Michigan Data Collaborative

PCMH Care Coordination Reports

►REFERENCE DOCUMENT

Revision History			
Version	**Date of Release**	**Summary of Changes**	**Owner**
3.1	11/25/2019	Updates to reflect current file naming convention	Brittany Bragg
3.1	3/22/2019	Updates to reflect current report columns	Gillian Mayman
3.1	2/5/2019	Updates to reflect new file naming convention and column names (due to rolling quarters)	Kendra Mallon
3.0	1/10/2019	Updates to reflect new rolling quarter releases	Kendra Mallon
2.0	12/18/2018	Updates to the PCP Follow-Up after Inpatient Charges section Added the Claims Detail Report information	Kendra Mallon
1.7	7/12/2018	Updated file name convention and made other minor edits	Kendra Mallon
1.6	4/30/2018	Updated title of Percentage Report (to match title in the reports	Kendra Mallon
1.5	4/18/2018	Added text explaining claims runout	Kendra Mallon
1.4	3/5/2018	Updated file name format	Kendra Mallon
1.3	1/25/2018	Added procedure codes	Kendra Mallon
1.2	10/19/2017	Updates to reflect addition of quarterly reports	Kendra Mallon
1.1	9/21/2017	Minor updates, clarify that there are two reports	Kendra Mallon
1.0	8/23/2017	New document	Gillian Mayman

About the PCMH Care Coordination Reports

The Care Coordination Reports provide a view of both the frequency of care management services and appropriate follow-up care for members with inpatient encounters.

Starting in January 2019, the Care Coordination and Detail Reports will be posted each month with a rolling quarter timeframe (replacing the previous single month and quarter reports). Each month's report will include the most recent three months of available data.

Included Reports

The following reports are included with each monthly release:

- Percentage of Patients with a Care Management Claim
- PCP Follow-Up after Inpatient Discharge
- Care Coordination Claims Detail

Accessing the Reports

The reports are provided in .xls format and can be accessed on the SIM PCMH Dashboard. Depending on your access level, you can download the files for your practice or managing organization (MO). MO-level files include all applicable practices in the same spreadsheet.

Claims Runout Explanation

Each month, MDC creates the Care Coordination reports using data for patients who received services during a three-month time period. This data comes from the monthly claims files that we receive from Medicaid. Each Medicaid claims file contains claims that were processed that month. However, the service dates for those claims span several previous months because the adjudication process occurs over time.

To ensure we are including complete data, we also include data from the two monthly claims files that follow the last month of the report timeframe. (There is a two month "runout" for these reports.)

For example, if MDC is reporting on patient services for January through March 2018, we will use the January, February, and March claims files, and also include claims processed in the April and May 2018 claims files.

The sample claims lag triangle report below shows this concept. (Note that while claims analysis follows the pattern displayed below, this is an example only and does not represent actual claims counts.)

Paid Month	Incurred Month									
	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Jan-17	125,000									
Feb-17	200,000	125,000								
Mar-17	135,000	200,000	125,000							
Apr-17	3,000	135,000	200,000	125,000						
May-17	3,000	3,000	135,000	200,000	125,000					
Jun-17	2,000	3,000	3,000	135,000	200,000	125,000				
Jul-17	1,000	2,000	3,000	3,000	135,000	200,000	125,000			
Aug-17	500	1,000	2,000	3,000	3,000	135,000	200,000	125,000		
Sep-17	500	500	1,000	2,000	3,000	3,000	135,000	200,000	125,000	
Oct-17	500	500	500	1,000	2,000	3,000	3,000	135,000	200,000	125,000
Nov-17	100	500	500	500	1,000	2,000	3,000	3,000	135,000	200,000
Dec-17	50	100	500	500	500	1,000	2,000	3,000	3,000	135,000

Paid Month = The month when the claims adjudication process is complete and represents the files MDC receives.

Incurred Month = The service dates associated with the claims included in the processed month file.

In the table below:

yellow highlighted fields = the number of claims both incurred and processed in that month

blue highlighted fields = the additional claims that are processed in subsequent months

Attribution

Members who are attributed to multiple practices in the rolling quarter will be included in statistics for each practice.

Example

A patient is attributed to Dr. A and Practice AAA in January and February, and with Dr. B and Practice BBB in March. Both practices are in the same PO (PO 123). This patient has a CM claim with Dr. A in February and another one with Dr. B in March.

In this example, the following attribution occurs:

- The patient is counted in the denominator for Practice A once and Practice B once.
- The CM claim in February is included in the numerator for Practice A.
- The CM claim in March is included in the numerator for Practice B.
- Members are deduped in the denominator. Reporting and attribution are based on the unique combination of patient and attributed PCP. If a patient was with the same PCP for the quarter, they are counted in the denominator once.

Additional Information

For technical definitions of the measures included in the Care Coordination reports, including service and revenue code details, see the SIM PCHM Dashboard Technical Guide.

Percentage of Patients with a Care Management Claim Report

This report shows the unique number of patients who received a care management service in the rolling quarter based on medical claims data.

Care management claims are defined as any service with the following set of procedure codes:

Procedure Code	Short Description	Notes
G9001	Comprehensive Assessment	
G9002	In-Person Encounter	
98966	Telephone Services	
98967	Telephone Services	
98968	Telephone Services	
99495	Care Transition	
99496	Care Transition	
G9008	Physician Coordinated Care Oversight Services	These code are effective January 1, 2018 and will be available in reporting in April 2018
98961 and 98962	Group Education and Training	
S0257	End of Life Counseling	

Naming Format

The reports are listed in chronological order with the most recent report at the top. They have the following naming format:

MO Reports: < MO Name>_CC_PercentYYYY_MM_to_YYYY_MM.xls

Practice Reports: <MO Name>_<Practice Name>_CC_PercentYYYY_MM_to_YYYY_MM.xls

Additional Information

- All claims are included, regardless of paid status.
- Two months of paid claims runout is used for each report.
- Percentages are calculated based on the membership and provider attribution information for the reporting timeframe.
- For purposes of counting a care management claim, Procedure Code G9007/Team Conference is not counted if it is the patient's only claim within the measurement period.

- The numerator counts unique patients and not claims. Therefore, you may have patients with multiple care management claims within the time period of the report; however, they represent a single unique patient. The table below provides an example:

Patient	Service Date	Procedure Code
A	1/04/18	G9002
A	1/10/18	98966
B	1/15/18	G9002
B	1/23/18	98966

In this example, the Percentage of Patients with a Care Management Claim Report shows two unique patients with a Care Management claim during January 2018.

Report Columns

The following fields are included in each report:

- Managing Organization and Practice Name
- MO/PU ID
- Number of Members with a Care Management Claim
- SIM Membership
- Percentage of Patients with a Care Management Claim

Sort Order

Managing organization reports contain information for each practice in alphabetical order by practice name. This is based on the provider hierarchy file for the rolling quarter.

PCP Follow-Up after Inpatient Discharge Report

This report includes the percentage of discharges with an acute inpatient stay in the measurement period that include a follow-up visit with a SIM primary care physician within 14 days of the discharge date.

- For purposes of this report, discharges are counted as an acute inpatient stay if they have any claim with a room and board revenue code with a discharge date in the measurement rolling quarter.
- The patient's attribution is determined by their attribution at the time of the room and board claim, not the PCP visit.
- PCP follow-up is calculated from the discharge date associated with the acute inpatient stay.
- A PCP visit is defined as any professional claim where either the servicing or billing provider's NPI is on the measurement quarter's provider hierarchy file.
- The billing or servicing provider does not have to be the patient's attributed PCP to count as a follow-up visit.
- All claims are counted regardless of paid status.
- Two months of paid claims runout is used for each report.
- Exclude discharges with status death or transfer to a Skilled Nursing Facility (SNF).
- Exclude inpatient stays with value sets related to: Nonacute Inpatient Stay, Mental and Behavioral Health, Chemical Dependency and Rehabilitation, IPU Exclusions, Maternity and Delivery, Newborn/Neonates, or Surgery

Naming Format

The reports are listed in chronological order with the most recent report at the top. They have the following naming format:

MO Reports: <MO Name>_CC_IPYYYY_MM_to_YYYY_MM.xls

Practice Reports: <MO Name>_<Practice Name>_CC_IPYYYY_MM_to_YYYY_MM.xls

Report Columns

The following fields are included in each report:

- Managing Organization and Practice Name
- MO/PU ID
- Number of Acute Inpatient Discharges with a PCP visit within 14 days of the discharge date
- Number of Acute Inpatient Discharges
- Percentage of Acute Inpatient Discharges with a PCP visit within 14 days of the discharge date

Sort Order

Managing organization reports contain information for each practice in alphabetical order by practice name. This is based on the provider hierarchy file for the rolling quarter.

PCMH Care Coordination Claims Detail Report

This report provides member-level demographic and claims detail information for patients who are included in the numerator of the *Percentage of Patients with a Care Management Claim* reports. It provides managing organizations and practices the ability to see which care management claims and patients are being counted towards their metrics.

Unlike the population included in the aggregated Care Coordination reports, patients are not deduplicated, so all claims for a patient in the reporting period are included. However, as with the aggregated Care Coordination reports, patients whose only claim is for the G9007/Coordinated care fee, scheduled team conference procedure code are not displayed in the Detail reports.

Naming Format

The reports are listed in chronological order with the most recent report at the top. They have the following naming format:

MO Reports: <MO Name>_CC_Detail_YYYY_MM_to_YYYY_MM.xls

Practice Reports: <MO Name>_<Practice Name>_CC_Detail_YYYY_MM_to_YYYY_MM.xls

Report Columns

The following fields are included in each report:

- Managing Organization Name
- Managing Organization ID
- Practice Name
- Practice ID
- Attributed PCP Name
- Attributed PCP NPI
- Patient Fist Name
- Patient Last Name
- Patient Date of Birth
- Patient Gender
- Service Date
- Procedure Code
- Servicing Provider NPI
- Servicing Provider First Name
- Servicing Provider Last Name
- Billing Provider NPI
- Billing Provider Name
- Claim Status Code
- Provider Practice Flag (Indicates if the Servicing Provider is attributed to the same practice as the member's attributed PCP for the month of service. Y = Yes, N = No)

Sort Order

The reports are sorted in the following order:

1. Managing Organization name
2. Practice Name
3. Patient Last Name