TMA'S
Health REFORM School

Survive and Thrive in the New Health Care Landscape

News for physicians who treat Medicare patients

Texas Medical Association
Physicians Caring for Texans

What the New Health Care Law Means for Physicians' Medicare Fees

Even though the Affordable Care Act (ACA) did not fix or replace the flawed Medicare formula used to pay physicians, many other provisions in the new law will affect Medicare fees. Some of new provisions were retroactive to Jan. 1, 2010. Others won't go into effect until future years.

Retroactive Changes

Two temporary retroactive changes to geographic practice cost indices (GPCIs) had a largely positive effect on Texas payment areas. They included an extension of the work GPCI floor and a reduction in the impact of the practice expense variations. The net effect was small, retroactive Medicare fee increases for most Texas payment areas, as follows:

Austin 0.8 %
Beaumont 3.8 %
Brazoria 1.7 %
Fort Worth 1.2 %
Galveston 1.4 %
Houston 0.3 %
Rest of Texas 4.6 %

Dallas geographic adjustors were not affected, but a very small downward correction to the Medicare conversion factor did affect Dallas fees. Although these changes were retroactive, Medicare carriers were not instructed to reprocess the underpaid claims for the first five months of 2010 until early 2011. These carriers will automatically pay the adjusted amounts only if the billed charge on the filed claim exceeded the new Medicare allowable. Physicians who originally reported the lower Medicare fee in the charge field have an opportunity to reopen and revise the claims to receive increased payment.

Other changes that went into effect in 2010 include the extension of several payment policies, such as some specific imaging payment changes and an extension of Physician Quality Reporting system (PQRS) incentive payments.

Current and Future Changes

Several payment changes take effect now and in the coming years, including these:

- The 20-percent Medicare coinsurance requirement was eliminated for a broad range of preventive care services starting in 2011.
- Primary care bonus: From 2011 through 2015, in addition to other bonuses, a 10-percent bonus payment is available to physicians with primary specialties of family medicine, internal medicine, geriatric medicine, or pediatric medicine for whom 60 percent of the allowed Medicare charges are for new or established patient office visits; home visits; or nursing home, boarding home, or assisted-living facility visits. This also applies to nurse practitioners, clinical nurse specialists, and physician assistants.
- General surgery bonus: From 2011 through 2015, a 10-percent additional bonus payment is available for general surgeons who perform major surgical procedures (those with global periods of at least 10 days) in health professional shortage areas.
- E-prescribing Medicare bonuses will continue through 2012 (1-percent, Medicare Part B) but be reduced in 2013. However, eligible physicians who do not report successful e-prescribing on their claims and have

continued on back

not received an exemption will be penalized 1 percent. **To avoid the 1-percent penalty in 2012, by June 30 THIS YEAR, physicians must e-prescribe successfully and report via claims using the G-code 8553 on at least 10 Medicare encounters.** Physicians who report 25 claims using the G-code by Dec. 31 this year will be eligible for the 1-percent 2012 incentive and avoid the 1.5-percent penalty in 2013.

- PQRS incentive payments decrease to 1 percent in 2011 and to 0.5 percent in 2013 and 2014, but an additional 0.5-percent bonus will be available under some circumstances.
- PQRS penalties begin in 2015 at 1.5 percent, increasing to 2 percent in 2016.
- Payments for advanced imaging services are reduced for 2011 and thereafter under the assumption that equipment is used at 75 percent of capacity.

Future Uncertainty

In addition to the ongoing uncertainty about the Sustainable Growth Rate fee schedule update, the new health care law includes some provisions that could create unpredicted effects on Medicare payment, including these:

- A new Independent Medicare Advisory Board is charged with reducing the per-capita rate of growth in Medicare spending by developing detailed proposals for Congress to apply whenever Medicare spending exceeds targets. Recommendations must result in a net reduction in total Medicare spending without rationing health care, raising revenues, increasing beneficiary premiums or cost sharing, or reducing payment rates for services prior to Dec. 31, 2018. It is not clear what actions might meet those criteria, but the new board will have unprecedented power to affect Medicare policy.
- The Centers for Medicare & Medicaid Services (CMS) must publish proposed measures and rules for a value-based payment adjustor starting in 2012, then implement the payment adjustment in 2015 for a select group of physicians and in 2017 for all physicians. The adjustment is to be budget-neutral, so any improved payment to one group of physicians will reduce payments for others. The value-based payment adjustment is intended to cut payments to physicians whose patients incur higher-than-average Medicare cost or utilization unless the physician rates equally high in selected quality measures. Conversely, it will increase payments to physicians whose measured quality is high and Medicare cost is low. This could result in imprudent fee cuts for Texas physicians who serve the most disadvantaged patient populations.
- Differing payment models in the Medicare Shared Savings Program for accountable care organizations are allowed.
- A national five-year pilot program on payment bundling for an episode of care provided around a hospitalization will start in 2013.
- CMS now has a process for revising relative values for "misvalued" codes independently from the American Medical Association Relative Value Update Committee's (RUC's) work. This would target codes that have had the fastest growth or have experienced substantial changes in practice expenses; multiple codes that are billed frequently in conjunction with furnishing a single service; and codes with low relative values, particularly those that often are billed multiple times for a single treatment. In published rules, CMS has indicated an intention to continue working with the AMA RUC on these issues.
- A new Center for Medicare and Medicaid Innovation within CMS will test innovative payment and service delivery models to reduce expenditures. These include risk-based comprehensive payment or salary-based payment, varying payment to physicians according to their adherence to certain criteria in test ordering, paying physicians for using patient decision-support tools, and allowing states to test and evaluate systems of all-payer payment reform.

Questions? Turn to TMA for Answers.

TMA has a wealth of information posted on our website. We also have webinars, online tools, publications, and live seminars to help you learn more about how the new law affects you and your Medicare patients. Call the TMA Knowledge Center at (800) 880-7955 for more information or go to texmed.org/hsr for more information on ACA.