Thursday, September 8, 2016

Breaking News: CMS Makes MACRA Announcement

Today, the Centers for Medicare & Medicaid Services (CMS) released a blog from Andy Slavitt, Acting Administrator of CMS, to share plans about the timing of reporting during the first year of the new Quality Payment Program (QPP). The QPP will be the basis for the new Medicare physician payment system called for by passage of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015. **Read below.**

The US Oncology Network Submits Comments to CMS on Proposed Medicare Payment Rules for CY2017

On September 6, The US Oncology Network submitted formal comments to the Centers for Medicare & Medicaid Services (CMS) in response to the proposed rules for "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017" and "Medicare Program: Calendar Year Outpatient Prospective System and Ambulatory Surgical Center Payment System." **Read below.**

Alliance for Site Neutral Payment Reform Submits Comments to CMS on Outpatient Prospective Payment System for CY2017

On September 6, the Alliance for Site Neutral Payment Reform submitted formal comments to the Centers for Medicare & Medicaid Services (CMS), applauding CMS' proposed implementation of site neutral payment policy. **Read below.**

Bipartisan Lawmakers Ask HHS Secretary for Flexibility in Implementation of MACRA

On September 6, bipartisan lawmakers in the House Ways and Means and House Energy and Commerce Committees sent a letter to HHS Secretary Sylvia Burwell urging flexibility in implementation of the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). **Read below.**

House Budget Committee Holds Hearing on CMMI Programs and Spending

On September 7, the House Budget Committee hosted a hearing, "*Center for Medicare and Medicaid Innovation: Scoring Assumptions and Real-World Implications*," during which lawmakers sought to examine potential consequences of CMMI programs, including Medicare's proposed Part B Drug Payment Model. **Read below.**

Breaking News: CMS Makes MACRA Announcement

Today, the Centers for Medicare & Medicaid Services (CMS) released a blog from Andy Slavitt, Acting Administrator of CMS, to share plans about the timing of reporting during the first year of the new Quality Payment Program (QPP). The QPP will be the basis for the new Medicare physician payment system called for by passage of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015. Choosing one of these options would ensure providers do not receive a negative payment adjustment in 2019. These options and other supporting details will be described fully in the final rule, which will be released by November 1, 2016.

First Option: Test the Quality Payment Program.
With this option, as long as providers submit some data to the Quality Payment Program, including data from after January 1, 2017, providers will avoid a negative payment adjustment.

Second Option: Participate for part of the calendar year.
Providers may choose to submit Quality Payment Program information for a reduced number of days. This means the first performance period could begin later than January 1, 2017 and the practice could still qualify for a small positive payment adjustment.

Third Option: Participate for the full calendar year.
For practices that are ready to go on January 1, 2017, they may choose to submit Quality Payment Program information for a full calendar year. This means the first performance period would begin on January 1, 2017.

Fourth Option: Participate in an Advanced Alternative Payment Model in 2017.
Instead of reporting quality data and other information, the law allows providers to participate in the Quality Payment Program by joining an Advanced Alternative Payment Model, such as Medicare Shared Savings Track 2 or 3 in 2017. If providers receive enough of their Medicare payments or see enough Medicare patients through the Advanced Alternative Payment Model in 2017, then they would qualify for a 5 percent incentive payment in 2019.

To read the full blog post, click here.

The US Oncology Network Submits Comments to CMS on Proposed Medicare Payment Rules for CY2017

Physician Fee Schedule

On September 6, The US Oncology Network submitted formal comments to the Centers for Medicare & Medicaid Services (CMS) in response to the proposed rule for "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017." In the letter, The Network reiterates its strong commitment to participating in CMS's Oncology Care Model, a type of alternative payment model, and offers recommendations in several areas impacting the delivery of cancer care:

- **Flow Cytometry Interpretation:** The Network urges CMS not to cut CPT codes: 88184, 88185, 88187, 88188, 88189. The Network also supports examining a single CPT code, but urges CMS to freeze CPT codes 88184 and 88185 at the current CY2016 rates while such an examination occurs.
- **Radiation Therapy Codes:** The Network urges CMS to maintain CPT 77470 as it is currently constructed due to the fact that it believes it would be unnecessary to bifurcate the service into a physician service and clinical staff service/treatment planning equipment.
- **PE Inputs for Digital Imaging Services:** The Network supports CMS's valuation for professional PACS workstation (ED053) at $14,616.93 but strongly urges CMS to add ED053 to the following CPT codes for radiation therapy: 77261, 77262, 77263, 77293, 77295, 77301, 77321, 77387, 77014, G6017, and 77470.
- **Medicare Telehealth Services – Advance Care Planning:** The Network supports CMS' proposal to add advance care planning CPT codes 99497 and 99498 to the telehealth list on a category 1 basis for CY 2017. The Network hopes CMS will create an exception and allow clinical social workers to bill codes 99497 and 99498 so that the role of the social worker can be expanded to include routine advance care planning services.
- **Appropriate Use Criteria for Advanced Diagnostic Imaging Services:** The Network requests that CMS modify its proposal to allow qualified CDSMs (Clinical Decision Support Mechanisms) that are tailored to the types of advanced imaging ordered by a practice or physician.
- **G-Code Values Established by the Patient Access and Medicare Protection Act:** The Network believes that the proposed changes to photon treatment delivery code G6011 is not consistent with existing statutes and urges CMS not to finalize these changes.

To read The Network's letter to CMS on the PFS, click here.

Outpatient Prospective Payment System

On September 6, The Network also submitted comments to CMS in response to the "Medicare Program: Calendar Year Outpatient Prospective System and Ambulatory Surgical Center Payment System" proposed rule.

In the letter, The Network reiterates its support for payment parity across sites of service, which would eliminate large reimbursement disparities for different settings of care that have created an incentive for hospitals to acquire independent physician practices. The Network affirms its support for Section 603 of the Bipartisan Budget Act of 2015 (BBA), which establishes a site neutral payment policy for all newly acquired off-campus outpatient provider-based departments (off-campus PBDs). The Network believes that this site neutral payment policy should apply to all off-campus outpatient departments and will continue to work with Congress and the Administration to expand upon the progress made in the BBA.

The Network urges CMS to apply its BBA interpretation for site neutral payment parity to all off-campus facilities, even those acquired before the act was implemented.

To read The Network's letter to CMS on the OPPS, click here.

Alliance for Site Neutral Payment Reform Submits Comments to CMS on Outpatient Prospective Payment System for CY2017

On September 6, the Alliance for Site Neutral Payment Reform submitted formal comments to the Centers for Medicare & Medicaid Services (CMS), applauding CMS' proposed implementation of Section 603 of the Bipartisan Budget Act of 2015 (BBA).

The Alliance offers CMS the following feedback on the proposed implementation of the site neutral payment policy:

- The Alliance agrees with CMS' interpretation that the BBA provided "excepted" status to off- campus PBDs as they existed on the date of enactment and thus prohibits relocation of "excepted" facilities.
- The Alliance commends CMS' proposed restriction on the scope of services "excepted" off-campus PBDs are able to furnish and bill at the higher OPPS rate.
- The Alliance recommends CMS institute mandatory attestation for all hospital provider-based facilities to protect patients and Medicare from overpaying for services provided in non-compliant facilities.
- The Alliance believes that the site neutral payment policy should apply to all off-campus outpatient departments and will continue to work with Congress to expand upon the progress made in the BBA.

To read the full Alliance letter to CMS, click here.

Bipartisan Lawmakers Ask HHS Secretary for Flexibility in Implementation of MACRA

On September 6, bipartisan lawmakers in the House Ways and Means and House Energy and Commerce Committees sent a letter to HHS Secretary Sylvia Burwell urging flexibility in implementation of the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). The letter stressed the importance of a successful implementation of MACRA so physicians and other health care providers can deliver the quality care patients deserve.

In the letter, the committee leaders ask CMS to consider the following flexibilities for all practitioners:

- Simplified, streamlined, coordinated requirements;
- Clear pathways to succeed in Merit-Based Incentive Payment System (MIPS) or the Alternative Payment Model (APM) tracks;
- Opportunities to move to the APM track and flexibilities to be rewarded for meaningful delivery system reform activities in MIPS and in the APMs; and
- Appropriate systems ready and in place prior to January 2017 reporting.

"The Congressional intent for MACRA was twofold: to consolidate, streamline and ease the burden of the various quality reporting programs for physicians and practitioners and to incentivize quality, value-based care through aligned payment bonuses and reductions for physicians and practitioners," the lawmakers wrote. "With these principles, we urge the Center for Medicare and Medicaid Services (CMS) to ensure that all physicians and practitioners have an equal opportunity to succeed under the Quality Payment Program."

To read the letter to Secretary Burwell, click here.

House Budget Committee Holds Hearing on CMMI Programs and Spending

On September 7, the House Budget Committee hosted a hearing, "*Center for Medicare and Medicaid Innovation: Scoring Assumptions and Real-World Implications*," during which lawmakers sought to examine potential consequences of policy changes, including Medicare's proposed Part B Drug Payment Model. The primary focus of the hearing was the Congressional Budget Office's (CBO) analysis of Center for Medicare and Medicaid Innovation (CMMI) programs, which is tasked with developing and testing new delivery and payment models for health care providers under Medicare and Medicaid.

Witnesses at Wednesday's hearing included:

- Mark Hadley, Deputy Director of the Congressional Budget Office;
- Dr. Joseph Antos, the Wilson H. Taylor Scholar at the American Enterprise Institute;
- Ted Okon, Executive Director of the Community Oncology Alliance;
- Dr. Mark Madden, an orthopedic surgeon at OrthoVirginia; and
- Topher Spiro, Vice President for Health Policy at the Center for American Progress.

Specific to the Part B Model, Hadley suggested the CBO will publish an estimated cost for repeal of Medicare's Part B Model in a matter of weeks. "For the Part B demonstration, we're looking very carefully at what we know about that demonstration to figure out what the budgetary effects would be," he stated.

COA's Ted Okon expressed strong opposition to the Part B Model, calling the demonstration "an inappropriate, dangerous, and perverse mandatory, national experiment on the cancer care of seniors and others covered by Medicare," warning that the model would reduce payment for standard-of-care cancer drugs by trying to force oncologists to use less expensive, older therapies, which in some cases is not even possible.

To read Chairman Tom Price, MD's opening statement, click here.