# Payment Cuts for Specialists Projected by CMS

BY MARY ELLEN SCHNEIDER

The Obama administration's proposed rule on the 2010 Medicare Physician Fee Schedule addresses increased pay for primary care physicians, decreased pay for specialists, and a way to get rid of the sustainable growth rate formula.

Physicians' organizations have sought repeal of the sustainable growth rate (SGR)—the statutory formula used to set payment rates under Medicare—saying it does not reflect the true cost of care.

One criticism is that the formula counts the price of physician-administered drugs as a physician service. Since the SGR is designed to cut payments when health care expenditures rise above a certain target, the inclusion of drugs has caused physicians to exceed those targets more rapidly.

The removal of physician-administered drugs from the SGR should reduce the number of years that physicians see pay cuts, according to the Centers for Medicare and Medicaid Services. And the American Medical Association is betting that the change will make it less expensive for Congress to repeal the SGR, which would also benefit physicians.

**The proposals will result in an average 11% cut in Medicare payments for cardiologists, because of the elimination of consultation codes and because of practice expense changes.**

The change is one of several included in the 2010 Medicare Physician Fee Schedule proposed rule, published in the Federal Register on July 13. A final rule is expected in November.

Even if enacted, the proposal will not stop the 21.5% pay cut, effective Jan. 1, 2010, which would affect physicians across the board. The rest of the fee schedule proposal affects physicians differently, depending on their specialty. For example, the proposed rule includes plans to eliminate the use of consultation codes, increase payments for evaluation and management (E&M) services, and update the practice expense component of physician fees based on new survey data.

Under the proposal, the CMS would eliminate the use of all consultation codes except telehealth codes starting Jan. 1. "We believe the rationale for a different payment for a consultation service is no longer supported because documentation requirements are now similar across all E&M services," the CMS wrote in the proposed rule.

The CMS estimates that the combination of the various proposals would mean a 6%-8% payment increase for primary care physicians, excluding the impact of the 21.5% cut.

Conversely, subspecialists would lose out under the schedule proposal, experiencing either cuts or only small increases.

The combined proposals will result in an average 11% cut in Medicare payments for cardiologists, in part due to the elimination of consultation codes, but also because of practice expense changes based on new survey data. The American College of Cardiology criticized the CMS for proposing significant payment cuts based on a small amount of survey data.

The cuts "are based on the incorporation of a few esoteric pieces of data into a complex formula," Dr. Alfred Bove, ACC president, said in a statement. "The focus on this formula completely ignores the very important issues of access that are certain to be created by these huge slashes in payment." ■

# Proposed CMS Rule Increases Pay for Cardiac Rehabilitation

BY JOYCE FRIEDEN

A proposed payment rule from the Centers for Medicare and Medicaid Services would increase the number and duration of payments to hospitals for cardiac and pulmonary rehabilitation services.

The expanded cardiac benefit is "very exciting," said Dr. Alfred Bove, president of the American College of Cardiology. "A lot of us have been advocating rehabilitation for a long time, and lots of patients say, 'I can't afford it.' This would be a tremendous program for a lot of people after a major heart event."

Currently, Medicare patients who experience a heart attack or heart failure usually are covered for 8 weeks of cardiac rehabilitation with a maximum of three 1-hour sessions per week, Dr. Bove said. Under the proposed benefit, patients could receive up to 72 sessions—up to 6 sessions per day—of intensive cardiac rehabilitation over an 18-week period.

Being able to spread the sessions out would be quite valuable, Dr. Bove said. "So much of recovering is giving people confidence in what they can handle … Improvement of depression and other symptoms [also] is better if you can get them into a rehab program."

Medicare's approval of the expanded sessions also would put pressure on private insurers to create the same kind of benefit, he noted.

Other outpatient payment changes proposed in the rule include:

► **Physician supervision requirements.** Nonphysician providers may directly supervise all hospital outpatient therapeutic services that they are personally able to perform within their state scope of practice and hospital-granted privileges. Current Medicare policy allows only for physicians to provide direct supervision of these services.

► **Kidney disease education.** Establish payment to rural providers under the Medicare Physician Fee Schedule for kidney disease education services furnished on or after Jan. 1, 2010, for beneficiaries diagnosed with stage IV chronic kidney disease.

► **Validation of quality reporting.** To ensure that hospitals are accurately reporting measures using chart-abstracted data, the CMS would take samples of actual patient records and compare the hospital reports with the requirements of the Hospital Outpatient Department Quality Reporting Program. Although the CMS will begin validating hospital-submitted data for purposes of the 2011 payment update, the validation results will not affect a hospital's outpatient payments until 2012, according to the proposal.

The CMS also plans to implement the third of four phases of its revised payment system for ambulatory surgery centers (ASCs). The revised payment rate for any given service is a percentage of the rate for the same service under the Outpatient Prospective Payment System. However, for new ASC services usually performed in physicians' offices, the ASC payment is capped at the amount the physician is paid under the Medicare fee schedule for practice expenses in the office.

The CMS will accept comments on the proposed rule until Aug. 31; the final rule will be issued by Nov. 1. ■

*Information on the outpatient payment proposals is available online at www.cms.hhs.gov/HospitalOutpatientPPS.*