STRENGTHEN YOUR REVENUE CYCLE MANAGEMENT

ACCC 2022 ONCOLOGY REIMBURSEMENT MEETING

DECEMBER 13
Virtual

Association of Community Cancer Centers

Welcome!

Welcome and Opening Remarks

Matt Devino, MPH

Director of Cancer Care Delivery & Health Policy

Association of Community Cancer Centers

28,000+

multidisciplinary practitioners from every discipline in oncology

CANCER PROGRAM LEADERSHIP

Hospital Presidents
CEOs, COOs, CMOs
Vice Presidents
Department Directors

ADMINISTRATION

Oncology Program and Practice Administrators, Managers, and Service Line Executives
Program Administrative Staff

CLINICIANS

Medical
Radiation
Surgical
Pharmacy

PATIENT CARE

Allied Physicians
Oncology Nurses
Nurse Practitioners
Physician's Assistants

SUPPORTIVE CARE STAFF

Social Workers
Patient Navigators
Financial Advocates
Palliative Specialists

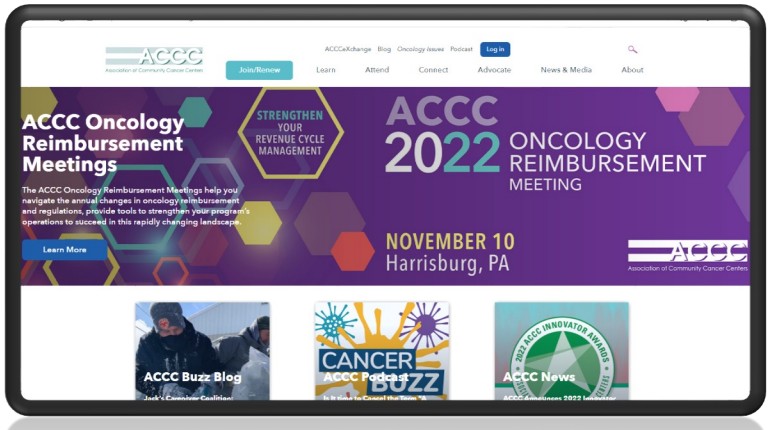
THE ENTIRE TEAM

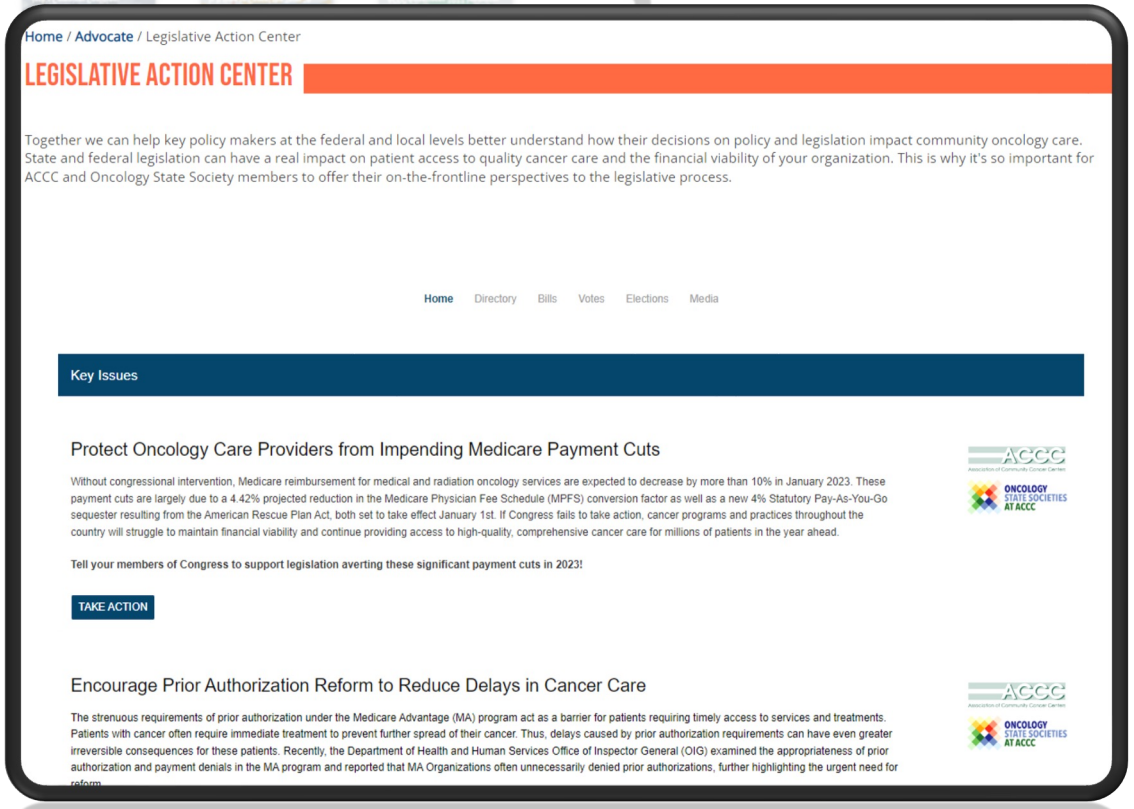
Genetic Counselors
Quality Officers
Data Manager/Registrars
Billers & Coders

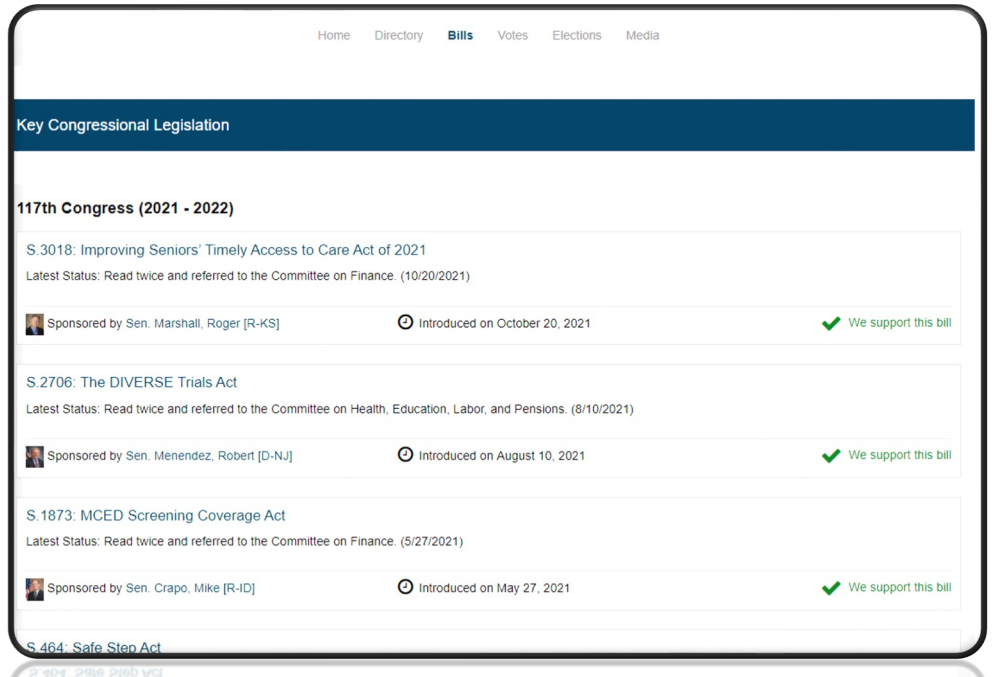
1,700

Private Practices, Hospital Cancer Programs, Healthcare Systems, & Major Academic Centers Nationwide

Stay Abreast of Key Congressional Legislation And Take Action In A Few Steps







Highlights from the 2023 MPFS and HOPPS Final Rules

Teri Bedard,BA, RT(R)(T), CPC
Executive Director, Client & Corporate Resources,
Revenue Cycle Coding Strategies

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Notices

- When a third-party payer is involved, the determination of reimbursement for services is the decision of the individual insurance company based on the patient's policy and the third-party payer's guidelines. No guidance can adequately address reimbursement issues for the hundreds of insurance payers that exist. Efforts have been made to ensure the information was valid at the date of presentation. Reimbursement policies vary from insurer to insurer, and the policies of the same payer may vary within different United States regions. All policies should be verified to ensure compliance. Therefore, it is essential that each payer be contacted for their individual requirements.
- Current Procedural Terminology (CPT®) codes, descriptions, and other data are copyrighted by American Medical Association (AMA) (or such other date of publication of CPT®) for 2022. All rights reserved. CPT® is a registered trademark of the AMA. Code descriptions and billing scenarios are references from the AMA, Centers for Medicare & Medicaid Services (CMS), local and national coverage determinations (LCD/NCD) and standards nationwide.

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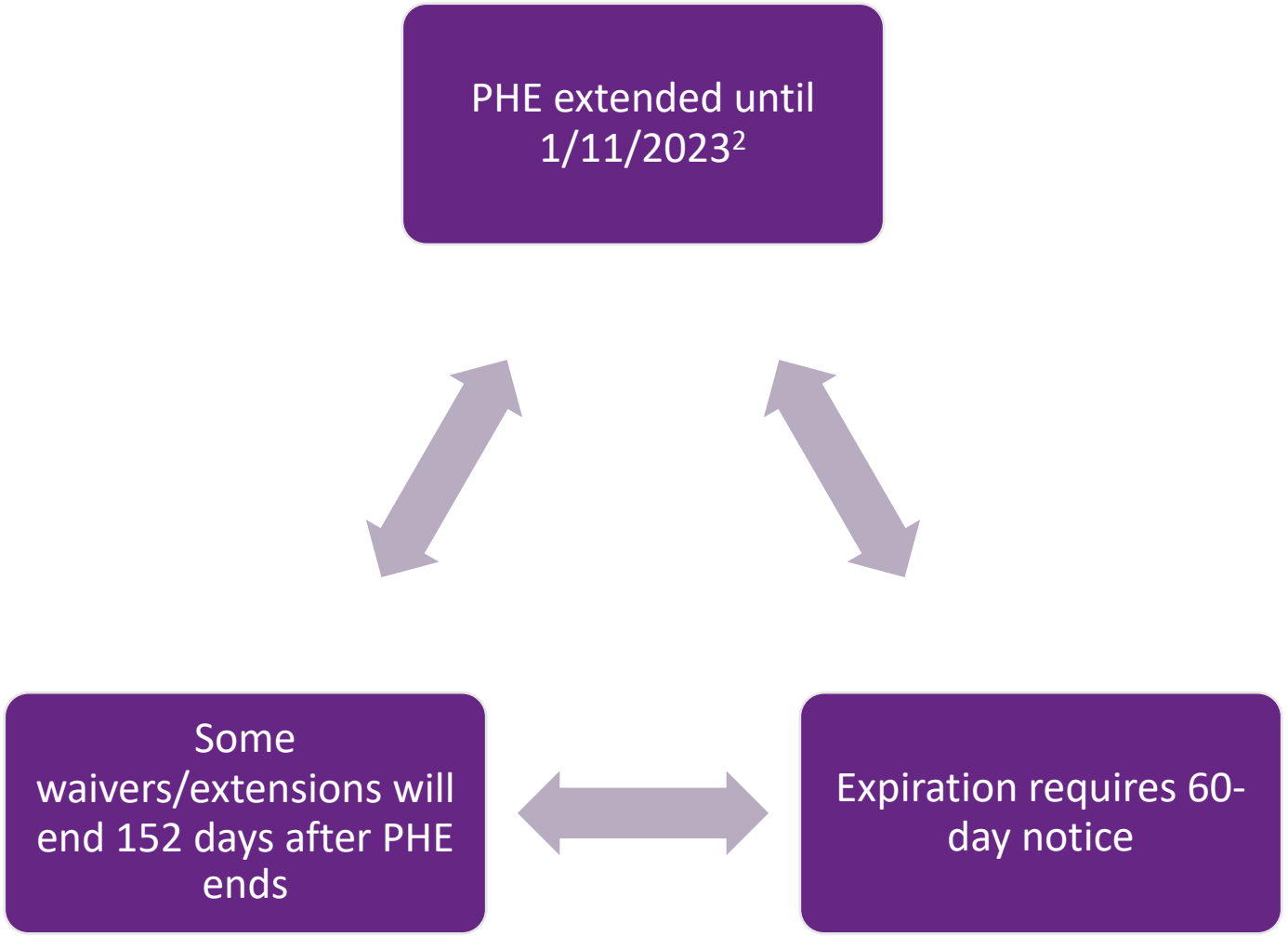
Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Final Rule[1]

STATUS OF THE Public Health Emergency (PHE)



Return to Normal

- **Permanent Changes**
  - New rules codified to make certain flexibilities permanent (mental/behavioral health)
- **Phased Out**
  - Allow for extension of the flexibilities for transition period after PHE ends
- **Cease Immediately**
  - Ends with the PHE declaration

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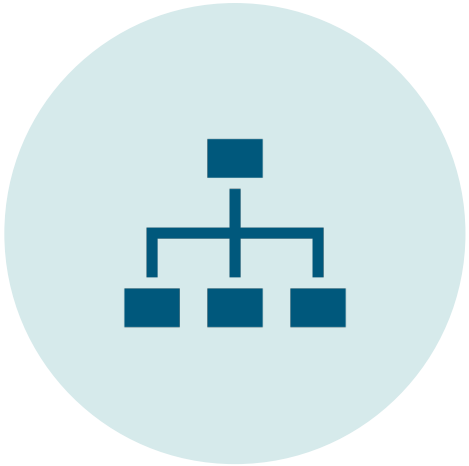
Key Flexibilities in Oncology



Supervision

Telehealth

Supervision Flexibilities

- Definition of direct supervision adjusted to include “virtual presence”
- Allowed supervision of clinical staff through real-time audio and video technology
- Set to return to pre-PHE rules at the end of the calendar year that the PHE ends

CMS reminds required use of the “FR” modifier on any applicable telehealth claim where supervision using virtual presence is utilized

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"We also solicited comment regarding the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services, as we recognize that it may be inappropriate to allow direct supervision without physical presence for some services due to potential concerns over patient safety. As discussed in last year's final rule (86 FR 65063), and based on gaps in the currently available evidence, we are in need of more information as we consider whether to make permanent a temporary exception to our direct supervision policy."

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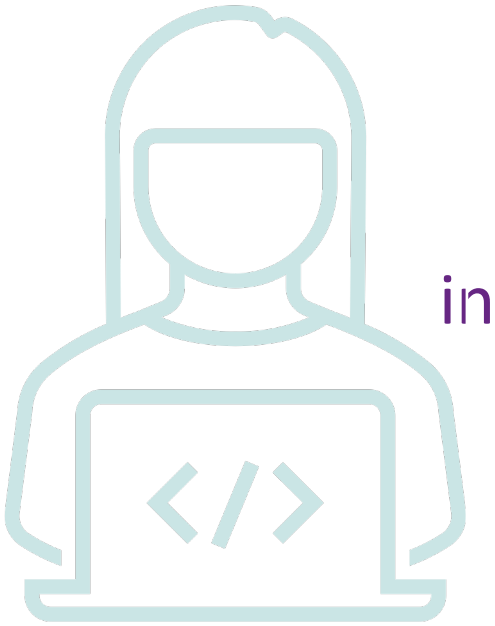
Telehealth Update



According to the September 2021 Medicare Telemedicine Snapshot, telehealth services have increased more than 30-fold since the start of the PHE and have been utilized by more than half of the Medicare population.

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Current Telehealth Flexibilities

- Telehealth available regardless of setting
- Patient not required to be at “originating site”
- Use of smartphones and other audio/video technologies
- Expanded allowable telehealth services
  - Audio-only encounters by utilization of telephone evaluation and management services
  - Virtual check-ins and e-visits for new patient visits
  - Treatment management visits (CPT® 77427) for radiation oncology

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Consolidated Appropriations Act of 2022

- Extends certain telehealth flexibilities for Medicare patients for 151 days after the official end of the PHE

Key Provisions

- Telehealth provided at home
- Expanded telehealth practitioners
- Audio-only telehealth
- Delayed in-person requirement for mental health services
- Extension for federally qualified health centers (FQHCs) and rural health clinics (RHCs) as distant sites
- 77427 provided via telehealth

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Calculating Conversion Factor (CF)

TABLE 146: Calculation of the CY 2023 PFS Conversion Factor

CY 2022 Conversion Factor		34.6062
Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		33.5983
Statutory Update Factor	0.00 percent (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.60 percent (0.9840)	
CY 2023 Conversion Factor		**33.0607**

Budget neutrality factor to maintain budget within +/- $20 million

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Estimated Specialty Impacts

CY 2023 MPFS Estimated Impact on Total Allowed Charges by Specialty					
(A) Specialty	(B) Allowed Charges (millions)	(C) Impact of work relative value unit (RVU) changes	(D) Impact of practice expense RVU changes	(E) Impact of malpractice RVU changes	(F) Combined impact
Hematology/Oncology	$1,713	0%	-1%	0%	-1%
Radiation Oncology and Radiation Therapy Centers	$1,615	-1%	0%	0%	-1%

*Column F may not equal the sum of columns C, D, and E due to rounding.

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Congressional Action Expected

Cancel Pay-As-You-Go Rule (PAYGO)

Physician Fee Patch

Telehealth Extension

Mental Health Provisions

Medicaid Support from PHE Changed

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Evaluation and Management (E/M) Services

Delay in Split/Shared Revision

Inpatient and Observation Coding Changes

Clarification of Initial and Subsequent

New Prolonged Services

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Split/Shared Visits

E/M Visit Code Family	2022 & 2023 Definition of Substantive Portion	2024 Definition of Substantive Portion
Other Outpatient	History, or exam, or medical decision-making (MDM), or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/ Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

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Clarifying Initial and Subsequent

Initial Definition

- An initial service would be defined as one that occurs when the patient has not received any professional services from the physician or other qualified healthcare professional or another physician or other qualified healthcare professional of the same specialty who belongs to the same group practice during the stay.

Subsequent Definition

- A subsequent service would be defined as one that occurs when the patient has received any professional services from the physician or other qualified healthcare professional or another physician or other qualified healthcare professional of the same specialty who belongs to the same group practice during the stay.

CMS does not recognize subspecialties as outlined in CPT® manual

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CPT® Revisions

Initial Hospital Inpatient or Observation Care	MDM	Total Time (2023)
99221	Straightforward or low	40 minutes
99222	Moderate	55 minutes
99223	High	74 minutes

Subsequent Hospital Inpatient or Observation Care	MDM	Total Time (2023)
99231	Straightforward or Low	25 minutes
99232	Moderate	35 minutes
99233	High	50 minutes

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Inpatient Prolonged Service (AMA)

99418

Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time

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Inpatient Prolonged Service (CMS)

G0316

Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact

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TABLE 24: Required Time Thresholds to Report Other E/M Prolonged Services

Primary E/M Service Prolonged	Prolonged Code*	Time Threshold to Report Prolonged	Count Physician/Non-Physician Practitioner (NPP) Time Spent Within this Time Period (surveyed timeframe)
Initial inpatient/observation(s) (IP/Obs.) visit (99223)	G0316	105 minutes	Date of visit
Subsequent IP/Obs. visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. same-day admission/discharge (99236)	G0316	125 minutes	Date of visit to 3 days after
IP/Obs. discharge day management (99238-9)	n/a	n/a	n/a
Emergency department visits	n/a	n/a	n/a
Initial nursing facility (NF) visit (99306)	G0317	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF visit (99310)	G0317	85 minutes	1 day before visit + date of visit +3 days after
NF discharge day management	n/a	n/a	n/a
Home/residence visit new Patient (99345)	G0318	141 minutes	3 days before visit + date of visit +7 days after
Home/residence visit established patient (99350)	G0318	112 minutes	3 days before visit + date of visit +7 days after
Cognitive assessment and care planning	n/a	n/a	n/a
Consults	n/a	n/a	n/a

* Time must be used to select visit level. Prolonged service time could be reported when furnished on any date within the primary visit's surveyed timeframe and would include time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we would not assign a frequency limitation.

CPT® vs. CMS

Visit Type	99418 (per CPT®)	G0316 (per CMS)
Initial Inpatient or Observation	90 minutes or longer	105 minutes
Subsequent Inpatient or Observation	65 minutes or longer	80 minutes

Colorectal Cancer Screening

- CMS finalized its proposal to update coverage for colorectal cancer screening services to align with the updated United States Preventive Services Task Force (USPSTF)
- Recommendation to begin screening at age 45 rather than age 50
- CMS also finalized its intent to expand the definition of colorectal cancer screening to include a follow-up screening colonoscopy after a positive result on a Medicare-covered, non-invasive, stool-based screening test
- CMS believes this will reduce screening barriers by ensuring patients will not be responsible for cost sharing for the additional test

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Discarded Drugs

Data for 2020 shows that Medicare paid nearly **$720 million** for discarded amounts of drugs from a single-dose container or single-use package paid under Part B, with claims identifying the discarded amounts with the JW modifier

Large percentage of these drugs are dosed based on patients' body weight or body service area

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Infrastructure Investment and Jobs Act

Signed into law November 2021

Requires manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug

Determined based on amount of discarded drug that exceeds an applicable percentage (10%) of total charges for a drug in a calendar quarter

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Refundable Drugs vs. Excluded Drugs

NDCs assigned to the drug's code must be single-dose containers or single-use packages, as described in each product's labeling

Excluded drugs would be radiopharmaceuticals, imaging agents, drugs requiring filtration during the drug preparation process, and drugs approved on or after the date of enactment of the Infrastructure Act (November 15, 2021) for which payment under Part B has been made for fewer than 18 months

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Facility Setting

- **Included:**
  - Separately payable drugs and biologicals status indicator (SI) “K” or “G”

- **Excluded:**
  - Packaged drugs in hospital outpatient setting
  - FQHCs
  - RHCs

Data Collection

Modifier JW

Identify discarded billing units to calculate the refund amount

Modifier JZ

Required when there was no discarded amount from the single-dose vial or single-use package paid under Part B

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"Analysis of Medicare claims found that the level of compliance is variable among providers, and that nearly two-thirds never used the modifier at all."

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Portion of Codes Meet Criteria

Portion of Table from CMS - Estimated Refund Amounts Based on CY 2020 JW Modifier Data

HCPCS Code	CY 2020 Total Allowed Amount	Percent Units Discarded	Percent Discarded Units – 10%	Estimated Annual Refund	Estimated Quarterly Refund
J9262	$342,668.12	19.96%	9.96%	$34,129.74	$8,532.44
J2796	$240,489,959.82	16.83%	6.83%	$16,425,464.26	$4,106,366.06
J9309	$49,591,437.88	15.79%	5.79%	$2,871,344.25	$717,836.06
J9153	$8,651,250.34	14.63%	4.63%	$400,552.89	$100,138.22
J9179	$45,528,228.20	12.60%	2.60%	$1,183,733.93	$295,933.48
J9264	$352,102,440.73	14.46%	4.46%	$15,703,768.86	$3,925,942.21

25 Healthcare Common Procedure Coding System (HCPCS) codes met the definition of refundable, with a more than 10% or more discarded amount, which were utilized to demonstrate an estimated quarterly refund based on CY 2020 JW modifier data.

Implementation

- 6-month delay to allow for necessary updates to claims systems
- Lacking modifiers on or after **July 1, 2023,** may be subject to audits
- Lacking modifiers on or after **October 1, 2023,** returned as un-processable
- Recommended to hold claims until systems are capable of reporting modifiers

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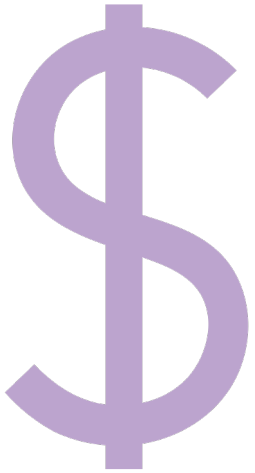
CY 2023 Hospital Outpatient Prospective Payment System (HOPPS) Final Rule[3]

HOPPS Payment Rates

3.8% increase to Outpatient Department (OPD) fee schedule



Total payments of $86.2 billion for CY 2023

Drugs, Biologicals, & Radiopharmaceuticals

- Drugs & biologicals **finalized** to be packaged at per-day admin cost of ≤ $135
- Drugs & biologicals >$135 paid separately, *except*
  - Diagnostic radiopharmaceuticals
  - Contrast agents
  - Anesthesia drugs
  - Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure
  - Drugs and biologicals that function as supplies or devices when used in a surgical procedure
- Drugs with no sufficient pricing data during initial sales period paid at **wholesale acquisition cost (WAC) +3%**

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Biosimilar Biological Products

CMS will continue to make all biosimilar biologicals eligible for pass-through payment, not just the first biosimilar of a reference drug

Inflation Reduction Act of 2022 included a temporary increase to average sales price (ASP) +8 for a 5-year period for qualifying biosimilars

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340B Drug Program

- June 15, 2022 – The Supreme Court ruled that the Department of Health and Human Services (HHS) may not vary payment rates without survey of hospitals acquisition costs
- Returned payment rate of ASP+6 for separately payable drugs and biologicals purchased under 340B program
- Continue to require JG and TB modifiers for informational purposes
- Reconciliation for payments prior to reversal will be established via future rulemaking

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"…since the Supreme Court invalidated the previous payment rate of ASP-22.5 percent for 340B acquired drugs and biologicals, we must decrease other rates to offset the increase in 340B drug payment. We believe the best interpretation of the statute is to require budget neutrality across the program."

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New Technology – Scalp Cooling

- Effective July 1, 2021
- Initial measurement and calibration of a scalp cooling device for use during chemotherapy administration to prevent hair loss
- Medicare's NCD policy, NCD 110.6 *(Scalp Hypothermia During Chemotherapy to Prevent Hair Loss)*
  - Scalp cooling cap is classified as a supply and not paid separately under HOPPS
- Assigned to New Technology APC for CY 2023

CPT Code	Long Descriptor	Final CY 2023 OPPS APC	Final CY 2023 National Rate
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	1520	$1,850.50

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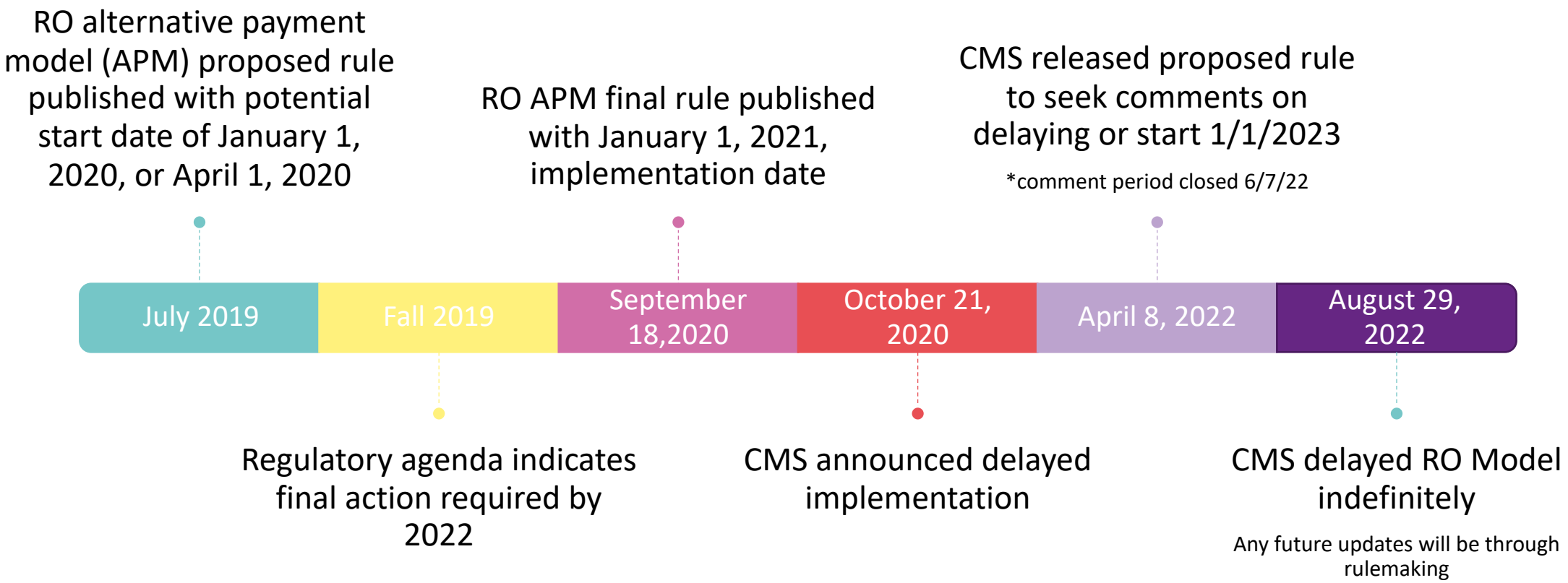
Timeline of Radiation Oncology (RO) Model



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"On August 29, 2022, CMS finalized delaying the current start date of the Radiation Oncology (RO) Model to a date to be determined through future rulemaking. In the CY 2020 MPFS final rule (84 FR 62797), we finalized that, in the interest of payment stability, we would continue to maintain current coding for radiation treatment services, including HCPCS G-codes with their current work RVUs and direct PE inputs, given the introduction of the RO Model, and to prevent disruption in beneficiary access to radiation treatment services. While we did not make any proposals for payment for these radiation treatment services under the MPFS for CY 2023, we note that we are reviewing our current coding and payment policies for the radiation therapy services, including whether we should adopt the revised CPT coding that was established in CY 2015 to allow for coding and payment consistency, considering the fact that CMS finalized delaying the current start date of the RO Model earlier this year. Any such changes would be addressed in future rulemaking."

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OPEN FOR QUESTIONS

Federal Policy Updates

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Association of Community Cancer Centers

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Congressional Updates

Summary of the Inflation Reduction Act (IRA)[4]

Extension of Enhanced ACA Subsidies	• Increases the duration of financial assistance for those already eligible to buy subsidized Affordable Care Act (ACA) Marketplace plans and expanded subsidies to more middle-income individuals through 2025 • Originally set to expire at the end of 2022

Medicare Part D Redesign	• Eliminates the 5% coinsurance requirement above the catastrophic threshold in 2024 and implements a $2,000 cap on out-of-pocket drug spending in 2025
	  • Allows the option to spread the annual out-of-pocket costs into monthly payments
	  • Limits Part D premium growth to no more than 6% per year through 2030
	• Eliminates cost sharing for adult vaccines and limits copayments to $35/month for Part D insulin products

Prescription Drug Price Negotiation	• Requires Department of Health and Human Services (HHS) to negotiate prices for a set number of high-cost prescription drugs covered by Medicare Parts B and D • Negotiation-eligible drugs include brand-name drugs or biologics that are without generic or biosimilar equivalents that are 9 or more years (small-molecule drugs) or 13 or more years (biologics) from U.S. Food and Drug Administration (FDA) approval • Would establish a negotiated “Maximum Fair Price” for Medicare and impose a financial penalty in the form of an excise tax on drug manufacturers that do not negotiate with HHS

Implementation Timeline of IRA Prescription Drug Provisions[4]

2023	2024	2025	2026	2027	2028	2029
Rebates required if drug companies increase drug prices faster than the rate of inflation The rebate is assessed only on units sold in Medicare; commercial units are excluded	Eliminates the 5% coinsurance requirement above the Part D catastrophic threshold Expands income eligibility for Part D Low-Income Subsidy full benefits up to 150% FPL	Caps Part D out-of-pocket spending at $2,000 annually and implements other Part D Benefit Changes	HHS is authorized to negotiate the price of 10 high-cost Part D drugs	Expanded HHS authority to negotiate prices for an additional 15 Part D drugs Delays implementation of Trump Administration's Rebate Rule to 2032	Price negotiation for 15 more Part D *and* Part B drugs	Price negotiation expands to 20 additional Part B *and* Part D drugs (Cumulatively up to 60 Part D drugs and 35 Part B drugs)

Medicare prescription drug price negotiation

Part D premium growth capped at 6% per year through 2030

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MPFS CF & Budget Neutrality[5]

Supporting Medicare Providers Act of 2022 (HR 8800)

- On Sept. 13, 2022, Reps. Ami Bera, MD, (D-CA) and Larry Bucshon, MD, (R-IN) introduced bipartisan legislation to mitigate CMS' proposed MPFS CF cuts for CY 2023, effectively putting the cuts on hold for a year.
- While the lawmakers recognized that physicians face payment cuts of more than 8% in 2023, this piece of legislation would negate only the 4.5% reduction to the CF for CY 2023.
- Gaining lots of momentum for inclusion in end-of-year legislative package.

Predictions for the 118th Congress

Continuation of Telehealth Flexibilities[6]

Advancing Telehealth Beyond COVID-19 Act of 2021 (HR 4040)

- Would extend many Medicare telehealth flexibilities and waivers through December 31, 2024, regardless of when the COVID-19 PHE ends, including:
  - The ability for beneficiaries to continue to receive telehealth services from any site including their homes
  - The provision of E/M and behavioral health services via audio-only technology
- Passed the House by a vote of 416 to 12 on July 27

Prior Authorization Reform in Medicare Advantage[7]

Improving Seniors' Timely Access to Care Act of 2021 (HR 3173/S 3018)

- Would streamline and standardize prior authorization processes within the Medicare Advantage program by requiring these plans to:
  - Establish an electronic prior authorization program, including the ability to provide real-time decisions in response to requests for items and services that are routinely approved;
  - Annually publish specified prior authorization information, including the percentage of requests approved and the average response time; and
  - Meet other standards relating to the quality and timeliness of prior authorization determinations.
- House passed by unanimous voice vote on Sept. 14

FTC Inquiry Into PBM Business Practices[8,9]

- On Feb. 24, the Federal Trade Commission (FTC) announced a request for information soliciting public comments on PBM "business practices" that affect drug affordability and access, including contract terms, rebates, fees, pricing policies, steering methods, conflicts of interest, and consolidation.
- In response to more than 24,000 public comments received, the FTC voted unanimously to launch an inquiry into the pharmacy benefit manager (PBM) industry and send compulsory orders to CVS Caremark, Express Scripts, OptumRx, Humana, Prime Therapeutics (BCBS), and MedImpact Healthcare Systems (Kaiser).
- The inquiry is aimed at shedding light on a variety of PBM practices, including:
  - Fees and clawbacks charged to unaffiliated pharmacies
  - Methods to steer patients towards pharmacy benefit manager-owned pharmacies
  - Potentially unfair audits of independent pharmacies
  - Complicated and opaque methods to determine pharmacy reimbursement
  - Prevalence of prior authorizations and other administrative restrictions
  - Use of specialty drug lists and surrounding specialty drug policies
  - Impact of rebates and fees from drug manufacturers on formulary design and the costs of prescription drugs to payers and patients

Federal PBM Reform Legislation: The PBM Transparency Act of 2022 (S 4293)[10]

- Introduced by Senators Chuck Grassley (R-IA) and Maria Cantwell (D-WA) on May 24 to empower the FTC to increase drug pricing transparency and hold PBMs accountable for unfair and deceptive practices that drive up the costs of prescription drugs at the expense of consumers.
- Advanced by Senate Committee on Commerce (19-9) on June 22 to full Senate vote.
- Specifically, this legislation:
  - Prohibits spread pricing; arbitrarily, unfairly or deceptively reducing or clawing back drug reimbursement payments to pharmacies; and charging pharmacies more to offset federal reimbursement changes;
  - Incentivizes fair and transparent PBM practices by providing exceptions to liability for PBMs that pass along 100 percent of rebates to health plans
  - Requires PBMs to report the amount of money they obtain from spread pricing, pharmacy fees and claw backs; report any differences in the PBMs' reimbursement rates or fees PBMs charge affiliated vs. non-affiliated pharmacies; report whether and why they move drugs in formulary tiers to increase costs;
  - Enhances enforcement by authorizing the FTC and state attorneys general to enforce the legislation and hold bad actors accountable.

Thank you!
Please reach out and stay in touch:

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Director of Cancer Care Delivery & Health Policy
Association of Community Cancer Centers

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Closing Remarks!

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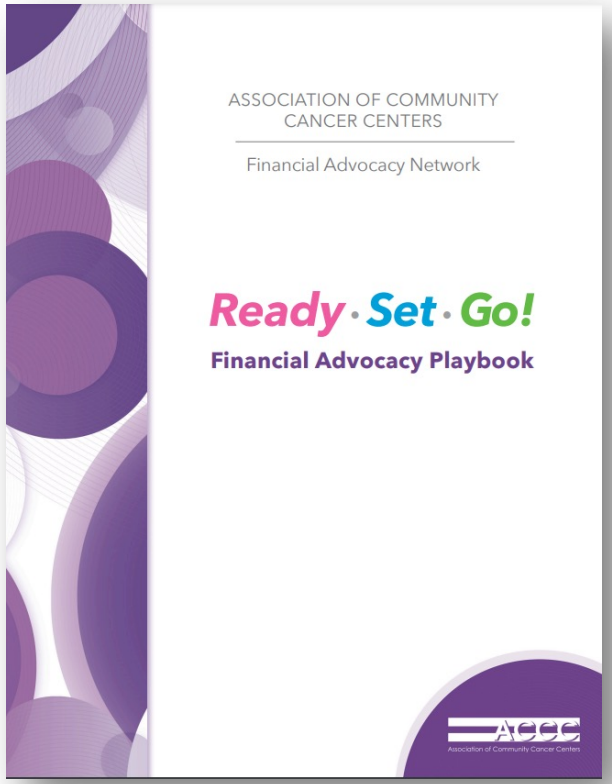
ACCC Financial Advocacy Network Resources and Tools

Financial Advocacy Playbook



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Tool Kit

- The Financial Advocacy Toolkit includes a multitude of resources, including:

BENEFITS VERIFICATION	FILING CLAIMS	MEDICARE & MEDICAID
COMMUNICATION	FINANCIAL ASSISTANCE	PRIOR AUTHORIZATION
DENIALS & APPEALS	FINANCIAL TOXICITY & SCREENING	PROGRAM DEVELOPMENT
EMPLOYMENT & DISABILITY	INSURANCE EDUCATION & OPTIMIZATION	TRACKING & REPORTING

Boot Camp

ACCC 2022

THANK YOU FOR YOUR PARTICIPATION!

Association of Community Cancer Centers