Affordable Care Act Provisions in the 2011 Medicare Physician Fee Rule

BY WENDY KRASNER, ANDREA MARESCA, AND IAN SPATZ

On July 13, 2010, the Centers for Medicare & Medicaid Services published in the Federal Register (75 Fed. Reg. 40040) a proposed rule (RIN 0938-AP79) that updates policies and payment rates for services by physicians, non-physician practitioners (NPPs), and certain other suppliers that are paid under the Medicare Physician Fee Schedule (PFS) during calendar year (CY) 2011. In addition, the proposed rule implements several provisions in the Patient Protection and Affordable Care Act (ACA) not directly related to the Medicare PFS. CMS stated it expects to issue a final rule on or around Nov. 1.

The key payment, benefit, and quality-related ACA initiatives addressed in this rule include:

- Eliminate out-of-pocket costs for beneficiaries for most preventive services, including the new annual wellness visit;
- Implement an incentive payment for primary care services furnished by primary care practitioners;

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1 The proposed rule is available at http://edocket.access.gpo.gov/2010/pdf/2010-15900.pdf. The Patient Protection and Affordable Care Act (P.L. 111-148) and amendments made to it by the Healthcare and Education Reconciliation Act (P.L. 111-152) are collectively referred to as the Affordable Care Act, or ACA.
Implement changes to the structure and function of the Physician Quality Reporting Initiative (PQRI) program; and
Implement changes to the E-Prescribing Incentive program for eligible Medicare providers.

### Primary Care and Prevention

**Preventive services**

The ACA revised the definition of Medicare “preventive services” to include the following three general components:

- Screening and preventive services\(^3\) described in the law (see Table 1)
- An initial preventive physical examination (IPPE)
- Annual wellness visit (also referred to as the Personalized Preventive Plan Services or PPPS)

**Table 1. ACA-defined Medicare screening and preventive services**

<table>
<thead>
<tr>
<th>Preventive services</th>
<th>Preventive services</th>
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<tbody>
<tr>
<td>Pneumococcal, influenza, and hepatitis B vaccine and administration*</td>
<td>Cardiovascular screening blood tests</td>
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<tr>
<td>Screening mammography</td>
<td>Diabetes screening tests</td>
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<tr>
<td>Screening pap tests and screening pelvic exam</td>
<td>Ultrasound screening for abdominal aortic aneurysm</td>
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<tr>
<td>Prostate cancer screening tests (excluding digital rectal examinations)</td>
<td>Initial Preventive Physical Examination</td>
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<tr>
<td>Colorectal cancer screening tests (excluding barium enemas)</td>
<td>Personalized Prevention Plan Services</td>
</tr>
<tr>
<td>Bone mass measurement*</td>
<td>Additional preventive services identified for coverage through the national coverage determination (NCD) process</td>
</tr>
<tr>
<td>Medical nutrition therapy (MNT) services*</td>
<td>Personalized health advice and referral to health education or preventive counseling services or programs which seek to reduce identified risk factors and improve self-management/wellness</td>
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*added to the definition of preventive services by the ACA

The proposed rule establishes that Medicare Part B will pay 100 percent of the Medicare cost for preventive services, thereby waiving the deductible and the 20 percent coinsurance that applied to most preventive services prior to the ACA. The new benefit does not affect the pre-ACA provisions that waive the deductible and coinsurance for specific services, for example, clinical laboratory tests.

**Medicare Coverage of Annual Wellness Visit**

Effective Jan. 1, 2011, Medicare Part B will cover an annual wellness visit provided by a health professional without any cost-sharing or coinsurance by an eligible beneficiary.\(^4\) As required by the statute, the initial annual wellness visit includes the initial preventive physical examination (IPPE) and the development of a PPPS for beneficiaries (see Table 2). Subsequent annual wellness visits are to include provision of the PPPS and updates of such plan.

\(^3\) The covered preventive services include those recommended with a grade of A or B from the U.S. Preventive Services Task Force. CMS also considered additional preventive services not meeting this criteria, and as indicated in Table 1 of this brief, some of which the agency proposes to classify as screening and preventive services.

\(^4\) The proposed rules defines health professional as a physician who is a doctor of medicine or osteopathy; a physician assistant, nurse practitioner, or clinical nurse specialist; or a medical professional (including a health educator, registered dietitian, or nutritionist) or a team of medical professionals, who are working under the supervision of a physician.

<table>
<thead>
<tr>
<th>Table 2. Services included in the first annual wellness</th>
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<tbody>
<tr>
<td>Establishment of medical and family history</td>
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<tr>
<td>Establishment of current providers and suppliers regularly involved in providing medical care to the individual</td>
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<tr>
<td>Routine measurements such as height, weight, and blood pressure</td>
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<tr>
<td>Detection of cognitive impairment</td>
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<tr>
<td>Review of the individual’s potential (risk factors) for depression</td>
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<tr>
<td>Review of the individual’s functional ability and level of safety</td>
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<tr>
<td>Personalized health advice and referral to health education or preventive counseling services or programs which seek to reduce identified risk factors and improve self-management/wellness</td>
</tr>
</tbody>
</table>
| Establishment of the following:
  - Individualized written screening schedule such as a checklist for the next 5 to 10 years based on United States Preventive Services Task Force and the Advisory Committee on Immunization Practices recommendations, and the individual’s health status, screening history, and age-appropriate preventive services covered by Medicare; and
  - List of risk factors and conditions for which primary, secondary or tertiary interventions are recommended/underway, including mental health conditions, and a list of treatment options and associated risks and benefits |
| Other services determined appropriate through the National Coverage Determination Process |

The ACA also mandates that the annual wellness visit include a health risk assessment (HRA). However CMS states in the preamble that, because the necessary guidelines, standards, and tools for a model HRA are not yet available, CMS will not now require the HRA as a component of the wellness visit.

### Medicare Federally Qualified Health Centers (FQHCs)

**Preventive Services Benefit and Payment**

Effective Jan. 1, 2011, the proposed rule applies the new Medicare preventive services definition (see previous section on preventive services) to the definition of Medicare Federally Qualified Health Center (FQHC) benefit preventive services. The rule proposes to provide FQHCs a 100 percent reimbursement rate for Medicare preventive services. Medicare will continue to waive the Part B deductible for all FQHC services, including preventive services added by the ACA.

The ACA establishes a new Medicare FQHC prospective payment system (PPS), beginning on or after Oct. 1, 2014. The rule proposes to require Medicare FQHCs to begin reporting all services furnished beginning Jan. 1, 2011. According to the preamble, this additional reporting would include the information needed to develop and implement a PPS for FQHCs.

CMS states the proposed new data collection effort would not be utilized to determine Medicare payment to the FQHCs. Medicare FQHC payment would continue in the current manner until the Medicare FQHC PPS is implemented in 2014 and the Medicare claims processing system is revised to reflect such a system.

### Incentive Payment Provisions

**Primary Care Services Incentive Payment Program**

The proposed rule implements the ACA’s “Incentive Payments for Primary Care Services.” For services provided as of Jan. 1, 2011, and before Jan. 1, 2016, primary care providers would receive a quarterly incentive payment equal to 10 percent of the payment amount for
their primary care services under Part B. For purposes of this program, the rule establishes a two-part test for eligible provider.

First, a primary care provider must be a physician\(^5\) having a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or a nurse practitioner, clinical nurse specialist, or physician assistant.\(^6\) Second, primary care services must represent at least 60 percent of the allowed charges under Part B for the practitioner for the most current full year of Medicare claims data.

A primary care physician furnishing a primary care service in a Health Professionals Shortage Area (HPSA) may receive both a HPSA physician bonus payment and a primary care incentive payment under the new program.

**Physician Quality Reporting Initiative**

**ACA Changes to the Physician Quality Reporting Initiative (PQRI)**

The ACA extended the voluntary PQRI incentive program for eligible providers with additional changes through calendar year 2014. The PQRI incentive payment amount is calculated using estimated Medicare Part B PFS allowed charges for all covered professional services.

The proposed rule implements the payment schedule for qualified providers established by ACA as follows:

- For 2011 PQRI, a 1.0 percent incentive,
- For 2012 through 2014, a 0.5 percent incentive, for qualified eligible providers.

In 2015, eligible providers and group practices that do not satisfactorily report quality measures will be subject to PQRI payment penalties as follows:

- In 2015, payment reduction of 1.5 percent in 2015,
- In 2016 and thereafter, payment reduction of 2.0 percent.

**Additional Incentive Payments for PQRI Reporting.**

The rule implements provisions of the ACA that allow an eligible provider to receive an additional 0.5 percent incentive payment for 2011 through 2014 if they provide data on quality measures through a Maintenance of Certification Program (MOCP) operated by a specialty body of the American Board of Medical Specialties (ABMS).

The rule proposes specific reporting criteria for 2011 that an eligible provider must meet in order to receive the additional incentive payment, including:

- Meet the proposed requirements for satisfactory PQRI reporting, for program year 2011, based on the 12-month reporting period, rather than only a 6-month period,
- Submitted data through an MOCP,
- Participate in an MOCP for a year and successfully complete a qualified MOCP practice assessment for such year more frequently than is required to qualify for or maintain board certification.

**Feedback for PQRI program participants.** CMS proposes to provide feedback to eligible providers regarding their submission of quality measures data on or close to the issuance of incentive payments. The rule also proposes to provide interim feedback reports for eligible providers reporting 2011 measures through the claims-based reporting mechanism. These interim reports are expected in June 2011.

**Appeals.** The proposed rule implements the informal appeals process required by the ACA by Jan. 1, 2011. Eligible providers may seek a review of the determination that they did not satisfactorily submit data on quality measures for purposes of qualifying for a PQRI incentive payment. However, in the preamble, CMS notes that the agency is not required to reverse its decision and will only make corrections due to mathematical errors.

For appeals, CMS proposes the following process:

- A provider must request an informal review within 90 days of the release of his or her feedback report by notifying the Quality Net Help Desk,
- CMS proposes to provide a response to the request within 60 days of receiving the original request,
- CMS will not include a hearing or evidence submission process, although the EP may submit information to assist in the review,
- CMS will provide a written response.

By Dec. 31, 2011, CMS plans to post, on the CMS PQRI Web site, further information regarding the operational aspects of the informal review process for 2011.

**Electronic Prescribing (eRx) Incentive Program**

CMS clarifies in the proposed rule that physicians who qualify for and participate in the meaningful use incentive program for electronic health records (EHRs) in 2011 are not eligible for additional incentive payments under the Medicare electronic prescribing (eRX) incentive program.

The rule also proposes that physicians who earned incentives under the meaningful use program in 2011 could still be subject to penalties in 2012 for not participating and being successful e-prescribers in the eRx incentive program. CMS also proposed criteria for applying the penalty in 2012 and 2013 for providers that fail to participate in e-prescribing. Those criteria also included proposals for “hardship exemptions.”

The eRx Incentive Program is voluntary for group practices selected to participate in the PQRI group practice reporting option. However, for 2011, the proposed rule would require that group practices must participate in the PQRI group practice reporting option in order to be eligible to participate in the eRx group practice reporting option for 2011 PQRI.

CMS also proposes to deem group practices participating in the Medicare PGP, Medicare Care Management Performance (MCMP), and EHR demonstrations to be participating in the PQRI GPRO for purposes of the 2011 PQRI.

For purposes of the 2011 eRx Incentive Program, CMS proposes that group practices participating in such demonstration projects would be required to meet the proposed 2011 eRx Incentive Program GPRO requirements or the proposed 2011 eRx Incentive Program requirements for individual eligible providers in order to qualify for a 2011 eRx incentive.

CMS plans to post the final 2011 PQRI participation requirements for group practices on the PQRI section of the CMS Web site at [http://www.cms.gov/PQRI](http://www.cms.gov/PQRI) by Nov.

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\(^5\) Described in section 1861(r)(1) of the Social Security Act (the Act).

\(^6\) As defined in section 1861(aa)(5) of the Act.
Integration of PQRI and EHR Reporting

As required by the ACA, CMS proposes to integrate the PQRI program and EHR-reporting. CMS proposes to include many ARRA core clinical quality measures in the PQRI program, to demonstrate meaningful use of EHR and quality of care furnished to individuals. In the preamble, CMS stated the agency is working towards a plan to integrate reporting on quality measures to make available by Jan. 1, 2012.

Physician Feedback Program and Payment Modifier

There are two provisions in the ACA addressed in this rule that are relevant to the Physician Resource Use Measurement & Reporting (RUR) Program. CMS states it will use an iterative process to enhance the measures and methods and the content of the RUR program reports per the ACA and previously planned efforts. In turn, the reporting initiative will inform and serve as the foundation for implementing the payment modifier created by the ACA.

1) CMS has begun to implement Phase II of the RUR program, expanding the program to group practices (approximately 40 large physician groups and the approximately 2,000 physicians affiliated with those groups) and will include cost and quality data in the reports. The agency expects every Medicare practitioner, as applicable, will receive a report prior to implementation of the payment modifier. Beginning in 2012, the ACA requires CMS to provide reports that compare patterns of resource use of individual physicians to other physicians. CMS does not intend to include PQRI data in the RUR reports at this time. CMS expects the Phase II RUR program reports will be distributed electronically in the fall of 2010.

2) The ACA also requires CMS to develop a new, separate, budget-neutral payment modifier to the Fee-For-Service PFS payment formula according to the following schedule:

- By Jan. 1, 2012, establish a payment modifier,
- By Jan. 1, 2012, publish the cost and quality measures that will be used in determining the payment modifier,
- In 2013, through rulemaking, begin implementing the modifier program parameters,
- On Jan. 1, 2015, the payment modifier is effective with a phased implementation,
- By Jan. 1, 2017, all physicians paid under the physician fee schedule will be subject to the modifier,
- On or after Jan. 1, 2017, CMS may apply the payment modifier to other eligible professionals.

7 The RUR provides confidential reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries.