The US Oncology Network
Health Policy Report

Tuesday, February 21, 2012

Congress Passes 10-Month Medicare Physician Payment Fix

On February 17, Congress passed HR 3630, legislation that will avert the 27.4% cut to Medicare physician reimbursement that was scheduled to take place March 1, 2012. This 10-month Medicare physician payment patch will continue payment levels at current rates until the end of this year. In addition, HR 3630 extends the payroll social security tax cut and unemployment benefits for the same time period. Thanks to the concerted efforts of community oncology advocates, the offsets used to pay for this bill did not include the $3.2 billion cut to reimbursement for cancer care medications under Medicare Part B.

Health care offsets that were used to pay for this physician payment patch include: a $6.9 billion provision reducing hospital payments for Medicare bad debt, $2.7 billion through resetting clinical lab payment rates, $4.1 billion by rebasing Medicaid Disproportionate Share Hospital allotments, $2.5 billion from eliminating Medicaid payments to Louisiana, and $5 billion by reducing the health reform law's prevention fund.

The agreement calls on the Department of Health and Human Services and the Government Accountability Office to submit reports to assist Congress in the development of a long-term replacement for the sustainable growth rate (SGR) formula. The final agreement also includes short-term extenders including higher wage payments to Section 508 hospitals through March 31 and payment for technical component of certain physician pathology services through June 30.

Other extenders that last through the end of the year include: hospital outpatient hold harmless payments, physician work geographic adjustment, outpatient therapy caps, ambulance add-on payments, funding for the Medicare Qualifying Individual program, which provides federal reimbursement for states to cover Part B premiums for seniors with incomes between 120 percent and 135 percent of the federal poverty level, and an extension of Transitional Medical Assistance funding.

With the passage of this legislation the Congress is presented with another, steeper SGR fix (the scheduled cut will now escalate to 32% for 2013), the extension of Bush-era tax cuts, and the payroll tax cut, all during the lame duck session at the end of this year. Offsets will be needed to pass these provisions and it is likely that the $3.2 billion cut to reimbursement for cancer care medications under Medicare Part B will continue to be discussed.

For a summary of the Conference Agreement click here.

To read the bill text click here.

President Obama Releases FY 2013 Budget Proposal

On February 13, the Obama administration released its $3.8 trillion budget proposal for fiscal year 2013, which aims for $4 trillion in deficit reduction over the next decade. The proposed budget includes $360 billion in Medicare and Medicaid savings – including reduced payments and policies that would impact medical imaging procedures – while providing a permanent fix for Medicare's sustainable growth rate (SGR) formula.

The President's budget is unlikely to be passed by the House or Senate but could serve as a guide for future health care provisions. Cuts to the average sales price (ASP) reimbursement formula in Medicare Part B for cancer drugs are not included in the budget, but may still pose a threat to community cancer care as Congress will strive to fix the SGR for 2013.

The proposed budget includes a policy that would require physicians to obtain prior authorization from a radiology benefit manager (RBM) when ordering advanced medical imaging services for Medicare beneficiaries, and calls for Medicare cuts to payments for advanced medical imaging services. The reimbursement cuts are estimated to save $820 million over the next 10 years, and the RBM policy does not include estimated savings.

The medical imaging community has spoken out against these proposed policies, saying they would create barriers and delays in care that could be harmful to patients. According to a statement from the Medical Imaging and Technology Alliance, "Medical imaging is a critical component of the modern standard of care. Recklessly limiting access and further reducing reimbursements by raising utilization rates will not serve patients or providers. It's essential that patients have access to the right scan at the right time."

Read more about the President's proposed budget here.

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CMS Issues Proposed Provider Overpayment Regulations

On February 13, the Centers for Medicare and Medicaid Services (CMS) issued proposed new regulations related to the Patient Protection and Affordable Care Act's (PPACA) "60-Day Rule," which requires that all Medicare or Medicaid participating providers and suppliers report and refund known overpayments 60 days from the date the overpayment is identified or the date the corresponding cost report is due, whichever is later.

Although the 60-Day Rule has been in effect as a statutory requirement since March 23, 2010, it has lacked regulatory guidance regarding a number of important details, such as when an overpayment is "identified" and when the 60-day time period begins. Due to this lack of information, the rule has thus far led to confusion among providers striving to meet the required timeframe and avoid penalties. The new proposed rule intends to clarify some of these details.

The proposed rule includes language similar to that of the 60-Day Rule aside from two important updates:

1) **A "reasonable inquiry" principle:** According to the proposed rule, an overpayment is "identified" when a person has "actual knowledge of the existence of an overpayment, or acts in reckless disregard or deliberate ignorance of the overpayment". The 60-day timeframe does not start until *after* a provider has the opportunity to undertake a "reasonable inquiry" into the basis of the alleged overpayment. (Under the proposed rule, receiving information about a potential overpayment would create an obligation to make a reasonable inquiry to determine if an overpayment exists.)

2) **An expanded retrospective overpayment review:** While existing Medicare regulations allow look-back periods of only three to four years for simple overpayments, the proposed rule requires providers to report and refund overpayments received during the previous 10 years. If the proposed regulation goes into effect as written, this will result in materially increased liability for providers. Providers are expected to push back on this timeframe, as it seemingly will equate simple billing errors with actionable false claims.

Comments to the proposed rule will be accepted until April 16, 2012. Read the proposed rule in the February 16 issue of the Federal Register.

HHS Announces Plans to Delay ICD-10 Compliance Date

On February 16, the Department of Health and Human Services (HHS) announced its intent to postpone the date by which certain health care entities must comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10). The January 2009 final rule adopting ICD-10 as a standard set a compliance date of October 1, 2013, and while HHS has announced this will be delayed it has not yet announced the new compliance date.

ICD-10 is the medical classification list for the coding of diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases as maintained by the World Health Organization (WHO). The ICD-10 provides updates and much greater detail on the previous ICD-9 system and is already in use in Europe and most industrialized nations.

U.S. providers have spoken out against the logistical and administrative burdens of implementing the codes according to this timing, however, particularly as many practices are administratively and financially engaged in setting up electronic health records systems. The American Medical Association issued a supportive statement in response to the ICD-10 delay, saying "We look forward to having a productive dialogue with the administration regarding the impact of ICD-10 and decreasing unnecessary hassles for physicians so they can take care of their patients."

Health Care Stakeholders Offer Commentary on Sunshine Act

McKesson Corporation, the Healthcare Distribution Management Association (HDMA), physician specialty societies and coalitions of continuing education groups have recently provided comments on a proposed rule issued in December regarding application of the Physician Payment Sunshine Act.

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Health Care Stakeholders Offer Commentary on Sunshine Act *(cont'd)*

The Sunshine Act specifies that almost all payments or services provided directly or indirectly to physicians directly by drug or device companies must be reported to the Centers for Medicare and Medicaid Services (CMS). These payments will be recorded and maintained in a publicly searchable database by CMS, with data to be made available beginning in March 2013.

Recommendations from McKesson for the successful implementation of reporting related to physician ownership and investment interests included:

- Clarify the definition of "applicable manufacturer" (clarify the exclusion of repackagers, relabelers and kit assemblers from the definition of applicable manufacturer; clarify what constitutes the provision of assistance and support to an applicable manufacturer by a commonly owned entity; and explicitly exclude full-service wholesale distributors from the definition of an applicable manufacturer);
- Limit the definition of "covered devices" to those that require premarket approval or exclude covered devices such as examination gloves;
- Allow community-based research organizations that include site maintenance organizations to report at the site maintenance level;
- Tie reporting of physician payments to receipt of a 1099;
- Exclude "blinded" surveys used in community-based research such as cancer treatment studies;
- Incorporate federal preemption of state reporting to eliminate inconsistencies in state requirements; and
- Extend the 90-day implementation period to a minimum of 180 days to allow an adequate timeframe for organizations to develop reporting systems.

For more information on the Sunshine Act – including details on the bill, CMS regulations and future impact – please access the recording of the February 21 McKesson Specialty Health Legislative Teleconference "Special Update on the Sunshine Act" by calling 888.203.1112 and entering the ID #2304500.

CMS will now consider stakeholder comments before publishing a final rule.

Read the McKesson letter and the HDMA letter.

Senators Burr, Coburn Endorse Medicare Premium Support Bill

On February 16, Senators Richard Burr (R-NC) and Tom Coburn (R-OK) introduced the Seniors Choice Act, legislation that would transform Medicare into a premium support system driven by competition between private plans and Medicare fee-for-service to keep costs low.

The Burr-Coburn proposal draws upon elements of several earlier Medicare reform recommendations, such as gradually increasing Medicare eligibility from age 65 to 67 by 2027, but differs in that it would implement major changes to the program in 2016 rather than in 2022.

Additional proposal details include: Raising Part B premiums by 3 percent over three years starting in 2016; combining Part A and B deductibles; creating a 20 percent co-insurance up to $5,500 in out-of-pocket spending (after which the co-insurance drops to 5 percent); and establishing a $7,500 annual out-of-pocket maximum.

Under the legislation, wealthier seniors would pay a larger share of their health benefits, and millionaires would be required to cover their entire premiums. The legislation would also create a new Medicare Consumer's Protection Agency to oversee the new program and ensure that all plans are offering actuarially equivalent benefits.

The plan does not yet have a Congressional Budget Office (CBO) assigned score, but the Senators anticipate that it would save $700 billion to $1 trillion over 10 years. Part of the savings from their bill would be used to correct the sustainable growth rate (SGR) formula.

Read a Questions & Answers document about the bill here.