



Proposed 2013 Medicare Physician Fee Schedule

Summary

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Background

On July 6, the Centers for Medicare & Medicaid Services (CMS) released the [proposed 2013 Medicare Physician Fee Schedule](#) (link will expire on July 30). This regulation addresses changes to the physician fee schedule and other Medicare Part B payment policies and implements certain provisions of the *Affordable Care Act* (ACA). It also discusses the 2013 Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, potentially misvalued codes, and proposes additions to the Medicare Telehealth Services. In this regulation, CMS also proposes creation of a new post discharge care coordination service code for primary care providers and payment rates for newly covered preventive services, discusses updates to the Physician Compare website, and further implements the Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program.

Notable for primary care, the related CMS [press release](#) states that the proposal would "...increase payments to family physicians by approximately 7 percent and other practitioners providing primary care services between 3 and 5 percent." Of this 7 percent, 2 percent stems from the phased-in use of the Physician Practice Information Survey (PPIS) data, discussed further in the Changes to Relative Value Units section, and the remaining 5 percent is a result of a newly proposed "post discharge transitional care management" code, further discussed in the Primary Care and Care Coordination section.

Comments on the proposed rule are due to CMS no later than September 4, 2012. The AAFP will analyze the regulation extensively and submit a formal response. The agency is expected to release the final 2013 Medicare physician fee schedule in early November 2011.

Conversion Factor for 2013

On December 23, 2011, the *Temporary Payroll Tax Cut Continuation Act* was signed into law resulting in a two-month zero-percent update for physician fee schedule claims submitted from January 1, 2012 through February 29, 2012. On February 22, 2012, the President signed the *Middle Class Tax Relief and Job Creation Act*, which extended the zero-percent update for the remainder of 2012. As a result of these two laws, the 2012 physician fee schedule conversion factor was \$34.0376.

In this proposal, CMS estimates that the statutory formula used to determine Medicare physician payments will result in a decrease of 27 percent. The AAFP has asked Congress to prevent these drastic payment cuts and

to end the practice of enacting retroactive “fixes.” The AAFP continues to call on Congress to stabilize Medicare payments to physicians by repealing the flawed SGR formula and specifying a payment rate for the next three to five years while demonstration programs generate data to determine the best payment method. To begin closing the gaping disparity between primary care and subspecialist services, the AAFP strongly recommends that Congress stipulate at least a 3 percent higher rate for primary care physicians.

Changes to the Relative Value Units

Background

Since 1992, Medicare pays for physician services based on relative value units (RVUs) for physician work, practice expenses (such as office rent and personnel wages), and malpractice expenses. CMS establishes physician work RVUs for new and revised codes based in part on recommendations received from the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC). In the past, CMS used Clinical Practice Expert Panels and the AMA’s Socioeconomic Monitoring System (SMS) data to develop practice expense RVUs, but beginning in 2010, CMS began utilizing the AMA’s Physician Practice Information Survey (PPIS). In 2010, CMS implemented the second review and update of malpractice RVUs.

To calculate the payment for a physician's service, the components of the fee schedule (physician work, practice expense, and malpractice RVUs) are adjusted by geographic practice cost indices (GPCIs). The GPCIs reflect the relative costs of physician work, practice expense, and malpractice in an area compared to the national average costs for each component. RVUs are converted to dollar amounts through the application of a conversion factor.

The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU practice expense} \times \text{GPCI practice expense}) + (\text{RVU Malpractice} \times \text{GPCI Malpractice})] \times \text{conversion factor.}$$

Proposed changes

In 2010, CMS initiated a four year transition to the use of PPIS data for practice expense RVUs, and 2013 is the final year of the transition. The final year of the PPIS transition results in family physicians receiving an estimated 2-percent increase due to the changes in the RVU distribution. CMS proposes to continue the current method for determining malpractice RVUs by crosswalking codes to the malpractice RVUs of a similar source code and adjusting for differences in work between the source code and the new or revised code.

Potentially Misvalued Codes under the Physician Fee Schedule

Background

In addition to the 5-year review of RVUs, CMS and the RUC identify and review potentially misvalued codes on an annual basis. The *Affordable Care Act* requires CMS to periodically identify, review, and adjust values for potentially misvalued codes with an emphasis on codes that:

- Have grown the most,
- Have experienced substantial changes in practice expenses,
- Are recently established for new technologies or services,
- Are multiple ones frequently billed together in conjunction with furnishing a single service,
- Have low relative values, particularly those that are often billed multiple times for a single treatment,
- Are so-called 'Harvard valued codes,' which have not been reviewed since the implementation of the Resource-Based Relative Value Scale (RBRVS), or
- Are determined inappropriate by CMS.

In the final 2012 Medicare physician fee schedule, CMS consolidated the formal 5-year review of work and practice expense RVUs with the annual review of potentially misvalued codes and established a process for CMS to accept public nominations of potentially misvalued codes for review coinciding with the release of the annual Medicare physician fee schedule. CMS plans to review malpractice RVUs at 5-year intervals.

Proposed changes

CMS discusses that over 1,000 potentially misvalued codes have been identified and that within 2012, they “intend to enter into a contract to assist us in validating RVUs of potentially misvalued codes that will explore a

model for the validation of physician work under the physician fee schedule, both for new and existing services.” Of these identified codes, over 650 are surgical services. Of these 650, CMS completed a review of 450 codes. CMS further discusses that 36 codes (listed in Tables 5 and 6) were nominated by the public as potentially misvalued. CMS proposes to reduce the procedure time assumptions used in developing RVUs for intensity modulated radiation treatment (IMRT) delivery and stereotactic body radiation therapy (SBRT) delivery, which would more accurately pay for these radiation therapy services. These services have been identified as potentially misvalued by CMS and the Medicare Payment Advisory Commission (MedPAC). In addition, CMS requests the RUC and the public to review these codes and provide valid and reliable alternative data sources to develop appropriate RVU amounts.

Geographic Practice Cost Indices

Background

CMS is required to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three components (physician work, practice expense, and malpractice) of the fee schedule. The agency must review and adjust as necessary the GPCIs at least every 3 years. Since 2009, a permanent 1.5 work GPCI floor for services furnished in Alaska has existed. Separately and since 2011, Congress set a permanent 1.0 practice expense GPCI floor for services furnished in “frontier states” (defined as at least 50 percent of the state’s counties have a population density of less than 6 persons per square mile). CMS identified five frontier states (Montana, Wyoming, North Dakota, Nevada and South Dakota). For all other states, the current 1.0 physician work floor will expire at the end of 2012 unless Congress intervenes before 2013. CMS last updated the physician work GPCI in 2011 based on 2006-2008 Bureau of Labor Statistics (BLS) Occupational Employment Statistics data

Proposed changes

CMS discusses that 2013 is the final year of the sixth GPCI update and therefore the agency will propose changes in 2014. CMS does not propose GPCI changes in this regulation, though the regulation discusses the permanent 1.5 work GPCI floor for services furnished in Alaska, the 1.0 practice expense GPCI floor for the five frontier states, and the agency’s anticipation of the Institute of Medicine’s Phase II report scheduled for release later this summer.

Medicare Telehealth Services for the Physician Fee Schedule

Background

In 2001, CMS defined Medicare telehealth services to include consultations, office visits, office psychiatry services, and any additional service specified by HHS when delivered via an interactive telecommunications system. CMS defines an interactive telecommunications system as, “multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way real time interactive communication between the patient and the practitioner at the distant site.” CMS notes that telephones, fax machines, and email systems do not meet this definition. In 2002, CMS established a process for adding or removing services from the list of Medicare telehealth services. Since establishing this process and with certain coding requirements, CMS added individual and group health and behavior assessment and intervention services, psychiatric diagnostic interview examination, end-stage renal disease related services with 2 to 3 visits per month and 4 or more visits per month, individual and group medical nutrition therapy, neurobehavioral status exam, initial and follow-up inpatient telehealth consultations for beneficiaries in hospitals and skilled nursing facilities, subsequent hospital care, subsequent nursing facility care, individual and group kidney disease education, and individual and group diabetes self-management training services, and smoking cessation services.

Provided that the health care professional is licensed under state law to deliver the service being furnished via a telecommunications system, eligible providers at the distant site include physicians, physician assistants, nurse practitioners, clinical nurse specialist, nurse-midwives, clinical psychologists, clinical social workers, or registered dietitian or nutrition professionals.

Proposed changes

CMS proposes to add the following Healthcare Common Procedure Coding System (HCPCS) codes to the list of telehealth services for 2013:

- G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention, 15 to 30 minutes
- G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention greater than 30 minutes
- G0442: Annual alcohol misuse screening, 15 minutes
- G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- G0444: Annual Depression Screening for adults, 15 minutes
- G0445: High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semiannually, 30 minutes
- G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
- G0447: Face-to-face behavioral counseling for obesity, 15 minutes

CMS notes that all coverage guidelines continue to apply when these services are furnished via telehealth, and discusses that, "...when the national coverage determination requires that the service be furnished to beneficiaries in a primary care setting, the qualifying originating telehealth site must also qualify as a primary care setting. Similarly, when the national coverage determination requires that the service be furnished by a primary care practitioner, the qualifying primary distant site practitioner must also qualify as primary care practitioner."

Primary Care and Care Coordination

Background

CMS states that, "In recent years, we have recognized primary care and care coordination as critical components in achieving better care for individuals, better health for individuals, and reduced expenditure growth." CMS then lists a "series of initiatives designed to ensure accurate payment for, and encourage long-term investment in, primary care and care management services." These include the:

- Medicare Shared Savings Program, including the Pioneer Accountable Care Organization (ACO) model and the Advance Payment ACO model;
- Primary Care Incentive Payment program;
- Multi-payer Advanced Primary Care Practice;
- Federally Qualified Health Center Advanced Primary Care Practice demonstration; and
- Comprehensive Primary Care initiative.

CMS proceeds to discuss that they "continue to explore other potential refinements to the physician fee schedule that would appropriately value primary care and care coordination within Medicare's statutory structure for fee-for-service physician payment and quality reporting." The agency notes that they continue, "...to hear concerns from the physician community that the care coordination included in many of the evaluation and management (E/M) services, such as office visits, does not adequately describe the non-face-to-face care management work involved in primary care."

Proposed changes

Noting that, "the current E/M office/outpatient visit CPT codes were designed to support all office visits and reflect an overall orientation toward episodic treatment," CMS then agrees that E/M codes may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries such as those who are returning to a community setting following discharge from a hospital or skilled nursing facility (SNF) stay.

CMS therefore proposes to create a HCPCS G-code that specifically describes "post-discharge transitional care management services". The code would describe "all non-face-to-face services related to the transitional care management furnished by the community physician or qualified nonphysician practitioner within 30 calendar days following the date of discharge from an inpatient acute care hospital, psychiatric hospital, long-

term care hospital, skilled nursing facility, and inpatient rehabilitation facility; hospital outpatient for observation services or partial hospitalization services; and a partial hospitalization program at a community mental health center to community-based care.” In this discussion, CMS refers to the “community-based physician managing and coordinating a beneficiary’s care in the post-discharge period. We anticipate that most community physicians will be primary care physicians and practitioners.” The post-discharge transitional care management service would include:

- *Assuming responsibility for the beneficiary’s care without a gap.*
 - *Obtaining and reviewing the discharge summary*
 - *Reviewing diagnostic tests and treatments*
 - *Updating of the patient’s medical record based on a discharge summary to incorporate changes in health conditions and on-going treatments related to the hospital or nursing home stay within 14 business days of the discharge.*
- *Establishing or adjusting a plan of care to reflect required and indicated elements, particularly in light of the services furnished during the stay at the specified facility and to reflect result of communication with beneficiary.*
 - *An assessment of the patient’s health status, medical needs, functional status, pain control, and psychosocial needs following the discharge.*
- *Communication (direct contact, telephone, electronic) with the beneficiary and/or caregiver, including education of patient and/or caregiver within 2 business days of discharge based on a review of the discharge summary and other available information such as diagnostic test results, including each of the following tasks:*
 - *An assessment of the patient’s or caregiver’s understanding of the medication regimen as well as education to reconcile the medication regimen differences between the pre- and post-hospital, CMHC, or SNF stay.*
 - *Education of the patient or caregiver regarding the on-going care plan and the potential complications that should be anticipated and how they should be addressed if they arise.*
 - *Assessment of the need for and assistance in establishing or re-establishing necessary home and community based resources.*
 - *Addressing the patient’s medical and psychosocial issues, and medication reconciliation and management.*

When indicated for a specific patient, the post-discharge transitional care service would also include:

- *Communication with other health care professionals who will (re)assume care of the beneficiary, education of patient, family, guardian, and/or caregiver.*
- *Assessment of the need for and assistance in coordinating follow up visits with health care providers and other necessary services in the community.*
- *Establishment or reestablishment of needed community resources.*
- *Assistance in scheduling any required follow-up with community providers and services.*

CMS proposes that the post-discharge transitional care code would be payable only once in the 30 days following a discharge, per patient per discharge, to a single community physician or qualified nonphysician practitioner (or group practice) who assumes responsibility for the patient’s post-discharge transitional care management. The post-discharge transitional care management service would be distinct from services furnished by the discharging physician or qualified nonphysician practitioner reporting CPT codes 99238, 99239, 99217, and 99234 - 99236.

CMS proposes to pay this new code by utilizing:

- The work RVU of CPT code 99238 (Hospital discharge day management; 30 minutes or less). This results in a proposed work RVU of 1.28. CMS also proposes the following physician times: 8 minutes pre-evaluation, 20 minutes intra-service, and 10 minutes immediate post-service.
- The clinical labor practice expense inputs for CPT 99214 (Level 4 established patient office or other outpatient visit). This results in a proposed practice expense RVU of 1.41.
- The malpractice expense RVUs for CPT 99214, which results in a proposed malpractice expense RVU of 0.09.

The post-discharge transitional care management code, like all other services paid under the physician fee schedule, is subject to a 20 percent beneficiary coinsurance and the Part B deductible.

Based off the proposed RVU amounts and assuming that Congress intercedes before 2013 and prevents the projected 27 percent reduction to the conversion factor, the AAFP estimates that payment for this new code would approximately be \$94.62. CMS estimated that physicians or qualified nonphysician practitioners would provide the post-discharge transitional care management service for 10 million discharges in 2013. Since this proposal is subject to budget neutrality policies, this proposed code would move about \$95 million annually from other services to primary care.

The agency concludes this section by discussing future proposals to support primary care under the Medicare physician fee schedule. Without making any specific proposal, CMS discusses methods to identify and pay "advanced primary care practices" that have implemented the patient centered medical home. CMS states that, "Should any of these discrete proposals, like this one, become final policy, they may be short-term payment strategies that would be modified and/or revised to be consistent with broader primary care and care management and coordination services if the agency decides to pursue payment for a broader set of management and coordination services in future rulemaking."

Payment for New Preventive Service G-Codes

Background

The *Affordable Care Act* authorizes CMS to add coverage of "additional preventive services" as determined through the national coverage determination (NCD) process and if the service is:

- Reasonable and necessary for the prevention or early detection of illness or disability;
- Recommended with a grade of A or B by the United States Preventive Services Task Force, and
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

As a result of this authority, Medicare now covers:

- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse, effective October 14, 2011;
- Screening for Depression in Adults, effective October 14, 2011;
- Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs, effective November 8, 2011;
- Intensive Behavioral Therapy for Cardiovascular Disease, effective November 8, 2011; and
- Intensive Behavioral Therapy for Obesity, effective November 29, 2011.

Proposed changes

While the NCD process already established coverage for these five services, that process was not completed in time for the final 2012 Medicare physician fee schedule thus in this regulation, interim RVUs and CMS' proposed justification for each of these preventive services is discussed.

Durable Medical Equipment (DME) Face-to-Face Encounters and Written Orders Prior to Delivery

Background

The *Affordable Care Act* requires a face to face encounter with a patient before physicians may certify eligibility for home health services or durable medical equipment. Specific to DME, this section requires that an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by CMS.

Proposed changes

Referencing a need to combat fraud and reduce improper payments in DME items, CMS proposes policy to implement the face-to-face requirement as a condition of payment for certain high-cost DME covered items. Table 24 from the proposed regulation contains a list 175 specified covered items. The list includes many items that have historically been targets of Medicare fraud as identified by various program integrity experts. As a condition of payment for certain covered items of DME, a physician must have documented and communicated

to the DME supplier that the physician or a PA, an NP, or a CNS has had a face-to-face encounter with the beneficiary no more than 90 days before the order is written or within 30 days after the order is written.

CMS proposes that when the face-to-face encounter is performed by a physician, the submission of the pertinent portion(s) of the beneficiary's medical record, containing sufficient information to document that the face-to-face encounter meets CMS requirements, would be considered sufficient and valid documentation of the face-to-face encounter when submitted to the supplier and made available to CMS or its agents upon request. CMS states that they "strive to find the option that strikes a balance between minimizing the effect on physicians, while still meeting the statutory objective to limit fraud, waste, and abuse."

Recognizing this provision imposes a new burden on physicians, CMS proposes to create a G-code, estimated at \$15, to compensate a physician who documented that a physician assistant, a nurse practitioner, or a clinical nurse specialist practitioner has performed a face-to-face encounter for an item from the list of specified covered items. Only a physician who does not bill an E/M code for the beneficiary in question would be eligible for this G-code.

Physician Compare Website

Background

The *Affordable Care Act* requires that, no later than January 1, 2013, CMS implement a plan for making information on physician performance publicly available through the [Physician Compare Website](#). In 2012, CMS finalized policy that bases public reporting of performance rates for group practices that submitted data under the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) for 2012. CMS finalized its proposal to make public performance rates for other CMS demonstrations using group practice reporting on the Physician Compare Web site as early as 2013.

Proposal

CMS discusses their intentions to phase in an expansion of the Physician Compare website over the next several years by incorporating quality measures from several sources. The agency specifically proposes to make available on the website performance rates on the quality measures that group practices submit through the GPRO web-interface under the 2013 PQRS and the Medicare Shared Savings program. When feasible but no earlier than 2014, CMS proposes to publicly report composite measures that reflect group performance across several related measures. CMS also proposes to add patient experience survey-based measures, and, no earlier than 2014, to publicly report 2013 patient experience data for all group practices participating in the 2013 PQRS GPRO and for all participants in the Medicare Shared Savings program.

Physician Quality Reporting System

Background

The Physician Quality Reporting System (PQRS) provides incentive payments or payment penalties to identified eligible professionals or group practices who satisfactorily report (via Medicare Part B claims, qualified PQRS registry, or qualified PQRS electronic health record) data on quality measures for covered professional services furnished during a specified reporting period (full and half year options).

In 2011, the incentive payment for successful PQRS participation was 1 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. For 2011 through 2014, an additional 0.5 percent is available if the individual professional participates via a "continuous assessment program" such as a qualified American Board of Medical Specialties Maintenance of Certification (MOC) program or an equivalent program as determined by CMS. In 2012 through 2014, the incentive payment is lowered to 0.5 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. Under current law, CMS will impose a 1.5 percent penalty on practices in 2015 that did not successfully participate in the 2013 PQRS. For those that did not successfully participate in 2014, the payment penalty would be 2 percent in 2016 and beyond.

Proposed changes

CMS proposes to include a total of 264 individual measures that eligible professionals can choose from for the 2013 and 2014 PQRS. This regulation also includes several proposals to align PQRS measures available for the electronic health record (EHR) based reporting option with measures available for reporting under the EHR Incentive Program. CMS also proposes the inclusion of 26 measure groups for reporting. CMS also proposes to align measures for reporting via the Group Practice Reporting Option (GPRO) web-interface with the measures required under the Medicare Shared Savings Program.

In regards to PQRS participation by individual eligible professionals, CMS is proposing criteria similar to the criteria for satisfactory reporting for the 2012 incentive. Notable proposed changes include:

- Proposing criteria for reporting using the EHR-based reporting mechanism that would align with the proposed reporting criteria for meeting the clinical quality measure (CQM) component of meaningful use for the Medicare EHR Incentive Program;
- For the proposed 12-month 2013 and/or 2014 incentive reporting period, proposing to decrease the minimum threshold of patients on which eligible professionals are required to report using measures groups via registry from 30 to 20;
- To encourage participation for these eligible professionals and group practices who have not previously participated in the PQRS, CMS proposes an alternative criterion for satisfactory reporting during the 12-month reporting periods for the 2015 and 2016 payment adjustments. For these eligible professionals and group practices, CMS proposes they report on 1 measure or measures group using the claims, registry, or EHR-based reporting mechanisms. CMS understands that this particular proposed alternative criterion for satisfactory reporting is significantly less stringent than the satisfactory reporting criteria proposed for the 2013 and 2014 incentives.
- Proposing a new “administrative claims-based reporting mechanism option” (which does not require an eligible professional to submit quality data codes on Medicare Part B claims) for a proposed set of administrative claims-based measures.

For group practices participating in the GPRO, notable proposed changes include:

- Expanding the definition of group practice to include groups of 2-24 eligible professionals;
- Proposing to expand the use of the claims, registry, and EHR-based reporting mechanisms to groups of 2-99 eligible professionals, in addition to groups of 25 or more eligible professionals;
- Proposing to use an assignment methodology similar to the one used under the Medicare Shared Savings Program for groups that report using the GPRO web-interface;
- Proposing to allow group practices to elect using the proposed administrative claims-based reporting option; and
- Proposing the satisfactory reporting criteria for the PQRS payment adjustment that would apply to eligible professionals within group practices in accountable care organizations (ACOs) under the Medicare Shared Savings Program.

Electronic Prescribing Incentive Program

Background

From 2009 through 2013, CMS is authorized to provide eligible professionals who are successful electronic prescribers an incentive payment equal to a percentage of the eligible professional's total estimated Medicare Part B physician fee schedule allowed charges for all covered professional services furnished by the eligible professional during the respective reporting period. However, CMS is also conducting the Medicare EHR Incentive Program. Successful participation in the Medicare EHR Incentive Program supersedes eRx incentive payments for an eligible professional, though successful participation in the Medicare EHR program does not satisfy eRx reporting requirements needed to avoid the payment penalty. For years 2012 through 2014, CMS will apply a payment penalty to eligible professionals who are not reporting, using specified processes, their electronic prescribing behaviors.

For years 2012 through 2014, CMS will apply a payment penalty to eligible professionals who are not successfully electronic prescribing. The applicable eRx percent for payment incentives and penalties under the eRx Incentive Program are as follows:

- 2011: 1.0 percent incentive for successful electronic prescribers.

- 2012: 1.0 percent incentive for successful electronic prescribers or 1.0 percent penalty for non-successful electronic prescribers.
- 2013: 0.5 percent incentive for successful electronic prescribers or 1.5 percent penalty for non-successful electronic prescribers.
- 2014: 2.0 percent penalty for non-successful electronic prescribers.

The requirements for the 2013 eRx incentive and 2013 and 2014 eRx payment adjustment (i.e., penalty) were established in the 2012 MPFS final rule with comment period. Also in the 2012 final rule, CMS finalized four circumstances under which an eligible professional or eRx GPRO can request consideration for a significant hardship exemption for the 2013 and 2014 eRx payment adjustments, these are:

- The eligible professional or group practice practices in a rural area with limited high speed internet access.
- The eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing.
- The eligible professional or group practice is unable to electronically prescribe due to local, state, or Federal law or regulation.
- The eligible professional or group practice has limited prescribing activity, as defined by an eligible professional generating fewer than 100 prescriptions during a 6-month reporting period.

Proposed changes

In the 2013 proposed rule, CMS is proposing new criteria for being a successful electronic prescriber for groups of 2-24 eligible professionals using the eRx GPRO. CMS is proposing to establish an informal review process. CMS is also proposing two additional significant hardship exemptions to the 2013 and 2014 payment adjustments related to participation in the EHR Incentive Program. These new hardship exemptions are:

- Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods.
- Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology.

Physician Value-Based Payment Modifier and the Physician Feedback Program

Background

The *Affordable Care Act* call for CMS to establish a Value Modifier that provides for differential payment to a physician or group of physicians under the Medicare physician fee schedule based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a performance period. Further, the statute requires CMS to begin applying the Value Modifier in 2015, with respect to items and services furnished by specific physicians and groups of physicians and to apply it to all physicians and groups of physicians beginning not later than January 1, 2017. The statute also requires that the Value Modifier be implemented in a budget neutral manner, meaning that upward payment adjustments for high performance will balance the downward payment adjustments applied for poor performance.

In 2012, CMS established 2013 as the performance period for the determination of the Value Modifier to be applied in 2015 and proposes to use 2014 as the performance period for the Value Modifier to be applied in 2016. The law requires CMS to measure quality of care furnished as compared to cost using composites of appropriate quality and cost measures. Also in 2012, CMS adopted both a total per capita cost measure for all beneficiaries, as well as four total per capita cost measures for beneficiaries with certain chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes) to be used under the Value Modifier.

Proposed changes

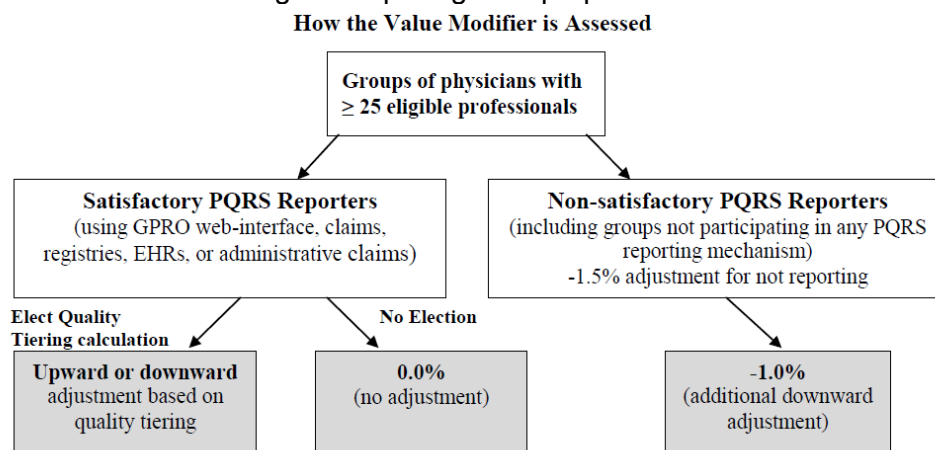
In this first phase of implementation, CMS is proposing that groups of physicians with 25 or more eligible professionals would be included in the Value Modifier framework. In this regulation, CMS discusses a goal of providing physicians choices as to how their quality of care will be measured and how their payments will be adjusted. CMS highlights that physician groups could avoid all negative adjustments through PQRS participation. Physicians seeking to be paid according to their measured cost and quality may elect to do so for 2015.

CMS proposes to apply the Value Modifier at the Tax Identification Number (TIN) level to items and services paid under the Medicare physician fee schedule to physicians under that TIN. Thus, if a physician moves from one group to another between the performance period (2013) and the payment adjustment period (2015), the physician’s payment will be adjusted based on the Value Modifier earned by the TIN where the physician is practicing in 2015.

To obtain the quality data, CMS proposes that groups of physicians with 25 or more eligible professionals satisfactorily submit data using one of the proposed PQRS quality reporting mechanisms for groups of physicians. Reported data would include:

- A common set of quality measures based on clinical data and that focus on preventive care and care for prevalent and costly chronic conditions in the Medicare population;
- Quality measures of their own selection that they report through claims, registries, or EHRs; or
- A common set of quality measures that focus on preventive care and care for chronic conditions that CMS would calculate from administrative claims data that require no action for the physician group beyond notifying CMS that the group elects this option.

Further details on the Value Modifier payment adjuster can be found in a CMS [fact sheet](#) on this subject. The agency also provides a useful visual diagram depicting their proposals:



For groups of physicians that request to have their Value Modifier calculated using a quality-tiering approach, CMS proposes to examine which groups of physicians have performance that is significantly above or below the national mean on each quality and cost measure using a standardized score approach. This proposed approach takes into account the varying distributions of scores among physicians across different quality and cost measures.

In order to achieve the legislatively-mandated budget neutrality for the program, positive adjustments to groups of physicians would be offset by negative adjustments to other groups of physicians. Since the total sum of downward adjustments is unknown at this time, CMS is not proposing a specific upward payment amount percentage. Rather, as shown in the table below, CMS is proposing to give groups that are high quality and low cost the highest upward adjustment. The value of “x” will depend on the total sum of negative adjustments in a given year. In addition, to ensure that the Value Modifier encourages physicians to care for the severely ill and beneficiaries with complicated cases, CMS is proposing an additional upward payment adjustment for groups of physicians furnishing services to high risk beneficiaries.

Proposed Calculation of the Value Modifier using the Quality-Tiering Approach

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

Medicare Coverage of Hepatitis B Vaccine

Background

Medicare Part B coverage of hepatitis B vaccine and its administration is currently covered if furnished to an individual who is at high or intermediate risk of contracting hepatitis B. In late 2011, the Centers for Disease Control and Prevention (CDC) published a *Morbidity and Mortality Weekly Report*, which included an article entitled "Use of Hepatitis B Vaccination for Adults with Diabetes Mellitus: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." As a result of this report and other findings, ACIP recommended that:

- Hepatitis B vaccination should be administered to unvaccinated adults with diabetes mellitus who are aged 19 through 59 years.
- Hepatitis B vaccination may be administered at the discretion of the treating clinician to unvaccinated adults with diabetes mellitus who are aged 60 years and older.

Proposed changes

Based on the ACIP recommendations, CMS proposes to expand coverage for hepatitis B vaccine and its administration to all individuals diagnosed with diabetes mellitus, not just those individuals with diabetes that are receiving glucose monitoring in facilities.

TABLE 84: CY 2013 PFS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty by Selected Proposal*

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (mil)	Baseline (PPIS transition, new utilization and other factors)	Updated Equipment Interest Rate Assumption	Discharge Transition Care Management	Input Changes for Certain Radiation Therapy Procedures	Total (Cumulative Impact)
TOTAL	\$ 85,485	0%	0%	0%	0%	0%
01-ALLERGY/IMMUNOLOGY	\$ 198	0%	1%	-2%	1%	0%
02-ANESTHESIOLOGY	\$ 1,969	-2%	0%	-1%	0%	-3%
03-CARDIAC SURGERY	\$ 366	-1%	0%	-1%	0%	-2%
04-CARDIOLOGY	\$ 6,565	-1%	0%	-1%	0%	-3%
05-COLON AND RECTAL SURGERY	\$ 153	1%	0%	-1%	0%	1%
06-CRITICAL CARE	\$ 261	1%	0%	-1%	0%	0%
07-DERMATOLOGY	\$ 3,008	0%	1%	-2%	0%	-1%
08-EMERGENCY MEDICINE	\$ 2,819	0%	0%	-1%	0%	-1%
09-ENDOCRINOLOGY	\$ 434	1%	0%	-1%	0%	0%
10-FAMILY PRACTICE	\$ 5,872	2%	0%	5%	0%	7%
11-GASTROENTEROLOGY	\$ 1,885	1%	0%	-1%	0%	0%
12-GENERAL PRACTICE	\$ 577	1%	0%	-1%	0%	0%
13-GENERAL SURGERY	\$ 2,261	1%	0%	-1%	0%	0%
14-GERIATRICS	\$ 217	2%	0%	2%	0%	4%
15-HAND SURGERY	\$ 134	1%	0%	-1%	0%	0%
16-HEMATOLOGY/ ONCOLOGY	\$ 1,891	0%	1%	-2%	0%	-1%
17-INFECTIOUS DISEASE	\$ 623	2%	0%	-1%	0%	1%
18-INTERNAL MEDICINE	\$ 11,049	1%	0%	3%	0%	5%
19-INTERVENTIONAL PAIN MGMT	\$ 533	0%	0%	-1%	0%	-1%
20-INTERVENTIONAL RADIOLOGY	\$ 202	-2%	0%	-1%	0%	-3%
21-MULTISPECIALTY CLINIC/OTHER PHY	\$ 201	-1%	0%	-1%	0%	-2%
22-NEPHROLOGY	\$ 2,064	0%	0%	-1%	0%	-1%
23-NEUROLOGY	\$ 1,596	2%	0%	-1%	0%	1%
24-NEUROSURGERY	\$ 680	0%	0%	-1%	0%	-1%
25-NUCLEAR MEDICINE	\$ 48	-2%	-1%	-1%	0%	-4%
27-OBSTETRICS/ GYNECOLOGY	\$ 698	1%	0%	-1%	0%	0%
28-OPHTHALMOLOGY	\$ 5,621	2%	0%	-1%	0%	1%
29-ORTHOPEDIC SURGERY	\$ 3,609	0%	0%	-1%	0%	-1%
30-OTOLARNGOLOGY	\$ 1,069	1%	1%	-1%	0%	0%
31-PATHOLOGY	\$ 1,185	-1%	0%	-1%	0%	-2%
32-PEDIATRICS	\$ 64	1%	0%	3%	0%	5%
33-PHYSICAL MEDICINE	\$ 980	2%	0%	-1%	0%	1%
34-PLASTIC SURGERY	\$ 351	1%	0%	-1%	0%	0%
35-PSYCHIATRY	\$ 1,149	1%	0%	-1%	0%	0%
36-PULMONARY DISEASE	\$ 1,691	1%	0%	-1%	0%	0%
37-RADIATION ONCOLOGY	\$ 1,982	-3%	-3%	-2%	-7%	-15%
38-RADIOLOGY	\$ 4,724	-2%	-1%	-1%	0%	-4%
39-RHEUMATOLOGY	\$ 544	0%	1%	-2%	0%	0%
40-THORACIC SURGERY	\$ 340	-1%	0%	-1%	0%	-2%
41-UROLOGY	\$ 1,905	-1%	0%	-1%	0%	-2%
42-VASCULAR SURGERY	\$ 881	-2%	0%	-1%	0%	-3%
43-AUDIOLOGIST	\$ 57	-3%	0%	-1%	0%	-5%
44-CHIROPRACTOR	\$ 738	2%	0%	-1%	0%	0%
45-CLINICAL PSYCHOLOGIST	\$ 567	-2%	0%	-1%	0%	-3%
46-CLINICAL SOCIAL WORKER	\$ 400	-2%	0%	-1%	0%	-3%
47-DIAGNOSTIC TESTING FACILITY	\$ 848	-5%	-2%	-2%	1%	-8%
48-INDEPENDENT LABORATORY	\$ 1,064	-2%	1%	-2%	1%	-2%
49-NURSE ANES / ANES ASST	\$ 1,142	-3%	0%	-1%	0%	-4%
50-NURSE PRACTITIONER	\$ 1,606	2%	0%	3%	0%	5%
51-OPTOMETRY	\$ 1,048	2%	0%	-1%	0%	1%
52-ORAL MAXILLOFACIAL SURGERY	\$ 44	1%	1%	-1%	0%	0%
53-PHYSICAL/OCCUPATIONAL THERAPY	\$ 2,263	3%	0%	-1%	0%	3%
54-PHYSICIAN ASSISTANT	\$ 1,219	1%	0%	2%	0%	3%
55-PODIATRY	\$ 1,897	2%	1%	-2%	0%	1%
56-PORTABLE X-RAY SUPPLIER	\$ 104	2%	1%	-2%	1%	2%
57-RADIATION THERAPY CENTERS	\$ 71	-4%	-5%	-2%	-8%	-19%
98-OTHER	\$ 19	1%	0%	-1%	0%	0%

*Table 84 shows only the proposed payment policy impact on PFS services. We note that these impacts do not include the effects of the negative January 2013 conversion factor change under current law