Medicare: Issue of the Day

August 10, 2004

BETTER BENEFITS – MORE CHOICES

Good News about the Medicare Prescription Drug, Improvement and Modernization Act of 2003!

MEDICARE PROPOSES PAYMENT RATES AND POLICY CHANGES FOR HOSPITAL OUTPATIENT SERVICES

Increased Payments For Preventive Services And Lower Beneficiary Co-payments

- Medicare beneficiaries will have **greater access to preventive benefits and lower co-payments** for hospital outpatient services, while **hospitals will see a 3.3 percent inflation update in payment rates** for outpatient services under a proposed rule announced today by the Centers for Medicare & Medicaid Services.

- The proposed payment rate update and other policy changes in the annual Outpatient Prospective Payment System (OPPS) rule will increase projected Medicare payments to hospitals for outpatient services to $24.2 billion compared to projected payments of $22.7 billion in 2004 – a **6.6 percent increase in total payments**.

- The proposed rule introduces proposed changes to payments for outpatient services that were required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), signed into law by President Bush on December 8, 2003. The MMA authorized Medicare to pay, for the first time, for a **"Welcome to Medicare Physical" for new beneficiaries**.

  - This comprehensive examination will provide **baseline information on the health status of the beneficiary;**
  - **allow for early detection and treatment of disease states;**
  - provide an **opportunity for the physician to refer beneficiaries to other Medicare-covered services**.

  To be paid for by Medicare, the physical must be performed within six months of the beneficiary's enrollment in the program.

- When this examination is provided in a hospital outpatient department, Medicare is proposing to pay the hospital $75 for the use of the hospital facility. A **separate payment will be made for the physician's professional services under the Medicare Physician Fee Schedule**, as proposed on July 27, 2004.

- In addition to the new physical, the **proposed rule would increase payment rates to hospitals for screening examinations that are already covered by Medicare**. Proposed payment increases are as follows:

  - ✓ Pelvic and breast exams to detect cervical and breast cancer, 3.24 percent
  - ✓ Barium enema to detect colorectal cancer, 4.25 percent
  - ✓ Bone density studies, 4.25 percent
  - ✓ Flexible sigmoidoscopy to detect colorectal cancer, 7.42 percent
  - ✓ Screening colonoscopy, also for colorectal cancer, 9.9 percent
  - ✓ Glaucoma screening, 10.4 percent

- The proposed rule will also implement **significant increases in payments for mammograms**. It implements a provision of the MMA that requires diagnostic mammograms to be removed from payment under the OPPS and paid, like screening mammograms, under the Medicare Physician Fee Schedule (MPFS).

Although CMS has not finalized the payment rates for the MPFS for 2005, CMS expects that the **payment for traditional diagnostic mammograms under the MPFS will increase by nearly 40 percent over current OPPS rates**. Payment for digital diagnostic mammograms is expected to increase under the MPFS by about 60 percent over current rates under the OPPS.

- In addition, the proposed rule would decrease beneficiary liability for coinsurance for outpatient services. The rule proposes to **reduce the maximum coinsurance rate for any service to 45 percent of the total payment to the hospital in 2005, down from 50 percent this year**.
  - As a result, the average coinsurance rate would drop from 34 percent in 2004 to 32 percent in 2005.
  - Under the Medicare law the **cap on coinsurance rates is to be reduced gradually until all services have a coinsurance rate of 20 percent of the total payment**.

- The proposed rule would also implement provisions of the MMA designed to **speed beneficiary access to state-of-the-art treatments** and **strengthen the financial viability of hospitals in rural areas**.
  - For example, the rule **proposes a way for hospitals to receive payment for new drugs and biologicals as soon as they are approved by the FDA**, rather than having to wait several months until a code and payment rate are assigned.
  - In addition, the **proposed rule would continue into 2005 the Medicare modernization law provision that sets rates for brachytherapy sources on charges adjusted to cost**, and would create new definitions for new codes for high activity brachytherapy sources.
  - Brachytherapy is an advanced treatment for cancer that involves the placement of radioactive seeds near the tumor site, thus reducing the exposure of non-cancerous tissue to radiation.

- The proposed rule would **continue the current drug packaging policy, providing for separate payment for most drugs that cost more than $50 per administration**, rather than packaging them into the associated APCs.

- Also, as provided in the MMA, the proposed rule would **continue into 2005 the two-year extension of the "hold harmless" payments for small rural hospitals** having fewer than 100 beds, as well as for sole community hospitals in rural areas.
  - These payments, which were set to expire at the end of 2004, are intended to ensure that small rural hospitals are paid at least as much under the outpatient prospective payment system as they would have received under the cost-based payment methodology in effect before August 2000.

- CMS is proposing to **simplify how it pays for observation services for patients with asthma, congestive heart failure, or chest pain**.
  - In accordance with recommendations of an APC advisory panel, CMS is proposing to eliminate the current requirements specifying the diagnostic tests which must be used in connection with each diagnosis, and to modify the rules for reporting the times for the observation period to be more compatible with customary hospital practice.

- CMS is also proposing to use a number of strategies to **improve the accuracy for payments for blood and blood products used in outpatient departments in 2005**.
  - For example, CMS proposes a **new method for calculating appropriate payment rates**, and creating individual ambulatory payment classifications (APCs) for all blood products.

- The proposed rule would also **increase the number of claims used to calculate payments for low volume products by analyzing two years of claims**.

❖ The proposed rule would **target outlier spending to cases that have truly unexpected high costs**. This would be achieved by applying a fixed dollar threshold in addition to the current threshold based on a percentage relationship between the cost of the service and the payment for the APC.

- To be eligible for an outlier payment in the outpatient setting, the **cost of furnishing a service would have to exceed both thresholds**.
- The proposed rule sets these **thresholds at 1.5 times the payment of the APC and $625 over the APC payment rate**.

❖ The proposed rule will be published in the August 16 *Federal Register*. Comments will be accepted until October 8, 2004, and a final rule is scheduled to be published by November 1, 2004.

Note: For more information, visit the CMS Website at: www.cms.hhs.gov.