

HERE'S LOOKING TO CMS – IMPLEMENTING PHYSICIAN PAYMENT UNDER PPACA

By Jeanine Freeman, JD

Federal health reform as adopted by the Patient Protection and Affordable Care Act (PPACA or ACA) and amended by the Health Care and Education Reconciliation Act of 2010, is moving forward. CMS' proposed CY 2011 physician payment rule (Federal Register on July 13, 2010 (<http://edocket.access.gpo.gov/2010/pdf/2010-15900.pdf>) advises physicians on how the agency intends to implement certain of PPACA's Medicare physician payment provisions.

Medicare cost challenges. Calls for physician payment reform are matched by harsh Medicare program budget realities now and in the future. Currently, Medicare spending is 12% of the federal budget and one-fifth of national health expenditures. From 2010-2030, the number of Medicare beneficiaries is projected to rise from 47 million to 79 million while the ratio of workers per beneficiaries is expected to decline from 3.7 to 2.4. Medicare spending is projected to increase from \$528 billion in 2010 to \$1,038 billion in 2020, amounts that assume scheduled SGR cuts. PPACA is expected to save the Medicare program as much as \$575 billion between now and 2019, but the cost of "fixing" physician payment has not been factored in.

Medicare and the SGR. A congressional decision was made early on to deal with the complexities of SGR payment reform on its own and not within the context of health reform. The 2010 roller coaster ride for physicians is not over. Congress' authorized 2.2% payment increase is effective through November 30, at which time the SGR reduction increases to 23% and starting in January 1, to nearly 30%. There is near consensus among the President, congressional representatives, and HHS Secretary Sebelius that a permanent alternative to the SGR is needed but

there is no consensus on what that alternative might be. Repeal of the SGR is anticipated to cost \$276 to \$330 billion between now and 2020. Congress wants to know where the money will come from.

GPCIs. IMS remains a lead advocate of GPCI reform. The practice expense (PE) GPCI, based in substantial measure on proxies and weights that fail to accurately reflect the cost realities of operating a medical practice, is particularly troublesome. A 2009 analysis performed by the AMA of its own PPIS data (which CMS extensively relies upon for other RVU/GPCI purposes) concludes that there are no measurable differences in physician practice expenses between urban and rural areas and among Census regions. The PE GPCI, a key driver in Medicare payment disparity, is not a reliable indicator. Iowa suffers as a result of such obvious data imprecision.

The leadership of Senator Charles Grassley and Congressman Bruce Braley, supported by Senator Tom Harkin, resulted in critical albeit temporary PPACA payment relief for Iowa physicians and physicians in other lower-paid Medicare localities in the form of: 1) a 1.0 floor on the work GPCI for CY 2010 (retroactive to January 1); and 2) for CY 2010 and 2011, recognition of only 1/2 of the differences in office rents and nonphysician personnel within the PE GPCI for those localities, like Iowa, that would benefit and holding harmless localities that otherwise would experience a loss. As a result, Iowa physicians are now seeing a 5% increase in Medicare payment, translating to an additional \$20 million available for payment in our state.

PPACA further directed CMS to conduct a study of the PE GPCI, its data sources and its weights and to make PE GPCI adjustments



Jeanine Freeman, JD, is Senior Vice President of Legal Affairs for the Iowa Medical Society.

consistent with the study's findings by CY 2012. In its proposed physician payment rule, CMS addresses: 1) the results of its statutorily mandated 6th 3-year GPCI review; and 2) its findings to-date in the conduct of the PPACA-directed study of the PE GPCI. CMS proposes changes to the PE GPCI as a result of its findings but, unfortunately, CMS continues to rely upon proxy data for rent; proxy data for and limited categories of non-physician employees; and weightings among the PE GPCI inputs not in accord with findings of other data studies.

Under CMS' proposed payment rule, Iowa's CY 2011 GAF is reduced by -2% and Iowa moves to become the 86th lowest paid Medicare locality (in part because of movement up by the five frontier states granted 1.0 PE GPCI floors beginning in 2011) but we continue to benefit from PPACA's PE GPCI relief. PPACA relief expires in CY 2012. Then Iowa becomes the 87th lowest paid Medicare region and suffers a substantial decline in its PE GPCI. Very telling in CY 2012 is the 36.556% band of disparity between the highest paid Medicare locality and the lowest, much too high given other data sources showing no measurable distinctions in physician practice expenses among regions of the country.

Congressman Braley and Senator Grassley have written Secretary Sebelius expressing serious concerns with CMS's GPCI studies to-date (go to www.iowamedical.org). IMS is preparing its comments on CMS' proposed physician payment rule (due August 24). And, in mid-September, the Institute of Medicine (IOM) will convene its study, as directed by Secretary Sebelius, of geographic payment adjusters (the GPCIs for physicians, the wage index for hospitals).

Primary care incentive payment (PCIP).

CMS' proposed physician payment rule sets forth criteria for eligibility for PPACA's 5-year (CY 2011-2015) 10% PCIP. A physician must be submitting Medicare claims under a specialty designation of family medicine (08), internal medicine (11), geriatric medicine (38), or pediatric medicine (37), and primary care services must account for at least 60% of the physician's allowed charges under Part B of all claims submitted in a prior period (for CY 2011, CMS will use CY 2009 claims data processed through June 30, 2010). "Primary care services" include HCPCS codes 99201-99215, 99304-99340, and 99341-99350. The PCIP is equal to 10% of Medicare allowed charges for those primary care services and will be paid quarterly. CMS will post a list of physicians eligible for the CY 2011 PCIP.

HPSA surgical incentive payment program.

CMS' proposed rule also sets forth eligibility criteria for general surgeons (specialty code designation 02) performing major surgical procedures (a 10-day or 90-day global period, listed in Addendum B of the rule under "Global 010 or 090) in a health professional shortage area (HPSA). Professional claims or institutional claims are eligible. Incentive payments will be made quarterly.

Psychotherapy bonus payment. The proposed physician payment rule acknowledges PPACA's extension of Medicare's 5% payment bonus for 24 psychiatric CPT codes (90804-90819, 90821-90824, 90826-90829) through December 31, 2010.

Removal of barriers to preventive services in Medicare. Consistent with PPACA directives, CMS' proposed rule defines "preventive services" and lists in Table 38 those services for which deductibles and coinsurances will be waived and Medicare will pay the full 100% amount beginning in CY 2011.