

ACP Positions on Centers for Medicare and Medicaid Services’ Proposed Changes for the Medicare 2010 Physician Fee Schedule

Answers to Frequently-Asked-Questions

Background

The Centers for Medicare and Medicaid Services (CMS) released its proposed Medicare 2010 physician fee schedule in July 2009. The proposal, known as a “proposed rule,” contains envisions many changes that affect physicians of all specialties. CMS accepted comments from public on its proposed rule through August 31, 2009. ACP submitted detailed comments on many of the proposals in the form of an August 31 letter to the agency. The ACP positions pertaining to the CMS proposals are explained through the answers to frequently-asked-questions below. CMS is expected to release the final Medicare 2010 fee schedule by November 1, 2009. This “final rule” may contain changes as a result of public comments.

Changes to Practice Expense Payments

Does ACP support CMS use of data from a recent survey of physician practice costs to update practice expense payments?

Yes, ACP supports the CMS proposal to use the practice cost data derived from the recent survey to update payment for the practice expense component for each physician service in the Medicare fee schedule but the College also calls on CMS to create an open and transparent process to address concerns by individual subspecialties about some of the data in the new survey as it applies to their specialty.

As background, CMS assigns a relative value unit (RVU) to each physician service that, after adjusted for geographic cost differences, is multiplied by a dollar “conversion factor” amount, currently \$36.07. The practice expense component, or practice expense RVU, on average, makes up about 44% of the total RVU for each service. CMS uses data on the cost of operating a physician practice to establish a practice expense per hour (PE/hour) figure for each Medicare-recognized physician specialty. The PE/hour figure plays a large role in determining the practice expense RVU assigned to each service.

ACP does support the CMS proposal to use the PE/hour figures derived from the results of a recent practice cost survey conducted through the American Medical Association (AMA) to update practice payments in 2010. This AMA survey is referred to as the Physician Practice Information Survey (PPIS). College support for use of the AMA PPIS is based on:

- Long-standing ACP support for an all-specialty survey of practice costs to update the data that CMS uses its practice expense payment methodology. The College established this as an official policy statement in 2006.
- The practice cost data that CMS is currently using is dated and was collected from multiple sources. CMS is using cost data collected in the mid-to-late 1990s for most physician specialties that was collected from a since discontinued AMA survey. The agency is using data for 13 specialties that was collected through a survey conducted by the specialty organization for each. The data from these “supplemental surveys” were collected from 1999 through 2004. While CMS determined that each survey met the agency’s criteria for acceptance—and implemented these data into its practice methodology at various times from 2000 through 2007, the data were not collected through a single instrument to provide data from a consistent method across specialties,. Using the PPIS survey data would allow practice expense payments to be based on data collected in 2007-2008 using a single survey instrument.

Why did AMA conduct the PPIS survey?

A committee of physicians appointed by major specialty organizations-- maintained by the AMA in conjunction with physician specialty organizations--which, advises CMS on RVU recommendations—known as the Relative-value Update Committee (RUC)—began petitioning to conduct the survey in 2005. In 2006, 75 specialty societies, including the ACP, told CMS that it was “imperative” to conduct such a survey as a basis for updating practice expense payments. Also in 2006, the Medicare Payment Advisory Commission (MedPAC), which advises the Congress on issues related to the Medicare program, indicated support for need for up-to-date practice cost data for all specialties. After CMS expressed interest in nearly all specialty organizations agreed to contribute financially, the AMA decided to conduct the survey.

Does ACP have faith in the PPIS process?

Yes, The AMA took great care to design, test, and field the PPIS. Specialty organizations—primarily through the RUC and its expansive Advisory Committee—provided input and were received updates throughout. The RUC, in its official comment letter to CMS, states that the PPIS was conducted in a “fair and consistent manner for all specialties.” ACP agrees with this sentiment. CMS and an expert contractor, the Lewin Group, assisted with: the survey design, the methodology used to conduct survey, and the programming to translate the survey data into the PE/hour figure for each specialty. CMS showed confidence in the process by purchasing the information from AMA and proposing to use the PE/hour figures to update practice expense payments in 2010. At the same time, we do recognize that some internal medicine subspecialty organizations have specific concerns about some of the data from the survey that applies to their subspecialty that should be addressed by CMS in an open and transparent manner.

What is the impact on internists?

CMS has provided a rough estimate of the aggregate change in payments to physicians in each Medicare-recognized specialty that results from using the updated PE/hour for each specialty derived from the PPIS. The CMS estimates indicate a significant shift in aggregate Medicare payments for many specialties, including general internal medicine and internal medicine subspecialties. Aggregate general internal medicine revenues would increase about 4% (other changes in the proposed rule would increase the average gain for general IM by another 2 percent, or 6 percent total).. Most internal medicine subspecialties would also gain, with examples being: geriatrics, 6%, infectious disease, 4%; endocrinology, 3%; and pulmonary, 3%. Aggregate payments for a few internal medicine subspecialties would decline—cardiology, -10% and hematology/oncology, -5%.

Because the law requires that CMS to roughly maintain its expenditures on physician services consistent from one year to the next, using the PPIS data to update practice expense methodology redistributes payments with the physician payment pool; it does not increase the overall amount devoted to payment for physician services. While the PPIS-derived all-physician average practice cost increased from the all-physician amount derived from the data CMS currently uses, the PPIS PE/hour for some specialties increased significantly more than for others.

While the PPIS is used to calculate the per-specialty PE/hour and CMS estimates impact of the updated PE/hour in the form of aggregate payments to each specialty, individual physicians experience the impact in the form of how use of the PPIS data affects payments for individual services. Use of the PPIS data increases the practice expense RVU, and, thus, the total payment, for many evaluation and management (E/M) services that are furnished by all physicians. Payments for some procedures and tests do decrease as a result of the data. Accordingly, the mix of services you provide will determine precisely how the use of the PPIS data affects you.

Does that mean that ACP is supporting substantial cuts in payments to cardiologists, hematologists/oncologists?

No. ACP has a responsibility to all internists, regardless of subspecialty. On issues where the impact varies so widely across our various disciplines we cannot advocate for one subspecialty over another, but instead, our responsibility is to ensure that payment changes are based on the most recent data available, developed with physician input, and that there is an open and transparent process to address any concerns about the data as it relates to any subspecialty of internal medicine.

ACP supports the PPIS process and believes that CMS should use the PE/hour figures that result from the survey data as more up-to-date information is needed and the survey was conducted fairly and consistently across all specialties.

At the same time, we recognize that individual specialties, including cardiology and hematology/oncology, have concerns about the application of specific data elements from

the PPIS to services provided by their members and how this will affect total Medicare payments for such services.

While indicating support for the CMS proposal to use the PPIS data, the College urged the agency to create an “open and transparent process” to address individual specialty society’s concerns about the application of the data and methodology to their members’ services and to consider refinements in the PE-RVUs, as derived from the PPIS, as appropriate based on the comments of individual specialties. CMS will announce whether it makes any changes to in the final rule that the agency is to release by November 1.

Does ACP agree with CMS that high cost equipment, such as MRI or CT machines, are used more frequently than the agency currently assumes?

CMS proposes to increase the rate that it assumes that equipment involved in furnishing services or tests that costs over \$1 million from the current 50% to 90%. The assumption rate makes a difference in payment amount in our resource based system. The use of a higher utilization rate assumption would spread the cost of the equipment over more units of service. This is because the physician payment for using the equipment for each service is based on the assumed use of the equipment over its lifetime.

ACP commented to CMS in support of an increase in the assumed utilization rate for equipment priced over \$1 million. The College stated that it agrees that the current 50% assumption is far too low but noted that it has no way to independently assess the precision of the proposed 90% utilization rate. CMS cites work by MedPAC, including a survey of use of expensive equipment in selected markets, in support of its proposed 90% rate. The agency established the current 50% rate in 1997 without any specific equipment use information.

ACP has long-standing policy urging CMS to review the equipment utilization assumption rate, with an emphasis on reassessing rate pertaining to high-cost equipment. MedPAC and the RUC also recommend an increase in the assumed rate to more accurately reflect the use of expensive equipment. MedPAC and other experts have documented how inaccurate payment rates impact the availability of services and affect utilization. The non-partisan Congressional Budget Office (CBO) has stated that the high acquisition cost for advanced imaging equipment, which is generally over \$1 million, provides a strong incentive to optimize the amount of time it is in use. ACP believes it necessary to increase beyond the current low rate that distorts payments and incentives for services involving expensive equipment.

Further, ACP has encouraged CMS to create mutually exclusive categories of equipment with different utilization rates for equipment after it takes this initial step. The College has also urged CMS to address whether use varies by geographic area, especially for less expensive equipment. These steps would increase the accuracy of payments for all services that involve equipment.

Sustainable Growth Rate Formula Issues

Did CMS propose anything to fix the flawed Sustainable Growth Rate (SGR) formula system that has been a long-standing problem?

CMS is unable to eliminate the SGR as that would take an act of Congress. The agency did, however, propose to make a technical change to the formula that is within its administrative authority that represents a significant, positive step toward a lasting solution to the SGR problem. This technical change, which involves removing the rapidly growing expenditures on drugs that physicians administer in the office setting going back to the inception of the SGR formula, would not eliminate the untenable SGR-induced payment cuts slated over each of the next few years but it would drastically reduce the cost for the Congress to fix the SGR based on esoteric rules used to determine the cost of Congressional actions. In its comment letter, ACP commended CMS for its proposal and encouraged the agency to continue to work with the Congress to realize an enduring fix to this dire SGR problem.

Payment to Physicians for Furnishing Consultation Services

I understand that CMS proposes to no longer pay for consultation services? How can it do that?

CMS proposes to no longer recognize the Current Procedural Terminology (CPT) codes describing office/outpatient and inpatient consultations starting January 2010. This would not mean that you cannot be paid for service during which you provide an opinion or advice back to a requesting physician, but it would mean that you would bill and be paid differently for that consultation service. CMS proposes that physicians bill office consultations using the CPT office visit codes, 99201-99215, and inpatient consultations using the CPT initial hospital care codes, 99221-99223. The money that CMS spent in 2009 to pay the CPT consultation service codes would be used to increase payment for office and initial hospital visit services—the component of payment attributed to physician work would increase by 6% for each office visit service and by 2% for each initial hospital visit service.

What is the ACP position on the CMS proposal to no longer recognize the CPT consultation codes for payment purposes?

ACP indicated its support for this CMS proposal while urging the agency to address important related issues prior to implementing the change.

A primary reason that ACP supports the proposal is that it removes a great deal of anxiety generated by threat of audit that stem from the inherent difficulty in accurate coding for consultation services and from the 2006 CMS policy clarification. The College has repeatedly urged CMS to rescind its policy “clarification”—which expanded the agency’s

definition of when one physician transferred care to another—as it overly restricts the ability to bill consultations which the College and others viewed as restrictive and at odds with common medical practice. ACP has sent multiple letters urging CMS to change the policy and limit the new audit exposure it generated. In addition, it worked with the AMA and other physician organizations as well as the panel that maintains the CPT code book to engage CMS to resolve the situation in a manner acceptable to the agency and the physician community. These extensive efforts have all failed to break the impasse.

ACP was surprised by the sweeping nature of the CMS proposal to no longer recognize the CPT consultation service codes and deliberately evaluated it. While ACP understands that implementation of the proposal would resolve the audit liability issues, the College urges CMS to clearly articulate that the proposal would resolve this on-going discord between the agency and the physician community prior to implementation. The College also urges CMS to provide clear direction to all its contractors who audit physician claims for services.

Is ACP concerned about how this proposal affects internal medicine subspecialists?

ACP recognizes the need for all internal medicine disciplines to get adequately compensated for the consultation and other services. All physicians will benefit from the smodest increase in payment for the non-consultative office and initial hospital visit services they furnish. While this modest up-tick in revenue will not offset the reduction that results from CMS no longer payment for the higher-paid CPT consultation service codes for physicians who frequently furnish consultations, the actual impact on each physician depends on the mix of services he or she provides. Regardless, ACP is concerned that all internists, especially subspecialists, lack the ability to be recognized for high-level cognitive work. This was true prior to this CMS proposal and even more acute in light of it. The College expressed this view to CMS—and recommended actions to address it—in the portion of its comment letter to CMS that identified actions the agency should take before implementing this proposal.

What are all of the related-issues that ACP urged CMS to address before implementing the proposal?

ACP urged CMS to clarify:

- The agency’s expectation regarding the selection of a level of service for an inpatient consultation service to be billed using the initial hospital care service codes. A comparison of the CPT description of the codes in the five-level inpatient consultation service family and the three-level initial hospital care service family indicates that there would be no code to report what is now defined as a low-level inpatient consultation service, i.e. 99251 and 99252.
- How it will mitigate problems—e.g. payment delays, record requests, denials—related to the submission of multiple, initial hospital care claims (from multiple physicians) for the same date of service.

- The uncertainty related to how Medicare would interact with other payers, e.g. how Medicare would handle claims if it were the secondary payer and the primary payer continues to recognize the CPT consultation codes.

ACP urged CMS to take action to:

- Explore how to best recognize physician provision of high-end cognitive work, as described above.
- Educate physicians on when it is appropriate to bill critical care.
- Educate physicians on appropriate use of the prolonged service codes.
- Consider a mechanism that allows physicians to be paid a higher rate for some outpatient consultative services that involve a patient known to them, e.g. a pre-operative clearance service in the office setting, a service to a patient in the emergency department setting.
- Ensure that implementation of the proposal does not detract from emphasis on optimal patient care through communication among physicians and providers caring for a patient, e.g. handoffs, transitions.

Other Issues in the Proposed 2010 Fee Schedule

What else did ACP address in its comment letter to CMS on the proposed Medicare 2010 fee schedule?

In addition to the issues described above, ACP:

- Supported establishing a panel of experts that CMS would use to help maintain the accuracy of RVUs assigned to services paid in the physician fee schedule. This panel would supplement the work of the AMA/specialty society convened committee that provides CMS recommendations on the relative value of physician services.
- Urged CMS to proceed cautiously to implement a program mandated by Congress to provide physicians information on how the cost and quality of services they furnish compare to their peers. It is essential that physicians can feel confident that the information is accurate and that the reports be actionable.
- Recommended improvements to the Medicare pay-for-reporting incentive program, the Physicians Quality Reporting Initiative (PQRI) and the e-prescribing incentive program.
- Supported the proposal to increase payment for the “Welcome to Medicare” visit, a comprehensive preventive-oriented examination available to beneficiaries within 12 months of enrolling in Part B.
- Supported the CMS proposal to implement the decision by Congress to gradually eliminate the punitive limitation on what Medicare pays for a physician service justified by a beneficiaries’ psychiatric diagnosis—which results in higher patient co-payments and, thus, out-of-pocket costs.

- Reiterated the recommendations made by internal medicine specialty organizations to improve the CMS proposed implementation of new Medicare programs, authorized by Congress through a 2008 law, related to pulmonary and cardiac rehabilitation services.

I am interested in reading the full ACP comment letter. Where can find it?

The full ACP comment letter to CMS is available at http://www.acponline.org/advocacy/where_we_stand/medicare/frizzera.pdf.

Miscellaneous Issues

How does the CMS proposal relate to efforts by the Congress and President Obama to enact health care reform?

It is also important to distinguish this rule-making process, which is a budget-neutral exercise that takes place each year, from current legislative efforts to reform the broader health care system. ACP has consistently advocated that pending health reform legislation dedicate additional dollars to fund improvements in payments for primary care internists rather than funding them through budget-neutral adjustments in Medicare physician payments to other physicians. We also have advocated for legislative changes to redefine budget neutrality under the Medicare physician fee schedule to take into account the impact of primary care, the Patient-Centered Medical Home, and care coordination and prevention on achieving system-wide Medicare savings, such as from reductions in preventable hospital admissions, rather than funding these services from payments to other physicians.

You make multiple references to how ACP policy dictated the position the College takes on an issue. How does the College develop policy?

ACP policy is developed through the College Governance. The composition of the Committees, Board of Governors, and Board of Regents that comprise the Governance is largely reflective of the ACP membership. A detailed description of how ACP develops policy related to health reform legislation, available at <http://blogs.acponline.org/advocacy/2009/08/how-acp-determines-its-positions-on.html>, provides insight into the College policy development process.