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Senate Approves One-Month Medicare Physician Fee Fix

The cost of the one-month extension is an estimated $1 billion and would be paid for by cutting reimbursement for physical therapy services.

The current 2.2 percent fee update in Medicare physician payments, in effect since June 1, expires Nov. 30. The next day, a cut of 24.9 percent is scheduled to take effect, with an additional cut of an estimated 7 percent due Jan. 1.

The Senate by unanimous consent on Nov. 18 passed legislation cancelling the 24.9 percent cut and continuing the 2.2 fee update through Dec. 31. The House Democratic leadership pledged to take up the measure after the Thanksgiving recess.

Senate lawmakers said they are working on a one-year payment fix through 2011, which they hope to pass after the lame-duck Congress resumes the week of Nov. 29 for a limited session before adjourning in early December.

Senate Finance Committee Chairman Max Baucus (D-Mont.) and the ranking Republican, Charles Grassley (R-Iowa), said in a statement, they will "pursue a year-long fix that could be enacted before the one-month patch expires and are working together to secure a mutually agreeable way to pay for the cost of a fix through 2011 as well as other extenders."

Continued on p. 6

Extensions Urged for Pathology Grandfather Protection, Other Expiring Medicare Policies

Fourteen leading health care provider groups, including the American Clinical Laboratory Association (ACLA) and the College of American Pathologists (CAP), have appealed to Democratic and Republican leaders in the House and the Senate to take immediate action to extend a host of Medicare policies that expire Dec. 31.

Two of the policies are laboratory-specific: an extension of the pathology "grandfather" protection and an extension of reasonable cost reimbursement for clinical lab services provided by certain small rural hospitals.

The provider groups made their appeal in a Nov. 1 letter to Senate Majority Leader Harry Reid (D-Nev.) and minority leader Mitch McConnell (R-Ky.) and House Speaker Nancy Pelosi (D-Calif.) and John Boehner (R-Ohio), minority leader.

The expiring policies also affect the physician fee schedule, ambulance services, the exceptions process for

Continued on p. 2

INSIDE *NIR*

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Extensions Urged for Pathology, *from p. 1*

therapy caps, and extensive rehabilitation services needed to return Medicare beneficiaries to their homes and communities.

Signatories to Letter Urging Medicare Extensions

American Ambulance Association
American Clinical Laboratory Association
American Health Care Association
American Hospital Association
American Medical Rehabilitation Providers Association
American Occupational Therapy Association
American Physical Therapy Association
American Psychological Association
American Speech-Language-Hearing Association
Clinical Social Work Association
College of American Pathologists
National Association for the Support of Long Term Care
National Association of Social Workers
National Rural Health Association

At press time, industry sources said there is a chance that the extensions could be attached to an SGR fix before the lame-duck session adjourns in early December (*related story, p. 1*). Otherwise, they would be taken up again when the new Congress opens in January. Provider groups advocate extensions of at least through 2011, retroactive to Jan. 1. CAP and ACLA, while calling for an extension of the pathology grandfather protection for at least a year, support making the protection permanent.

Failure to pass legislation to extend these various Medicare policies, the provider groups said in their appeal to the congressional leaders, "will prompt limited access to services for beneficiaries in rural and other underserved areas, payments cuts to health care professionals, as well as the creation of an unsustainable health care environment.

"The combination of these policies impact a wide spectrum of the health care delivery process, including access to care through ambulance services, performance of diagnostic laboratory tests, and extensive rehabilitation services needed to return Medicare beneficiaries to their homes and communities. The policies impact patients, solo practitioners, post-acute care facilities, and community hospitals that serve patients with various diagnoses and impairments.

"Many of these Medicare policies have been temporarily addressed by Congress in multiple bills over the past decade, including a temporary extension of these provisions for 2010 as part of the recently passed health care reform law."

Physician Fee Schedule

The groups backed an extension under the Part B physician fee schedule "of the floor on geographic adjustments to the work portion of the physician service through the end of 2010, with the effect of increasing practitioner fees in rural areas. It also would provide immediate relief to areas negatively impacted by the geographic adjustment for practice expenses and require the secretary of HHS to improve the methodology for calculating practice expense adjustments."

Pathology Grandfather Protection

This allows independent clinical labs to bill Medicare Part B directly for the technical component (TC) of anatomic pathology services to hospital inpatients and outpatients. It expires Dec. 31, and the Centers for Medicare and Medicaid Services (CMS) has declared its intent to eliminate such billings after that date (*NIR 10, 20/Nov. 8, p. 1*).

CMS has long advocated this policy change, contending that the TC is reimbursed through the hospital's prospective payment and the lab should seek payment for the service from the hospital, not Part B.

Congress has repeatedly blocked the agency from moving ahead by enacting a series of short-term extensions of the "grandfather" protection, most recently last year by approving a one-year extension, through Dec. 31, 2010. The protection is of special benefit, advocates say, to rural hospitals that cannot afford to perform the pathology work in-house but must send it to an outside clinical lab.

The grandfather protection applies to hospital-lab arrangements in effect as of July 22, 1999, the date when CMS first proposed to eliminate such billings. Further, it applies to the hospital, not the lab, CMS has ruled. Hospitals may switch labs without forfeiting the protection; however, independent labs cannot switch hospitals and still be protected. The TC of pathology services includes anatomic services, cytopathology, and surgical pathology.

Expanded Medicare Preventive Services in the New Year

As of Jan. 1, 2011, beneficiaries will no longer pay out-of-pocket for most preventive services covered by Medicare, and they will get coverage of a new annual wellness visit, also with no cost sharing.

The changes were announced in the final 2011 Medicare physician fee schedule rule released this month and scheduled for publication in the Nov. 29 *Federal Register*. The rule implements provisions in the health care reform law expanding beneficiary access to preventive services with the aim of assuring better health and fewer costly hospitalizations.

Most Cost Sharing Eliminated

The Part B deductible and 20 percent coinsurance that would apply to most preventive services are waived for those recommended with a grade of A (strongly recommends) or B (recommends) by the U.S. Preventive Services Task Force, as well as the initial "Welcome to Medicare" baseline exam and the new annual wellness visit.

The Part B deductible also is waived for tests that begin as colorectal cancer screening but, based on findings during the test, become diagnostic or therapeutic services.

New Annual Wellness Visit

The final rule implements provisions that, for the first time, provide coverage under the traditional fee-for-service program for an annual wellness visit. "This visit augments the benefits of the Initial Preventive Physical Examination (IPPE or 'Welcome to Medicare' Visit) with an annual visit that allows the physician and patient to develop a personalized prevention plan that considers not only the age-appropriate preventive services generally available to Medicare beneficiaries, but additional services that may be appropriate because of the patient's individual health status," CMS said.

CMS has established two separate Level II HCPCS codes to bill for the first and subsequent annual wellness visit:

- G0438, annual wellness visit, including personalized prevention plan services, first visit. To be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE).
- G0439, annual wellness visit, including personalized prevention plan services, subsequent visit. To be paid at rate of a level 4 office visit for an established patient.

Group Health Plans Get a Break on Preventive Service Mandates

Employers will be able to change insurers and still keep group health care plans that are similar to what they have had without having to meet all the new requirements of the health care reform law under an amended regulation issued Nov. 15 by three departments—Health and Human Services, Labor, and Treasury.

Under the original regulation, a plan could lose its grandfathered status if employers changed issuers, but self-funded plans could change third-party administrators without losing grandfathered status, according to a fact sheet issued by HHS.

But a change of issuers in the individual market will result in the loss of grandfathered status.

Under the new amendment, "all group health plans are allowed to switch insurance companies and shop for the same coverage at a lower cost while maintaining their grandfathered status, so long as the structure of the coverage doesn't violate one of the other rules for maintaining grandfathered plan status," the departments said.

Employers that offer the same level of coverage through a new issuer can remain grandfathered as long as the change does not result in significant cost increases, a reduction in benefits, or other changes in the original rule.

Plans Not Exempt, However, From Some Consumer Protections

While exempt from mandated preventive services and other consumer requirements, grandfathered plans must, under insurance reforms that took effect Sept. 23, 2010:

- ❑ Provide dependent coverage for children until age 26
- ❑ Not use pre-existing condition exclusions for children this year (and everyone in 2014)
- ❑ Impose no lifetime insurance limits (but not annual limits)
- ❑ Not retroactively cancel coverage after a policyholder gets sick (called rescissions)

Small-group plans must spend at least 80 percent of premiums on medical expenses or improving the quality of care.

Source: National Association of Insurance Commissioners

What the Law Requires

For plan years (policy years in the individual market) on and after Sept. 23, 2010, private insurers must cover, at a minimum, without cost sharing, a range of preventive services. But the law—the Patient Protection and Affordable Care Act (PPACA)—also provides an exemption from this mandate for health plans that qualify for "grandfather" protection. A grandfathered plan is a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of the law (March 23, 2010). Renewal of the plan after such date does not alter the grandfathered status of the plan.

The federal departments issued a "grandfather" interim final rule in June that sharply limited benefit reductions or consumer cost increases that could be made to plans that existed before enactment of the health care reform law in order to retain grandfathered status (*NIR 10, 11/June 10, p. 2*). The new amendment "will result in a small increase in the number of plans retaining their grandfathered status relative to the estimates made in the grandfathering regulation," they said.

The departments made the change in response to comments on the original grand-

father rule stating that a group health plan would relinquish grandfathered status if it changed issuers or policies. "Under this amendment, all employers have the flexibility to keep their grandfathered plan but change insurance company or third-party administrator," according to an official fact sheet. For example, a group health plan may need to make administrative changes that do not affect benefits or costs, which could happen if an insurer stops offering coverage in a market, it said. Companies can also change ownership.

The 'Grandfather' Exemption

New employer plans cannot have copays and deductibles after Sept. 23, but grandfathered plans are not required to drop their cost-sharing policies. However, when state-based health exchanges become effective in 2014, private plans participating in the exchange will be required to comply with full coverage of the mandated preventive services.

Mandated Preventive Services

Absent grandfathered status, the services that must be covered with no cost sharing by health plans or coverage include:

- ❏ Preventive services with an A or B rating from the U.S. Preventive Services Task Force;
- ❏ Recommended immunizations from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- ❏ With respect to infants, children, and adolescents, evidence-informed preventive care and screenings stipulated in comprehensive guidelines supported by the Health Resources and Services Administration.

Cost sharing is defined as:

- ❏ Deductibles, coinsurance, copayments, or similar charges; and
- ❏ Any other expenditure required of an insured individual which is a qualified medical expense with respect to essential health benefits covered under the plan.

There are certain exceptions: premiums, balance billing amounts for non-network providers, and spending for noncovered services.

An interval of one year is allowed from the time a preventive service recommendation or guideline is issued and the plan or policy year for which it takes effect.

CMS Establishes New Center for Innovation

On Nov. 16, the Centers for Medicare and Medicaid Services (CMS) formally established the new Center for Medicare and Medicaid Innovation. Created by the health care reform law, the center will examine new ways of delivering health care and paying health care providers that can save money for Medicare and Medicaid while improving the quality of care.

"For too long, health care in the United States has been fragmented—failing to meet patients' basic needs, and leaving both patients and providers frustrated. Payment systems often fail to reward providers for coordinating care and keeping their patients healthy, reinforcing this fragmentation," said Donald Berwick, M.D., CMS administrator. "The center will help change this trend." *Continued on p. 8*

Medicare Physician Fee Fix, *from p. 1*

In the House, Democratic leaders Nov. 18 introduced a bill to cancel the scheduled cuts in physician fees and replace them with a 1 percent increase for the remainder of this year and all of 2011.

The American Medical Association, the American Society for Clinical Pathology, the College of American Pathologists, and other medical specialties had called on Congress to act before Thanksgiving to cancel the cuts for 13 months and grant an extension of current pay rates plus 1 percent at least through 2011 at a cost of $15 billion. The Obama administration also supports a fix through 2011.

The steep reductions in Medicare physician fees are caused by the Sustainable Growth Rate (SGR) formula used to calculate the annual update to the Part B physician fee schedule. The SGR has triggered negative updates for most of the past decade, but Congress has repeatedly intervened since 2003 to block cuts with a series of short-term fixes.

In advocating fast action by Congress, AMA President Cecil Wilson said in a statement, "Without physicians, there is no care in Medicare. The roller coaster ride caused by Congress' inability to stop the cut for at least a year is eroding physicians' confidence and commitment to Medicare, right during the open enrollment season for physicians. There is growing concern that Medicare is becoming an unreliable payer. Congress must allay that fear by stopping the cut for at least 13 months, which will provide time to begin working on a permanent solution in the new year."

Paying for a Fundamental Overhaul

The cost of replacing the SGR is a major obstacle in devising an alternative. A permanent reform could cost upward of $300 billion over 10 years, according to a Congressional Budget Office estimate.

The House in November 2009 passed a bill (H.R. 3961) that repealed the SGR and replaced it with an annual update that would allow the volume of physician services to grow at the rate of the gross domestic product (GDP) plus 1 percent per year (for primary care and preventive services, the GDP plus 2 percent per year). However, the reform was not paid for. The Senate rejected a similar bid to replace the SGR because its cost was not fully paid for.

Latest to weigh in on the issue are the chairmen of the bipartisan National Commission on Fiscal Responsibility and Reform. In an initial deficit reduction proposal unveiled Nov. 10, Erskine Bowles, chief of staff in the Clinton White House, and Alan Simpson, former GOP senator from Wyoming, said "the physician payment system could be repaired and paid for through savings from payment reforms, expanding beneficiary cost-sharing, and adopting medical malpractice reform."

The payment reforms in the draft include:

- ❏ In the short term, replacing SGR cuts through 2015 with "modest reductions" while directing CMS to establish a new payment system, beginning in 2015, to reduce costs and improve quality.
- ❏ In the midterm, fund a permanent fix by paying doctors and other providers less, improving efficiencies, and rewarding quality by accelerating payment reforms, and requiring rebates for brand-name drugs as a condition of Medicare Part D.

Lab National Coverage Policies: Coding Changes in January

The next quarterly update to contractor edits of claims for tests subject to Medicare's clinical laboratory national coverage determinations (NCDs), effective Jan. 1, 2011, makes one addition to and one deletion from the list of covered diagnosis codes for two of the 23 NCDs.

Thyroid Testing

❏ Add ICD-9-CM code 780.66 to the list of covered diagnosis codes.

Gamma Glutamyl Transferase

❏ Delete ICD-9-CM code 780 from the list of covered diagnosis codes.

The changes result from coding analysis decisions and biannual updates to the diagnosis codes, said the Centers for Medicare and Medicaid Services in Change Request 7204.

The NCDs affect frequently ordered clinical laboratory procedures and stipulate requirements for uniform coverage, claims processing, and medical necessity documentation. They specify the circumstances under which Medicare will pay for a test, the appropriate CPT and ICD-9-CM codes to use, coverage limitations (such as frequency limits), and other guidelines.

The NCDs were developed by a laboratory-negotiated rulemaking required by the 1997 Balanced Budget Act and were published in a final rule on Nov. 23, 2001. Lab claims for each of the NCDs have been processed uniformly nationwide since April 1, 2003. Details for each NCD are posted at *www.cms.hhs.gov/CoverageGenInfo.*

In Memoriam

Robert Waters, AAB.

Robert Waters, the Washington representative of the American Association of Bioanalysts (AAB) since 1988, passed away Oct. 27, following a lengthy illness. Waters, 55, is survived by his wife, Patty, and their two daughters, Laura (22) and Kate (19).

He was a leading figure in the Clinical Laboratory Coalition (CLC), which he helped establish in 1995 to focus on payment policy and other issues in Medicare and Medicaid. The CLC eventually included all the major laboratory organizations. In its early years, he served as its de facto chair/facilitator/referee/mediator, AAB said. "Most importantly, he earned the respect of CLC members and played a major leadership role in the CLC's successful 2003 campaign against a congressional proposal to reinstitute a 20% copayment for Part B clinical laboratory services and in its successful 2006 campaign opposing HHS's Part B lab competitive bidding demonstration," culminating in the project's repeal by Congress.

Waters began his career in Washington, D.C., as a policy and budget analyst in the Office of the Secretary of the Department of Health and Human Services (HHS), receiving the secretary's award for exceptional achievement in 1980. In 1983 he began working for then Rep. Tom Harkin (D-Iowa) and became his chief of staff when Harkin was elected to the Senate in 1984. During his tenure on Capitol Hill, he earned his law degree from Georgetown University. In 1987 he joined the law firm of Arent Fox Kintner Plotkin & Kahn LLP, where he eventually became a partner. In 2004 he joined the Washington firm of Gardner, Carton & Douglas, which merged with Drinker Biddle & Reath in 2006.

The center is authorized to spend $5 billion for startup and $10 billion over 10 years for new pilot programs that can be implemented without congressional approval.

CMS Establishes New Center, *from p. 5*

CMS also announced demonstration projects to support better coordinated care and better health outcomes for patients, including pilots to test the medical home and health home care concepts, as well as bundling payments for episodes of care. The center will identify, support, and test care models that may be relatively unknown but provide beneficiaries with a seamless care experience, better health, and lower costs, said acting director Richard Gilfillan, M.D.

In one project, eight states were selected to participate in a demonstration to evaluate the effectiveness of doctors and other health professionals across working in a more integrated fashion and receiving payments from Medicare, Medicaid, and private health plans. Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota will participate, which will ultimately include up to approximately 1,200 medical homes serving up to 1 million Medicare beneficiaries, CMS said. Another project will test the effectiveness of doctors and other health professionals working in teams to treat low-income patients at community health centers. According to CMS, the project will provide coordinated care to up to 195,000 Medicare beneficiaries.

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