The Tax Relief and Health Care Act of 2006 Passed by Congress 12/8/06
Signed Into Law December 20, 2006
Summary

1. **Dollar Conversion Factor (CF) Reduction of 5% (to $35.9848) Averted By Congressional Action 12/8/06 - Freeze at 2006 ($37.8975)**

The dollar conversion factor is the source of ongoing frustration in the medical provider community. It is vitally important to your revenue stream and whether that stream goes up or down, since the CF is what converts the relative values for billing codes to dollars and cents in reimbursements in the Medicare program. The trickle down effect from a lowered conversion factor is significant as it relates to managed care contracts.

In years past, Congress has intervened to either maintain the prior year CF or to slightly increase the CF. This year is no different. Congress passed legislation 12/8/06; and one provision in this new bill is to freeze the dollar conversion factor for 2007 at the 2006 level. Thus, the conversion factor for 2007 will be $37.8975. Note that the conversion factor has now been the same for 3 years.

Affect on Conversion Factor for 2008?

Maintaining the dollar conversion factor at the 2006 level still DOES NOT fix the formula used for calculating the CF in subsequent years.

In fact, the bill specifically states that the calculation of the CF for 2008 will be computed as if the computation used for 2007 never occurred.

Translated, this means that the 2008 CF computation will use the ORIGINAL calculated dollar conversion factor of $35.9848.

Concerns regarding this provision of the law are already being expressed with a projection that the CF for 2008 could be reduced by anywhere from 7-10%.

Physician Assistance and Quality Initiative Fund

$1.35 BILLION is allocated to this fund under the new legislation "for payment with respect to physician services furnished during 2008". The design is to promote stability for physician payments in 2008; however this dollar amount would not begin to cover the potential pay cuts in 2008 if the dollar conversion is, in fact, reduced by as much as 7-10%.

For your information, below is the pattern of changes in the Dollar Conversion Factor since 1998. Even though the Resource Based Relative Value Scale (RBRVS) using dollar conversion factors was implemented in 1992 as the mechanism for determining reimbursements in the Medicare program, the year 1998 has been chosen as the starting point for comparison since 1998 was the first year that only one conversion factor for all physician services was used. Prior to 1998, there were two conversion factors - one for primary care services, and one for surgical services.

Medicare Dollar Conversion Factors (CF) 1998-2006

Year	CF
1998 - Conversion to one CF for all services	**$36.6873**
1999 -	$34.7315
2000 -	$36.6137
2001 -	$38.2581
2002 - Biggest drop ever in CF (-5.4%)	$36.1992
2003 - Was going to ↓ 5.4%-averted by Congress 3/1/03(↑ 1.6%)	$36.7856
2004 - Was going to ↓ 4.5% to $35.1339 MMA mandated 1.5% ↑ for 2004 and 2005	$37.3374
2005	$37.8975
2006 - Was going to ↓ 4.4% to $36.1770 Congress intervened with DRA to maintain at at 2005 level	$37.8975
2007 - Was going to ↓ 5% to $35.9848 Congress intervened to maintain at 2006 level	$37.8975

Overall increase 1998 to 2007 - approximately 3%

1998-2007 - Would have been MINUS 2% if Congress had maintained the $35.9848 !!!

(In 1992 when RBRVS was first implemented, CF was $31.001 !!)

Continuing to accept managed care contracts offering less than Medicare rates needs to stop based on this data alone. Use this in your negotiations.

2. **The Bill Does Not Alter 10.1% Reduction to Work Relative Values (More Food for Thought for Managed Care Contracting)**

A comprehensive review of work relative values is required every 5 years in the Medicare program's RBRVS payment methodology. The 2007 final rules reflect the completion of this process for all billing codes for the third time since the inception of RBRVS in 1992.

The work relative value (WRVU) makes up 52.5% of the total amount Medicare pays you for a billing code.

Increases to work relative values for E/M services have been touted by CMS as *"correcting the dramatic erosion of the relative weight accorded to E/M services over the past 14 years"*. In addition, at the time of the publishing of the 2007 final rules, CMS stated, *"The rule we are announcing* (for 2007) *will pay physicians more for the time they spend talking with patients about their health care...We believe that this emphasis on personalized care will lead to better outcomes for patients, and more efficient use of health care resources."*

The problem with these statements:

A. Yes, work values for the majority of E/M services increased such as:

99213 - increased 37%
99214 - increased 29%
99232 - increased 31%

BUT

B. To maintain <u>budget neutrality</u> for 2007, <u>every CPT code has a 10.1% reduction to the work relative value</u>.

In the formula for calculating Medicare payments, every work relative has been adjusted by <u>0.8994</u>

Due to this adjustor, work RVUs for approximately 5800 billing codes would decrease, while only approximately 750+ would see increases.

Budget Neutrality - What Is It?

There is a law that was passed by Congress long ago which stipulates that total payments made in the Medicare program on an annual basis may not increase from one year to the next by anymore **<u>than $20 million</u>** due to policy changes.

With new CPT codes authorized for payment each year, and new payment regulations created expanding payment benefits, the <u>$20 million</u> is a minuscule figure to try to stay within.

In order to maintain "budget neutrality" (and stay within only increasing spending by $20 million), something has to be taken away. That "something" is to manipulate (lower) the Dollar Conversion Factor and/or the Relative Values which means you, the physician/provider, get paid less than what the real value of the service should be.

Since managed care companies may simply be loading their databases with the Medicare allowed amounts published by the Medicare carrier, YOU WILL BE GIVING THEM a further and unnecessary reduction to your managed care rates.

Should managed care companies benefit from a 10.1% work relative value decrease due to something the government has implemented to maintain the <u>federal government budget</u>??

3. **Physician Voluntary Reporting Program (PVRP)**
Reporting Data Will Allow Providers a 1.5% Bonus Payment IF You Comply with the Rules

http://www.cms.hhs.gov/PVRP/
(This website has everything posted that you will need to understand and bill under PVRP)
Participating in PVRP is Voluntary

A. Initial voluntary reporting program started 1/1/06.
Providers voluntarily registered to participate by registering at:
www.qualitynet.org/pvrpintent
This is still the site where you may register for participation

B. The Phase I project for 2006 captured data for the period April 1-June 30, 2006 and involved **16 "quality measures"** with specific reporting codes across a broad spectrum of areas such as MI, Beta blockers, antibiotics for pneumonia, cholesterol treatment, high blood pressure, diabetes, etc.

The original 16 measures covered 19 of the 39 physician specialty designations representing physician specialties accounting for approximately 58% of physician fee schedule payments.

There was no compensation for participation.

C. During 2006, CMS has worked with a number of organizations (physician and other) to continue development of quality measures.

Effective January 1, 2007 there are now a total of 66 quality measures for reporting purposes covering approximately 32 of the 39 physician specialty designations.

http://www.cms.hhs.gov/PVRP/Downloads/PVRPQualityMeasuresList.pdf

There are hundreds (over 400) of new "G" reporting codes. In addition, you may choose to use the CPT Category Code II Code listed instead. The document posted on the CMS website (see below for site) as of 12/6/06 is 113 pages! Each quality measure lists the CMS "G" Codes as well as the CPT Category II codes.

http://www.cms.hhs.gov/PVRP/Downloads/PVRPMeasureSpecifications.pdf
NOTE: Oncology has their own specific list for download

Effective July 1, 2007 You May Qualify for Bonus Payment Based on Participating in the PVRP

Congressional legislation passed 12/8/06 will provide an incentive for participation in PVRP by providing a 1.5% bonus payment. Here are the rules:

a. The bonus will be paid to those participating in the program for the period 7/1/07 thru 12/31/07.

Reporting measures in 2008 will continue; BUT we have no legislation at the current time guaranteeing payment for reporting.

b. The quality measures to be used are those as mentioned above; but they can be changed at any time. Any changes, however, must be finalized and posted by CMS no later than 7/1/07.

c. Individuals reporting data will be identified by their individual billing numbers (such as but not limited to the NPI); but for the 2007 bonus payment, the tax identification will be used as the "billing unit".

d. **In order to be eligible for the 1.5 % bonus payment: (80% rule)**

1. If your specialty has no more than 3 quality measures available for reporting, you must report all 3 measures **at least 80% of the time**.

2. If your specialty has 4 or more quality measures available for reporting, you must report at least 3 of the measures **at least 80% of the time**.

e. **Payment will be based on "Average Per Measure Payment Amount" Calculated as follows:**

The total amount of allowed charges reported with a quality measure will be determined for all data submitted during the reporting period (based on claims submitted not later than 2 months after the end of the reporting period).

That figure will then be divided by the total number of quality measures for which data are reported.

f. **Payment Limitation**

Total payment may not exceed the product of:

The total number of quality measures submitted AND 300 per cent of the average per measure payment amount (described above).

g. **Payment will be made** in the form of a single consolidated payment in 2008.

4. **Therapy Caps**

Use of KX Modifier and Exceptions Process Should Still Be In Effect For 2007

2006 marked the implementation of therapy caps for physical therapy/speech language, and occupational therapy. If a beneficiary exceeded the caps, then the services could only be paid if furnished directly or under arrangement by a hospital to an outpatient or to an inpatient who is not in a covered Part A stay.

Congress authorized a one year exception process, but only for 2006, to allow services beyond the cap to continue to be paid in the office setting based on patient diagnosis and the use of a KX modifier. **As of 12/9/06 Congress renewed this exception process to continue for one more year (1/1/07-12/31/07).**

The new caps for therapy services compared to 2006 are as follows:

	2006	**2007**
Physical Therapy/Speech Language Annual Cap -	$1,740	$1,780
Occupational Therapy Cap -	$1,740	$1,780

5. **Composite Rate for Dialysis Services**

Increase by 1.6% for 2007 for ESRD facilities.

6. **Quality Reporting for Hospital Outpatient Services and ASCs**

Starting in 2009 if these entities are not reporting quality data, they will receive a payment update that is 2% less than others who are reporting.

7. **Reporting Anemia Quality Indicators for Medicare Part B Cancer Anti-Anemia Drugs**

For drugs furnished on or after January 1, 2008 (quoted from the law) *"each request for payment, or bill submitted for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin and hematocrit levels for the individual."*

Development of these quality indicators will occur during 2007, will be published, and will be effective 1/1/08.

8. **Expansion of Recovery Audit Contractors RAC) to All States by 2010**

Right now only Florida, California, and New York have been scrutinized by the RAC.

As of 11/17/06 CMS reported that the RACs had recovered $54 MILLION dollars in just these 3 states with another $232 MILLION identified as potential overpayments.

The audits may be conducted with respect to payments made under Medicare Part A or B for services that have been paid during the current fiscal year and for a period of not more than 4 fiscal years prior to such fiscal year.

Evaluation and management services are excluded from review by the RACs.

9. **Extension of TC Billing for Certain Pathology Services**

Direct billing for the TC for pathology services by independent laboratories is extended for one more year.

10. **Reimburse Providers for Administration of Vaccines that are covered under Medicare D**

Fearing that non-payment of the administration to providers would cause access issues for beneficiaries to receive the vaccine, the law allows for administration payment to be made to providers for 2007. Starting in 2008 administration would be paid through Part D.

11. **Restore the <u>Work</u> Geographic Practice Cost Indice (GPCI) to 1.0**

Allowing this to expire would have been costly especially to rural providers. The other GPCIs are not affected.

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