 COLLEGE of AMERICAN PATHOLOGISTS


CAP Advocacy Update on MACRA for Pathologists


Florida Society of Pathologists Meeting

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Baptist Health System, San Antonio, Texas

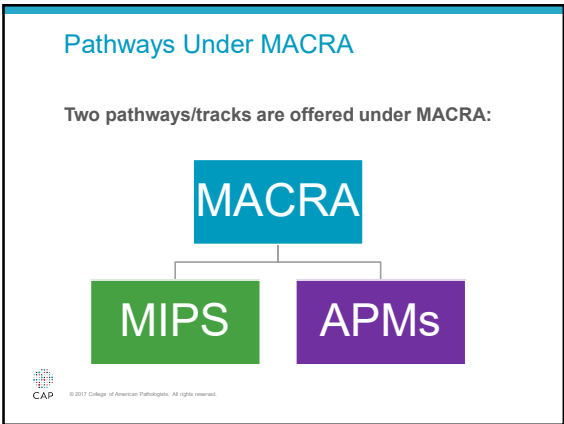


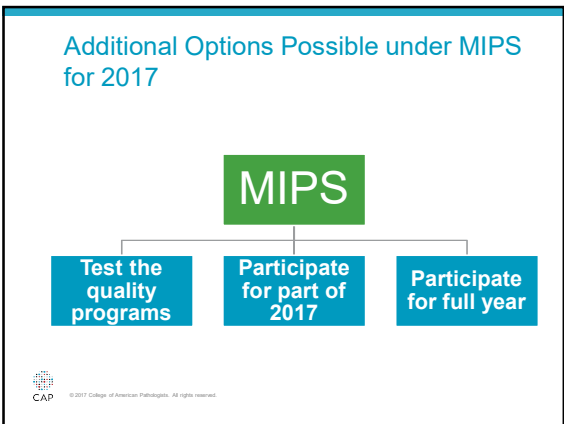
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Key Points

- CMS released the final MACRA rule on October 14
- Beginning in 2019, pathologists' Medicare payment will be influenced by MIPS and Alternative Payment Models (APMs)
- Implementation of these programs is happening now
- The CAP continues to engage with the CMS and stakeholders to address pathologists' concerns

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Merit-Based Incentive Payment System (MIPS)

- Assesses the total performance according to performance standards for a year
- Uses a composite performance score (CPS) calculated for each performance period
- The score determines a MIPS adjustment factor applied to the Medicare reimbursement for the year

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CAP's MACRA Strategy


- **Extend the life of current PQRS measures and develop new measures**
- **Broaden non-patient facing EC definition**
- **Broaden scope of Clinical Practice Improvement Activities**
- **Develop alternative measures for Resource Use and Advancing Care Information categories**



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CAP's MACRA Strategy: Qualified Clinical Data Registry (QCDR)

- **Moving to establish a Qualified Clinical Data Registry (QCDR) option for pathologists**
- **Board approved in August 2016**
- **Plan to launch in 2017**
- **QCDR will ease compliance for CAP Members**



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Merit-based Incentive Payment System (MIPS)



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MIPS Eligible Clinicians

Defining an eligible clinician (EC):

- For the first and second years of MIPS, includes physicians and other providers
- A group that includes such professionals
- For year three and beyond, CMS may expand to other individuals and groups
- Pathologists at independent laboratories are considered eligible for MIPS



Patient Facing vs. Non-Patient Facing ECs in 2017

Patient Facing ECs	Non-Patient Facing ECs
Bill > 100 patient-facing encounters in a calendar year	Bill ≤ 100 patient-facing encounters in a calendar year
Report on all three MIPS performance categories	Report on two MIPS performance categories (Quality and Clinical Practice Improvement Activities)
Report on four clinical practice improvement activities (CPIA)	CMS will notify eligible clinicians at the beginning of the year; report two CPIA or one high CPIA



Non-Patient-Facing Clinicians in Groups

- The entire group practice can also meet the non-patient-facing definition when:
 - 75% of the group's national provider identifiers (NPIs) billing under the group's tax identification number (TIN) meet the definition of a non-patient facing individual MIPS eligible clinician
- **Benefits of group reporting:** the group will only need to attest to two improvement activities rather than two per eligible clinician



MIPS Exclusions

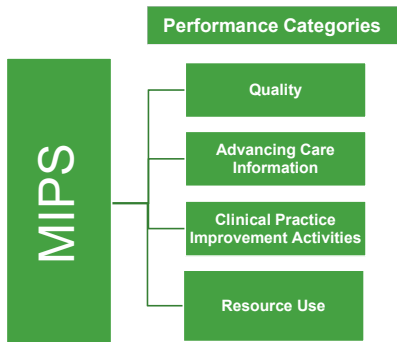
- A **qualifying/partially qualifying** Alternative Payment Model (APM) participant
- ECs who do not exceed the low-volume threshold measurement
 - <100 Medicare pts seen in a year OR <\$30K in billing
- **First time enrollees**



How to Avoid a Penalty in 2019?


- **Submit data in 2017**
- **Examples**
 - One quality measure, regardless of number of cases
OR
 - Attest to one clinical practice improvement activity
- **CMS estimates 90% of MIPS ECs will receive zero or positive adjustments**
 - 80% of those will be in groups of ≤10





MIPS Performance Categories and Scores


- Eligible clinicians will receive a single MIPS composite performance score (CPS)
- The score is based on the three weighted performance categories in 2017
- Scores range on a scale from 0-100
- Those with scores above 70 are eligible for a high-performance bonus



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MIPS Category Weights for 2017


60%	Quality	• Replaces Physician Quality Reporting System (PQRS); report up to six quality measures
15%	Clinical Practice Improvement Activities	• New category; attest that you complete up to four improvement activities
25%	Advancing Care Information	• Replaces EHR Incentive Program; non-patient-facing clinicians do not need to report this category
0%	Cost	• Replaces value-based modifier; not a factor for 2017, will start to count in 2018



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MIPS Category Weights for 2017: Non-Patient-Facing Physician

85%	Quality	• Replaces Physician Quality Reporting System (PQRS); report up to six quality measures
15%	Clinical Practice Improvement Activities	• New category; attest that you complete two medium-weighted or one high-weighted activity
0%	Advancing Care Information	• Replaces EHR Incentive Program; non-patient-facing clinicians do not need to report this category
0%	Cost	• Replaces value-based modifier; not a factor for 2017, will start to count in 2018



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How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System (MIPS)

CAP

CMS Quality Performance Reporting and Scoring

- ECs report on 6 applicable measures for 50% of Medicare patients through claims reporting or 50% of their patients for whom the measure applies (all payers) for other reporting mechanisms
- Each measure will have a score ranging from 0-10 points based on performance compared to others
- Bonus points available for high value measures

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Quality Performance Category Reporting


Use current PQRS reporting mechanisms

- Claims Based
- Traditional Registry (cost involved)
- Group Practice Reporting Option
 - Web Interface for Multispecialty practices only
- Electronic Health Record
- Measure Groups (none available for pathology)
- Qualified Clinical Data Registry (QCDR)

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Resource Use Performance Category


- This is equivalent to the cost calculation of the current value-based modifier (VBM) program
 - CMS calculation is based on claims, so no reporting requirements for clinicians,
 - Patients are attributed to physicians based on primary care services.
- CMS plans to score Resource Use using cost measures in the future
 - CMS will not use this category in 2017



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Advancing Care Information Performance Category


- Currently, this is the Electronic Health Record Meaningful Use program
 - CAP had secured exemption for pathologists
- Scoring is based on key measures of health IT interoperability and information exchange
 - LIS currently doesn't fit
- Non-patient-facing ECs will not be scored in this category due to a lack of applicable measures
 - CMS will reweight the category to 0



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Clinical Practice Improvement Activities Performance Category

- Eligible clinicians are rewarded for activities such as care coordination, patient engagement and safety
- Not all of the activities apply to pathologists
- Examples:
 - Provide 24/7 access to MIPS ECs
 - Timely communication of test results
 - Participation in MOC Part IV



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Clinical Practice Improvement Activities (CPIA) Reporting

- ECs report by attestation or registry
- Patient-facing ECs must report 4 medium-weighted or 2 high-weighted CPIA for full credit
- Non-patient facing specialties only need to report on 2 medium-weighted, or 1 high-weighted, CPIA for full credit

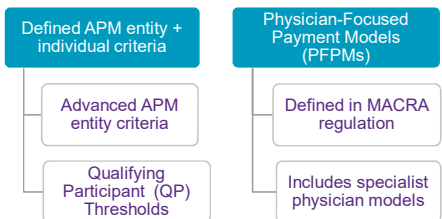


Alternative Payment Models (APMs)



The APM Pathway

- MACRA's 2 primary types of APMs



- MIPS APMs—APM-scoring standard applies




Advanced APMs

- Qualifying participants excluded from MIPS payment adjustments & receive annual bonus of 5% in 2019 – 2024
- Starting in 2026 a higher fee schedule update of 0.75%
- Thresholds based on percentage of revenue or number of patients, determined at APM Entity level

	Medicare Only Option % of Payments In an Advanced APM	All Payer Option % of Payments In an Advanced APM
2019-2020	25%	NA
2021-2022	50%	25% Medicare/50% all other payers
2023-2024	75%	25% Medicare/50% all other payers
2025 and on	75%	25% Medicare/50% all other payers


% of revenue example provided, patient count method based on # of attributed beneficiaries also exist



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Advanced APMs

- The models that presently qualify as advanced APMs are:
 - Medicare Shared Savings Program track 2
 - Medicare Shared Savings Program track 3
 - Next Generation Accountable Care Organization (ACO) Model
 - Oncology Care Model (2 sided risk model)
 - Comprehensive ESRD (large dialysis organizations (LDO) and non-LDO)
 - Comprehensive Primary Care+
 - Two-Sided Risk Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
 - Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)



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New 2018 Models

- CMS seeks to retrofit existing models to qualify as Advanced APMs and anticipates offering participation including, but not limited to:
 - Medicare ACO Track 1+
 - New voluntary bundled payment model
 - Comprehensive Care for Joint Replacement Payment Model (CEHRT track)
 - Coordination through Episode Payment Models Track 1 (CEHRT track)



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Physician Focused Payment Models (PFPMs) Defined

- **Broad definition – An APM that must:**
 - Include Medicare, may also include other payers
 - “Be Anticipated to reduce cost, improve care or both”
 - Close an existing payment policy gap
- **Criteria: 3 categories above, with subcategories**
- **Information: Models CMS accepts will go through its process for APMs, public announcement, and request for application**
- **CAP Assessment: Definition not unreasonable – but bar is high and not very well-suited to pathology**



APMs and the CAP's Focus

- **Education and information to enable pathologists compliance with the APM pathway, as applicable**
- **Engage with stakeholders, monitor models submitted to PTAC should option for pathologists that will fulfill MACRA requirements and be beneficial present**



Questions?

