Medicare Physician Payment Update
AFROC 23nd Annual Meeting

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Physician Fee Schedule (PFS) Update

- Medicare payment rates will be reduced by 27.0 percent in 2013—less than the 27.4 percent reduction that CMS estimated for 2012.
- Congress must pass a law to avert these cuts prior to January 1.
- The President's budget calls for averting these cuts and finding a permanent solution to this problem.

Potentially Misvalued Codes 5 Year Review

- Beginning CY 2009, CMS and the AMA RUC have identified and reviewed potentially misvalued codes:
  - Codes with high growth rates,
  - Codes that are frequently billed together in one encounter,
  - Codes valued as inpatient services but that are now predominantly performed as outpatient services.
  - Reviews have not included codes identified by the public as potentially misvalued.

Potentially Misvalued Codes 5 Year Review

- In the 2011 PFS proposed rule, CMS referred codes in three additional areas:
  - Codes on the RUC's multi-specialty points of comparison list
  - Services with low work RVUs that are billed in multiples
  - Codes that have low work RVUs for which CMS claims data show high volume.

Potentially Misvalued Codes
5 Year Review

- §3134(a) of the Affordable Care Act directed CMS examine seven categories:
  1. Codes and families of codes for which there has been the fastest growth,
  2. Codes and families of codes that have experienced substantial changes in practice expenses,
  3. Codes that are recently established for new technologies or services,
  4. Multiple codes that are frequently billed in conjunction with furnishing a single service,
  5. Codes with low relative values, esp. those that are billed multiple times for a single service,
  6. Codes which have not been reviewed since the implementation of the RBRVS (the so-called "Harvard-valued codes"),
  7. Other codes to be determined by the Secretary.

Potentially Misvalued Codes 5 Year Review

- 2012 Final Rule:
  - 5-year review, annual misvalued code combined into one annual review that includes a public nomination process.
  - All codes, including new and revised codes, will appear in the final rule as interim for one year subject to public comment.
  - Review 70 high expenditure codes across most specialties.
  - Decided not to refer E&M codes but still interested in ways to improve payment for primary care services.

Improving Payment for Primary Care

- Delivery system reform:
  - Accountable Care Organizations
  - Patient Centered Medical Home: Making the primary care physician the focus of managing the patient's chronic conditions.
  - Partnership for Patients – Reduce hospital complications and improve care transition through Community Based Care Transitions
- AMA/CPT – Chronic Care Workgroup: Coding changes and payment for chronic care E/M service.
  - Pay for non face-to-face services in the interim.
- AAFP – Establish a primary care office visit set of codes and value higher than current E/M codes.

Practice Expense (PE)

- CY 2012 is the third year of the 4-year transition to the PE RVUs calculated using the Physician Practice Information Survey (PPIS) data.
- CY 2012: PE RVU is a 25 percent/75 percent blend of SMS and supplemental survey data and PPIS data.
- Changes to direct practice expense inputs, physician time, etc… affect PE RVUs for many codes.

Geographic Practice Cost Indices (GPCIs)

- Separate GPCIs for physician work, PE and malpractice.
- Statutory Adjustments:
  - Work reflects ¼ of the difference – Permanent.
  - Physician work floor of 1.0 for several years.
  - ½ of the variation in employee compensation and rent for 2010 and 2011 pending analysis of methodology and data sources.

Geographic Practice Cost Indices

- CMS proposed the following revisions to the PE data sources and cost share weights:
  1. Revise the occupations used to calculate the non-physician employee wage component of the PE using BLS wage data specifically used in physicians' offices,
  2. Use rental data from the 2006-2008 American Community Survey as the proxy for physician office rent in place of HUD data,
  3. Create a purchased service index that accounts for regional variation in labor input costs from contracted services from industries
  4. Use the 2006-based MEI to determine the GPCI cost share weights.

Geographic Practice Cost Indices

- Payment Impacts:
  - Impacts from the changes to the practice expense GPCIs were modest.
  - Much larger payment impacts from expiration of statutory provisions.
  - Changes to PE GPCI are largely consistent with requests in public comments. Small impact shows that the GPCIs have largely been consistent with best data sources that can be used for this purpose.

Institute of Medicine (IOM)

- Significant controversy over Medicare's geographic payment adjustments as part of Affordable Care Act debate.
- Provisions included in House bill not part of final enacted legislation.
- Secretary agreed to ask IOM to study geographic adjustment factors (GPCI and hospital wage index) and geographic variation in payment per beneficiary.
- September 27: IOM Report on Geographic Adjustment Factors.

Institute of Medicine

- Key Recommendations:
  1. Use MSAs as the localities for both physician and hospital payment systems.
  2. Data should come from all health care employers (already being done for GPCI).
  3. Cost share weights should continue to be national (already being done for GPCI).
  4. Continue to use proxies for physician work GPCIs (already being done for GPCI) but evaluate accuracy of current proxies.
  5. Consider empirical alternative to adjusting based on 25 percent of physician work GPCI .
  6. Develop commercial office rent data source.
  7. PE GPCI should be adjusted for non-clinical staff costs (already being done for GPCI)

Multiple Procedure Payment Reduction (MPPR)

- Long standing policy: Reduce payment by 50 percent for the second and subsequent surgical procedures for efficiencies in practice expense and pre- and post-surgical physician work.
- MPPR extended to the technical (TC) component of certain diagnostic imaging procedures for efficiencies in clinical labor, supplies, and equipment time.
- Under current imaging MPPR policy, full payment is made for the TC of the highest paid procedure, and payment is reduced by 50 percent of the TC for each additional procedure.

Multiple Procedure Payment Reduction

- For CY 2012, MPPR expanded to professional component (PC) of advanced imaging services (CT, MRI, and Ultrasound) where TC MPPR applies.
- 25 percent reduction to the PC and a 50 percent reduction to the TC for the second and subsequent advanced imaging services furnished to a patient by the same physician to the same patient, in the same session, on the same day.

Value-based Modifier

- Value modifier will start in 2015 for certain physicians and groups of physicians and in 2017 for all physicians and other eligible professionals.
- Differential payment "based on the quality of care compared to cost" beginning in 2015 based on 2013 performance.
- Budget neutral.
- Payment continue to be resource based but also adjust for quality of care and patient outcomes.

Thank You

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