



AAFP Summary of Key Provisions of the Proposed Rule on the 2010 Medicare Physician Fee Schedule

Issues of High Impact to AAFP Members

Resource Based Practice Expense (PE) Relative Value Units (RVUs) – Physician Practice Information Survey

Provision:

The Centers for Medicare and Medicaid Services (CMS) proposes to update the PE per hour data used in its PE RVU methodology. Specifically, CMS proposes, with few exceptions, to use data from the Physician Practice Information Survey (PPIS), rather than continuing to rely on the combination of data from the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) and supplemental survey data supplied by selected specialties.

Primary winners and losers:

Impact of PE RVU changes on total allowed charges under Medicare:

Winners

Ophthalmology (+11%)
Optometry (+11%)
Physical/Occupational Therapy (+10%)

Losers

Diagnostic Testing Facilities (-19%)
Radiation Oncology (-17%)
Nuclear Medicine (-12%)

Impact on family physicians:

CMS estimates that family physicians will experience a 5% increase in total allowed Medicare charges as a result of PE RVU changes, primarily attributable to the use of PPIS data.

Explanation of impact:

The PPIS data show a significant increase in the PE per hour for family physicians compared to the SMS data currently used by CMS. The use of the more current and higher PE per hour data translates into an increase in Medicare-allowed charges resulting from the new PE RVUs calculated with the new data.

AAFP position:

AAFP supports CMS's proposal to use the PPIS data. The SMS data currently used by CMS is at least 10 years old, and CMS does not use it across the board. SMS is no longer conducted. For some specialties, CMS uses supplemental survey data collected at different time periods with different survey instruments. The PPIS data was collected at the same time for all specialties using the same survey instrument. The PPIS methodology was consistent with the SMS and supplemental survey methodologies, and virtually all physician specialty societies participated in and supported the PPIS. As a contemporaneous, consistently collected, and comprehensive multispecialty survey, the PPIS represents the best currently available data source on physician practice expenses. For this reason AAFP supports CMS's proposal.

Resource Based PE RVUs – Equipment Utilization Rate

Provision:

CMS proposes to change the equipment usage assumption from the current 50% usage rate to a 90% usage rate for equipment priced over \$1 million.

Primary winners and losers:

CMS estimates a significant impact from this provision on only two specialties. Specifically, CMS estimates that, for diagnostic testing facilities and radiation oncology, this provision will result in an impact on total Medicare-allowed charges of -2% and -5%, respectively.

Impact on family physicians:

CMS estimates that this provision will not substantially affect overall Medicare payments to family physicians and all other specialties.

Explanation of impact:

The increase in the assumed usage rate will reduce the allowance per use for services that involve the affected equipment. The specialties that own that equipment and provide those services will be negatively affected.

AAFP position:

AAFP supports CMS's proposal to increase the assumed usage rate for equipment priced at over \$1 million. The proposal is supported by studies previously noted by the Medicare Payment Advisory Commission (MedPAC). It also comports with common business sense (i.e., no one would typically invest millions of dollars in equipment that they only planned to use half of the time). Absent empirical data to the contrary, CMS's proposal likely more closely approximates reality than the current 50% assumption for such equipment.

Consultation Services

Provision:

Effective January 1, 2010, CMS proposes to eliminate the use of all consultation codes (except for telehealth consultation G-codes) and, in a budget neutral manner, increase the work RVUs for new and established office visits, increase the work RVUs for initial hospital and initial nursing facility visits, and incorporate the increased use of these visits into the PE and malpractice RVU calculations. CMS also proposes to create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions.

Primary winners and losers:

Impact of work RVU changes (almost entirely attributable to the proposal on consultation services) on total allowed charges under Medicare:

Winners

Family Medicine (+2%)
(Seven other specialties) (+1%)

Losers

Neurology (-2%)
(15 other specialties) (-1%)

Impact on family physicians:

As noted, CMS estimates family physicians will see a 2% increase in their total allowed Medicare charges as a result of this provision.

Explanation of impact:

CMS currently values consultation services higher than corresponding office and inpatient visit services at the same level. (For example, a mid-level outpatient consultation has 1.88 work RVUs compared to 1.34 or 0.92 work RVUs for a mid-level new or established patient office visit, respectively.) CMS's proposal to eliminate the consultation codes in a budget neutral way will shift that difference in RVUs to office visits and initial hospital and facility visits. According to CMS, this will increase the work RVUs for office visits by approximately 6% and the work RVUs for initial hospital and facility visits by approximately 2%.

AAFP position:

AAFP supports the appropriate valuation of all services paid under the Medicare physician fee schedule. As noted in the proposed rule, the distinction between consultations and other evaluation and management (E/M) services has become increasingly blurry over time, leading to significant misuse of the consultation codes, which the Office of Inspector General has documented. Thus, it is increasingly difficult to justify the difference in physician work assigned to these services, and we support CMS's decision to take a critical look at their current relative value. Absent compelling evidence to justify the current work RVUs for consultation codes, we also support CMS's proposal to effectively revalue those services equal to other E/M services done in the same setting.

Potentially Misvalued Codes under the Physician Fee Schedule – Site of Service Anomalies**Provision:**

CMS proposes to recalculate and change the work RVUs for codes for which the AMA Relative Value Scale Update Committee (RUC) review process has resulted in the deletion or reallocation of pre-service and post-service times, hospital days, office visits, and discharge day management services.

Primary winners and losers:

Unknown; CMS does not provide impact data specific to this provision.

Impact on family physicians:

Unknown but probably close to none; the affected services are not those commonly done by family physicians.

Explanation of impact:

The AMA RUC has previously made recommendations to CMS to change the components of certain global surgical services. This includes changing the pre- and post-service physician time and mix of post-service E/M services associated with those global surgical services. However, there was no corresponding change in the work RVUs assigned to those services as a result. CMS's current proposal would make work RVU changes corresponding to the changes in pre- and post-service time and mix of post-service E/M services associated with the global surgical services in question.

AAFP position:

AAFP supports the appropriate valuation of all services paid under the Medicare physician fee schedule. To the extent that certain services have had a change in their resource inputs without a corresponding change in the relative values assigned to them, AAFP supports CMS's decision to take a critical look at their current relative values. Absent compelling evidence to justify the current work RVUs in light of changes in resource inputs, we also support CMS's proposal to revalue those services.

Establishing Appropriate Relative Values for Physician Fee Schedule Services

Provision:

MedPAC has previously recommended that CMS establish a group of experts, separate from the AMA RUC, to help the agency review RVUs. In response, CMS seeks input on the following questions:

- How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations?
- What specifically would be the roles of a group of experts?
- What should be the composition of a group of experts, and how could such a group provide expertise on services that clinician group members do not furnish?
- How would such a group relate to the AMA RUC and existing Secretarial advisory panels, such as the Practicing Physician Advisory Committee?

Primary winners and losers:

Unknown

Impact on family physicians:

Unknown

Explanation of impact:

(Not applicable)

AAFP position:

AAFP has supported MedPAC's recommendation that CMS establish a group of experts, separate from the AMA RUC, to help the agency review RVUs. Although the RUC provides valuable expertise, the review process would benefit if CMS had an additional means of identifying misvalued services and if supporting evidence was collected and analyzed not only by specialty societies but also by experts who were less invested financially in the outcome. Like MedPAC, we believe that such a panel would not supplant the RUC, but would augment it, and like MedPAC, we believe that such a panel would assist CMS by using the results of data analyses to identify potentially misvalued services. We anticipate that the RUC would be allowed to comment on any recommendations or findings of such a group.

Physician Fee Schedule Update for Calendar Year (CY) 2010

Provision:

CMS proposes to remove physician-administered drugs from the definition of "physicians' services" for purposes of computing the Sustainable Growth Rate (SGR) and for purposes of calculating the levels of allowed expenditures and actual expenditures. This applies both prospectively and retrospectively to the 1996/1997 base year. This proposal will not change the CY 2010 update, which CMS currently estimates to be -21.5%, under current law. It also will not "fix" the underlying problem posed by the use of the SGR. Instead, the proposal will reduce the number of years in which physicians are projected to experience a negative update under current law and thus reduce the cost of "fixing" the SGR problem, if Congress decides to do so.

Primary winners and losers:

All physicians paid under the Medicare physician fee schedule benefit from the proposal to remove physician-administered drugs from the definition of "physicians' services." Likewise, all

physicians paid under the Medicare physician fee schedule will be negatively affected by a -21.5% update in the conversion factor, if Congress allows it to occur. Those specialties (e.g., geriatrics) for whom Medicare is a greater percentage of their patient base will be affected more than specialties (e.g., pediatrics) for whom Medicare is a smaller percentage of their patient base.

Impact on family physicians:

CMS estimates that its proposals related to consultation services, practice expense data, and an update of its malpractice RVUs will yield an 8% increase in Medicare-allowed charges for family physicians, all other things being equal. Thus, if Congress permits the conversion factor to decrease by 21.5%, the impact on family physicians will only be a negative 13.5% (i.e., -21.5% + 8%), which is still significant, especially given that Medicare patients comprise 22.1% of the typical family physician's practice.

If Congress maintains or increases the 2009 conversion factor, as is widely expected, then, as noted, family physicians should expect to see at least approximately an 8% increase in total Medicare-allowed charges in 2010. For some services commonly done by family physicians, the gains could be even greater. For instance, under the proposed rule, the total relative value of code 99213, the most common service done by family physicians, would increase about 12% in 2010. Similarly, the total relative value of 99214, another commonly performed service, would increase over 10%.

Explanation of impact:

As noted in the proposed rule, growth in the cost of prescription drugs has far outpaced growth in the cost of other physicians' services and has become an increasing percentage of the volume of Medicare spending. Consequently, spending on physician-administered drugs has contributed significantly to the deviation between target and actual spending as well as to the large projected reductions in future fee schedule updates. Removing physician-administered drugs from the definition of "physicians' services" for purposes of the SGR and calculation of the updates will help reduce the deviation and thus reduce the number of years of projected negative updates under current law.

AAFP position:

AAFP has consistently advocated for removing physician-administered drugs from the definition of "physicians' services" for purposes of the SGR and calculation of the fee schedule updates. From an AAFP perspective, drugs that are not paid for by the Medicare physician fee schedule do not belong in the formula to determine the fee schedule rates. Thus, AAFP supports CMS's proposal.

Other Issues of Importance to the AAFP

Payment for Initial Preventive Physical Examination (i.e., Welcome to Medicare Visit)

Provision:

Effective January 1, 2010, CMS proposes to increase the work RVUs for this service from 1.34 to 2.30.

Primary winners and losers:

Unknown; CMS does not provide impact data specific to this provision.

Impact on family physicians:

Family physicians that provide this service should benefit from the increase in work RVUs for it. At the current conversion factor of \$36.0666, the proposed 0.96 increase in work RVUs would yield an additional \$34.62 in payment per Welcome to Medicare Visit.

Explanation of impact:

The increase in the work RVU yields an increase in the total RVUs for this service and an increase in the Medicare payment allowance for it, all other things being equal.

AAFP position:

AAFP supports CMS's proposal to increase the work RVUs for this service. The AAFP has argued, since the service's inception, that this service was undervalued. The increase in work RVUs, equivalent to a level 4, new patient office visit, brings this service more in line with the relative value of other E/M services done by family physicians.

Medicare Improvements for Patients and Providers Act (MIPPA) Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services**Provision:**

Section 102 of MIPPA amends the law to phase out the statutory outpatient mental health treatment limitation. That limitation currently results in Medicare paying only 50% of the Medicare approved amount while the patient is responsible for the remaining 50%. When the limitation is fully phased out in 2014, Medicare will pay for outpatient mental health services at the same level (i.e., 80%) as other Part B physician services.

Primary winners and losers:

Medicare patients will be the primary winners under this provision, since they will have to pay progressively less out-of-pocket for outpatient mental health services until 2014. There are no obvious losers under this provision. Physicians are held harmless as they may continue to collect the full Medicare-allowed amount for these services.

Impact on family physicians:

This provision is positive for family physicians and other providers of outpatient mental health services, because they have to collect less from the patient. As noted, the provision does not impact what physicians may collect in total for these services. It only impacts what percentage of the Medicare-allowed amount must be collected from the beneficiary.

Explanation of impact:

As noted, current law effectively sets the coinsurance for outpatient mental health services under Medicare at 50%, rather than the usual 20%. MIPPA gradually changes this 50/50 split to the usual 80/20 split applicable to other Medicare Part B physician services.

AAFP position:

AAFP policy supports mental health parity: "The AAFP supports parity of health insurance coverage for patients, regardless of medical or mental health diagnosis. Health care plans should cover mental health care under the same terms and conditions as that provided for other medical care." Accordingly, AAFP supports CMS's implementation of Section 102 of MIPPA.

MIPPA Section 131(b): Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting Initiative (PQRI)

Provision:

- Potential Bonus: +2% of allowed charges billed in the applicable reporting period
- 168 individual measures, 13 measures groups, and 10 measures for electronic health record (EHR)-based reporting
- Proposes to add a minimum patient sample of 15 patients (full year reporting) or 8 patients (half-year reporting) for one individual measure or measures group.
- Proposed reporting periods are:
 - Individual quality measures reported using claims-based or EHR-based (if approved) reporting - January 01, 2010 – December 31, 2010 only
 - Individual quality measures reported using registry-based reporting - January 01, 2010 – December 31, 2010 or July 01, 2010 – December 31, 2010
 - Measures Groups reported using claims-based or registry-based reporting - January 01, 2010 – December 31, 2010 or July 01, 2010 – December 31, 2010
- CMS is considering significantly limiting the claims-based mechanism of reporting clinical quality measures for the PQRI after 2010.
- Proposes to simplify registry-based reporting by removal of the requirement to report consecutive patients (reporting of patients in order seen). Physicians will be able to successfully report on any patients who meet the numerator and denominator criteria for the measure or measures group being reported during the reporting period regardless of date seen.
- EHR-based reporting may be an option in 2010. CMS expects to address this in the final rule but has made provisions for the option by selecting 10 measures that may be reported if EHR-based reporting is approved.
- CMS proposes a large group practice (over 200 eligible professionals) PQRI reporting option. Large groups may report and receive a bonus based on the groups overall PQRI success rather than by individual physician or provider. Performance rates of participating groups will be posted on CMS's web site for consumer information. CMS will be creating a database for participating large groups to use in entering their PQRI data. If successful with groups of this size, CMS may open this option to smaller group practices in the future.

Primary winners and losers:

(Not applicable)

Impact on family physicians:

Family physicians may earn a bonus up to 2% of allowed Medicare charges billed in the reporting period for PQRI in 2010. Simplified registry reporting may make this option more accessible to family physicians. Likewise, the potential for EHR-based reporting may also facilitate family physician participation in PQRI, at least for those family physicians that have an EHR.

Explanation of impact:

(Not applicable)

AAFP position:

The AAFP has been a supporter of PQRI, although it has expressed concerns regarding CMS's administration of the program and encouraged CMS to make the program more "user friendly" and more timely in its feedback to participating physicians. The simplified registry reporting and potential EHR-based reporting would seem to be steps in the right direction in this regard.

MIPPA Section 131(c): Physician Resource Use Measurement and Reporting Program**Provision:**

Section 131(c) of MIPPA established a Physician Feedback Program using Medicare claims and other data to provide confidential feedback reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. In the proposed rule, CMS describes its implementation of Phase I of this program and solicits comment on the design and elements of the sample resource report used in Phase I. CMS also solicits comments on its expansion plans related to Phase II, including proposals to add reporting to groups of physicians and to use quality measures in addition to resource use measures.

Primary winners and losers:

(Not applicable)

Impact on family physicians:

Limited; CMS has implemented the program in only a dozen sites thus far and indicates that it will add "a limited number of new locations" for 2010. Family physicians in those sites are among the specialties receiving resource use reports. There are currently no rewards or penalties attached to these reports.

Explanation of impact:

(Not applicable)

AAFP position:

The AAFP commented extensively on this program in its comments on the final rule on the 2009 Medicare physician fee schedule. In general, the AAFP is not opposed to the program, as long as it is conducted consistent with AAFP policy on "Performance Measures Criteria" and "Physician Profiling, Guiding Principles."

MIPPA Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners**Provision:**

Section 131(d) of MIPPA requires the Secretary to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for covered professional services made under, or based on, the physician fee schedule. It also requires the Secretary to submit a report to the Congress containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The report is due by May 1, 2010. The proposed rule provides an update on CMS's efforts in this regard and solicits original comments on development of the VBP plan for physician services and the related report to Congress. CMS is particularly interested in comments on the appropriate level of accountability and appropriate data submission mechanisms.

Primary winners and losers:

(Not applicable)

Impact on family physicians:

Unknown

Explanation of impact:

(Not applicable)

AAFP position:

The AAFP Board of Directors will consider a proposed policy on "Value-Based Purchasing" at its July 2009 meeting. That proposed policy otherwise supports adherence to existing the AAFP policies on "Performance Measures Criteria," "Physician Profiling," "Data Stewardship," and "Transparency."

MIPPA Section 132: Incentives for Electronic Prescribing (E-Prescribing) – The E-Prescribing Incentive Program**Provision:**

- An e-prescribing incentive offers physicians an opportunity to earn a 2% bonus. Physicians may report both PQRI measures and the e-prescribing incentive code using the same registry, if they use the registry reporting option.
- CMS has simplified the reporting requirements for 2010
 - They have changed the G-codes for submission in 2010 to only one code. This code is for when at least one prescription is sent electronically.
 - Now instead of requiring reporting on 50% of eligible visits, a physician must report that at least one prescription was sent electronically at 25 visits in a year.
 - This reduces the burden on reporting as physicians do not have to report on visits where no prescriptions were written (or not sent electronically) and it moves CMS closer to being able to use Part D claims data to do the reporting (i.e. physicians would not have to report).
- There are multiple ways to submit the e-prescribing measure including through claims, registries, and EHRs.
 - This is important as it allows for integration into EHRs for those that have one but also allows stand-alone eRx practices to submit through claims
 - Allows for the same processes that are allowed for PQRI
- They have expanded the visits that qualify under the e-prescribing incentive program to include professional services outside of the practice including home care and skilled nursing care.
 - This is good for those practices that only see Medicare patients in these setting and for those where those settings represent a high portion of the Medicare visits for the physician

Primary winners and losers:

(Not applicable)

Impact on family physicians:

Unknown

Explanation of impact:

(Not applicable)

AAFP position:

The AAFP supports incentives that promote e-prescribing, and the proposed changes to the Medicare e-prescribing program all appear to be headed in the right direction. The simplified reporting and multiple avenues for reporting are both improvements to the program. Likewise, the expanded types of visit codes are consistent with previous AAFP advocacy that encouraged CMS to include home care codes in the denominator. That said, e-prescribing is only one small aspect of health information technology (HIT), and there should be an adequate focus on and efforts toward creating a conversion to broadly used HIT, including electronic health records, consistent with AAFP principles.

MIPPA Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services**Provision:**

Beginning January 1, 2012, Medicare payment may only be made for the technical component (TC) of advanced diagnostic imaging services to a supplier who is accredited by an accreditation organization designated by the Secretary of HHS.

These services are defined to include only diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography, which are generally owned and operated by hospitals, larger group practices and independent diagnostic testing facilities.

The estimated prorated average annual accreditation fee is \$1,666. Accrediting agencies will be required to have plans for reducing the burden and cost of accreditation to small and rural suppliers.

Primary winners and losers:

The relative impact on small and rural providers will likely be greater than on other owners/providers/suppliers of this technology, which is acknowledged and accounted for in the proposed rule.

Impact on family physicians:

Some small number of family physician practices may wholly or partially own these technologies and thus be defined as a supplier and subject to the accreditation requirement. However, the anticipated impact on family physicians is minimal.

Explanation of impact:

(Not applicable)

AAFP position:

AAFP does not have a position on accreditation of providers of advanced imaging services.