The 2008 Medicare fee schedule

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The Centers for Medicare & Medicaid Services (CMS) released the final rule on the 2008 Medicare physician fee schedule on November 1, 2007, and published it in the November 27 *Federal Register.* The regulation includes important payment policy changes for Medicare physician services in 2008, which became effective January 1.

At press time, Congress still was considering legislation that could affect many provisions in the final rule. In particular, legislative changes may involve the fee schedule conversion factor and expiring provisions of Medicare law that aim to support physicians practicing in rural and other underserved areas.

This article is intended to answer questions that surgeons may have about the new Medicare payment policies for 2008 as described in the final rule. Any other policy changes that Congress may implement between publication of this article and its adjournment for 2007 will be published in *ACS NewsScope*, the College's weekly electronic newsletter, and in a future edition of "Dateline: Washington," which is published in the *Bulletin* each month.

What will the fee schedule conversion factor be for 2008?

Unless Congress intervenes, the fee schedule conversion factor will be reduced 10.1 percent in 2008, dropping from $37.8975 to $34.0682.

Why does Congress have to intervene every year to prevent a cut in the Medicare conversion factor?

The formula for setting the annual update to the Medicare fee schedule conversion factor is based, in part, on the sustainable growth rate (SGR), which is a prospectively determined allowable rate of spending growth that is established each year. If aggregate Medicare physician spending in a given year exceeds the SGR, it must be recouped in subsequent years through reductions in the fee schedule conversion factor. Every year since 2002, aggregate spending on physician services has exceeded the target, fueled by increases in the volume and intensity of services provided to Medicare beneficiaries. Volume growth has been particularly high for minor procedures, imaging, and laboratory tests.

The conversion factor update formula restricts efforts to recoup "excess" spending by imposing a limit of 7 percentage points on the amount that can be deducted from the normal inflation update, known as the Medicare Economic Index (MEI). So, when excessive spending occurs over a period of years, the 7 percent limit effectively spreads the accumulated "debt" over a very long period. Currently, negative conversion factor updates are anticipated annually for approximately 10 more years.

Typically, the MEI for a given year falls in the range of 1.5 percent to 2.5 percent; when combined with the –7 percent update, the result is a conversion factor update somewhere in the range of –5 percent. The cut is significantly steeper in 2008 because of the mechanism Congress used to finance the short-term conversion factor "fix" for 2007: To freeze the 2007 conversion factor at the 2006 rate, Congress eliminated a scheduled 5 percent cut by allocating additional funds for one year only. Consequently, the calculation for determining the 2008 conversion factor began at the rate that *would* have been effective in 2007 if the freeze had not been implemented. In effect, the two 5 percent pay reductions that were scheduled for 2007 and 2008 were implemented at the same time.

In 2007, significant payment redistributions occurred among the various specialties following the five-year review of the relative value units (RVUs) for physician work in the Medicare fee schedule. Does the 2008 regulation make any changes in the work RVUs?

Yes, there will be changes. The most significant changes in this year's fee schedule involve the work RVUs for anesthesia services.

During the five-year review process, a so-called "building block" approach was used to determine if anesthesia services were properly valued. The American Medical Association/ Specialty Society Relative Value Scale Update Committee (RUC) determined that the work associated with anesthesia services was significantly undervalued, and it subsequently recommended a 32 percent increase in the anesthesia work RVUs. This recommendation was adopted for 2008 and, in order to maintain budget neutrality, an additional 1 percent negative adjustment in all physician fee schedule work RVUs was applied. In other words, all work RVUs in the fee schedule are reduced by approximately 12 percent (using an adjuster of 0.8806) as a first step in calculating payment amounts.

The first year of a four-year transition to new RVUs for practice expenses was implemented in 2007. Is that transition continuing in 2008?

Yes, this transition will continue. In 2008, practice expense payments will reflect a 50-50 blend of new and old (2006) values. In 2007, the blend was composed of 25-75 new and old values. For most surgical specialties, the net result will be a small decrease in payments (between 0% and 1%) beyond the reduction that will be imposed by the lower conversion factor and the increased anesthesia work values. Table 1 (this page) shows CMS' estimate of the combined impact of all the RVU changes on each surgical specialty.

Were any changes made in the malpractice RVUs for 2008?

No changes will be made in malpractice payments, other than what may be produced by the revised geographic practice cost indexes described as follows.

What is the bottom-line impact of the work and practice expense RVU changes and fee schedule conversion factor reduction?

Table 1

Combined impact of 2008 work and practice expense RVU changes on surgical specialties

Specialty	2008 RVU change impacts (%)
Cardiac surgery	–2
Colon and rectal surgery	0
General surgery	–1
Hand surgery	–2
Neurosurgery	–2
Obstetrics/gynecology	–1
Ophthalmology	1
Orthopaedic surgery	–1
Otolaryngology	1
Plastic surgery	–1
Thoracic surgery	–2
Urology	–1
Vascular surgery	–1

Table 2 (page 10) shows the average combined impact of all the changes on payments for key surgical services across various specialties. The first column that provides percentages shows the impact of the RVU changes alone; the other column that provides percentages shows the percentage change in payments that will occur if Congress has failed to act and the 10.1 percent conversion factor cut has, in fact, taken effect on January 1.

Were any changes made in the geographic practice cost indices (GPCIs)?

Yes, there were GPCI changes. By law, the GPCIs applied to the physician work, practice expense, and malpractice components of the fee schedule must be revised at least once every three years to reflect more current cost data. In addition, authority to use a 1.0 "floor" (the

national average) on geographic adjustments for the physician work component of the fee schedule that tends to benefit rural areas expires January 1, unless Congress intervenes.

The most significant positive change resulting from the GPCI revisions occurred in the "Rest of Maine" locality, where changes in the GPCIs for the three components combine to produce a 5.91 percent payment increase. The most significant decreases produced by the GPCI changes will take place in Detroit, MI, where payments will drop by 4.32 percent. In absolute terms, the nation's highest payment amounts are in San Mateo, CA, where the combined geographic adjustment is 1.232 percent of the national average, and the lowest payments are in the territory of Puerto Rico at 0.789 percent of the national average.

The costs of practice have been going up everywhere. Certainly, the growth in practice costs has outpaced Medicare reimbursement trends throughout the country. How can CMS justify any GPCI reductions?

Increases or decreases in GPCI values do not necessarily reflect changes in the actual costs in a particular locality; rather, they reflect relative costs when compared to a national average. As a hypothetical example, if the rate of growth in office rents is 5 percent in Locality A and 20 percent in Locality B, and the national average growth in office rents is 10 percent, the practice expense GPCI will be reduced in Locality A and increased in Locality B, even though both areas experienced a net increase in office rent costs.

The fee schedule purports to be a relative value scale that is intended to produce relatively appropriate payment amounts. Few policy experts would claim it produces "correct" payments.

For some time, there has been controversy regarding the GPCIs in California, where

Table 2

2008 payments for selected surgical services under two scenarios

Procedure	2007 average payment ($)	2008 average payment if conversion factor is frozen at 2007 level	% change 2008–2007	2008 average payment with 10.1% conversion factor reduction ($)	% change 2008–2007
19307, Removal of breast	1,008	1,001	–0.7	900	–10.7
27130, Total hip replacement	1,361	1,329	–2.3	1,195	–12.2
31290, Nasal/sinus endoscopy	1,104	1,070	–3.1	962	–12.9
33512, Coronary artery bypass graft 3—vein	2,327	2,276	–2.2	2,046	–12.1
35301, Rechanneling of artery	1,072	1,039	–3.0	934	–12.8
44140, Partial removal of colon	1,191	1,169	–1.9	1,051	–11.8
49505, Repair inguinal hernia	451	446	–1.0	401	–11
52601, Prostatectomy	776	794	2.3	713	–8.0
63047, Removal of spinal lamina	1,013	995	–1.8	894	–11.7
66984, Remove cataract, insert lens	642	623	–3.0	560	–12.9

communities with high costs have been included with lower cost rural areas in a single payment locality. Has CMS addressed this inequity?

No, this issue has not yet been addressed. A number of options have been suggested, including three that were discussed in the proposed rule issued last summer. Unfortunately, GPCI changes in states that have more than one payment locality must be made in a budget-neutral manner. In other words, payments in one locality cannot be increased unless offsetting payment reductions are made in another locality in the same state. As a result, CMS has been unable to identify a supportable option for addressing a widely acknowledged need to address inappropriately low payments in certain communities in California and elsewhere. However, CMS is looking at other suggested methodologies and has indicated that it intends to address the issue again.

Medicare payments in underserved areas have been eligible for bonus payments in an effort to further encourage physicians to practice in these communities. Will this policy continue in 2008?

On January 1, the 5 percent "bonuses" paid for services provided in CMS-designated primary care or specialty care scarcity areas will expire unless Congress passes legislation extending them. These incentives were effective between January 1, 2005, and January 1, 2008.

In the proposed rule, CMS indicated that it was considering the possibility of expanding the list of procedures subject to payment reductions when multiple procedures are performed at the same session. Was that policy implemented?

Yes, the policy was implemented. Until now, Mohs' micrographic surgery procedures have not been subject to the multiple payment reduction policy that applies to all other procedure codes in the surgery/integumentary section of the *Current Procedural Terminology* manual. Starting January 1, a 50 percent payment reduction for subsequent Mohs' procedures performed during a single session will be applied.

What plans does CMS have for the Physicians Quality Reporting Initiative (PQRI) for 2008?

CMS intends to continue the PQRI program in 2008, with an expanded list of measures and a full-year reporting period. (See "Socioeconomic tips" on page 48 for a detailed description of the 2008 PQRI program.) Physicians and other providers who bill under the Medicare fee schedule will be asked to choose from among 117 PQRI measures, as opposed to the 74 measures that were used in 2007. Like last year, PQRI relies primarily on process measures for reporting quality information, although two new structural measures were added to the list pertaining to the use of electronic medical records and electronic prescribing.

What sort of payment bonus will be applied for those who report the PQRI measures?

The bonus payment rate has not yet been set. Through legislation passed in late 2006, Congress allotted $1.35 billion for quality measurement purposes. Whatever bonuses are paid at the conclusion of the 2008 PQRI project are subject to that aggregate payment cap. Preliminarily, CMS estimates that the bonus rate for those reporting PQRI measures on their Medicare claims forms in 2008 will fall between 1.5 percent and 2.0 percent. Once again, the bonus payments will be made in a lump sum after the reporting period ends.

The College and many other medical and surgical specialty organizations argued in comments on the proposed rule that this $1.35 billion should be allocated to reducing the scheduled cut in the fee schedule conversion factor. Given the overwhelming support for this recommendation, why did the CMS choose to continue the PQRI instead?

In their comments, the College and others noted the poor logic behind providing "bonuses"

of 1.5 percent to 2 percent as an incentive to physicians whose payments have been slashed more than 10 percent. In the final rule, CMS acknowledged the overwhelming support for using the $1.35 billion to partially offset the negative fee schedule update, which would make a "fix" less expensive for Congress to legislate. However, because this amount is a fixed sum and Medicare is an entitlement program with no fixed spending, CMS said it was unable to guarantee that reducing the negative update by one or two percentage points would not result in additional program spending beyond the $1.35 billion available. Because of concerns about the legal ramifications of exceeding or falling short of the capped amount, the agency opted instead to apply the additional funding to an extension of the PQRI.

Has CMS given any indication of the 2007 PQRI program's success?

No, that information is still being collected. CMS said in the final rule that, after the 2007 PQRI reporting has concluded, the agency intends to assess and make available to the public information such as participation rates by specialty, associated trends in clinical performance and beneficiary outcomes, and other observable effects. These assessments may include aggregated data by specialty, state, and so forth, but no plans are in place to release data that would enable the public to identify individual physician participants or practices.

Where can surgeons and their staff obtain information about the 2008 PQRI measures and the rules involved in reporting them?

At press time, only some of the measure specifications had been finalized. However, federal legislation requires CMS to publish the final list of measures no later than November 15. After that date, no new measures can be added, although technical corrections and minor refinements may be made until January 1. CMS makes all PQRI-related information available on its Web site, at *www.cms.hhs.gov/PQRI*. In addition, the College has been developing its own PQRI material, which has more of a surgeon focus; this information is available at *www.facs.org/ahp/pqri*. Members of practices that plan to participate in PQRI in 2008 should check both Web sites often for the latest information. Ω