AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Summary of the 2014 proposed Medicare physician fee schedule

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Executive Summary

On July 8, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2014 Medicare Physician Fee Schedule. This proposed rule would revise payment polices under the Medicare Physician Fee Schedule (MPFS) and make other policy changes related to Medicare Part B payments. These changes would be applicable to services furnished in 2014.

CMS is required to establish payments under the MPFS based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service. RVUs are established for three categories of resources: work, practice expense (PE); and malpractice (MP) expense. CMS also applies geographic adjustments to reflect the variations in the costs of furnishing services in different areas. In addition, this proposed rule includes discussions regarding:

- Misvalued MPFS Codes;
- Telehealth Services;
- Requiring the Compliance with State law as a Condition of Payment for Services Furnished Incident to Physician and Other Practitioner Services;
- Revising the Medicare Economic Index (MEI); and
- Updating the:
  - Physician Compare Website;
  - Physician Quality Reporting System (PQRS);
  - Electronic Health Record (EHR) Incentive Program;
  - Medicare Shared Savings Program; and

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- Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program.

Of note to family and other primary care physicians, the regulation says the agency is "committed to primary care and we have increasingly recognized care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth." CMS then lists existing CMS efforts to address primary care services, including the Medicare Shared Savings Program: Accountable Care Organization (ACO), Pioneer ACO, Advance Payment ACO, Primary Care Incentive Program (PCIP), Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration, and the Comprehensive Primary Care (CPC) initiative.

The regulation then says, "under current MPFS policy, the payment for non-face-to-face care management services is bundled into the payment for face-to-face evaluation and management (E/M) visits because care management is a component of those E/M services." The regulation then continues with, "However, the physician community continues to tell us that the care management included in many of the E/M services, such as office visits, does not adequately describe the typical non-face-to-face care management work involved for certain categories of beneficiaries. Because the current E/M office/outpatient visit Current Procedural Terminology (CPT) codes were designed to support all office visits and reflect an overall orientation toward episodic treatment, we agree that these E/M codes may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries."

Later, CMS continues with, "…for 2015, we are proposing to establish a separate payment under the MPFS for complex chronic care management services furnished to patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."

CMS continues and says they "believe that successful efforts to improve chronic care management for these patients could improve the quality of care while simultaneously decreasing costs (for example, through reductions in hospitalizations, use of post-acute care services, and emergency department visits.)" and that the agency intends "to develop standards for furnishing complex chronic care management services to ensure that the physicians who bill for these services have the capability to provide them. One of the primary reasons for our proposed 2015 implementation date is to provide sufficient time to develop and obtain public input on the standards necessary to demonstrate the capability to provide these services." Further information on the newly proposed complex chronic care management services are detailed later in the AAFP summary.

In a statement after the proposed rule became available, the AAFP highlighted favorable steps CMS proposes to make toward meaningful payment reform; however, the AAFP statement also noted that CMS is constrained by the dysfunctional sustainable growth rate (SGR) formula that dictates Medicare physician payment. While these proposals are encouraging, they can go only so far, because the pending SGR cuts undermine CMS' efforts.

Therefore, the AAFP continues to call on Congress to repeal the SGR. Legislators in the House of Representatives are currently reviewing the *Medicare Physician Payment Innovation Act* (HR 574) and discussing physician payment reform. The bipartisan bill, introduced by Reps. Joe Heck, DO (R-NV) and Allyson Schwartz (D-PA), repeals the SGR, establishes annual, positive updates on physician payment, provides for a transition to a sustainable payment system, and helps better recognize the value of primary medical care.

Click [here]() to access the AAFP's current physician payment action alert and urge your Representatives to co-sponsor HR 574 and continue to support SGR repeal.

Conversion Factor for 2014

To calculate the payment for each service, the components of the fee schedule (work, PE, and MP RVUs) are adjusted by geographic practice cost indices (GPCIs) to reflect the variations in the costs of furnishing the services. RVUs are converted to dollar amounts through the application of a conversion factor, which is calculated based on a statutory formula.

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

Payment = [(RVU work x GPCI work) + (RVU practice expense x GPCI practice expense) + (RVU Malpractice x GPCI Malpractice)] x conversion factor.

When regulatory policy changes to the RVUs cause expenditures to change by more than $20 million, CMS must apply an adjustment to the conversion factor to preserve budget neutrality. These adjustments can affect the distribution of Medicare expenditures across medical specialties. In addition, several proposed changes would affect the specialty distribution of Medicare expenditures. According to CMS, "For most specialties the projected impacts are a small percentage change in Medicare payments under the MPFS. For a few specialties a larger impact is projected. Diagnostic Testing Facilities, Independent Laboratory, Pathology, Radiation Oncology, and Radiation Therapy Centers are projected to have a change of 5 percent or more."

Included at the end of the AAFP summary are Table 71 (proposed rule estimated impact on total allowed charges by specialty) and Table 72 (proposed rule estimated impact on total allowed charges by specialty by selected proposal). Compared to other medical specialists, family physicians will receive an estimated 1 percent update. E/M codes are estimated to rise by 3-4 percent. These estimates do not take into account the 24.4 percent reduction in the SGR slated to occur at the end of 2013.

On January 2, 2013, the *American Taxpayer Relief Act* was signed into law. It specified a zero percent update to the conversion factor for 2013. As a result, the 2013 PFS conversion factor was revised to $34.0320. On March 5, 2013, CMS estimated a -24.4 percent update to the conversion factor for Medicare payments for physicians' services in 2014. The actual values used to compute physician payments for 2014 will be based on later data, and the final 2014 conversion factor will be published by November 1, 2013, as part of the 2014 MPFS final rule. CMS currently estimates the 2014 conversion factor will be $25.7109 which includes a budget neutrality adjustment to account for separate 2014 proposed changes.

Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

<u>Proposed Changes</u>

CMS first proposes several modifications to the RVU amounts for certain procedures and then discusses how they "typically establish two PE RVUs for procedures that can be furnished in either a nonfacility setting, like a physician's office, or facility setting, like a hospital. The difference between the facility and nonfacility RVUs is because Medicare makes a separate payment to the facility for its costs of furnishing a service when a service is furnished in a facility."

When services are furnished in the facility setting, such as a hospital outpatient department (OPPS) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when

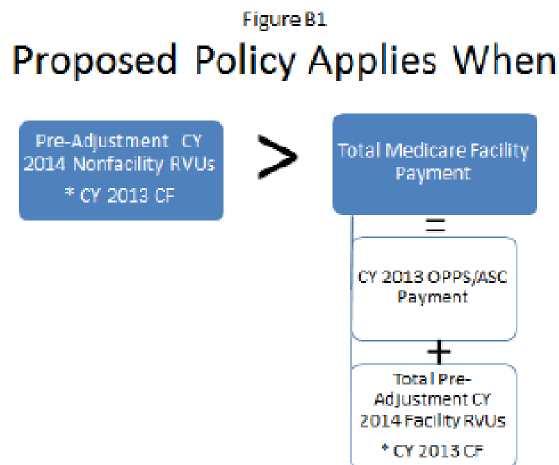
furnished in the physician office or other nonfacility setting. CMS believes that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings.

CMS then discusses that, "for some services, the total Medicare payment when the service is furnished in the physician office setting exceeds the total Medicare payment when the service is furnished in an hospital outpatient department or an ambulatory surgical center. When this occurs, we believe it is not the result of appropriate payment differentials between the services furnished in different settings. Rather, we believe it is due to anomalies in the data we use under the MPFS and in the application of our resource-based PE methodology to the particular services."

CMS then argues that PE RVU data heavily relies on the voluntary submission of information by individuals furnishing the service and that the agency has "little means to validate whether the information is accurate or reflects typical resource costs." The agency feels that "such incomplete, small sample, potentially biased or inaccurate resource input costs may distort the resources used to develop nonfacility PE RVUs used in calculating MPFS payment rates for individual services."

Given the differences in the validity of the data used to calculate payments, CMS argues that the nonfacility MPFS payment rates for procedures that exceed those for the same procedure when done in a facility result from inadequate or inaccurate direct PE inputs, especially in price or time assumptions, as compared to the more accurate OPPS data.

In order to improve the accuracy of MPFS nonfacility payment rates beginning in 2014 and for each calendar year thereafter, CMS proposes to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the MPFS. CMS proposes to limit the nonfacility PE RVUs for individual codes so that the total nonfacility MPFS payment amount would not exceed the total combined amount Medicare would pay for the same code in the facility setting. If this proposal is finalized, CMS will reduce the nonfacility PE RVU rate, so the total nonfacility payment does not exceed the total Medicare payment made for the service in the facility setting." CMS illustrates this concept via Figure B1:



CMS then discusses several exemptions, including services without separate OPPS payment rates, codes subject to the *Deficit Reduction Act* imaging cap, codes with low volume in the OPPS or ASC, codes with ASC rates based on MPFS payment rates, codes paid in the facility at nonfacility MPFS rates, and codes with PE RVUs developed outside the PE methodology.

The proposed regulation then discusses the agency's belief that "this proposal provides a reliable means for Medicare to set upper payment limits for office-based procedures based on relatively more

reliable cost information available for the same procedures when furnished in a facility setting where the cost structure would be expected to be somewhat, if not significantly, higher than the office setting."

Misvalued Codes

Background

Medicare pays for physician services based on RVUs for physician work, practice expenses (such as office rent and personnel wages), and malpractice expenses.

In recent years, CMS and the Relative Value Scale Update Committee (RUC) have taken increasingly significant steps to identify and address potentially misvalued codes. In lieu of the traditional 5-year review of RVUs, CMS and the RUC now 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.

Proposed Changes

To fulfill CMS' statutory mandate, the agency identified and reviewed potentially misvalued codes in all seven categories. CMS entered into contracts with RAND Corporation and with the Urban Institute to develop validation models for RVUs. Despite establishing a process for the public to nominate potentially misvalued codes, the proposed rule states that CMS "did not receive publicly nominated potentially misvalued codes for inclusion in this proposed rule. We look forward to receiving new code nominations for inclusion in the 2015 proposed rule to continue with our efforts to identify potentially misvalued codes."

However, CMS received input from Medicare contractor medical directors (CMDs) to develop a list of potentially misvalued codes. CMDs identified fourteen codes (Table 11 from the proposed MPFS) as potentially misvalued, and the proposed rule includes a brief explanation for each code. These fourteen codes are not commonly offered by family physicians.

The regulation then discusses methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. Noting an inadvertent exclusion in previous rulemaking, CMS proposes to replace missing post-operative hospital E/M visit information and time for 117 codes identified by the RUC. CMS also proposes to address nearly 200 codes they believe have misvalued resource inputs. Discussed further in the PE RVUs section, these are codes for which the total MPFS payment, when furnished in an office or other nonfacility setting, would exceed the total Medicare payment (the combined payment to the facility and the professional) when the service is furnished in a facility, either a hospital outpatient department or an ASC.

CMS concludes this section discussing their intent to continue existing MPPR policies in this regulation. The agency includes a complete list of services subject to the MPPRs on diagnostic imaging services, therapy services, diagnostic cardiovascular services, and diagnostic ophthalmology services as shown in Addenda F through J. CMS concludes that they will continue their current approach for determining malpractice RVUs for new and revised codes.

Medicare Economic Index (MEI)

Background

The Medicare Economic Index (MEI) is a measure of practice cost inflation developed as a way to estimate annual changes in physicians' operating costs and earnings levels. The MEI reflects the weighted-average annual price change for various inputs involved in furnishing physicians' services. This index is comprised of two broad categories: physicians' own time and physicians' practice expenses.

The current form of the MEI was described in 1992 and based, in part, on recommendations from a Congressionally-mandated meeting of experts held in March 1987. Since that time, the MEI has been updated or revised on four occasions. The MEI was rebased in 1998, which moved the cost structure of the index from 1992 data to 1996 data. The methodology for the productivity adjustment was revised in 2003 to reflect the percentage change in the 10-year moving average of economy-wide, private, nonfarm business multifactor productivity. The MEI was rebased again in 2003, which moved the cost structure of the index from 1996 data to 2000 data. Finally, the MEI was rebased most recently in 2011, which moved the cost structure of the index from 2000 data to 2006 data.

Proposed Changes

For 2014, CMS proposes to revise the MEI based on the recommendations of its MEI Technical Advisory Panel (TAP). CMS is not rebasing the MEI and will continue to use the data from 2006 to estimate the cost weights, arguing that these are the most recently available, relevant, and complete data the agency has available to develop these weights. CMS also proposes to reorganize the cost categories and to select the price proxies in the MEI.

The regulation then discusses the results of the proposed revisions to the MEI based on the MEI TAP recommendations. For 2014, CMS proposes to implement 10 of the 13 recommendations made by the MEI TAP. These proposed changes only involve revising the MEI categories, cost shares, and price proxies. Instead of proposing to rebase the MEI, since the MEI TAP concluded that there is not a reliable, ongoing source of data to maintain the MEI, the advisory panel suggests CMS consider using data from the Medical Group Management Association's Cost Survey, the Bureau of the Census Services Annual Survey (SAS), and if feasible, a CMS survey, possibly conducted jointly with the American Medical Association, that focuses exclusively on physician expenses as they relate to the MEI. CMS asks for public feedback on these approaches.

Geographic Practice Cost Indices (GPCIs)

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. Since 2011, there has also been 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 has identified five frontier states -- Montana, Wyoming, North Dakota, Nevada and South Dakota.

A 1.0 work GPCI floor was set to expire at the end of 2012, and the *American Taxpayer Relief Act* extended the 1.0 floor through December 31, 2013. Except for Alaska, the current 1.0 physician work floor expires at the end of 2013, unless Congress intervenes.

Proposed Changes

Current law requires that "if more than 1 year has elapsed since the date of the last previous GPCI adjustment, the adjustment to be applied in the first year of the next adjustment shall be 1/2 of the adjustment that otherwise would be made." Since the previous GPCI update was implemented in 2011 and 2012, CMS is proposing to phase in 1/2 of the latest GPCI adjustment in 2014.

CMS completed a review of the GPCIs and proposes new GPCIs. CMS also proposes a revision to the cost share weights that correspond to all three GPCIs.

As noted, the 1.0 work GPCI floor extends only through December 31, 2013. Therefore, the proposed 2014 work GPCIs do not reflect the 1.0 work floor, with the exception of Alaska's permanent 1.5 work GPCI floor. CMS lists the proposed 2014 GPCIs on the CMS website.

To determine the proposed 2014 GPCI updates, CMS intends to use updated Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) data (2009 through 2011) as a replacement for the 2006 through 2008 data to compute the work GPCIs. CMS proposes to use 2008-2010 American Community Survey (ACS) rental data as the proxy for physician office rent. CMS cites a June 15, 2013, Medicare Payment Advisory Commission (MedPAC) report that assesses GPCI policies and then states that the agency did not have sufficient time to review this report for inclusion in this proposed rule.

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 CMS 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.

The law provides for coverage of and payment for consultation services delivered via a telecommunications system to Medicare beneficiaries residing in rural health professional shortage areas (HPSAs). 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 specialists, nurse-midwives, clinical psychologists, clinical social workers, or registered dietitian or nutrition professionals.

In 2002, CMS established a process for adding or removing services from the list of Medicare telehealth services. Currently, Medicare covers 21 telehealth services, including initial inpatient consultations; follow-up inpatient consultations; office or other outpatient visits; individual psychotherapy; pharmacologic management; psychiatric diagnostic interview examination; end-stage renal disease (ESRD) related services; individual and group medical nutrition therapy (MNT); neurobehavioral status exam; individual and group health and behavior assessment and intervention (HBAI); subsequent hospital care; subsequent nursing facility care; individual and group kidney disease education (KDE); individual and group diabetes self-management training (DSMT); smoking cessation services; alcohol and/or substance abuse and brief intervention services; screening and behavioral counseling interventions in primary care to reduce alcohol misuse; screening for depression in adults; screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs; intensive behavioral therapy for cardiovascular disease; and behavioral counseling for obesity.

CMS established a process for public requests to add services to the list of Medicare telehealth services. These requests must be submitted no later than December 31 of each calendar year to be considered for the next rulemaking cycle.

Proposed Changes

CMS proposes to modify polices regarding originating sites to define rural HPSAs as those located in rural census tracts as determined by Office of Rural Health Policy. CMS proposes this under the belief that defining "rural" to include geographic areas located in rural census tracts within Metropolitan Statistical Areas (MSAs) would allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites. CMS also believes that adopting the more precise definition of "rural" for this purpose would expand access to health care services for Medicare beneficiaries located in rural areas.

CMS also proposes to change their policy so that geographic eligibility for an originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies. CMS suggests this proposed change would reduce the likelihood that mid-year changes to geographic designations would result in sudden disruptions to beneficiaries' access to services, eliminate unexpected changes in eligibility for established telehealth originating sites, and avoid operational difficulties associated with administering mid-year Medicare telehealth payment changes. CMS proposes to establish geographic eligibility for Medicare telehealth originating sites for each calendar year based upon the status of the area as of December 31 of the prior calendar year.

For consideration within this proposed rule, CMS received a request to add online assessment and E/M services (98969 and 99444) as Medicare telehealth services effective for 2014. Reiterating a position taken in 2008, CMS did not propose to include these codes. CMS argues Medicare telehealth services pay the physician or practitioner an amount equal to the amount that would have been paid if the service was furnished without the use of a telecommunications system. Since CPT codes 98969 and 99444 are currently noncovered, there would be no Medicare payment if these services were furnished without the use of a telecommunications system. Since these codes are noncovered services, CMS did not propose to add online evaluation and management services to the list of Medicare Telehealth Services for 2014.

In the 2013 MPFS, CMS finalized payment policy for two new CPT transitional care management (TCM) codes:

- 99495 (TCM services which requires communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge and medical decision making of at least *moderate complexity* during the service period face-to-face visit, within *14* calendar days of discharge) and
- 99496 (TCM services which requires communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge and medical decision making of *high complexity* during the service period face-to-face visit, within *7* calendar days of discharge).

These services are for a patient whose medical or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospitalization, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living).

TCM codes are comprised of one face-to-face visit within the specified time frames following a discharge, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction.

In the 2014 proposed MPFS, CMS states their belief that interactions between the furnishing practitioner and the beneficiary described by the required face-to-face visit component of the TCM services are sufficiently similar to services currently on the list of Medicare telehealth services for these TCM services to be added. Specifically, CMS believes that the required face-to-face visit component of TCM services is similar to the office/outpatient evaluation and management visits described by CPT codes 99201-99205 and 99211- 99215. Therefore, CMS proposes to add CPT codes 99495 and 99496 to the list of telehealth services for 2014.

Requirements for Billing "Incident To" Services

Background

"Incident to" services and supplies are "of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in physicians' bills." These are services and supplies furnished as "incident to" the professional services of a physician. Medicare regulations set forth specific requirements that must be met in order for physicians and other practitioners to bill Medicare for "incident to" physicians' services. In addition, regulations specific to each type of practitioner (clinical psychologists, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives) stipulate who is allowed to bill for "incident to" services.

"Incident to" services are treated as if they were furnished by the billing practitioner for purposes of Medicare billing and payment. Since CMS treats "incident to" services as services furnished by the billing practitioner for purposes of Medicare billing and payment, payment is made to the billing practitioner under the MPFS, and all relevant Medicare rules apply including, but not limited to, requirements regarding medical necessity, documentation, and billing. Those practitioners who can bill Medicare for "incident to" services are paid at their applicable Medicare payment rate as if they furnished the service. When "incident to" services are billed by a physician, they are paid at 100 percent of the fee schedule amount, and when the services are billed by a nurse practitioner or clinical nurse specialist, they are paid at 85 percent of the fee schedule amount. Payments are subject to the usual deductible and coinsurance.

As the services commonly furnished in physicians' offices and other nonfacility settings have expanded to include more complicated services, the types of services that can be furnished "incident to" physicians' services have also expanded. States have increasingly adopted standards regarding the delivery of health care services in all settings, including physicians' offices, to protect the health and safety of their citizens. These state standards often include qualifications for the individuals who are permitted to furnish specific services or requirements about the circumstances under which services may be actually furnished.

CMS became aware of several situations where Medicare was billed for "incident to" services that were provided by auxiliary personnel who did not meet the state standards for those services in the state in which the services were furnished. The physician or practitioner billing for the services would have been permitted under state law to personally furnish the services, but the services were actually provided by auxiliary personnel who were not in compliance with state law in providing the particular service. Practitioners authorized to bill Medicare for services that they furnish to Medicare beneficiaries are required under Medicare to comply with state law.

However, the Medicare requirements for services and supplies incident to a physician's professional services do not specifically make compliance with state law a condition of payment for services and

supplies furnished and billed as “incident to” services. Nor do any of the regulations regarding services furnished “incident to” the services of other practitioners/MD contain this requirement. Thus, Medicare has had limited recourse when services furnished incident to a physician’s or practitioner’s services are not furnished in compliance with state law.

In 2009, the Office of Inspector General (OIG) issued a report entitled “Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services” that considered in part the qualifications of auxiliary personnel providing “incident to” physician services. After finding that services were being provided and billed to Medicare by auxiliary personnel “. . .who did not possess the required licenses or certifications according to State laws, regulations, and/or Medicare rules,” the OIG recommended that CMS revise the “incident to” rules to, among other things, “require that physicians who do not personally perform the services they bill to Medicare ensure that no persons except…nonphysicians who have the necessary training, certification, and/or licensure, pursuant to state laws, state regulations, and Medicare regulations personally perform the services under the direct supervision of a licensed physician.”

Proposed Changes
CMS proposes amendments to applicable regulations to address the OIG recommendation. To ensure that auxiliary personnel providing services to Medicare beneficiaries incident to the services of other physicians and practitioners do so in accordance with the requirements of the state in which the services are furnished and to ensure that Medicare dollars can be recovered when such services are not furnished in compliance with the state law, CMS proposes to add a requirement to the “incident to” regulations. Specifically, CMS proposes to add a new paragraph stating, “Services and supplies must be furnished in accordance with applicable State law.” CMS is also proposing to amend the definition of auxiliary personnel to require that the individual performing “incident to” services “meets any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished.” CMS is also proposing to amend regulations applicable to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to conform to these changes.

The proposed rule then discusses that the proposed amendments are consistent with the traditional approach of CMS relying primarily on the states to regulate the health and safety of their residents in the delivery of health care services.

Complex Chronic Care Management Services
Background
In the final 2013 MPFS, CMS began coverage of post-discharge, transitional care management (TCM) codes as part of a short term payment strategy that recognizes “primary care and care coordination as critical components in achieving better care for individuals, better health for individuals, and reduced expenditure growth.”

In a December 3, 2012, letter to CMS, the AAFP and other groups expressed gratitude for creating the TCM codes and urged CMS to also begin Medicare coverage for complex chronic care (CCC) management services. In a separate letter sent March 18, 2013, the AAFP again joined other groups urging CMS to implement CCC management codes within the 2014 proposed MPFS.

Proposed Changes
As advocated by the AAFP, in this proposed rule, CMS states their belief that the resources required to furnish CCC management services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes. CMS states that the CCC management services are part of a "broader strategy" and that "the physician community continues to tell us that the care management

included in many of the E/M services, such as office visits, does not adequately describe the typical non-face-to-face management work involved for certain categories of beneficiaries."

CMS says, "Furnishing care management to beneficiaries with multiple chronic conditions requires complex and multidisciplinary care modalities that involve: regular physician development or revision of care plans; subsequent reports of patient status; review of laboratory and other studies; communication with other health professionals not employed in the same practice who are involved in the patient's care; integration of new information into the care plan; or adjustment of medical therapy."

Therefore, for 2015, CMS proposes to establish a separate payment under the MPFS for CCC management services furnished to patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

The regulation then discusses that "successful efforts to improve chronic care management for these patients could improve the quality of care while simultaneously decreasing costs." CMS intends, through separate rulemaking, "to develop standards for furnishing complex chronic care management services to ensure that the physicians who bill for these services have the capability to provide them."

To that point, CMS then notes, "Not all physicians and qualified nonphysician practitioners who wish to furnish complex chronic care management services currently have the capability to fully provide the scope of services without making additional investments in technology, staff training, and the development and maintenance of systems and processes to furnish the services. We intend to establish standards that would be necessary to provide high quality, safe complex chronic care management services."

CMS says the following potential standards could be required:

- The practice must be using a certified EHR for beneficiary care that meets the most recent Health and Human Services (HHS) regulatory standard for meaningful use. The EHR must be integrated into the practice to support access to care, care coordination, care management and communication.
- The practice must employ one or more advanced practice registered nurses or physicians assistants whose written job descriptions indicate that their job roles include and are appropriately scaled to meet the needs for beneficiaries receiving services in the practice who require complex chronic care management services provided by the practice.
- The practice must be able to demonstrate the use of written protocols by staff participating in the furnishing of such services, with further requirements.
- All practitioners, including advanced practice registered nurses (APRNs) or physicians assistants (PAs), involved in the delivery of complex chronic care management services must have access at the time of service to the beneficiary's EHR, which includes all of the elements necessary to meet the most recent HHS regulatory standard for meaningful use, with further detailed requirements.

CMS then discusses and requests feedback on various national organizations that formally recognize primary care practices as patient-centered medical homes. CMS then reiterates that any regulatory changes would be addressed through separate rulemaking.

CMS proposes two separately payable CCC management services as G-codes, one for an initial service and the other for subsequent care after the initial service. Patients will be required to provide advance consent to the practice for the CCC management codes to be used and this consent must be

reaffirmed at least every 12 months. Patients can revoke consent at any time, and CMS includes details about patient handoffs in these situations. Patients must first receive an annual wellness visit or initial preventive physical exam (i.e. "Welcome to Medicare Visit") within the previous 12 months before a provider can bill the CCC management code.

CMS proposes to pay only one G-code per patient per 90 days. CMS has not yet determined the payment amount; however, CMS indicates this code will require at least 60 minutes of clinical time. CMS seeks input on the standards required to provide these services, and the work and PE that would be associated with these services.

CMS proposes that CCC management codes can be furnished "incident to" a physician's service under general physician supervision requirements when provided outside normal office hours. Non-physician practitioners must be employed by the practice, and the 60 minutes of required clinical service per 90 days must be personally performed by the physician or directed by the physician.

As this code relates to the Primary Care Incentive Program, CMS reiterates their belief that they do not have authority to add codes to the PCIP definition of primary care services. CMS then argues that CCC management services are similar to the services that the agency already excluded from the PCIP denominator. Therefore, while physicians and qualified nonphysician practitioners who furnish CCC management services would not receive an additional incentive payment under the PCIP for the service itself, CMS proposes that the allowed charges for complex chronic care management services would not be included in the denominator when calculating a physician's or practitioner's percent of allowed charges that were primary care services for purposes of the PCIP.

Ultrasound Screening for Abdominal Aortic Aneurysms

Background

Medicare covers ultrasound screening for abdominal aortic aneurysms for a beneficiary that meets certain criteria, including that he or she must receive a referral during the initial preventive physical examination (IPPE) and has not previously had an AAA screening covered under the Medicare program. The IPPE includes a time restriction and must be furnished not more than one year after the effective date of the beneficiary's first Part B coverage period. CMS argues this time limitation for the IPPE effectively reduces a Medicare beneficiary's ability to obtain a referral for AAA screening.

CMS has authority to modify coverage of certain preventive services to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force (USPSTF). In 2005, the USPSTF recommended with a Grade B a "one-time screening for [AAA] by ultrasonography in men ages 65 through 75 who have ever smoked."

Proposed Changes

The USPSTF recommendation does not include a time limit with respect to the referral for this test, so CMS proposes to modify coverage of AAA screening consistent with the recommendations of the USPSTF to eliminate the one-year time limit with respect to the referral for this service. This proposed modification would allow coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the IPPE.

Colorectal Cancer Screening: Modification to Coverage of Screening Fecal Occult Blood Tests

Background

Medicare covers colorectal cancer screening via fecal occult blood tests (FOBT), screening flexible sigmoidoscopies, screening colonoscopies, and other tests determined to be appropriate, subject to certain frequency and payment limits.

Current policies were established in 1997 and require a written order by the beneficiary's attending physician. CMS required this written order as a way to ensure beneficiaries receive appropriate preventive counseling about the implications and possible results of having these examinations performed.

Since then, Medicare coverage of preventive services has expanded to include, among other things, coverage of an annual wellness visit. The annual wellness visit includes provisions for furnishing personalized health advice and appropriate referrals. In addition to physicians, the annual wellness visit can be furnished by certain nonphysician practitioners, including physician assistants, nurse practitioners, and clinical nurse specialists.

Nonphysician practitioners (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners, and physician assistants) who furnish services that would be physician services if furnished by a physician, and who are operating within the scope of their authority under state law and within the scope of their Medicare statutory benefit, may be treated the same as physicians treating beneficiaries.

Proposed Changes

CMS proposes to revise their "Condition for coverage of screening fecal-occult blood tests" policies to allow an attending physician, physician assistant, nurse practitioner, or clinical nurse specialist to furnish written orders for screening FOBT. CMS believes this proposed modification would allow for expanded coverage and access to screening FOBT, particularly in rural areas, and the agency invites public comment on this proposal and whether a practitioner permitted to order a screening FOBT must be the beneficiary's attending practitioner.

Physician Compare Website

Background

The *Affordable Care Act* requires that, no later than January 1, 2011, CMS develop a Physician Compare website with information on physicians enrolled in the Medicare program as well as information on other eligible professionals who participate in the Physician Quality Reporting System (PQRS). CMS launched the first phase of Physician Compare on December 30, 2010, by posting the names of eligible professionals that satisfactorily submitted quality data for the 2009 PQRS.

The *Affordable Care Act* also requires that, no later than January 1, 2013, and for reporting periods that begin no earlier than January 1, 2012, CMS implement a plan for making publicly available through Physician Compare information on physician performance that provides comparable information on quality and patient experience measures. CMS met this requirement in advance of January 1, 2013, and intends to continue to address elements of the plan through rulemaking.

CMS is also required to submit a report to the Congress, by January 1, 2015, on Physician Compare development and include information on the efforts and plans to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice. Initial work on this report is currently underway.

In June of 2013, CMS launched a full redesign of Physician Compare including a complete overhaul of the underlying database and a new intelligent search feature. Users can now view information about approved Medicare professionals, such as name, primary and secondary specialties, practice locations, group affiliations, hospital affiliations that link to the hospital's profile on Hospital Compare as available, Medicare Assignment status, education, languages spoken, and American Board of Medical Specialties (ABMS) board certification information. In addition, for group practices, users can also view group

practice names, specialties, practice locations, Medicare Assignment status, and affiliated professionals.

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Proposed Changes

CMS will continue to expand the Physician Compare website over the next several years by incorporating quality measures from a variety of sources. For 2014, CMS proposes to expand the quality measures posted on Physician Compare by publicly reporting performance on all measures collected through the Group Practice Reporting Option (GPRO) web interface for groups of all sizes participating in 2014 under the PQRS GPRO and for ACOs participating in the Medicare Shared Savings Program. These data would include measure performance rates for measures reported that met the minimum sample size of 20 patients and that prove to be statistically valid and reliable. CMS proposes a 30-day preview period prior to publication of quality data on Physician Compare, so group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported.

CMS also proposes to publicly report on Physician Compare performance on certain measures that groups report via registries and EHRs in 2014 for the PQRS GPRO. No earlier than 2015, CMS plans to post performance information on the GPRO registry and EHR measures that can also be reported via the GPRO web interface in 2014. By proposing to include on Physician Compare performance on these measures reported by participants under the GPRO through registries and EHRs, as well as the GPRO web interface, CMS states they are providing beneficiaries with a consistent set of measures over time.

For data reported for 2014, CMS proposes to continue public reporting of Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) data for PQRS GPRO group practices of 100 or more eligible professionals participating in the GPRO via the web interface and for Shared Savings Program ACOs reporting through the GPRO web interface or other CMS-approved tool or interface. Finally, CMS seeks comment on posting performance on patient experience survey-based measures for individual eligible professionals starting with data collected for 2015.

Physician Quality Reporting System

Background

The Physician Quality Reporting System (PQRS) provides incentive payments 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). Payment penalties apply to those who do not report or do not report satisfactorily.

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. 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. 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.

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. After 2016, the penalty remains at 2 percent and is applied (or not)

depending on the providers performance two years before (i.e. application of the penalty depends on performance in 2015).

Proposed Changes
CMS states the PQRS proposals within this regulation are intended to facilitate the alignment of programs, reporting systems, and quality measures and that the agency believes that alignment of CMS quality improvement programs will decrease the burden of participation on physicians and allow them to spend more time and resources caring for beneficiaries.

For 2014, CMS proposes to add 47 new individual measures and 3 measures groups to fill existing measure gaps and to retire several claims-based measures to encourage reporting via registry and EHR-based reporting mechanisms.

For PQRS participation by individual eligible professionals, CMS proposes to establish certain requirements for the 2014 PQRS incentive, which is the final year for positive incentive payments under the PQRS. CMS proposes to:

- Increase the number of measures that must be reported via the claims and registry-based reporting mechanisms from 3 to 9;
- Change the reporting threshold for reporting individual measures via registry to require that eligible professionals report on 50 percent of the eligible professional's Medicare Part B fee-for-service patients rather than 80 percent;
- Eliminate the reporting option for claims-based measures groups reporting.

CMS also proposes that if an eligible professional meets the criteria for the 2014 PQRS incentive, doing so will satisfy the reporting for the 2016 PQRS payment adjustment. In other words, eligible professionals who meet the criteria for the 2014 PQRS incentive will automatically avoid the downward payment adjustment for 2016.

For PQRS reporting using clinical data registries, CMS proposes to implement *American Taxpayer Relief Act* policies that allow eligible professionals to be treated as satisfactorily submitting data on quality measures for covered professional services if the eligible professional satisfactorily participates in a qualified clinical data registry.

Under this clinical data registry option, participants must report the measures used by the clinical data registry instead of those on the PQRS measure list. Eligible professionals may report measures on all patients, regardless of whether or not they are Medicare Part B fee-for-service patients. For the 2014 PQRS incentive and 2016 PQRS payment adjustment, CMS proposes that eligible professionals using clinical data registries would meet the criteria for satisfactory participation by reporting on at least 9 measures to the registry covering at least 3 of the National Quality Strategy domains, and report each measure for at least 50 percent of the eligible professional's applicable patients. At least one of the measures must be an outcome measure.

For group practices reporting PQRS measures under the GPRO, CMS proposes to change the requirements by:

- Eliminating the option for group practices of 25 to 99 eligible professionals to report PQRS measures via the GPRO web interface. That is, only groups with 100 or more eligible professionals could use the GPRO web interface.
- Offering a new reporting mechanism, the certified survey vendor reporting mechanism, which would allow a group comprised of 25 or more eligible professionals to count reporting of CG

CAHPS survey measures towards meeting the criteria for satisfactory reporting for the 2014 PQRS incentive and the 2016 PQRS payment adjustment.

- Increasing the number of measures that must be reported from 3 to 9 for groups reporting individual measures via registry and proposing a 50 percent threshold instead of an 80 percent threshold.

CMS also proposes that if a group practice reports through one of the GPRO reporting options (including ACOs in the Medicare Shared Savings Program) and meets the criteria for the 2014 PQRS incentive, this will serve to satisfy the reporting for the 2016 PQRS payment adjustment (in other words, group practices that meet the criteria for the 2014 PQRS incentive will automatically avoid the downward payment adjustment for 2016).

Tables 24 and 25 within the proposed rule provide a summary of the proposed criteria for satisfactory reporting and participation for individual eligible professionals for the 2014 PQRS incentive and 2016 PQRS payment adjustment, respectively. Tables 26 and 27 provide a summary of the proposed criteria for the satisfactory reporting of data on PQRS quality measures via the GPRO for the 2014 PQRS incentive and 2016 PQRS payment adjustment.

Electronic Health Record (EHR) Incentive Program

Background

The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Eligible professionals can receive up to $44,000 through the Medicare EHR Incentive Program and up to $63,750 through the Medicaid EHR Incentive Program.

Proposed Changes

CMS propose additional options for eligible professionals to report clinical quality measures (CQMs) under the Medicare EHR Incentive Program beginning in 2014.

CMS proposes an option for eligible professionals to submit CQM information using qualified clinical data registries as defined by the PQRS for purposes of meeting the CQM reporting component of meaningful use for the Medicare EHR Incentive Program beginning in 2014. Eligible professionals would have to use certified EHR technology, as required under the Medicare EHR Incentive Program, and report on CQMs that were included in the EHR Incentive Program Stage 2 final rule.

The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. The CPC initiative uses a subset of the CQMs finalized in the Stage 2 final rule. In a continuing effort to align quality reporting programs and innovation initiatives, CMS proposes to add a group reporting option to the Medicare EHR Incentive program beginning in 2014 for eligible professionals who are part of a CPC initiative practice site that successfully submits at least 9 CQMs covering 3 domains. CMS proposes that each of the eligible professionals in the CPC initiative practice site would satisfy the CQM reporting component of meaningful use if the practice site successfully submits and meets the reporting requirements of the CPC initiative.

The electronic specifications for the clinical quality measures that were finalized under the Medicare EHR Incentive Program for use by eligible professionals beginning in 2014 are updated routinely to account for issues such as changes in billing and diagnosis codes and changes in medical practices. CMS proposes that eligible professionals who seek to report clinical quality measures electronically under the Medicare EHR Incentive Program must use the most recent version of the electronic

specifications for the clinical quality measures and have certified EHR technology that is tested and certified to the most recent version of the electronic specifications for the clinical quality measures. Eligible professionals who do not wish to report clinical quality measures electronically using the most recent version of the electronic specifications (for example, if their certified EHR technology has not been certified for that particular version) would be allowed to report clinical quality measure data to CMS by attestation for the Medicare EHR Incentive Program.

Medicare Shared Savings Program

Background

The Medicare Shared Savings Program is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

Proposed Changes

CMS proposes changes to the Medicare Shared Savings Program to further align with the PQRS reporting requirements. CMS states that they believe alignment of quality improvement programs such as the EHR Incentive Program, Value-based Payment Modifier, and Medicare Shared Savings Program, are critical for programs involving physicians and other healthcare eligible professionals. As such, CMS proposes that ACOs will report through a CMS web interface on behalf of eligible professionals and must meet the criteria for the 2014 PQRS incentive to satisfactorily report to avoid the 2016 PQRS payment adjustment.

CMS had previously indicated that the agency would use the national Medicare Advantage and FFS Medicare performance data and seek to incorporate actual ACO performance into establishing quality benchmarks for the program. The agency is now proposing to include data submitted by the Shared Savings Program and Pioneer ACOs to set the benchmark for the 2014 performance period. In addition, CMS proposes a method to increase the spread of tightly clustered performance rates in order to continue providing incentives to improve quality and provide achievable benchmarks for newly formed ACOs. Finally, CMS proposes to increase the scoring for the CG-CAHPs survey measure modules within the patient experience of care domain, so that the CAHPS survey measure modules carry greater weight within the patient experience of care domain.

Value-Based Payment Modifier and Physician Feedback Program

Background

The *Affordable Care Act* calls 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 proposed to use 2014 as the performance period for the value modifier to be applied in 2016.
The final 2013 MPFS applies the value modifier to groups of physicians with 100 or more eligible professionals in 2015, a change from the 2013 proposed MPFS, which would have set the group size at 25 or above.

Proposed Changes

In the 2014 proposed rule, CMS proposes additions and refinements to the existing value-based payment modifier policies. Specifically CMS proposes:

- To modify the performance period. CMS previously established 2014 as the performance period for the value-based payment modifier adjustments that will apply during 2016. However, CMS states a belief that it is important to propose the performance period for the value-based payment modifier that will apply in 2017, when all physicians and groups of physicians will be subject to the value-based payment modifier. CMS proposes that 2015 be the performance period for the value-based payment modifier that will apply during 2017.
- To lower the group size threshold from groups of physicians of 100 or more eligible professionals that are subject to the value-based payment modifier in 2015 to groups of physicians with 10 or more eligible professionals for 2016. CMS estimates that this proposal would cause approximately 17,000 groups and nearly 60 percent of physicians to be affected by the value-based payment modifier in 2016.
- A two-category approach for establishing the 2016 value-based payment modifier based on how a group of physicians participates in the PQRS. CMS proposes that Category 1 would include those groups of physicians with 10 or more eligible professionals that meet the satisfactory reporting criteria through the PQRS GPRO for the 2016 PQRS payment adjustment. In addition, CMS proposes that if a group of physicians subject to the 2016 value-based payment modifier does not participate in the PQRS GPRO, at least 70 percent of the eligible professionals billing under the group must meet the satisfactory reporting for the 2016 PQRS payment adjustment, in order to be included in Category 1 and avoid a downward payment adjustment under the value-based payment modifier. CMS states this proposal allows eligible professionals in those groups to continue to report data for the PQRS individually if they so choose. Groups of physicians with 10 or more eligible professionals that do not meet either of these two standards will be in Category 2 and be subject to an automatic downward payment adjustment under the value-based payment modifier in 2016.
- To make quality-tiering (the method for evaluating performance on quality and cost measures for the value-based payment modifier) mandatory for groups with 10 or more eligible professionals. However, CMS proposes that groups of physicians with between 10 and 99 eligible professionals will not be subjected to a downward payment adjustment (that is, they will either receive an upward or neutral adjustment) determined under the quality-tiering methodology. Groups of physicians with 100 or more eligible professionals, however, would receive upward, neutral, or downward adjustments under the quality-tiering methodology. CMS believes this new approach to implementing quality-tiering would reward groups of physicians that provide high-quality/low-cost care, reduce program complexity, and more fully engage groups of physicians in plans to implement the value-based payment modifier.
- For the 2016 value-based payment modifier, to use all of the PQRS measures that would be available to be reported under the various PQRS reporting mechanisms in 2014, including quality measures reported by individual eligible professionals in a group through qualified clinical data registries, to calculate a group of physicians' value-based payment modifier in 2016 to the extent that a group of physicians submits data on these measures.
- That groups of 25 or more eligible professionals would be able to elect to have the patient experience of care measures collected through the PQRS CG-CAHPS survey for 2014 included in their value-based payment modifier for 2016.
- To increase the downward adjustment under the value-based payment modifier from 1.0 percent in 2015 to 2.0 percent for 2016. That is, for 2016, a -2.0 percent value-based payment modifier would apply to groups of physicians that are subject to the value-based payment modifier and fall in Category 2. In addition, CMS proposes to increase the maximum downward

adjustment under the quality-tiering methodology to -2.0 percent for groups of physicians that are subject to the 2016 value-based payment modifier, fall in Category 1, and are classified as low quality/high cost; the adjustment would be set to -1.0 percent for groups classified as either low quality/average cost or average quality/high cost.

- To include the Medicare Spending per Beneficiary (MSPB) measure as an additional measure in the cost composite of the value-based payment modifier beginning with 2016. The measure includes all Medicare Part A and Part B payments during an MSPB episode. An MSPB episode spans from 3 days prior to an index admission at a subsection (d) hospital through 30 days post discharge with certain exclusions. The MSPB measure is already included in the Hospital Inpatient Quality Reporting Program and in the Hospital-Value-based Purchasing Program. This measure would be included in the total per capita costs for all attributed beneficiaries domain along with the total per capita cost measure. Each measure would be weighted equally in the domain. CMS does not propose to convert the MSPB amount to a ratio as is done to compute a hospital's MSPB measure, but rather to use the MSPB amount as the measure's performance rate.
- To attribute an MSPB episode to a group of physicians subject to the value-based payment modifier when any eligible professional in the group bills a Part B Medicare claim for a service rendered during an inpatient hospitalization that is an index admission for the MSPB measure.
- To require attribution of a minimum of 20 MSPB episodes during the performance period to a group in order to have their performance on this measure included in the value-based payment modifier cost composite. CMS believes that including the MSPB in the value-based payment modifier would help to align performance incentives across the delivery system.
- To refine the current peer group methodology to account for physician specialty mix.

TABLE 71: CY 2014 PFS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work and MP RVU Changes	(D) Impact of PE RVU Changes	(E) Combined Impact
TOTAL	$86,995	2%	-2%	0%
01-ALLERGY/IMMUNOLOGY	$213	1%	-4%	-3%
02-ANESTHESIOLOGY	$1,862	4%	-1%	3%
03-CARDIAC SURGERY	$355	3%	-1%	2%
04-CARDIOLOGY	$6,425	2%	0%	2%
05-COLON AND RECTAL SURGERY	$158	2%	-2%	0%
06-CRITICAL CARE	$273	3%	-1%	2%
07-DERMATOLOGY	$3,113	2%	-4%	-2%
08-EMERGENCY MEDICINE	$2,929	3%	0%	3%
09-ENDOCRINOLOGY	$447	2%	-2%	0%
10-FAMILY PRACTICE	$6,358	2%	-1%	1%
11-GASTROENTEROLOGY	$1,901	3%	-2%	1%
12-GENERAL PRACTICE	$528	2%	-2%	0%
13-GENERAL SURGERY	$2,236	3%	-2%	1%
14-GERIATRICS	$231	3%	-1%	2%
15-HAND SURGERY	$151	2%	-2%	0%
16-HEMATOLOGY/ONCOLOGY	$1,890	2%	-3%	-1%
17-INFECTIOUS DISEASE	$635	3%	-1%	2%
18-INTERNAL MEDICINE	$11,416	3%	-2%	1%
19-INTERVENTIONAL PAIN MGMT	$640	2%	-3%	-1%
20-INTERVENTIONAL RADIOLOGY	$219	2%	-6%	-4%
21-MULTISPECIALTY CLINIC/OTHER PHY	$79	2%	-2%	0%
22-NEPHROLOGY	$2,123	3%	-2%	1%
23-NEUROLOGY	$1,498	2%	-4%	-2%
24-NEUROSURGERY	$712	2%	-1%	1%
25-NUCLEAR MEDICINE	$51	2%	-1%	1%
27-OBSTETRICS/GYNECOLOGY	$688	2%	-2%	0%
28-OPHTHALMOLOGY	$5,592	2%	-2%	0%
29-ORTHOPEDIC SURGERY	$3,683	2%	-2%	0%
30-OTOLARNGOLOGY	$1,128	2%	-4%	-2%
31-PATHOLOGY	$1,134	3%	-8%	-5%
32-PEDIATRICS	$63	3%	-3%	0%
33-PHYSICAL MEDICINE	$999	3%	-3%	0%
34-PLASTIC SURGERY	$367	2%	-2%	0%
35-PSYCHIATRY	$1,165	3%	-1%	2%
36-PULMONARY DISEASE	$1,775	3%	-2%	1%
37-RADIATION ONCOLOGY	$1,783	1%	-6%	-5%
38-RADIOLOGY	$4,635	2%	-3%	-1%
39-RHEUMATOLOGY	$551	2%	-5%	-3%
40-THORACIC SURGERY	$332	3%	-1%	2%
41-UROLOGY	$1,858	2%	-4%	-2%
42-VASCULAR SURGERY	$925	2%	-4%	-2%
43-AUDIOLOGIST	$56	2%	-1%	1%
44-CHIROPRACTOR	$722	3%	-1%	2%
45-CLINICAL PSYCHOLOGIST	$579	4%	-1%	3%
46-CLINICAL SOCIAL WORKER	$408	4%	-1%	3%
47-DIAGNOSTIC TESTING FACILITY	$779	0%	-7%	-7%
48-INDEPENDENT LABORATORY**	$812	1%	-27%	-26%
49-NURSE ANES / ANES ASST	$1,055	4%	0%	4%
50-NURSE PRACTITIONER	$1,937	3%	-2%	1%
51-OPTOMETRY	$1,106	2%	-2%	0%
52-ORAL/MAXILLOFACIAL SURGERY	$44	2%	-4%	-2%
53-PHYSICAL/OCCUPATIONAL THERAPY	$2,797	2%	-1%	1%
54-PHYSICIAN ASSISTANT	$1,405	3%	-2%	1%
55-PODIATRY	$1,975	2%	-2%	0%
56-PORTABLE X-RAY SUPPLIER	$110	1%	-2%	-1%
57-RADIATION THERAPY CENTERS	$62	0%	-13%	-13%
98-OTHER	$25	3%	-2%	1%

*Table 71 shows only the payment impact on PFS services. These impacts use a constant conversion factor and thus do not include the effects of the January 2014 conversion factor change required under current law.
**PFS Payments only, which account for ~17% of Independent Laboratory payments from Medicare.

TABLE 72: CY 2014 PFS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty by Selected Proposal*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of 2012 Claims Data, 90% Utilization Assumption, Ultrasound Changes, and Other Minor Changes	(D) Impact of OPD/ ASC Cap	(E) Impact of MEI Revisi on	(F) Total (Cum-ulative) Impact
TOTAL	$86,995	0%	0%	0%	0%
01-ALLERGY/IMMUNOLOGY	$213	-1%	0%	-2%	-3%
02-ANESTHESIOLOGY	$1,862	0%	0%	3%	3%
03-CARDIAC SURGERY	$355	0%	0%	2%	2%
04-CARDIOLOGY	$6,425	2%	0%	0%	2%
05-COLON AND RECTAL SURGERY	$158	0%	0%	0%	0%
06-CRITICAL CARE	$273	0%	0%	2%	2%
07-DERMATOLOGY	$3,113	0%	0%	-2%	-2%
08-EMERGENCY MEDICINE	$2,929	0%	0%	3%	3%
09-ENDOCRINOLOGY	$447	-1%	1%	0%	0%
10-FAMILY PRACTICE	$6,358	0%	1%	0%	1%
11-GASTROENTEROLOGY	$1,901	0%	0%	1%	1%
12-GENERAL PRACTICE	$528	0%	0%	0%	0%
13-GENERAL SURGERY	$2,236	0%	0%	1%	1%
14-GERIATRICS	$231	0%	1%	1%	2%
15-HAND SURGERY	$151	-1%	1%	0%	0%
16-HEMATOLOGY/ONCOLOGY	$1,890	-1%	1%	-1%	-1%
17-INFECTIOUS DISEASE	$635	0%	0%	2%	2%
18-INTERNAL MEDICINE	$11,416	0%	1%	0%	1%
19-INTERVENTIONAL PAIN MGMT	$640	-1%	0%	0%	-1%
20-INTERVENTIONAL RADIOLOGY	$219	-1%	-2%	-1%	-4%
21-MULTISPECIALTY CLINIC/OTHER PHY	$79	-1%	0%	1%	0%
22-NEPHROLOGY	$2,123	0%	0%	1%	1%
23-NEUROLOGY	$1,498	0%	-1%	-1%	-2%
24-NEUROSURGERY	$712	0%	0%	1%	1%
25-NUCLEAR MEDICINE	$51	0%	1%	0%	1%
27-OBSTETRICS/GYNECOLOGY	$688	0%	0%	0%	0%
28-OPHTHALMOLOGY	$5,592	0%	1%	-1%	0%
29-ORTHOPEDIC SURGERY	$3,683	-1%	1%	0%	0%
30-OTOLARNGOLOGY	$1,128	-1%	0%	-1%	-2%
31-PATHOLOGY	$1,134	1%	-6%	0%	-5%
32-PEDIATRICS	$63	0%	0%	0%	0%
33-PHYSICAL MEDICINE	$999	-1%	1%	0%	0%
34-PLASTIC SURGERY	$367	0%	1%	-1%	0%
35-PSYCHIATRY	$1,165	0%	0%	2%	2%
36-PULMONARY DISEASE	$1,775	0%	1%	0%	1%
37-RADIATION ONCOLOGY	$1,783	1%	-4%	-2%	-5%
38-RADIOLOGY	$4,635	-1%	0%	0%	-1%
39-RHEUMATOLOGY	$551	-3%	1%	-1%	-3%
40-THORACIC SURGERY	$332	0%	0%	2%	2%
41-UROLOGY	$1,858	-1%	0%	-1%	-2%
42-VASCULAR SURGERY	$925	1%	-3%	0%	-2%
43-AUDIOLOGIST	$56	0%	1%	0%	1%
44-CHIROPRACTOR	$722	1%	1%	0%	2%
45-CLINICAL PSYCHOLOGIST	$579	0%	0%	3%	3%
46-CLINICAL SOCIAL WORKER	$408	0%	0%	3%	3%
47-DIAGNOSTIC TESTING FACILITY	$779	-4%	0%	-3%	-7%
48-INDEPENDENT LABORATORY**	$812	1%	-25%	-2%	-26%
49-NURSE ANES / ANES ASST	$1,055	0%	0%	4%	4%
50-NURSE PRACTITIONER	$1,937	0%	1%	0%	1%
51-OPTOMETRY	$1,106	0%	1%	-1%	0%
52-ORAL/MAXILLOFACIAL SURGERY	$44	0%	-1%	-1%	-2%
53-PHYSICAL/OCCUPATIONAL THERAPY	$2,797	0%	1%	0%	1%
54-PHYSICIAN ASSISTANT	$1,405	0%	1%	0%	1%
55-PODIATRY	$1,975	-1%	1%	0%	0%
56-PORTABLE X-RAY SUPPLIER	$110	1%	1%	-3%	-1%
57-RADIATION THERAPY CENTERS	$62	0%	-8%	-5%	-13%
98-OTHER	$25	0%	1%	0%	1%

*Table 72 shows only the payment impact on PFS services. These impacts use a constant conversion factor and thus do not include the effects of the January 2014 conversion factor change required under current law.
**PFS Payments only, which account for ~17% of Independent Laboratory payments.