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prepared by the Division of Advocacy and Health Policy

Final rule on 2005 Medicare fee schedule released

On November 2, 2004, the Centers for Medicare & Medicaid Services (CMS) released a final rule outlining changes to the 2005 Medicare fee schedule. The regulation included refinements to practice expense relative value units (RVUs) as well as other payment policy changes. Of particular interest:

- The RVUs assigned to compensate physicians for their medical liability costs were updated to reflect more recent premium data. However, methodological changes proposed by the College and others that would have directed relatively more liability RVUs toward high-risk services were not adopted.
- Policies involving the 10 percent health professional shortage area (HPSA) bonus payments were revised, and a new 5 percent physician scarcity area (PSA) bonus payment system was established. Included in the new PSA program are specialty shortage areas. (Details about both bonus payment programs are available at <http://www.cms.hhs.gov/providers/bonuspayment>.)
- Payments for physician-administered drugs were revised, although estimates of net reductions to oncologists and others who provide these services were far lower than originally predicted.
- Medicare will base all payments for diagnostic and screening mammography services on the physician fee schedule, including those services provided under the outpatient prospective payment system.
- The congressionally mandated 1.5 percent update to the Medicare fee schedule raised the 2005 conversion factor to \$37.8975. Absent this action by Congress, the sustainable growth rate mechanism would have produced a 3.3 percent payment reduction.

Following are estimates of the impact that RVU changes in the 2005 fee schedule will have on aggregate Medicare payments for the surgical specialties (before applying the 1.5 percent conversion factor update):

Cardiac surgery	1%	Orthopaedic surgery	0%
Colon and rectal surgery	1	Otolaryngology	0
General surgery	1	Plastic surgery	0
Hand surgery	0	Thoracic surgery	1
Neurosurgery	0	Vascular surgery	4
Ophthalmology	-1		

Overall payments to urologists are expected to decline by about 8 percent, due to additional changes that were made in policies and payment rates pertaining to drugs provided incident to physician services.

Sample payment rate changes for some key surgical services include:

CPT/Procedure	2004 Average	2005 Average	% Increase
19240, Removal of breast	\$ 979	\$ 996	1.8
27130, Total hip replacement	1,370	1,396	1.9
31255, Removal of ethmoid sinus	436	447	2.4
33512, CABG, three vein	2,012	2,044	1.6
35301, Rechanneling of artery	1,115	1,129	1.2
44140, Partial removal of colon	1,204	1,223	1.6
49505, Repair inguinal hernia	457	468	2.3
52601, Prostatectomy (TURP)	687	694	1.1
63047, Removal of spine lamina	1,030	1,047	1.6
66984, Remove cataract, insert lens	684	684	0

New outpatient prospective payment policies issued

All payment policy changes became effective on January 1. The full text of the final rule, which was published in the November 15 *Federal Register*, can be accessed through the CMS Web site at <http://www.cms.hhs.gov/physicians/pfs/>.

Also on November 2, CMS released a final rule setting policies and payment rates for the hospital outpatient prospective payment system (OPPS). It is projected that the aggregate impact of the payment policy changes for hospitals and outpatient services will be a 6.5 percent increase in total payments. For the various hospital categories, payment increases are expected to be:

All hospitals	4.0%
Urban hospitals	3.9
Rural hospitals	4.5
Teaching hospitals	2.6
Cancer hospitals	0.7

Although the final OPPS conversion factor for calendar year 2005 increased 4.4 percent, net payment increases for hospitals were lower primarily because of the decline in the statutory minimum payment for sole source specified covered outpatient drugs.

The entire regulation can be viewed on the CMS Web site at <http://www.cms.hhs.gov/providers/hopps/>.

Institute analyzes postelection climate

According to a recent report released by PriceWaterhouseCoopers' Health Research Institute, growing federal budget deficits coupled with increased health care spending and an aging population will very likely force deep Medicare reimbursement cuts. The last time the nation faced a mounting budget deficit, the report notes, Congress enacted the Balanced Budget Act of 1997, which significantly reduced Medicare payment for most provider services.

Expected annual deficits of \$300 billion, combined with growing health care cost pressures, could produce budget balancing legislation that targets physicians. At the very least, the budget environment will probably make it difficult for Congress to commit the funding necessary to restructure Medicare's flawed physician payment system. There also are concerns that some of the payment increases allocated by the Medicare Modernization Act of 2003 will be rolled back, including quality bonuses for reporting on specific quality indicators and payment increases to rural and teaching hospitals.

There is also an indication that the Bush Administration's policy of creating an "ownership society" will place more emphasis on high deductible health plans and health savings accounts, which could encourage consumers to become more engaged and more conscious of cost. In addition, it is possible that competition between providers will increase, bad debt levels will grow, and utilization rates for many health care services may fall. The report may be viewed at www.pwc.com/healthcare.