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Proposed Physician Fee Schedule Update Implements Key Reform Provisions

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The Centers for Medicare & Medicaid Services (CMS) published its annual regulatory update to the Medicare Physician Fee Schedule (the proposed 2011 update), including rules implementing key 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). Published in the July 13, 2010, *Federal Register*, CMS is accepting comments on the proposed 2011 update until August 24, 2010. A final rule will be issued on or about November 1, 2010, to be effective January 1, 2011.

The proposed 2011 update addresses a range of payment policies and rates affecting physicians and an array of Medicare Part B suppliers, including outpatient rehabilitation, diagnostic imaging and telehealth. This White Paper discusses some notable provisions of the proposed 2011 update, including the new patient-notice provision of the Stark in-office exception and other provisions mandated by the Affordable Care Act.

Physician Payment Update

The update projects a 6.1 percent reduction to physician payment rates in 2011 under the sustainable growth rate (SGR) formula. Enacted by Congress in 1997, this formula has called for an across-the-board reduction in physician payment rates every year beginning with 2002. Beginning in 2003, these cuts have been averted by Congressional action, most recently by the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, which replaces the 21.3 percent reduction in physician payment rates that was required by the SGR formula for 2010 with a 2.2 percent payment increase for services furnished on or after June 1, 2010 through November 30, 2010. Congress has been pressured to devise a permanent fix to the SGR problem, but such a fix is complicated by the fact that any fix will be controversial.

Wellness and Preventative Services

REMOVAL OF BARRIERS TO PREVENTIVE SERVICES

The Affordable Care Act revises the definition of "preventive services" under the Social Security Act to include the following: a list of specific preventive services, an initial preventive physical examination (IPPE), and an annual wellness visit (discussed further below). The proposed 2011 update would also add preventive services to benefits covered under Medicare Part B. The Affordable Care Act requires 100 percent Medicare payment for the IPPE and certain preventive services to which the U.S. Preventive Services Task Force has given a grade of A or B, and the provision waives any coinsurance or Part B deductible that would otherwise be applicable to such preventive services or for the annual wellness visit. This provision is specifically designed to remove barriers to affording and obtaining preventive services under Medicare. Such provisions are effective for services provided on and after January 1, 2011. The deductible for the IPPE was the subject of a statutory waiver, effective January 1, 2009. CMS notes that all existing Medicare coverage policies for such services, including any limitations based on indication or population, continue to apply.

The update also proposes the inclusion of influenza and hepatitis B vaccines and their administration as services *not* subject to the Part B annual deductible, as well as new exceptions from the Part B annual deductible for bone mass measurement, medical nutrition therapy services and the annual wellness visit. With regard to Federally Qualified Health Centers (FQHCs), the update proposes application of the new definition of preventive services as described above to the new Medicare FQHC preventive services definition, waiver of coinsurance for the preventive services that are recommended with a grade of A or B by the U.S. Preventive Services Task Force for any indication or population and the addition of a 20 percent co-pay on all FQHC services after implementation of the FQHC prospective payment system. The update also proposes the extension of the Affordable Care Act's waiver of deductible to services furnished in connection with or in relation to a colorectal cancer screening test that becomes diagnostic or therapeutic.

COVERAGE OF ANNUAL WELLNESS VISIT

Extending the preventive focus of Medicare coverage, which currently pays for a one-time-only initial preventive physical examination, the Affordable Care Act expanded Medicare coverage under Part B to include an annual wellness visit that provides personalized prevention plan services, effective January 1, 2011. CMS proposes definitions for key terms and stipulates the required elements for the first annual wellness visit and subsequent annual wellness visits. The annual wellness visit will be paid under the Physician Fee Schedule. For this purpose, CMS proposed two new HCPCS G codes for reporting the first and subsequent visits.

Notice of Alternative Imaging Suppliers

The Affordable Care Act amended the statutory Stark in-office ancillary services exception to require that CMS impose a requirement (under the exception) that a Medicare beneficiary referred for an MRI, CT or PET scan be given, at the time of the referral, a written notice that the patient may receive the services from a supplier other than the referring practice and that informs the patient of alternative suppliers located in the area in which the patient resides. This statutory amendment was effective January 1, 2010.

The proposed 2011 update includes an amendment to the Stark regulatory exception for in-office services consistent with this provision of the Affordable Care Act. This regulatory amendment is effective January 1, 2011, and thus addresses concerns that the Affordable Care Act's amendment to the exception was self-implementing, effective January 1, 2010. The regulatory amendment requires that a Medicare beneficiary referred for MRI, CT or PET scans be given a written notice at the time of referral that the patient may receive the scan from a supplier other than the referring practice and that lists at least 10 alternative imaging suppliers located within a 25-mile radius of the practice site. If there are not 10 alternative imaging suppliers within a 25-mile radius of the practice site, then the list must include all of the alternative imaging suppliers within this area. If there are no alternative imaging suppliers within this 25-mile area, the practice is only required to give the patient a written notice that the patient may receive the referred services from a supplier other than the referring practice.

The written notice must include for each supplier on the list the supplier's name, address, telephone number and distance from the referring practice's site. CMS has requested comments on whether it should expand the notice requirement to additional imaging modalities and whether it should require the notice include alternative "providers of services," in addition to suppliers. Notably, the statutory amendment and the proposed rule only require that the list include alternative "suppliers," a defined term that excludes hospitals and other institutional providers of imaging services.

Electronic Prescribing Incentive Program

2011 eRx INCENTIVE PAYMENT

For 2011, the update proposes that the incentive payment for successful electronic prescribers equal 1 percent of the total estimated Medicare Part B Physician Fee Schedule allowed charges for all covered professional services furnished during the 2011 reporting period. The incentive payment for successful electronic prescribers for 2012 is anticipated to be at 1 percent and will decrease to 0.5 percent in 2013.

To determine whether an individual eligible professional (EP) or group practice is a successful electronic prescriber, EPs and group practices must submit reports to CMS using an eRx measure. Under the proposed measure, individual EPs must report a minimum of 25 Medicare Part B professional service patient encounters during the 2011 reporting period, where certain current procedural terminology (CPT®) codes (pre-identified by the U.S. Department of Health and Human Services [HHS]) are implicated and where at least one prescription is generated and transmitted electronically through a qualified e-prescribing system. Group practices, on the other hand, must meet the applicable minimum patient encounter benchmark, which is based on a sliding scale, based on the number of national provider identifier (NPI) numbers linked to the group practice (*e.g.*, 75 reporting patient encounters for a group of 2-10 NPIs). HHS plans to post the final eRx measure by December 31, 2010, on the CMS website at http://www.cms.gov/ERXIncentive.

In addition, the EP or group practice's total 2011 Physician Fee Schedule allowed charges for all covered professional services submitted under the eRx measure, divided by the EP's total Physician Fee Schedule allowed charges for all covered professional services, must be 10 percent or more. If the result of this calculation is less than 10 percent, then the EP or group practice will not earn an eRx incentive payment.

2012 eRx PENALTY

Beginning in 2012, if an EP or group practice is not a successful electronic prescriber for the reporting year, the Physician Fee Schedule amount for covered professional services furnished by such professional during the year will be less than the amount that would otherwise apply by: 1 percent for 2012, 1.5 percent for 2013 and 2 percent for 2014. CMS has stated this penalty should not penalize those for whom the adoption and use of e-prescribing may be impractical given the lower volume of prescribing.

Physician Quality Reporting and Related Payment Incentives

The Physician Quality Reporting Initiative (PQRI) is a voluntary program for EPs (physicians and other specified non-physician practitioners) to receive incentive payments for reporting data to CMS on selected quality measures. The update proposes continued reporting of PQRI measures via claims-based, registry-based or electronic health record (EHR)-based reporting for a 12-month period (for all reporting methods) or a six-month period (for claims-based and registry-based reporting methods). The proposed 2011 update seeks comment on limiting the option for claims-based reporting, as well as other options for additional reporting methods.

The update proposes to use the same method for selection of new PQRI measures that it used for 2009 and 2010. New measures would be required to have a high impact on health care, facilitate alignment with other federal health care programs, be endorsed by the National Quality Forum, address gaps in the existing PQRI measure set, measure various aspects of clinical quality and be functional. Based on the proposed criteria, CMS proposes to include a total of 198 measures for 2011, comprising 190 individual measures and 14 measures groups (some individual measures are also included within measures groups).

Finally, the update proposes to make several changes to the PQRI in response to Affordable Care Act provisions. As required by the act, CMS would reduce the incentive payment amount from 2 percent to 1 percent of estimated Part B Physician Fee Schedule allowed charges. CMS would also convert the existing Physician and Other Health Care Directory into the Physician Compare website. The update also proposes to implement the Affordable Care Act provision providing for additional incentive payments to EPs that submit PQRI data through a Maintenance of Certification Program operated by the American Board of Medical Specialties.

In order to implement the provision requiring alignment of PQRI measures with meaningful use of EHRs, CMS proposes to include many of the core clinical quality measures from the American Recovery and Reinvestment Act that demonstrate meaningful use of EHR as PQRI measures. CMS also proposes to expand their existing feedback process to include an interim feedback report available in June 2011 in order to comply with the Affordable Care Act's requirement that CMS implement a "timely" feedback program and to make modifications to their existing inquiry process to comply with the act's requirement that CMS implement an informal review process permitting EPs to seek review of a determination that the EP did not meet PQRI submission requirements.

Resource Use Measurement and Reporting Program

CMS implemented the Physician Resource Use Measurement and Reporting Program on January 1, 2009. Under the program, physicians receive confidential reports measuring the resources involved in furnishing care to Medicare beneficiaries. Phase I of the program involved data analysis activities and sending reports to individual practicing physicians in 12 geographic areas that provided feedback on resource use measures. Phase II will involve reporting on the quality of care furnished to Medicare beneficiaries by physicians or groups of physicians (anticipated in fall of 2010).

Section 3007 of the Affordable Care Act requires the secretary to phase in a budget-neutral payment modifier to the fee-for-service physician fee schedule payment formula beginning January 1, 2015. The modifier will provide for differential payment under the fee schedule to physicians and groups of physicians based on the relative quality and cost of care to their Medicare beneficiaries. The work done in connection with the confidential feedback reports will inform the implementation of the payment modifier and Medicare physicians will receive a confidential feedback report prior to implementation of the payment modifier.

In the proposed 2011 update, CMS seeks comment on various aspect of program design, including cost and quality measures, methodologies for compositing measures, and feedback report content and delivery. CMS also continues to seek public comment on the statistical issues involved in the implementation of a program that compares physicians to their peers and institutes differential payment, including risk adjustment, attribution, benchmarking, peer groups, minimum case sizes, cost and quality measures and compositing methods.

Incentives for Primary Care Services and Rural General Surgery

The Affordable Care Act provides incentive payments equal to 10 percent of a primary care practitioner's allowed charges for specified primary care services under Part B. The law defines primary care practitioners as physicians 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, 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 the HHS. These incentive

payments would be made quarterly and the 10 percent would be applied to the Medicare allowed charges for primary care services furnished by the primary care practitioner, including any physician bonus payments for services furnished in health professional shortage areas. In the update, CMS proposes to determine a practitioner's eligibility for incentive payments using claims data and the provider's specialty designation from calendar year 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.

The Affordable Care Act also provides for a 10 percent increase in payment for major surgical procedures performed in health professional shortage areas by surgeons enrolled as general surgeons. The increase is effect for calendar years 2011–2016.

Payment Reductions for Advanced Imaging Services

The update includes three provisions that will effectively lower payment for certain diagnostic imaging services. First, as mandated by the Affordable Care Act, effective January 1, 2011, CMS will assign a 75 percent utilization rate assumption to CT and MRI equipment, an increase that has the effect of lowering the practice expense relative value units, and, thus, payment for imaging services utilizing this equipment. In 2010 CMS began a four-year transition of the utilization rate assumption for CT and MRI equipment from 50 percent to 90 percent, a change preempted by this provision of the Affordable Care Act.

Second, CMS proposes to expand the list of imaging services affected by this change in the utilization rate assumption to include CT angiography and MRI angiography services. This reduction in expenditures for CT and MRI services is not being made on a budget-neutral basis. Finally, CMS proposes to expand the multiple procedure payment reduction ("MPPR") to the technical component of 20 percent more imaging services than under current policy. Currently, as revised by the Account Care Act, the MPPR imposes a 50 percent payment reduction on the second and any subsequent CT, MRI or ultrasound service furnished during the same session, on the same or a contiguous body part, and involving the same imaging modality. Effective January 1, 2011, CMS proposes to apply the MPPR to multiple CT, MRI and ultrasound services performed in the same session without regard to imaging modality or body part.

Addition of Telehealth Services

The proposed 2011 update includes the addition of the following services to the list of Medicare telehealth services for calendar year 2011:

i) Individual and group kidney disease education services (HCPCS codes G0420 and G0421, respectively)

ii) Individual and group diabetes self-management training (DSMT) services, with a minimum of one hour of in-person instruction to be furnished in the year following the initial DSMT service to ensure effective injection training (HCPCS codes G0108 and G0109, respectively)

iii) Group medical nutrition therapy and health and behavior assessment and intervention services (CPT codes 97804, and 96153 and 96154, respectively)

iv) Subsequent hospital care services, with the limitation for the patient's admitting practitioner of one telehealth visit every three days (CPT codes 99231, 99232, and 99233)

v) Subsequent nursing facility care services, with the limitation for the patient's admitting practitioner of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310).

Regulations regarding payment for telehealth services will be revised to add the above-listed services and the list of telehealth services for which payment will be made at the applicable Physician Fee Schedule payment amount for the service of the practitioner will be reorganized. CMS is continuing to specify that the initial and periodic personal physician visits required to be made to residents of skilled nursing facilities (SNFs) under 42 C.F.R. 483.40(c) may not be furnished as telehealth services.

In proposing the additions, CMS emphasizes that the requirements for certain minimum in-person instruction or interaction, or limits on the number of telehealth visits in a certain span of time, sufficiently address concerns regarding the centrality of in-person interaction to the effectiveness of the service, or, in the case of subsequent hospital care services, concerns regarding the potential acuity of hospital inpatients. While providing for the addition of subsequent nursing facility care services, CMS is also imposing limitations of one telehealth visit every 30 days, to address its concerns regarding the potential acuity and complexity of SNF inpatients. CMS has requested public comments on this issue, including any evidence regarding patterns of high quality care

and clinical outcomes, with regard to its proposal to limit the provision of subsequent nursing facility care services furnished through telehealth to once every 30 days.

Shortened Period for Submitting Medicare Claims

As mandated by the Affordable Care Act, CMS proposes that Medicare fee-for-service claims for services furnished on or after January 1, 2010, must be filed no later than one calendar year after the date of service. Under prior rules, providers and suppliers had up to 27 months to submit a claim, depending on the date of service. The current filing deadlines 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.

Physician Assistants Included as "Physician Extenders"

Medicare Part A pays for post-hospital SNF care furnished by an SNF or critical-access hospital (CAH) with swing-bed approval, only if there is a level-of-care certification of the needed skilled services and, as necessary, recertification of continued need. Effective for items and services furnished on or after January 1, 2011, the Affordable Care Act adds physician assistants (PAs) to the list of "physician extenders" (currently, nurse practitioners and clinical nurse specialists) who, working in collaboration with a physician, can perform the required initial coverage certification and periodic recertification that an individual needs skilled nursing care or other skilled rehabilitation services that, as a practical matter, can only be provided in an SNF or a hospital swing-bed on an inpatient basis. In light of the Affordable Care Act's provision adding PAs to the category of physician extenders, CMS proposes to revise the Medicare regulation to add PAs to the list of physician extenders permitted to certify coverage for post-hospital SNF care. Legal prohibitions that apply to the direct or indirect employment of physician extenders by the skilled nursing facility would, of course, apply to PAs ordering post-hospital extended care services as a result of the inclusion of PAs as physician extenders.

Reasonable Cost Payments Extended for Additional Cost-Reporting Periods

The Medicare Modernization Act established a reasonable cost payment for outpatient clinical diagnostic laboratory tests furnished by hospitals with fewer than 50 beds located in qualified rural areas for cost-reporting periods during the two-year period beginning July 1, 2004. This period was subsequently extended twice, most recently to cost-reporting periods beginning July 1, 2004 and ending June 30, 2008. For some hospitals with cost reports that began as late as June 30, 2008, this extension affected services performed as late as June 29, 2009, because this was the date those cost reports would have closed. The Affordable Care Act reinstitutes this reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds 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 with cost reports that begin as late as June 30, 2011, this reinstitution of reasonable cost payment could affect services performed as late as June 29, 2010, because this is the date those cost reports will close.

Therapy Services

In the proposed 2011 update, CMS solicits comments on three potential alternatives to outpatient therapy caps, which impose a per beneficiary combined cap on expenses incurred for outpatient physical therapy and speech-language pathology services under Part B, and a separate cap on outpatient occupational therapy services under Part B. The alternatives are intended to improve upon existing payment policies by identifying appropriate payments for medically necessary and effective therapy

services, and CMS makes clear that the alternatives are not intended as mutually exclusive of one another. The alternatives proposed in the update are based on the June 30, 2009, report from the Short Term Alternatives to Therapy Services project, a two-year project funded by the Tax Relief and Health Care Act of 2006, as well as stakeholder input and further communications with the contractor who prepared the report. CMS is not formally proposing any of the options at this time; rather, the agency is soliciting comments to assess the strengths and weaknesses of each approach.

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