ASCO's Clinical Practice Committee

Physician Payment Policy: An American Pie

By Peter Paul Yu, MD

This edition of the Journal features an article on the 2007 Medicare Physician Fee Schedule, which was recently released by the Centers for Medicare & Medicaid Services (CMS). The Physician Fee Schedule is an annual rite of passage that begins in the summer of the preceding year as a proposal for public comment and eventually leads to a final

determination of the Medicare reimbursement level for physician services. As this is written, the fate of the Oncology Demonstration Project for 2007, which is distinct from the fee schedule determination and is not subject to the same public rulemaking process as the fee schedule, has not yet been announced.

In this article, I review the complex framework for Medicare Part B physician payment policy, the significant challenges and considerations that may influence CMS decision making in the future, and the often pivotal role ASCO plays in improving reimbursement for oncology treatment.

Funding for Medicare Part B, which pays for physician services, is derived primarily from a combination of general revenue (75%) and beneficiary (25%) premiums, which have undergone substantial increases in the last decade. As the baby-boomer generation enrolls in Medicare throughout the coming decade, combined with the cost of the Part D benefit, the strain on the program due to the projected increase in service volume will provide strong pressure to scrutinize physician utilization of services.

Growth in physician reimbursement is already capped by CMS through the statutorily mandated Sustainable Growth Rate (SGR) formula, which is an expenditure target for physician services. Each year, CMS considers four factors when calculating the SGR by projecting: (1) estimated percent change in input prices for physician services (determined by changes to the RVU and the conversion factor); (2) estimated change in average number of Medicare fee-for-service beneficiaries; (3) estimated changes in expenditures due to changes in law and regulations; and (4) estimated 10-year average annual growth in real gross domestic product per capita. The last consideration creates asynchrony between actual health care cost inflation,

measured by the Medicare economic index, and the rate at which health care dollars are actually increased to reimburse physician services. Furthermore, when actual physician expenditures for a given year exceed the SGR target, a reduction to the physician conversion factor is set for the following year. As a consequence of the SGR formula, reductions to the physician conversion factor of 5.1% for 2007 and a similar percentage each year going forward are scheduled, unless Congress acts to reverse the cuts and/or fix the formula, which many have acknowledged does not work for physician services. [Editor's note: Prior to its December adjournment, the 109th Congress approved a freeze in physician payments at the 2006 rate for the first 6 months of 2007.]

On a year-to-year basis, Medicare statute requires that coding changes (with some exceptions such as congressionally mandated benefits) remain budget neutral. Budget neutrality means that increases in payments to physicians for one service result in an equivalent dollar decrease spread over reimbursement for other services. In health care, budget neutrality can mean "robbing Peter to pay Paul." Understanding the constraints this statutory requirement puts on the entire physician payment system is key to understanding the complexity of advocating for reimbursement for new services within the existing framework. New Current Procedural Terminology (CPT) codes may increase reimbursement to those physicians who use these codes at the expense of those who do not.

Having said that, ASCO has been effective in advocating for appropriate recognition of the work and expense associated with providing high-quality cancer care through its participation in the American Medical Association (AMA) CPT Editorial Panel and AMA/Specialty Society Relative Value Scale Update Committee. Another article in this issue of the Journal of Oncology Practice highlights ASCO's role with these influential committees and ASCO's success in introducing new and revised drug administration codes that better reflect both the physician work and nonphysician clinical staff resources involved with chemotherapy. The requirement for budget neutrality might have negated the re-evaluation of the chemotherapy administration codes, were it not for ASCO's efforts to prevent this. Instead, the additional reimbursement dollars for chemotherapy administration paid to oncologists in 2004 and 2005 were exempted from budget neutrality and represent a permanent addition to the total pool of dollars for physician services. This means that some of the chemotherapy drug reimbursement dollars lost to oncologists as a result of the

reduction were redeployed to more fairly compensate for drug administration.

Also as a result of ASCO's efforts, the Medicare Modernization Act of 2003 (MMA) included a mandate for CMS to use data on practice expense, the source of which was an ASCO-commissioned Gallup organization survey in 2002. Before this, CMS had used outdated information from an AMA study that involved few oncology practices, from an era when office chemotherapy was vastly less complex than today's prolonged, infusion center-based chemotherapy and biologic therapy. Using ASCO's Gallup survey data of practices' expenses led to additional significant increases in chemotherapy administration reimbursement.

During the 109th Congress, the increasingly unsustainable growth in physician spending spurred a desire to see future expenditure growth linked to improved quality, and not an encouragement to consume more resources. The AMA has agreed to provide measures for use in pay-for-performance programs to CMS. In response, ASCO has submitted medical oncology quality measures based on the recent ASCO and National Comprehensive Cancer Network (NCCN) collaboration to map ASCO's National Initiative in Cancer Care Quality (NICCQ) measures to NCCN recommendations. ASCO also continues to work on

promoting quality oncology care through the adoption and use of electronic health records, and is sponsoring a policy roundtable with key stakeholder groups later this month to start moving that agenda forward.

The successful fight for fair reimbursement begins with an accurate understanding of the history of the multiple issues and with recognition of the concerns of Congress and CMS. Our position cannot be that our quality of care is already the best that it can be and therefore deserving of all that we ask. Oncologists need to participate in achieving better quality of cancer care and better quality of life for cancer patients. We need to recognize our pivotal role in consuming reduced Medicare funds if we do not wish to see limitations in our patients' access to new and expensive technologies. If our actions and words result in a loss of credibility with Congress and CMS, we will hurt our patients and ourselves in this fight—one that ASCO does not intend to lose.

Peter Paul Yu, MD, is a medical oncologist with Camino Medical Group, a division of the Palo Alto Medical Foundation in Sunnyvale, California. He is currently chair of ASCO's Clinical Practice Committee.

DOI: 10.1200/JOP.0714501

Plan to Attend ASCO's Prostate Cancer Symposium

Registration is still open for this three-day, information-packed symposium. The Prostate Cancer Symposium is a premier event featuring experts in prevention, screening, diagnosis, and the latest treatment strategies.

The Prostate Cancer Symposium
February 22-24, 2007
Gaylord Palms Resort & Convention Center
Orlando, Florida

For more information, visit www.ASCO.org/Prostate2007.