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How Medicare Pay Reforms Under MACRA Will Affect Pathologists

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November 2, 2016

Agenda

- **Background on the Medicare Access and CHIP Reauthorization Act (MACRA)**
- **Payment Penalties and bonuses under the Merit-based Incentive Payment System (MIPS)**
- **Participation in Alternative Payment Models (APMs)**
- **Questions/Answers**

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Welcome

Patrick Godbey, MD, FCAP

- **Chair, CAP Council on Government and Professional Affairs**

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Welcome

Diana M. Cardona, MD, FCAP

- **EAC Measures & Performance Assessment Subcommittee Chair**

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Welcome

W. Stephen Black-Schaffer, MD, FCAP

- **Vice Chair, CAP Economic Affairs Committee**

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Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- **Ended the broken Sustainable Growth Rate (SGR) formula**
- **Established a new framework for rewarding health care providers for giving better care not more just more care**
- **Combined existing Medicare quality reporting programs into one new system (Merit-Based Incentive Payment System, or MIPS)**

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Key Points

- **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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MACRA Background

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MACRA Regulation

- **CMS released the final MACRA rule on October 14**
  - **CMS now calls it the Quality Payment Program (QPP)**
- **CMS received over 4,000 comments on the proposed rule**
  - **CAP comments submitted on June 27**
- **More than 600,000 clinicians will now be reimbursed under Medicare's QPP**

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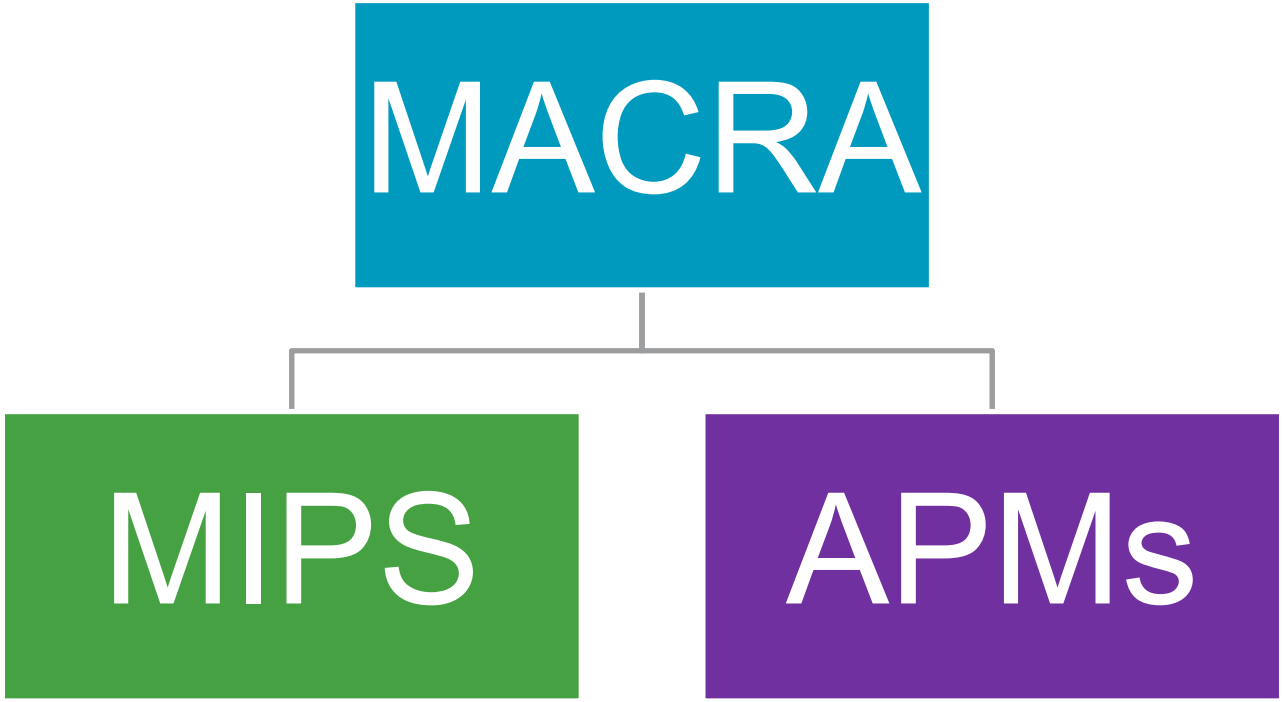
Pathways Under MACRA

Two pathways/tracks are offered under MACRA:



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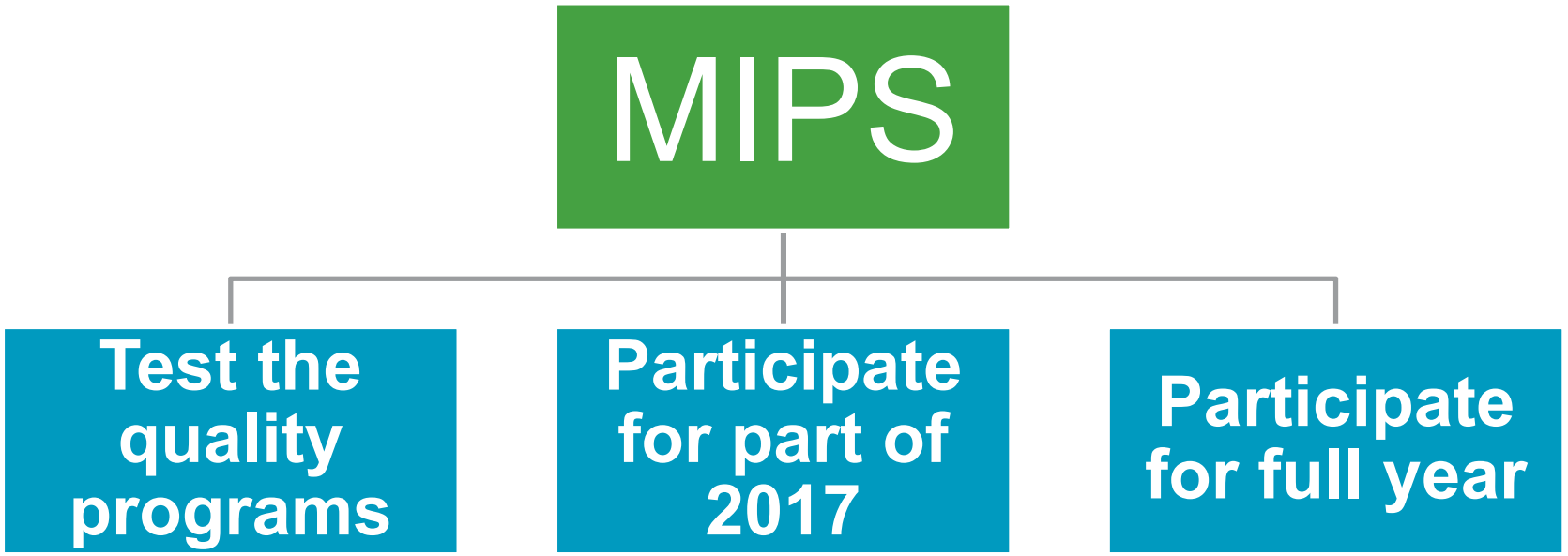
Additional Options Possible under MIPS for 2017



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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**

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Framing the MIPS Impact on Pathology Medicare Payments

Year	Program	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	MIPS	-4%	$ 2,169	$ 2,224	$ 2,279	4%	$110
2020	MIPS	-5%	$ 2,180	$ 2,251	$ 2,321	5%	$141
2021	MIPS	-7%	$ 2,176	$ 2,277	$ 2,378	7%	$ 202
2022	MIPS	-9%	$ 2,171	$ 2,304	$ 2,437	9%	$ 266
2023	MIPS	-9%	$ 2,195	$ 2,331	$ 2,467	9%	$ 272
2024	MIPS	-9%	$ 2,218	$ 2,358	$ 2,497	9%	$ 278
2025	MIPS	-9%	$ 2,242	$ 2,384	$ 2,526	9%	$ 284
Total Difference between Upper and Lower Bounds for Pathology Specialty 2019-2025							**~$1,553**

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*Projections based on ten 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**

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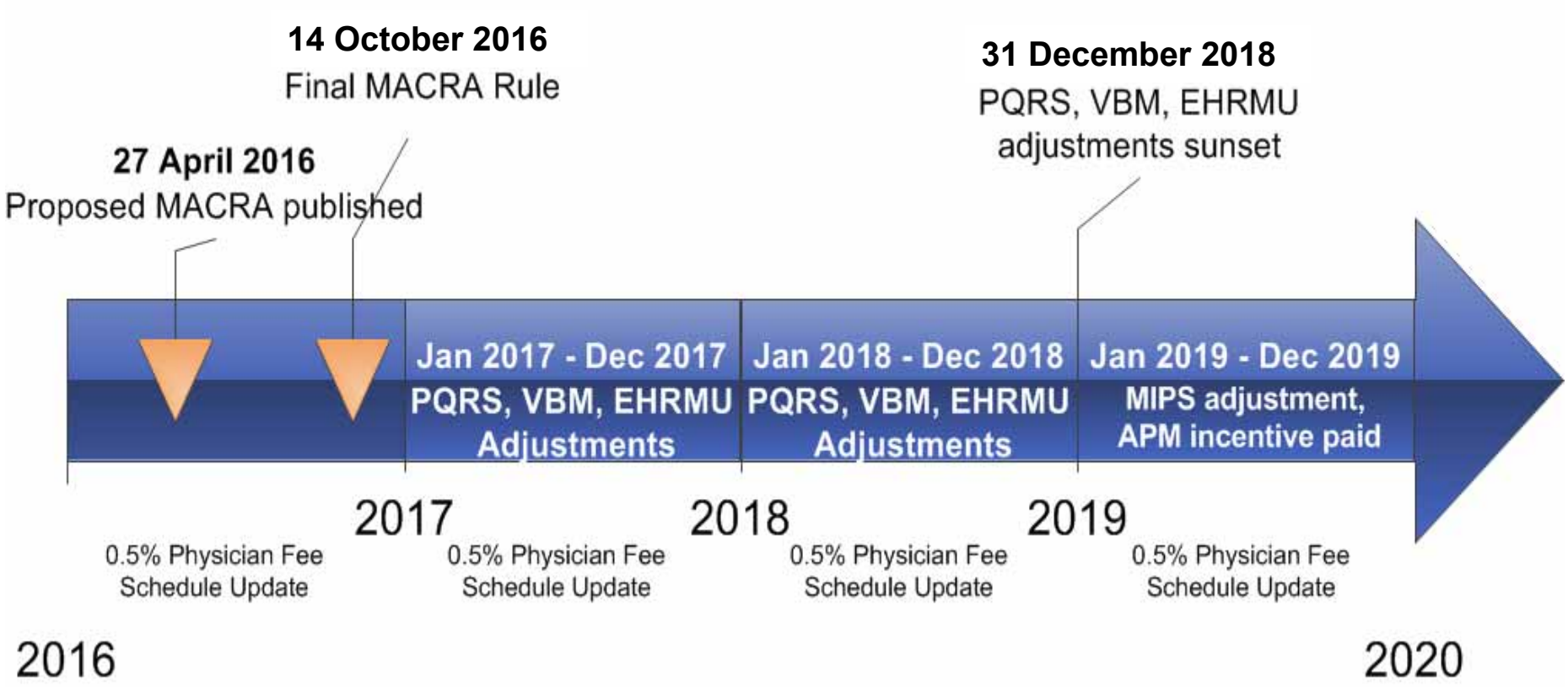
Medicare Regulatory and Payment Update Timeline



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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**
- **Develop a Qualified Clinical Data Registry (QCDR) option for pathologists**

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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 all physicians and various other providers**
- **A group that includes such professionals**
- **For year three and beyond, CMS may expand to include other individuals and groups**
- **Pathologists at independent laboratories are considered eligible for MIPS**

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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

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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**

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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 a neutral or a positive adjustment**
  - **80% of those will be in groups of ≤10**

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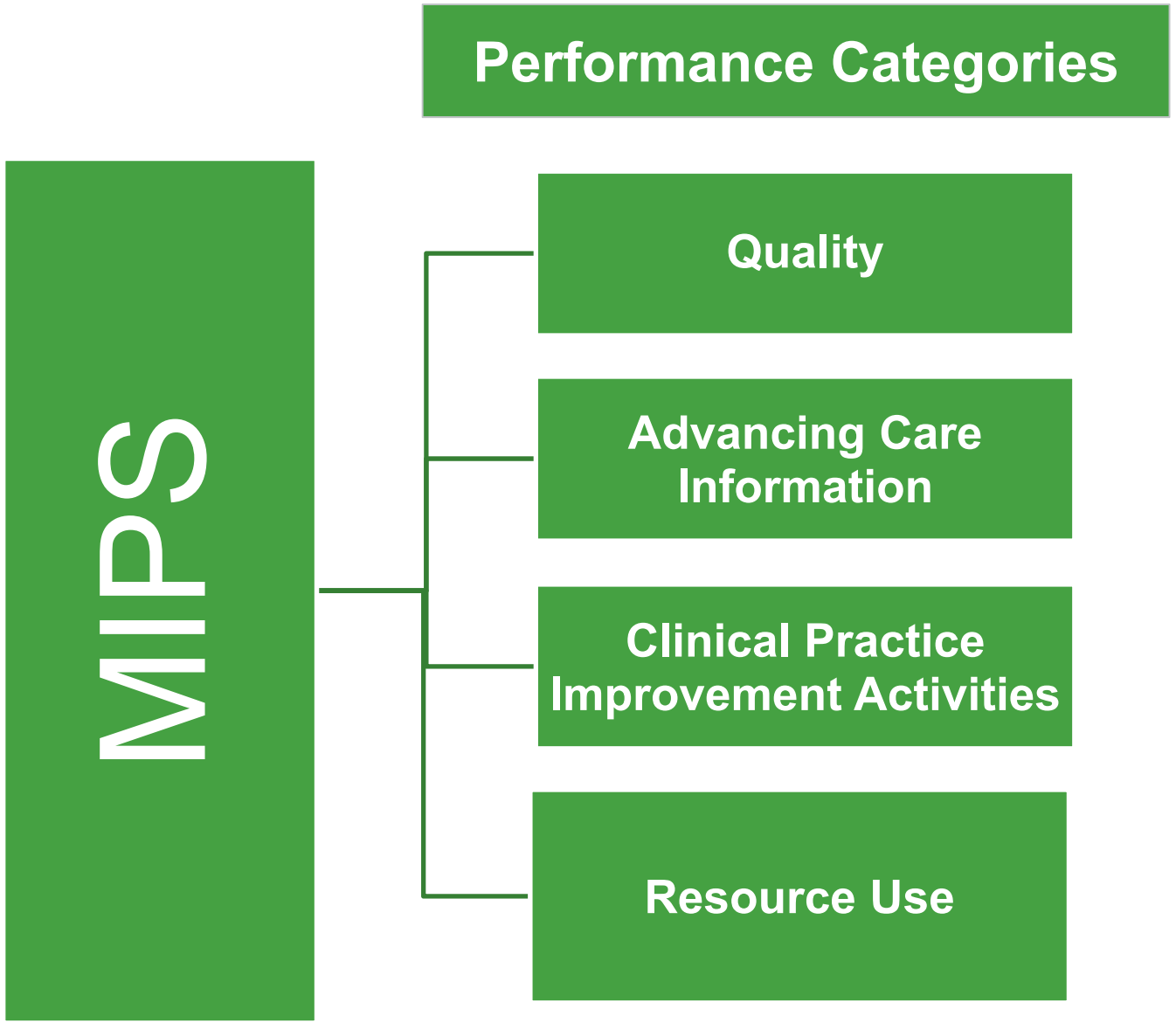

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MIPS Performance Categories and Scores

- **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 completed up to four improvement activities
25%	Advancing Care Information	• Replaces EHR Incentive Program; non-patient-facing clinicians do not need to report on this category
0%	Resource Use	• Replaces value-based modifier; will not be scored 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 on this category
0%	Resource Use	• Replaces value-based modifier; will not be scored for 2017, will start to count in 2018

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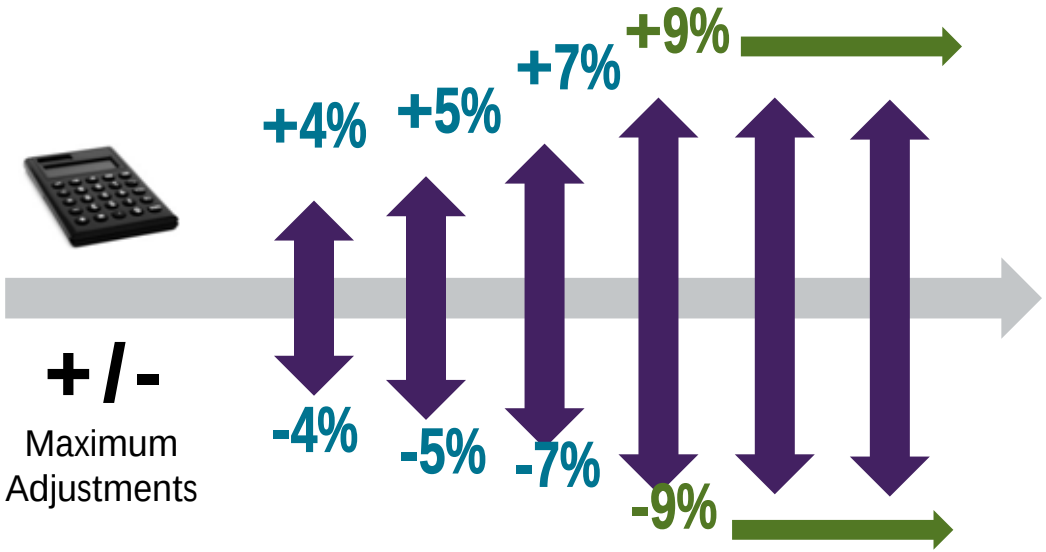
How much can MIPS adjust payments?

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

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Quality Performance Reporting and Scoring

- **ECs must report on 6 applicable measures (or all that apply) for 50% of their Medicare patients via claims reporting OR 50% of all their patients (all payers) when utilizing 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**
- **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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CAP Measures in the Quality Performance Category

- Breast Cancer Resection Pathology Reporting
- Colorectal Cancer Resection Pathology Reporting
- Barrett's Esophagus Pathology Reporting
- Radical Prostatectomy Pathology Reporting
- Evaluation of HER2 for Breast Cancer Patients
- Lung Cancer Reporting (biopsy/cytology specimens)
- Lung Cancer Reporting (resection specimens)
- Melanoma Reporting

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Quality Performance Scoring

- **Measures that are submitted but cannot be scored based on performance will automatically meet the performance threshold of 3 points**
- **Calculation for 6 applicable measures**

  N Points/60 X 60% = Point contribution to Composite Score
- **Calculation for 3 applicable measures**

  N Points/30 X 60% = Point contribution to Composite Score

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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 listed activities apply to pathologists**
- **Examples of potentially applicable activities:**
  - **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 Reporting

- **Total of 40 points available**
- **ECs report by attestation or via a 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**

N Points/40 X 15% = Point contribution to Composite Score

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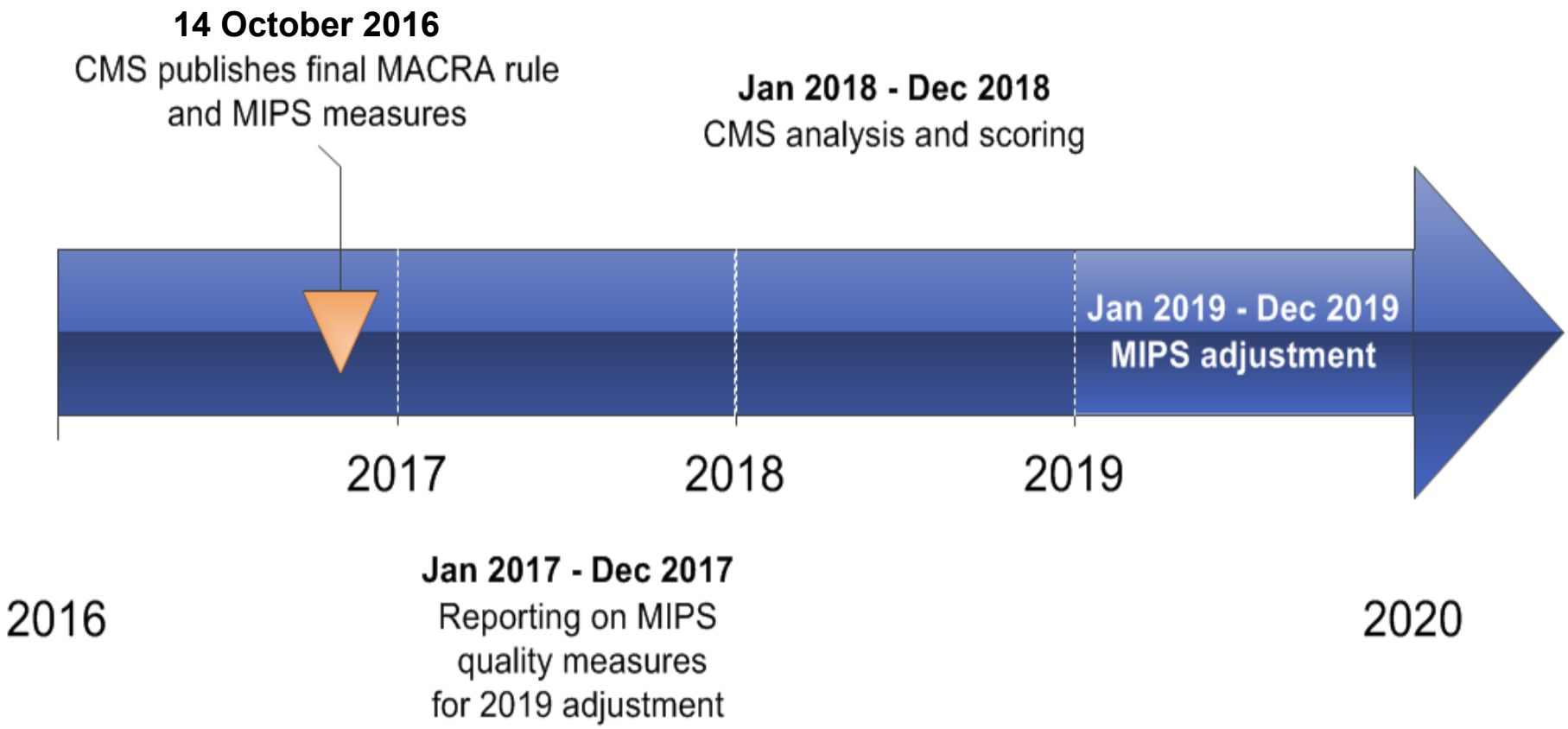
MIPS Timeline: 2016-2019



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MIPS Reporting: Case Example 1

- **What happens if I do not report measures and do not attempt to meet MIPS criteria?**
  - **The average pathologist receives $75,000 annually in Medicare Part B fee-for-service payments**
  - **Failing to report or meet any of the MIPS criteria in 2017 will result in a -4% penalty in 2019**
  - **The average pathologist would receive only $72,000 in 2019**

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MIPS Reporting: Case Example 2

- **What happens if I can only report on 1 measure within the Quality Performance category?**
  - **CMS will award 3 points, i.e., the performance threshold**
  - **No penalty**

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MIPS Reporting: Case Example 3

- **What if I cannot participate in the Quality Performance Category?**
  - **Pathologists (as non-patient facing ECs) report on the Quality and Clinical Practice Improvement categories**
  - **If unable to participate in the Quality Performance Category, CMS will not give a Composite Performance Score based on one category (i.e. CPIA)**
  - **EC will be held "neutral" for MIPS as long as they attest to CPIA.**

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MIPS Reporting: Case Example 4

- **What if I am in an Independent Laboratory?**
  - **All pathologists, including pathologists at independent laboratories, are considered eligible for MIPS**

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MIPS Reporting: Case Example 5

- **What if I am in a Multi-specialty Group Practice?**
  - **Can report via CMS Web Interface (group practice of 25 or more ECs), via a registry**
  - **Register by June 30, 2017 for the 2017 performance period**
  - **Individuals can report via claims or a registry if the group chooses not to use the GPRO**

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Alternative Payment Models (APMs)

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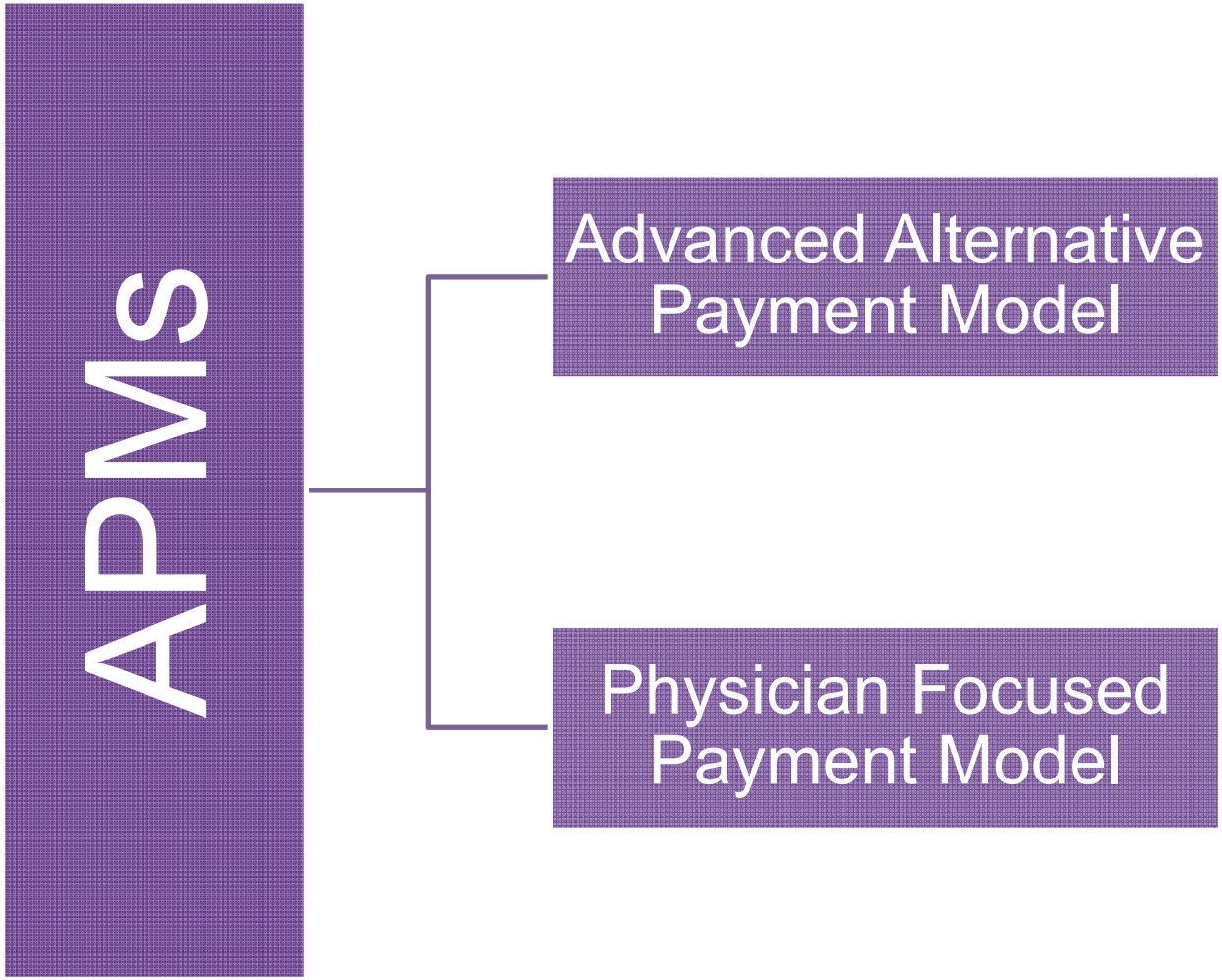

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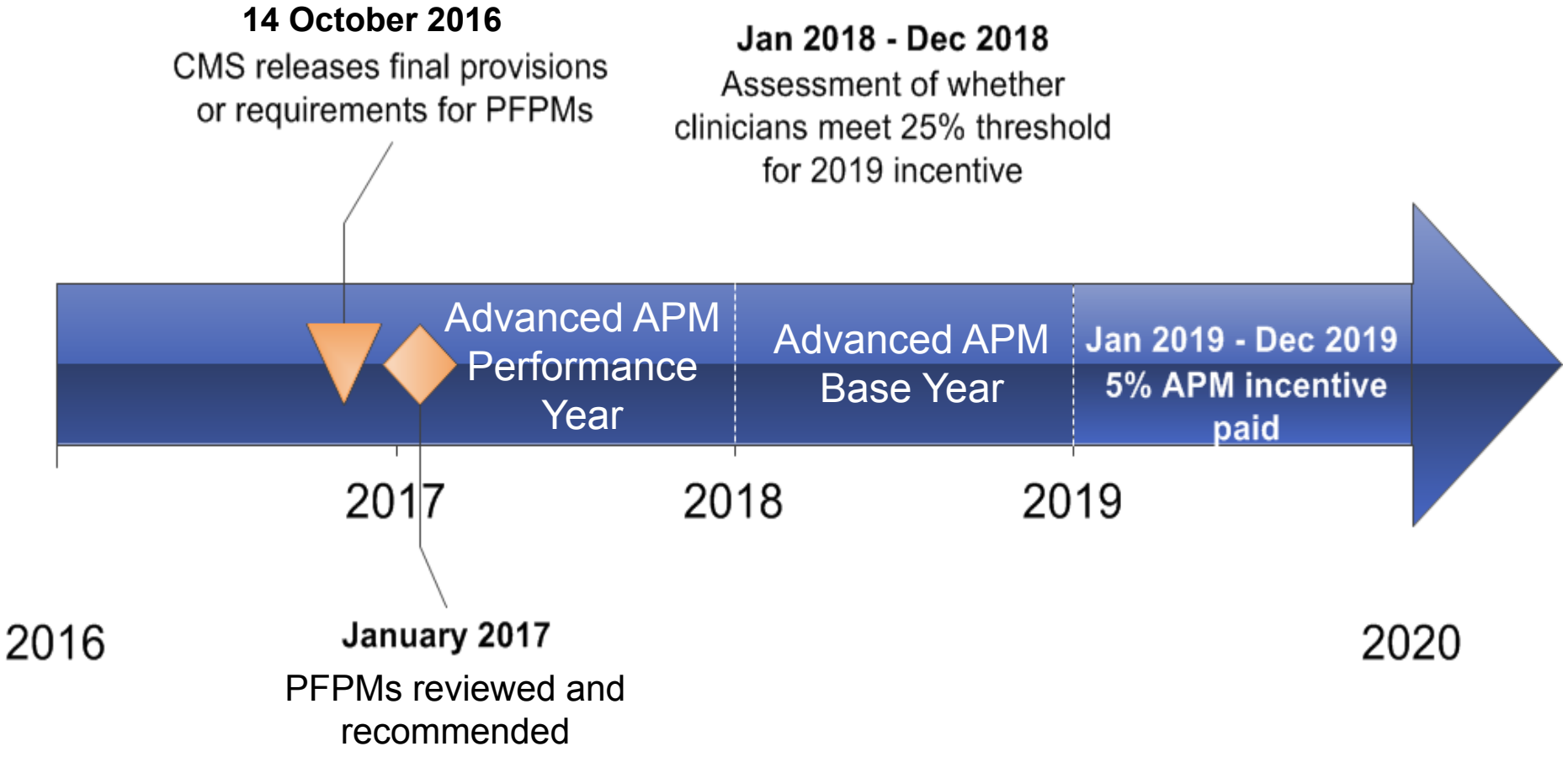
APM Timeline: 2016-2019



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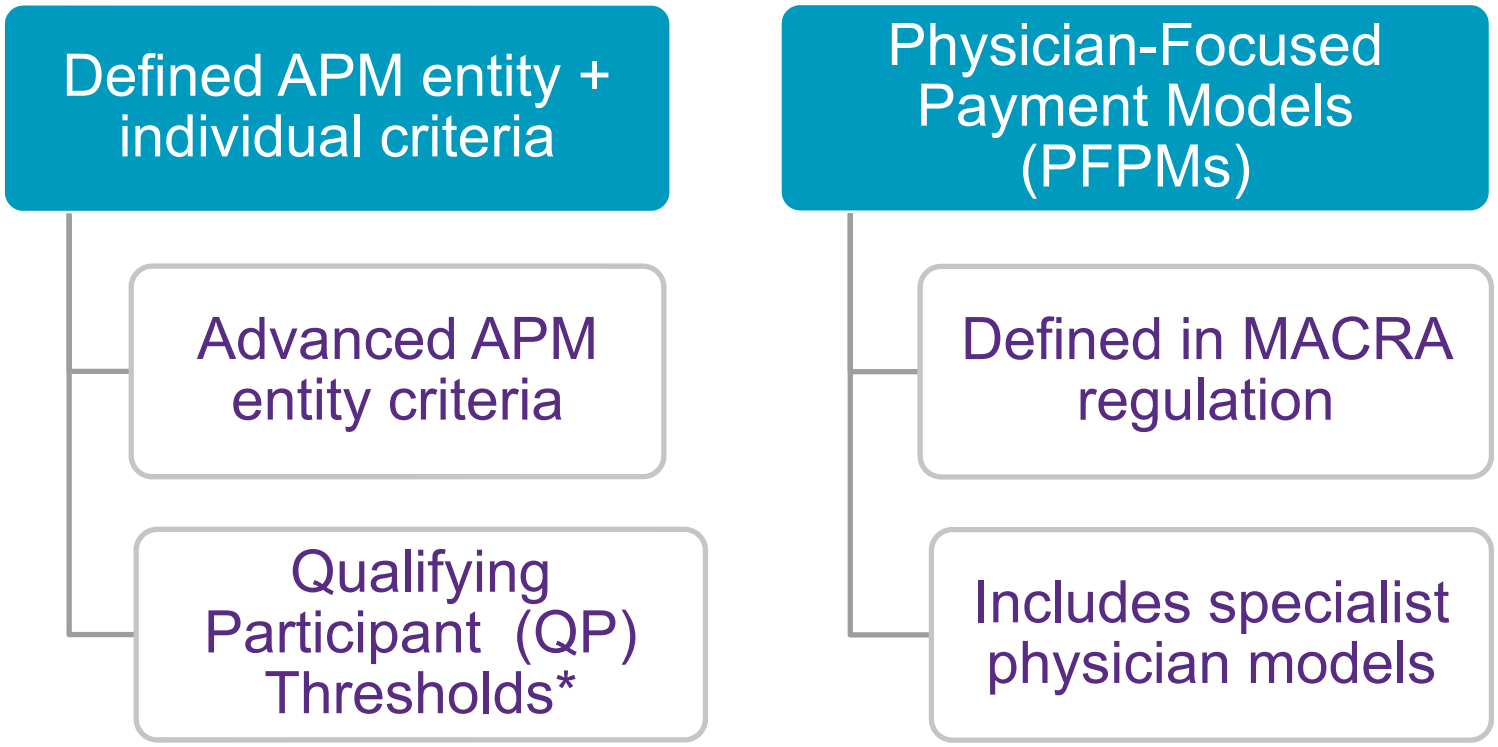
The APM Pathway

- **MACRA's 2 primary types of APMs**



* **MIPS APMs—APM-scoring standard applies**

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3 Advanced APM Criteria: #1 & #2 = Measures & EHR

1. Measures Comparable to MIPS

- **no minimum # of measures or domain requirements except must have 1 outcome measure (unless no appropriate measure available)**

2. Use of Certified EHR Technology

- **1st year: at least 50% eligible clinicians in APM Entity use CEHRT to document clinical care**
- **75% after 1st year**

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3 Advanced APM Criteria: #3 = More than Nominal Financial Risk

- **3 previously proposed financial risk criteria condensed to meeting one of the following**
- **If the APM's actual Medicare expenditure exceeds its expected (benchmark) expenditure, the APM is:**
  - **At risk for at least 8%* of its total Medicare revenues**

  or
  - **At risk for at least 3% of its expected Medicare expenditures**

***CMS expresses its intention to increase this % of revenues for 2019.**

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Advanced APMs

- **Fully qualifying participants:**
  - **excluded from MIPS payment adjustments**
  - **receive annual bonus of 5% in 2019 – 2024**
- **Starting in 2026: higher fee schedule update 0.75% (vs 0.25%)**
- **Threshold to qualify based on percent of revenue or fraction of patients through APM, both as 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 shown above, patient count method based on fraction of attributed beneficiaries

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Partial Qualifying APM Participants

- **Partially qualifying participants = slightly reduced threshold of Advanced APM payments or patients**
- **As partial QPs, entities can choose to:**
  - **Opt out of MIPS & receive no payment adjustment (+ / -)**

  or
  - **Participate in MIPS (payment adjustments would apply)**

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Advanced APMs

- **The five 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+**
- **CMS will post is final list of Advanced APMs before 1/1/2017.**

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New 2018 Models

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

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Physician Focused Payment Models (PFPMs) Defined

- **Broad definition – An APM that:**
  - **Includes Medicare; may also include other payers**
  - **Is "anticipated to reduce cost, improve care or both"**
  - **Closes an existing payment policy gap**
- **Criteria: 3 above, each 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 both high and not well-suited to pathology**

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PFPM Review

- **PFPM Technical Advisory Committee (PTAC)**
  - **Receives PFPM proposals from stakeholders, reviews & makes recommendations to HHS Secretary**
    - **Independent 11 member committee created by MACRA**
- **HHS Secretary**
  - **Comments on CMS website**
- **CMS**
  - **Considers testing proposed models, no timeframe specified**

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APMs and the CAP's Focus

- **Education and information to enable pathologists compliance with the APM pathway, as applicable**
- **Engage with stakeholders and monitor models submitted to PTAC to identify options that would fulfill MACRA requirements and benefit pathologists**

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Questions

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