Trends-in-Medicine

November 2006
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Quick Pulse

Trends-in-Medicine
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CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) ISSUES NEW RULES

On November 1, 2006, CMS Acting Administrator Leslie Norwalk and Acting Deputy Administrator Herb Kuhn announced several new Medicare rules being implemented. Norwalk said the measures are designed to provide "higher quality, increased transparency, personalized care, and accurate payments." Key features of the announcement included:

Outpatient Prospective Payment System (OPPS) – a 3.4% market basket increase for calendar year 2007. However, after other factors are considered, CMS estimates hospitals will receive an overall average increase of 3% in Medicare outpatient payments. This rule applies to general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals.

OPPS spending for 2007 is predicted to be $32.5 billion, up ~9.2% from 2006, following a 12% increase the year before. Kuhn commented, "That rate of growth is a great concern to us…It impacts on all taxpayers and on beneficiaries…It concerns us a great deal…Certainly, there is some migration from inpatient to outpatient, but we are also seeing volumes and intensity of service beyond migration. Our actuaries are looking at that, and we hope to have more information on that in the future…What we noticed with physicians was a real growth in imaging, lab services, procedures, and office visits. We are starting to see similar increases in the outpatient setting, and it is a concern to us. At mid-year we saw this, and we continue to see it now."

Other issues in this regulation worth noting:

- **Device recalls and how to deal with those in the future.** There are new regulations on how to code and capture that information so Medicare doesn't pay twice for a device. An official said, "In 2005 and 2006, we saw a lot of recalls and we were paying the same amount if the device was replaced without cost to the hospital, or if they were paying full price for it. So, we are reducing APC payments in these cases to make sure we are having appropriate cost charging."
- **Brachytherapy.** Estimated payments are unchanged, but payment will be based on source-specific median costs for brachytherapy sources.
- **Partial hospitalization payments to community mental health centers (CMHCs).** CMS officials said they "continue to be concerned about increases in outlier payments to CMHCs," but payment trends have stabilized, and the new rule maintains the existing threshold. Per diem payment for partial hospitalization services were cut by 5%, rather than the 15% that had been proposed.
- **Drugs, biologicals, radiopharmaceuticals, and anti-nausea drugs costing more than $55.** CMS finalized its proposed policy to pay separately for that. Drugs and biologicals will be paid at 106% of ASP (not 105% as proposed earlier).
- **Ambulatory surgery centers.** 19 procedures have been added, including surgical services furnished to maintain vascular access fistulas and for grafts for hemodialysis patients.

Quality measures are being imposed, but not until 2009. Kuhn explained, "In the proposed rule, we talked about (the quality measures) starting in January 2007, but now they are starting January 2009, so that gives two full years for the hospital industry…to try to pull together an updated set of quality measures specifically designed for that setting…Many inpatient quality measures have applicability to outpatients…but to give time for this ramp up and to get cooperation from hospitals, we thought a two-year lead-in time would give us more time." Norwalk commented, "We are taking one more step toward rewarding hospitals for providing quality care, not just in the inpatient setting, but also in the outpatient department. While our primary focus is on quality for Medicare beneficiaries, we expect that our quality initiatives will stimulate better care for all patients who come to the hospital outpatient department."

Home Health Services – a 3.3% market basket increase for 2007. This translates to a $410 million boost for home health agencies next year. Norwalk said, "We are dedicated to ensuring quality care for all beneficiaries…We want to be sure (beneficiaries) can be treated at home if at all possible." Kuhn added, "We are seeing growth here, too…And an opportunity to begin getting more quality reporting in home health, where the requirement begins in 2007."

Payments are also changed for **oxygen and oxygen equipment**, **wheelchairs, and hospital beds**.

- **36-week cap on continuous rentals maintained.** Kuhn said this is a change from an unlimited or non-capped benefit, which he predicted would create savings. The cap began January 1, 2006. The new rules also address maintenance, servicing, and replacement. He said, "After 36 months, title transfers to the beneficiary…and we address maintenance and servicing once the beneficiary owns it."
- **Anti-switching regulations.** These are to ensure that the equipment that is transferred to a beneficiary is the same as was rented.
- **Stationary and portable oxygen payments equalized.**

Ambulance fee schedule – a 4.3% inflation factor for 2007.

Medicare Physician Fee Schedule (MPFS) – a 5.0% cut but increased fees for patient counseling. Medicare had proposed a 5.1% cut, but reduced that by 0.1% to a flat 5% cut. Medicare will pay $61.5 billion to >900,000 physicians in 2007, "to account for combined growth, volume, and intensity."

Some specialty therapy areas are especially hard hit. Clinical social workers, for example, will see a significant decrease in 2007, but not as much as the 14% feared. Kuhn said, "Other limited license providers are somewhat impacted…We went through the same process with everyone."

At the same time, Medicare will pay physicians more in 2007 for the time they spend talking with beneficiaries about their healthcare and will pay for a broader range of preventive services next year. Norwalk said, "The real hallmark…is a stronger emphasis on physician/patient relationships…and to make sure we increase rates for evaluation and management (E&M) services. It is during the office visit that they discuss patient status and steps to maintain or improve patient health…Since Medicare has an emphasis on prevention now, we thought it was appropriate and agreed to increase payments to physicians for time spent talking to beneficiaries." Kuhn added, "It is important to remember that this was an effort by the American Medical Association's (AMA's) RVU committee. There was an elevation of a number of codes, especially those that encourage and reward physicians that spend a lot of time with patients…We plan to phase in practice expense over four years, so continue to watch these very carefully, and for the RUC to go back and look at RVUs in case they want to make changes."

Asked how the extra counseling fees will be paid, Kuhn said, "Currently, there are 7,000 codes we pay physicians under. Every five years, we review those codes to see if they are (properly) valued…A good 600+ codes were reviewed (this time), and the codes they valued much more favorably were evaluation and management codes – hopefully office-based procedures. They took them and assigned higher values…For example, a code with a 0.67 RVU, now might be 0.92 – much greater value. The idea is to give physicians more time to spend with patients. It is not new codes. It is that the overall value for the codes are much richer and more valuable."

- **Intermediate office visit**, the most frequently billed physician service, is increasing 37%.
- **Office visit** requiring moderately complex decision-making is increasing 29%.
- **Hospital visit** requiring moderately complex decision-making is increasing 31%.

Preventive services for which coverage will be added in 2007 include:

- **Ultrasound** screening for abdominal aortic aneurysms (AAA) for at-risk beneficiaries (men age 65-75 who have smoked at least cigarettes in their lifetime) as part of the Welcome to Medicare physical.
- **Bone density measurement** due to long-term steroid therapy is expanded. The new rule reduces the dosage required for eligibility by one-third, from an average of 7.5 mg/day of prednisone for at least 3 months to 5.0 mg/day.
- **Colorectal cancer screening** will be exempted from the Part B deductible.

Other changes in this rule include:

- A cap on payments for imaging services under the physician fee schedule to the amount paid for the same services when performed in hospital outpatient departments.
- Finalization of a 25% reduction in the payment for multiple imaging procedures on contiguous body parts.
- Intravenous immune globulin (IVIG) pre-administration-related services fee continuing in 2007.

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