MEDICARE FINAL RULE ANNOUNCES 2008 PHYSICIAN FEES AND REFORMS FOR ACCURATE PAYMENTS AND QUALITY

The Centers for Medicare & Medicaid Services (CMS) today issued a final physician payment rule designed to improve accuracy of Medicare payments and give physicians and health care professionals additional financial incentives to provide higher quality and value in the delivery of care.

Under the new rule, Medicare estimates that it will pay approximately $58.9 billion to about 900,000 physicians and other health care professionals. The revised payments, quality incentive rates and related policy changes, which will become effective January 1, 2008, are included in the Medicare Physician Fee Schedule (MPFS) final rule. The rule went on display today at the *Federal Register*.

"This rule builds on the changes we have made to pay more appropriately and transform Medicare into an active purchaser of higher quality services" said acting CMS Administrator Kerry Weems. "It also encourages the use of electronic prescribing to improve the speed and accuracy of care to beneficiaries, and extends payment incentives for quality measures."

As directed by the Tax Relief and Health Care Act of 2006, CMS implemented a voluntary reporting program for 2007 for physicians and other health care practitioners. Since July 1, 2007, under the Physician Quality Reporting Initiative (PQRI), eligible professionals who report specific measures on quality of care furnished to Medicare beneficiaries may earn incentives up to 1.5 percent of their total allowed charges, subject to a cap.

In the 2008 final rule, CMS outlines PQRI measures that were endorsed by the National Quality Forum, and other sources completing development for upcoming PQRI implementation.

These structural measures, which focus on whether a health care professional uses electronic health records and/or electronic prescribing, emphasize the importance of this technology for delivery of high-quality health care services. Physician and non-physician professionals not meeting PQRI measures will be allowed to participate by reporting on their use of health information technology. The Physician Assistance and Quality Initiative Fund will provide $1.35 billion for physician payment and quality improvement initiatives for services furnished in 2008.

The Medicare law includes a statutory formula requiring CMS to implement a negative 10.1 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 the number of Medicare fee-for-service beneficiaries and statutory or regulatory changes in benefits. CMS has no choice but to implement this negative update because it is mandated by a statutory formula.

Under this law, if the actual rate of spending growth exceeds the target rate, the update is decreased; if it is less, the update is increased. Since 2002, because payment for physician services increased faster than projections, the statutory update formula dictated payment cuts. A negative update went into effect in 2002, but for 2003 to 2007, Congress intervened and temporarily suspended requirements in favor of specific, statutory updates.

"CMS will continue to work with Congress and physician groups to identify payment methods that help improve the quality and efficiency of care in a way that is mindful to not increase costs to taxpayers, Medicare, and its beneficiaries," Weems said. "Medicare needs to compensate physicians appropriately for the services they furnish to people with Medicare. We believe the early work on the Physician Quality Reporting Initiative is one of those reforms that can help lead to better quality and more efficient care."

The proposal to eliminate the computer-generated fax exemption from e-prescribing was modified in response to comments to provide for retention of the exemption only in instances of temporary/transient transmission failure and communication problems that would preclude the use of the NCPDP SCRIPT standard adopted in the final rule. The new provision will be effective January 1, 2009. This transition period is intended to allow all prescribers and dispensers adequate time to obtain or upgrade existing software.

For an additional year, CMS will continue payments for pre-admission-related services for intravenous infusion of immunoglobulin (IVIG). This payment is for extra resources expended to locate and obtain IVIG products that are appropriate for patient treatments and to schedule infusions. Health care providers may bill for each related physician office visit when IVIG treatments are administered.

The 2008 rule also adopts recommendations of the American Medical Association's Relative Value Update Committee to increase the payments for the work involved in providing anesthesia services by 32 percent. In addition, the value of the work component of certain physician visits to patients' homes will increase.

"This builds upon increases for primary care services that Medicare implemented last year," said Weems "By paying physicians more to spend time talking to their patients about their health, we hope to improve health status of Medicare beneficiaries."

Other provisions in this rule include:

- Updating the Geographic Practice Cost Indices to reflect more recent data;
- Updating regulations governing payment of certain services furnished in Comprehensive Outpatient Rehabilitation Facilities, to reflect payment under the MPFS;
- Adding neurobehavioral status exams to the list of Medicare telemedicine services;
- Adding certain ophthalmologic imaging procedures to the list of procedures subject to the Deficit Reduction Act of 2005 provision that caps payment for the technical component of imaging procedures at the payment amount under the hospital outpatient prospective payment system;
- Specifying requirements under the competitive acquisition program for Part B drugs for verifying that a drug ordered by a physician has been administered;
- Improvements to the process for determining payment for new clinical laboratory tests;
- Modifying enrollment standards for Independent Diagnostic Testing Facilities;
- Imposing an anti-markup restriction on the technical component (TC) or professional component (PC) of diagnostic tests (other than clinical lab tests) that are ordered by the billing supplier, if the TC or PC is purchased by the billing supplier, or the TC or PC is performed outside of the office of the billing supplier; and
- 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 discipline in which they practice. This rule also changes the time frames for certifying a therapy plan of care.

The final rule, effective for services on or after January 1, 2008, will go on display today and will be published in the *Federal Register* on November 27, 2007. The rule can be found at http://www.cms.hhs.gov/center/physician.asp.
For more information, please see fact sheets on Preventive Services, Physician Participation, and Imaging Services at www.cms.hhs.gov/apps/media/?media=facts.