



American Society of Clinical Oncology

PRESIDENT

Michael P. Link, MD

IMMEDIATE PAST PRESIDENT

George W. Sledge, Jr., MD

PRESIDENT-ELECT

Sandra M. Swain, MD

TREASURER

Clifford A. Hudis, MD

CHIEF EXECUTIVE OFFICER

Allen S. Lichter, MD

DIRECTORS

James L. Abbruzzese, MD
Eduardo L. Cazap, MD, PhD
Gary I. Cohen, MD
Susan L. Cohn, MD
Daniel F. Hayes, MD
Lori J. Pierce, MD
Carolyn D. Runowicz, MD
Lynn M. Schuchter, MD
Frances A. Shepherd, MD
Everett E. Vokes, MD
Julie M. Vose, MD
Eric P. Winer, MD
Peter P. Yu, MD
Robin T. Zon, MD

Proposed Medicare Physician Fee Schedule for Calendar Year 2012: Initial Summary of Issues of Concern to ASCO Members

Background

The Centers for Medicare and Medicaid Services (CMS) released the proposed Medicare Physician Fee Schedule (MPFS) for Calendar Year (CY) 2012 on July 1, 2011. Comments on the rule are due by August 30, 2011. This initial summary provides a review of the issues of greatest concern to ASCO members. We are conducting additional review of the data and statements presented by CMS and will be preparing detailed comments for submission to CMS prior to the deadline in late August.

CMS projects that total payments under the 2012 MPFS will be \$80B and changes to Relative Value Units (RVUs) and the application of the Multiple Procedure Payment Reduction (MPPR) policy (see below) will have a net effect of 0% both overall and for hematology/oncology from 2011 to 2012.

While the MPFS proposed rule historically provides an estimate of the following year's conversion factor (CF), the 2012 rule does not incorporate the estimated 2012 CF in rate calculations. The agency uses the current 2011 CF (\$33.9762) for these calculations, despite the fact that the CF is set to decrease by 29.5% under current law in 2012 (to \$23.9635). CMS discusses how a long-term solution to the Sustainable Growth Rate (SGR) issue is critical to solve the annual issues with physician payments under the Medicare program.

The following is a brief summary of some of the items of relevance to ASCO members in the proposed rule.

Changes to RVUs

In 2012, there are two policies that will affect the Practice Expense (PE) and Work RVUs assigned to procedures. These include the Physician Practice Information Survey (PPIS) and the 5 year review of Work RVUs.

PPIS Transition

CMS continues to move toward full incorporation of the PPIS survey data into the calculation of Practice Expense per Hour (PE/HR), which is included in the calculation of PE RVUs. In 2012, PPIS data will be in the third year of its four year transition period and will have a stronger effect on physician PE RVUs with a 75/25 blend (75% based on the PPIS survey data and 25% based on the old Socioeconomic Monitoring Surveys (SMS)). The PE/HR data for oncology

drug administration services will not be transitioned over to PPIS survey data; rather the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires CMS to use the medical oncology SMS data to calculate PE/HR for medical oncology, hematology, and hematology/oncology. However, it is important to note that changes in PE/HR data for other specialties are likely to alter the payment rates established for services performed by oncologists.

5 Year Review of Work RVUs

In May 2011, CMS released the proposed rule for the 5 year review of Work RVUs. The modifications to the Work RVUs are estimated to redistribute \$66 million (0.08% of the MPFS) between codes. The review has resulted in relatively small tweaks to mostly minor services, which have a very limited effect on oncology.

PE and Work Code Review Process

CMS is proposing to end the 5 year review process for PE and work RVUs and to instead identify and assess potentially misvalued codes on an annual basis. Malpractice RVUs will continue to be reviewed every 5 years due to their role in the PPIS data collection process. CMS will be targeting two types of codes through July of 2012:

- E&M codes: The goal is to have half of the E&M codes completed by July of 2012 and the rest by July of 2013.
- Highest non-E&M expenditure codes for each specialty: These are codes with allowed charges of at least \$10M at the specialty level in 2010 that have not been reviewed since 2006. The goal is to have these reviewed by July 2012. CMS included HCPCS code 96413 (*Chemo, IV Infusion, 1 Hr*) on this list of codes for review.

Multiple Procedure Payment Reduction (MPPR) Policy

Since 2006, CMS has maintained a policy reflecting efficiencies and economies of scale on the technical component (TC) of 119 imaging services when those services are provided in the same session on the same day. In the 2012 rule, CMS proposes to extend this policy to the professional component (PC) of these same services, reducing payment for that component by 50% for all but the most expensive in any series of procedures performed in the same session on the same day (the highest paid procedure would still be paid at the full rate). The rationale for this expansion revolves around the duplication of physician work in the pre- and post-service periods.

The savings for this policy are estimated at \$200M. CMS also discusses the future goal of applying the MPPR to all imaging services (approximately 410 additional procedures) and diagnostic tests (approximately 700 procedures).

Payment Issues for Part B Drugs and Biologicals

Under the Medicare Modernization Act (MMA), the Office of Inspector General (OIG) is directed to make periodic comparisons of each product's Average Sales Price (ASP) to Average Manufacturer Price (AMP) and Widely Available Market Price (WAMP). CMS is directed to substitute AMP or WAMP in situations where ASP exceeds these benchmarks by a threshold percentage set by the agency. If ASP exceeds AMP by the threshold, CMS is directed to substitute 103% of AMP for the typical payment rate of 106% of ASP.

In last year's proposed rule, CMS seemed to be nearing an exercise of its authority to substitute AMP for ASP in some situations where ASP exceeds AMP by the threshold amount of 5%. CMS did not finalize its proposal due to ongoing litigation and to regulatory changes to AMP as required by the Affordable Care Act. In the ensuing period, the AMP litigation was withdrawn.

This year, CMS once again proposes procedures under which it would substitute AMP for ASP. CMS notes that ASP may exceed AMP as a result of a "temporary market fluctuation," which the agency says is demonstrated by how few products have ASPs that exceed the threshold over multiple quarters. Because of this concern and other issues, CMS proposes to limit the situations in which it will exercise the substitution authority. Specifically:

- CMS proposes to substitute AMP for ASP only when ASP exceeds AMP by 5% or more for two consecutive quarters or three of the last four prior quarters;
- The substitution will only be applied when the comparison provided by OIG is based on the same set of NDCs; and
- The substitution will only be applied if the substituted price was lower than the calculated price using 106% of ASP for the target quarter.

Substitutions will occur on a three quarter lag, since OIG receives the data it uses to compare ASP to AMP during the quarter when the ASP in question is already being used in payment rates. CMS will use a final comparison between OIG's 103% of AMP and 106% of ASP for the current quarter to ensure that ASP is used in cases where a product's price is dropping. Price substitutions will last for one quarter.

CMS welcomes comments on all aspects of its proposal and is seeking specific comments on the differences between ASP and AMP, particularly in light of the ACA's revisions to AMP and the impact of these revisions on ASP/AMP price comparisons.

Electronic Prescribing (eRx)

In order to encourage the use of eRx among Medicare physicians, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) established the eRx Incentive Program, which runs through 2014 and provides incentive payments (positive payments) to eligible professionals who are successful electronic prescribers and payment adjustments (cuts) to otherwise eligible professionals who fail to electronically prescribe. The agency's criteria for 2012 and 2013

incentives are comparable to the 2011 incentive program. Similarly, the 2013 and 2014 payment adjustments are parallel to the adjustment for 2012.

The statute specifies incentive payments in the amount of 1% of total estimated MPFS allowed charges in 2012 and 0.5% in 2013 for successful electronic prescribers. Those that do not meet the program requirements will face a 1.0% reduction in the MPFS amount in 2012, a 1.5% cut in 2013 and a 2.0% cut in 2014.

CMS proposes to add a 6 month reporting period for the 2013 and 2014 payment adjustments in order to maximize the opportunities for participation in the program. In addition, CMS plans to maintain the 12 month reporting periods for the 2012 and 2013 incentive payments and the 2012, 2013 and 2014 payment adjustments. Essentially, the 6 month reporting period adds an additional period for physicians to comply with the program and avoid payment penalties.

For purposes of the 6 month reporting period in 2012, in order to be a successful electronic prescriber, an eligible professional must report that “at least 1 prescription for Medicare Part B PFS patients created during an encounter was generated and transmitted electronically using a qualified electronic prescribing system at least 10 times during the 6-month payment adjustment reporting period (that is, January 1, 2012 through June 30, 2012).” For the 6-month reporting period in 2013 (to avoid the 2014 payment adjustment), the system must also be used successfully at least 10 times. Prescribers are not required to participate in the Physician Quality Reporting System (PQRS). Eligible professionals may use either a qualified electronic prescribing system as described in the original program criteria or certified electronic health record (EHR) technology. Additionally, eligible professionals may report as an individual or as part of a group practice reporting option (GPRO). Individuals do not need to sign up or notify CMS of their intention to participate, but GPROs must alert CMS that they will participate.

For reporting periods that take place during 2012 and 2013, eRx participants may report on the electronic prescribing measure using one of three different mechanisms: claims, a qualified registry or a qualified EHR product. To qualify for the incentive payment, the prescriber’s Part B allowed charges for services to which the electronic prescribing quality measure applies must be at least 10 percent of all Part B allowed charges for the provider.

Physicians may be exempted from eRx payment adjustments if they practice in rural areas with limited high speed internet access, areas with limited available pharmacies for electronic prescribing, or areas where local, state or federal regulations limit electronic prescribing. CMS is also proposing to exempt “an eligible professional who has prescribing privileges but prescribes fewer than 100 prescriptions during a 6-month payment adjustment reporting period.”

Physician Quality Reporting System (PQRS)

CMS continues to march forward with the PQRS and as such has proposed changes for 2012 and beyond. The proposed rule describes at length the rules of participation and requirements for the Group Practice Reporting Option (GPRO); however, CMS is proposing to change the definition of a group practice to a practice consisting of 25 or more professionals, as identified by their NPIs, who have assigned billing rights to the Tax Identification Number (TIN) of the group

practice. CMS defined a group practice in 2011 as a practice with 2 or more professionals. CMS notes that the proposed change in definition would not preclude participation by professionals in group practices of less than 25 as those providers can still report measures at the individual level.

CMS is proposing for 2012 and beyond a 12 month reporting period (January 1 through December 31) for all three reporting mechanisms (claims, registries, and EHR) except for measures groups reported through a registry, which will retain a 6 month reporting period option. In removing the 6 month reporting period option for most reporting mechanisms, the agency notes that it believes that a 12 month reporting period “aligns with other CMS quality reporting programs.” CMS will continue to retain the three reporting mechanisms currently in place for measures reporting. By retaining three means of reporting quality, CMS hopes that providers can satisfactorily report measures and that the three options of reporting will provide flexibility for the providers.

CMS proposed that it will not combine data from the three reporting mechanisms when calculating if a provider is eligible for an incentive payment. CMS stated that the provider must satisfy all criteria using one of the methods of reporting in order to qualify for the incentive. While CMS has proposed new specific reporting requirements for certain specialties (internal medicine, family practice, general practice and cardiology) for all three reporting mechanisms, CMS is generally retaining the existing reporting requirements for all other specialties for reporting quality measures.

CMS has introduced 18 new measures and retired 3 measures under the GPRO program. CMS is retaining all existing quality measures for reporting by individual eligible professionals and is adding 26 additional measures. New measures that may be of particular interest to the cancer community include “Image Confirmation of Successful Excision of Image-Localized Breast Lesion,” “Radical Prostatectomy Pathology Reporting,” “Immunohistochemical (IHC) Evaluation of HER2 for Breast Cancer Patients,” “Preoperative Diagnosis of Breast Cancer,” “Sentinel Lymph Node Biopsy for Invasive Breast Cancer,” and “Biopsy Follow-up.” Also, CMS is proposing 10 new measures groups, including a radiology measures group. Nevertheless, there continue to be insufficient measures for medical oncology under the PQRS.

Professionals and group practices that successfully report 2012 Physician Quality Reporting System measures can qualify for an incentive payment of 0.5% of their total Part B allowed charges for all services furnished during the year. Beginning in 2015, CMS will be making a negative payment adjustment for those providers who fail to satisfactorily report quality measures. With this proposed rule, CMS announces that it will use data from 2013 to calculate payment adjustments for providers in 2015.

Value-Based Purchasing

CMS continues to build a value-based purchasing program within the physician fee schedule. As such, CMS has proposed to establish a payment modifier “that provides for differential payment to a physician or a group of physicians.” CMS believes that the development of payment modifiers under the MPFS will be used to reflect value for the care and cost of that care provided to Medicare beneficiaries.

The payment modifier will be implemented as budget neutral, as payments will increase for some physicians and decrease for others. In addition CMS believes that the use of the modifier will “lead to more efficient use of services.”

The new modifier will be effective to specific physicians and groups of physicians beginning January 1, 2015. CMS has yet to define who the specific physicians or groups of physicians will be, but it is anticipated that CMS will define this in upcoming rules. Finally, the value-based modifier will then apply to all physicians and groups of physicians beginning January 1, 2017. Table 62 of the proposed rule lists the measures CMS is proposing to use. CMS is seeking comment as to whether these measures are appropriate, inappropriate or if additional measures should be added.

Dual-Energy X-ray Absorptiometry (DXA)

The Affordable Care Act addressed a special payment methodology for two dual-energy x-ray absorptiometry (DXA) CPT codes (77080 – “Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)” and 77082 – “Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment”). This special methodology was to be used during 2010 and 2011, and CMS is proposing to begin payment for these codes in 2012 using resource-based RVUs as opposed to the imputed RVUs used during the past two years. CMS is also requesting the AMA RUC to review these two CPT codes for appropriate valuation.

* * * *

ASCO will be providing additional information as further analyses of the proposed rule are completed. In the interim, please do not hesitate to contact publicpolicy@asco.org with questions or concerns.