ACCC
Association of Community Cancer Centers

Federal Updates Including EOM

September 16, 2022

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CY 2023 Medicare PFS Proposed Rule

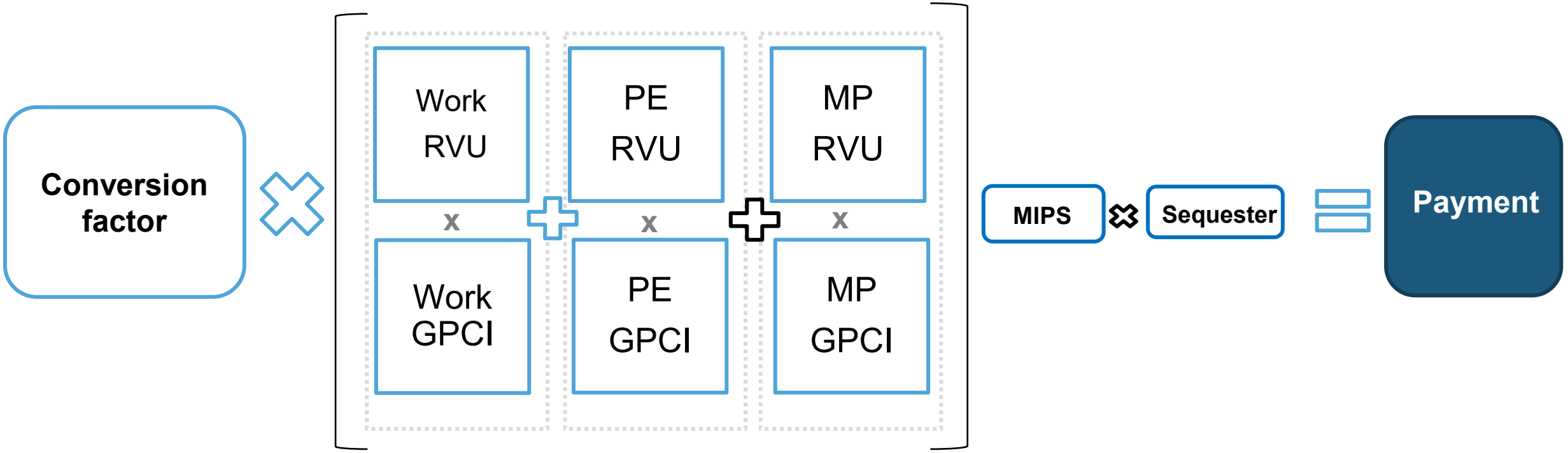
CY 2023 PFS Conversion Factor (CF)

TABLE 136: 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	-1.55 percent (0.9845)	
CY 2023 Conversion Factor		**33.0775**

- **Difference of -4.42% from the finalized CY 2022 CF**
- **Does not include RVU changes, sequestration (-2%), or the statutory PAYGO sequester triggered by the American Rescue Plan Act (-4%)**

Medicare Service Payment Calculation



RVU Changes: Specialty Impact by Setting

Specialty	Total Non-Facility/Facility	Allowed Charges (mil)	Combined Impact
Hematology/Oncology	TOTAL	$1,707	-1%
	Non-facility	$1,130	-2%
	Facility	$577	1%
Radiation Oncology and Radiation Therapy Centers	TOTAL	$1,609	-1%
	Non-facility	$1,540	-1%
	Facility	$69	-1%

“OTHER” EVALUATION AND MANAGEMENT (E/M) SERVICES

MDM & Time-based

Inpatient and observation, Emergency department (ED), Nursing facility, Domiciliary or rest home, Home visits, and Cognitive impairment assessment

CMS Accepting Most of AMA Guidelines

Clarified Initial and Subsequent

Different Criteria for Prolonged Services

E/M Split (or Shared) Visit Definitions

CMS is proposing to maintain the 2022 definition of the "substantive portion" of an E/M service performed by both a physician and a non-physician practitioner in a facility setting through 2023.

E/M Visit Code Family	2022 & 2023 Definition of Substantive Portion	2024 Definition of Substantive Portion
Outpatient Facility*	History, or exam, or 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

***Non-facility office visits will not be billable as split (or shared) services.**

Status of the COVID-19 PHE

PHE Extended July 15, 2022

Extension beyond October 13, 2022?

Some waivers/extensions will end 152 days after PHE ends

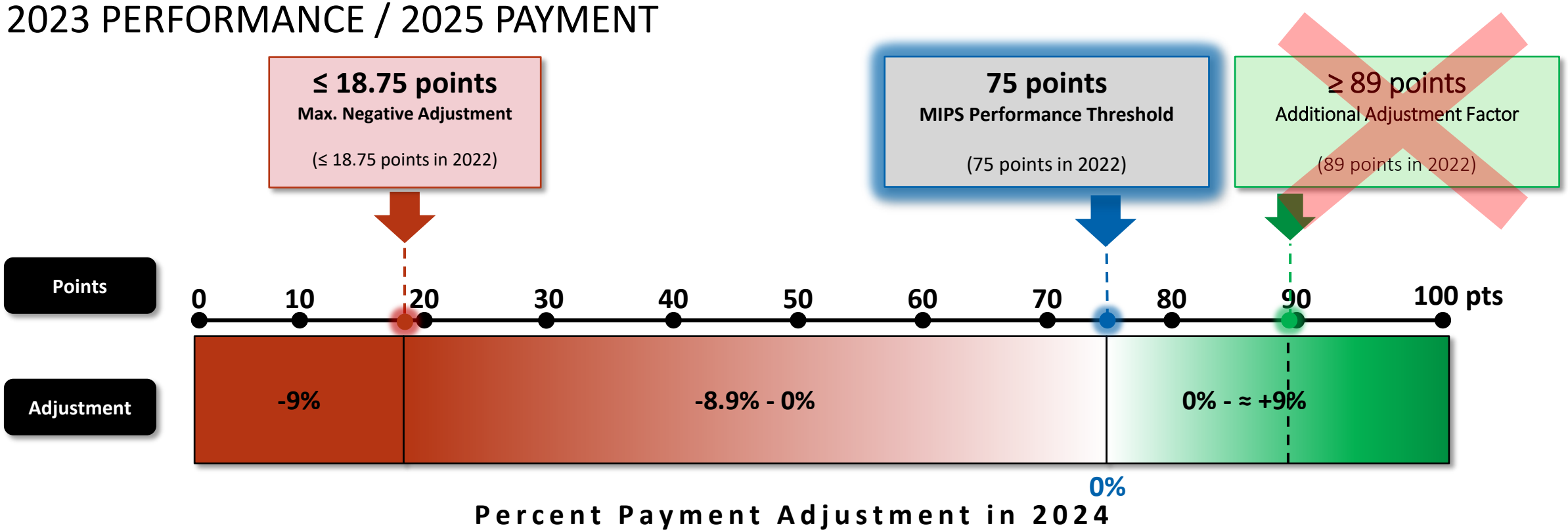
Medicare Telehealth After the COVID-19 PHE

Temporary Codes	• End day 152 Post-PHE to align with Consolidated Appropriations Act of 2022, **including Audio-only E/M codes 99441-99443**
Modifiers and POS Codes	• Modifier 95 No Longer Applies • Use POS Codes – 02 & 10
Location of Patient Telehealth Services	• Telehealth no longer allowed in any geographic area or any originating site, including the beneficiary's home, except for a select subset of services/illnesses
Physician Supervision	• Returns to "Direct supervision", virtual presence ends Dec. 31st of Year PHE ends • Seeking comments on the possibility allowing virtual supervision for a select subset of services

Quality Payment Program Updates

Proposed Merit-Based Incentive Payment System (MIPS) Thresholds

2023 PERFORMANCE / 2025 PAYMENT



In CY 2022, there was an additional MIPS Payment Adjustment for Exceptional Performance above 89 points. These percentages are multiplied by a scaling factor to proportionally distribute statutorily allocated funds of $500 million. **By statute, the 2024 payment year will be the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.**

MIPS Value Pathways (MPVs)

MIPS Value Pathways (MVPs)

Aligning measures across performance categories to be more relevant to practice specialty

Guiding principles for MVPs:

- Cohesion between performance categories and measures, reducing reporting burden
- Focused participation around Pathways that are meaningful to clinician's specialty/practice or public health priority
- Clinicians report fewer measures and activities based on specialty and/or outcome within a Pathway
- Measures selected using Meaningful Measures approach, considering the patient voice
- Support the transition to digital quality measures

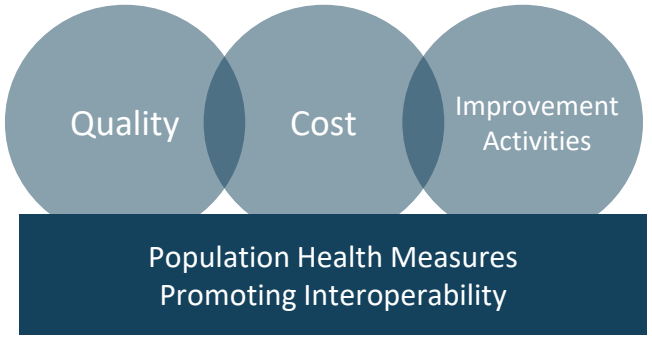
MVP Reporting Requirements:

Reporting Across all MVPs:

- **Population Health Measures:** Report on 1 selected population health measure
- **Promoting Interoperability:** Report on same PI measures as required under traditional MIPS

MVP Specific Performance Category Reporting:

- **Quality:** Report on 4 selected quality measures, one must be an outcome measure
- **Improvement Activities:** Report on either 2 medium-weighted or 1 high-weighted
- **Cost:** Performance calculated only using cost measures in the MVP using administrative claims data



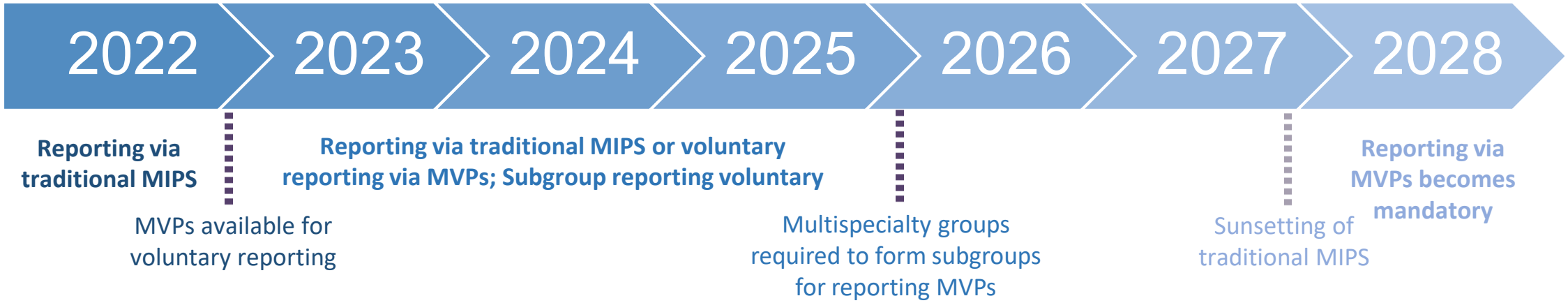
MVPs Implementation Timeline

In the CY 2022 PFS & QPP proposed rule, CMS finalized seven MVPs available for reporting in the 2023 performance year and introduced the proposed transition timeline from traditional MIPS reporting to MVPs.

In the CY 2023 PFS & QPP proposed rule, CMS proposed five new MVPs for reporting in PY 2023:

1. **Advancing Cancer Care**
2. Optimal Care for Kidney Health
3. Optimal Care for Neurological Conditions
4. Supportive Care for Cognitive-Based Neurological Conditions
5. Promoting Wellness.

Proposed MVP Implementation Timeline (*Performance Years*)



Alternative Payment Models

The Enhancing Oncology Model (EOM)

- The EOM is a new oncology-specific alternative payment model announced by the Centers for Medicare & Medicaid Services (CMS) on June 27.
- Builds upon the Oncology Care Model (OCM) with a new focus on health equity.
- EOM will be a five-year voluntary, multi-payer model beginning July 1, 2023.
- Like OCM, EOM participants will be responsible for the total cost of care during a 6-month episode for patients undergoing chemotherapy.
- Drug reimbursement is same as FFS Medicare: payment typically ASP+6%; total cost of care responsibility includes Part B drug payment and certain Part D expenditures.
- **Applications are open now through September 30, but applications are non-binding. Accepted applicants will need to sign an EOM participation agreement in early 2023 to confirm participation.**

Key Design Differences: OCM vs. EOM

Model Design	OCM	EOM
Beneficiary Population	**Beneficiaries with a cancer diagnosis receiving chemotherapy** (including hormonal therapies)	**Beneficiaries with a cancer diagnosis for one of 7 included cancer types** (breast, lung, lymphoma, multiple myeloma, small intestine/colorectal, prostate, and chronic leukemia) **receiving systemic chemotherapy** (not including exclusively hormonal therapies)
Price Prediction Models and Risk Adjustment	**All cancer types included in one price prediction model**, novel therapy adjustment and trend factors calculated in aggregate	**Included cancer type-specific price prediction models**, novel therapy adjustments and trend factors calculated separately for each included cancer type
Required Participant Redesign Activities (PRAs)	**Six cross-cutting requirements** that provide for broad improvements in cancer care including documenting a care plan, 24/7 access to a clinician, and patient navigation services.	**Same as OCM with the addition of two new PRAs**: the gradual implementation of electronically submitted patient reported outcomes and screening EOM beneficiary social needs using a health-related social needs screening tool. Also, participants must establish **a health equity plan** as part of the continuous quality improvement (CQI) requirement.
Data Collection	Participants not required to collect any sociodemographic data	Required submission of sociodemographic data, if available

Key Financial Differences: OCM vs. EOM

Model Design	OCM	EOM
Monthly Enhanced Oncology Services (MEOS) Payment	**MEOS payment amount = $160 PBPM** for each OCM beneficiary; the entire $160 is included as episode expenditures	**MEOS payment amount = $70 PBPM** (beneficiary not dually eligible for Medicaid and Medicare); or $100 PBPM (beneficiary dually eligible for Medicaid and Medicare) of which $70 will be included as episode expenditures in reconciliation calculation
Risk Arrangements	**One-sided risk in performance period (PP) 1, followed by the option for one- or two-sided risk in PP2-PP7**. Participants earning a performance-based payment by the initial reconciliation of PP4 had the option to stay in one-sided risk in PP8—PP11; other participants had to either accept two-sided risk in PP8—PP11 or be terminated from the model.	**Two-sided risk required from the start of the model. Participants to choose one of two options with downside risk**: 1) Less aggressive two-sided risk arrangement option (RA1): *Discount=4% of benchmark* *Upside=4% of benchmark; Downside=2% of benchmark* 2) More aggressive two-sided risk arrangement option (RA2): *Discount=3% of benchmark* *Upside=12% of benchmark; Downside=6% of benchmark* **For both risk arrangements, if the EOM participant's performance period episode expenditures are greater than 98% of the benchmark, they will owe a performance-based recoupment (PBR).**

The Radiation Oncology (RO) Model

July 10, 2019	Sept. 18, 2020	Dec. 27, 2020	Dec. 10, 2021	April 8, 2022	Aug. 25, 2022
• RO APM Proposed Rule published with potential start date of Jan. 1, 2020, or April 1, 2020	• RO APM Final Rule published with Jan. 1, 2021, start date	• Congress passes law prohibiting start date until Jan. 1, 2022	• Congress passes law prohibiting start date until Jan. 1, 2023	• CMS released proposed rule seeking comments on delaying the model indefinitely or start date of January 1, 2023	• CMS final rule delays start of RO Model indefinitely

Congressional Updates

The Inflation Reduction Act of 2022

- This budget reconciliation bill encompasses key pieces of the Biden administration's "Build Back Better" social and environmental agenda
- It is a significantly paired-down version of the $2.2 trillion *Build Back Better Act*, which originally that passed the House in November 2021.
- In early July 2022, the Senate Finance Committee released legislative text outlining the prescription drug provisions of the reconciliation package, largely aligned with the House version.
- On July 27, Sens. Manchin and Schumer announced they had reached a deal on a broader package including deficit reduction, tax reform, domestic energy and climate, and healthcare provisions, intending to bring it to the Senate floor the following week
- **The $740 billion *Inflation Reduction Act of 2022* (IRA) passed by the Senate on August 7 and the House on August 12. It was signed into law by President Biden on August 16.**

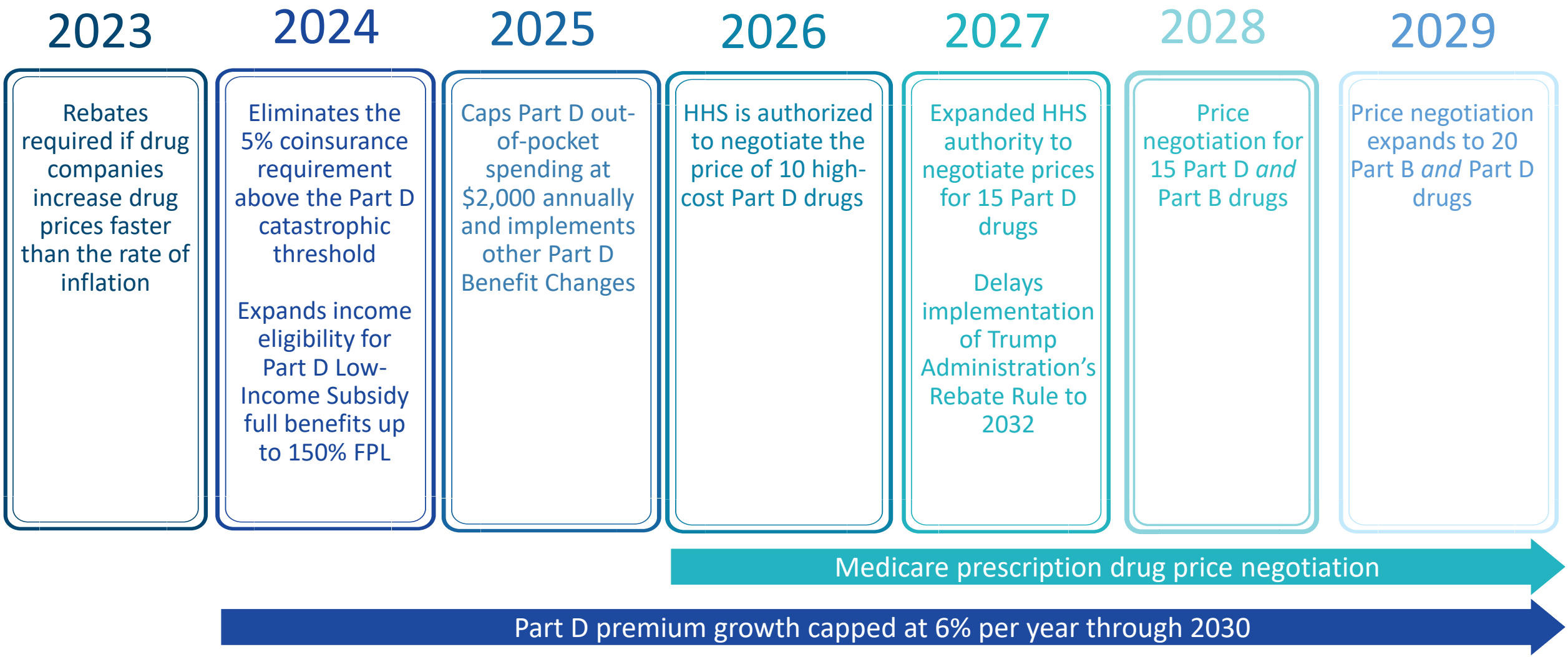
IRA: Key Healthcare Provisions

Extension of Enhanced ACA Subsidies	• Increases the duration of financial assistance for those already eligible to buy subsidized 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 (OOP) 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 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 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

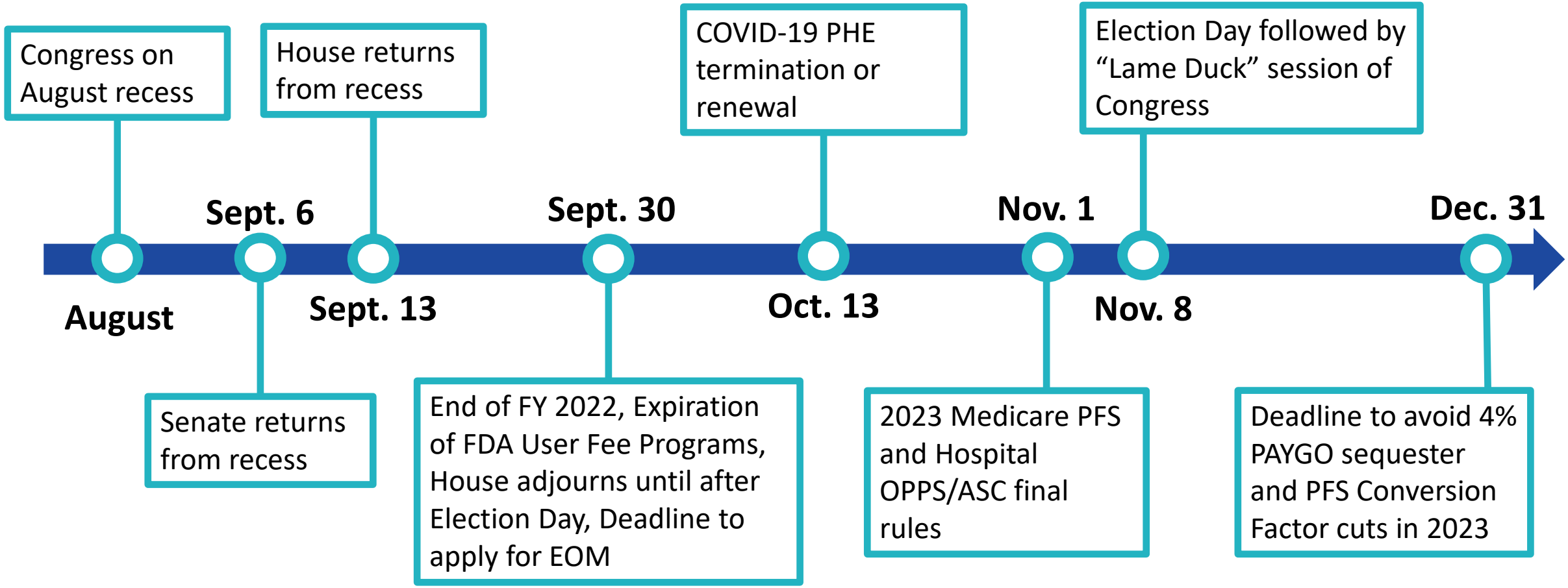


Medicare PFS CF & Budget Neutrality

Supporting Medicare Providers Act of 2022

- On Sept. 13, 2022, Reps. Ami Bera, M.D., (D-CA) and Larry Bucshon, M.D., (R-IN) introduced bipartisan legislation to mitigate CMS' proposed PFS conversion factor cuts for 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 4.42% reduction to the CF for CY 2023.

The Remainder of 2022: Important Dates



QUESTIONS

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Thank you!

Please feel free to contact me with any questions or comments on today's presentation:

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