MEDICARE PHYSICIAN FEE SCHEDULE
PROPOSED RULE FOR CY 2012

AT A GLANCE

The Issue:
The Centers for Medicare & Medicaid Services (CMS) published its physician fee schedule (PFS) proposed rule for calendar year (CY) 2012 in the July 19 Federal Register. The proposed rule is available at http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage, and comments are due by August 30. A final rule will be issued by November 1, and changes generally will take effect January 1, 2012.

Without congressional action, CMS states that physician payments will decline by an estimated 29.5 percent on January 1, 2012 due to the sustainable growth rate (SGR) formula.

In addition to updating payment weights and rates, the rule proposes to:
- Apply a 50 percent multiple procedure payment reduction (MPPR) to the professional component of advanced imaging services;
- Consolidate the two group practice reporting options and define “group practice” as a group with 25 or more eligible professionals;
- Create a new value-based modifier to adjust physician payments;
- Modify the criteria for approving Medicare telehealth services to provide additional flexibility; and
- Bundle physician services provided within the three-day inpatient payment window and reimburse for these services at the lower facility rate if they are delivered in a physician’s office wholly owned and operated by the hospital.

Our Take:
Payment cuts of almost 30 percent are unsustainable. The AHA will urge Congress to fix the flawed physician payment formula, and to do so in a manner that does not result in reduced payments to other providers. We also are concerned about CMS’s proposed expansion of the MPPR as well as its new, more restrictive, definition of group practice.

What You Can Do:
- Share this advisory with your chief medical officer, chief financial officer and other members of your senior management team.
- Assess the potential impact of the proposed payment changes on your Medicare revenue and operations.
- Consider submitting comments to CMS identifying your concerns about the proposed rule.

Further Questions:
Please contact Ashley Thompson, AHA director of policy, at (202) 626-2688 or athompson@aha.org.

AHA’s Regulatory Advisories are produced whenever there are significant regulatory developments that affect the job you do in your community. A 15-page, in-depth examination of this issue follows.
On July 1, the Centers for Medicare & Medicaid Services (CMS) released its proposed rule for calendar year (CY) 2012 with changes to the Medicare physician fee schedule (PFS) and other revisions under Medicare Part B. The proposed rule, published in the July 19 Federal Register, is available at http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage. Changes in the rule generally will be effective January 1, 2012. Comments are due to CMS by August 30. A final rule will be issued by November 1.

**Conversion Factor**

The Medicare and Medicaid Extenders Act of 2010 (MMEA) halted significant physician payment cuts projected for CY 2011 by extending physician payments at current levels through December 31, 2011. Without additional congressional action, however, CMS estimates that physician payments will decline by a mandated 29.5 percent on January 1, 2012. CMS states that the conversion factor will drop from $33.9764 to $23.9635. Cuts of this magnitude are unsustainable. The AHA will urge Congress to fix the flawed physician payment formula, and to do so in a manner that does not result in reduced payments to other providers.

**Potentially Misvalued Services**

CMS is required to review relative-value units (RVUs) at least every five years. Currently, the agency conducts separate “free-standing” reviews of the RVUs. In the June 6 Federal Register, CMS published its most recent five-year review of the RVUs, with proposed revisions to work RVUs and corresponding changes to the practice expense (PE) and malpractice RVUs. In the PFS proposed rule, CMS proposes to discontinue its practice of conducting separate reviews of the work and PE RVUs, and instead consolidate the formal five-year reviews with the ongoing annual reviews of potentially misvalued codes. Review of malpractice
RVUs would continue to occur at five-year intervals. CMS proposes an annual process for the public to submit codes for review, stating that submissions must be made during the 60-day time period following release of the PFS final rule (typically November 1–December 31 of each year) for consideration in the following year’s proposed rule.

**Multiple Procedure Payment Reduction (MPPR) for Imaging Services**

The rule proposes to apply a 50 percent MPPR to the professional component of advanced imaging services (computed tomography (CT) scans, magnetic resonance imaging (MRI) and ultrasound) provided by the same practitioner to the same patient in the same session. Specifically, beginning January 1, 2012, CMS proposes to provide full payment for the professional component for the highest paid advanced imaging procedure and reduce by 50 percent the professional component for each additional advanced imaging procedure furnished to the same patient in the same session. Currently, CMS applies a 50 percent MPPR to the technical component for advanced diagnostic imaging services performed in a single session, and, as of January 1, 2011, not limited to contiguous body areas.

To support its proposal, CMS references the work of the American Medical Association’s (AMA) Resource Use Committee, which continues to review code pairs to account for efficiencies in a bundle of services; a July 2009 Government Accountability Office report that recommended expanding the imaging MPPR policy to reflect efficiencies in physician work for certain imaging services; and a March 2010 Medicare Payment Advisory Commission (MedPAC) report that recommended exploring whether expanding the unit of payment through packaging or bundling would improve payment accuracy. In addition, in its June 2011 report, MedPAC specifically recommended that CMS should apply a MPPR to the professional component of diagnostic imaging services provided by the same practitioner in the same session.

The agency indicates that it will be aggressively exploring further expansion of the MPPR policy in CY 2013, including expanding the MPPR policy to the technical component of all imaging services, the technical component of all diagnostic tests, and/or the professional component of all imaging services. CMS estimates that its current proposal would redistribute approximately $100 million in payments through a small increase in the conversion factor and a small adjustment to all PE RVUs. This change would primarily reduce payments to the specialties of radiology and interventional radiology.

**Geographic Practice Cost Indices (GPCIs)**

By law, CMS is required to develop separate GPCIs to measure the differences in resource costs associated with physician work, PE and malpractice among localities compared to the national average. CY 2012 is the second year of the two-year transition to the latest GPCI rates that began in CY 2011. Addendum D of the [proposed rule](#) shows the estimated effects for the revised GPCIs on locality...
geographic adjustment factors for CY 2012, and includes the additional changes described below.

The Institute of Medicine (IOM) is evaluating the accuracy of the geographic adjustment factors used for Medicare physician payment and will submit three reports to Congress and the Department of Health and Human Services (HHS). The first IOM report (available at http://www.iom.edu/Reports/2011/Geographic-Adjustment-in-Medicare-Payment-Phase-I-Improving-Accuracy.aspx) was released June 1 and includes an evaluation of the accuracy of geographic adjustment factors for the hospital wage index used in the Medicare inpatient prospective payment system and the GPCIs, and the methodology and data used to calculate them. The IOM is expected to release a supplemental report in summer 2011 that discusses physician payment issues further. A third report, expected in spring 2012, will evaluate the effects of the adjustment factors on health care quality, population health and the distribution of the health care workforce.

In its June 1 report, the IOM recommended that the same labor market definitions be used for both the hospital wage index and the physician geographic adjustment factor, with metropolitan statistical areas and statewide non-metropolitan statistical areas serving as the basis for defining labor markets. CMS was unable to address the IOM recommendations in this proposed rule given the timing of the first report and the fact that the second report, which also will address GPCIs, has yet to be released. Thus, the agency does not propose any changes to the 89 locality configurations for CY 2012.

**Physician Work GPCI**
The MMEA extended the 1.0 work GPCI floor through CY 2011. The proposed rule does not reflect this floor given it is set to expire on December 31. Note that the 1.5 work GPCI floor for Alaska, as well as the 1.0 PE GPCI floor for the frontier states (which continue to be defined as Montana, Nevada, North Dakota, South Dakota and Wyoming,) are permanent and thus applicable for CY 2012. CMS proposes to revise the physician work cost share weight from 52.466 to 48.266 to reflect the 2011 Medical Economic Index (MEI) rates, which are based on 2006 data. **The AHA will continue to urge Congress to extend the 1.0 work GPCI floor for CY 2012.**

**Practice Expense GPCI**
The Patient Protection and Affordable Care Act (ACA) requires the HHS Secretary to analyze the current methods and data sources it uses to determine the PE component of the PFS, specifically the relative cost differences in employee wages and office rent compared to the national average, and to make appropriate adjustments to the PE GPCI by no later than January 1, 2012. CMS proposes to make the following four revisions to the PE data sources and cost share weights for CY 2012:
• Revise the occupations used to calculate the employee wage component of PE using Bureau of Labor Statistics wage data specific to the Office of Physicians’ Industry;
• Utilize two-bedroom rental data from the 2006-2008 American Community Survey as the proxy for physician office rent;
• Create a purchased service index that accounts for regional variation in labor input costs for contracted services from industries comprising the “all other services” category within the MEI office expense and the standalone “other professional expenses” category of the MEI; and
• Use the 2006-based MEI to determine the GPCI cost share weights.

In addition, beginning January 1, 2012, the ACA provision that requires the employee wage and rent portions of the PE GPCI to reflect half (rather than all) of the relative cost differences for each locality compared to the national average, holding harmless those localities that would receive a reduction, will expire. CMS proposes to revise the cost share weight for the PE GPCI from 43.669 to 47.439.

**Malpractice GPCIs**
CMS proposes to revise the cost share weight for the malpractice GPCI from 3.865 to 4.295, given its updated analysis of data.

**Medicare Telehealth**
Currently, Medicare telehealth services may be approved by CMS on a Category 1 basis, where new services are similar to services currently on the telehealth list, or on a Category 2 basis, where services are not similar to those currently on the list but where there is evidence that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to in-person delivery of the service.

The rule proposes to add smoking cessation counseling (CPT codes 99406 and 99407, HCPCS codes G0436 and G0437) to the list of approved telehealth services, on a Category 1 basis, in CY 2012. CMS reasons that smoking cessation counseling is similar to the education, assessment and counseling elements of kidney disease education and medical nutrition therapy, which are currently covered telehealth services. CMS rejects requests to add to the list critical care services, domiciliary or rest home evaluation & management (E&M) services, genetic counseling services, online E&M services, data collection services and audiology services.

CMS also proposes to change its criteria for adding services to the Medicare telehealth list beginning in CY 2013. Specifically, the agency proposes to modify Category 2 approval so that services that meet a new “clinical benefit standard,” rather than the current “comparability standard,” may be approved. Providers have had difficulty demonstrating that the clinical outcomes of a service delivered via telehealth are comparable to the outcomes of the in-person service, and, in
many cases, admit that the alternative to a telehealth service may be no service at all. Also, to date, CMS has not added any services to the telehealth list on a Category 2 basis. The more flexible clinical benefit standard would allow the agency to add a service to the list if it demonstrates a clinical benefit to the patient. **The AHA strongly supports this modification, which should result in an expanded list of telehealth services and better medical care for beneficiaries who might otherwise not have access to certain diagnostic or treatment services.**

**Chiropractic Services Demonstration**

CMS proposes to continue its five-year recoupment of $50 million in expenditures for a two-year demonstration project to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. The demonstration project, which ended in March 2007, was to be budget neutral. CY 2011 was the second-year of a five-year recoupment. Thus, CMS is proposing to recoup $10 million in CY 2012 by reducing the payment amount under the PFS for chiropractic codes by approximately 2 percent.

**Productivity Adjustment**

The ACA requires that beginning in CY 2011 CMS adjust the update factors under the ambulatory surgical center payment system, the ambulance fee schedule, the clinical laboratory fee schedule and the durable medical equipment, prosthetics, orthotics, and supplies fee schedule by changes in economy-wide productivity. By statute, the productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP). CMS proposes to revise the portion of the MFP used as a proxy for labor from man-hours to hours of all persons, stating that doing so would better account for the changes in the skill-mix of workers over time.

**Technical Component of Certain Physician Pathology Services**

The MMEA required CMS to continue to pay independent laboratories for the technical component of physician pathology services for Medicare beneficiaries who are hospital inpatients or outpatients through CY 2011. Unless this provision is further extended by Congress, beginning January 1, 2012, independent laboratories will have to bill hospitals directly for technical component services. **The AHA will continue to press Congress to extend the ability of independent labs to bill Medicare directly for the technical component of physician pathology services.**

**Annual Wellness Visit Health Risk Assessment (HRA)**

The ACA provides Medicare beneficiaries with annual wellness visits including "personalized prevention plan services," with zero cost-sharing, effective January 1, 2011. While the law required that an HRA be included in the new annual wellness visit benefit, it also provided the Secretary additional time to develop HRA guidelines and a model tool in consultation with relevant groups and entities. Over the past year, CMS has commissioned the Agency for Healthcare Research
and Quality to describe key features of HRAs and collaborated with the Centers for Disease Control and Prevention (CDC) to develop guidelines for a personalized prevention plan tool. Consistent with the CDC’s guidance document, CMS proposes to define an HRA as an evaluation tool that meets the following requirements:

- Collects self-reported information about the beneficiary;
- Can be administered independently by the beneficiary or by a health professional prior to or as part of the annual wellness visit encounter;
- Is appropriately tailored to and takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs;
- Takes no more than 20 minutes to complete; and
- Addresses, at a minimum, the following topics:
  - Demographic data
  - Self assessment of health status
  - Psychosocial risks (such as stress, depression)
  - Behavioral risks (such as tobacco use)
  - Activities of daily living (such as dressing and feeding)
  - Instrumental activities of daily living (such as shopping and housekeeping)

CMS states that this would be the minimum set of topics that need to be part of an HRA, but that health professionals would have the flexibility to evaluate additional topics and beneficiary needs, as appropriate. The agency requests public comment on the proposed elements of the HRA, including whether additional elements such as biometric assessments should be included, and on the overall impact and burden it would have on health professionals.

**Physician Quality Reporting System (PQRS)**

*Payment Adjustment and Reporting Requirements*

For CY 2012, PQRS incentive payments will equal 0.5 percent of an eligible professional’s (EP) total estimated Part B allowed charges for professional services delivered during the reporting period. CMS estimates that it will pay approximately $60 million in PQRS incentive payments in CY 2012.

For 2012, CMS proposes to allow EPs to submit quality data through one of three methods: claims-based reporting mechanism, registry-based reporting and an electronic health record- (EHR) based reporting option. CMS proposes to retain the six-month reporting period (July 1-December 31) for the reporting of PQRS measure groups via registry, but to specify a 12-month reporting period (January 1-December 31) for all other reporting options, including claims-based, registry reporting of individual measures (as opposed to measure groups) and EHR-based reporting.
**Group Practice Reporting Option**

There are two ways an EP may participate in the PQRS – as an individual EP or as part of a group practice under the PQRS group practice reporting option (GPRO). Currently CMS defines a “group practice” as “a single Tax Identification Number (TIN) with two or more EPs, as identified by their individual National Provider Number (NPI), who have reassigned their Medicare billing rights to the TIN.”

CMS allows for two types of group practices – GPRO 1 for groups with 200 or more EPs, and GPRO 2 for groups with 2-199 EPs. In the rule, CMS proposes to consolidate the two GPROs to define a group practice as one with 25 or more EPs, thus eliminating group practices comprised of 2 to 24 EPs. The AHA is concerned that CMS’s more narrow definition of a group practice would exclude a significant number of physicians in group practices from participating in the GPRO option. The AMA data from 2005 found that about half of all physicians practicing in a group did so in a group that had between three and 25 physicians.

Since the introduction of the PQRS GPRO in 2010, EPs within a group practice were required to assign their billing rights to a single TIN. CMS is proposing to retain this requirement for CY 2012, but is considering amending the definition to allow EPs who practice using multiple TINs to participate in the PQRS GPRO in the future. The agency indicates this would better align the PQRS with other quality reporting group programs and may be beneficial to providers who wish to participate in multiple CMS quality reporting programs that apply to group practices. CMS requests comment on this potential change, including what parameters could be set to ensure that multiple TINs represent a single, integrated practice.

In order to participate in the PQRS GPRO for CY 2012 (and subsequent years), CMS requires group practices to complete a self-nominating process by January 31 of the calendar year of the reporting period and meet certain participation requirements. For example, in order to participate in the GPRO for the CY 2012 PQRS, the group would need to self-nominate by January 31, 2012. CMS proposes to allow those group practices who have previously participated in the PQRS GPRO to automatically be qualified to participate in the GPRO in CY 2012 and future program years. CMS notes that EPs participating in a Medicare approved demonstration project (such as the Physician Group Practice (PGP) demonstration, the Medicare Shared Savings Program/Accountable Care Organization (ACO), the Pioneer ACO, or EHR demonstrations) would be deemed to be participating in the PQRS GPRO.

For the 2012 GPRO reporting option, CMS proposes to require the reporting of 40 core measures. Among those 40 proposed measures, 18 are new measures. CMS also proposes to retire three measures that were used in the 2011 GPRO reporting option. A list of the new proposed GPRO measures is included below.
Proposed New Group Reporting Measures
CY 2012 PQRS Program

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Mechanism</th>
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<tbody>
<tr>
<td>Ischemic vascular disease – use of aspirin or another antithrombotic</td>
<td>Claims, Registry, EHR</td>
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<tr>
<td>Tobacco use assessment and cessation intervention</td>
<td></td>
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<tr>
<td>Ischemic vascular disease – complete lipid profile and low densitylipoprotein control &lt; 100</td>
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<tr>
<td>Proportion of adults 18 years and older who have had their blood pressure measured within the preceding two years</td>
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<tr>
<td>Chronic obstructive pulmonary disease – bronchodilator therapy</td>
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<tr>
<td>Adult weight screening and follow-up</td>
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<tr>
<td>Ischemic vascular disease – blood pressure management control</td>
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<tr>
<td>Chronic obstructive pulmonary disease – spirometry evaluation</td>
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<tr>
<td>30-day post-discharge physician visit</td>
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<tr>
<td>Medication reconciliation – reconciliation after discharge from an inpatient facility</td>
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<tr>
<td>Diabetes – aspirin use</td>
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<tr>
<td>Falls – screening for fall risk</td>
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<tr>
<td>Osteoporosis – management following fracture of hip, spine or distal radius for men and women aged 50 years and older</td>
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<tr>
<td>Diabetes – tobacco use</td>
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<tr>
<td>Coronary artery disease – low density lipoprotein level &lt; 100</td>
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<tr>
<td>Diabetes – hemoglobin A1c poor control in diabetes</td>
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<tr>
<td>Chronic obstructive pulmonary disease – smoking cessation counseling received</td>
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<td>Monthly international normalized ratio for beneficiaries on warfarin</td>
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Non-Group Practice Reporting
CMS proposes several substantial expansions to the quality measures that may be reported in CY 2012.

First, the agency proposes to require that professionals specializing in internal medicine, family practice, general practice or cardiology report on at least one of the seven PQRS core measures (below) aimed at promoting the prevention of cardiovascular conditions. CMS indicates that it hopes to develop similar reporting requirements and core sets of measures for other specialties in future years. CMS requests public comment on whether other specialties, such as geriatricians, should also be included in this requirement. Thus for these four specialties, in order to successfully report under the PQRS, EPs would need to report on at least one PQRS core measure (related to cardiac prevention) along with two additional measures that apply to the services they deliver.

Proposed New Non-Group Practice Reporting Core Measures
CY 2012 PQRS Program

<table>
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<th>Measure</th>
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American Hospital Association
density lipoprotein control < 100
Controlling high blood pressure
Diabetes – low density lipoprotein control
Tobacco use assessment and cessation intervention
Proportion of adults 18 years and older who have had their blood pressure measured within the preceding two years
Preventive care – cholesterol low density lipoprotein test performed

Second, CMS adds 26 individual measures, bringing the total list of individual measures to 212. Only two of the new measures – anticoagulation for acute pulmonary embolus patients and pregnancy test for female abdominal pain patients are currently endorsed by the National Quality Forum. About half of the measures would be registry-based reporting, and the other half would be available for claims and registry reporting. Below is a list of all 26 proposed new individual measures. A list of all 212 proposed measures available for either claims-based or registry-based reporting is in Table 30 (page 42865) of the proposed rule.

<table>
<thead>
<tr>
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<tr>
<td>Anticoagulation for acute pulmonary embolus patients</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Pregnancy test for female abdominal pain patients</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Chronic wound care – use of wound surface culture technique in patients with chronic skin ulcers</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Chronic wound care – use of wet to dry dressings in patients with chronic skin ulcers</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Hypertension – blood pressure control</td>
<td>Registry</td>
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<tr>
<td>Coronary artery disease – symptom management</td>
<td>Registry</td>
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<tr>
<td>Substance abuse disorders – counseling regarding psychosocial and pharmacologic treatment options for alcohol dependence</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Substance abuse disorders – screening for depression among patients with substance abuse or dependence</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Cardiac rehabilitation referral from an outpatient setting</td>
<td>Registry</td>
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<tr>
<td>Barrett’s esophagus</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Ultrasound determination of pregnancy location for pregnant patients with abdominal pain</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Rhogam (Rh) immunoglobulin for Rh negative pregnant women at risk of fetal blood exposure</td>
<td>Registry</td>
</tr>
<tr>
<td>Surveillance after endovascular abdominal aortic aneurysm repair</td>
<td>Registry</td>
</tr>
<tr>
<td>Referral for otology evaluation for patients with acute or chronic dizziness</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Image confirmation of successful excision of image – localized breast lesion</td>
<td>Claims &amp; Registry</td>
</tr>
<tr>
<td>Improvement in patient’s visual function within 90-days following cataract surgery</td>
<td>Registry</td>
</tr>
</tbody>
</table>
Third, CMS proposes to add 10 new measure groups, bringing the total list of measure groups to 24. The new groups, which contain between four and 10 measures each, are:

- Chronic obstructive pulmonary diseases;
- Inflammatory bowel disease;
- Sleep apnea;
- Epilepsy;
- Dementia;
- Parkinson’s disease;
- Elevated blood pressure;
- Radiology;
- Cardiovascular prevention; and
- Cataracts.

Finally, the agency intends to make available all 44 EHR quality measures for the Medicare EHR Incentive Program in addition to six measures available for EHR-based reporting under the 2011 PQRS. A list of all 50 proposed EHR measures is in Table 31 (page 42871) of the proposed rule.

**Maintenance of Certification (MOC)**

In addition to PQRS reporting, the ACA provided an additional 0.5 percent payment incentive from CY 2011 through CY 2014 for EPs providing PQRS data through a MOC program operated by a specialty body of the American Board of Medical Specialties. CMS requires, among other things, that quality data be submitted “more frequently than is required to qualify for, or maintain, board certification status.” CMS proposes to give each Specialty Board the flexibility to determine what “more frequent” participation means for its particular MOC program, as long as the EP participates in and successfully completes at least one
MOC program practice assessment per year, and submits patient experience with care survey information.

**Feedback Reports**
CMS will continue to provide interim feedback reports to those EPs participating in PQRS. For those EPs that fail to satisfactorily meet the qualifications of the program and who request an informal review, CMS proposes to respond to the requests within 90 days (rather than the current 60 days).

**Electronic Prescribing (eRx) Incentive Program**
By law, EPs that are successful electronic prescribers (e-prescribers) may receive an incentive bonus of 1.0 percent in CY 2012 and 0.5 percent in CY 2013. Payment penalties of 1.0 percent in CY 2012, 1.5 percent in CY 2013, and 2.0 percent in CY 2014 will apply to non-successful e-prescribers. The eRx program is not authorized beyond CY 2014. CMS estimates that eRx incentive payments will total $74 million in CY 2012 and $36 million in 2013. The agency estimates that the total payment penalty will be $111 million in 2013 and $148 million in CY 2014 (no estimate of the CY 2012 penalty was provided).

As with PQRS, EPs may participate in the eRx program as an individual or as part of a GPRO. There is no sign-up or pre-registration for individual EPs to participate in the eRx Incentive Program. However, there are certain limitations for who can qualify for an eRx incentive payment. First, an EP must have and use a qualified eRx system and report on his or her adoption and use of the eRx system. Second, the EP must meet the criteria for successful e-prescriber specified by CMS for a particular reporting period. Finally, at least 10 percent of a successful e-prescriber’s Medicare Part B covered services must be made up of codes that appear in the denominator of the eRx measure. Eligible group practices may participate in the program, but they must self-nominate to specifically indicate intent to participate as an eRx GPRO. Also, CMS proposes to apply its revised definition of group practice to the eRx program, such that EPs in group practices comprised of less than 25 EPs will need to participate in the eRx program as individuals.

In the 2011 PFS final rule, CMS finalized a six-month reporting period (January 1, 2011–June 30, 2011) to determine the 2012 payment adjustment for both EPs and group practices participating in the eRx GPRO. CMS does not propose changes to its current policy to use the first six months of 2011 to determine whether a 2012 payment penalty will apply. The AHA will continue to encourage CMS to determine the 2012 eRx payment adjustment based on a full year of 2011 data, which would allow more EPs to meet the requirement.

Also in the 2011 PFS final rule, CMS finalized a 12-month reporting period (January 1, 2011 – December 31, 2011) for the purpose of the 2013 payment adjustment for both EPs and group practices. CMS proposes an additional six-month reporting period (January 1, 2012 – June 30, 2012) for the 2013 payment
penalty for both EPs and group practices. For the 2014 payment penalty, CMS proposes that a 12-month reporting period (January 1, 2012 – December 31, 2012) will apply to individual EPs, and a six-month reporting period (January 1, 2013 – June 30, 2013) will apply to individual EPs and group practices. The AHA is pleased that CMS expanded the reporting periods for the 2013 and 2014 payment penalties, but believes the agency should do so beyond the additional six-months to an entire calendar year so that the 2013 eRx payment adjustment is based on a full year of 2013 data and the 2014 eRx payment adjustment on a full year of 2014 data.

Beginning January 1, 2012, CMS proposes to expand its definition of a “qualified” e-prescribing system to include one that has certified EHR technology. Also for the purposes of the 2013 and 2014 payment adjustment, CMS proposes to provide significant hardship exemption categories for professionals who:

- Practice in a rural area with limited high-speed Internet access;
- Practice in an area with limited available pharmacies for e-prescribing;
- Are unable to electronically prescribe due to local, state or federal law; or
- Prescribe fewer than 100 prescriptions during a six-month, payment adjustment reporting period.

**Physician Compare Website**

The ACA requires the HHS Secretary to develop a Physician Compare Internet website by January 1, 2011. CMS launched the first phase of the website on December 30, 2010, which included posting the names of physicians and EPs that satisfactorily submitted quality data for the 2009 PQRS. The law includes a number of additional requirements related to the website, including making physician performance information available on Physician Compare by January 1, 2013. In the rule, CMS indicates that during the second phase of the website (in 2011 and 2012) it will include the names of EPs who are successful e-prescribers and the names of EPs participating in the EHR Incentive Program.

CMS also proposes to begin reporting quality data on group practices (rather than individual physicians). Specifically, CMS proposes to start with data collected in CY 2012 from those practicing in the PGP demonstration and from those participating in the 2012 PQRS GPRO. CMS would modify the GPRO data collection tool to allow collection of these data, and would allow group practices the opportunity to review their performance results before data are made public. CMS proposes to require a minimum of 25 patients for reporting and displaying measure performance on the website. While Physician Compare would reflect performance data only by group, CMS proposes to identify each individual EP associated with each group during the reporting period.

**Medicare EHR Incentive Program for 2012**

For those EPs voluntarily participating in the Medicare EHR Incentive Program, CMS proposes that in 2012 EPs continue to use a web-based attestation to report
clinical quality measure (CQM) data generated by a certified EHR, rather than reporting the CQMs electronically directly from the EHR.

In addition, CMS proposes to begin a voluntary PQRS-Medicare EHR Incentive Pilot in 2012 to test automated reporting of CQM using certified EHR technology. The same quality measures would be used in the pilot (see AHA’s August 13, 2010 Regulatory Advisory on the EHR incentive program for a listing of quality measures at http://www.aha.org/aha/advisory/2010/100813-regulatory-adv.pdf). However, the actual data submitted to CMS would be different. CMS proposes that rather than submitting summary data (numerator, denominator and exclusions), as currently required, EPs participating in the pilot would:

- Submit CQM data on Medicare patients only;
- Submit Medicare patient-level data from which CMS may calculate CQM results using a uniform calculation process, rather than aggregate results calculated by the EHR;
- Submit one full year of CQM data, regardless of the year of participation in the EHR incentive program (CMS only requires a 90-day reporting period for the first year of participation in the EHR incentive program); and
- Use new CMS-specified data standards.

CMS proposes to require that EPs participating in the pilot also participate in the PQRS itself, because the pilot will rely on the infrastructure used for PQRS. To participate, EPs must have an EHR that is both certified for meaningful use and qualified for PQRS. Similar to PQRS, EPs who elect to participate in the pilot may choose one of two options: reporting through an EHR Data Submission Vendor or reporting directly to CMS from their own EHRs.

CMS proposes that EPs can fulfill their CQM reporting requirements under meaningful use by participating in the pilot. Participation could delay when EPs receive their incentive payment if they are in their first payment year for meaningful use, however, because CMS proposes to collect 12 months of CQM data from those participating in the pilot, rather than the 90 days of data required for the first year of meaningful use.

**Value-Based Payment Modifier**
The ACA requires CMS to adopt a budget-neutral value-based payment modifier to the PFS beginning January 2015 to improve quality and decrease costs. It also requires that by January 1, 2012, CMS publish quality of care and cost measures for the payment modifier, the dates for implementation of the payment modifier, and the initial performance period used to adjust payment.

To assess quality, the agency proposes to create a core measure set that would include:

- 2012 measures in the core set of the PQRS;
- All measures in the GPRO of the PQRS; and
• All measures in the 2012 EHR incentive program.

CMS is exploring the addition of other measures related to outcomes, care coordination/patient transition, patient safety, patient experience of care, and functional status. The agency also is developing an all-cause hospital readmission measure for potential use in the Shared Savings/ACO program and seeks comments about the use of this, and other measures, for physicians. Table 62 (page 42909) of the proposed rule lists all the proposed quality measures for the value-based modifier.

CMS proposes five measures to assess cost of care. These five measures include total Medicare Parts A and B spending for beneficiaries, and total Medicare Parts A and B spending for beneficiaries with the following four conditions: chronic obstructive pulmonary disease, heart failure, coronary artery disease and diabetes. CMS also solicits comments on future cost of care measures for episodes of care and hospital-based episodes for all services furnished on the day of admission through a specific number of days after the day of discharge.

CMS proposes to use the full calendar year 2013 as the initial performance period to adjust payment in 2015.

**Bundling/Three-Day Payment Window**
*The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010* requires that all outpatient diagnostic and therapeutic services provided within three days of a hospital admission be rolled up into the hospital inpatient payment. CMS discussed the implementation of this policy in its fiscal year 2012 inpatient prospective payment system proposed rule and its application to services delivered in physician practices that are wholly owned or operated by the hospital receiving the admission. In the PFS rule, CMS proposes that beginning January 1, 2012 Medicare payments for physicians’ services that are subject to the three-day payment window and delivered in a hospital’s wholly owned or operated physician practice would be made at the lower facility (rather than non-facility) rate.

**Hospital Discharge Care Coordination**
While CMS is not proposing any changes at this time, the agency is interested in broad public comment on how to further improve physician care coordination within the statutory structure for physician payment and quality reporting, particularly for a beneficiary’s transition from the hospital to the community. The agency is seeking comment on the activities and resources involved in the ability of a physician to provide effective care coordination surrounding a hospital discharge, and whether the coding and relative values assigned to these post-discharge care coordination services need modification. Any changes would be proposed through future notice and comment rulemaking and would be budget neutral.
**NEXT STEPS**

The AHA encourages members to submit comments on how CMS’s proposals will affect their facility. Watch for more information from AHA that may assist you in preparing your organization’s comment letter.

Comments are due to CMS by August 30 and may be submitted electronically at [http://www.regulations.gov](http://www.regulations.gov). Follow the instructions for “submitting a comment.”

CMS also accepts written comments via regular or overnight/express mail.

**Via regular mail**
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Dept. of Health and Human Services
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Baltimore, MD 21244-8013

**Via overnight or express mail**
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Attention: CMS-1503-P; Mailstop: C4-26-05
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