WASHINGTON G–2 REPORTS

NATIONAL INTELLIGENCE REPORT®

Covering Government Policy For Diagnostic Testing & Related Medical Services

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Vol. 09, Iss. 20, November 9, 2009

Medicare Physician Fee Update: House Bill Aims for Fundamental Fix With 2010 Kickoff

*Unless Congress intervenes, Medicare payments for physician services are due for a 21.2 percent cut, starting Jan. 1, 2010 (*related story below*).*

The House will consider an overhaul of the Medicare update formula for physician payments separate from broader health care reform legislation, Democratic leaders announced Oct. 29.

A newly introduced bill (H.R. 3961) would repeal the Sustainable Growth Rate (SGR) factor used to calculate the annual update to the Medicare physician fee schedule and replace it with a new update system, starting in 2010.

The bill would cancel the pending 21.2 percent cut in Medicare physician fees in 2010 and base the update on the Medicare Economic Index.

In subsequent years, the update 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).

The new update formula would remove items such as physician-administered drugs and diagnostic laboratory services not paid directly to practitioners from the spending targets. *Continued on p. 2*

INSIDE NIR

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CMS Issues Interim Final Rule for 2010 Medicare Physician Fee Schedule

In an interim final rule with comment period released Oct. 30, the Centers for Medicare and Medicaid Services announced that in the absence of congressional action, the scheduled update to Medicare payment rates for physicians in 2010 is a cut of 21.2 percent versus the 21.5 percent cut projected in the proposed rule.

The difference, CMS said, is due to the use of the most recently available data on Medicare spending for physician services.

CMS said it had no choice but to issue the rule since it is required by law to do so by Nov. 1. "The administration tried to avert the pending cut in its fiscal 2010 budget proposal and remains committed to repealing the SGR," said Jonathan Blum, director of the CMS Center for Medicare Management.

"In the meantime, CMS is finalizing its proposal to remove physician-administered drugs from the definition of physician services for purposes of computing the fee schedule update. *Continued on p. 2*

Medicare Physician Fee Update, *from p. 1*

The cost of the change is an estimated $245 billion over 10 years. But it would not increase total payments to physicians above what they are today and thus would not add to the federal deficit, according to a statement from House Democratic leaders.

Removing Medicare physician payment reform from the broader health care reform bill before the House (H.R. 3962, introduced Oct. 29) lowers the cost of the latter below the $900 billion benchmark set by the Obama administration.

H.R. 3961 will be considered, House Democratic leaders said, under a procedure that will add the text of H.R. 2920, the Statutory PAYGO Act, as passed by the House on July 22, before being sent to the Senate.

In the Senate, a similar move to tackle physician payment reform apart from a broader health care reform bill was defeated Oct. 21 when it failed to get the 60 votes needed to come to the floor (*NIR 09, 19/Oct. 26, p. 1*). The measure would have cost an estimated $247 billon over 10 years. It was opposed by all Republicans, 12 Democrats, and one independent, Joseph Lieberman (Conn.), who objected that the fix was not paid for and would add to the deficit.

The broader reform bill approved by the Finance Committee would cancel the 2010 cut in Medicare physician fees and grant a 0.5 percent increase at a cost of $10.9 billion. However, it makes no provision for further changes to the SGR.

Repealing the SGR

This has been a top legislative priority for pathology and other medical groups for years, and this year it is included in a new House bill and in the reform bill passed by the Senate HELP Committee.

The Sustainable Growth Rate (SGR) factor ties the yearly update to the Medicare physician fee schedule to a spending target. If the target is exceeded, the update is decreased.

The SGR was adopted in the 1997 Balanced Budget Act. It has yielded negative updates every year beginning in 2002, though the Centers for Medicare and Medicaid Services took administrative steps to avert a reduction in 2003 and Congress prevented SGR cuts from 2004 through 2009.

Physician Fee Schedule, *from p. 1*

While this decision will not affect payments for services during 2010, CMS projects it will have a positive effect on future payment updates."

The interim final rule is set to be published in the Nov. 25 Federal Register. *It affects more than 1 million physicians and nonphysician practitioners paid under the Medicare physician fee schedule. It sets payment rates for more than 7,000 types of services in physician offices, hospitals, and other settings.*

Highlights of the Rule

- ❑ Improve payment rates for primary care. In setting practice expense (PE) relative value units (RVUs), CMS will include data about physician practice costs from a new survey, the Physician Practice Information Survey, designed and conducted by the American Medical Association, but will phase it in over four years. CMS will not use the survey in setting PE for medical oncology.
- ❑ Stop paying for consultation codes other than the G codes used to bill for telehealth consults and use the savings to increase payment for office visit codes.
- ❑ Modify the equipment utilization percentage assumed for setting PE RVUs. For equipment priced over $1 million, CMS will increase the rate assumption from 50 percent to 90 percent over a four-year period. This will not apply to expensive therapeutic equipment.
- ❑ Increase payment for the "Welcome to Medicare" exam to be more in line with payment rates for higher complexity services. The Initial Preventive Physician Exam benefit pays for an initial assessment of key elements of a beneficiary's health within one year of the beneficiary's enrollment in Part B.
- ❑ Add new Medicare benefit categories for cardiac and pulmonary rehabilitation services and for chronic kidney disease education, beginning Jan. 1, 2010.

- Add measures to report under the Physician Quality Reporting Initiative (PQRI) and simplify reporting requirements under the PQRI and the Electronic Prescribing Incentive Program. For the latter, CMS would provide more reporting options and create a new process for group practices to be considered successful e-prescribers. Those that meet the requirements of each program in 2010 are eligible for incentive payments for each program equal to 2 percent of their total estimated allowed charges for the reporting periods.

Proposed DOS Change for Molecular Tests Under Attack

Pathology and hospital groups continue to lobby hard against a provision in the health care reform bill passed by the Senate Finance Committee that would change Medicare's date of service (DOS) policy to allow independent clinical labs to bill Part B directly for complex molecular tests performed within 14 days of a beneficiary's hospital discharge. The bill earmarks $100 million from the lab fee schedule update to pay for the change.

The current DOS policy involves blood or tissue samples collected by a hospital for inpatients and outpatients. Under the 14-day rule, if a lab performs testing on such a specimen, it must be paid by the hospital through its inpatient DRG payment, rather than a direct payment from Medicare.

The groups are urging senators to modify the provision to allow all lab settings to qualify for direct payment or remove the provision altogether. Their opposition is spelled out in a letter to the Senate co-signed by the College of American Pathologists, the American Hospital Association, the Association for Molecular Pathology, the Association of Pathology Chairs, the Association of Medical Colleges, and the American Society for Investigative Pathology.

In its current form, the provision, they argue, benefits a select group of commercial reference laboratories and excludes the vast majority of hospital-based labs, medical schools, and teaching hospitals, even if they perform the same tests or a less costly but equally effective alternative.

The Finance committee bill provides that for a two-year period, beginning July 1, 2011, when a lab test is ordered within 14 days of a beneficiary's discharge from the hospital, the lab furnishing the test may bill Part B for the test if certain criteria are met:

- The test is an analysis of DNA, RNA, chromosomes, proteins, or metabolites that detects, identifies, or quantitates genotypes, mutations, chromosomal changes, biochemical changes, cell response, protein expression, or gene expression or similar method or is a cancer chemotherapy sensitivity assay or similar method but does not include methods principally comprising routine chemistry or routine immunology.
- The test is performed only by the lab offering the test.
- The test is not furnished by the hospital where the sample was collected from the patient directly or under arrangements.

The American Clinical Laboratory Association supports the DOS policy change, saying it is needed to spur innovation and improve patient access to critical lab tests. But it does not support paying for the change by reducing the fee update for all Medicare lab services.

focuson: Health Care Reform

House Bill Makes Major Medicare Cuts But Backs New Payment Models to Reward Quality

Health care reform legislation introduced by House Democratic leaders Oct. 29 would not only make major reductions in Medicare payments to managed care plans and fee-for-service providers, but also open the door to new business arrangements that reward quality performance in delivering services to Medicare beneficiaries, including clinical lab and pathology services.

At press time, the House Democratic leadership plans to bring the bill to the floor soon. Meantime, the GOP plans to offer an alternative whose main goal is to control costs using market forces to cover 83 percent of Americans by 2019. It would expand tax-sheltered medical savings accounts, let insurers market products across state lines, and aid states to form high-risk pools to help individuals and families obtain coverage. It contains no individual or employer mandate and no subsidies to help people obtain coverage. It does not bar insurers from exclusions for preexisting conditions but does ban annual or lifetime caps on benefits and cancellation of coverage when the policyholder becomes ill.

The bill, H.R. 3962, is a revised version of separate reform bills approved by three House committees of jurisdiction: Ways and Means, Energy and Commerce, and Education and Labor. It will expand health care coverage to 96 percent of people legally residing in the United States at a net cost of $894 billion, Democratic leaders said in introducing the measure. The tab would be paid by controversial higher taxes on wealthy Americans and new levies on business and industry, including a 2.5 percent excise tax on medical devices sold for use in the United States, raising $20 billion over seven years, according to the Joint Committee on Taxation. It would not apply to exported devices or to retail sales of devices.

Key Features of H.R. 3962

The bill includes an individual and employer mandate, expanded eligibility for Medicaid and the State Children's Health Insurance Program, a public insurance plan option to compete with private insurers, a health insurance exchange where individuals and small businesses can comparison shop among private and public insurers, including new health insurance co-ops, and premium subsidies to help people buy affordable coverage.

The public plan option, which has drawn fire from Republicans and the health insurance industry, would be subject to the same market reforms and consumer protections as private plans in the exchange and would be financed by premiums. Startup funds would be provided but would have to be amortized from future premiums.

The Health and Human Services secretary would administer the public plan and negotiate rates for providers participating in the plan. Providers would be presumed to be participating unless they opt out.

A new advisory committee, to be chaired by the Surgeon General, is established to help define the essential benefits package under the public plan to be offered in the exchange. Over time, it is to become the minimum quality standard for employer plans.

The basic package is to include preventive services with no cost sharing, mental health services, oral health and vision care for children, and caps on the amount of money a person or family spends on covered services in a year (a maximum of $5,000 for an individual and $10,000 for a family, with lower levels for lower-income and middle-income families).

There will be four plan levels: basic, standard, premium, and premium plus. All will cover the essential benefits package but have varied levels of cost sharing. The premium plus

plans will offer additional benefits such as adult dental or vision care, gym memberships, and private hospital rooms.

In a separate provision to inject competition into the health insurance marketplace, the bill would eliminate the antitrust exemption for health insurers and medical malpractice insurers. According to a House Democratic leadership statement, this will "remove their shield that has allowed them to price fix, divide up territory, and effectively create monopolies in particular markets."

Medicare Plan, Provider Cuts

The House reform bill would cut $170 billion from payments to Medicare Advantage (MA) plans and $229 billion from annual payment updates to Medicare fee-for-service

Comparison of Key Provisions in Reform Bills

	House bill (H.R. 3962)	*Senate Finance bill*	*Senate HELP bill*
Individual mandate	Those who do not obtain health insurance coverage pay up to 2.5 percent of adjusted gross income or the average cost of premiums on the health care exchange, whichever is lower. Exemptions for individuals earning less than $9,350 and couples earning less than $18,700. Estimated to yield $33 billion in receipts. The Treasury is authorized to establish a hardship exemption from the tax.	Penalty for not obtaining health insurance, starting at $200 per adult in 2014, rising to $750 per adult, $1,500 per family in 2017; thereafter, indexed to inflation rate. Exemption for those who cannot find a policy costing less than 8 percent of adjusted gross income.	Penalty up to $750.
Employer mandate	Businesses must provide health insurance coverage for their employees or pay a percentage of payroll on their behalf. Those that provide coverage pay 72.5 percent of the premium for individuals, 65 percent for couples. Businesses whose payroll does not exceed $500,000 are exempt. The payroll penalty would be phased in starting at 2 percent for firms with annual payrolls over $500,000, rising to the full 8 percent penalty for those with payrolls above $750,000. Small businesses with 10 employees or fewer and $20,000 or less in average wages would be eligible for a two-year tax credit to make health insurance more affordable. The credit would phase out if the employer has 25 employees or more or if average wages are $40,000 or more.	Businesses with 50-plus employees to provide coverage or pay a fee based on the number of employees who get a federal subsidy to buy coverage. Fee capped at $400 per employee. No requirement for sharing in premium costs.	Businesses with 25-plus employees to provide coverage for workers or pay penalty of $750 for every employee over age 25. Employers to pay 60 percent of premium costs.
Health insurance exchange	One-stop shop for small businesses and people not covered at work to find affordable health insurance choices, with standard set of minimum benefits. States may opt to run an exchange as long as they follow federal rules.	Similar	Similar
Public plan option	Creates a government health insurance plan to compete with private insurers in the exchange market.	Creates state-based nonprofit cooperatives to compete. Also allows states to negotiate with insurers to cover low-income individuals. (Senate majority leader has since said the Senate reform legislation will include a public option.)	Similar to House bill
Insurance market reforms	Bar insurers from discriminating based on health status, denying coverage due to preexisting conditions, or dropping coverage. Eliminate yearly and lifetime limits on coverage.	Same	Same
Independent body on medicare payments	No provision; instead, calls for Institute of Medicine studies on geographic differences in Medicare payment rates and on geographic variations in health care spending.	Establish Medicare commission whose proposals for spending reductions would take effect unless Congress intervenes.	No provision

providers, including clinical laboratories paid under Part B.

MA plans would see their payments reduced over three years to fee-for-service levels, beginning in 2013. Currently, plans get approximately 14 percent more in payments than traditional fee-for-service for comparable services. "Massive MA cuts would cause millions of seniors to lose their MA coverage altogether, while millions more would face benefit cuts and higher out-of-pocket costs," America's Health Insurance Plans said in a statement.

Fee-for-service providers would see their payment updates hit with a productivity adjustment (PA). This is a reduction in payment to encourage providers to be more efficient in the delivery of care. Clinical labs are among those to get a PA for the first time. The House bill would replace the current Part B lab fee schedule update formula (the Consumer Price Index for All Urban Consumers—CPI-U—minus 0.5 percent) with a new formula in 2010: the full CPI-U minus the PA (estimated at minus 1.3 percent). The lab fee update for 2010, announced in the final physician fee schedule rule, is a negative 1.9 percent. Under the House formula, lab fees would be cut 1.4 percent under the CPI-U plus a further 1.3 percent PA reduction, for a total reduction of 2.7 percent.

New Medicare Payment Models

The House reform measure includes provisions to promote prevention and wellness services and to improve the quality of care while lowering costs. It would eliminate deductibles and copayments for all preventive services covered by Medicare and would establish new incentives to encourage providers to coordinate care.

One new model is the accountable care organization (ACO) that allows providers to share in Medicare savings they help create through care coordination and quality improvement initiatives. This alternative within fee-for-service Medicare would reward physician-led organizations that take responsibility for the costs and quality of care, according to a summary of the bill. ACOs could include groups of physicians organized around a common delivery system (including a hospital), an independent practice association, a group practice, or other common practice organizations, the summary said.

Another payment model in the bill is a medical home pilot program to reward providers who agree to provide services necessary to make their practice a medical home by ensuring full access to patients and providing coordinated and comprehensive care.

Further, a new Center for Medicare and Medicaid Payment Innovation is to be created by 2011 within the Centers for Medicare and Medicaid Services to test and expand new payment models that encourage higher quality and lower cost.

Physician Ownership of Hospitals

H.R. 3962 closes a loophole in the Stark self-referral rules that allows physicians to refer Medicare and Medicaid patients to hospitals in which they have a direct financial interest. It would prohibit physician ownership in hospitals that are new as of Jan. 1, 2009, and grandfather those operating prior to that date.

Other Delivery System Reforms

The measure provides financial incentives to reduce preventable hospital admissions, expanding this policy over time to take into account the important role that physicians and post-acute care providers play in avoiding readmissions.

It also calls for demonstrations of bundled payments that encourage providers to coordinate care across the entire spectrum: from the physician's office to the hospital, through a rehabilitative or nursing facility stay, and back to home. The HHS secretary is to submit to Congress no later than three years after enactment a detailed plan on how to implement post-acute care bundled payments.

♦ Medicare Claims *Advisory*

Changes in Billing Modifiers for Advance Beneficiary Notices

The Centers for Medicare and Medicaid Services has announced it will update HCPCS Level 2 modifiers to distinguish between voluntary and required uses of the Medicare Advance Beneficiary Notice (ABN). The ABN is used to alert beneficiaries that they may be financially liable for an item or service that Medicare is likely to deny. It is never required in emergency or urgent cases.

Effective April 1, 2010, CMS will introduce one revised and one new modifier.

- ***Revised:*** The modifier–GA will be redefined to mean "waiver of liability statement issued, as required by payer policy." It is only to be used to report when a required ABN was issued for a service. It should not be reported in association with any other liability-related modifier and should continue to be submitted with covered charges. However, Medicare systems will now deny these claims as a beneficiary liability (rather than subjecting them to possible medical review), and the beneficiary will have the right to appeal this determination.
- ***New:*** The modifier–GX "notice of liability issued, voluntary under payer policy," is to be used to report when a voluntary ABN was issued for a service. Providers may use this to provide beneficiaries with notice of their liability for services excluded from Medicare coverage by statute. In these cases, -GX must be submitted with noncovered charges only and will be denied by the Medicare contractor as a beneficiary liability.

The changes were announced in CMS Change Request 6563 (Oct. 29, 2009).

Since March 1 of this year, Medicare has recognized as valid only its revised single-page ABN (CMS-R-131), as well as a version tailored to clinical laboratory use (*NIR 09, 4/Feb. 23, p. 5*). They replace three notices previously in use: the general ABN-G, the lab-specific ABN-L, and the Notice of Exclusion From Medicare Benefits. The ABN is formatted to help a beneficiary match a listed or checked service, the reasons Medicare may not pay, and the estimated cost of the service. It should be kept for five years from discharge or completion of the delivery of care when there are no other applicable requirements under state law.

Interest Rate Drops for Overpayments, Underpayments

The rate of interest that Medicare will pay you for claims that were underpaid or collect from you for claims that were overpaid, dropped to 10.875 percent effective Oct. 22, down from 11.25 percent in effect from July 17 to Oct. 21. At the start of this year, the rate was 11.75 percent, the same since April 18, 2008. The highest rate in this decade was in early 2001, 14.125 percent, but for most of the decade, the rate has hovered between 11 percent and 12 percent.

Medicare regulations provide for assessing interest at the higher of the current value of funds rate (3 percent for 2009) or the private consumer rate fixed by the Treasury. The Centers for Medicare and Medicaid Services announced the quarterly update to the interest rate in Change Request 6651 (Oct. 15, 2009).

Regina Benjamin Confirmed as New U.S. Surgeon General

The Senate Oct. 29 confirmed the president's choice of Dr. Regina Benjamin as the new U.S. surgeon general. Benjamin, 52, is a physician in family practice who has devoted most of her career to serving poor patients in a Gulf Coast clinic in Alabama.

In announcing his selection, the president said, "When people couldn't pay, she didn't charge them. When the clinic wasn't making money, she didn't take a salary for herself." He called her a "relentless promoter" of programs to combat preventable illness.

Benjamin is the immediate past chair of the Federation of State Medical Boards of the United States. She has advanced degrees in medicine and business administration and has held numerous medical association leadership posts.

Under the Democratic health care reform bill unveiled in the House Oct. 29, she would chair a new independent advisory committee charged with developing an essential benefits package under the public plan option (*related story, p. 4*). Over time, the package would become the minimum quality standard for employer plans.

Upcoming G-2 Events

Webinar

Nov. 24
Practical Planning and Preparation for 2010: Lab and Pathology Coding, Billing, and Reimbursement
2:00 p.m. (Eastern)

Conferences

Nov. 12
Lab Leaders Summit
Driving Growth in Your Business
The Princeton Club of New York

Dec. 7-9
2nd Annual LabCompete: 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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