

ACP AMERICAN COLLEGE OF PHYSICIANS INTERNAL MEDICINE | *Doctors for Adults*

Tax Relief and Health Care Act of 2006 and Other Changes Affecting 2007 Medicare Payments

Frequently-Asked-Questions

UPDATED: December 21, 2006

How is Congress's action to avert the 5 percent across-the-board cut that would have resulted from the flawed Sustainable Growth Rate (SGR) formula reflected in the 2007 Medicare physician fee schedule?

The Centers for Medicare and Medicaid Services (CMS), the federal agency that runs the Medicare program, planned to implement the 5 percent SGR formula-induced across-the-board cut to payments for all physician services by lowering the 2007 conversion factor (CF), the dollar amount that is multiplied by the relative value units assigned to each physician service. Accordingly, the 2007 CF would have been \$35.98, down 5 percent from its 2006 level of \$37.90. Congress's decision to avert the 5 percent cut means that the 2007 CF will stay at its 2006 level of \$37.90.

ACP, the American Medical Association (AMA), and others strongly urged the Congress to prevent the 5 percent cut. Although the College would have preferred an increase in the CF, maintaining the current conversion factor is clearly better than a cut. *Even though the CF will remain at the same dollar level as in 2006 (\$37.90) most internists will actually see a substantial gain in total Medicare payments because of increases in the payment rates for mid-to-higher level office visits and other evaluation and management services (E/M) that will be implemented on January 1, 2007, as explained below.*

Will Medicare payments for specific services change in 2007?

For 2007, CMS made the decision to change the relative value units (RVUs) assigned to many E/M services in comparison to other services, *increasing the RVUs assigned to most mid-to-higher level new and established patient office visits, inpatient visits, and consultations.* This was the result of a review of the accuracy of the relative value units (RVUs) as determined by the Resource-Based Relative Value Scale (RBRVS) required to take place every five years, known as the "five year review." Based on recommendations from the Relative-Value Scale Update Committee (RUC), an entity comprised of representatives appointed by major specialty organizations, including ACP, which advises CMS on changes in RVUs, CMS announced major increases in the RVUs for many E/M services in November 2006, with a January 1, 2007 implementation date. The RVUs for each physician service, when multiplied by the dollar conversion factor for a particular calendar year (as described above), determine the amount Medicare pays.

ACP successfully organized and led a multi-specialty effort to persuade its colleagues through the RUC and to then to convince CMS that these increases are warranted and needed. These changes are independent of the SGR formula.

How do these relative value changes affect the Medicare payment for E/M services?

Specifically, CMS increased the relative value units for most mid-to-higher level services in the office, inpatient, and consultation families of services, and, thus, payments for these services will rise. For example, the most commonly billed service, the 99213 (mid level established office visit) increased from an average payment of \$52.68 to \$59.40.

Will all of the services provided by internists get higher payments? Or will some stay the same or see reductions?

Not all services will see an increase in payments. Some evaluation and management services (mainly lower level codes) and many procedures will see their payments reduced by 5 percent because of a “budget neutrality” adjustment. For example, the payment for a 99202 (level 2 new patient office visit) will decrease by 4.6 percent. *This 5 percent budget neutrality offset does not take any money out of the total physician payment pool, but represents a redistribution of dollars within Medicare physician payments to keep total spending the same.*

This is because CMS is required by law to offset the costs associated with increasing payments for the mid-to-higher level E/M services, and any other increased spending that resulted from review of RVUs for other procedure codes, by applying an across-the-board “budget neutrality” offset, to keep total spending for physician services the same. Because the increased E/M service relative values—without the budget neutrality offset—would have increased Medicare spending by approximately \$4 billion, CMS applied a “budget neutrality” offset to the RVUs for all physician services that will result in payments for procedure codes—the ones that are not slated for increases because of the “five year review” of the RVUs--being reduced by approximately 5 percent to achieve budget neutrality. It also means that the gains for the E/M services that are slated for increases are actually 5 percent lower than they would have been without the budget neutrality adjustment. The CMS budget neutrality adjustment is completely independent of the adjustment to the CF driven by the SGR formula. A full table of the national changes in Medicare payments for E/M services is available at <http://www.acponline.org/hpp/sgr2007table.xls>.

So if some of internists’ services will see higher payments, and others will see lower payments, why does ACP believe that most internists will come out ahead?

Most internists should see substantial increases in total Medicare payments because they bill disproportionately more of the procedure codes that are slated for increases—mid-to-higher level E/M services—than procedures and lower level E/M codes that will be decreased because of the budget neutrality adjustment. CMS estimates that, on average,

internists will see a 5 percent increase in total Medicare payments in 2007, even with the budget neutrality adjustments. Most internal medicine subspecialties will also come out ahead or at least break even.

Can you explain how Congress’s decision to “maintain the floor on geographic adjustments” affects an internist’s practice?

Under the RBRVS, CMS assigns a RVU for physician work, practice expense (overhead), and malpractice liability insurance for each service. The RVU for each of these three components is adjusted by a factor that reflects the relative difference in these inputs for a certain geographic area. Medicare maintains 89 different geographic areas—each with a separate adjustment factor for work, practice expense, and professional liability insurance.

In legislation enacted in 2003, Congress established a “floor” below which no work RVU geographic adjustment factor could go. For the period January 1, 2004 through December 31, 2006, Congress established this floor as the national average work RVU geographic adjustment factor, i.e. no geographic area’s adjustment factor is set below the national average. Congress’s provided a one year extension of the work RVU geographic adjustment factor floor in the Tax Relief and Health Care Act of 2006. This legislative provision means that the 58 of the 89 Medicare-defined geographic adjustment areas will maintain the increase in payments that they received from 2004-2006. *If Congress had not acted to maintain that floor on geographic adjustments, internists in those affected geographic areas would have seen their Medicare payments reduced.*

What is the bottom line Medicare payment impact for an internist?

As explained above, most internists will see their Medicare revenue rise after all of the changes/factors described above. **The typical internist furnishes the E/M services for which payment increased more frequently than the services for which payment fell.** *Although CMS projects that the internists, on average, will see Medicare payments increase by 5 percent from 2006 to 2007, the specific change in the revenue you receive from Medicare depends on the mix of services you provide.* Generally speaking, internists who see larger numbers of Medicare patients and who bill more mid-to-higher level visits, and fewer of the procedures or lower level visits that will be reduced because of the budget neutrality offset, will fare the best. Based on Medicare data on allowable charges per internist and surveys of internal medicine practices, ACP estimates that internists will typically see an increase of \$5,000 to \$10,000 in total Medicare allowable charges in 2007, depending on the mix of services and patients seen in a particular office. *The ACP-developed interactive reimbursement calculator at <http://www.acponline.org/private/pmc/emimpact.html> enables you to enter the E/M services you provide in a typical week to determine the revenue change specific to your practice.*

Why does ACP say that the increase in the payments for E/M services are “permanent” and will benefit internists beyond 2007?

Simply put, E/M services will get a greater share of total Medicare dollars, and other services a lesser share, because of the RVU changes. This shift is now a permanent part of Medicare's total "baseline" spending amount that will be updated each year based on changes in the conversion factor. ***So in any year when Congress allows the annual dollar conversion factor to increase, this increase will be applied to the higher 2007 "baseline" payment rates for E/M services, and the effect will be compounded each year that the conversion factor is increased.*** Even if Congress allowed the conversion factor to be reduced in a given year (ACP, of course, will oppose any cuts in the conversion factor), the cut would be applied to a higher baseline payment level for E/M services than if the RVU increases for 2007 not been implemented.

Will private health plans pay me more for E/M services?

ACP is urging private health plans to recognize the Medicare increase in the relative value assigned to many E/M services. A recent AMA survey of health plans indicates that approximately 80 percent use the RBRVS in some form to determine payments to physicians, so the College expects internists to receive increased reimbursement from many private health plans. However, ACP is unable to project a specific increase because of the sheer number of health plans and the diffuse nature of their decision-making. ***Internists may want to ask the private insurers with whom you contract if they intend to fully implement the Medicare RVU increase for E/M services and advocate that they do so.*** ACP will also be working directly with health plans and employees to urge them to accept the full increases for E/M services in their own payment schedules.

Are there any noteworthy changes that affect Medicare payment for other services?

Beginning in 2007, Medicare will pay physicians for the administration of vaccines covered under Medicare Part D prescription drug plans as required by the Tax Relief and Health Care Act of 2006. Medicare did not reimburse for the administration of vaccines provided under the Part D program in the past even though the actual vaccine product could be covered by a prescription drug plan. The herpes zoster vaccine, approved by the Food and Drug Administration (FDA) in 2006, is an example of a vaccine that Part D plans can cover. The law change does not affect how you report the administration of influenza, pneumococcal, and other vaccines covered under Medicare Part B to the program—continue to use the same codes you used in 2006.

Can you provide more detail on the transitional, voluntary Medicare pay-for-reporting program that begins July 1, 2007?

The Tax Relief and Health Care Act establishes a transitional program by which physicians will receive extra payment for reporting on quality measures relevant to their patients from July 1, 2007 to December 31, 2007. The voluntary program would give internists the option of reporting on at least three quality measures on 80 percent of their eligible patients in order to receive a bonus that will equal up to 1.5 percent of their total Medicare payments during that given period.

This program will be based on the current Medicare Physicians Voluntary Reporting Program (PVRP) that was introduced by CMS in 2006. The legislation states that the pay-for-reporting program will use the 66 unique clinical measures that CMS announced on December 5, 2006, with additional modifications that are made through a consensus process through April 2007. ACP communicated recommendations to CMS on the PVRP that influenced the agency's selection of the 66 measures. The quality measures most relevant to internists have been approved by the multi-stakeholder consensus processes of the National Quality Forum and the AQA (formerly called the Ambulatory Care Quality Alliance) as called for by ACP policy. CMS lists the current list of 66 quality measures at

<http://www.cms.hhs.gov/PVRP/Downloads/PVRPQualityMeasuresList.pdf>.

Physicians will be able to report on the quality measures through codes—either CMS-established “G” codes or Current Procedural Terminology (CPT) performance measures codes, known as CPT Category II codes—attached to the claim form submitted to Medicare for the relevant services provided to eligible patients. Medicare will make a lump-sum payment to the physician at the end of the reporting period. *ACP is preparing a detailed guide pertaining to the voluntary pay-for-reporting program that will be available before the start of the program.*

The legislation only funds the voluntary reporting program from July 1, 2007 through December 31, 2007. The legislation also establishes a framework to continue the voluntary reporting program in 2008 but the new 110th Congress, which takes office in January, will need to enact legislation, before the close of the 2007 calendar year, to establish how much of a payment bonus, if any, will be given to those who participate in the 2008 voluntary reporting program. The new Congress could also decide to alter the reporting program for 2008.

Will Medicare payments be cut in 2008?

Because Congress did not enact a permanent solution to the annual payment cuts caused by the flawed SGR, physicians are likely to be facing another payment cut in 2008. Congress did set aside some money for HHS to apply to next year's conversion factor update to reduce the amount of the cut, but even with this dollar set aside, the conversion factor will be cut by at least 5 percent, unless the new Congress acts to avert the cut, and preferably, get rid of the SGR and replace it with a system that will result in predictable, fair and positive updates. *ACP will be working diligently to influence the new Congress to stop any future SGR cuts and to enact a permanent solution.*

FREQUENTLY ASKED QUESTIONS (FAQs) ABOUT THE MEDICARE MEDICAL HOME DEMONSTRATION PROJECT (MMHD)

Some of the ways in which members will benefit from the end-of-the-session Congressional action were outlined in a Dec. 14 letter to ACP membership by President Lynne M. Kirk, MD, FACP. The “Medicare Medical Home,” which is how the ACP proposal was termed, received prominent attention:

“The legislation includes ACP’s proposal for a medical home pilot which will provide internists who participate in the pilot with a ‘care coordination fee’ for managing the care of patients with multiple chronic conditions and allow physicians to share in savings, such as from reduced hospitalizations, that result from effective physician-directed care management. Also referred to as the Patient-Centered Medical Home (PC-MH), the pilot is a key component to ACP’s efforts to reform Medicare payments to recognize the value of care managed by a patient’s personal internist in partnership with the patient.”

What is the Medicare Medical Home Demonstration Project?

The Medicare Medical Home Demonstration (MMHD) project is authorized in the *Tax Relief and Health Care Act of 2006* and attempts to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care by a personal physician practicing in a Medical Home to Medicare beneficiaries with multiple chronic conditions.

What is the proposed start-up date, duration, geographic scope and practice-size focus of this demonstration project?

The MMHD currently has no specific start-up date and is scheduled to operate for a 3-year period. Participating physicians and practices will be located in urban, rural and underserved areas in a total of no more than eight states. The demonstration will include the participation of physicians in practices of fewer than three full-time equivalents, as well as physicians in larger practices particularly in rural and underserved areas.

What are the requirements for a physician to qualify as a personal physician for this demonstration project?

Qualifying personal physicians participating in the MMHD must be board certified, willing to provide first contact and continuous care, and have the staff and resources to manage the comprehensive and coordinated health care of each participating beneficiary under their care. While the demonstration project is focused on the delivery of primary care, specialist and subspecialist physicians can qualify for participation if they meet all the designated project requirements.

What are the specific service responsibilities that will be required by a personal physician under the MMHD?

The following service responsibilities will be required from a personal physician under the MMHD project:

- Advocate for and provides ongoing support, oversight, and guidance to implement a plan of care that provides an integrated, coherent, cross-discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies).
- Use evidence-based medicine and clinical decision support tools to guide decision making at the point-of-care based on patient specific factors.
- Use health information technology that may include remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.
- Encourage patients to engage in the management of their own health through education and support systems.

What payments can participating physicians and practices expect to receive for participating in the MMHD?

Participating physicians and practices will continue to receive payments for services currently included under the Medicare Physician Fee Schedule. In addition, they will be eligible for the following additional payments:

- a. A care management fee for each participating beneficiary under their care that will be determined through the relative value scale update committee (RUC) process.
- b. An additional bonus fee based upon the achievement of Medicare (Parts A and B) savings and defined quality goals. The bonus methodology to be employed matches that previously used in the Medicare Physician Group Practice Demonstration (PGPD).

How does the MMHD project compare to the concept of the Advanced Medical Home outlined in recent ACP policy papers?

The legislative language authorizing the MMHD project outlines a model of the Medical Home that is generally consistent with the concept of the Advanced Medical Home (AMH) outlined in recent ACP policy papers. Both models describe a medical home containing a personal physician who provides first contact, continuous, and comprehensive and coordinated care. Also, both models promote a payment structure that includes traditional Fee-for-Service, care management and pay for performance components. Differences are that while the AMH is conceptually applicable to all patients, the MMHD is limited to a high-need population of individuals with “multiple chronic illnesses.” ACP’s legislative proposal for a Medicare pilot test of the AMH specified that the project would begin by January 1, 2008 and continue for three years,

while the legislation adopted by Congress does not specify when the project will begin, leaving it to the discretion of the Centers for Medicare and Medicaid Services (CMS). The College called for the Secretary of Health and Human Services to establish a process to invite a variety and sufficient number of practices *nationwide* to participate in the pilot project and that is sufficient to assess the impact of the qualified PC-MH in rural and urban communities, underserved areas, large and small states, whereas the language adopted by Congress limits the pilot to no more than eight states.

Finally, the AMH model specifies the need for a care management payment structure to reimburse physicians in qualified PC-MH practices based on the value of the services provided by such practices. ACP stated that such methodology shall include, at a minimum:

- (A) recognition of the value of physician and clinical staff work associated with patient care that falls outside the face-to-face visit, such as the time and effort spent on educating family caregivers and arranging appropriate follow-up services with other health care professionals, such as nurse educators;
- (B) recognition of expenses that the PC-MH practices will incur to acquire and utilize health information technology, such as clinical decision support tools, patient registries and/or electronic medical records;
- (C) additional performance-based reimbursement payments based on reporting on evidence-based quality, cost of care, and patient experience measures;
- (D) reimbursement for separately identifiable email and telephonic consultations, either as separately-billable services or as part of a global management fee;
- (E) recognition of the specific circumstances and expenses associated with physician practices of fewer than five (5) full-time employees (FTEs) in implementing the attributes of the chronic care model and the qualified PC-MH; and
- (F) recognition and sharing of savings under parts A, B, C, and D of the Medicare program that may result from the qualified PC-MH.

The ACP AMH proposal further stated that reimbursement for services in the qualified PC-MH practice shall consist of the following components:

- (A) a prospective, bundled and risk adjusted structural practice component to cover practice expenses (e.g. equipment, maintenance, training) linked to the delivery of services under the PC-MH model. These expenses include the costs associated with enhanced access and communication functions, population management and registry functions, patient medical data and referral tracking functions, provision of evidence-based care, implementation and maintenance of health information technology, and reporting on performance and improvement conditions;

- (B) a prospective, bundled and risk adjusted care coordination component that recognizes the value of physician work that falls outside the face-to-face visit. This work includes care plan oversight, e-mail and telephonic consultations, extended patient medical data review including data stored and transmitted electronically, and physician supervision of self-management education and follow-up that is accomplished by non-physician personnel;
- (C) visit-based fee-for-service component to recognize visit-based services already covered in traditional fee-for-service payments;
- (D) performance-based component to recognize achievement of defined quality and efficiency goals as reflected on evidence-based quality, cost of care, and patient experience measures.

By comparison, the MMHD language is currently very general and the actual payment structure will need to be defined. ACP plans to work closely with the CMS to ensure that the primary elements regarding the AMH outlined in the recent policy papers are included in the MMHD implementation.

How can I sign-up to participate in the MMHD project?

There is currently no process to sign-up to participate in the MMHD. The passed legislation only authorizes the MMHD project and provides a broad outline for how it should be implemented. CMS now has to convert this broad legislative language into the specific rules and regulations under which the project will be implemented. This process may take up to a year or more. ACP will monitor and participate in this process. ACP will further provide our members with ample notice regarding both a planned start-up date for the demonstration and details on how to enroll as a physician participant as these are announced by CMS.