WASHINGTON G–2 REPORTS

NATIONAL INTELLIGENCE REPORT®

Covering Government Policy For Diagnostic Testing & Related Medical Services

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Vol. 09, Iss. 13, July 13, 2009

CMS Proposes Medicare Physician Fee Schedule for 2010

CMS will accept comments on the proposed rule until Aug. 31 and will publish a final rule addressing comments by Nov. 1.

In a rule that went on display at the *Federal Register* July 1, the Centers for Medicare and Medicaid Services is proposing changes to the relative value units (RVUs) and other payment policies in the Medicare physician fee schedule for 2010. CMS also includes, as required by law, a negative update in physician fees under the Sustainable Growth Rate (SGR) formula used to calculate the annual update.

Unless Congress steps in before Jan. 1, as it is expected to do with a modest fee hike, the SGR requires a cut of 21.5 percent in physician fees under the 2010 Part B fee schedule. The conversion factor for 2010 is an estimated $28.3208, down from $36.0666 in 2009.

For pathology, there would be no change in allowed charges ($985 million) stemming from revisions to work, practice expense, and malpractice RVUs, but for independent laboratories, the revisions mean a decline of 5 percent, to $960 million. For diagnostic testing facilities, they amount to a cut of 24 percent, to $1,044 million.

For certain high-volume pathology and mammography procedures, CMS estimates major cuts from the combined impact of the RVU changes and the negative SGR update. For example, payment for CPT 88305, tissue exam by pathologist, *Continued on p. 2*

Key Controversies in Health Care Reform: Public Plan, Employer Mandate, Price Tag

Lawmakers returned from the Fourth of July recess to pick up where they left off on health care reform legislation, as polls show broad public support for health system changes mixed with anxiety over the estimated cost, most recently pegged at a conservative $1 trillion.

The most contentious issues before House and Senate committees are a proposed new public plan option and an employer mandate. Republicans object to the public plan as a federal intrusion into the health care market and side with health insurers who say the option puts them at a competitive disadvantage and would force them to reduce or end benefits. Employers, both large and small, have objected to the "play or pay" requirement that they offer their workers affordable coverage or pay a fee to help subsidize coverage for the uninsured.

Democrats on the Senate committee on Health, Education, Labor, and Pensions (HELP) on July 2 released a revised draft bill that offers details on these issues that were absent from the first draft unveiled in mid-June. *Continued on p. 6*

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The changes in the proposed physician fee schedule rule include several contained in the House tricommittee health care reform draft, including higher reimbursement for primary care and removing office-administered drugs from the update formula. The draft legislation also proposes to replace the SGR with physician fee updates tied to the Medicare Economic Index.

Physician Fee Schedule, *from p. 1*

would be cut 21 percent, from $37.15 to $29.45. The professional component of CPT 77056, mammogram, both breasts, would be reduced by 23 percent, from $44.36 to $33.98, and that for CPT 77057, mammogram, screening, would be trimmed by 23 percent, from $35.71 to $27.47.

Anticipating congressional action to overhaul the SGR update formula, CMS is proposing to drop office-administered Part B drugs when calculating the fee schedule, a move welcomed by the American Medical Association (AMA). This will not alter the projected update for services during 2010, CMS said, but "it could reduce the number of years in which physicians are projected to experience a negative update."

Primary Care Gains

CMS is making several proposals to increase payment rates for primary care services, including an update to the practice expense component of physician fees, using data from a new survey, the Physician Practice Information Survey, designed and conducted by the AMA. The agency also wants to substitute evaluation and management (E/M) office visit codes for consultation codes billed by specialists and paid at a higher rate. The savings would be redistributed to existing E/M codes.

'Welcome to Medicare' Exam

This baseline physical checkup would see a payment increase, CMS says, in line with rates for higher complexity services. The benefit is available to beneficiaries within one year of their enrollment in Part B and includes referrals, where appropriate, for clinical laboratory, pathology, and other tests.

PQRI and E-Prescribing

CMS would add 22 individual measures and six measure groups on which eligible professionals can report under the Physician Quality Reporting Initiative (PQRI), provide a mechanism for participants to submit data from electronic health records (EHR), and create a process for group practices to use for reporting the quality measures. The agency also would add EHR-based reporting mechanism to allow CMS to begin accepting data from qualified EHR products on 10 proposed individual PQRI measures and allow eligible professionals to count their submission of EHR-based measures towards their eligibility for a PQRI incentive payment.

For e-prescribing, CMS would simplify the reporting requirements by streamlining how often an eligible professional must report, providing more choice to report e-prescribing measures, and include skilled nursing facilities or the home care setting as part of the services for which the e-prescribing measure is reportable.

Eligible professionals who successfully report under each of the two programs, the PQRI and e-prescribing, are entitled to an incentive payment of 2 percent of total allowed charges for the reporting year.

Lab Fee Update Prognosis

Not good: if figures for the Consumer Price Index (CPI-U) hold up, the Medicare lab fee update as of Jan. 1, 2010 would fall into negative territory. According to the latest Bureau of Labor statistics, the CPI-U has fallen 1.3 percent over the last 12 months. The lab fee update approved by Congress from 2009 to 2013 is the CPI-U update minus 0.5 percent. The final update is based on June 30 figures due for release on July 15.

CAP Pushes Its Priorities for Health Care Reform

Laboratory testing influences 60 percent to 70 percent of health care decision-making, says the College of American Pathologists. "Whether we're analyzing a skin biopsy, performing complex blood work, or examining a woman's Pap smear, for many patients, pathologists are at the center of their care."

As congressional committees labor to craft health care reform legislation, the College of American Pathologists (CAP) is lobbying for its priorities on Capitol Hill and at the local level. The college is holding Washington fly-ins of pathologists from throughout the country to discuss CAP's agenda with members of Congress and staff and supports member efforts to sponsor lab tours and other campaigns in their communities to show their elected representatives how pathology contributes to quality care.

CAP is pursuing a "two-pronged legislative strategy," said its president, Jared N. Schwartz, M.D., Ph.D., FCAP, in a statement announcing the advocacy agenda. "The immediate priority is to ensure uninterrupted delivery of pathology services to patients under the current system. Our longer effort will focus on making better use of the information and expertise in the pathology lab as part of the coordinated care team," which puts primary care at the center of patient management.

Medicare Physician Fee Fix

An immediate CAP priority is to fix or replace the Sustainable Growth Rate (SGR) formula used to calculate the annual Medicare physician fee update. The SGR has triggered negative updates since 2002. In 2010, the scheduled cut is a whopping 21.5 percent. Over the next 10 years, CAP warns, the negative update will hit 40 percent.

In a letter to Senate Finance committee chairman Max Baucus (D-Mont.), the college called for blocking the projected cut in 2010, granting an increase, and moving to "a stable payment system that includes positive annual updates and accurately reflects increases in medical practice cost." Short-term fixes, resorted to repeatedly in the past by lawmakers, only result in deeper and deeper projected cuts under the SGR in subsequent years, making each fix more costly in the long run.

CAP supports a higher Medicare fee increase for primary care, but says it should be paid for by new funding rather than cuts from other providers, as happened to pathologists in 2007 when budget-neutral increases to evaluation and management services reduced their reimbursement by 8 percent.

Health IT Incentive Payments

Hospital-based pathologists are barred from receiving direct incentive payments available to independent-practice pathologists, other physicians, and hospitals to adopt electronic health records. In approving the health information technology pay incentives, Congress assumed that hospital-based pathologists would receive support from the hospital's incentive payment (*NIR, 09, 11/June 8, p. 1*).

CAP urges Congress to ensure that "all pathologists, including those whose practices are located in the hospital, are eligible to receive funding to modernize laboratory information systems and the necessary connectivity software and electronic infrastructure that are essential to coordinating care with primary care and other clinicians both inside and outside the hospital setting." Support is needed, the college notes, to link LIS and APIS systems that order and track tests with the patient's health records so the pathologist can get all the clinical information necessary to determine appropriate testing, test interpretation, and follow-up.

Pay for Performance

The college supports value-based purchasing and quality measures "if properly designed and implemented." It wants the process for getting quality measures approved for the Physician Quality Reporting Initiative (PQRI) to be more flexible and streamlined. CAP says the current design for getting measures approved is too restrictive and prone to gridlock and urges Congress to require the Centers for Medicare and Medicaid Services (CMS) to establish a timely review process and allow for quality measure alternatives.

Of the 11 measures developed by the college for the PQRI, only two have been approved, while nine measures developed in 2007 are stuck in the pipeline. Pathologists and other eligible Part B providers are entitled to an incentive payment of 2 percent of total allowed charges for successfully participating in the 2009 PQRI. The approved pathology measures are:

- ❑ Breast cancer resection pathology reporting: pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade.
- ❑ Colorectal cancer reaction pathology reporting: pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade.

Pathologist-Initiated Consultations

As part of the policy shift toward coordinated care under the medical home model, CAP is asking Congress to require CMS to conduct a demonstration project that would evaluate the role of pathologist-initiated consultations on test selection and assisting in therapy management as a method to improve patient care and control costs. The project would "focus on complex and costly genetic and other diagnostic tests that not only assist in the management and diagnosis of disease, but also delineate an individual's unique responsiveness to preventive and therapeutic interventions."

Under current Medicare payment policies, pathologists are not compensated if they initiate consultation with a primary care doctor. The consultation must be formally requested by the attending physician. "This may have made sense," CAP says, "when lab test results were considered routine and understood by most primary care providers, but this clearly is not the case today," given the evolution of molecular and genetic testing that has led to advances in personalized medicine.

Contractual Joint Ventures

CAP is asking Congress to remove anatomic pathology from the in-office ancillary services exception under the Stark physician self-referral law. This would close a loophole that allows physician specialty groups, typically in dermatology, gastroenterology, and urology, to increase their revenue by referring pathology work for their patients to their own in-office histology labs.

Lab Workforce

CAP supports efforts by lawmakers to develop a National Workforce Strategy and wants Congress to stipulate that it must address the laboratory workforce shortage and the growing needs of laboratory medicine with input from pathology and laboratory organizations. The college emphasized that it is "strongly concerned about a growing shortage of medical technologists, clinical laboratory scientists, cytotechnologists, and histotechnicians" and about the number of lab personnel training programs that have closed due to lack of funding.

Comparative Effectiveness Research: How Far Should It Go?

Comparative effectiveness research is the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat, and monitor health conditions in 'real world' settings. The purpose is to provide evidence-based information to patients, clinicians, and other decision-makers about which interventions are most effective for which patients under specific circumstances. Interventions include medications, procedures, medical and assistive devices and technologies, and diagnostic testing, among others.

With $1.1 billion in new federal spending approved for comparative effectiveness research (CER), that's a politically charged question as Senate committees labor to write health care reform legislation, aiming to wrap up their work before the August congressional recess.

The Obama administration and congressional allies see CER as an essential tool in achieving twin goals for health care reform: raising quality and lowering costs by focusing on where dollars can be best spent for the best outcomes for patients.

Republicans have objected that unless reined in, CER could interfere with doctor-patient medical decisions, expose physicians to medical liability risk, and result in the rationing of health care. They want the legislation to bar the use of federally supported CER data in coverage and payment determinations.

Finance chairman Max Baucus (D-Mont.) has sought to quell the controversy by assuring GOP senators that CER will not include a cost-benefit analysis. "Patients and their doctors will make decisions based on costs, not the government," he said. Practicing physicians also need to have input into CER, he noted, and research findings should be debated publicly.

Opportunities Seen for Labs, Pathologists

Despite the partisan skirmishing, clinical laboratory and pathology groups see the CER initiative as a new opening to gain greater recognition of their essential role in disease diagnosis and management and thus a prominent role at the CER policymaking table.

The College of American Pathologists has urged Congress to designate pathology and laboratory medicine for representation in CER efforts, noting the pathologist's "significant contribution to scientific and medical research." The college also called on lawmakers to "affirm that CER would not be used to make reimbursement and coverage decisions."

CER is an "important emerging topic for the lab industry," David Mongillo, vice president for policy and medical affairs at the American Clinical Laboratory Association, told *NIR*. Recognizing this, ACLA, he noted, has commissioned a white paper from the Lewin Group on this topic. The study, begun in January, has already identified two important roles for labs in CER, he said:

- Labs will provide the measurement tools needed to rate effectiveness of different modalities for prevention, diagnosis, treatment, and therapy.
- Lab services could become, over time, part of CER itself, for example, use of alternative testing processes such as a single diagnostic test to identify whether an organ transplant is being rejected versus doing multiple biopsies.

"No patients should be restricted from therapies that may have value," Mongillo said. "Decisions should not be made on cut-and-dry positions. Sometimes, a therapy may be personalized medicine for a subset of the population. We would hate to lose that if the decision were based on a judgment that the therapy is of little or no value to a larger population." ACLA has also commissioned a Lewin Group study, Mongillo said, on the value of screening and diagnostic tests. The findings are set for release at an ACLA forum, with call-in option, on July 30.

Funding for CER

The American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5, ARRA) approved $1.1 billion in new spending to study the effectiveness of different treatments—such as medical devices or drugs—for a given condition. Of that amount, $400 million is allocated to the National Institutes of Health, $300 million to the HHS Agency for Healthcare Research and Quality, and $400 million to the HHS secretary for discretionary use.

Regarding the latter amount, recommendations for investing it were submitted June 29 in a report from the Federal Coordinating Council on CER, established by ARRA to coordinate this research and guide funding allocations to support it. The money should mainly go to data infrastructure, the council said, which would link current data sources, such as claims databases, so that questions on comparative effectiveness can be raised and answered.

Other priorities for spending include:

- ❑ "High priority" populations overlooked by medical research, such as racial and ethnic minorities, persons with disabilities, persons with multiple chronic conditions, the elderly, and children. CER "will be an important tool to inform decisions for these populations and reduce health disparities," the report said.
- ❑ "High-impact health arenas" such as medical and assistive devices, surgical procedures, behavioral interventions, and prevention.

CER has proven its value, the council noted, citing examples of evidence obtained on treatments for prostate cancer and osteoporosis, lifestyle change to prevent type 2 diabetes, and heart attack prevention. In preparing its report, the 15-member council, composed solely of federal officials, held three public listening sessions, two in the District of Columbia and one in Chicago, and received comments for two months on its public Web site (*related NIR coverage: 09, 7/Apr. 13, p. 5, and 09, 8/Apr. 27, p. 5*).

The council's report is part of the effort by the HHS secretary to develop an agency-wide operational plan for the combined $1.1 billion that ARRA approved for CER. The plan is scheduled to go to Congress by July 30.

Health Care Reform, *from p. 1*

Under the revised HELP bill, the public plan option:

- ❑ Would be available in all states and would be administered by the U.S. Department of Health and Human Services (HHS), which would negotiate premiums and provider payment rates. The latter would not be higher than average local payment rates and could be less. Provider participation would be voluntary.
- ❑ Would be held to the same requirements as private health insurers in defining benefits, setting premiums, and protecting consumers.
- ❑ Would be capitalized by the federal government for the first three months of claims and then would be self-sustaining through collection of premiums.
- ❑ Would be offered through proposed exchanges where consumers can compare and buy coverage policies, with subsidies for those with incomes below 400 percent of the federal poverty level. Small employers could access the exchanges as could individuals, but not those covered by their employer unless the coverage offered is not affordable (that is, the premium exceeds 12.5 percent of salary). Employer plans would have to meet an adequate coverage threshold set by HHS.

The House tricommittee bill, released in mid-June by Ways and Means, Energy and Commerce, and Education and Labor, would require HHS to develop a public

plan option to be offered, starting in 2013. It would have to "participate on a level playing field with private plan choices" and offer the same benefits, abide by the same insurance reforms, and follow provider network requirements and other consumer protections. Provider payment rates in the first three years would be based on Medicare rates, "with a 5 percent add-on for practitioners who also participate in the Medicare program," according to an analysis of the draft.

Senate Finance committee chairman Max Baucus (D-Mont.) has expressed support for a public plan option, but details had yet to be fleshed out at press time. Two alternatives to a government-run plan have been floated as a compromise. Kent Conrad (D-N.D.) has proposed introducing health insurance "consumer cooperatives" to compete with private plans. This could include a federal charter to license and regulate nonprofit cooperatives, permitting them to provide health insurance around the country. The cooperatives could also be operated by the states either within states or as regional entities. A compromise, aired by Olympia Snowe (R-Me.), would hold off for now on a public plan and give private insurers time to show they can provide affordable quality coverage options. If they cannot, the government could institute a public plan option.

Employer Mandate

Under the revised HELP bill, employers would pay an annual fee of $750 for each full-time employee not offered coverage through his or her job. For part-time workers, the annual fee would be $375. Companies with fewer than 25 employees would be exempt. The fees are projected to produce $52 billion over 10 years that would be used to provide subsidies to those who cannot afford insurance.

The House tricommittee draft would establish a payroll tax of 8 percent of the wages that an employer pays to its employees for those employers who choose not to offer coverage, though certain small employers are exempt.

Prevention and Wellness

The HELP draft legislation includes an amendment backed by the Clinical Laboratory Coalition to enhance prevention and wellness programs. The coalition noted that reliance on the A and B recommendations of the U.S. Preventive Services Task Force (USPST) is too limiting and does not keep pace with clinical practice advances. The amendment, offered by Kay Hagan (D-N.C.) and Richard Burr (R-N.C.), states, "The USPST recommendations should consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, National Institute of Health, CDC, Institute of Medicine, specialty medical associations, patient groups, and scientific societies."

The Price Tag

According to preliminary estimates by the Congressional Budget Office (CBO), the Senate Finance proposals would cost $1.5 trillion over 10 years. The original HELP bill was scored by CBO at $1 trillion over 10 years, but the revised bill has scaled the cost down to $611.4 billion over that period. It also will cover 20 million more people in 2019, CBO estimated. However, the estimate does not consider any proposed expansion of Medicaid eligibility, which is under the jurisdiction of the Finance committee. This expansion would hike the price tag, but further reduce the number of uninsured, a HELP staffer noted. Raising eligibility to 150 percent of the federal poverty level would reduce the number of uninsured by an additional 20 million, it is estimated.

CMS Warns Medicare Providers on Faxing Scam

Physicians and other Medicare fee-for-service providers should be on the lookout for a faxing scam to obtain their account information, the Centers for Medicare and Medicaid Services has advised.

The agency said it has become aware of a scam where perpetrators are sending faxes to physician offices posing as the Medicare carrier or Medicare Administrative Contractor (MAC). The fax instructs staff to respond to a questionnaire to update account information within 48 hours to prevent a gap in Medicare payments. The fax may have the CMS logo and/or the contractor logo to enhance the appearance of authenticity.

CMS's advice: Be wary of such requests. If you receive a request for information in the manner described above, check with your contractor before submitting any response. Medicare providers should only send information to a Medicare contractor using the address found in the download section of the CMS.gov Web site at *www.cms.hhs.gov/MLNGenInfo/* or *www.cms.hhs.gov/MedicareProviderSupEnroll*.

G-2 Conference Calendar, 2009

SEPT. 23-25
27th Annual Lab Institute
Advancing in the Eye of the Storm
Crystal Gateway Marriott Hotel, Arlington, Va.

NOV. 12
Lab Leaders Summit
Driving Growth in Your Business
The Princeton Hotel, New York City

DEC. 7-9
Laboratory Sales and Marketing Conference
Scaling New Heights in a Volatile Market
Sheraton Wild Horse Pass Resort and Spa, Chandler, Ariz.

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 NATIONAL INTELLIGENCE REPORT (ISSN 0270-6768) is published twice monthly (except August and December, which are one-issue months) by Washington G-2 Reports, 1 Washington Park, Suite 1300, Newark, NJ 07102-3130. Telephone: (973) 718-4700. Fax: (973) 718-0595. Web site: www.g2reports.com. Order Line: (212) 629-3679.

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