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Quick Pulse

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CMS Reimbursement Announcements for 2006

On Wednesday, November 2, 2005, the Centers for Medicare & Medicaid Services (CMS) released its annual update – the final 2006 rule – on physician payment rates under the Medicare Physician Fee Schedule and new reimbursements under the hospital Outpatient Prospective Payment System (OPPS). Physicians will get a 4.4% decrease, but acute care hospitals get a 3.7% inflation increase, home health payments will go up 2.8%, and some rural hospitals get an extra 7.1%.

On the cut in physician fees, CMS Administrator Dr. Mark McClellan said, "The existing law calls for a decrease in payment rates for physicians in response to continued rapid increases in use of services and spending growth, and Medicare does not have the authority to change this. The current system is not sustainable, and the payment reduction offers further proof that we must move to a payment system that ensures adequate payments to physicians, but also supports high quality and efficient healthcare services. We want to continue to work with Congress toward a payment system that is more sustainable. In this rule, we continue to refine payment rates to reflect current medical practice, while doing all we can under current law to support physicians' efforts to provide greater quality and efficiency of care for Medicare beneficiaries."

Asked how CMS's decision to cut physician fees jives with the Senate Finance Committee's proposal to increase physician fees by 1% for 2006, Dr. McClellan said, "We are very interested in working with Congress on implementing changes in the payment system for 2006…That 1% payment update in 2006 was linked to a pay-for-performance fund for physician services. While we have not endorsed that specified approach…we definitely want to work with interested members of Congress."

Other changes CMS announced as part of these regulations include:

Billable drugs. The cumulative impact will be a 1.2% increase in payment per treatment. Under the new methodology, the payment rate will be set at average sales price (ASP) plus 6%, consistent with payment rates for most other drugs under Medicare Part B. This approach will apply for all separately billed drugs in both independent and hospital based facilities. At the same time, the rule increases the drug add-on adjustment to the composite rate, which was established to offset payment cuts that occurred when the payment for drugs and biologicals was reduced as a result of the ASP plus 6% methodology.

Competitive Acquisition Program (CAP). CAP is a voluntary program for physicians who administer certain drugs – including oncology drugs – in their offices. It does not apply to Medicare Part D drugs.

CMS announced major revisions in this program, which goes into effect on July 1, 2006, including revisions in the bidding process, more covered drugs, improved access to newly approved drugs, and clarification on how unused drugs will be treated. CMS also established a framework by which vendors may enter into arrangements with CAP physicians for the collection of co-insurance and related information.

Through CAP, doctors have the option of obtaining drugs through a new, competitive, specialized service that takes care of purchasing the drugs and handling billing issues. Vendors will be selected in a competitive bidding program. Dr. McClellan said, "This may be less costly and burdensome than the current buy-and-bill method…Included in the revision are new steps to assist vendors in getting better pricing…We think it will make the program attractive to physicians and vendors."

End stage renal disease (ESRD). The rule revises geographic designations and wage index adjustments with respect to ESRD payments, but provides for a four-year transition.

Glaucoma. The rule expands Medicare coverage of glaucoma screening to include Hispanic-Americans age ≥65 "because they are identified as an ethnic group at high risk for the disease." Currently, this benefit is limited to diabetics, people with a family history of glaucoma, and African-Americans age ≥50.

Home Healthcare. Home health agencies will get a 2.8% increase next year, which should give them an additional $370 in federal payments. Dr. McClellan said, "Rural home health agencies will experience an estimated 3.4% increase in payment, while urban agencies will see a 2.5% increase in payments."

Imaging. CMS is reforming payment for multiple imaging procedures performed on a beneficiary at one session. A 50% reduction in payments for certain diagnostic imaging procedures is being phased in over two years, with a 25% reduction in 2006. CMS says this is being done to reflect "limited additional costs when performed on contiguous body parts in the same session with the patient." However, CMS will not apply this reduction to transvaginal ultrasound and ultrasound of the breasts, pending further study.

Inhalation therapy. CMS is cutting the dispensing fee for inhalation therapy drugs (e.g., albuterol) covered under Part B. In 2006, CMS will pay $57 for the first month, and then $33 in all subsequent months – and the 90-day dispensing fee will be $66. There is only one first-month payment in a beneficiary's lifetime.

CMS concluded that the industry cost data on which the 2005 dispensing fee was based included care (such as in-home visits, patient education, caregiver training, and care coordination) that do not fall within the scope of a dispensing fee, and that do not have a Medicare benefit category. Dr. McClellan also cited a September 2005 report by the Office of the Inspector General (OIG) which found that care management services often aren't actually provided to beneficiaries.

CMS also announced a demonstration program for care management and care coordination for inhalation therapy users to determine whether those services have a positive impact on outcomes and reduce overall Medicare spending. The demonstration will focus on Medicare patients with relatively severe or complex respiratory conditions, including patients who need both nebulizers and metered dose inhalers (MDIs), which will be covered as part of the new Medicare drug benefit.

IVIG. The rule establishes a temporary add-on payment for intravenous immune globulin (IVIG) to cover the additional pre-administration-related services required to locate and acquire adequate IVIG and prepare for the infusion of IVIG during a "period of market instability." CMS said it has determined that the pricing for IVIG is accurate, and that there is no overall product shortage, but beneficiaries are concerned about access to IVIG, IVIG demand is increasing, and manufacturers have allocated many formulations. All of this combined, CMS decided, to cause physician offices to expend extra resources locating and obtaining appropriate IVIG products and scheduling patient infusions.

Thus, for calendar year ***2006 only***, physicians and hospitals will be permitted to bill an add-on code to compensate for the administrative burdens associated with IVIG administration. Meanwhile CMS said it will work with other agencies, the IVIG patient community, product manufacturers, distributors, physicians, and hospitals to develop a common understanding of the evolving IVIG marketplace, to assure continued collection of accurate pricing data, and to focus attention on the medical necessity of IVIG utilization.

Oncology drug demonstration project. This voluntary program is being expanded in 2006 to cover 13 cancers. This demonstration will use the CMS billing system to generate information on coordination of care, treatment design, and patient monitoring. Dr. McClellan said, "We believe the early results from the demonstration, which we are analyzing now, show some important improvements in patient care and monitoring related to quality of life of cancer patients. For 2006, we are moving the program forward to provide even more support for cancer patients and physicians. In 2006, we will focus on evidence-based medical practice in cancer care. We are asking physicians who participate in this voluntary program to provide the status of the patient's cancer and to report on whether the patient management conforms with evidence-based clinical guidelines…By focusing on evidence-based practice, we hope to reduce unnecessary tests and bring about better quality of life for patients."

Asked if this demonstration will limit off-label use of chemotherapy agents, Dr. McClellan said, "Not at all…We are not requiring guidelines be followed…(just) reporting on whether guidelines were used or, in cases where, for various reasons, they are not used…we want to learn more about that – the reasons physicians might not use guidelines. Does the patient want a different course, or does the physician think the guidelines aren't appropriate? So, we will get information not only on whether they follow guidelines but why they don't. A large range of cancers are included…For certain cancers, the guidelines are not being followed widely in clinical practice, and we will learn why not. This is not any kind of prohibition on off-label use of drugs. In fact, many of the guidelines reflect off-label use of drugs where there is some evidence to support it…There may be some very good reasons (for off-label use)."

Referrals. CMS delayed until January 1, 2007, the effective date for the inclusion of diagnostic and therapeutic nuclear medicine services and supplies in the physician self-referral ban. That ban prohibits physicians from making referrals to an entity with which they (or an immediate family member) have a financial relationship.

Rural beneficiaries. Access for rural beneficiaries enrolled in Medicare Advantage plans to services of federally qualified health centers (FQHCs) is expanded.

Telemedicine. CMS is expanding the list of Medicare telehealth services to include certain medical nutrition therapy services, to give greater access to these services to beneficiaries in rural areas.

HOSPITAL OUTPATIENT SERVICES

Acute care hospitals will receive a 3.7% inflation increase in Medicare payment rates in 2006 for outpatient services. About 400 community hospitals in rural areas will receive an additional 7.1%, instead of the proposed 6.6% increase.

- **Co-insurance.** Co-insurance rates that Medicare beneficiaries pay for many hospital outpatient services for an additional 31 medical and surgical Ambulatory Payment Classifications (APCs) will decline to the 20% minimum. The maximum co-insurance rate in 2006 for any service is reduced to 40% of the total payment to the hospital for the APCs in 2006, down from 45% this year. Overall, average beneficiary co-payments for all outpatient services are expected to fall from 33% of total payments in 2005 to 29% in 2006.

- **Screenings.** In a continuing effort to strengthen prevention and early detection of diseases, CMS is increasing payments to hospitals for most screening examinations that are covered by Medicare. For example, CMS is increasing payment for the "Welcome to Medicare Physical" when furnished in a hospital outpatient department by 7% in 2006.

- **ASP.** CMS will begin paying for most Part B drugs and biologicals administered in hospital outpatient departments based on 106% of the manufacturer's average sales price (ASP). This payment will cover both the cost of the drug and the pharmacy fee.

- **Radiopharmaceuticals.** For 2006, radiopharmaceuticals will be paid based on the hospital's costs, based on the hospital's charges. In the future, however, CMS intends to develop a "more accurate methodology."

- **Blood and blood products.** These will be paid based on blood-specific cost-to-charge ratios. As in 2005, CMS will impute a blood-specific cost-to-charge ratio for those hospitals that do not have blood-specific cost centers. However, in 2006, CMS will limit decreases in payment rates to 95% of the 2005 rates.

- **New technology.** CMS did not adopt a proposal that would have required that a copy of the application submitted to the AMA's CPT Editorial Panel for a new technology service be provided to CMS for its review of a New Technology APC request. CMS plans to seek further comment from device manufacturers, hospitals, and other stakeholders on this and other options for incorporating new technologies in the outpatient payment system.

- **Outlier payments.** The final rule sets the outlier threshold at $1,250 for 2006. To be eligible for an outlier payment, the estimated costs for a service must be greater than 1.75 times the payment amount for the APC and greater than the APC payment amount plus the outlier threshold.

MEDICARE/MEDICAID DUAL ELIGIBLES

CMS outlined steps it is taking to help dual eligibles move to comprehensive Medicare drug coverage. Dual eligibles are people who qualify for Medicare and for a state low-income Medicaid program. These "full-benefit dual eligibles" are being automatically and randomly enrolled in a prescription drug plan to make sure that they do not lose prescription coverage when Medicare Part D goes into effect on January 1, 2006.

CMS has started mailing letters to the 5.5 million Medicare beneficiaries, letting them know which Medicare prescription drug plan they will be enrolled in if they take no action prior to January 1st. In addition, in May 2005, full-benefit dual eligibles received a letter from CMS informing them that they automatically qualify for the low-income subsidy and do not need to apply. In October 2005, all Medicare beneficiaries received a "***Medicare & You***" 2006 handbook. Medicare prescription drug plans also will mail enrollment materials (with a list of covered drugs and the pharmacy network) to full-benefit dual eligibles assigned to their plan.

Also, if a full-benefit dual eligible beneficiary goes to a pharmacy after January 1 unaware that prescription drug

coverage is now through Medicare, the pharmacist can determine the beneficiary's enrollment information by submitting an on-line query through its billing system. If the pharmacy is in network, the pharmacist can then fill the prescription with no further information required from the beneficiary for billing. If the pharmacy is not in network, the pharmacist can help the beneficiary call their plan's help desk or 1-800-MEDICARE to determine a participating pharmacy.

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