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CMS PROPOSES POLICY, PAYMENT CHANGES FOR PHYSICIANS' SERVICES IN 2008

The Centers for Medicare & Medicaid Services (CMS) projects that it will pay approximately \$58.9 billion to 900,000 physicians and other health care professionals in calendar year (CY) 2008, under a proposed rule released today that would revise payment rates and policies under the Medicare Physician Fee Schedule (MPFS). This proposed rule is a further step in Medicare's efforts to ensure that payment policies provide incentives to improve the quality of care.

“This proposed rule builds on the changes the Centers for Medicare & Medicaid Services made last year to pay more appropriately for practice expenses and to transform Medicare into an active purchaser of higher quality services, rather than just paying for procedures” said acting CMS Administrator Leslie V. Norwalk, Esq. “It also includes an important new initiative to encourage the use of electronic prescribing to improve the speed and accuracy of care furnished to beneficiaries, as well as proposals for additional quality measures for use in the Physician Quality Reporting Initiative in 2008.”

The Tax Reform and Health Care Act of 2006 (TRHCA) directed that quality measures in future years be developed through the notice and comment rulemaking process. In this proposed rule, CMS outlines measures from seven categories for inclusion in the 2008 Physician Quality Reporting Initiative (PQRI), provided that the measures are either endorsed by the National Quality Forum (NQF) or adopted by the AQA Alliance.

The 2008 proposed measures include existing measures from the AQA Starter Set, other measures from the NQF Ambulatory measure set, and new quality measures currently being developed with input from American Medical Association (AMA) Physician Consortium for Performance Improvement (physician measures), the Pennsylvania Quality Improvement Organization (QIO) (non-physician and structural

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measures), and the American Podiatric Medical Association. The proposed rule would also retain the 2007 PQRI measures to the extent that they have been NQF endorsed.

As required by the sustainable growth rate (SGR) formula specified in the Medicare statute, the estimated update to the physician fee schedule for 2008 is -9.9 percent.

“For the past 5 years, Congress has intervened to prevent the implementation of the negative updates resulting from this formula,” said Ms. Norwalk. “CMS will continue working with Congress as well as physician groups to identify payment methods that help improve the quality and efficiency of care in a way that is cognizant of the costs to taxpayers and to Medicare and its beneficiaries. The Medicare program needs to compensate physicians appropriately for the services they provide to people with Medicare. But how the program pays also matters. We think the early work on the PQRI program is one of those reforms that could help lead us to a point where we can promote better quality care and more efficient care.”

The proposed rule would make a number of changes to payments for specific services paid under the MPFS. For example, the proposed rule would adopt the recommendation of the American Medical Association’s Relative Value Update Committee (RUC) that would increase the value of the work component of anesthesia services by 32 percent. In addition, it would adopt the recommendations of the RUC with regard to more than 50 procedures which were included in the 2007 five year review of work, but for which a decision was deferred until the 2008 proposed rule.

CMS is proposing to revise the methodology for determining the average sales price (ASP) for Part B drugs by defining bundled arrangements and requiring that drug manufacturers allocate bundled price concessions proportionately to the dollar value of units of each drug sold under the bundled arrangement when reporting ASPs. This proposal will help the ASPs to better reflect the true costs incurred by physicians when purchasing Part B covered drugs. The CMS proposal is in response to MedPAC’s January 2007 report to Congress, suggesting that CMS policy on reporting discounts might need to change over time. In addition it is consistent with the proposed Medicaid policy for bundled sales.

CMS is also proposing to continue to pay for preadmission-related services for intravenous infusion of immunoglobulin (IVIG) under a temporary HCPCS code, G0332. This payment is for the extra resources expended in locating and obtaining IVIG products that are appropriate for the patient’s treatment, and for scheduling the patient’s infusions. This service may be billed for each visit to the physician’s office at which IVIG is administered.

Other provisions in the proposed rule include:

- Updating the Geographic Practice Cost Indices (GPCI) to reflect more recent data.
- Revising certain physician payment localities according to one of three proposed options
- Using the Physician Assistance and Quality Initiative Fund (PAQI), created by TRHCA that provides \$1.35 billion for physician payment and quality improvement initiatives, to extend voluntary quality reporting bonus payments into 2008.
- Requiring that persons furnishing physical and occupational therapy services to people with Medicare meet licensing, registration, or certification requirements in the state in which they practice, and that they complete an approved educational program for the services they are furnishing. The proposed rule would also change the time frames for certifying a plan of care.
- Updating regulations governing payment of certain services furnished in Comprehensive Outpatient Rehabilitation Facilities (CORFs), to reflect payment under the MPFS. This conforms to a statutory mandate.
- Adding neurobehavioral status exams to the list of telemedicine services eligible for Medicare payment.
- Adding certain ophthalmologic imaging procedures to the list of procedures that would be subject to the Deficit Reduction Act of 2005 (DRA) provision that caps payment for the technical component of imaging procedures at the payment amount under the hospital outpatient prospective payment system.
- Modifying the requirements under the competitive acquisition program (CAP) for Part B drugs for verifying that a drug ordered by a physician has been administered.
- Requiring the reporting of hemoglobin or hematocrit data on claims for drugs used to treat anemia secondary to anticancer treatment.
- Modifying a number of physician self-referral provisions to close loopholes that have made the Medicare program vulnerable to abuse.

- Modifying enrollment standards for Independent Diagnostic Testing Facilities (IDTFs).
- Eliminating the exemption for computer-generated faxes from the e-prescribing standards.

Comments will be accepted on the proposed rule until August 31, 2007, and a final rule will be published later in the fall. The final rule will be effective for services on or after January 1, 2008.

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

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