

From the President's Desk: Now and Future Policy Agenda

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June 2013—My father and his brother were teenagers when they found steerage on a ship to the United States in 1910. They arrived with neither English nor assets but with a firm belief that this democracy would provide opportunity. My father completed high school, college, and medical school under difficult circumstances; the long effort gave shape to his hopes. He became a physician who loved his work. We absorbed by osmosis the satisfactions of a life devoted to thoroughly unreasonable goals. I still believe what we learned then: In this country, effort that is intentional and persistent will be respected and rewarded.

Change and challenge are part of life. We are grappling now with changes coming to health care in general and, by extension, to pathology. Coordinated care models, originally feared, are picking up speed; on closer examination, it appears they may play to our strengths and provide advantages. By last July, 150 accountable care organizations covering 3.6 million beneficiaries had joined a Medicare ACO program. The private sector is driving this expansion: Some 220 private sector ACOs or coordinated care organizations are now in place and many more are coming.

Advocacy is about providing good information, acting as a reliable resource, and building trust. It happens in Washington, DC, our state capitols, and anywhere we live and work. Much of the action in coordinated care will be local and regional. For example, in Massachusetts, ACOs are regulated under a new health care reform law. Members of the Massachusetts Society of Pathologists, who met with state legislators to talk about how pathologists might contribute to coordinated care initiatives, were able to show how laboratory personnel can monitor quality and utilization of care. They described how the medical director of a CLIA laboratory who is clinically integrated in the functions of an ACO his or her laboratory supports can provide valuable insights. Working with the College, they secured enactment of a provision in the new Massachusetts health care reform law authorizing the state's ACO oversight entity to evaluate the extent to which the functions of a medical director of a CLIA laboratory providing services to an ACO are clinically integrated. The rest, as they say, is history—a history that we hope will repeat in other states (such as California and Illinois) where we are pursuing similar legislative initiatives with the hope of establishing a regulatory framework for pathology within ACOs.



All specialties are experiencing downward pressure on compensation. We know that diagnostic precision promotes quality care and generates sustainable savings downstream, but knowing isn't showing. If we are to be competitive, each of us must show concrete evidence of our clinical value and our ability to contribute efficiencies and economies. The CAP Promising Practice Pathways offer ideas that will help us make that happen.

Long before health care reform, there were models for showing our strengths. For example, pathologists and blood bank personnel at Presbyterian Hospital in Albuquerque, NM, recognized some time ago that giving blood on the basis of blood counts did not always translate to optimal patient safety. They developed evidence-based guidelines for blood use in adults and children that their medical executive committee reviewed and endorsed. Prospective review of requests for blood products has benefited patients, saved money, and generated goodwill.

Multispecialty collaboration is a highly effective way to enable informed health care policymaking. For example, the CAP holds a seat and has an advisor who advocates on the American Medical Association/Specialty Society Relative Value Scale Update Committee. The RUC develops practice expense and professional component relative value recommendations that will be forwarded to the Centers for Medicare and Medicaid Services for use in making annual updates to the Medicare physician fee schedule.

The CAP led a multi-stakeholder effort to develop CPT codes for the physician fee schedule to cover molecular services, but in November, the CMS—citing differences of opinion within the stakeholder community—announced that 101 new CPT codes for billing of molecular services would be placed on the Medicare clinical laboratory fee

schedule. The good news is that the CMS did provide an interim G code for physician work performed in connection with these tests. Jonathan Myles, MD, who chairs the CAP Economic Affairs Committee and advocates for pathology before the RUC, says the CMS' willingness to do so shows that it recognizes the important professional role of pathologists in molecular diagnostics and that physician interpretation of these tests is medically necessary under certain conditions.

The CMS will monitor billing with the G code and use the gap-filling method to reimburse tier 1 and tier 2 molecular services listed on the clinical lab fee schedule. For the balance of 2013, it will be important for pathologists to use the G code to bill for the professional component of molecular services. To use the G code, the pathologist must ensure that the interpretation is requested by the patient's attending physician, results in a written narrative report included in the patient's medical record, and requires the exercise of medical judgment by the consultant physician. (The hospital's standing order policy can be used as a substitute for the individual request by a patient's attending physician.)

Pathologists who attended the May 6-8 CAP Policy Meeting had more than 100 personal meetings with members of Congress and their staff, a new record for this annual meeting. For 70 of the attendees, this was a first visit to the Hill. As Kathryn T. Knight, MD, who chairs the CAP Federal and State Affairs Committee, likes to say, personal advocacy for our profession, whether in Washington or at the state or local level, may be a bit intimidating initially but then quickly becomes addictive. It certainly helps us get things done. Over the years many of us have built close friendships with our legislators.

Two days of education enabled Policy Meeting participants to present the CAP Now and Future Policy Agenda, which highlights immediate and long-term health systems issues. Among other things, pathologists and policymakers discussed the importance of fair payment for pathologists, the value of pathologists in ACOs, the promise of properly managed genomic medicine services, the need for sufficient graduate medical education funding, the vital role of properly structured and managed health information systems, and the rationale for eliminating the in-office ancillary services exception.

As the meeting wrapped up and pathologists returning from the Hill were debriefed, the room buzzed with energy. Standing there, I recognized the effective democracy that my father had sought, a model for the citizen engagement with which we will continue to give shape to our hopes.□

Dr. Robboy welcomes communication from CAP members. Send your letters to him at president@cap.org.