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CMS announces policy, payment rate changes for the Physician Fee Schedule in 2012

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule with comment period that updates payment policies and rates for physicians and nonphysician practitioners (NPPs) for services paid under the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2012. More than 1 million providers of vital health services to Medicare beneficiaries – including physicians, limited license practitioners such as podiatrists, and NPPs such as nurse practitioners and physical therapists – are paid under the MPFS. CMS projects that total payments under the MPFS in CY 2012 will be approximately $80 billion.

CMS is required to issue a final rule that reflects current law. Under current law, providers will face steep across-the-board reductions in payment rates, based on a formula– the Sustainable Growth Rate (SGR) – that was adopted in the Balanced Budget Act of 1997. Without a change in the law from Congress, Medicare payment rates to providers paid under the MPFS will be reduced by 27.4 percent for services in CY 2012—less than the 29.5 percent reduction that CMS had estimated in March of this year because Medicare cost growth has been lower than expected. This is the eleventh time the SGR formula has resulted in a payment cut, although the cuts have been averted through legislation in all but CY 2002. The Obama Administration is committed to fixing the SGR and ensuring these payment cuts do not take effect.

"This payment rate cut would have dire consequences that should not be allowed to happen," said Donald M. Berwick, M.D., CMS administrator. "We need a permanent SGR fix to solve this problem once and for all. That's why the President's Budget and his Plan for Economic Growth and Deficit Reduction call for permanent, fiscally responsible reform and why we are committed to working with the Congress to achieve a permanent and sustainable fix."

In the CY 2012 final rule, CMS is expanding the potentially misvalued code initiative, an effort to ensure Medicare is paying accurately for physician services and more closely managing the payment system. This year, CMS is focusing on the codes billed by physicians in each specialty that result in the highest Medicare expenditures under the

MPFS to determine whether these codes are overvalued. In the past, CMS has targeted specific codes for review that may have affected a few procedural specialties like cardiology, radiology or nuclear medicine but has not taken a look at the highest expenditure codes across all specialties. This effort results in increased payments for primary care services that have historically been undervalued by the fee schedule.

"We believe strong efforts are needed to evaluate Medicare's fee schedule to ensure that it is paying accurately and to ensure that Medicare beneficiaries continue to have access to vital services," said Jonathan Blum, deputy administrator and director for the Center for Medicare.

CMS is also making changes in how it adjusts payment for geographic variation in the cost of practice. The Affordable Care Act and the Medicare and Medicaid Extensions Act made some temporary adjustments that were in place for two years while CMS and the Institute of Medicine (IOM) began to comprehensively study these issues. As part of this initiative, CMS is replacing some of the data sources—such as using data from the American Community Survey (ACS) in place of the Department of Housing and Urban Development (HUD) rental data and also using ACS data in place of the data currently used for non-physician employee compensation. Consistent with IOM's recommendation, CMS is also adjusting its payments for the full range of occupations employed in physicians' office as well as making other adjustments called for in prior year public comments. Although these improvements result in very little change to the indices, they show that the data Medicare has used in the past and will be using in the future produce consistent results—suggesting past year adjustments have accurately reflected geographic variations in the cost of practice.

The IOM provided its first of three reports on geographic adjustment factors to CMS on June 1. IOM provided a supplement to its report at the end of September that largely supported changes CMS is making in the final rule and recommended additional changes, many of which would require a change in law. CMS is continuing to evaluate all of the IOM's recommendations.

Other changes being adopted in the final rule include:

- CMS is expanding its multiple procedure payment reduction policy to the professional interpretation of advance imaging services to recognize the overlapping activities that go into valuing these services. This policy better recognizes efficiencies that are expected when multiple imaging services are furnished to the same patient, by the same physician or group practice, in the same session on the same day.

- CMS is adopting criteria for a health risk assessment (HRA) to be used in conjunction with Annual Wellness Visits (AWVs), for which coverage began Jan. 1, 2011 under the Affordable Care Act. The HRA is intended to support a systematic approach to patient wellness and to provide the basis for a personalized prevention plan. CMS is increasing AWV payment modestly to reflect the

additional office staff time required to administer an HRA to the Medicare population.

- CMS is expanding the list of services that can be furnished through telehealth to include smoking cessation services. CMS is also changing the criteria for adding services to the telehealth list to focus on the clinical benefit of making the service available through telehealth. This change will affect services proposed for the telehealth list beginning in CY 2013.

- The final rule updates or modifies aspects of a number of physician incentive programs including the Physician Quality Reporting System, the ePrescribing Incentive Program and the Electronic Health Records Incentive Program.

- The final rule also finalizes quality and cost measures that will be used in establishing a new value-based modifier that would adjust physician payments based on whether they are providing higher quality and more efficient care. The Affordable Care Act requires CMS to begin making payment adjustments to certain physicians and physician groups on Jan. 1, 2015, and to apply the modifier to all physicians by Jan. 1, 2017. CMS intends to work closely with physicians to ensure that efforts to improve the quality, safety, and efficiency of care do not diminish patient access to care. The rule also finalizes CY 2013 as the initial performance year for purposes of adjusting payments in CY 2015.

- The final rule also implements the third year of a 4-year transition to new practice expense relative value units, based on data from the Physician Practice Information Survey that was adopted in the MPFS CY 2010 final rule.

The final rule with comment period will appear in the Nov. 28, 2011, *Federal Register*. CMS will accept comments on those provisions that are subject to comment until Jan. 3, 2012, and will respond in the MPFS for CY 2013.

For more information, see:
http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

Also, please see additional CMS Fact Sheets issued today (11/1) can be found here:
http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4153
http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4154
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