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
  o 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

Medicare Payments to Pathologists By Yearly CMS Regulatory Cycle

- **2017**: Impact of CAP Advocacy: +$8 million
- **2018**: Impact of CAP Advocacy: +$7 million
- **2019**: Impact of CAP Advocacy: +$7 million

<table>
<thead>
<tr>
<th>Year</th>
<th>Proposed Rule</th>
<th>Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$1.110</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>$1.120</td>
<td>+$7 million</td>
</tr>
<tr>
<td>2019</td>
<td>$1.150</td>
<td>+$7 million</td>
</tr>
</tbody>
</table>
CAP Advocacy on Medicare Payment

• CAP continues to work with the CMS on Medicare reimbursement:
  o Advocating directly to the CMS throughout the year through face-to-face meetings
  o Via the CAP’s seat at the AMA/Specialty Society Relative Value Scale Update Committee (RUC)
  o 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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (millions)</th>
<th>Work RVU Impact Change</th>
<th>Combined Work + PE Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology</td>
<td>$1,165</td>
<td>~0%</td>
<td>-2%</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>$646</td>
<td>~0%</td>
<td>-2%</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>85390</td>
<td>Fibrinolysins or coagulopathy screen, interpretation and report</td>
<td>0.37</td>
<td>0.75</td>
<td>0.75</td>
<td>103%</td>
</tr>
<tr>
<td>85060</td>
<td>Blood smear, peripheral, interpretation by physician with written report</td>
<td>0.45</td>
<td>0.45</td>
<td>0.45</td>
<td>0%</td>
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<tr>
<td>85097</td>
<td>Bone marrow, smear interpretation</td>
<td>0.94</td>
<td>1.00</td>
<td>0.94</td>
<td>0%</td>
</tr>
</tbody>
</table>
## CMS Final for 2019: Fine Needle Aspiration without/with Ultrasound

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10021</td>
<td>Fine needle aspiration biopsy, without imaging guidance; first lesion</td>
<td>1.27</td>
<td>1.20</td>
<td>1.03</td>
<td>-19%</td>
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<tr>
<td>10004</td>
<td>Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)</td>
<td>NA</td>
<td>0.80</td>
<td>0.80</td>
<td>NA</td>
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<tr>
<td>10005</td>
<td>Fine needle aspiration biopsy, including ultrasound guidance; first lesion</td>
<td>NA</td>
<td>1.63</td>
<td>1.46</td>
<td>NA</td>
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<tr>
<td>10006</td>
<td>Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)</td>
<td>NA</td>
<td>1.00</td>
<td>1.00</td>
<td>NA</td>
</tr>
</tbody>
</table>
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

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

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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:

- MIPS
- Advanced APMs
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**

Payment Year 2017 2018 2019 2020 2021 2022 2023 2024

-4% +4% -5% +5% -7% +7% -9% +9% -9% +9% -9% +9% -9% +9% -9% +9%
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

= 85%

Improvement Activities: Score out of 15 points
- 90 days
- New improvement activities added

= 15%

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:
  - $\leq \$90K$ in Part B allowed charges for covered professional services
  - Provide care to $\leq 200$ beneficiaries
  - Provide $\leq 200$ 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
  o Inpatient hospital (POS 21) or
  o On-campus outpatient hospital (POS 22) or
  o 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)
  o Individuals or groups in small practices can use claims-based reporting
  o 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
  o Clinicians will be able to submit a single quality measure via multiple mechanisms
  o 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
  o Maximize your MIPS score
  o MIPS Reporting Options
  o 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
Stay Informed Through the CAP

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• Read STATLINE
• Join PathNET, the CAP’s grassroots advocacy network
Questions