CMS Releases Final Physician Fee Schedule Rule for CY 2015

On October 31, 2014, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule for the CY 2015 Physician Fee Schedule.

Overview
Major changes in the Final Rule relate to payments for chronic care management (CCM) services that will benefit family practitioners (+ 1%), internists (+ 1%), and geriatricians (+ 1%). Other widespread specialty impacts in PERVUs relate to the implementation of the RUC recommendation to move from film-to-digital imaging inputs, which primarily affects portable x-ray suppliers, diagnostic testing facilities, and interventional radiology. Overall, however, CMS indicates that the impact of the Final Rule for most specialties is roughly flat. This is true for those specialties chiefly involved in the treatment of peripheral artery disease such as cardiology, interventional radiology and vascular surgery.

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).

OPD/ASC Cap Codes
Key CVC codes are relatively flat in the 2015 PFS Final Rule as evidenced by the table below.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>0 %</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>0 %</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>0 %</td>
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</table>
Certain codes were subject to some fluctuation due to updates to the indirect practice cost index (IPCI). The object of the IPCI (part of the practice expense methodology of the PFS) is to reallocate indirect costs for each CPT code to account for variations in specialty-reported indirect costs. Fluctuations in the IPCI (and, therefore, overall reimbursement) can occur for many reasons, including (1) low-volume issues or (2) the use of new data for newly created CPT codes. In the case of 37235, the fluctuation is due to low-volume. Specifically, total billing in 2012 (used for 2014 rate-setting) was 83 and in 2013 (used for 2015 rate-setting) billing increased to 128. The change in specialty mix billing for this code changed substantively (peripheral vascular disease physicians billed less and interventional radiologists billed more) between 2012 and 2013 which resulted in an overall increase to the IPCI (and therefore higher valuations to the code) due to a higher weighted average IPCI.

Other codes – CPT codes 36222, 36225, and 36226 – also were subject to payment fluctuations from the IPCI as a result of the use of new data for newly created CPT codes. These codes were new codes in 2013 and, as a result, CMS estimated the weighted average of physicians who would bill to these codes. For 2015, CMS was able to use actual billing for the codes (using 2013 data). Here again, changes in specialty mix billing changed substantively which resulted in changes to the IPCI and, therefore, changes in payments to the codes (i.e. cuts in the case of 36222 and 36225 and an increase in the case of 36226).

Using OPPS and ASC Rates in Developing PE RVUs
In the 2014 PFS Proposed Rule, CMS proposed to limit the nonfacility practice expense RVUs (PERVUs) for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount (OPPS technical plus PFS professional) Medicare would pay for the same code in the facility setting. In the 2014 PFS Final Rule, CMS decided not to implement this policy given broad stakeholder concern with the proposal.
In the 2015 PFS Final Rule, CMS stated it continues to believe there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology. The agency noted, “we continue to believe that the routinely updated, auditable resource cost information submitted contemporaneously by a wide array of providers across the country is a valid reflection of “relative” resources and could be useful to supplement the resource cost information developed under our current methodology based upon a typical case that are developed with information from a small number of representative practitioners for a small percentage of codes in any particular year.”

**Maintenance Factor**

CMS notes in the Final Rule that several stakeholders have suggested the maintenance factor should be variable and the agency has solicited comments regarding reliable data on maintenance costs that vary for particular equipment items. However, in the Final Rule, the agency states it would like to receive “multiple invoices containing equipment prices that are accompanied by maintenance contracts” to provide support for a maintenance cost other than the currently assumed 5 percent “[r] other than assertions that a particular maintenance rate is typical.”

To download the CY 2015 PFS Final Rule, [click here](#).

**CBO Releases New Estimates for Physician Payment Options**

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.

CBO now projects the cost of repealing Medicare’s sustainable growth rate (SGR) formula would be $138 billion over 10 years. The numbers represent a $6 billion departure from the CBO’s original $144 billion estimate. The agency released its first projection this February, when the legislation was introduced.

The agency also released its updated 10-year estimate of the cost of freezing Medicare payments to physicians, lowering its projection by $5 billion. The cost of the pay freeze would now be just under $119 billion.

A 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.

**MedPAC Commissioners Meet to Discuss Payment Policies Based on Clinical Evidence**

MedPAC Commissioners met on November 7 to discuss Medicare payment policies, including the development of payment approaches that promote the use of services based on clinical evidence opposed to cost of service.
The Commission continued its September 2014 discussion on linking the payment rate of Part B drugs to comparative clinical evidence. At this month’s meeting, the Commission specifically focused on the consolidation of payment codes and bundling. The commissioners also discussed the role of Accountable Care Organizations (ACOs).

To view the MedPAC presentation on payment policy reforms based on clinical evidence, click here.

Supreme Court to Hear Affordable Care Act Subsidies Case

The Supreme Court will hear a case challenging the use of healthcare subsidies in states without their own exchanges, raising questions about the Affordable Care Act’s future.

Specifically, the court will consider the legality of the federal government’s decision to distribute tax subsidies in the 34 states that did not construct their own insurance exchanges. Currently, 87 percent of Americans purchasing plans through the Affordable Care Act receive subsidies.

The plaintiffs in the case, King v. Burwell, will argue that residents of such states cannot receive subsidies. The White House, however, promised to defend the law, affirming that they “have high confidence in the legal arguments” and “expect a vigorous defense.”

If the court rules against the Obama Administration, the decision would rescind one of the law’s most vital components. More than four million Americans have already received premium credits. That number is expected to rise to 7.3 million by 2016, according to a Robert Wood Foundation study. The rollback would equate to $36 billion in lost subsidies.

The King case may be heard in March 2015, according to SCOTUS Blog.

CMS Provides Updated Financial Information on ACO Performance

The Centers for Medicare and Medicaid Services (CMS) issued an updated fact sheet on November 7, stating that Accountable Care Organizations (ACOs) created under the Affordable Care Act have generated more than $417 million in annual savings for Medicare.

The numbers represented a $45 million increase in expected savings by those in the Pioneer ACO Model and Medicare Shared Savings Program (MSSP), compared to the $372 million originally reported by CMS in their September 16 fact sheet.

The updated fact sheet included information from 16 additional MSSP ACOs – groups of doctors, hospitals and other healthcare providers who come together voluntarily to give coordinated high quality care to their Medicare patients – that were not previously included in September.

CMS, therefore, released the latest savings and payment information for MSSP ACOs. The new fact sheet states that 58 MSSP ACOs held spending $705 million below their targets and earned
performance payments of more than $315 million as their share of program savings. The September sheet reported that the 53 organizations held spending $652 million below their targets and earned performance payments of more than $300 million.

Sixty ACOs, in addition to those that earned performance payments, also reduced health costs compared with their benchmark but didn’t qualify for shared savings, compared to 52 originally noted. Twenty-three Pioneer ACOs, which are now in their second year, and 220 MSSP ACOs that debuted in 2014 also qualified for total shared savings payments of $460 million, according the new sheet, up from the $445 million CMS reported in September.

The MSSP is a program for Medicare fee-for-service providers. The Pioneer ACO program is administered under the agency’s Center for Medicare and Medicaid Innovation and is designed for healthcare organizations and providers that have experience coordinating care for patients across care settings.

For the updated November 7 fact sheet, click here.
For the original September 16 fact sheet, click here.

Providers, Consumers Urge NAIC To Address Network Adequacy Concerns

A number of healthcare groups are urging the National Association of Insurance Commissioners (NAIC) to address several critical issues as it constructs its final model regulation on network adequacy. In a letter, groups such as the American Medical Association and Children’s Hospital Association addressed quantitative standards and patient access to care, as well as network accuracy and transparency.

NAIC decided to update the 1996 Managed Care Plan Network Adequacy Act as stakeholders and lawmakers raise concerns about a trend towards increasingly narrow networks, in exchanges and other plans, and high-cost drug formulary tiers. The agency is accepting public comment on the draft model until January of next year.

“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 groups write in the letter.

The letter, which was signed by over 115 healthcare groups, 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.

To read the full letter, click here.

CMS Issues Guidance Regarding Coverage with Evidence Development

The Centers for Medicare and Medicaid Services (CMS) issued guidance for the public, industry, and CMS staff regarding Coverage with Evidence Development (CED) on November 20.

CMS said it issued the guidance in order to “help the public understand CMS’ implementation of coverage with evidence development (CED) through the national coverage determination process.”

The agency concluded that, while it embraces an evidence-based medicine coverage paradigm, CMS should support evidence development for certain innovative technologies that are likely to show benefit for the Medicare population, even when there is not a comprehensive evidence base – which is often the case for new technologies or existing technologies for which the evidence is incomplete.

CMS describes CED as “a paradigm whereby Medicare covers items and services on the condition that they are furnished in the context of approved clinical studies or with the collection of additional clinical data.”

To read the full guidance, click here.