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The Source

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LEGISLATIVE NEWS

Medicare Bill Still Up in the Air

After weeks of negotiations, House and Senate leaders appear to have made little progress on a Medicare package that would stave off a scheduled 10% physician reimbursement cut next year, as well as potentially make other changes to the Medicare and Medicaid programs. While it is now clear that any Medicare legislation that makes its way to the President's desk will be a much smaller package than stakeholders originally anticipated, with the end of the year approaching, the chances of Congress passing any such bill are decreasing.

Last week, Senate Finance Committee Chairman Max Baucus (D-MT) announced that his committee would not be marking-up a Medicare package, but would instead move directly to negotiations with the House. The House had approved a broad Medicare package earlier in the year, which was expected to be pared down during negotiations.

With no shortage of Democratic Medicare and Medicaid priorities beyond the physician payment fix, negotiations have centered on how to pay for a package. Weeks ago, substantial cuts to the Medicare managed care program (Medicare Advantage) seemed imminent, but when the Bush Administration issued a veto threat on legislation that broadly cut the managed care program, lawmakers were forced to significantly scale back their priority list and look for other ways to pay for the doctor fix. The White House has, though, blessed the elimination of certain payments for indirect medical education under Medicare Advantage as a potential funding source for the bill and it now appears a likely, but partial, "pay-for."

With widespread disagreement between House and Senate leadership on the content of the bill and between Democrats and Republicans on how to pay for the package, bicameral and bipartisan negotiations all but broke down this week. On Thursday, House Speaker Pelosi (D-CA) announced that any new Medicare legislation this year would have to originate in the Senate. And, with the end of the session soon approaching, Senate Minority Leader McConnell (R-KY) stated today that any Medicare legislation will have to be considered by unanimous consent.

At this point, in order to get the needed Republican votes, the Medicare bill will likely have to be very "slim." With one week left on the 2007 Congressional calendar, Democratic leaders must now decide if they should pass a bare-bones Medicare bill

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that accomplishes few of their party's priorities, or wait until early next year to address the physician payment issue.

Medicare Physician Fee Schedule 2008 Final Rule Released

Medicare Payment Amounts

The 2008 Medicare Physician fee Schedule final rule was posted on the CMS website on November 1, 2007. Rates and policies described in the rule will become effective January 1, 2008.

The final rule indicates that, unless Congress acts, physician fees overall will be reduced by 10.1% in CY 2008 as the result of the Sustainable Growth Rate (SGR) formula; however, it is widely anticipated that Congress will intervene to preclude this adjustment from being implemented.

Regardless of what action Congress may take on the SGR issue; however, CMS will continue to phase in changes to the practice expense relative value units (PE-RVUs), which are largely responsible for determining Medicare payment levels for radiation oncology technical component services. As the result of the phase-in of these changes, Medicare payment for conventional radiation therapy will increase, and payment for IMRT treatment will decrease, in CY 2008.

CMS decided not to make any modification to the assumptions used to determine PE-RVUs in 2008; however, the agency is continuing to study whether its current assumptions regarding the utilization of medical equipment (including radiation oncology equipment) are reasonable. CMS will also continue to monitor whether the interest rate used in the calculation of equipment costs (11%) is reasonable, and will continue to study whether the Physician Fee Schedule adequately reflects malpractice costs associated with the provision of TC services, including radiation oncology TC services.

CMS also decided to increase Medicare payment (work-RVUs, or W-RVUs) for anesthesia services by approximately 32%, resulting in an overall decrease in Medicare W-RVUs for all other services paid under the Physician Fee Schedule.

This adjustment likely will reduce Medicare payment for radiation oncology professional component payment by approximately one percent.

Overall, as a result of all of these changes, it is anticipated that payments for radiation oncology services in 2008 will increase by 1%, according to CMS. However, because this year CMS will implement revised Geographic Practice Cost Indices (GPCIs), Medicare payment in CY 2008 may vary substantially from payment levels in effect in CY 2007, depending on the locality involved.

Impact of DRA

Medicare payment for a number of radiation oncology services have been affected this year by the Deficit Reduction Act of 2005 (DRA), which caps the amounts payable for TC services reimbursed under the Physician Fee Schedule at the amounts paid to hospital outpatient departments for the same services, under the Hospital Outpatient Prospective Payment System. For example, Medicare payment for CPT 77014 (CT guidance for placement of radiation fields); and CPT 77421 (stereoscopic x-ray guidance) are subject to the DRA "cap." In CY 2008, Medicare payment for these services no longer will be separately payable: Rather, the amounts paid to hospital outpatient departments will be "packaged" into the payment amounts for other services. As a result, the DRA cap will no longer apply to these services, and Medicare payment will be made on the basis of the Physician Fee Schedule, resulting in payment increases.

Physician Self-Referral and "Mark-Up" of Diagnostic Tests

CMS decided not to finalize its proposed modifications of the physician self-referral regulations at this time, but has indicated that the changes that it had proposed (which generally make referring physicians' participation in space sharing and management turn key arrangements more difficult) will be finalized in a separate rule. CMS did, however, expand and finalize provisions of the regulations that preclude the "mark-up" of the professional and technical components of diagnostic tests. These provisions may impact those radiation oncology practices that provide diagnostic tests, including, for example, CT services and PET/CT.

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Under the final rule, diagnostic tests provided by part-time employees and independent contractors in the office of the billing supplier (i.e. the radiation oncology practice) will not be subject to the anti-mark-up provisions, unless the services of the independent contractor are billed as a purchased diagnostic test. However, if a full or part-time employee or any independent contractor performs diagnostic services off-site, then the billing party is not permitted to mark up the charge from the performing entity.

While these provisions are aimed at "pod" lab operations and imaging shared facility arrangements, their reach is considerably broader, and may require relocation of diagnostic services into the principal offices of physician practices.

Physician Quality Reporting

CMS is continuing its quality reporting program. Eligible providers that meet the reporting requirements will be eligible for bonus payments, which CMS anticipates will be approximately 1.5% of allowed charges. There is one PQRI measure specific to radiation oncology, related to radiation therapy recommended for invasive breast cancer patients who have undergone breast conserving surgery.

Two More Insurance Plans Agree to New York AG Model Standards for Physician Rankings

Two more large health insurance plans have agreed to settlements requiring them to adhere to model standards for physician ranking programs, New York Attorney General Andrew M. Cuomo announced Nov. 20. With the latest settlements, reached with United Healthcare and the combined Group Health Inc. (GHI) and Health Insurance Plan of New York (HIP), five insurers have adopted the reforms. United, the second-largest U.S. health insurer, will apply the model standards nationally, as will CIGNA Health Care, Aetna, and Wellpoint, the parent of Empire Blue Cross Blue Shield, Cuomo said. The CIGNA, Aetna, and Empire settlements were reached in the last month, following the August announcement of a Cuomo investigation into allegations that the ranking programs hide financial considerations from consumers and can have more to do with cost control than quality.



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1501 M Street, NW
7th Floor
Washington, DC 20005
Phone: 202-872-6767
Fax: 202-785-0564
Email: Sheila.Gell@ppsv.com



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