

# MACRA Rules are Final: Time to Implement the Quality Payment Program

FLASCO Spring Meeting

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April 1, 2017



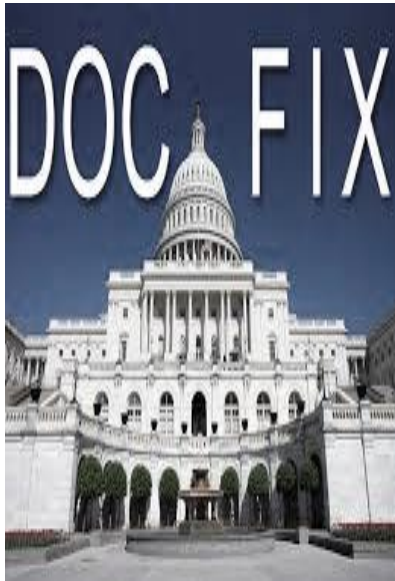
# Are you ready for MACRA?

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

# Physician Reimbursement

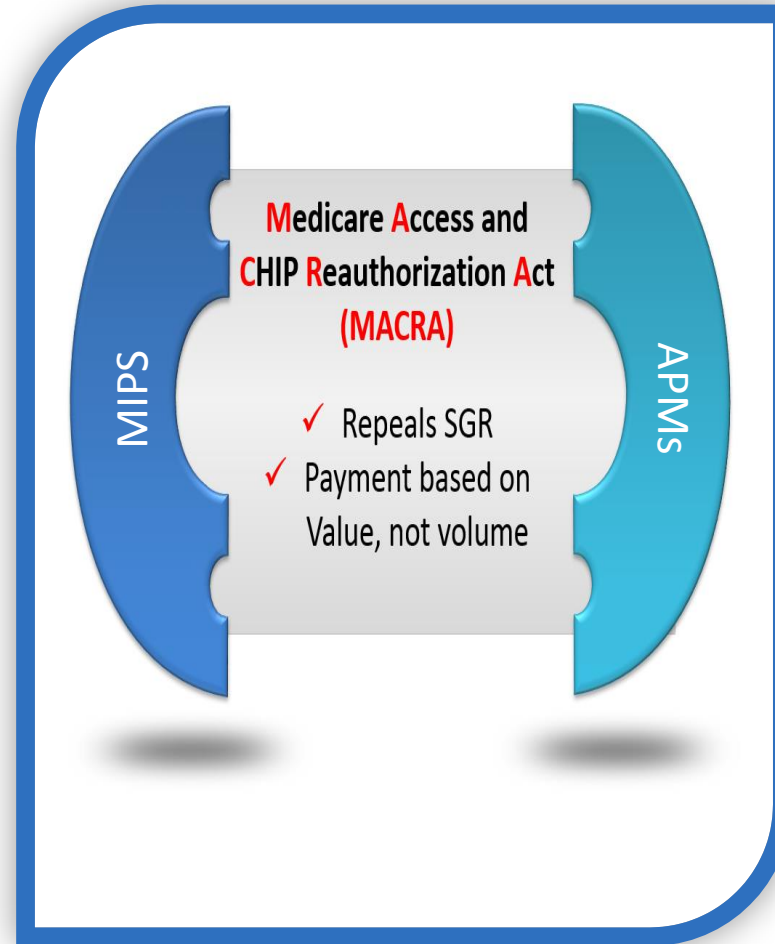
## HISTORY AND OVERVIEW

# Medicare Provider Reimbursement



Sustainable Growth  
Rate (SGR)

1997



2015

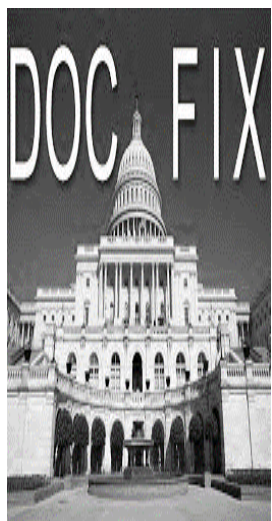
# MACRA- April, 2016...

## ASCO Response to MACRA Proposed Rule

- **Impact of Merit Based Incentive Payment System (MIPS) performance year options**
- **Adoption of specialty-specific alternative payment models (APMs)**
- **Address resource use methodology in the Merit-Based Incentive Payment System (MIPS) and Advanced APMs**
  - **Appropriate episode groups for oncology**
  - **Excluding all drug costs**
  - **Delay application**
- **Support for critical access practices**
- **Ensure reporting of clinically relevant quality data**

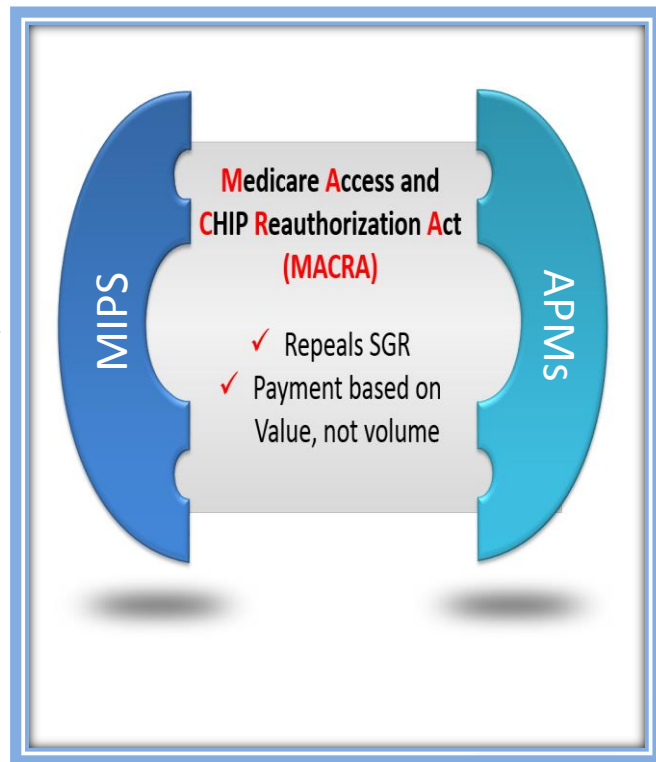


# Medicare Provider Reimbursement



Sustainable  
Growth Rate  
(SGR)

1997



2015



2017

# MACRA- October, 2016...

## MACRA Update

- Overall more flexibility/less administration
- Physicians allowed to pick their own pace for participating
- Resource use not counted in 2017
- General Oncology specialty measure set
- Additional flexibility for small/rural practices
- Oncology Care Model (OCM) practices do not have to report on quality twice
- OCM get 100% and Oncology Medical Homes may get at least 50% Improvement Activity
- More advanced Alternative Payment Models (APMs)



# MACRA- January, 2017...

## Implications of New Congress & Administration

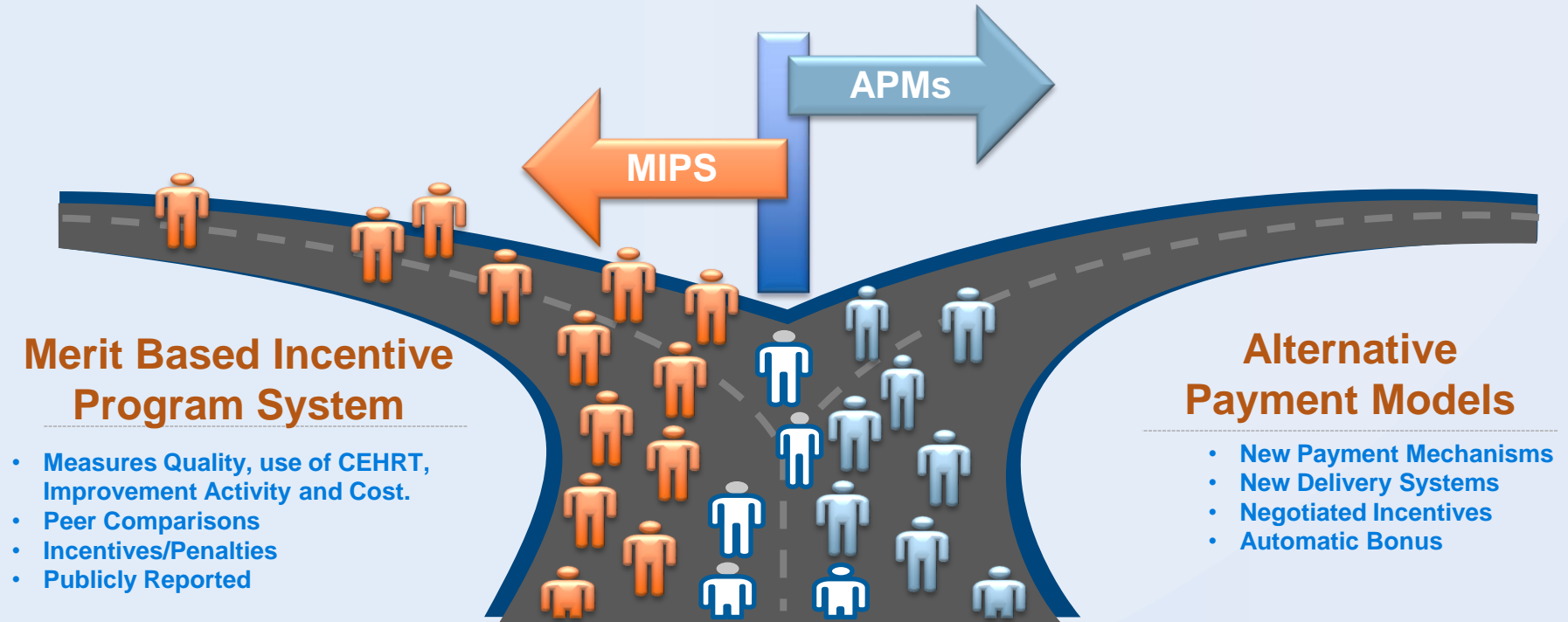


- Don't anticipate change in direction
- CMS has been fairly responsive to stakeholders and physicians
- MACRA was a largely bipartisan bill, but Congress eager to hear if refinements needed
  - May be opportunity for reduction in administrative burden
  - May be openness to delay in some requirements
  - Opportunity to raise oncology specific issues





# Medicare Quality Payment Program (QPP)



## Quality Payment Program

**CMS**

CENTERS for MEDICARE & MEDICAID SERVICES

Modernizing Medicare to provide better care and smarter spending for a healthier America.

# MACRA/QPP

## MERIT BASED INCENTIVE PAYMENT SYSTEM OVERVIEW

# I am a physician, and I bill Medicare Part B for services provided. Do I have to participate in the QPP?

- A. No, it's my first year in the program.
- B. No, I only bill \$10K per year
- C. No, I'm in an APM
- D. Yes
- E. All of the above are correct if they apply to me...

# Will It Affect Me?



Medicare Part B  
(Physician  
Services)

1<sup>st</sup> time Part B  
Participant

**EXEMPT**

Low Volume ( \$30K ) or  
Low Patient Count (100 Patients)

**EXEMPT**

APM Qualified  
Participant

**EXEMPT**

# How Will Medicare Reimbursement Change?

## The Merit Based Incentive Payment System (MIPS)

### Legacy Reporting Systems

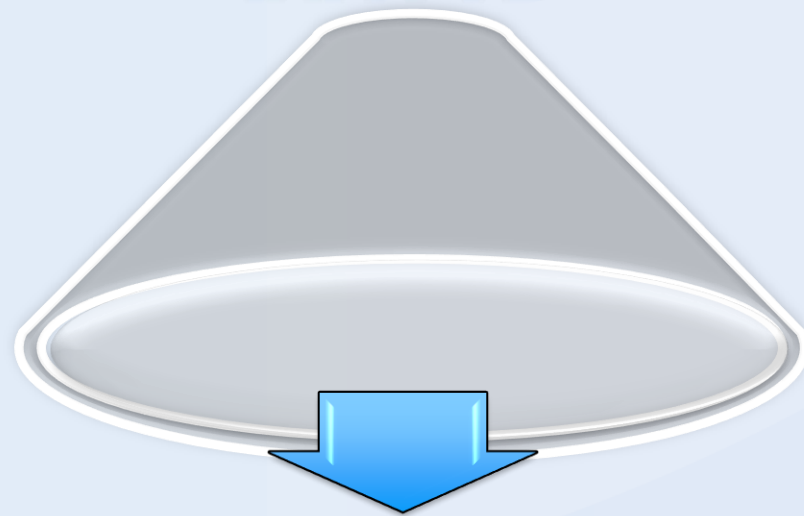
2016

Last Reporting Period

2018

Last Payment Adjustment

# MIPS



### MIPS

2017

Adds Improvement Activity

First MIPS

Performance Period

2018

Cost category Scored

2019

First MIPS Payment Adjustment



Not included in 2017

# MIPS Reporting Requirements

- **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 (dependent on size of practice)
- Attest to completion

- **Advancing Care Information (EHR capability)**

- Security, Electronic Prescribing, Patient Electronic Access

# 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
<b>Total Measures by Submission Mechanism</b>	<b>5</b>	<b>18</b>	<b>6</b>	<b>1</b>		

# Advancing Care Information

## Base Score (50%)

- Up to 5 required measures
- Security, E-Prescribing, Patient Access, Health information Exchange

## Performance Score (90%)

- Up to 9 measures

## Bonus Score (15%)

- Public health and clinical data registry reporting

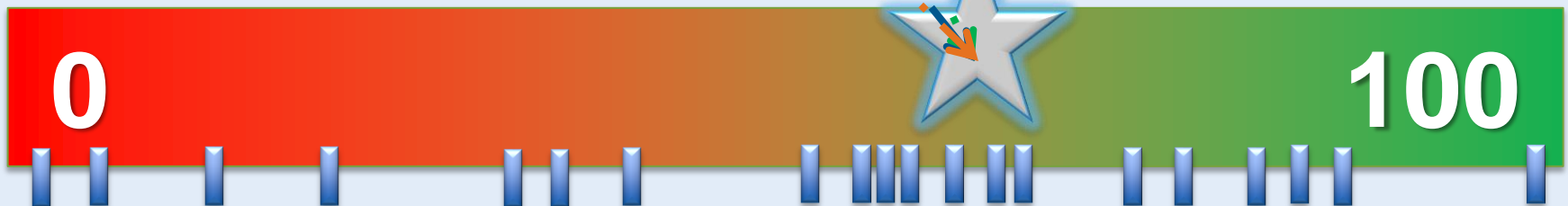
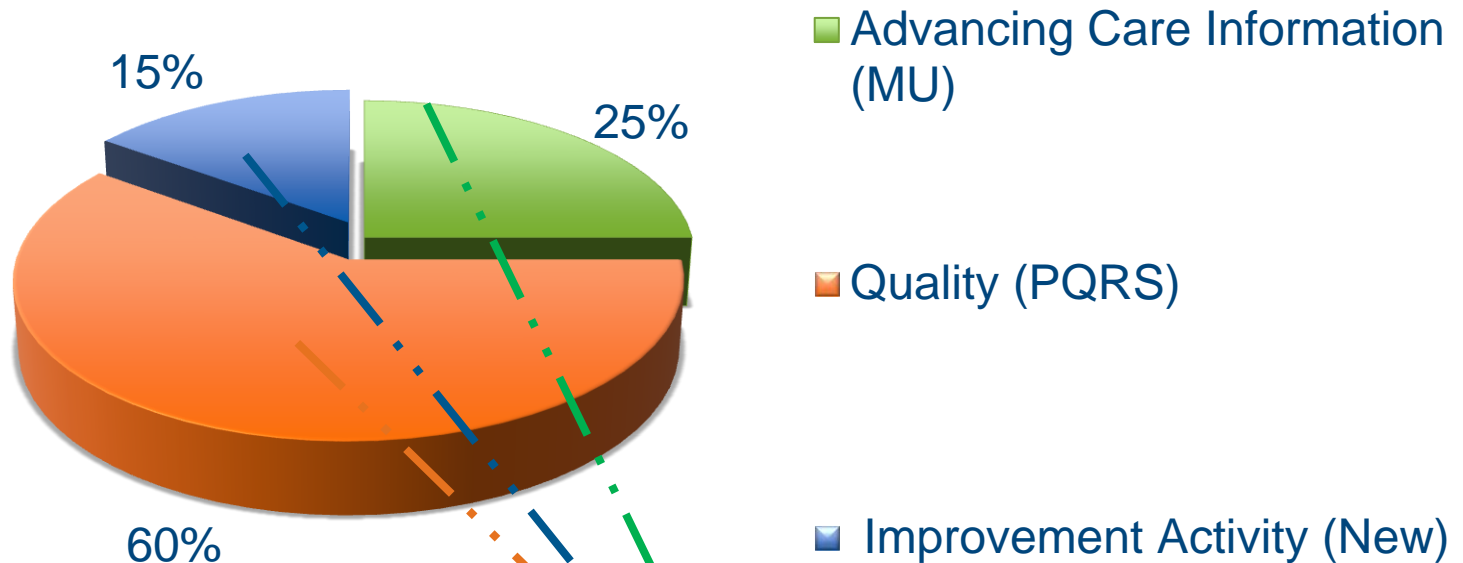


# Improvement Activity



2017

# How is My Score Calculated?



Low Performers -4%

High Performers +4%

★ National Median Composite Score  
| Medicare Provider Composite Score

# 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

# 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

# Making Every Activity Count

**Improvement  
Activity:**

**10 – 20 pts**

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

**Activity:**

**Chemotherapy  
plan  
documented in  
EHR**

**Advancing Care  
Information:**

**Up to 10% +  
10% Bonus: IA  
using CEHRT**

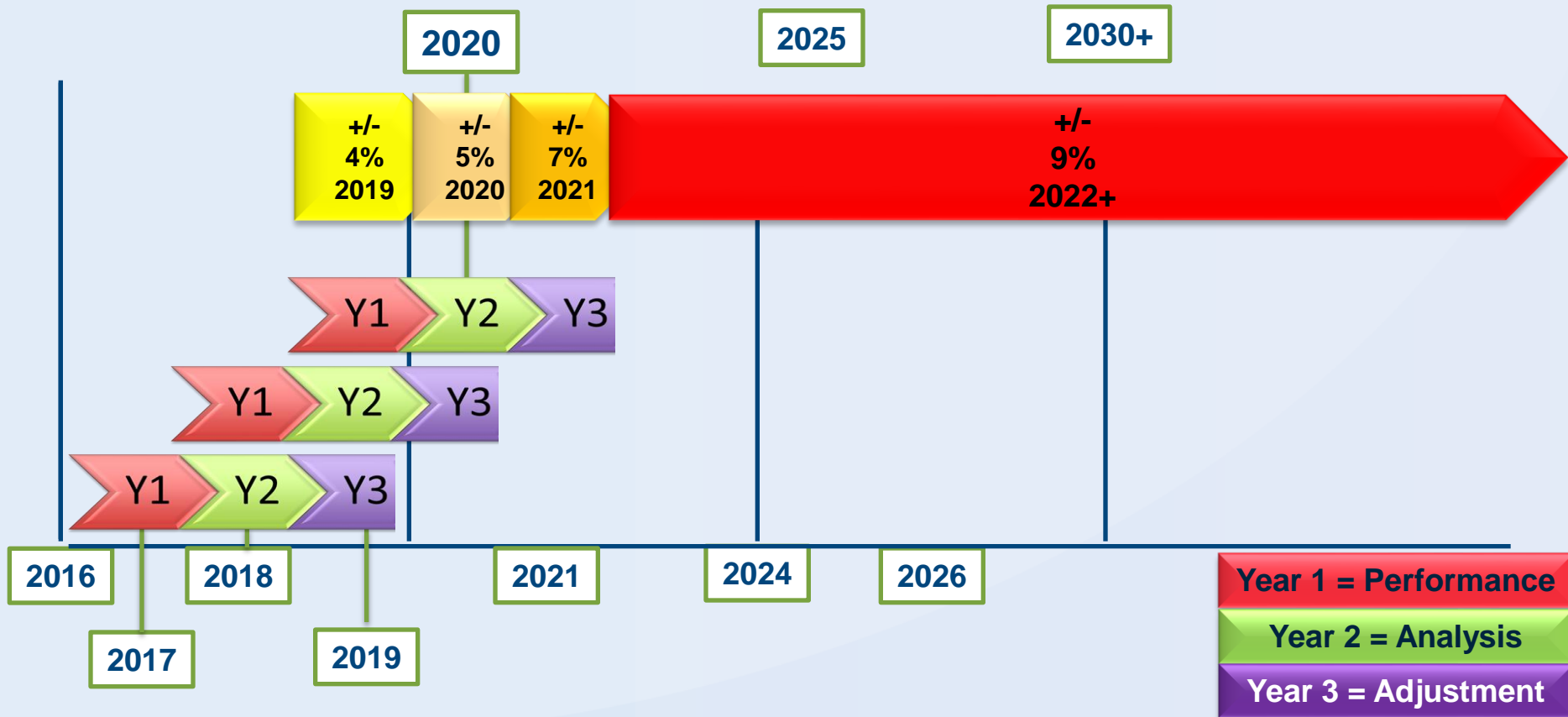
Patient specific education

**Quality  
Measurement:**

**3-10 points**

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

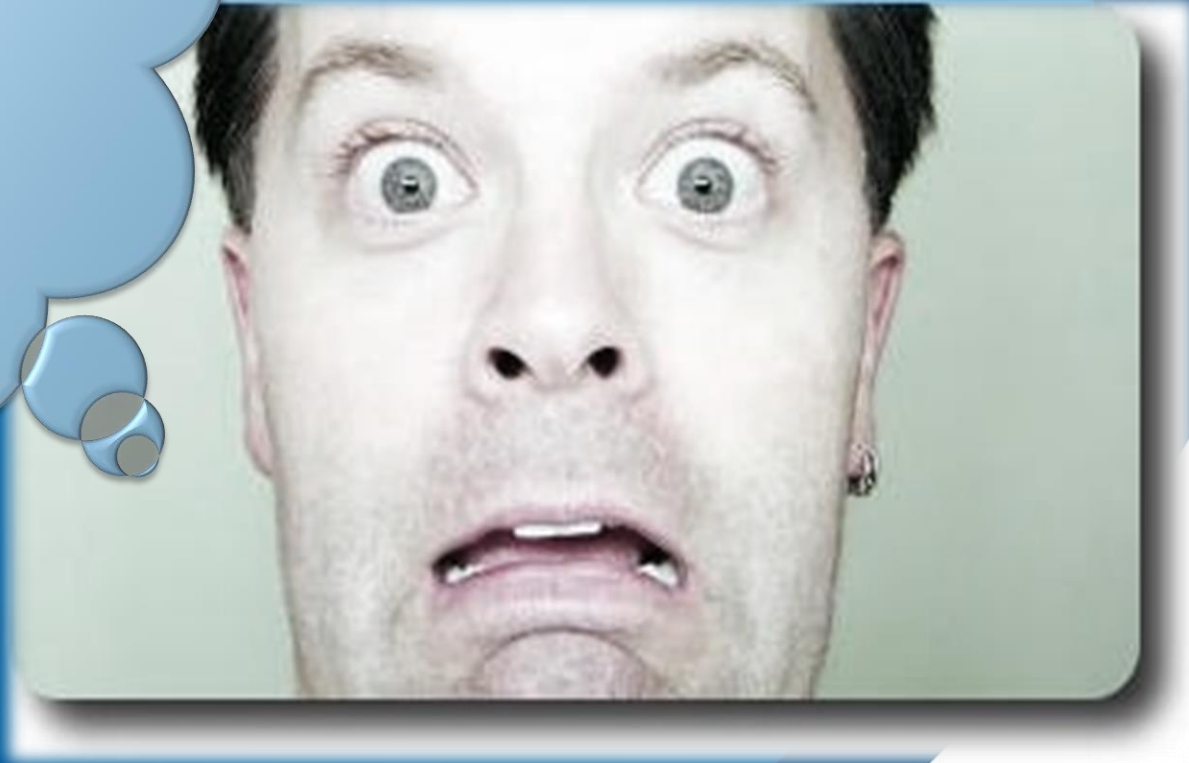
# MIPS Payment Adjustments Timeline



# FAQs on Final Performance Score

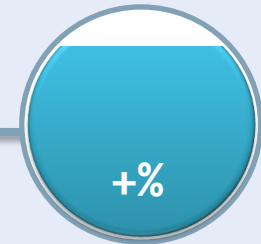
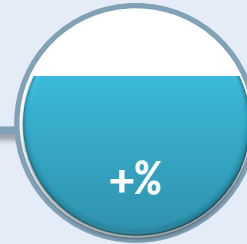
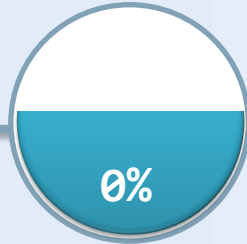
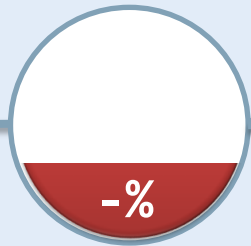
- CMS will use the TIN/NPI's historical performance from the performance period associated with the MIPS payment adjustment
  - regardless of whether that NPI is billing under a new TIN after the performance period
- Your payment adjustment follows you
  - if you switch from Practice A in the performance year to Practice B in the payment year, your TIN/NPI score from Practice A will follow you to Practice B and impact that payment year
- Will use the highest final score associated with an NPI from the performance period
  - If you switch practices mid-year (so 2 different TIN/NPIs) or bill under more than one TIN
- If an NPI bills under multiple TINs in the performance period and bills under a new TIN in the MIPS payment year, will take the highest final score associated with that NPI in the performance period

**UNCLE!!**





# Pick-Your-Pace for 2017: MIPS Reporting



2017

Don't Participate	Test the Program	Partial MIPS Reporting	Full MIPS Reporting
<p><b>Not participating in the Quality Payment Program:</b> If you don't send in any 2017 data, then you receive a</p>	<p><b>Report:</b></p> <ul style="list-style-type: none"> <li>✓ 1 quality measure</li> <li><b>or</b></li> <li>✓ 1 Improvement Activity</li> <li><b>or</b></li> <li>✓ The required ACI measures</li> </ul>	<p><b>Report for at least 90 days:*</b></p> <ul style="list-style-type: none"> <li>✓ 1+ Quality measure</li> <li><b>or</b></li> <li>✓ 1+ Improvement Activity</li> <li><b>or</b></li> <li>✓ More than the required ACI</li> </ul>	<p><b>Report for at least 90 days:*</b></p> <ul style="list-style-type: none"> <li>✓ Required Quality measures</li> <li><b>and</b></li> <li>✓ Required Improvement Activities</li> <li><b>and</b></li> <li>✓ Required ACI</li> </ul>

2018

\*consecutive days

\*consecutive days

*Full program Implementation.*

2019

Negative 4% payment adjustment	Avoid penalties	Avoid penalties; eligible for partial positive payment adjustment	Avoid penalties; eligible for full positive payment adjustment; exceptional performance bonus
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# Preparing for 2018

Category	2017 Reporting Requirements	2018 Reporting Requirements
Quality	Minimal: 1 measure, 1 patient/chart Partial: 90 days, 50% of all patients Full: 1 year, 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

# In 2018, my payment adjustment will be:

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

Whew!!

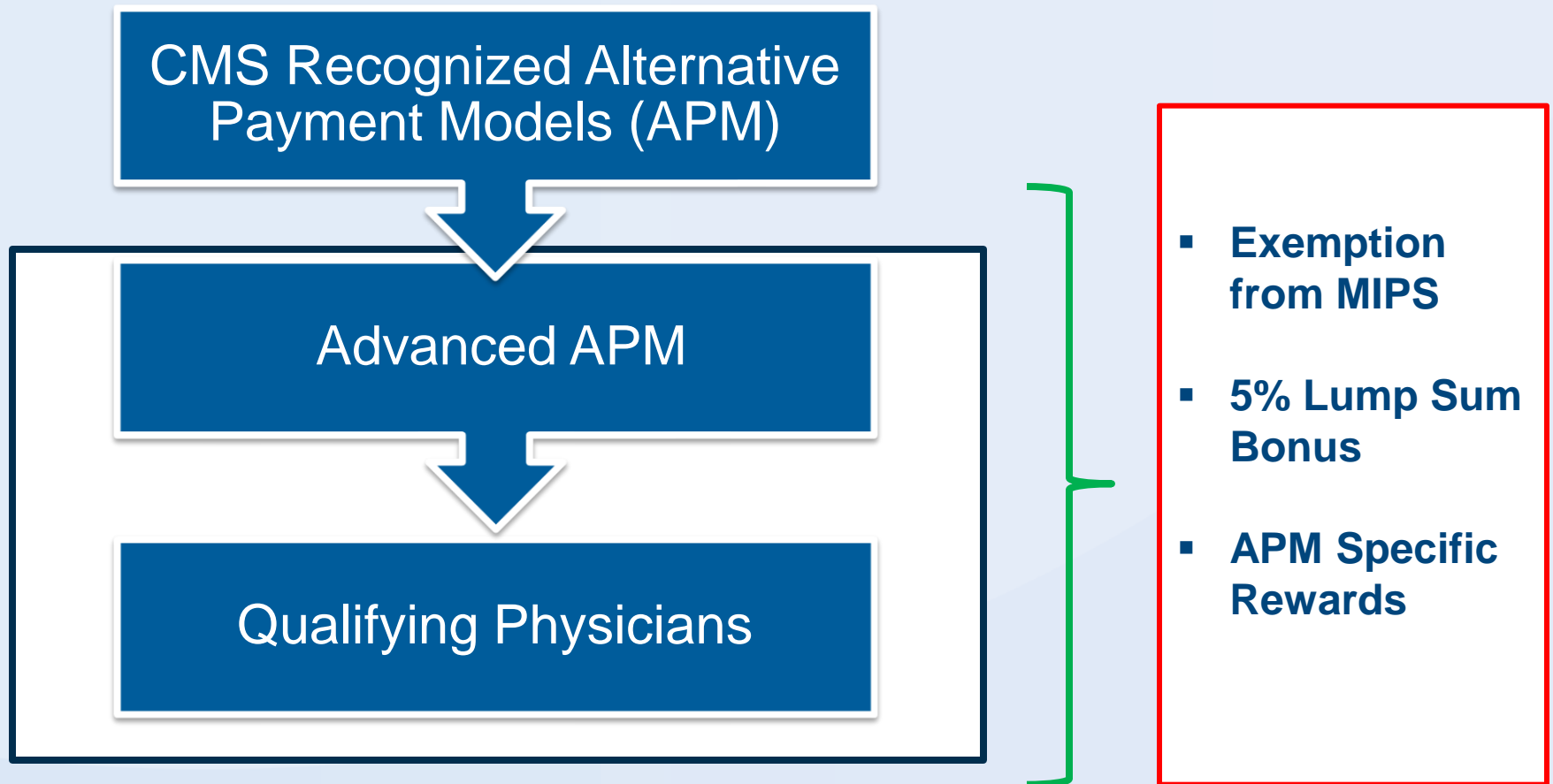


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# MACRA/QPP

## ALTERNATIVE PAYMENT MODELS OVERVIEW

# Pick-Your-Pace for 2017: APM Participation



# 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**

# MACRA/QPP

## SURVIVING IN 2017

**QPP**





4. Check that your electronic health record (EHR) is certified by the Office of the National Coordinator. It must meet

are you  
ready for  
**MACRA?**



## ASCO's Top Ten List for MACRA Implementation in 2017



## ASCO's Top Ten List for MACRA Implementation in 2017

- ✓ **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.
- ✓ **Ensure data accuracy.** Review your QRUR and ensure that the data is correct. It is also important to review the NPIs for each provider in your practice and ensure they are accurate with the correct specialty, address, and group affiliation.
- ✓ **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.
- ✓ **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.
- ✓ **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.

# ASCO Offers Solutions



## Certification

- Improvement Activity
- APM Participation



## Rapid Learning

- Quality Reporting (PQRS)



## Reporting

- Quality Reporting (PQRS)
- Meaningful Use
- Improvement Activity
- Cost
- APM Participation



## Reimbursement

- APM Participation
- Improvement Activity



## Transformation

- APM Participation



# QOPI is a Viable Tool for QPP Success

- The QOPI platform can be used to report the minimum data in 2017 to avoid a 2019 penalty
- 2017 is a transition year for the QOPI QCDR to become electronically functional to be able to report at 60% of charts for 2018
  - Both the QOPI QCDR and the practices will be asked to “test” electronic reporting in 2017 so all will be positioned to report at the higher volume requirement in 2018
- If a practice has the electronic capability to achieve 50% reporting in 2017, they can use another reporting mechanism and try for a positive adjustment for 2019

# Additional ASCO Support



## EDUCATION AND RESOURCES

- Check the ASCO website regularly for new tools and resources
  - Webinars
  - Fact Sheets
  - Quality Improvement library (*planned*)
- [www.asco.org/macra](http://www.asco.org/macra)



## CONSULTING & ADVOCACY

- Practice Transformation
- Readiness for Alternative Payment Models
- Filing Extensive Comments

# Ongoing Discussion... Healthcare Reform

- 1. Yes, you can stay on your parents' insurance until you're 26.**
- 2. Big penalties for on-again, off-again coverage.**
- 3. Existing conditions cannot disqualify you for insurance.**
- 4. Exchanges will stay, for now.**
- 5. Medicaid stays the same-ish until 2020.**
- 6. The requirement to buy insurance is gone.**
- 7. It's only the first round.**

Source: <http://www.npr.org/sections/health-shots/2017/03/07/519001659/7-things-to-watch-in-the-gops-american-health-care-act>

# ASCO Principles for Patient Centered Health Reform

- All Americans should have **access to affordable and sufficient healthcare coverage regardless of their income or health status**. To ensure protected access, the current ban on pre-existing condition limitations, elimination of annual and lifetime coverage caps, and maintenance of guaranteed renewability should be preserved.
- Any efforts to reform the healthcare system **at the national, state, or local levels should ensure that individuals with healthcare insurance can continue to access affordable insurance without interruption**.
- All individuals with cancer should have health insurance that **guarantees access to high-quality cancer care that is delivered by a cancer specialist and that provides the full range of services** needed by patients with cancer in a timely manner.

# ASCO The Principles for Patient Centered Health Reform

- Policymakers should, in any policy changes, **promote and protect cancer prevention and screening services**, as they are key to reducing cancer mortality. Policymakers should **preserve the “no copay” access to screening services** that currently exists.
- All patients should have **meaningful access to clinical trials**, and health insurance coverage should not be a barrier to clinical trials participation.
- 
- Current **efforts to improve quality, affordability, and access to care for patients and communities through value-based reform strategies should be continued**. Current efforts to improve value in healthcare should continue to be **prioritized**, and value-based reforms should be designed and **implemented in a patient-centered way**.



# ASCO The Principles for Patient Centered Health Reform

- Healthcare reform efforts **should engage patients and providers to obtain meaningful input in order to avoid unintended consequences** during implementation.

# QUESTIONS AND DISCUSSION



# For more information....

[www.asco.org/macra](http://www.asco.org/macra)

[www.qpp.cms.gov](http://www.qpp.cms.gov)