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**SWEEPING MEDICARE REFORMS ENACTED,
REIMBURSEMENT UP FOR 2004**

During the fall of 2003, major legislation affecting AFROC moved through Congress, including the final enactment of a Medicare reform and prescription drug bill. Most importantly, the final bill included a provision that increased physician payments by 1.5 percent for 2004 and an additional 1.5 percent increase projected in 2005. This article features a general summary of the legislation with emphasis on the major provisions expected to affect diagnostic imaging services, but this landmark legislation will generate new and unexpected challenges to Medicare generally and to coverage of patients and providers for years to come.

Medicare Reform and Prescription Drugs

President Bush signed into law the Medicare reform and prescription drug legislation on December 8, 2003. The legislation cleared the House on November 22 by a vote of 220-215 and the Senate on November 25 by a vote of 54-44. Despite the fiercely partisan nature of the debate and votes, nevertheless, the 1100-page Medicare reform and prescription drug bill will add a long-sought prescription drug benefit, place a greater reliance on

2004 DUES

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private, managed care health plans to provide Medicare benefits, make many changes to provider payments and regulatory processes under fee-for-service (FFS) Medicare, and allow all Americans, not just Medicare beneficiaries, to contribute to tax-free "Health Savings Accounts." These reforms, taken as a whole, constitute the largest reform of the Medicare program since its inception in 1965 and will markedly change how Medicare beneficiaries receive and health care providers deliver Medicare benefits.

The following is a brief summary of the key provisions:

Physician Fee Schedule Update—Although the final physician fee schedule rule, published on November 7, 2003, proposed to cut physician payments by 4.5 percent in 2004, the Medicare bill contained a provision that increased Medicare payments to physicians by at least 1.5 percent per year in 2004 and 2005 (over 2003 levels). The bill also permanently corrects the sustainable growth rate (SGR) formula, which was viewed by many as a flawed method of updating physician payments. The new formula, pending regulations by CMS, is expected to attenuate large fluctuations in physician payments over time. This constitutes a major legislative victory for AFROC and organized medicine and should be viewed as a very positive outcome to a multiple-year effort.

Screening Benefits—The legislation includes a number of expansions of screening and other preventive health benefits, including authorization to expand cancer screening programs.

Transitional Drug Discount Card—Until the implementation of a full Medicare drug benefit for beneficiaries in 2006, Medicare will administer a drug discount card program to provide immediate discounts of approximately 20 percent to beneficiaries. An interim final regulation was published on December 10, 2003, that specifies rules for how the cards will operate; the enrollment period for the cards will begin by early summer this year, but it will end when the prescription drug benefit becomes available in 2006. In summary, all Medicare beneficiaries, except for those dually-enrolled in Medicaid, will have access to the discount cards:

- Beneficiaries will have a choice of at least two Medicare-endorsed discount cards for a \$30 enrollment fee.
- The card will enable beneficiaries to receive negotiated prices and discounts, expected to be as much as 20% off current prices.
- Medicaid beneficiaries are not eligible for the discount cards as these beneficiaries are covered under

state plans until Medicare plans cover drugs in 2006.

- Subsidies up to \$600 per year are available for beneficiaries under 135% of FPL with no asset test, but coinsurance of 5-10% depending on income.

Medicare Drug Benefit—Beginning in 2006, all Medicare beneficiaries (including beneficiaries with End Stage Renal Disease) will have the option to purchase private, "stand alone" drug coverage at the following benefit levels:

- Separate from Part A and B.
- Approximately \$35 monthly premium.
- \$250 annual deductible.
- 75% coverage from \$251 to \$2,250 in combined total drug costs.
- \$3,600 out-of-pocket catastrophic coverage.
- "Gap" in coverage--\$750 in out-of-pocket costs up to \$2,250 benefit limit, must spend an additional \$2,850 on drugs before reaching out-of-pocket limit
- 5% coinsurance on all drug costs after the \$3,600 limit is reached.

Low Income Subsidies—Low-income beneficiaries would have access to a subsidized premium, deductible, and copayments. For beneficiaries below 135% of the federal poverty line ("FPL"), including those "dually eligible" for Medicare and Medicaid, the full premium would be subsidized, with \$2 copayments for generics drugs and \$5 for brand name drugs, no "gap" in coverage, and no coinsurance above the catastrophic limit. Eligibility would be subject to an asset test of \$6,000/\$9,000 (single/couple), which measures a person's/family's resources to ensure they are low enough to qualify for federal subsidies. For beneficiaries between 135% and below 150% of the FPL, there will be a sliding scale premium based on income, a \$50 deductible, 15% coinsurance up to the catastrophic limit during the "gap" in coverage, and \$2/\$5 copayments thereafter. The asset test would be set higher, at levels of \$10,000/\$20,000 (single/couple).

New Medicare Managed Care—Under the Medicare bill, private, managed care insurance companies are encouraged to offer Medicare benefits similar to the existing Medicare+Choice system. Although Medicare+Choice plans have had limited success since their creation in 1997, the new plans will receive greater federal subsidies to participate in Medicare and are

expected to proliferate throughout the country when they are scheduled to begin in 2006. These new managed care plans will offer combined Medicare Part A and B coverage in addition to prescription drug coverage similar to that which could be purchased separately through "stand alone" Medicare drug plans.

Two types of Medicare managed care models would be available to beneficiaries. The first, entitled "Medicare Advantage," would incorporate benefits similar to Medicare+Choice (i.e. enhanced benefits within a managed care model, a restrictive network of providers, capitation arrangements, formularies, etc.). The second option, "Enhanced Fee-for-Service," would rely less on HMO-style managed care and instead provide the standard set of Medicare benefits in privately-administered "Preferred Provider Organizations." This model would use negotiated discounts from a restricted network of providers to lower coinsurance and deductibles while still allowing the freedom for patients to seek care from providers without traditional HMO "gatekeeper" restrictions.

Impact on Freestanding Centers—Freestanding radiation oncology providers should expect that implementation of new Medicare managed care health plans will entail entering into contracts with private entities to provide Medicare benefits, much in the same manner as is currently done for private, group health plans. Often these arrangements will discount reimbursement in exchange for being included in a particular health plan's "network" with a defined set of patients. However, many patients who have chronic health care issues and have a compromised health are more likely to eschew managed care and stay in fee-for-service Medicare.

There are likely to be many new regulations expected to be promulgated by CMS as a result of the Medicare bill. It is very likely that many will impact AFROC. AFROC will continue to monitor and anticipate potential regulatory issues and respond appropriately through comments and meetings with CMS as the implementation of the new law progresses.

Premium Support—The final Medicare bill includes a controversial provision that will require a "demonstration" beginning in 2010 that requires traditional, fee-for-service (FFS) Medicare and private, managed care plans to compete directly for Medicare beneficiaries. The provision is known as "premium support" because the federal government would contribute a defined, percentage subsidy toward a beneficiary's premium to health plans *and Medicare FFS* rather than direct Medicare payment for services. Based on the subsidy, plans would compete for beneficiaries based on premium (by lowering the

beneficiary portion of the premium) and lower deductibles/copayments.

Proponents (mostly Republicans) maintain the provision will hold down Medicare costs and provide beneficiaries with "choice." Opponents (mostly Democrats) generally believe that it would effectively "privatize" the Medicare program and cause Part B premiums to move higher for beneficiaries who remain in traditional FFS Medicare, who would more likely be those with complex, chronic, or expensive conditions.

Conclusion

While the recently enacted Medicare reform and prescription drug bill is likely to offer some benefit to Medicare beneficiaries by assisting them with coverage for prescription drugs, it is also likely to have many unintended consequences. AFROC will continue to monitor developments as they relate to freestanding radiation oncology and be actively involved in the issuance of Medicare regulations and new legislation as the overall Medicare debate continues.

PERCENTAGE COMPENSATION IN SELF-REFERRAL RULE DELAYED YET AGAIN

For the fourth time, the CMS is delaying for six months the percentage compensation provision in Phase I of the physician self-referral law that otherwise became effective at the beginning of last year; the agency stated in a final rule published in the December 23, 2003, *Federal Register*. The new effective date is July 7, 2004; the previous six-month delay was published April 25, 2003.

CMS stated that the extension will give it more time to reconsider the definition of compensation that is "set in advance" as it relates to percentage compensation methodologies to avoid unnecessarily disrupting existing contractual arrangements for physician services. "We expect that the definition of 'set in advance' will be addressed definitively before July 7, 2004 in a final rule with comment period, entitled 'Medicare Program; Physicians Referrals to Health Care Entities With Which They Have Financial Relationships' (Phase II)," the agency stated in the December rule.

Percentage compensation arrangements are those that base physician compensation on such factors as percentage of revenue, which the Phase I rule calls "fluctuating and indeterminate measures." Such arrangements generally mean individual physician compensation varies from one payment to the next. Percentage compensation arrangements are used primarily by academic medical centers and medical foundations.

NATIONAL COVERAGE DECISIONS MODIFIED UNDER MEDICARE BILL

Among many provisions of the regulatory system modified by the Medicare prescription drug and reform bill, one of the most important was amendments to several portions of the National Coverage Determination (NCD) development process with an effective date of January 1, 2004. However, due to time constraints upon final enactment of the bill on December 8, 2003, it was not possible to develop a formal document explaining the changes and revised process by the effective date. Accordingly, CMS issued a note effective for NCDs undertaken on or after January 1, 2004, that will serve as an alert for outlining the changes being made to the NCD process as a result of the legislation.

According to CMS, on and after January 1, 2004, the following changes to the NCD process will be effective:

- For NCD requests not requiring an external technology assessment (TA) or Medicare Coverage Advisory Committee (MCAC) review, the decision on the request shall be made not later than 6 months after the date the completed request is received;
- For those NCD requests requiring either an external TA and/or MCAC review, and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date the completed request is received;
- Not later than the end of the 6 or 9 month period described above, a draft of the proposed decision shall be made available on the CMS website (or other appropriate means) for public comment. This comment period shall last 30 days, and comments will be reviewed and a final decision issued not later than 60 days after the conclusion of the comment period. A summary of the public comments received and responses to the comments will continue to be included in the final NCD.

These and other modifications as required by the legislation will be further defined in a subsequent guidance document.

CMS IMPLEMENTS PROVISIONS OF MPDIMA GOVERNING PAYMENT FOR DRUGS; IMPLEMENTS INCREASE IN CONVERSION FACTOR

On January 7, 2004, CMS published in the Federal Register an interim final rule which implements those provisions of the Medicare Prescription Drug, Improvement and Modernization Act (MPDIMA) of 2003, that affect the Physician Fee Schedule, including provisions that effectively increase the conversion factor by 1.5%.

In addition, another part of the rule revises current payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis, including payment for chemotherapy drugs and its administration. Under these provisions, many such drugs will be reimbursed at 85% of the Average Wholesale Price in CY 2004, rather than 95% of AWP, as in 2003. While payment reductions for chemotherapy drugs are partially offset by increases in payment for chemotherapy administration, it is anticipated that many medical oncology practices may experience decreased revenues in CY 2004 and coming years.

The provisions also make changes to the geographic practice cost indices. Information contained in this interim final rule supercedes information contained in the November 7 final rule to the extent that the two are inconsistent. All other provisions of the November 7 rule are essentially unchanged.

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The Source

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1875 Eye Street, NW
Twelfth Floor
Washington, DC 20006-5409
Phone: 888-334-4542
Fax: 202-466-5938
Email: Sheila.Gell@ppsv.com

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