The MACRA Quality Payment Program: *It's not too late to participate in 2017!*

QOPI's QCDR
ASCO COME HOME

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A. Yes
B. No
C. What's MACRA??

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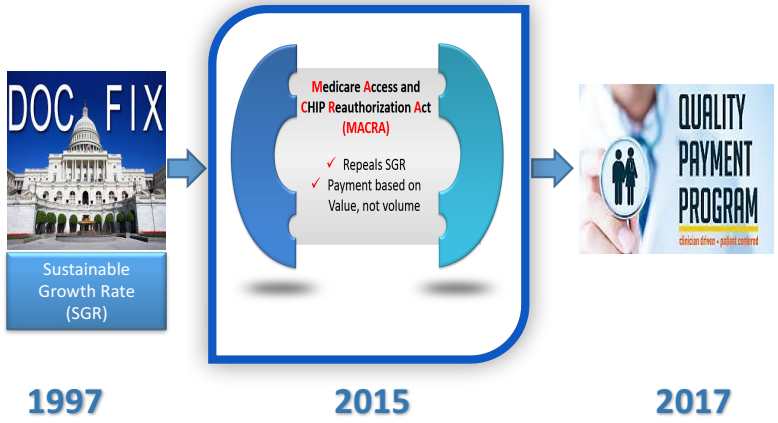
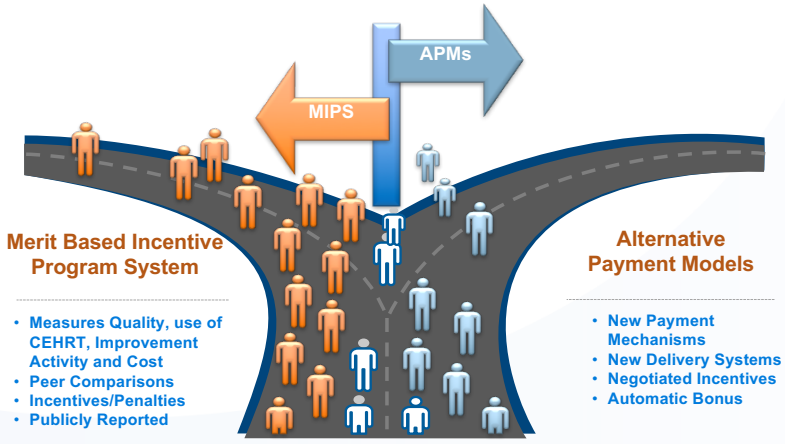
Medicare Provider Reimbursement



Quality Payment Program (QPP)



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Will It Affect Me?

Medicare Part B (Physician Services)

1st time Part B Participant	EXEMPT
Low Volume ($30K) or Low Patient Count (100 Patients)	EXEMPT
APM Qualified Participant	EXEMPT

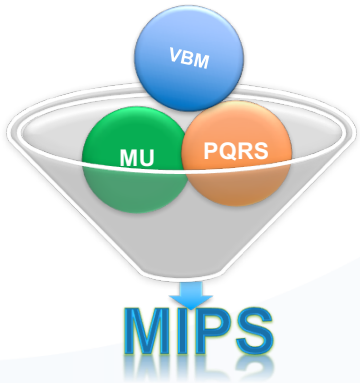
How Will Medicare Reimbursement Change?

Legacy Reporting Systems

Physician Quality Reporting System (PQRS)

Meaningful Use (MU)

Value Based Modifier (VBM)



MIPS

Consolidates penalties

Increases incentives

Ranks peers nationally

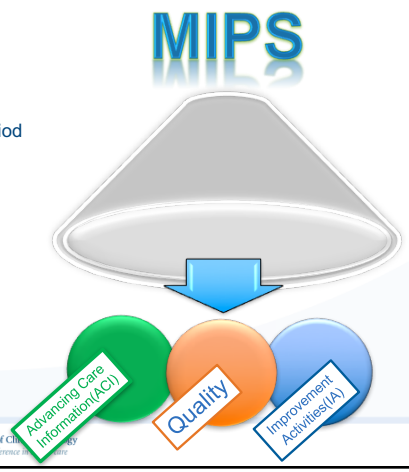
Reports publicly

How Will Medicare Reimbursement Change?

Legacy Reporting Systems

2016
Last Reporting Period

2018
Last Payment Adjustment



MIPS

2017
Adds Improvement Activity

First MIPS Performance Period

2018
Cost category Scored

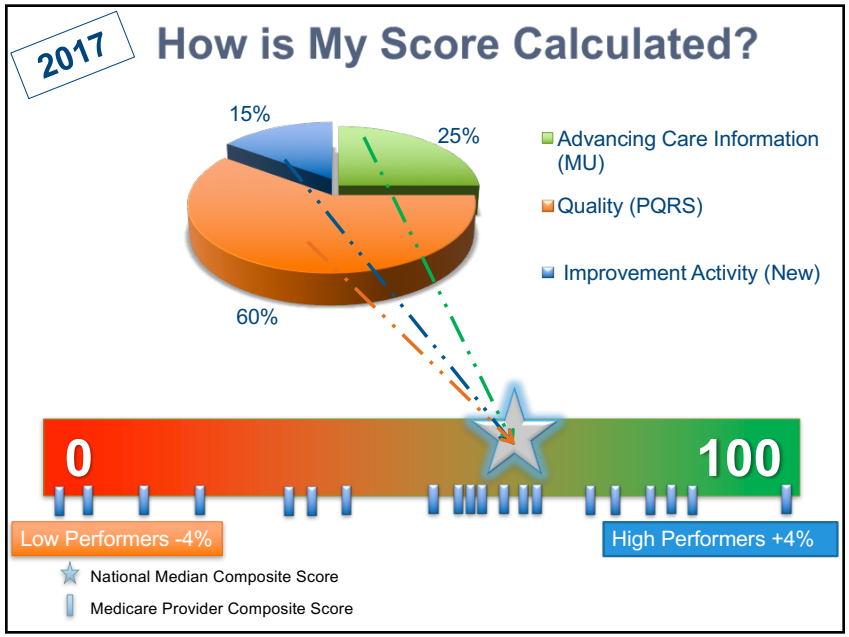
2019
First MIPS Payment Adjustment

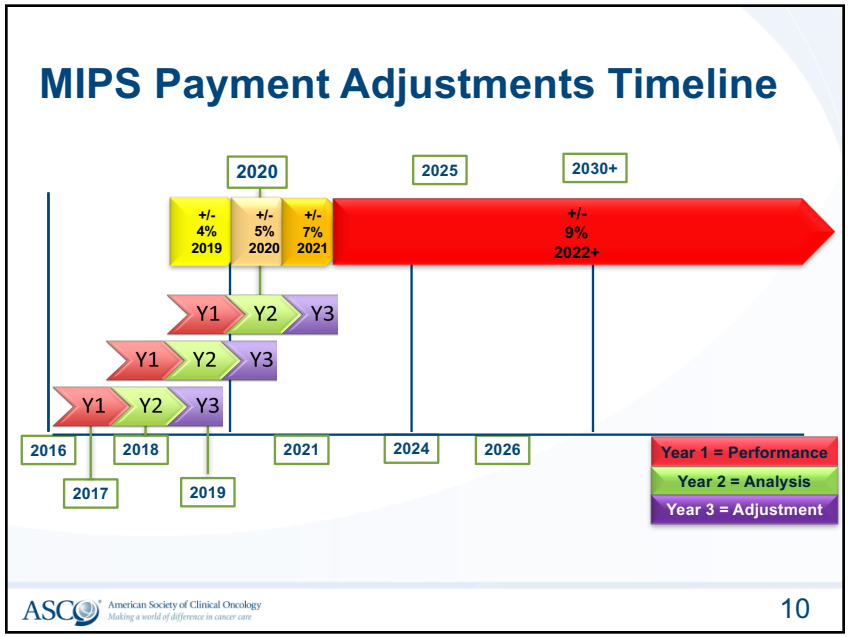
Cost

Not included in 2017

MIPS Categories

Quality	Improvement Activities	Advancing Care Information	Cost
Replaces PQRS.	New Category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.


2017
How is My Score Calculated?
15%
25%
60%
Advancing Care Information (MU)
Quality (PQRS)
Improvement Activity (New)
0
100
Low Performers -4%
High Performers +4%
National Median Composite Score
Medicare Provider Composite Score


MIPS Payment Adjustments Timeline
2020
2025
2030+
+/- 4% 2019
+/- 5% 2020
+/- 7% 2021
+/- 9% 2022+
Y1 Y2 Y3
Y1 Y2 Y3
Y1 Y2 Y3
2016
2017
2018
2019
2021
2024
2026
Year 1 = Performance
Year 2 = Analysis
Year 3 = Adjustment
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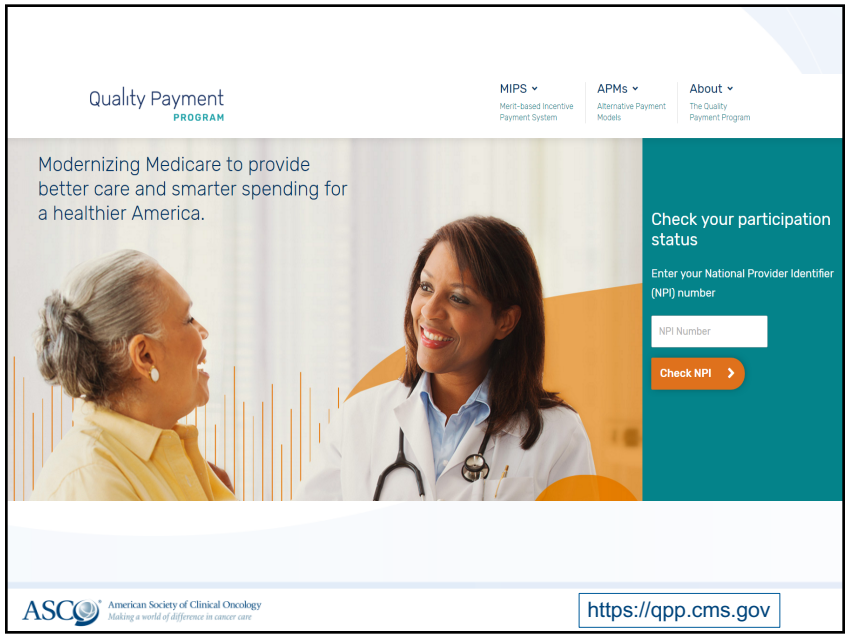

What should I be doing now?

QPP

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are you ready for MACRA?

ASCO's Top Ten List for MACRA Implementation in 2017

1. **Pick Your Pace in 2017.** Test the program and submit a minimum amount of data to avoid a 2019 penalty; OR report some data for at least 90 days; OR report full data for at least 90 days. If you do not report at all, you will receive a 4% penalty in 2019.

2. **Test the program.** If you choose to test the program in 2017, report more than the minimum required number of measures to improve your chances of successful reporting. And use the end of 2017 – July to December – to practice full reporting for 2018.

3. **Explore the quality measures on the Quality Payment Program (QPP) website.** Identify which measures best fit your practice. Many of the measures in the General Oncology Measure Set are included in ASCO's Quality Oncology Practice Initiative (QOPI®) program.

4. **Check that your electronic health record (EHR) is certified by the Office of the National Coordinator.** It must meet the 2015 certification standards by 2018; for 2017, you may use an EHR certified to either 2014 or 2015 standards. And remember that you must perform a security analysis to pass the Advancing Care Information (ACI) requirements in 2017.

5. **Review the Improvement Activities on the QPP website.** See which activities best fit your practice. QOPI participation and QOPI certification activities will prepare you to meet these requirements.

6. **Obtain your Quality and Resource Use Reports (QRUR).** While cost is not included in the scoring in 2017, it is being measured and will be reported in the QRUR. It will be included in the scoring beginning in 2018 so be prepared.

7. **Ensure data accuracy.** Review your QRUR and ensure that the data is correct. It is also important to review the National Provider Identifier (NPI) for each provider in your practice and ensure they are accurate with the correct specialty, address, and group affiliation.

8. **Consider using a qualified clinical data registry (QCDR) to extract and submit your quality data.** The *QOPI Reporting Registry*, currently in development, will be your one-stop shop for quality reporting and attestation for ACI and Improvement Activities.

9. **Evaluate your payer relationships and begin discussions with commercial payers about value-based reimbursement and alternative payment models.** Identify your top two or three commercial payers and initiate discussions with them about value-based care. Introduce them to ASCO's Patient-Centered Oncology Payment (PCOP) model – we are happy to help.

10. **Prepare your practice and staff for value-based care.** Does your staff understand the changes that are coming? Is your practice culturally prepared for the shift to value-based payment models? Are you employing elements of an oncology medical home including pathway utilization and ER and hospitalization avoidance? ASCO COME HOME provides consulting services to help practices transform for new reporting and payment models.

Avail yourself of ASCO resources.
Check ASCO's website, **www.asco.org/macra**, regularly for news, resources and tools for your practice. Contact macra@asco.org with questions.

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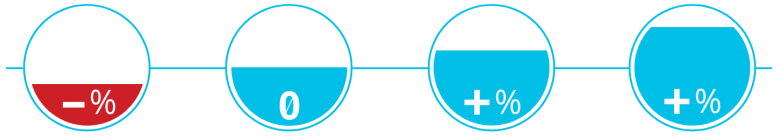
Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.



Don't Participate	Submit Something	Submit a Partial Year	Submit a Full Year
Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.	**Test:** If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.	**Partial:** If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment and may even earn the max adjustment.	**Full:** If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

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Pick Your Pace in MIPS

- The MIPS payment adjustment is based on the data submitted. The best way to get the maximum MIPS payment adjustment is to participate full year.
  - The most measures to pick from to submit
  - More reliable data submissions
  - Ability to get bonus points
- If you report only 90 days, you could still earn the maximum adjustment – there is nothing in the program that gives a reporter a lower score for 90-day reporting

- *Pick the Pace* that's best for your practice

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In 2019, my payment adjustment will be….

A. -4%, I'm not participating at all this year.
B. Neutral, I'm submitting at least one measure this year.
C. I'm all in, I might get a positive adjustment.

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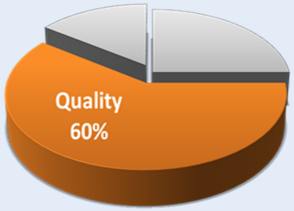

MIPS

QUALITY REPORTING

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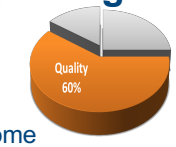
For more information on quality scoring, refer to slides from the 5/15/17 webinar at www.asco.org/macra

Oncology Quality Measures Reporting



- Formerly: PQRS
- General Oncology Measures Set
  - 19 reportable measures, both process and outcome
- Reporting Requirements
  - Report on 6 measures
  - At least one measure must be an outcome/high priority measure
  - Must report on at least 50% (2017) of patients eligible for each measure and have a 20 case minimum
  - Can report >6 measures and will be judged on 6 highest scores
- Patient population:
  - **All Payer** – **NOT** Medicare only
  - Must report a minimum of one measure for one Medicare beneficiary

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General Oncology Measure Set

Measure	Data Submission Method				Measure Type	High Priority
	Claims	Registry	EHR	Web Interface		
Advance care plan	X	X			Process	
Prostate bone scan (overuse)		X	X		Process	Yes
Current meds	X	X	X		Process	
Pain intensity		X	X		Process	Yes
Tobacco screening	X	X	X	X	Process	
Prostatectomy path reports	X	X			Process	
Hypertension screening & f/u	X	X	X		Process	
Receipt of specialist report			X		Process	
Adolescent tobacco use		X			Process	
Alcohol screening		X			Process	
HER2 negative		X			Process	Yes
HER2 positive		X			Process	Yes
KRAS testing/+EGFR		X			Process	
KRAS testing/-EGFR		X			Process	Yes
Chemo last 14 days		X			Process	Yes
Not admitted to hospice		X			Process	Yes
>1 ED visit last 30 days		X			*Outcome*	Yes
ICU last 30 days		X			*Outcome*	Yes
Hospice for less than 3 days		X			*Outcome*	Yes
Total Measures by Submission Mechanism	5	18	6	1		

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How Many Measures do I Have to Report? What Kind? Which Patients?

- If reporting individual measures:
  - 6 applicable measures (including one outcome measure or high priority if outcome not available)
- If reporting specialty measure set:
  - If set has 6 or more measures, report on 6 applicable measures
  - If set has less than 6 measures, report on all applicable measures
- Can report >6 measures and will be scored on 6 highest (must include an outcome/high priority measure)
- If reporting through CMS Web Interface:
  - All measures (11)
  - Patient sample provided by CMS (248)
- Patient population:
  - All Payer
  - Must report a minimum of one measure for one Medicare beneficiary

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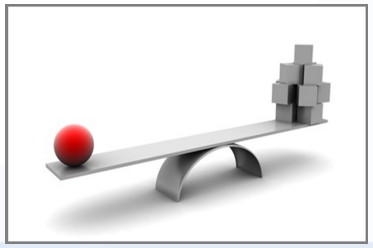
How Much do I Have to Report?

- In order for a submitted measure to be scored, it must meet the following criteria:
  - 50% of all eligible patients (all-payer)
  - 20-case minimum
  - Performance score >0%
- CMS has built in scoring "floors" for transition year
  - Recognition that "data completeness" requirements will not be met by many practices

Who am I being compared to?

- Quality Measure Benchmarks
  - Compared to all physicians and groups who reported that measure
  - Established by CMS using largely earlier data
  - Most benchmarks will be published prior to performance period



Measure Benchmarks

- Historical performance/baseline period
  - Will include data from APMs
- Each submission mechanism will have its own benchmark
- For a measure to have a benchmark, it must have at least 20 data points (group/individual reports), each of which has to meet the case minimum (20), data completeness thresholds, and score above zero
- Will be available prior to performance period
- If no historical benchmark, will use performance period to develop benchmark
  - Will not be available prior to performance period
- CMS creates an array of percentile distributions for benchmarks and decile breaks

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2017 MIPS Quality Benchmarks

Decile	3	4	5	6	7	8	9	10
Quantify Pain Intensity	35-75	76-81	82-89	90-95	96-99	-	-	100
Staging within 1 month	5-8	9-22	23-61	62-82	83-93	94-98	99	100

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Which Measures Can be "Scored" for Performance?

"Class 1" Measures: CAN be Scored Based on Performance

"Class 2" Measures: CANNOT be Scored Based on Performance

*Based on performance compared to benchmark

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3-Point Floor/Automatic Score

- Transition Year Only
  - 3-point "global" floor for all submitted measures and ACR measure (if applicable to your group)
  - Regardless of whether submitted measures meet case minimum or data completeness standards or have a benchmark, and even if you report a performance rate of zero
- All Years
  - New measures
  - Measures without a benchmark based on baseline period data ("Class 2" measure)
    - 20 clinicians did not report the measure with case minimum and data completeness requirements
    - CMS expects establishment of baseline data will take 2 years
- "New measure" 3-point floor for measures without a benchmark vs. Class 2 measures
  - New measures can score up to 10 if there's a benchmark and you meet case minimums/data completeness requirements
  - Class 2 measures is not a floor but rather an automatic score of 3 points; you're not scored on performance so can receive only 3 points

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Let's get real….

- Pick measures that are measurable electronically
  - 50% requirement in 2017….. Eventually 90%
- Think about workflow and documentation as you choose your measures
  - Who?
  - What?
  - When?
  - Where?
  - How?

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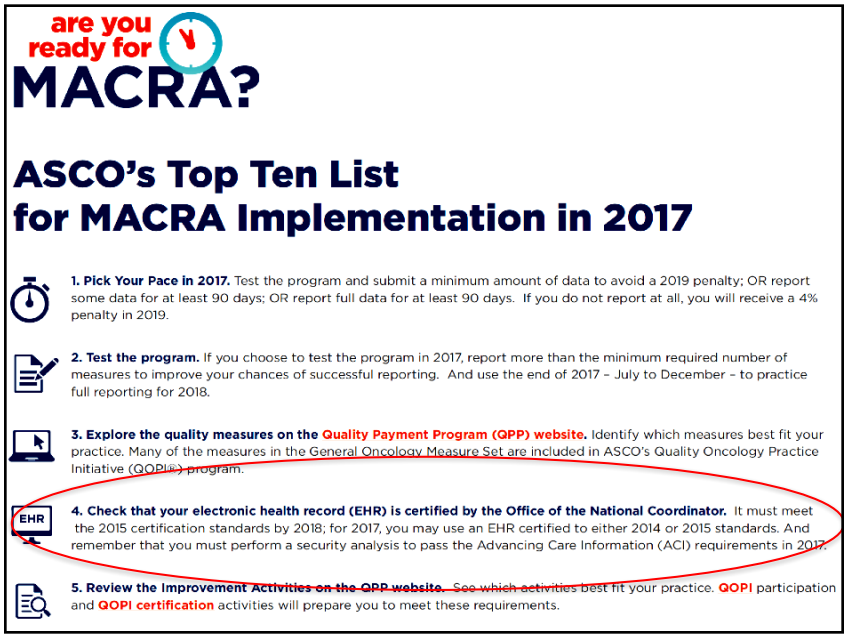

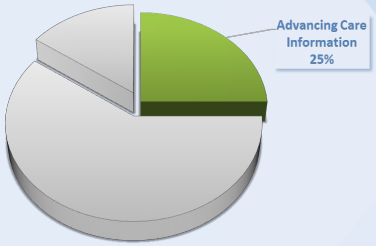

MIPS

ADVANCING CARE INFORMATION

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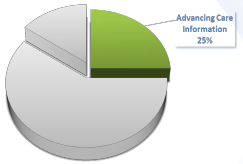
For more information on ACI scoring, refer to slides from the 6/19/17 webinar at www.asco.org/macra

Advancing Care Information



- Formerly: EHR Incentive Program or Meaningful Use
- Scoring from three EHR categories:
  - Base score is required from traditional EHR activities (Security, E-Prescribing, Patient Access, Health information Exchange)
  - Performance measures
  - Bonus score for public health and clinical data registry reporting

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SCORING

Base Score (50%)

- Up to 5 required measures

Performance Score (90%)

- Up to 9 measures

Bonus Score (15%)

- Public health and clinical data registry reporting

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Base Score (Required, 50%)

Objective	Measure	
	ACI (Stage 3)	ACI Transition (Mod Stage 2)
Protect Patient Health Information	Security Risk Analysis	Security Risk Analysis
Electronic Prescribing	E-Prescribing	E-Prescribing
Patient Electronic Access	Provide Patient Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care (SOC)	Health Information Exchange
	Request/Accept SOC	

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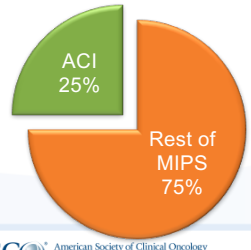
Base Score: Things to Know

- All or Nothing
  - Must report all required measures
  - Numerator/Denominator measures: Require at least a "1" in the numerator
  - "Yes/No" measures: Require a "yes" in the numerator
- Failure to achieve the above results in a base score of "zero"
- A base score of "zero" automatically gives you a performance score of "zero"



**ZERO BASE SCORE +
ZERO PERFORMANCE SCORE =
ZERO ACI SCORE**

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Security Risk Analysis

- Both HIPAA and the ACI category of the QPP require physicians to protect their patient information by conducting a security risk analysis
  - In fact, physicians cannot scare any points in the ACI category without a security risk analysis
- ***Have you done this yet?***

- The AMA is hosting a one-hour webinar on Wednesday, September 13, 1 – 3 pm ET
- https://cc.readytalk.com/registration/#/?meeting=cljb5eb6trdy&campaign=up4d5e9fi57a

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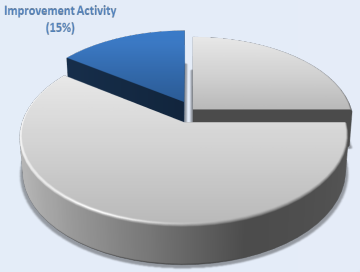

MIPS

IMPROVEMENT ACTIVITIES

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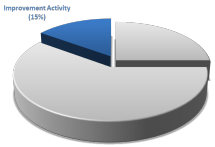
Improvement Activities



- A **new** performance category
  - Defined as "an activity that relevant eligible clinical organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes."
- 90+ activities in 9 subcategories
- Each activity is weighted either medium or high

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Improvement Activity

Scoring Considerations

- **Groups with more than 15 clinicians: 40 points**
  - Medium-weighted activities – 10 points each
  - High-weighted activities – 20 points each
- **Groups with 15 or fewer participants or if you are in a rural or health professional shortage area: 40 points**
  - Medium-weighted activities – 20 points each
  - High-weighted activities – 40 points each
- **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.

Scoring Considerations (2)

- **Participants in MIPS APMs such as 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.
- **Participants in any other APM**
  - You will automatically earn half credit and may report additional activities to increase your score.

What are you already doing?

- Expanded practice access
- **Participation in QOPI**
- Provide longitudinal care management to patients at high risk of adverse health outcome
- Management across transitions and referrals
- **Reconciliation of medications across settings or period structured review**
- **Pharmacist integration into care team**
- Specialist reports to referring clinician
- **Timely communication of abnormal test results to patient with follow up**
- **Document care coordination activities**
- Documented practices/processes for developing regularly updated individual care plans and sharing with patient
- Documentation of "patient-centered action plan" for first 30 days following a discharge
- Care coordination agreements with frequently used consultants
- **Tracking of patients referred to specialists**
- Specialist referral information systematically integrated into plan of care
- **Structured referral notes**
- **Provision of community resource guides**
- Peer-led self-management programs for patients
- Refer/link patients to condition-specific chronic disease self-management support programs in the community
- Provide self-management materials at an appropriate literacy level and in an appropriate language
- **PDMP – registration and/or consultation**
- Use of patient safety tools that assist specialists in tracking specific patient safety measures meaningful to their practice
- **Participation in private payer practice improvement activities**

These are all CMS-recognized Improvement Activities under MIPS

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are you ready for MACRA?

List of CMS Improvement Activities That Can Be Crosswalked to ASCO Quality Programs

Category of Improvement Activity (Subcategory Name)	CMS ID (Improvement Activity ID)	Specifics on Activity (Activity Description)	ASCO Quality Program
Patient Safety & Practice Assessment	IA_PSPA_7	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.	QCP QCDR
Patient Safety & Practice Assessment	IA_PSPA_8	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator.	QCP
Patient Safety & Practice Assessment	IA_PSPA_19	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.	QCP QTP

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https://www.asco.org/sites/new-www.asco.org/files/content-files/CMS-Improvement-Activities-Corresponding-ASCO-Programs.pdf

Crosswalk: ASCO's Quality Oncology Practice Initiative (QOPI) Certification Program (QCP) Selected Activities and Standards with CMS 2017 Improvement Activities Under the Merit-Based Incentive Payment System (MIPS)

CMS Improvement Activity ID	Subcategory Name	Activity Description	Activity Weighting	ASCO's QCP Activity
		General Program Characteristics		
IA_PSPA_19	Patient Safety & Practice Assessment	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.	Medium	Participation in the QCP requires the involvement of practice leadership and administration; the certification process includes an extensive on-site survey including interviews with practice staff members The QOPI Certification Program has defined Domains of responsibility: organization (**Creating a Safe Environment-Staffing and General Policy**), processes prior to treatment (**Treatment Planning, Patient Consent and Education**), safe practices during treatment (**ordering, preparing, dispensing and administering chemotherapy),** and patient safety monitoring (**Monitoring after chemotherapy is given, including adherence, toxicity and complications**). Within each Domain are Standards, and for each Standard there are Elements that provide more specificity for the Standard. A vital component of implementation includes staff education and engagement. Domain 1 encompasses general education, competency, and documenting standards that require the involvement of practice leadership and administration to engage staff and patient participation in quality cancer care.
IA_PSPA_20	Patient Safety & Practice Assessment	Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following: Make responsibility for guidance of practice change a component of clinical and administrative leadership roles; Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings; and/or Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.	Medium	Participation in the QCP requires the involvement of practice leadership and administration; the certification process includes an extensive on-site survey including interviews with practice staff members To achieve certification, a practice /institution must meet all the certification Standards and Elements. To create practice change, standards need to be developed from within the healthcare community. The QCP standards were developed by oncology stakeholders including physcians, government agencies, patient advocates, pharmacists, nurses and other stakeholders. By gaining the insight of healthcare constituents, including the patient and family community, the initiative developed best practices based on the

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IA Documentation

- Attestation will be the most commonly used reporting mechanism
- CMS documentation requirements: *"Eligible clinicians are encouraged to retain documentation for 6 years as required by the CMS document retention policy."*
- ASCO recommends practices maintain dated documentation describing the improvement activity, when it was conducted, and any policies, procedures, or practice changes related to the activity; maintain all documentation for at least 6 years

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IA Documentation (cont'd)

- CMS has released "MIPS Data Validation Criteria" for the IA category
- Lists "validation" criteria and "suggested documentation"
- https://qpp.cms.gov → Education & Tools → Download the zip file "MIPS Data Validation Criteria"
- File contains a fact sheet and 2 files (Excel and PDF) listing all activities with associated suggested documentation

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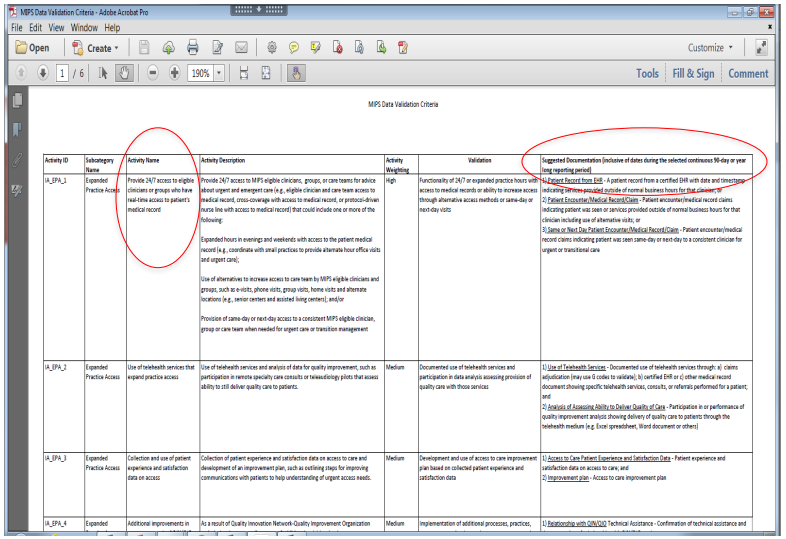

6. Obtain your Quality and Resource Use Reports (QRUR). While cost is not included in the scoring in 2017, it is being measured and will be reported in the QRUR. It will be included in the scoring beginning in 2018 so be prepared.

7. Ensure data accuracy. Review your QRUR and ensure that the data is correct. It is also important to review the National Provider Identifier (NPI) for each provider in your practice and ensure they are accurate with the correct specialty, address, and group affiliation.

8. Consider using a qualified clinical data registry (QCDR) to extract and submit your quality data. The *QOPI Reporting Registry*, currently in development, will be your one-stop shop for quality reporting and attestation for ACI and Improvement Activities.

9. Evaluate your payer relationships and begin discussions with commercial payers about value-based reimbursement and alternative payment models. Identify your top two or three commercial payers and initiate discussions with them about value-based care. Introduce them to **ASCO's Patient-Centered Oncology Payment** (PCOP) model – we are happy to help.

10. Prepare your practice and staff for value-based care. Does your staff understand the changes that are coming? Is your practice culturally prepared for the shift to value-based payment models? Are you employing elements of an oncology medical home including pathway utilization and ER and hospitalization avoidance? **ASCO COME HOME** provides consulting services to help practices transform for new reporting and payment models.

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MIPS
COST

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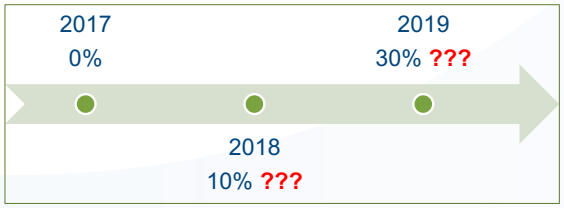
Cost

- Formerly: Value-Based Modifier
- Cost is being calculated but not counted in scoring for 2017
  - Based on claims data
- Providers will receive a report for feedback purposes on cost for 2017 (QRUR)
- Cost will be included in scoring in future years



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Cost Basics

- Total per capita cost measure – risk-adjusted by specialty
- Medicare Spending Per Beneficiary (MSPB) measure
- 41 episode measures – none oncology-related
- Attribution by majority/plurality of E&M visits
- Part B drugs included, Part D not included
- Compared nationally to all physicians/groups
- Methodology subject to change based on forthcoming rules

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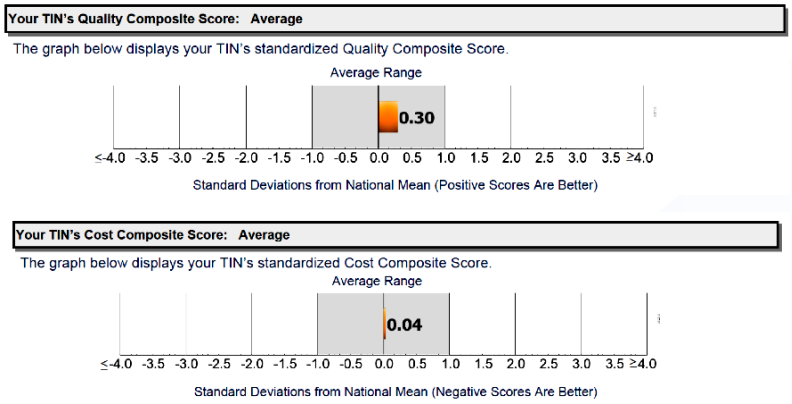
What is the QRUR?

- Quality and Resource Use Reports
  - Show how you performed on quality and cost
  - QRURs provided for each TIN (tax ID number)(
- Annual QRUR available in the fall after the reporting period (fall 2017 for calendar year 2016)
- One person from your TIN must register to obtain your QRUR
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

What does the QRUR show?



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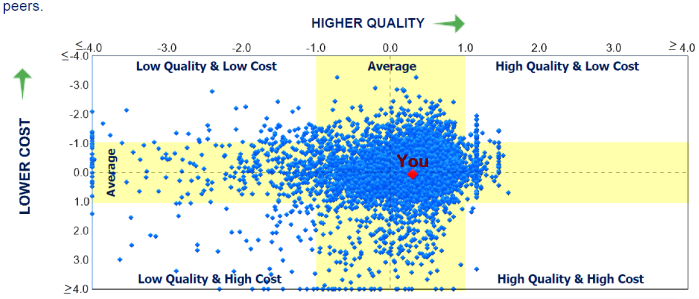
What does the QRUR show?

Your TIN's Performance: Average Quality, Average Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.



What does the QRUR show?

High-Risk Bonus Adjustment: Not Eligible

The average beneficiary risk for your TIN is at the 77th percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for an additional upward adjustment for serving high-risk beneficiaries based on whether your TIN met (✓) or did not meet (✖) the following criteria in 2014:

- ✓ Your TIN's average beneficiary's risk is at or above the 75th percentile of beneficiaries nationwide.
- ✖ Your TIN had strong quality and cost performance.
- ✓ Your TIN met the criteria to avoid the PQRS payment adjustment as a group, or at least 50 percent of your TIN's eligible professionals met the criteria to avoid the PQRS payment adjustment as individuals in 2016.

What does the QRUR show?

Your TIN's Value Modifier: Neutral Adjustment

The highlighted payment adjustment will be applied to payments under the Medicare Physician Fee Schedule for physicians billing under in your TIN in 2016.

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0 x AF	+2.0 x AF
Average Cost	-1.0%	**0.0%**	+1.0 x AF
High Cost	-2.0%	-1.0%	0.0%

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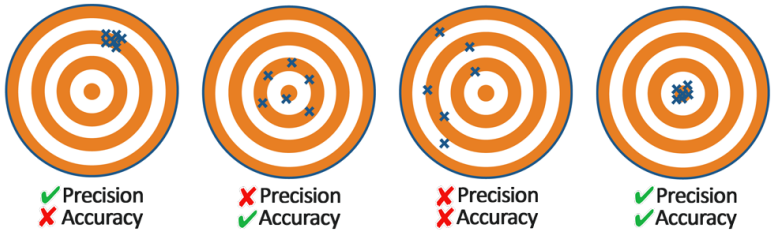
Precision vs Accuracy



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QOPI® The Quality Oncology Practice Initiative
Quality Cancer Care: Pursuing Excellence

Reporting Registry
…now available!

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QOPI is a CMS-approved QCDR

- What is a QCDR?
  - Qualified Clinical Data Registry
  - Collects medical and/or clinical data for patient and disease tracking to foster improvement of quality of care
  - CMS Approved
  - Quality Measures
    - National Quality Foundation
    - MIPS Measures
    - ASCO measures approved by CMS
  - New for 2017, can also report Improvement Activities and Advancing Care Information

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QOPI® Reporting Registry
Qualified Clinical Data Registry

Brought to you by ASCO and ASTRO

2017 MIPS Reporting

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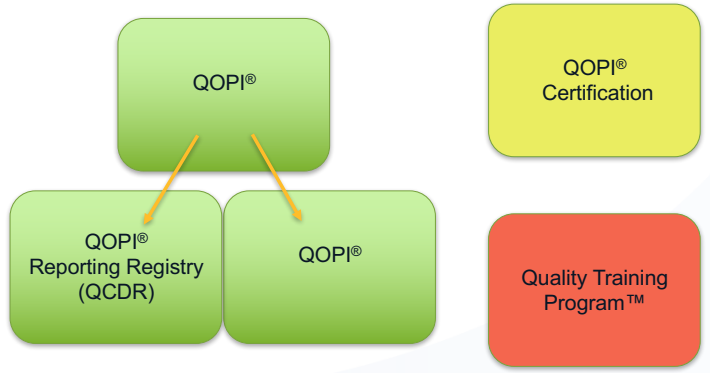
ASCO's Quality Programs



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QOPI The Quality Oncology Practice Initiative

QOPI® Reporting Registry (QCDR) Submission Methods

System-Integrated Approach

- Software-installation behind practice firewall
- Data pulls directly from EHR

COST

$75 per NPI
(costs will increase for 2018 reporting)

Web-Interface Tool Approach

- Web-based
- Manual data input

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CMS Approved Measures

MEASURE NAME	NQF	QUALITY ID
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	389	102
Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer	390	104
Documentation of Current Medications in the Medical Record	419	130
Oncology: Medical and Radiation - Pain Intensity Quantified	384	143
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	28	226
Radical Prostatectomy Pathology Reporting	1853	250
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	N/A	317
HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies	1857	449
Trastuzumab Received By Patients With AJCC Stage I (T1c) - III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy	1858	450
KRAS Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy	1859	451
Patients with Metastatic Colorectal Cancer and KRAS Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies	1860	452
Proportion Receiving Chemotherapy in the Last 14 Days of Life	210	453
Proportion Admitted to Hospice for less than 3 days	216	457
Chemotherapy treatment administered to patients with metastatic solid tumor with performance status of 3, 4, or undocumented. (Lower Score - Better)	N/A	N/A
Combination chemotherapy treatment received within 4 months of diagnosis by women under 70 with AJCC stage IA (T1c) and IB - III ER/PR negative breast cancer	559	N/A
GCSF administered to patients who received chemotherapy for metastatic cancer (Lower Score-Better)	N/A	N/A

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Systems Integrated Workflow

- Sign up for QCDR participation
- Sign QCDR Agreements (BAA and Participation Agreement)
- Set up Call for Remote Practice Connector (RPC) Install
  - Data pull only
- Begin Mapping
  - ASCO would like to stress the iterative nature of the mapping process for 2017 and beyond so practices understand that performance can actually improve with better mapping for most of the measures
  - ASCO will work with practices/EHRs to help change the documentation practice by providing evidence of why it is crucial
- Practice reviews performance on dashboard
- ASCO submits data to CMS

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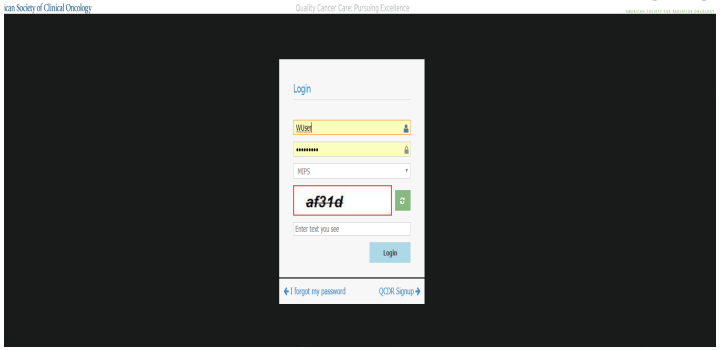
QOPI® Reporting Registry (QCDR)



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Web Demo Practice
MIPS
Welcome
Individual Reporting
Logout
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MIPS › Welcome
Web Demo Practice (6)
What's the Quality Payment Program?
Get Started
The Quality Payment Program improves Medicare by helping you focus on care quality and the one thing that matters most — making patients healthier. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate formula, which threatened clinicians participating in Medicare with potential payment cliffs for 13 years. If you participate in Medicare Part B, you are part of the dedicated team of clinicians who serve more than 55 million of the country's most vulnerable Americans, and the Quality Payment Program will provide new tools and resources to help you give your patients the best possible care. You can choose how you want to participate based on your practice size, specialty, location, or patient population.
The Quality Payment Program has two tracks you can choose:
• Advanced Alternative Payment Models (APMs) or
• The Merit-based Incentive Payment System (MIPS)
If you decide to participate in an Advanced APM, through Medicare Part B you may earn an incentive payment for participating in an innovative payment model.
If you decide to participate in MIPS, you will earn a performance-based payment adjustment.
Who's in the Quality Payment Program?
You're a part of the Quality Payment Program in 2017 if you are in an Advanced APM or if you bill Medicare more than $30,000 in Part B allowed charges a year and provide care for more than 100 Medicare patients a year. You must both meet the minimum billing and the number of patients to be in the program. If you are below either, you are not in the program.
For MIPS, you must also be a:
• Physician
• Physician assistant
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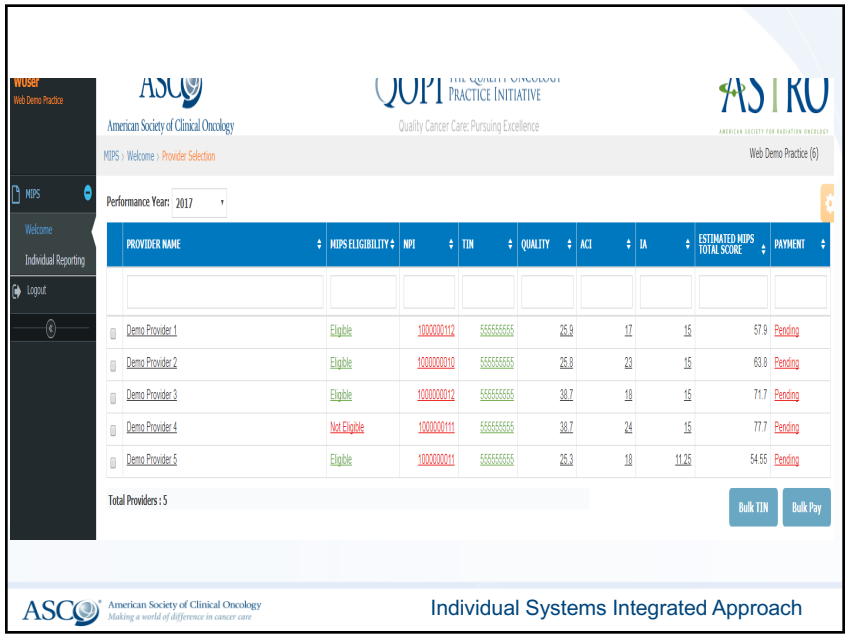
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MIPS
Welcome
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QOPI PRACTICE INITIATIVE
Quality Cancer Care: Pursuing Excellence
MIPS › Welcome › Provider Selection
Web Demo Practice (6)
Performance Year: 2017
PROVIDER NAME
MIPS ELIGIBILITY
NPI
TIN
QUALITY
ACI
IA
ESTIMATED MIPS TOTAL SCORE
PAYMENT
Demo Provider 1 Eligible 1000000112 555555555 26.9 17 15 57.9 Pending
Demo Provider 2 Eligible 1000000010 555555555 25.8 23 15 63.8 Pending
Demo Provider 3 Eligible 1000000012 555555555 38.7 18 15 71.7 Pending
Demo Provider 4 Not Eligible 1000000111 555555555 38.7 24 15 77.7 Pending
Demo Provider 5 Eligible 1000000011 555555555 25.3 18 11.25 54.55 Pending
Total Providers : 5
Bulk TIN
Bulk Pay
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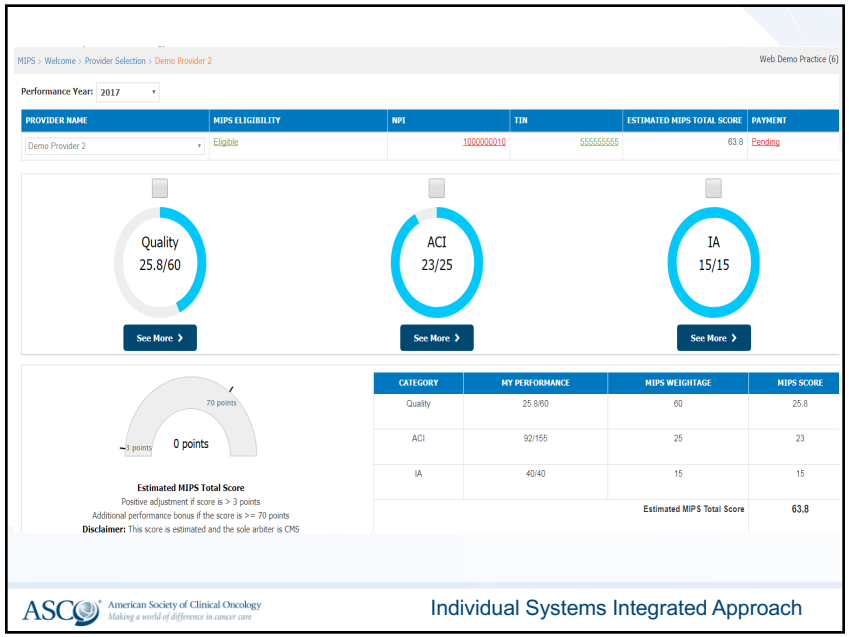
MIPS › Welcome › Provider Selection › Demo Provider 2
Web Demo Practice (6)
Performance Year: 2017
PROVIDER NAME
MIPS ELIGIBILITY
NPI
TIN
ESTIMATED MIPS TOTAL SCORE
PAYMENT
Demo Provider 2
Eligible
1000000010
555555555
63.8
Pending
Quality
25.8/60
ACI
23/25
IA
15/15
See More
See More
See More
70 points
0 points
Estimated MIPS Total Score
Positive adjustment if score is > 3 points
Additional performance bonus if the score is >= 70 points
Disclaimer: This score is estimated and the sole arbiter is CMS
CATEGORY
MY PERFORMANCE
MIPS WEIGHTAGE
MIPS SCORE
Quality
25.8/60
60
25.8
ACI
92/155
25
23
IA
40/40
15
15
Estimated MIPS Total Score
63.8
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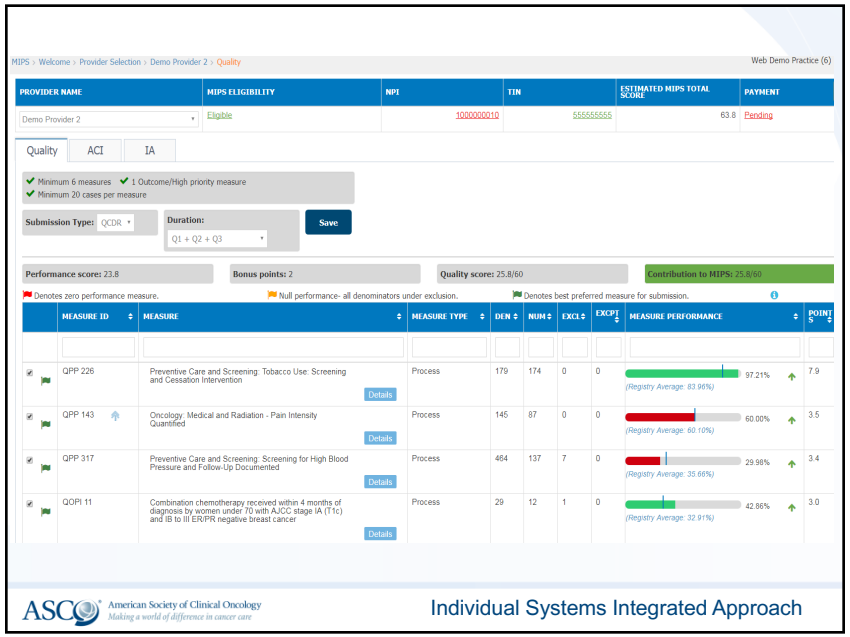
MIPS › Welcome › Provider Selection › Demo Provider 2 › Quality
Web Demo Practice (6)
PROVIDER NAME
MIPS ELIGIBILITY
NPI
TIN
ESTIMATED MIPS TOTAL SCORE
PAYMENT
Demo Provider 2
Eligible
1000000010
555555555
63.8
Pending
Quality
ACI
IA
Minimum 6 measures
1 Outcome/High priority measure
Minimum 20 cases per measure
Submission Type: QCDR
Duration:
Q1 + Q2 + Q3
Save
Performance score: 23.8
Bonus points: 2
Quality score: 25.8/60
Contribution to MIPS: 25.8/60
Denotes zero performance measure.
Null performance- all denominators under exclusion.
Denotes best preferred measure for submission.
MEASURE ID
MEASURE
MEASURE TYPE
DEN
NUM
EXCL
EXCPT
MEASURE PERFORMANCE
QPP 226
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Process
179
174
0
0
97.21%
(Registry Average: 83.96%)
7.9
QPP 143
Oncology: Medical and Radiation - Pain Intensity Quantified
Process
145
87
0
0
60.00%
(Registry Average: 60.10%)
3.5
QPP 317
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Process
464
137
7
0
29.96%
(Registry Average: 35.66%)
3.4
QOPI 11
Combination chemotherapy received within 4 months of diagnosis by women under 70 with AJCC stage IA (T1c) and IB to III ER/PR negative breast cancer
Process
29
12
1
0
42.86%
(Registry Average: 32.91%)
3.0
Details
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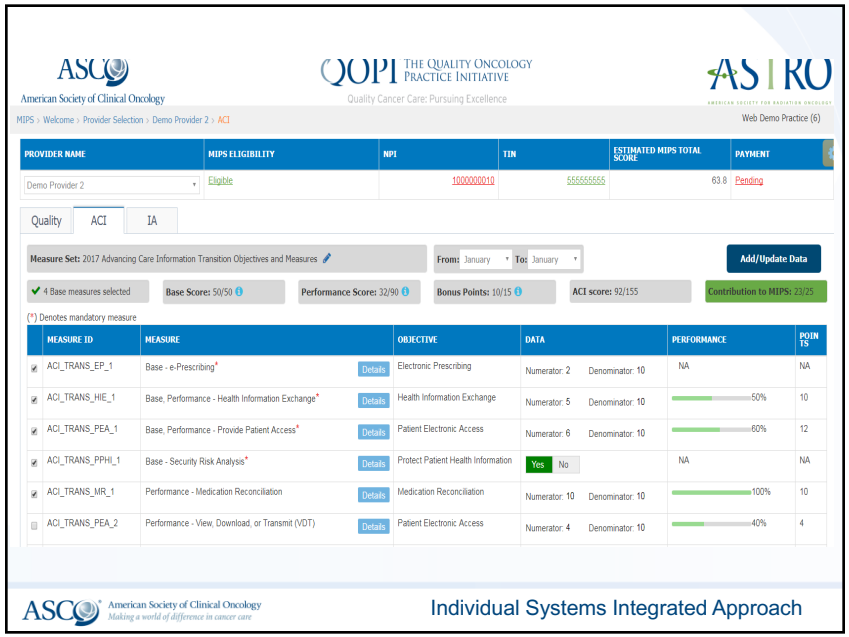
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MIPS › Welcome › Provider Selection › Demo Provider 2 › ACI
Web Demo Practice (6)
PROVIDER NAME
MIPS ELIGIBILITY
NPI
TIN
ESTIMATED MIPS TOTAL SCORE
PAYMENT
Demo Provider 2
Eligible
1000000010
555555555
63.8
Pending
Quality
ACI
IA
Measure Set: 2017 Advancing Care Information Transition Objectives and Measures
From: January
To: January
Add/Update Data
4 Base measures selected
Base Score: 50/50
Performance Score: 32/90
Bonus Points: 10/15
ACI score: 92/155
Contribution to MIPS: 23/25
(*) Denotes mandatory measure
MEASURE ID
MEASURE
OBJECTIVE
DATA
PERFORMANCE
POINTS
ACI_TRANS_EP_1
Base - e-Prescribing*
Details
Electronic Prescribing
Numerator: 2
Denominator: 10
NA
NA
ACI_TRANS_HIE_1
Base, Performance - Health Information Exchange*
Details
Health Information Exchange
Numerator: 5
Denominator: 10
50%
10
ACI_TRANS_PEA_1
Base, Performance - Provide Patient Access*
Details
Patient Electronic Access
Numerator: 6
Denominator: 10
60%
12
ACI_TRANS_PPHI_1
Base - Security Risk Analysis*
Details
Protect Patient Health Information
Yes
No
NA
NA
ACI_TRANS_MR_1
Performance - Medication Reconciliation
Details
Medication Reconciliation
Numerator: 10
Denominator: 10
100%
10
ACI_TRANS_PEA_2
Performance - View, Download, or Transmit (VDT)
Details
Patient Electronic Access
Numerator: 4
Denominator: 10
40%
4
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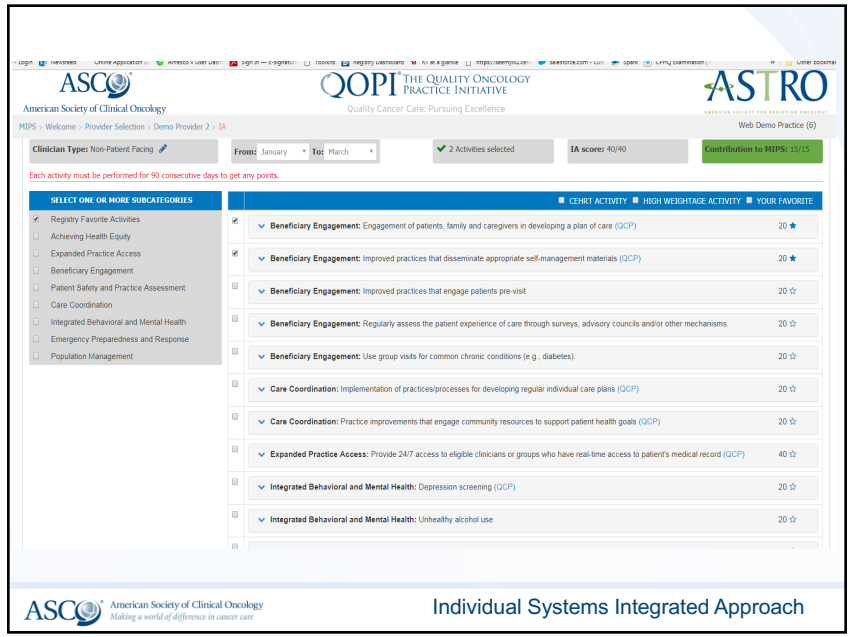
Individual Systems Integrated Approach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QOPI THE QUALITY ONCOLOGY PRACTICE INITIATIVE
Quality Cancer Care: Pursuing Excellence
ASTRO
MIPS › Welcome › Provider Selection › Demo Provider 2 › IA
Web Demo Practice (6)
Clinician Type: Non-Patient Facing
From: January
To: March
2 Activities selected
IA score: 40/40
Contribution to MIPS: 15/15
Each activity must be performed for 90 consecutive days to get any points.
SELECT ONE OR MORE SUBCATEGORIES
Registry Favorite Activities
Achieving Health Equity
Expanded Practice Access
Beneficiary Engagement
Patient Safety and Practice Assessment
Care Coordination
Integrated Behavioral and Mental Health
Emergency Preparedness and Response
Population Management
CEHRT ACTIVITY
HIGH WEIGHTAGE ACTIVITY
YOUR FAVORITE
Beneficiary Engagement: Engagement of patients, family and caregivers in developing a plan of care (QCP) 20
Beneficiary Engagement: Improved practices that disseminate appropriate self-management materials (QCP) 20
Beneficiary Engagement: Improved practices that engage patients pre-visit 20
Beneficiary Engagement: Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms 20
Beneficiary Engagement: Use group visits for common chronic conditions (e.g., diabetes). 20
Care Coordination: Implementation of practices/processes for developing regular individual care plans (QCP) 20
Care Coordination: Practice improvements that engage community resources to support patient health goals (QCP) 20
Expanded Practice Access: Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record (QCP) 40
Integrated Behavioral and Mental Health: Depression screening (QCP) 20
Integrated Behavioral and Mental Health: Unhealthy alcohol use 20
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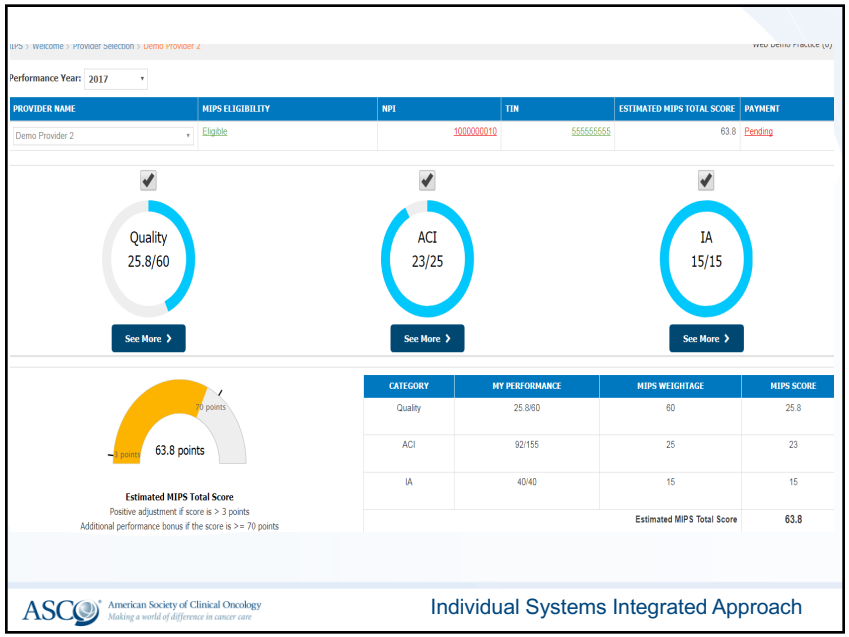
Performance Year: 2017
PROVIDER NAME
MIPS ELIGIBILITY
NPI
TIN
ESTIMATED MIPS TOTAL SCORE
PAYMENT
Demo Provider 2
Eligible
1000000010
555555555
63.8
Pending
Quality
25.8/60
ACI
23/25
IA
15/15
See More
See More
See More
63.8 points
Estimated MIPS Total Score
Positive adjustment if score is > 3 points
Additional performance bonus if the score is >= 70 points
CATEGORY
MY PERFORMANCE
MIPS WEIGHTAGE
MIPS SCORE
Quality
25.8/60
60
25.8
ACI
92/155
25
23
IA
40/40
15
15
Estimated MIPS Total Score
63.8
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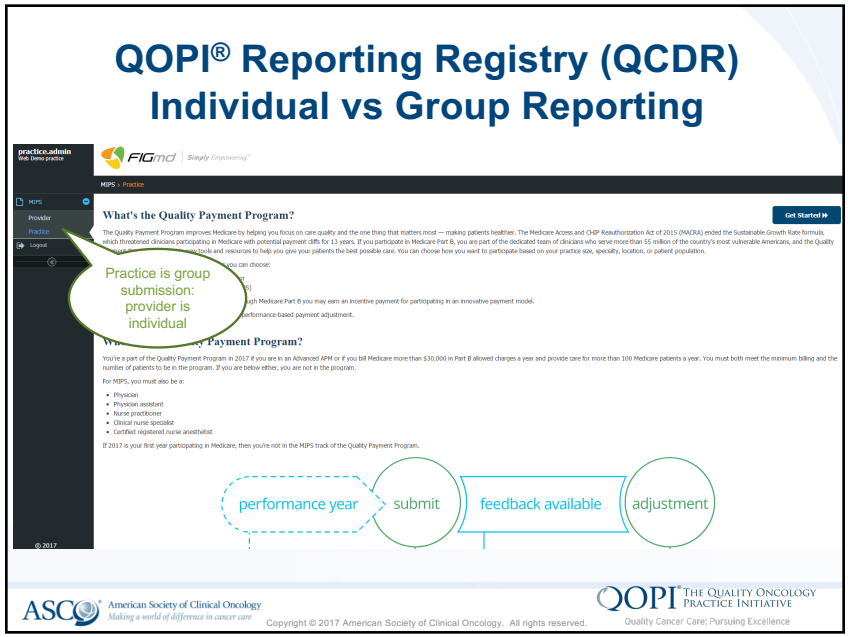
QOPI® Reporting Registry (QCDR)
Individual vs Group Reporting
practice.admin
Web Demo practice
MIPS
Provider
Practice
Logout
What's the Quality Payment Program?
Get Started
Practice is group submission: provider is individual
performance year
submit
feedback available
adjustment
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QOPI® Reporting Registry (QCDR) Individual vs Group Reporting

- Report as **individual** clinician within a group:
  - Each clinician evaluated individually based on specific measures they choose to report
  - The **payment adjustment is applied to the individual NPI** and is **portable** with the provider if they change TINs
- Report as a **group:**
  - MIPS eligible clinicians that report as part of a group are evaluated on the measures that are reported by the group, **regardless** of whether the group's measures are **specifically applicable** to the individual MIPS-eligible clinician
  - The subsequent **group payment adjustment is applied to each NPI** within the group and is not **portable with the NPI if he/she changes** TIN

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Web Interface Tool

- Register for QCDR participation
- Sign QCDR Agreements
- Begin manual abstraction of data
- Practice reviews performance on dashboard
- ASCO submits data to CMS

- Practice should use this time to become systems-integrated in order to be ready for 2018

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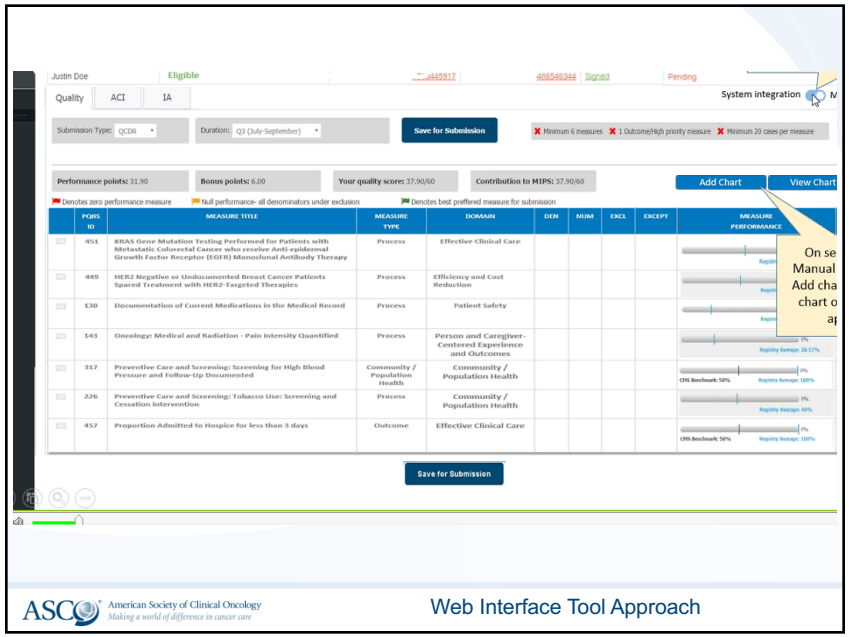

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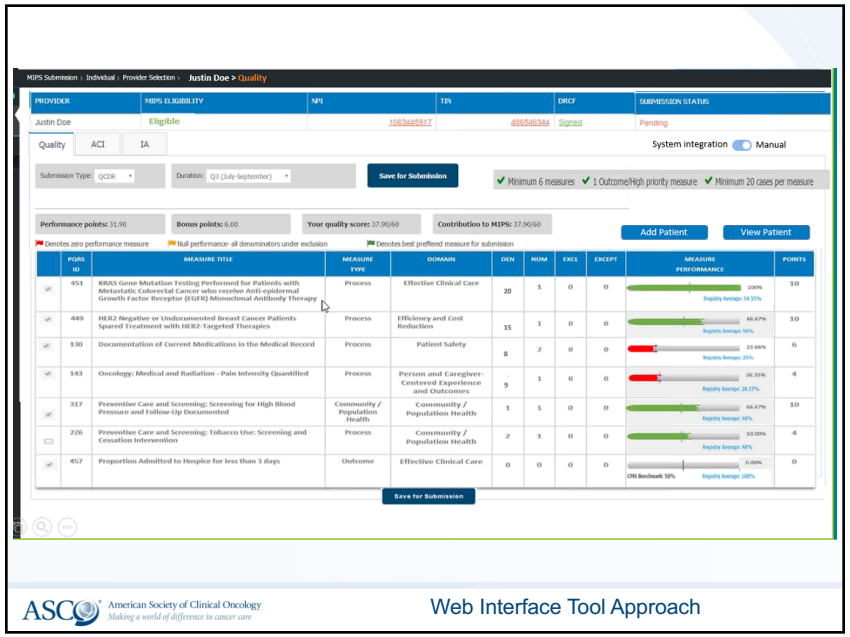
Web Interface Tool Approach



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Web Interface Tool Approach

What's required in 2018?

Practices will be required to report on **60%** of their eligible charts for ALL measures to avoid a Medicare reimbursement penalty in 2020.

- ASCO is using 2017 as a transition year to modify the QOPI QCDR to allow practices to meet this requirement and will provide updates on our progress throughout 2017.
- ASCO encourages all oncology practices to use 2017 to ensure they are positioned to report at the significantly higher volume requirement in 2018.

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QCDR Timeline

- QCDR Sign up opened on July 01, 2017
- Practices must have legal agreements signed **by October** in order to participate in the 2017 QOPI QCDR
  - This is due to onboarding time require
- Data submission by practices to QCDR due by 12/31/2017
- Onboarding of practice will be first come first served…. SIGN UP TODAY!

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Recommendations

- Practices should try to do Systems-Integrated
  - If your practice cannot for EHR or legal reasons, we recommend using the rest of 2017 to make steps to transition to systems-integrated before 2018 so that your practice will be ready
- Encourage documentation in existing fields in EHR to facilitate better mapping of data
- We are happy to work with your practice's EHR vendor to help develop fields but work will need be to done on the practice end regarding modifying documentation practices

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Further Resources

For more information on how to register for any of these programs or if you have additional questions, please contact:

- QOPI®/QOPI® QCDR: email qopi@asco.org or visit qopi.asco.org
- QOPI Certification: email qopicertification@asco.org or visit qopi.asco.org
- Quality Training Program™: email qualitytraining@asco.org or visit http://goo.gl/zxtY9u
- For more information on MACRA: email macra@asco.org or visit asco.org/MACRA

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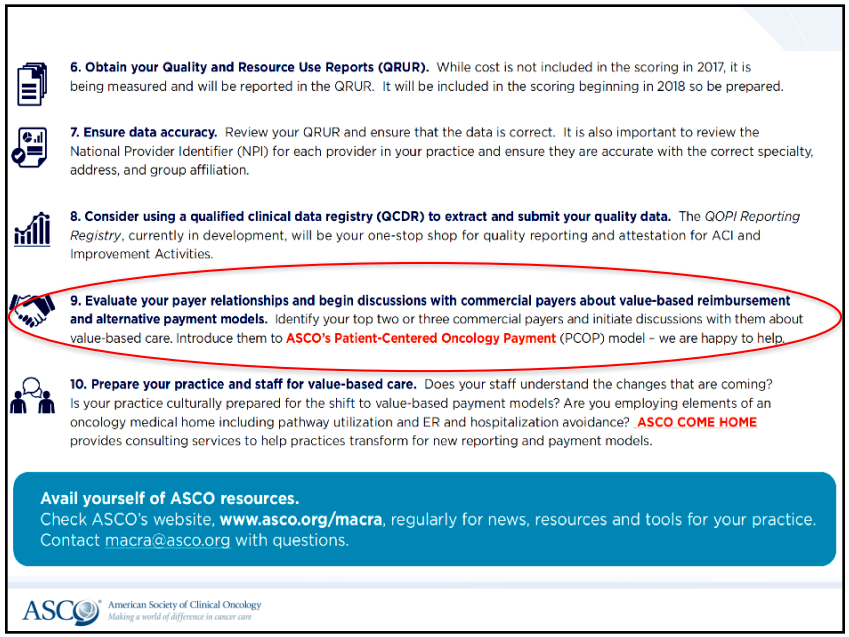
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7. Ensure data accuracy. Review your QRUR and ensure that the data is correct. It is also important to review the National Provider Identifier (NPI) for each provider in your practice and ensure they are accurate with the correct specialty, address, and group affiliation.
8. Consider using a qualified clinical data registry (QCDR) to extract and submit your quality data. The QOPI Reporting Registry, currently in development, will be your one-stop shop for quality reporting and attestation for ACI and Improvement Activities.
9. Evaluate your payer relationships and begin discussions with commercial payers about value-based reimbursement and alternative payment models. Identify your top two or three commercial payers and initiate discussions with them about value-based care. Introduce them to ASCO's Patient-Centered Oncology Payment (PCOP) model – we are happy to help.
10. Prepare your practice and staff for value-based care. Does your staff understand the changes that are coming? Is your practice culturally prepared for the shift to value-based payment models? Are you employing elements of an oncology medical home including pathway utilization and ER and hospitalization avoidance? ASCO COME HOME provides consulting services to help practices transform for new reporting and payment models.
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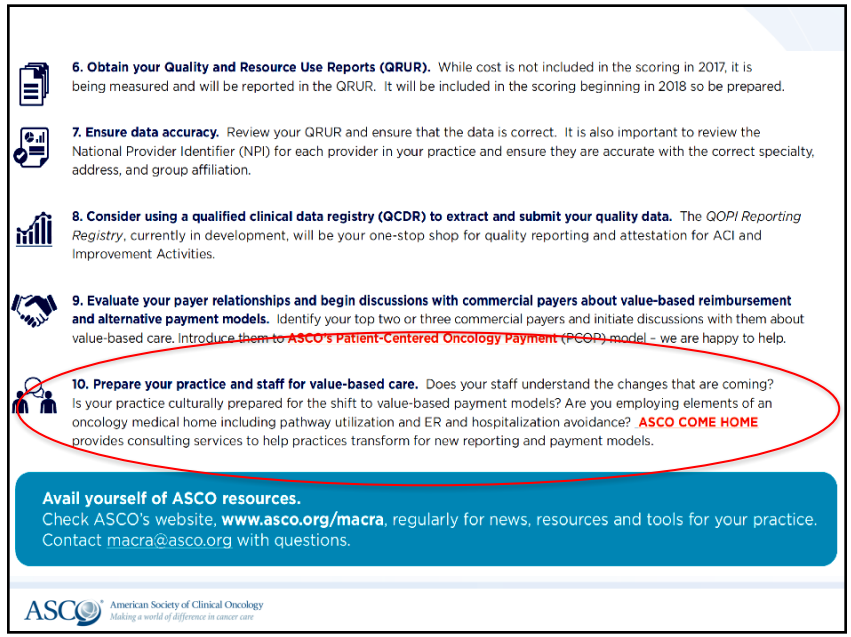
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ASCO COME HOME

Community Oncology Medical Home Program

Program Overview

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What contributes to total cost of care?

- Chemotherapy and other treatments
  - Medical oncologists have little control
  - Pass through costs
- ED Visits
  - North Carolina 2008 data[1]: 37,760 ED Visits
    - 63.2% resulted in admissions
    - Mostly for symptom control
      - GI, Pain, Neurological Symptoms, Malaise, Injury Fever
- Inpatient Admissions
  - Medical homes have been shown to reduce inpatient admissions by 15-50%[1]

[1]J Clin Onco 29:2683-2688

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Oncology Patient-Centered Medical Home

- John Sprandio, MD, Consultants in Medical Oncology, Pennsylvania, 2010
- First oncology practice recognized by NCQA as Level III PCMH with oncology model
- Targeted costs, improved quality, enhanced patient care processes
- Reduced ED visits and hospitalizations
- Overall cost savings estimated at $1M per physician annually

Sprandio, Comm Oncol, 2010, 565-572

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Presented by Dr. Ray Page at 2015 ASCO Annual Meeting

COME HOME Project

- CMMI grant ($19.8 MM) to establish Community Oncology Medical Homes
- July 2012 – July 2015
- Seven Practices (FL, GA, TX (2), NM, ME,OH)
- Grant supported practice transformation
  - Triage line support for patient symptom management
  - Enhanced outpatient care access, expanded hours
  - Utilized treatment pathways
- 5349 patients with 30,000 services

COME HOME
Innovative Oncology Business Solutions, Inc.

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COME HOME Results

- Quantitative
  - 13 ED visits avoided per 1,000 patients**
  - 3 ambulatory care sensitive hospitalizations avoided per 1,000 patients*
  - 4 readmissions avoided per 1,000 admissions*
  - Average cost lowered by $612 per patient
  - Significant decreases in cost of care in last 30-180 days of life: $959 in last 30 days; $3,346 in last 90 days; $5,790 in last 180 days
- Qualitative
  - "Findings in this report validate the [triage] pathways as a means to improved outcomes for patients"
  - Key facilitators of positive findings:
    - Patient symptom management through triage pathways
    - Enhanced access to program providers

*p<0.1
**p<0.05

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COME HOME Overview

1. Robust use of health IT systems (EMR, PMS, lab systems, etc.)
2. An ongoing relationship with a personal oncologist to provide first contact and continuous, comprehensive care
3. Physician-led, team-based care where every member of the team works at the top of their license and have control over their schedule
4. Patient and family orientation, with patient education on how a patient can best benefit from the new system
5. Integrated and coordinated care with automated real-time decision support system to provide aggressive symptom management
6. Evidence-based medicine and performance measures to assure quality and safety and generate true outcomes data
7. Enhanced access, such as late hours and same-day appointments
8. **Payment models to recognize the value of a medical home**

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ASCO COME HOME Collaboration

- Disseminate and expand best practices of COME HOME Model through collaboration between IOBS and ASCO
- Launched January 1, 2017
- Goals:
  - Practice transformation as payment systems change from volume to value
  - MACRA readiness for all ASCO member practices
  - Participation in alternative payment models

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ASCO
COME HOME
Community Oncology Medical Home Program

Consulting Services

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Readiness Assessment

- On-site practice assessment
- Readiness for oncology medical home, alternative payment models like Oncology Care Model
- MACRA/QPP readiness
- Deliverable: gap analysis & recommendations to practice

The Process

- Process includes a planning call, the on-site visit, report
- Process workflow questionnaire sent prior to on-site visit
- Site visit
  - Practice walk through – emphasis on patient flow
  - Readiness Assessment tool
    - 6 domains of care: enhanced access, enhanced care, quality improvement, team-based care, patient experience, financial stability
  - Staff interviews

Practice Transformation Implementation Support

- Consulting services, customized to practice needs
  - Patient access
  - Patient flow
  - Workflow
  - Telephone management
  - Change management
  - QPP readiness & reporting
  - Policies & procedures; Job descriptions
  - Oncology medical home accreditation readiness

Analytical Services

- Practice data analytics
  - Financial
  - Clinical
  - Operational
- Alternative payment model (APM) support
  - Financial reporting
    - Bundled payment financial forecasting
    - Claims-based analytical services
  - Quality reporting support
  - Administration and compliance support

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Triage Pathways

- Cloud-based clinical decision support tool for aggressive symptom management
- 38 Symptom Specific Pathways
  - Additional associated follow-up pathways
  - Consistent systematic triage of patient symptoms
  - Nurses work to top of license with control over schedule
- Real time dashboard visible to all triage staff
  - The dashboard is pre-populated with patient demographic data from PMS, updated nightly.
- Standard order sets for defined patient groups

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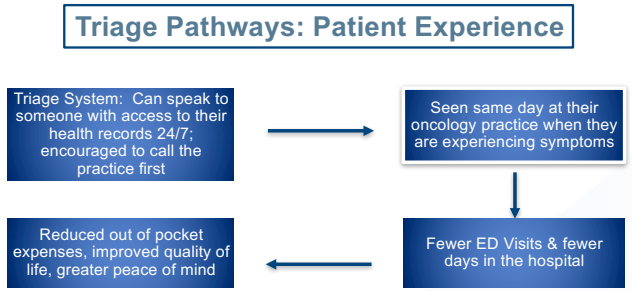
ASCO COME HOME Vision



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ASCO COME HOME Vision

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ASCO COME HOME Consulting Services

- Readiness assessment
- Practice transformation implementation support
  - –Customized consulting services
- Analytical services
- Triage pathways

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ASCO COME HOME
Community Oncology Medical Home Program

Veronica Gorman
Program Manager, Consulting Services
American Society of Clinical Oncology
Veronica.Gorman@asco.org
(571) 366-5335

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More Tools & Resources
www.asco.org/macra

- **New! ASCO MACRA Decision Tree**
  - How does MACRA affect me?
- **Improvement Activities and ASCO Quality Programs**
  - A crosswalk to help you attest to improvement activities you may already be doing
- **Practice Improvement Library….coming soon**
  - QOPI, Quality Training Program, Quality Certification Program, ASCO University
- **Webinar series**
  - Slides and recordings available now
  - Next webinar in late 2017 on the MACRA 2018 Final Rule

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But what do I do today??

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ASCO's
Top Five Things
MIPS Practices Need to Know

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Prepare for 2018

Category	2017 Reporting Requirements	2018 Reporting Requirements
Quality	Minimal: 1 measure, 1 patient/chart Partial: 90 days, 50% of all patients Full: at least 90 days, 50% of all patients	Full year 60% of all patients
ACI	Minimal: base score for 90 days No performance thresholds used in scoring	At least 90 days Potential addition of performance thresholds for scoring
IA	Minimal: 1 activity for 90 days Full: 2-4 activities for at least 90 days	At least 90 days 2-4 activities
Cost	Full year Calculated automatically by CMS 0% weight in MIPS	Full year Calculated automatically by CMS 10% ??? weight in MIPS

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Example of MIPS Participation for an Oncologist

Sample Quality Measures

- Chemotherapy plan documented
- Documentation of current medications/medication reconciliation
- Advance care plan
- Pain intensity quantified
- Tobacco use - screening & cessation counseling
- HER2 negative – no HER2 targeted therapies administered
- Metastatic CRC – anti-EGFR w/KRAS testing
- >1 ED visit last 30 days of life

Sample Improvement Activities

- Participation in a QCDR (e.g. QOPI)
- Participation in MOC IV
- Registration/use of PDMP
- Engagement of patient/family/caregivers in developing care plan
- Implementation of medication management practice improvements
- Implementation of practices / processes for developing regular individual care plans
- Participation in private payer improvement activities
- Use of decision support and standard treatment protocols
- Telehealth services that expand access to care

ACI (Base Score)

- Protect PHI/security risk analysis
- E-prescribing
- Provide patient electronic access
- HIE – send/receive summary of care

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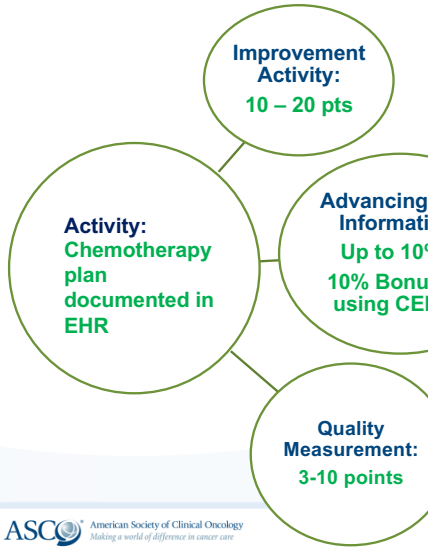
Making Every Activity Count



Personalized plan for high risk patients; integrate patient goals, values, priorities

Patient specific education

Personalized plan for high risk patients; integrate patient goals, values, priorities

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For more information….

www.asco.org/macra

www.qpp.cms.gov

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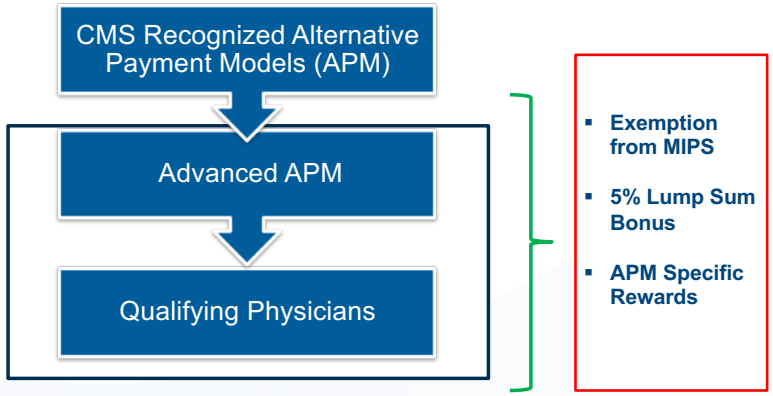
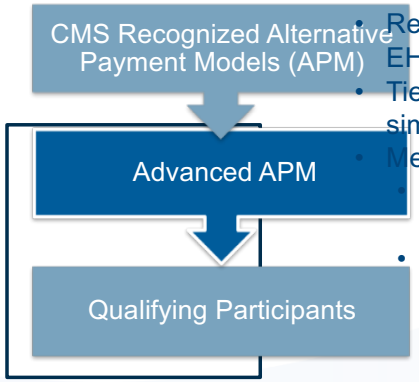
ALTERNATIVE PAYMENT MODELS

Pick-Your-Pace for 2017: APM Participation

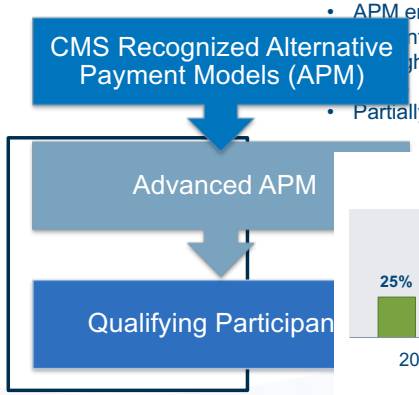


What is an Advanced APM?

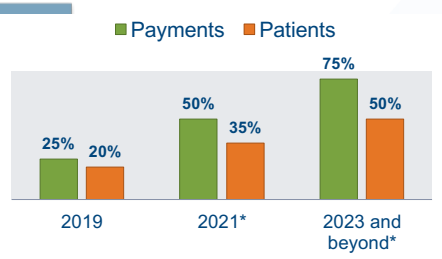


- Requires use of Certified EHR
- Ties payment to quality, similar to MIPS
- Meets Financial Standards
  - At least 5% of **revenues** at risk; or
  - Maximum loss of at least 3% of **spending benchmark** at risk

Who is a Qualifying Participant?



- APM entities must meet thresholds for nt of Medicare Payments Received gh, or Medicare Patients in Advanced
- Partially Qualifying Participants



*Beginning in 2021, other payer APMs may be considered

Any Advanced APMs in 2017?

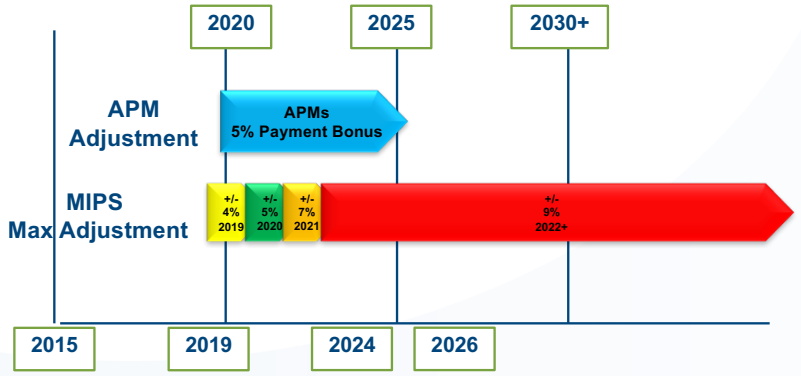
- ✓Medicare Shared Savings Program (2 Tracks)
- ✓Next Generation ACO
- ✓Comprehensive ESRD Care (2 models)
- ✓Comprehensive Primary Care Plus
- ✓**Oncology Care Model (OCM) - two-sided risk track available in 2017**

Advanced APM and MIPS APM Status

- CMS maintains a list of Advanced APMs and MIPS APMs
- Go to qpp.cms.gov → Education & Tools → Comprehensive List of APMs
  - https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf

QPP Payment Adjustment Timeline

(reporting begins in 2017)



And there's more….

Reporting Mechanisms

Both Individuals and Groups	
QCDR	
EHR	
Qualified Registry	
Individuals Only	**Groups Only**
Claims	CMS Web Interface*
	CAHPS for MIPS (Vendor)
	Administrative Claims (ACR)**

*Groups of 25 or more

**Groups of >15

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Data Submission Mechanisms
Individual & Group Reporting

- Each performance category can utilize a separate and distinct reporting mechanism.
- Must report as a group or individual across all categories.

Performance Category	Individual Reporting Mechanisms	Group Reporting Mechanisms
Quality	QCDR Qualified Registry EHR Administrative Claims Claims	QCDR Qualified Registry EHR CMS Web Interface (>25 providers) CMS-approved survey vendor for CAHPS for MIPS (>25 providers) Administrative Claims Claims
Resource Use	Administrative Claims	Administrative Claims
Advancing Care Information	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface
Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry CMS Web Interface EHR

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Group or Individual Reporting?

- Overview:
  - This module is intended for individuals or groups who have determined they will attempt at least "partial" MIPS reporting
  - After completion of this module, you should be able to:
    - Identify the requirements for individual vs. group reporting, and the associated advantages and disadvantages
    - Identify groups or categories of professionals who have different reporting requirements when reporting individually vs. with a group
    - Identify who in your group will be scored, and how that score may impact individual or group payment adjustments

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General Reporting Requirements (Full Participation)

Individual

- 6 quality measures
  - 20-case minimum/measure
- Base requirements of ACI
- 1-2 improvement activities

Group

- 6 quality measures
  - 20-case minimum/measure
- Base requirements of ACI
- 1-4 improvement activities

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Group or Individual Reporting? Performance Category Considerations

- Quality Category
  - If reporting individually, each clinician must meet 20-case minimum in order for measure to be scored
  - If reporting as a group, entire group contributes to 20-case minimum; clinicians to whom measure does not apply simply do not report that measure
  - If reporting as a group, not all individual clinicians necessarily have to contribute to each measure
- Improvement Activities Category
  - If reporting individually, each clinician must perform 1-2 improvement activities for full score
  - If reporting as a group, anyone in the group can contribute to the needed 1-4 improvement activities
- ACI Category
  - Reporting as group likely increases occurrences of necessary events
  - When reporting as a group, not all individual clinicians necessarily have to contribute to each measure
  - If reporting individually, must meet all required components of the base score as an individual

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Individual Reporting: Potential Advantages

- Can individualize choice of quality measures
- May increase the number of relevant quality measures each individual can report on
- Clinicians who are individually exempt from MIPS (first year and low-volume) will maintain those exemptions
- Clinicians who have lessened reporting requirements in certain performance categories (e.g. non-patient facing) will maintain those lessened reporting requirements

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Individual Reporting: Potential Disadvantages

Individuals who lack choice in measures may do poorly by themselves

Each NPI may receive a different score and payment adjustment; billing/record keeping more difficult for practice

Each clinician must individually meet "case minimums" for each quality measure, individually do 2-4 improvement activities, and individually pass the base score of ACI

Group Reporting: Potential Advantages

- One score and payment adjustment for each NPI under the TIN
- The group as a whole, regardless of number of practitioners, must meet the same case minimums for quality, the minimums for ACI, and perform the same number of improvement activities* as an individual
- *Quality Category:*
  - More likely that you will meet the "case minimum" required for better scoring on quality measures
  - Quality measures do not have to apply to each clinician individually – you just need to meet the 20-case minimum for each measure across the entire group
- *Improvement Activities Category*:
  - The engagement of one or more providers in an improvement activity counts for the whole group
- *Advancing Care Information Category:*
  - Reporting as a group likely increases occurrences of necessary events
  - Not all individual clinicians necessarily have to contribute to each measure
- You can determine if you want your otherwise-exempt staff to report (e.g. OT, PT, clinical social workers)

Group Reporting: Potential Disadvantages

Certain clinicians that would be exempt from MIPS individually will have to report with the group (first-year Medicare providers, low-volume providers)

Clinicians that may have had lessened requirements individually under MIPS may be subject to broader reporting requirements (e.g. non-patient facing clinicians in the IA category)

Clinicians that would be individually exempt from the ACI category (non-patient facing, hospital-based, APPs) will need to be excluded from your ACI reporting in order for them to keep that exemption – if you report any ACI measures for them they'll be scored like everyone else

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Questions to Consider for Group Reporting

- What is the specialty mix of my group?
  - If largely *oncology specialists*, most in the group could report at least some measures from the *oncology measure set*
  - If *multi-specialty*, individual reporting increases the number of quality measures available to each clinician; group reporting lessens the number of applicable measures available to each individual clinician
- What professional provider types are part of my group?
  - Advanced practice providers, non-patient facing clinicians, and hospital-based clinicians are exempt from the ACI category of MIPS, but may choose to report
  - Nutritionists, etc. are exempt from MIPS but may report with their group

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Considerations (2)

- What is the size of my group?
  - If <16 clinicians, you have decreased requirements in the improvement activity category and access to free technical resources, including on-the-ground assistance
- Low-volume clinicians and first-year are individually exempt from MIPS but must report if reporting as a group

MIPS Reporting Requirements Summary

- **Quality Reporting**
  - Six applicable measures (including at least one outcome)
  - 50% of eligible patients per measure (minimum of 20 patients)
  - All payer reporting (at least one Medicare beneficiary)
- **Practice Improvement**
  - Improve clinical practice or care delivery
  - 90 potential activities
  - Perform 2 to 4 activities (depending on size of practice)
  - Attest to completion
  - Save documentation
- **Advancing Care Information** (EHR capability)
  - Security, Electronic Prescribing, Patient Electronic Access

Special Circumstances and Exemptions

- ACI Category Exemptions (Automatic)
  - NP, PA, CNS, CRNA
  - Hospital-based clinicians
  - Non-patient facing clinicians
- Quality Category Exemptions
  - Any clinician that has NO measures that are available and applicable (per CMS, unlikely scenario)
- IA Category Exemptions
  - Per CMS, all clinicians should be able to participate
  - If participating in a MIPS APM, will automatically get full score under MIPS

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