ASCO Update

Oklahoma Society of Clinical Oncology

August 20, 2016

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Parkland Health System / UTSW
Editor, ASCO’s Journal of Oncology Practice
ASCO Update

Medicare Access & CHIP Reauthorization Act (MACRA)
Effects on Your Medicare Reimbursement

CMS Part B “Demonstration”
ASCO Initiatives

- New CEO – Cliff Hudis
- CancerLinQ – Bob Miller
- TAPUR – ASCO’s clinical trial
  - Targeted Agent and Profiling Utilization Registry (TAPUR) Study
- Policy – Deborah Kamin
- Clinical Affairs – Steve Grubbs
- Education – Jamie Von Roenn
- Journals
  - JCO – Precision Oncology
  - JCO - Clinical Cancer Informatics
Leadership Development Program

• Is ASCO's Leadership Development Program for you?
• Have you completed your final subspecialty training between 2007 and 2012?
• Are you interested in becoming a future leader in both ASCO and the practice of oncology?
• We NEED you….. Practice’s Voice
ASCO Clinical Affairs Department

Stephen S. Grubbs, MD

Elaine Towle & Tom Barr
Clinical Affairs – it’s cool
ASCO Clinical Affairs Department

Helping practices survive and thrive...today AND in the future

- Approved by the Board in 2014 to provide direct support and services to oncology practices
- In response to
  - Rapid escalation in scope of practice issues
  - Increasingly volatile practice environment
    - Economic pressures
    - Consolidations and mergers
    - Focus on value
    - New care delivery and payment models
    - Growing administrative burden
    - MACRA legislation
Resources for Practices

• Hands on help
  – Practice efficiency
  – Staffing models/work flow
  – Quality reporting
  – QI training and projects
  – Learning networks
  – Billing and coding reimbursement support

• Information and analysis
  – Practice trends
  – Economic analysis
  – Performance measurement
  – Payment reform
Clinical Affairs Divisions

• Analysis and Consulting
• Practice Management
• Performance and Quality
Analysis and Consulting Services Division

- PracticeNET
- Practice trends and forecasting
- Practice management forums
- MACRA education
- Clinical Affairs Data Warehouse and analysis
- Payment reform modeling
- Direct consulting services
• A rapid learning network for oncology practice knowledge – benchmarking, standards and best practices
  – Initial focus on administrative, operational, financial and quality improvement activities
• For practices in all practice settings
• Peer to peer interactive collaboration for knowledge sharing
• Reports:
  • Quarterly benchmarks produced by practice and by physician, compared against a national database of similar practices
  • Annual “state of your practice” assessment for key production and cost measurements
• Our vision is for PracticeNET to become the largest oncology practice collaborative of its kind, allowing greater opportunities for sharing, assessment, reporting, and identifying practice trends and patterns
Weighted average among *Practice* physicians for established patient office visits (99211 – 99215)
% deviation of all physicians at Practice, established patient office visits (99211 – 99215)
% deviation among Society practices, established patient office visits (99211 – 99215)
SAMPLE REPORT:
How busy are your physicians?

-150%  -100%  -50%  0%  50%  100%  150%

-150%  -100%  -50%  0%  50%  100%  150%

% Deviation from PracticeNET Average

NOTE: This is sample data for illustrative purposes only.
• Networking opportunities
  – Peer to peer meetings
    • Agenda driven by practice needs
    • First meeting, spring 2016
  – Moderated listserv

• Enrollment is open!
  – First practices have enrolled and are submitting data
  – For more information…. Elaine.towle@asco.org or PracticeNET@asco.org
Clinical Affairs Data Warehouse

• A new data resource to support the work of Clinical Affairs, Policy & Advocacy, and other ASCO departments and initiatives
  – Publicly available data from CMS
    • Medicare provider Utilization and Payment Data: Physician and Other Supplier Public Use File, CY 2012 and 2013; Medicare Provider Utilization and Payment Data: Part D Prescriber for CY2013
    • Physician Compare
      – Relative value units
      – Data from practices participating in PracticeNET
  • Additional information: surveys; data from analytical work performed by ASCO when use is authorized
  • Data aggregation processes allow analysis across disparate data sources
What is a PUF?

- **Public Use File**
- There are lots of them now and new ones are being produced by CMS at a steady pace.
- The ones we are using are the *Physician and Other Supplier PUF* for part B and D; and *Physician Compare*
- *Physician and Other Supplier PUF, Part B*
  - Data include utilization, payment (allowed amount and Medicare payment), and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code, and place of service for calendar years 2012 and 2013 and contains 100% final-action physician/supplier Part B non-institutional line items for the Medicare fee-for-service population.
What’s in the Medicare PUF?

- NPI – National Provider Identifier
- Provider last name
- Provider first name
- Provider street address
- Provider city
- Provider zip
- Provider state
- Place of service
- HCPCS code
- HCPCS description
- HCPCS drug indicator
- Line srvc cnt
- Bene unique cnt
- Bene day srvc cnt
- Avg Med allowed amt
- Avg submitted chrg amt
- Avg Medicare pmt amt
What’s in Physician Compare that can be linked to the PUF?

- NPI
- PAC ID
- Professional Enrollment ID
- Gender
- Medical credential
- Medical school name
- Graduation year
- Primary specialty
- First - fourth secondary medical specialties

- Organization legal name
- Organization DBA name
- Practice PAC ID
- Number of Group
- Street Address Group Practice
- City Group Practice
- Zip Code Group Practice
- Participating in eRx
- Participating in PQRS
- Participating in EHR
- Received PQRS Maintenance of Certification Program Incentive
And why are we talking about it?

• Because these data are public, complete, and very detailed.

• Others will misunderstand and/or misrepresent “conclusions” that are reached and preached from these data.

• This gives you the opportunity to see how you compare to the population of oncologists.
ASCO Provider Utilization File: The ASCO PUF

Medicare Physician and Other Supplier Public Use File, Part B

Medicare Physician and Other Supplier Public Use File, Part D

Medicare Physician Compare

Work Relative Value Units
Weighted average for established patient office visits (99211 – 99215)
Medicare PUF
Beneficiary service count per physician, established patient office visits (99211-99215)
Practice Management Division

- Clinical Practice Committee and work groups
- Patient Centered Oncology Payment (PCOP) model evolution and implementation
- Billing and Coding hot line
- Oncology Practice Insider e-newsletter
- FDA Alerts
- Medicare and commercial payer forums
- Support ASCO representatives to CPT & RUC committees and AMA HOD
- Member of AMA Advanced payment Model Work Group
Clinical Affairs Department Volunteers

• Clinical Practice Committee
  – Practice Administrators Workgroup
  – PCOP Implementation Workgroup
  – Data Review Workgroup
  – Physician Compensation Workgroup
  – Coding, Reimbursement, and Billing Workgroup

• Quality
  – QOPI Certification Oversight Council
  – Quality Training Program Faculty Workgroup
  – Niarchos Grant Steering Group
• Developed by ASCO volunteers and consultants and published May, 2015
• Multiple meetings and phone calls with practices and payers
• Educational webinars with payers, practices, practice managers and meetings with payers and practices
• ASCO is prepared to perform data modelling
  – Claims data (payer) and Clinical data (practice EMR)
• Developing and acquiring tools to prepare practices to be successful in Alternative Payment Models
PCOP Level One Model

TREATMENT MONTHS

ACTIVE MONITORING

0 $0
1 $200
2 $600
3 $600
4 $600
5 $600
6 $600
7 $800
8 $1,000
9 $1,200
10 $1,200
11 $1,200
12 $1,200
13 $1,200
14 $1,200
15 $1,200

E&M
Care Mgt.
Care Mgt.
Care Mgt.
Care Mgt.
Care Mgt.
Care Mgt.
Care Mgt.
New Patient
Infusion
Infusion
Infusion
Infusion
Infusion
Infusion
Infusion
CM
EM
CM
EM
CM
EM
CM
EM
A Continuum for Practice Transformation

Level 1
New E&M Codes

Level 2
Monthly Payments

Level 3
Bundled Monthly Payments

Allows any practice—regardless of starting point—to participate in some alternative payment model
Practice Related Activities

- Practice Administrators
  - CPC Work Group expansion
  - Expanded ASCO Membership
- AMA activities: Support CPT meetings and CPT Advisory Committee, RUC meeting and RUC Advisory Committee, House of Delegates
- Annual meetings: Carrier Advisory Committee (with ASH); Provider Payer Initiative
- Billing and Coding Reimbursement Service (billingandcoding@asco.org)
Oncology Practice Insider (OPI)

- A free e-newsletter devoted to oncology practice management
- Updates on Medicare initiatives, Medicare coverage information, FDA drug alerts, legislative activities, coding and billing and more
- Redesigned and relaunching
- Over 600 subscribers and expanding audience
- Subscribe to OPI by e-mailing practice@asco.org
Performance and Quality Division

- QOPI Certification Program (QCP)
- Quality Training Program (QTP)
- Quality Improvement grant management
  - Niarchos Grant
The primary goal of the program is to improve care provided to patients with cancer and to recognize those practices that provide quality oncology care.

**Your Practice Name** has been recognized by the Quality Oncology Practice Initiative (QOPI®) Certification Program, an affiliate of the American Society of Clinical Oncology (ASCO).
Certification Standards

- Consistent expectations for patient safety across diverse settings providing chemotherapy
  - A framework for best practices in cancer care
  - Encourages a review and update practice policies and procedures
- Encourages internal quality assessment
- Encourages external quality monitoring
Certification Process

- Practices submit data for 26 Certification measures via pathway
- Must meet scoring thresholds
- Overall quality score: 75%

- Attests to compliance with 20 chemotherapy safety standards
- Payment

- Three randomly selected charts for concordance audit of QOPI chart abstraction
- Policies related to 3 of the certification standards

- Structured on-site audits are conducted by certified oncology nurses
- Exit interview with practice leadership outlines findings
- Written report that has been reviewed by committee member
On-Site Survey

Review concordance with the 20 program standards

<table>
<thead>
<tr>
<th>Patient Tracer</th>
<th>Policy Review</th>
<th>Record Review</th>
<th>Staff Interviews</th>
</tr>
</thead>
</table>

Focus is one of coaching/mentoring by the surveyors

Surveyors are advanced degree oncology nurses with special training to conduct audits

Report of Findings: practice-specific improvement roadmap

| Requirements | Best practice suggestions | Targeted education | Tools (e.g., policy templates) |
QOPI Certification Program Growth

525 Applicant Practices
298 Certified practices
336 New Applicants
189 Recertifying
Representing
3,826 Oncologists
QOPI Certification Program Practice by Ownership

- Academic Full-Time: 35%
- Private with Academic Affiliation: 14%
- Private Independent: 26%
- Employee: 17%
- Employee - Hospital Based: 26%
- Other: 5%
ASCO – Quality Training Program

• Empowers practice teams to improve clinical care and operational performance
• Teaches teams how to balance Quality improvement projects with demanding schedules and competing priorities
• The program prepares your oncology providers to design, implement, and lead successful QI activities in busy practice settings.
• Prepares you for Practice PIA – MACRA / MIPS
Quality Training Program

- ASCO HQ --- Alexandria Va
  - July, October and January

- Three in person meets for the entire team
  - Didactic / Coached interactive sessions

- Develop project with heavy critique
Quality Training Program (QTP)

**Purpose**
- Oncology providers design, implement and lead successful quality improvement (QI) activities in their practice settings.
- Oncologists assume quality leadership positions and champion quality initiatives.

**Design/ Curriculum**
- 6-month, comprehensive education and training for interdisciplinary oncology teams. Structured improvement project selected by each team.
- In-person and virtual learning sessions with expert Faculty and Improvement Coaches experienced in oncology.
- Topics: improvement science, team building, and leadership.

**Value/ Benefits**
- Knowledge and skills to lead local QI activities.
- Expert assistance to complete a QI project.
- Achieve and sustain improvements – processes of care; clinical outcomes.

www.asco.org/qualitytraining
Clinical Affairs Special Projects

- UVA Darden School of Business MBA student project
- ASCO Practice Account Manager Pilot
- 2017 Oncology Business Conference
- 2016 MACRA practice workshops
- MIPS and OCM measurement packages
Preaching ..... An East Texas Trait

• Be involved.....
  – More than ever it will take a village.....
  – We must, indeed, all hang together or, most assuredly, we shall all hang separately.

• Reprise
  – Prepare for the future.......
  – Practice regardless of the site....
  – ‘transformation’ ‘manage change’ ‘value’ ‘cost’
High Noon

- Harken to the 1952 film with Gary Cooper / Grace Kelly....
The Issue in a Nutshell...

How can an oncology practice transform to adapt to the future / APMs / OCM?

**Dilemma:**

Every aspect of the market is rapidly trending toward value-based APMs – most oncology groups practice technically and culturally only, with structures to treat patients in a Fee-for-Service (FFS) environment.
How do Oncologists Currently *Technically* Operate in a FFS Environment?

- Decentralized Patient Intake
- Decentralized Phone Banks
- Decentralized Symptom Management
- Limited (within the practice) Psychosocial Support Mechanisms
- Scheduling Driven by Individual Physician Templates
- Limited Survivorship Structure
- Standard Palliative Care/Hospice Processes

- Physicians trained and focused on fixing all problems in the exam room. Team-based care not the typical MO in the clinic
- “Regimen du jour”
- Clinical focus - treating disease, not healing lives
- Nursing focus - solve the immediate issue, not the bigger problem – chemo room triage
- Satellite clinic staff focused on “ownership of their patients”
- Limited coordination with the patient post ER visit or hospital stay
- Limited patient education about what to expect from beginning to end of their journey
Making the Necessary Changes…

Embark on a path to transform practice from the very traditional approaches in treating patients to healing lives and improving value.

Models to follow – a *Medical Home* –

*It is not just for Primary Care*…

*Basis for OCM, multiple private payer contracts* -
Medical Home Purpose

- Improved access to healthcare
- Increased patient satisfaction
- Improved medical outcomes
- Efficient delivery of care
- Reduced costs
Large Reductions in Avoidable Hospitalizations Are Possible

Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004-2010

Source: Sprandio JD. “Oncology patient-centered medical home and accountable cancer care.” Community Oncology, December 2010
## Sources of OMH-OCM Cost Savings

<table>
<thead>
<tr>
<th>Source</th>
<th>% Cost Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug pathways compliance</td>
<td>1.0% to 3.0%</td>
</tr>
<tr>
<td>Avoidable ER utilization</td>
<td>0.6% to 1.1%</td>
</tr>
<tr>
<td>Avoidable hospital admissions</td>
<td>4.0% to 7.0%</td>
</tr>
<tr>
<td>Diagnostics (imaging, lab)</td>
<td>0.2% to 0.5%</td>
</tr>
<tr>
<td>End-of-life care management</td>
<td>0.9% to 1.9%</td>
</tr>
<tr>
<td>Total potential savings</td>
<td>6.7% to 13.5%</td>
</tr>
</tbody>
</table>

Spending on Drugs, Imaging, and Hospitals Varies by More Than 60%

Spending Per Medicare Beneficiary During Chemotherapy Episodes on Chemotherapy, Imaging, and Inpatient Admissions, 2012

Source: Clouagh, Patel, Riley, Rajkumar, Conway, Bach. "Wide Variation in Payments for Medicare Beneficiary Oncology Services Suggests Room for Practice-Level Improvement." Health Affairs, April 2015
A Medical Home, also referred as a Patient-Centered Medical Home (PCMH), is a team-based healthcare delivery model led by a physician. The model provides comprehensive and continuous medical care to patients, with the goal of obtaining maximized health outcomes.
Implementing OMH Model
Changing a practice *technically* and *culturally*

- Dedicated triage nurses, centralized phones
- Scripted triage pathways
- Expanded hours and dedicated triage clinic time
- Navigators/Nurse educators
- Coordinated emergency/hospital management
- Treatment pathways
- Patient portal and communication
- Clinical trials support
- Psychosocial distress evaluation
- Survivorship clinic
OMH Key Points

• Much of the value gained from the OMH infrastructures comes through refinement of day-to-day patient care processes resulting in superior outcomes

• An OMH infrastructure gives the best opportunity for sustaining contracted bundled payments with risk sharing/shared savings, which are the anticipated APMs in the near future
Metrics / Quality Measures
Tied to Resource Use / Shared Savings

- ER visits (and costs)
- Hospitalization rates (and costs)
- Chemotherapy costs
- Adherence to evidence-based treatment guidelines (including treatment exceeding lines of therapy and documentation of off-pathways reasons)
- Cancer staging, performance status, pain assessment
- End-of-life metrics (ACP documentation, hospice enrollment, hospice length of stay)
- Patient satisfaction
Medical Home Concluding Thoughts

- **Administrative burdens** continue to adversely impact oncology practices.
- The **costs of cancer care** are unsustainable.
- **MACRA** – we now have law that will drive how we get paid in the near future.
- For oncology to remain viable going forward, successful management of the **financial risks** associated with APMs can be achieved by incorporating OMH processes.
- **Practice transformation** is essential to prepare for APMs.
Vision More than Today
and more preaching....

• Strategy / framework / a way of thought
• ... to relate Practice transformation activity / APM participation into a higher order of goals.... A larger context
Porter

• Our purpose in caring for patients – to provide value
• Value classically = outcome / cost
• Financial success is the result of delivering value – not an end in itself
• Path to success is to organize care delivery to improve patient value
“Patient” Value

• Defined as a parameter for a patient’s condition over the full cycle of care
• Outcomes inclusive of the full set of health results for the patient (see ICHOM – International Consortium for Health Outcomes Measurement)
• Costs are total care cost for the patient’s condition
  – Most powerful lever at reducing costs is improving outcomes
• *** Yet we don’t know outcomes & don’t know costs
Porters’ Stratagem

• Re-organize care around patients condition in an environment that is integrated
• Measure outcomes and costs for every patient
• Pay providers differently – APM toward global payments
• Integrate multi-site care delivery systems (attack silos)
• Expand geographic Reach – work together – leverage volume – drives excellence
• Enable IT platforms around measurement
The Bottom Line

Prepares NOW

Affects most practices

ASCO will HELP
More Information:

Go to ASCO website:

http://www.asco.org/qualitytraining

www.asco.org/macra
Thanks …..

Questions / Discussion / Feedback……..

Slides poached from Steve Grubbs, Elaine Towle Harold Miller, Ray Page
• Added Slides from initial talk…..

• Detail re: MACRA
MACRA

WHY SHOULD YOU CARE?
ASCO, along with other medical societies supported the repeal of the Sustainable Growth Rate (SGR) formula:

- Imperfect fee-for-service program
- Unworkable adjustment formula
- Annual uncertainty
- Piecemeal approach to incentives

The promise of MACRA aligns with ASCO’s goals:

- Rewards quality and value-based care
- Allows practice payment system and reporting options
- Consolidated incentive programs
Why is it Important Now?

• Completely changes basis for Medicare payment

• Moves to performance based updates

• Effective date 2019 ...

...but measurements will be based on 2017 performance
Overview

• How does Medicare pay me now?
• How will it change?
• When will it change?
• What should I be doing to prepare?
• Where can I get help?
MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (QUALITY PAYMENT PROGRAM) OVERVIEW
What is “MACRA”? 

Medicare Access and CHIP Reauthorization Act of 2015 

• Repeals the Sustainable Growth Rate (SGR) Formula 

• Authorizes CMS to establish the new Quality Payment Program 

• More of the payment based on value, not volume 

• Streamlines reporting programs into 1 new system: Merit Based Incentive Payment System (MIPS) 

• Incentivizes involvement in Alternative Payment Models (APMs)
How Does Medicare Pay Me Now?

- **Physician Quality Reporting System** (PQRS)
- **Meaningful Use**
  - Electronic Health Records Incentive Program (MU)
- **Value Based Modifier** (VBM)
How Does Medicare Pay Me Now?

Adjustments

Physician Fee Schedule Payment

PQRS

MU

VBM

Final Payment
Cost are risk adjusted based on patient factors and specialty-mix of the group.
How Will it Change?

The Merit Based Incentive Payment System (MIPS)

**TODAY**
- Physician Quality Reporting System (PQRS)
- Meaningful Use (MU)
- Value Based Modifier (VBM)

SUNSETS DEC 2018

**JAN 2019**
- Adds Clinical Practice Improvement Activity (CPIA)
  - Consolidates penalties
  - Increases incentives
  - Ranks peers nationally
  - Reports publicly

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**Today’s sunset:**
- Physicians migrate to MIPS.

**JAN 2019:**
- MQP (CPIA) is added.
  - Adds CPIA to MIPS.
  - Consolidates penalties.
  - Increases incentives.
  - Ranks peers nationally.
  - Reports publicly.

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**TODAY**
- Physician Quality Reporting System (PQRS)
- Meaningful Use (MU)
- Value Based Modifier (VBM)

SUNSETS DEC 2018

**JAN 2019**
- Adds Clinical Practice Improvement Activity (CPIA)
  - Consolidates penalties
  - Increases incentives
  - Ranks peers nationally
  - Reports publicly
### Clinical Practice Improvement Activity

| **MIPS weight** | - 15% of total MIPS score  
- 90-day reporting period |
|-----------------|-----------------------------|
| **CPIA categories** | - 8 activity categories  
- 90+ activities  
- Do not need activities in each category |
| **Scoring** | - 60 points = 100% CPIA score  
- 7 of 8 categories have both high (20 points) and medium (10 points) weighted activities |
| **Exceptions** | - Certified PCMH (60 points); other APM (30 points)  
- Non-patient facing specialties & small rural practices need fewer points (one activity for partial credit, 2 activities for full credit) |
| **Concerns** | - High weight activities should be expanded, required activities reduced  
- Credit for APM participation should be increased  
- Practices should be able to maintain CPIA activities over time |
Clinical Practice Improvement Activity Categories

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety & Practice Assessment
- Achieving Health Equity
- Emergency Response and Preparedness
- Integrated Behavioral & Mental Health
How is My Score Calculated?

MIPS Composite and Potential Impact

- Advancing Care Information (MU) 25%
- Quality (PQRS) 15%
- Resource Use (VBM) 10%
- Clinical Practice Improvement Activity 50%

Low Performers -9%
High Performers +9%
Exceptional Performers: Up to 27%

National Median Composite Score
Medicare Provider Composite Score
How is My Reimbursement Adjusted?

Adjustments

Physician Fee Schedule Payment +/MIPS Composite Score Adjustment +/
MIPS Exceptional Performance

= Final Payment
Payment Adjustments Timeline

Year 1 = Performance
Year 2 = Analysis
Year 3 = Adjustment
Will it Affect Me?

Medicare Part A (Hospital, SNF, Hospice)
NO

Medicare Part B (Physician Services)
YES

Medicare Part C (Medicare Advantage)
NO

Medicare Part D (OP Prescription Drugs)
NO
Will it Affect Me?

1st time Part B Participant

Low Volume (< $10K)
Low Patient Count (< 100 Patients)

APM Qualified Participant

Medicare Part B (Physician Services)
Is MIPS the Only Option?

- Exemption from MIPS
- 5% Lump Sum Bonus
- APM Specific Rewards

CMS Recognized Alternative Payment Models (APM)

Advanced APM

Qualifying Physicians 25% 2019
Eligible APMs are the most advanced APMs:

1. Base payment on quality measures comparable to those in MIPS

2. Require use of certified EHR technology

3. Either:

   (1) bear more than nominal financial risk for monetary losses (two sided risk); or

   (2) is a medical home model expanded under CMMI authority
Any Advanced APMs in 2017?

- Shared Savings Program
- Next Generation ACO
- Comprehensive ESRD Care
- Comprehensive Primary Care Plus
- **Oncology Care Model (OCM) - two-sided risk track available in 2018**
How do Program Adjustments Differ?

**MIPS Only**
- MIPS adjustment

**APMs**
- Favorable Treatment in MIPS

**Advanced APMs**
- APM-Specific rewards
- 5% lump sum bonus
How Will My Payment Adjustments Differ?

Adjustments

- MIPS Composite Score Adjustment
- MIPS Exceptional Performance

or

5% Lump Sum APM Bonus

Final Payment
Most practitioners will be subject to MIPS

Not in APM

In non-advanced APM

In APM, but not a QP

Qualifying Physician (QP) in APM

Some people may be in APMs but not have enough payments or patients through the APM to be a QP.

Note: Figure not to scale.
When is this all happening?

- **APM Adjustment**: 2020
- **APMs 5% Payment Bonus**: 2025
- **MIPS Max Adjustment**:
  - +/- 4% 2019
  - +/- 5% 2020
  - +/- 7% 2021
  - +/- 9% 2022+
- **2030+**
HOW TO PREPARE
Rulemaking and Implementation

Nearly 3,100 stakeholders provided input on the 962 page MACRA proposed rule.

Final Rule expected November, 2016; things are still subject to change.
Avoid 2018 penalties

• PQRS
  • Successfully report to avoid negative payment adjustment

• Medicare EHR Incentive Program
  • Must successfully attest to avoid negative payment adjustment

• Value Modifier
  • Receive an upward or neutral payment adjustment and avoid downward payment adjustment

*Any applicable Value Modifier payment adjustment is separate from payment adjustments made under the Physician Quality Reporting System (PQRS) or EHR Incentive Program.*
Step 2: Review your QRUR

Quality and Resource Use Reports (QRUR)

• Shows how you performed on quality and cost
  – QRUR is provided for each TIN (tax i.d. 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 your QRUR show?

Your TIN’s Quality Composite Score: Average

The graph below displays your TIN’s standardized Quality Composite Score.

Average Range

Standard Deviations from National Mean (Positive Scores Are Better)

Your TIN’s Cost Composite Score: Average

The graph below displays your TIN’s standardized Cost Composite Score.

Average Range

Standard Deviations from National Mean (Negative Scores Are Better)
What does your 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 your 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 your 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.

<table>
<thead>
<tr>
<th></th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Cost</strong></td>
<td>+0.0%</td>
<td>+1.0 x AF</td>
<td>+2.0 x AF</td>
</tr>
<tr>
<td><strong>Average Cost</strong></td>
<td>-1.0%</td>
<td>0.0%</td>
<td>+1.0 x AF</td>
</tr>
<tr>
<td><strong>High Cost</strong></td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>0.0%</td>
</tr>
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</table>
Step 3: Focus on Performance

- Review quality measure benchmarks and understand what is required for above average performance.

- Implement practice strategies and clinical workflows to help meet your chosen quality measures for PQRS and the quality and cost measures used under the VM program.
Performance Improvement Examples

• EHR Use
  – Implement workflows to introduce patients to patient portal and encourage utilization

• Cost measures
  – Establish processes to monitor hospitalizations and measure length of stay
  – Consider medical home-type services to reduce hospitalizations
Step 4: Ensure Data Accuracy

• Accuracy of comparison group critical: your performance is compared to others like you

• Check the NPI for each physician in practice
  – Is the specialty correct?
  – Is the address correct?
  – Is the group affiliation correct?

• Review your own information in Physician Compare
Step 5: ICD-10 Coding

• As we move to a risk-adjusted world, co-morbidities and other conditions become increasingly important

• Are you coding to the highest level of specificity?

• Are you coding all co-morbidities and other pertinent conditions for your patients?
• Hospitals that employ physicians
  – Will directly bear the cost of implementation and ongoing compliance
  – Will bear the risk of MIPS and adjustments
  – Will be called upon to participate in APMs in order for physicians to qualify from exemption

• Physicians practicing in hospital groups
  – Use hospital’s quality reporting system and pay for performance programs to measure participation in MIPS
Essential to Practice Survival

Practice Leadership

Payer Relationships

Communication & training – organizational cultural readiness for value-based practice
Additional Considerations

• What is the impact of value-based payment on
  – physician compensation
  – contracts, professional services agreements with hospitals
  – commercial payer contracts

• Does your EHR support quality reporting, practice improvement?
  – Patient Portal
  – e-prescribing capability
  – Health Information Exchange (HIE) capability
• More detailed practice data
• Compliance with Pathways as a quality measure
• Fully integrated tools to collect and monitor quality measures
• Support for practice transformation and expense
• Real time data acquisition
• Tools to help nurses proactively manage patients to decrease hospitalizations and costs
• Options and experience with two-sided risk options for hospitals and POs
• More resources in private, underserved and rural practices there are no resources available
ASCO’s Three-Pronged Strategy

VOLUNTEER TASKFORCE
• Multi-committee task force leading key areas, including:
  • Focus on QOPI & performance measures
  • Alternative payment model strategy (PCOP)
  • Practice tools

EDUCATION AND RESOURCES
• Readiness assessment
• Webinars
• Workshops
• ASCO Oncology Practice Conference: The Business of Cancer Care launching in March 2, 2017

INFLUENCING POLICYMAKERS
• Filing Extensive Comments
• Meetings with CMS and Policymakers
• Congressional education, outreach and testimony
STATUS Update:

• Pursuing designation as “advanced payment model” that will qualify under MACRA

• Active dialogue with several practices and commercial payers

• One pilot underway
Quality Oncology Practice Initiative (QOPI)

- CMS deemed Qualified Clinical Data Registry (QCDR)
  - Includes Oncology Specific Measures
- Included measures may be used by QOPI users for reporting
- eQOPI will allow for easier reporting of quality measures
- Measures Task Force routinely updates and develops new measures
### Education & Resources

#### MACRA: Learn the basics, great ready for a post-SGR world
- Webinar slides and recording available at www.asco.org/macra

#### MACRA Town Hall at Best of ASCO
- Chicago, June 24-25, 2016
- San Diego, August 12-13, 2016

#### New webinar series Summer/fall 2016
- How to prepare for MACRA
- Successfully reporting for PQRS and the Value Modifier
- Understanding your QRUR
- Reporting for Meaningful Use
- New payment systems: How to prepare for alternative payment models
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<td><strong>Webinar December 2016</strong></td>
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The Bottom Line

Prepare NOW

Affects most practices

ASCO will HELP
DISCUSSION AND QUESTIONS

Visit [www.asco.org/macra](http://www.asco.org/macra) for more information.