CMS Releases CY 2015 Physician Fee Schedule Proposed Rule

On July 3, the Centers for Medicare & Medicaid Services (CMS) released its Proposed Rule for the CY 2015 Physician Fee Schedule, which preliminary analysis shows will have an overall impact on radiation therapy of approximately -3.4 percent.

CMS has proposed a cut of -5 percent to freestanding ("non-facility") radiation oncologists and a +1.5 percent increase in payments to hospital-based ("facility") radiation oncologists, which would further widen the payment differential between cancer care delivered in the two settings.

The payment reduction is a result of the CMS' proposal to remove the radiation therapy vault as a direct cost input for radiation therapy delivery codes. CMS has proposed to remove the vault as a direct cost input in the following delivery codes: 77373, 77402, 77403, 77404, 77405, 77406, 77407, 44708, 77409, 77411, 77412, 77413, 77414, 77416, and 77418.

CMS expressed the following as rationale for removal of the vault:

- The radiation treatment vault appears to be more similar to building infrastructure costs than to medical equipment costs.
- It is difficult to distinguish the cost of the vault from the cost of the building because the electrical, plumbing, and other building specifications are often unique to the intended functionality of a given building, including costs that are attributable to the specific medical equipment housed in the building.
- Specific structural components required to house the linear accelerator are similar in concept to components required to house other medical equipment such as expensive imaging equipment.

Other changes found in the Proposed Rule include:

- CMS estimates that the 2015 conversion factor will be $35.7977.
- CMS proposes to list as "potentially misvalued," 65 codes captured in a newly established statutory screen category, "codes that account for the majority of spending under the physician fee schedule," which includes two radiation oncology codes: 77263 (Radiation therapy planning) and 77334 (Radiation treatment aid(s)).
- CMS proposes to delete the G-codes used to represent robotic delivery of SRS for CPT codes 77372 and 77373.

### Impact of Proposed CY 2015 PFS Rule on Total Allowed RT Charges (By Setting)

<table>
<thead>
<tr>
<th>Setting</th>
<th>CY 2014 Payments</th>
<th>CY 2015 Payments</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>409,074,358</td>
<td>415,334,282</td>
<td>1.5%</td>
</tr>
<tr>
<td>Non-Facility</td>
<td>1,381,846,219</td>
<td>1,314,296,989</td>
<td>-4.9%</td>
</tr>
<tr>
<td>Total</td>
<td>1,790,920,576</td>
<td>1,729,631,272</td>
<td>-3.4%</td>
</tr>
</tbody>
</table>
Using OPPS and ASC Rates in Developing PE RVUs

CMS did not propose an iteration of its CY 2014 PFS proposal to cap physician payments based on the hospital Outpatient Department (OPD) rates, stating it was "persuaded that the comparison of OPPS (or ASC) payment amounts to PFS payment amounts for particular procedures is not the most appropriate or effective approach to ensuring that PFS payment rates are based on accurate cost assumptions." However, CMS continued to raise "longstanding concerns regarding the accuracy of direct PE inputs" and also notes the allocation of indirect PE is based on information collected several years ago and indicates it will likely need to be updated in the coming years. CMS further notes the difficulty that the agency has uncovered regarding collecting data directly from practices, obtaining recent invoices for medical supplies and equipment, and the fact that "many in the community expressed serious concerns over the accuracy of this (the PPIS) or other PE surveys as a way of gathering data on PE inputs from the diversity of providers paid under the PFS."

In this light, CMS continues to believe "there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology to ensure that the relative costs for PFS services are developed using data that is auditable and comprehensively and regularly updated." As a result, the agency indicates its interest in seeking comments on the best possible use of hospital outpatient cost data "to validate or, perhaps, in setting the relative resource cost assumptions within the PFS PE methodology."

CMS also raises related concerns regarding "the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments affects payments under PFS and beneficiary cost-sharing." CMS also notes "it is difficult to know which PE costs typically are actually incurred by the physician, which are incurred by the hospital, and whether our bifurcated site-of-service differential adequately accounts for the typical resource costs, given these relationships."

**CMS Proposes Increased Transparency in Payment Rate Changes**

In its Proposed Rule, CMS also included changes to the agency's procedure for establishing payment rates for Medicare services, a change recently encouraged by bipartisan lawmakers in both chambers of Congress. According to CMS, "payment changes will go through notice and comment rulemaking before being adopted," beginning in 2016, to make the process "more transparent and allow for greater public input prior to payment rates being set."

Comments are due to the Agency by September 2, 2014.

To view CMS' fact sheet, "Proposed policy and payment changes to the Medicare Physician Fee Schedule for Calendar Year 2015," [click here](#).

**RTA Develops Backgrounder on Radiation Treatment Vault**

In response to the CY 2015 Physician Fee Schedule Proposed Rule, the Radiation Therapy Alliance (RTA) developed the following points to distinguish the vault from the building and "other expensive imaging equipment."

**Vault is Distinguishable From the Building**

The vault is distinguishable from typical physician offices for the following reasons:

- Medical office buildings are not routinely built with radiation treatment vaults, which must be added through a laborious and expensive internal retrofit or an external abutting addition.
- The costs of a radiation treatment vault (including electrical, plumbing and other specifications) are unique to
the vault itself and not attributable to the building.

- The vault is often excluded from the tenant improvement allowance, as landlords typically do not treat the vault as medical office space, but rather as specialty medical equipment that is the tenant’s responsibility to provide, install, and remove.

- Land lease contracts typically require that facilities be turned back into standard space through the removal of the radiation treatment vault should the freestanding center vacate the premises.

- Internal Revenue Code (IRC) cost-segregation rules treat the radiation treatment vault as medical equipment, separately depreciable from the building itself.

Vault is Distinguishable From Shielding for Low-Level Radiation Emitting Equipment

The vault for a linear accelerator is distinguishable from shielding for low-level radiation emitting equipment for the following reasons:

- Characterizing medical linear accelerators and low-level radiation emitting equipment as "expensive imaging equipment" is flawed because (1) radiation therapy is not diagnostic imaging and (2) the proper comparator is the clinical aspect of the level of radiation produced, not the expense. Because linear accelerators are used to kill cancer cells rather than only produce images, a linear accelerator typically produces radiation that is up to 400 times more powerful than standard diagnostic imaging equipment can produce (e.g. 50-150 thousand volts for diagnostic imaging, as opposed to 6-20 million volts for radiation therapy).

- The radiation treatment vault is inextricably linked to the linear accelerator and literally cannot be built without the linear accelerator as the two are interlocking pieces of the same equipment system. Specifically, the linear accelerator medical equipment is interlocked into a base plate in the floor, which itself is held by concrete poured wall-to-wall as the vault is built around the linear accelerator it holds in place. Plumbing and electrical components are embedded into the flooring of this structure. In contrast, a room for low-level radiation emitting equipment is often routinely built as part of standard medical office space prior to determining whether any low-level radiation emitting equipment will be utilized in the facility.

- From a structural perspective, vault walls and ceilings are completely self-supporting and independent and do not provide support for any other part of the main building. In contrast, low-level radiation emitting equipment walls are not self-supporting and contain elements that are part of the building itself.

- The massive vault structure relies on its own foundation system to support the high density concrete walls and ceiling required to meet radiation shielding standards. Low-level radiation emitting equipment walls do not require their own foundation.

- If a linear accelerator were to be removed from a vault, there is no other medical or non-medical purpose for which a vault could be used. In contrast, a room containing low-level radiation emitting equipment could be used for other medical purposes if the equipment is removed.

- Radiation treatment vaults are built according to precise specifications based on the linear accelerator itself. As such, a freestanding radiation therapy center decides to change a linear accelerator, the vault must be retrofitted. Shielding for low-level radiation emitting equipment generally is not specific to the kind of equipment contained within the room and a change in low-level radiation emitting equipment typically will not necessitate a room retrofit.

- Radiation treatment vaults are unique within the Physician Fee Schedule. While the vault is a direct cost input for essentially one medical intervention (characterized by approximately 15 codes), shielding for low-level radiation emitting equipment is utilized in literally thousands of procedures (including diagnostic imaging, neurosurgery, cardiology, orthopedic surgery, pulmonology, and others).

- The costs associated with a radiation treatment vault are typically more than 5 times more expensive than the shielding associated with low-level radiation emitting equipment. In the former case, the costs are about one-third of the total set-up cost for the linear accelerator-vault system, while, in the latter case, shielding costs are nominal.

- Radiation treatment vaults have been included as a direct cost input for radiation therapy services since at least 2003. Indeed, as part of a comprehensive effort in 2004 to update equipment pricing and consider direct
cost status for many different items, CMS reviewed the radiation treatment vault and decided both to maintain its direct cost status and update its pricing by more than $200,000. In contrast, lead shielding has not been included as a direct cost input for certain low-level radiation emitting equipment since 2001.

**Courts Issue Conflicting Rulings on ACA Subsidies**

On July 22, two U.S. circuit courts issued conflicting rulings on whether or not the federal healthcare marketplace, operated through Healthcare.gov, has the authority to issue subsidies to low and middle-income Americans necessary to purchase health insurance coverage under the Affordable Care Act (ACA). Both lawsuits were filed under the argument that premium tax credits cannot flow through the federal exchange within the constraints of the ACA.

In the first of the two rulings, *Halbig v. Burwell*, the U.S. Court of Appeals for the D.C. Circuit ruled that the Internal Revenue Service (IRS) had erroneously moved tax credits through the federal exchange. The court ruled 2-1 that only state-run exchanges have the authority to issue these subsidies under the ACA.

In the second ruling, issued by the U.S. Court of Appeals for the 4th Circuit in Richmond in *King v. Burwell*, the court ruled unanimously that, conversely, the IRS has the authority to move subsidies through both federal and state insurance marketplaces.

The Department of Justice (DOJ) responded immediately, stating that it will challenge the Halbig v. Burwell ruling and request an en banc review by the full D.C. court of appeals. DOJ spokesperson Emily Pierce stated:

"Today, the Fourth Circuit unanimously ruled in support of Congressional intent and common sense: that an American may receive tax credits to make health care more affordable regardless of whether they are participating in a state-run or a federally-facilitated marketplace. While two appeals judges ruled differently, four appeals judges have now cast their votes with two lower courts, Congress, and the Affordable Care Act. In the meantime, to be clear, people getting premium tax credits should know that nothing has changed, tax credits remain available."

HHS data show that 60 percent — or 5.4 million of the 8 million new Americans enrolled in healthcare plans obtained insurance through the federal exchange. If the Halbig v. Burwell ruling stands, it could have direct implications on the insurance coverage for a majority of Americans who have signed up for healthcare under the ACA since October 2013. Only 16 states and the District of Columbia have their own exchanges. Americans residing in all other states seeking healthcare coverage under the ACA are dependent on the federal insurance exchange.

**Health Affairs: Big Data is the Next Big Thing in Healthcare**

The July 2014 edition of *Health Affairs* focuses largely on "big data" — a term commonly used to describe any collection of data sets so large and complex that it becomes difficult to process using on-hand database management tools or traditional data processing applications — in the American healthcare delivery system. The edition includes a series of studies that explore the availability of big data, how it is being collected and consumed currently, and what steps must be taken to ensure big data is utilized to effectively improve care and cut costs.

One study, "*Creating Value In Health Care Through Big Data: Opportunities And Policy Implications*," examines the many opportunities that exist in the use of big data and the multiple barriers that must be addressed in using big data in influencing the delivery of healthcare in America. While big data has the potential to create significant
value in healthcare by improving outcomes and lowering costs, the insights provided by big data are likely to be limited unless the right IT infrastructure, analytic tools, visualization approaches, work flows, and interfaces are developed.

The authors examine the nation's existing health IT infrastructure and conclude that big data's success in creating value in the healthcare sector may require changes in current public policies to balance the potential societal benefits of big data approaches and the protection of patient information. Public policy must also keep pace by establishing policies related to data use, access, sharing, privacy and stewardship.

The authors write, "To realize big data’s promise, health organizations and policy makers alike, may need to set aside traditional mind-sets and embrace new approaches, overcoming barriers to promote data sharing with appropriate protections, and collaboratively working toward the goal of delivering better outcomes at lower costs."

Another study published in last month’s *Health Affairs*, "Big Data In Health Care: Using Analytics To Identify And Manage High-Risk And High-Cost Patients," specifically examines opportunities for reducing healthcare costs in the United States. The authors identified six areas where there is the clearest opportunity to reduce costs through the use of big data:

- Early screening for newborns using currently available but unanalyzed data;
- Triaging patients to estimate the risk of complications for patients when they first present in a hospital setting;
- Determining predictive factors for hospital readmissions;
- Identifying high-cost patients before problems arise;
- Predicting adverse events before they occur; and
- Assessing which patients are at risk for rapid decline due to health conditions and intervening before complications arise.

The study identifies insights that are likely to emerge from clinical analytics, the types of data needed to obtain such insights, and the infrastructure organizations will need to perform the necessary analyses and then implement changes to improve care while reducing costs. The authors note that the use of big data will have policy implications for regulatory oversight, ways to address privacy concerns, and the support of research on analytics.

The authors stress the importance of predictive analytics, which they note will involve linking data from multiple sources including clinical, genetic, outcomes, claims and social data. Payment reform strategies that incentivize value such as bundling "are intended to motivate organizations to improve the efficiency of their care. One tactic that healthcare organizations will likely deploy is the more effective use of predictive analytics," they write.

Another analysis specifically examines how the Centers for Medicare and Medicaid Services (CMS) — as the largest single payer for healthcare in the US — is utilizing big data, entitled "Leveraging The Big-Data Revolution: CMS Is Expanding Capabilities To Spur Health System Transformation."

While CMS has faced technological challenges in storing, analyzing, and disseminating information because of its volume and privacy concerns, rapid progress in the fields of data architecture, storage, and analysis over the past several years has given CMS the capabilities to use data in new and innovative ways. The authors detail the different types of CMS data being used both internally and externally, including the use of real-time analytics for program monitoring and detecting fraud and abuse, and the increased provision of data to providers, researchers, beneficiaries, and other stakeholders.
Other articles included in Health Affairs' June edition include analyses of legal and ethical issues related to big data; assessing the use of big data in comparative effectiveness research; the use of electronic medical records; insights from the Veterans Health Administration; and how Medicare's release of physician payments demonstrated the strengths and weaknesses of releasing big data.

Health Affairs editor Alan Weil noted with respect to these studies, "Big data has the potential to improve clinical decision making at the point of care. Tapping into vast databases, a physician can access knowledge relevant to the individual patient, yielding better decisions and outcomes."

CBO Estimates Health Spending to Reach 8 Percent of Gross Domestic Product

On July 15, the Congressional Budget Office (CBO) released its long-term budget outlook, which predicts that spending on the federal government's healthcare programs will reach 8 percent of the nation's gross domestic product in 2039.

The CBO projected that in 2039, 4.6 percent of GDP would be on Medicare spending and 3.4 percent would be on Medicaid spending, the Children's Health Insurance Program (CHIP) and Affordable Care Act insurance exchange subsidies. The CBO estimated 2014 spending would amount to 4.8 percent of GDP.

The estimated boost in healthcare spending is due to the nation's aging population, growth in per-capita spending on healthcare, and an expansion of federal healthcare programs. According to the CBO, 54 million people will receive Medicare benefits and 61 million will receive Medicaid benefits in 2014.

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