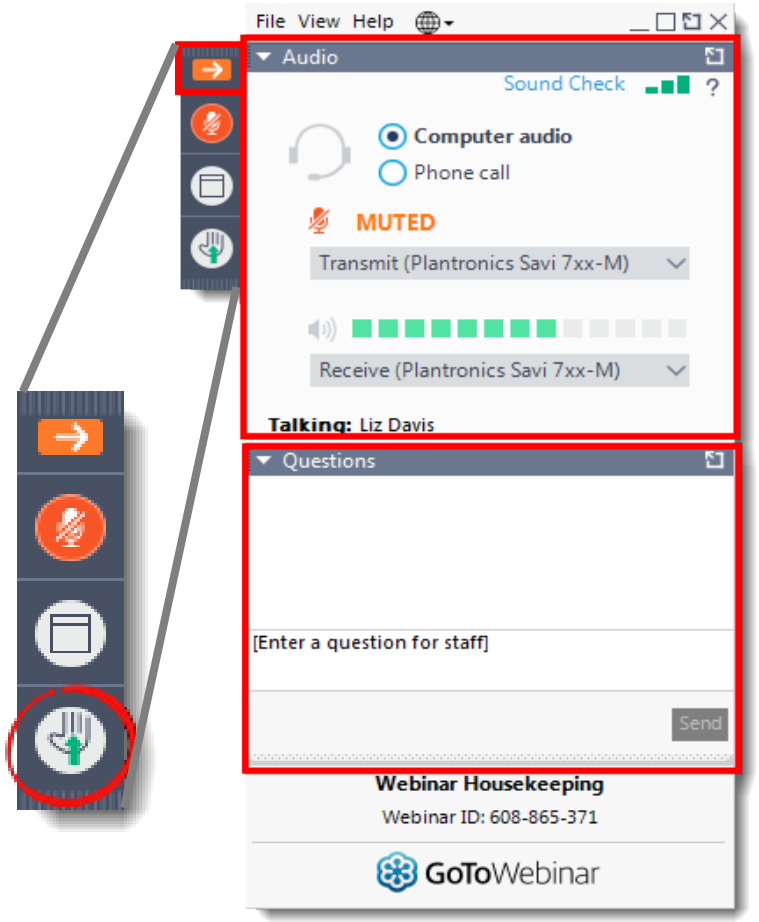
2019 PCMH Initiative

ANNUAL KICK-OFF WEBINAR

JANUARY 8, 2019 | 12:00 – 1:00PM

Housekeeping:
Webinar Toolbar Features



Your Participation

Open and close your control panel

Join audio:

- Choose **Mic & Speakers** to use VoIP
- Choose **Telephone** and dial using the information provided

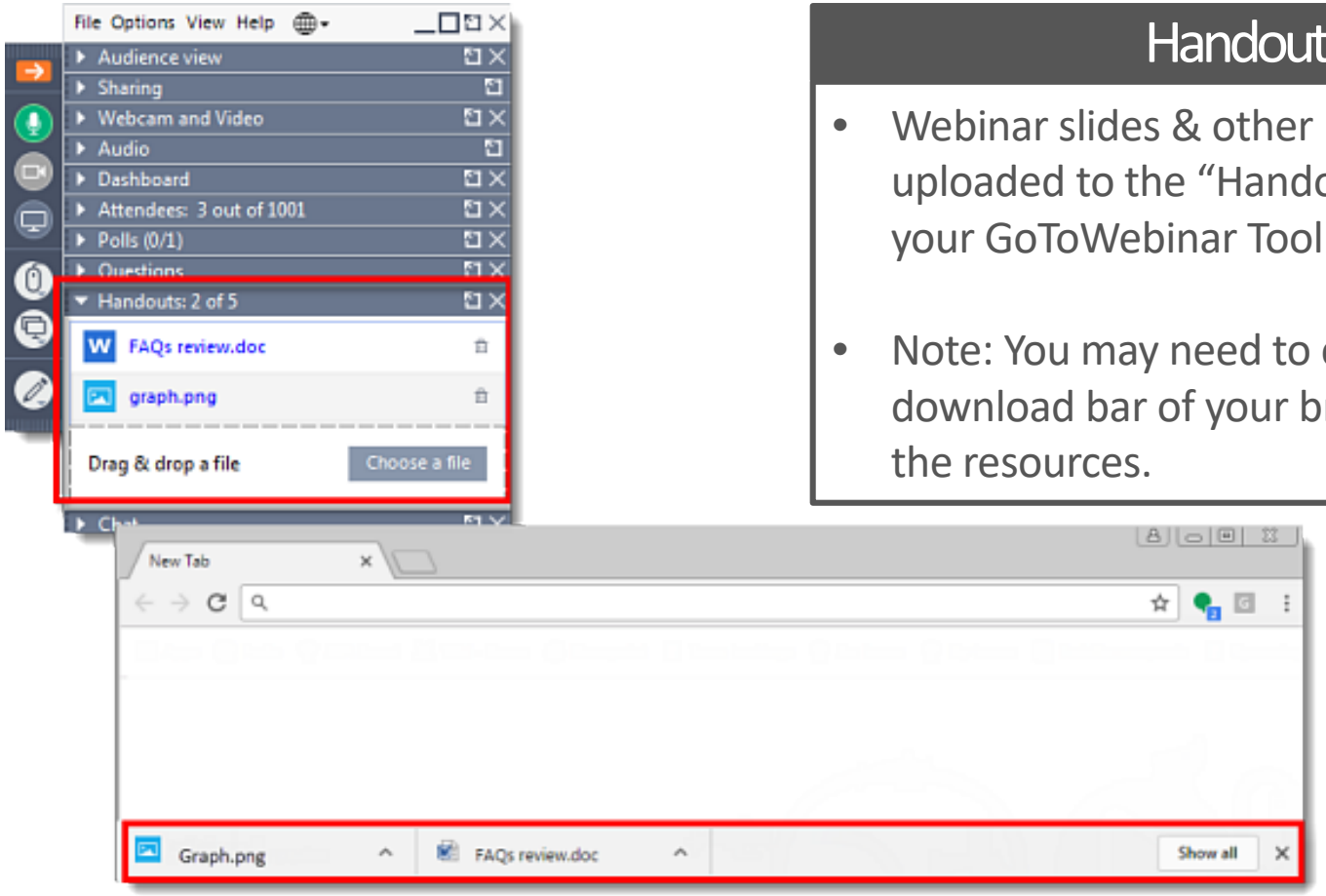
Submit questions and comments via the Questions panel

Note: If time allows, we will unmute participants to ask questions verbally.

- Please raise your hand to be unmuted for verbal questions.

NOTE:
In the event that there is not time to answer questions live, all questions submitted via the Question Function of the GoToWebinar toolbar will be recorded, an FAQ generated and posted to our webpage

Housekeeping:
Webinar Resources/Handouts



Handouts

- Webinar slides & other resources are uploaded to the “Handouts” section of your GoToWebinar Toolbar.
- Note: You may need to check the download bar of your browser to view the resources.

Overview

2018 RECAP, 2019 GOALS, YOUR PCMH INITIATIVE TEAM

PCMH Initiative Team:

MDHHS Team Members

Katie Commey, MPH
SIM Care Delivery Lead

Laura Kilfoyle, MPA
SIM Care Delivery Coordinator

Lyndsay Tyler
Business Analyst

Nell Newton
Project Manager

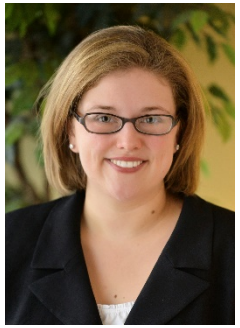
MI-SIM Care Delivery Governance Team	
Kathy Stiffler	Medicaid Care Management and Quality Assurance, Deputy Director Acting Medicaid Director
Brian Keisling	Medicaid Operations and Actuarial Services, Bureau Administrator
Kim Hamilton	Managed Care Plan, Division Director
Penny Rutledge	Actuarial Division, Manager
Theresa Landfair	Managed Care Plan Division, Specialist
Tom Curtis	Quality Improvement and Program Development, Section Manager

PCMH Initiative Team:
U of M Team Members

Clinical Values Institute

Veralyn Klink
Administrator

Diane Marriott
Director



Amanda First-Kallus, MHSA
Analyst

Yi Mao
Analyst

Michigan Data Collaborative

Jessie Chen
Application Systems Analyst / Programmer

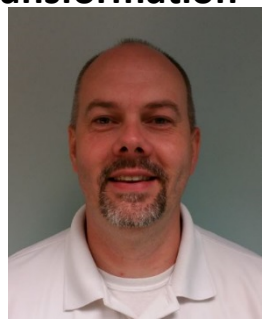
Susan Stephan
Business Systems Analyst, Staff Specialist

Alice Stanulis
Manager, Michigan Data Collaborative

Marty Kosla
Sr. Business Systems Analyst

Michigan Institute for Care Management and Transformation

Marie Beisel, Administrative Manager Sr. Healthcare



Scott Johnson
Int. Project Manager

Betty Rakowski,
Curriculum Designer

Sarah Fraley, Int. Project Manager

SIM
MDHHS State Innovation Model

MI-SIM Components

Care Delivery

- Patient-Centered Medical Home (PCMH) Initiative
- Advanced Payment Models

Population Health

- Community Health Innovation Region (CHIR)

Focused on:
Clinical-Community Linkage

Supported by:

Stakeholder Engagement

Data Sharing and Interoperability

Consistent Performance Metrics

2018
A Year in Review

The PCMH Initiative experienced several accomplishments in 2018:

- Approximately 350,000 Medicaid beneficiaries per month covered with services
- About 310 practices and 2,135 providers participating in the Initiative
- Initiative Participants utilized funding to transform practices through care management, SDoH screening, expanded access, improved team functioning, practice workflow improvements, etc.
- Three successful Summits with integration of ideas of Planning Committee
- Launch of Care Coordination Collaborative with two successful virtual events
- Cadre of Technical Assistance Office Hours Offerings
- Successful onboarding and integration of QMI use case data to Dashboard
- Launch of CCL Data Partnership

PCMH Initiative Objectives

1. Create a Sustainable PCMH Model – Implement payment models that provide meaningful incentives to Primary Care Providers for advancing health outcomes and delivery system transformation through public/private Payer and Practice collaborations to improve health care value and transform primary care in ways that are sustainable and can be replicated statewide.

2. Improve Quality and Outcomes – Maintain and expand measurable improvements in quality of care, total cost of care, and patient satisfaction through continuous quality improvement of participating PCMH Practices.

3. Lower Overall Health Care Costs – Reduce unnecessary or avoidable costs through the timely and effective transformation of care delivery by the PCMH Practice and stronger coordination of care in other settings.

Practice Support and Learning Opportunities: *Monthly Newsletters*

Distributed via GovDelivery & on our website!

- To sign up for the distribution:
  - Email us at MDHHS-SIMPCMH@michigan.gov, or
  - Sign up for MDHHS subscriptions: when managing your "subscriptions" select State Innovation Model Patient Centered Medical Home Initiative"

Will be released late month for the following month (ex. February Newsletter will be released in late January)

Designed to have upcoming events, training information, topics of interest, participant highlights, suggested resources and other pertinent information

Suggestions always welcome, please email them to MDHHS-SIMPCMH@Michigan.gov

MDHHS
Michigan Department of Health & Human Services

SIM PCMH Initiative Newsletter

A publication of Michigan's State Innovation Model
December 2017

In this Issue

- Initiative Announcements
- Upcoming Events
- Monthly Calendar

About the Initiative

The Patient Centered Medical Home (PCMH) Initiative is a core component of the State Innovation Model (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. For more information and resources, check out our webpage.

Contact Us

Questions can be sent to:
MDHHS-SIMPCMH@michigan.gov

Welcome to the 2017 Patient Centered Medical Home Initiative, and the eleventh release of our monthly newsletter. Each month we will bring together all the updates, news and upcoming events relevant to PCMH Initiative Participants. Additionally, we will provide updates on other happenings across the State Innovation Model.

You will continue to receive other regular communications and event reminders from the PCMH Initiative. This newsletter has been developed as a method to share information in one common location. Previous editions of the newsletter can be found here.

Program News and Updates

PCMH Initiative Quarter 4 Progress Report

The PCMH Initiative Quarter 4 Progress Report is expected to be released on December 21, 2017. Submission deadline is Wednesday, January 31, 2018 by 5:00pm. The link to the electronic submission will be distributed to your organization's key contact. You can preview the requirements and instructions to complete report in the report guide. The guide can be found under "Resources" at the main PCMH Initiative website.

PCMH Initiative 2018 Launch

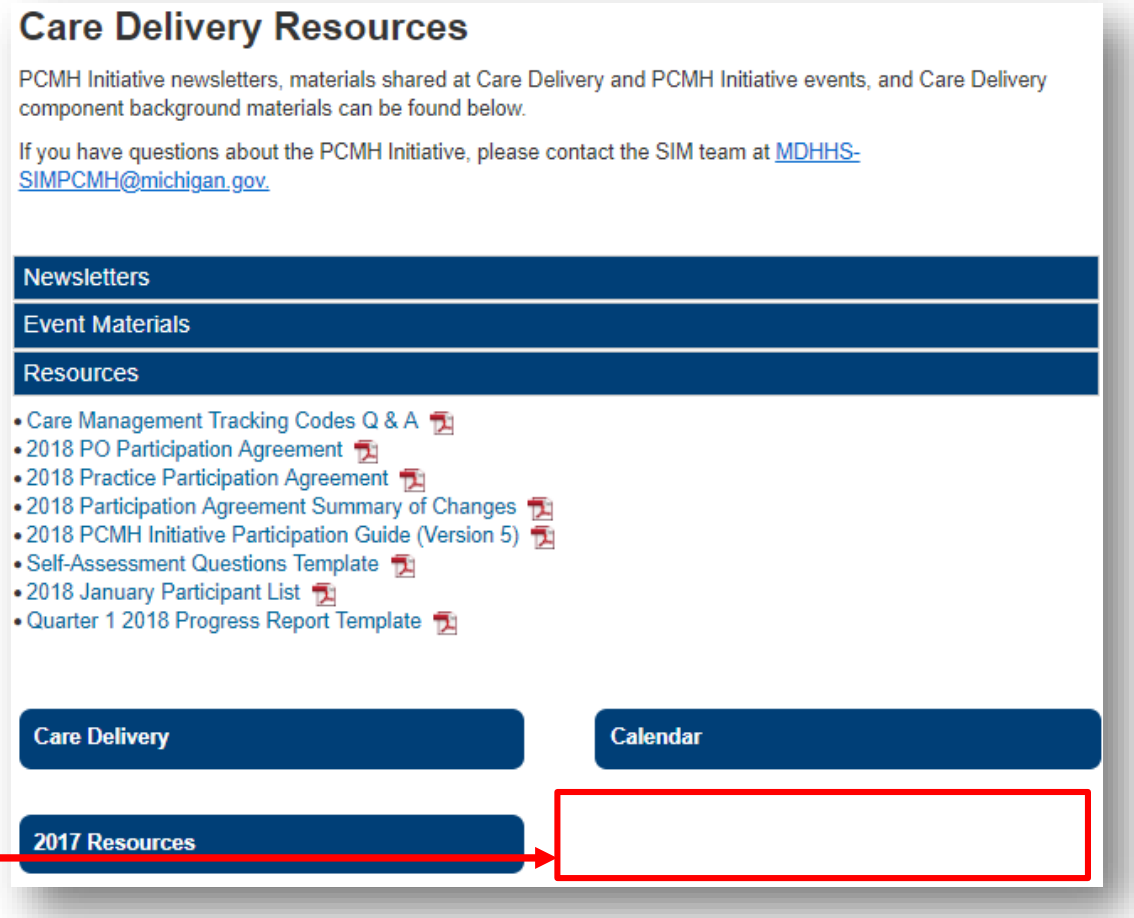
We look forward to connecting with at least one representative from each Physician Organization or Practice at our PCMH Initiative 2018 Launch webinar on January 9, 2018 from 12:00-1:00pm. Topics covered will include a recap of 2017, an overview of 2018, an outline of resources available to participants, a guide to PCMH Initiative team members and who to contact, reporting requirements including the 2018 Practice Self-Assessment, and a time for questions and answers. Register to reserve your spot. See you there! Please Note: participation in this webinar is a requirement of the PCMH Initiative.

Initiative Resources:
Website Features for 2019

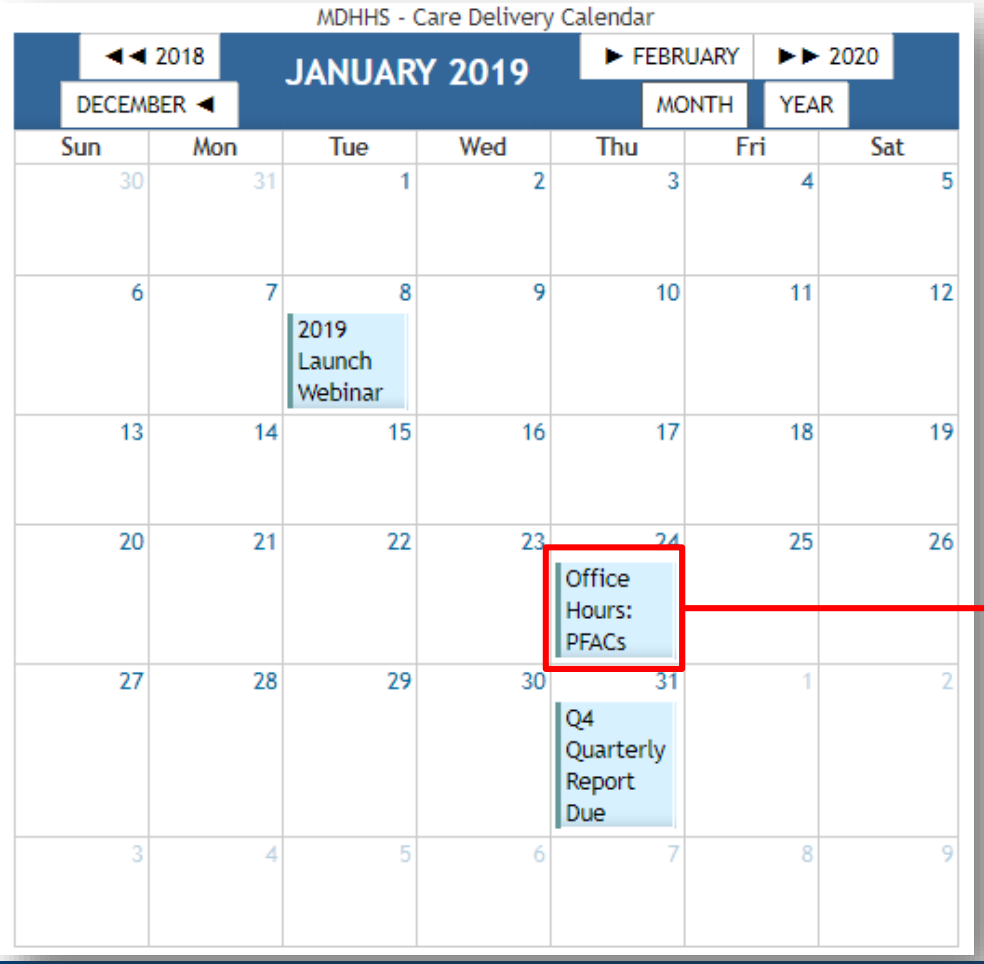
- www.Michigan.gov/SIM

State Innovation Model | Care Delivery | Population Health | Technology

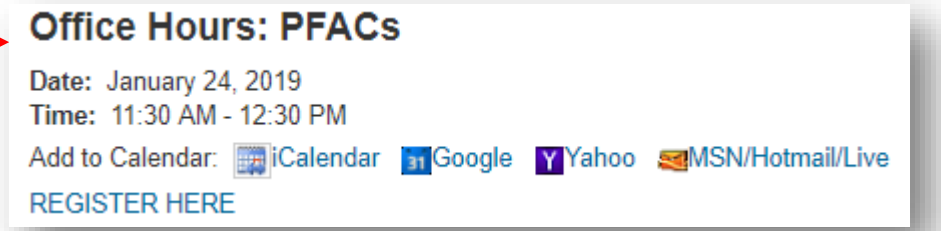
- All 2018 material will be archived in the coming weeks similar to what was done for 2017 resources
  - A new 2018 button will be available at the bottom of the Care Delivery Page



Initiative Calendar:



- Most 2019 office hours are available through the end of the participation year
- Events will likely be added each month including reporting deadlines and in-person events



How to get the most out of the PCMH Initiative Participation Guide?

- The Participation Guide can be found on the Resources Page
- Every major change will be called out in the footnotes on the page changes were made
- They will also be listed in the table at the end of the document

Revision History

Revision Date	Version	Section(s)	Page(s)	Summary
12.19.2017	V1	All	NA	Initial Release
02.14.2018	V2	Initiative Operations: Initiative Payment Model	6-7	Detail on Adult and Pediatric attribution for the purposes of payment calculations.
02.14.2018	V2	Clinical Practice Improvement Activities: Clinical-community Linkages	9-10	Additional detail added regarding screening patients for social need, including the differentiation between screening and assessment, and the intent and purpose of screening within the Initiative. Information added to guide development of linkage documentation processes.
02.14.2018	V2	Clinical Practice Improvement Activities: Population Health Management	11-12	Addition of sample activities to support each of the required Population Health Management activities.
02.14.2018	V2	Care Management and Coordination: Longitudinal Learning Requirements	20	Added information on IHI Open School courses that support the CMCC Longitudinal Learning Requirements
02.14.2018	V2	Performance Monitoring: 2018 Dashboard Releases	30-31	Addition of "Quality of Care with QMI Supplemented Data" to 2018 Release table
02.14.2018	V2	Practice Support and Learning Activities: Pediatric Office Hours	40	Addition of Pediatric Office Hours details

Initiative Resources:
Partner Websites

Michigan Care Management Resource Center

Michigan Data Collaborative

Michigan Health Information Network

Michigan Community Health Worker Alliance

Practice Transformation Institute

Integrated Health Partners

Michigan Center for Clinical Systems Improvement

What's Coming in 2019

TECHNICAL ASSISTANCE & PARTICIPANT SUPPORT OPPORTUNITIES

Practice Support and Learning Opportunities:
How to Engage with the Initiative in 2019

Activity	Purpose	Occurrence	Who Should Attend	
Monthly Office Hours	Topic focused sessions to bring current health policy information, pertinent topics and operational details of the Initiative to participants.	Offered virtually monthly—usually 2nd or 3rd week	Open to all participants. Specific offerings: General Office Hours Supplemental—as needs arise Pediatric Office Hours	**There's a Peds Workgroup!**
Care Coordination Collaborative	Network with payer partners and other SIM participants, supporting alignment in care coordination	Building upon 2018—two in person events	Care Management and Coordination staff, including managers and administrators	**CCC Planning Committee!**
Quarterly Update Meetings	Regularly scheduled Initiative updates, providing key information for successful participation (1 hour in length).	Offered virtually: 4/17 /2019, 7/17/2019, and 10/16/2019	Required: Physician Organization Representatives, and key practice staff (for practices participating independently).	
Annual Regional Summits	Provide an opportunity for participant to engage in learning and networking face to face, building on the foundation of regular learning opportunities throughout the year.	Fall 2019	Participant staff including but not limited to administrative staff, care managers and coordinators, quality improvement staff, and other leaders	**Summit Planning Committee!**

Do you have suggestions for other learning opportunities or events that would be helpful to you and your organization? Email us at MDHHS-SIMPCMH@Michigan.gov

Care Manager & Coordinator Learning:
Required Initial Training for SIM CMCCs

Initial Required Training	Care Coordinator	Care Manager	Time Required
MiCMRC Approved Self-Management Support Course	X	X*	Varies by vendor
MiCMRC CCM Course		X	Click here for details
SIM Overview Recorded Webinar	X	X	30 minutes
PCMH, Chronic Care Model, and ACOs Recorded Webinar	X	X**	20 minutes
Team Based Care Recorded Webinar	X	X**	45 minutes
Introduction to Social Determinants of Health Recorded eLearning Module	X	X***	25 minutes
The Role of Care Managers & Care Coordinators in Developing and Maintaining Community Linkages eLearning Module	X	X***	30 minutes
Social Determinants of Health and the Implications for Care Management eLearning Module	X	X***	20 minutes
Social Determinants of Health Case Study eLearning Module	X	X***	20 minutes

*Care Managers are strongly encouraged to complete the Self-Management course prior to enrolling 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.

Note: CCM course redesign to launch 2nd quarter 2019

Care Manager & Coordinator Learning:
Complex Care Management Training

The SIM PCMH Initiative partners with the Michigan Care Management Resource Center to offer Complex Care Management Training to all Care Managers supporting SIM PCMH Initiative patients, that have not been previously trained.

The MiCMRC Complex Care Management Course (CCM) curriculum provides the framework for the complex care management role, foundational elements of integration into the ambulatory care setting, and development of complex care management skills.

Course Schedule

DAY 1: Introduction, Live one-hour logistics webinar

Day 2: Self-study, recorded webinars, post-tests, (approximately 6 hours of self-study)

Day 3&4: In-person training, 8 hours each day

*Note: This course is required for Care Managers only

Check here course dates | For more information, contact: micmrc-ccm-course@med.umich.edu

Care Manager & Coordinator Learning: *Self Management Training Options*

To provide additional flexibility and convenience for SIM PCMH Initiative participants, three organizations will be available for self-management training for Care Managers and Coordinators who have not been trained previously:

- Integrated Health partners (IHP)
- Michigan Center for Clinical Systems Improvement (MiCCSI)
- Practice Transformation Institute (PTI)

If self-management training is completed through one of these vendors, the PCMH Initiative will cover the cost of the course. (Travel and any other related expenses are the responsibility of the attendee or their organization.)

Trainees must attest that they have not been previously been trained in self-management. Those who completed self-management training with a MiCMRC-approved vendor with MiPCT or another initiative do not need to be retrained.

Care Manager & Coordinator Learning:
Self Management Training Options Cont.

Class availability and the number of training slots may vary at each organization. If classes with a particular vendor are full, you will be put on a wait list or can explore availability at the other organizations.

- Integrated Health Partners (IHP) - based in Battle Creek
  - Note: this is a 2 part series and participants must attend both session dates
  - For more information, contact: Emily Moe | moee@integratedhealthpartners.net | Phone: 269-425-7138.
- Michigan Center for Clinical Systems Improvement (Mi-CCSI) - based in Grand Rapids
  - For more information, contact: Amy Wales | amy.wales@miccsi.org | Phone: 616-551-0795 ext. 11
- Practice Transformation Institute (PTI) - based in Southfield
  - For more information, contact: Yang Yang | yyang@transformcoach.org | Phone: 248-475-483

For a summary of MiCMRC approved Self Management Support Courses (includes details for the above courses): www.micmrc.org

Care Manager & Coordinator Learning:
Longitudinal Learning Opportunities

Care Management Webinars offered monthly by MiCMRC. Check out: http://micmrc.org/webinars

Upcoming Live Webinars:

Title: Suicide Assessment, Risk and Prevention
Date and Time: Wednesday, January 23, 2019 2-3 pm
Presenter: Kristyn Spangler, LMSW
Behavioral Health Program Manager
Integrated Health Associates
Register HERE

Title: 5 Steps to Help Patients Prevent Type 2 Diabetes
Date and Time: Wednesday, February 27, 2019 at 2pm
Presenter:
Tamah Gustafson, MPH, CHES
Public Health Consultant
Diabetes and Kidney Disease Unit
Michigan Department of Health and Human Services
Register HERE

Note: Several of the Live and recorded webinars provide CE Contact Hours for Nursing, Social Work and Commission for Case Management Certification

Care Manager & Coordinator Learning:
Longitudinal Learning Opportunities Cont.

Additional Learning Opportunities available: www.micmrc.org

eLearning modules are available for all PCMH team members

- CE Contact Hours for Nursing and Social Work upon completion of each module and
  - Module Topics
    - Medication Reconciliation
    - Transition of Care
    - Introduction to Palliative Care and Advance Care Planning
    - Role of the Care Manager
    - 5 Step Process
    - Care Planning
    - Patient engagement

NEW Behavioral Health web page – includes BH recorded webinars and resources

Care Manager & Coordinator Learning

MiCMRC Website www.micmrc.org

E Learning Courses

Behavioral Health webinars and resources

Recorded webinars offering CE for Nursing, Social Work and CCMC

Do you have a success you would like to share? Sharing your success story only takes a moment.

- Go to www.micmrc.org
- Click on the success story link
- Fill out the brief questionnaire
- Click submit

It's that easy!

A member of the Michigan Institute for Care Management and Transformation team will:

- take your information and put together a draft of your story
- work with you to ensure all aspects of your story is captured.
- once approved your story will be published in an upcoming statewide newsletter

2019 Participation Agreement

- Bureau of Purchasing will send out 2019 Participation Agreement*
  - This is the version that should be signed and returned
- Participants should continue operating under terms of 2018 Participation Agreement until receipt of 2019 Participation Agreement
- Questions can be emailed to MDHHS-SIMPCMH@Michigan.gov

*This is the memorandum of understanding used to signify participation in the 2019 PCMH Initiative, signed by both MDHHS and either a PO (on behalf of member practices) or an individual practice. There are two versions: PO Agreement and Practice Agreement. There is also a 2019 Participation Agreement Summary of Changes resource which will be made available to support identifying the changes from the 2018 to 2019 Participation Agreement.

2019 Participation Requirements: Highlights

- Changes from 2018
  - Payment Model Update:
    - Care Management Improvement Reserve (CMIR)
    - Performance Incentive Program (PIP)

- Notable continuances from 2018
  - Care Management and Coordination Requirements
    - CMCC Tracking Code set remains unchanged
    - 2.5% CMCC benchmark remains

Payment Model Update:
Care Management and Coordination

Met/Exceeded 2018 CMCC Benchmark	Below 2018 CMCC Benchmark
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)	Adult Beneficiaries (19 years and above) • **$2.85** for Adult General Low Income Beneficiaries (TANF) • **$4.85** for Healthy Michigan Plan Beneficiaries (HMP) • **$6.85** for Aged, Blind and Disabled Beneficiaries (ABD) Pediatric Beneficiaries (18 years and under) • **$2.60** for Pediatric General Low Income Beneficiaries (TANF) • **$6.85** for Aged, Blind and Disabled Beneficiaries (ABD)

*All Care Management and Coordination rates are paid as a Per Member Per Month payment

Payment Model Update:
Care Management and Coordination

EXAMPLE:

Participant Organization	2018 Aggregate Performance	2018 Performance Rate	2019 PMPM Payments	2019 Performance *	Action Related to 2018 Performance	Action Related to 2019 Performance
Participant 1	596 / 34,965	1.70%	Reduced by $0.15	Above 2.5%	CMIR returned	None
Participant 2	225 / 5,145	4.37%	NO Change	Above 2.5%	None	None
Participant 3	138 / 1,464	9.43%	NO Change	Below 2.5%	None**	Final Initiative Payment Reduced
Participant 4	62 / 4,687	1.32%	Reduced by $0.15	Below 2.5%	CMIR retained by Initiative	Final Initiative Payment Reduced

* The 2019 Benchmark has been set--2.5% of patients within the attributed population received care management and coordination services as measured on aggregated quarterly reports for service delivery.

** No 2018 Care Management Improvement Reserve was imposed as performance in 2018 was acceptable, therefore 2019 Performance will be assessed independently, and action will be as defined for the 2019 PCMH Initiative.

Payment Model Update:
Performance Incentive Program (PIP)

Participants that perform at or above the PCMH Initiative defined benchmark on a set of select quality and utilization measures will be eligible for a base performance incentive payment. Those that meet the benchmark on at least 80% of the measures for which they are eligible may receive a bonus incentive payment.

MEASURE TYPE	AGE GROUP	MEASURE NAME	BENCHMARK
QUALITY	Pediatric	Adolescent Well-Care Visits	48.54
		Childhood Immunization Status	45.00
		Lead Screening	78.67
	Adult	Diabetes Nephropathy	86.67
		Diabetes HbA1c Testing	85.63
		Cervical Cancer Screening	59.61
UTILIZATION	Adult	Prevention Quality Indicator Chronic Composite 92 (PQI 92)	8.77
	Both	Acute Hospital Admissions	67.78
		Emergency Department Visits	606.01

Data Collection

PARTICIPANT DATA MAINTENANCE & REPORTING

Progress Reporting Change

- Q4 2018 Progress Report sent out to PO contacts in December, due 1/31/2019
- Beginning in 2019, Progress Reports will be required on a semi-annual basis instead of quarterly (April/October)
- Semi-annual practice transformation reports will be required as usual
- Progress report content will continue to be similar
  - PO contacts and clinical champion, practice contacts and clinical champions
  - MHP contracting information
  - Infrastructure, practice, provider changes
  - Participation Experience, Strengths and Challenges

Practice Self-Assessment

TOPICS	
Engaged Leadership	Care Management and Coordination Sustainability
Quality Improvement	Medical Neighborhood and Clinical-Community Linkages
Integrated Behavioral Health Care	Population Health
Team-based Care	Patient and Family Caregiver Engagement, Health Literacy & Shared Decision Making

Released: December 21, 2018

Due: February 8, 2019

Reminder: A self-assessment must be completed for each practice.

Practice and Provider Changes

- Provider list directly affects attribution and payment
- Enter changes using the following site: Change Submission Website
- Quarterly practice and provider list sent for verification: February, May, August, November
- MDC Portal: Practice and Provider List

Michigan Data Collaborative (MDC)

REPORTING PROVIDED FOR THE INITIATIVE

MDC Additions in 2018

New Dashboard Pages

- Physician Organization Comparisons
- Care Coordination: Percentage of Patients and Inpatient Follow-Up

Measures Updated

- Quality measures updated to HEDIS 2018
- Utilization measures revised to align more closely with HEDIS 2018
- Supplemented Quality measures with Quality Measure Information (QMI) data

Reports Added

- Care Coordination Claims Detail Reports

Measures Added in 2018

QUALITY OUTCOME MEASURES

Adult BMI (Body Mass Index)

Controlling High Blood Pressure

Diabetes HbA1c Poor Control

Screening for Depression and Follow-Up

Tobacco Use Screening and Cessation

Weight Assessment and Counseling for Children/Adolescents

COST AND UTILIZATION

Ambulatory Care Sensitive Condition (ACSC) Hospitalizations

- Adult Overall Composite (Comprised of 11 PQIs)
- Adult Acute Composite (Comprised of 3 PQIs)
- Adult Chronic Composite (Comprised of 8 PQIs)
- Adult Diabetes Composite (Comprised of 5 PQIs)
- Pediatric Overall Composite (Comprised of 4 PDIs)
- Pediatric Acute (Comprised of 2 PDIs)
- Pediatric Chronic (Comprised of 2 PDIs)

Preventable ED Visits

Total Cost PMPM

PQI = Prevention Quality Indicator
PDI = Pediatric Quality Indicator

Coming in 2019

Release 7.0 end of February

- Reporting Period of October 2017 – September 2018
- Add quarterly releases that were skipped in the initial release cycle in order to produce more recent results
  - ✓ April 2016 – March 2017
  - ✓ July 2016 – June 2017
- Reprocess so that all measures will be available in all quarterly releases in consistent definition
- Add Trend Lines
- Add trends to the Care Management visualizations

Care Management Rolling Quarter Reporting Starts in January 2019

- Each monthly report will contain the most recent three months of data
- Better capture the bigger picture of care coordination services

Evaluation

SIM PCMH Initiative Evaluation Components

Evaluation Activity	Purpose	Target Audience	Timeline	Owner
Provider Survey (PO reps, PCPs, CM/CC, Office Managers)	Identify attitudes and experiences of health providers who participate in Clinical Community Linkages (CCLs) directly or indirectly	• PCMH Initiative Participants identified as members or partners of a CHIR	May – July, 2018	MSU ✓
		• PCMH Initiative Participants in CHIRs NOT identified as members or partners	Aug. 1-31, 2018	MPHI ✓
		• PCMH Initiative Participants outside of CHIRs	Aug. 1-31, 2018	MPHI ✓
Patient Experience Survey	Identify experiences of patients who participate in CCLs	• Sample of patients from PCMH Initiative Participants	Fall, 2018	CHEAR ↻
CCL Data Partnership *(optional)*	Connect individual-level CCL data (Social Determinant of Health screening and linkages) to Medicaid utilization and costs (claims data from MDC)	• Patients within PCMH Initiative participants selected to participate.	Oct. 2018, quarterly thereafter	MPHI ↻

2020 and Beyond

Questions?

Appendix

TRACKING CODES

2019 Tracking Codes

CARE MANAGEMENT AND COORDINATION

Care Management and Coordination: *2019 Tracking Codes*

- The PCMH Initiative requires all participating practices to track Care Management and Coordination Service provision using a designated set of Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's Current Procedural Terminology (CPT) codes.

Code	Quick Description
G9001	Comprehensive Assessment
G9002	In-person Encounter
98966, 98967, 98968	Telephone Services
99485, 99496	Care Transition
G9007	Team Conference
G9008	Physician Coordinated Care Oversight Services
98961, 98962	Group Education and Training
S0257	End of Life Counseling

New codes added for 2018

See Appendix C: Care Management and Coordination Tracking Quick Reference in the 2019 Participant Guide for more complete details on each code

Care Management and Coordination: *Service Documentation*

All Services rendered should be documented in electronic Care Management and Coordination Documentations Tools (either a stand alone product or component of EHR), with information accessible to all care team members at the point of care.

Documentation should, at a minimum, include the following:

- 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

** 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:
Claims Submission Guidelines

Submission of the Care Management and Coordination claims supports one of the SIM PCMH Initiative Care Management and Coordination Metrics:

$$\frac{\text{Any patient who has had a claim with one of the applicable codes during the reporting period}}{\text{Eligible Population}}$$

All claims must be formally submitted to the appropriate payer (Medicaid Health Plan) directly at the practice's customary charge to be included as a part of service provision tracking

- 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.
- 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