issues

News from Capitol Hill, Regulatory Agencies & Oncology Stakeholders

ACCC Efforts Pay Off in Proposed HOPPS Rule!

On July 6, 2012, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2013 rule to update payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and ambulatory surgical centers. Among the changes, ACCC was pleased to see the agency is proposing to pay for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at the statutory default of average sales price (ASP)+6 percent. ACCC has long advocated for this change, and is hopeful to see this increase carry over into the final rule. For more on the 2013 HOPPS proposed rule keep reading.

HOPPS Proposed Rule

For 2013 CMS is proposing to increase HOPD payment rates by 2.1 percent. CMS proposes to continue the 2.0 percentage point reduction in payments for hospitals failing to meet the hospital outpatient quality reporting requirements. Total projected payments to hospitals under the Outpatient Prospective Payment Systems (OPPS) in 2013 will be approximately $48.1 billion.

The comment period ended Sept. 4, 2012. A final rule will be published by Nov. 1, 2012, and will take effect on Jan. 1, 2013.

Significant proposals for CY 2013 include:

- ***Change in payment methodology from median costs to geometric mean costs.*** CMS is proposing to use the geometric mean costs of services within an APC to determine the relative payment weights of services, rather than the median costs that have been used since the inception of the HOPPS. CMS believes geometric mean costs better reflect average sales costs of services than the median. The agency's analysis shows that the proposed change would have a limited payment impact on most providers.
- ***Drugs and pharmacy overhead.*** CMS is proposing to pay for the acquisition and pharmacy overhead costs of separately payable drugs and biological without pass-through status at the statutory default of average sales price (ASP)+6 percent.
- ***Packaged drugs, biologicals, and radiopharmaceuticals.*** CMS is proposing to increase the packaging threshold from $75 to $80 per day in 2013.
- ***Cancer hospitals.*** CMS proposes continuation of cancer hospital adjustment policies finalized in 2012.
- ***Supervision regulations.*** In the proposed rule, CMS clarifies the application of the supervision regulations to physical therapy, speech-language pathology, and occupational therapy services that are furnished in OPPS hospitals and critical access hospitals (CAHs) and extends the non-enforcement instruction for CAHs and certain small rural hospitals for one final year through 2013.
- ***Multiple imaging composite APCs.*** For 2013 CMS proposes to continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite payment methodology.

CMS is not proposing any new measures for the Hospital Outpatient Quality Reporting Program in addition to those previously finalized for the CY 2014 and CY 2015 payment determinations. CMS proposes to extend the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs through 2013 without changes.

An in-depth analysis of the proposed 2013 HOPD rule is available on the members-only section of ACCC's website, *www.accc-cancer.org*.

MPFS Proposed Rule

On Jul. 6, 2012, CMS issued the proposed Medicare Physician Fee Schedule (MPFS) rule for services furnished on or after Jan. 1, 2013.

For 2013 CMS projects a 27 percent reduction in MPFS payment rates under the Sustainable Growth Rate (SGR) methodology due to the expiration of the adjustment made for CY 2012 in the statute.

Under the 2013 proposed MPFS rule, radiation oncology will face significant payment reductions due in part to changes in reimbursement for IMRT and SBRT, as well as expansion of the Multiple Payment Procedure Rate (MPPR). In 2013 under the proposed MPFS, medical oncology rates will see roughly a 1 percent decrease, assuming Congress eliminates the SGR and not taking sequestration

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into account. Radiation oncology faces a 14 percent decrease in payment rates. (See Table 1, below).

CMS proposes changes to several of the quality reporting initiatives associated with MPFS payments—the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, and the PQRS-EHR Incentive Pilot—as well as changes to the Physician Compare tool on the Medicare.gov website. CMS also includes proposals for implementing the physician value-based modifier (Value Modifier) required by the Affordable Care Act (ACA) that would affect payments to physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in traditional Medicare Fee-for-Service.

The comment period ended Sept. 4, 2012. CMS will publish the final rule on or about Nov. 1, 2012.

Significant proposals for CY 2013 include:

- Reductions in payments for certain services considered potentially misvalued by CMS.
- Expanded application of the MPPR policy to additional categories of physician services. CMS proposes applying the MPPR to the professional component of certain diagnostic imaging services when two or more physicians in the same group practice furnish services "to the same patient, in the same session, on the same day."
- Significant reductions in procedure time assumptions for IMRT delivery services (from 60 minutes to 30 minutes for CPT 77418) and stereotactic body radiation therapy SBRT delivery services (from 90 minutes to 60 minutes for CPT 77373).
- Review and adjustment to 22 codes with stand-alone procedure time assumptions used in developing nonfacility PE RVUs, including some radiation therapy and radiation treatment delivery codes, hyperthermia treatment, brachytherapy services, and electron microscopy.
- Change in interest rate assumption used in pricing equipment costs for purposes of calculating practice expense (PE) relative value units (RVUs).
- Adoption of a new transitional care management HCPCS G-code describing post-discharge transitional care management. The code would permit payment to community physicians or qualified nonphysician practitioners for the non-face-to-face work involved in coordinating services for a beneficiary after discharge from hospital, skilled nursing facility, and certain other settings.
- Policies related to a new value-based payment modifier.

An in-depth analysis of the proposed 2013 MPFS rule is available on the members-only section of ACCC's website, *www.accc-cancer.org*.

Table 1. Proposed 2013 MPFS Payment Policy Impact on PFS*

SPECIALTY	ALLOWED CHARGES (MILLIONS)	IMPACT OF WORK & MP RVU CHANGES	IMPACT PE RVU CHANGES	COMBINED IMPACT
Hematology & Oncology	$1,900	-1%	0%	-1%
Radiation Oncology	$1,983	-1%	-14%	-14%
Radiology	$4,791	-1%	-3%	-4%

Source: Health Policy Alternatives, Inc.
* Table 1 does not include effects of a negative January 2013 conversion factor change under current law.

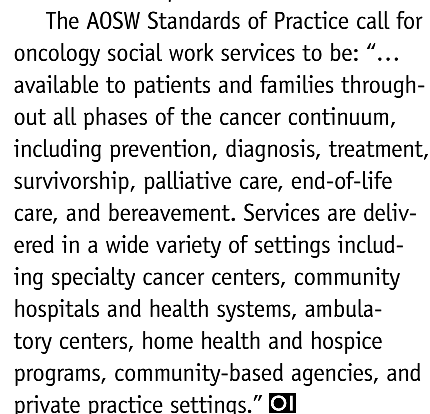
ACCC Submits Comments on PET NCD Non-Coverage Language

On Aug. 9 ACCC submitted comments to CMS regarding reconsideration of the National Coverage Determination (NCD) for the use of positron emission tomography (PET). ACCC strongly supports the request for reconsideration and urges CMS to remove the current blanket non-coverage language of the PET NCD as applied to new PET radiopharmaceuticals approved by the FDA. This revision will allow new and improved tracers to reach patients battling cancer much sooner than under the current language that requires CMS to reopen the NCD to cover each new PET radiopharmaceutical approved by the FDA.

ACCC's comments state that, "Our patients cannot afford to wait so long for technologies that, under the FDA's rigorous approval process, already have demonstrated meaningful clinical benefit."

AOSW Releases New Standards of Practice

The Association of Oncology Social Work has released its 2012 "Standards of Practice in Oncology Social Work (*www.aosw.org/html/prof-standards.php*). The Standards include qualifications, services to patients and families, services to institutions and agencies, services to the community, and services to the profession.



The AOSW Standards of Practice call for oncology social work services to be: "… available to patients and families throughout all phases of the cancer continuum, including prevention, diagnosis, treatment, survivorship, palliative care, end-of-life care, and bereavement. Services are delivered in a wide variety of settings including specialty cancer centers, community hospitals and health systems, ambulatory centers, home health and hospice programs, community-based agencies, and private practice settings." OI