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
Proposed 2019 Medicare Physician Fee Schedule and Quality Payment Program Regulations

• Proposed 2019 Medicare Physician Fee Schedule was released on July 12
  ○ CAP members received a STATLINE Alert with initial analysis of this proposed ruling
• CAP will continue to engage with the Centers for Medicare & Medicaid Services (CMS)
  ○ Including formal comments due September 10
• Final regulations expected Fall of 2018
Agenda

• CAP Policy and Advocacy
• Proposed 2019 Fee Schedule and Reimbursement Policy Overview
• Proposed 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 $15 million Difference: Advocacy on the Medicare Fee Schedule in 2017 and 2018

Medicare Payments to Pathologists by Yearly CMS Regulatory Cycle

Impact of CAP Advocacy
2017: +$8 million

Impact of CAP Advocacy
2018: +$7 million

<table>
<thead>
<tr>
<th>Year</th>
<th>Proposed Rule (CMS)</th>
<th>Final Rule (CMS)</th>
<th>Impact of CAP Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$1.127</td>
<td>$1.135</td>
<td>+$8 million</td>
</tr>
<tr>
<td>2018</td>
<td>$1.147</td>
<td>$1.154</td>
<td>+$7 million</td>
</tr>
</tbody>
</table>

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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
Proposed 2019 Fee Schedule and Reimbursement Policy Overview
## Proposed 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>$1,158</td>
<td>~0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>$640</td>
<td>~0%</td>
<td>4%</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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</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>0.36</td>
<td>-20%</td>
</tr>
<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>
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</table>
## CMS Proposal for 2019: Fine Needle Aspiration

<table>
<thead>
<tr>
<th></th>
<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>
</tr>
<tr>
<td>10022</td>
<td>Fine needle aspiration; with imaging guidance</td>
<td>1.27</td>
<td></td>
<td>** - Deleted - **</td>
<td></td>
</tr>
<tr>
<td>10X11</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>
</tr>
</tbody>
</table>
# CMS Proposal for 2019: Fine Needle Aspiration

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10X12</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>
</tr>
<tr>
<td>10X13</td>
<td>Fine needle aspiration biopsy, including ultrasound guidance; each additional</td>
<td>NA</td>
<td>1.00</td>
<td>1.00</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>lesion (List separately in addition to code for primary procedure)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CMS Proposes 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 provides mixed outcomes for professional and technical components
### CMS Proposed Supplies and Equipment Repricing Top Impacted Pathology

<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>-0.24</td>
<td>-43%</td>
</tr>
<tr>
<td>88323</td>
<td>TC</td>
<td>MICROSLIDE CONSULTATION</td>
<td>-0.18</td>
<td>-20%</td>
</tr>
<tr>
<td>88361</td>
<td>26</td>
<td>TUMOR IMMUNOHISTOCHEM/COMPU</td>
<td>-0.08</td>
<td>-20%</td>
</tr>
<tr>
<td>88305</td>
<td>26</td>
<td>TISSUE EXAM BY PATHOLOGIST</td>
<td>-0.02</td>
<td>-6%</td>
</tr>
<tr>
<td>88305</td>
<td>TC</td>
<td>TISSUE EXAM BY PATHOLOGIST</td>
<td>0.05</td>
<td>4%</td>
</tr>
<tr>
<td>88346</td>
<td></td>
<td>IMMUNOFLUOR ANTB 1ST STAIN</td>
<td>0.43</td>
<td>23%</td>
</tr>
<tr>
<td>88346</td>
<td>TC</td>
<td>IMMUNOFLUOR ANTB 1ST STAIN</td>
<td>0.45</td>
<td>28%</td>
</tr>
<tr>
<td>88381</td>
<td>TC</td>
<td>MICRODISSECTION MANUAL</td>
<td>0.89</td>
<td>31%</td>
</tr>
<tr>
<td>88350</td>
<td>TC</td>
<td>IMMUNOFLUOR ANTB ADDL STAIN</td>
<td>0.9</td>
<td>33%</td>
</tr>
<tr>
<td>88361</td>
<td>TC</td>
<td>IMMUNOFLUOR ANTB ADDL STAIN</td>
<td>0.92</td>
<td>76%</td>
</tr>
<tr>
<td>88361</td>
<td></td>
<td>TUMOR IMMUNOHISTOCHEM/COMPU</td>
<td>3.31</td>
<td>105%</td>
</tr>
<tr>
<td>88365</td>
<td>TC</td>
<td>INSITU HYBRIDIZATION (FISH)</td>
<td>4.62</td>
<td>110%</td>
</tr>
<tr>
<td>88365</td>
<td>TC</td>
<td>INSITU HYBRIDIZATION (FISH)</td>
<td>4.65</td>
<td>122%</td>
</tr>
<tr>
<td>88361</td>
<td>TC</td>
<td>TUMOR IMMUNOHISTOCHEM/COMPU</td>
<td>3.39</td>
<td>124%</td>
</tr>
<tr>
<td>88360</td>
<td>TC</td>
<td>TUMOR IMMUNOHISTOCHEM/MANUA</td>
<td>4.25</td>
<td>146%</td>
</tr>
<tr>
<td>88360</td>
<td>TC</td>
<td>TUMOR IMMUNOHISTOCHEM/MANUA</td>
<td>4.33</td>
<td>175%</td>
</tr>
</tbody>
</table>
Improve PAMA Data Collection for CLFS Rates

- The CMS is seeking input on alternative approaches for expanding the definition of applicable laboratories
- 2018 clinical laboratory fee schedule payment rates are based on information from a subset of laboratories
- The CAP urges the CMS to expand this definition
Proposed 2019 Medicare Quality Payment Program Requirements
Proposed 2019 Medicare Quality Payment Program

QPP

APMs

MIPS
The CMS proposes to increase the Performance Threshold to **30 points** in 2019, and to increase the Exceptional Performance Bonus Threshold to **80 points**.
Part B Impact is Rescaled for MIPS

- Payment Adjustments will apply **only to covered professional services paid under or based on the Physician Fee Schedule** beginning with 2019
  - This means CLFS billing not included in the calculation for bonus adjustment
  - Payment adjustments based on 2017 performance take effect on January 1, 2019.

- Beginning with 2019 performance year, the low volume threshold calculations will also be **based only on covered services** in the Medicare Physician Fee Schedule
# Proposed Modifications 2019 QPP

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>Weight*</th>
<th>Requirement</th>
<th>What’s New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (measures)</td>
<td>85%</td>
<td>✓ 6 measures (one of which being an outcome or high-priority measure)</td>
<td>Measures can be submitted via multiple mechanisms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ 12 months reporting</td>
<td>Small practice bonus added to Quality score</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ 60% data completeness</td>
<td></td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>✓ 90 days reporting</td>
<td>New improvement activities added</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>0% (rewighted to Quality)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>(15% if applicable)</td>
<td>Non-patient-facing MIPS eligible clinicians who have sufficient case volume, in accordance with the attribution methodology</td>
<td>CAP is conducting further analysis to determine impact on pathologists</td>
</tr>
</tbody>
</table>

*Scoring weights for non patient facing clinicians

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# Proposed Low Volume Threshold Expansion

## MIPS Policies

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>2018 Requirements</th>
<th>2019 Proposed Requirements</th>
</tr>
</thead>
</table>
| **Low-Volume Threshold (LVT)**    | To be excluded from MIPS, clinicians and groups must meet one of the following two criterion:  
• ≤ $90K in Part B allowed charges for covered professional services OR  
• provide care to ≤ 200 beneficiaries | To be excluded from MIPS, clinicians or groups would need to meet one of the following three criterion:  
• ≤ $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) |
| **Opt-in**                        | None available                                                                    | 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 |
CMS Proposes New Facility-Based 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 and the CMS will use the highest score
CMS Focuses on “Meaningful Measures”

• 96% of claims-based measures are topped out, and are being phased out
• The CMS proposed the removal of the following three of the eight CAP-developed QPP measures:
  o Breast Cancer Resection Reporting
  o Colon Cancer Resection Reporting
  o 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 proposes a limit to claims submission to small practices only (15 or fewer clinicians)
  o Groups larger than 15 pathologists continue to not be able to report as a group via claims

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

From the Proposed Rule:
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

• One stop shopping for Quality measures and Improvement Activities

• CAP’s Registry staff can help practices navigate these changes and determine the best reporting for your practice

Email us at MIPS@cap.org
Advanced APM Details for 2019

• CMS is proposing increasing the percentage of eligible clinicians that must use Certified EHR Technology from 50% to at least 75%

• Clarifying their Advanced APM requirement for “MIPS-comparable quality measures,” and outcome measures

• Maintaining the 8% revenue-based financial risk requirement

• Increased flexibility for the All-Payer Combination Option and Other Payer Advanced APMs
Before we take questions ...
MIPS Educational Webinar Series

• **Maximize Your MIPS Bonus Potential** webinar on Aug. 9 at 12 PM ET/11 AM CT

• **MIPS Reporting Deep Dive: Which Path is Right for Your Practice?** webinar on Sept. 6 at 11 am ET/10 am CT

• **Pathologist Improvement Activities You Can Attest to Under MIPS** webinar on Sept. 20 at 1 PM ET/12 PM CT

• **Earn the Maximum Bonus - 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
Save These Dates

CAP18 – The Pathologists’ Meeting™
October 20-24, 2018
Hyatt Regency Chicago, Chicago, IL

2019 CAP Policy Meeting
April 29-May 1, 2019
Washington Marriott, Washington, DC
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Questions