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200 Independence Avenue, SW
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Contact: CMS Media Affairs
(202) 690-6145

CMS PROPOSES POLICY, PAYMENT CHANGES FOR PHYSICIANS' SERVICES IN 2007

The Centers for Medicare & Medicaid Services (CMS) projects that it will pay approximately $61.5 billion to 875,000 physicians and other health care professionals in 2007, under a proposed rule released today that would revise payment rates and policies under the Medicare Physician Fee Schedule. These proposals are in addition to the proposed revisions to the work relative value units (RVUs) and proposed changes in the methodology for calculating practice expense RVUs released in a separate proposed notice in the June 29 *Federal Register*.

"Medicare's coverage of preventive care is better than ever, and we are taking another step in 2007," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "We're also going to provide better support for physicians to spend time with their patients, and greater accuracy in payments for some services."

Preventive services will continue to expand under the proposed rule. For example, the proposed rule would implement provisions in the Deficit Reduction Act of 2005 (DRA) that would add abdominal aortic aneurysm (AAA) screening to the growing list of preventive services covered by Medicare. As required by the DRA, the screening benefit will include a one-time only ultrasound screening for individuals who take advantage of the Initial Preventive Physical Examination ("Welcome to Medicare") benefit, as well as appropriate education, counseling and referral services. The screening benefit is limited to individuals who are at risk for AAAs, including anyone with a family history of AAA; a man aged 65 to 75 who has smoked at least 100 cigarettes in his lifetime; and any other individual who manifests risk factors that are recommended for screening by the United States Preventive Services Task Force.

The proposed rule also implements a provision in the DRA that exempts the colorectal cancer screening benefit from the Part B deductible, eliminating a potential financial barrier to using this benefit. The proposed rule would also expand the number of beneficiaries who qualify for bone mass measurement due to long time steroid therapy. For these beneficiaries, the proposed rule would reduce the dosage equivalent required for eligibility by one-third, from an average of 7.5 milligrams per day of prednisone for at least three months to 5.0.

The proposed rule also codifies in regulation a DRA provision that adds diabetes outpatient self-management training and medical nutrition therapy services to the list of covered and separately payable services included in the Federally Qualified Health Center benefit. This

proposal is intended to make these services more available to beneficiaries in underserved areas, whether rural or urban.

The Medicare law includes a statutory formula that will require CMS to implement an expected minus 5.1 percent update in payment rates for physician-related services. This formula compares the actual rate of growth in spending to a target rate, which is based on such factors as the growth in number of Medicare fee-for-service beneficiaries and statutory or regulatory changes in benefits. If the actual rate of growth exceeds the target rate, the update is decreased; if it is less, the update is increased.

The update is determined by the Medicare Economic Index (MEI), which is a measure of inflation in the physician's costs of doing business, and the adjustment under the target. Since the maximum adjustment under the Medicare law that can be made in a year will apply in 2007, changes to the update for 2007 are solely determined by the MEI. CMS uses the latest available economic data in determining the MEI.

The negative update is projected for 2007 because spending on physicians' services and other Part B services has been growing at a much faster rate than target spending. Expenditures for physicians' services in 2005 increased 10 percent over 2004, even faster than had been previously projected, mainly due to an increase in the number and complexity (or volume and intensity) of services furnished to Medicare beneficiaries, including more frequent and intensive office visits, and rapid growth in the use of imaging techniques, laboratory services, and physician-administered drugs. Physician-related expenditures are also a principal contributing factor to the projected growth of Part B services in 2006 of 10.6 percent. Additional details on recent expenditure growth in Part B and the impact of growth in physician-related spending are available on the CMS website at
www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895.

Every year since 2002, in response to this rise in spending, the statutory update formula would have operated to impose payment cuts. In 2002, an update of negative 4.8 percent was applied to payment rates. To avoid further payment reductions, Congress intervened and temporarily suspended the requirements of the formula in favor of specific, statutorily dictated updates for 2003 through 2006. In passing these measures, Congress did not adjust the target, further increasing the gap between actual spending and the targets, and exacerbating the already difficult situation.

As a result of continued rapid growth in utilization of services, coupled with legislative action to eliminate the payment reductions, Part B spending has increased more rapidly than had been forecast, and beneficiary premiums for Part B services have increased as well.

"We need to get out of the vicious circle of rapid growth in utilization and spending, and falling real payment rates," said Dr. McClellan. "Physician groups have been working hard to identify better ways to pay – ways that help them provide higher-quality care without increasing overall health care costs. We will continue to work with Congress and with physician groups to provide more efficient and higher quality care for beneficiaries without increasing Medicare spending."

CMS is working with physician organizations, the Ambulatory Care Quality Alliance, the National Quality Forum, and others to develop specialty-specific quality measures, in order to identify and support higher-quality, efficient care.

The proposed rule also includes further guidance on how drug manufacturers should address particular issues related to their reporting requirements. In 2005, as required by the Medicare Modernization Act, CMS implemented a new method of paying for Part B drugs, such as those administered by a physician in the office. This new methodology is based on the manufacturer's average sales price (ASP), plus six percent. Payment rates are updated quarterly. The proposed rule addresses the treatment of *bona fide* service fees in the context of the ASP calculation, the definition of nominal sales and a discussion of the bundling of discounts on drugs – for example, an arrangement by which a manufacturer requires the purchase of one drug as a condition of granting price concessions on another. CMS is also reopening the comment period on the April 2004 interim final rule with comment on ASP reporting, to allow for public input based on experience with the ASP system before finalizing that rule.

The proposed rule would continue to impose a 25 percent reduction in payment for the technical component of multiple imaging procedures on contiguous body parts. This reduction, which was first imposed in 2006, recognizes that there are significant overlaps of resources when multiple imaging procedures are performed. CMS had indicated in the 2006 final MPFS rule that it would increase the reduction for multiple imaging procedures in 2007 to 50 percent, but is proposing not to do so at this time.

The proposed reduction in payments for multiple imaging procedures would not apply to the physician's interpretation of multiple imaging procedures. Because the Deficit Reduction Act of 2005 (DRA) exempts the multiple imaging savings from the budget neutrality requirement, CMS is not proposing to increase payments for other services to offset the savings from the multiple imaging reduction.

The proposed rule would also implement a provision in the DRA that would cap payments for multiple imaging procedures under the physician fee schedule at the amount paid for the same services when performed in hospital outpatient departments. The proposed rule includes a list of CPT codes to which the outpatient prospective payment system (OPPS) cap would apply. CMS is proposing to apply the multiple imaging reductions first, followed by the OPPS imaging cap, if applicable, which will result in a higher payment than if OPPS imaging cap were applied first.

Other proposals include:

- Adding to the regulations the process for providing public input into payment rates for new clinical laboratory tests. CMS has been using this process for a number of years but the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) requires CMS to codify it in regulation. The rule also proposes a new methodology for use when gap-filling to set payment rates for new tests and clarifies several technical issues related to the clinical laboratory fee schedule.

- Updating the wage index and drug add-on adjustments applied to the composite payment rate for dialysis services provided by ESRD facilities. The total drug add-on adjustment

to the composite rate for CY 2007, including the growth update adjustment of 0.6 percent, would be 15.2%.

- Assigning work relative value units to medical nutrition therapy services, CPT codes 97802, 97803, and 97804 and HCPCS codes G0270 and G0271.

- Amending the reassignment regulations to clarify that any reassignment pursuant to the contractual arrangement exception is subject to program integrity safeguards that relate to the right to payment for diagnostic tests; and amending the physician self-referral regulations to place restrictions on what types of space ownership or leasing arrangements will qualify for purposes of the in-office ancillary services exception or the physician services exception to the physician self-referral prohibition.

- Amending the reassignment regulations so that employees who reassign benefits are allowed unrestricted access to the billing information submitted on the employee's behalf, similar to what is allowed independent contractors under the contractual arrangement reassignment exception.

- Establishing supplier standards applicable to independent diagnostic testing facilities. Failure to comply with one or more of these standards could result in a denial of enrollment, and failure to maintain compliance could result in revocation of billing privileges.

Comments will be accepted until October 10, and a final rule will be published later in the fall. The new payment rates and policies included in the final rule will be effective January 1, 2007.

Note: For more information, see *www.cms.hhs.gov/center/physician.asp*

Fact Sheets on the Medicare Economic Index and on Multiple Imaging Policy can be found at: *www.cms.hhs.gov/apps/media/?media=facts*