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## CMS Releases Proposed Rule for 2016 Medicare Physician Fee Schedule



On July 8, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule to update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS). This is the first PFS proposed rule since the repeal of the Sustainable Growth Rate (SGR) formula. Throughout the rule, CMS begins the implementation of the new payment system for physicians and other practitioners – the Merit-Based Incentive Payment System (MIPS) – as mandated by Congress. The repeal of the SGR also provided a 0.5% increase to CY 2016 PFS conversion factor to be \$36.1096. The final rule is expected by November 1st and is effective January 1, 2016. Here are the highlights:

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

- Hematology/Oncology: 0%
- Radiation Oncology: -3%
- Radiation Therapy Centers: -9%
- Urology: 0%
- Rheumatology: 0%
- Gastroenterology: -5%
- Diagnostic Testing Facility: +1%
- Independent Lab: +9%

### *Misvalued Codes*

Consistent with amendments to the Affordable Care Act, in this year's proposed rule, CMS proposes to add 118 codes to the list of potentially misvalued codes, including 77263 – radiation therapy planning. CMS identified these codes using the high-expenditure screen. Codes reviewed since calendar year (CY) 2010 were excluded, as are 10- and 90-day global periods.

### *Misvalued Code Changes for Radiation Therapy*

In 2012, CMS identified radiation treatment delivery services as potentially misvalued. The American Medical Association's (AMA) CPT Editorial Panel subsequently recommended the addition and deletion of several codes and the development of new guidelines and coding instructions. Because of the magnitude of the coding changes, implementation of the new code sets was delayed until 2016. Based on the AMA's Relative Value Update Committee (RUC) recommendations, CMS is proposing 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) instead of 25 hours per week (a 50% utilization rate). This change would be implemented over two years.

### *Misvalued Codes Target*

Last year, Congress set an estimate 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 is proposing a methodology for implementing this provision and, based on this proposed rule, has identified changes that achieve 0.25% in net reductions. The effect of the target is not included in the proposed payments rates because CMS anticipates making further code changes in the final rule, which could move net reductions closer to the 1% goal. The adjustment will be applied to the conversion factor.

### *Implementation of the Statutory Phase-In of Significant RVU Reductions*

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% as compared to the total RVUs for the previous year, the adjustments must be phased-in over a two-year period. This requirement applies only to services described by existing codes, and not to services described by new or revised codes.

CMS is proposing to reduce a service by the maximum allowed amount (e.g., 19%) in the first year, and phase in of the percent remainder of the reduction in the second year. CMS believes that this approach avoids differential treatment due to an arbitrary cutoff (e.g., 19% reduction vs. 20% reduction).

### *Advance Care Planning*

The rule also seeks comment on a proposal that would better enable seniors and other Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it. Following CMS's review of the comments submitted on advance care planning services in the CY 2015 PFS rule, CMS is proposing to establish a payment rate and make separate payment to physicians for providing advance care planning services through the PFS for CY 2016.

### *Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging Services*

Beginning January 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 clinical decision support tools that ordering professionals can use to consult with AUC. In this 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 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.

## *Quality Improvement Initiatives*

The proposed rule proposes changes to several of the quality reporting initiatives that are associated with PFS payments – the Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, and the Physician Value-Based Payment Modifier. CMS is not proposing significant changes to these programs since the separate penalties tied to these programs will sunset after 2018. Beginning in 2019 adjustments to payments for quality and other factors will be made under the new MIPS.

Other provisions included in the proposed rule include:

- Changes to public reporting on Physician Compare
- Modifications to the Medicare Shared Savings Program
- Additions of codes to the list of Medicare telehealth services
- Revisions to regulations specifying the requirements for which physicians or other practitioners can bill for incident-to services
- Implementation of 2014 law that reduces payment for the technical component (TC) (and the TC of the global fee) of the PFS service and the hospital outpatient prospective payment system payment (5 percent in 2016 and 15 percent in 2017 and subsequent years) for computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association CT equipment standard.

The US Oncology Network will submit comments on this proposed rule by the Sept. 8, 2015, deadline.

To access a fact sheet on the proposed rule [CLICK HERE](#).

To view the proposed rule in its entirety [CLICK HERE](#).

## U.S. House Passes 21<sup>st</sup> Century Cures Legislation



On July 10, bipartisan lawmakers in the U.S. House of Representatives overwhelmingly passed the 21st Century Cures Act, which aims to speed up new treatments for patients. The bill passed 344-77.

The legislation includes \$8.75 billion in new funding for research by the National Institutes of Health. It also overhauls the process that the Food and Drug Administration uses to assess and approve new medicines.

According to the House Energy & Commerce Committee [website](#), “H.R. 6, the 21st Century Cures Act, will bring our health care innovation infrastructure into the 21st

Century, delivering hope for patients and loved ones and providing necessary resources to researchers to continue their efforts to uncover the next generation of cures and treatments.”

House lawmakers also passed five amendments by a voice vote, including:

- Amendment expressing the sense of Congress that recording unique device identifiers at the point-of-care in electronic health record systems could significantly enhance the availability of medical device data for post-market surveillance purposes.
- Amendment directing CDC to conduct a study to determine how additional Medicare payments for antimicrobials are affecting the development of drug resistance.
- Amendment giving NIH authority to incentivize health innovation by offering competitors the chance to win a prize for creating breakthrough research and technology.
- Amendment to ensure underrepresented individuals, such as women and minorities, are included in the Supporting Young Emerging Scientists Report.
- Amendment directing the HHS secretary to conduct outreach to Historically Black Colleges and Universities, Hispanic Serving Institutions, Native American colleges and rural colleges to ensure that health professionals from underrepresented populations are aware of research opportunities under the Cures bill.

To read the legislative text of H.R. 6, [CLICK HERE](#).

To read the two-page summary, [CLICK HERE](#).

To read the section-by-section summary, [CLICK HERE](#).

## GAO Study: Eliminate Incentives for Expensive Drugs at 340B Hospitals

In June, the Government Accountability Office (GAO) released a report comparing 340B hospitals with non-340B hospitals for financial characteristics and spending for Medicare Part B drugs. GAO recommended that Congress consider eliminating the incentive to prescribe more drugs or more expensive drugs than necessary to treat Medicare Part B beneficiaries at 340B hospitals.

In 2012, 340B hospitals were generally larger and more likely to be teaching hospitals compared with non-340B hospitals. They tended to provide more uncompensated and charity care than non-340B hospitals, but there were notable numbers of 340B hospitals providing low amounts of these types of care.

The GAO study found that in both 2008 and 2012, per beneficiary Medicare Part B drug spending was higher at 340B hospitals than non-340B hospitals. The agency reports that beneficiaries at the 340B hospitals were either prescribed more drugs or more expensive drugs than in other hospitals.

The Centers for Medicare & Medicaid Services (CMS) uses a statutorily defined formula for drugs at set rates regardless of hospitals' costs for acquiring drugs. The GAO finds that this financial incentive encourages 340B hospitals to prescribe more drugs or more expensive drugs to Medicare beneficiaries, which makes patients financially liable for larger copayments.

The Health Resources and Services Administration (HRSA) and CMS can do little to remove this incentive due to the 340B statute, which does not restrict covered entities from using drugs purchased at the 340B discounted price for Medicare beneficiaries and the Medicare statute does not limit CMS reimbursement for such drugs.

Approximately 40 percent of all U.S. hospitals participate in the 340B Drug Pricing Program, and the majority of 340B-discounted drugs are sold to hospitals.

For the full GAO report, [CLICK HERE](#).

## CMS Helps Physicians Transition to ICD-10 with 12-Month Safe Harbor Period, Ombudsman, and Training

The Centers for Medicare & Medicaid Services (CMS) issued a joint statement with the American Medical Association (AMA) last week outlining efforts allowing for physicians to better prepare for the upcoming transition from the ICD-9 to ICD-10 medical coding system on October 1.

To help ease the transition, CMS also released [additional guidelines](#) creating a 12-month "safe harbor" period beginning on October 1, which will allow flexibility with claims auditing and quality reporting.

During the safe harbor period, CMS has promised that physicians who submit incorrect ICD-10 codes for Medicare claims will not be denied or audited as long as the ICD-10 code is in the correct broad category.

CMS will also be providing an ICD-10 Ombudsman to help assist with physician and provider issues throughout the transition. Regional CMS offices will be working with the Ombudsman to help physicians with concerns, and more information about how to submit concerns to the Ombudsman will be released before October 1.

The AMA has also joined with CMS to help provide tools for physicians to make the transition with webinars, on-site training, educational articles, and national provider calls. The two are working to address specific concerns and obstacles faced by

smaller physician practices in rural areas and specialty-specific providers through the new website "[Road to 10](#)."

To read the CMS press release, [CLICK HERE](#).

For FAQs answered by CMS, [CLICK HERE](#).

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