VALUE BASED TOOLKIT FOR PRIMARY CARE PROVIDERS

The Value Based Toolkit for Primary Care describes how to develop a strategy and operational Transition Plan to achieve financial success with a mix of Fee For Service (FFS) and Alternative Payment Model (APM) contracts. The 2-part webinar and slide deck explains Alternative Payment Models (APMs) and clearly identifies which patient populations, services, and approaches to chronic condition management boost revenue and financial success in MIPS, Medicare Advantage, Medicaid, and commercial insurance contracts.

Part 1 explains principles, approaches, and tools that practices can use to improve total cost of care and quality in Medicare, Medicaid and commercially insured populations. It provides detailed explanations of risk and mitigation strategies for all three payer categories. High cost, ambulatory sensitive populations are identified, and processes with high impact on cost and quality improvement are introduced. Tools and protocols used to manage risk effectively are explained in depth, and usable examples are contained in the Toolkit.

Part 2 guides the participants through a practice-specific analysis and decision-making process to develop an operational Transition Plan suited to the group's patient population, resources, and their particular mix of FFS and value based contracts. The process begins with identification of strategic factors that will be crucial to planning by the individual practice. Next, the practice is guided through an assessment of its patient population, the value of its current contracts, and its performance on them. Practices are lead through a decision-making process with a drill down specific to payer categories and high-risk populations. Participants will learn how to use their self-assessment to select management approaches that will be effective for their patient population and contracts. Groups also receive guidance on adding services that increase FFS revenue without compromising performance on APMs. Last, participants are given a step-by-step guide to developing a Transition Plan designed to optimize their performance on their own unique mix of FFS and value based contracts.

The toolkit that accompanies the webinars includes dozens of downloadable examples, tools, templates, and guidelines to improve performance on APMs, or increase practice revenue on contracts with traditional payment methods without compromising APM contract success.

A Value Based Toolkit for Primary Care
Part 1: What Works

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Value Based Toolkit: Content & Purpose

- Part 1 – slide deck & webinar
  - Increase understanding of
    - Risk in Value Based (VB)/Alternative Payment Model (APM) contracts
    - Target processes that support success on VB/APM contracts
    - Which patient populations provide significant cost savings when managed using the target processes
    - Which services are aligned with the goals of VB payment & can increase practice revenue on Fee For Service (FFS) contracts
- Part 2 – slide deck & webinar
  - Guides groups through development of a *practice-specific* **Transition Plan**
    - The Transition Plan plots a pathway to financial success with a mix of FFS and VB/APM contracts, based on a simple analysis of the practice's current situation
- The Tools
  - Are focused on the target processes and populations, with examples that practices can implement or adapt as part of their Transition Plan
- All 3 Toolkit components
  - Will be downloadable from the Healthier Washington Resource Portal at: http://www.waportal.org/value-based-toolkit-primary-care-providers

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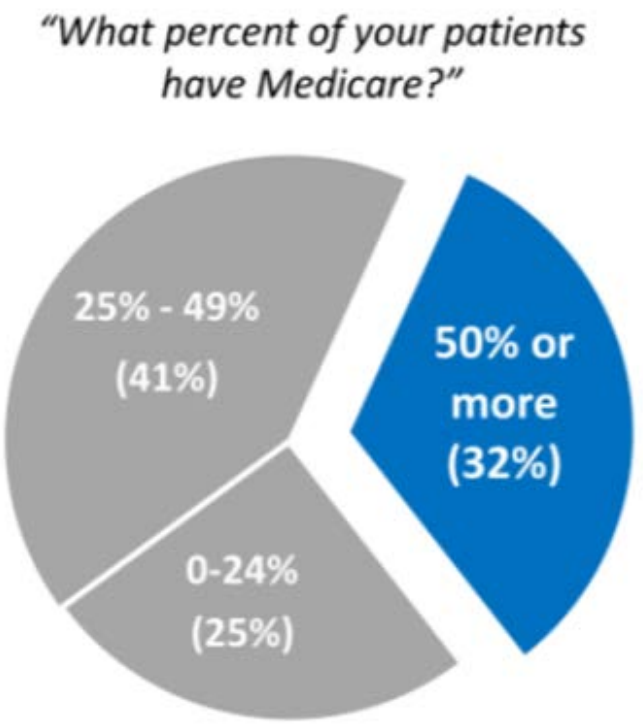
Question: How Can Practices Maintain Profitability with a Mix of APMs & FFS?

- Medicare Alternative Payment Models
  - Medicare FFS (MIPS)
    ~45%
  - Medicare ACOs
    ~22%
  - Medicare Advantage
    ~33%
    - Health plan increases now based on Medicare FFS inflation rate (MACRA)
    - P4P incentives offset fall in rates
- WA Medicaid APMs
  - At health plans
    - Next: coming to providers
- Commercial APMs
  - WA PEBB
  - Boeing
  - Blues PCP conversion factor



Percent of non-pediatric primary care physicians, by percent of patients with Medicare, 2015

Answer:
Implement A Payment Transition Plan

- A blend of Fee For Service (FFS) and Alternative Payment Models (APMs) complicates operations
  - Different operational processes are required for financial success under FFS than APMs
  - Some processes that support financial success under FFS, contribute to failure under APMs
- A Payment Transition Plan organizes operations around 3 goals:
  1. Successful performance on a core set of quality measures
  2. Implementation of selected processes that support your competitive position on total cost of care
  3. Increase or addition of services that boost FFS revenue, and are aligned with APM contract goals for total cost of care and quality

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Alternative Payment Models (APMs) - Upside Risk Only

- Types of Upside Risk
  - Bonus
    - An amount above the base payment for achieving a goal
    - Example: MIPS ≥ 70 points earns a bonus payment
  - Shared Savings
    - A portion of the costs saved is paid to contributing providers when actual cost is below the budgeted cost
  - Other Examples
    - Medicare Advantage
      - Pay for Performance on Stars Measures & RAF Scores
    - WA Blues commercial PCP Fee Schedule Adjustment
      - Higher conversion factor based on competition in cost with peers

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With Both Upside & Downside Risk

- Upside Risk is that
  - Actual cost for the contracted services & population is at, or below, the target cost for the contract, ***plus***
    - A contractually defined minimum achievement in quality goals
- Success means
  - Payment to provider of a contractually defined minimum, ***plus***
    - An additional amount (bonus),
    - A portion of the savings (shared savings), or
    - All or a portion of the withhold
- Downside Risk is that
  - Actual population cost is above the contract budget, ***and/or***
  - Minimum quality goals are not met
- Loss means
  - Forfeit of a bonus, or
  - Provider is responsible for a portion of the amount over budget (shared losses), or
  - Forfeit of all or a portion of the withhold

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MIPS Pays a % of the Medicare Physician Fee Schedule Based on Performance in Four Weighted Categories

 Quality	 Cost	 Improvement Activities	 Advancing Care Information
2017: 60%	2017: 0%	2017: 15%	2017: 25%
2018: 60%*	2018: 0%*	2018: 15%	2018: 25%
2019: 30%	2019: 30%	2019: 15%	2019: 25%

*Proposed Rule for 2018

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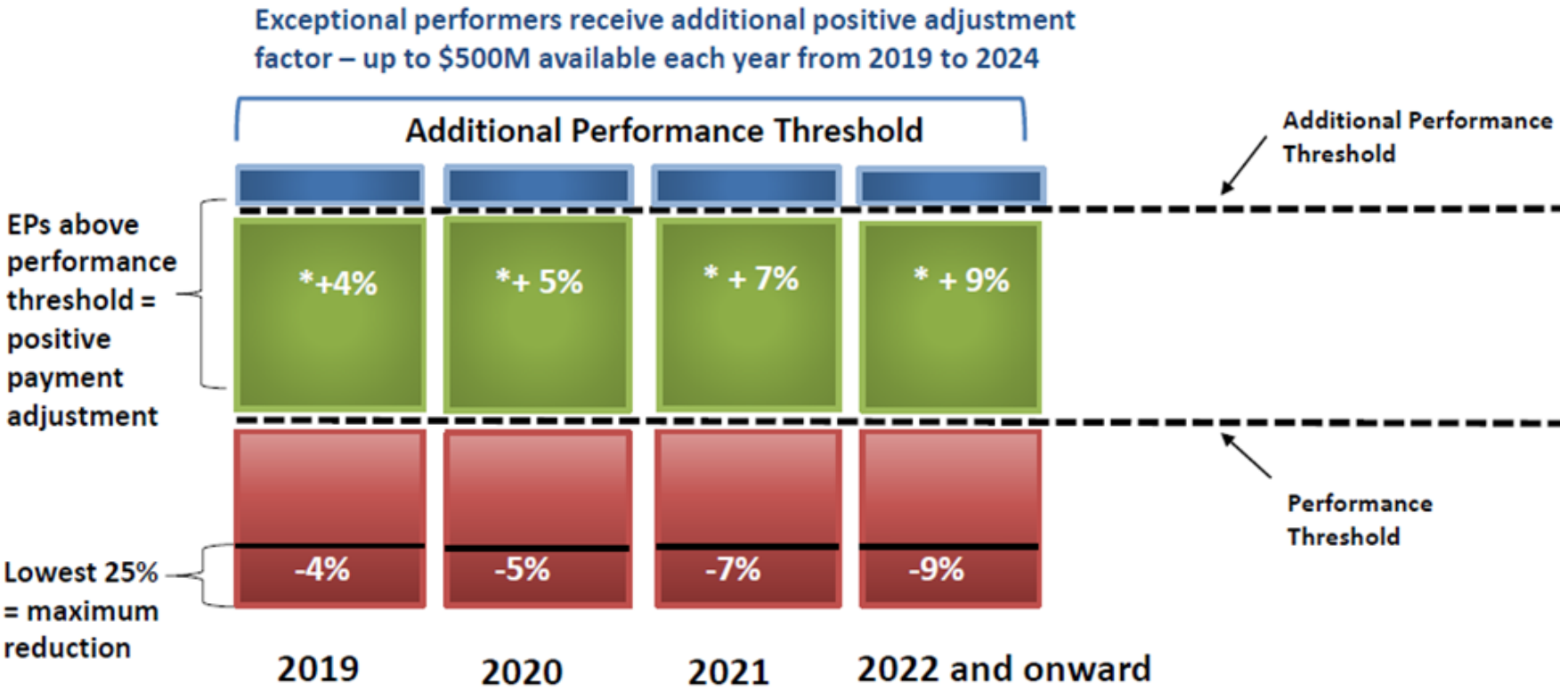
MIPS Is An Alternative Payment Model With Upside & Downside Risk



**MACRA allows potential 3x upward adjustment BUT unlikely*

Patient Centered Medical Home Domains with Cost Savings

- Planned Care
  - Organize visits based on Evidence Based protocols and care gaps
  - Visits routinely address both acute and planned care needs
  - Scheduling system accommodates customized visit lengths, urgent/same day visits
  - Medication reconciliation on all patients regularly
  - Each patient has a designated PCP

- Patient & Caregiver Engagement
  - Self-management support/action plans
    - Heart failure, COPD, asthma, CAD, diabetes, hypertension

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Patient/Caregiver Engagement: Self Management Action Plans

HEART FAILURE ZONES

EVERY DAY

EVERY DAY:
- Weigh yourself in the morning before breakfast, write it down and compare to yesterday's weight.
- Take your medicine as prescribed.
- Check for swelling in your feet, ankles, legs and stomach.
- Eat low salt food.
- Balance activity and rest periods.

Which Heart Failure Zone are you today? GREEN, YELLOW or RED?

GREEN ZONE

ALL CLEAR – This zone is your goal

Your symptoms are under control. You have:
- No shortness of breath.
- No weight gain more than 2 pounds (it may change 1 or 2 pounds some days).
- No swelling of your feet, ankles, legs or stomach.
- No chest pain.

YELLOW ZONE

CAUTION – This zone is a warning

Call your doctor's office if:
- You have a weight gain of 3 pounds in 1 day *or* a weight gain of 5 pounds or more in 1 week.
- More shortness of breath.
- More swelling of your feet, ankles, legs, or stomach.
- Feeling more tired. No energy.
- Dry hacky cough.
- Dizziness.
- Feeling uneasy, you know something is not right.
- It is harder for you to breathe when lying down. You are needing to sleep sitting up in a chair.

RED ZONE

EMERGENCY

Go to the emergency room or call 911 if you have any of the following:
- Struggling to breathe. Unrelieved shortness of breath while sitting still.
- Have chest pain.
- Have confusion or can't think clearly.

Toolkit Action Plans:

- Heart Failure
- Asthma
- COPD
- CAD
- Diabetes
- Hypertension

Reduce acute episodes

Support Medicare Chronic Care Management billing

PCMH Domains with Cost Savings (Cont.): Integration/Care Coordination

- Transitions of Care – inpatient & ER follow up
  - Research: contact 75% in 72 hours
    - Alternative - contact within 72 hours on:
      - Patients with ≥ 6 chronic conditions
      - Those with Serious Mental Illness w/o Addiction
      - Frequent ER visitors (~ 5 visits in 6 months)
- Collaborative Care Agreements
- Palliative Care Coordination
- Access to Behavioral Health specialists

Cost Savings through Collaborative Care Agreements (CCAs)

- Created through practice relationships & protocols to
  - Improve outcomes & patient satisfaction with
    - Evidence based protocols for diagnosis & treatment
    - Shared Decision Making with patients
    - Coordinated care
  - Improve costs
    - Through elimination of waste & duplication
    - By shifting care to cost effective locations
- See sample Collaborative Care Agreements

Target Specialties	
Pulmonary	Psychiatry
Cardiology	Gastroenterology
Oncology	Orthopedic Surgery
Hospitalists	Emergency Physicians

Quality & Cost Strategies from Your Quality & Resource Use Report (QRUR)

Exhibit 3-CCC-B – At TIN Level	Strategy
1. CMS-1 Hospitalizations/1,000 for Ambulatory Care-Sensitive Conditions – • Bacterial Pneumonia, UTIs, Dehydration	• Identify whether facilities & providers are/not performing well while caring for your patients in hospitals & SNFs • Check Hospital Compare & SNF Compare
2. CMS-2 Hospitalizations/1,000 for Ambulatory Care-Sensitive Conditions – • Heart Failure, COPD, Diabetes	• Identify whether your TIN and specialists are/not performing well in care of 3 High Impact Chronic Conditions
3. CMS-3 All-Cause Readmissions – • QRUR $\geq$ 200 cases • Reported on groups of 16 or more in MIPS	• Identify if you have a problem in Transitions of Care follow up process or specialist care

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Cost Strategies From Your QRUR – See Sample QRUR in Toolkit

Information – At TIN Level	Strategy

• Medicare Spending Per Beneficiary for inpatient episodes –
  • Available on CMS Enterprise Portal
  • Table 5A: IDs Admitting Hospital, Table 5B: IDs individual patients & episode $, Table 5C: costs per episode by categories of service, Table 5D: spending per patient by episode & service category
	• Helps you develop your hospital strategy i.e. what hospitals are high cost => can you divert patients to lower cost hospitals or other settings through the specialists to whom you refer

• Per Capita Costs for 4 High Impact conditions: Heart Failure, COPD, CAD, & Diabetes • Includes costs billed by all providers (not just your TIN)	• Internal Practice Strategy: use of condition-specific protocols and self-management action plans • External Practice Strategy: consider change in specialists and/or hospitals or adding Collaborative Care Agreements

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Share QRURs for Collaborative Care Agreement Decisions & Protocols

B. Communication and Care Coordination Domain CMS-Calculated Quality Outcome Measures

Exhibit 4-CCC-B provides information on the three quality outcome measures calculated from Medicare Part A and Part B claims data.

			Your TIN				All TINs in Peer Group	
Performance Category	**Measure Identification Number**	**Measure Name**	Number of Eligible Cases	**Performance Rate**	Standardized Performance Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions	**CMS-1**	**Acute Conditions Composite**	0	**0.00**	0.00	No	**0.00**	0.00
	-	Bacterial Pneumonia	0	**0.00**	0.00	—	**0.00**	0.00
	-	Urinary Tract Infection	0	**0.00**	0.00	—	**0.00**	0.00
	-	Dehydration	0	**0.00**	0.00	—	**0.00**	0.00
	CMS-2	**Chronic Conditions Composite**	0	**0.00**	0.00	No	**0.00**	0.00
	-	Diabetes (composite of 4 indicators)	0	**0.00**	0.00	—	**0.00**	0.00
	-	Chronic Obstructive Pulmonary Disease (COPD) or Asthma	0	**0.00**	0.00	—	**0.00**	0.00
	-	Heart Failure	0	**0.00**	0.00	—	**0.00**	0.00
Hospital Readmission	**CMS-3**	**All-Cause Hospital Readmission**	0	**0.00%**	0.00	No	**0.00%**	0.00

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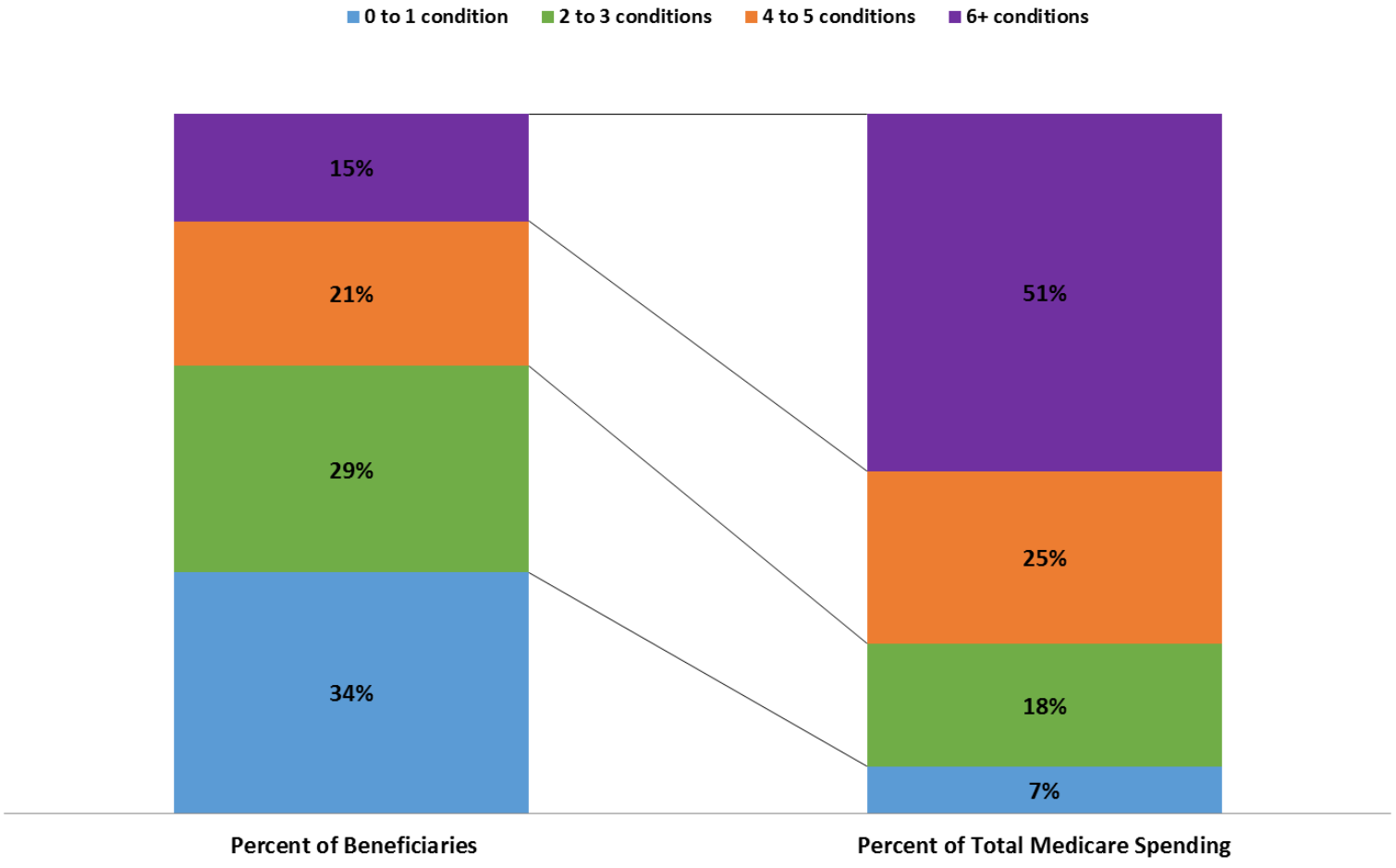
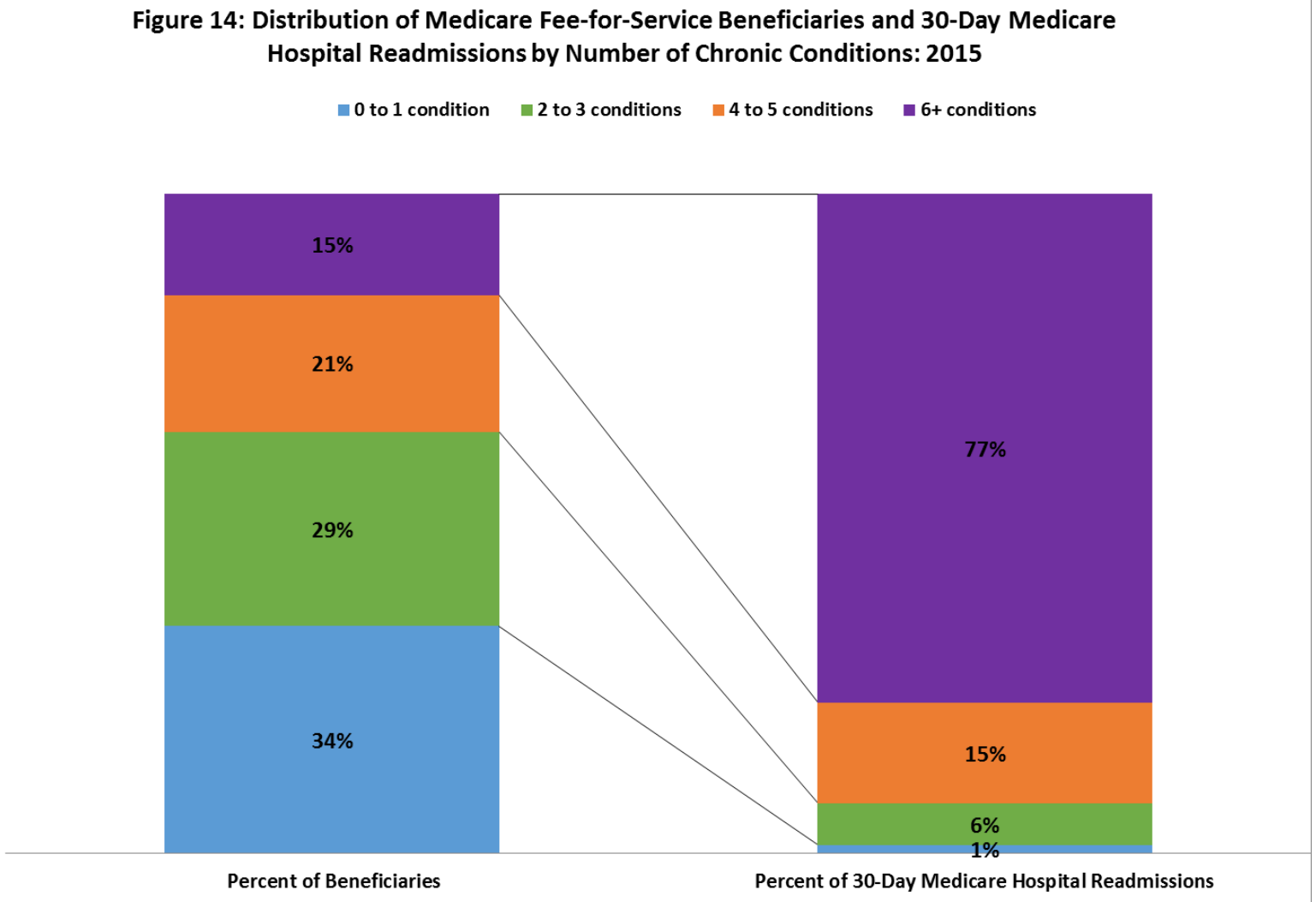
Medicare ≥ 6 Chronic Conditions Have High Impact on Costs

Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2015



Medicare w/ ≥ 6 Chronic Conditions = 77% of Hospital Readmits



Medicaid Targets: Serious Mental Illness with/without Addiction

- Serious Mental Illness affects 4% of adults in the US
  - Includes
    - Schizophrenia
    - Bipolar disorder
    - Major depression
    - Severe forms of PTSD and obsessive-compulsive disorder
- Patients with Serious Mental Illness
  - Have higher rates of certain chronic conditions
    - Cardiac disease, hypertension, & diabetes

Targeted Management for Medicaid Patients with SMI w/o Addiction

- Preventive Services & Screening
  - Vaccination schedule
  - Developmental screening
  - Substance use screening & referral in pregnancy
- Approaches
  - Patient registries and patient outreach for care gap closure
  - Action plans for CAD, heart failure, hypertension, diabetes, COPD, asthma (adult & school-based)
- Care Coordination with Behavioral Health Organizations Targeting
  - Medication consult & management of SMI conditions
  - Addiction Recovery referral & treatment
  - Frequent ER visits follow up
  - Readmission prevention
  - Referral to Community Mental Health Centers with integrated primary care practice[1]

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Managing those with SMI, ≥ 6 Chronic Conditions, & Frequent ER Visits

- Facility Discharges Transitions of Care
  - Inpatient follow-up within 72 hours
    - Medication reconciliation
    - Caregiver adequacy
    - Functional assessment
    - Schedule appt. in optimal time
      - Home Health if indicated
- Frequent ER Visits Transitions of Care
  - ER follow up within 72 hours
    - Frequent ~ 5 visits in 6 months
    - Requires external data source for patient identification
    - Pursue issue resolution if needed (clinical & coping)
      - Appt., referrals, resources, education, care coordination
- High Risk Registry
  - Composed of targeted patients
  - Patient Outreach to close care gaps & prevent acute episodes

In Part 2

- We will use the information from today's presentation
- Learn how to analyze your practice goals, population, & contracts at a high level
- Step by step, you will see how to develop a Transition Plan that will be customized for your practice

A Value Based Toolkit for Primary Care
Part 2: Develop Your Transition Plan

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Steps to Developing A Customized Transition Plan for Your Practice

- Develop
  - Critical Success Factors
  - Analysis of existing contracts & practice performance
- Select
  - Target populations, approaches/processes, & tools
  - Services to boost FFS revenue
  - Core measure set
- Define
  - Data & work flow changes
  - Reporting needs, IT system/software changes
  - Training, audit & improvement approach
  - Financial needs
- Prioritize
  - Selected services, processes, measures
  - Roll-out, timing

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Define Goals & Critical Success Factors

- Practice goals
  - Practice sale, growth & retirement
- Critical Success Factors
  - Relationships
    - Hospitals, other groups
  - Payers
    - Payer & patient mix – Medicare/Medicaid/Commercial
    - Business practices, contract terms, incentives
  - Systems adequacy
    - Clinical documentation & tools, scheduling, billing, reporting
  - Ability to manage process change
    - To achieve goals & efficiencies
  - Skills & staffing needs
    - Coding, understanding reports, protocol development & use
  - Training
    - Materials/documentation, audit process & use

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Patient Population Analysis

- Purposes:
  - It is necessary for analyzing your existing contracts
  - It is used in creating a High-risk Patient Registry
    - A High-risk Patient Registry is used in:
      - Planned Care for outreach & closing care gaps
      - Patient identification for Transitions of Care follow up
      - Alerts for scheduling patients as high priority for urgent appointments & reminders
  - It informs decision-making
    - Core Measure Set and MIPS measures

- Differences in Systems
  - The next example provides the logic for a patient population analysis – systems vary and adaptations may be required

Active Patient List for Contract Analysis and High Risk Patient Registry

1. Pull Active Patients from billing system & load into a spreadsheet (Ex. Excel)
   - "Active" = patients who received care in the previous 24 months – each unique patient & all their information is shown on one row
     - Retain the following information for each patient
       - » All ID numbers, full name, Date of Birth, patient address, phone #s, email, insurance carrier (ex. United Health Care), insurance product identifier (ex. PPO, or Medicare Advantage), preferred provider
2. Pull & enter the Date of Service for 1st encounter during 24 months
3. Enter Termination Date for patients you know have terminated their practice relationship, as of
   - Date of death
   - Effective date of removal from payers' list of patients assigned to your practice
   - Date of permanent move out of area
4. If no preferred provider, add provider most recently seen & flag patients that had no preferred provider
   - PCPs coordinate with each other to reach agreement on preferred provider on Active Patient List – update in your system & make it mandatory to verify with patient in appointment check in/out process
   - For patients covered by capitation – replace 1st encounter date, with 1st date patient was effective in the 24 month period

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Contract Analysis

- Purposes:
  - Identify which FFS and APM contracts
    - Bring a significant number of patients to your practice
    - Provide the most favorable revenues to the practice
  - To quantify the available revenue that the practice has not been earning and collecting on APM contracts
  - Helps identify the performance measures that may be good choices to include in the practice's Core Measure Set
  - Informs decision-making on which carriers it would be best to increase or decrease patient membership
- Differences in Systems
  - The next example provides the logic for developing a simple contract analysis – systems vary and adaptations may be required

Step 1:
Carrier, Contract, & Member Months

- Make a copy of the Active Patient List, and use it to:
  - Select a 12 month period for analysis based on Date of Service - allow for 3-4 months of run-out revenue
  - Group patients Carrier and each Contract
    - Sort the Active Patient List by Carrier name 1st and product name 2nd
  - Calculate Member Months
    - In a new column, calculate the actual number of months for each individual patient Active in the 12 months selected
      - Use 1st encounter Dates of Service that occurs in 12 month period
      - Used Termination Dates that occur in 12 month period
      - The remaining patients 12 Member Months for the period
    - Sum (add together) the total number of individual Member Months for each contract

Step 2: Calculate & Load Revenue into Spreadsheet

Calculate the following 3 revenue components for each contract. These are the sums of potential or actual revenues for each contract – enter into new column with bolded label:

1. Pull & enter sum into a new column **"1. Regular Revenue"** received by Date of Service for the 12 month period for all patients in the contract
   - Record both member collections & payer revenue for each Active Patient
     - *Excluding* incentives & withhold amounts

2. Pull & enter sum into a new column **"2. Max Incentive Revenue"** possible for all patients in the contract during the 12 month period
   - These are the maximum *possible* incentives or withhold amounts by each contract's terms
   - There are no/zero incentives for simple Fee For Service contracts

3. Pull & enter sum into a new column **"3. Actual Incentive Revenue"** received for the 12 month period
   - The incentive and withhold amounts actually received
   - This is zero for simple Fee For Service contracts

Step 3:
Analyze Revenue on Individual Contracts

Calculate the following components for each contract & enter into new column with the bolded label

4. Calculate **"4. Potential Value of Contract"**:
   - Add 1. Regular Revenue & 2. Max Incentive Revenue. This is the *potential* contract revenue for the period
   - To obtain Per Member Per Month or "PMPM" of Potential Value of Contract, divide #4 by member months for the 12 month period
     - This produces a comparison of the relative value of all your contracts – FFS and APM

5. Calculate **"5. Actual Payout"**:
   - Add 1. Regular Revenue & 3. Actual Incentive Revenue
   - This is actual revenue for the 12 months
   - Divide by contract member months = Actual Payout PMPM

6. Calculate **"6. Improvement Margin"**:
   - Subtract 5. Actual Payout from 4. Potential Value of Contract
     - This is the additional revenue that your practice could have earned on the contract for the 12 month period
   - Divide by contract member months = Improvement Margin PMPM

Step 4: Evaluate Carriers

- Create a Carrier Summary
  - Show the various contract types in the same order
    - For each contract show
      - Number of members covered
      - Revenue $ and PMPM
        - » Potential Value of Contract
        - » Actual Payout
        - » Improvement Margin

- Select carriers to
  - Increase membership
  - Maintain at same level
  - Improve contract terms or replace carrier

- For the carriers selected to increase or maintain members
  - Identify individual contracts for practice improvement efforts, & prioritize them, considering
    - The patient populations & their prevalence in your practice
    - Whether the target measure is present in multiple contracts
    - Whether target improvement measure should be in your Practice Core Measures Set
    - The amount of the incentive, and the difficulty of improvement & reporting

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Select Target Populations

Ambulatory Sensitive Conditions	High Risk Populations
Heart Failure	≥ 6 Chronic Conditions
COPD	SMI w/o Addiction
Asthma	Frequent ER Visitors
CAD	Terminal Illness
Diabetes	Others – practice specific
Hypertension	

Considerations for Selecting Processes

Approach	Heart Failure	COPD	Asthma	Diabetes	CAD	Hyper-tension	≥ 6 Chronic Conditions	Serious Mental Illness	Frequent ER Visitors
Registry/ Care Gaps	o|×|†	o|×|†	o|×|†	o|×|†	o|×|†	o|×|†	o|×|†	o|×|†	o|×|†
Clinical Protocol	o|×|†	o|×|†	o|×|†	o|×|†	o|×|†	o|×|†	o|×|†	o|×	o|×|†
Action Plan	o|×|†	o|×|†	o|×|†	o|×	o|×	o|×	o|×|†		
TOC Follow Up	o|×|†	o|×	o|×	o|×	o|×	o	o|×|†	o|×	o|×|†
TCM	o	o	o	o	o	o	o	o	
CCM ≥ 2 Conditions	o	o	o	o	o	o	o	o	
Care Coordination	o|×|†	o|×|†	o|×|†	o|×|†			o|×|†	o|×|†	o|×|†

o = Medicare | × = Medicaid | † = Commercial

Choose Processes for Your Transition Plan

Internal Processes	External Processes
Planned Care • Registries, Protocols, Care Gaps	Collaborative Care Agreements (CCAs) • Care coordination, Protocols
Flexible Scheduling	Facility preferences on cost & quality
Patient & Caregiver Engagement • Action Plans • Shared Decision Making (w/ CCAs) • Advance Directives	Care Coordination • Transitions of Care • Palliative Care • Behavioral Health
Total Cost of Care Initiatives • Standards for Prescribing	Total Cost of Care Initiatives • Protocols for labs & imaging
Chronic Care Management	Registry Participation
Measure Tracking & Improvement	

Collaborative Care Agreement Targets

- Created through practice relationships & protocols to
  - Improve outcomes & patient satisfaction with
    - Evidence based protocols for diagnosis & treatment
    - Shared Decision Making with patients
    - Coordinated care
  - Improve costs
    - Through elimination of waste & duplication
    - By shifting care to cost effective locations
- See sample Collaborative Care Agreements

Target Payer	Pulmonary	Cardiology	Oncology & Palliative Care	Hospitalist	Psychiatry	Gastro-enterology	Orthopedic
Value for Medicare	High	High	High	High	High	Moderate	Moderate
Value for Medicaid	High	High	High	High	High	Moderate	Low
Value for Commercial	High	High	High	High	Moderate	Moderate	Moderate

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Analyze Patient Population; Create a High Risk Patient Registry

- Purpose of the Analysis
  - The analysis helps you to see the prevalence of populations in your patient base that are high risk and high cost
  - Knowing their relative incidence can help you to decide which populations to target for intervention
- Purpose of the Patient Registry
  - A High-risk Patient Registry is used in:
    - Planned Care for outreach & closing care gaps
    - Patient identification for Transitions of Care follow up
    - Alerts for scheduling patients as high priority
      - Urgent/same day appointments & reminders
    - Consistent use of protocols
- Differences in Systems
  - The next example provides the logic for developing a simple patient registry – systems vary and adaptations may be required

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Patient Population Analysis & Creating a High Risk Patient Registry

1. Make a copy of the Active Patient List. Add columns for 20 text descriptions from the EHR Problem List and the corresponding diagnosis code next to it (40 columns)
2. Load each Problem (text) and its corresponding diagnosis code into separate cells on the patient's row on the spreadsheet
3. Identify patients with any of these diagnoses as High Risk: schizophrenia, bipolar disorder, major depression, and severe PTSD
4. Sum number of problems for each patient and flag those with 6 or more problems
5. Sort those with ≥ 6 problems by preferred provider
   - Each provider reviews their patient list with ≥ 6 problems & flags problems that are not chronic conditions
     - Consider adding EHR check box/flag to a reportable field for PCP to indicate a Chronic Condition when adding a new problem
     - Or, retain a composite list of problems identified as not chronic so that you can match them on future reports & reduce the number of problems that the PCP has to review
6. Recalculate the number of chronic conditions for each patient (exclude conditions that are not chronic). Identify patients with ≥ 6 chronic conditions as High Risk
7. If you receive a Frequent ER User Report from payers (≥ 5 visits in most recent 6 months), identify these patients as High Risk on the Registry
8. Remove the remaining patients who were not identified as High Risk

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FFS Revenue Enhancement: Billable Services

- Original/Traditional Medicare
  - Annual visits
  - Advance Care Planning
  - Chronic Care Management
  - Initial Preventive Physical Exam
  - Screening for Colorectal CA
  - Screening for Breast CA
  - Tobacco Cessation Counseling
  - Transitional Care Management
  - Vaccines – Flu & Pneumovax
- WA Medicaid
  - Advance Care Planning
    - Apple Physician Billing Guide
      - Advance Care Planning Washington Medicaid
  - New to Medicaid Visit
    - Apple Physician Billing Guide
      - Patient Visits Washington Medicaid
  - Smoking Cessation Referral
    - Apple Physician Billing Guide
      - Tobacco Cessation Referral Washington Medicaid

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Revenue Enhancement: Medicare Advantage Pay For Performance

- Some Medicare Advantage carriers offer incentives for achieving goals on
  - Stars Measures
    - 2018 Star Ratings Measures List
  - RAF score accuracy & completeness
  - Welcome to Medicare Visits (IPPE)
  - Annual Wellness Visits

Align Choice of MIPS Improvement Activities with Transition Plan

- The list of MIPS Improvement Activities in the Appendix were selected for their contribution to cost & quality improvement initiatives by primary care practices

- To select MIPS Improvement Activities that will support your practice Transition Plan, cross reference Appendix 4 with your lists of targeted:
  - Patient populations
  - Management processes &
  - Practice Core Measures

Create a Practice Core Measure Set

- Summarize measures from Targeted Carrier contracts
  - Record contracts, PMPM revenues, measures w/ benchmarks & score
  - Highlight measures in common across multiple contracts
  - Consider stretch between contract benchmark & practice score
- For inclusion, consider measures of
  - Process and outcome measures of quality
  - Utilization measures
  - Access and patient experience
  - Billable screening & preventive services
  - Adherence to protocols for
    - Patient Self-Management initiatives
    - Transitions of Care follow up
    - Collaborative Care Agreements
- Cross reference
  - MIPS Outcome Measures (Appendix 2)
  - MIPS Measures Supporting Cost Initiatives (Appendix 3)
  - Medicare Advantage Stars Measures (Appendix 5)
  - Medicaid measures: WA Medicaid-QPP Crosswalk Measures
- Select a Core Measure Set with
  - Foundational measures, short term, & longer term targets

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Prepare to Implement the Set

- Preparing for implementation
  - Assess need for EHR gap alerts/dashboards
  - Examine work flow efficiencies to support success
  - Individual providers set personal improvement goals
    - Report results within practice, unblinded
  - Report progress toward goals quarterly
    - Continue to evaluate processes to increase efficiency
    - Continue to assess human-IT interface to make it user friendly
- Consider
  - Adding incentives to internal practice compensation formula focused on Core Measure Set

Define Operational Needs for Your Transition Plan

- Clinical protocols
- Operational process & work flow changes
  - Documentation
  - Roles & responsibilities – top of license
  - Tools
- Training plan & schedule
  - Who will develop materials & train
  - What will be audited & by whom
  - How will audit results be incorporated into training

Identify System Needs

- Identify changes to documentation processes
  - Consider changes to workflows for user support and efficiency
- Revise patient scheduling for flexible access
  - Build in sources of rapid patient feedback to changes
- Define reporting requirements & production schedule
  - Determine adequacy of internal staff abilities and training to create and produce accurate, actionable reports
  - If necessary, engage external support to build reports and train staff to run them
- Review adequacy of resources in
  - Electronic infrastructure
  - Physical infrastructure

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Define Financial Requirements

- Prioritize resource needs
  - IT revisions
  - Report development & training
  - Clinical protocols, skills & operations training
- Pricing of new services
- Align internal compensation plan with financial goals

Review Critical Success Factors; Document Implementation Plan

- Review
  - Target relationships: shift in hospitals, other practices
  - Consider how practice plans should impact the Transition Plan
  - Document systems needs & timeline for updates
  - Define process changes needed to achieve goals & efficiencies
  - Skills, staffing needs, & training
  - Financial analysis of change in revenue and expenses

- Develop
  - Project plan including
    - Specific measures of accomplishment
    - Due dates
    - Responsibilities & assigned leads

Too Much, Too Soon?
Select an Incremental Approach

Choice	Considerations
1. Select 1 Payer contract	MIPS – no sorting patient populations
2. Select 1 target population	Diabetes population is largest & you probably have a good basis for quality measures with it
3. Select 1 quality measure	Diabetes: HbA1c Poor Control (>9) – it's a Outcome Measure, High Priority, & data can be submitted 3 ways
4. Implement Diabetes Action Plan	Develop Diabetes registry & workflow, train staff, document in EHR in reportable fields

Could Do More? Add 1 More Step

Choice	Considerations
1. Select 1 Payer contract	MIPS – no sorting patient populations
2. Select 1 target population	Diabetes population
3. Select 1 quality measure	Diabetes: HbA1c Poor Control (>9)
4. Implement Diabetes Action Plan	Develop Diabetes registry & workflow, train staff, document in EHR in reportable fields
5. Select 1 Improvement Activity	IA_BE_15 Engage patients, families, caregivers in developing a plan of action, documented in the EHR – check QPP website list – other IA projects may apply

Use of the Appendix in Transition Plan Development

- The Appendix includes information on
  - MIPS Cost, Quality, and Improvement Activity measures, and
  - Medicare Advantage Stars measures

- These MIPS measures were selected for their usefulness in improving the total cost of the care attributed to primary care practices, and the quality of care delivered or coordinated by them

- Use the Appendix to help you understand
  - Which measures are good candidates for your practice's Core Measure Set because they measure or promote success in managing cost and/or quality, and
  - How to structure the documentation and training for new processes you will use as part of your Transition Plan for financial success in APM contracts

Quality Payment Program Resources

Quality Payment Program Resources

Small & Solo Practices

Small, Underserved Rural Support Technical Assistance (SURS)

- Supports clinicians in small practices (15 or fewer) in meeting the Quality Payment Program requirements through customized technical assistance.
- The organization in Idaho and Washington selected to provide assistance is Qualis Health.
- Qualis Health Quality Payment Program Resource Center
- QPP-SURS@qualishealth.org • 877-560-2618

Large Practices

Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- Supports clinicians in large practices (more than 15 clinicians) in meeting Quality Payment Program requirements through customized technical assistance.
- Qualis Health Quality Payment Program Resource Center
- QPP-SURS@qualishealth.org • 877-560-2618

Primary Care & Specialist Physicians

Transforming Clinical Practice Initiative (TCPI)

- Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs) are located in all 50 states to provide technical assistance to improve quality of care and reduce costs.
- The goal is to help practices move toward Advanced Payment Models (APMs).

Washington & Idaho Practice Transformation Networks (PTNs)

Rural Accountable Care: Contact Linda Lang at LLang@nationalruralaco.com

Peace Health: Contact Eric Blake at EBlake@peacehealth.org

University of Washington: Contact Brieana White 206.221.6387, brieana@uw.edu

Washington State DOH: Contact the Hub Help Desk at (206) 288-2540, (800) 949-7536 ext. 2540 or by email at HubHelpDesk@qualishealth.org

Qualis Health is Here to Help Clinicians in Washington and Idaho

Qualis Health Quality Payment Program Resource Center

QPP-SURS@qualishealth.org • 877-560-2618

Technical Support

Available to All Eligible Clinicians

- Quality Payment Program Website: qpp.cms.gov
- Quality Payment Program
  QPP@cms.hhs.gov • 1-866-288-8292 • TTY: 1-877-6222
- Advanced Alternative Payment Model (APM) Learning Networks
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMS.

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Questions & Discussion

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Footnote

1. Scharf, Deborah M., Eberhart, Nicole K., Hackbarth, Nicole S., Horvitz-Lennon, Marcela, Beckman, Robin, Han, Bing, Lovejoy, Susan L., Pincus, Harold A. Burnam, & M. Audrey, "Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program, Final Report, the Rand Corporation, 2014.

Appendix: Select Cost, Quality, Improvement Activities Measures

Appendix – 1. MIPS Cost Measures

1. Total Per Capita Costs
   - Primary Care Services HCPCS/CPT codes:
     - 99201 – 99215
     - 99304 – 99340
       - Exclude services billed under CPT codes 99304-99318 when claim includes POS 31 modifier (SNF)
     - 99341 – 99350
     - G0402 (Welcome to Medicare Visit)
     - G0438 & G0430 (Annual Wellness Visits)
     - 99495 & 99496 (Transitional Care Management
     - 99490 (Chronic Care Management)
   - Two step attribution process
     - Step 1: Beneficiary is attributed to a TIN if they received more primary care services from primary care providers in that TIN than any other TIN.
     - Step 2: If the beneficiary did not receive any primary care service codes (shown above) from any PCP, NP, PA, or CNS during the performance period, then they are attributed to a TIN if the patient received more primary care services from specialist physicians within the TIN than in any other TIN.

Appendix – 1. MIPS Cost Measures

2. Medicare Spending Per Beneficiary
   - Per episode costs are based on Medicare Part A and Medicare Part B Allowed Amounts surrounding specified inpatient hospital stays (3 days prior to admission through 30 days post-discharge) for episodes attributed to your TIN for this measure.
   - CMS attributes MSPB episodes to the one TIN responsible for the plurality of Part B services, as measured by Medicare Allowed Amounts, performed by eligible professionals during the episode's index hospitalization.

Appendix 1. MIPS Cost Measures

3. Episode Based Measures
   - 10 Episode based measures for 2017
     - For primary care: colonoscopy & biopsy
   - Episodes
     - Outpatient: triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day
     - Inpatient: Medical condition episodes are triggered by an inpatient stay with specified MS-DRGs
   - Attribution – procedural episode
     - Episode assigned to each clinician billing a Part B claim with a trigger code during the trigger event episode

Appendix 2. MIPS Quality Outcome Measures for Primary Care

Measure Title	eMeasure ID	eMeasure NQF	NQF	Quality Number (Q#)	Measure Type	High Priority	Claims	CSV	EHR	CMS Web Interface	Administrative Claim	Registry
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v5	N/A	0059	001	Intermediate Outcome	X	X	-	X	X	-	X
Adult Kidney Disease: Blood Pressure Management	N/A	N/A	N/A	122	Intermediate Outcome	X	-	-	-	-	-	X
Controlling High Blood Pressure	CMS165v5	N/A	0018	236	Intermediate Outcome	X	X	-	X	X	-	X
Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks (Overuse)	N/A	N/A	N/A	335	Outcome	X	-	-	-	-	-	X
Depression Remission at Twelve Months	CMS159v5	N/A	0710	370	Outcome	X	-	-	X	X	-	X
Hypertension: Improvement in Blood Pressure	CMS65v6	N/A	N/A	373	Intermediate Outcome	X	-	-	X	-	-	-
Optimal Asthma Control	N/A	N/A	N/A	398	Outcome	X	-	-	-	-	-	X

Appendix 3. MIPS Quality Measures Supporting Cost Initiatives

Measure Title	NQF	Quality Number (Q#)	Measure Type	High Priority	Claims	CSV	EHR	CMS Web Interface	Administrative Claims	Registry
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	0059	001	Intermediate Outcome	X	X	-	X	X	-	X
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0081	005	Process		-	-	X	-	-	X
Coronary Artery Disease (CAD): Antiplatelet Therapy	0067	006	Process		-		-	-	-	X
Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	0070	007	Process		-	-	X	-	-	X
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0083	008	Process		-	-	X	-	-	X
Care Plan/Advance Directives	0326	047	Process	X	X	-	-	-	-	X
Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	0091	051	Process		X	-	-	-	-	X
Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy	0102	052	Process		X	-	-	-	-	X
Preventive Care and Screening: Influenza Immunization	0041	110	Process		X	-	X	X	-	X
Pneumococcal Vaccination Status for Older Adults	0043	111	Process		X	-	X	X	-	X
Colorectal Cancer Screening	0034	113	Process		X	-	X	X	-	X

Appendix 3. MIPS Quality Measures Supporting Cost Initiatives – Cont.

Measure Title	NQF	Quality Number (Q#)	Measure Type	High Priority	Claims	CSV	EHR	CMS Web Interface	Administrative Claims	Registry
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	0066	118	Process		-	-	-	-	-	X
Diabetes: Medical Attention for Nephropathy	0062	119	Process		-	-	X	-	-	X
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	0417	126	Process		-	-	-	-	-	X
Falls: Plan of Care	0101	155	Process	X	X	-	-	-	-	X
Diabetes: Foot Exam	0056	163	Process		-	-	X	-	-	-
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	0068	204	Process		X	-	X	X	-	X
Controlling High Blood Pressure	0018	236	Intermed Outcome	X	X	-	X	X	-	X
Use of High-Risk Medications in the Elderly	0022	238	Process	X	-	-	X	-	-	X
Childhood Immunization Status	0038	240	Process		-	-	X	-	-	-
Dementia: Caregiver Education and Support	N/A	288	Process	X	-	-	-	-	-	X
CAHPS for PQRS Clinician/Group Survey	0005 & 0006	321	Patient Engagement /Experience	X	-	X	-	-	-	-
Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	N/A	325	Process	X	-	-	-	-	-	X

Appendix 3. MIPS Quality Measures Supporting Cost Initiatives – Cont.

Measure Title	NQF	Quality Number (Q#)	Measure Type	High Priority	Claims	CSV	EHR	CMS Web Interface	Administrative Claims	Registry
Hypertension: Improvement in Blood Pressure	N/A	373	Intermed Outcome	X	-	-	X	-	-	-
Functional Status Assessments for Congestive Heart Failure	N/A	377	Process	X	-	-	X	-	-	-
Optimal Asthma Control	N/A	398	Outcome	X	-	-	-	-	-	X
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	N/A	438	Process		-	-	-	X	-	X
Persistence of Beta-Blocker Treatment After a Heart Attack	0071	442	Process		-	-	-	-	-	X
Medication Management for People with Asthma	1799	444	Process	X	-	-	-	-	-	X
Proportion Not Admitted To Hospice	0215	456	Process	X	-	-	-	-	-	X

Appendix 4. MIPS Improvement Activities Supporting Cost Initiatives

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	ACTIVITY WEIGHT	TOOLKIT REFERENCE
Care coordination agreements that promote improvements in patient tracking across settings	Include 1 of the following: Establish effective care coordination and active referral management that could include one or more of the following: Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements; Track patients referred to specialist through the entire process; and/or Systematically integrate information from referrals into the plan of care.	IA_CC_12	Medium	Collaborative Care Agreements
Care transition documentation practice improvements	Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).	IA_CC_10	Medium	Transitions of Care
Care transition standard operational improvements	Establish standard operations to manage transitions of care that could include one or more of the following: Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or Partner with community or hospital-based transitional care services.	IA_CC_11	Medium	Transitions of Care
Chronic care and preventative care management for empanelled patients	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning; Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; Use panel support tools (registry functionality) to identify services due; Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients	IA_PM_13	Medium	Planned Care; Action Plans; Advance Directives

Appendix 4. MIPS Improvement Activities Supporting Cost Initiatives - Cont.

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	ACTIVITY WEIGHT	TOOLKIT REFERENCE
Collection and use of patient experience and satisfaction data on access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.	IA_EPA_3	Medium	Access
Engagement of community for health status improvement	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	IA_PM_5	Medium	Collaborative Care Agreements
Engagement of patients, family and caregivers in developing a plan of care	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology.	IA_BE_15	Medium	Action Plans
Evidenced-based techniques to promote self-management into usual care	Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning or motivational interviewing.	IA_BE_16	Medium	Action Plans

Appendix 4. MIPS Improvement Activities Supporting Cost Initiatives – Cont.

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	ACTIVITY WEIGHT	TOOLKIT REFERENCE
Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance year and onward. Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.	IA_PM_4	High	Planned Care + Action Plans
Implementation of condition-specific chronic disease self-management support programs	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	IA_BE_20	Medium	Action Plans
Implementation of episodic care management practice improvements	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or Managing care intensively through new diagnoses, injuries and exacerbations of illness.	IA_PM_15	Medium	Transitions of Care
Implementation of fall screening and assessment programs	Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).	IA_PSPA_21	Medium	See Annual Wellness Visit Folder for Materials

Appendix 4. MIPS Improvement Activities Supporting Cost Initiatives – Cont.

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	ACTIVITY WEIGHT	TOOLKIT REFERENCE
Implementation of formal quality improvement methods, practice changes or other practice improvement processes	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following: Train all staff in quality improvement methods; Integrate practice change/quality improvement into staff duties; Engage all staff in identifying and testing practices changes; Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.	IA_PSPA_19	Medium	Practice Core Measure Set
Implementation of medication management practice improvements	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; Integrate a pharmacist into the care team; and/or Conduct periodic, structured medication reviews.	IA_PM_16	Medium	Planned Care + Collaborative Care Agreements; Transitions of Care
Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	IA_PM_14	Medium	Transitions of Care for ≥ 6 Chronic Conditions, SMI, Frequent ER Visitors

Appendix 4. MIPS Improvement Activities Supporting Cost Initiatives – Cont.

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	ACTIVITY WEIGHT	TOOLKIT REFERENCE
Measurement and improvement at the practice and panel level	Measure and improve quality at the practice and panel level that could include one or more of the following: Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group(panel); and/or Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.	IA_PSPA_18	Medium	Planned Care + Practice Core Measure Set
Participation in CAHPS or other supplemental questionnaire	Participation in the Consumer Assessment of Healthcare Providers and Systems Survey or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).	IA_PSPA_11	High	Access & Shared Decision Making in CCAs
Population empanelment	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team. Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management. Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the "active population" of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define "active patients" operationally, but generally, the definition of "active patients" includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care.	IA_PM_12	Medium	Planned Care
Practice improvements for bilateral exchange of patient information	Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following: Participate in a Health Information Exchange if available; and/or Use structured referral notes.	IA_CC_13	Medium	Collaborative Care Agreements

Appendix 4. MIPS Improvement Activities Supporting Cost Initiatives - Cont.

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	ACTIVITY WEIGHT	TOOLKIT REFERENCE
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.	IA_EPA_1	High	Access
Use of decision support and standardized treatment protocols	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	IA_PSPA_16	Medium	Planned Care

Appendix 5. Stars Measures for 2017-2018 Medicare Advantage

2018 Part C & D Star Ratings Measures					
2018 ID	2017 ID	Measure	Primary Data Source	Improvement Measure	Weight
C01	C01	Breast Cancer Screening	HEDIS	Yes	1
C02	C02	Colorectal Cancer Screening	HEDIS	Yes	1
C03	C03	Annual Flu Vaccine	CAHPS	Yes	1
C04	C04	Improving or Maintaining Physical Health	HOS	No	3
C05	C05	Improving or Maintaining Mental Health	HOS	No	3
C06	C06	Monitoring Physical Activity	HEDIS / HOS	Yes	1
C07	C07	Adult BMI Assessment	HEDIS	Yes	1
C08	C08	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	Yes	1
C09	C09	Care for Older Adults – Medication Review	HEDIS	Yes	1
C10	C10	Care for Older Adults – Functional Status Assessment	HEDIS	Yes	1
C11	C11	Care for Older Adults – Pain Assessment	HEDIS	Yes	1
C12	C12	Osteoporosis Management in Women who had a Fracture	HEDIS	Yes	1
C13	C13	Diabetes Care – Eye Exam	HEDIS	Yes	1
C14	C14	Diabetes Care – Kidney Disease Monitoring	HEDIS	Yes	1
C15	C15	Diabetes Care – Blood Sugar Controlled	HEDIS	Yes	3
C16	C16	Controlling Blood Pressure	HEDIS	Yes	3
C17	C17	Rheumatoid Arthritis Management	HEDIS	Yes	1
C18	C18	Reducing the Risk of Falling	HEDIS / HOS	Yes	1
C19	DMC22	Improving Bladder Control	HEDIS / HOS	No	1
C20	DMC23	Medication Reconciliation Post-Discharge	HEDIS	No	1
C21	C19	Plan All-Cause Readmissions	HEDIS	Yes	3
C22	C20	Getting Needed Care	CAHPS	Yes	1.5
C23	C21	Getting Appointments and Care Quickly	CAHPS	No	1.5
C24	C22	Customer Service	CAHPS	No	1.5
C25	C23	Rating of Health Care Quality	CAHPS	Yes	1.5
C26	C24	Rating of Health Plan	CAHPS	Yes	1.5
C27	C25	Care Coordination	CAHPS	No	1.5