



COLLEGE of AMERICAN  
PATHOLOGISTS

# CAP Advocacy Update on MACRA for Pathologists

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Florida Society of Pathologists Meeting

Emily Ellen Volk, MD, MBA, FCAP  
Governor, CAP Board of Governors  
Vice Chair, CAP Council on Government  
and Professional Affairs

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# Baptist Health System, San Antonio, Texas



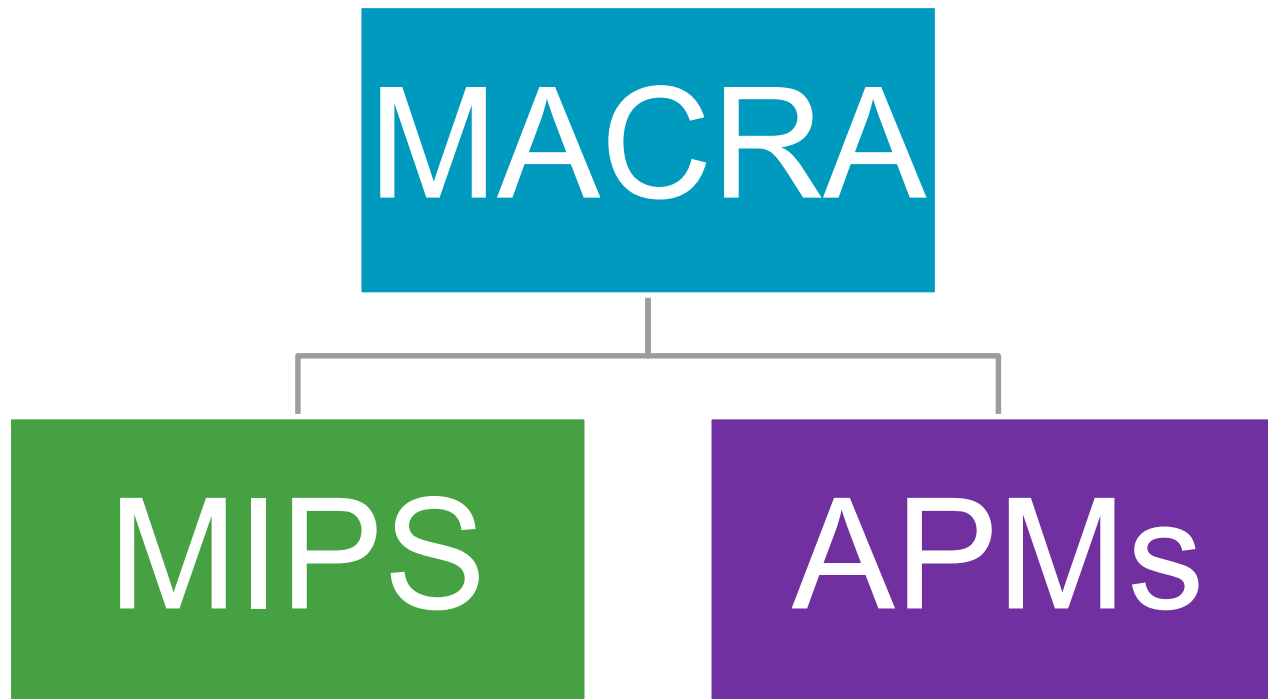
# Key Points

- **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**

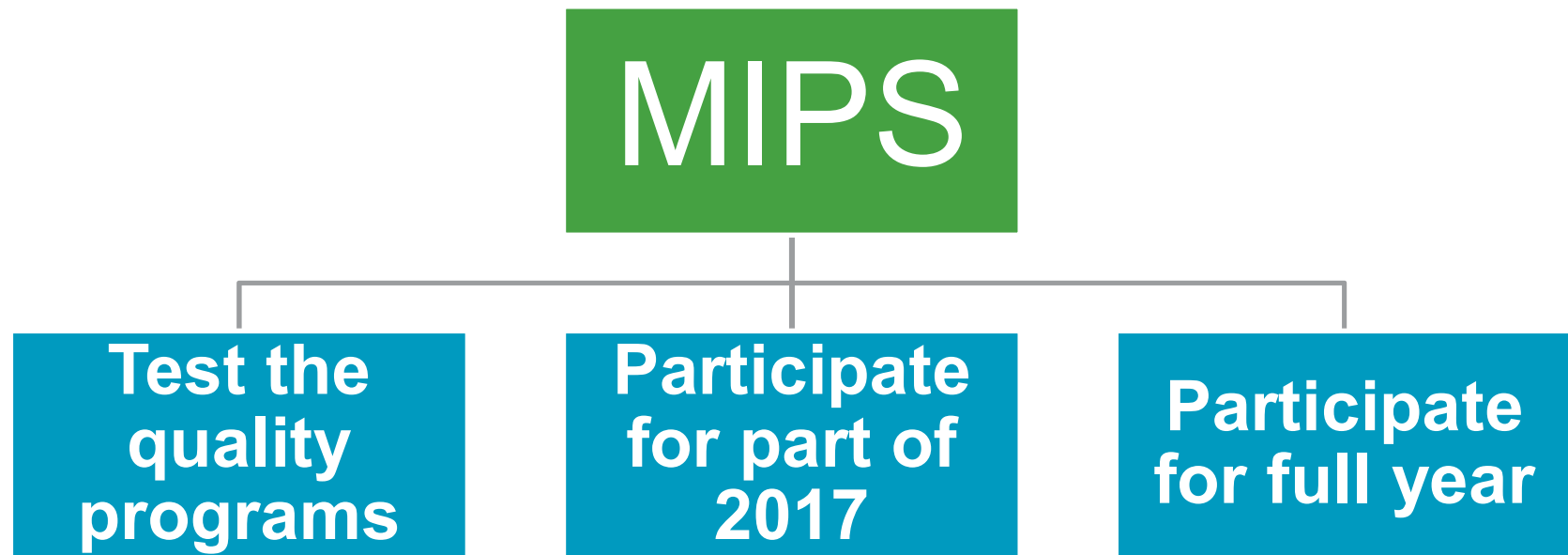


# Pathways Under MACRA

Two pathways/tracks are offered under MACRA:



# Additional Options Possible under MIPS for 2017



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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**

# Framing the MIPS Impact on Pathology Medicare Payments

Year	Possible Penalty	Lower Bound: Full Penalty (millions)	Projected Total: No Adjustments (millions)*	Upper Bound: Full Bonus (millions)	Possible Bonus	Difference: Full Bonus – Full Penalty (millions)
2019	-4%	\$1,914	\$1,994	\$2,074	4%	\$160
2020	-5%	\$1,897	\$1,997	\$2,097	5%	\$200
2021	-7%	\$1,861	\$2,001	\$2,141	7%	\$280
2022	-9%	\$1,824	\$2,004	\$2,184	9%	\$361
2023	-9%	\$1,827	\$2,007	\$2,188	9%	\$361
2024	-9%	\$1,830	\$2,011	\$2,192	9%	\$362
2025	-9%	\$1,833	\$2,014	\$2,195	9%	\$363
<b>Total Difference between Upper and Lower Bounds for Pathology Specialty 2019-2025</b>						<b>~\$2,086</b>



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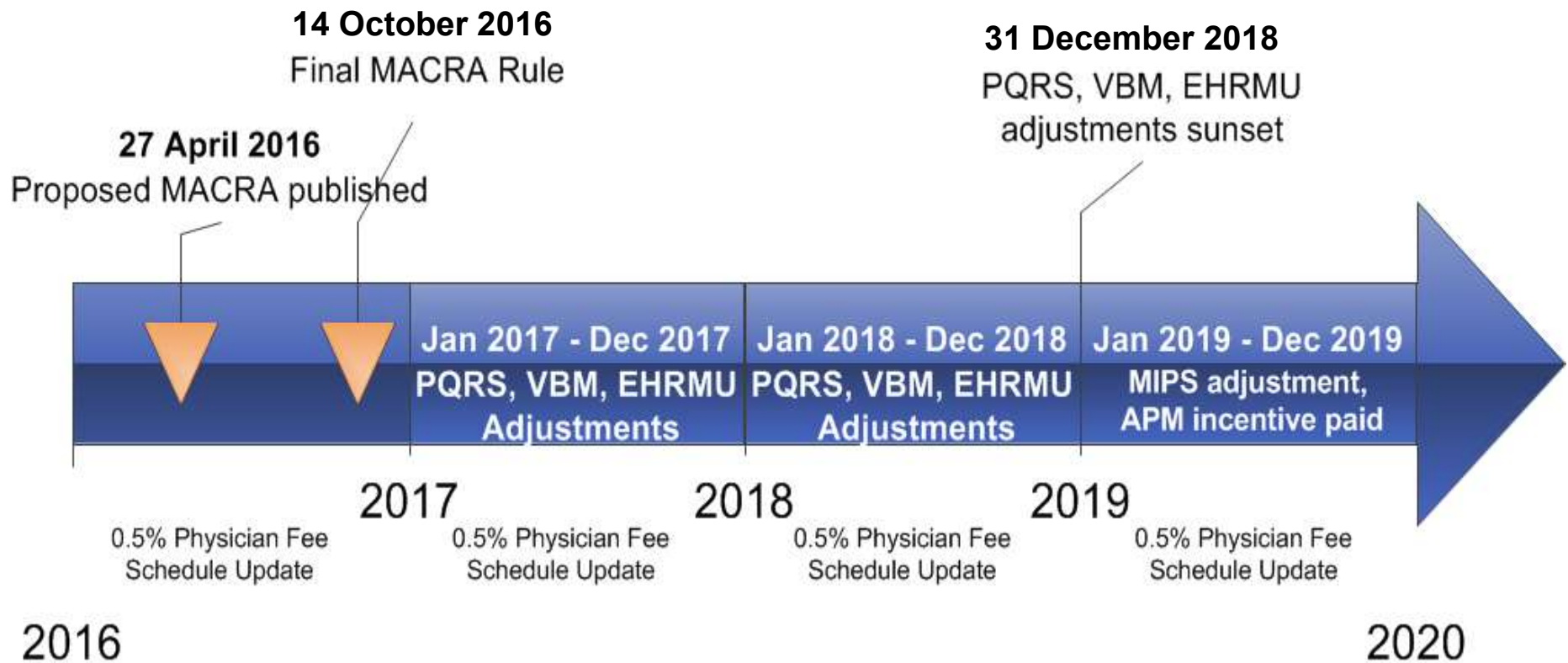
\*Projections based on twelve previous years of Medicare spending

# Alternative Payment Models (APMs)

- **Payment approach with added incentives for clinicians to provide high-quality and cost-efficient care**
- **APMs can apply to a specific clinical condition, care episode or population**
- **Only “Advanced APMs” qualify for the MACRA APM payment incentives**



# Medicare Regulatory and Payment Update Timeline



# 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

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

# 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**

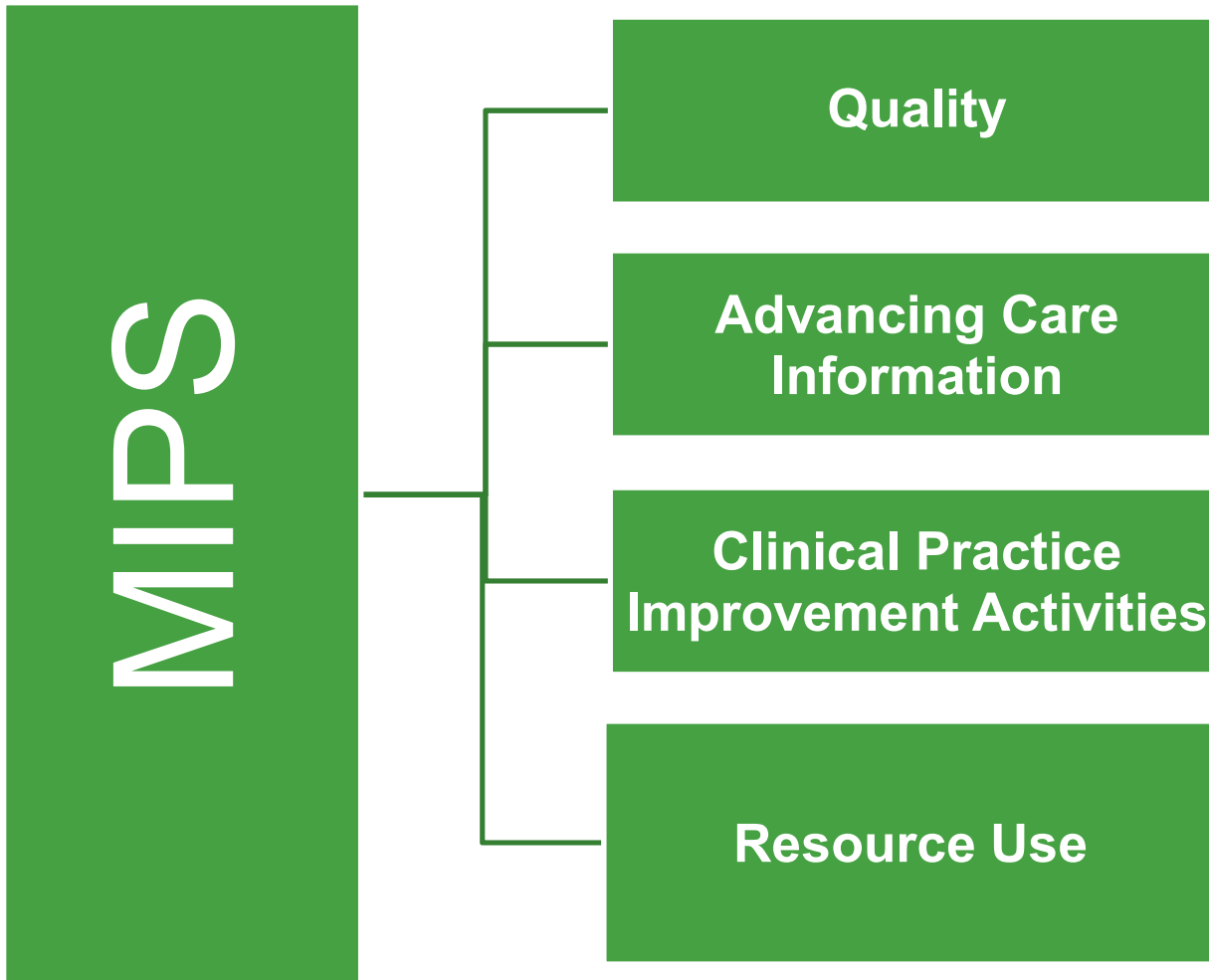


# How to Avoid a Penalty in 2019?

- **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  $\leq 10$



## Performance Categories



# 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**



# MIPS Category Weights for 2017

60%	Quality	<ul style="list-style-type: none"><li>Replaces Physician Quality Reporting System (PQRS); report up to six quality measures</li></ul>
15%	Clinical Practice Improvement Activities	<ul style="list-style-type: none"><li>New category; attest that you complete up to four improvement activities</li></ul>
25%	Advancing Care Information	<ul style="list-style-type: none"><li>Replaces EHR Incentive Program; non-patient-facing clinicians do not need to report this category</li></ul>
0%	Cost	<ul style="list-style-type: none"><li>Replaces value-based modifier; not a factor for 2017, will start to count in 2018</li></ul>

# 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%

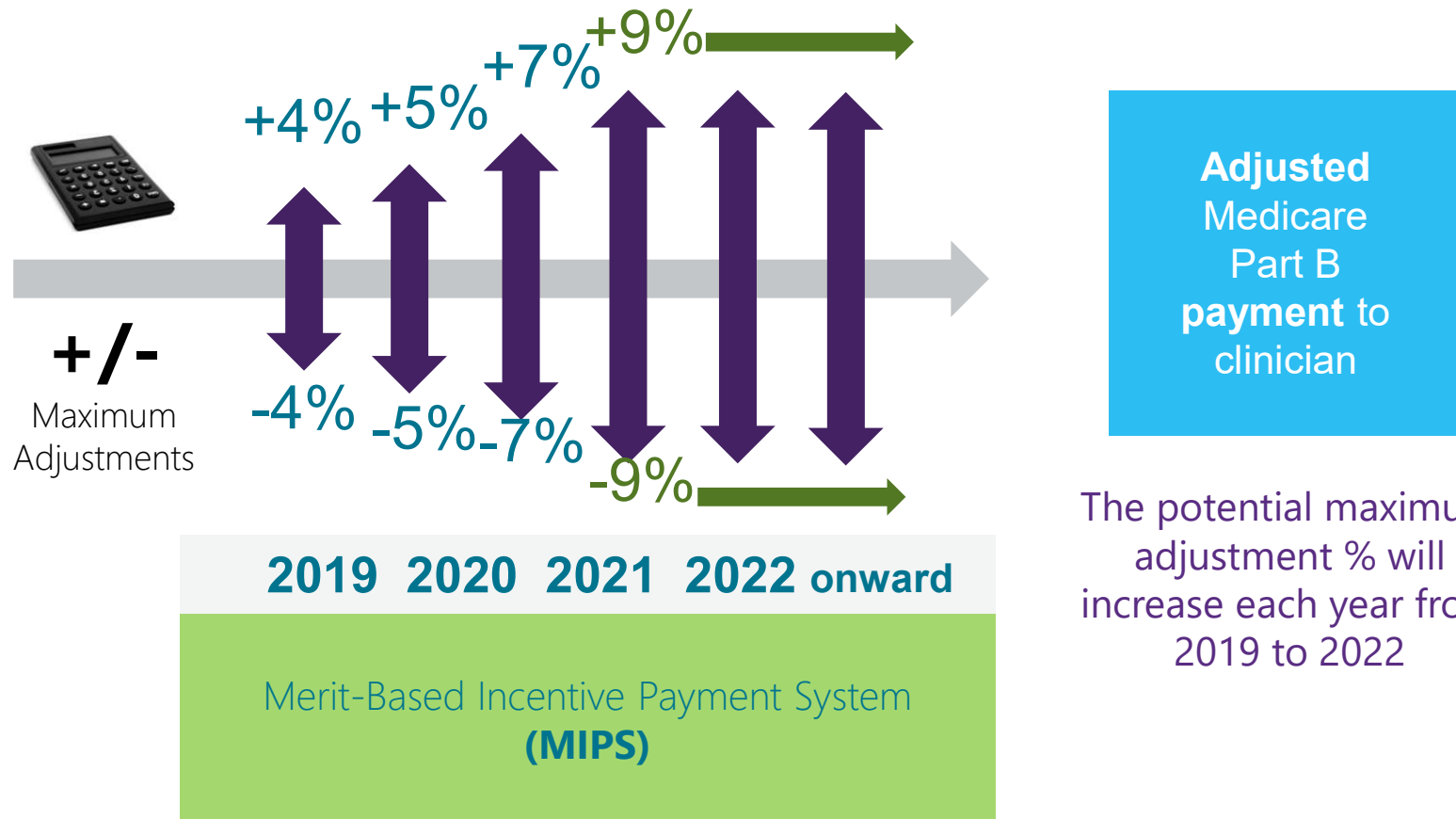
Cost

- Replaces value-based modifier; not a factor for 2017, will start to count in 2018

# How much can MIPS adjust payments?

Based on a MIPS

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



# 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**



# 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)***



# 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**

# 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**



# 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**



# 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**

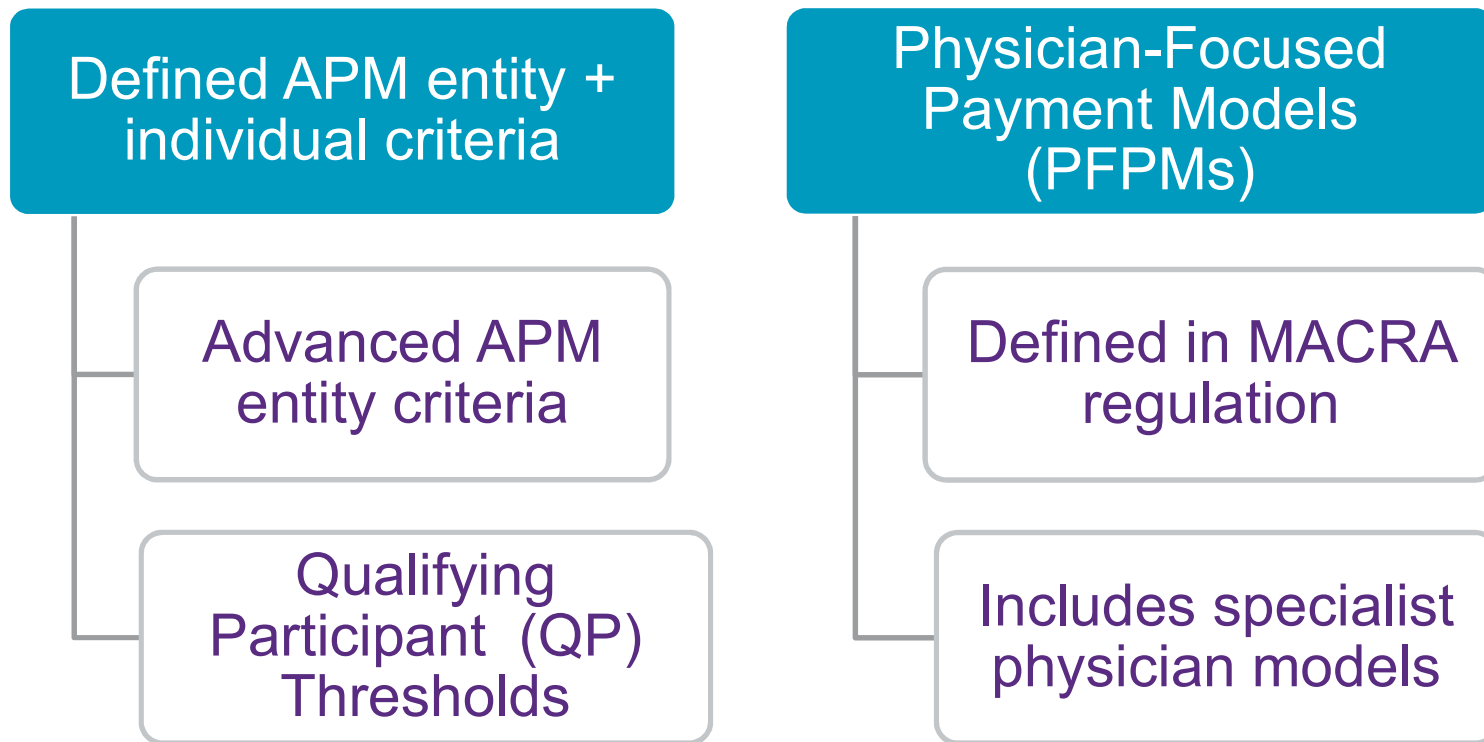


# Alternative Payment Models (APMs)



# 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

	<b><u>Medicare Only Option</u></b> <b>% of Payments in an Advanced APM</b>	<b><u>All Payer Option</u></b> <b>% of Payments in an Advanced APM</b>
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**



# 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)

# 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)



# 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**



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# Questions?



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