Medicare Physician Fee Schedule
Proposal to Limit Physician Pathology Payments to OPPS Rates (OPPS Cap)

Presentation for BD
January 22, 2014
In the CY2014 Medicare Physician Fee Schedule (MPFS) Proposed Rule, the Centers for Medicare & Medicaid Services (CMS) proposed a significant change to the way it sets rates for physician services—including physician/surgical pathology services—such that the payment rate for a service in a non-facility setting (e.g., independent laboratory) would be capped by the payment for the same service performed in the hospital outpatient or ambulatory surgical center setting.

Under the proposal, the limit would apply:

- (1) If the rate in the non-hospital setting were higher than the hospital/ASC setting and
- (2) Where at least 5% of services were performed in OPPS/ASC settings.
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Why Was CMS Proposing the Change?

- CMS believes Relative Value Update Committee (RUC) inputs may be biased or inaccurate
- CMS believes OPPS data are more accurate because these are auditable and updated annually
- Part of a broader shift toward “site neutral” payments—CMS believes it generally should not pay more for a service in one setting than it pays in another setting if the procedure can be performed safely in multiple settings
- Broader policy consistent with recommendations of MedPAC, but specific approach not what had been recommended by MedPAC
Although the proposal was not targeted against pathology specifically, the proposed change would have had a disproportionate impact on pathology services:

- **Independent Lab** –27%
- Radiation Therapy Centers –13%
- **Pathology** –8%
- Diagnostic Testing Facility –7%
- Radiation Oncology –6%
- Interventional Radiology –6%
- All others (~50 specialties) 0 to –5%

- Overall impact –2%
BD joined with key stakeholders to challenge the CMS proposal

- PFS Pathology Payment Coalition (BD, Beckman/Leica, Abbott, Roche, GE/Clarient, Novartis/Genoptix)
- American Clinical Laboratory Association
- AdvaMed
- College of American Pathologists
- Patient groups—including Cancer Leadership Council (umbrella for multiple patient organizations)
Comments Made to CMS

- OPPS rates are a poor proxy for laboratory costs
  - Problems with hospital claims data on which rates are based
  - “Charge compression”—OPPS data not intended to represent costs for individual services
  - Low volume for many of these services in OPPS setting; hospitals may not have complained about the low rates because of the low volume

- Fee Schedule rates supposed to be based upon practice expenses—not hospital costs
Laboratory costs are substantially higher than OPPS rates

- Time and cost surveys of labs to support new procedure code valuations showed higher costs than OPPS
- Moran analysis of ACLA member data showed higher costs than OPPS for most affected services
Additional Concerns

- **Transparency**
  - How CMS determined which tests meet threshold – errors found (e.g., urinary FISH)
  - How CMS proposed to set rates (basing upon 2013 vs 2014 OPPS rates)

- **Threshold for cap**
  - 5% threshold allows services rarely performed in OPPS or ASC setting to drive rates when hospitals/ASCs may have little incentive to assure rates fully reflect costs

- **OPPS allows relative cost shifts among services—not applicable to laboratories under CMS’s proposal**
  - Laboratories do not offer the full range of OPPS services typical hospitals furnish
  - Laboratories targeted solely for reductions where payments higher than OPPS (no parallel increases if OPPS rates are higher)
Recommendations to CMS

1. CMS not move forward with this proposal.

2. If CMS believes certain physician pathology services may be misvalued because of substantial differences between payments allowed under the PE RVUs in the noninstitutional setting versus payments allowed in the hospital setting, then the Agency should identify these as potentially misvalued codes and follow established processes to consider the appropriate valuation.
Meetings

- Meetings with CMS
  - ACLA met with CMS leadership
  - PFS Pathology Payment Coalition met with CMS staff directly involved with proposal

- HHS—Office of the Secretary

- MedPAC

- Office of Management and Budget (White House)

- Capitol Hill
  - Letter signed by >100 members of the House
  - Letter signed by members of the Senate
In the Final Rule, CMS decided not to finalize the proposal to cap non-hospital rates at hospital/ASC levels.

However, CMS indicated that they believe the disparity between non-hospital and hospital payments is a problem and they intend to revisit the issue:

*Given the many thoughtful and detailed technical comments that we received, we are not finalizing our proposed policy in this final rule with comment period. We will consider more fully all the comments received, including those suggesting technical improvements to our proposed methodology. After further consideration of the comments, we expect to develop a revised proposal for using OPPS and ASC rates in developing PE RVUs which we will propose through future notice and comment rulemaking.*
## Net Effect on Tests Relevant to Clinical Flow Cytometry—Minimal Change

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The fees for the professional interpretation of flow cytometry were not impacted by the proposal.