Wednesday, July 9, 2014

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Registration in the CMS Open Payments system is set to begin mid-July. While the program is voluntary, The US Oncology Network strongly encourages participation by physicians in order to gain access and dispute data reported by industry partners relating to financial interactions between manufacturers, GPOs and physicians. **Read below**

CMS Releases Proposed Rule Setting 2015 Medicare Physician Fee Schedule Payment Rates

On July 3, 2014, the Centers for Medicare & Medicaid Services (CMS) released an advance copy of the Proposed Rule for the 2015 Medicare Physician Fee Schedule (MC-PFS). The official version of the Proposed Rule will be published in the Federal Register on July 11 and CMS will accept comments on the proposal through September 2. CMS anticipates releasing the MC-PFS Final Rule around November 1 and the adopted changes will become effective January 1, 2015.

Although most MC-PFS Proposed Rules published in the recent past have discussed the across-the-board rate cuts required by the operation of the Sustainable Growth Rate (SGR) formula, this year's proposal takes a different tact. Since the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113-93) established a zero percent update for the MC-PFS through March 31, 2015, CMS has projected the Conversion Factor (CF) for the first quarter of 2015 will hold relatively steady at $35.7977 (the CF in effect for 2014 is $35.8228). CMS will update the budget neutrality factors used in the calculation of the CF based on more recent data and provide the precise CF for the first quarter of 2015 when it publishes the Final Rule.

The Proposed Rule notes that across-the-board payment reductions will be necessary starting April 1, 2015 if Congress fails to enact another SGR "fix," but it offers no estimate of the potential magnitude of such cuts. That said, in March of this year, CMS indicated that, absent Congressional action, physicians would face an SGR reduction of 20.9 percent during the last three quarters of 2015.

Key changes in payment policy detailed in the Proposed Rule are outlined below.

<u>Improved Reimbursement for Primary Care</u>

- The MC-PFS proposal would (1) set a payment rate of $41.92 for 20 minutes or more per 30-day period of non-face-to-face chronic care management (CCM) services furnished to patients with two or more chronic conditions expected to last at least 12 months, or until death, that place the patient at significant risk of death, exacerbation/ decompensation, or functional decline, (2) codify a general supervision requirement for clinical staff providing CCM services, and (3) add standards for electronic health records as a condition of payment for such services.
- Even though any specialty providing CCM services would be allowed to bill for them, CMS projects the Work Relative Value Unit (RVU) changes associated with implementation of CCM billing in 2015 will have a measurable impact only on overall reimbursement for Geriatrics, Family Practice and Internal Medicine, which is expected to increase by 1 percent for each of the affected specialties.

Misvalued Code Initiatives

- The MC-PFS proposal would add about 80 codes to the list of potentially misvalued codes that will be subject to review over the next year or two. Most were identified by looking at high-expenditure services by specialty and selecting those codes that have not been recently reviewed.
    - 20 codes selected for review relate to imaging and have the potential to impact future payments for CT, MRI, plain X-rays and radiation oncology as well as interventional radiology.
- The Proposed Rule would shift the costs associated with radiation treatment vaults required to house linear accelerators from the calculation of direct practice expenses (PE) to the calculation of indirect PE.
    - CMS justifies this proposal by saying it announced its intent to review the issue during the 2012 MC-PFS cycle and has concluded, based on its review of invoices and comments, that vault expenditures are more akin to building infrastructure costs typically considered part of indirect PE than to equipment costs incorporated into direct PE.
    - The most dramatic payment cuts contemplated by the Proposed Rule – 4 percent for Radiation Oncology and 8 percent for Radiation Therapy Centers – are a direct result of this proposal.
- In recognition of changes in practice patterns, the MC-PFS proposal would revise PE estimates to recognize the conversion from film to digital imaging.
    - Some procedures such as chest X-rays performed outside a hospital would be cut by as much as 6 percent.
- Because the Office of Inspector General has determined that a number of surgical procedures include more visits in the global period than are being furnished, CMS is proposing to transform all 10- and 90-day global surgery codes to 0-day global codes beginning in 2017. Subsequent visits will then be paid for separately.

Enhanced Rate-Setting Transparency

- Under the Proposed Rule, CMS would adopt new procedures for revising the inputs underlying final payment rates assigned to particular services to ensure that, to the extent possible, revisions will be subject to notice and comment rulemaking prior to adoption.
    - Since the MC-PFS was implemented in 1992, CMS has announced payment rates for new and revised codes for the following calendar year in the MC-PFS Final Rule and accepted comments on those rates only after they have been implemented.
    - The practice of adopting payment rates prior to public review has now become problematic from CMS' perspective because the agency is reviewing so many existing codes under misvalued code initiatives.
    - Starting in 2016, changes in payment rates for particular services, except for those that are entirely new and have never before been

valued under the PFS, would be published in the MC-PFS Proposed Rule so that CMS can evaluate and respond to public comments before finalizing revised payment rates.

Other Payment Changes

- The Proposed Rule would eliminate the distinction between robotic and non-robotic stereotactic radiosurgery (SRS), meaning that all SRS services with dates of service on or after January 1, 2015 would be billed using HCPCS Codes 77272 and 77273 and the G Codes previously used for robotic services (G 0339 and G0340) would be eliminated.
- Pursuant to the statutory review schedule, the MC-PFS Proposed Rule outlines adjustments required to update the malpractice (MP) RVUs for all services.
    - With the exception of Ophthalmology, where the impact of the MP RVU update would be a payment cut of 2 percent, the impact on payments to other affected specialties would be ± 1 percent or less. In reality, most specialties would not experience any change in reimbursement due to the proposed MP update.
- Payment rates in the MC-PFS Proposed Rule reflect the expiration of the PAMA-mandated 1.0 floor on the PE Geographic Practice Cost Index (GPCI) for most states on March 31. Only the 1.5 work GPCI floor for Alaska, the 1.0 work GPCI floor for all other states, and the 1.0 PE GPCI floor for frontier states (MT, NV, ND, SC, and WY) are incorporated in the proposed fee schedule rates for the entire year.
- Beneficiary cost-sharing for anesthesia related to a screening colonoscopy would be eliminated as of January 1, 2015 under the Proposed Rule, finally making this preventive screening cost-sharing free for all Medicare beneficiaries.
- To permit CMS to collect data on the cost of services furnished in off-campus provider-based hospital outpatient departments (facility located more than 250 yards from the main hospital building), hospitals would be required to report a modifier on claims for both the facility fee and physician services in 2015.

According to CMS, the specialty-specific projected combined impact of the changes in payment policy included in the 2015 MC-PFS Proposed Rule would be as follows:

Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Gastroenterology	0%	0%	0%	0%
Hematology/Oncology	0%	1%	0%	1%
Nephrology	0%	0%	0%	0%
Neurology	0%	0%	0%	0%
Ophthalmology	0%	0%	-2%	-2%

Radiation Oncology	0%	-4%	0%	-4%
Radiation Therapy Center	0%	-8%	0%	-8%
Urology	0%	0%	0%	0%

As has become the norm in the MC-PFS Proposed Rule, CMS also outlines proposed changes to the Physician Quality Reporting System (PQRS), EHR Incentive Program, Shared Savings Program, and Physician Compare Website. In addition, the proposal addresses expansion of the Value Modifier in calendar year 2017 to physicians in groups with two or more eligible professionals and physicians in solo practice and an increase in the upward and downward adjustments under the Value Modifier from ±2 percent in 2016 to ±4 percent in 2017.

Reimbursement in 2017 will be based on performance in 2015 and assessments of performance for purposes of applying Value Modifier payment adjustments will continue to be tied to PQRS reporting.

In a surprise move, CMS also elected to use the MC-PFS rulemaking process to make several revisions to the reporting requirements applicable to manufacturers and GPOs under the Open Payments regulations. Since Open Payment reports detail payments and other transfers of value to physicians and teaching hospitals, it is noteworthy that one proposed change would eliminate the current exemption for the reporting of some indirect payments made to speakers at certain accredited or certified continuing medical education events.

The US Oncology Network will submit comments on this Proposed Rule by the September 2, 2014 deadline.

To view a general fact sheet on the proposed rule, CLICK HERE.

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

HRSA Releases 340B Auditing Process Changes

On July 3, 2014, the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs announced changes to the 340B Drug Pricing Program auditing process, which according to HRSA, is its "most visible effort in overseeing covered entity compliance."

In its announcement, HRSA writes, "While notification to the covered entity and audit processes remain relatively unchanged, the steps that take place after the audit has been conducted have undergone several enhancements. The most notable change is that HRSA no longer issues preliminary reports to the audited covered entities. HRSA notifies audited covered entities of the audit findings in the HRSA Final Report."

Under the new process, the covered entity has 30 calendar days following the Final Report to review the report and 60 days to submit a Corrective Action Plan (CAP) to the agency if the covered entity is in agreement with the Final Report. If the covered entity does not agree, it must submit documentation outlining the disagreement within 30 calendar days of the Final Report. In all cases, the covered entity must submit a CAP addressing the findings noted in the Final Report or else face removal from the 340B Drug Pricing Program.

According to HRSA, "our goal is to increase the number of audits and make improvements in our processes to make them more efficient and effective."

In recent months, critics of the 340B program have voiced concern that increased oversight is needed to ensure the program has not deviated from its original purpose of helping poor and vulnerable patients and is not leading to unintended consequences for patients. In February, the Office of the Inspector General (OIG) released a report, examining the oversight, diversion and methodologies for identifying 340B-eligible entities, which found that there are varying criteria for identifying which prescriptions are 340B-eligible. The OIG also found that covered entities reviewed by the IOG did not conduct all of the oversight activities required by the HRSA.

Study Finds Cost of Care for Some Nonemergency Patient Services Doubles in HOPD

The National Institute for Health Care Reform (NIHCR) released a study last month entitled "Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services," in which the authors concluded prices for common patient services performed in a physician's office *or* community-*based setting* doubled when provided in the hospital outpatient department (HOPD) setting.

The study analyzed private insurance claims data for nearly 600,000 active and retired nonelderly autoworkers and their dependents across 18 metropolitan areas. Of the three common patient services reviewed, researchers found that HOPD costs were higher in all cases:

HOPD vs. Physician Office
Spending for Common Patient Services

Patient Service	Average HOPD Cost	Average Physician-Office Cost	Cost Differential
MRI of Knee	$900	$600	$300
Colonoscopy	$1,383	$625	$758
Comprehensive Metabolic Panel	$37	$13	$24

The study also found that prices varied considerably between the two sites of care for varying services. For example, average HOPD prices for simple laboratory tests were as much 14 times higher than average community-based lab prices in some geographic areas, but less than 50 percent higher in others.

The data suggest that price differentials present an opportunity for considerable healthcare savings by shifting patients to lower-cost settings such as community-based physician offices and ambulatory surgical centers (ASCs).

The study authors write, "Private insurers and Medicare generally pay more for services provided in hospital outpatient departments…A key question for purchasers is whether the higher cost for routine, nonemergency services in HOPDs is justified when the same services are widely available at lower prices in community settings."

Open Payments System Registration for Physicians Begins Mid-Month

Open Payments is a system created in accordance with the Sunshine Act to create greater transparency about the financial relationships of manufacturers, physicians, and teaching hospitals. Open Payments is a national disclosure program that will make information abut the financial relationships between the medical industry and physicians available to the public on a CMS-developed website.

While the program is voluntary for providers, The US Oncology Network strongly encourages participation by physicians because registration is required to gain access and dispute data reported by industry partners relating to financial interactions industry has had with physicians.

Registration is a two-phase process, which you can begin immediately.

Phase 1: Physicians must complete the user registration process through CMS' Enterprise Portal. To review CMS' instructions for Enterprise Portal Registration,

CLICK HERE. This process is a *required first step* for participation in the Open Payments system.

Phase 2: In mid-July, physicians will be permitted to register in the Open Payments system. At this time, physicians may review and dispute data submitted by manufacturers and group purchasing organizations (GPOs) prior to public posting of the data.

On July 22, CMS will host a National Provider Call. In the coming weeks, the registration link for the call will be posted here.

The Open Payments data will be made available to the public no later than September 30, 2014.

To visit the Open Payments website and learn more, CLICK HERE.