Transforming Clinical Practices Initiative

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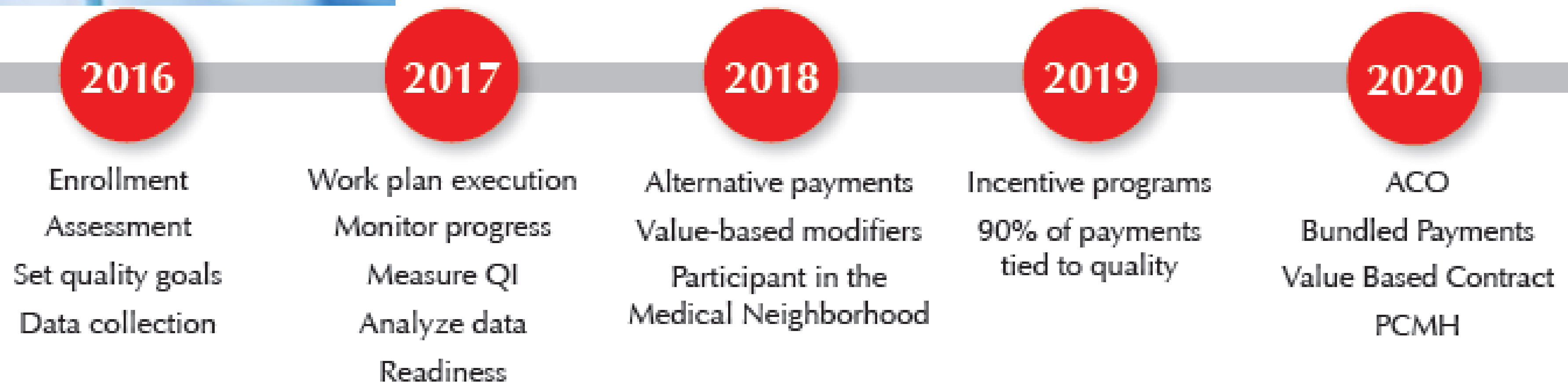
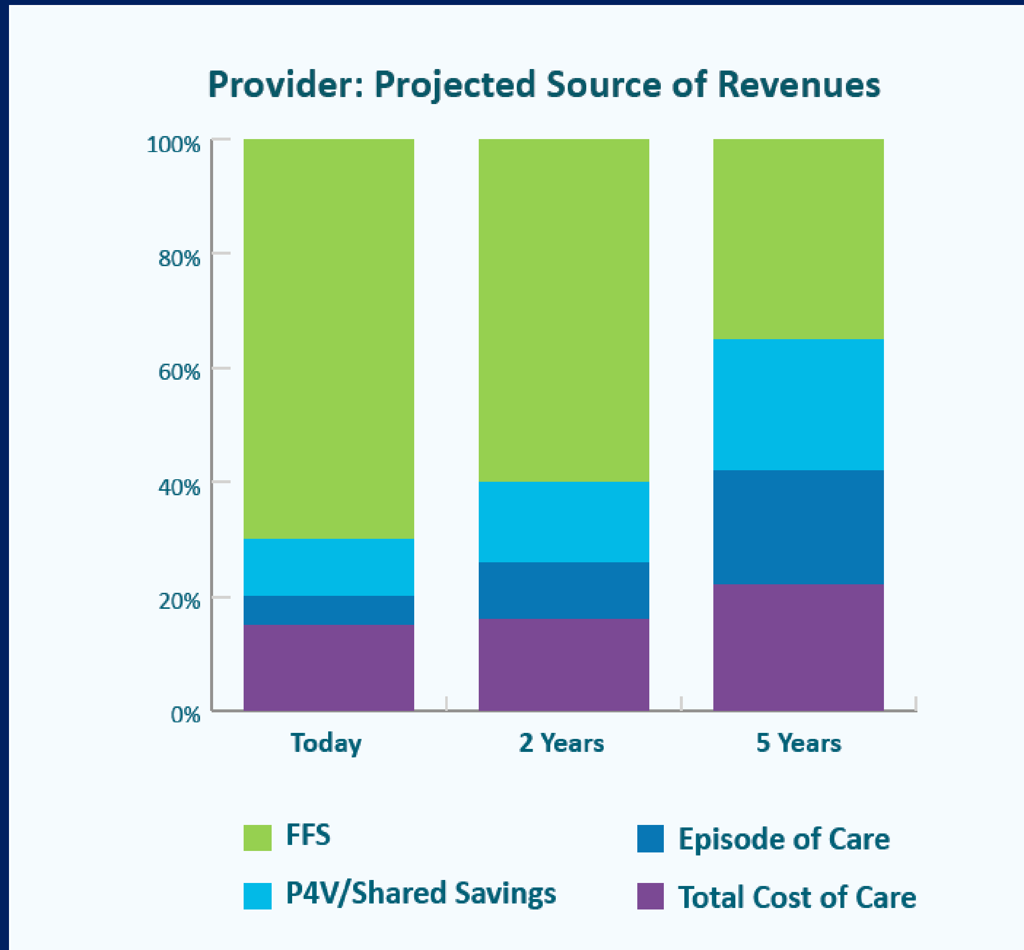
Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

The **Quality Payment Program** replaces current Medicare programs and requires providers to choose one of two paths that link quality to payments:

- **Advanced Alternative Payment Models (AAPM)**
- **Merit-Based Incentive Payment System (MIPS)**



The Future of Provider Revenue



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Merit-Based Incentive Payment System (MIPS)

Clinicians Eligible for MIPS are providers who bill for Medicare Part B services

Years 1 and 2

-Physicians (MD/DO, DMD/DDS)

-Physician Assistants

-Nurse Practitioners

-Clinical Nurse Specialists

-Certified Registered Nurse Anesthetists

Years 3+ (subject to change)

-Physical/Occupational Therapists

-Nurse Midwives

-Audiologists

-Clinical Social Workers

-Clinical psychologists

-Dieticians/Nutritional Professionals

*Low-volume Threshold Exemption – Practices with less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients will be exempted from MIPS

MIPS Scoring for Year 1 (CY 2017)

MIPS Composite Performance Score (CPS)
0-100 point scale

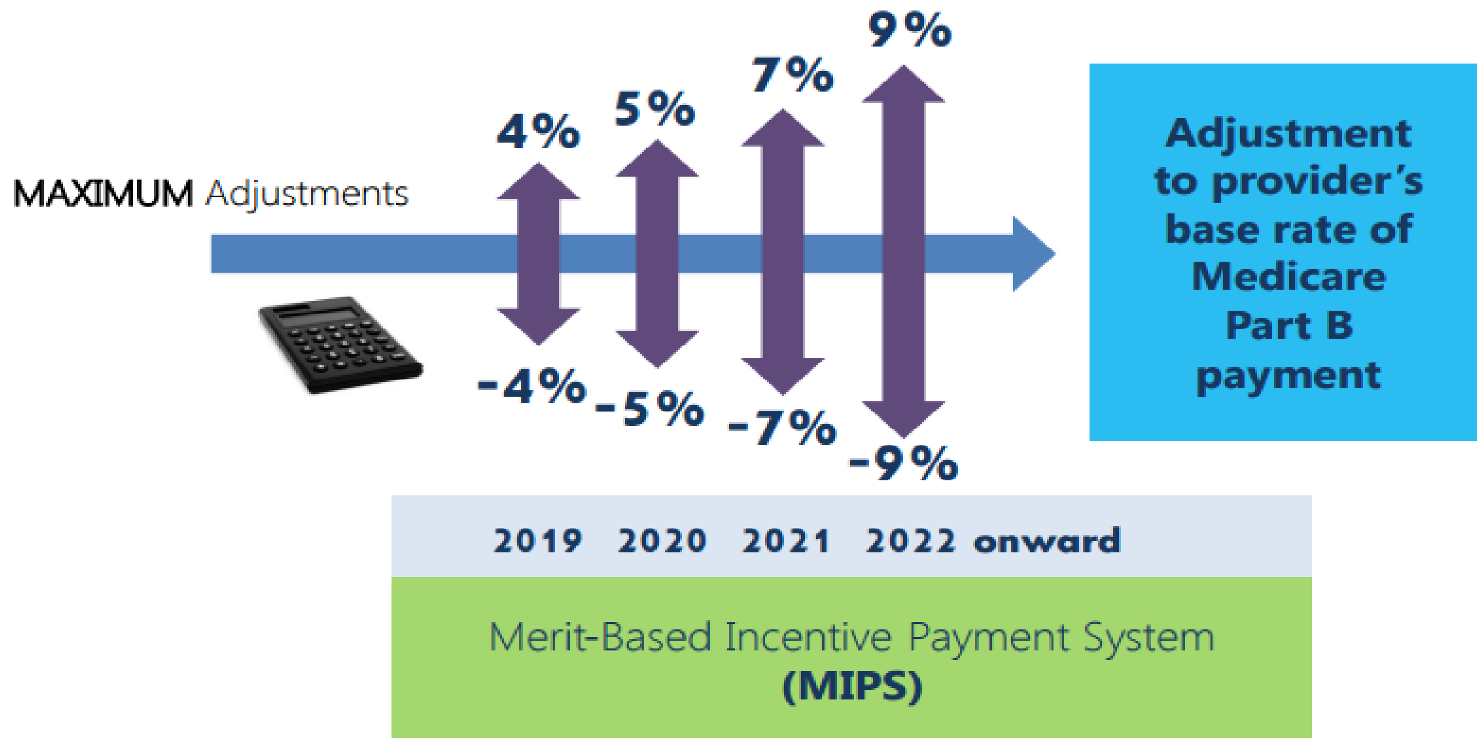
Quality – 60% (PQRS)

Resource Use – 0% (Value-Based Modifier)

Clinical Practice Improvement Activities – 15%

Advancing Care Information – 25% (EHR or MU)

How Will MIPS Affect Your Reimbursement Rates?



"Transition Year" Options – Pick Your Pace - https://qpp.cms.gov/

The MACRA rule was finalized and made public on October 14, 2016. The rule provides for flexibility in the first year of the program (CY2017) by offering 4 tracks of participation:

Track 1: Participate in an Advanced Alternative Payment Model

Pros:

- Five percent bonus payment based on Medicare payments
- Medicare will not calculate a Composite Performance Score for providers for QPs, so there will not be public reporting of a MIPS score on the Performance Score on the CMS Physician Compare website
- Potential increased earnings associated with high-performance in a shared-risk advanced APM

Cons:

- Limited availability of Advanced APMs in 2017.
- Minimum payment and volume thresholds are (a) 25 percent of Medicare Part B payments, or (b) 20 percent patient volume associated with an Advanced APM
- The potential for revenue lost through the shared-risk programs

Eligible Alternative Payment Models

- Next Generation Accountable Care Organization Model
- Medicare Shared Savings Program (MSSP) - Tracks 2 & 3
- Comprehensive End-Stage Renal Disease (ESRD) Care (CEC)
- Comprehensive Primary Care Plus (CPC+) – 2017
- Oncology Care Model (OCM) Two-sided risk model – 2018
- *Medicare ACO Track 1 Plus (1+) – to be developed in 2018

"Transition Year" Options – Pick Your Pace - https://qpp.cms.gov/

If you do not participate in Track 1 (APMs) you must participate in MIPS track 2,3 or 4.

Track 2 – Full Participation in MIPS in 2017

Pros:

• The potential to receive up to a four percent positive payment adjustment and in some cases a much larger exceptional performance payment adjustment.
• Even minimal participation in MIPS in 2017 will result in avoidance of any negative payment adjustments.

Cons:

• The potential to have a less than optimal MIPs final score published on the CMS Physician Compare website.
• The additional resources needed to capture and analyze the necessary data, establish workflows, and educate staff about the need to attain very high measure reporting levels.
• By choosing to enroll in MIPS the eligible clinician or group loses the potential five percent bonus associated with being a qualified participant in an Advanced APM.

“Transition Year” Options – Pick Your Pace - https://qpp.cms.gov/

Track 3 – Partial MIPS Participation

Pros:

- Practices will have more time to prepare for MIPS
- There is the potential to achieve a small positive payment adjustment
- The clinician avoids potential negative payment adjustments under MIPS
- This level of participation will help practices prepare for 2018, when reporting under MIPS may require a full year of data

Cons:

- Practices will not be able to achieve the higher payment adjustment levels or the exceptional payment adjustment
- By choosing to enroll in MIPS, an eligible clinician or group loses the potential five percent bonus associated with being a qualified participant in an Advanced APM

"Transition Year" Options – Pick Your Pace - https://qpp.cms.gov/

Track 4 – Minimal MIPS Participation

Pros:

- Avoid negative payment adjustments associated with non-participation or poor performance in 2017
- Relatively little effort needs to be expended in order to meet this minimum requirement
- CMS will not have a complete data set, therefore the Composite Performance Score will not be published

Cons:

- Choosing this option will most likely eliminate any potential positive payment adjustment associated with the 2017 performance year.
- By choosing to enroll in MIPS, the eligible clinician or group loses the potential five percent bonus associated with being a qualified participant in an Advanced APM
- The minimum level of effort required may not position the practice well for required reporting under MIPS in 2018

If you do not participate in any of the four tracks, you will willingly accept a 4% reduction automatically

MIPS Categories

Category	What do you need to do?	2017 weight
Quality Replaces the Physician Quality Reporting System (PQRS).	**Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. **Groups using the web interface:** Report 15 quality measures for a full year. **Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for MIPS quality.	60%
Improvement Activities New category.	**Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days. **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days. **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit. **Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model:** You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.	15%
Advancing Care Information Replaces the Medicare EHR Incentive Program, also known as Meaningful Use.	**Fulfill the required measures for a minimum of 90 days:** Security Risk Analysis e-Prescribing Provide Patient Access Send Summary of Care Request/Accept Summary of Care Choose to submit up to 9 measures for a minimum of 90 days for additional credit. **For bonus credit, you can:** Report Public Health and Clinical Data Registry Reporting measures Use certified EHR technology to complete certain improvement activities in the improvement activities performance category **OR** You may not need to submit advancing care information if these measures do not apply to you.	25%
Cost Replaces Value-Based Modifier.	No data submission required. Calculated from adjudicated claims.	Counted starting in 2018

CMS Transforming Clinical Practices Initiative

TCPi Transforming Clinical Practices Initiative

Practice Transformation Networks
National Infrastructure
Support and Alignment Networks
Public and Private Partners

- NJII awarded $49.6 million by CMS for the "Garden Practice Transformation Network" to prepare physicians and other providers for the shift from FFS to more Value-Based Care

- One of 29 Practice Transformation Networks around the country responsible for:

  - **Recruitment –** Primary and Specialty care providers
  - **Transformation –** Tech Support, Goal Setting, Enhanced Workflows
  - **Quality Improvement –** 10+ Quality Measures to Target Improvement
  - **Cost Savings –** Improve Quality and Efficiency to Reduce Costs

Who Is Eligible?

Eligible Providers Include:

✓ Primary Care:
Internal Medicine, Family Medicine, Gerontology

✓ Internal Medicine Sub Specialties:
Cardiology, Pulmonology, Endocrinology, Nephrology

✓ Nurse Practitioners and Physician Assistants who bill Medicare

How Will We Transform Practices?

Practice Transformation Coaches will be assigned to each individual practice to work with staff to achieve transformation. Coaches will:

- Perform a baseline assessment and work with the practice to develop work plans
- Assess practices every 6 months to monitor and manage progress
- Use performance data dashboards to identify where to implement improvement actions including evidence based interventions
- Assist practices in achieving improved health outcomes for their patients, including:
  - Reduce potentially preventable ER visits
  - Reduce potentially preventable hospital readmissions
  - Reduce potentially preventable and unnecessary testing

Key Performance Indicators

Metric
Adult Smoking Rate Reduction
HbA1c Poor Control
Controlling high BP for patients with hypertension aged 18-85
Potentially Preventable ER Visits (PPV) – Primary Care Related and Non-Emergent
Advance Care Plan
Third next available appointment (TNAA) - Total # practices with measure fully implemented
Increase Transitional care Management (TCM)
Reduction in unplanned 30 day readmissions per 1,000
Colorectal Cancer Screening
Medical Attention for Nephropathy

Advantages of Joining the GPTN

The GPTN will help practices:

- Report to the Physician Quality Reporting System (PQRS) for FREE
- Obtain Quality and Resource Use Reports (QRUR)
- Improve financial performance, quality and clinical outcomes
- Avoid up to 9% potential MIPS penalties; and maximize potential to receive a 9%+ increase in Medicare reimbursements
- Obtain resources and earn continuing education credits through its learning network, run by the Health Care Quality Institute
- Choose the right Alternative Payment Model and reporting options

Additional Opportunities to Generate Revenue

Medicare Transitional Care Management (TCM)

Additional codes for taking ownership of discharged patients

$150 to $250 per beneficiary

TCM Clearinghouse and best practices

Medicare Chronic Care Management (CCM)

20 minutes per beneficiary per month

Coordinate care and engage with patients

$43 per beneficiary per month

Payment Programs with Commercial Payers

Plan Workgroup to explore incentive payment opportunities

Join the Garden Practice Transformation Network – Questions and Next Steps

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