

BACKGROUNDER

PLANS FOR IMPLEMENTING MEDICARE PROVISIONS IN H.R. 6111, THE TAX RELIEF AND HEALTH CARE ACT OF 2006

On December 20, 2006, President Bush signed the Tax Relief and Health Care Act into law. This legislation contains a number of very important provisions affecting physicians and other providers and suppliers of services to people enrolled in the Medicare fee-for-service program. While some of the provisions do not become effective until July 1, 2007, the legislation requires the Centers for Medicare & Medicaid Services (CMS) to implement major changes to the Physician Fee Schedule, effective January 1, 2007. In this Backgrounder, CMS outlines the steps it is taking to implement these provisions in a timely and efficient manner.

I. New Physician Fee Schedule Rates Effective for Services on or After January 1, 2007 (Section 101 of Division B)

Based on Section 101 of this Act that revises the 2007 update to the physician fee schedule “conversion factor” from negative 5.0 percent to 0 percent, with an effective date of January 1, 2007, we are taking the following actions to implement this provision with minimal disruption to providers and beneficiaries.

We have recently issued instructions to Medicare contractors concerning the processing of claims using the new rates. We expect that contractors will be able to timely implement the new rates for services provided on or after January 1, 2007. We do not anticipate the need to reprocess any claims as a result of this change to the physician update.

II. Changes in Physician Payment Rates for 2007

This Act sets the 2007 conversion factor for the physician fee schedule at the same level as in 2006, thus reversing the 5.0 percent negative update that would have applied under prior law. However, it does not reinstate the payment rates for individual physicians’ services at 2006 levels. A number of other factors will affect these payment rates in 2007. Among these factors are: (1) the statutorily mandated 5-year review of physician work relative value units (RVUs); (2) s statutorily required budget neutrality adjustment to the work RVUs; and (3) a revision to the methodology for calculating practice expense RVUs.

This year, through notice and comment rulemaking issued in the *Federal Register* on November 1, 2006, we completed the 5-year review of physician work RVUs. (This review is required by statute to be performed at least once every 5 years.) The review resulted in increases in work RVUs for certain services (primarily affecting certain high volume office visits) that would have resulted in increased total expenditures under the physician fee schedule unless we made adjustments to achieve budget neutrality.

Since the statute requires CMS to make a budget-neutrality adjustment, which we applied to the work portion of the fee schedule in the regulation issued November 1, 2006, payments in 2007

for many services will decrease. The aggregate amount of 2007 Medicare Part B spending will be the same as it would have been without the work RVU changes, but because there are more work RVUs in the system, payments for individual services are reduced by about 5.0 percent.

While the budget-neutrality adjustment has the impact of reducing payments by about 5.0 percent for many services, the combined impact of this and other changes will vary by procedure and specialty. (See Table 35 of the physician fee schedule final rule, attached, for estimates of the impact by specialty of the budget-neutrality adjustment. This table was included in the physician fee schedule final rule issued on November 1, 2006, following two proposed rules issued earlier in 2006 and our consideration of comments received on those proposed rules. As a result of the revised conversion factor, the relevant column in the table is the one entitled “Combined Impact RVU and DRA 5102.”)

Other changes adopted in the physician fee schedule final rule that affect 2007 payment rates include changes in the practice expense RVU-setting methodology, refinements to the practice expense RVUs, re-weighting of geographic adjustment factors, limits on payments for imaging services required by the Deficit Reduction Act of 2005 (DRA), and other annual refinements including coding changes.

III. Implementation of Other Significant Changes to the Physician Fee Schedule

We will also implement these additional changes to the physician fee schedule as required by the Act, effective for services furnished on or after January 1, 2007:

- Extend application of the 1.0 floor in the work geographic index for any locality for which the index is less than 1.0, first established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), to services furnished from January 1, 2007, through December 31, 2007. (Section 102)
- Extend through calendar year 2007 the MMA provision that mandates separate payment under the laboratory fee schedule for the technical component of certain physician pathology services furnished to hospital patients. (Section 104)
- Extend the exception process for therapy caps, first established under the DRA, until December 31, 2007. (Section 201)
- Provide for payment under Part B of the Medicare program in 2007 for the administration of vaccines covered under Part D. (Section 202)

IV. Other Medicare Changes Effective January 1, 2007

We would also note that we will implement timely other provisions of the Act that are not part of the physician fee schedule but affect the traditional Medicare program early in 2007. Specifically:

- Extend the MMA special payment rule under the hospital outpatient prospective payment system for brachytherapy devices for 2007. (Section 107)
- Revise payment processes by April 1, 2007, for drugs supplied by a competitive acquisition program vendor, including requiring the Secretary to establish a post-payment review process to assure that payment is made only for drugs that have actually been administered. (Section 108)
- Extend the composite rate component for the end stage renal disease basic case-mix adjusted system for 2006 until April 1, 2007. Update the composite rate component for services on or after April 1, 2007, by 1.6 percent above the 2006 rate. (Section 103)

V. Extension of Physician Participation Process for 2007

The annual participation election period typically ends on December 31. However, because the change to the physician update could affect a physician's decision regarding his or her participation status for 2007, we plan to extend the current enrollment period for an additional 45 days to February 14, 2007. Should the physician decide to revise his or her participation election during this extended enrollment period, the participation election will be retroactive to January 1, 2007.

TABLE 35: Combined CY 2007 Total Allowed Charge Impact for the 5-year Review of Work RVUs and Practice Expense Changes, Multiple Imaging Reduction, OPPS Imaging Cap, and CY 2007 Update

	Specialty	Allowed Charges (mil)	Impact of Work and PE RVU Changes*	Impact of DRA 5102	Combined Impact RVU and DRA 5102**	CY 2007 Update	Combined Impact with CY 2007 Update**
1	Total	\$ 75,408	0%	-1%	-1%	-5%	-6%
2	ALLERGY/IMMUNOLOGY	\$ 168	2%	0%	2%	-5%	-3%
3	ANESTHESIOLOGY	\$ 1,725	-7%	0%	-7%	-5%	-12%
4	CARDIAC SURGERY	\$ 391	3%	0%	3%	-5%	-2%
5	CARDIOLOGY	\$ 7,512	-1%	-1%	-2%	-5%	-7%
6	COLON AND RECTAL SURGERY	\$ 120	0%	0%	0%	-5%	-5%
7	CRITICAL CARE	\$ 173	4%	0%	4%	-5%	-1%
8	DERMATOLOGY	\$ 2,156	-3%	0%	-3%	-5%	-8%
9	EMERGENCY MEDICINE	\$ 2,010	7%	0%	7%	-5%	2%
10	ENDOCRINOLOGY	\$ 321	6%	0%	6%	-5%	1%
11	FAMILY PRACTICE	\$ 4,852	5%	0%	5%	-5%	0%
12	GASTROENTEROLOGY	\$ 1,745	0%	0%	0%	-5%	-5%
13	GENERAL PRACTICE	\$ 1,029	3%	-1%	2%	-5%	-3%
14	GENERAL SURGERY	\$ 2,346	0%	-1%	-1%	-5%	-6%
15	GERIATRICS	\$ 134	2%	0%	2%	-5%	-3%
16	HAND SURGERY	\$ 77	-2%	0%	-2%	-5%	-7%
17	HEMATOLOGY/ONCOLOGY	\$ 1,771	3%	0%	3%	-5%	-2%
18	INFECTIOUS DISEASE	\$ 454	9%	0%	9%	-5%	4%
19	INTERNAL MEDICINE	\$ 9,601	5%	0%	4%	-5%	-1%
20	INTERVENTIONAL RADIOLOGY	\$ 235	-5%	-2%	-7%	-5%	-12%
21	NEPHROLOGY	\$ 1,600	-1%	0%	-1%	-5%	-6%
22	NEUROLOGY	\$ 1,343	2%	-1%	1%	-5%	-4%
23	NEUROSURGERY	\$ 577	-2%	-1%	-3%	-5%	-8%
24	NUCLEAR MEDICINE	\$ 87	-3%	-2%	-4%	-5%	-9%
25	OBSTETRICS/GYNECOLOGY	\$ 630	1%	0%	1%	-5%	-4%
26	OPHTHALMOLOGY	\$ 4,808	-3%	0%	-3%	-5%	-8%
27	ORTHOPEDIC SURGERY	\$ 3,289	-1%	0%	-1%	-5%	-6%
28	OTOLARNGOLOGY	\$ 898	0%	0%	0%	-5%	-5%
29	PATHOLOGY	\$ 942	-6%	0%	-6%	-5%	-11%
30	PEDIATRICS	\$ 75	2%	0%	2%	-5%	-3%
31	PHYSICAL MEDICINE	\$ 793	2%	0%	2%	-5%	-3%
32	PLASTIC SURGERY	\$ 283	-1%	0%	-1%	-5%	-6%
33	PSYCHIATRY	\$ 1,150	-2%	0%	-2%	-5%	-7%
34	PULMONARY DISEASE	\$ 1,592	7%	0%	6%	-5%	1%
35	RADIATION ONCOLOGY	\$ 1,460	1%	0%	0%	-5%	-5%
36	RADIOLOGY	\$ 5,407	-5%	-5%	-9%	-5%	-14%
37	RHEUMATOLOGY	\$ 471	2%	-1%	2%	-5%	-3%
38	THORACIC SURGERY	\$ 445	3%	-1%	3%	-5%	-2%
39	UROLOGY	\$ 1,959	1%	-1%	0%	-5%	-5%
40	VASCULAR SURGERY	\$ 611	-1%	-4%	-6%	-5%	-11%

	Specialty	Allowed Charges (mil)	Impact of Work and PE RVU Changes*	Impact of DRA 5102	Combined Impact RVU and DRA 5102**	CY 2007 Update	Combined Impact with CY 2007 Update**
41	AUDIOLOGIST	\$ 32	-2%	0%	-2%	-5%	-7%
42	CHIROPRACTOR	\$ 783	-8%	0%	-8%	-5%	-13%
43	CLINICAL PSYCHOLOGIST	\$ 562	-9%	0%	-9%	-5%	-14%
44	CLINICAL SOCIAL WORKER	\$ 370	-9%	0%	-9%	-5%	-14%
45	NURSE ANESTHETIST	\$ 657	-8%	0%	-8%	-5%	-13%
46	NURSE PRACTITIONER	\$ 719	0%	0%	0%	-5%	-5%
47	OPTOMETRY	\$ 846	-3%	0%	-3%	-5%	-8%
48	ORAL/MAXILLOFACIAL SURG	\$ 38	-1%	0%	-1%	-5%	-6%
49	PHYS/OCC THERAPY	\$ 1,613	-5%	0%	-5%	-5%	-10%
50	PHYSICIANS ASSISTANT	\$ 543	2%	0%	2%	-5%	-3%
51	PODIATRY	\$ 1,563	-1%	0%	-1%	-5%	-6%
52	DIAGNOSTIC TESTING FACILITY	\$ 1,228	-2%	-11%	-13%	-5%	-18%
53	INDEPENDENT LABORATORY	\$ 673	2%	0%	2%	-5%	-3%
54	PORTABLE X-RAY SUPPLIER	\$ 88	-1%	0%	-1%	-5%	-6%