Self-Assessment Module
2017 ASTRO Annual Meeting

Are you down with QPP? You better be if you want $.

David Beyer, MD, FASTRO, Shannon Fogh, MD, Anne Hubbard, MBA

Question 1:
What is the Merit-based Incentive Program (MIPS)?

a) An optional reporting program for Medicare patients in which all physicians can receive an increase in Medicare payments.
b) A transitional payment program from pay-for-service to pay-for-performance in which eligible clinicians submit data to CMS on both Medicare and other payer patients to CMS and can receive incentives or penalties.
c) A mandatory program for all physicians to report on all patients to CMS to avoid penalty payments.
d) A continuation of the PQRS and Meaningful Use programs with no modifications

Answer:

b) Transitional payment program from pay-for-service to pay-for-performance in which eligible clinicians submit data to CMS on both Medicare and other payer patients to CMS and can receive incentives or penalties.

Feedback:
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program (QPP). QPP transitions Medicare payment away from fee-for-service to pay-for-performance, emphasizing quality care. The program represents a significant change in the way all physicians, including radiation oncologists, will be paid by Medicare. MIPS combines and replaces the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM) and Medicare EHR Incentive (Meaningful Use) programs into one comprehensive program. The MIPS program involves four performance categories: Quality, Advancing Care Information (ACI), Improvement Activities (IA) and Cost. All eligible clinicians who report $30,000 in Medicare services **and** provide care for more than 100 Medicare patients a year are subject to QPP. Eligible clinicians (EC) include physicians, physician assistants, nurse practitioners and clinical nurse specialists. ECs can receive a positive or negative payment adjustment based on their performance and level of participation.

Location:
MIPS section slide 2

Reference:
www.astro.org/MIPS
https://qpp.cms.gov/

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Question 2:

Individual eligible clinicians can submit data on the MIPS approved Quality measures to CMS through which reporting options?

a) Claims, Qualified Registry, and EHR
b) Claims, Qualified Registry, EHR, and CMS Web Interface
c) Claims, Qualified Registry, EHR, and Qualified Clinical Data Registry (QCDR)
d) Qualified Clinical Data Registries (QCDR) only

Answer:

c) Claims, Registry, EHR, and Qualified Clinical Data Registry (QCDR)

Feedback:

Individual physicians can submit data for the Quality performance category via claims, qualified registry, EHR or QCDR. Groups, regardless of size, can report via qualified registry, EHR, or QCDR. Additionally, groups with 25 or more clinicians can utilize the CMS Web Interface or CAHPS for reporting. However, to utilize the CMS Web Interface, groups needed register by June 30, 2017.

Location:

MIPS section slide 5

Reference:

https://www.astro.org/Daily-Practice/Medicare-Quality-Payment-Program/MIPS/Physician-or-Group-Billing/
https://qpp.cms.gov/mips/individual-or-group-participation
https://qpp.cms.gov/docs/QPP_Group_Participation_in_MIPS_2017.pdf

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Question 3:
What defines a group?

a) Two or more individual eligible clinicians (ECs)
b) Two or more individual ECs who have reassigned their billing rights to the group Tax Identification Number
c) Twenty-five or more individual ECs who have reassigned their billing rights to the group Tax Identification Number
d) Twenty-five or more individual ECs

Answer:
b) Two or more individual ECs who have reassigned their billing rights to the group Tax Identification Number

Feedback:

There are two reporting options for MIPS based on TIN/NPI combination – individual and group.

	Individual	**Group**
Definition	A single NPI tied to a single TIN	A single TIN. All NPIs who have assigned their billing rights to a single TIN would be part of this group.
Impact on Payment Adjustment	Your performance will directly impact your payment adjustment	Groups' performance is assessed across all of the MIPS performance categories and the group will get one payment adjustment based on the group's performance
Data submission options	EHR, registry, QCDR, claims	Web interface (only for groups with 25 or more clinicians; requires group registration by June 30, 2017), EHR, registry, QCDR

Each eligible clinician participating in MIPS via a group will receive a payment adjustment based on the group's performance.

Under MIPS, a group is defined as a single Taxpayer Identification Number (TIN) with 2 or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their National Provider Identifiers (NPI), who have reassigned their Medicare billing rights to the TIN.

We expect most radiation oncologists to report as groups; however, the decision to report as an individual or group should play a role in your MIPS strategy.

Location:
MIPS section slide 2

Reference:
https://www.astro.org/Daily-Practice/Medicare-Quality-Payment-Program/MIPS/MIPS/
https://qpp.cms.gov/mips/individual-or-group-participation
https://qpp.cms.gov/docs/QPP_Group_Participation_in_MIPS_2017.pdf

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Question 4:

Which of the following MIPS performance categories will not affect a clinician's composite performance score (weight of 0%) in 2017?

a) Cost
b) Improvement Activities
c) Advancing Care Information
d) Quality

Answer:

a) Cost

Feedback:

In future years of the program, MIPS will include a fourth "Cost" performance category, similar to the previous Value-Based Modifier program. For 2017, CMS will collect cost data and provide feedback to clinicians but will not incorporate performance in this category in the 2019 payment adjustment. Providers will not need to report any data for this category, as CMS will use administrative claims data to attribute patients and costs to radiation oncologists.

Location:

MIPS Section slide 4

Reference:

https://www.astro.org/Daily-Practice/Medicare-Quality-Payment-Program/MIPS/MIPS/

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Question 5:

Which individuals or groups have reduced reporting requirements in the Improvement Activities performance category?

a) Solo practitioners
b) Practices with less than 15 eligible clinicians
c) Practices located in a rural area
d) All of the above

Answer:

d) All of the above

Feedback:
Activities are either medium-weighted (worth 10 points) or high-weighted (worth 20 points) -- most activities are listed as medium-weighted. You can report any combination of medium and high-weighted activities to meet the necessary points for full credit. The table below provides the points requirements based on the type of practice.

Individual/Group Description	IA Requirements
• Solo practitioners • Practices with less than 15 eligible participants • Practices located in a rural area ("rural" is defined by most recent HRSA Area Health Resource File data set available) • Practices located in geographic health profession shortage area (HPSAs)	Requires 20 points for full credit
Patient-centered medical home (PCMH) certified practices	Automatically receive full credit; no submission required
Remaining Physicians and Groups (majority)	Requires 40 points for full credit

To determine your IA performance score, combine all of the accomplished and reported activities and divide by the maximum amount of points available for full credit. To determine how many points are awarded towards the total Composite Performance Score (CPS), multiple by the category-weight percentage. ASTRO will update this information when full details of scoring have been released by CMS.

Location:
MIPS Section slide 6

Reference:
https://qpp.cms.gov/mips/improvement-activities
https://qpp.cms.gov/docs/QPP_2017_Improvement_Activities_Fact_Sheet.pdf
https://www.astro.org/Daily-Practice/Medicare-Quality-Payment-Program/MIPS/Physician-or-Group-Billing/

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