CMS Proposes 30% Physician Pay Cut for 2012

Quality, cost measures may be used to set incentive payments.

BY ALICIA AULT

FROM THE FEDERAL REGISTER

As expected, the Centers for Medicare and Medicaid Services proposed that physician fees for 2012 would be reduced by 29.5%. The proposed rule was released in the Federal Register July 1.

The reduction is required by the Sustainable Growth Rate (SGR) formula that was part of the Balanced Budget Act of 1997. But Dr. Donald M. Berwick, CMS administrator, said in a statement that the agency is hoping to find a way to avoid the statutory decrease.

"This payment cut would have serious consequences and we cannot and will not allow it to happen," Dr. Berwick said. "We need a permanent SGR fix to solve this problem once and for all. That's why the president's budget and his fiscal framework call for averting these cuts and why we are determined to pass and implement a permanent and sustainable fix."

Dr. Peter W. Carmel, president of the American Medical Association, said that the reductions called for by the SGR formula are a constant threat to physicians' stability. "We are pleased that there is support from the administration and bipartisan members of congress for permanent reform of this broken system, but agreement is not enough," Dr. Carmel said in a statement.

The AMA has been seeking a review and revision of the Medicare Economic Index (MEI), a measure of cost increases that affect physician practices. Dr. Carmel said that such a review was promised in the 2011 Medicare Physician Fee Schedule final rule, but the newly released proposed rule for 2012 shows it has not yet begun. Revisions in the MEI could significantly reduce the legislative cost of permanent reform of the Medicare physician payment formula," said Dr. Carmel, noting that cost is an estimated $300 billion over the next 10 years, and is on its way to hit half a trillion dollars in a few years.

The reductions could be deeper for some specialties – especially for radiation oncology and diagnostic imaging – based on the impact of the Physician Practice Information Survey. The changes would reflect the third year of a 4-year transition to new practice expense relative value units.

And more payment changes may be looming. The CMS said in a statement that it is proposing to continue its efforts to identify what it calls "potentially misvalued codes." As part of those efforts, it will be taking a look at all evaluation and management (E/M) codes to determine if they are undervalued. The agency also proposes to examine the highest non–E/M expenditure codes for each specialty to see if they are overvalued.

The agency said that the reviews will improve payment accuracy, in particular ensuring that primary care services are appropriately reimbursed. It's the first time the agency has looked across all specialties, according to the CMS.

"We believe strong efforts are needed to evaluate Medicare's fee schedule to ensure that it is paying accurately and ensuring that Medicare beneficiaries continue to have access to vital services, such as primary care services," Jonathan Blum, director of the Center for Medicare, said in a statement.

Diagnostic imaging has been a target for Medicare, and it is again in this proposal. The agency wants to extend the multiple procedure payment reduction (MPPR) policy to the professional component of advanced imaging services, which includes computed tomography (CT) scans, MRI, and ultrasound.

The agency said the reduction would affect about 100 types of services. It is also the first time that the CMS has taken aim at the professional component of these services. That component would be reduced by 50% for subsequent procedures furnished to the same patient, on the same day, in the same session, resulting in an estimated $200 million in savings, according to the CMS.

For the first time, the agency is proposing quality and cost measures to be used in setting incentive payments for physicians who provide higher quality and more efficient care. That lays the groundwork for 2015, when the Affordable Care Act requires the CMS to begin making payment adjustments for certain physicians and physician groups. The requirement goes into effect for all physicians in 2017. The agency is proposing to use 2013 as the initial performance year.

In other issues addressed by the proposed rule, CMS seeks to add smoking cessation to the list of services that can be provided through telehealth. In the future, new services would be examined according to the clinical benefit they provide rather than on whether they are equivalent to a corresponding in-person service.

Finally, the CMS proposed some changes to the Physician Quality Reporting System, the ePrescribing Incentive Program, and the Electronic Health Records Incentive Program. The agency, for instance, is expanding the ways physicians can qualify for incentive payments under the meaningful use criteria.

Comments to the proposed rule can be submitted until Aug. 30 at http://www.regulations.gov; a final rule is expected by Nov. 1. ■

Medicare Regulation Aims to Cut Paperwork

BY MARY ELLEN SCHNEIDER

Physicians and their staffs may have a little less insurance paperwork to do, thanks to a coming Medicare regulation.

Scheduled to be published in the Federal Register, the interim final rule puts into place two rules on electronic health care transactions: one to make it easier to determine patients' health care coverage and the other to ascertain the status of a submitted claim.

Currently, when a physician's office staff seeks information on patient health care coverage, they may have to make the request in a different format for each health plan, but under the operating rules set out by Medicare the format will be standardized across all health plans. The changes, which were mandated under the Affordable Care Act, will go into effect on Jan. 1, 2013.

The new Centers for Medicare and Medicaid Services requirements are based largely on operating rules developed by the Council for Affordable and Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE), an industry coalition that works on administrative simplification issues. The CAQH CORE rules are currently in use on a voluntary basis, CMS officials said.

The CMS estimates that the adoption of these two operating rules will result in about $12 billion in savings to physicians and health plans over the next decade, largely because of fewer phone calls between physicians and health plans, reduced paperwork and postage costs, increased opportunities to automate the claims process, and fewer denials.

In the future, the CMS plans to issue additional rules mandating the adoption of standards for electronic funds transfer and remittance advice, a standard unique identifier for health plans, a standard for claims attachments, and requirements that health plans certify compliance with the standards and HIPAA operating rules.

The interim final rule was released by CMS on June 30; the deadline to submit comments on the rule is Sept. 6. ■

Study Shows Wide Variation in Medicaid Spending Among States

BY MARY ELLEN SCHNEIDER

FROM HEALTH AFFAIRS

A look at Washington state's Medicaid program could provide some clues for how to control costs as states prepare for the massive 2014 expansion of Medicaid under the Affordable Care Act.

Washington has been able to provide widespread access to outpatient services and prescription drugs, while keeping down spending on inpatient care, according to an analysis published in the journal Health Affairs (doi: 10.1377/hlthaff.2011.0106).

The per beneficiary cost for inpatient stays was about 35% below the national average in Washington state, while outpatient visits and prescriptions were each 15% above the national average, according to authors Todd P. Gilmer, Ph.D., and Richard G. Kronick, Ph.D., who were both at the University of California, San Diego, when the article was written. Dr. Kronick is now a deputy assistant secretary for health policy at the Department of Health and Human Services.

Dr. Gilmer and Dr. Kronick analyzed Medicaid claims data from 2001-2005 to see how the volume and the price of services affected the variation in spending across the states. They limited their analysis to claims for Medicaid-only, disabled beneficiaries receiving cash assistance.

"Several states are using their Medicaid resources in a way that's helping to reduce the need for more expensive hospital care," Dr. Gilmer said in a statement. "This suggests that there is a great deal of room for innovation in Medicaid. By increasing access to primary care and experimenting with team-based delivery models and low-cost providers, states may be able to improve quality while reducing Medicaid spending."

For example, the Medicaid programs in Connecticut, Massachusetts, New Hampshire, and Vermont spent more than most on prescription costs and outpatient visits, but had a lower-than-average number of hospital days. The inpatient and outpatient spending offset each other, the researchers wrote, resulting in average overall spending that was just below the mean among all states.

The researchers also found that having a large primary care workforce was associated with reduced hospital stays for some chronic conditions such as diabetes, chronic obstructive pulmonary disease, and adult asthma. Paying more for outpatient visits was also linked to reduced hospital admissions. Similarly, paying more for hospital stays was associated with more admissions.

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