COLLEGE of AMERICAN PATHOLOGISTS

Final 2019 Medicare Policy and Payment Changes for Pathologists

Donald S. Karcher, MD, FCAP
W. Stephen Black-Schaffer, MD, FCAP
Emily Volk, MD, FCAP
John Scott, Vice President, CAP Policy & Advocacy

November 9, 2018

Welcome

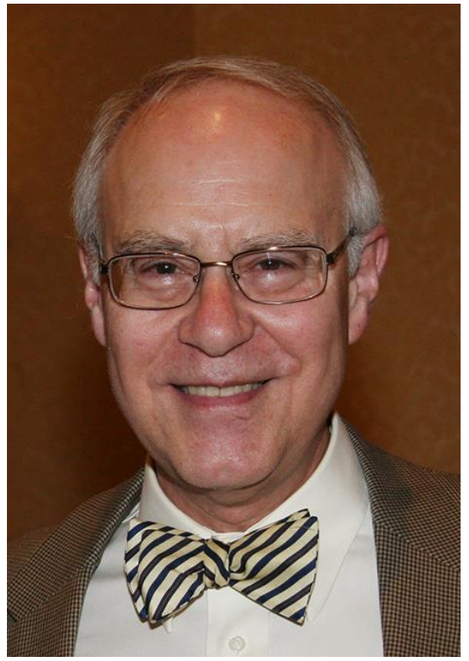
Donald S. Karcher, MD, FCAP

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

Welcome

W. Stephen Black-Schaffer, MD, FCAP

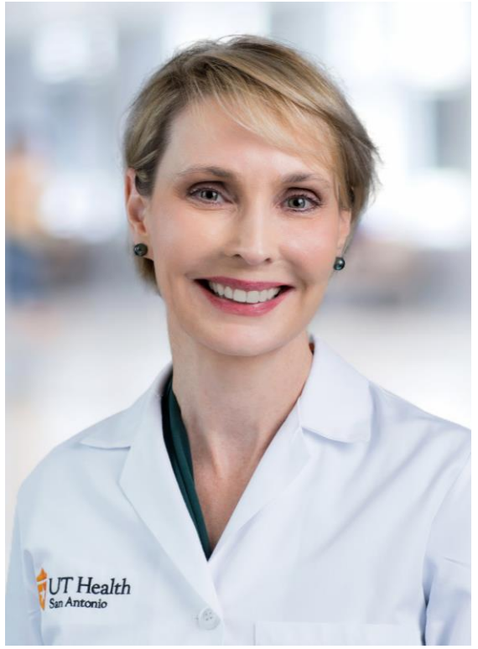
- **Chair, CAP Economic Affairs Committee**



Welcome

Emily Volk, MD, MBA, FCAP

- **Vice Chair, CAP Council on Government and Professional Affairs**
- **Chair of the CAP Clinical Data Registry Ad-Hoc Committee**



Final 2019 Medicare Physician Fee Schedule and Quality Payment Program Regulations

- **Final 2019 Medicare Physician Fee Schedule and Quality Payment Program regulations were released on November 1**
  - **CAP members received a *STATLINE* Alert with initial analysis of this final ruling**

Agenda

- CAP Policy and Advocacy
- Final 2019 Fee Schedule and Reimbursement Policy Overview
- Final 2019 Quality Payment Program Policy Overview
- Questions

CAP Policy and Advocacy

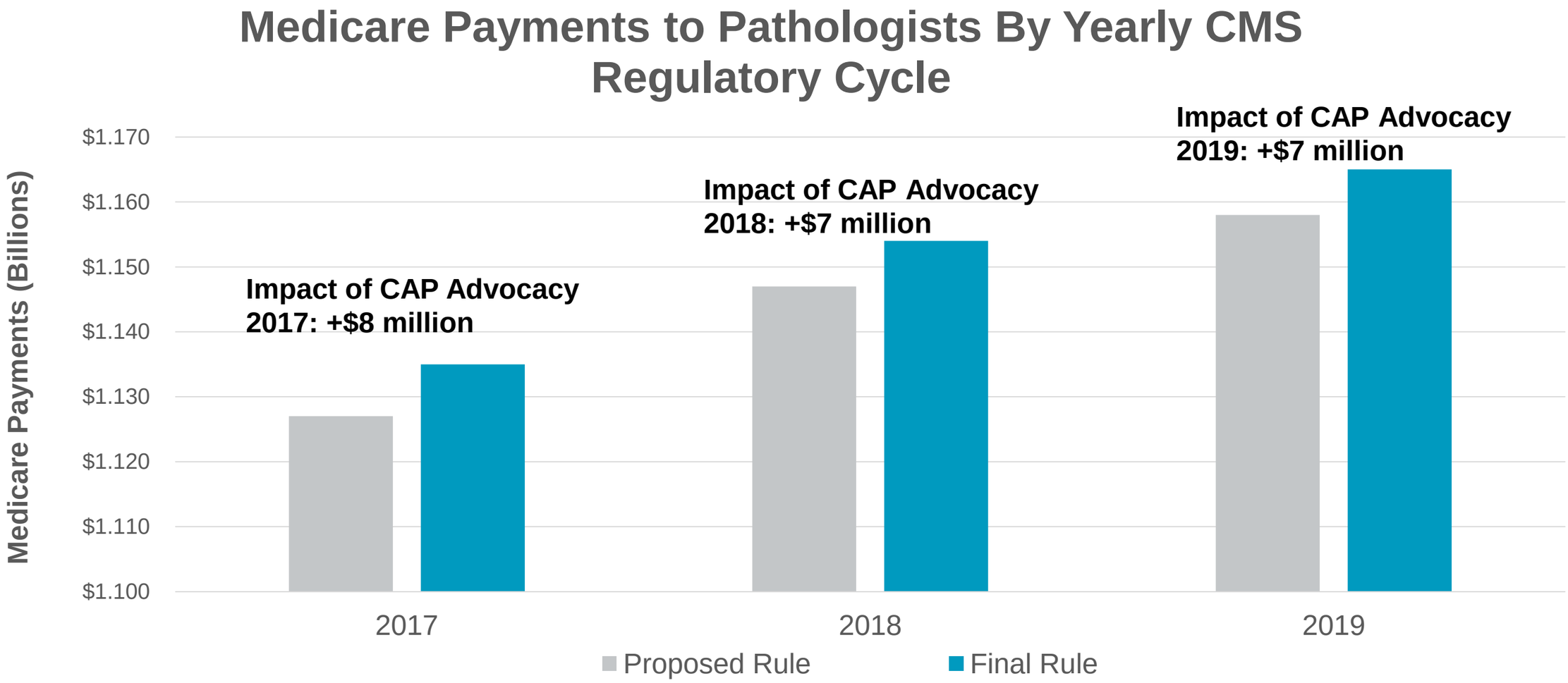
CAP's Policy and Advocacy Agenda

Protect the value of pathology services

Ensure pathologists can adapt to new payment models

Sustain a favorable laboratory regulatory environment

A $22 million Difference: Advocacy on the Medicare Fee Schedule in 2017, 2018, 2019



CAP Advocacy on Medicare Payment

- **CAP continues to work with the CMS on Medicare reimbursement:**
  - **Advocating directly to the CMS throughout the year through face-to-face meetings**
  - **Via the CAP's seat at the AMA/Specialty Society Relative Value Scale Update Committee (RUC)**
  - **Submitting formal comments on fee schedules, QPP, Quality measures and other Medicare regulations**
- **Overall, ~2% decrease in payment due to PE RVU updates**
- **CAP engaged extensively with CMS to mitigate cuts to pathology services; total impact of CAP advocacy is $7 million between the proposed and final rules**

Final 2019 Fee Schedule and Reimbursement Policy Overview

A never-ending process . . .

Since 2006, 47% of pathology CPT codes have been targeted for revaluation by CMS.

Final Payment for Pathology Services 2019

Specialty	Allowed Charges (millions)	Work RVU Impact Change	Combined Work + PE Impact
Pathology	$1,165	~0%	-2%
Independent Laboratory	$646	~0%	-2%

- **Reflects averages by specialty (based on Medicare utilization)**
- **The impact depends on mix of services and payers (Medicare and non-Medicare)**
- **Physicians receive pay from other Medicare payment systems**
- **No new pathology services identified as potentially misvalued**

CMS Response to CAP Recommendations

CPT Code	2018 DESCRIPTION	Work RVU 2018	RUC Rec Work RVU	Work RVU 2019	% Change 2018-2019
85390	Fibrinolysins or coagulopathy screen, interpretation and report	0.37	0.75	0.75	103%
85060	Blood smear, peripheral, interpretation by physician with written report	0.45	0.45	0.45	0%
85097	Bone marrow, smear interpretation	0.94	1.00	0.94	0%

CMS Final for 2019: Fine Needle Aspiration without/with Ultrasound

CPT Code	DESCRIPTION	Work RVU 2018	RUC Rec Work RVU	Work RVU 2019	% Change 2018-2019
10021	Fine needle aspiration biopsy, without imaging guidance; first lesion	1.27	1.20	1.03	-19%
10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure	NA	0.80	0.80	NA
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	NA	1.63	1.46	NA
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)	NA	1.00	1.00	NA

CMS Finalizes Supply and Equipment Pricing Update for 2019

- Current direct practice expense (PE) supply and equipment prices were developed in 2004-2005
- A CMS contractor conducted a market research study to update the PFS direct PE inputs for supply and equipment pricing
- Updated pathology supplies and equipment provided mixed outcomes for professional and technical components

Examples of Supplies and Equipment Repricing

Code	Modifier	Short Descriptor	Practice Expense RVU Change	Practice Expense RVU Percent Change
88187		Flowcytometry/read 2-8	-0.25	-45%
85097		Bone marrow interpretation	-0.49	-30%
10021		Fna w/o image	-0.42	-21%
88323	TC	Microslide consultation	-0.18	-20%
88185		Flowcytometry/tc add-on	-0.16	-19%
88360	26	Tumor immunohistochem/manual	-0.07	-16%
G0416		Prostate biopsy, any mthd	-1.35	-16%
88361		Tumor immunohistochem/comput	-0.40	-13%
88305		**Tissue exam by pathologist**	**0.00**	**0%**
88305	**26**	**Tissue exam by pathologist**	**-0.01**	**-3%**
88305	**TC**	**Tissue exam by pathologist**	**0.01**	**1%**
88314	TC	Histochemical stains add-on	0.19	11%
88350	TC	Immunofluor antb addl stain	0.14	12%
88346		Immunofluor antb 1st stain	0.44	23%
86327	26	Immunoelectrophoresis assay	0.05	31%
88371	26	Protein western blot tissue	0.05	36%
88358		Analysis tumor	0.92	54%
85390	26	Fibrinolysins screen i&r	0.15	107%

CMS Delays Evaluation and Management Coding Update for 2019

- The CMS delayed the proposed coding and payment changes to new and established office visit E/M services
- The two-year delay will allow the CMS to consider any changes made to the E/M CPT codes by the AMA CPT Editorial Panel
- These changes include:
  - Payment of a single rate for E/M outpatient/office visits levels 2-4
  - Maintaining a separate payment rate for E/M level 5 visits
  - Addition of add-on codes that describe additional resources that could be applied to level 2-4 E/M outpatient/office visit codes
  - Removal of the provision to reduce payment when E/M office/outpatient visits are furnished on the same day as procedures

Impact on Independent Laboratories

- **Medicare physician fee schedule payments are estimated to decrease by 2% in 2019 due to changes to the technical component direct practice expense inputs**
- **This does not reflect the total effect of Medicare changes on independent laboratories, as they receive approximately 83% of their Medicare revenue from clinical laboratory services paid under the clinical laboratory fee schedule**

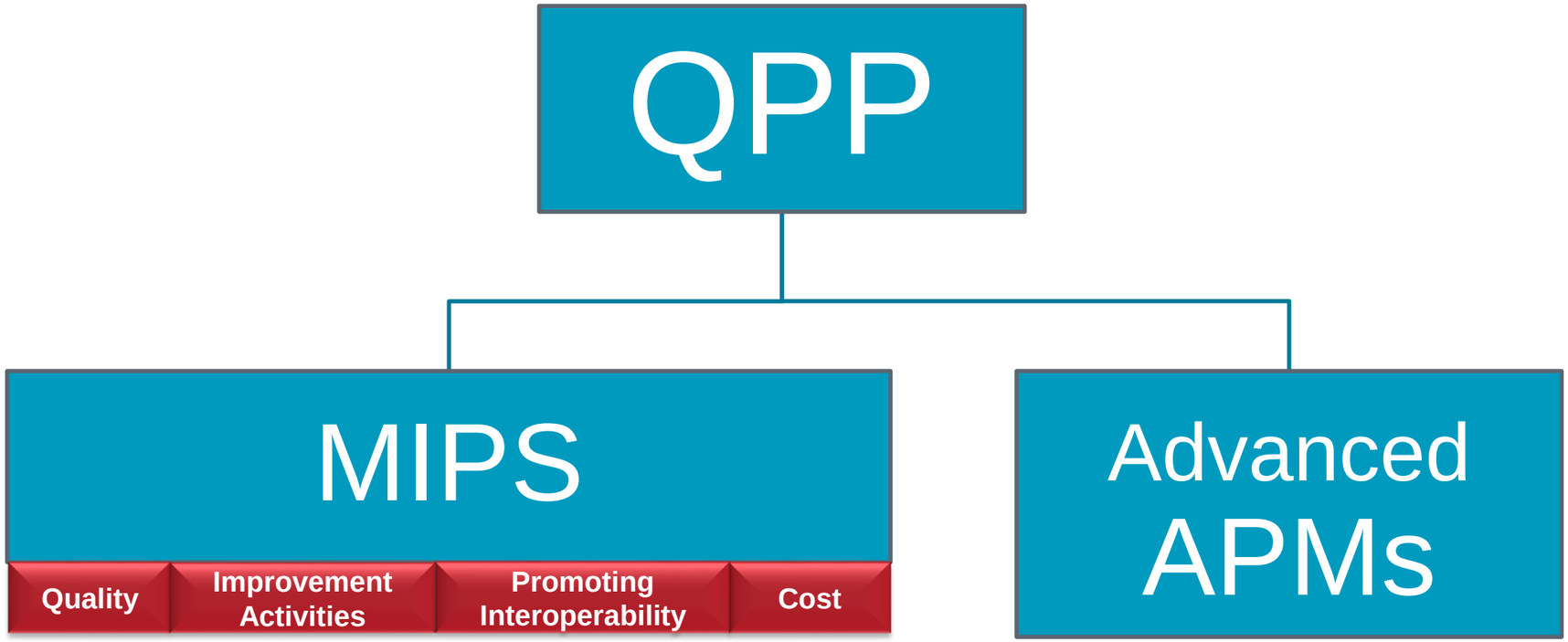
Improve PAMA Data Collection for CLFS Rates

- The CMS' failure to include a large portion of the laboratory market in payment reporting results in a skewing of the PAMA payment rates
- Reflects a disproportionate weighting of large commercial clinical laboratories
- The CMS acknowledged these concerns and will exclude Medicare Advantage plan payments from total Medicare revenues for purposes of the applicable laboratory definition
- More representative data will be collected from a broader segment of the laboratory industry

Final 2019 Medicare Quality Payment Program Requirements

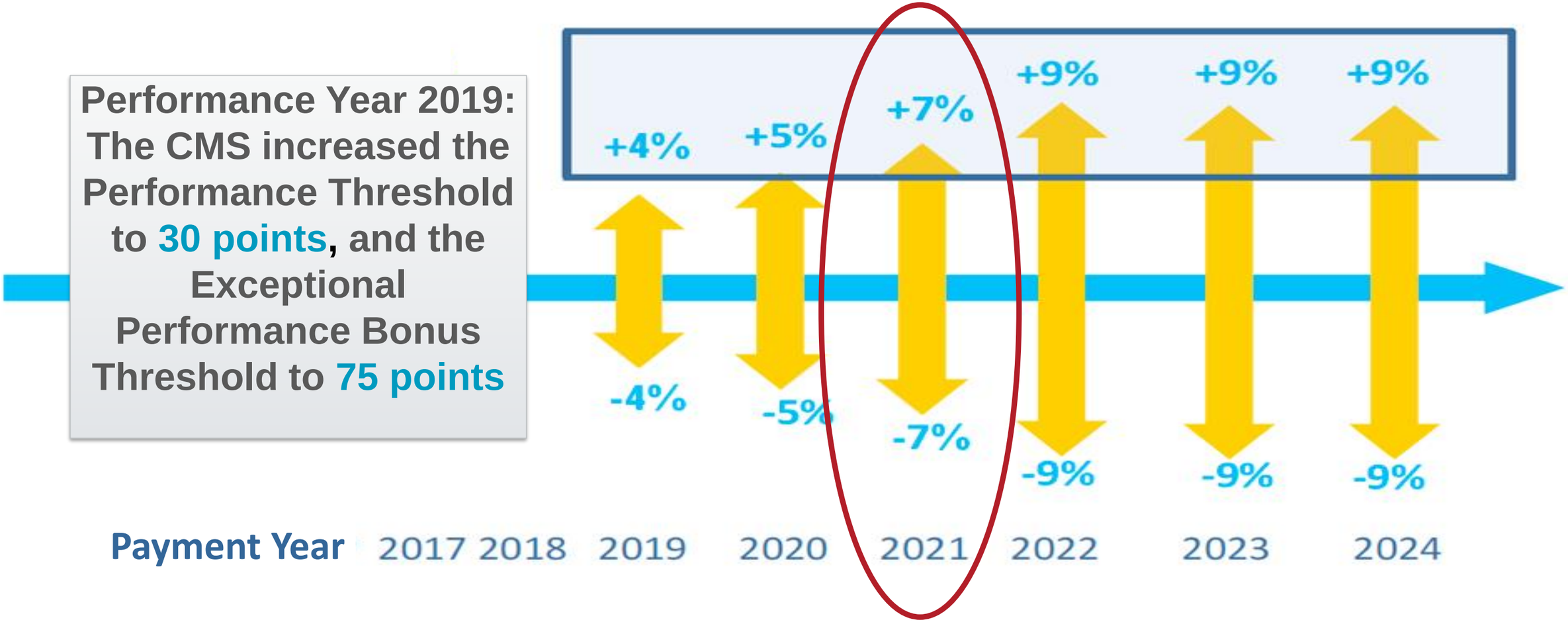
Quality Payment Program Pathways

Two pathways/tracks are offered under the QPP:



Year 3 MIPS Implementation

Performance Year 2019: The CMS increased the Performance Threshold to 30 points, and the Exceptional Performance Bonus Threshold to 75 points



MIPS 2019 Performance Year Scoring For Pathologists

Quality Measures: Score out of 85 points

- 6 measures for 12 months; 60% data completeness
- Measures can be submitted via multiple mechanisms
- Small practice bonus added to Quality score

Improvement Activities: Score out of 15 points

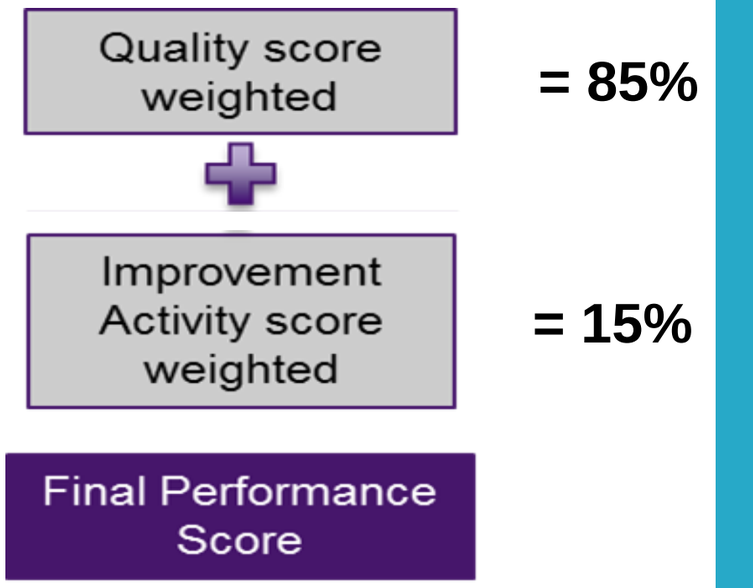
- 90 days
- New improvement activities added

Minimum Score:

- If your total MIPS score is not at least 30 points in 2019, you are subject to a penalty

Exceptional Performance Bonus:

- Clinicians whose MIPS final score is 75 points or above are eligible to receive additional incentive payments from a pool of $500 million for exceptional performance



Low Volume Threshold Expansion + Opt-In

- **Third Criterion Added to Expand Eligibility for Low Volume threshold:**

  To be excluded from MIPS, clinicians or groups would need to meet one of the following three criteria:

  - **≤ $90K in Part B allowed charges for covered professional services**
  - **Provide care to ≤ 200 beneficiaries**
  - **Provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)**

- **New Opt-In Participation for Low Volume practices:**

  - **Starting in Year 3, clinicians or groups would be able to opt-in to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criterion**

New Facility-Based Scoring Option

- Quality and cost category scores would be assigned based on attributed facility's Hospital Value-Based Purchasing program
- 75% or more of covered professional services
  - Inpatient hospital (POS 21) or
  - On-campus outpatient hospital (POS 22) or
  - Emergency Room (POS 23), and
- At least one service billed with POS 21 or 23
- Facility-based pathology groups must still attest to Improvement Activities separately from the facility
- Facility-based pathologists can also report separately/individually and the CMS will use the highest score

CMS Focuses on “Meaningful Measures”

- 69% of claims-based measures are topped out, and are being phased out
- The CMS finalized the removal of the following three of the eight CAP-developed QPP measures:
  - Breast Cancer Resection Reporting
  - Colon Cancer Resection Reporting
  - Quantitative IHC Evaluation of HER2 Testing in Breast Cancer Patients

“Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care. This Administration has listened and is taking action.”

Seema Verma, MPH, CMS administrator

Claims-Based Reporting Continues to be Phased Out

- **CMS is limiting claims submission to small practices only (15 or fewer clinicians)**
  - Individuals or groups in small practices can use claims-based reporting
  - Individuals in groups larger than 15 pathologists will no longer be able to report via claims

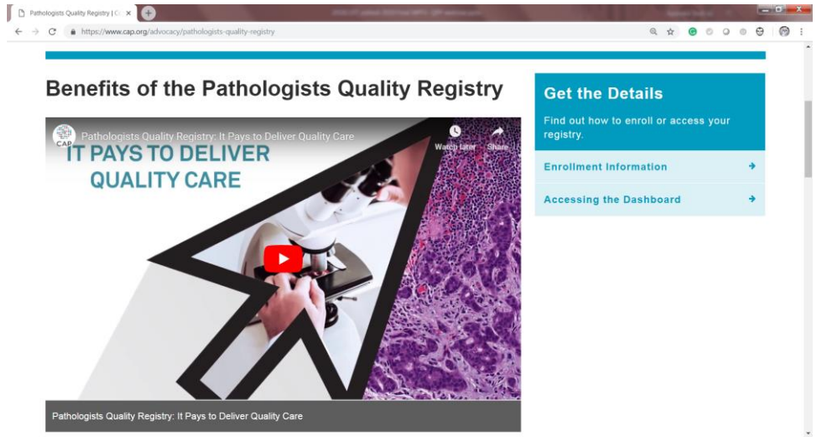
- **CMS finalized multiple reporting options to help clinicians maximize their score**
  - Clinicians will be able to submit a single quality measure via multiple mechanisms
  - Clinicians who are part of a group or are facility-based will also be able to report as individuals to try to maximize their score

From the CMS:

As previously expressed in the 2017 Final Rule, we want to move away from claims reporting, since approximately 69 percent of the Medicare Part B claims measures are topped out.

The Pathologists Quality Registry Helps Our Members with MIPS

Enrollment is “high-touch” customer service experience from the CAP



Quality Measures:

1. Manual data entry
    - Via web portal
    - Via excel file upload
2. Automated data entry with billing and/or LIS

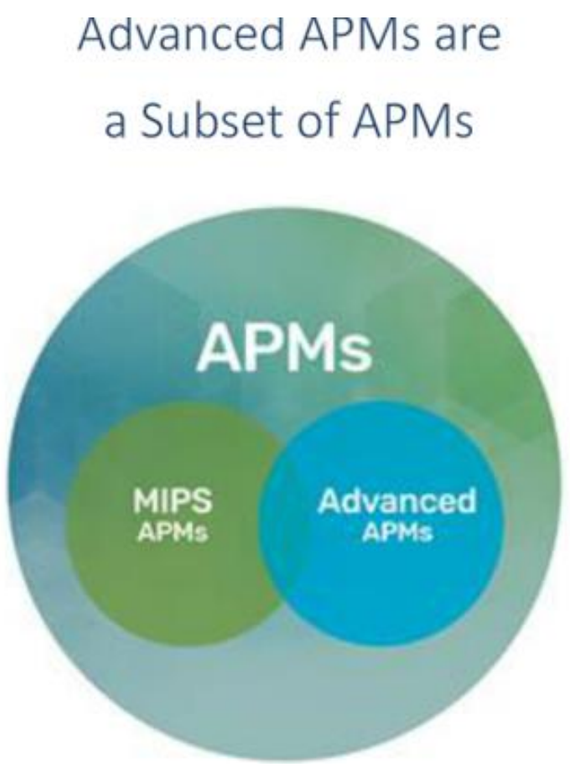
Improvement Activities (IA):

- The registry makes it easy to understand and choose from a subset of IA most pathologists are already doing
- Most billing companies cannot submit IA
- Pathologists can use our registry just for IA this year, while still reporting claims-based measures (to ensure they get the 15%)

Email us at MIPS@cap.org

Advanced APM Details

- CEHRT use requirement increased from 50% to 75% of eligible clinicians
- Streamlining definition of MIPS comparable measures to reduce confusion and burden
- Maintaining the 8% revenue-based financial risk requirement
- Increased flexibility for the All-Payer Combination Option and Other Payer Advanced APMs
- Physician-Focused Payment Model Technical Advisory Committee (PTAC)



Before we take questions …

MIPS Educational Webinar Series

Upcoming Webinars

- A look At Pathology Specific Quality Measures That Will Improve Your Score webinar on Dec. 4 at 12 PM ET/ 11 AM CT
- **Steps Pathologists Should Take Before Reporting MIPS Data to the CMS** webinar on Jan. 8, 2019 at 3 PM ET/ 2 PM CT

Previous Webinars

- Still available on www.cap.org/advocacy/mips-for-pathologists
  - Maximize your MIPS score
  - MIPS Reporting Options
  - Improvement Activities

Save The Date

2019 CAP Policy Meeting

April 29-May 1, 2019
Washington Marriott, Washington, DC
Registration is open at www.cap.org

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Questions

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