CMS Releases Final Physician Fee Schedule Rule for CY 2015

On October 31, the Centers for Medicare & Medicaid Services (CMS) issued the Physician Fee Schedule (PFS) Final Rule that updates Medicare payment policies and payment rates.

The impact of the Final Rule to the overall radiation oncology specialty is neutral. Although the Proposed Rule proposed to reduce payments to freestanding radiation therapy centers by around 5 percent due to CMS' decision to remove the radiation treatment vault as a direct cost input for radiation treatment delivery codes, CMS decided not to implement this policy in the Final Rule. The disaggregated effects of the rule to different settings are reflected in the tables below.

### Impact of Final CY 2015 PFS Rule on Total Allowed Charges (By Setting)

<table>
<thead>
<tr>
<th></th>
<th>CY 2014 Payments</th>
<th>CY 2015 Payments</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>413,677,355</td>
<td>408,288,956</td>
<td>-1.3%</td>
</tr>
<tr>
<td>Non-Facility</td>
<td>1,381,827,038</td>
<td>1,378,409,609</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Total</td>
<td>1,795,504,394</td>
<td>1,786,698,565</td>
<td>-0.5%</td>
</tr>
</tbody>
</table>

**Conversion Factor**

CMS notes in the Final Rule that, due to budget neutrality requirements from other policies in the rule, the 2015 conversion factor is estimated to be $35.8013 (assuming no SGR cuts).

**Radiation Treatment Vault**

In the Proposed Rule, the vast majority of the cut to freestanding radiation oncology related to CMS' proposal to remove the vault as a direct cost input for the following radiation treatment delivery codes: 77373, 77402, 77403, 77404, 77405, 77406, 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416 and 77418. As rationale for removing the vault, CMS stated it could not distinguish (1) the vault from the building, or (2) the vault from shielding used for "other expensive imaging equipment." In response, the radiation oncology community provided several reasons why it believed the vault should be included as a direct cost, including (1) the vault is typically (indeed, solely) used in the performance of a radiation therapy treatment delivery service, (2) radiation treatment vaults are unique within the Physician Fee Schedule and (3) Internal Revenue Code (IRC) cost-segregation rules treat the radiation treatment vault as medical equipment, separately depreciable from the building itself.

In the Final Rule, CMS states, "We are not finalizing our proposal at this time, but intend to further study the issues raised by the vault and how it relates to our PE methodology." CMS noted it understood "the essential nature of the vault in the provision of radiation therapy services and its uniqueness to a particular piece of medical equipment but [was] not convinced that either of these factors leads to the conclusion that the vault should be considered medical equipment for purposes of the PE methodology under the PFS." The agency also noted, "We appreciate the information commenters provided regarding the IRS treatment of the vault under tax laws, but the purposes and goals of the tax code and the PFS PE methodology are different, and, as such, attempts to draw parallels between the two are not necessarily instructive or relevant."
Certain New Codes Delayed Until 2016

In the CY 2013 PFS Final Rule, CMS requested a number of codes be submitted to the CPT/RUC for revaluation. Major code categories included: External beam radiation therapy (77402-77416, 77418), radiation therapy field setting (77280-77295), and brachytherapy. The 2014 Final Rule included CMS approved, RUC reported codes for radiation therapy field setting and brachytherapy codes, but not external beam radiation therapy codes. Because those external beam radiation therapy codes were not included in the 2015 Proposed Rule, it was possible they could have been included in the 2015 Final Rule.

However, in the 2015 Proposed Rule, CMS also proposed to change its processes so that new codes would be included in proposed PFS rules, rather than final PFS rules. Radiation oncology stakeholders requested that the proposed transparency process be implemented immediately in order to allow comment on new radiation oncology codes. As a result, CMS is not adopting code changes for certain radiation therapy services until they can go through notice and comment rulemaking for the 2016 PFS rule. CMS will not recognize these new CPT codes for 2015 and created G-codes in place of CPT codes for 2015 to continue current payment rates.

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

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

Specialty Societies Recommend Payers Accept 2015 G-Codes for Radiation Oncology Services

The American Society for Radiation Oncology (ASTRO) and the American College of Radiation Oncology (ACRO) are recommending that payers accept and adjudicate the G-codes established by CMS in the 2015 Medicare Physician Fee Schedule Final Rule beginning January 1, 2015.

To view ASTRO’s notice, click here.

To view ACRO’s notice, click here.

CBO Releases New Estimate for Physician Payment Reform

The Congressional Budget Office (CBO) released new cost estimates for legislation to replace the Medicare physician payment system (H.R. 4015/S. 2000) last month. The agency reduced the cost of repealing Medicare’s sustainable growth rate (SGR) formula to $138 billion over 10 years from the $144 billion estimate CBO released in February when the legislation was introduced. Another temporary SGR patch would cost $13.6 billion.

If Congress does not pass a permanent or temporary fix by March 31, 2015, physician pay will be cut by 21.2 percent on April 1.

If lawmakers choose to freeze Medicare physician payments, CBO estimates it would cost slightly under $119 billion over 10 years - $5 billion lower than their previous estimate. However, some in Congress are pushing for a physician pay increase, which CBO estimates would cost $140.2 billion over the next decade if physicians received a pay raise of 0.5 percent.
Supreme Court Agrees to Take Up Affordable Care Act Subsidy Lawsuit

The Supreme Court of the United States (SCOTUS) announced on November 7 that it will take up King vs. Burwell, a lawsuit that has the potential to alter implementation of the Affordable Care Act. The plaintiff argues that it is illegal for the federal government to offer subsidies to individuals to buy healthcare insurance in states that are not running their own health insurance exchanges.

According to the SCOTUSblog, the case questions, "Whether the Internal Revenue Service may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through exchanges established by the federal government under Section 1321 of the Patient Protection and Affordable Care Act."

The King vs. Burwell case could be heard in March 2015, according to SCOTUS Blog.

MedPAC Commissioners Meet to Discuss Payment Policies Based on Clinical Evidence

MedPAC Commissioners met November 7 to discuss the development of payment approaches that promote the use of services based on clinical evidence. The Commission continued its September 2014 discussion on ways to improve the value of Medicare spending by defining payment strategies that create incentives for providers to consider comparative effectiveness evidence of drugs and other health services.

MedPAC staff specifically presented on bundled and episode payments, which would provide a fixed payment amount for a combination of drugs and services for a patient’s treatment by examining both Peter Bach’s cancer bundles proposal and UnitedHealthcare’s oncology episodes.

The Commission is exploring ways to better ensure beneficiaries are getting the most clinically- and cost-effective care by crafting Medicare payment policies based on clinical evidence.

To view the MedPAC presentation on the development of payment policies to promote services based on clinical evidence, click here.

CMS Proposes Medicare Coverage for CT Screening for High-Risk Lung Cancer Patients

On November 10, the Centers for Medicare and Medicaid Services issued a proposed National Coverage Determination (NCD) for lung cancer screening for high-risk patients using low dose computer tomography (LDCT). Under the proposed NCD, beneficiaries aged 55-75 who are either current smokers or have stopped smoking in the past 15 years and have a pack-a-day smoking history of 30 years will be eligible for a CT screening with an order from their physician or another qualified practitioner.

New CMS ACO Performance Data Reports $417 Million in Medicare Savings

The Centers for Medicare and Medicaid Services (CMS) released new data on both the financial and quality performance of Accountable Care Organizations (ACO) created under the Affordable Act on November 7. According to the latest CMS fact sheet, ACOs "have successfully improved the quality of care for Medicare beneficiaries by fostering greater collaboration between doctors, hospitals, and health care providers to coordinate care for beneficiaries."

CMS reports that the Pioneer ACO Model and Medicare Shared Shavings Program have generated more than $417 million in savings for the Medicare program. ACOs have also qualified for shared savings payments of $460 million.
Healthcare Groups Outline Priorities to NAIC for Crafting New Network Adequacy Proposal

A group of more than 115 healthcare provider and consumer groups — including the American Medical Association (AMA) — sent a letter to the National Association of Insurance Commissioners (NAIC) on November 16, asking the group to consider a set of priorities for ensuring network adequacy when developing a proposal for updating the 1996 Managed Care Plan Network Adequacy Act. The groups are concerned that increasingly narrow insurance networks are limiting patient choice and state that these provisions are necessary to ensure patients have access to the physicians and care they need.

"By adopting provisions consistent with the principles outlined in this letter, we believe lawmakers and regulators can adapt the model act to establish reasonable, meaningful standards, while still allowing for market flexibility and choice," the letter says.

The letter details a set of provisions outlined on the AMA Wire:

1. Provider networks must include a full range of primary, specialty and subspecialty providers for all covered services for children and adults.
2. Regulators must actively review and monitor all networks using appropriate quantitative and other measurable standards. Determinations of network adequacy must be the responsibility of regulators, utilizing strong quantitative and objective measures that take into consideration geographic challenges and the entire range of consumers' health care needs.
3. Appeals processes must be fair, timely, transparent and rarely needed. Model legislation must make clear that out-of-network arrangements and procedures are not an acceptable alternative to plans having an adequate network.
4. The use of tiered and narrow provider networks and formularies must be regulated. Specific patient protections must be included in the Model Act for networks that are tiered or are limited in scope and number of providers in order to prevent unfair discrimination based on health status.
5. Insurers must be transparent in the design of their provider networks. It is critical that consumers have clear information regarding the design of their plan's provider network.
6. Provider directories must be accurate and up-to-date. Consumers must have access to robust provider directories to enable them to determine which providers are in-network when they purchase their plans, and, in the event their medical needs change, when they need new providers.

CMS Issues Coverage with Evidence Development Guidance

On November 20, the Centers for Medicare and Medicaid Services (CMS) issued a guidance document to help the public understand CMS' implementation of coverage with evidence development (CED) through the national coverage determination process. The guidance describes the history of CED, its statutory basis, and reflects comments received by CMS on the draft guidance document issued publicly in 2012. CED is a model in which Medicare covers services on the condition that they are provided in the context of approved clinical studies or with the collection of data that demonstrate clinical value.

*****

The information provided in this newsletter is to be used only to educate clients on health care related news and actions from the Federal Government. Information in this newsletter is not intended to provide investment, financial, legal, medical or tax advice and should not be relied upon in that regard. Liberty Partners Group, LLC disclaims any and all responsibility for decisions made or actions taken based on the information contained in this newsletter.