Wednesday, November 4, 2015

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CMS Releases Final Rule for 2016 Medicare Physician Fee Schedule

On October 30, the Centers for Medicare & Medicaid Services (CMS) issued the final rule to update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS). This is the first PFS final rule since the repeal of the Sustainable Growth Rate (SGR) formula. For calendar year (CY) 2016, the PFS conversion factor is estimated to be $35.8279, which reflects a 0.5% statutory update and a -0.77% recapture amount because the 1% misvalued target was not met. Here are the highlights:

Changes in payment policy outlined in the final rule result in the overall average impact for the following specialties:

- Hematology/Oncology: 0%
- Radiation Oncology: -2%
- Radiation Therapy Centers: -1%
- Urology: 0%
- Rheumatology: 0%
- Gastroenterology: -4%
- Diagnostic Testing Facility: 0%
- Independent Lab: +9%

Misvalued Codes
CMS has finalized 91 codes as potentially misvalued, including 77263 — radiation therapy planning. CMS identified these codes using the high-expenditure screen. Codes reviewed since CY 2010 were excluded, as are 10- and 90-day global periods.

Misvalued Code Changes for Radiation Therapy
In 2012, CMS identified the codes for radiation therapy as potentially misvalued. Through the Relative Value Update Committee (RUC), the AMA provided recommended values for the new codes issued in 2015, including changes to the assumed number of services that are furnished with the capital equipment.

Based on a review of public comments, CMS is not finalizing the proposal to implement the new code set for payment of radiation therapy treatment under the PFS and will continue work to address the radiation therapy codes and pricing in future years.

CMS is finalizing its proposal to change the utilization rate assumption used to determine the per minute cost of the capital equipment by assuming that the equipment is generally used for 35 hours per week (a 70% utilization rate). This change will be implemented over two years beginning in CY 2016.

Misvalued Codes Target
Last year, Congress set an estimated PFS expenditure target of 1% for CY 2016 that must be met from net reductions in misvalued codes. If the target is not met, fee schedule payments will be reduced to achieve the target. CMS has identified in this final

rule payment changes that achieve 0.23% in net reductions. The effect of not hitting the 1% target is a 0.77 percent reduction to all PFS services, as required by statute.

Implementation of the Statutory Phase-In of Significant RVU Reductions
The Protecting Access to Medicare Act (PAMA) specified that if the total RVUs for a service would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total RVUs for the previous year, the adjustments must be phased-in over a 2-year period. This requirement applies only to services described by existing codes, and not to services described by new or revised codes.

CMS is finalizing its proposal to reduce a service by the maximum allowed amount (e.g., 19 percent) in the first year, and phase in of the percent remainder of the reduction in the second year.

Advance Care Planning
CMS is finalizing its proposal to establish a payment rate and make separate payment to physicians for providing advance care planning services through the PFS for CY 2016. CMS is also finalizing payment for advance care planning when it is included as an optional element of the "Annual Wellness Visit."

Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging Services
The Protecting Access to Medicare Act of 2014 establishes a program requiring adherence to AUC using clinical decision support (CDS) for advanced imaging services. Beginning Jan. 1, 2017, professionals who furnish an advanced imaging test must document the ordering professional's consultation of appropriate use criteria to be paid for the service. The law also directs CMS to require prior authorization for ordering professionals who are outliers. Prior to the effective date of the program, CMS is required to select AUC for the program and to deem CDS tools.

In this rule, CMS is finalizing the initial component of the program and its plan for full implementation. Specifically, CMS establishes in this rule which organizations are eligible to develop or endorse appropriate use criteria, the evidence-based requirements for appropriate use criteria development and the process CMS will follow for qualifying provider-led entities.

"Incident to" Policy
In the CY 2014 PFS final rule, CMS required that, as a condition for Medicare Part B payment, all "incident to" services and supplies must be furnished in accordance with applicable state law. The definition of auxiliary personnel was also clarified to require that the individual furnishing "incident to" services must meet any applicable requirements to provide such services, including licensure, imposed by the state in which the services are furnished. In some cases, the physician or practitioner supervising the service is not the same individual treating the patient more broadly. For 2016, CMS is finalizing a proposal to specify that in those cases, only the supervising physician or practitioner may bill Medicare for "incident to" services.

Part B Drugs/Payment for Biosimilar Biological Products
CMS has finalized its proposal to update the regulations to clarify that the payment amount for a biosimilar biological product is based on the ASP of all biosimilar biological products included within the same billing and payment code.

Quality Improvement Initiatives
The rule finalizes changes to the Physician Quality Reporting System (PQRS) and the Physician Value-Based Payment Modifier for 2016 reporting and performance assessment. Key changes include:

- PQRS – Group practices will be allowed to report quality measures data using a Qualified Clinical Data Registry (QCDR).

- Value Modifier – For the CY 2018 payment adjustment, the quality-tiering methodology would apply to all groups and solo practitioners who are successful PQRS reporters. All groups and solo physician practitioners would be subject to upward, neutral, or downward adjustments derived under the quality-tiering methodology.

- Value Modifier – Application of the value modifier will apply to the following non-physician eligible professionals: PAs, NPs, CNSs and CRNAs.

To access a fact sheet on the final rule, CLICK HERE.

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

President Obama Signs Budget Deal with Site-Neutral Payment Provision

On November 2, President Barack Obama signed the Bipartisan Budget Act of 2015 (H.R. 1314), which will fund the government for 2 years, reduce the scheduled Medicare Part B premium hike, and extend the debt ceiling until March 15, 2017.

The budget deal includes a site-neutral payment policy for all new or newly acquired provider based off-campus hospital outpatient departments (HOPD). The policy would prohibit any new off-site hospital location that is more than 250 yards from the main campus from billing under the Outpatient Prospective Payment System (OPPS) and would align their payments with other physician practices paid under either the Ambulatory Surgical Center (ASC PPS) or the Medicare Physician Fee Schedule (PFS).

The Alliance for Site-Neutral Payment Reform – a coalition of healthcare providers, patient and consumer groups and insurers created to advocate for policy reforms that eliminate disparities in payments between the same clinical services provided in different healthcare settings – and other physician groups support the measure, which advocates say will reduce healthcare spending and preserve patient choice. The provision is estimated to save Medicare roughly $9 billion over the next 10 years.

To read the Alliance's press statement commending the bill enactment and calling for continued action, CLICK HERE.

Site-Neutral Advocates to Host Capitol Hill Briefing

The Alliance for Site-Neutral Payment Reform is hosting a policy briefing on Capitol Hill on November 178 to address the need for payment parity across sites of service in order to decrease Medicare and commercial spending, ensure patient access to the right care in the right setting and lower taxpayers and beneficiary costs.

Senior advocates from AARP and healthcare providers as well as representatives from state government and the private insurance sector will discuss the importance of site-neutral payment reforms and detail examples of programs that have successfully reduced costs while preserving patient access to high-quality, community-based care.

To learn more about the briefing, CLICK HERE.

Medicare Scales Back Claims Review Program

The Centers and Medicare & Medicaid Services (CMS) is reducing auditing practices meant to recover payments for hospital services deemed improper by recovery audit contractors (RACs), according to a new report in the *Wall Street Journal*.

According to their reporting, RACs recouped $2.4 billion last year, down more than a third from the $3.7 billion recovered in 2013.

In January, auditors will be permitted to review only 0.5% of Medicare claims paid to a hospital or provider every 45 days, which reduces services to a quarter of their previous review limit of 2% per hospital or provider.

Reports indicate the reduction in auditing services is a direct result of push back from hospital and provider stakeholders who warn the audits disrupt patient care.

Medicare claims data estimates that hospitals were paid $125 billion by Medicare for in-patient services in 2013. Approximately 94% of funds recouped by RACs that year were for hospital services.

340B Comments Submitted To HRSA On ‘Mega-Guidance’

More than 820 individuals and organizations submitted comments on the new 340B guidelines unveiled by Health Resources and Services Administration (HRSA), according to the Federal Register website. In many cases, organizations warned that the proposed guidelines could harm patient access to discount medications if hospitals no longer qualified for participation in the program.

Cancer care in the United States has been heavily affected by hospitals acquiring freestanding, community-based oncology centers, with the 340B discount seen as one of the driving causes. In a comment on the 340B guidelines, the American Society of Clinical Oncology (ASCO) asked HRSA and Congress to revise the rules for the program and allow private cancer practices that treat many people living in poverty to gain access to the discount medicines. Julie Vose, president of the ASCO, commented that the lack of access to these lower-cost drugs is a significant barrier for the practices.

Further, up to one third of hospitals currently participating in the 340B drug-pricing program say they would consider opting out of the program if the proposed regulatory changes are finalized. The hospitals are particularly concerned with a proposed ban on allowing patients to receive prescription medications under 340B upon their discharge from a hospital.

To read the Omnibus Guidance, CLICK HERE.

Ways & Means Chairmanship Vacant After Ryan Elected Speaker

On October 29, Congressman Paul Ryan (R-WI) was officially elected as the 54th Speaker of the U.S. House of Representatives after receiving 236 votes from the full House, officially taking the reigns from former Speaker John Boehner, who resigned from his post in late September.

As Paul Ryan begins his new role in Congress, he leaves behind a race for chair of the House Ways and Means Committee. Possible Republican candidates to control tax, health, and trade policies by taking over the vacant seat include Congressman Kevin Brady (R-TX) and Pat Tiberi (R-OH).

The two lawmakers had been seen as potential future candidates to chair the Ways and Means committee, but not until 2021 when Speaker Ryan was due to hit his six-year term limit.

It’s unclear how the next committee chair will be picked, because Republicans are considering changes to their internal rules. Congressman Sam Johnson (R-TX) will serve as interim chair until there is a steering committee vote.