DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES

OFFICE OF THE ACTUARY

Date: September 23, 2013

From: Paul Spitalnic
Chief Actuary
To: Marilyn Tavenner
Administrator

Re: Imaging Analysis Required by Affordable Care Act (ACA) Section 3135(c)

*Summary*

Section 3135(c) of the Affordable Care Act (ACA) tasks the Chief Actuary of CMS with analyzing the projected spending impact of two ACA provisions.

- Section 3135(a): An increase in the practice expense utilization assumption for expensive diagnostic imaging equipment from the utilization assumptions established in the November 25, 2009 final rule to a 75-percent utilization assumption for fee schedules established for 2011 and subsequent years. This change results in the fixed cost of the imaging equipment being spread out over more services causing a reduction in the Medicare payment per service.

- Section 3135(b): An increase in the multiple procedure payment reduction (MPPR) applicable to the technical component for advanced imaging services from 25 percent to 50 percent for services furnished on or after July 1, 2010.

Specifically, the Act requires the Chief Actuary to make publicly available an analysis of whether the cumulative expenditure reductions over the 10-year period from 2010 to 2019 are projected to exceed $3.0 billion. After analyzing the impact of these provisions as implemented, the Office of the Actuary has determined that the estimated cumulative expenditure reductions from 2010 to 2019 total $1.6 billion, and therefore are not projected to exceed $3.0 billion. Further details are shown in the table below.

**Estimated Expenditure Reductions due to ACA Sections 3135(a) and 3135(b)**
**(in $millions)**

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2010-2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Section 3135(a) | 0 | −10 | −10 | −10 | −30 | −30 | −40 | −40 | −40 | −50 | −260 |
| Section 3135(b) | −70 | −120 | −130 | −140 | −120 | −130 | −140 | −150 | −160 | −170 | −1,330 |
| Total | −70 | −130 | −140 | −150 | −150 | −160 | −180 | −190 | −200 | −220 | −1,590 |

Section 3135(c) requires the Chief Actuary to make this analysis publicly available. We are posting this analysis on the OACT section of the CMS website.

*Background*

The utilization assumption to be used in the methodology for computing practice expense (PE) relative value units (RVUs) for expensive diagnostic imaging equipment was specified in the CY 2010 Physician Fee Schedule final rule with comment period (November 25, 2009). The imaging utilization assumption was scheduled to transition in a budget neutral fashion over a 4-year period from 50 percent to 90 percent beginning in calendar year 2010. Under the transition schedule, the 2010 utilization assumption of 60 percent was applied to the net practice expense (PE) relative value units (RVUs) and was budget neutralized within the physician fee schedule (PFS).

The imaging utilization assumption for calendar year 2011 was scheduled to be 70 percent (one-half times a 50-percent utilization assumption plus one-half times a 90-percent utilization assumption equals a 70-percent utilization assumption) and was again to be applied in a budget neutral fashion along with the other transitioning PE changes in the November 25, 2009 final rule. However, section 3135(a) of the ACA specifies that the imaging utilization assumption be 75 percent in 2011, and that this change should not be applied in a budget neutral fashion.

Section 3135(a) of the ACA was implemented in 2011 as follows. First, the PE RVUs were calculated, in effect, using a transition formula of one-half times a 50-percent utilization assumption plus one-half times a 70-percent utilization assumption, which equals a 60-percent utilization assumption. Any resulting changes were applied in a budget neutral manner. Then, the PE RVUs for imaging were re-determined, in effect, using one-half times a 50-percent utilization assumption plus one-half times a 75-percent utilization assumption, which equals a 62.5 percent utilization assumption. These changes were not applied in a budget neutral manner. The 2.5 percentage point change in the utilization rate assumption resulted in program savings.

For 2012, the imaging utilization assumption was calculated similarly using one-fourth of the 50-percent assumption and three-fourths of the 75 percent assumption. The imaging utilization assumption was then fully transitioned to the 75 percent in 2013. These changes were applied in a budget neutral manner within the fee schedule. Therefore section 3135(a), as implemented, had a one-time impact in calendar year 2011, which lowers the baseline spending each year thereafter.

The MPPR policy applicable to the technical component of imaging services was established in the physician fee schedule final rule published in the Federal Register on November 21, 2005. The policy reduces Medicare payment for the second and subsequent imaging services furnished on the same day by 25 percent. Section 3135(b) of the ACA also increased the MPPR discount from 25 percent to 50 percent which reduced Medicare payment effective for services furnished beginning with July 1, 2010.

In addition, other changes were made in 2010 and 2011 that affected payments for imaging services, including changes to the 2010 PE RVUs to reflect new survey data and to reflect new cost shares to be consistent with rebasing of the Medicare Economic Index (MEI) applicable beginning with 2011.

*Data*

Procedure volumes both subject to and unaffected by the MPPR were estimated through an analysis of claims data from the Integrated Data Repository (IDR) for calendar years 2010 through 2012. A forecast of growth in volume for procedure codes impacted by the legislation was constructed using historical trends.

Outpatient prospective payment system (OPPS) payment rates and fee schedules for second half 2010, and all of calendar years 2011 and 2012 were obtained from the CMS website (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html).

In addition, this analysis is supplemented in part by a data file for calendar year 2011 supplied by CMS' Center for Medicare containing the non-facility PE RVUs affected by section 3135(a), both before and after the equipment utilization assumption change.

*Methodology*

Section 3135(a)

Section 3135(a) of the Affordable Care Act changed the equipment utilization assumption for expensive diagnostic imaging equipment from 90 percent, which was to be transitioned with other PE changes over the four-year period 2010-2013 and budget neutralized (per the November 25, 2009 final rule), to 75 percent effective January 1, 2011. This change impacted only the practice expense portion of the technical component of the payment rates for each procedure.

Savings due to this provision were determined by comparing total allowed charges for the affected procedure modifier combinations using payment rates in effect (calculated using the amended equipment utilization assumption) to the total allowed charges for the same services using payment rates calculated as if there had been no amendment.

Payment rates under the pre- and post-ACA equipment utilization assumptions were calculated for services to which the MPPR applies. The pre- and post-ACA payment rate differences were then multiplied by their respective estimated volume in order to determine total spending associated with each payment scenario. Furthermore, in order to isolate the impact of section 3135(a) of ACA, the total charge differences were calculated using the MPPR rate of 25 percent, which was the rate prior to section 3135(b) taking effect.

Section 3135(b)

Section 3135(b) of the Affordable Care Act changed the multiple procedure payment reduction (MPPR) percentage for advanced imaging services from 25 percent to 50 percent for services furnished on or after July 1, 2010. This change affected only the technical component of the payment rates for each procedure.

The savings due to this provision were estimated by comparing the actual allowed charges under the amended MPPR percentage to allowed charges calculated using the prior MPPR percentage for the procedure code/modifier combinations impacted by the legislation. The differences in payment rates were then multiplied by procedure volume to capture the estimated effect of the legislation. Note that both the pre- and post-ACA MPPR payment scenarios were calculated using the 75-percent utilization assumption that was specified in section 3135(a) of the ACA.

For each procedure code/modifier combination, PFS payment rates under the pre- and post-ACA equipment utilization assumptions were calculated by multiplying the total non-facility RVUs by the PFS conversion factor applicable for that year (or partial year) and then compared to the OPPS payment rate for the service.[1] The lower of these two rates was multiplied by the procedure volume to estimate total allowed charges. For 2013 through 2019, the conversion factor was estimated based on physician updates in the FY 2014 President's Budget projection. In addition, OPPS payment caps were estimated according to the outpatient market basket assumptions consistent with the FY 2014 President's Budget projections.

MPPR physician fee schedule rates were determined by reducing the technical component separately for both the pre- and post-ACA MPPRs—25 percent and 50 percent respectively. Then the remaining work, malpractice, and non-technical portion PE RVUs along with the MPPR reduced technical component were summed. The resulting total RVUs for procedures subject to the imaging MPPR were then multiplied by the physician fee schedule conversion factor applicable for that year (or partial year) to obtain the payment amount for each procedure if subject to the imaging MPPR. The associated OPPS payment cap was then applied in the event that an OPPS service payment was lower than the MPPR PFS payment rate.

*Limitations*

In order to develop estimates of the impact of ACA section 3135(a) and 3135(b), a number of assumptions were necessary. Among these are expectations that volume growth will be consistent with historical growth in volume through the end of the 10-year projection period, and that the volume and distribution of services was unaffected by the legislation. In addition, the estimates use current law payment updates, including the negative updates that result from the SGR system.[2]

[1]The PFS payment rate is capped by the OPPS rate for the same service.
[2]Under a 0-percent physician fee schedule update scenario, the 10-year impact over 2010-2019 is approximately $1.9 billion.