Quality Payment Program: Scoring the Quality Measures

May 15, 2017

Today’s Speakers

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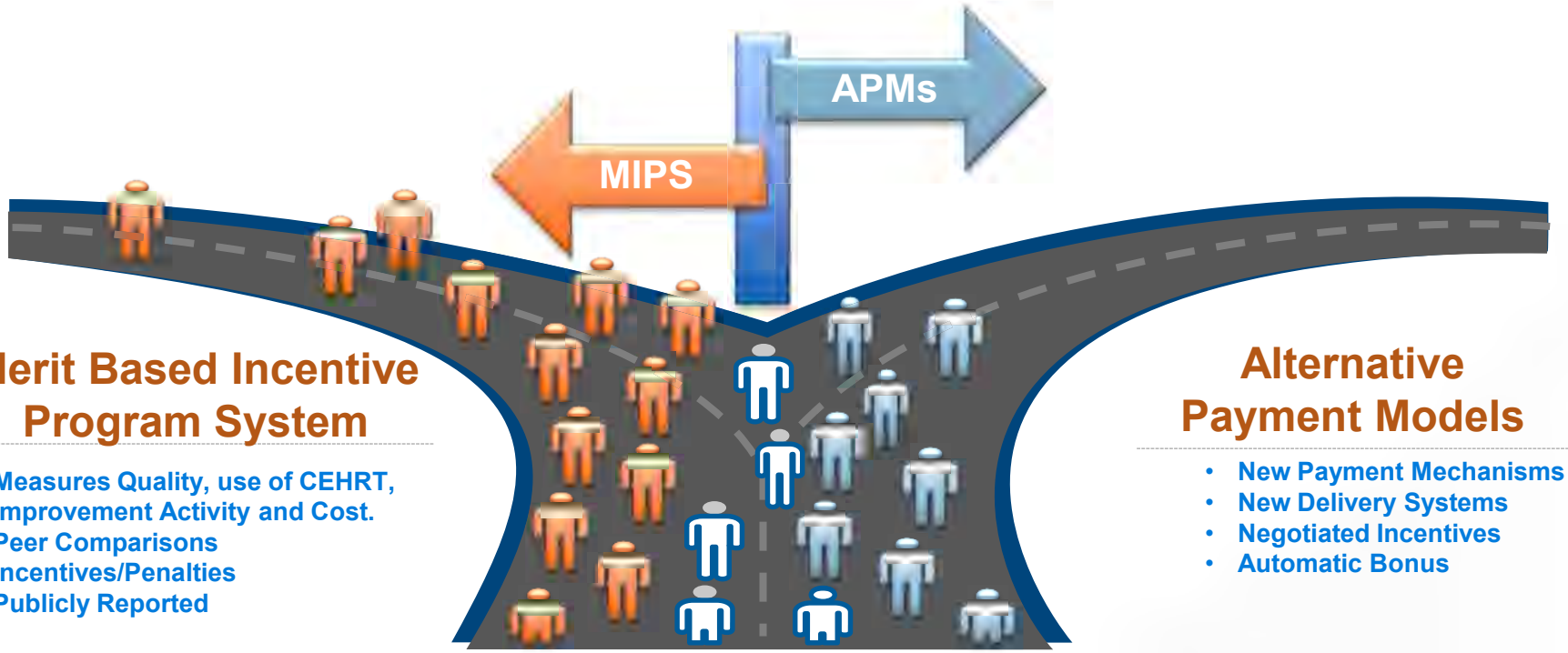
- Karen Hagerty, MD, Associate Director, Quality and Health Information Technology Policy, Policy and Advocacy Department

Medicare Quality Payment Program (QPP)



Merit Based Incentive Program System

- Measures Quality, use of CEHRT, Improvement Activity and Cost.
- Peer Comparisons
- Incentives/Penalties
- Publicly Reported

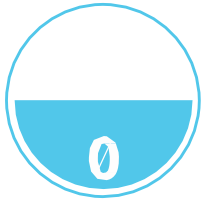
Alternative Payment Models

- New Payment Mechanisms
- New Delivery Systems
- Negotiated Incentives
- Automatic Bonus

Pick Your Pace for Participation for the Transition Year

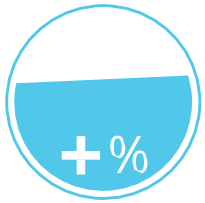
MIPS

Test



- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year



- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

Adapted from: CMS

Will It Affect Me?

Medicare Part B

(Physician Services)

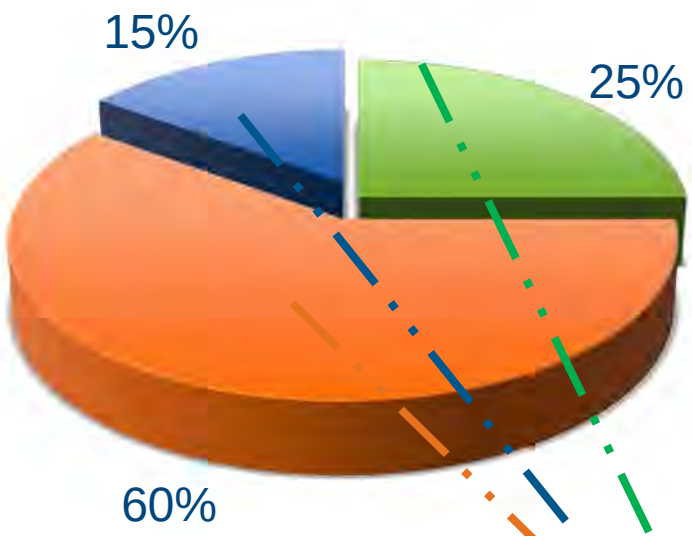
1st time Part B Participant — **EXEMPT**

Low Volume($30K) or Low Patient Count (100 Patients) — **EXEMPT**

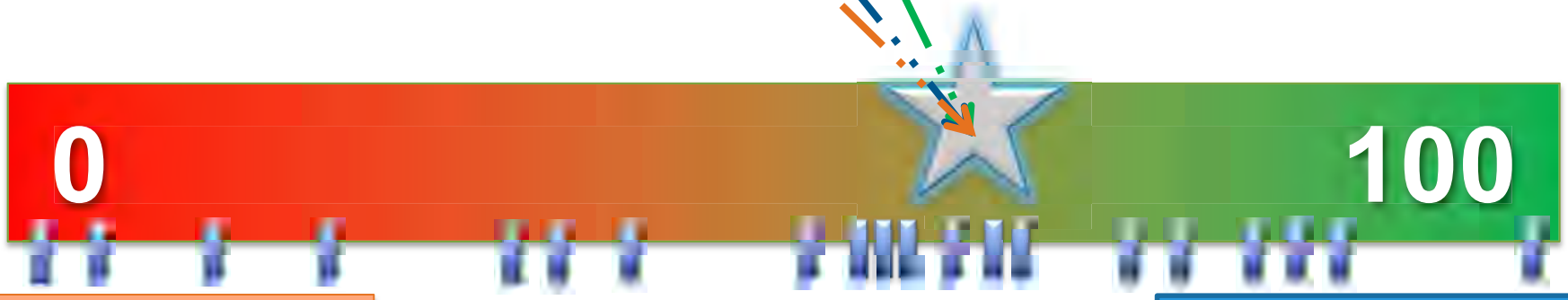
APM Qualified Participant — **EXEMPT**

2017

How is My Score Calculated?



- Advancing Care Information (MU)
- Quality (PQRS)
- Improvement Activity (New)



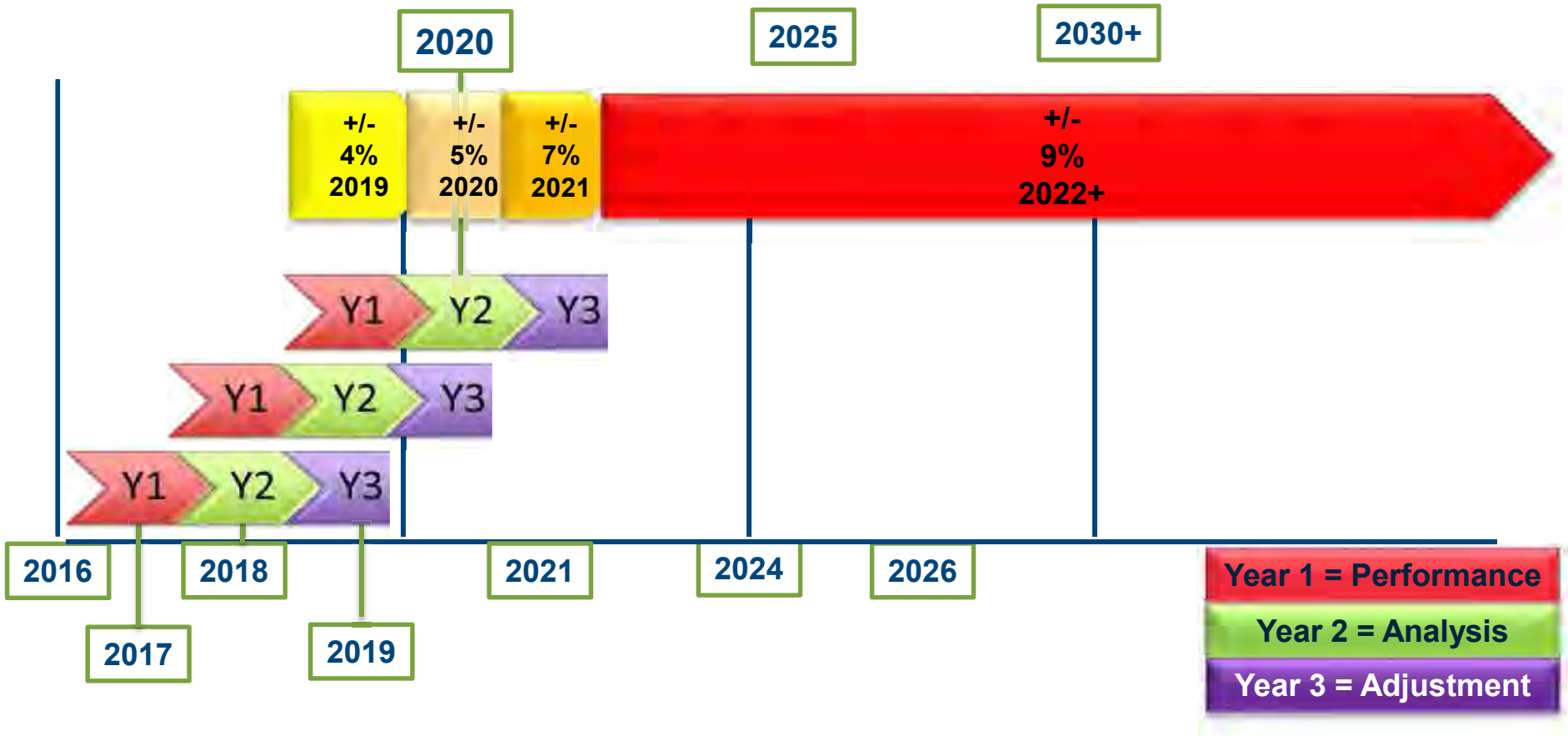
Low Performers -4%

High Performers +4%

National Median Composite Score

Medicare Provider Composite Score

MIPS Payment Adjustments Timeline



MIPS/Quality Performance Category Eligibility

- Physicians (MD, DO, chiropractic, optometrists, dentists, podiatrists)
- Physician Assistants (PA)
- Nurse Practitioner (NP)
- Certified Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA)

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

Evaluation and Payment Adjustment: Group vs. Individual Reporting

- Report as a group:
  - Individual clinicians are evaluated on measures reported by the group, regardless of whether the measures are applicable to the individual clinician
- Report as individual clinician within a group:
  - Each clinician evaluated individually based on specific measures they choose to report
- **Payment adjustment applied at TIN/NPI (individual level) regardless of whether individual or group reporting is elected**

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

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

Administrative Claims Measures (Global and Population-Based Measures)

- CMS did not finalize the acute and chronic composite measures of AHRQ PQIs
  - Will calculate these measures for all MIPS eligible clinicians and provide as feedback
- CMS did finalize the all-cause readmission (ACR) measure
  - Applies only to groups of more than 15
  - Must meet case minimum of 200 cases
  - If case minimum not met, measure will not be scored
  - Will calculate this measure for all MIPS eligible clinicians and provide as feedback

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		

What am I being compared to?

- Measure benchmarks
- How they’re established
- How you’re scored against them

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

Converting Deciles to Points

Benchmark Decile	Sample Quality Measure Benchmarks	Possible Points Without 3-Point Floor (Future Years)	Possible Points With 3-Point Floor (2017 Transition Year)
1	0 – 9.5%	1.0 – 1.9	3.0
2	9.6 – 15.7%	2.0 – 2.9	
3	15.8 – 22.9%	3.0 – 3.9	3.0 – 3.9
4	23.0 – 35.9%	4.0 – 4.9	4.0 – 4.9
5	36.0 – 40.9%	5.0 – 5.9	5.0 – 5.9
6	41.0 – 61.9%	6.0 – 6.9	6.0 – 6.9
7	62.0 – 68.9%	7.0 – 7.9	7.0 – 7.9
8	69.0 – 78.9%	8.0 – 8.9	8.0 – 8.9
9	79.0 – 84.9%	9.0 – 9.9	9.0 – 9.9
10	85.0 – 100%	10	10

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

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

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

Scoring for a Submitted Measure With Transitional Year 3-Point Floor: Putting it All Together

Data Completeness (50%) Met	Case Minimum Criteria (20) Met	Measure Has Benchmark	Your Performance Rate	Range of Scores for Measure
No	No	?	N/A	3
No	?	No	N/A	3
Yes	No	?	N/A	3
Yes	?	No	N/A	3
Yes	Yes	Yes	0%	3
Yes	Yes	Yes	>0%	3-10

Scoring Mechanics: First, the Denominator (aka Total Possible Score)

- Reporting 6 Individual Measures OR Specialty Measure Set With 6 or More Measures
  - Individual clinicians or groups <16: 6 measures x 10 points/measure = 60
  - Groups >15: (6 measures + ACR measure) x 10 points/measure = 70

- Reporting Less Than 6 Individual Measures* OR Specialty Measure Set With Less Than 6 Measures**
  - Individual clinicians or groups <16: 3 measures x 10 points/measure = 30
  - Groups >15: (3 measures + ACR measure) x 10 points/measure = 40

*only applies when there are less than 6 measures *available* and *applicable*

**assume 3 measures for sake of example

Scoring Mechanics: Second, Incorporate the Category Weight

- FORMULA: Your performance score/total possible score x quality performance category weight (60) = Final Score

- Formula adjusts for variances in denominator. Example (assume everyone scores 8 points on each measure):

- (6 measures x 8 points) 48/60 x 60 = 48
- (7 measures x 8 points) 56/70 x 60 = 48
- (3 measures x 8 points) 24/30 x 60 = 48
- (4 measures x 8 points) 32/40 x 60 = 48

Bonus Points: High Priority Measures and CEHRT

- High Priority Measures*
  - Outcome (2 points)
  - Patient Experience (2 points)
  - Appropriate Use (1 point)
  - Patient Safety (1 point)
  - Efficiency (1 point)
  - Care Coordination (1 point)

- Measures must meet case minimum/data completeness/performance rate >0 in order to get bonus points
- Cap for bonus points is 10% of denominator (total possible points you could receive)
- Bonus points are also available for measures that are not scored

- CEHRT
  - Each measure reported using “end-to-end” electronic reporting (1 point)
  - Cap for bonus points is 10% of denominator (total possible points you could receive)

*For non-MIPS (e.g. QCDR) measures, CMS will decide which are high priority
Caps apply for first 2 years of MIPS; CMS will adjust (likely decrease) in subsequent years

High Priority Measures: General Oncology Measure Set

	Measure	Bonus Points	Data Submission Mechanism		Measure Type	Domain
			Registry	EHR		
	Pain intensity	2	X	X	Process	Person and Caregiver Centered Experience and Outcome
	KRAS testing/-EGFR	1	X		Process	Patient Safety/Appropriate Use
	Prostate bone scan (overuse)	1	X	X	Process	Efficiency and Cost Reduction/Appropriate Use
	HER2 negative	1	X		Process	
	HER2 positive	1	X		Process	
Patient Deceased	Chemo last 14 days	1	X		Process	Effective Clinical Care/Appropriate Use
	Not admitted to hospice	1	X		Process	
	>1 ED visit last 30 days	2	X		*Outcome*	
	ICU last 30 days	2	X		*Outcome*	
	Hospice for less than 3 days	2	X		*Outcome*	

Automatic Scoring of ACR Measure

- If a group submits any quality measures, it will be automatically scored on ACR measure
- If a group submits no quality measures, but submits to other categories (ACI, CPIA), it will be automatically scored on the ACR measure and receive at least 3 points in the quality category
- If a group submits no quality measures and does not submit to other categories, it will not be scored on the readmission measure (and of course will receive a -4% penalty)

Quality Performance Category Scoring: Example 1

Measure Type	Possible Points	Your Performance	Bonus Points	
			High Priority	CEHRT
Outcome – using CEHRT	10	4.1	0*	1
Outcome – using CEHRT	10	9.3	2	1
Patient Experience [High Priority] – using CEHRT	10	10	2	1
Care Coordination [High Priority] – using CEHRT	10	10	1	1
Outcome – using CEHRT	10	9	2	1
Outcome – using CEHRT	10	8.4	2	1
Total Points	**60**	**50.8**	**9**	**6**
Points w/Cap		50.8	6**	6
Total Points w/Cap		50.8 + 6 + 6 = 62.8		
Final Score		**60*** **		

Quality Performance Category Scoring: Example 2

Measure Type	Possible Points	Your Performance	Bonus Points	
			High Priority	CEHRT
Outcome – using CEHRT	10	4.1	0*	1
Process – using CEHRT	10	9.3	0	1
Process – using CEHRT	10	10	0	1
Process	10	10	0	0
Patient Safety [High Priority]	10	8.5	1	0
Process – below case minimum	10	3***	0	0
ACR - Claims	10	5	n/a	n/a
Total Points	**70**	**49.9**	**1**	**3**
Points w/Cap**		49.9	1	3
Total Points w/Cap		49.9 + 1 + 3 = 53.9		
Final Score		53.9 (your total points) / 70 (possible points) x 60 (quality performance category weight) = **46.2**		

Quality Performance Category Scoring: Example 3

Measure Type	Possible Points	Your Performance	Bonus Points	
			High Priority	CEHRT
Outcome	10	7.5	0*	0
Process	10	10	0	0
Process	10	6.5	0	0
Process	10	8.0	0	0
Total Points	**40**	**32**	**0**	**0**
	Points w/Cap**	32	0	0
	Total Points w/Cap	32		
	Final Score	32 (your total points) / 40 (possible points) x 60 (quality performance category weight) = **48**		

Scoring for a Submitted Measure With Transitional Year 3-Point Floor: Putting it All Together (Again)

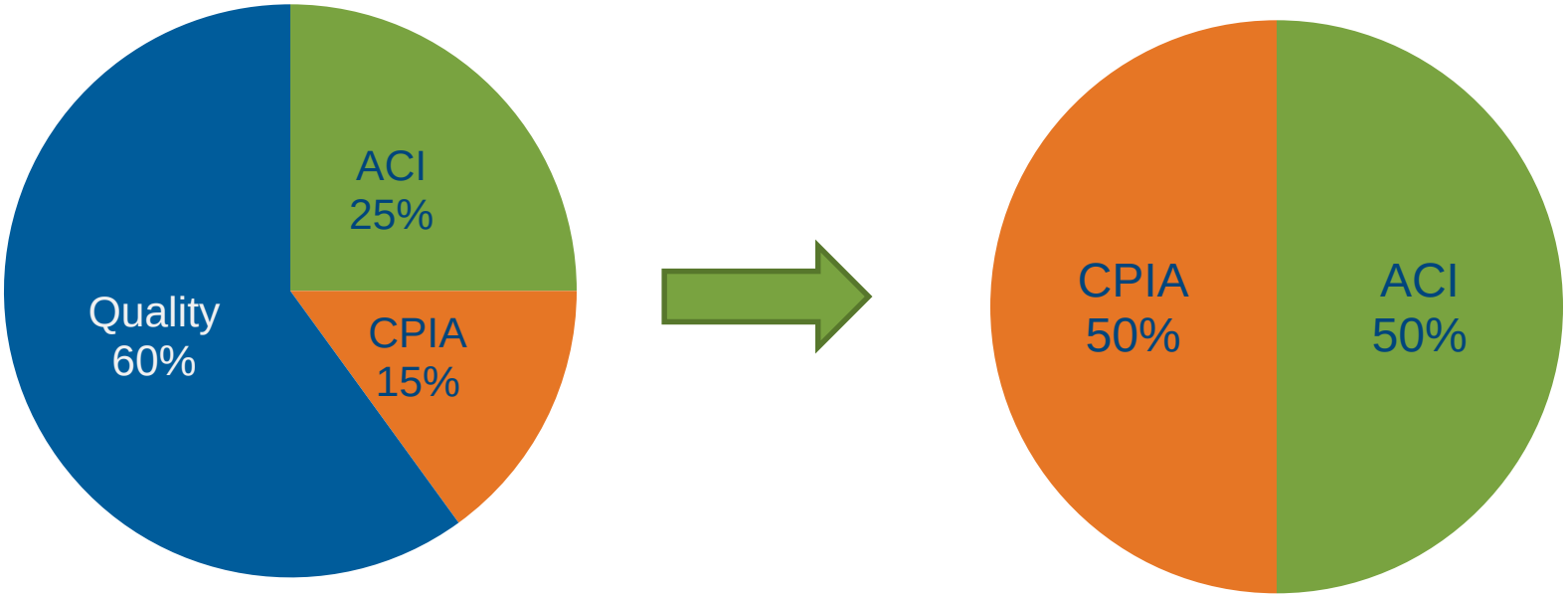
Data Completeness (50%) Met	Case Minimum Criteria (20) Met	Measure Has Benchmark	Your Performance Rate	Range of Scores for Measure
No	No	?	N/A	3
No	?	No	N/A	3
Yes	No	?	N/A	3
Yes	?	No	N/A	3
Yes	Yes	Yes	0%	3
Yes	Yes	Yes	>0%	3-10

Data Validation by CMS (Or, Why You Need to Submit all Required/Applicable Measures)

- Applies to claims and registry submissions
- Will apply if a clinician:
  - Submits fewer than 6 measures (if reporting individual measures or a specialty measure set with 6 or more measure)
  - Submits less than the full set of measures from the specialty set (if set has 6 or less measures)
  - Fails to submit the required outcome/high priority measure
- If CMS determines you failed to report on an applicable measure, you will be scored on that measure with a zero

*Similar to existing MAV process for PQRS, but will occur during scoring, not after

2017 Quality Performance Category Reweighting if No Measures Applicable/Available



The only people who qualify for reweighting of the performance category to zero are people who have absolutely no available and applicable measures to report.

This will be extremely rare because you can get 3 free points for reporting just one measure with a zero performance score, no benchmark, and lacking data completeness and minimum case requirements.

How Much/How Long Should I Report?

- CMS has emphasized you are being scored on performance, not the amount of data you submit or the length of the reporting period
- *Possible* to get MAX score if you submit 90 days and not the whole year
- CMS encourages everyone to report for full year – you should be practicing for 2018
- You *can* avoid a penalty if you report one quality measure, one CPIA measure, or the base score requirement of ACI – this will NOT prepare you for 2018 when reporting requirements grow significantly more stringent

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

Pick-Your-Pace for 2017: MIPS Reporting

2017

Don't Participate	Test the Program	Partial MIPS Reporting	Full MIPS Reporting
Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a	**Report:** ✓ 1 quality measure ***or*** ✓ 1 Improvement Activity ***or*** ✓ The required ACI measures	**Report for at least 90 days:*** ✓ 1+ Quality measure ***and/or*** ✓ 1+ Improvement Activity ***and/or*** ✓ More than the required ACI	**Report for at least 90 days:*** ✓ Required Quality measures ***and*** ✓ Required Improvement Activities ***and*** ✓ Required ACI

*consecutive days

*consecutive days

2018

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**

Pick Your Pace in 2017 Transition Year

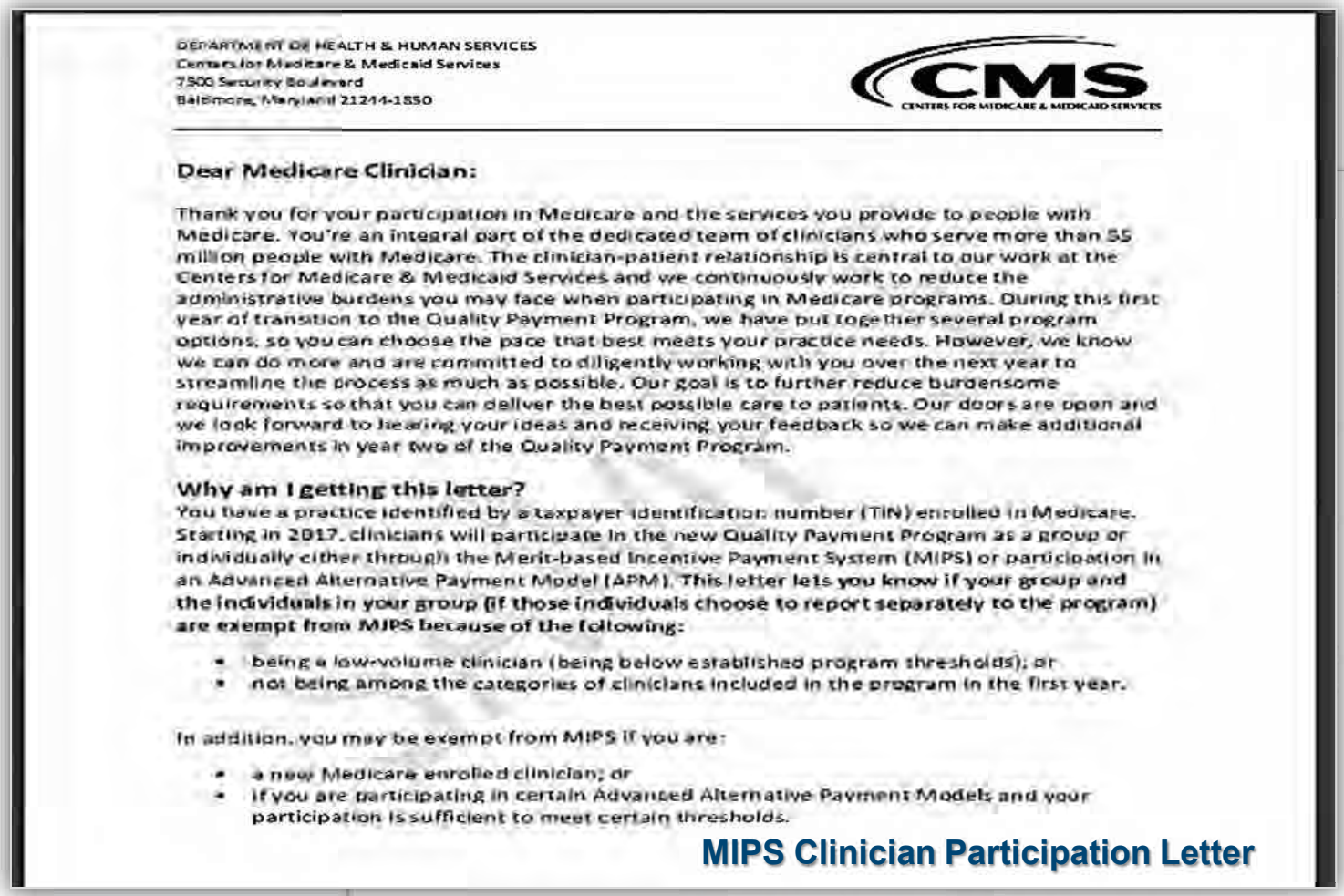
-4%

Failure to Participate in QPP in 2017 results in a Negative Payment Adjustment

MIPS Participation Status Letter

- CMS letters to clinicians sent end of April
  - Informs clinicians (by NPI) of their participation status
    - Eligibility for MIPS
  - One letter for every TIN they are associated with
  - Based on claims
    - September 2015 through August 2016
- Clinicians should participate in MIPS for the 2017 transition year if they do not meet any of the exemptions previously discussed.
- Clinicians may use the letters to determine if they will participate in the program as a group on individual.
- Can also check participation status on qpp.cms.gov based on NPI number

Dear Medicare Clinician:



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Dear Medicare Clinician:

Thank you for your participation in Medicare and the services you provide to people with Medicare. You're an integral part of the dedicated team of clinicians who serve more than 55 million people with Medicare. The clinician-patient relationship is central to our work at the Centers for Medicare & Medicaid Services and we continuously work to reduce the administrative burdens you may face when participating in Medicare programs. During this first year of transition to the Quality Payment Program, we have put together several program options, so you can choose the pace that best meets your practice needs. However, we know we can do more and are committed to diligently working with you over the next year to streamline the process as much as possible. Our goal is to further reduce burdensome requirements so that you can deliver the best possible care to patients. Our doors are open and we look forward to hearing your ideas and receiving your feedback so we can make additional improvements in year two of the Quality Payment Program.

Why am I getting this letter?

You have a practice identified by a taxpayer identification number (TIN) enrolled in Medicare. Starting in 2017, clinicians will participate in the new Quality Payment Program as a group or individually either through the Merit-based Incentive Payment System (MIPS) or participation in an Advanced Alternative Payment Model (APM). This letter lets you know if your group and the individuals in your group (if those individuals choose to report separately to the program) are exempt from MIPS because of the following:

- being a low-volume clinician (being below established program thresholds); or
- not being among the categories of clinicians included in the program in the first year.

In addition, you may be exempt from MIPS if you are:

- a new Medicare enrolled clinician; or
- if you are participating in certain Advanced Alternative Payment Models and your participation is sufficient to meet certain thresholds.

MIPS Clinician Participation Letter

Attachment A-QPP Letter Individual Clinicians

Attachment B- QPP Letter FAQs

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.

ASCO Offers Solutions

Certification
- Improvement Activity
- APM Participation

Rapid Learning
- Quality Reporting

Reporting
- Quality Reporting
- Advancing Care Information
- 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
  - Available by mid-year 2017
- 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 QOPI QCDR or another reporting mechanism and try for a positive adjustment for 2019

Questions?

- Please submit questions by clicking on the Chat panel from the down arrow on the Webex tool bar (at the top of the screen):

  1. Open the Chat panel
  2. Send to: David Harter
  3. Type your question in the text box and hit “send”

  Additional questions after the webinar can be sent to: macra@asco.org

Visit www.asco.org/macra for more information