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MEDICARE FACT SHEET

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AFFORDABLE CARE ACT PROVISIONS AND THE CY 2011 MEDICARE PHYSICIAN FEE SCHEDULE PROPOSED RULE

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on June 25, 2010 that would update payment policies and Medicare payment rates for services furnished by physicians and nonphysician practitioners (NPPs) that are paid under the Medicare Physician Fee Schedule (MPFS). In addition to payment policy and payment rate updates, the MPFS includes a number of provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the “Affordable Care Act”). While several of these provisions directly affect payments provided under the MPFS, the proposed rule also addresses a number of policies that are not directly related to physician payment rates.

BACKGROUND

Since 1992, Medicare has paid for the services of physicians, NPPs and certain other suppliers under the MPFS, a system that pays for covered physicians’ services furnished to a person with Medicare Part B. Under the MPFS, a relative value is assigned to each of more than 7,000 types of services to capture the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing the service. The higher the number of relative value units (RVUs) assigned to a service, the higher the payment. The RVUs for a particular service are multiplied by a fixed-dollar conversion factor and a geographic adjustment factor to determine the payment amount for each service.

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AFFORDABLE CARE ACT PROVISIONS INCLUDED IN THE CY 2011 MPFS PROPOSED RULE

Primary Care & Prevention

- Elimination Of Deductible And Coinsurance For Most Preventive Services: Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services. Specifically, the provision waives both the deductible and coinsurance for Medicare covered preventive services that have been recommended with a grade of A (“strongly recommends”) or B (“recommends”) from the U.S. Preventive Services Task Force (USPSTF), as well as the initial preventive physician examination and the annual wellness visit. The Affordable Care Act also waives the Part B deductible for tests that begin as colorectal cancer screening tests but, based on findings during the test, become diagnostic or therapeutic services.

- Coverage Of Annual Wellness Visit Providing A Personalized Prevention Plan: The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time only initial preventive physical examination (IPPE or the “Welcome to Medicare Examination”), to provide coverage for annual wellness visits where beneficiaries receive personalized prevention plan services (PPPS). The law requires the annual wellness visit to include at least the following six elements:
 - Establish or update the individual’s medical and family history.
 - List individual’s current medical providers and suppliers and all prescribed medications.
 - Record measurements of height, weight, body mass index, blood pressure and other routine measurements.
 - Detect any cognitive impairment.
 - Establish a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient’s risk factors.
 - Furnish personal health advice and coordinate appropriate referrals and health education.

CMS is proposing to develop separate Level II HCPCS codes for the first annual wellness visit, to be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE), and for the subsequent annual wellness visits, to be paid at the rate of a level 4 office visit for an established patient.

- Incentive Payments To Primary Care Practitioners For Primary Care Services: The Affordable Care Act provides for incentive payments equal to 10 percent of a primary care practitioner's allowed charges for primary care services under Part B. The law defines

primary care practitioners as physicians (1) who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; (2) for whom primary care services accounted for at least 60 percent of the practitioner's allowed charges under Part B for a prior period as determined by the Secretary of Health and Human Services. The law also defines primary care services as limited to new and established patient office or other outpatient visits (CPT codes 99201 through 99215); nursing facility care visits, and domiciliary, rest home, or home care plan oversight services (CPT codes 99304 through 99340); and patient home visits (CPT codes 99341 through 99350). These incentive payments would be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in Health Professional Shortage Areas (HPSAs).

CMS is proposing to determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009. For subsequent years, CMS is proposing to revise the list of primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

Expanding Access

- *Incentive Payments For Major Surgical Procedures In Health Professional Shortage Areas:* The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the MPFS - in HPSAs between January 1, 2011 and December 31, 2016. To be eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments would be made quarterly to the general surgeon when the major surgical procedure is furnished in a zip code that is located in a HPSA. CMS proposes to use the same list of HPSAs that is used under the existing HPSA bonus program that is applicable to all services furnished by physicians in HPSAs.
- *Revisions To The Practice Expense Geographic Adjustment:* As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice cost components of each of more than 7,000 types of physician services. The proposed rule discusses CMS' analysis of PE GPCI data and methods and incorporates new data and GPCI cost share weights as part of the sixth GPCI update proposed for CY 2011. The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana, Wyoming, Nevada, North Dakota, and

South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless to any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from this alternative methodology. In addition, the Affordable Care Act requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

- Permitting Physician Assistants To Order Post-Hospital Extended Care Services: The Affordable Care Act newly authorizes physician assistants to perform the level of care certification that is one of the requirements for coverage under Medicare's skilled nursing facility (SNF) benefit.
- Payment For Bone Density Tests: The Affordable Care Act increases the payment for two dual-energy x-ray absorptiometry (DXA) CPT codes for measuring bone density for CYs 2010 and 2011. This provision revises payments for these preventive services to use 70 percent of their CY 2006 RVUs, and the 2006 conversion factor with the current year geographic adjustment.
- Improved Access To Certified Nurse-Midwife Services: The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent to 100 percent of the amount physicians are paid under the MPFS.
- Extension Of Medicare Reasonable Costs Payments For Certain Clinical Diagnostic Laboratory Tests Furnished To Hospital Patients In Certain Rural Areas: The Affordable Care Act reinstates reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds that are located in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011. For some hospitals whose cost reports begin as late as June 30, 2011, this could affect services performed as late as June 29, 2012, because this is the date those cost reports will close.
- Physician Self-Referral For Certain Imaging Services: The Affordable Care Act amends the in-office ancillary services exception to the self-referral law as applied to magnetic resonance imaging, computed tomography, and positron emission tomography, to require a physician to disclose to a patient in writing at the time of the referral that there are other suppliers of these imaging services, along with a list of other suppliers in the area in which the patient resides. CMS is proposing to require that the referring physician provide the patient with a list of ten alternative suppliers within a 25-mile radius of the physician's office who provide the same imaging services.

- *Adjustments To The Medicare Durable Medical Equipment, Prosthetics, Orthotics, And Supplies Competitive Bidding Program:* The Affordable Care Act expands round 2 of the durable medical equipment (DME) competitive bidding program from 70 metropolitan statistical areas (MSAs) to 91 MSAs by adding the next 21 largest MSAs by total population not already selected for rounds 1 or 2. The 2009 annual population estimates from the U.S. Census Bureau are the most recent estimates of population that will be available prior to the round 2 competition mandated to take place in CY 2011. CMS is proposing to use these estimates to determine the additional 21 MSAs to be included in round 2 of the program.

Improving Payment Accuracy

- *Misvalued Codes Under The Physician Fee Schedule:* The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes and includes a discussion of these activities in the proposed rule. CMS also identifies additional categories of services that may be misvalued, including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs.
- *Modification Of Equipment Utilization Factor For Advanced Imaging Services:* The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment and, thereby, reduces payment rates for the associated procedures. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the Affordable Care Act increases the established MPFS multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.
- *Revision To Payment For Power-Driven Wheelchairs* – As required by the Affordable Care Act, CMS is proposing to adjust the payment schedule for power-driven wheelchairs under the Medicare Part B Durable Medical Equipment Orthotics and Prosthetics (DMEPOS) fee schedule to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the 13 month rental period and 6 percent (instead of 7.5 percent) for the remaining months. Payment is based on the lower of the supplier's actual charge and the fee schedule amount.

In addition, the Affordable Care Act eliminates the lump sum (up-front) purchase payment option for standard power-driven wheelchairs. CMS is proposing revisions to the regulations

to conform to this change, which permits payment for standard power-driven wheelchairs only on a monthly rental basis effective for items furnished on or after January 1, 2011. The Affordable Care Act also specifies that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011 as part of the Medicare DMEPOS competitive bidding program. For complex rehabilitative power-driven wheelchairs, the regulations will continue to permit payment to be made on a lump sum purchase method or a monthly rental method.

- *Maximum Period For Submission Of Medicare Claims Reduced To Not More Than 12 Months* – To implement the Affordable Care Act, CMS is proposing that Medicare fee-for-service claims for services furnished on or after January 1, 2010 must be filed no later than 1 calendar year after the date of service. This reflects a reduction in the maximum prior timely filing deadline of 15 to 27 months. The current timely filing requirements will continue to apply to claims for services furnished before January 1, 2010, except CMS is proposing that claims for services furnished during the last three months of 2009 must be filed no later than December 31, 2010.

CMS will accept comments on the proposed rule until August 24, 2010, and will respond to them in a final rule to be issued on or about November 1, 2010 that sets forth the policies and payment rates effective for services furnished to Medicare beneficiaries on or after January 1, 2011.

For more information, see: www.federalregister.gov/inspection.aspx#special

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