Tuesday, July 12, 2016

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Virginia Cancer Specialists Receives Clinical Trials Research Award from Conquer Cancer Foundation

Virginia Cancer Specialists (VCS) announced it is one of only three community oncology practices in the country recognized this year by the Conquer Cancer Foundation of the American Society of Clinical Oncology (ASCO) for its commitment to providing high-quality clinical trials to patients. **Read below.**

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The Centers for Medicare & Medicaid Services (CMS) released the Hospital Outpatient Prospective Payment System (OPPS) proposed rule for 2017 on July 6, which includes a strong interpretation of the site neutral provisions in the Bipartisan Budget Act of 2015 (BBA). CMS's proposed rule provides guidance on Section 603 of the BBA and defining the parameters of the provision.

The OPPS proposed rule includes implementation of a site neutral payment policy in any new or acquired off-campus hospital outpatient department (HOPDs). CMS determines that new or acquired HOPDs will be paid under the Physician Fee Schedule in 2017. The proposed rule does not allow existing HOPDs to relocate or expand services and retain their "excepted status." The proposed rule does permit change of ownership if the new owner accepts the existing Medicare provider agreement from the prior owner.

The Network and its coalition partners in the Alliance for Site Neutral Payment Reform led the efforts for the site neutral policies in the BBA of 2015. Both The Network and its coalition partners commended CMS's interpretation in the proposed OPPS rule for protecting the intent of the Congress and encouraged policymakers to seek expanded payment parity policies to equalize reimbursement across sites of service.

To read the Alliance's press statement, CLICK HERE.

To read the Network's press statement, CLICK HERE.

To view the CMS fact sheet on the OPPS proposed rule, CLICK HERE.

To view the proposed rule in its entirety, CLICK HERE.

CMS Releases Proposed Physician Fee Schedule Rule for 2017

The Centers for Medicare & Medicaid Services (CMS) issued the proposed rule to update payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on July 7. CMS will be accepting comments on the proposed PFS rule until September 6, 2016. The final rule is expected by November 1st and will be effective Jan. 1, 2017.

Payment Policy Changes

The CY 2017 PFS conversion factor is estimated to be $35.7751. Changes in payment policy outlined in the proposed rule result in the overall average impact for the following specialties:

- Hematology/Oncology: +2%
- Radiation Oncology: 0%
- Radiation Therapy Centers: -1%
- Urology: -1%
- Rheumatology: +2%
- Gastroenterology: -1%
- Diagnostic Testing Facility: -2%
- Independent Lab: -5%
- Ophthalmology: -2%

Potentially Misvalued Codes

The Affordable Care Act requires the Secretary to periodically identify potentially misvalued services and to review and make appropriate adjustments to the relative values for those services. Through the Achieving a Better Life Experience (ABLE) Act of 2014, Congress set a target for adjustments to misvalued codes in the fee schedule for 2016, 2017, and 2018. The target will be 0.5 percent for 2017 and 2018.

In the proposed rule, CMS has proposed misvalued code changes that would achieve 0.51 percent in net expenditure reductions. If finalized, these changes would meet the misvalued code target of 0.5 percent, therefore avoiding a broad overall reduction to PFS services.

Medicare Telehealth Services

CMS is proposing to add several codes to the list of services eligible to be furnished via telehealth. These include:

- End-stage renal disease (ESRD) related services for dialysis;
- Advance care planning services;
- Critical care consultations furnished via telehealth using new Medicare G-codes.
- CMS is also proposing payment policies related to the use of new place of service code specifically designed to report services furnished via telehealth.

Payment for Mammography Services

CMS is proposing to implement new CPT coding for mammography services. The coding revision reflects use of current technology used in furnishing these services, including a transition from film to digital imaging equipment and elimination of separate coding for computer aided detection services. CMS is proposing to maintain current valuation for the technical component of mammography services in order to implement coding and payment changes over several years.

Updated Geographic Practice Cost Indices (GPCI) for CY 2017

As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in practice costs using GPCIs for each component of PFS payment—physician work, practice expense, and professional liability insurance. Consistent with the law, CMS is proposing new GPCIs using updated data to be phased in over CY 2017 and CY 2018.

California Localities
The Protecting Access to Medicare Act of 2014 requires that, beginning in CY 2017, CMS use new locality definitions for California based on a combination of Metropolitan Statistical Areas as defined by the Office of Management and Budget and the current locality structure. The California locality provision is not budget-neutral, meaning that payments to physicians in California will increase in the aggregate without across-the-board reductions in physician services elsewhere.

The movement to the new locality structure in California may increase payment to many physicians in urban parts of California without any reductions in specified counties that the law "holds harmless" from payment reductions. In a few areas of California, the new locality structure may decrease Medicare PFS payments.

0-day Global Services Typically Billed with an E/M Service with Modifier 25

CMS has noted that several high volume procedure codes are typically reported with a modifier that unbundles payment for visits from the procedure, even though the modifier should only be used for reporting services beyond those usually provided. As a result, CMS is proposing to prioritize 83 services for review as potentially misvalued.

Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services

CMS is proposing several revisions to the PFS billing code set to more accurately recognize the work of primary care and other cognitive specialties to accommodate the changing needs of the Medicare patient population.

Program Integrity and Data Transparency in Medicare Advantage

CMS is proposing to require that health care providers and suppliers be screened and enrolled in Medicare in order to contract with Medicare Advantage health plans to provide Medicare-covered items and services to beneficiaries enrolled in Medicare Advantage. CMS is also proposing to increase transparency of Medicare Advantage pricing data and Medical Loss Ratio data from Medicare health and drug plans.

In the proposed rule, CMS outlines the initial component of the program and its plan for full implementation. Specifically, CMS proposes a clarifying definition for AUC and a

definition for provider-led entity (for the purposes of AUC development). CMS also proposes to identify priority clinical areas of AUC that will be used in identifying outlier ordering professionals.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 established a new program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services under fee for service Medicare. This year's proposed rule focuses on the second of four components of the Medicare AUC program and includes proposals for priority clinical areas, clinical decision support mechanism (CDSM) requirements, the CDSM application process, and exceptions for ordering professionals for whom consultation with AUC would pose a significant hardship. CMS has indicated in this proposed rule that the third component of the program (when ordering professionals must begin consulting CDSMs and furnishing professionals must append AUC related information to the Medicare claim) will not begin earlier than January 1, 2018.

The US Oncology Network will submit comments on the proposed PFS rule.

To view the CMS fact sheet on the PFS proposed rule, CLICK HERE.

To view the proposed rule in its entirety, CLICK HERE.

The US Oncology Network Practices Selected for Participation in Oncology Care Model

On July 1, the Center for Medicare & Medicaid Innovation launched the Oncology Care Model, a new payment and delivery model designed to improve the effectiveness and efficiency of cancer care. Under the Oncology Care Model (OCM), physician practices enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.

Through 12 selected practices in The Network, roughly 800 physicians will participate in the OCM. When considering practices supported through Onmark purchasing and Vantage Oncology-affiliated practices, McKesson Specialty Health supports nearly 50 practices that have been selected.

For the past six months, The Network has been working on an OCM support program to help practices prepare for implementation of the OCM and other alternative payment models. The support program concentrates on five key areas including: care and support team structure, developing and deploying patient care paths, technology and reporting needs, financial models for incentive alignment and revenue cycle management.

Practices in The US Oncology Network that are participating in the OCM program

include:

- Arizona Oncology
- Blue Ridge Cancer Center
- Compass Oncology
- Illinois Cancer Specialists
- New York Oncology Hematology
- Optim Oncology
- Rocky Mountain Cancer Centers
- Shenandoah Oncology
- Texas Oncology
- Virginia Cancer Specialists
- Virginia Oncology Associates
- Willamette Valley Cancer Institute

To read the Network's press statement, CLICK HERE.

To view the OCM website, CLICK HERE.

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The PMI Cohort Program is a longitudinal research effort that aims to engage 1 million or more U.S. participants to improve the nation's ability to prevent and treat disease based on individual differences in lifestyle, environment and genetics.

The goal of the Precision Medicine Initiative is to modernize and accelerate biomedical discoveries, bringing new treatments to patients faster through research that aims to tailor disease prevention and treatment to a specific person's characteristics.

To view the NIH statement, CLICK HERE.

Virginia Cancer Specialists Receives Clinical Trials Research Award from Conquer Cancer Foundation

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Foundation of the American Society of Clinical Oncology (ASCO) for its commitment to providing high-quality clinical trials to patients. As a recipient of the Conquer Cancer Foundation of ASCO Clinical Trials Participation Award, the VCS Research Institute is being honored for its contribution to the improvement of cancer care through clinical research in a community-based setting.

The Conquer Cancer Foundation awards are given to increase awareness and participation in clinical trials among physicians. The awards were based on various criteria that emphasize high patient accrual in clinical trials by overcoming barriers to enrollment.

To view the press statement, CLICK HERE.