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LEGISLATIVE NEWS

SENATE TO CONSIDER MEDICARE BILL LATER THIS YEAR

The Senate Finance Committee is currently working to assemble what many believe will be a large and comprehensive Medicare package, with the primary goal of addressing a scheduled 10 percent Medicare physician payment cut in fiscal year (FY) 2008.

In July, the House approved the Children's Health and Medicare Protection ("CHAMP") Act of 2007 – which would reauthorize the State Children's Health Insurance Program (SCHIP) as well as eliminate the Medicare physician payment cut in FY 2008, providing doctors with a 0.5 percent payment bump each year for the next two years. The CHAMP Act would pay for the changes through an increase in the tobacco tax and cuts to many Medicare provider groups including hospitals, skilled nursing facilities, and home health agencies.

At the same time, the Senate approved an SCHIP reauthorization bill funded entirely by a tobacco tax increase. The Senate bill contained no provisions impacting the Medicare program.

The compromise SCHIP sent to the President in early October closely resembled the Senate's SCHIP package and did not address Medicare physician payments. The President promptly vetoed that SCHIP bill on philosophical grounds, stating that a sizable expansion of the program represents a step toward government-run healthcare.

Now, as Congress considers their SCHIP options, it is also beginning to consider options for Medicare legislation this year. The House will likely not "re-pass" another Medicare bill, but will instead use the Medicare provisions included in the CHAMP Act as the basis for negotiations with the Senate with respect to any Medicare changes enacted this year. Meanwhile, the Senate Finance Committee is compiling a Medicare legislative package, and a draft may emerge by late October or early November. It remains unclear as to what will be in the Senate bill, other than some form of a Medicare physician payment "fix" to avert projected across-the-board reductions resulting from application of the Sustainable Growth Rate

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(SGR) formula.

Significantly, much is at stake for radiation oncology. While there appears to be widespread commitment on the Hill for a two year physician payment “fix” that would avert application of the SGR at least until after the Presidential elections, the House CHAMP legislation would also change the SGR formula thereafter in a way that may result in a lower conversion factor for radiation oncology than for many other services paid under the Physician Fee Schedule. Specifically, the SGR formula would be modified so that growth targets would be applied separately to different categories of services (e.g. primary and preventive care, surgery, imaging, and “minor procedures and other services” procedures). Different conversion factors would be established for each of the different categories of services, and those with the highest growth rates would experience the lowest conversion factors. Radiation oncology likely would be included in the catch-all category with “minor procedures and other services”, whose growth rate has been relatively high. This may result in significant reductions in Medicare payment after the initial two year “freeze.”

The House-passed CHAMP bill also includes new payment reductions for medical imaging services, which may impact certain radiation oncology services.

AFROC plans to communicate its support for a two year physician payment “fix” – as well as its opposition to the House approach of establishing six payment categories – to key legislators.

CMS ISSUES STARK III CHANGES; FURTHER CHANGES TO STARK REGULATIONS UNDER CONSIDERATION

CMS recently published “Phase III” of the regulations implementing the federal physician self-referral law (the “Stark Law”). These final regulations, which will become effective on December 4, 2007, modify and “clarify” a number of the physician self-referral regulations. However, in addition, CMS is currently considering broad **additional** changes to the physician self referral rules which would have much more significant implications. It is anticipated that these **additional** changes will be finalized in November as part of the final Physician Fee Schedule rule for CY 2008.

A complete summary of the changes is beyond the scope of this newsletter. Nonetheless, the Phase III Stark regulations themselves do have a number of implications for AFROC members, including the following:

- In order to bill for radiation oncology services, a group practice of non-radiation oncologists (e.g. medical oncologists, urologists) generally

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must meet the definition of a “group practice” that is in the Stark Law regulations. The preamble to the Phase III regulations reiterate that a group practice may not pay a physician a productivity bonus that is based on that physician’s referrals for, or supervision of, technical component services. This may impact the extent to which radiation oncologists who are members of such a group may be paid a bonus based on his or her supervision of radiation oncology services. The group practice may, however, institute a “profit sharing plan” that takes into account technical component services provided by the group, provided certain requirements are met.

- The Phase III regulations modify the definition of a physician “in a group practice” to require that an independent contractor physician must furnish patient care services for the group under a *direct* contractual arrangement with the group. Thus, for example, if a urology group that wants to provide radiation oncology technical component services, those services can be supervised by a radiation oncologist who is not a member of the group only if the group has a direct contractual relationship with *that radiation oncologist*. The group cannot contract with the radiation oncologist’s group to provide supervision. Moreover, in order for the group to bill for the professional component of the service on a global basis, the radiation oncologist must also provide professional component services *on the group’s premises*. Since most physician groups do not contract with individual radiation oncologists but rather contract with a radiation oncology practice, this change may impact the ability of group practices to provide and bill for radiation

oncology services on a global basis, or at least disrupt their current contractual relationships for the provision of radiation oncology supervision and professional component services.

- The Phase III regulations indicate that a physician in a group practice or other physician organization “stands in the shoes” of the group practice for the purpose of determining whether a financial arrangement is a “direct” or an “indirect” financial arrangement. This change, which may seem relatively technical on its face, has broad implications, since it means that many transactions that otherwise would be eligible for an extremely broad exception that is available for “indirect” compensation arrangements now will have to be analyzed under much more narrowly drawn exceptions available for “direct” compensation arrangements. For example, the indirect compensation exception is currently used to support the legality of arrangements under which physician organizations provide a broad range of equipment, space, and other items and services using “turn key” contractual arrangements with the provider, which ultimately bills Medicare for the service. In the future, such arrangements may have to be structured much more carefully, to take advantage of specific, narrow exceptions, and this may have a dampening effect on the formation of joint ventures that include referring physicians that provide radiation oncology equipment, facilities, and staff to radiation oncology practices and other providers on a “turn key” basis. In addition, while current indirect compensation arrangements by physician organizations are “grandfathered” if

they pre-date September 5, 2007, the grandfather lasts only through the current term of the arrangement.

- The Phase III regulations, taken as a whole, create uncertainty for academic medical centers, especially those with separate faculty practice plans or other physician organizations. It is anticipated that CMS will address a number of areas of uncertainty in November, when it finalizes the additional Stark regulation changes that are currently under consideration; however, in the interim, there may be a “chilling effect” on academic medical centers while they analyze the potential impact of the rules on their compensation arrangements with their physicians.
- The Phase III regulations limit the availability of certain exceptions -- such as the “fair market value” exception -- to arrangements that involve space leases. CMS also states that office space and equipment cannot be shared, in effect requiring that such leases be on a block time basis and precluding arrangements under which facilities are shared by a number of providers on a patient-by-patient or similar basis. Please note that the Stark regulation changes that are still pending likely will preclude “click” and other volume-related payment arrangements under the space and equipment lease exception. Thus, these changes, taken together, will result in significant legal impediments for facility sharing arrangements.

For specific advice regarding the continued legality of your financial relationships with referring physicians, consult your health care attorney.

STUDY FINDS LITTLE IMPACT OF MMA CUTS ON ACCESS TO CANCER CARE

According to a study released October 8, 2007 by Duke University's Clinical Research Institute and published in *CANCER*, a peer-reviewed journal of the American Cancer Society, patient access to chemotherapy services was not reduced as a

result of reimbursement changes in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

The MMA significantly reduced Medicare reimbursements to many Medicare provider groups starting January 1, 2005. Because many in Congress considered oncologists to have been previously over-funded, this group was particularly targeted for cuts. Stakeholders feared that these cuts could result in access problems for patients.

Funded by a grant from the National Patient Advocate Foundation's Global Access Project, the study showed that, compared to patients treated before passage of the MMA, there was no difference in the time and location of treatment for patients with cancer treated after the MMA was signed into law. Researchers surveyed two groups of patients -- 684 who had received chemotherapy prior to the enactment of the bill and 737 patients who were treated after enactment. They found no difference between the groups in the amount of time from diagnosis to the beginning of chemotherapy and the median lapse time was 22 days.

The study observed a statistically significant, although small, trend in change in location for cancer care for post-MMA-enactment patients living in rural areas and with patients with Medicare but no supplemental insurance.

POSSIBLE HOLD ON PHYSICIAN PAYMENTS

For Medicare providers (physicians, CORFs, IDTFs, therapy providers, etc.) paid under the Physician Fee Schedule, the Medicare Program just initiated a payment hold for providers that do not have a 9-digit zip code for the provider's address and possibly its "pay to address" if the provider is located in a 5-digit zip code that crosses more than one payment locality for the Physician Fee Schedule and the provider does not have 9-digit zip code listed in its master file.

Example: In Texas there is a physician payment locality for the Houston area and there is another locality "for the rest of Texas." Some zip codes at

the edge of Houston are in more than one payment locality. For providers that are located in those zip codes that cover more than one payment locality, their Medicare master file must have a 9-digit zip code or they must include the 9-digit zip code on claims. If their Medicare master file has a 9-digit zip code, they will not get paid if the nine-digit zip code included on their claims does not match what is in the master file. In addition, the NPI filing must have the same 9-digit zip code for the practice location address.

If the master file has only a 5-digit zip code or if the 9-digit zip code is wrong, the provider must file an 855 change or a full 855 to get the master file corrected. In the meantime, the claims will be RTP'd (returned to provider). It could take as long as 6+ months to get these changes processed by the FIs and Carriers. It is possible that the CMS will figure out a way to prioritize the processing to add the 9-digit zip code update rather than subjecting the providers to the arduous process of

getting an 855 dealt with.

Printed below is a link to the notice on the Trailblazer website (posted 10/11):

<http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=12069>

Below are the links to the Medicare notices regarding the zip code and the list of zip codes (you must look at both to get an accurate list).

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5208.pdf>

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5730.pdf>

It appears that this zip code issue affects 30 states. The main locations tend to be at zip codes near major metropolitan areas. The longest list of zip codes is for the following states: California, Georgia, Illinois and Texas (which has the longest list).



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