Establish Your Value-Based Infrastructure at No Cost.
What is a Practice Transformation Network (PTN)?

• The Practice Transformation Network (PTN) program is designed to help small and safety net providers transition from fee-for-service (volume) payment models to advanced payment models (value), and to be able to succeed under the new value-based payment guidelines. This program is funded by the Transforming Clinical Practices Initiative (TCPI).
HOW DO WE TRANSITION FROM 

VOLUME
E & M
Procedures

TO

VALUE?

AWV
TCM - CCM

2015

2016

2017

2018

2019

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(MIPS) Performance Categories:

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>60%</td>
<td>15%</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>15%</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>2019+</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
<td>30%</td>
</tr>
</tbody>
</table>
MIPS: Quality

- Category Requirements
  - Replaces PQRS and Quality Portion of the Value Modifier
  - "So what?"—Provides for an easier transition due to familiarity

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:
  - Outcome measure OR
  - High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

60% of final score

Different requirements for groups reporting CMS Web Interface or those in MIPS APMs

May also select specialty-specific set of measures

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MIPS: Clinical Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access

Clinicians choose from 90+ activities under 9 subcategories:

1. Expanded Practice Access
2. Population Management
3. Care Coordination
4. Beneficiary Engagement
5. Patient Safety and Practice Assessment
6. Participation in an APM
7. Achieving Health Equity
8. Integrating Behavioral and Mental Health
9. Emergency Preparedness and Response
MIPS: Resource Use/Cost

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.
- *Keep in mind:*

  Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)

  Only the scoring is different
MIPS: Advancing Care Information

• Promotes patient engagement and the electronic exchange of information using certified EHR technology
• Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
• Greater flexibility in choosing measures
• In 2017, there are 2 measure sets for reporting based on EHR edition:
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures
Quality Payment Program Implementation

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.PDF

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QPP TIMELINE

• CMS finalized the initial policies for MIPS in October 2016

• Performance period begins Jan 1, 2017 for payments to be applied in CY2019

• Information about the performance of MIPS EPs must be made available on Physician Compare

• Future rulemaking is expected to follow a schedule similar to the Physician Fee schedule; proposal in August and final by November for changes effective in the following year
TCPI Program Elements that Drive Success in Quality Payment Program (QPP) and Population Health

**Billable Prevention Services:**
- Annual Wellness Visits
- Chronic Care Management – Transitional care Management
- Advanced Care Planning
- Behavioral Counseling
- Depression Screening
- Mental Health Support

**Coding:**
- HCC 101

**Quality:**
- Process
- Pre-visit Planning
- Patient Satisfaction
Step One: Set up your Care Coordination Program

EDUCATION: Attend Care Coordination Webinar
ACTION: Designate a Care Coordinator

- Certify your coordinators with the Clinical Health Coach (CHC) Training program offered by the Iowa Chronic Care Consortium.
  - A 26 hours on-line and self-paced program.
- Participate in hands-on Regional Workshops held quarterly.
Step Two: Develop Your Billable Chronic Care Management (CCM) Service

**EDUCATION:** Attend Chronic Care Management Webinar

**ACTION:** Download Consent Form and Support Materials

- Train and Certify your Care Coordinators as Clinical Health Coaches (CHC)
- Provide a federally-funded 24/7 nurse advice hotline
- Bill Medicare
Lightbeam Data Support

Action for Success: Designate a person as Super User for Lightbeam – Webinar training instruction for Care Planning.

Lightbeam Health Data Software

• for 24/7 access to your patient’s care plan
Care Management

Lightbeam Health Solutions, LLC

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Step Three: NurseWise/Evolve

EDUCATION:  Attend 24hr Nurse Advice Hotline Webinar
ACTION:  Complete Nursewise Survey on PTN website

• 24-hour telephonic access to medical advice for Medicare patients.
• Necessary for your billable care coordination program’s after-hours coverage.
Step Four: Point-of-Service Patient Satisfaction Survey Tool and Tablet

EDUCATION:  Attend webinar about survey tool and tablet.
ACTION:  Complete Survey posted on PTN webpage.

• Each practice is eligible to receive single use tablet for patients to complete satisfaction survey & receive feedback.
• Tablets will be deployed within 60 days of enrollment.
Step 5: Preparing to become a Patient-Centered Medical Home (PCMH)

ACTION: Complete Practice Baseline Assessment
EDUCATION: Attend webinar about PCMH.
ACTION: Complete Plan-Do-Study-Act activities.

- Assessment is aligned with PCMH goals and track’s your practice performance.
- Conducted by NRACC Quality Specialist or your state’s QIO/QIN with your leadership.
- Lays the foundation to apply for certification as a PCMH. PCMH elements are built into quarterly training workshops in a Plan, Do, Study, Act (PDSA) format.
Step 6: Practice Workflow Redesign

**EDUCATION / ACTION:**
Schedule staff to attend one Regional Workshop per quarter.

- Your practice will receive easy-to-implement workflow tools.
- We will work together to create custom implementation plan – tailored to your practice’s needs and challenges.
- Regional Workshop will be held in Michigan in April 2017.
OUTCOMES: Redesign Your Practice to Better Manage Population Health

- Modify clinic workflow to address care gaps
- Provide data to identify cost-savings opportunities
- Report and improve ambulatory quality scores
- Measure patient satisfaction at the point of care (Tablet)
- Get paid quality bonuses
OUTCOMES: Improved Billing and New/Increased Revenue Streams

Action for Success: Actively participate in program activities – PDSAs, Workflows, Trainings, and Workshops.

• Program activities designed to reduce cost and improve quality.
• Maximize additional population health payments
• Prevent value-based payment penalties
• Improve financial stability of local health systems.

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In Summary, TCPI is the First Step of a Strategic Plan for Practice Transformation

- Optimize Quality
- Form Clinically Integrated Networks (CIN) with Other Independents
- Participate in Qualifying APM – PCMH, Bundled Payments
- MIPS Incentive - Develop Pop Health Infrastructure (TCPI)
- Form ACO’s
  - MSSP, Commercial and Medicaid
TCPI Participation Requirements

• Participants must appoint or hire an in-house care coordinator (will bill Medicare for new services)
• Active participation in the program, including attendance at:
  • Training webinars
  • Regional workshops- Quality Improvement Workshop April 28, 2017- Columbus, OH
  • Divisional workshops, and

(Travel for regional & divisional workshops is reimbursed through the grant)
Questions? – Next Steps

Go to www.nationalruralaco.com
Click on Apply Now to get ready for the future.

OR CONTACT:

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THANK YOU!