

FINAL RULE ON 2011 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) RELEASED

2011 MPFS CONVERSION FACTOR: \$25.5217

CHANGES TO THE PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) PROGRAM FINALIZED

Today final changes to payment policies and rates under the 2011 Medicare Physician Fee Schedule from the Centers for Medicare and Medicaid Services (CMS) were reviewed. The final rule will be published in the Federal Register on November 29, 2010.

2011 Medicare Physician Fee Schedule (MPFS) Conversion Factor: \$25.5217

Congress did not address the pending reductions that are scheduled to take effect due to the flawed Sustainable Growth Rate (SGR) formula before leaving for the election recess, therefore, unless they take action upon their return after the elections, physicians will face a cut of 23% in Medicare physician payments on December 1, 2010 that will increase to 24.9% on January 1, 2011. As a result, the final rule sets the 2011 MPFS conversion factor at **\$25.5217**.

Rebasing and Revising of the Medicare Economic Index (MEI)

The percent change of the rebased and revised MEI for the CY 2011 PFS final rule is an increase of 0.4 percent, one tenth of a percentage point higher than the 2000 based MEI for the same period. The MEI was last rebased and revised in 2003 for purposes of the 2004 MPFS, and is based on data from 2000.

In addition, CMS will implement several provisions of the Affordable Care Act (ACA) that changed the structure and function of the PQRS program. Specifically, the rule will implement the following:

* As a result of the Patient Protection and Affordable Care Act of 2010 (PPACA), CMS is authorized to make PQRS incentive payments through 2014, and impose a penalty beginning in 2015, for providers who do not satisfactorily submit quality data. **In 2011, the incentive will be 1% of the providers estimated total allowed charges for covered professional PFS services under Medicare Part B provided during the reporting period.**

* As a result of PPACA, and beginning in 2011 through 2014, an additional incentive payment of 0.5% can be earned if a provider, who successfully participates in the PQRS, also provides data on quality measures through a Maintenance of Certification Program (certain requirements and criteria must be met).

* CMS will use its new authority under the PPACA and modify the criteria for satisfactory reporting of individual quality measures for those providers who participate using the claims-based reporting mechanism. Specifically, CMS will reduce the reporting threshold from 80% on each of the three measures reported, to 50%.

* CMS will implement a provision from PPACA to develop a “Physician Compare Web site,” which CMS will populate with 2011 PQRS data. Specifically, CMS will post on the site the names of providers who: (1) submit data on the 2011 PQRS quality measures through one of the reporting mechanisms available for the 2011 PQRS; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2011 PQRS; and (3) qualify to earn a PQRS incentive payment for covered professional services furnished during the applicable 2011 PQRS reporting period. Eventually, CMS will begin reporting performance information, including the measures collected under PQRS, through the Physician Compare Web site.

* CMS is considering options that would allow them to provide timely feedback reports to providers about their PQRS reporting habits, including proposals for interim feedback reports.

* CMS will create an informal review process for those who wish to have CMS review its determination that her/she has not submitted data for PQRS satisfactorily. Specifically, providers would have 90 days from the release of his/her feedback report to request an informal review. The request would go through the Quality Net Help Desk and a response would be given in writing within 60 days. Decisions made would be final, and there will be no further review or appeal.

* CMS will retain the claims-based reporting mechanism, the registry-based reporting mechanism, and the EHR-based reporting mechanism in 2011; however, CMS states that it will consider significantly limiting the claims-based mechanism of reporting in future program years.

Potentially Misvalued Codes

As explained in a press release on the 2011 MPFS NPRM, CMS is required, as a result of PPACA, to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. Although CMS continues to work with the American Medical Association’s (AMA) Relative Value System Update Committee (RUC) on identifying and addressing potentially misvalued codes, CMS will refer to the AMA RUC for review several codes on the AMA RUC’s multispecialty points of comparison (MPC) list (The MPC list contains reference codes of established comparison services that are used in the valuation of new codes). The AMA RUC will review codes with site-of-service anomalies, that is, codes that have experienced a shift in the site-of-service since they were originally valued.

Additional Proposals

Additional issues related to physician resource use, the Electronic Prescribing Incentive Program, and practice expense inputs, among other things, will be detailed in upcoming updates.

The final rule will be effective for services on or after January 1, 2011