



Making Sense of MACRA: Aligning Transitional Care Management (TCM) with the Quality Payment Program (QPP)

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Learn how coordinated care benefits patients, QPP performance, and your bottom line.



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INTRODUCTION

Medicare beneficiaries who have medical and/or psychosocial conditions can benefit from the management and coordination of care during the transition from a hospital or other health care facility to a community setting (e.g., home, assisted living facility, nursing home, etc.).

The service to coordinate this care is called transitional care management (TCM). It ensures patients who have a high-risk medical condition will receive the care they need immediately after discharge from a hospital or other facility. TCM services may include contacting the patient or caregiver after discharge to reconcile medications, scheduling primary care visits, and/or developing a plan to coordinate with other care providers.

The Centers for Medicare & Medicaid Services (CMS) began paying separately for TCM services in 2013. The American Academy of Family Physicians (AAFP) supports the separate payment, as it provides family physicians additional revenue to offer patient-centered, team-based care.

The AAFP's TCM Toolkit (www.aafp.org/tcm-toolkit) provides further details beyond the scope of this supplement about TCM. Among other resources, the toolkit includes a step-by-step process, component and requirement table, and patient brochure.



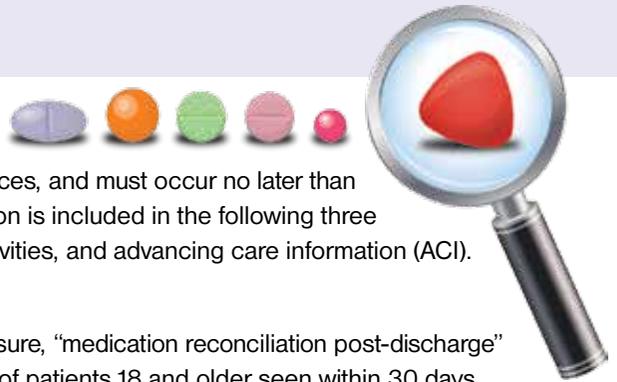
CONNECT MACRA TO TCM

The Medicare Access and CHIP Reauthorization Act (MACRA) established the Quality Payment Program (QPP), which is the umbrella term for the two new tracks for Medicare payment: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs).

Transitional care management services support efforts to be successful in the MIPS track. This supplement provides examples of how the components of TCM services overlap with a variety of MIPS reporting measures.

MEDICATION RECONCILIATION MEASURES

Medication reconciliation must be performed as part of TCM services, and must occur no later than the date of the required face-to-face visit. Medication reconciliation is included in the following three MIPS performance category measures: quality, improvement activities, and advancing care information (ACI).



MIPS: Quality Category – The quality measure, “medication reconciliation post-discharge” (Quality ID: 046), measures the percentage of patients 18 and older seen within 30 days following discharge from any inpatient facility who had their discharge medication list reconciled with their current medication list in their outpatient record.



MIPS: Improvement Activities Category – The improvement activity, “implementation of episodic care management practice improvements” (Activity ID: IA_PM_15), requires the provision of episodic care management that could include one or more of the following: routine and timely follow up to hospitalization; emergency department visits and stays in other institutional settings; and medication reconciliation and management.



MIPS: Advancing Care Information (ACI) Category – The ACI measure, “clinical information reconciliation” (Measure ID: ACI_HIE_3), requires a MIPS-eligible clinician to perform clinical information reconciliation for patients transferred or referred to their care, or for patients in which the eligible clinician has never encountered the patient previously. Clinical information reconciliation includes a review of patients’ medication, medication allergies, and current problem list.

ALIGN OTHER MIPS MEASURES WITH TCM COMPONENTS

A number of MIPS measures align with certain aspects of TCM components. These components include providing expanded hours, assisting caregivers in accessing community resources, and coordinating care with other providers. The following improvement activities can be satisfied by accomplishing aspects of corresponding TCM components.

Provide Expanded Hours

MIPS: Improvement Activities Category –

The improvement activity, “provide 24/7 access to eligible clinicians or groups who have real-time access to a patient’s medical record” (Activity ID: IA_EPA_1), can be satisfied by providing 24/7 access to MIPS-eligible clinicians, groups, or care teams. This activity can include providing expanded hours, or a provision of same-day or next-day access to a MIPS-eligible clinician when needed for urgent or transition management.



TCM: To bill for TCM services, a face-to-face visit must be provided within certain time frames. By providing expanded access, practices can ensure they are meeting TCM requirements, while also satisfying a MIPS improvement activity.



Assist Caregivers with Community Resources

MIPS: Improvement Activities Category –

The improvement activity, “practice improvements that engage community resources to support patient health goals” (Activity ID: IA_CC_14), relates to developing pathways to neighborhood and community-based resources that are designed to support patient health goals.



TCM: Transitional care management includes assisting the beneficiary or caregiver with communication and accessing agencies and community resources used by the beneficiary. Providing connections to community-based resources helps link patients with programs and support services to help them with their post-discharge transition. This service counts as a MIPS improvement activity.



Coordinate With Other Providers

MIPS: Improvement Activities Category –

The improvement activity, “care transition standard operational improvements” (Activity ID: IA_CC_11), requires the establishment of standard operations to manage transitions of care. This activity includes establishing formalized lines of communication with local settings to ensure that the flow of information and transition of care is seamless, and involves partnering with community or hospital-based transitional care services.



TCM: Coordinating with other post-acute care providers includes interacting with other health care providers who may assume or reassume care for specific problems, and may include establishing referrals to community providers and services. This TCM component aligns with a MIPS improvement activity.



REDUCE COST, ENHANCE HEALTH, AND IMPROVE PERFORMANCE

By implementing TCM services provided in this supplement, your practice has the potential to help reduce care costs, enhance patient health, and improve your performance in MIPS.

Clinicians will be measured on total per capita costs in MIPS. Some clinicians will also be measured on all-cause hospital readmission. TCM enables the successful transitions of care that may help reduce the number of unnecessary hospital readmissions. In turn, this reduces costs associated with your MIPS score, as well as for the broader health system.

When your practice participates in TCM services, patients are better able to understand changes in medications; develop coordinated treatment plans with multiple clinicians; and receive connections to community resources and programs that can help prevent a readmission and enhance patient health.

As the examples in this supplement illustrate, various components that meet TCM service requirements also align with MIPS measures. From reconciling medication to coordinating care with other providers, implementing TCM services can improve your practice's performance in all four performance categories in MIPS: cost, quality, ACI, and improvement activities.

To further your knowledge of TCM, the AAFP's TCM Toolkit (www.aafp.org/tcm-toolkit) is available to guide practices through the process of setting up and maintaining TCM services. The toolkit contains the following resources to help implement TCM services in your practice:

- Step-by-step process
- Component and requirement table
- 30-day worksheet
- Patient brochure
- Sample script for staff members to speak with patients about the service
- Frequently asked questions

Purchase and download the AAFP's TCM Toolkit at www.aafp.org/tcm-toolkit.

