MA-HMP-MC	Healthy Michigan Plan – Managed Care	CSHCS	Children’s Special Health Care Services (FFS)	Not Medicaid Health Plan
MA-MC	Medicaid – Managed Care	CSHCS-MC	Children’s Special Health Care Services – Managed Care	Existing and/or Potentially Duplicative Payment Structure
TCMF	Targeted Case Management Flint	HHMICARE	Primary Care Health Homes	Existing and/or Potentially Duplicative Payment Structure
		HHBH	Health Home Behavioral Health	Existing and/or Potentially Duplicative Payment Structure
		Hospice	Hospice	Not Medicaid Health Plan
		ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	Not Medicaid Health Plan
		ICO-MC	Integrated Care - MI Health Link	Existing and/or Potentially Duplicative Payment Structure
		INCAR-ESO	Incarceration – Emergency Services Only	Not Full Coverage
		INCAR-MA	Incarceration - MA	Not Medicaid Health Plan
		INCAR-MA-E	Incarceration – MA Emergency Services Only	Not Full Coverage
		MA	Full Fee-for-Service Medicaid	Not Medicaid Health Plan

		MA-ESO	Medical Assistance Emergency Services Only	Not Full Coverage
		MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only	Not Full Coverage
		MA-HMP	Healthy Michigan Plan (FFS)	Not Medicaid Health Plan
		MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only	Not Full Coverage
		MA-HMP-INC	Healthy Michigan Plan Incarceration	Not Medicaid Health Plan
		MME-MC	Medicaid – Medicare Dually Eligible – Managed Care	Existing and/or Potentially Duplicative Payment Structure (Medicare)
		MiChild - ESO	MiChild Program – Emergency Services Only	Not Full Coverage
		MI Choice-MC	Home and Community Based Services – Managed Care	Existing and/or Potentially Duplicative Payment Structure
		MOMS	Maternity Outpatient Medical Services	Not Full Coverage
		NH	Nursing Home	Not Medicaid Health Plan
		PACE	Program of All-Inclusive Care for Elderly	Not Medicaid Health Plan
		Plan First!	Family Planning Waiver	Not Full Coverage
		QMB	Qualified Medicare Beneficiary – All Inclusive	Not Medicaid Health Plan
		Spend-down	Medical Spend-down	Not Full Coverage
		SPF	State Psychiatric Hospital	Not Medicaid Health Plan
		QDWI	Qualified Disabled Working Individual	Not Full Coverage / Not Medicaid Health Plan
		SLMB	Specified Low Income Medicare Beneficiary	Not Full Coverage / Not Medicaid Health Plan



		ALMB	Additional Low Income Medicare Beneficiary	Not Full Coverage / Not Medicaid Health Plan
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**Not Applicable for Inclusion/Exclusion Decisions**

*The following benefit plans are either not directly relevant to deciding whether or not a beneficiary can be included in the population (dental, mental health etc.) or represent services that are additions/enhancements to the standard Medicaid state plan benefit (waivers etc.).*

- HK-Dental Healthy Kids Dental
- HK-EXP Full Fee-for-Service Healthy Kids Expansion
- HK-EXP-ESO Healthy Kids Expansion Emergency Services Only
- NEMT Non-Emergency Medical Transportation
- PIHP Prepaid Inpatient Health Plan
- PIHP-HMP PIHP Healthy Michigan Plan
- DHIP Foster Care and CPS Incentive Payment
- AUT Autism Related Services
- CWP Children’s Home and Community Based Services Waiver
- HSW Habilitation Supports Waiver Program
- SED Children's Serious Emotional Disturbance Waiver Program
- SED-DHS Children's Serious Emotional Disturbance Waiver Program – DHS

For a full Medicaid Benefit Plan Listing:


[https://www.michigan.gov/documents/mdch/Benefit\\_Plan\\_Table\\_293077\\_7.pdf](https://www.michigan.gov/documents/mdch/Benefit_Plan_Table_293077_7.pdf)

Appendix E: 2018 Annual PCMH Initiative Calendar


**January 2018 SIM PCMH CALENDAR**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 Use New SIM PCMH Email <a href="mailto:MDHHS-SIMPCMH@michigan.gov">MDHHS-SIMPCMH@michigan.gov</a>	2	3	4	5 Sept '17 PMCH Care Coord. Reports Release	6
7	8	9 2018 Launch Webinar 12:00 - 1:00pm <a href="#">REGISTER HERE</a> Practice Self-Assessment Release	10	11	12	13
14	15	16	17 January Office Hours 11:30-12:30 <a href="#">REGISTER HERE</a>  Quality Metrics in Ambulatory Care Webinar 2:00 - 3:00pm <a href="#">REGISTER HERE</a>	18	19 Q3 '17 PCMH Care Coord. Reports Release	20
21	22	23 February Newsletter Release	24	25	26	27
28	29	30	31 Q4 Progress Report Submission Deadline  MDC Dashboard R3: Oct '16 - Sept'17  Januray PPL Release			

## February 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6 <b>Practice Self-Assessment Submission Deadline</b>	7	8	9  Oct '17 PCMH Care Coord. Reports Release	10
11	12	13	14	15	16	17
18	19	20  March Newsletter Release	21 <b>February Office Hours: Michigan 211</b>	22	23	24
25	26	27	28  February PPL Release			


### March 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
					Nov '17 PCMH Care Coord. Reports Release	
11	12	13	14	15	16	17
18	19	20	21	22	23	24
		April Newsletter Release	March Office Hours: Care Management and Tracking Codes			
25	26	27	28	29	30	31
	Q1 '18 Progress Report Release				March PPL Release	


## April 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5  Quarterly Update Meeting	6  Dec '17 PCMH Care Coord. Reports Release	7
8	9	10	11	12	13  Q1 Aggregated Patient Report Release	14
15	16	17  May Newsletter Release	18  April Office Hours: Coding Opportunities in CCL Implementation	19	20  Q4 '17 PCMH Care Coord. Reports Release	21
22	23	24	25	26	27	28
29	30  Q1 '18 Progress Report Submission Deadline  MDC Dashboard R4: Jan '17 - Dec '17  April PPL Release					


### May 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4  Jan '18 PCMH Care Coord Reports Release	5
6	7	8	9	10	11	12
13	14	15	16  May Office Hours: Operating as a Multidisciplinary Team	17	18	19
20	21	22  June Newsletter Release	23	24	25	26
27	28	28	30	31  May PPL Release		

## June 2018 SIM PCMH CALENDAR


Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
					Feb '18 PCMH Care Coord. Reports Release	
10	11	12	13	14	15	16
17	18	19	20	21	22	23
		<b>July Newsletter Release</b>  <b>Semi-Annual Practice Transformation &amp; Q2 '18 Progress Reports Release</b>	<b>June Office Hours:</b> SDoH and EMR Capture			
24	25	26	27	28	29	30
					June PPL Release	

## July 2018 SIM PCMH CALENDAR


Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
					Mar '18 PCMH Care Coord. Reports Release	
8	9	10	11	12	13	14
				Quarterly Update Meeting	Q2 Aggregated Patient Report Release	
15	16	17	18	19	20	21
			July Office Hours: MDC Release 5		Q1 '18 PCMH Care Coord. Reports Release	
22	23	24	25	26	27	28
		August Newsletter Release				
29	30	31				
		Semi-Annual Practice Transformation & Q2 '18 Progress Reports Submission Deadline  MDC Dashboard R5: Apr '17 - Mar '18  July PPL Release				



## August 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	
		September Newsletter Release			August PPL Release	
			August Office Hours: SIM CHIR Update		Apr '18 PCMH Care Coord. Reports Release	


## September 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
					May '18 PCMH Care Coord. Reports Release	
9	10	11	12	13	14	15
16	17	18	<b>September Office Hours</b> Attracting & Retaining Care Coordinators/ Care Managers	19	20	21
		<b>October Newsletter Release</b>				22
23	24	25	26	27	28	29
			<b>Q3 '18 Progress Report Release</b>		<b>September PPL Release</b>	
30						


## October 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4 Quarterly Update Meeting	5  June '18 PCMH Care Coord. Reports Release	6
7	8	9	10	11	12  Q3 Aggregated Patient Report Release	13
14	15	16	17 NO Office Hour Session	18	19  Q2 '18 PCMH Care Coord. Reports Release	20
21	22	23  November Newsletter Release	24	25	26	27
28	29	30	31 Q3 '18 Progress Report Submission Deadline  MDC Dashboard R6: Jul '17 - June '18  October PPL Release			

## November 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2  <b>Semi-Annual Practice Transformation Report Release</b>	3
4	5	6	7	8	9  <b>July '18 PCMH Care Coord. Reports Release</b>	10
11	12	13	14  <b>November Office Hours Patient Engagement</b>	15	16	17
18	19	20  <b>December Newsletter Release</b>	21	22	23	24
25	26	27	28	29	30  <b>November PPL Release</b>	

## December 2018 SIM PCMH CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18 <b>January 2019 Newsletter Release</b>	19 <b>December Office Hours Alternative Visit Types</b>	20	21 <b>Semi-Annual Practice Transformation Report Submission Deadline</b>	22
23	24	25	26	27	28 <b>December PPL Release</b>	29
30	31					

## Revision History

<b>Revision Date</b>	<b>Version</b>	<b>Author</b>	<b>Section(s)</b>	<b>Summary</b>
12.19.2017	V1	PCMH Initiative Team	All	Initial Release