

Medicare-Covered Preventive Services

Medicare has historically prohibited coverage of services in the “absence of sign, symptom, or injury.” Congress has legislated periodic exceptions to this stipulation in the original Medicare authorizing statute to provide coverage for preventive services and other services that would otherwise be precluded from coverage. Congress has used U.S. Preventive Services Task Force (USPSTF) recommendations to guide its addition of specific prevention-related benefits but its decisions also reflect the input of other stakeholders. Through a 2008 law, Congress provided the Centers for Medicare and Medicaid Services (CMS) explicit authority to add new evidence-based preventive services. CMS maintains a complete list of the Medicare-covered preventive services at: <http://www.cms.gov/PreventionGenInfo/>. The beneficiary 20 percent co-payment and/or Part B deductible that usually applies to physician services has been waived for many but not all Medicare-covered preventive services.

The Patient Protection and Affordable Care Act (ACA) included a number of provisions that impact Medicare coverage of preventive services. In general, the provisions direct more specific alignment with USPSTF recommendations. The Congressional Research Service describes the USPSTF in an April 21, 2010 “Medicare Provisions in the ACA” as:

The U.S. Preventive Services Task Force (USPSTF), administered by the Health and Human Services Agency for Healthcare Research and Quality (AHRQ), is an independent panel of private-sector experts in primary care and prevention that conducts assessments of scientific evidence of the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. It provides evidence-based recommendations for the use of preventive services, which may vary depending on age, gender, and risk factors for disease, among other considerations. Services are given a grade of A, B, C, D or an I Statement. Services graded A or B are recommended. For services graded C, the USPSTF makes no recommendation for or against their routine use. For services graded D, the USPSTF recommends against routinely providing the service to asymptomatic patients, based on evidence that the service is not beneficial, and may be harmful. “I” Statements are provided when evidence is insufficient to support a recommendation.

Does the reform law explicitly provide coverage for any new preventive services?

Yes. The ACA established a new benefit—that began January 1, 2011—through which beneficiaries are eligible to receive an annual wellness visit that focuses on establishing a personalized prevention plan. CMS defined the specific elements required to be provided during the visit, as well as the eligible population. Detailed information concerning this benefit is available at:

http://www.acponline.org/running_practice/practice_management/payment_coding/wellness.htm. While the enabling legislation required that the wellness visit include both a personalized preventive plan and a risk assessment that the beneficiary completed prior to or as part of the visit, the risk assessment had been eliminated as a requirement for 2011, but it was mandatory starting in 2012.

Medicare pays for the service in full, meaning that beneficiaries do not have to contribute the usual 20 percent co-payment nor pay toward any deductible that they had yet to meet.

What does Medicare pay for the wellness visit providing a personalized preventive plan service?

CMS, for 2013, defined a basic rate of \$169.18 for the initial Wellness Visit and \$111.99 for such visits in subsequent years. The actual amount paid will be adjusted based upon the geographic location where the service is provided through the Medicare Geographic Price Cost Index (GPCI).

How does coverage of this service relate to coverage of the “Welcome to Medicare” exam?

Medicare covers a one-time initial preventive physical exam (IPPE), also known as a Welcome to Medicare exam, if it is furnished to a beneficiary within the first 12 months of his or her Part B enrollment. While the IPPE has a specific definition that includes many required elements, e.g. advance care planning, it also focuses on health promotion, counseling, and provision of/referral for other Medicare-covered preventive services. Accordingly, the health reform law prohibits Medicare coverage of a wellness visit providing a personalized preventive plan service within 12 months of a beneficiary’s receipt of the IPPE.

Can only physicians furnish this newly-covered service?

The service is typically provided by a physician, but the law does allow it to be furnished by other providers, including nurse practitioners and physician assistants. These providers would have to be acting with their existing scope of practice as defined by state law. It can also be provided by a team of medical professionals, e.g. registered dietician, health educator, under supervision of a physician.

Evidence-Based Coverage of Medicare Preventive Services:

Does the reform law do anything to ensure that Medicare-covered preventive services are truly evidence-based?

The ACA authorized CMS to modify the coverage of any Medicare-covered preventive service in place at the time of its enactment to make the coverage consistent with USPSTF recommendations. The ACA provision specifically allowed CMS to withhold Medicare payment for these currently-covered preventive services that have an USPSTF grade of D (not recommended). The authority Congress granted CMS through a 2008 law to expand coverage to additional preventive services already comes with the stipulation that they be evidence-based.

Removal of Barriers to Preventive Services in Medicare:

What does the reform law do to remove the barrier to beneficiaries getting Medicare-covered preventive services?

The ACA eliminated co-payments and deductibles for most Medicare-covered preventive services, meaning that Medicare pays the full allowable payment amount for most services beginning January 1, 2011. Specifically, the co-payment is waived for Medicare-covered preventive services: in place at the time of ACA enactment that are USPSTF recommended (have a grade of A or B); and for future evidence-based services that CMS decides to cover using the administrative authority Congress provided through the 2008 law. The deductible is essentially waived for the same preventive services covered at the time of ACA enactment for which there is no co-payment. The ACA provision did not prospectively waive the deductible related to evidence-based preventive services CMS decides to cover in the future using its administrative authority. Presumably, Congress declined to prospectively waive the deductible pertaining to future Medicare-covered preventive services to avoid assignment of an even higher cost to these provisions.

Further, the ACA clarified that Medicare-covered preventive services are considered preventive even if the rendering physician initiated diagnostic testing or treatment during the course of the preventive service. This clarification ensures that beneficiaries are not subjected to a co-payment and/or deductible that does not apply for preventive services. The clarification is especially pertinent to colorectal cancer screening services. For example, Medicare will make full 100 percent allowable payment for the screening colonoscopy service—which is set at the same amount paid for a diagnostic colonoscopy even if the gastroenterologist detects and removes a polyp during the screening procedure. The clarification prevents the beneficiary from being made responsible for 20 percent of the full payment amount, which would be the case if the gastroenterologist provided a diagnostic colonoscopy. The gastroenterologist will still be paid for the extra work of removing the polyp but the beneficiary will not incur the co-payment charge, which is consistent with the beneficiary's expectation at the time of seeking the preventive service.

Are there any other provisions that encourage health-promotion activities?

The ACA also established a number of wellness programs, including a grant program for businesses to assist them in establishing workplace wellness programs. The ACA authorized \$200 million for the effort, beginning in FY2011. Additionally, the ACA authorized the Centers for Disease Control (CDC) to provide technical assistance to help employers evaluate their wellness initiatives. Federal funds were appropriated to implement this project.

Additional Resources

- *A complete list of current Medicare preventive services is available at:*

<http://www.healthcare.gov/law/features/65-older/medicare-preventive-services/index.html>