California Society of Pathologists

2016 Annual Report to the Membership

Submitted by

Tim Hamill, MD

President

Prepared for

Members of the

California Society of Pathologists

December 2016

CALIFORNIA SOCIETY OF PATHOLOGISTS
2016 ANNUAL REPORT TO THE MEMBERSHIP

Welcome to our colleagues from California, across the U.S. and abroad to our 69th Annual Meeting in San Francisco. Thanks to the hard work of the Education Committee led by Dr. Balaram Puligandla, I know you will enjoy an outstanding educational program.

We appreciate the support of our members and will continue to explore ways to better serve the pathology community and benefit the patients that you serve. Please feel free to approach any member of the Board of Directors with comments and suggestions; we want to hear from you!

I. LEGISLATIVE AND REGULATORY ACTIVITIES

The CSP continues its legislative advocacy. Following is a highlight of some of the issues that were monitored this year. Also, the Legislative section of the CSP website, www.calpath.org, provides access to CSP's entire legislative bill tracking activity throughout the year.

Out of Network/Balance Billing Prohibition

On September 23, Governor Brown signed AB 72 (Bonta)—the final vehicle which would ban balance billing and create a process for determining interim payment rates for out of network physicians who provide services in contracted hospitals and other facilities. It was clear that the Legislature wanted to pass a solution to this long standing issue.

AB 72, as amended, passed both the Senate and Assembly during the end of the legislative session with near unanimous votes in both Houses. The interim payment amount for an out-of-network physician is now the greater of 125% of Medicare or the average contracted rate of the plan. The bill continues to contain an IDRP process whereby a physician/group could appeal for a higher level of payment above the interim payment amount. The bill does include some provisions to address the network adequacy requirements for plans that we believe contribute in large part to the out-of-network billing issue. The law will not take effect until July 1, 2017 for any policy that is issued or renewed on or after that date. Both the DMHC and DOI have to establish an IDRP process and there will be some stakeholder engagement on issues prior to that date. Health plans will also have to provide data to the regulators on their contracted rates and the process as to how they were developed. The CSP had moved to a neutral position on AB 72, and the CMA also changed their position to neutral prior to the floor votes.

The Association of American Physicians and Surgeons, an Arizona based organization, filed suit in US District Court in California against the Governor and DMHC challenging the provisions of AB 72 and requesting injunctive relief to halt implementation. The suit alleged that the law violated the Constitution by improperly delegating authority to plans to set reimbursement rates for physicians who are not contracted. Typically, lawsuits requesting injunctive relief are heard quickly, but since the laws does not take effect until July, the Court could simply decide the case on its merits. We will monitor the case and keep you informed.

Bill Signed to Alter Cancer Registry Reporting

We are pleased to report that the Legislature has passed and the Governor signed AB 2325 by Assemblywoman Susan Bonilla. AB 2325 would require that, on or after January 1, 2019, all pathologists diagnosing cancer will report those cancer diagnoses via electronic means to the California Cancer Registry (CCR). The bill resulted from a dialogue with the author who had an interest in clinical trials for cancer patients and the possible use of California Cancer Registry data to advance the goals of cancer treatment and outcomes.

In early 2015, representatives of the CSP began a dialogue with the CCR over the need for changes for cancer reporting. From those discussions came the creation of the California Data Modernization Consortium (CDMC), and our hopes for reforming the current reporting method to CCR. The CDMC includes representatives from the CSP, CAP, major EHR vendors, and the large health care systems. It was decided that though other details of the possible changes to the CCR would come from the deliberations of the CDMC, that it was already clear three things needed to change: (1) initial reporting of cancer diagnoses should come from the pathologist, (2) that reporting should be done in a standardized format, and (3) the report should be submitted electronically. There have been several pilots at select California hospitals using the CAP eCancer checklist and electronic reporting to CCR.

After introduction, AB 2325 was amended several times as it moved through the legislative process. The reporting will be required to use the College of American Pathologists cancer protocols data elements, but the pathologist can submit in any electronic means directly from the Electronic Medical Record, or through a web portal provided by California Department of Public Health (CDPH). CDPH will prescribe the data to be submitted and will work with stakeholders to designate a standardized format for submission.

There were amendments to not penalize or make the pathologist responsible for missing or inaccessible patient demographic information that exceeded the required cancer-specific data elements. CDMC and its workgroups will be developing the specific patient identifier elements that should be provided in the reports.

AB 2325 was also amended to specifically indicate that a pathologist is not required to submit the same report more than once. In essence, if a specific report is submitted electronically, CDPH can't require the same pathology report via different means.

AB 2325 establishes the basic foundation that will help CCR to move towards its goal of near real-time identification and surveillance of cancer throughout the state. It enables the governance structure and workgroups of CDMC to now build upon that framework of standardized data, electronic versus paper submission, and improved timeliness of reporting. It will allow the CCR to become a pioneer in the aggregation, management and clinical utility of cancer data. The CSP is continuing to engage with the CDMC as it works to develop policies and enhancements over current CCR operations we can revisit the specifics of the statutes contained in AB 2325.

CSP Supported Bill to Eliminate State Lab Licensing Stalls/ But Changes Occur

This year, the CSP supported AB 1774 (Bonilla), which would have implemented the recommendation of the State Auditor's review of Laboratory Field Services (LFS) performance in the licensing, inspection and regulation of clinical laboratories. Their recommendation was to eliminate separate state licensure of labs and rely on federal CLIA certification. The State Audit, which is a follow-up to a previous audit in 2008, found many areas of failure, poor performance and little improvement.

The CSP participated in multiple meetings with the author and other lab organizations. Though AB 1774 passed the Assembly Business and Professions Committee on a unanimous vote of 18-0 it was held in the Assembly Appropriations Committee based upon the impact on state revenues and not a vote on the merits. Some lab organizations and the unions that represent lab personnel continued to question the wisdom of removing state licensing even though LFS could continue to inspect or investigate any clinical laboratory based upon a complaint.

What happened was that LFS has finally approved or given deemed status to two important accrediting organizations, both the CAP and JCAHO. Both have waited years for approval and now join COLA as approved accrediting organizations. A lab can now indicate accreditation by any of these entities on their license renewals and not be subject to routine inspections by LFS. LFS can still inspect upon complaint or do validation surveys.

There are also likely more changes to be made by LFS as they attempt to address the recommendations for change made by the State Auditor. Some of those include an evaluation of current state license fees with hopeful reductions to be forthcoming. The Auditor found that LFS overcharged labs by $1M in 2014. LFS has also tried to ramp up their regulatory overhaul on lab personnel standards which again have been languishing for many years. We will continue to engage in the reform process.

Bill to Expand Direct Access to Lab Services Pulled from Hearing

Senate Bill 1418 (Lara) was amended in March to expand the current California law that allows consumers/patients direct access to a limited number of lab tests without the lab requiring physician or other provider referral and order. Current law limits direct access to those tests that are approved by the FDA for over-the-counter test kits and included pregnancy, glucose level, and occult blood.

SB 1418 would have expanded the ability to any lab test that a lab offers to the general public, require the report of the results go to the person that ordered the test, and include a notice in bold type that it is the responsibility of the patient to arrange with their health care provider for consultation and interpretation of the test results. It would have also exempted the patient's provider for any liability or sanction for failure to review a test that they did not order.

The CSP did not oppose the bill, but suggested that the author consider the breadth of the tests that could be ordered and the need for more consumer awareness of the types of tests and importance of certain results. We also suggested that any lab offering direct access should be required to enroll in a PT program for any test where a PT program was available. The bill was permissive so any lab was free to offer or not offer tests as they saw fit. The bill died without a hearing.

Bill Passed to Require Forensic Autopsies Only Be Performed by A Physician

The CSP supported SB 1189 (Pan and Jackson) to address the issue of forensic autopsies performed under the auspices of county coroners or sheriff coroners. Prior law did not require that the autopsies be performed by a qualified forensic pathologist or even physician. The authors were concerned with a lack of standards for performance of these important forensic procedures and were driven in part by a situation in a California county where unlicensed personnel performed portions of an autopsy while the was absent and directing the process by phone.

The CSP supported the earlier version of SB 1189 that would have mandated that the autopsy be performed by a board certified pathologist. Based upon opposition from counties based upon potential cost and availability of pathologists the requirement was changed to a physician and surgeon. The CSP did oppose initial provisions that would have required retention by hospitals of all blood and urine specimens if the deceased had been admitted to a hospital. That provision was then removed.

SB 1189 also prohibits any law enforcement personnel being present in the autopsy suite if they were part of any police action that involved the death of the decedent. SB 1189 was signed by the Governor.

II. MEDI-CAL AND MEDICARE PROGRAMS

Medi-Cal to Change Clinical Lab Reimbursement

As a result of a last minute budget fix in 2012, DHCS was granted the authority to create a new clinical lab fee schedule based upon actual rates paid by private payers. Rates were initially reduced by 10% in 2012.

- The CSP participated in a stakeholder meeting with DHCS on their proposed changes to clinical laboratory rates in 2013-14. This proposal was driven by the settlements with several large clinical labs over allegations pursued by the Attorney General that these labs charged Medi-Cal more than they charged some private paying patients.

- The CSP participated in a series of stakeholder meetings to discuss what types of reporting would be required on payments by other payers and how the data would be collected. We were concerned that requiring providers to submit payment data on any entity that reimbursed them would be too onerous. Likewise, the actual payment amount could be impacted by co-insurance and deductibles.

- DHCS began collecting reimbursement data from labs in 2013 with a very low response rate. The CSP was successful in achieving a variety of changes in who and how data was submitted but DHCS continued to move forward.

Some important points on changes that CSP requested, and was later granted:

- Requires labs that had either a total Medi-Cal paid claims amount of $100,000 or more, or total claims paid 5,000 or greater to submit their payments for 2011 from other private payers. There is a list of NPI numbers that have been determined to be required to submit this data. If you have multiple NPI numbers for different locations, you can submit only one data report.

- You are only required to submit global payments, therefore no split billed charges. No reporting for hospital services unless there is an outreach lab that operates in the hospital and provides services to non-hospital patients.

- You submit payment data only from your top five fee-for-service with the largest volumes. If the top five don't account for 80 percent of your aggregate Fee-for-Service payments, then submit for others until you reach that percentage, in no case more than 10 payers. If a payer, like Blue Shield, has multiple types of plans/programs within its portfolio, you can count each of the

different ones as one of the five. You don't need to ID the payer, but you should maintain that information in your records if it needs to be confirmed. You don't submit Medi-Cal or Medicare payments as part of your FFS payments.

- The deadline for providers to submit data was delayed multiple times to allow compliance.

A new lab fee schedule was implemented in July 2015. The rate reductions averaged about 24 percent over current lab rates with a limited number of procedures receiving a small increase. DHCS also announced that they would impose a 10 percent claw back on lab payments from 2011 to 2014 since they determined that they were required to impose that 10 percent cut on top of the 10 percent reduction that was made while the new fee schedule was being developed. That claw back has yet to be implemented and would likely only be taken from Medi-Cal fee for service payments and not Medi-Cal Managed Care payments.

The CSP joined with other lab organizations to oppose this 10 percent claw back both with the Administration and in separate legislation to eliminate the retroactivity. That effort did not succeed and the CSP will continue to seek legislative relief in 2017.

Bills to Expand Scope of Practice for Optometrists Include Broader Lab Services

The CSP successfully opposed a provision in SB 622 (Hernandez) regarding the scope of practice for optometrists. The purpose was to expand the pool of possible practitioners to provide service in medically underserved areas and the growth of patient demand due to the roll out of the ACA.

Optometrists have limited authority to perform some waived tests related to diseases of the eye. SB 622 would have expanded the types of tests that could be performed and removed the limitation. We were able to convince the author and sponsors to restore the original language, but ultimately the bill did not make it to the Governor. The issue could surface again next year.

Medi-Cal and the Duals Initiative

DHCS continues to pursue implementation of the Duals Initiative, or MediConnect program, to transition dual eligible beneficiaries to a Medi-Cal managed care plan. The initial pilot program involving eight large counties has been slowed multiple times, staggering implementation dates or delays and the use of passive enrollment.

Dual beneficiaries can opt out of Medi-Cal assuming the Medicare portion of the patient's care meaning that the patient could obtain services through a Medicare Advantage Plan or FFS. The opt out rate has been very high in some cases 40-50% and the entire Duals Initiative continues to undergo scrutiny.

DHCS announced in November 2014 that Alameda County and the use of the Alameda Alliance will not go forward. The Alliance has had serious financial issues, and the Department of Managed Health Care took action to restore their financial solvency.

Meanwhile the Medi-Cal program enrollment has continued to grow via the ACA with almost 1 out of every three Californians now enrolled in Medi-Cal.

Medi-Cal Rolls Out Web-based Provider Enrollment Program

DHCS has finally announced that their Provider Automated Validation Enrollment (PAVE) program is now ready for use by physicians. PAVE will substantially automate the document submission and response system for provider enrollment allowing providers to track the progress of their submission, upload missing or updated documents and in general eliminate what was a slow paper based system to a web based provider friendly system. The CSP participated in multiple stakeholder meetings to help create a more efficient means for pathology groups to add or remove individual members of their groups.

CSP to Partner with California Registry on Synoptic Reporting

CSP representatives have been actively engaged this year with California Cancer Consortium and innovations for the operation of the California CDPH Cancer Registry Program . The Consortium includes a number of organizations including major hospital systems, EHR vendors, county public health officers and numerous other groups. Our focus is to develop a collaboration to improve the collection of cancer data and to move towards use of the CAP synoptic reporting and the use of the CAP electronic Cancer Checklists (eCC).

The CSP, in collaboration with the CCR, has developed a governance structure for the effort. Our goal is to move away from non-standardized reporting format to one that will allow for greater data collection, analysis and improve both the utility of the data and patient outcomes.

Medicare Carrier for California

The CSP continues an active liaison with Noridian, the regional Medicare carrier for California. My thanks to Drs. Gerry Hanson who monitors and attends the Medicare CAC committee meetings for California to advocate for the interests of the pathology community. He has active collaboration with the CAP on local policy development since our region has been a leader in policy development or LCDs on molecular pathology and the use of advanced testing techniques.

The CSP also submitted comments on several draft Local Carrier Determinations (LCDs) that impact the pathology community. There has been both litigation filed and legislation at the federal level that challenges the LCD process and the delegation of authority by CMS to Medicare MACs. In the meantime, the input to this process remains crucial.

Medicare 2016 Fee Schedule

The new fee schedule showed some improvement in adjusting allowables upward for pathology services. CMS is about to embark on collection of lab reimbursement data from many non-hospital labs for the stated purpose of adjusting the existing fee schedule in 2018, no doubt downward. We also are faced with MACRA and other rate methodology changes that will move Medicare from a traditional fee for service reimbursement to a value based payment system. We will have reports from the CAP during our meeting that will update pathologists on the changes.

III. EDUCATIONAL PROGRAMS

California Seminars in Pathology

Once again, Education Committee Chairperson Balaram Puligandla, MD and the members of the Committee have created an extraordinary program, California Seminars in Pathology. The Committee's hard work has continued the Society's tradition of providing a premier scientific meeting for pathologists.

IV. MEMBERSHIP

The financial resources provided by members' dues drive the activities and services of the CSP. The CSP, like most medical associations, is struggling with sagging membership numbers. The CSP cannot survive if only a small number of pathologists in a group belong on behalf of the entire group. We encourage senior members of practice groups to discuss joining the CSP with junior members. If you are not currently a member, or have colleagues in your group who do not belong, we would encourage you to join and participate in the Society's services.

Practice Management Members

The Practice Management Committee has continued to confer on Medicare and Medi-Cal claims processing issues.

The CSP has begun to develop some additional webinar programs to provide information to practice managers and pathologists. We hope to continue to expand those offerings.

The CSP continues its efforts to build a database of individual pathology practice managers. If you would like to have your group manager become involved as an Associate Member, simply call the CSP office or go the CSP website at www.calpath.org. The membership information is available on the website under the membership section.

V. NOMINATING COMMITTEE REPORT

The Nominating Committee of the California Society of Pathologists nominates the following members to serve as Officers and Directors of the Board for 2017-2018. The election will take place at the Annual Business Meeting, Friday, December 2, 2016.

Officers	
President	James Carry, MD
Vice President	Derek Marsee, MD, PhD
Secretary-Treasurer	Kristie White, MD
Board of Directors (Three-year terms)	Brent Larson, MD
	James Harris, MD
Board of Directors (One-year term)	Emily Ann Green, MD
	Wayne Garrett, DO

VI. FINANCIAL REPORT

Our accountant's audited our year-end financial statement for the fiscal year ending December 31, 2016. CSP had revenue of $371,018 with expenses of $350, 737 for a net surplus of $20,281. A copy of the year-end report can be obtained from the CSP Central Office.

VII. CONCLUSION

It has been an honor and privilege to serve as President, and I thank you all for your support.

The CSP is an organization that continues to achieve its goal of enhancing the specialty of Pathology. This success is due to the collective efforts of an active and extremely capable Board of Directors and staff.

Join me in thanking each of members of the CSP Board of Directors:

Officers

Vice President	James Carry, MD
Secretary Treasurer	David Slater, MD
Past President	Ellen Klapper, MD

Board of Directors

Derek Marsee, MD, PhD	David Kaminsky, MD, FIAC
Luke Perkocha, MD, MBA, FCAP	Balaram Puligandla, MD
Kim Dickinson, MD, MBA	David Park, MD
Kristie White, MD	Melvin Hoshiko, MD
Gerald Weiss, MD	Ryanne Brown, MD
Michelle Don, MD	

Respectfully submitted,

Tim Hamill, MD
President