Quality Payment Program: 
Scoring for Advancing Care 
Information & Improvement Activities

June 19, 2017
Today’s Speakers

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  – 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

<table>
<thead>
<tr>
<th>Test</th>
<th>Partial Year</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% Submit something</td>
<td>+% Submit a partial year</td>
<td>+% Submit a full year</td>
</tr>
</tbody>
</table>

- **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

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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?

1st time Part B Participant  EXEMPT

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

APM Qualified Participant  EXEMPT

Medicare Part B (Physician Services)
How is My Score Calculated?

- 60% of the score is based on Improving Activity (New).
- 25% is based on Advancing Care Information (MU).
- 15% is based on Quality (PQRS).

Low Performers -4%
National Median Composite Score
Medicare Provider Composite Score

High Performers +4%

2017
MIPS Payment Adjustments Timeline

Year 1 = Performance
Year 2 = Analysis
Year 3 = Adjustment
MIPS
ADVANCING CARE INFORMATION
MIPS/ACI Eligibility

- Physicians (non-hospital based)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Certified Registered Nurse Anesthetists (CRNA)
- Certified Nurse Specialists (CNS)
Eligible...But Ready?

- Physicians
- NP
- PA
- CRNA
- CNS
MIPS Eligible Clinicians
ACI Category Weight of Zero

ACI Category Automatically Reweighted to Zero
- NP, PA, CNS, CRNA
- Hospital-based Clinicians
- Non-patient Facing Clinicians

ACI Category Potentially Reweighted to Zero
- Significant Hardship Exceptions
Am I a Hospital-based Clinician?

- Hospital-based MIPS eligible clinicians: **75%** of professional covered services provided in the
  - inpatient setting
  - ED
  - on-campus outpatient hospital
Hospital-based Clinician: Time Frame for Determination

- Originally proposed to use the year 3 years preceding payment adjustment year
- Final rule: will use claims with dates of service between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period

2017 Performance Year
Dates of Service:
09/01/2015-08/31/2016
Significant Hardship Categories

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over availability of CEHRT
- [Lack of face-to-face patient interaction]
- Must submit application, CMS will make determination

Forget it.
This doesn’t apply to you.
2017 ACI Performance Category
Redistribution if ACI Category Reweighted to Zero
A (Big) Caveat

Eligible for ACI Zero Weight

Report Nothing

Choose to Report at Least 1 Measure

ACI Weight Remains Zero

Go Back to 25% Weight Scored Like Everyone Else
Data Submission

Individual/Group Reporting
Reporting Period
Stages & CEHRT Edition
ACI Individual Clinician Reporting

• Data Submission
  – Attestation
  – CEHRT/EHR (through QRDA)
  – QCDR
  – Qualified Registry
ACI Group Reporting

- Data Submission
  - Attestation
  - CEHRT/EHR (through QRDA)
  - QCDR
  - Qualified Registry
  - CMS Web Interface Submission
Group Reporting

- Group calculation of the numerators and denominators for each measure must reflect **all of the data from all individual MIPS eligible clinicians** that have been captured in CEHRT for the given advancing care information measure.
- If an individual MIPS eligible clinician meets the criteria to exclude a measure, their data can be excluded from the calculation of that particular measure only.

**Do I have CEHRT capable of supporting group reporting?**

- **Yes**
  - Submit aggregated date produced by CEHRT

- **No**
  - Aggregate data by adding together the numerators and denominators for each MIPS eligible clinician with CEHRT data
Reporting Period & CEHRT Edition

• 2017
  – Minimum of 90 days, but encourage full year
  – 2014 and/or 2015 CEHRT
  – Modified Stage 2 and/or Stage 3 (adapted)

• 2018
  – Minimum of 90 days, but encourage full year
  – 2015 CEHRT
  – Stage 3 (adapted)
## Stages: I’m so Confused!

<table>
<thead>
<tr>
<th>Historic*</th>
<th>Proposed Rule</th>
<th>Final Rule</th>
<th>EHR Certification Edition</th>
<th># of Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified Stage 2</td>
<td>Modified Stage 2</td>
<td>2017 ACI Transition Objectives and Measures (Option 2)</td>
<td>2014</td>
<td>11</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Stage 3 (adapted)</td>
<td>ACI Objectives and Measures (Option 1)</td>
<td>2015</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>MIPS objectives and measures</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*2015 Final Rule EHR Incentive Program*
SCORING

Base Score (50%)
• Up to 5 required measures

Performance Score (90%)
• Up to 9 measures

Bonus Score (15%)
• Public health and clinical data registry reporting
## Base Score (Required, 50%)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td></td>
<td>E-Prescribing</td>
<td>E-Prescribing</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>Provide Patient Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td></td>
<td>Send a Summary of Care (SOC)</td>
<td>Health Information Exchange</td>
</tr>
<tr>
<td></td>
<td>Request/Accept SOC</td>
<td></td>
</tr>
</tbody>
</table>
Base Score: Things to Know

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

ZERO BASE SCORE + ZERO PERFORMANCE SCORE = ZERO ACI SCORE
# Performance Score (Optional)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Performance Score (Max)</th>
<th>Measure (Objective)</th>
<th>Performance Score (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Electronic Access</strong></td>
<td>Provide Patient Access</td>
<td>10%</td>
<td>Provide Patient Access</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Patient-Specific Education</td>
<td>10%</td>
<td>Patient Specific Education (Patient Specific Education)</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Coordination of Care Through Patient Engagement</strong></td>
<td>VDT</td>
<td>10%</td>
<td>VDT (Patient Electronic Access)</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Secure Messaging</td>
<td>10%</td>
<td>Secure Messaging (Secure Messaging)</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Patient-Generated Health Data</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Information Exchange</strong></td>
<td>Send a Summary of Care</td>
<td>10%</td>
<td>Health Information Exchange</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Request/Accept Summary of Care</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Information Reconciliation</td>
<td>10%</td>
<td>Medication Reconciliation (Medication Reconciliation)</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Public Health and Clinical Data Registry Reporting</strong></td>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
</tr>
</tbody>
</table>
# Bonus Score

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACI (Stage 3)</td>
<td>ACI Transition (Mod Stage 2)</td>
</tr>
<tr>
<td>Report improvement activities (CPIA) using CEHRT</td>
<td>10%</td>
</tr>
<tr>
<td>Report to =&gt;1 additional public health and clinical data registries beyond the Immunization Registry Reporting Measure</td>
<td>5%</td>
</tr>
<tr>
<td>*Report Cancer Registry data under the Public Health Registry Reporting measure</td>
<td></td>
</tr>
<tr>
<td>*Report Cancer Registry data under the Specialized Registry measure</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE 1**

You can get the bonus score for registries even if you don’t report/pass the Immunization Registry measure.

**NOTE 2**

The weight of the improvement activity (medium/high) has no effect on bonus.
<table>
<thead>
<tr>
<th>BASE SCORE (Measures)</th>
<th>Category Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Risk Analysis</td>
<td>1/100</td>
</tr>
<tr>
<td>E-Prescribing</td>
<td>1/100</td>
</tr>
<tr>
<td>Provide Patient Access</td>
<td>1/100</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>1/100</td>
</tr>
</tbody>
</table>

**You Report**
- Yes
- 1/100
- 1/100
- 1/100

**You Score**: 50%

**PERFORMANCE SCORE (Measures)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Category Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access (20%)</td>
<td>45/100 (45%)</td>
</tr>
<tr>
<td>VDT (10%)</td>
<td>51/100 (51%)</td>
</tr>
<tr>
<td>Patient Specific Education (10%)</td>
<td>33/100 (33%)</td>
</tr>
<tr>
<td>Secure Messaging (10%)</td>
<td>12/100 (12%)</td>
</tr>
<tr>
<td>Health Information Exchange (20%)</td>
<td>20/100 (20%)</td>
</tr>
<tr>
<td>Medication Reconciliation (10%)</td>
<td>65/100 (65%)</td>
</tr>
<tr>
<td>Immunization Registry (0 or 10%) (yes/no)</td>
<td>No</td>
</tr>
</tbody>
</table>

**You Report**
- 45/100 (45%)
- 51/100 (51%)
- 33/100 (33%)
- 12/100 (12%)
- 20/100 (20%)
- 65/100 (65%)

**You Score**
- 10%
- 6%
- 4%
- 2%
- 4%
- 7%
- 0%

**TOTAL SCORE**: 88%
Final Score

- Factors in weight of ACI category within MIPS
- Total score x ACI category weight
- 88% x 25 = 22
ACI: Looking Ahead

• May establish benchmarks in ACI performance category and use them as a baseline or threshold for future reporting

• May include scoring for performance improvement over time
  – May use a MIPS eligible clinician’s prior performance as comparison for the subsequent year’s performance category score
  – May compare a MIPS eligible clinician’s performance category score to peer groups to measure their improvement and determine a performance category score based on improvement over those benchmarks or peer group comparisons
MIPS

IMPROVEMENT ACTIVITIES

IA 15%
Improvement Activities

• A new performance category
  – Defined as “an activity that relevant eligible clinical organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.”

• Choose from 90+ activities in 9 subcategories

• Each activity is weighted either medium or high
Scoring Considerations

• Groups with more than 15 clinicians: 40 points
  – Medium-weighted activities – 10 points each
  – High-weighted activities – 20 points each

• Groups with 15 or fewer participants or if you are in a rural or health professional shortage area: 40 points
  – Medium-weighted activities – 20 points each
  – High-weighted activities – 40 points each

• Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model
  – You will automatically earn full credit.
Scoring Considerations (2)

- **Participants in MIPS APMs such as the Oncology Care Model**
  - You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

- **Participants in any other APM**
  - You will automatically earn half credit and may report additional activities to increase your score.
What are you already doing?

- Expanded practice access
- **Participation in QOPI**
- Provide longitudinal care management to patients at high risk of adverse health outcome
- Management across transitions and referrals
- **Reconciliation of medications across settings or period structured review**
- Pharmacist integration into care team
- Specialist reports to referring clinician
- **Timely communication of abnormal test results to patient with follow up**
- Document care coordination activities
- Documented practices/processes for developing regularly updated individual care plans and sharing with patient
- Documentation of “patient-centered action plan” for first 30 days following a discharge
- Care coordination agreements with frequently used consultants

- Tracking of patients referred to specialists
- Specialist referral information systematically integrated into plan of care
- **Structured referral notes**
- **Provision of community resource guides**
- Peer-led self-management programs for patients
- Refer/link patients to condition-specific chronic disease self-management support programs in the community
- Provide self-management materials at an appropriate literacy level and in an appropriate language
- **PDMP – registration and/or consultation**
- Use of patient safety tools that assist specialists in tracking specific patient safety measures meaningful to their practice
- **Participation in private payer practice improvement activities**

These are all CMS-recognized Improvement Activities under MIPS
## ASCO’s QOPI Certification Program

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

<table>
<thead>
<tr>
<th>CMS Improvement Activity ID</th>
<th>Subcategory Name</th>
<th>Activity Description</th>
<th>Activity Weighting</th>
<th>ASCO’s QOPI Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_PSPA_19</td>
<td>Patient Safety &amp; Practice Assessment</td>
<td>Adapt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following: Train all staff in quality improvement methods, integrate practice change, quality improvement into staff duties, engage all staff in identifying and testing practice changes, designate regular team meetings to review data and plan improvement cycles, promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with patients and families.</td>
<td>Medium</td>
<td>Participation in the QCP requires the involvement of practice leadership and administration; the certification process includes an extensive on-site survey including interviews with practice staff members. The QOPI Certification Program has defined Domains of responsibility: organization (Creating a Safe Environment, Staffing and General Policy), processes prior to treatment (Treatment Planning, Patient Consent and Education), safe practices during treatment (ordering, preparing, dispensing and administering chemotherapy), and patient safety monitoring (Monitoring after chemotherapy is given, including adherence, toxicity and complications). Within each Domain are Standards, and for each Standard there are Elements that provide more specificity for the Standard. A vital component of implementation includes staff education and engagement. Domain 1 encompasses general education, competency, and documenting standards that require the involvement of practice leadership and administration to engage staff and patient participation in quality cancer care.</td>
</tr>
<tr>
<td>IA_PSPA_20</td>
<td>Patient Safety &amp; Practice Assessment</td>
<td>Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following: Make responsibility for guidance of practice change a component of clinical and administrative leadership roles, allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings, and for incorporating population health and patient experience metrics in regular reviews of practice performance.</td>
<td>Medium</td>
<td>Participation in the QCP requires the involvement of practice leadership and administration; the certification process includes an extensive on-site survey including interviews with practice staff members. To achieve certification, a practice/institution must meet all the certification Standards and Elements. To create practice change, standards need to be developed from within the healthcare community. The QCP Standards were developed by oncology stakeholders including physicians, government agencies, patient advocates, pharmacists, nurses and other stakeholders. By gaining the insight of healthcare constituents, including the patient and family community, the initiative developed best practices based on the...</td>
</tr>
</tbody>
</table>
### ASCO’s QOPI Certification Program

<table>
<thead>
<tr>
<th>CMS Improvement Activity ID</th>
<th>Subcategory Name</th>
<th>Activity Description</th>
<th>Activity Weighting</th>
<th>ASCO’s QCP Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_FSPA_7</td>
<td>Patient Safety &amp; Practice Assessment</td>
<td>Use of QCDR data, for ongoing practice assessment and improvements in patient safety.</td>
<td>Medium</td>
<td>As a requirement to apply to the QCP, practices must first score &gt;75% on 26 oncologist-developed quality measures. ASCO’s QCDR will be accepted as an alternative mechanism to submit measures.</td>
</tr>
</tbody>
</table>

#### Examples of Specific QCP Requirements & Standards

| IA_BMH_4                  | Behavioral & Mental Health          | Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or, at minimum, integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NOF #0418) for patients with co-occurring conditions of behavioral or mental health conditions. | Medium            | Before the first administration of a new chemotherapy regimen chart documentation is available that includes at least eight specific elements. These elements include initial psychosocial assessment, with action taken when indicated. QCP standards require that the practice has a systematic approach to patient psychosocial assessments during chemotherapy treatment and that the practice has this systematic approach documented in policy or written procedure describing the workflow and referral process if needed to address patient concerns. |

| IA_BE_15                  | Beneficiary Engagement             | Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology. | Medium            | Before the first administration of a new chemotherapy regimen chart documentation is available that includes at least eight specific elements. These elements include the chemotherapy treatment plan, including, at minimum, the patient diagnosis, drugs, doses, anticipated duration, and goals of therapy, and assessment of the patient's and/or caregiver's comprehension of information regarding the disease and the treatment plan. QCP has patient education standards that engage the patient and family and ensure they are equipped to take an active role in their care and share in decision-making. The standard requires the practice to have a standardized policy or process to educate patients prior to chemotherapy that provides information to patients about their diagnosis, stage, and treatments, likely outcomes and side effects of treatment, including long-term outcomes. The patient can describe self-care measures and verbalizes the appropriate action for common outcomes, oncologic emergencies, and problems associated with the |
IA Documentation

• Attestation likely to be most commonly used reporting mechanism

• CMS documentation requirements: “Eligible clinicians are encouraged to retain documentation for 6 years as required by the CMS document retention policy.”

• ASCO recommends practices maintain dated documentation describing the improvement activity, when it was conducted, and any policies, procedures, or practice changes related to the activity; maintain all documentation for at least 6 years
IA Documentation (cont’d)

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

<table>
<thead>
<tr>
<th>Activity ID</th>
<th>Subcategory Name</th>
<th>Activity Name</th>
<th>Activity Description</th>
<th>Activity Weighting</th>
<th>Validation</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_EPA_1</td>
<td>Expanded Practice Access</td>
<td>Provides 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record</td>
<td>Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven access through access to medical records that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with on-call practices to provide after-hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management</td>
<td>High</td>
<td>Functionality of 24/7 or expanded practice hours with access to medical records or ability to increase access through alternative access methods on same-day or next-day visits</td>
</tr>
<tr>
<td>IA_EPA_2</td>
<td>Expanded Practice Access</td>
<td>Use of telehealth services that expand practice access</td>
<td>Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleendoscopy pilots that assess ability to still deliver quality care to patients.</td>
<td>Medium</td>
<td>Documented use of telehealth services and participation in data analysis assessing provision of quality care with those services</td>
</tr>
<tr>
<td>IA_EPA_3</td>
<td>Expanded Practice Access</td>
<td>Collection and use of patient experience and satisfaction data on access</td>
<td>Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understand urgent access needs.</td>
<td>Medium</td>
<td>Development and use of access to care improvement plan based on collected patient experience and satisfaction data</td>
</tr>
<tr>
<td>IA_EPA_4</td>
<td>Expanded</td>
<td>Additional Improvements in as a result of Quality Improvement Network-Quality Improvement Organization</td>
<td>Implementation of additional processes, practices, and other improvements that may result from participation in a quality improvement network.</td>
<td>Medium</td>
<td>Implementation of additional processes, practices, and other improvements that may result from participation in a quality improvement network.</td>
</tr>
</tbody>
</table>

**Notes:****

- **Patient Encounter/Medical Record/Claims** - Patient encounter (medical record) claims indicating patient was seen or services provided outside of normal business hours for that clinician, or
- **Same or Next Day Patient Encounter/Medical Record/Claims** - Patient encounter (medical record) claims indicating patient was seen same day or next day to a consistent clinician for urgent or transitional care.

**Suggested Documentation:** Inclusive of dates during the selected continuous 90-day or year-long reporting period.
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
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](http://www.asco.org/macra), regularly for news, resources and tools for your practice. Contact macra@asco.org with questions.