CMS Releases Final Rule in the Medicare Physician Fee Schedule (PFS) for the Calendar Year (CY) 2017

On November 2, 2016, CMS released the Final Rule for the CY 2017 Physician Fee Schedule ("Final Rule"). This memorandum provides a preliminary analysis of the impact of the Final Rule.

OVERVIEW

Major changes in the Final Rule relate to reductions to services for certain specialties due to the Misvalued Code Initiative. Interventional radiology and independent labs would experience decreases while endocrinology and family practice would experience increases. The impacts on radiation oncology and radiation therapy centers are neutral.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology</td>
<td>0 %</td>
</tr>
<tr>
<td>Radiation Therapy Centers</td>
<td>0 %</td>
</tr>
</tbody>
</table>

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 Final Rule, CMS finalized misvalued code changes that would achieve 0.32 percent in net expenditure reductions. Since this amount does not meet the 0.5 percent target, the CY 2017 target recapture amount will produce a reduction to the conversion factor of -0.18 percent.

CMS notes in the Final Rule that the 2016 conversion factor is estimated to be $35.8043 and the 2017 conversion factor is estimated to be $35.8887 due to net effect of the 0.5% legislatively mandated update factor, the -0.18 percent reduction pursuant to the PAMA/ABLE legislation and other minor factors. It is worth noting that CMS did not finalize its proposal to add a new payment code (G0501) to describe additional services furnished in conjunction with E/M services to beneficiaries with disabilities that impair their mobility. In the Proposed Rule, this policy was responsible for reductions to the conversion factor due to budget neutrality.
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 in the CY 2017 PFS Final Rule 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. ACRO commented that the reduction was inconsistent with the law and based on an error by CMS. Avalere Health noted the following with respect to inputs for G6011 in the CY 2017 PFS Proposed Rule:

- Direct Practice Expense Inputs for the HCPCS code remained the same from FR 2016 and NPRM 2017;
- There were no changes in the specialty level Practice Expense Per Hour for Radiation Oncology;
- There were no duration of service changes for the HCPCS Code; and
- The change in the Indirect Practice Expense Index for Radiation Therapy went up slightly, which, given other factors would cause reimbursement to go up, not down, if changes occurred.

In the Final Rule, CMS noted that the change to G6011 was caused by a significant shift in the specialties furnishing the service in the Medicare claims data. In the claims data CMS used to establish the PE RVUs for CY 2016, dermatology furnished 51 percent of the services, while radiation oncology furnished 43 percent. However, the most recent claims data reflected a major shift, with radiation oncology now furnishing about 85 percent of the services and dermatology only about 6 percent. The decrease in the PE RVU between CY 2016 and CY 2017 resulted from this shift in specialty mix, as the specialties actually furnishing the service, reflected in the claims data, have a higher percentage of direct PE relative to indirect PE, and therefore, a lower percentage of indirect PE, than the specialties that were previously furnishing the service in the claims data. This updated specialty mix resulted in a lower percentage of indirect PE and, therefore, fewer indirect PE RVUs being allocated and a lower overall PERVUs being allocated for the code (even as direct PE inputs remained the same).

CMS notes, "we recognize that this change would be unanticipated, but we do not believe there is a straightforward, transparent way to offset the change since the statutory provision requires that we maintain the direct inputs for the PE RVUs." It appears unlikely at this time that other significant changes to the treatment delivery codes would occur due to such a change in specialty mix for CY 2018.
OTHER ISSUES

A. Radiation Treatment Devices (CPT codes 77332, 77333, and 77334)

In the proposed rule, CMS disagreed with the RUC's recommendation to maintain the work values below the survey 25th percentile for CPT code 77332, 77333 and 77334. Instead, CMS recommended a crosswalk to CPT code 93287 Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system (work RVU = 0.45).

ACRO agreed with the RUC that the CMS crosswalk code 93287 is not a radiation treatment service and should not be used to determine the value of 77332. ACRO urged CMS to accept the RUC recommended work RVUs of 0.54, 0.84 and 1.24 for CPT codes 77332, 77333 and 77334 respectively. In the final rule, CMS stated that it commonly valued codes by crosswalks to other codes furnished by different kinds of physicians and that it believed the crosswalk to 93287 was similar in terms of time and intensity.

B. Special Radiation Treatment (CPT code 77470)

In the proposed rule, CMS sought comment to determine if creating two G-codes, one which describes the work portion of this service and one which describes the PE portion, may be a more accurate method of valuing and paying for the service or services described by 77470. ACRO stated it did not believe the proposal to create two G-codes for this service, one for the work portion and one for the PE portion, had merit. This code has historically represented the additional physician work and time necessary under specific circumstances, and has not had a PE component. While greater clarification of the clinical indications for utilization of the code may be appropriate, separation into two component codes would not be appropriate or helpful. ACRO also urged CMS to finalize the practice expense RUC recommendation for CPT code 77470.

In the final rule, CMS noted it was finalizing the RUC-recommended work RVU and PE inputs as proposed; however, it noted it continued to have serious concerns about the validity of this coding. CMS indicated that the description of work provided for this service includes cognitive work the physician performs such as planning, consideration of test results, and therapeutic treatment contingency planning that is in addition to what he or she would typically be performing for most radiation treatments. Meanwhile, the radiation therapist handles the treatment devices, performs tasks such as positioning the patient, and helps facilitate the scan of the patient. CMS stated it believed that these descriptions were fundamentally disconnected.

To view the PFS press release, click here.

To view the PFS fact sheet, click here.

To view the Final Rule, click here.

MedPAC Holds Commission Meeting on Provider Consolidation
On November 3, the Medicare Payment Advisory Commission (MedPAC) held a meeting to discuss the role of Medicare policy and provider consolidation, as well as implications for the Medicare program and the privately insured.

Key points discussed during the presentation included three types of provider consolidation:

- Horizontal consolidation, where hospitals merge into larger systems and physicians merge into bigger practices.
- Vertical financial integration, where hospital systems acquire and employ physician practices.
- Vertical integration of provider functions and acceptance of insurance risk by ACOs or MA plans, where providers take on insurance risk or insurers acquire providers.

MedPAC staff noted, in 2015, Medicare paid hospitals $1.6 billion more for E&M visits than if hospitals were paid physician office rates; beneficiary cost sharing also was $400 million higher. MedPAC staff also noted it "has a standing recommendation to equalize rates for certain services across all sites."

To view the presentation, click here.

AMA Releases Framework Outlining Vision on Health Reform

On November 15, the American Medical Association (AMA) released a summary of their vision on health reform.

The summary included the following key points on health reform:

- Continue efforts to cover the uninsured and make sure that any proposals or provisions do not result in individuals covered under ACA to become uninsured.
- Ensure that patients have access to the care and providers they need under their health insurance.
- Improve health equity for minority, underserved and special needs populations.
- Support including medical liability reforms consistent with policy.
- Support the ability of patients to privately contract for medical services of their choice with no penalties.
- Support graduate medical education funding consistent with policy.
- Support reforms to the Medicaid and Medicare programs to guarantee that they are workable and effective mechanisms to provide health insurance to low-income individuals, seniors and disabled.
- Continue to advocate for market-based strategies to better achieve the affordability of prescription drugs, and support initiatives to incentivize the pharmaceutical industry to exercise practical restraint in the pricing of drugs.
- Support and advance initiatives that improve practice efficiency and professional satisfaction, improve the delivery of health care, decrease administration burdens of public and private insurance programs, and reduce health care spending.

To view the full AMA framework, click here.
PTAC Hosts "How to Submit a Proposal to PTAC" Webinar

On Wednesday, November 16, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) hosted its second webinar "How to Submit a Proposal to the Physician-Focused Payment Model Technical Advisory Committee". PTAC members Harold Miller and Kavita Patel, M.D, led the webinar, during which they addressed:

- PTAC's role and membership
- Proposal submission process and key dates
- Proposal review and evaluation process
- Timeline for PTAC evaluation and recommendation to the Secretary
- Opportunities for public participation in PTAC work

PTAC will continue to host webinars in order to inform stakeholders about the resources that are available to them to support the proposal development process.

To listen to a full recording of the webinar and view the slides, click here.

PTAC Hosts Webinar on Role of Committee in Payment Reforms

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) hosted its webinar on November 2. The webinar was led by PTAC Chair Dr. Jeff Bailet and PTAC Vice President Elizabeth Mitchell.

The webinar covered the following topics:

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Highlights of MACRA
- How MACRA provides additional rewards for participation in Advanced Alternative Payment Models (APMs)
- PTAC's Statutory Charge
- PTAC's Criteria for Evaluating Models
- Secretarial Response by the Secretary of HHS on PTAC comments and recommendations
- PTAC Composition—what type of members make up the PTAC
- What is a Physician-Focused Payment Model?
- PTAC Goals and Process
- Stakeholder Model Submissions
- Principles Guiding Request for Submissions
- Overall Proposal Submission Timeline
- Proposal Review and Recommendation Process
- Overall PTAC Timeline
- PTAC Priorities
- Opportunities for public participation

Instructions for submission can be found here.

To listen and view the conference power point, click here.

To view CMS new Alternative Payment Model Design Toolkit, click here.
House Energy and Commerce Subcommittee on Health Holds Hearing to Examine USPSTF Transparency and Accountability Act Updates

On November 30, the House Energy and Commerce Health Subcommittee hosted a hearing to examine a new discussion draft of the USPSTF Transparency and Accountability Act of 2015. H.R. 1151 was introduced last year by full committee Vice Chairman Marsha Blackburn (R-TN) and Rep. Bobby Rush (D-IL) to improve the oversight and transparency of the United States Preventive Services Task Force (USPSTF).

The revised bill would:

- require specialists and sub-specialists to be involved in reviewing the preventive services that the task force examines;
- require the Government Accountability Office to submit a report comparing USPSTF's recommendations with other federal government health guidelines; and
- Allows the Secretary of Health and Human Services to remove certain preventive services under the Medicare program, if such changes are needed.

To view the updated legislation, click here.

To view the background memo, click here.

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