WHAT’S NEW IN MEDICARE

Kansas Society of Clinical Oncology
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THE BUDGET CONTROL ACT OF 2011

- The last-minute agreement to prevent a default on the nation’s debt.
- The law does not address the sustainable growth rate formula that is projected to reduce physician pay by 29.5% on January 1, 2012.
- Doctors could see another cut projected at $10 billion to $15 billion if a special congressional committee fails to agree on a long-term deficit reduction plan that can pass Congress and be signed into law.
The debt legislation starts by reducing budget deficits by $917 billion between 2012 and 2021.

But those cuts would not touch Medicare or Medicaid programs.

Under the second phase of the plan, a special bipartisan panel of 12 members of Congress will meet to find an extra $1.5 trillion in deficit reduction over 10 years.

In exchange, Obama could raise the federal debt ceiling by an equal amount meaning no risk of default until 2013.
BUTGET CONTROL ACT, cont.

• In raising the debt ceiling, the Budget Control Act relieved concerns that Medicare pay to physicians and hospitals would be put on hold if the U.S. Treasury could not borrow enough money to pay the government’s debts.

• Associations representing physicians had hoped Congress would address the SGR issue when it raised the debt ceiling.

• Now, payment reform could be addressed by the joint committee.
The AMA anticipates the Medicare physician issue will be among the issues the committee will address.

Everyone agrees that a 30% cut in payments to those who care for Medicare patients would hurt senior’s access to the health care they need and deserve.

But the panel’s ultimate goal will be to reduce total federal deficits and a long term SGR repeal would result in higher federal spending in the neighborhood of $300 billion over 10 years.

This would require cuts elsewhere in the federal budget to hit their savings target.
2012 FINAL RULE

• You face a 27.4% pay cut next year, with a conversion factor of 24.6712, under the 2012 final Medicare Physician Fee Schedule released Nov. 1. The cut will be effective Jan. 1, 2012, unless Congress acts to change your fees. The impending cut is slightly less than the 29.5% cut projected by CMS earlier under the sustainable growth rate (SGR) formula, which is due to Medicare costs growing slightly slower than expected, the agency says.
• Higher e-Prescribing (e-Rx) requirements. Group practices with 25 to 99 providers must successfully e-Rx 625 times in 2012 and 2013 to get the incentive payment and practices with more than 100 providers now have to report 2500 times, CMS writes in the rule. Also, CMS is now prohibiting double payments for physicians associated with large group practices. You will only get one incentive payment for e-Rx individually or as a member of the group practice.
Affordable Care Act (ACA)

• On April 14, 2011, President Obama signed into law a modest change to the Affordable Care Act (ACA). The law, the "Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011," eliminates the ACA's revision to the Form 1099 tax-reporting requirement.
Accountable Care Organizations (ACOs)

- ACO is a group of health care providers, including physicians and hospitals, that will work closely together in caring for their patients, all under Medicare’s coverage guidelines. The point of this organization is to eliminate fragmented care and the duplication of services and risk of errors that comes with it,
ACOs, cont.

• CMS has made several big changes to the accountable care organizations (ACO) final rule in effort to ease physician participation requirements. Here is a rundown of the most important changes from the propose rule that will affect you:
ACOs, cont.

- **New risk-free track.** CMS added a bonafide upside-only track in which providers will only share in savings and not losses. A second two-sided track, allows sharing in both savings and losses where the ACO can take home up to 60% of the savings.
ACOs, cont.

• Upfront payments to help with capital costs. CMS will provide upfront payments to ACOs to help defray the capital costs of forming an ACO, with the expectation that the payments be recouped via savings over time. There was no such assistance in the proposed rule.
ACOs, cont.

- Less burdensome reporting requirements. CMS dropped the required number of measures from 65 measures in 5 domains to 33 measures in 4 domains complete with a gradual implementation process.
- No more EH R mandate.
- Advanced identification of ACO patients. Patients participating in the ACO are identified before services are rendered rather than retrospectively.
ACOs, cont.

• Specialists get credit for primary care services. In situations where a patient is receiving primary care services from a specialist instead of a defined primary care physician, the specialist can get credit for providing those services.
Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)

- Pursuant to section 4103 of the Affordable Care Act (ACA) of 2010, the Centers for Medicare & Medicaid Services (CMS) expanded coverage to allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within the 12 months of the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply.
Annual Wellness Visit (AWV)

- This AWV will include the establishment of, or update to, the individual’s medical and family history, measurement of his or her height, weight, body-mass index or waist circumference, and blood pressure with the goal of health promotion and disease detection and fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B.
Breast Cancer Screening

- All women with Medicare age 40 and older can get a screening mammogram every 12 months. Medicare also pays for one baseline mammogram for women with Medicare between ages 35 and 39.
Cervical and Vaginal Cancer Screening

- A Pap test and pelvic exam are covered by Medicare once every 24 months. However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.
Colon Cancer Screening

• Fecal Occult Blood Test - Once every 12 months
• Flexible Sigmoidoscopy - Once every 48 months
• Screening Colonoscopy - Once every 24 months (if you're at high risk); once every 10 years, but not within 48 months of a screening sigmoidoscopy (if you're not at high risk)
• Barium Enema - Your doctor can decide to use this test instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.
Prostate Cancer Screening

- Digital Rectal Examination - Once every 12 months
- Prostate Specific Antigen (PSA) Test - Once every 12 months
Unlabeled Uses of Anti-Cancer Drugs

- The term “drugs” also includes any drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication.

- The term “medically accepted indication”, with respect to the use of a drug, includes any use which has been approved by the Food and Drug Administration for the drug.
Unlabeled Uses, cont.

• Such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary,
Unlabeled Uses, cont.

- Existing - American Hospital Formulary Service-Drug Information (AHFS-DI)
- Effective June 5, 2008 - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Effective June 10, 2008 - Thomson Micromedex DrugDex
- Effective July 2, 2008 - Clinical Pharmacology
Unlabeled Uses, cont.

• In general, a use is identified by a compendium as **medically accepted** if the:
  1. indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
  2. narrative text in AHFS-DI or Clinical Pharmacology is supportive.

• A use is **not medically accepted** by a compendium if the:
  1. indication is a Category 3 in NCCN or a Class III in DrugDex; or,
  2. narrative text in AHFS or Clinical Pharmacology is “not supportive.”
Unlabeled Uses, cont.

- The carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications.
Unlabeled Uses, cont.

• Use Supported by Clinical Research That Appears in Peer-Reviewed Medical Literature:

The prevalence and life history of the disease when evaluating the adequacy of the number of subjects and the response rate. While a 20% response rate may be adequate for highly prevalent disease states, a lower rate may be adequate for rare diseases or highly unresponsive conditions.
Unlabeled Uses, cont.

• American Journal of Medicine;
• Annals of Internal Medicine;
• Annals of Oncology;
• Annals of Surgical Oncology;
• Biology of Blood and Marrow Transplantation;
• Blood;
• Bone Marrow Transplantation;
• British Journal of Cancer;
• British Journal of Hematology;
• British Medical Journal;
• Cancer;
• Clinical Cancer Research;
• Drugs;
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- LCDs:
  Chemotherapy Drugs and Their Adjuncts
  Erythropoiesis Stimulating Agents
- NCDs:
  Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions
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