Patient-Centered Medical Home (PCMH)

Meridian recognizes that health care goes beyond screenings and treatments and includes continuous and coordinated patient-first health care to empower patients to become active in their health care management. To reward forward-thinking clinicians like you, Meridian is pleased to share our revamped Patient-Centered Medical Home (PCMH) Incentive Program.

Effective January 1, 2023, all providers are eligible for incentives for managing and coordinating care for their patients. Higher incentive amounts will be available to PCMH designated offices to further reward groups for achieving this recognition. Care Management and Care Coordination has been found to reduce health risks and decrease the cost of care leading to healthier patients. Meridian would like to reward our providers who are going above and beyond to manage and coordinate the care of their patients. We look forward to partnering with you to provide the best care for our members!

Incentive Program for PCMH designated offices:

Qualifications for program:

- Contracted
- NCQA, PGIP, URAC, AAAHC, TJC, or CARF recognition

Incentive Program Payment Structure	
Care Coordination/Case Management	
PCMH Certified Provider Groups (NCQA, PGIP, AAAHC, TJC, CARF, URAC)	$150 per code paid to the servicing provider

Incentive Program for non-PCMH designated offices:

Qualifications for program:

- Contracted

Incentive Program Payment Structure	
	Care Coordination/Case Management
Non-PCMH Certified Provider Groups	$50 per code paid to the servicing provider

Care Coordination/Case Management Codes

Primary Care Providers (PCP) are encouraged to continue to utilize the CC/CM code sets when seeing patients to demonstrate and promote coordinated care. Meridian recommends alignment of the extra incentive dollars with embedded case managers in an effort to reduce barriers to quality health care. The eligible codes and descriptions are displayed in the table below.

Code Description	Code
Comprehensive Assessment	G9001
In-Person Encounter	G9002
Care Team Conference	G9007
Physician Coordinated Care Oversight Services	G9008
Telephone CC/CM Services	98966, 98967, 98968
Education/Training for Patient Self-Management	98961, 98962
Care Transition	99495, 99496
End of Life Counseling	S0257
Chronic Care Management for FQHCs	G0511
Psychiatric Collaborative Care Model for FQHCs	G0512
Advanced Care Planning	99497, 99498
***Complex Chronic Care Management**	*99487
***Chronic Care Management Services**	*99490

*New for 2023

Additional Notes:

- PCMH designation status is identified at the office level in 2023.
- *Payments will be made to the PCP's primary tax ID number or affiliated PHO group based on contract specifications.
- Providers can be incentivized for up to 100 CC/CM codes per NPI per year.
- Incentives for this program include Meridian and Healthy Michigan Plan members only. This program excludes MeridianComplete (Medicare-Medicaid Plan), Ambetter from Meridian, and WellCare members.
- Any member who is enrolled in the Michigan Care Team Program will be excluded from the CC/CM incentive portion of the 2023 program.

Seeking PCMH Designation? We can help!

Care Management and Care Coordination are key components of PCMH designation. Meridian encourages non-PCMH providers to take the next step toward becoming PCMH-designated. If you are interested in becoming a PCMH through the National Committee for Quality Assurance (NCQA), Meridian has developed a partnership with NCQA that provides a 20 percent discount on initial recognition application fees to all our PCPs. Please contact your local Network Management Representative for more information.