



AMA Summary and Analysis: 2012 Medicare Physician Payment Proposed Rule

On July 1, the Centers for Medicare and Medicaid Services (CMS) published a proposed regulation detailing Medicare physician payment policies for 2012. The rule, which is open for comment until close of business on Aug. 30, 2011, confirms that unless Congress intervenes, Medicare's physician conversion factor will fall next January by 29.5%--from the current \$34.01 to \$23.96.

In a statement accompanying the release, CMS Administrator Don Berwick, MD, acknowledged that a cut "would have serious consequences," and expressed the Administration's determination to pass "a permanent SGR fix to solve this problem once and for all." The rule provides no information on how the Administration intends to accomplish this though it does reassert last year's promise to look at potentially helpful changes in the Medicare Economic Index (MEI) used to calculate physician cost inflation.

In response to primary care physicians' continued concerns regarding payments for their services, the proposed rule calls on the AMA/Specialty Society RVS Update Committee (RUC) to review 91 evaluation and management (E/M) codes that CMS thinks may be undervalued and 70 high volume, high dollar services the agency believes may be over-valued. The rule also would impose new payment cuts on advanced imaging services, modify the way geographic practice cost indexes (GPCIs) are calculated, make the electronic prescribing incentive program more flexible, align quality measures in the electronic health record incentive program and the physician quality reporting system, and establish 2013 as the base year for determining value-based payment modifiers in 2015. A summary of major provisions in the rule follows:

Potentially Misvalued Codes

As noted in the proposed rule, "in recent years CMS and the RUC have taken increasingly significant steps to address potentially misvalued codes" and since 2009 have reviewed over 700 such codes identified through the use of objective screens such as whether a service is now typically done on an outpatient rather than an inpatient basis. All told, the AMA estimates that about \$1.5 billion has been redistributed among services as a result of these reviews which have been conducted in addition to four comprehensive five-year reviews.

While values for the major (E/M) codes were increased significantly in the 2006 five-year review, CMS says a new review is warranted due to primary care's evolution to a more comprehensive care management focus. At the same time, the agency is calling on the RUC to review a "select list of high expenditure procedural codes" that may have dropped in value since the last review. Half of each category would be reviewed in 2012 and half in 2013 and some either have been or are scheduled for review as part of the RUC's misvalued code initiative. In addition, CMS wants to eliminate future five-year reviews and incorporate the publically nominated reviews normally handled through that process into the annual reviews.

Multiple Procedure Payment Reduction

Currently, Medicare applies a multiple procedure payment reduction to a number of services, including certain CT, MRI, and ultrasound tests whenever two or more procedures are provided by the same physician to the same patient on the same day. The policy, in which Medicare makes full payment for one procedure and then cuts payment for all additional tests by 50 percent, currently is applied only to the test itself (technical component). However, CMS is now proposing to extend the policy to the professional component, or physician interpretation of the test. According to the impact statement that accompanies the rule, this would reduce payments to the affected services by about \$100 million a year, thereby leading to modest increases for other services. The Medicare Payment Advisory Commission has also recommended this policy change. However, the RUC's review of codes that are generally performed at the same time indicates that the amount of duplication varies across codes and rarely amounts to 50 percent.

GPCI Changes

The proposed rule includes a number of changes in the GPCIs, including reweighting the work, practice expense and professional liability components so that a larger share is assigned to practice expense and less to work. In addition, CMS wants to replace two of the data sources used in the calculation of the practice expense GPCI and make regional adjustments in certain purchased services. GPCIs will also be affected by the expiration of the legislation that created a floor on the work GPCI and the completion of the two-year phase-in of the sixth regular GPCI update. None of the recommendations recently made by the Institute of Medicine (IOM) are included in the proposal and CMS says it will not propose any of these changes until the IOM's study is completed.

Electronic Prescribing

The AMA has repeatedly expressed concerns to CMS about the e-prescribing incentive program. While we have made headway, we will continue to press CMS to make changes in the program so that physicians will not be penalized during 2012. On a positive note, physicians will only have to report the e-prescribing code 25 times each year to receive the incentives for 2012 and 2013. Physicians can also use a certified electronic health record (EHR) to e-prescribe. Just as in 2011, there will be only one G-code (G8553) to report, a reporting option for qualified group practices, and an option of submitting e-prescribing data through claims or a qualified registry or EHR product. The rule also outlines policies regarding the penalties for 2013 and 2014.

Physician Quality Reporting System (PQRS)

The incentive payment for successful participation in the 2012 PQRS is 0.5 percent of an eligible professional's Medicare Part B charges for the reporting period. CMS is proposing a number of changes to the PQRS, including: consolidating group reporting options into a single option which defines a group as 25 or more eligible professionals; eliminating the six-month reporting period for individual measures; adding 26 new individual measures and 10 new measures groups; providing interim feedback reports for those reporting through claims based reporting; including an EHR-based reporting option that is identical to the reporting requirements for clinical quality measures under the EHR incentive program; and allowing eligible professionals to qualify for an additional 0.5 percent incentive payment if they participate "more frequently" in either the education and self-assessment program, secure examination, or practice assessment Maintenance of Certification.

Physician Feedback and Value-Based Payment Modifier

Under the Affordable Care Act, CMS is required to begin making "value-based payment adjustments" to some physicians in 2015 and to all physicians by 2017. The groundwork for this adjustment is being laid in the physician feedback reports that the agency began piloting in 2009. In the current phase of the pilot, CMS is providing reports that include both quality and cost data to 36 group practices and their approximately 1650 individual physicians. The program would be expanded to 100,000 physicians in 2012. In 2013, performance as measured in the feedback reports would become the basis for determination of the value-based modifiers in 2015. This appears to start counting performance a year earlier than the law required and it is not yet clear whether it could be applied to all physicians by that time. CMS is seeking input on potential quality measures to be included in the feedback reports and value-based payment adjustment and is particularly interested in "quality measures that assess the care provided by specialists. Initially, the cost side of the value-based modifier would be based on total per capita cost and per capita costs for chronic obstructive pulmonary disease, heart failure, coronary artery disease and diabetes. Future plans include the use of episode groupers and a measure based on inpatient hospital diagnostic groups.

Other provisions in the proposed rule would:

- Add a health risk assessment to be used in conjunction with the annual wellness visits initiated in Medicare this year.
- Expand the list of covered telehealth services to include smoking cessation and modify the criteria for adding services to the telehealth list so that they no longer have to be equivalent to a corresponding in-person service.
- Move to the third year of a four-year transition to new practice expense values based on data from the Physician Practice Information Survey.

- Substitute 103 percent of the average manufacturer's price for certain drugs currently paid at 106 percent of the manufacturer's average sales price.

Excerpt from pages 559-560 of the Proposed Rule:

The following is an explanation of the information represented in Table 64:

- Column A (Specialty): The Medicare specialty code as reflected in our physician/supplier enrollment files.
- Column B (Allowed Charges): The aggregate estimated PFS allowed charges for the specialty based on CY 2010 utilization and CY 2011 rates. That is, allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Column C (Impact of Work and Malpractice (MP) RVU Changes): This column shows the estimated CY 2012 impact on total allowed charges of the changes in the work and malpractice RVUs, including the impact of changes due to potentially misvalued codes. These impacts are primarily due to the multiple procedure payment reduction (MPPR) for the professional component of advanced imaging services.
- Column D (Impact of PE RVU Changes - Full): This column shows the estimated CY 2012 impact on total allowed charges of the changes in the PE RVUs if there were no remaining transition to the full use of the PPIS data.
- Column E (Impact of PE RVU Changes - Tran): This column shows the estimated CY 2012 impact on total allowed charges of the changes in the PE RVUs under the third year of the 4-year transition to the full use of the PPIS data. This column also includes the impact of the MPPR policy and, and the impact of changes due to potentially misvalued codes.
- Column F (Combined Impact - Full): This column shows the estimated CY 2012 combined impact on total allowed charges of all the changes in the previous columns if there were no remaining transition to the new PE RVUs using the PPIS data.
- Column G (Combined Impact - Tran): This column shows the estimated CY 2012 combined impact on total allowed charges of all the changes in the previous columns under the third year of the 4-year transition to the new PE RVUs using the PPIS data.

TABLE 64: CY 2012 PFS PROPOSED RULE TOTAL ALLOWED CHARGE ESTIMATED IMPACT FOR RVU AND MPPR CHANGES*

Specialty (A)	Allowed Charges (mil) (B)	Impact of Work and MP RVU Changes (C)	Impact of PE RVU Changes		Combined Impact	
			Full (D)	Tran (E)	Full (F)	Tran (G)
TOTAL	\$83,014	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$194	0%	1%	1%	1%	1%
ANESTHESIOLOGY	\$1,847	0%	4%	2%	4%	2%
CARDIAC SURGERY	\$384	0%	-2%	-1%	-2%	-1%
CARDIOLOGY	\$6,778	0%	-3%	-1%	-3%	-1%
COLON AND RECTAL SURGERY	\$146	0%	2%	1%	2%	1%
CRITICAL CARE	\$252	0%	1%	0%	1%	0%
DERMATOLOGY	\$2,931	0%	0%	0%	0%	0%
EMERGENCY MEDICINE	\$2,658	0%	-1%	-1%	-1%	-1%
ENDOCRINOLOGY	\$415	0%	1%	0%	1%	0%
FAMILY PRACTICE	\$5,640	0%	2%	1%	2%	1%
GASTROENTEROLOGY	\$1,837	0%	1%	0%	0%	0%
GENERAL PRACTICE	\$656	0%	2%	1%	2%	1%
GENERAL SURGERY	\$2,277	0%	1%	0%	1%	0%
GERIATRICS	\$200	0%	2%	1%	2%	1%
HAND SURGERY	\$121	0%	3%	1%	2%	1%
HEMATOLOGY/ONCOLOGY	\$1,912	0%	-1%	0%	-2%	0%

Specialty (A)	Allowed Charges (mil) (B)	Impact of Work and MP RVU Changes (C)	Impact of PE RVU Changes		Combined Impact	
			Full (D)	Tran (E)	Full (F)	Tran (G)
INFECTIOUS DISEASE	\$597	0%	1%	1%	1%	0%
INTERNAL MEDICINE	\$10,737	0%	1%	1%	1%	1%
INTERVENTIONAL PAIN MGMT	\$448	0%	3%	2%	2%	1%
INTERVENTIONAL RADIOLOGY	\$211	-1%	-3%	-1%	-4%	-2%
MULTISPECIALTY CLINIC/OTHER	\$84	1%	1%	1%	2%	1%
NEPHROLOGY	\$2,011	0%	0%	0%	0%	0%
NEUROLOGY	\$1,520	0%	4%	2%	4%	2%
NEUROSURGERY	\$669	0%	1%	0%	1%	0%
NUCLEAR MEDICINE	\$53	0%	-4%	-2%	-5%	-3%
OBSTETRICS/GYNECOLOGY	\$678	0%	0%	0%	0%	0%
OPHTHALMOLOGY	\$5,316	0%	3%	2%	3%	2%
ORTHOPEDIC SURGERY	\$3,572	0%	2%	1%	2%	1%
OTOLARNGOLOGY	\$1,001	0%	2%	1%	1%	1%
PATHOLOGY	\$1,122	0%	-2%	-1%	-2%	-1%
PEDIATRICS	\$68	0%	1%	1%	1%	1%
PHYSICAL MEDICINE	\$928	0%	3%	2%	3%	2%
PLASTIC SURGERY	\$339	0%	2%	1%	1%	0%
PSYCHIATRY	\$1,134	0%	0%	0%	0%	0%
PULMONARY DISEASE	\$1,758	0%	1%	0%	1%	0%
RADIATION ONCOLOGY	\$1,968	0%	-8%	-4%	-8%	-4%
RADIOLOGY	\$4,722	-1%	-5%	-2%	-6%	-4%
RHEUMATOLOGY	\$530	0%	0%	0%	0%	0%
THORACIC SURGERY	\$371	0%	-2%	-1%	-1%	-1%
UROLOGY	\$1,919	0%	-3%	-2%	-3%	-2%
VASCULAR SURGERY	\$749	0%	-2%	-1%	-2%	-1%
AUDIOLOGIST	\$56	0%	-6%	-3%	-6%	-3%
CHIROPRACTOR	\$743	0%	2%	1%	2%	1%
CLINICAL PSYCHOLOGIST	\$559	0%	-5%	-3%	-5%	-3%
CLINICAL SOCIAL WORKER	\$386	0%	-6%	-3%	-6%	-3%
DIAGNOSTIC TESTING FACILITY	\$833	0%	-8%	-2%	-8%	-3%
INDEPENDENT LABORATORY	\$1,047	0%	-3%	-1%	-3%	-1%
NURSE ANES / ANES ASST	\$769	0%	5%	2%	5%	2%
NURSE PRACTITIONER	\$1,376	0%	2%	1%	2%	1%
OPTOMETRY	\$980	0%	4%	2%	4%	2%
ORAL/MAXILLOFACIAL SURGERY	\$43	0%	2%	1%	2%	1%
PHYSICAL/OCCUPATIONAL THERAPY	\$2,324	0%	5%	3%	5%	3%
PHYSICIAN ASSISTANT	\$1,055	0%	1%	0%	1%	0%
PODIATRY	\$1,902	0%	3%	2%	3%	2%
PORTABLE X-RAY	\$97	0%	4%	3%	4%	3%
RADIATION THERAPY CENTERS	\$73	0%	-9%	-5%	-9%	-5%
OTHER	\$17	0%	5%	4%	5%	4%

* Table 64 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the January 2012 conversion factor change under current law.