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CMS Releases Final Rule for 2015 Medicare Physician Fee Schedule

On October 31, the Centers for Medicare & Medicaid Services (CMS) issued the final rule that updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS). The rule also finalizes changes to several of the quality reporting initiatives that are associated with PFS payments, including the Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, and the Medicare Shared Savings Program, as well as changes to the Physician Compare website on Medicare.gov. The final rule will become effective January 1, 2015.

Key changes in payment policy outlined in the Final Rule include the combined impact for the following specialties:

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

Key Provisions The US Oncology Network commented on in the Proposed Rule

Radiation Therapy and Gastroenterology: CMS is not adopting code changes for gastroenterology and radiation therapy services until they can go through notice and comment rulemaking to propose values for 2016. As a result of this decision, CMS will not recognize some new CPT codes, and will create G-codes in place of CPT codes to continue current payment rates for CY 2015.

Radiation Therapy: CMS decided not to finalize the way it accounts for the infrastructure costs associated with radiation therapy equipment, specifically to remove the radiation treatment vault as a direct expense when valuing radiation therapy services. CMS will reconsider whether the vault is a direct or indirect cost through rulemaking in a future year.

As a reminder, The US Oncology Network was successful in getting more than 125 Members of the House of Representatives and more then 30 Senators to send a letter to CMS opposing the above proposals in the proposed rule.

To view the House letter, click here.

To view the Senate letter, click here.

The Physician Quality Reporting System (PQRS)

PQRS is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by eligible professionals (EPs). Beginning in 2015, CMS is adding 20 new individual measures and two measures groups to fill existing measure gaps. They are removing 50 measures from reporting for the PQRS. These changes bring the PQRS individual measure set to 255 total measures. Generally, EPs need only report nine measures covering three National Quality Strategy (NQS) domains.

For the 2017 PQRS payment adjustment, CMS established criteria for satisfactory reporting and satisfactory participation that are generally similar to the criteria CMS finalized for the 2014 PQRS payment incentive. However, the final criteria for satisfactory reporting for the 2017 PQRS payment adjustment differ from the established criteria for the 2014 incentive in the following ways.

Medicare EHR Incentive Program

The PFS 2015 final rule includes an Interim Final Rule with a request for public comment (IFC) related to the EHR Incentive Programs. This IFC provisionally adopts changes to the regulatory language about hardship exceptions from the Medicare payment adjustment in the EHR Incentive Programs.

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments under Medicare for eligible hospitals, critical access hospitals, and eligible professionals that are not meaningful users of certified EHR technology. ARRA allows the Secretary to consider, on a case-by-case basis, hardship exceptions for eligible hospitals, critical access hospitals, and eligible professionals to avoid the payment adjustments.

While CMS is still requiring EPs who report clinical quality measures electronically for the Medicare EHR Incentive Program to use the most recent version of electronically specified clinical quality measures (eCQMs), EPs would not be required to ensure that their Certified EHR Technology (CEHRT) products are recertified to the most recent version of the electronic specifications for the CQMs.

Medicare Shared Savings Program

The CY 2015 PFS final rule includes updates to parts of the Shared Savings Program regulations.

Additional Quality Improvement Reward

In this rule, CMS finalized the quality scoring strategy to recognize and reward ACOs that make year-to-year improvements in quality performance scores on individual measures by adding a quality improvement measure that adds bonus points to each of the four quality measure domains based on improvement. CMS finalized that ACOs can receive up to four points to reward improvements in quality performance, beginning in 2015.

Revisions to Quality Measure Benchmarks
CMS is modifying its benchmarking methodology for "topped out" measures. CMS will use flat percentages to establish the benchmark for a measure when the national FFS data results in the 90th percentile are greater than or equal to 95 percent.

Modifications to the Quality Measures that Make Up the Quality Reporting Standard
The 2015 revisions reflect up-to-date clinical guidelines and practice, reduce duplicative measures, increase focus on claims-based outcome measures, and reduce ACO reporting burdens. The changes do not change the total number of measures used in the Shared Savings Program – the total number of measures will continue to be 33. However, CMS increased the number of measures calculated through claims and decreased the number of measures reported by the ACO through the GPRO web interface.

CMS will also continue aligning the Shared Savings Program with the EHR Incentive Program.

Physician Compare Website

The 2015 PFS final rule continues to build on the CMS phased approach for public reporting on Physician Compare. CMS is finalizing the proposal to expand public reporting of group-level measures by making all 2015 PQRS GPRO web interface, registry, and EHR measures for group practices of two or more EPs and all measures reported by ACOs available for public reporting on Physician Compare in 2016. They are finalizing that these data must meet the minimum sample size of 20 patients and prove to be statistically valid, reliable, comparable, and accurate.

To view the CY 2015 PFS Final Rule, click here.

To view the CY 2015 PFS Final Rule Payments Fact Sheet, click here.

To view the CY 2015 PFS Final Rule Quality Fact Sheet, click here.

To view the CY 2015 Final Rule Value Modifier Fact Sheet, click here.

HRSA Asks Drug Manufacturers to Refund 340B Overcharges

The Health Resources and Services Administration (HRSA) notified pharmaceutical manufacturers that they must, in some cases, provide orphan drugs at a discounted price to hospitals participating in the 340B drug program and refund past overcharges.

The decision comes on the heels of a controversial interpretive rule laid out by HRSA earlier this year, stating that orphan drugs – often pricey medications used to treat rare diseases – must be discounted if used to treat patients for whom the drug was not originally designed. The agency has officially sent letters to manufacturers, providing 30 days to determine "plans to repay affected covered entities and to institute the offer of the discounted price in the future."

The HRSA said it issued the rule to provide greater clarity for the market, while maintaining sufficient economic incentive for manufacturers to innovate and produce orphan drugs. However, the primary lobby for the drug industry – the Pharmaceutical Research and Manufacturers of America (PhRMA) – has taken issue with the new regulation.

In fact, PhRMA filed a suit against the Department of Health and Human Services (HHS), citing recent legal precedent, which invalidated an earlier rule that also had given 340B discounts to orphan drugs used to treat non-orphan conditions.

The orphan drugs available for refunds through the 340B program are provided to freestanding cancer hospitals, critical access hospitals, rural referral centers, and sole community hospitals. The disputed total sum of repayments is currently unknown.

The 340B drug discount program – which requires drug manufacturers to provide outpatient drugs to eligible healthcare organizations and covered entities at significantly reduced prices – has been a topic of heated debate since its inception. The Affordable Care Act expanded the range of health care providers that could be eligible to buy drugs through the 340B program, but originally exempted orphan drugs from the discounts entirely.

To view the interpretive rule, click here.

Medical Costs Up to 20% Higher at Hospital-Owned Physician Groups, Study Finds

Hospital ownership of physician groups in California led to higher overall costs for patient care, according to a study published in the Journal of the American Medical Association (JAMA) last month, raising new questions about healthcare consolidation.

Specifically, University of California Berkeley researchers found that total spending per patient was 10.3 percent higher

for hospital-owned physician offices compared with doctor-owned organizations. Costs were even higher when large health systems running multiple hospitals owned medical groups, as their per-patient spending was 19.8 percent higher than independent physician groups.

The findings suggest serious financial implications for employers, consumers, and taxpayers, as health insurers – especially as health insurers typically pass along these increased costs in the form of higher premiums for employers and workers. In turn, consumers face higher prices associated with rising insurance deductibles.

Proponents of consolidation practices, however, argue that mergers between hospitals and physician groups are an efficient ways to coordinate care. By encouraging care coordination – an approach that facilitates communication between specialists treating the same patient – hospitals believe they can eliminate unnecessary tests, stifle readmission rates, and lower costs.

A number of advocates argue that care coordination can be achieved in a cheaper manner. Furthermore, they suggest that consolidation eliminates competition, fueling higher costs.

This is because buyers of medical groups are often the biggest hospital systems in their local markets, possessing complete control over prices. Newly acquired physician groups can also be pressured to refer patients to more expensive imaging and other outpatient treatments that can be cheaper at freestanding clinics.

"There is a strong case for coordination of care," said James Robinson, the study's lead author and a UC Berkeley professor of health economics. "But there is a weak case for consolidation of physicians and hospitals into large mega-systems."

Ultimately, Robison indicated that, regardless of its potential effects, may be inevitable.

"I think this consolidation wave is virtually unstoppable," said Robinson. "Left to itself, it will increase the cost of healthcare."

To read the full study, click here.

Supreme Court Not Taking Up Insurance Subsidies Lawsuit Yet

The U.S. Supreme Court announced November 3 that it has decided not to take up a case right now that challenges the legality of federal tax credits extended to Americans in order to purchase health insurance under the Affordable Care Act.

The tax credits were challenged in the 4th Circuit Court of Appeals (King v. Burwell). The plaintiffs argue that federal tax credits used to subsidize insurance premiums are

illegal in states that are not running their own health insurance exchanges. The appeals court ruled in favor of the Administration in July.

The D.C. Circuit Court of Appeals heard a similar case (Halbig vs. Burwell), ruling in July that the subsidies are not legal. The Administration requested a full court review in response to the D.C. verdict, which the appeals court granted and the case was vacated.

Similar challenges are pending in Indiana and Oklahoma, but remain in various states of review. The next opportunity for the high court to announce it will take up King v. Burwell is November 10.

To track the status of the case on the Supreme Court's website, click here.

Simpler home test for colon cancer offered

A new, non-invasive home test for colon cancer will now be available to millions of American patients. The test – called Cologuard – is able to identify blood that may suggest tumors. It can also detect DNA that may be a sign of cancer or precancerous growth called polyps. Proponents of the test believe the assessment could greatly boost screening rates.

The simple test is the first of its kind to look for cancer-related DNA in a patient's stool. However, the preventative measure is not without flaws as some critics say it may lure patients away from proven, yet more invasive, tests.

For instance, when a patient receives a colonoscopy, growths can be removed and checked for cancer. When this is done for screening and precancerous polyps are removed, it can prevent cancer, not just detect it.

Ultimately, the new test may become an additional tool in the cancer prevention process with a diagnostic colonoscopy as the next step following a positive Cologuard test.

Estimates suggest colon cancer takes more than 50,000 American lives each year.