AMA summary and analysis:

2011 Medicare Physician Payment Proposed Rule

July 1, 2010

The Centers for Medicare & Medicaid Services (CMS) recently released a proposed regulation detailing Medicare physician payment policies for 2011. The rule is scheduled for publication in the *Federal Register* on July 13, 2010, and is open for comment until August 24, 2010. At 1,250 pages, the rule includes both the standard annual update to the Medicare payment schedule and implementation of many provisions of the Affordable Care Act (ACA.) The following summary touches on the issues that are likely to be of most interest to physicians but does not review every element of the entire proposed rule.

2011 update and Medicare Economic Index (MEI)

When the legislation that temporarily replaced the 21 percent cut with a 2.2 percent increase expires, physicians face a 23 percent cut on December 1, 2010. The proposed rule estimates that the 2011 MEI will be 0.3 and that there will be an additional 6 percent payment reduction on January 1, 2011.

For years, the AMA has argued that the MEI, which measures practice cost increases tied to the composition of a 1973 medical practice, does not adequately reflect the costs of care in 2010. **In response to AMA advocacy, the proposed rule contains a welcome provision announcing CMS's intent to convene a technical panel to review all aspects of the MEI and inviting comments on issues to be considered by the panel.** At the same time, however, the rule appears to jump ahead of the technical panel's recommendations with a proposal to eliminate some current MEI cost categories and add others next year.

CMS also intends to "rebase" the MEI using 2006 data collected in the Physician Practice Information survey that is also being used to update practice expense values. The impact of this change is to increase index weights for practice expense and professional liability insurance (PLI) and reduce them for physician work. This then triggers increases in practice expense and PLI relative value units but, rather than reducing work relative values to offset the practice expense and PLI increases, the offsets would be applied to the conversion factor. This approach will generally increase payments for specialties with high expenses and reduce them for those with lower expenses (see attached impact table). It also results in another 7.9 percent reduction in the conversion factor on top of the previously mentioned 23 percent and 6 percent cuts. While the AMA will continue to analyze this proposal, we have questions about both the substance and the timing of the proposed changes and

the wisdom of adopting them in advance of the technical panel's more comprehensive review of the MEI.

Physician Quality Reporting Initiative (PQRI)

The AMA has strongly advocated for key improvements to the PQRI program. **As a result, CMS is proposing to lower the PQRI threshold for claims-based reporting of individual measures from 80 percent to 50 percent, so more physicians will be able to successfully report and qualify for incentive payments.** In addition, the proposed rule implements ACA provisions to ensure timely feedback and establish an informal appeals process. PQRI bonus payments will apply from 2011 through 2014 for physicians that satisfactorily report PQRI measures. For 2011, the bonus for successful reporting is one percent. An additional bonus payment of 0.5 percent per year is available for those who participate in a maintenance of certification (MOC) program required for board certification by a recognized physician specialty organization for at least one year, and complete an MOC practice assessment. Other key AMA-supported PQRI provisions in the proposed rule include:

- New 2011 PQRI care coordination measures developed by the Physician Consortium for Performance Improvement (PCPI);
- lowering the threshold for the group practice reporting option so that groups with less than 200 physicians, including as few as two, may qualify to participate; and
- ensuring that the 2011 PQRI offers additional measures for electronic prescribing so that additional physician specialties can participate using this reporting modality.

PQRI penalties will begin in 2015 for those who do not satisfactorily submit quality data. The AMA, consistent with our policy, will continue to aggressively work with Congress to delay penalties until the PQRI has been refined to be more efficient and physician friendly.

As required by the ACA, CMS will develop a Physician Compare web site by January 1, 2011, where the names of physicians and groups that successfully participate in PQRI will be posted. The AMA supports CMS's proposal not to publicly report any individual or group performance information for the 2011 PQRI, although such reporting is required by law in future years.

Electronic prescribing incentive payments

To qualify for Medicare e-prescribing incentive payments equal to one percent of their total Medicare Part B charges, eligible physicians need to report the e-prescribing measure for at least 25 visits during 2011. The AMA successfully persuaded CMS to reduce the e-prescribing reporting burden from 50 percent of all applicable services to reporting just 25 times. Similar to 2010, physicians have several options for reporting e-prescribing information and certain group practices can participate as well. Physicians who participate in the 2011 Medicare electronic health records incentive program cannot simultaneously participate in the 2011 e-prescribing incentive program.

CMS proposes that eligible physicians who fail to participate in the 2011 e-prescribing incentive program and do not qualify for an exemption would be subject to financial penalties starting in 2012. **The AMA will urge CMS to revise the penalty program so that financial penalties are based on lack of e-prescribing activity in 2012, not 2011, which is consistent with the law.** The AMA will also recommend that the exemption from penalties category be broadened.

Practice expense and PLI relative values

During 2011, the data from the Physician Practice Information (PPI) Survey will continue to be phased in. Practice expense relative values will be computed utilizing a 50/50 blend of the prior practice expense relative values based on the SMS and supplemental survey data and the new practice expense relative values utilizing the PPI Survey data.

CMS will fully implement the ACA equipment utilization provision on January 1, 2011. An equipment utilization rate of 75 percent will be used for diagnostic imaging services using CT and MRI scanners, including an expansion to angiography when used with these modalities. Also per the ACA, the technical component multiple procedure payment reduction for multiple imaging studies performed in a single imaging session on contiguous body parts increases from 25 to 50 percent effective July 1, 2010. CMS estimates that this ACA provision, coupled with the equipment utilization change to 75 percent, will save Medicare $160 million in 2011.

CMS will implement recommendations from the AMA/Specialty Society RVS Update Committee (RUC) to correct direct practice expense inputs for several services. Also, in response to a RUC recommendation that CMS review the pricing of high cost disposable medical supplies on a more frequent basis, utilizing input from the national medical specialty societies, CMS will re-price the 62 supplies that currently cost more than $150 every two years, starting in 2011. CMS proposes to utilize the United States General Services Administration (GSA) medical supply schedule, augmented by comments and documentation received through the public comment process. A process for requesting supply and equipment price modifications is also outlined, and a number of technical corrections to address minor errors in the CMS direct practice expense database are proposed.

CMS will make the process of assigning PLI relative values for new and revised CPT codes more transparent and will allow comment on the underlying assumptions for specific codes. The RUC has submitted relevant crosswalks to utilize for this purpose and will continue to discuss this methodology with CMS.

Potentially misvalued services

CMS acknowledges the significant progress of the RUC and the agency in addressing potential misvaluation within the RBRVS, noting the statement in the March 2009 MedPAC report to Congress, “CMS and AMA RUC have taken several steps to improve the review process.” The ACA identified seven categories of potentially misvalued services and CMS explains that the RUC has identified and reviewed numerous services in all seven categories. CMS solicits comments on possible approaches and methodologies to further validate data collected in the valuation process. CMS specifically mentions the desire for public comments regarding the use of time and motion studies “to validate estimates of physician time and intensity that are factored into the work RVUs for services with rapid growth in Medicare expenditures.”

As part of the ongoing effort to address potentially misvalued services, CMS is requesting the RUC to review services that fall into five categories: high volume/cost items on the RUC’s Multi-Specialty Points of Comparison (e.g., cataract surgery, colonoscopy); codes with low work RVUs commonly reported with multiple units (e.g., allergy tests); codes with high volume and low work RVUs (e.g., X-ray exams); site-of-service anomalies (i.e., services initially performed inpatient that have migrated to outpatient); and 23+ hour stay services.

The RUC is engaged in ongoing discussions with CMS regarding valuation of approximately 20 physician services that require an overnight stay, but are categorized in Medicare claims data as "outpatient." In this rule, CMS acknowledges that this phenomenon does occur and that the physician work related to the post-procedure effort on the additional hospitals days should be recognized. Ongoing CPT and valuation solutions are being explored to best address this issue.

Multiple procedure payment reductions

Effective January 1, 2011, CMS proposes to expand the multiple procedure payment reduction (MPPR) to CT and CTA, MRI and MRA and ultrasound procedures provided to a patient in the same session, regardless of the imaging modality, and not limited to contiguous body parts. Although CMS acknowledges that it is highly unlikely that a physician would provide more than one advanced imaging service involving two different modalities (e.g., MRI and CT) to the same patient on the same date, it plans to implement a 50 percent reduction to account for the perceived efficiencies in the cost of performing the subsequent services. The AMA has serious concerns about this proposal as the efficiencies in this situation are most likely related to a few minutes of clinical staff time saved on retrieving records and greeting the patient and a 50 percent reduction seems unwarranted.

CMS proposes an aggressive modification to the payment for therapy services. Beginning on January 1, 2001, CMS will apply a 50 percent payment reduction to the practice expense component of the second and subsequent therapy services furnished to a patient on the same day. The basis for this proposal is a report from the General Accounting Office (GAO) that asserted that efficiencies occur when more than one unit of therapy service is reported on the same date. The AMA had previously argued that the GAO assumptions were flawed as physical therapy services are designed by CPT to be reported with multiple units, each based on 15 minutes of a physical therapist's face-to-face time with the patient.

Geographic adjustments

The proposed rule makes a number of changes to the geographic practice cost indexes (GPCIs). The ACA extended the floor of 1.00 on the work GPCI just through 2010, so the 2011 proposed GPCIs do not incorporate this floor. The ACA also required that the PE GPCIs only reflect ½ of the geographic differences in employee wages and rents for 2010 and 2011, except in localities where this would reduce payments, and it established a permanent, non-budget neutral floor of 1.00 on the PE GPCI for five frontier states.

In addition, the ACA also required CMS to evaluate certain aspects of the PE GPCIs and implement indicated revisions no later than January 1, 2012. Specifically, CMS was asked to analyze the office expense component of the PE GPCI, the weights that are assigned to the various components, and the feasibility of using actual data, for example, office rent data, in place of proxies like apartment rental data. The original law establishing the Medicare payment schedule required CMS to update the GPCIs every three years. **Instead of waiting until the 2012 payment schedule, in the proposed rule for 2011, CMS has combined the ACA-required review with the 2011 regular update of the GPCI data.** Several changes have been made, such as using employee wage data from the Bureau of Labor Statistics instead of the 2000 Census, which has become dated, and using Physician Practice Information survey data to update the weights of the different elements. As required by law, the GPCI updates are being phased in over two years, in 2011 and 2012.

The percentage changes from the 2010 to 2011 geographic adjustment factors are displayed in Addendum D. The 2010 GPCIs and the 2011 and 2012 proposed GPCIs are shown in Addendum E. Because there are so many different changes to the GPCIs occurring at one time, it is not possible to differentiate their various effects on locality payments. For example, increases and decreases in geographic adjustments from 2010 to 2011 could be driven by the expiration of the work GPCI floor, the change to BLS data, or a combination.

Disclosure requirement for in-office ancillary services

The proposed rule implements an ACA provision requiring physicians whose practices both refer patients for and also provide MRI, CT and PET scans to inform patients that they may obtain the services from other providers and furnish them with a list of those providers in their area. CMS proposes that at the time of the referral for these services, the referring physician must provide the patient with a written list of at least 10 alternate suppliers of the services within 25 miles of the physician's office. If there are fewer than 10 alternate suppliers, then the referring physician will need to list all of the alternate suppliers within 25 miles. If there are no alternative suppliers, CMS proposes that the referring physician document that they have disclosed to the patient that they may receive the services from another supplier but not provide a list. The disclosure requirements will become effective on January 1, 2011, following issuance of the final rule.

Preventive services

As required by the ACA, CMS proposes Medicare coverage and payment policies for annual preventive visits including development of personalized prevention plans. CMS proposes two new services, one for the patient's first annual preventive visit, which is distinct from and must occur at least 12 months after the patient's "Welcome to Medicare" physical, and a second code for subsequent annual preventive visits. Relative values for the first annual visit are linked to code 99204, a level 4 new patient office visit, and subsequent visits are linked to code 99214, and level 4 established patient office visit.

The rule also implements ACA provisions eliminating cost-sharing for Medicare-covered preventive services with a grade of A or B from the U.S. Preventive Services Task Force. For these services, which include flu and pneumonia immunizations and most cancer screening, the Medicare program will pay physicians 100 percent of the payment schedule amount and patients will not be responsible for the usual 20 percent copayment. Some Medicare preventive services do not have a grade of A or B, however, including diabetes self-management training and glaucoma screening, so patients will continue to be responsible for cost-sharing for these services.

Bonus payments for primary care practitioners

The ACA provides for a 10 percent payment bonus to some primary care practitioners with more than 60 percent of their Medicare allowed charges attributable to a defined set of nursing home and outpatient visits. The bonus will apply to the same set of visit codes and will be made on a quarterly basis.

A key issue has involved the identification of which practitioners will be eligible for the bonuses. Some had interpreted the law to say that bonuses were available to any internist (including sub-specialists) who met the threshold while others believed it was restricted to general internists. In the rule, CMS says that to be eligible, physicians must have met the 60 percent threshold in 2009 and must have listed family practice, internal medicine, pediatrics, or geriatrics as their primary specialty designation at the time the service was provided. Several non-MD/DO groups, including nurse practitioners and physicians assistants, are also eligible. The threshold will be calculated as a percentage of all Part B allowed charges, including lab and other ancillary services, which is expected to greatly limit the number of physicians who qualify.

Eligibility will be redetermined each year based on claims patterns and specialty designations from two years earlier. This means new physicians will not be eligible until two years after they enroll in Medicare, although CMS is looking for suggestions on how to get around this problem. The agency will be monitoring requested modifications in specialty designations

Bonus for major surgical procedures in shortage areas

As is also required under the ACA, the rule contains a proposal to pay a 10 percent bonus to general surgeons for some 4,300 major surgical procedures when they are furnished in an area that the government has designated as a health professions shortage area. These payments also will be made on a quarterly basis. To qualify, physicians must have designated general surgery as their primary specialty and CMS will be closely watching for specialty switching here as well.

Confidential feedback reports and value-based modifier

In the ACA, Congress directed CMS to refine and expand its current efforts to provide confidential feedback reports comparing the cost and quality of care across physicians and to use this data to create a value-based payment modifier by 2015. As required under a prior law, the agency has done some limited testing with confidential feedback reports based on existing commercial software to compare resource use for different types of care episodes. As noted in the rule, CMS found these groupers “do not work well” for beneficiaries with chronic conditions and has been directed by Congress to create a Medicare-specific, transparent method of grouping episodes by January 1, 2012. Until that software exists, CMS intends to provide physicians with feedback reports showing how they compare to their peers on total costs per Medicare beneficiary and total costs of treatment with any of the following five conditions: diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease and prostate disease. The rule also lays out CMS’s current thinking regarding attribution methods, integration of cost and quality data, risk adjustment, minimum number of patients to be included in comparisons, and other statistical issues.

Impacts

Table 73 of the proposed rule displays specialty impact estimates and is reprinted on the following page. This table does not include the impact of the SGR-driven pay cuts scheduled for December 1, 2010 and January 1, 2011 under current law. Column D shows the impact of the practice expense changes and multiple procedure reductions at the completion of the practice expense transition, and column E shows the impact of these policy changes for 2011, which are moderated by the continuing phase-in of the practice expense changes. There is no transition for the equipment utilization requirement from the ACA or for the multiple procedure payment reductions. Among physician specialties, the 2011 impacts in column E range from a 3 percent increase for ophthalmology to a 6 percent decrease for radiology. The impact of the proposed rebasing of the MEI is shown in column F and, for physician specialties, ranges from a 4 percent increase for radiation oncology to a 3 percent cut for anesthesiology, emergency medicine and psychiatry. Column H shows the combined impacts of all the 2011 changes, which range from an increase of 4 percent for allergy/immunology to a decrease of 6 percent for radiology.

(See table on next page)

TABLE 73: CY 2011 PFS Proposed Rule Total Allowed Charge Estimated Impact for RVU, MPPR, and MEI Rebasing Changes*

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Specialty	Allowed Charges (mil)	Impact of Work and MP RVU Changes	Impact of PE RVU and MPPR Changes		Impact of MEI Rebasing	Combined Impact	
			Full	Tran		Full	Tran
TOTAL	$79,731	0%	0%	0%	0%	0%	0%
01-ALLERGY/IMMUNOLOGY	$176	0%	0%	0%	4%	4%	4%
02-ANESTHESIOLOGY	$1,729	0%	3%	1%	-3%	0%	-2%
03-CARDIAC SURGERY	$373	0%	-1%	0%	0%	-1%	0%
04-CARDIOLOGY	$6,801	0%	-5%	-2%	0%	-5%	-2%
05-COLON AND RECTAL SURGERY	$134	0%	4%	1%	0%	4%	1%
06-CRITICAL CARE	$233	0%	2%	1%	-2%	0%	-1%
07-DERMATOLOGY	$2,678	0%	1%	1%	2%	3%	3%
08-EMERGENCY MEDICINE	$2,527	0%	1%	1%	-3%	-2%	-2%
09-ENDOCRINOLOGY	$382	0%	3%	1%	-1%	2%	0%
10-FAMILY PRACTICE	$5,351	0%	3%	1%	0%	3%	1%
11-GASTROENTEROLOGY	$1,752	0%	2%	1%	-1%	1%	0%
12-GENERAL PRACTICE	$704	0%	2%	1%	0%	2%	1%
13-GENERAL SURGERY	$2,221	0%	3%	1%	0%	3%	1%
14-GERIATRICS	$182	0%	5%	2%	-2%	3%	0%
15-HAND SURGERY	$100	0%	3%	1%	2%	5%	3%
16-HEMATOLOGY/ONCOLOGY	$1,870	0%	-5%	-2%	1%	-4%	-1%
17-INFECTIOUS DISEASE	$567	0%	4%	2%	-2%	2%	0%
18-INTERNAL MEDICINE	$10,381	0%	3%	1%	-1%	2%	0%
19-INTERVENTIONAL PAIN MGMT	$379	0%	4%	2%	1%	5%	3%
20-INTERVENTIONAL RADIOLOGY	$222	0%	-9%	-4%	0%	-9%	-4%
21-MULTISPECIALTY CLINIC/OTHER	$44	0%	-5%	-4%	1%	-4%	-3%
22-NEPHROLOGY	$1,891	0%	0%	0%	-1%	-1%	-1%
23-NEUROLOGY	$1,415	0%	4%	1%	0%	4%	1%
24-NEUROSURGERY	$622	0%	2%	1%	1%	3%	2%
25-NUCLEAR MEDICINE	$57	0%	-7%	-4%	1%	-6%	-3%
27-OBSTETRICS/GYNECOLOGY	$649	0%	1%	0%	1%	2%	1%
28-OPHTHALMOLOGY	$5,154	0%	7%	3%	1%	8%	4%
29-ORTHOPEDIC SURGERY	$3,339	0%	2%	1%	1%	3%	2%
30-OTOLARNGOLOGY	$915	0%	3%	1%	1%	4%	2%
31-PATHOLOGY	$1,040	0%	-1%	0%	-1%	-2%	-1%
32-PEDIATRICS	$65	0%	2%	1%	0%	2%	1%
33-PHYSICAL MEDICINE	$868	0%	4%	1%	-1%	3%	0%
34-PLASTIC SURGERY	$306	0%	4%	2%	1%	5%	3%
35-PSYCHIATRY	$1,105	0%	1%	1%	-3%	-2%	-2%
36-PULMONARY DISEASE	$1,736	0%	2%	1%	-1%	1%	0%
37-RADIATION ONCOLOGY	$1,889	0%	-5%	-2%	4%	-1%	2%
38-RADIOLOGY	$4,975	0%	-12%	-6%	0%	-12%	-6%
39-RHEUMATOLOGY	$496	0%	0%	0%	1%	1%	1%
40-THORACIC SURGERY	$388	0%	-1%	0%	0%	-1%	0%
41-UROLOGY	$1,909	0%	-6%	-2%	1%	-5%	-1%
42-VASCULAR SURGERY	$702	0%	-2%	-1%	2%	0%	1%
43-AUDIOLOGIST	$52	0%	-2%	-2%	1%	-6%	-1%
44-CHIROPRACTOR	$732	0%	3%	1%	-2%	1%	-1%
45-CLINICAL PSYCHOLOGIST	$557	0%	-6%	-2%	-5%	-11%	-7%
46-CLINICAL SOCIAL WORKER	$376	0%	-5%	-2%	-5%	-10%	-7%
47-DIAGNOSTIC TESTING FACILITY	$851	0%	-26%	-13%	6%	-20%	-7%
48-INDEPENDENT LABORATORY	$1,009	0%	-6%	-2%	4%	-2%	2%
49-NURSE ANES / ANES ASST	$706	0%	2%	2%	-3%	-1%	-1%
50-NURSE PRACTITIONER	$1,175	0%	4%	1%	-1%	3%	0%
51-OPTOMETRY	$937	0%	7%	3%	1%	8%	4%
52-ORAL/MAXILLOFACIAL SURGERY	$38	0%	3%	2%	2%	5%	4%
53-PHYSICAL/OCCUPATIONAL THERA	$2,138	0%	-7%	-11%	-1%	-8%	-12%
54-PHYSICIAN ASSISTANT	$868	0%	3%	1%	0%	3%	1%
55-PODIATRY	$1,738	0%	4%	2%	1%	5%	3%
56-PORTABLE X-RAY SUPPLIER	$91	0%	3%	2%	6%	9%	8%
57-RADIATION THERAPY CENTERS	$69	0%	-9%	-3%	8%	-1%	5%
OTHER	$67	0%	2%	1%	-1%	2%	2%

* Does not include the impact of the current law -6.1 percent CY 2011 update.