CMS Releases Physician Fee Schedule Proposed Rule

On July 8, CMS released the Proposed Rule for the CY 2016 Physician Fee Schedule ("Proposed Rule"). The impact of the Proposed Rule to the overall radiation oncology specialty is −3%. As in past years, however, the Physician Fee Schedule combines the effect on freestanding and hospital-based providers, thereby masking the effect on freestanding providers. The impact of the Proposed Rule to freestanding providers is −6%.

The disaggregated effects of the rule to the different settings are reflected in the table below.

<table>
<thead>
<tr>
<th></th>
<th>CY 2015 Payments</th>
<th>CY 2016 Payments</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$1,785.2</td>
<td>$1,723.2</td>
<td>-3.48%</td>
</tr>
<tr>
<td>Facility</td>
<td>$414.2</td>
<td>$431.7</td>
<td>+4.24%</td>
</tr>
<tr>
<td>Non-Facility</td>
<td>$1,371.1</td>
<td>$1,291.5</td>
<td>-5.8%</td>
</tr>
</tbody>
</table>

Conversion Factor

CMS notes in the Proposed Rule that the 2015 conversion factor is estimated to be $35.9335 and the 2016 conversion factor is estimated to be $36.1096.

Although CMS did not remove the radiation treatment vault from the treatment delivery codes, radiation oncology codes were affected in a number of other ways, including:

- The implementation of new treatment delivery codes which were delayed in the CY 2016 Physician Fee Schedule Final Rule as well as CMS modifications to those codes;
- CMS's proposal to increase the equipment utilization assumption for the linear accelerator from 50% to 70%; and
- Corresponding increases in other radiation oncology codes due to an increase in the indirect practice cost index.

*Using the proposed 2016 fee schedules for both of these systems, Avalere estimates freestanding radiation oncology will be paid 80.3% of what hospital outpatient departments will be paid for the same set of services.*

NEW TREATMENT DELIVERY CODES

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 did not adopt code changes for certain radiation therapy services until they could go through notice and comment rulemaking for the 2016 PFS rule. CMS did not recognize these new CPT codes for 2015 and created G-codes in place of CPT codes for 2015 to continue current payment rates.

For the CY 2016 PFS Proposed Rule, CMS adopted these new treatment delivery and imaging codes, including:

- 77402 (Radiation Treatment Delivery, Simple)
  - Incorporated old 77402, 77403, 77404, and 77406
  - Payment roughly comparable to old codes; billable with new 77387
- 77407 (Radiation treatment delivery, intermediate)
  - Incorporated old 77407, 77408, 77409
  - Payment roughly comparable to old codes; billable with new 77387
- 77412 (Radiation treatment delivery, complex)
  - Incorporated old 77412, 77413, 77414, 77416
  - Payment roughly comparable to old codes; billable with new 77387
- 77385 (IMRT treatment delivery, simple) o Split from old 77418
  - At least a 30% decrease from old 77418; not billable with 77387
  - 46% lower than payments for the same code in the hospital setting ($279 for freestanding vs. $519 for HOPD)
- 77386 (IMRT treatment delivery, complex)
  - Split from old 77418
  - 5% increase from old 77418; not billable with 77387
  - 19% lower than payments for the same code in the hospital setting ($421 for freestanding vs. $519 for HOPD)
- 77387 (Guidance for localization of target volume for delivery of treatment, includes intrafraction tracking when performed)
  - Evolved from old 77421
  - 180% increase from 77421

EQUIPMENT UTILIZATION

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 percent utilization rate) instead of 25 hours per week (a 50 percent utilization rate). CMS is proposing to implement this change over two years. CMS is also seeking comment on additional sources of accurate data regarding how often the machines are in use.

CMS notes in the rule that it reviewed a 2014 staffing survey conducted by the American Society for Radiology Technicians (ASRT) and found that there are an average of 2.3 linacs per radiation treatment facility and 52.7 patients per day treated per radiation treatment facility. CMS found these data suggest that an average of 22.9 patients is treated on each linac per day, which yielded a total of 670.39 minutes or 11.2 hours that a single linac is in use per day. CMS contrasted this with the number of hours of use reflected in its default assumptions (5 of the 10 available business hours per day) and its proposed revision to the equipment utilization rate assumption (7 hours out of 10 available business hours per day).

Although CMS did make certain modifications to the treatment delivery codes recommendations received from the RUC, a large majority of reductions beyond what the RUC proposed for these codes relates to the increase in
the equipment utilization assumption. Moving from a 50% assumption to a 60% assumption in 2016 lowered the
payment by approximately 15%. Because CMS is also phasing in an additional increase in the utilization rate
assumption to 70% in 2017, CMS effectively is also proposing another cut in 2017 to the radiation therapy
treatment delivery codes and, due to the effect on the indirect practice cost index (see below), another increase in
professional services payments for hospital-based radiation oncologists (on top of any additional raise hospital-
based providers will receive through technical payment increases in the hospital outpatient regulation).

INDIRECT PRACTICE COST INDEX

The indirect practice cost index (IPCI) is the method that CMS uses to reallocate indirect costs for each CPT code to
account for variations in specialty-reported indirect costs.

The IPCI uses multiple inputs, including:

- the number of services billed,
- the associated physician minutes for each service,
- the indirect PE/HR for each specialty based on the PPIS, and
- the indirect costs calculated from the direct costs and the work RVU

Previous work by Avalere has found that increases in zero-minute services (e.g. radiation therapy treatment
delivery services) results in a lower IPCI for the specialty. Conversely, reducing the input costs for zero-minute
services results in a higher IPCI. A higher IPCI benefits all radiation oncologists through higher PERVUs, whereas
cuts to radiation therapy treatment delivery services only cut freestanding radiation oncology.

Due to the net cuts to radiation treatment delivery codes in the Proposed Rule, the radiation oncology ICPI
increases significantly from 1.05 to 1.25. It is for these reasons that most of the non-treatment delivery radiation
therapy codes see increases of roughly 4 – 8%. The IPCI effect masks the cuts to the treatment delivery codes and
also is a significant reason for the increase in payments to hospital based radiation oncology providers.

OTHER ISSUES

A. Imaging

CMS is seeking comment on the "apparent contradiction between technical component billing for image guidance
in the context of the inclusion of a single linac with integrated imaging guidance technology being included for all
external beam treatment codes." CMS notes that the RUC recommendations incorporate the same capital cost of
image guidance equipment (a linear accelerator, or linac), for all radiation treatment delivery codes, including the
codes that describe IMRT and Stereotactic Radiation Treatment delivery services. Except as noted above, however,
imaging is not separately billable for 77385 and 77386 while it is separately billable for 77402, 77407 and 77412.

B. Potential Changes to the Conversion Factor or other Codes in the Final Rule

In the Protecting Access to Medicare Act of 2014 (PAMA), Congress set a target for adjustments to misvalued
codes in the fee schedule for calendar years 2017 through 2020, with a target amount of 0.5 percent of the
estimated expenditures under the PFS for each of those four years. Subsequently, the Achieving a Better Life
Experience Act of 2014 (ABLE) accelerated the application of the target by specifying it would apply for calendar
years 2016 through 2018 and increasing the target to 1 percent for 2016. If the net reductions in misvalued codes
in 2016 are not equal to or greater than 1 percent of the estimated expenditures under the fee schedule, a
reduction equal to the percentage difference between 1 percent and the estimated net reduction in expenditures
resulting from misvalued code reductions must be made to all PFS services (i.e. to the conversion factor).

In this proposed rule, CMS is proposing a methodology for the implementation of this provision, which includes
how net reductions in misvalued codes would be calculated. Based on that methodology, CMS has identified
changes that achieve 0.25 percent in net reductions. However, CMS could make further misvalued code changes in
the final rule to move closer to the statutory goal of 1 percent based on public comment and new
recommendations.

CMS notes that because CY 2016 represents a transition year in its new process of proposing values in the
proposed rule rather than the final, it will establish interim final values for any codes received after the February
10th deadline but in time for CMS to value for the final rule. CMS states that for CY 2016, there will still be a
significant number of codes valued not in the proposed rule but in the final rule with comment period. Therefore,
for CY 2016, unlike for the targets for CY 2017 and CY 2018, because CMS will not be able to calculate a realistic
estimate of the target amount at the time the proposed rule is published, the agency will not incorporate the
impact of the target into the calculation of the proposed PFS payment rates.

Comments are due to the Agency by September 8, 2015.

Site-Neutral Reform Bill Introduced in the House

Representatives Mike Pompeo (R-KS) and Don Beyer (R-VA) introduced the Medicare Patient Access to Cancer
Treatment Act (H.R. 2895) on June 25, legislation to equalize Medicare payments for outpatient cancer care
services. Under current Medicare policy, hospital outpatient departments (HOPD) are reimbursed at a higher rate
for administering chemotherapy services to cancer patients.

Advocates for the bill say the legislation will reduce spending for patients and Medicare alike and reduce hospital
acquisitions of community cancer care clinics.

According to a 2011 Milliman study, it costs Medicare $6,500 more per patient when care is delivered in the HOPD
setting under current Medicare payment policy. Hospital outpatient chemotherapy spending is approximately 25
to 47 percent higher per beneficiary than physician clinic chemotherapy spending.

"I am proud to introduce this pro-patient Medicare legislation to reverse an alarming trend in cancer care delivery
that has resulted in limited patient choice and higher Medicare spending. This legislation is an important first step
in preserving access to community-based cancer care for our seniors," Congressman Pompeo said in a press
statement.

GOP Doctors Caucus Urges Rejection of IOASE Repeal

Fourteen members of the GOP Doctors Caucus sent a letter to House Leadership on June 17 supporting the in-
ofice ancillary services exception (IOASE) to the physician Stark self-referral law.

The letter warns that the proposed repeal of the IOASE in President Obama’s 2016 budget proposal would increase
healthcare spending and discourage physicians from operating freestanding, community-based practices.

"We encourage you to reject repeal of the IOASE as an offset for any future legislation, and we look forward to
working with you to expand patient choice on where to receive high quality, affordable care and to support
competition in the health care market place," the lawmakers write.

The letter cites several studies illustrating that the utilization of ancillary services in physician practices is a small
percentage of total spending on these services, including data showing Medicare payments for advanced imaging
services are 36 percent to 53 percent higher in a HOPD setting opposed to in a physician’s office.
Another study of 4.5 million Medicare patients found that expenditures per patient were 10.3 percent higher for physician groups owned by hospitals than independent practices and expenditures were 19.8 percent higher for physician groups owned by multi-hospital systems.

The lawmakers also warn that repeal of the IOASE would lead to more independent practice closures due to trends showing that physician practices are consolidating with hospitals and larger hospital systems.

Finally, the lawmakers warn that repeal of the IOASE would be contradictory to the Administration's proposals to implement more value-based payment models because IOASE repeal would limit care coordination and integration necessary to implement alternative payment models (APMs).

CMS Announces One-Year Safe Harbor Period for ICD-10 Implementation

On July 6, the Centers for Medicare & Medicaid Services (CMS) – in coordination with the American Medical Association (AMA) – announced new efforts to help physicians get ready for the October 1 deadline for transitioning from ICD-9 to ICD-10 coding for medical diagnoses and inpatient hospital procedures.

CMS also released additional guidance that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set.

For a one-year period starting October 1, Medicare claims will not be denied or audited solely on the specificity of the ICD-10 diagnosis codes provided, as long as the physician submits an ICD-10 code from an appropriate family of codes. The new guidance also states that CMS will not penalize providers reporting for quality programs if the agency has problems calculating quality scores because of the new codes.

CMS and AMA also plan to educate providers through webinars, on-site training, educational articles and national provider calls to help physicians and other health care providers learn about the updated codes and prepare for the transition. CMS has also released training videos that offer helpful ICD-10 implementation tips.

Free help is also available at the "Road to 10" website, which is aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation.

To read the CMS press release, click here.

To view the AMA tools to assist practices make the transition, click here.

Reconciliation Pushed Beyond August Recess

The five House and Senate committees charged with producing required budget reconciliation legislation missed their July 24 deadline to report bills. Lawmakers are likely not to act until after the August recess at the earliest. Reconciliation could then become part of the mix with other major issues such as a potential deal to raise discretionary spending caps and raising the debt limit.

The fiscal 2016 budget resolution (S Con Res 11) adopted by the Senate in May set July 24 as the deadline for three House and two Senate committees to report reconciliation legislation reducing the deficit by at least $1 billion over a decade to the Budget committees.

There is no penalty for missing the July 24 deadline, and in the past, reconciliation bills have often been late.
New JAMA Study Finds 'Watchful Waiting' Trend for Prostate Cancer

A new study, "Trends in Management for Patients With Localized Prostate Cancer, 1990-2013," published in the Journal of the American Medical Association in July found that the use of active surveillance to monitor patients diagnosed with prostate cancer has increased sharply in the last five years.

The study found that from 2010 through 2013, doctors used "watchful waiting" practices on about 40 percent of these patients, compared to around 14 percent in 2009. The authors note that the shift toward extended monitoring comes amid overwhelming medical consensus that prostate cancer is greatly overtreated.

The researchers further concluded that monitoring prostate cancer patients rather than moving immediately to treatment led to smarter decisions about who to treat and when to treat them.

The analysis was done using data from the Cancer of the Prostate Strategic Urologic Research Endeavor (CaPSURE) national registry to report on changes in the types of treatment patients with low-risk prostate cancer received from 1990 through 2013. They analyzed records of nearly 10,500 patients from 45 urology practices nationwide.

To view the JAMA study, click here.

U.S. House Passes 21st Century Cures Bill

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 bill maintains two key provisions:

SECTION 3081 - IMPROVEMENTS IN THE MEDICARE LOCAL COVERAGE DETERMINATION (LCD) PROCESS
The local coverage determination (LCD) process is an important means by which seniors can access treatments that would not otherwise be covered by Medicare due to the length of time it takes for the national process to conclude its work. However, improvements are needed. This section would increase transparency around the LCD process and begin the process of bringing greater accountability to the actions of those contracting with the Centers for Medicare and Medicaid Services to manage the operation of the Medicare program.

SECTION 3121 - MEDICARE SITE-OF-SERVICE PRICE TRANSPARENCY
The Medicare benefit currently pays varying rates for the same services depending on where they are delivered. As a result, seniors' out-of-pocket costs can be higher or lower for a given procedure based upon where the service is provided. This section would give seniors the ability to shop among certain sites of service for certain services so that they can identify the most cost-effective treatments.

The policy provisions in the bill are largely the same as what the Energy and Commerce Committee passed on May 19. To view an overview of major bill changes (since 5/21), click here.

Estimates suggest the bill would cost approximately $12 billion. To view the Congressional Budget Office (CBO) estimate of the bill, click here.

The view the legislation language of H.R. 6, click here.
CMS Releases Projections of National Health Expenditures Data

The Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) released new projections of health care spending for categories within the National Health Expenditure Accounts on July 28. The report projects that total health care spending growth is expected to average 5.8 percent in aggregate over 2014-2024, which is lower than the 9 percent average rate seen in the three decades before 2008.

To access the data, click here.

To view the CMS statement, click here.

To read the Health Affairs article, click here.

Medicare Trustees Predict Medicare Part A Depletion in 2030

On July 22, the Boards of Trustees for Medicare released it annual report, which projects the hospital insurance (Part A) trust fund will run out of money in 2030, the same date as projected last year. Medicare Part B (outpatient services) and Part D (prescription drug benefits) are projected to remain adequately financed into the indefinite future because premium and general revenues for those programs are reset annually.

Total Medicare expenditures are projected to increase from 3.5 percent of the U.S. GDP in 2014 to 5.4 percent by 2035, largely due to the rapid influx of new beneficiaries entering the Medicare program.

To read the report, click here.

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