MEDICAL PHYSICS ECONOMICS UPDATE

AAPM Annual Meeting
July 2014

CMS Proposed Rules for 2015

Jim Goodwin
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Jerry White

Medicare

- Medicare Part A
  - Hospital Inpatient
- Medicare Part C
  - Managed Care (Medicare Advantage)
- Medicare Part D
  - Prescription Drugs
- Medicare Part B
  - Physician Payment
  - Freestanding Cancer Centers
  - Hospital Outpatient Departments & Clinics
  - Ambulatory Surgical Centers

Medicare

- Part B has three different payment systems!
  - Medicare Physician Fee Schedule Payment System (MPFS)
  - Hospital Outpatient Prospective Payment System (HOPPS)
  - Ambulatory Surgical Center Payment System (ASC)

	TECHNICAL COMPONENT	PROFESSIONAL COMPONENT
HOSPITAL	HOPPS	MPFS
FREE STANDING CENTER	MPFS	MPFS

Medicare

- Medicare Jargon:
  - Reimbursement has two components:
    - "Professional" means physician
    - "Technical" means everything else, including equipment, supplies, expenses, and non-physician labor, which includes the medical physicist
  - Physician-owned practices bill a "global" fee that includes both professional and technical

Medicare

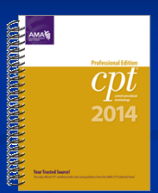
- Medicare is administered through private Medicare Administrative Contractors (MAC's)
  - 15 jurisdictions; 10 contractors
- Contractor Medical Director (CMD)
- Local Coverage Determinations (LCD's)
  - Outline coverage policies of MAC
  - LCD's differ
- Carrier Advisory Committee (CAC)

Medicare Rulemaking Cycle

- Rules are updated annually
- Proposed rules published June/July
  - 60 day comment period
- Final rules published November 1st
  - 60 day comment period (certain items)
- Final rule effective January 1

Service Descriptors

- Current Procedural Terminology (CPT®)
  - Listing of descriptive terms/identifying codes for reporting of medical services and procedures (>7000)
  - Published by American Medical Association (AMA); copyrighted
  - Updated Yearly



Medicare Physician Fee Schedule (MPFS)

- Determines reimbursement for Physicians and Freestanding Cancer Centers under Medicare Part B

MPFS

- Under MPFS the cost of providing services are broken down into 3 components that are valued by RUC:
  - Physician work
  - Practice expense
  - Malpractice insurance
- Relative Value Units (RVUs) are calculated for each

Physician Work

- Physician Work RVU based on:
  - Time
  - Technical skill and effort
  - Mental effort and judgment
  - Intensity
- New/revised codes are compared to reference codes to determine RVU

Practice Expense Categories

- Direct Practice Expense
  - Non-physician clinical labor (Physics)
  - Medical supplies
  - Medical equipment
- Indirect Practice Expense
  - Administrative labor
  - Office supplies and equipment
  - Overhead and everything else

Direct Practice Expense

- Equipment costs depend upon:
  - Actual purchase price
  - Assumed utilization rates (50% for therapy, 90% for CT,MR)
  - CMS determined interest rates

Indirect Expenses

- AMA Physician Practice Information Survey (PPIS) data used for indirect expense cost
  - Determines specialty-specific Practice Expense/Hour (PE/HR)

MPFS Payment Calculation

- Resource Based Relative Value Unit (RVU)
  - Physician work RVU
  - Practice expense RVU
    - PE RVUs calculated for PC and TC
  - Professional liability insurance RVU
- Adjustments
  - Geographic practice cost index (GPCI)
- Convert RVUs To Dollars
  - Monetary conversion factor is updated annually

Division of RVUs

- PC: $RVU_{pw}+RVU_{pe}+RVU_{pli}$
- TC: $RVU_{pe}+RVU_{pli}$
- Global=PC+TC

MPFS Payment Calculation

- Total Payment = Total RVU * Conversion Factor

Conversion Factor (CF)

- Scaling factor that converts RVU's to $
- By statute CF is updated annually with formula that takes into account the Medicare Economic Index (MEI) and compares expenditures with target called Sustainable Growth Rate (SGR)
  - CF adjusted up or down as needed

Conversion Factor 2015

- CF for 2014: $35.82
- Protecting Access to Medicare Act of 2014 (PMMA) specifies 0% update until 3/31/15
- CF for rest of year based on SGR: -21%
- Congress has provided rescue every year since 2003
- System must be fixed

Practice Expense Changes: Treatment Vault

- CMS proposes to classify radiation vault as indirect expense rather than direct.
- Would consider vault no different than other infrastructure costs
- Would result in practice expense RVU decrease for treatment codes
- Total impact on free standing centers: -8%

MPFS: Specific CPT Payment Changes

- Generally, 2015 changes are small:
  - Medical Physics (77336, 77370): +5%
  - Simulation/planning: +1% – 4%
  - Devices: +4%
- Exceptions:
  - Treatment codes: -10%
  - Hyperthermia and neutrons: + & -
  - Simple interstitial: +21%
  - Respiratory motion: +12%

MPFS: Potentially Misvalued Codes

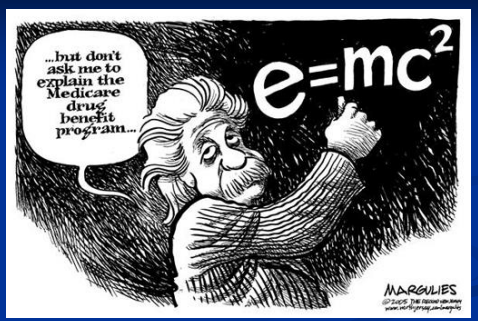
- Affordable Care Act directs HHS Secretary to review and identify potentially misvalued codes
- PMMA expanded categories of codes to be examined
- Public can also nominate codes
- CMS prioritized list includes:
  - 77263 Complex Treatment Planning (PC)
  - 77334 Complex Treatment Device

MPFS: Outside Contracts

- CMS has contracted with two entities to validate RVU's of misvalued codes:
  - 1. The Urban Institute to collect time data from practices
  - 2. RAND Corporation to build a validation model for work RVU's
- Indicative of CMS skepticism with RUC and RVU system

MPFS: Bottom Line

- Free Standing Centers: - 8%
- Radiation Oncologists: -4%
- Radiology: -2%



Hospital Outpatient Prospective Payment System (HOPPS)

- Determines payment for hospital outpatient services under Medicare Part B
  - Facility payments (TC) only; not MD's
- Inpatient services paid with DRG-based system (Part A)

HOPPS

- MPFS: Resource-based; "bottom-up" methodology
- HOPPS: Cost-based; uses actual hospital claims

HOPPS

- Under HOPPS, CPT codes are grouped into Ambulatory Payment Classifications (APCs)
  - CPT codes within an APC are similar clinically and in resources required
  - "2x Rule"
  - >800 APCs
  - Each APC is assigned reimbursement level; all codes within APC receive same payment

Radiation Oncology APCs

APC	Name	CPT Codes
65	IORT	77424, 77425
66	Level I SRS	77373
67	Level II SRS	77371, 77372

Radiation Oncology APCs

APC	Name	CPT Codes
299	Hyperthermia & Radiation Treatment	77470, 77600-77620
300	Level I Radiation Therapy	77401-77404, 77407
301	Level II Radiation Therapy	77406, 77408-77416, 77422, 77423, 77750, 77789
303	Treatment Device Construction	77332-77334

Radiation Oncology APCs

APC	Name	CPT Codes
304	Level I Therapeutic Radiation Treatment Prep	77280, 77299, 77300, 77305, 77310, 77326, 77331, 77336, 77370, 77399
305	Level II Therapeutic Radiation Treatment Prep	77285, 77290, 77315, 77321, 77327, 77328, 77338
310	Level III Therapeutic Radiation Treatment Prep	32553, 49411, 55876, 77295, 77301, C9728

Radiation Oncology APCs

APC	Name	CPT Codes
312	Radioelement Applications	77761, 77762, 77763, 77776, 77777, 77799
313	Brachytherapy	77785, 77786, 77787, 0182T
651	Complex Interstitial Radiation Source Application	77778
8001	LDR Prostate Brachytherapy Composite	55875+77778

Radiation Oncology APCs

APC	Name	CPT Codes
412	Level III Radiation Therapy	77418, 0073T
667	Proton Beam Therapy	77520, 77522, 77523, 77525

HOPPS

- CMS looks at hospital outpatient claims (bills) from 2 years prior (2 year data lag)
- Reduces hospital charges to cost using cost-to-charge ratios (CCR) obtained from reported hospital data
- Calculates geometric mean costs for each APC

HOPPS

- Converts data to APC weightings
- APC weights are multiplied by conversion factor based on Hospital Market Basket economic index to convert weights to $
- 2015 Conversion Factor increases 2.1% over 2014

Proposed 2015 Payment Changes

- Payment for a given CPT code changes due to:
  - CF adjustment
  - Changes in APC valuation based on claims data
  - Transfer of codes between APC's

Changes by CPT Code

- Generally, 2015 changes are small:
  - Medical Physics: 0%
  - Simulation/planning: +0 – 2%
  - Devices: +1 – 2%
  - IMRT treatment: +1%
  - Ext beam treatment: +2%
  - HDR treatment: -1%
  - SBRT treatment: -1.5%

Changes by CPT Code

- Exceptions:
  - Hyperthermia (APC change): -53 – +25%
  - Sp. treatment procedure (APC change): +25%
  - Photon treatments (APC change): -34 – +21%

Changes by CPT Code

- SRS (77371, 77372)
- IORT (77424,77425)

HOPPS: Comprehensive APC's

- Gives single payment that includes device, primary service and all adjunct services necessary to support primary service (=packaging)
- New for 2015
- In Rad Onc:
  - APC 648: Level IV Breast and Skin Surgery
  - APC 67: Single Session Cranial SRS

Comprehensive APC's

- SRS (77371, 77372): +172%
- IORT (77424, 77425): +587%
- Catch: It is not yet clear what other tasks/codes will be included in comprehensive APC
  - All codes on same claim?
  - All codes for month?

HOPPS: Packaging

- Packaging: A procedure/service is considered to be ancillary and cost is paid as part of another code that is considered the primary procedure/service
  - Packaged codes are not paid separately
  - Packaged codes should still be reported
  - 12 categories of codes considered to be ancillary

HOPPS: Packaging

- For 2015 Rad Onc's 6 IGRT codes will remain packaged (considered "guidance services") – no separate payment
- For 2015 CMS will package additional ancillary tests and procedures w/cost < $100
  - No Rad Onc codes included
  - Does include Level 1&2 plain films & Level 1 US diagnostic screenings

HOPPS: Composite APC's

- Composite APC: Provides a single payment for two or more services that are performed together on the same day

HOPPS: Composite APC's

- 2015: CMS will continue existing composites:
  - APC 8001 LDR Prostate Brachytherapy Composite
    - When 55875 & 77778 are billed on same day
    - Payment -9% for 2015
  - Imaging APCs 8004-8008
    - US, CT/CTA, MR/MRA with & without contrast
    - Single payment if more than one exam within same family on same day
    - Payment -1.4 - +4.3% for 2015

HOPPS: Brachytherapy Sources

- I-125: -8%
- Ir-192 HDR source: -0.3%

Financing Strategies

- Nationalized Healthcare
  - England, Norway, Sweden
- Medicare
  - Canada, Taiwan
- Subsidized/Regulated Insurance
  - Holland, Switzerland, France, Germany
- Cash

Financing Strategies

- Nationalized Healthcare
  - Veterans System, Military, Indian Health Service
- Medicare
  - Medicare, Medicaid
- Subsidized/Regulated Insurance
  - Employer or group based insurance, Individually purchased.
- Cash
  - Wealthy, "Self" -Pay"

New York Times 23 July 2014

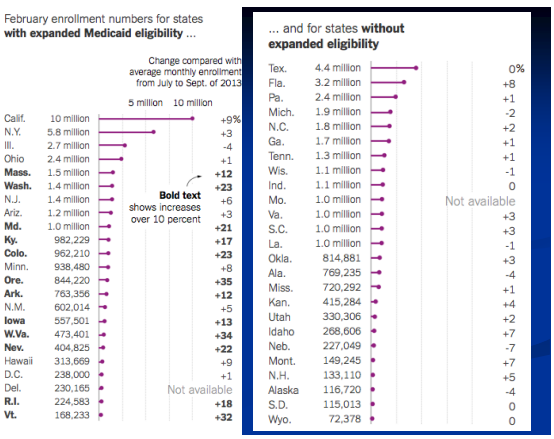
New Questions on Health Law As Courts Differ on Subsidies

By ROBERT PEAR

WASHINGTON — Two federal appeals court panels issued conflicting rulings Tuesday on whether the government could subsidize health insurance premiums for millions of Americans, raising yet more questions about the future of the health care law

Circuit struck down a regulation issued by the Internal Revenue Service that authorizes the payment of premium subsidies in states that rely on the federal insurance exchange.

If it stands, the ruling could cut off financial assistance for more



William Brody, M.D. Ph.D.
President

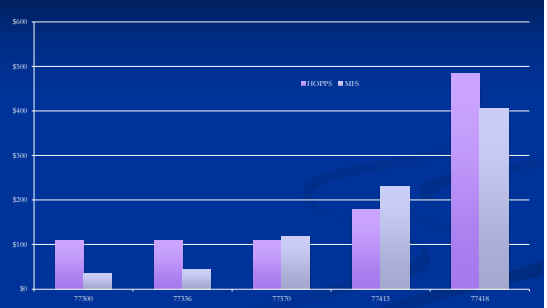
Johns Hopkins University

- Not so very long ago, hospitals dealt with only a small number of organizations that paid for medical care. There was Medicare and Medicaid, Blue Cross/Blue Shield and a handful of private insurers. Recently, I asked my chief financial officer how many payers we deal with today. The number shocked even me. He said Johns Hopkins Hospital has to bill more than 700 different payers and insurers.

Payment Reduction Initiatives

- Multiple procedure reductions
- Bundling and Packaging
- AMA RUC mis-valued code reviews
- Scrutiny of improvements in technology
- Urban Institute / Rand Corporation Reviews

HOPPS vs. MFS 2013



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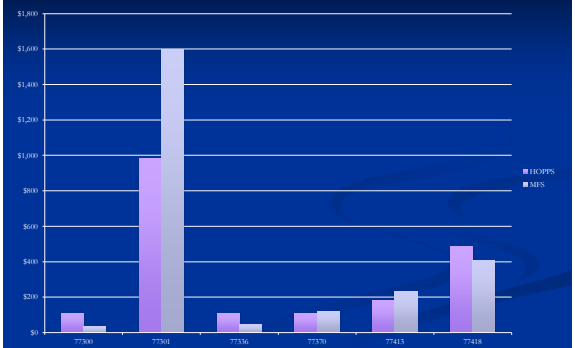

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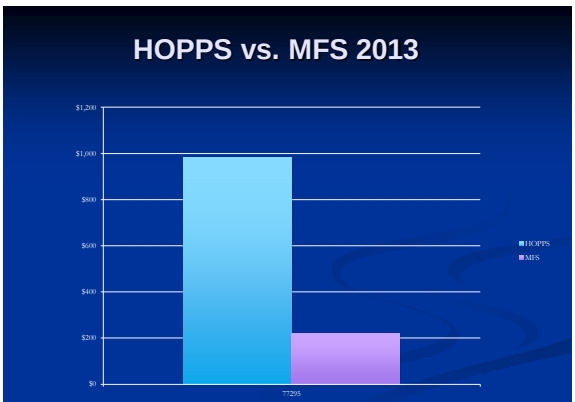

Potentially Misvalued Codes

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- The ACA requires the Secretary to develop a Validation Process
  - RAND Corp. validation model to predict work RVUs, including time and intensity
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2014 Practice Expense Methodology

- Continue "Bottom-up" methodology
- Continued use of AMA Physician Practice Information Survey (PPIS) data to determine practice expense per hour (PE/HR) for each specialty used to calculate indirect practice expense costs
- Continue interest rates based on SBA to calculate equipment cost per minute
  - 5.5% to 8.0% interest rate for different categories of loan size (equipment cost) and maturity (equipment useful life)

2014 Practice Expense Policy

- American Taxpayer Relief Act of 2012 requires 90% equipment utilization policy for expensive diagnostic over $1 million
  - Change from 75% to 90% effective 2014
  - Impacts all CT, CTA, MRI and MRA PE RVUs
- No change to 50% utilization rate for therapeutic imaging equipment or diagnostic imaging equipment less than $1 million

Cost Savings

Medicare Part D Patient Assignment

Random Assignment → Intelligent Assignment

2009 Savings $5 Billion

Cost Savings

- Lucentis → Avastin
- 10 year savings:
  - $ 18 Billion - Medicare
  - $ 5 Billion – Patients
  - $ 6 Billion – Other Healthcare expenses

Total: $29 Billion

Health Affairs June 2014

AAPM Response to Proposed Rules

- Comments are due September 2, 2014
- AAPM will coordinate with sister societies and will file comment letters
- PEC contacts:
  - Wendy@HealthPolicySolutions.net
  - Jim Goodwin, Blake Dirksen