2018 SIM PCMH Initiative Participation Agreement Changes Summary

I. Added

Page 2: To the definition of care coordinator: Registered Medical Assistant

Page 3: Definition of Clinical Community Linkage and Community Health Innovation Region

Page 4: Definition of “Medicaid Health Plan 4275 file” or “4275” and Definition of “Payment Correction”

Page 5: Definition of "Social Determinants of Health” or “SDoH”

Appendix A: Medicaid health plans will not make payments for retroactive Medicaid eligibility periods or attempt to recoup payments or work through payment corrections previously made for a beneficiary which experiences a change in eligibility type or status**, with the exception of beneficiary incarceration, the beneficiary was found to be in a nursing facility or deceased.**

Appendix B: A provider may only select a single participating organization for which they are employed or contracted by to prevent any potential duplicative payments.

Appendix C: Ensure participating payers are billed for Care Management and Coordination services provided, as represented by the Care Management and Coordination Tracking Codes identified by the Initiative to monitor CM/CC services delivered within the practice.

II. Removed

Page 2: From the major objectives of the PCMH Initiative: Improve Access

Appendix A:

- PCMH Initiative payments from commercial payers (as applicable) will be made based upon payer agreements entered into by the Initiative, its vendors, or contractors.
- Each Medicaid health plan will determine payment frequency within this guideline.

III. Changed

Highlights:

- Care Management Payment for ABD beneficiaries from $8.00 PMPM to $7.00 PMPM
- Care Management Payment for Pediatric TANF beneficiaries from $3.00PMPM to $2.75PMPM
- 2:5000 Care Manager Ratio no longer required
- Ensure at least 3% of attributed Practice patients receive care management/coordination services
- Ensure at least 40**%** of attributed Practice patients receive a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient stay, as measured quarterly
- 24/7 access to a care team practitioner **with real-time access to the EHR** must be available
- Instead of requiring 6 hours of availability outside normal business hours, if desired practices can choose

other **alternatives for providing expanded access to care**, including e-visits, phone visits, group visits, home visits, or alternate location visits.

- Maintain HIE Use Cases and Clinical Community Linkages/Social Determinants of Health work
- Second Practice Transformation objective is not required; all practices will work on Population Health
- Addition of three tracking codes: Education/Training for Patient Self-Management (98961, 98962), Provider Oversight (G9008) and End of Life Counseling (S0257)
- 8 hours of Practice Learning Credits are not required, though attendance at the Annual Virtual Launch and Quarterly Update meetings is still required

IV. Updated Language by Subject

Subject	2017 Agreement	2018 Agreement
24/7 Access	Ensure 24-hour access to a clinical decision maker (i.e., physician, advanced practice registered nurse, or physician assistant) for all patients of the Practice.	Ensure patients have 24/7 access to a care team practitioner **with real-time access to the EHR.**
Alternative to Traditional Office Visits	Provide clinical care for patients of the Practice beyond normal business hours (i.e., 8:30 am to 5:00 pm) for a minimum of 6 hours per week.	Regularly offer at least one alternative to traditional office visits, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.
Care Management Pediatric TANF Beneficiary Breakout	Both Adult and Pediatric TANF = $3 PMPM	Pediatric TANF = $2.75PMPM
Care Management PMPM Aged, Blind and Disabled Beneficiaries (ABD) - Adult and Pediatric	$8.00 PMPM	$7.00 PMPM
Care Management Training Requirements	1. Care Management Learning Requirement a. Each Care Manager and Care Coordinator must have completed a Self-Management Support Training Program approved by the PCMH Initiative within six months of hire. b. Each Care Manager must have completed the Complex Care Management Course provided by the PCMH Initiative within six months of hire. c. Each Care Manager/Coordinator must complete a total of twelve (12) contact hours of continuing education per year. This can be satisfied through attendance at PCMH Initiative-led events, PO-led trainings, or other related continuing education credit-granting events.	Care Managers and Care Coordinators must receive 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 annually.
Care Manager/Coordinator Team composition	Care Managers and Care Coordinators must function as an integral part of the Care Team. Maintain a ratio of at least 2 Care Management and Coordination staff	Care Managers and Care Coordinators must function as an integral part of the Care Team. The Initiative encourages Practices to include a licensed Care Manager as part of the Care Management and Coordination team. However, a Practice may staff their

	members per 5,000 patients attributed to the Practice as part of the PCMH Initiative. • At least one member of the Care Management and Coordination team must be a licensed Care Manager.	team(s) using both licensed Care Manager(s) and/or Care Coordinators(s) as needed to meet the needs of the patient population and other programmatic/ payer/administrative requirements outside the Initiative.
Care Team Meetings	Ensure that all Care Team(s) meet at least monthly with time dedicated to team-based management and review of reports.	Ensure that all Care Team(s) have planned meetings at least monthly (or, alternatively, team huddles more frequently) with time dedicated to reviewing practice and panel level data from payers and internal monitoring, and use this data to guide tactics to improve care and achieve practice goals.
Clinical Community Linkages	Assess patients' social determinants of health to better understand socioeconomic barriers using a brief screening tool with all attributed patients. b. 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. c. 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.	Focus moved from establishing to maintaining CCL efforts in year 2. Additional detail will be provided in the requirements, some focused on outlining expectations for participants located within Community Health Innovation Region and those outside of Community Health Innovation Regions.
CM/CC % Population Served	Assure that embedded Care Managers/Care Coordinators are serving attributed patients from all participating Payers. Assure that Billing Codes for Care Management and Coordination services delivered within the Practice are submitted to participating Payers as requested by the Payer(s).	Ensure at least 3% of attributed Practice patients receive care management and coordination services (represented through billing MHPs using the Initiative's tracking codes).
CM/CC Service Types	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.	Provide targeted, proactive, relationship-based (longitudinal) care management and coordination to all patients identified as at increased risk, based on a defined risk stratification process, and who are likely to benefit from intensive care management. • Provide short-term (episodic) care management and coordination along with medication reconciliation to patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management/coordination. • Use a plan of care centered on patient's actions and support needs in the management of chronic conditions for patients receiving longitudinal care management.
CM/CC Tracking Codes	Assure that Billing Codes for Care Management and Coordination services delivered within the Practice are submitted to participating Payers as requested by the Payer(s).	• Practices must bill MHPs for Care Management and Coordination Tracking Codes developed by the Initiative to monitor CM/CC services delivered within the Practice. • Addition of 3 codes: • Education/Training for Patient Self-Management (98961, 98962)- NEW • Provider Oversight (G9008) • End of Life Counseling (S0257)

EHR	Possess and utilize a fully implemented ONC certified EHR system.	Added clarification to 2017 Requirement: Either 2015 Edition or 2014 Edition CEHRT
Electronic Decision Support	Possess and utilize an electronic system capable of providing decision support prompts and care alerts to clinicians at the point of care.	Added clarification that the decision supports should, at a minimum, encompass measures from Quality Measure Information use case
HIE	Complete technical onboarding and be actively participating in the following Michigan Health Information Network Health Information Exchange use cases (by specified date): Active Care Relationship Service (ACRS); Health Provider Directory (HPD); Admissions, Discharge, Transfer Notification Service (ADT) Quality Measure Information (QMI);	Language updated to focus on maintenance and continued participation
Patient Registry	Possess and utilize an All-Patient Registry or Registry Functionality. The Registry may be a separate technology/system or be a component of an EHR. The Registry must be used on a consistent basis (no less often than quarterly) to generate population-level performance reports, pursue population health improvement, and close gaps in care for preventive services and chronic conditions	Added clarification to 2017 requirement: Performance reports should include measures from Quality Measure Information use case
Practice Learning Activity	All Participating Practices must complete eight (8) hours of Initiative led learning activities during the period of this agreement. In addition to the required hours, all Participating practices must have a representative participate in each Quarterly Update Meeting.	Ensure a representative from the Participating Organization participates in the annual Initiative virtual launch meeting. • Ensure a representative from the Participating Organization participate in each Quarterly Update Meeting, and shares relevant information with participating practice locations. • Ensure a clinical champion and other care team members from participating practice units/locations participate in the annual Initiative virtual launch meeting. • Ensure clinical champion and other care team members from participating practice units/locations participate in PCMH Initiative hosted learning activities as appropriate and relevant to their position in the practice
Practice Transformation Objective #2	Selection of one objective from a menu of 11 practice transformation objectives	All Participants will be required to focus on Population Health, current participants which selected an objective other than population health during year one will be asked to realign their objective as an activity which corresponds with improving performance on one or more of their population health objectives.
Self-Management Support	Defined as an activity or service of Care Management and Coordination	Implement self-management support for at least 1 high risk condition.
Team-Based Care	…encouraging team-based care and attention to other aspects of the PCMH Initiative model.	Organize care by practice identified teams responsible for a **specific, identifiable panel of patients** to optimize continuity.
Timely Follow-up Visit Metric Definition and %	Ensure at least 40% of attributed Practice patients receive a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient stay, or emergency discharge or transfer from one care setting to another.	Ensure at least 40% of attributed Practice patients receive a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient stay, as measured quarterly Definition: The percentage of a Practice's attributed patients receiving a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient stay.

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