



Summary of 2008 Proposed Physician Fee Schedule

On Monday, July 2, the Centers for Medicare & Medicaid Services (CMS) released its notice of proposed changes in the Medicare physician fee schedule for 2008. The proposal will be open for comment through Friday, August 31.

Reduction in Physician Conversion Factor

This notice announces the estimated 9.9% reduction in the Medicare physician conversion factor for 2008. In order to avert this cut, Congress would need to enact legislation specifying a different update factor. ASCO is working actively with the AMA and others to reverse the scheduled payment cut.

Changes in Physician Work Values

Based on the 5-year review of physician work values, CMS is revising the relative values for several non-oncology procedures and services codes. Mandated budget neutrality requirements provide that increased payments for some codes due to relative value changes must be offset by reductions in the relative values for the other codes. CMS estimates that Medicare payments to hematologists and oncologists will decline an average of 1% in 2008 as a result of these changes.

Geographical Adjustment Factors

CMS is required by law to revise the geographical practice cost indices every three years to reflect relative resource costs in the areas involved. Accordingly, CMS is proposing to revise these geographical adjustment factors. In addition, the current floor of 1.000 on the geographical adjustment factor for physician work would expire at the end of 2007.

Intravenous Immune Globulin

CMS is proposing to continue through 2008 the add-on payment for "preadministration-related services" for IVIG. Although CMS states that it is concerned that the add-on payment for IVIG could further distort the market and provide inappropriate incentives for IVIG utilization, the add-on payment will be continued in 2008 at the same amount as in 2007.

Calculation of Average Sales Price (ASP)

CMS has not previously issued instructions to drug manufacturers on how to calculate ASP in the case of "bundled" pricing arrangements. These arrangements involve discounts on one product that are contingent on purchase of another product and similar pricing involving multiple products.

CMS is proposing that the total amount of price concessions should be allocated to the various products involved in proportion to the sales of each drug sold under the bundled

arrangement. This is the allocation method currently used to calculate average manufacturer price under the Medicaid rebate program. For example, if Drug A is sold at a discount to persons who buy Drug B at the regular price, under the proposal part of the discount on Drug A would be considered a discount on Drug B, thus affecting the ASPs for both products.

Widely Available Market Price

The Medicare statute allows CMS to set the payment rate at a level lower than 106% of ASP if the “widely available market price” or the average manufacturer price of a drug exceeds the drug’s ASP by more than a specified percentage. For 2006 and 2007, CMS set the specified percentage at 5%, and CMS is proposing to continue that threshold in 2008.

Competitive Acquisition Program

CMS is proposing a number of changes in the competitive acquisition program (CAP). Physicians who elect to participate in the CAP obtain their drugs from the CAP contractor, which bills Medicare and also bills the patient for the coinsurance. CMS’s proposals include the following issues:

Effective April 1, 2007, the CAP contractor is permitted to bill Medicare when it supplies a drug to a physician, rather than having to wait until the drug has been administered, as had previously been the case. The notice describes a post-payment review process by which CMS will determine that the drug was actually administered to the patient. Physicians may be asked to supply records as part of the review.

Although Medicare now pays the CAP contractor for a drug before it is administered to the patient, the contractor still cannot bill the patient for the coinsurance until administration of the drug has been verified. CMS proposes two ways in which the contractor can verify administration: (1) a voluntary agreement with the physician by which the physician notifies the contractor, or (2) the contractor can contact the physician’s office to request verbal confirmation.

Ordinarily, a physician must commit to the CAP program for the entire calendar year. CMS is proposing to permit a physician to terminate enrollment in the CAP within 30 days of the physician’s election becoming effective if the physician shows that remaining in the CAP would be a significant burden. Examples of burden cited by CMS include a demonstration of financial hardship due to CAP participation, the practice’s inability to update its billing system, or reliance on misleading information about the program from outside sources.

The current rules require the CAP contractor to ship drugs to the site at which they will be administered and prohibit transfer of the drugs to another location, such as a satellite office. CMS is seeking comment on the feasibility of changing this rule to permit drugs to be transported to a different site for administration.

Physicians in the CAP must include the CAP contractor's prescription number in their claim to Medicare for the drug administration services. CMS is not proposing a change to this requirement, but it is requesting comments on possible alternatives.

Drug Compendia

The notice includes a discussion of the statutorily recognized drug compendia. If a use of a drug in a chemotherapy regimen is listed in U.S. Pharmacopoeia – Drug Information (USP-DI) or the American Hospital Formulary Service, Medicare is required to cover the use even if it has not been approved by FDA. CMS acknowledges the recent change in the law requiring Medicare to recognize “successor publications” to the named compendia, and the notice states that CMS will continue to recognize the compendium now called USP-DI after its impending name change “if it is in fact a successor publication rather than a substitute publication.”

CMS commissioned a technology assessment of the currently listed and other published compendia and presented the compendia issue to the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) in March 2006. MedCAC concluded that none of the compendia fully met all of the desirable characteristics and that there was significant variability among the compendia.

The notice asks for comment on a process to add new compendia to the recognized list or remove current compendia from the list. CMS is proposing a procedure under which the agency would annually post a notice on its Internet site offering an opportunity to request changes in the list of recognized compendia. A request would need to show how the compendium at issue complies (or does not comply) with the desirable characteristics identified by MedCAC.

Physician Quality Initiative for 2008

The notice includes a proposal on how the Physician Quality Reporting Initiative, which went into effect on July 1, 2007, will operate in 2008. For 2008, quality measures would be limited to measures adopted by the National Quality Forum (NQF) or the AQA Alliance. Measures adopted by other organizations could theoretically be used, but CMS is not aware of other organizations that meet the statutory standards.

CMS is proposing to continue use of the 2007 oncology-related measures, provided that they are endorsed by the NQF by November 15, 2007. CMS may also add measures currently under development by the American Medical Association – Physicians Consortium for Performance Improvement if endorsed by the NQF by that date. Oncology-related measures in that group are:

- Breast cancer patients who have a pT and pN category and histologic grade for their cancer

- Colorectal cancer patients who have a pT and pN category and histologic grade for their cancer
- Appropriate initial evaluation of patients with prostate cancer
- Inappropriate use of bone scan for staging low-risk prostate cancer patients
- Review of treatment options in patients with clinically localized prostate cancer
- Adjuvant hormonal therapy for high-risk prostate cancer patients
- Three-dimensional radiotherapy for patients with prostate cancer

For 2007, the law establishes a 1.5% bonus payment to physicians who submit information on quality measures. For 2008, the law authorizes CMS to spend \$1.35 billion but does not require a specific payment method. CMS is proposing to make bonus payments in 2008 in the same manner as in the 2007 system. The bonus payment would apply to allowed charges throughout 2008 and would be paid in a lump-sum in 2009. CMS is not able to translate the available \$1.35 billion fund to an exact percentage bonus, but CMS estimates that it would again be approximately 1.5%.

Reporting of Anemia Quality Indicators

The proposal implements the recent legislation requiring that claims submitted to Medicare for the treatment of anemia in connection with patients undergoing cancer treatment must include information on the patient's hemoglobin or hematocrit, beginning in 2008. CMS states that it will use this information to help determine the prevalence and severity of anemia associated with cancer therapy, the clinical and hematologic responses to anti-anemia therapy, and the outcomes associated with various doses of anti-anemia therapy.

Stark Law Changes

CMS is raising issues about potentially abusive situations that are now permitted under its regulations implementing the so-called Stark Law. The Stark Law prohibits physicians from referring patients for "designated health services" to an entity with the physician has a financial relationship unless certain conditions are met. The issues include the following:

One issue relates to physicians in a group practice who make referrals to a specialist who is an independent contractor of the group practice. The contractor performs the service in a "centralized building" to meet the Stark Law requirements, and the group practice bills Medicare at a profit. CMS is not making a specific proposal on this issue but is soliciting comment on appropriate changes.

Currently, physicians may lease space and equipment to another entity, such as a hospital, and be paid on a per service ("per click") basis in the lease. CMS is proposing to prohibit per click payments on the ground that they are inherently susceptible to abuse.

Under the current rules, academic medical centers, hospitals, and other entities can use percentage arrangements to compensate physicians for the services they perform. The proposal would clarify that the percentage must relate to the physician services furnished and not to other factors such as a percentage of savings by a hospital department. In addition, percentage arrangements cannot be used for space and equipment leases.

CMS is proposing to change the rule relating to furnishing services “under arrangements.” Currently, a referral is problematic under the Stark Law only if the entity to which the physician makes the referral is the entity that bills Medicare. Consequently, the Stark Law is not implicated if a physician makes a referral to an entity that furnishes services under arrangements to a hospital or other provider, since it is the provider that bills Medicare. Under the proposal, the Stark Law would apply to the entity that furnishes the service as well as the entity that bills Medicare.

Computer-Generated Fax Transmission of Medicare Part D Prescriptions

Physicians are not required to use electronic methods for transmitting prescriptions for Medicare Part D beneficiaries, but if they do, the transmission methods must conform to CMS standards.

Under the current standards, computer-generated faxes are permitted as an exception to the otherwise applicable standards in electronic transmission of prescriptions. CMS is proposing to eliminate this exemption, thus requiring physicians to use true e-prescribing or stop using electronic transmission of prescriptions altogether.