2011 Medicare Physician Fee Schedule
Final Rule Summary

On November 29, 2010, the Centers for Medicare and Medicaid Services (CMS) published the final Medicare physician fee schedule (PFS) for 2011. The final rule in its entirety can be found at: http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf. The rule includes the standard annual fee schedule update, as well as implementation of provisions included in the Affordable Care Act (ACA). The provisions of the rule are effective January 1, 2011 unless stated otherwise.

Physician Fee Schedule Update

SGR and Conversion Factor (CF) Impact

The current CF, which expires on November 30, 2010, is $36.87. Without congressional action, the CF will be $28.39 on December 1, 2010 and $25.52 on January 1, 2011, due to the SGR formula. These estimated reductions to the CF are due to SGR-driven reductions in 2010 (-2.9 %) as well as changes being made under the final rule which include a rescaling of the RVU weights (-8.2 %) and a positive budget neutrality adjustment (+ 0.5%) caused by RVU changes. The SGR portion of the reduction is about 25 percent.

Both the Administration and the Congress seem supportive of taking action to prevent the SGR-driven reductions from occurring. Assuming that the SGR reductions are prevented by legislation, we are estimating a 2011 CF of $34.00. This is based on the current CF of $36.87, multiplied by the rescaling adjustment of -8.2 percent (0.9181) and the positive budget neutrality adjustment of 0.5 percent (1.0045). For purposes of the 2011 payment projections in the prepared charts we are using a CF of $34.00.

Background information on SGR

While Medicare annually updates payment rates for inflation for most provider services, physician services are updated by a formula mandated in legislation known as the Sustainable Growth Rate (SGR).
The conversion factor (CF) for a year is based on the prior year's CF adjusted for inflation by the Medicare Economic Index (MEI) and performance under the SGR. The SGR is a cumulative target whereby actual expenditures for all physician services are compared to a target rate of spending. The target is based on a statutory formula and includes an allowance for changes in the Medicare population, statutory and regulatory changes, and an allowance for volume and intensity growth based on GDP growth. If the SGR target is exceeded, the update to the CF is reduced and, conversely, if actual spending is less than the target, the CF is increased. For a number of years the actual expenditures for all physician services exceeded the target suggesting a need for a substantial reduction in the CF. Most observers believe that the statutory formula using GDP as a proxy for appropriate volume and intensity growth is flawed by not providing adequately for changes due to new technology, medical improvements, transfer of services from the hospital and other reasons. The Congress has acted each year since 2003 to prevent reductions in the CF from occurring. Since the SGR is a cumulative target, the potential reductions have reached massive proportions.

Specialty Impact

Attached to this summary are several charts comparing the relative value units and payment for neurology, epilepsy surgery, and evaluation and management services from 2010 to 2011 and 2010 to 2013 (when changes to the practice expense values are fully phased in). As stated above, we based the 2011 payment rates in the charts on a conversion factor of $34. This year, in addition to showing payment we also provided the relative value units (RVUs) for each code on the charts. The professional component (code with the 26 modifier) RVUs are important, because they are frequently used by many private insurers to determine payment and by hospitals to assess physician revenue.

Across the board the RVUs and payment for most neurology and neurosurgery services provided in epilepsy centers are increasing in both 2011 and 2013. Most of the professional component values for neurology services are increasing by approximately 8% in 2011 and by 9 - 11% in 2013. The RVUs for EEG with video are increasing by 8.4% in 2011 and by 11.3% in 2013. The RVUs for almost all epilepsy surgery codes are increasing by 12 - 13% in 2011 and even higher in 2013. The RVUs for the Evaluation and Management (E/M) codes provided in the hospital setting are increasing by 7 - 8% in 2011 and by another 9 - 12% in 2013.

Attachment 1, extracted from the final rule, provides a summary of the impact of the rule by specialty. The impact, positive or negative, is due to a number of factors highlighted in the table particularly the continued transition to the new practice expense (PE) values, the change in the weights assigned to physician work, PE and professional liability insurance (PLI) components, the reduction in imaging equipment payments, and the multiple procedure reduction.

The overall impact of the 2011 final rule on neurologists and neurosurgeons is shown below.

(A)	(B)	**(C)**	(D)	(E)	(F)	(G)	(H)
Specialty	Allowed Charges (mil)	Impact of Work and MP RVU Changes	Impact of PE RVU and MPPR Changes		Impact of MEI Rebasing	Combined Impact	
			2013	2011		2013	2011
TOTAL	$81,980	0%	0%	0%	0%	0%	0%
NEUROLOGY	$1,457	0%	5%	2%	0%	5%	2%
NEUROSURGERY	$642	-2%	1%	0%	1%	0%	-1%

* Table 101 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the December 2010 and January 2011 conversion factor changes under current law.

NOTE: In the 2010 Final Rule, the calculation for the practice expense was changed. CMS decided to implement this change over a period of 4 years. The column header "2011" reflects the 2nd year of the transition. The column header "2013" reflects the change after 4 years.

Practice Expense Changes

Rebasing of Fee Schedule Weights

Over the years, CMS has periodically rebased the elements of the Medicare Economic Index (MEI) which is used to measure changes in the costs of operating a medical practice. When this is done, CMS adjusts the proportion of the relative value units (RVUs) assigned to physician work, practice expenses and professional liability insurance (PLI). This change in the relative weights must be done in a budget neutral manner and can be accomplished by a change in the conversion factor (CF) or a change in the physician work RVUs.

In the proposed rule, CMS indicated its intention to use 2006 survey data to determine the expenditure weights and proposed the following changes: physician work from 52.5 percent to 48.3; practice expense, including PLI from 47.5 to 51.7 percent. For CY 2011, CMS proposed to increase the PE RVUs and the malpractice RVUs and by adjusting the CF to incorporate these revised weights into the physician fee schedule in a budget neutral way.

While there were comments urging CMS not to rescale the MEI proportions at this time or to phase them in gradually, CMS decided to finalize its proposal without a transition. CMS is increasing the PE RVUs by an adjustment factor of 1.181 and the malpractice RVUs by an adjustment factor of 1.358. And, consistent with

the proposed rule, rather than adjust the work RVU shares, CMS is reducing the CF by 8.2 percent to preserve budget neutrality. The RVUs in Addendum B to this final rule reflect the application of these adjustment factors.

Correction of Supply and Equipment Prices

The actual pricing of supplies and equipment is conducted by CMS, and not the AMA RUC. The rule includes minor corrections to the supply prices for a number of codes (see Table 6 in the rule). The rule also establishes a process for physicians to seek a correction if they believe that the price assigned to a piece of equipment or a supply item is not reflective of current market conditions. This would be subject to annual rulemaking.

Pricing of High Cost Disposable Supplies

Based in large part on a RUC recommendation, CMS will re-price the cost of expensive supplies (defined as over $150) every two years. This will help to assure that the practice expense values for services utilizing these costly supplies are accurate. Some 62 supply items currently fall into this category. CMS indicates it will utilize the United States General Services Administration (GSA) pricing schedules to augment the pricing provided by the public.

Geographic Practice Cost Index

CMS finalized technical changes to the geographic practice cost indices. The impact on most localities is +/- 1 percent. However, there are some areas that experience larger increases or decreases. (See Attachment 2 - Addendum D).

Consultation Codes

Although the CY 2011 proposed rule did not address consultation services, CMS received numerous comments regarding its decision in CY 2010 to no longer recognize consultation codes. CMS continues to believe that evaluation and management (E/M) services that could previously have been reported using the CPT consultation codes are now appropriately reported and paid using other E/M codes (i.e., office and other outpatient, initial hospital, and subsequent hospital care E/M codes). The agency also stated that there is no significant difference in physician work between E/M visits and consultation services.

CMS rejected the following alternatives presented to recognize the unique nature of consultation services: 1) revising the definition of "new" patient to allow for recognition of sub-specialties; and 2) revising prolonged services criteria to include inpatient floor time. CMS maintains that the current definition of "new" patient is sufficient and its Medicare physician specialty codes already recognize sub-specialties. CMS notes its policy to only recognize face-to-face time for inpatient prolonged services is longstanding and questioned how/when a physician could meet the requirements. They noted that the highest level initial hospital care E/M visit by a physician typically extends for 70 minutes. In order to the meet the requirements for prolonged services, the physician would need to spend, at a minimum, an additional 30 minutes. CMS rejected the proposal stating they did not believe that these services would meet the requirement of 100 minutes.

Interim RVUs for CY 2011

Establishing Interim Final RVUs for CY 2011

CMS received RUC recommendations for 291 new, revised and potentially misvalued codes for CY 2011. As noted previously, the ACA directs the Secretary to establish a process to validate RVUs within the PFS. While this process is under development, CMS has initiated a more rigorous clinical review when valuing codes. In the 291 code recommendations, the RUC used a variety of methodologies, consistent with previous

years, to evaluate the codes. CMS did not accept all RUC recommendations but instead established alternative interim final values as listed below. CMS is accepting comments on interim final RVUs for 2011. Comments must be submitted by 5 p.m. on January 3, 2011.

Vagus Nerve Stimulator (61885, 64568-64570)

CMS rejected the AMA RUC recommendations for the VNS surgical codes, stating that the methodology used by the RUC lacked a defined logic. CMS is assigning alternative values on an interim final basis for CY 2011,which are lower than the RUC recommendations of work values for the codes. The new RVUs are as follows: 6.05 work RVUs for 61885; 9.00 work RVUs for 64568; 11.00 work RVUs for 64569; and 9.10 work RVUs for 64570.

Subsequent Hospital Observation Care

At the June 2009 CPT Editorial Panel meeting, three new codes were approved to report subsequent observation services in a facility setting: Code 99224 (Level 1 subsequent observation care, per day); Code 99225 (Level 2 subsequent observation care, per day): and Code 99226 (Level 3 subsequent observation care, per day). The RUC-recommended work values for the codes was based on the subsequent day hospital inpatient care codes (99231-99233). CMS disagreed with these codes as comparison, stating that observation codes are similar to outpatient codes and not inpatient. CMS did not accept the RUC recommendations and therefore, assigned alternative work RVUs of 0.54 to Code 99224, 0.96 to Code 99225, and 1.44 to Code 99226 on an interim final basis for CY 2011.

Misvalued Codes Under the Physician Fee Schedule

Identification of Misvalued Codes

Section 3134 of the ACA directed CMS to identify misvalued codes. Seven categories of services were identified for review:

- Codes and code families for which there has been the fastest growth
- Codes or code families that have experienced substantial changes in practice expenses
- Recently established codes for new technologies or services
- Multiple codes that are frequently billed in conjunction with furnishing a single service
- Codes with low relative values, particularly those that are billed multiple times in a single treatment
- Codes that have not been subject to review since implementation of RBRVS (i.e., so-called Harvard valued codes)
- Other codes determined to be appropriate by the Secretary

The ACA also directed the Secretary to establish a process to validate RVUs within the PFS including validating the elements of physician work (time, mental effort, skill, risk, etc.). CMS continues to solicit public comments from stakeholders on possible approaches to consider for a validation process.

CMS finalized its proposal (with modifications) to identify potential codes that may be misvalued, which will be referred to the RUC for review during 2011. It is not clear what process the RUC will be asked to use to review these codes; i.e., to go through a complete survey process or to have some short cut process as has been used the last couple of years with codes that experienced substantial volume increases.

Physician Quality Reporting System

The Physician Quality Reporting Initiative (PQRI) was first implemented as a voluntary pilot program in 2007. The ACA made a number of changes to the program and extended incentive payments for several years. Due to the permanent nature of the program, CMS is transitioning the name of the program from PQRI to the "Physician Quality Reporting System." The program will continue to provide incentive

payments to eligible physicians and other practitioners, who satisfactorily report data on quality measures for covered services furnished during a reporting period. In 2010, participating professionals reporting measures were eligible for an incentive payment equal to 2.0 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period. In 2010, eligible professionals (EPs) could report individual measures or measure groups through one of three reporting mechanisms: claims-based reporting, registry-based reporting, and electronic health record (EHR)-based reporting. In addition to reporting individual measures, participants could also report a limited number of preselected measure groups.

In 2011, eligible professionals can earn a 1.0 percent incentive payment based on total Part B allowed charges for successfully reporting measures in the reporting period. Incentive payments will be 0.5 percent for 2012 – 2014. Penalties will begin in 2015 for those who do not satisfactorily submit quality data. The key changes to the Physician Quality Reporting System for 2011 are as follows:

Reporting of Individual Measures & Measure Groups- CMS provided two tables that list the detailed criteria for satisfactorily reporting data for individual measures and measure groups. (See Attachment 3, Tables 73-74).

Reporting by a Group Practice- CMS will continue to allow reporting by group practices as a whole and provide incentive payments to the group rather than the individual EP. CMS is changing the definition of a group practice to include any group with 2 or more EPs (currently only groups of 200 or more practitioners can participate as a group practice). The smaller groups' participation will be piloted with the first 500 groups to sign up. Small group practices (2 - 199 EPs) must report a specific amount of individual measures and measure groups, which will depend on the size of the group practice. For groups of more than 200, all 26 of the current NQF-endorsed quality measures for coronary artery disease, diabetes, heart failure, hypertension and preventive care measures must be reported.

Quality Measures for CY 2011- CMS finalized 204 measures individual EPs can report in 2011. Measures are listed in the rule in four categories: 1) claims-based and registry-based reporting measures; 2) registry-based reporting measures only; 3) new individual measures; and 4) EHR-based reporting measures. Individual measures can be found in Tables 78- 80. CMS also finalized the 14 measure groups listed in tables 83-96. There is a general requirement that all measures be endorsed by the National Quality Forum, but there is an allowance for the Secretary of HHS to include additional measures in the program. CMS received many comments requesting that measures be developed for specific areas/topics. They subsequently urged stakeholders to submit specific measure suggestions via their '2012 Call for Measures', which will take place in late 2010 or early 2011. CMS will post the directions to submit measures on their website at a later date.

Maintenance of Certification Program- The ACA provided for an additional mechanism for reporting quality measures through a Maintenance of Certification Program operated by a specialty board of the ABMS. An additional bonus payment of 0.5 percent for years 2011 through 2014 is provided if the EP participates in the Maintenance of Certification Program for at least one year and completes a Maintenance of Certification Program practice assessment. Maintenance of Certification Programs must qualify as a Physician Quality Reporting System registry for 2011 in order to submit quality measures on behalf of EPs.

Physician Compare Web Site- The ACA requires CMS to establish a website by January 1, 2011, where the names of physicians and groups that successfully participate in the Physician Quality Reporting System will be posted. CMS will not publicly report any individual or group performance information for the 2011 Physician Quality Reporting System program, although such reporting is required by law in future years. CMS will address future expansion of the Physician Compare Web site in future rulemaking.

Feedback Mechanism and Appeals Process- The ACA requires the Secretary to provide timely feedback to EPs on their reporting performance under the Physician Quality Reporting System program. CMS finalized its proposal to provide the reports to all EPs on or about the time of issuance of the incentive payments. CMS initially proposed to provide interim 2011 feedback reports, however they subsequently determined they would be unable to complete the programming and development work necessary to provide the reports in a timely manner. Instead, CMS plans to provide the feedback reports for 2012. CMS finalized the ACA provision that requires an informal review process be established for EPs to seek review of a determination that the practitioner did not satisfactorily submit quality data under Physician Quality Reporting System.

E-Prescribing (eRx) Incentive Program

Electronic Prescribing (eRx) is the transmission using electronic media, of prescription or prescription-related information between prescriber, dispenser, pharmacy benefit manager (PBM), or health plan, either directly or through an intermediary, including an eRx network. The 2011 eRx Incentive Program is separate from the incentive payments that eligible professionals may earn through the Physician Quality Reporting System.

The eRX Incentive Program will enter its third year in 2011. Eligible professionals and group practices who are successful e-prescribers for 2011 may earn an incentive payment based on the estimated total allowed charges for PFS services under Medicare Part B provided during the reporting period. The reporting period for the 2011 eRx incentive will be the entire 2011 calendar year. To qualify for the program, eligible practitioners will need to submit e-prescribing measures for at least 25 unique electronic prescribing events in 2011. Successful participants will be eligible for the following bonus payments: 1% in 2011; 1% in 2012; and, 0.5% in 2013. In 2012, eligible professionals who are not successful or do not participate will encounter reductions to their Medicare payments: – 1% in 2012; – 1.5% in 2013; and -2.0% in 2014. CMS finalized the reporting period for determining the 2012 eRx payment adjustments to include data from January 1, 2011 through June 30, 2011.

CMS also finalized the following key changes to the eRx Incentive Program:

- Prohibit eligible professionals participating in the Electronic Health Records (EHR) Incentive Program from receiving an eRx Incentive Program payment
- Impose penalties in 2012 on eligible professionals participating in the EHR Incentive Program in 2011, but not participating in the eRx Incentive Program
- Allow group practices with less than 200 members to participate in the eRx Incentive Program as a group practice

CMS rejected comments to expand the hardship exceptions and finalized the proposal for hardship exceptions to only apply to EPs in rural areas without access high speed internet and who lack a sufficient amount of available pharmacies. CMS also noted they will be developing a plan to integrate measure reporting requirements under the Physician Quality Reporting System, eRx Incentive Program, and the EHR Incentive Program.

Physician Feedback Program & the Value-Based Modifier

In 2009, CMS established and implemented the Physician Feedback Program. Initially, Phase I of the program used Medicare claims data and other data to provide confidential feedback to individual physicians comparing the cost and quality of care provided to Medicare beneficiaries with other participating physicians

in the program. CMS intends to continue the program and will eventually provide every Medicare practitioner a feedback report.

The ACA contained two provisions relevant to the Physician Feedback Program. First, the Secretary is required, beginning in 2012, to provide reports that compare patterns of resource use of individual physicians to other physicians. Second, the ACA requires the Secretary to apply a separate, budget-neutral payment modifier, known as the value-based payment modifier, to the physician fee schedule payment formula which will be phased in beginning January 1, 2015 through January 1, 2017. The modifier will provide for differential payment under the fee schedule to a physician or group of physicians, and later possibly to other eligible professionals, based upon the relative quality and cost of care of their Medicare beneficiaries. CMS plans to begin implementing the parameters for the value-based payment modifier through rulemaking in 2013.

CMS is proceeding with Phase II of the Physician Feedback Program, which will include quality measures and will expand reporting to group practices. CMS finalized its proposal to use quality measures derived from the Generating Medicare Physician Quality Performance Measurement Results Project (referred to as GEM), which are claims-based measures calculated from administrative claims data. CMS will also produce reports containing per-capita cost information instead of the episode specific cost information, for the following conditions: congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, prostate cancer and diabetes.

Signature Requirements for Clinical Laboratory

Currently Medicare does not require a physician's signature on a requisition for clinical diagnostic laboratory tests paid on the basis of the clinical laboratory fee schedule (CLFS). However, it must be evident that the physician ordered the tests. CMS will begin requiring a physician’s or non-physician provider's (NPP’s) signature on requisitions for clinical diagnostic laboratory tests paid on the basis of the CLFS. According to CMS, this policy will make it easier for the reference laboratory technicians to know whether a test is appropriately requested, and potential compliance problems will be minimized for laboratories during the course of a subsequent Medicare audit because a signature will be consistently required.

Primary Care and Preventive Services

Payment for Annual Wellness Visits

Currently Medicare pays for one "Welcome to Medicare" visit, but does not pay for routine physical examinations. Based on a provision in the ACA, CMS will cover an annual wellness visit, including the establishment of a personalized prevention plan service (PPPS), which is payable in addition to the “Welcome to Medicare” initial preventive physical examination (IPPE, Code G0402).

CMS established two new codes for the newly covered wellness visits: Code G0438, for the initial annual wellness visit and G0439 for the subsequent wellness visits, which will be payable annually thereafter. These wellness visits will not be subject to deductibles or coinsurance. G0438 will be priced based on the rate of a level 4 new patient office visit (99204) and G0439 will be priced based on the rate for a level 4 established patient visit (99214).

Removal of Deductibles and Coinsurance for Preventive Services in Medicare

The rule finalizes the ACA provision that waives the deductible and coinsurance for most preventive services provided to Medicare beneficiaries, which will include the new annual wellness visits. The provision applies to preventive services 'strongly recommended (grade A)' or 'recommended (grade B)' from the U.S. Preventive Services Task Force (USPDTF) as well as the initial preventive physician examination (IPPE) and annual wellness exam.

Primary Care Incentive Payment Program (PCIP)

The ACA established the PCIP to provide incentive payments to qualified providers and practitioners for primary care services furnished between January 1, 2011 and January 1, 2016. CMS will provide a 10 percent incentive payment to primary care practitioners defined as: 1) a physician who has a primary specialty designation of family practice, internal medicine, geriatrics, or pediatrics; or 2) a nurse practitioner, clinical nurse specialist, or physician assistant.

HPSA Surgical Incentive Payment Program (HSIP)

The ACA also contains a provision to provide incentive payments to surgeons in designated Health Professional Shortage Areas (HPSA) for services furnished between January 1, 2011 and January 1, 2016. CMS will provide a 10 percent quarterly bonus payment to general surgeons for approximately 4,300 surgical procedures provided in a HPSA.

Other Miscellaneous Issues

Telehealth Services

Medicare policy allows for coverage and reimbursement for telehealth services for an eligible telehealth beneficiary which include consultation, office visits, individual psychotherapy, pharmacologic management, and additional services specified by the Secretary delivered via a telecommunications system to an approved originating site. CMS finalized the proposal to add the following services to its list of approved telehealth services:

- Subsequent hospital care services- patient's admitting practitioner has a limit of one telehealth visit every three days (99231, 99232, 99233)
- Subsequent nursing facility care services- patient's admitting practitioner has a limit of one telehealth visit every 30 days (99307, 99308, 99309, 99310)

Neuropsychological Testing Services (Code 96119)

CMS rejected the request to add neuropsychological testing services (Code 96119) to the Medicare telehealth services list. CMS does not believe that these services are similar to services currently on the Medicare telehealth services list and, therefore concluded that the code is not appropriate for consideration.

Permitting Physician Assistants to Order Post-Hospital Extended Care Services

CMS finalized the ACA provision adding physician assistants (PAs) to a list of practitioners who can perform initial certification and recertification for beneficiaries requiring skilled nursing facilities. Previously, PAs could not provide this service.

Attachment 1

TABLE 101: CY 2011 PFS Final Rule Total Allowed Charge Estimated Impact for RVU, MPPR, and MEI Rebasing Changes*

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Specialty	Allowed Charges (mil)	Impact of Work and MP	Impact of PE RVU and MPPR Changes		Impact of MEI Rebasing	Combined Impact	
			Full	Tran		Full	Tran
TOTAL	$81,980	0%	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$181	0%	0%	1%	4%	4%	5%
ANESTHESIOLOGY	$1,793	0%	4%	2%	-3%	2%	-1%
CARDIAC SURGERY	$382	0%	-1%	0%	*0%*	-1%	0%
CARDIOLOGY	$6,951	0%	*-5%*	-2%	1%	-5%	-2%
COLON AND RECTAL SURGERY	$138	0%	4%	2%	0%	5%	3%
CRITICAL CARE	$240	0%	3%	2%	-2%	1%	0%
DERMATOLOGY	$2,749	0%	2%	2%	3%	5%	4%
EMERGENCY MEDICINE	$2,600	0%	2%	1%	-3%	-2%	-3%
ENDOCRINOLOGY	$395	1%	4%	2%	0%	4%	2%
FAMILY PRACTICE	$5,512	0%	4%	2%	0%	4%	2%
GASTROENTEROLOGY	$1,800	0%	3%	1%	-1%	2%	1%
GENERAL PRACTICE	$728	0%	3%	1%	0%	3%	1%
GENERAL SURGERY	$2,286	0%	3%	1%	0%	3%	1%
GERIATRICS	$188	0%	5%	2%	-2%	4%	1%
HAND SURGERY	$103	0%	4%	2%	2%	6%	4%
HEMATOLOGY/ONCOLOGY	$1,912	0%	-4%	-2%	2%	-2%	0%
INFECTIOUS DISEASE	$584	0%	4%	2%	-2%	3%	0%
INTERNAL MEDICINE	$10,696	0%	3%	2%	-1%	3%	1%
INTERVENTIONAL PAIN	$390	-1%	3%	1%	1%	2%	0%
INTERVENTIONAL RADIOLOGY	$224	-2%	-8%	-4%	0%	-9%	-5%
MULTISPECIALTY CLINIC/OTHER	$46	0%	-7%	-5%	1%	-5%	-4%
NEPHROLOGY	$1,946	1%	1%	1%	-1%	1%	1%
NEUROLOGY	$1,457	0%	5%	2%	0%	5%	2%
NEUROSURGERY	$642	-2%	1%	0%	1%	0%	-1%
NUCLEAR MEDICINE	$59	0%	-7%	-4%	0%	-6%	-4%
OBSTETRICS/GYNECOLOGY	$670	0%	1%	1%	1%	2%	2%
OPHTHALMOLOGY	$5,287	-1%	4%	0%	1%	4%	0%
ORTHOPEDIC SURGERY	$3,432	0%	3%	1%	1%	4%	3%
OTOLARNGOLOGY	$941	0%	3%	2%	1%	5%	3%
PATHOLOGY	$1,069	-1%	-1%	0%	0%	-2%	-1%
PEDIATRICS	$68	0%	2%	1%	0%	2%	1%
PHYSICAL MEDICINE	$895	0%	4%	2%	-1%	4%	1%
PLASTIC SURGERY	$317	0%	4%	2%	1%	5%	3%
PSYCHIATRY	$1,149	1%	2%	1%	-3%	0%	-1%
PULMONARY DISEASE	$1,786	-1%	2%	1%	-1%	1%	-1%

RADIATION ONCOLOGY	$1,939	-2%	-9%	-3%	4%	-7%	-1%
RADIOLOGY	$5,052	-2%	-12%	-7%	-1%	-14%	-10%
RHEUMATOLOGY	$511	0%	1%	0%	2%	2%	2%
THORACIC SURGERY	$398	0%	-1%	0%	0%	-1%	0%
UROLOGY	$1,950	-1%	-6%	-3%	1%	-7%	-3%
VASCULAR SURGERY	$708	-1%	-3%	-2%	0%	-4%	-2%
AUDIOLOGIST	$54	0%	-6%	-1%	2%	-5%	0%
CHIROPRACTOR	$756	0%	4%	2%	-2%	2%	0%
CLINICAL PSYCHOLOGIST	$577	0%	-6%	-2%	-4%	-10%	-6%
CLINICAL SOCIAL WORKER	$390	0%	-5%	-2%	-4%	-9%	-5%
DIAGNOSTIC TESTING FACILITY	$909	0%	-27%	-16%	2%	-23%	-15%
INDEPENDENT LABORATORY	$1,039	-1%	-7%	-3%	5%	-4%	1%
NURSE ANES / ANES ASST	$726	0%	4%	2%	-4%	1%	-1%
NURSE PRACTITIONER	$1,212	0%	4%	2%	-1%	4%	1%
OPTOMETRY	$970	0%	4%	1%	1%	6%	2%
ORAL/MAXILLOFACIAL SURGERY	$40	0%	*5%*	3%	2%	7%	5%
PHYSICAL/OCCUPATIONAL THERAPY	$2,204	0%	0%	-3%	-2%	-1%	-5%
PHYSICIAN ASSISTANT	$893	0%	3%	2%	0%	3%	1%
PODIATRY	$1,801	0%	6%	3%	1%	7%	4%
PORTABLE X-RAY	$94	0%	2%	0%	6%	7%	6%
RADIATION THERAPY	$71	*0%*	-13%	-5%	8%	-6%	3%
OTHER	$69	*2%*	3%	1%	0%	5%	3%

* Table 101 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the December 2010 and January 2011 conversion factor changes under current law.

Attachment 2

ADDENDUM D: FINAL CY 2011 GEOGRAPHIC ADJUSTMENT FACTORS (GAFs)

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
10102	00	Alabama	0.949	0.938	-1.16%
00831	01	Alaska**	1.288	1.289	0.08%
03102	00	Arizona	0.984	0.980	-0.41%
00520	13	Arkansas	0.945	0.926	-2.01%
01192	26	Anaheim/Santa Ana, CA	1.128	1.129	0.09%
01192	18	Los Angeles, CA	1.112	1.106	-0.54%
01102	03	Marin/Napa/Solano, CA	1.112	1.119	0.63%
01102	07	Oakland/Berkeley, CA	1.130	1.133	0.27%
01102	05	San Francisco, CA	1.201	1.198	-0.25%
01102	06	San Mateo, CA	1.203	1.199	-0.33%
01102	09	Santa Clara, CA	1.148	1.156	0.70%
01192	17	Ventura, CA	1.121	1.113	-0.71%
01102	99	Rest of California*	1.012	1.025	1.28%
01192	99	Rest of California*	1.012	1.025	1.28%
04102	01	Colorado	0.984	0.984	0.00%
13102	00	Connecticut	1.100	1.094	-0.55%
12202	01	DC + MD/VA Suburbs	1.121	1.124	0.27%
12102	01	Delaware	1.013	1.012	-0.10%
09102	03	Fort Lauderdale, FL	1.056	1.057	0.09%
09102	04	Miami, FL	1.114	1.107	-0.63%
09102	99	Rest of Florida	1.015	1.003	-1.18%
10202	01	Atlanta, GA	1.004	1.002	-0.20%
10202	99	Rest of Georgia	0.968	0.959	-0.93%
01202	01	Hawaii/Guam	1.057	1.074	1.61%
05130	00	Idaho	0.957	0.945	-1.25%
00952	16	Chicago, IL	1.084	1.081	-0.28%
00952	12	East St. Louis, IL	1.013	1.010	-0.30%
00952	15	Suburban Chicago, IL	1.063	1.061	-0.19%
00952	99	Rest of Illinois	0.982	0.972	-1.02%
00630	00	Indiana	0.967	0.954	-1.34%
05102	00	Iowa	0.950	0.930	-2.11%
05202	00	Kansas	0.957	0.946	-1.15%
00660	00	Kentucky	0.956	0.944	-1.26%
00528	01	New Orleans, LA	1.018	0.997	-2.06%
00528	99	Rest of Louisiana	0.969	0.949	-2.06%
14102	03	Southern Maine	0.991	0.987	-0.40%
10102	00	Alabama	0.949	0.938	-1.16%
00831	01	Alaska**	1.288	1.289	0.08%

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
03102	00	Arizona	0.984	0.980	-0.41%
00520	13	Arkansas	0.945	0.926	-2.01%
01192	26	Anaheim/Santa Ana, CA	1.128	1.129	0.09%
01192	18	Los Angeles, CA	1.112	1.106	-0.54%
01102	03	Marin/Napa/Solano, CA	1.112	1.119	0.63%
01102	07	Oakland/Berkeley, CA	1.130	1.133	0.27%
01102	05	San Francisco, CA	1.201	1.198	-0.25%
01102	06	San Mateo, CA	1.203	1.199	-0.33%
01102	09	Santa Clara, CA	1.148	1.156	0.70%
01192	17	Ventura, CA	1.121	1.113	-0.71%
01102	99	Rest of California*	1.012	1.025	1.28%
01192	99	Rest of California*	1.012	1.025	1.28%
04102	01	Colorado	0.984	0.984	0.00%
13102	00	Connecticut	1.100	1.094	-0.55%
12202	01	DC + MD/VA Suburbs	1.121	1.124	0.27%
12102	01	Delaware	1.013	1.012	-0.10%
09102	03	Fort Lauderdale, FL	1.056	1.057	0.09%
09102	04	Miami, FL	1.114	1.107	-0.63%
09102	99	Rest of Florida	1.015	1.003	-1.18%
10202	01	Atlanta, GA	1.004	1.002	-0.20%
10202	99	Rest of Georgia	0.968	0.959	-0.93%
01202	01	Hawaii/Guam	1.057	1.074	1.61%
05130	00	Idaho	0.957	0.945	-1.25%
00952	16	Chicago, IL	1.084	1.081	-0.28%
00952	12	East St. Louis, IL	1.013	1.010	-0.30%
00952	15	Suburban Chicago, IL	1.063	1.061	-0.19%
00952	99	Rest of Illinois	0.982	0.972	-1.02%
00630	00	Indiana	0.967	0.954	-1.34%
05102	00	Iowa	0.950	0.930	-2.11%
05202	00	Kansas	0.957	0.946	-1.15%
00660	00	Kentucky	0.956	0.944	-1.26%
00528	01	New Orleans, LA	1.018	0.997	-2.06%
00528	99	Rest of Louisiana	0.969	0.949	-2.06%
14102	03	Southern Maine	0.991	0.987	-0.40%
14102	99	Rest of Maine	0.957	0.942	-1.57%
12302	01	Baltimore/Surr. Cntys, MD	1.035	1.052	1.64%
12302	99	Rest of Maryland	0.991	1.004	1.31%
14202	01	Metropolitan Boston	1.133	1.106	-2.38%
14202	99	Rest of Massachusetts	1.041	1.040	-0.10%
00953	01	Detroit, MI	1.071	1.060	-1.03%
00953	99	Rest of Michigan	0.987	0.983	-0.41%

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
00954	00	Minnesota	0.967	0.966	-0.10%
00512	00	Mississippi	0.961	0.940	-2.19%
05302	02	Metropolitan Kansas City, MO	0.995	0.989	-0.60%
05302	01	Metropolitan St Louis, MO	0.988	0.984	-0.40%
05302	99	Rest of Missouri	0.961	0.938	-2.39%
03202	01	Montana ***	0.954	0.968	1.47%
05402	00	Nebraska	0.947	0.928	-2.01%
01302	00	Nevada***	1.016	1.024	0.79%
14302	40	New Hampshire	0.996	1.000	0.40%
12402	01	Northern NJ	1.134	1.120	-1.23%
12402	99	Rest of New Jersey	1.082	1.074	-0.74%
04202	05	New Mexico	0.980	0.969	-1.12%
13202	01	Manhattan, NY	1.164	1.153	-0.95%
13202	02	NYC Suburbs/Long I., NY	1.162	1.161	-0.09%
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034	1.037	0.29%
13292	04	Queens, NY	1.130	1.140	0.88%
13282	99	Rest of New York	0.961	0.961	0.00%
05535	00	North Carolina	0.970	0.955	-1.55%
03302	01	North Dakota***	0.942	0.956	1.49%
00883	00	Ohio	0.993	0.990	-0.30%
04302	00	Oklahoma	0.953	0.934	-1.99%
00835	01	Portland, OR	0.987	0.991	0.41%
00835	99	Rest of Oregon	0.964	0.955	-0.93%
12502	01	Metropolitan Philadelphia, PA	1.075	1.068	-0.65%
12502	99	Rest of Pennsylvania	0.987	0.980	-0.71%
09202	20	Puerto Rico	0.904	0.854	-5.53%
14402	01	Rhode Island	1.045	1.042	-0.29%
00880	01	South Carolina	0.959	0.946	-1.36%
03402	02	South Dakota***	0.948	0.949	0.11%
10302	35	Tennessee	0.961	0.947	-1.46%
04402	31	Austin, TX	0.995	0.986	-0.90%
04402	20	Beaumont, TX	0.986	0.966	-2.03%

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percentage Change (2010 to 2011)
04402	09	Brazoria, TX	1.002	0.996	-0.60%
04402	11	Dallas, TX	1.009	1.004	-0.50%
04402	28	Fort Worth, TX	0.994	0.990	-0.40%
04402	15	Galveston, TX	1.000	0.997	-0.30%
04402	18	Houston, TX	1.019	1.008	-1.08%
04402	99	Rest of Texas	0.976	0.959	-1.74%
03502	09	Utah	0.981	0.969	-1.22%
14502	50	Vermont	0.977	0.968	-0.92%
00904	00	Virginia	0.975	0.972	-0.31%
09202	50	Virgin Islands	0.996	0.997	0.10%
00836	02	Seattle (King Cnty), WA	1.033	1.045	1.16%
00836	99	Rest of Washington	0.983	0.982	-0.10%
00884	16	West Virginia	0.976	0.956	-2.05%
00951	00	Wisconsin	0.960	0.959	-0.10%
03602	21	Wyoming***	0.961	0.983	2.29%

* Indicates multiple contractors.
** GAF reflects a 1.5 work GPCI floor in Alaska established by the MIPPA.
*** 2011 GAF reflects a 1.0 PE GPCI floor for frontier states as required by the AC A.
[1] 2010 GAF equation: (0.52466*work GPCI)+(0.43669*PE GPCI)+(0.03865*MP GPCI).
2010 GAF contains a 1.0 work GPCI floor and reflects a limited recognition of cost differences for the rent and employee compensation components of the PE GPCI and hold harmless provision as required by the ACA.
[2] 2011 GAF equation: (0.52466*work GPCI)+(0.43669*PE GPCI)+(0.03865*MP GPCI).
2011 GAF does not contain a 1.0 work GPCI floor which expires December 31, 2010 as required by the ACA.
2011 GAF reflects a limited recognition of cost differences for the rent and employee compensation components of the PE GPCI, hold harmless provision and 1.0 PE GPCI floor for frontier States as required by the ACA.

Attachment 3

TABLE 73: 2011 Criteria for Satisfactory Reporting of Data on Individual Physician Quality Reporting System Quality Measures, by Reporting Mechanism and Reporting Period

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	• Report at least 3 PQRI measures, or 1-2 measures if less than 3 measures apply to the eligible professional; and • Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2011 - December 31,2011
Claims-based reporting	• Report at least 3 PQRI measures, or 1-2 measures if less than 3 measures apply to the eligible professional; and • Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	July 1,2011 - December 31,2011
Registry-based reporting	• Report at least 3 PQRI measures (measures with a 0% performance rate will not be counted); and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1,2011- December 31,2011
Registry-based reporting	• Report at least 3 PQRI measures (measures with a 0% performance rate will not be counted); and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	July 1,2011- December 31,2011
EHR-based reporting	• Report at least 3 PQRI measures (measures with a 0% performance rate will not be counted); and • Report each measure for at least 80 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1,2011- December 31,2011

TABLE 74: 2011 Criteria for Satisfactory Reporting on Measures Groups, by Reporting Mechanism and Reporting Period

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	• Report at least 1 PQRI measures group ; • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1,2011- December 31,2011
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 50 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1,2011- December 31,2011
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 50 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1,2011- December 31,2011
Registry-based reporting	• Report at least 1 PQRI measures group (measures groups with a 0% performance rate will not be counted); • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1,2011 - December 31, 2011
Registry-based reporting	• Report at least 1 PQRI measures group (measures groups with a 0% performance rate will not be counted); • Report each measures group for at least 80 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1,2011 - December 31, 2011