CMS Releases Proposed Physician Fee Schedule Rule for CY 2017

The Centers for Medicare & Medicaid Services (CMS) on July 7 released the proposed rule for the CY 2017 Physician Fee Schedule (PFS).

The impact of the proposed rule to the overall radiation oncology specialty is 0%. 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. According to Avalere Health, the impact of the proposed rule to freestanding providers is −1%. The disaggregated effects of the rule to the different settings are reflected in the table below.

| Impact of Proposed CY 2017 PFS Rule on Total Allowed Charges (By Setting, in Millions) |
|-----------------------------------------|----------------------------------|-----------------|
| CY 2016 Payments | CY 2017 Payments | % Change |
| Total | $1,735.40 | $1,735.00 | -0.02% |
| Facility | $418.00 | $432.00 | 3.35% |
| Non-Facility | $1,317.30 | $1,303.00 | -1.09% |

Conversion Factor

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 to specify that target provisions apply for CYs 2016, 2017, and 2018. The ABLE Act also set a 1 percent target for reduced expenditures for CY 2016 and a 0.5 percent target for CYs 2017 and 2018. In the proposed rule, CMS has proposed misvalued code changes that would achieve 0.51 percent in net expenditure reductions. If finalized, these changes would meet the misvalued code target of 0.5 percent, therefore avoiding a broad overall reduction to PFS services.

CMS notes in the proposed rule that the 2016 conversion factor is estimated to be $35.8043 and the 2017 conversion factor is estimated to be $35.7751 due to other unrelated factors.

TREATMENT DELIVERY CODES

In the Patient Access and Medicare Protection Act, S. 2425, Congress provided a special rule for certain radiation therapy services as follows:
• SPECIAL RULE FOR CERTAIN RADIATION THERAPY SERVICES.— The code definitions, the work relative value units under subsection (c)(2)(C)(i), and the direct inputs for the practice expense relative value units under subsection (c)(2)(C)(ii) for radiation treatment delivery and related imaging services (identified in 2016 by HCPCS G-codes G6001 through G6015) for the fee schedule established under this subsection for services furnished in 2017 and 2018 shall be the same as such definitions, units, and inputs for such services for the fee schedule established for services furnished in 2016.

As a result of this provision, treatment delivery code definitions and valuations are generally consistent with those contained in the CY 2016 PFS Final Rule. One exception is G6011 (a conventional treatment delivery code) which is reduced by about 11 percent. This warrants further research given that the direct practice expenses for the code are identical in the 2016 PFS Final Rule and the 2017 PFS proposed rule.

It is noteworthy that the rule makes no mention of the radiation treatment vault, equipment utilization or the linear accelerator as they relate to radiation therapy.

To view the CMS fact sheet on the PFS proposal, click here.

To view the proposed rule, click here.

CMS Acting Administrator Suggests Possible MACRA Delay

On July 13, the Senate Finance Committee hosted a hearing, entitled "Medicare Access and CHIP Reauthorization Act of 2015: Ensuring Successful Implementation of Physician Payment Reforms," to review the Centers for Medicare and Medicaid Services' (CMS) proposed implementation of physician payment reforms under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Throughout the hearing, committee members highlighted the importance of ensuring that all physicians who care for Medicare beneficiaries receive fair treatment under MACRA and have the flexibility to participate in the program in a way that best fits their practices.

Chairman Orrin Hatch (R-UT) expressed his concern at the hearing that health care providers will not have enough time to prepare for changes in Medicare payments ahead of MACRA's January 1, 2017 implementation date. CMS Acting Administrator Andy Slavitt said that the agency has received many comments on the rule's start date and is considering a number of ways to address providers' concerns, such as:

• Delaying the MACRA start date to give physician practices enough time to prepare for the new Medicare payment models;
• Establishing shorter reporting periods to decrease the time that clinicians spend reporting data and increase the time they can devote to providing care to patients;
• Adjusting reporting requirements to allow for data collection through registries and providing exemptions for certain practices to reduce the burden of reporting on physicians.

A final rule on payment reforms under MACRA is expected to be released in November.

To view Mr. Slavitt's testimony, click here.

To watch the hearing, click here.
Senate Finance Committee Hosts Hearing on Stark Law

The Senate Finance Committee on July 12 held a hearing, "Examining the Stark Law: Current Issues and Opportunities," to address possible ways to improve and reform the Stark Law. During the hearing, committee members voiced concerns that the law is not workable in terms of enforcement and compliance for value-based payment models.

Witnesses stated that the Stark Law imposes unnecessary impediments to healthcare reform and includes excessive penalties for technical non-compliance. Witnesses also testified that the law restricts health systems, creates barriers between physicians and hospitals, and negatively impacts clinical performance improvement, patient care and the transition to value-based payment.

Recommendations offered to improve the Stark Law included clarifying key terms included in the law, reducing Stark penalties, and reforming Stark provisions to better serve new payment methodologies. Chairman Orrin Hatch (R-UT) indicated that the committee would take some sort of action on the law before the end of 2016, however it remains uncertain if lawmakers will seek modification or full repeal.

Witnesses at the hearing included:

- **Mr. Troy A. Barsky**, Partner, Crowell & Moring LLP
- **Dr. Ronald A. Paulus**, President And Chief Executive Officer, Mission Health
- **Mr. Peter Mancino**, Deputy General Counsel, The Johns Hopkins Health System Corporation

To view the hearing, click here.

CMS Hospital Outpatient Payment Proposed Rule Maintains Site-Neutral Provisions Passed by Congress

The Centers for Medicare and Medicaid Services (CMS) released the proposed CY 2017 Hospital Outpatient Perspective Payment System (OPPS) rule on July 6. The agency's proposal, which includes policies for interpreting the implantation of Section 603 of the Bipartisan Budget Act of 2015, addresses how it will ensure that certain items and services furnished in certain off-campus provider-based departments (PBDs) are paid under appropriate payment systems beginning January 1, 2017.

The OPPS proposed rule would implement site-neutral payment provisions and stop paying hospital off-campus facilities at the same rate as hospital-based outpatient departments, excluding certain dedicated off-campus emergency departments. Specifically, CMS' proposal includes following:

- **Excepted Items and Services** – Certain off-campus PBDs would be allowed to continue to bill for excepted items and services under the OPPS, including:
  - All items and services furnished in a dedicated emergency department.
  - Items and services furnished in a hospital department within 250 yards of a remote location of the hospital.
  - Items and services that were furnished and billed by an off-campus PBD prior to November 2, 2015.

- **Service Expansion in an Excepted Off-Campus PBD** – While excepted off-campus PBDs will be paid at OPPS rates for items and services furnished and billed as of November 2, 2015, additional items and services beyond those within
the clinical families of services furnished and billed prior to that date will not be excepted services.

- Relocation of Excepted Off-Campus PBDs – The excepted authority to bill under the OPPS is limited to the physical location of the off-campus site. An excepted off-campus PBD will lose its excepted status if it changes location.
- Changes of Ownership of Excepted Off-Campus PBDs – If an excepted status hospital has a change of ownership and the new owners accept the existing Medicare provider agreement from the prior owner, the off-campus PBD may maintain its excepted status.

CMS also proposed a one-year transitional period allowing all non-excepted items and services furnished in an off-campus PBD to be paid under the Physician Fee Schedule and projects that the rule would increase Medicare OPPS payments by 1.6 percent in 2017. The agency will accept comments on its proposal through September 6.

To view the CMS fact sheet on the OPPS proposed rule, click here.

To view the proposed rule, click here.

**Legislation to Reform Cancer Care Payments Introduced in the Senate**

On July 14, Senators John Cornyn (R-TX) and Tom Carper (D-DE) introduced the Cancer Care Payment Reform Act of 2016 (S. 3211), which would establish a national Oncology Medical Home (OMH) demonstration project for Medicare payment reform. The legislation would change the way that cancer treatments are paid for under the Medicare program to improve the quality and coordination of care and reduce overall costs for cancer patients.

Specifically, the Cancer Care Payment Reform Act would create a five-year OMH pilot program to provide oncology practices the option of participating in a model which compares cancer treatment methods and best practices. The goal of the demonstration project is to determine which cancer care approaches produce the best value and best outcomes for patients.

To read the text of the bill, click here.

*****

_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._