GCACH Practice Transformation Workgroup
Meeting Minutes

August 23, 2018 | 10:00 AM – 11:00 AM | Teleconference

Participants (* denotes they called in)	Mark Wakai*, Rhonda Hauff*, Barbara Mead*, Jorge Arturo Rivera*, Brian Gibbons*, Kevin Martin*, Brian Sandoval*, Kristy Needham*, Bill Dunwoody*, Wilson-Kadlec*, Mike Maples*, Stacy George*, Kathy McDaniel*, Dan Ferguson*, Lily Gonzalez*, Ryan Lantz*, Ed Thornbrugh*, Becky Grohs*, Carol Moser, Wes Luckey, Becky Kolln, Sam Werdel, Dian Halo, Ruben Peralta, Jenna Shelton, Martin Sanchez, Lauren Johnson
Welcome & Introductions	Carol thanked everyone for attending the Practice Transformation Workgroup teleconference. The focus of the 8/23 PTW teleconference is for attendees to listen to a presentation from Sam focused on Transitional Care Reimbursement and to be informed on the way our Practice Transformation team is providing technical assistance to organizations. Mark thanked Carol and the GCACH team for our organization in the process and thanked the Practice Transformation team for their expertise in Practice Transformation. Brian mentioned that he is encouraged in the way our work is progressing. Carol briefly reviewed the agenda and the 8-9 PTW Meeting Minutes. Bill Dunwoody moved to approve the 8-9 minutes, seconded by Lily Gonzalez. Motion passed. Rhonda Hauff abstained.
Transitional Care Reimbursement Training	During Sam's presentation, she explained the Transitional Care Management (TCM) Codes. The TCM codes are used for patients discharged from an inpatient setting to the patient's community setting (e.g., home, assisted living). TCM codes are 99495 (for moderately complex cases) and 99496 (for highly complex cases). Providers can bill Medicare or Commercial insurance for these services, but Washington State has not included them as reimbursable services for the Medicaid population. The TCM period begins on the date of discharge and continues for 29 days. Required action must be met within the 29-day period (or on the day of discharge): an interactive contact with patient and/or caregiver, medication reconciliation, and 7 or 14 day follow up office visit must be scheduled.

Elements for Each Level of Medical Decision Making

Type of Decision Making	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

The table below explains each level of medical decision making.

Those that can provide TCM services include primary care practices, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), Advanced Practice Providers (APP), and Licensed Clinical Staff under the direction of the Physician or APP.

When and Who Can Bill	Organizations can bill 30 days following discharge. Only one provider can report TCM services and only once in the 30-day period. The first to bill will be paid.

Documented in Medical Record	The following must be documented: discharge date, date of communication, date of face-to-face visit, documentation to support complexity of decision making.
When Billing TCM Cannot Bill	When billing TCM, organizations cannot bill Medicaid for the following services: Chronic Care Coordination Services (99487 – 99489) which is the same as Chronic Care Management Services, Home Health and Hospice Supervision (G0181, G0182), End Stage Renal Disease Services (90951-90970) and Coumadin patients may not bill E&M code (99211).
Panel Discussion	During the panel discussion, several attendees notes that they have started using PreManage/EDIE in their organizations and it has helped with follow-up procedures and prioritizing patients. It was also noted that these systems are mostly used for health home patients—although it is important for GCACH to identify when these programs are used for all Medicaid patients. Several attendees had questions on the broader population, Sam mentioned that more information will be sent out to after the conclusion of the meeting. Rhonda mentioned there are still problems identifying patient attribution and where the patient should go back to.
2018 Current State Assessment Summary Highlights and PCMH Overview	Wes briefly reviewed his slide deck titled, "2018 Current State Assessment Summary and Highlights and PCMH Overview." This presentation was given by Wes and Rubén at multiple Local Health Improvement Network (LHIN) meetings. Wes highlighted the Chronic Care Model which has now transitioned into Patient-Centered Medical Home (PCMH) model. The main difference between the two is PCMH adds enhanced access, patient safety and payment reform. Wes then briefly described the GCACH Timeline Toward PCMH.
PCMH as a Foundation for Transformation	Rhonda Hauff sent the GCACH staff three presentations titled, "Patient-Centered Medical Home Recognition (PCMH) as a Foundation for Transformation." This slide deck will be presented at the NACHC Community Health Conference.
Adjournment	Carol ended the meeting by thanking all for attending. Carol noted that the next Practice Transformation Workgroup Meeting is set for September 6th. The PTW will now be meeting once a month as opposed to bi-monthly.