What You Need to Know about Reporting Under MACRA's Mandatory Quality Payment Program

Association of Community Cancer Centers

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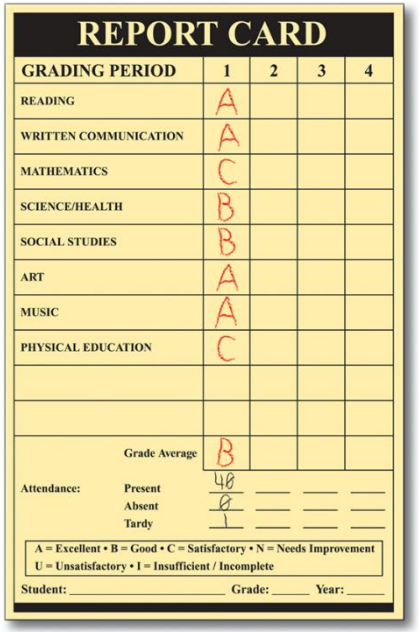
Impact

- The Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, modifies how Medicare pays clinicians (under Part B)
  - Shift toward payments to practices that provide high-quality care at low cost
  - Increase engagement in ACOs and other Advanced Alternative Payment Models
- CMS created the Quality Payment Program (QPP) under MACRA, which includes:
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (AAPMs)

QPP: Two Key Reporting Components

- Merit-based Incentive Payment System (MIPS)
  - Can impact Medicare reimbursement by as much as -9% or +37% (by 2022)
  - Composite Performance Score (MIPS Score) ***will be published***
- Advanced Alternative Payment Models (AAPMs)
  - Providers engage in programs that have shared risk
    - E.g., Oncology Care Model, ACOs, PCMH, others..
  - Qualified participants avoid MIPS reporting and penalties
  - Receive a fixed payment increase (5% through 2024) for each year that the provider or group qualifies
  - Medicare anticipates limited APM enrollment in 2017 (15% of providers or less)
    - This may rise to 25% in 2018
  - All clinicians may wish to consider reporting through MIPS to determine if they qualify for an advanced APM

MIPS



REPORT CARD

GRADING PERIOD	1	2	3	4
READING	A			
WRITTEN COMMUNICATION	A			
MATHEMATICS	C			
SCIENCE/HEALTH	B			
SOCIAL STUDIES	B			
ART	A			
MUSIC	A			
PHYSICAL EDUCATION	C			
Grade Average	B			

Attendance:

	1	2	3	4
Present	46			
Absent	0			
Tardy	1			

A = Excellent • B = Good • C = Satisfactory • N = Needs Improvement
U = Unsatisfactory • I = Insufficient / Incomplete

Student: _____ Grade: _____ Year: _____

Merit-based Incentive Payment System

- Composite Performance Score (CPS)
  - Assigned to individual eligible clinicians and groups
  - Range is from 0-100 points
  - Performance threshold set at 3 points for 2017 by CMS
    - CMS estimates it would have averaged 60 points
- How are MIPS scores determined?
  - Four performance categories
    - Quality (formerly the Physician Quality Reporting System {PQRS})
    - Resource Use (formerly the Value-Based Payment Modifier {VBM})
      - **But weighted at zero until the 2018 performance year***
    - Advancing Care Information (formerly Meaningful Use of Certified EHR Technologies)
    - Improvement Activities (new program)

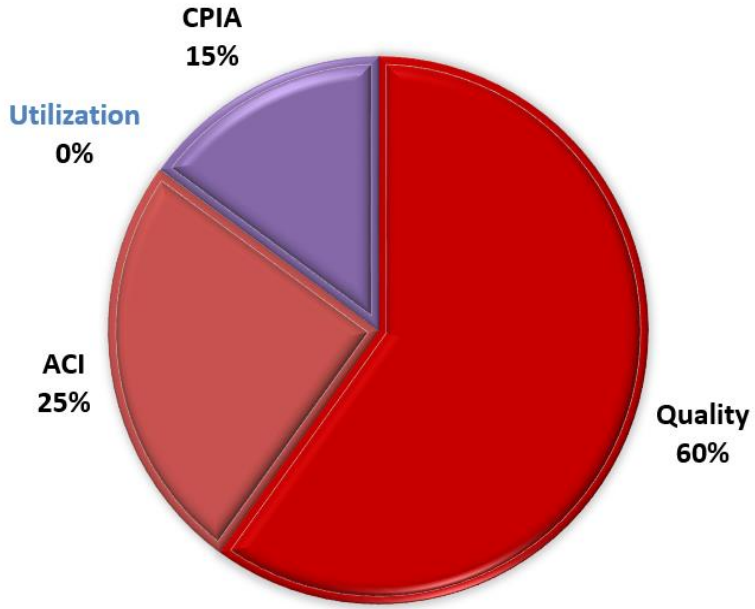
Eligible Clinicians Under MIPS

- ECs in 2017 and 2018 performance years:
  - Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists
- Starting in 2019 (CMS Option):
  - Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dietitians or nutrition professionals
- Exemptions:
  - Providers not meeting or exceeding a "low volume threshold“ established in the Final Rule as 100 or fewer Medicare pts/year or those who bill $30,000 or less per year to Medicare for Part B services
  - Oncology Care Model, Medicare Shared Savings Program ACO (Track 2 or Track 3) providers and other participants in Advanced Alternative Payment Models (APMs), including qualified and partially qualified APM participants
  - First-year Medicare providers

MIPS - Reporting

- The MIPS score measures clinicians' overall care delivery
- Not limited to Medicare patients
  - Unless reporting through the CMS Web Interface or through claims data
- May report as individuals or groups
  - Groups need to be ECs under the same Tax Identification Number
  - If reporting through the CMS Web Interface (25 or more ECs) they need to register by June 30, 2017
- 2017 performance data reporting is due by March 31, 2018
- Zero participation in 2017 will result in a 4% negative payment adjustment in 2019

COMPOSITE PERFORMANCE SCORE IN 2017



Quality (Formerly the Physician Quality Reporting System {PQRS})

- PQRS
  - Quality measures reported by Medicare eligible providers
  - In general the minimal thresholds are very low
    - E.g., only counseling one in twenty patients still qualifies as “meeting the requirements of a measure”
- PQRS is now the Quality Performance Category under MIPS
  - Numerator values from 6 quality measures will be used to determine 60% of the CPS
  - MIPS takes quality from meeting minimum thresholds (“pass/fail”) to quantitative scoring
  - Practices will compete for the highest performance scores

Quality Full Participation

- Clinicians or clinical groups choose 6 measures to report
  - Down from 9 under PQRS
  - Clinicians will need to choose at least one outcome measure, and if no outcome measures are available, one high-quality measure
- Total of 271 measures to choose from (and list will grow)
- CMS provides general oncology and radiation oncology quality measure tables
- All-Payer data used (same as PQRS)
  - Exception is submitting via claims or the CMS Web Interface, as noted previously

General Oncology Measures

Care Plan

Closing the Referral Loop: Receipt of Specialist Report

Documentation of Current Medications in the Medical Record

HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies

KRAS Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy

Oncology: Medical and Radiation - Pain Intensity Quantified

Patients with Metastatic Colorectal Cancer and KRAS Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies

Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Proportion Admitted to Hospice for Less Than 3 Days

Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life

Proportion Not Admitted To Hospice

Proportion of Patients Who Died from Cancer with More Than One Emergency Department Visit in the Last 30 Days of Life

Proportion Receiving Chemotherapy in the Last 14 Days of Life

Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Radical Prostatectomy Pathology Reporting

Tobacco Use and Help with Quitting Among Adolescents

Trastuzumab Received By Patients With AJCC Stage I (T1c) - III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy

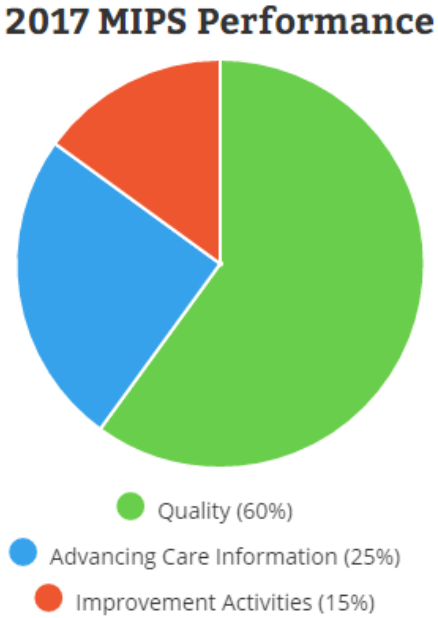
Quality Measures

Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.



Quality Reporting Patient Volumes

- Data completeness threshold for Qualified Registry, Qualified Clinical Data Registry, EHR submission mechanisms:
  - 50% all-payer data in 2017 performance year
  - 60% all-payer data in 2018 performance year

- Participation with certain APMs (even those that are not advanced APMs) allows the APM to report quality measures, i.e., the provider does not need to submit quality measures
  - ACO Track 1 is an example of how this would work

Summary of Final Quality Data Submission Criteria for MIPS Performance Year 2017

Performance Period	MeasureType	Submission Mechanism	Submission Criteria	Data Completeness
A minimum of one continuous 90-day period during CY2017	Individual MIPS eligible clinicians	Part B Claims	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty-specific measures in Table E.	**50 percent of MIPS eligible clinician's Medicare Part B patients for the performance period**
A minimum of one continuous 90-day period during CY2017	Individual MIPS eligible clinicians or Groups	QCDR Qualified Registry , EHR	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty-specific measures in Table E.	**50 percent of MIPS eligible clinician's or groups patients across all payers for the performance period**
Jan 1 – Dec 31	Groups	CMS Web Interface	Report on all measures included in the CMS Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module/measure. If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries.	**Sampling requirements for their Medicare Part B patients**
Jan 1 – Dec 31	**Groups**	**Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey**	CMS-approved survey vendor would have to be paired with another reporting mechanism to ensure the minimum number of measures are reported. CAHPS for MIPS Survey would fulfill the requirement for one patient experience measure towards the MIPS quality data submission criteria. CAHPS for MIPS Survey will only count for one measure.	**Sampling requirements for their Medicare Part B patients**

Cost (Resource Utilization) Category
(Formerly Value-based Modifier {VM})

- Weighted at 0% in 2017 so it will not influence the performance score
  - Weighted at 10% in 2018 and 30% in 2019 (and beyond)
- Assesses costs attributed to clinicians or groups to determine cost performance score
- Composite Performance Score (CPS) currently calculated by CMS in the VM program
  - Recommended that providers and groups request their **Quality and Resource Use Report (QRUR)**
    - Currently being tracked by Medicare
    - Gives feedback on where providers stand with quality and expenditures

Cost (Resource Utilization) Scoring

- Medicare will use claims data only
  - No reporting requirement
- 40 episode-specific measures will account for differences between specialties
- Minimum 20 patient sample
- Clinician's cost score would be calculated based on:
  - Average score of all the cost measures that can be attributed to the clinician
- If no measures apply, the cost category is reweighted to zero for the MIPS score (i.e., it does not count)
- Cost scores are adjusted for risk
  - Make sure all comorbid conditions are captured

Advancing Care Information

- Formerly Meaningful Use of Certified EHR Technology (CEHRT)
- MIPS eligible clinicians need to use CEHRT to achieve the highest possible scores
  - 25% of the total MIPS score in 2017
  - In future years figure can drop to a low of 15%, but only if 75% of EPs are meaningful users of CEHRT
- CMS has attempted to “simplify” reporting requirements, at least initially
  - Some core measures are being dropped
  - Providers must use CEHRT certified for 2014 (“Stage 2 MU”) or 2015 (“Stage 3 MU”) in 2017, and then all clinicians must use CEHRT certified for 2015 (Stage 3 MU) starting in 2018
    - 90-day reporting period for ACI in 2017 and 2018

Advancing Care Information (2)

- Clinicians choose to report a customizable set of measures that reflect how they use EHR technology
  - Emphasis on interoperability and information exchange
  - No longer require all-or-nothing EHR measurement reporting
- Two Scores under ACI:
  - Base Score:
    - 4-5 required measures for up to 50 points (depending on EHR version being used)
  - Performance Score:
    - Additional measures that emphasize patient care and information access
    - Up to 115 additional points available (if 100 points are attained or exceeded, the full 25 MIPS points are awarded)
- If 100 ACI points are attained during the 2017 performance year, the practice would receive 25 total MIPS points

ACI Performance Measures Overview

- Performance Score Component:
  - Choose measures from three objectives:
    - Patient electronic access
    - Coordination of care through patient engagement
    - Health Information Exchange

Advancing Care Information in 2017
(For practices using 2014 Edition CEHRT)

- The Basic Measures (for 90 days)
  - Security risk analysis
  - E-prescribing
  - Provide patient access
  - Send summary of care
- Choose up to 7 additional performance measures to report for additional points
  - Each is worth 10 to 20 percentage points
- Choose from a list of improvement activities to earn 10 bonus points in this category
- Report to disease or public health registry (other than an immunization registry) and earn 5 bonus points

2017 (Stage 2) Performance Year Advancing Clinical Information Requirements

2017 Advancing Care Information Transition Objective (2017 only)	2017 Advancing Care Information Transition Measure*(2017 only)	Required/Not Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	**Yes/No Statement**
Electronic Prescribing	E-Prescribing	Required	0	**Num./Demon.**
Patient Electronic Access	Provide Patient Access	Required	Up to 20%	**Num./Demon.**
	View, Download, or Transmit (VDT)	Not Required	Up to 10%	**Num./Demon.**
Patient-Specific Education	Patient-Specific Education	Not Required	Up to 10%	**Num./Demon.**
Secure Messaging	Secure Messaging	Not Required	Up to 10%	**Num./Demon.**
Health Information Exchange	Send Summary of Care Record	Required	Up to 20%	**Num./Demon.**
Medication Reconciliation	Medication Reconciliation	Not Required	Up to 10%	**Num./Demon.**
Public Health Reporting	Immunization Registry Reporting	Not Required	0 or 10%	**Yes/No Statement**
	Syndromic Surveillance Reporting	Not Required	Bonus	**Yes/No Statement**
	Specialized Registry Reporting	Not Required	Bonus	**Yes/No Statement**
Bonus upto 15%				
Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure			5% bonus	**Yes/No Statement**
Report improvement activities using CEHRT			**10% bonus**	**Yes/No Statement**

Advancing Care Information 2018 and Later

- **5 objectives and measures required* for base score**

1. Security Risk Analysis (yes/no)
2. Patient Electronic Access (numerator/denominator)
3. Send Summary of Care Document (numerator/denominator)
4. Electronic Prescribing (numerator/denominator)
5. Request/Accept Summary of Care Record** (numerator/denominator)

*If all 5 not achieved zero score for entire ACI performance category

** Measure not required for ECs using Stage 2 (2014 certification year) EHRs in 2017

Advancing Clinical Information Measure Requirements 2018 and Later

Advancing Care Information Objective	Advancing Care Information Measure	Required/Not Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	e-Prescribing	Required	0	Num./Denom.
Patient Electronic Access	Provide Patient Access	Required	Up to 10%	Num./Denom.
	Patient-Specific Education	Not Required	Up to 10%	Num./Denom.
Coordination of Care Through Patient Engagement	View, Download, or Transmit (VDT)	Not Required	Up to 10%	Num./Denom.
	Secure Messaging	Not Required	Up to 10%	Num./Denom.
	Patient-Generated Health Data	Not Required	Up to 10%	Num./Denom.
Health Information Exchange	Send a Summary of Care	Required	Up to 10%	Num./Denom.
	Request/Accept Summary of Care	Required	Up to 10%	Num./Denom.
	Clinical Information Reconciliation	Not Required	Up to 10%	Num./Denom.
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	Bonus	Yes/No Statement
	Electronic Case Reporting	Not Required	Bonus	Yes/No Statement
	Public Health Registry Reporting	Not Required	Bonus	Yes/No Statement
	Clinical Data Registry Reporting	Not Required	Bonus	Yes/No Statement
Bonus(up to 15%)				
Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure		5% bonus		Yes/No Statement
Report improvement activities using CEHRT		10% bonus		Yes/No Statement

ACI: Registry Options

- Immunization registry optional under MIPS
  - 10 performance points if EC is “actively engaging” with an immunization registry
- Choosing to report to an additional public health registry will be worth 5 additional “bonus” points
  - E.g. a cancer registry

2014 CERHT: Syndromic surveillance and specialty registries

2015 CEHRT: Also allows for Electronic Case Reporting and Clinical Data Registry reporting

Clinical Practice Improvement Activities

- Categories:
  - Expanded practice access (e.g., same-day appointments)
  - Population management (e.g., monitoring population health)
  - Care coordination (e.g., telehealth)
  - Beneficiary engagement (e.g., self-management training)
  - Patient safety and practice assessment (e.g., use of clinical checklists)
  - Participation in APMs

- 92 CPIAs identified in proposed rule
- More will be developed in future years

Improvement Activities (2)

- Large practices: 40 points = 15 MIPS points (15 or more ECs)
- Small practices: 20 points = 15 MIPS points
- Highly weighted CPIAs worth 20 points
  - Activities that support the patient-centered medical home
  - Activities that support the transformation of clinical practice
  - Activities that support a public health priority
- Medium weighted CPIAs worth 10 points
- For 2017 certain ACI activities will count toward points in this category (10 bonus points in the ACI category)

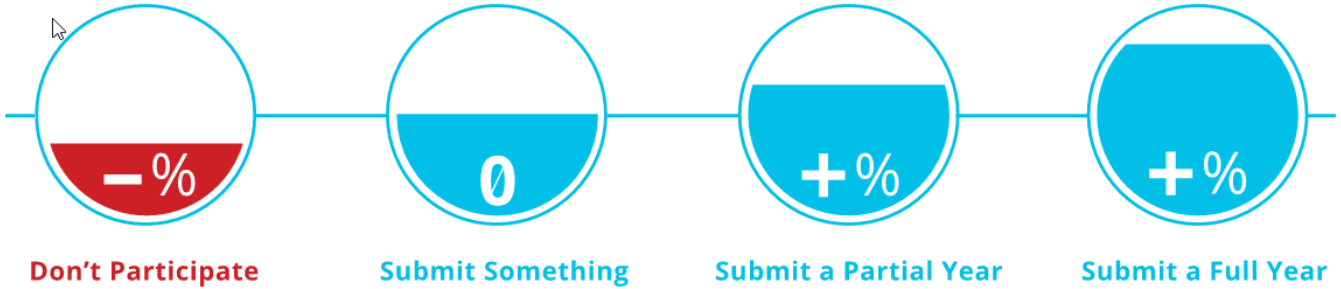
IA Reporting Requirements

- For groups, only one member needs to engage in one or more improvement activities for 90 days – all members get credit even if they are not actively involved
- Any combination of activities may be used to achieve the performance score (e.g., combination of highly and medium-weighted activities)
- Patient-Centered Medical Home (PCMH) participation = full score under this category
- APM participation credit
  - Full or 50% credit depending on APM type
- Weighted at 15% in 2017, but may increase in future years

Pick Your Pace in 2017

- Options for avoiding negative payment adjustments:
  - Join an advanced APM in 2017
  - Minimal Options:
    - Submit one quality measure
    - Submit one clinical practice improvement activity
    - Meet the minimum requirements for the ACI base score, a 90-day consecutive period
  - Intermediate Option: Engage in MIPS for more than 90 days in 2017 and submit:
    - More than one measure, or
    - More than one CPIA, or
    - More than the required base measures in the Advancing Care Information category
  - Full MIPS Option: Engage in MIPS for more than 90 days in 2017
- MIPS Performance Threshold will be 3/100 points in 2017
- ***Through a direct communication CMS shared that they will not publish a provider's CPS unless they have complete data***

Pick Your Pace in 2017



2017 MIPS Participation Impact

ACTION	IMPACT IN 2019
Do nothing	4% negative adjustment
Submit one measure	No payment adjustment
Submit one CPIA	No payment adjustment
Submit ACI measures for 90 days	No payment adjustment
Report on data for 90 or more days	Potential for small positive payment adjustment
Participate in MIPS for 180-365 days	Potential for 4% positive payment adjustment and additional bonuses

Payment Adjustments Under MIPS

- Payment adjustments based on composite performance score
  - Starting at +/- 4% in 2019 “payment year” based on 2017 performance
  - Gradually increasing to reach +/- 9% in 2022 and later
  - Positive payments can have up to a 3X increase, depending on relevant scoring
  - Additional payment adjustment of up to 10% also available in first 6 years of MIPS
- Budget neutral unless an exception applies
  - Payments held from low performing providers will be used to fund “bonuses” for high performing providers

Payment Adjustment Timeline

Payment Adjustment Timeline

Performance Thresholds

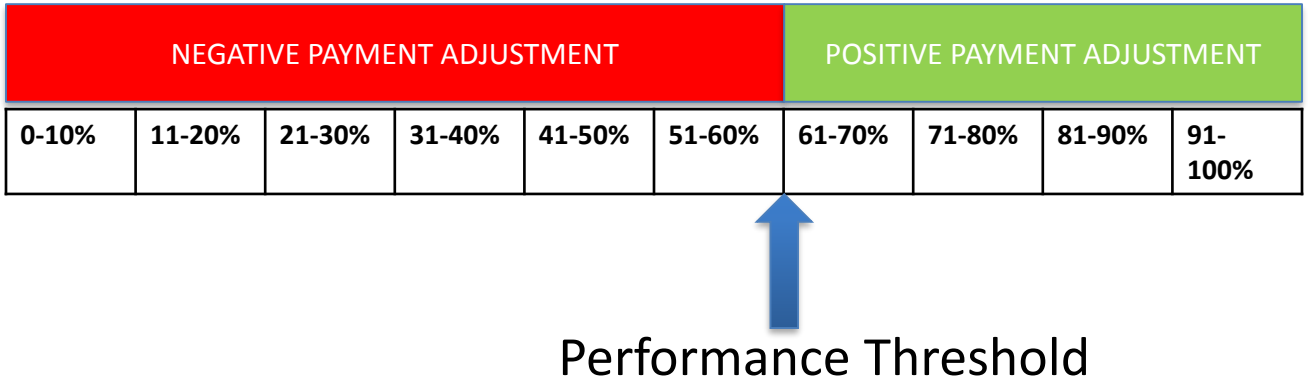
- Performance threshold will be established based on the mean or median of the composite performance scores during a prior period
  - The performance period end is always one year prior to the payment year
    - For example:
      - CPS scores for all eligible clinicians from patient care in 2017 will be compiled to determine the mean or median performance level
      - This will be used to determine Medicare payment adjustments under MIPS in 2019

Composite Performance Score

- Each clinician or group performance in 2017 will be assigned a CPS between 0 and 100 points, ***but as noted previously, only when CMS feels the data is complete***
- The data received from all MIPS participants will be used to determine a median CPS that will serve as the "Performance Threshold"
  - Artificially established at 3 points for 2017
- After the 2017 performance year:
  - Provider/Group CPS = Performance Threshold: no payment adjustment
  - Provider/Group CPS > Performance Threshold: potential positive payment adjustment
  - Provider/Group CPS < Performance Threshold: potential negative payment adjustment

CPS Threshold and Payment Impact

Example: Performance Threshold = 60



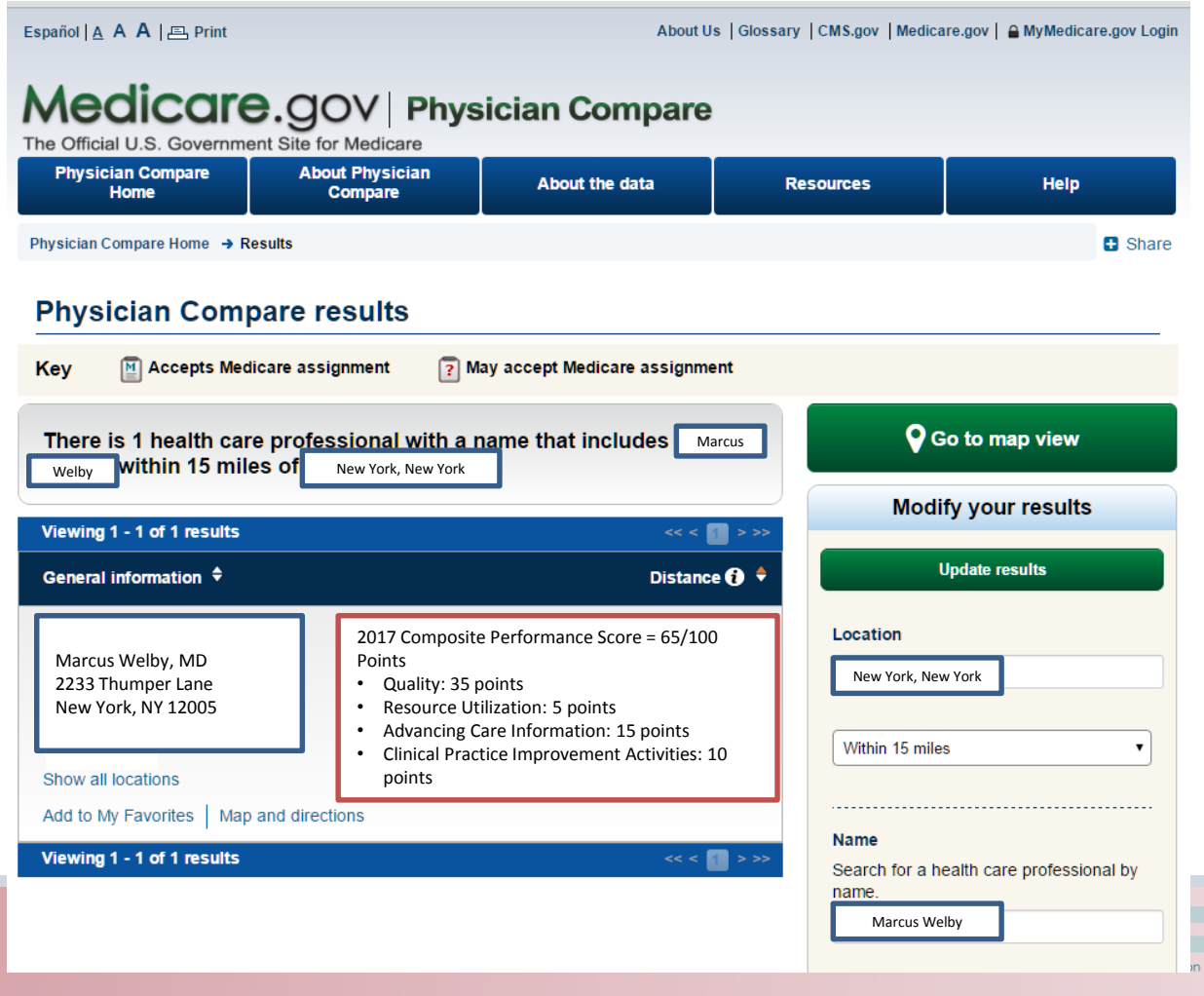
Note: Artificially established at 3% in 2017

Exceptional Performance Payment Adjustments

- Additional funding for positive adjustments for exceptional performance (2019 – 2024)
- Top tier performers could receive up to a 10% positive payment adjustment
  - Added to “standard” positive payment adjustments
- Limited funds in this pool
  - $500 million per year over 6 years
- Maximum positive payment adjustment could reach:
  - 22% in payment year 2019
  - 25% in payment year 2020
  - 31% in payment year 2012
  - **37% for payment years 2022-2024**
  - 27% for payment years 2025 and beyond
- Only a small number of eligible providers will qualify
  - Need to reach a CPS of at least 70 to be considered for additional upward payment adjustment in 2017

Physician Compare Website

- MIPS score will be publicly displayed on the CMS “Physician Compare” website
- These scores could impact patient recruitment and patient retention
  - Positively or negatively
- Physicians in general are highly competitive
- Expect to encounter a great deal of activity around MIPS Composite Performance Scores over the next several years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Key
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May accept Medicare assignment
There is 1 health care professional with a name that includes Marcus Welby within 15 miles of New York, New York
Go to map view
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Update results
General information
Distance
Location
Marcus Welby, MD
2233 Thumper Lane
New York, NY 12005
New York, New York
2017 Composite Performance Score = 65/100 Points
• Quality: 35 points
• Resource Utilization: 5 points
• Advancing Care Information: 15 points
• Clinical Practice Improvement Activities: 10 points
Within 15 miles
Show all locations
Add to My Favorites | Map and directions
Name
Search for a health care professional by name.
Marcus Welby
Viewing 1 - 1 of 1 results

Advanced Alternative Payment Models (AAPMs)

- To be eligible, an AAPM must:
  - Provide payment for covered professional services based on quality measures “comparable to” MIPS quality measures
  - Must be a model approved by Medicare
  - Must have “shared risk”
  - Must employ the same quality, utilization, and use of certified EHRs as MIPS
    - They must still report under the ACI component of MIPS

AAPMs (2)

- The CMS QPP Website identifies the following models as Advanced APMs:
  - Oncology Care Model – Two-Sided Risk
  - Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
  - Comprehensive Primary Care Plus (CPC+)
  - Medicare Shared Savings Program—Track 2 and Track 3
  - Next Generation ACO Model
  - Comprehensive Care for Joint Replacement Model
- Number of approved APMs will be expanded each year
  - List for each performance year to be finalized by January 1st of the performance year
  - Under consideration for 2018
    - Medicare Shared Savings-Track 1+

AAPMs (3)

- In order to qualify as an AAPM one of the following must be in place:
  - Require participants to bear financial risk for monetary losses under the APM that are in excess of a nominal amount; or
  - Be a medical home model expanded under section 1115A(c)*
- Note: as per Medicare, only a small minority of providers will qualify for the APM incentive payment in the early years
  - 15% in 2017
  - 25% in 2018
  - Expanding to majority over several years
- All non-APM participants will be subject to MIPS with a few exceptions

*Social Security Act section titled “CENTER FOR MEDICARE AND MEDICAID INNOVATION” (CMI)

AAPMs (4)

- If eligible providers qualify (they are then referred to as Qualified Providers or "QPs")
  - They will receive an incentive payment of 5% from 2019-2024
  - They will be exempt from the MIPS, i.e., ***they will not receive a Composite Performance Score or be subject to potential negative payment adjustments***
  - QP status to be validated during MIPS performance period
- Partially Qualifying APM Participants
  - Participation in **MIPS is Optional**
    - Providers who participate in AAPMs but do not have adequate patient volume or payments to qualify as a "full" QP
    - E.g., EC exceeds MIPS payment threshold ($30,000 in 2017)
    - However, the clinician is below Medicare payment or volume thresholds for APMs

AAPMs (5)

- **Quality measures used for payment determination must be comparable to those used in the MIPS**
  - Advanced APM must base payment on quality measures that are evidence-based, reliable, and valid
  - At least one such measure must be an outcome measure if an outcome measure appropriate to the Advanced APM is available on the MIPS measure list

AAPMs (6)

- Minimum payment of volume thresholds are needed for ECs to qualify for an APM incentive payment
  - Becomes more stringent over time

Minimum Requirements for Incentive Payments for Participation in Advanced APMs (Payments or Patient Volume Attributed to APM)						
Payment Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024 and later**
% Payments	25%	25%	50%	50%	75%	75%
% Patient Volume	20%	20%	35%	35%	50%	50%

APMs Will Evolve

- Starting in performance year 2019:
  - Clinicians could qualify for incentive payments based, in part, on participation in Advanced APMs developed by non-Medicare payers
  - Examples include models developed by private insurers or state Medicaid programs
- Physician-Focused Payment Technical Advisory Committee will review and assess additional physician-focused payment models suggested by stakeholders

Oncology Care Model

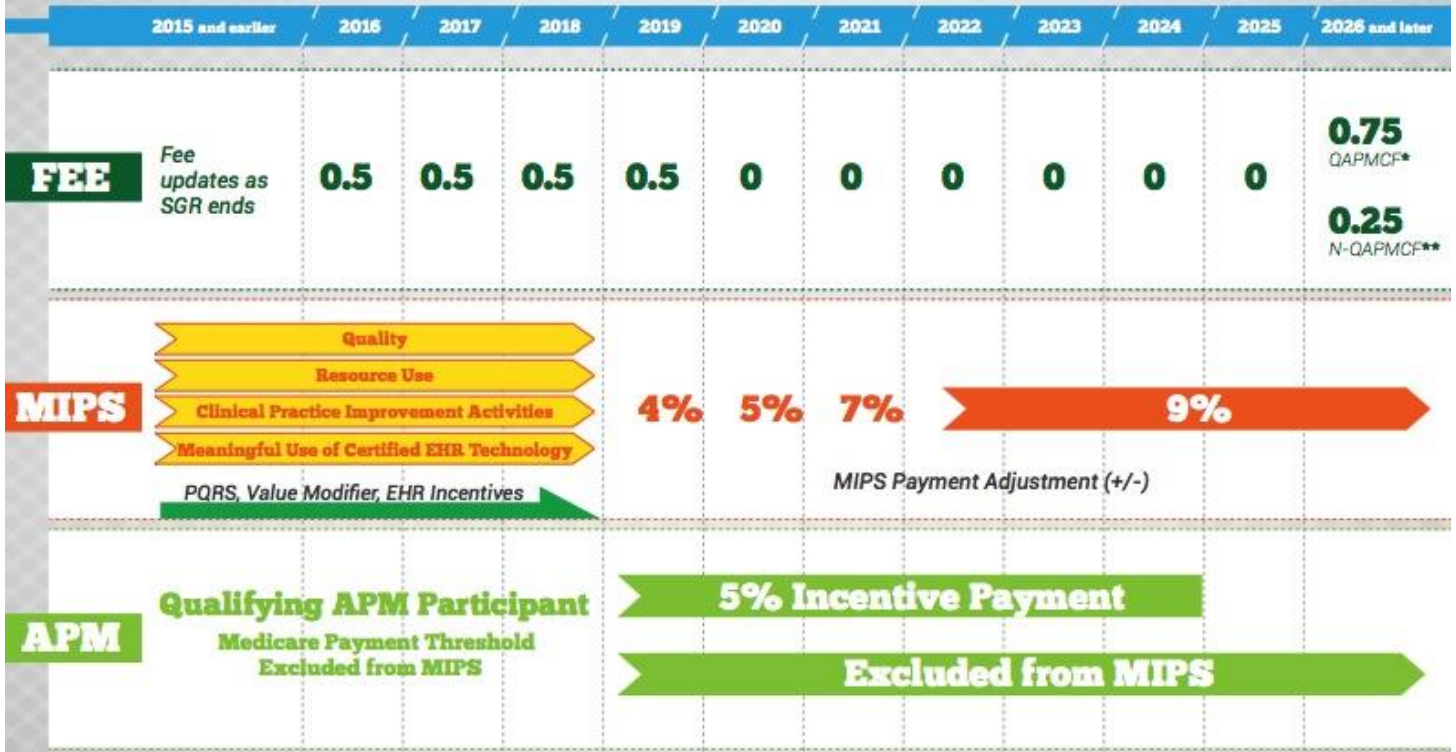
- Multi-payer model focused on providing higher quality, more coordinated oncology care
- Financial incentives to improve care and reduce cost surrounding chemotherapy administration to cancer patients
- Requirements:
  - Provide enhanced care coordination and improved access to care
    - Address complex care needs through collaboration with other providers
  - Adhere to nationally recognized treatment guidelines
  - Document a care plan for each patient
    - Must contain the 13 components of the Institute of Medicine's Care Management Plan
  - Use CEHRT (as per AAPM requirements)
  - Report clinical and quality data to the CMS Innovation Center

OCM Financial Incentives

Two financial incentives:

1. Per-beneficiary Monthly Enhanced Oncology Services (MEOS) payment for the duration of the episode ($160.00)
    - Paid each month for the 6-month episodes
2. Performance-based payments
    - Calculated on a semi-annual basis
    - Based on:
        - Achievement on quality measures
        - Reductions in expenditures below a target price
    - Performance determination based on benchmarks
        - Risk adjusted and adjusted for geographic distribution

Timeline



*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

How to Prepare

- Use your PQRS performance rates to assess performance in light of MIPS
  - Evaluate how the highest possible performance may be achieved
  - Consider the *benchmarks* for each of the 6 chosen quality measures
- Evaluate your Improvement Activity options (assign a group member)
- Consider joining an AAPM
- Gain an understanding of prior performance under the VBM process
  - Review your Quality and Resource Use Reports (QRUR)
- Optimize ICD-10-CM coding
  - Prevent denials
  - Ensure that risk adjusted scores are accurate (cost component of MIPS and used for AAPM scoring)

How to Prepare (2)

- Optimize EHR
  - Update templates
  - Review clinical workflow
  - Identify best practices for capturing measure-related data (quality and meaningful use)
    - Clinical content
    - Spreadsheets
    - Alerts and reminder settings
    - Staff and provider training
    - Ongoing due diligence and reviews
  - Ensure that documentation supports that the measure's requirements have been met
    - Not just clicking a button that says an action was completed
  - Optimize content, workflow, and training to meet CPIA requirements
  - "In-line" with documentation measure data capture highly successful and provider-friendly

Info

Additional Resources:

- Medicare: Quality Payment Program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html
- Quality Payment Program Face Sheet: https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf
- CMS Educational Website on the QPP: https://qpp.cms.gov/education
- MACRA University: www.macrauniversity.com
- How MACRA Changes Health Information Management (available at http://library.ahima.org/doc?oid=302051#.WLRco_nythE)

Questions?

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