

Medicare Minutes

CMS Needs Your Help to Fight Colorectal Cancer

The Centers for Medicare and Medicaid Services (CMS) needs your help to get the word out to your Medicare patients and their caregivers about the benefits of colorectal cancer screening. CMS asks that you encourage your eligible Medicare patients to take advantage of this potentially life-saving benefit. Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives.

Screening for colorectal cancer is recommended for all adults ages 50 and older, although screening may start at younger ages for individuals who are at high risk for colon cancer. The frequency of screening is based on an individual's risk for colorectal cancer and the type of screening test used.

An individual is considered to be at high risk for colorectal cancer if he or she has had colorectal cancer before or has a history of polyps, has a family member who has had colorectal cancer or a history of polyps, or has a personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis. In addition, risk for colorectal cancer increases with age. It is important to encourage patients who were screened before entering Medicare to continue with screening at clinically appropriate intervals.

Medicare Covers Screening Tests

Medicare covers the following screening tests to detect colorectal cancer early, when it is most treatable, and to identify people at high risk for developing this type of cancer:

- Fecal occult blood test (FOBT)—Medicare covers both guaiac and immunoassay tests, but Medicare will only pay for 1 FOBT each year.
- Colonoscopy—Medicare covers colonoscopy every 10 years for normal risk; more frequent-

ly for high-risk persons.

- Sigmoidoscopy—Medicare covers every 4 years.
- Barium enema—Medicare covers every 4 years for normal risk; every 2 years for high-risk persons.

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to Special Edition *MLN Matters* article SE0710 available at: www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf.

New Colorectal Screening Coverage for 2007!

Starting in January 2007, Medicare waived the requirement that beneficiaries meet the deductible for screening colonoscopy, sigmoidoscopy, or barium enema (as an alternative to colonoscopy or sigmoidoscopy). In addition, the coinsurance for colonoscopy and sigmoidoscopy is now 25% when performed in ambulatory surgical centers and non-outpatient prospective payment system hospital outpatient departments.

For specific details about these changes, see *MLN Matters* article MM5387 (coinsurance changes) at: www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf and *MLN Matters* article MM5127 (deductible change) at: www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf.

Premier Hospital Quality-Incentive Demonstration Extended

CMS has approved a 3-year extension of the Premier Hospital Quality Incentive Demonstration (HQID), a value-based purchasing project involving more than 250 hospitals across the country. The recently released Year 2 results of the demonstration show substantial improvement in quality of care across 5 clinical focus areas, with total gains over the first 2 years of 11.8%. (See "Bonus Pay Pays Off for Improved Quality" in *Medicare Patient Management*, March/April 2007, page 31.)

CMS will use the 3-year extension to test new incentive models and develop new ways to measure quality. The initial participating hospitals have reported process and outcome measures in 5 clinical areas—acute myocardial infarction (AMI), heart failure, coronary artery bypass graft (CABG), pneumonia, and hip and knee replacement—and have received incentive payments for providing high-quality care. During the first 3 years of the project, only top-performing hospitals have been eligible for incentive payments. The 3-year extension will test the effectiveness of offering incentive payments to hospitals achieving a defined level of quality, or quality threshold, and to hospitals achieving the greatest improvement in quality that also achieve the quality threshold. The extension will continue to track hospital performance in the 5 identified clinical focus areas, with flexibility to add quality measures and clinical conditions in the 5th and 6th years. New mortality and patient safety measures are among those that may be included.

Physician Quality Reporting Initiative Web Site

CMS has launched the 2007 Physician Quality Reporting Initiative (PQRI) Web page. PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services.

The Web page will be updated regularly, so check it often for timely and reliable information from CMS.

For more information on 2007 PQRI, visit www.cms.hhs.gov/pqri/ on the CMS Web site. Please also see page 22 of this issue for Dr. Rogers' (Medical Officer for CMS) discussion of the PQRI project. .

Medicare's Value-driven Health Care Initiative

The Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) project recently announced the participation of collaboratives in Arizona and California that will combine their claims data or

clinical information with that of Medicare to provide consistent measures of the quality of provider services.

The Arizona State University's Center for Health Information and Research and the California Cooperative Health Care Reporting Initiative join Indiana Health Information Exchange, Massachusetts Health Quality Partners, Minnesota Community Measurement, and Wisconsin Collaborative for Healthcare Quality.

"The measurement results from these collaboratives will ultimately provide information to Medicare beneficiaries about the quality of care physicians treating Medicare beneficiaries provide," said CMS Acting Administrator Leslie V. Norwalk. "It will also provide valuable performance information to physicians who treat Medicare beneficiaries, making it a win-win effort for both providers and people with Medicare."

Generic Drug Utilization on the Rise

Recent CMS data indicate that generic use is especially high among Medicare Part D beneficiaries, with generics accounting for 59.6% of the drugs dispensed to people in Medicare Prescription Drug Plans (PDPs) and Medicare Advantage (MA) plans through the third quarter of 2006.

According to the National Association of Chain Drug Stores (NACDS), generic dispensing increased among private third-party payers, growing by 9% over the past year—from 48.4% in 2005 to 52.6% in 2006. The recent CMS data demonstrate that generic use among those enrolled in the Medicare drug benefit is 13% higher than among those enrolled in private third-party payer plans.

For Part D enrollees who are concerned about the coverage gap, generics can lower costs and thus delay reaching the gap or help avoid it altogether. The new Medicare data mark the third consecutive quarter of growth in generic utilization among those in the Medicare prescription drug benefit.

US Prescription Sales Up 8.3% in 2006

According to a March IMS Health report, US prescription drug sales grew 8.3% to \$274.9 billion in 2006. Growth was fueled by the Medicare Part D prescription benefit, the increased utilization of generics within new

therapy classes, and the launch of new drugs targeted to specific diseases such as cancer and diabetes. Total US dispensed prescription volume grew at a 4.6% pace compared with an increase of 3.2% in 2005.

“Demand for pharmaceutical products in the world’s largest pharmaceutical market grew significantly for the third straight year,” said Diana Conmy, corporate director, IMS Market Insights. “This growth was driven by factors that include an aging population and the introduction of the Medicare prescription drug benefit, which increased prescription coverage to the previously uninsured and underinsured, and provided generous plan benefits to seniors.”

Looking ahead, IMS expects US prescription sales growth to decline in 2007 but remain in the range of 6% to 9% compounded annual growth through 2010 as the Medicare Part D benefit is annualized and more generic products enter the market, driving the cost of prescriptions lower.

Medicare Part D was an important contributor to

Medicare Part D was an important contributor to strong pharmaceutical sales growth in 2006, lifting sales by about 1%.

strong pharmaceutical sales growth in 2006. According to CMS, more than 38 million Medicare beneficiaries had some form of prescription drug coverage by June 2006. Although a sizeable number of beneficiaries without coverage—approximately 3 million—did not enroll, those who were previously uninsured benefited from access to needed medicines at a more affordable cost. This federal program lifted retail prescription volume by an estimated 1% to 2% and pharmaceutical sales by just under 1%.

CMS, wanting to maximize access to Part D, required insurers to reimburse for substantially all of the brands in 6 large, highly utilized classes including antidepressants, antipsychotics, anticonvulsants, antiretrovirals, antineoplastics, and immunosuppressants. Because of this requirement, these classes together comprised nearly one fifth of US pharmaceutical sales in 2006.

Prescriptions dispensed through a Medicare Part D

program accounted for 17% of retail prescriptions by year end. Of the top 20 products dispensed by Medicare Part D prescription volume, 15 were unbranded generic drugs. By the end of 2006, utilization of unbranded and branded generics through Medicare Part D accounted for 63% of all dispensed prescriptions.

“Medicare Part D clearly was the most significant event to occur within the industry in 2006,” stated Gerhard Gallwitz, vice president of managed care for IMS. “Consumers found the program especially beneficial because it offered greater choices and better access to medicines with fewer formulary restrictions than commercially available plans. For pharmaceutical manufacturers, Medicare Part D helped increase product demand through a larger pool of patients with prescription drug coverage.”

Report Indicates that 21,000 Medicare Providers Owe Taxes

Following a 9-month investigation, the Government Accountability Office (GAO) recently issued a report that more than 21,000 providers of Medicare’s physician and outpatient services failed to pay more than \$1 billion in taxes owed through September 2005. According to the report, Medicare providers failed to pay \$430 million in payroll taxes, \$523 million in individual income taxes, and \$93 million in other taxes such as corporate income and employment taxes.

CMS Medicare, which is funded through corporate, individual, and payroll taxes, has no explicit authority to deny physicians the right to participate in Medicare if they have tax debt and does have the authority to issue payments without going through the Financial Management Service (FMS). FMS, a bureau of the Treasury Department, provides central payment services to federal agencies, operates the federal government’s collections and deposit systems, provides government-wide accounting and reporting services, and manages the collection of delinquent debt owed to the government.

“We are very concerned about this issue and are working hard with the Department of Treasury and the Internal Revenue Service to ensure that we do not overpay providers or other entities who owe the IRS money,” said Leslie V. Norwalk, CMS acting administrator. She said HHS has no authority to “deny physicians the right to participate in Medicare if they have tax debt.”

MPM