



TESTIMONY OF
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ON
MEDICARE PAYMENT FOR PART B DRUGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY & COMMERCE

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**Testimony of
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Before the
House Subcommittee on Health
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On
Payment for Imaging Services under the Medicare Physician Fee Schedule**

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Chairman Deal, Representative Brown, distinguished members of the Subcommittee; I thank you for the opportunity to discuss with you some of the changes in payment for imaging services under the Medicare physician fee schedule. Spending for these services has risen dramatically in the past several years, prompting a number of recommendations by the Medicare Payment Advisory Committee (MedPAC), some proposals by CMS, and subsequent actions by the Congress to address the increased spending associated with the rise in the volume and intensity of these services. We want to insure that Medicare's payment mechanisms encourage clinically appropriate use of resources and the highest quality of care, and we welcome input from you, the physician community, and other interested parties as we do so.

Background

Medicare spending for imaging services has been growing rapidly. Between 2000 and 2005, spending for imaging services paid under the physician fee schedule more than doubled from \$6.6 billion to \$13.7 billion, an average annual growth rate of 15.7 percent. This compares to an annual growth rate of 9.6 percent for all physician fee schedule services.

As we noted in a letter to MedPAC on April 7, 2006 (see table 1), while imaging services represented an estimated 14 percent of 2005 spending included in the sustainable growth rate calculation (SGR-related spending), they represented 27 percent of the total increase in such spending between 2004 and 2005. Spending for imaging services contributed 2.3

percentage points of the 8.5 percent increase in SGR-related spending reported in our April 7th letter to MedPAC. No other service category affects the increase in SGR-related spending so disproportionately.

Table 2 shows growth rates for imaging services for calendar years 2003, 2004 and 2005, overall and for four subcategories of imaging services: standard imaging, advanced imaging, echography, and imaging procedures. Overall, spending for imaging services grew at 16 percent per year for each of these years.

The “standard imaging” category includes services such as chest x-rays, contrast gastrointestinal imaging, nuclear medicine procedures, and PET scans. Spending for standard imaging procedures increased by an estimated eight percent during 2005 and by 43 percent from 2003 to 2005. This category represents an estimated five percentage points of the 14 percent share that imaging represents of 2005 SGR-related spending. This category contributes an estimated 0.4 percentage points to the 2.3 percent increase in imaging spending and to the 8.5 percent increase in SGR-related spending.

Spending for the “advanced imaging” category, comprised largely of CAT scans and MRI procedures grew by 25 percent during 2005 and 82 percent from 2003 to 2005. This category represents an estimated five percentage points of the 14 percent share that imaging represents of 2005 SGR-related spending. This category contributes an estimated 1.3 percentage points to the 2.3 percent increase in imaging spending and to the 8.5 percent increase in SGR-related spending.

The “imaging procedures” category includes services such as cardiac catheterization, fluoroscopy, and 3-D holographic reconstruction. Estimated spending for the imaging procedures category of services increased by 20 percent during 2005 and 47 percent from 2003 to 2005. This category represents an estimated one percentage point of the 14 percent share that imaging represents of 2005 SGR-related spending. This category contributes an estimated 0.1 percentage points to the 2.3 percent increase in imaging spending and to the 8.5 percent increase in SGR-related spending.

Estimated expenditures for the “echography” category of services increased by 17 percent during 2005 and grew 49 percent from 2003 to 2005. This category represents an estimated three percentage points of the 14 percent share that imaging represents of 2005 SGR-related spending. This category contributes an estimated 0.6 percentage points to the 2.3 percent increase in imaging spending and to the 8.5 percent increase in SGR-related spending.

No matter how one looks at it, Medicare spending for imaging services under the physician fee schedule is growing very rapidly and more rapidly than spending for other services tracked under the SGR system. While MedPAC suggested that some imaging services have shifted from being furnished in facilities, such as hospitals, to physicians’ offices, MedPAC also observed that about 80 percent of the growth in the volume and intensity of these services is unrelated to a shift in setting. The rapid increase in Medicare spending for imaging services, coupled with extensive geographic variation in their use, raises questions about whether such growth is appropriate and whether all imaging services are used appropriately.

Last week the Administration released the Mid-Session Review of the Budget. Part B spending was up from prior estimates. Spending for physicians’ services is estimated to have increased by 10 percent during 2005, and 7 percentage points of this growth was attributable to the volume and intensity of physicians’ services. The volume and intensity of physicians’ services has increased at rates of 6 to 7 percent per year for the past few years. Growth in spending for physicians’ services has been a notable contributor to the increases in the Part B premium. Rapid increases in spending for imaging services contribute significantly to the increase in spending for physicians’ services.

MedPAC Recommendations and the 2006 Medicare Physician Fee Schedule

Limiting Physician Self-Referrals

Section 1877 of the Social Security Act, known as the “Stark Law,” prohibits a physician from making a referral for certain designated health services, payable by Medicare or

Medicaid, to an entity with which the physician or one of his/her close family members has a financial relationship, unless one of a specific list of exceptions applies. Among other things, the statute defines designated health services to include “radiology services, including magnetic resonance imaging, computerized axial tomography and ultrasound services” and “radiation therapy services and supplies”.

In its March 2005 report to Congress, MedPAC recommended inclusion of nuclear medicine services in a list of services for which a physician is prevented from making a self-referral under Medicare and Medicaid.

In the notice of proposed rulemaking (NPRM) for the 2006 physician fee schedule, we pursued this MedPAC recommendation and proposed including diagnostic and therapeutic nuclear medicine procedures under the designated health services categories for radiology and certain other imaging services, and radiation therapy services and supplies, respectively. After considering comments on this proposal, we finalized this policy in the 2006 physician fee schedule final rule. To provide time for the industry to adjust, we deferred the effective date of this policy until January 1, 2007.

Despite this change, most physicians in groups that own imaging equipment will be able to continue to make self-referrals for imaging services within their own group by qualifying for one of the broader exceptions to the law -- the “in-office ancillary services” exception. Thus, defining a given service as a designated health service and making it subject to the prohibition against self-referrals does not mean that it will no longer be delivered pursuant to a self-referral in all cases. This change in policy will therefore be only partially effective in addressing growth in the volume and intensity of that particular type of imaging services.

Taking Efficiencies into Account

In general, payment amounts under the Medicare physician fee schedule are calculated using the assumption that each service is furnished independently. Prior to 2006, fee schedule payments for imaging did not take into account efficiencies that occur when

multiple services are furnished sequentially. For example, the fee schedule amounts for CT scans of the pelvis and abdomen are established as if each imaging service were the only one being furnished to a beneficiary during a given encounter. The March 2005 MedPAC report recommended reducing the technical component of fee schedule payments for multiple imaging services performed on contiguous body areas. The technical component of an imaging service captures the administration of the test; it does not include the professional interpretation of the test.

In the NPRM for the 2006 physician fee schedule, we proposed revising payment amounts for the technical component of certain imaging services in order to more accurately reflect the economies of subsequent procedures when multiple imaging services are furnished within one of 11 families of imaging procedures on contiguous body parts in the same session with the patient. Specifically, we proposed establishing payment amounts at 50 percent of the technical component of any subsequent imaging procedures performed on a single patient during a single session if the initial and subsequent services were performed on contiguous body parts within one of 11 families of imaging procedure codes. The 50 percent figure was based on our view that most of the clinical labor and supplies are not furnished twice. In response to comments on the proposal, we indicated in the final rule for the 2006 physician fee schedule that we planned to phase in the 50 percent reduction over two years, beginning with a 25 percent reduction in 2006. However, we indicated that we would continue to accept comments and any supporting information from the public, and consider whether it would be appropriate to modify the 50 percent payment reduction policy scheduled to take effect for 2007.

The statute requires that we make physician fee schedule changes, such as the multiple imaging policy, in a budget-neutral fashion relative to overall physician fee schedule expenditures. If changes result in increased spending compared to spending that would occur without them, then a reduction in payments is needed to achieve budget-neutrality. Similarly, if changes result in decreased spending compared to spending that would occur without them, an increase in payments for all services is needed to achieve budget-

neutrality. Since the multiple procedure policy resulted in a decrease in spending, we increased payments for all 2006 physician fee schedule services in order to achieve budget-neutrality.

Assumptions Used in Setting Fee Schedule Payments for Imaging

The methodology for determining practice expense relative values for services that involve equipment such as that used in furnishing imaging services involves assumptions about how frequently the equipment is used. In its September 30, 2005, comments on the NPRM for the 2006 physician fee schedule, MedPAC raised concerns about the equipment utilization assumption for imaging services.

CMS's method of calculating payments for the technical component of imaging services assumes that imaging equipment is used only 50 percent of the time. MedPAC suggested that imaging equipment could be assumed to be used more than 50 percent of the time, given the rapid growth in imaging services. In its June 2006 report to Congress, MedPAC continued its analysis of the equipment utilization assumption for imaging services and indicated: "If a machine is actually used most of the time, its cost is spread across more units of service, resulting in a lower cost per service than if it were operated half the time. Such equipment is currently overvalued by CMS". In its June 2006 report to Congress, MedPAC also raised questions about the estimates of the cost of capital to purchase equipment such as imaging equipment.

MedPAC argues that the upshot of CMS's equipment utilization and capital cost assumptions is that Medicare payments for imaging services are too high. The June 2006 MedPAC report indicates, "increasing the equipment use assumption and lowering the interest rate assumption would reduce PE payment rates for services like CT and MRI studies." The report contains a table with examples of alternative assumptions; payments for imaging services could be reduced by 40 to 50 percent with alternative assumptions. However, data to substantiate alternative equipment utilization assumptions are not available.

The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 contains two major provisions that directly affect Medicare payments for imaging services.

Eliminating Budget-Neutrality for the Multiple Imaging Policy

Subsequent to the publication of the final rule for the 2006 Medicare physician fee schedule, section 5102(a) the Deficit Reduction Act (DRA) of 2005 exempted the multiple imaging savings from budget-neutrality. In other words, the DRA requires that, for the 2007 physician fee schedule, we do not offset the savings attributable to the multiple imaging payment reduction policy for 2006 and 2007 by increasing payments for other physician fee schedule services in 2007.

The Hospital Outpatient Department Cap on Physician Fee Schedule Imaging Payments

DRA establishes caps on physician fee schedule payments for certain imaging services at the payment levels established in Medicare's hospital outpatient prospective payment system (OPPS). The provision requires that Medicare not pay more under the physician fee schedule than Medicare would pay under the OPPS for furnishing the same imaging procedure. This policy applies to the technical components of imaging services including X-ray, ultrasound, nuclear medicine, MRI, CT, and fluoroscopy services. A physician's interpretation of the test for which Medicare will pay a separate fee is not affected by the provision. Screening and diagnostic mammograms are exempt from this policy change. This policy will begin in 2007.

An example of how this policy works can be seen in the case of an MRI of the brain or an MRI of the abdomen. In 2006, the Medicare physician fee schedule payment is \$903 for the technical component of either of these MRIs. At the same time, Medicare pays hospital outpatient departments \$506 for the exact same test. Thus, Medicare is paying almost \$400 or 78 percent more for doing these MRI imaging tests purely depending on whether the test is performed in a hospital outpatient department or in a physician's office (or other setting paid under the physician fee schedule). These comparisons do not include a physician's interpretation of the test for which Medicare will pay a separate fee.

Among imaging procedures, there is little consistency in the percentage by which payments for the technical component under the physician fee schedule exceed payments under the OPPS. The percentage difference varies by procedure. We are still working on the proposed rules for 2007 for both OPPS and the physician fee schedule. The fee schedule NPRM will contain the specific impacts of the DRA imaging provision.

Conclusion

Medicare spending for imaging services has experienced very rapid growth. In addition, through 2006, Medicare is often paying significantly larger amounts under the physician fee schedule than the OPPS for the same imaging service furnished in the two different settings. MedPAC's analysis of assumptions used to calculate payment amounts indicates payments for imaging services under the physician fee schedule are too high. However, there is a lack of information to support alternative assumptions.

We will implement the DRA provisions through notice and comment rulemaking. NPRMs for OPPS and the physician fee schedule are expected to be published this summer. Final rules will be published this fall and will be effective for services furnished on or after January 1, 2007.

We realize that significant technological advances in imaging capabilities have made a difference in clinical practice and in the lives of patients. However, we want to ensure that our payment systems reflect clinically appropriate care and do not provide inappropriate incentives for growth in volume and intensity of services with limited clinical benefit. To that end, CMS will continue to work with the physician community, other interested parties, and the Congress as we refine our payments for medical imaging. I thank the Subcommittee for its time and look forward to answering any questions you might have.

Table 1: Spending Growth by Type of Service from 2004 to 2005

Type of Service	Growth Rate	Percent of Spending	Contribution to Increase	Percent of Increase
Evaluation and Management	7%	37%	2.6%	31%
Procedures	9%	26%	2.5%	29%
Imaging	16%	14%	2.3%	27%
Lab and Other Tests	11%	12%	1.3%	15%
Drugs (under the SGR)	-3%	9%	-0.3%	-4%
Other Services	20%	1%	0.3%	4%
Total	8.5%	100%	8.5%	100%

Source: Table 2 in April 7, 2006 letter from Herb Kuhn, Director, Center for Medicare Management, CMS to Glenn M. Hackbarth, Chair, MedPAC

Table 2: Spending Growth for Four Categories of Imaging Services

Types of Imaging Services	2003 Growth Rate	2004 Growth Rate	2005 Growth Rate	2003-2005 Growth	Percent of 2005 Spending	2005 Contribution to Increase
Standard Imaging	15%	15%	8%	43%	5%	0.4%
Advanced Imaging	20%	21%	25%	82%	5%	1.3%
Echography	13%	13%	17%	49%	3%	0.6%
Imaging Procedure	10%	11%	20%	47%	1%	0.1%
Total Imaging	16%	16%	16%	56%	14%	2.3%

Source: From Table 6 in April 7, 2006 letter from Herb Kuhn, Director, Center for Medicare Management, CMS to Glenn M. Hackbarth, Chair, MedPAC