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Memo to: Executive Directors
State Medical Associations
County Medical Societies
National Medical Specialty Societies

From: Michael D. Maves, MD, MBA 

Date: July 6, 2007

Subject: 2008 Physician Fee Schedule NPRM

On July 2, the Centers for Medicare & Medicaid Services (CMS) released its annual proposed rule to revise payment rates and policies for the 2008 Medicare Physician Fee Schedule (MPFS). In addition to updating the MPFS, the proposal also outlines the Administration's plans for the future of the Physician Quality Reporting Initiative (PQRI). Notably, the \$1.35 billion fund created in last year's Medicare law is proposed to be used entirely for continuing the bonus payments into the 2008 program rather than using authority provided to the Secretary to reduce the Medicare physician payment cuts. As a result, the conversion factor update in 2008 is still predicted to fall by 9.9%.

Staff will continue to review the 900+ page document and may report back to you with additional details on elements warranting your further attention. We will also be drafting formal AMA comments detailing our views on the proposed rule.

PQRI

Measures

For 2008, CMS retains measures from the 2007 PQRI contingent on National Quality Forum (NQF) endorsement of each measure prior to issuance of the final rule expected in early November. The proposal sets forth new measures for 2008, including 50+ currently under development by the AMA-convened Physician Consortium for Performance Improvement. In addition, the rule proposes several non-physician and structural measures developed by the Pennsylvania Quality Improvement Organization as well as additional measures from the Ambulatory Quality Alliance (AQA) and NQF ambulatory measure sets.

Funding

The rule proposes to use the \$1.35 billion Physician Assistance and Quality Initiative Fund set aside in last year's Medicare law to fund bonus payments to be made during 2009 for physician reporting of measures during 2008. CMS estimates that the bonus payments could be 1.5 percent to 2 percent of allowed charges for participating professionals. CMS claims that there are legal and operational problems to using the fund to reduce the projected 9.9 percent payment cut for 2008. AMA, and 85 physician and other organizations representing medical practitioners wrote to Acting Administrator Norwalk urging the Secretary to apply the entire \$1.35 billion to mitigate the scheduled 2008 cut.

PHYSICIAN PAYMENTS

CMS announces reduction in Conversion Factor: While failing to reduce the impact of the SGR-triggered cuts, Acting CMS Administrator Leslie Norwalk trumpeted the PQRI program as a reform "that can help lead us to a point where we can promote better quality care and more efficient care." She went on to say that the Agency wants to "compensate physicians appropriately. But how the program pays also matters." CMS believes that extending the PQRI is a "reform" that improves Medicare for its beneficiaries.

Other Payment Changes Would:

- Increase the anesthesia work component by 32% as recommended by the AMA/Specialty Society RVS Update Committee (RUC).
- Bundle payment for doppler echocardiography color flow into other services, essentially eliminating the \$100 payment for this service.
- Increase the practice expense per hour for radiology.
- Add certain ophthalmologic imaging procedures to the list of procedures that would be subject to the Deficit Reduction Act of 2005 (DRA) payment cap.

Geographic Adjustments: The rule also reflects a reduction in payments in a number of geographic areas due to the expiration of a law that sets a floor on geographic adjustments for the work portion of the payment. In addition, the Geographic Practice Cost Indices (GPCI) are being adjusted to reflect more recent data and CMS has laid out three different proposals for budget neutral changes in payment localities. Initially, any change would apply just to California.

DRUG PAYMENTS PROVISIONS

- 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.
- Recognize the extra resources required in locating and obtaining intravenous immunoglobulin products by continuing to pay for preadmission-related IVIG services.
- Modify the requirements under the competitive acquisition program (CAP) for Part B drugs for verifying that a drug ordered by a physician has been administered.
- Require physicians to report hemoglobin or hematocrit data on claims for drugs used to treat anemia secondary to anticancer treatment.

OTHER PROVISIONS

- Modify a number of physician self-referral provisions to close “loopholes” that CMS asserts have “...made the Medicare program vulnerable to abuse.”
- Change enrollment standards for Independent Diagnostic Testing Facilities (IDTFs).
- Add a number of new requirements for those providing physical therapy and occupational therapy, including completion of an approved education program.
- Eliminate the exemption for computer-generated faxes from the e-prescribing standards.