

WYOMING MEDICAID  
PATIENT CENTERED MEDICAL  
HOME (PCMH)



# What is a Patient Center Medical Home (PCMH)?

## A Patient Centered Medical Home (PCMH):

- A value based purchasing model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.
- It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to coordinate on their patient's care from the simplest to the most complex conditions.
- Above all, it is a model for achieving primary care excellence so that care is received in the manner that best fits a patient's medical needs.

# Who can Enroll as a PCMH

**The following providers may apply to become a PCMH:**

- Physician offices
- Federally Qualified Health Centers
- Rural Health Centers
- Indian Health Services



# Becoming a PCMH Provider

- **Step 1**, Download the PCMH Attestation of Facility Compliance and follow the instructions listed on form. The form can be found at <http://wymedicaid.acs-inc.com/>
- The link is on the left hand side, titled Patient Centered Medical Home. (An example is listed below beginning on slide 19)
- **Step 2**, Review the following Wyoming Medicaid PCMH information. (Next slide)

# Becoming a PCMH Provider & NCQA

In September 2014, a State Plan Amendment on Primary Care Medical Homes was approved by CMS.

The Amendment allows Wyoming to pay an additional per-member per-month case management fee to primary care practitioners that meet certain requirements, such as reporting clinical quality measures into an online state database.

Another requirement that practices must meet to obtain the case management fee is that they must attest to meeting core medical home functions, as defined by NCQA's 2011 or 2014 Patient-Centered Medical Home (PCMH) standards. Specifically, practices are asked to submit their Summary Score Report from NCQA's Interactive Survey System (ISS) – the system practices can use to score themselves and upload documentation in preparation for NCQA Recognition.

# Becoming a PCMH Provider & NCQA

Obtaining formal NCQA PCMH Recognition is not mandated, although it is encouraged. The following information explains how to access the ISS tool, how to complete the survey report and how to print it out and submit it along with Wyoming Medicaid's attestation form.

## □ ***Practices with Experience Using NCQA's PCMH Survey Tool***

Practices that have already purchased access to NCQA's PCMH Survey Tool, including those practices that have applied for or received recognition, can print out their Summary Score Report following the step-by-step instructions on the next slide.

# Becoming a PCMH Provider & NCQA

A practice representative must log into their practice's PCMH Survey Tool and click the 'print' button in the upper left hand corner. He/she should then click "Print Numeric Results", a link in the middle of the page. Click through the agreement and then click the Patient-Centered Medical Home link next to "Evaluation Option." This will bring up your Summary Score Report.

There are two important things practices should keep in mind:

- First, some practices may have purchased access to the survey tool but not completed the self-scoring process that indicates their compliance with the PCMH elements. Practices just starting the PCMH journey may fall into this category.

# Becoming a PCMH Provider & NCQA

The self-scoring needs to be completed before printing the Summary Score Report. Also, keep in mind that Wyoming has set scoring thresholds (25% for most elements) that must be met to achieve compliance with the state's requirements. The specific thresholds are identified in the state's attestation form.

- Secondly, practices that have received formal NCQA PCMH Recognition will have two surveys – and thus two Summary Score Reports – to pick from. They can either print the report from their final survey that has been reviewed by NCQA, or they can use the report from their self-scoring.

# Becoming a PCMH Provider & NCQA

Again, practices should keep in mind that they need to achieve certain scoring thresholds to meet the state's requirements. If a practice's final NCQA reviewed survey does not meet those thresholds, they would need to use the self-scored version.

## □ ***New Practices***

Practices that do not have access to NCQA's PCMH Survey Tool will [need to visit the NCQA website](#) to purchase it. There is an \$80 fee that can be paid by credit card. Once they purchase access to the tool, they will have access to it indefinitely. The survey tool includes a full copy of the PCMH standard and guidelines, the ability to self-score against those standards (functionality that is being used by Wyoming), and the ability to upload supporting documentation and submit for NCQA PCMH Recognition.

# Becoming a PCMH Provider & NCQA

New practices will also need to self-score themselves so that the Summary Score Report reflects their practice's status and is compliant with Wyoming's requirements. After purchasing access and logging in, they should visit the 'Survey Tool' tab and work through the survey element-by-element. NCQA has [free online trainings](#) that can orient practices to the survey tool and how to self-score. In addition, NCQA is planning two webinars in February 2015 specifically for Wyoming practices that will walk through how practices can purchase PCMH survey tool access, self-score, and print out the Summary Score Report.

Once new practices have purchased access to the tool and self-scored, they can follow the directions below identifying how to print out their Summary Score Report.

# Becoming a PCMH Provider

## □ ***Applying for NCQA Recognition***

Although formal NCQA Recognition is not required by Wyoming Medicaid, practices are encouraged to seek it. The same free trainings noted above can help practices learn about the process and how to apply. Importantly, practices applying for NCQA Recognition must collect and upload supporting documentation that provides evidence of their compliance with the standards. After a survey is submitted, these documents are reviewed by experts at NCQA, which make scoring decisions that ultimately impact whether or not a practice is recognized and at what level.

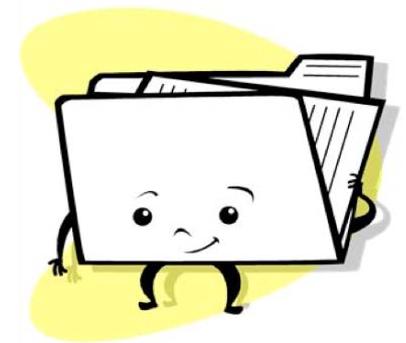
# Becoming a PCMH Provider, NCQA Discount & Contacting NCQA

- For practices that wish to formally apply for NCQA Recognition – something we encourage – you are eligible for a 20% discount on the associated fees. NCQA has provided this discount code **GWYDHA**, which you can use when applying.
- ***Contacting NCQA***

If you have specific questions about NCQA's PCMH program or how to use the Patient-Centered Medical Home Survey tool, please contact Mina Harkins, Assistant Vice President for Recognition Programs Policy, at [Harkins@ncqa.org](mailto:Harkins@ncqa.org). If the practice is pursuing Recognition, they will be assigned a survey manager.

# Becoming a PCMH Provider

- **Step 3**, Register in the State Level Registry Portal (SLR) to submit monthly Clinical Quality Measures (CQM's) for Wyoming Quality Care Coordination Program (WyQCCP)  
<https://wyqccp.htscqm.net/>
  
- **Step 4**, Submit a request to [THRCCDViewerAccess@acs-inc.com](mailto:THRCCDViewerAccess@acs-inc.com) with the following information:
  - Clinic Name
  - Address
  - Phone Number
  - Provider Names
  - Primary Contact to access the Continuity of Care Document (CCD) system



# What is the next step?

Once these steps have been completed and accepted by Wyoming Medicaid, the provider must complete the following to qualify for the Per Member, Per Month (PMPM) quarterly payments:

- Submit monthly practice data to the SLR portal on required Clinical Quality Measures
- Review CCD's on Medicaid encounters within the quarter.

Each quarter, Wyoming Medicaid will review each provider to ensure that all the conditions of participation have been met. Each quarter, each provider will be notified via email of approval and level of qualification or denial reason for denial.

# What is the expectation of PCMH to obtain PMPM?

- **In order to claim the PMPM:**
  - ▣ An office visit/encounter must be billed within the previous 365 days
  - ▣ Review CCDs on Medicaid visits/encounters
  - ▣ Submit data to the SLR Portal
  - ▣ Comply with all NCQA PCMH Elements

**Note:** Only bill PMPM for clients where you are their primary care physician. If the client is seen by more than one physician within the 365 days, it is the responsibility of the provider to determine who the PCMH is and to bill accordingly.

# How do I bill for PCMH & PMPM

*Upon quarterly approval, the provider will bill for each client for each month within the previous quarter.*

- *All billing will be completed on the CMS-1500 (After July 1, 2015 claims must be billed electronically) or 837P electronic transaction*
- *Procedure codes:*
  - *S0280 – 1<sup>st</sup> billing only – Medical home program, comprehensive care coordination and planning, initial plan. (This will establish that this is the first time that your office has billed for the client as a PCMH)*
  - *S0281 – Sequential billing – Medical home program, comprehensive care coordination and planning, maintenance of plan*

# How do I bill for PCMH & PMPM continued...

- S0281 is only allowed one time per client per month, therefore if two providers bill for the same client during the same time frame the first claim will pay and the second claim will deny. However, the paid claim will be adjusted and money taken back. It will be the provider's responsibility to know what clients are within their PCMH and to coordinate with other physician offices to determine PCMH.
- Note: Viewing of the CCD for your clients will provide diagnosis codes, procedures/services, medications, and name of practitioner/clinic that the client has utilized.

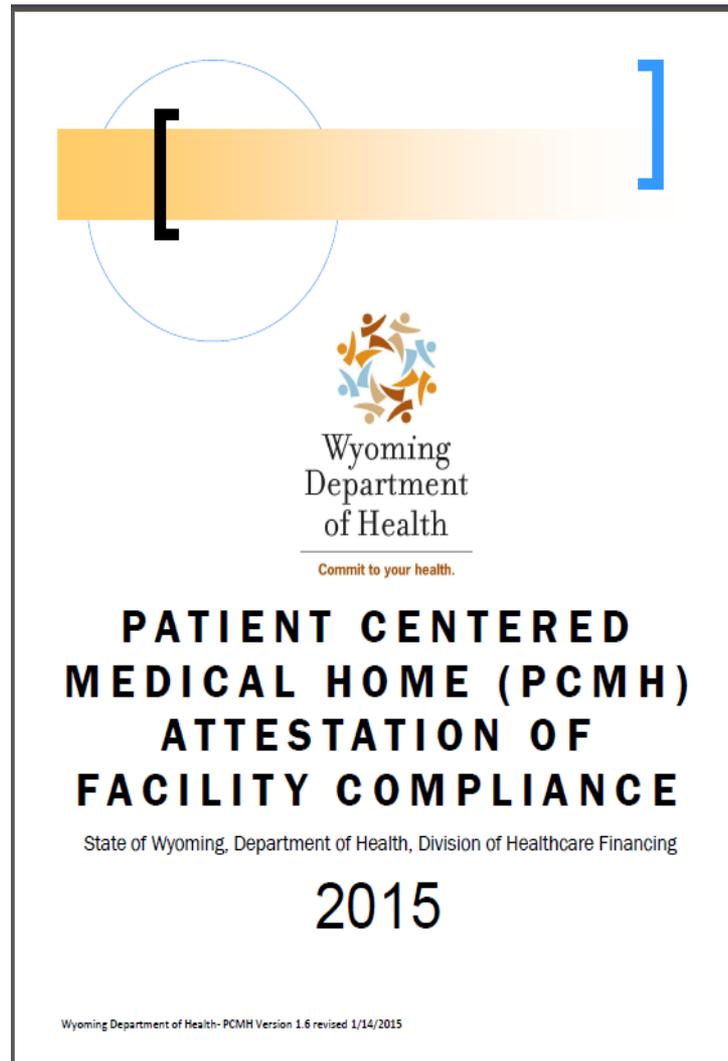
# How do I bill for PCMH & PMPM continued...

- Clients must be on a full Medicaid plan in order to qualify as a valid patient. Claims for clients that are not on a full Medicaid plan will be denied. An example of a non qualified client is a plan that covers only Medicare co-insurance and deductible or plans for emergency alien services.
- If your office is unsure of the type of coverage a client has, please contact Provider Relations at 1-800-251-1268 or the IVR at 1-800-251-1270 for verification.
- FQHC's/RHC's will need to bill using their physician provider/NPI number in order to receive payment for this program.

# Resources and Links

- NCQA self-assessment - <http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh.html>
- Wyoming Total Health Record - <http://wyomingthr.wyo.gov/home>
- SLR Portal - <https://wyqccp.htscqm.net/>
- Provider Relations – <http://wymedicaid.acs-inc.com/>

# Example of Completed Attestation Form



The image shows a completed attestation form for Patient Centered Medical Home (PCMH) Facility Compliance in 2015. The form is enclosed in a black border. At the top, there is a yellow horizontal bar with a black bracket on the left and a blue bracket on the right. Below this bar is a circular logo consisting of stylized human figures in orange and blue. Underneath the logo is the text "Wyoming Department of Health" and the slogan "Commit to your health." The main title of the form is "PATIENT CENTERED MEDICAL HOME (PCMH) ATTESTATION OF FACILITY COMPLIANCE" in bold, uppercase letters. Below the title is the text "State of Wyoming, Department of Health, Division of Healthcare Financing" and the year "2015". At the bottom left corner, there is a small footer: "Wyoming Department of Health- PCMH Version 1.6 revised 1/14/2015".

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**PATIENT CENTERED  
MEDICAL HOME (PCMH)  
ATTESTATION OF  
FACILITY COMPLIANCE**

State of Wyoming, Department of Health, Division of Healthcare Financing

**2015**

Wyoming Department of Health- PCMH Version 1.6 revised 1/14/2015



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## Practice Information

\* To be completed by facility Medical Director



1. PCMH Name (Practice):	John Smith M.D.
2. PCMH Address (Practice Physical Address):	1234 Main Street
3. City (Practice Physical Address):	Cheyenne
4. State (Practice Physical Address):	WY
5. Zip Code (Practice Physical Address):	82001
6. Primary Contact for PCMH Project: * Medical Director	Dr. John Smith
7. Telephone Number (Medical Director):	307-444-4444
8. Fax Number (Medical Director):	307-444-5555
9. Email (Medical Director):	medicaldirector@medicaldirector.com
10. Practice NPI Number (Current Wyoming Medicaid enrolled providers only):	1234567890
11. Medicaid Provider Number (Current Wyoming Medicaid enrolled providers only):	1111111 00
12. Number of Wyoming Medicaid patients receiving care in the PCMH at the present time:	245



## Mailing Address



13. PCMH Address (Mailing Address):	1234 Main Street
14. City (Mailing Address):	Cheyenne
15. State (Mailing Address):	WY
16. Zip (Mailing Address):	82001
17. Telephone Number (Practice Manager):	307-444-4444
18. Fax Number (Practice Manager):	307-444-5555
19. Email (Practice Manager):	practicemanager@practicemanager.com

For sections 20 through 29, your practice must attest to implementing core medical home functions as defined by NCQA's Patient-Centered Medical Home Standards. Practices must attest to achieving at least the identified scoring threshold for each corresponding PCMH element.

To verify compliance, please submit, along with this form, your 'Summary and Detailed Results' report from your practice's NCQA PCMH Interactive Survey System (ISS) tool. This summary report can be generated at any time – both prior to being NCQA-Recognized (self-assessment) or after receiving formal Recognition (final score). Formal Recognition is not required for this initiative.

The attached instructions (Appendix 1) identify how to: a) obtain access to the tool; b) locate the summary report within the tool; and c) print out or create a PDF of the summary report. The requirements around the CCD and reporting of CQM's will be verified at the State level.



**Medical Home Core Function A**

20. Do you certify that the PCMH provides enhanced access, electronic access, continuity of medical care, and works as a team to provide culturally and linguistically appropriate care?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**21. Scoring Threshold**

Practices must demonstrate at least a 25% score on all elements in their Summary and Detailed Results report. 2011 or 2014 may be used in 2015.

Does your practice currently meet the 25% score required on each of these elements?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**NCQA PCMH 2011 Elements**

PCMH Standard 1 Element A  
PCMH Standard 1 Element B  
PCMH Standard 1 Element C  
PCMH Standard 1 Element D  
PCMH Standard 1 Element E  
PCMH Standard 1 Element F  
PCMH Standard 1 Element G

**NCQA PCMH 2014 Elements**

PCMH Standard 1 Element A  
PCMH Standard 1 Element B  
PCMH Standard 1 Element C  
  
PCMH Standard 2 Element A  
PCMH Standard 2 Element B  
PCMH Standard 2 Element C  
PCMH Standard 2 Element D





**Medical Home Core Function B**

22. Do you certify that your PCMH practice will collect and use appropriate demographic and clinical data to support effective care management?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**23. Scoring Threshold**

Practices must demonstrate at least a 50% score on all elements in their Summary and Detailed Results report. 2011 or 2014 may be used in 2015.

Does your practice currently meet the 50% score required on each of these elements?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**NCQA PCMH 2011 Elements**

PCMH Standard 2 Element A  
PCMH Standard 2 Element B  
PCMH Standard 2 Element C  
PCMH Standard 2 Element D

**NCQA PCMH 2014 Elements**

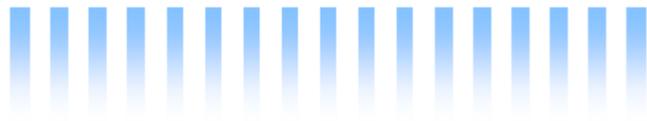
PCMH Standard 3 Element A  
PCMH Standard 3 Element B  
PCMH Standard 3 Element C  
PCMH Standard 3 Element D





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*Medical Home Core Function C*

24. Do you certify that your PCMH practice plans and manages care by using evidence-based guidelines, identifying high-risk patients, developing patient-centered care plans, managing medications and referring patients to effective community resources?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**25. Scoring Threshold**

Practices must demonstrate at least a 25% score on all elements in their Summary and Detailed Results report. 2011 or 2014 may be used in 2015.

Does your practice currently meet the 25% score required on each of these elements?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**NCQA PCMH 2011 Elements**

PCMH Standard 3 Element A  
PCMH Standard 3 Element B  
PCMH Standard 3 Element C  
PCMH Standard 3 Element D  
PCMH Standard 3 Element E

PCMH Standard 4 Element A  
PCMH Standard 4 Element B

**NCQA PCMH 2014 Elements**

PCMH Standard 3 Element E

PCMH Standard 4 Element A  
PCMH Standard 4 Element B  
PCMH Standard 4 Element C  
PCMH Standard 4 Element D  
PCMH Standard 4 Element E





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*Medical Home Core Function D*

26. Do you certify that your PCMH practice track and coordinate care for your patients, including tracking labs, tests, referrals and coordinating with health care facilities such as hospitals?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**27. Scoring Threshold**

Practices must demonstrate at least a 50% score on all elements in their Summary and Detailed Results report. 2011 or 2014 may be used in 2015.

Does your practice currently meet the 50% score required on each of these elements?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**NCQA PCMH 2011 Elements**

PCMH Standard 5 Element A  
PCMH Standard 5 Element B  
PCMH Standard 5 Element C

**NCQA PCMH 2014 Elements**

PCMH Standard 5 Element A  
PCMH Standard 5 Element B  
PCMH Standard 5 Element C





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*Medical Home Function E*

28. Do you certify that your PCMH practice measures, implements continuous quality improvement techniques and reports data externally?

YES  \_\_\_\_\_

NO \_\_\_\_\_

**29. Scoring Threshold**

Practices must demonstrate at least a 50% score on all elements in their Summary and Detailed Results report. 2011 or 2014 may be used in 2015.

Does your practice currently meet the 50% score required on each of these elements?

YES  \_\_\_\_\_

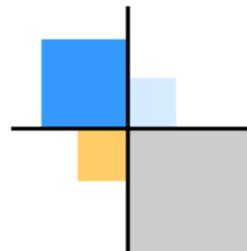
NO \_\_\_\_\_

**NCQA PCMH 2011 Elements**

- PCMH Standard 6 Element A
- PCMH Standard 6 Element B
- PCMH Standard 6 Element C
- PCMH Standard 6 Element D
- PCMH Standard 6 Element E
- PCMH Standard 6 Element F
- PCMH Standard 6 Element G

**NCQA PCMH 2014 Elements**

- PCMH Standard 6 Element A
- PCMH Standard 6 Element B
- PCMH Standard 6 Element C
- PCMH Standard 6 Element D
- PCMH Standard 6 Element E
- PCMH Standard 6 Element F
- PCMH Standard 6 Element G



For 2015, you must use the list of 9 measures below for reporting to meet the requirements in PCMH Standard 6 Element A.

1. Tobacco Use Assessment and Cessation Intervention
2. Breast Cancer Screening
3. Cervical Cancer Screening
4. Colorectal Cancer Screening
5. Childhood Immunization Status
6. Diabetes: Hemoglobin A1C Poor Control
7. Diabetes: Blood Pressure Management
8. Diabetes: LDL Management and Control
9. ADHD: Follow-Up Care for Children prescribed medication



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30. – Do you agree to report the 9 Clinical Quality Measures listed in section 29 into the State Level Registry (SLR) on a monthly basis ?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
31. Do you agree to pull CCD's for your Medicaid Patients from our Total Health Record on a quarterly basis for a minimum of 50% of your Medicaid encounters?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
32. This attestation is only valid for the current calendar year submitted. Do you understand that you will need to submit a new attestation of compliance annually by January each year, and also in the event that the facility director is no longer in this position?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
33. Do you understand that these requirements are expected to change in future years as Stages 2 and 3 of Meaningful Use are updated and NCQA PCMH requirements continue to be revised?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

*Form Certification. In signing this document you are attesting that you have read, understand and agree to all conditions for participation as a Patient Centered Medical Home and that all statements contained herein are true to the best of your knowledge. Also you are attesting that you understand that failure to abide by the certifications will result in the care management fees being recovered, denied, or withheld.*

34. Director's Name (Printed):	John Smith M.D.		
34. Director's Signature:	John Smith M.D.	Date Signed:	03.17.15

FOR STATE MEDICAID AGENCY USE

Date Attestation Received by DHCF:	
Action Taken:	

**Main Office**
**Detailed Summary Status Report - NCQA PCMH 2011**

Generated On 3/16/2015

Points: 94.75 % (Level 3)

Documents: 154%

Standard	Max Points	Points Earned	Must Pass	Docs Required	Docs Uploaded	Notes	Complete
<b>PCMH 1: ENHANCE ACCESS AND CONTINUITY</b>	<b>20.00</b>	<b>20.00</b>	<b>Yes</b>	<b>46</b>	<b>88</b>		<b>Yes</b>
Element A: Access During Office Hours	4.00	4.00	Yes	8	8	No	Yes
Element B: After-Hours Access	4.00	4.00	NA	9	14	No	Yes
Element C: Electronic Access	2.00	2.00	NA	3	15	No	Yes
Element D: Continuity	2.00	2.00	NA	2	6	No	Yes
Element E: Medical Home Responsibilities	2.00	2.00	NA	6	13	No	Yes
Element F: Culturally and Linguistically Appropriate Services	2.00	2.00	NA	3	7	No	Yes
Element G: The Practice Team	4.00	4.00	NA	13	25	No	Yes
<b>PCMH 2: IDENTIFY AND MANAGE PATIENT POPULATIONS</b>	<b>16.00</b>	<b>16.00</b>	<b>Yes</b>	<b>36</b>	<b>45</b>	<b>Yes</b>	<b>Yes</b>
Element A: Patient Information	3.00	3.00	NA	12	11	Yes	Yes
Element B: Clinical Data	4.00	4.00	NA	7	15	No	Yes
Element C: Comprehensive Health Assessment	4.00	4.00	NA	9	10	No	Yes
Element D: Use Data for Population Management	5.00	5.00	Yes	8	10	No	Yes
<b>PCMH 3: PLAN AND MANAGE CARE</b>	<b>17.00</b>	<b>17.00</b>	<b>Yes</b>	<b>24</b>	<b>35</b>	<b>Yes</b>	<b>Yes</b>
Element A: Implement Evidence-Based Guidelines	4.00	4.00	NA	3	3	Yes	Yes
Element B: Identify High-Risk Patients	3.00	3.00	NA	2	2	Yes	Yes
Element C: Care Management	4.00	4.00	Yes	7	7	Yes	Yes
Element D: Medication Management	3.00	3.00	NA	6	6	Yes	Yes
Element E: Use Electronic Prescribing	3.00	3.00	NA	6	18	No	Yes
<b>PCMH 4: PROVIDE SELF-CARE SUPPORT AND COMMUNITY RESOURCES</b>	<b>9.00</b>	<b>6.75</b>	<b>Yes</b>	<b>17</b>	<b>14</b>	<b>Yes</b>	<b>Yes</b>
Element A: Support Self-Care Process	6.00	4.50	Yes	6	7	Yes	Yes
Element B: Provide Referrals to Community Resources	3.00	2.25	NA	11	7	No	Yes
<b>PCMH 5: TRACK AND COORDINATE CARE</b>	<b>18.00</b>	<b>18.00</b>	<b>Yes</b>	<b>45</b>	<b>74</b>	<b>Yes</b>	<b>Yes</b>
Element A: Test Tracking and Follow-Up	6.00	6.00	NA	12	36	Yes	Yes
Element B: Referral Tracking and Follow-Up	6.00	6.00	Yes	13	24	No	Yes
Element C: Coordinates With Facilities and Care Transitions	6.00	6.00	NA	20	14	No	Yes
<b>PCMH 6: MEASURE AND IMPROVE PERFORMANCE</b>	<b>20.00</b>	<b>17.00</b>	<b>Yes</b>	<b>28</b>	<b>44</b>		<b>Yes</b>
Element A: Measure Performance	4.00	3.00	NA	4	10	No	Yes
Element B: Measure Patient/Family Experience	4.00	2.00	NA	5	4	No	Yes
Element C: Implement Continuous Quality Improvement	4.00	4.00	Yes	5	3	No	Yes
Element D: Demonstrates Continuous Quality Improvement	3.00	3.00	NA	4	4	No	Yes
Element E: Report Performance	3.00	3.00	NA	6	12	No	Yes
Element F: Report Data Externally	2.00	2.00	NA	4	10	No	Yes
Element G: Use Certified EHR Technology	0.00	0.00	NA	0	1	No	Yes
<b>Total:</b>	<b>100</b>	<b>94.75</b>	<b>Yes</b>	<b>196</b>	<b>302</b>		

# Contact information

- For questions or concerns regarding billing or attestation:
  - ▣ Sheree L Nall - [Sheree.Nall@wyo.gov](mailto:Sheree.Nall@wyo.gov)
- For questions or concerns regarding the CCD viewer or SLR Portal:
  - ▣ Linda Cramer – [Linda.Cramer@wyo.gov](mailto:Linda.Cramer@wyo.gov)
- For questions or concerns in general:
  - ▣ Dr. James Bush M.D. – [James.Bush@wyo.gov](mailto:James.Bush@wyo.gov)
- For questions regarding NCQA:
  - ▣ Mina Harkins – [Harkins@ncqa.org](mailto:Harkins@ncqa.org)



# Questions??

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