



Summary of the 2014 final Medicare physician fee schedule

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Executive Summary

On November 27, the Centers for Medicare & Medicaid Services (CMS) released the [final 2014 Medicare Physician Fee Schedule](#) (link expires December 10). This rule revises payment policies under the Medicare Physician Fee Schedule (MPFS) and makes other policy changes related to Medicare Part B payments.

The 2013 Medicare conversion factor is \$34.02. Unless Congress intervenes before December 31, 2013, the 2014 Medicare conversion factor will be \$27.20. The fee schedule payment cut due to the sustainable growth rate (SGR) is, in fact, approximately 24 percent. However, at the same time, changes were made in the weights assigned to the three fee schedule components—physician work, practice expense, and malpractice expense—to more closely match their assigned weights in the Medicare Economic Index. To offset the aggregate impact of this “rescaling” of the three fee schedule components, a positive 4.72 percent adjustment was made to the fee schedule conversion factor. The net impact of these changes produced a conversion factor that is 20.1 percent lower than the 2013 conversion factor.

Because it issued the 2014 final MPFS nearly four weeks late, CMS has extended until January 31, 2014, the period in which doctors can change their Medicare participation status. More detailed information on the three Medicare contractual options for physicians can be found on the AAFP’s [website](#).

In a media [statement](#) released after the final rule became available, the AAFP acknowledged that CMS is moving in the right direction in establishing a health care system that meets patients’ needs for a

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usual source of care and a continuous relationship with a primary care physician, but the statement acknowledged our disappointment that, unless Congress acts, the agency must implement cuts due to the flawed sustainable growth rate formula.

The AAFP continues to call on Congress to repeal the SGR. Click [here](#) to access the AAFP's current physician payment action alert and urge your Representative and your Senators to support SGR repeal and protect primary care.

Of particular interest to family physicians and other primary care physicians, the final rule states that CMS is "committed to supporting 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. Accordingly, we have prioritized the development and implementation of a series of initiatives designed to improve payment for, and encourage long-term investment in, care management services."

The final rule then lists several existing CMS efforts to address primary care services before stating that, "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. In addition, there has been substantial growth in medical practices that are organized as medical homes and devote significant resources to care management as one of the keys to improve the quality and coordination of health care services." Then later, "Because the current E/M office/outpatient visit 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 propose to establish a separate payment under the MPFS for chronic care management services furnished to patients with multiple 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 says that typically clinical staff directed by a physician or other qualified health care professional would provide the 20 minutes or more of chronic care management services covered by this payment . Further information on the chronic care management services are detailed later in the AAFP summary.

Included at the end of this summary is [Table 44](#), which illustrates how CMS calculated the 2014 conversion factor. Also included is [Table 93](#) which shows the final rule's estimated impact on total allowed charges by specialty. CMS estimates that changes to the RVUs in the final rule and the re-scaling of RVUs to match the MEI weights will have no impact on family physicians' Medicare allowed charges in 2014. This estimate does not take into account the SGR reduction slated to occur at the end of 2013.

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

Background

Since 1992, Medicare has paid 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 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.

2014 Proposed Changes

CMS proposed several modifications to the RVU amounts for certain procedures and then discussed 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. In the proposed rule, CMS stated the agency's belief that this difference in payment generally reflects the greater costs that facilities incur compared to those incurred by physicians and other practitioners furnishing services in offices and other non-facility settings.

CMS discussed 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 argued 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 felt 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 argued that the non-facility 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.

To improve the accuracy of MPFS nonfacility payment rates beginning in 2014 and for each calendar year thereafter, CMS proposed to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the MPFS. CMS proposed 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 was finalized, CMS would reduce the non-facility PE RVU rate, so the total nonfacility payment does not exceed the total Medicare payment made for the service in the facility setting.

CMS then discussed 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 discussed 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.”

AAFP recommendations

The AAFP supported CMS' efforts to adjust relative value unit (RVU) amounts for procedures to pay more accurately for services; however, we also encouraged CMS to not pay significantly more for services in the outpatient or ambulatory surgical center setting than in the physician office setting.

Final policy

CMS did not finalize the proposed policy. Citing overwhelming objection by the majority of commenters, CMS notes that the agency will more fully consider the comments received and revise the proposal for using OPPS and ASC rates in developing PE RVUs in future regulations. The AAFP will evaluate and comment on future CMS proposals.

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 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.

2014 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 the Urban Institute to develop validation models for RVUs. Despite establishing a process for the public to nominate potentially misvalued codes, the proposed rule stated 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) that developed a list of potentially misvalued codes. CMDs identified fourteen codes 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 proposed rule then discussed 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 proposed to replace missing post-operative hospital E/M visit information and time for 117 codes identified by the RUC. CMS also proposed 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 discussed their intent to continue existing multiple procedure payment reduction (MPPR) policies and included a complete list of services subject to the MPPRs on diagnostic imaging services, therapy services, diagnostic cardiovascular services, and diagnostic ophthalmology services. CMS concluded that they will continue their current approach for determining malpractice RVUs for new and revised codes.

AAFP recommendations

The AAFP appreciated the increasingly significant steps CMS has taken to identify and address potentially misvalued codes, although the AAFP urged that more be done to ensure that Medicare is not reimbursing based on biased data that further exacerbates the undervaluation of primary care services.

Final policy

CMS announced a 60-day comment period ending January 27, 2014, for the public to nominate misvalued codes for potential review in the proposed rule on the 2015 MPFS. Since CMS published the 2014 proposed MPFS, the AMA RUC sent recommendations for the codes identified by the Medicare CMDs. Since CMS now has AMA RUC recommendations, CMS published 18 interim final values for these codes and invites public comments. CMS finalized their proposals to review certain codes as potentially misvalued codes. CMS published a list of new and revised codes and the malpractice crosswalks used to determine their malpractice RVUs. These RVUs and crosswalks are subject to public comment and will be finalized in the 2015 MPFS final rule. The AAFP is currently evaluating the potentially misvalued codes open for review and will likely comment by the CMS deadline.

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.

2014 Proposed Changes

For 2014, CMS proposed to revise the MEI based on the [recommendations](#) of its MEI Technical Advisory Panel (TAP). CMS did not propose to rebase 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 proposed to reorganize the cost categories and to select the price proxies in the MEI.

The proposed rule then discussed the results of the proposed revisions to the MEI based on the MEI TAP recommendations. For 2014, CMS proposed 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 suggested 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 asked for public feedback on these approaches.

AAFP recommendations

The AAFP concurred with the proposal to revise the MEI based on recommendations of the MEI Technical Advisory Panel but expressed concern with the proposal to use the Employment Cost Index for Wages and Salaries for Hospital Workers as a price proxy for non-physician, health-related staff compensation.

Final policy

CMS finalized revisions to the MEI based on the recommendations of the MEI Technical Advisory Panel. Table 21 in the final MPFS shows the revised 2006-based MEI update for 2014, which is an increase of 0.8 percent.

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 three 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.

2014 Proposed Changes

Current law requires that "if more than one 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 half of the adjustment that otherwise would be made." Since the previous GPCI update was implemented in 2011 and 2012, CMS proposed to phase in half of the latest GPCI adjustment in 2014. CMS completed a review of the GPCIs and proposed new GPCIs. CMS also proposed 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. 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 proposed to use 2008-

2010 American Community Survey (ACS) rental data as the proxy for physician office rent. CMS cited a June 15, 2013, Medicare Payment Advisory Commission (MedPAC) report that assesses GPCI policies and then stated that the agency did not have sufficient time to review this report for inclusion in this proposed rule.

AAFP recommendations

The AAFP advocated for the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal.

Final policy

CMS finalized new GPICs using updated data and will phase in the new GPICs over 2014 and 2015. Due to the 1.0 work GPIC floor scheduled to expire under current law on December 31, 2013, CMS published the finalized GPICs at the lower amount. The AAFP will continue working with Congress to address cuts to Medicare physician payments.

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 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.

2014 Proposed Changes

CMS proposed to modify policies regarding originating sites to define rural HPSAs as those located in rural census tracts as determined by Office of Rural Health Policy. CMS proposed 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 stated the belief 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 proposed 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 suggested 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 proposed 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 the 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 argued 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 E/M 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 stated 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 argued that the required face-to-face visit component of TCM services is similar to the office/outpatient E/M visits described by CPT codes 99201-99205 and 99211- 99215. Therefore, CMS proposed to add CPT codes 99495 and 99496 to the list of telehealth services for 2014.

AAFP recommendations

The AAFP concurred with a proposed change to define "rural" to include geographic areas located in rural census tracts within Metropolitan Statistical Areas (MSAs) to allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites. The AAFP also supported the adoption of a more precise definition of "rural" for telehealth purposes would expand access in rural areas. The AAFP fully supported the proposal to add TCM codes to the list of telehealth services in 2014.

Final policy

CMS finalized their proposal to modify the geographic criteria for eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. CMS also established a policy to determine geographic eligibility for an originating site on an annual basis. In addition, CMS updated the list of eligible Medicare telehealth services to include TCM services.

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.”

2014 Proposed Changes

CMS proposed 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 proposed to add a requirement to the “incident to” regulations. Specifically, CMS proposed to add a new paragraph stating, “Services and supplies must be furnished in accordance with applicable state law.” CMS also proposed 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 also proposed to amend regulations applicable to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to conform to these changes.

The proposed rule discussed 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.

AAFP recommendations

The AAFP supported this technical correction that clarifies that those auxiliary personnel performing “incident to” services must furnish services in accordance with applicable state law.

Final policy

CMS finalized the proposals and will require as a condition of Medicare payment that “incident to” services be furnished in compliance with applicable state law. This policy will allow Medicare to deny or recoup payments when services are furnished not in compliance with state law. CMS also eliminated redundant regulations for each type of practitioner by consolidating the “incident to” requirements for all practitioners that are permitted to bill Medicare directly for their services.

Chronic Care Management Services

Background

In 2013, 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 chronic care management (CCM) services. In a separate [letter](#) sent March 18, 2013, the AAFP again joined other groups urging CMS to implement CCM codes within the 2014 proposed MPFS.

2014 Proposed Changes

As advocated by the AAFP, in the proposed rule for 2014, CMS stated that the resources required to furnish CCM services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes. CMS stated that the CCM 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."

Therefore, for 2015, CMS proposed to establish a separate payment under the MPFS for CCM services furnished to patients with multiple 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 noted, "Not all physicians and qualified nonphysician practitioners who wish to furnish 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 chronic care management services."

CMS proposed two separately payable CCM services as G-codes, one for an initial service and the other for subsequent care after the initial service. Patients would be required to provide advance consent to the practice for the CCM codes to be used, and this consent must be reaffirmed at least every 12 months. Patients could revoke consent at any time, and CMS included details about patient handoffs in these situations. CMS proposed that patients must first receive an Annual Wellness Visit (AWV) or Initial Preventive Physical Exam (IPPE) within the previous 12 months before a provider could bill the CCM code.

CMS proposed to pay only one G-code per patient per 90 days. CMS did not propose a payment amount; however, CMS indicated this code would require at least 60 minutes of clinical time. CMS sought input on the standards required to provide these services and the work and PE that would be associated with these services.

CMS proposed that CCM codes could 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 service relates to the Primary Care Incentive Program (PCIP), CMS reiterated their belief that they do not have authority to add codes to the PCIP definition of primary care services. CMS then argued that CCM services are similar to the services that the agency already excluded from the PCIP denominator. Therefore, while physicians and qualified nonphysician practitioners who furnish CCM services would not receive an additional incentive payment under the PCIP for the service itself, CMS proposed that the allowed charges for CCM 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.

AAFP recommendations

The AAFP generally supported the CMS proposal to pay CCM services in 2015 and agreed that resources required to properly provide CCM services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes. The AAFP called on CMS to value the new CCM codes as a 30-day service, because the AAFP advocates for primary care physicians to receive a monthly care management fee for all beneficiaries who are receiving services from a patient-centered medical home (PCMH). The AAFP also reiterated our concern that the current office/outpatient E/M codes are not adequate for primary care and that CMS needs to create dedicated codes for primary care physicians. The AAFP urged CMS to ramp up and expand the Comprehensive Primary Care

(CPC) initiative and pay a risk-adjusted care management fee for all Medicare beneficiaries as part of a blended-payment model for the PCMH.

Final policy

CMS continued discussing the agency's ongoing efforts to appropriately value primary care services and further discussed that Medicare will begin making a separate payment for CCM services starting in 2015. The final rule indicates that CMS intends to establish practice standards necessary to support payment for furnishing CCM services through future notice-and-comment rulemaking.

The final rule states that CCM services will include the development, revision, and implementation of a plan of care; communication with the patient, caregivers, and other treating health professionals; and medication management. Medicare beneficiaries with multiple chronic conditions who wish to receive these services can choose a physician or other eligible practitioner from a qualified practice to furnish these services.

In response to requests that CMS create billing codes for CCM services to reflect different patient severity levels or create an add-on code that recognizes additional time for more severe patients within the eligible patient population, CMS declined the adoption of such a coding structure at this time. CMS discussed that "paying separately for non-face-to-face chronic care management services is a significant policy change. As we gain more experience with separate payment for this service, we may consider additional changes in the coding structure in future rulemaking."

Instead of the proposed 90-day duration, CMS adopts a 30-day billing interval for CCM services. Given the shorter 30-day period, CMS establishes a billing code that corresponds to 20 minutes of service during the 30-day period instead of the proposed 60 minutes during a 90-day period.

At least 20 minutes of CCM services must be provided during the 30-day billing interval. Time of less than 20 minutes over the 30-day period could not be rounded up to 20 minutes to bill for these services. For purposes of meeting the 20-minute requirement, the practitioner could count the time of only one clinical staff member for a particular segment of time and could not count overlapping intervals such as when two or more clinical staff members are meeting about the patient.

CMS indicates they typically expect that the 20 minutes or more of CCM to be provided by clinical staff directed by a physician or other qualified health care professional. The clinical staff person furnishing the CCM services could be employed either by the physician or the practice.

To recognize the additional resources required to provide CCM services to patients with multiple chronic conditions, CMS will be creating one new separately payable alphanumeric G-code for 2015. CMS states the agency would "consider using a revised CPT code that meets our policy requirements instead of creating a new G-code. "

The CCM code is described as services "furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 20 minutes or more; per 30 days."

CMS finalized the scope of CCM services to include:

- 24-hour- a-day, 7-day- a-week access to address a patient's acute chronic care needs.
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.

- Care management for chronic conditions including systematic assessment of patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.
- A patient-centered plan of care document created in consultation with the patient, caregiver, and other key practitioners treating the patient.
- Management of care transitions within health care settings and other clinicians.
- Documented coordination with home and community based clinical service providers.
- Enhanced opportunities for a patient and caregiver to communicate with the provider regarding the patient's care through not only the telephone but also through the use of secure messaging, internet, or other asynchronous non face-to-face consultation methods.

In response to comments about whether specialist physicians can bill for CCM services, CMS discusses that while they expect the CCM code to be billed most frequently by primary care physicians, specialists who meet the requirements may also bill for these services. As for nonphysician qualified health care professionals, CMS believes only NPs, PAs, CNSs, and certified nurse midwives (CNMs) can furnish the full range of these services under their Medicare benefit, and only to the extent permitted by applicable limits on their state scope of practice. CMS believes other nonphysician practitioners (such as registered dietitians, nutrition professionals or clinical social workers) or limited-license practitioners, (such as optometrists, podiatrists, doctors of dental surgery or dental medicine), would be limited by the scope of their state licensing or their statutory Medicare benefit such that they would not be able to furnish chronic care management services. CMS then states there is no Medicare benefit category that allows payment under the MPFS to some of the other health professionals (such as pharmacists and care coordinators).

Patients will be required to provide advanced consent to the practice for the CCM code to be used, and this consent must be reaffirmed at least every 12 months. Patients can revoke consent at any time. If the revocation occurs during a current CCM code's 30-day period, the revocation is not effective until the end of that period.

Instead of requiring an Annual Wellness Visit (AWV) or Initial Preventive Physical Examination (IPPE) before a practitioner can bill separately for CCM services, CMS recommends that practitioners furnish an AWV or IPPE to a beneficiary prior to billing for CCM services.

For purposes of the PCIP, CMS finalized their proposal such that the allowed charges for CCM 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. The AAFP will continue working with CMS and other payers to properly structure and value CCM services and will provide members with further guidance prior to the service becoming payable in 2015.

Ultrasound Screening for Abdominal Aortic Aneurysms

Background

Medicare covers ultrasound screening for abdominal aortic aneurysms (AAA) 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 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.”

2014 Proposed Changes

CMS argues this time limitation for the IPPE effectively reduces a Medicare beneficiary’s ability to obtain a referral for AAA screening. The USPSTF recommendation does not include a time limit with respect to the referral for this test, so CMS proposed 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.

AAFP recommendations

The AAFP supported removing the IPPE as a prerequisite for abdominal aortic aneurysm (AAA) screenings to conform to the recommendation by the USPSTF.

Final policy

CMS finalized their proposal to allow coverage of AAA screenings for eligible beneficiaries without requiring 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.

2014 Proposed Changes

CMS proposed 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 believed this proposed modification would allow for expanded coverage and access to screening FOBT, particularly in rural areas, and the agency invited public comment on this proposal and whether a practitioner permitted to order a screening FOBT must be the beneficiary’s attending practitioner.

AAFP recommendations

The AAFP supported expanded coverage and access to colorectal cancer screening by allowing non-physician practitioners to order the screening fecal occult blood tests so long as they function under the direction and responsible supervision of a practicing and licensed physician.

Final policy

CMS finalized their proposal to allow an attending physician, physician assistant, nurse practitioner, or clinical nurse specialist to furnish written orders for screening FOBT.

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.

2014 Proposed Changes

CMS discussed expansion of the Physician Compare website over the next several years by incorporating quality measures from a variety of sources. For 2014, CMS proposed 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 proposed 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 proposed 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 stated they were providing beneficiaries with a consistent set of measures over time.

For data reported for 2014, CMS proposed 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 requested comments on posting performance on patient experience survey-based measures for individual eligible professionals starting with data collected for 2015.

AAFP recommendations

The AAFP commended the agency for the improvements made to the Physician Compare website and also urged CMS to extend the physician preview period and to translate physician quality scores into consumer friendly terms.

Final policy

For 2014, CMS finalized their proposal to publicly report all measures collected through the GPRO web interface for groups of all sizes participating in the 2014 PQRS GPRO and for ACOs participating in the Medicare Shared Savings Program. These data include measure performance rates for measures included in the 2014 PQRS GPRO web interface that meet the minimum sample size of 20 patients, and that prove to be statistically valid and reliable. CMS will provide 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 finalized their proposal to publicly report certain measures that groups report via registries and EHRs in 2014 under the PQRS GPRO.

Also for 2014, CMS finalized their proposal to continue to publicly report 2014 CG-CAHPS data on Physician Compare in 2015 for group practices with 100 or more eligible professionals participating in PQRS GPRO through the GPRO web interface. CMS also finalized their proposal to publicly report 2014 CG-CAHPS data on Physician Compare in 2015 for ACOs reporting through the GPRO web interface or other CMS-approved tool or interface.

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 do 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 provider's performance two years before (e.g. application of the penalty in 2017 depends on performance in 2015).

2014 Proposed Changes

For 2014, CMS proposed to add 47 new individual measures and three 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 proposed to establish certain requirements for the 2014 PQRS incentive, which is the final year for positive incentive payments under the PQRS. CMS proposed to:

- Increase the number of measures that must be reported via the claims and registry-based reporting mechanisms from three to nine;
- 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 proposed 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 proposed 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 proposed that eligible professionals using clinical data registries would meet the criteria for satisfactory participation by reporting on at least nine measures to the registry covering at least three of the National Quality Strategy (NQS) 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 proposed 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 three to nine for groups reporting individual measures via registry and proposing a 50 percent threshold instead of an 80 percent threshold.

CMS also proposed 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).

AAFP recommendations

The AAFP appreciated efforts to align the PQRS with other quality improvement programs but questioned the proposal to increase the number of reported PQRS measures from three to nine. The AAFP expressed concern that the burden of reporting multiple quality measures too often falls disproportionately on primary care physicians. Many sub-specialists, for whom fewer than nine measures will apply, will not be subject to the same reporting burdens as primary care physicians, who consistently have more reportable measures. Although the reporting burdens are unequal between primary care physicians and sub-specialists, the incentive payments and penalties remain the same. The AAFP strongly objected to this arrangement.

Final policy

In the final rule, CMS established certain requirements for the 2014 PQRS incentive, which is the final year that incentive payments may be earned under the PQRS. In lieu of satisfactory reporting, beginning in 2014, eligible professionals may satisfy the PQRS by satisfactorily participating in a qualified clinical data registry. Beginning in 2015, a downward payment adjustment will apply to eligible professionals who do not satisfactorily report data on quality measures for covered professional services in 2013.

For 2014, CMS added 57 new individual measures and 2 measures groups to fill existing measure gaps and plans to retire a number of claims-based measures to encourage reporting via registry and EHR-based reporting mechanisms. Therefore, the PQRS will contain a total of 287 measures and 25 measures groups in 2014.

CMS finalized certain changes and additions including the following:

- For certain reporting criteria, increasing the number of measures from three to nine that must be reported via the claims and registry-based reporting mechanisms.
- For certain satisfactory reporting criteria, changing the percent reporting threshold for reporting individual measures via registry to require that eligible professionals report on 50 percent of the eligible professional's applicable patients rather than 80 percent.
- Eliminating the reporting option to report claims-based measures groups

As a result of the changes CMS made, in some cases, if an eligible professional meets the criteria for satisfactory reporting for purposes of the 2014 PQRS incentive, the eligible professional will also satisfy the reporting for the 2016 PQRS payment adjustment (in other words, by satisfying the same reporting criterion that applies to both the 2014 PQRS incentive and 2016 PQRS payment adjustment, eligible professionals will earn a 2014 PQRS incentive and avoid the downward payment adjustment that is applied in 2016).

CMS retained with some modifications the criterion established in the 2013 MPFS final rule that an eligible professional using the claims and registry-based reporting mechanism may report three measures on 50 percent of the eligible professional's applicable patients for the 2016 PQRS payment adjustment.

For the 2014 PQRS incentive, eligible professionals participating in qualified clinical data registries may meet the criteria for satisfactory participation by reporting to the qualified clinical data registry at least nine measures covering at least three of the NQS 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 the 2016 PQRS payment adjustment, eligible professionals participating in qualified clinical data registries need only report three measures covering 1 NQS domain for at least 50 percent of the EP's applicable patients.

CMS finalized changes to certain criteria for satisfactory reporting, as well as adopting new criteria, for group practices for purposes of the 2014 PQRS incentive and 2016 PQRS payment adjustment. These include:

- Adopting a new reporting mechanism, the certified survey vendor reporting mechanism, under which a group comprised of 25 or more eligible professionals reports CG CAHPS survey measures in conjunction with other PQRS reporting mechanisms.
- Aligning the reporting criteria for group practices reporting individual measures via registry with the individual eligible professionals reporting criteria 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.

2014 Proposed Changes

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

CMS proposed 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 proposed 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 nine CQMs covering three domains. CMS proposed 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 CQMs 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 proposed that eligible professionals who seek to report CQMs electronically under the Medicare EHR Incentive Program must use the most recent version of the electronic specifications for the CQMs and have certified EHR technology that is tested and certified to the most recent version of the electronic specifications for the CQMs. Eligible professionals who do not wish to report CQMs 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.

AAFP recommendations

The AAFP continued to support efforts to align quality reporting programs and innovation initiatives yet also expressed increasing concerns with Meaningful Use Stage 2 expectations.

Final policy

CMS established an option for eligible professionals to submit CQM information using qualified clinical data registries (as defined for PQRS) for purposes of meeting the CQM reporting component of Meaningful Use for the Medicare EHR Incentive Program beginning in 2014. Among other requirements for this reporting option, 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.

In a continuing effort to align quality reporting programs and innovation initiatives, CMS added a group reporting option to the Medicare EHR Incentive Program beginning in 2014 for eligible professionals who are part of a Comprehensive Primary Care (CPC) initiative practice site that successfully submit at least nine CQMs covering three domains. CMS finalized that each of the eligible professionals in the CPC initiative practice site will satisfy the CQM reporting component of meaningful use if the practice site successfully submits and meets the reporting requirements of the CPC initiative.

CMS finalized policy that eligible professionals who seek to report CQMs electronically under the Medicare EHR Incentive Program must use the most recent version of the electronic specifications for the CQMs and have certified EHR technology (CEHRT) that is tested and certified to the most recent version of the electronic specifications for the CQMs. The electronic specifications for the CQMs that were finalized under the Medicare EHR Incentive Program for use by eligible professionals beginning in 2014 are updated annually to account for changes in billing and diagnosis codes.

CMS states that eligible professionals who do not wish to report CQMs electronically using the most recent version of the electronic specifications (for example, if their CEHRT 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).

2014 Proposed Changes

CMS proposed changes to the Medicare Shared Savings Program to further align with the PQRS reporting requirements. CMS stated 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 proposed 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 then proposed to include data submitted by the Shared Savings Program and Pioneer ACOs to set the benchmark for the 2014 performance period. In addition, CMS proposed 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 proposed to increase the scoring for the CG-CAHPS survey measure modules within the patient experience of care domain, so the CAHPS survey measure modules carry greater weight within that domain.

AAFP recommendations

The AAFP supported efforts to harmonize the Medicare Shared Savings Program with PQRS reporting requirements.

Final policy

CMS continues to align the Medicare Shared Savings Program with the PQRS. ACOs will report the ACO GPRO measures through a CMS web interface on behalf of eligible professionals and must meet the criteria for the 2014 PQRS incentive to avoid the 2016 PQRS payment adjustment. CMS finalized their proposals to use fee-for-service data, including data submitted by Shared Savings Program and Pioneer ACOs, to set the performance benchmarks for the 2014 and subsequent reporting periods. CMS did not finalize the proposal to use Medicare Advantage data alone or in combination with fee-for-service data in the short-term to set ACO performance benchmarks. Additionally, CMS will set benchmarks based on flat percentages when the 60th percentile is equal to or greater than 80.0 percent. Finally, CMS finalized their proposal to increase the scoring for the CG CAHPS survey measure modules within the patient experience of care domain that transition to pay-for-performance in the second year of an ACO's agreement period, so these CAHPS survey measure modules will carry greater weight within the patient experience of care domain. Although the weight of some measure modules within the domain will increase, the domain itself will continue to represent 25 percent of the total quality performance score.

Value-Based Payment Modifier and Physician Feedback Program

Background

The *Affordable Care Act* calls for CMS to establish a value-based 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-based 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-based 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-based modifier to be applied in 2015 and proposed to use 2014 as the performance period for the value-based modifier to be applied in 2016. The final 2013 MPFS applies the value-based 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.

2014 Proposed Changes

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

- 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 stated 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 proposed 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.
- 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 stated the belief 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 proposed 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 three 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 did 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 stated the belief 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.

AAFP recommendations

The AAFP found CMS proposals to implement the value-based payment modifier as reasonable and appreciated the fact that CMS did not initially subject groups of 10-99 eligible professionals to the penalties in Category 1.

Final policy

CMS finalized their proposal to lower the group size threshold from groups of physicians with 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 change in policy would cause approximately 17,000 groups and nearly 60 percent of physicians to be included in the value-based payment modifier program in 2016.

CMS finalized the proposed two-category approach for establishing the 2016 value-based payment modifier based on whether a group of physicians meets the criteria to avoid the PQR payment adjustment in 2016. Category 1 includes those groups of physicians with 10 or more eligible professionals that meet the satisfactory reporting criteria through the PQR GPRO for the 2016 PQR payment adjustment.

CMS proposed that if a group of physicians subject to the 2016 value-based payment modifier does not participate in the PQR GPRO, to be included in Category 1, at least 70 percent of the eligible professionals billing under the group's Tax Identification Number (TIN) must meet the criteria for satisfactory reporting (or the criteria for satisfactory participation, if reporting to a PQR qualified clinical data registry) for the 2016 PQR payment adjustment. However, CMS finalized that at least 50 percent

of the eligible professionals billing under the group's TIN must meet the criteria for satisfactory reporting (or satisfactory participation) for the 2016 PQRS payment adjustment in order to be included in Category 1. This policy 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 the criteria for inclusion in Category 1 will be in Category 2 and be subject to an automatic downward payment adjustment under the value-based payment modifier.

In addition, for the 2016 value-based payment modifier, CMS finalized the proposal to make quality-tiering (which is the method for evaluating performance on quality and cost measures for the value-based payment modifier) mandatory for groups of physicians with 10 or more eligible professionals. CMS also finalized their proposal that groups of physicians with between 10 and 99 eligible professionals would 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 either receive upward, neutral, or downward adjustments under the quality-tiering methodology. CMS believes this new approach to implementing quality-tiering will 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.

CMS decided to use for the 2016 value-based payment modifier 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. In addition, CMS finalized their proposal 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.

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

In the final rule, CMS also included 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 three 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 finalized its proposal not to convert the MSPB amount to a ratio as is done to compute a hospital's MSPB measure, but rather use the MSPB amount as the measure's performance rate.

CMS proposed 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. Instead, CMS finalized a single attribution methodology where an MSPB episode is attributed to the group of physicians (as identified by the Taxpayer Identification Number) that furnished the plurality of Part B services during the index admission.

CMS finalized the proposal that a group of physicians would have to be attributed a minimum of 20 MSPB episodes during the performance period to have their performance on this measure included in the value-based payment modifier cost composite.

In the final 2013 MPFS rule, CMS established policy to create a cost composite for each group of physicians subject to the value-based payment modifier. CMS discussed their examination of the distribution of the cost composite scores among all groups of physicians and solo practitioners to determine whether comparisons at the group level are appropriate once CMS applies the value-based payment modifier to smaller groups and solo practitioners. CMS found that their current peer grouping methodology could have varied impacts on different physician specialties. Thus, CMS proposed to refine their current peer group methodology to account for physician specialty mix. In the final 2014 MPFS rule, CMS finalized that policy proposal.

CMS affirmed the importance of notifying physicians and groups of physicians of 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 finalized their proposal to use 2015 as the performance period for the application of the 2017 value-based payment modifier. CMS encourages all physicians in groups of less than 10 eligible professionals and solo practitioners to use 2014 as a “practice” year with the PQRS quality reporting mechanism of their choice, so they are ready for the value-based payment modifier performance period in 2015.

Since 2010, CMS has provided annual Quality and Resource Use Reports (QRURs) to physicians and groups of physicians to provide feedback on the quality of care furnished, and the cost of that care, to Medicare beneficiaries. In the final 2014 MPFS, CMS discusses that they will continue to use the annual QRURs to explain how the value-based payment modifier would affect payment under the MPFS. In September 2013, CMS made QRURs available to all groups of 25 or more eligible professionals nationwide, based on 2012 data. In 2014, CMS anticipates providing QRURs to all groups of eligible professionals and solo practitioners nationwide.

TABLE 44: Calculation of the CY 2014 PFS CF

Conversion Factor in effect in CY 2013		\$34.0230
CY 2013 Conversion Factor had statutory increases not applied		\$25.0070
CY 2014 Medicare Economic Index	0.8 percent (1.008)	
CY 2014 Update Adjustment Factor	3.0 percent (1.03)	
CY 2014 RVU Budget Neutrality Adjustment	0.046 percent (1.00046)	
CY 2014 Rescaling to Match MEI Weights Budget Neutrality Adjustment	4.718 percent (1.04718)	
CY 2014 Conversion Factor		\$27.2006
Percent Change from Conversion Factor in effect in CY 2013 to CY 2014 Conversion Factor		-20.1%

We note payment for services under the PFS will be calculated as follows:

$$\text{Payment} = [(\text{Work RVU} \times \text{Work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})] \times \text{CF}.$$

TABLE 93: CY 2014 PFS Final Rule with Comment Period Estimated Impact Table: Impacts of Work, Practice Expense, and Malpractice RVUs, and the MEI Adjustment*

(A) Specialty	(B) Allowed Charges (mil)	Impact of RVU Changes		(E) Impact of Adjusting the RVUs to Match the Revised MEI Weights	(F) Combined Impact
		(C) Impact of Work and MP RVU Changes	(D) Impact of PE RVU Changes		
TOTAL	\$87,552	0%	0%	0%	0%
01-ALLERGY/IMMUNOLOGY	\$214	0%	0%	-3%	-3%
02-ANESTHESIOLOGY	\$1,871	0%	0%	1%	1%
03-CARDIAC SURGERY	\$357	0%	0%	2%	2%
04-CARDIOLOGY	\$6,461	0%	2%	-1%	1%
05-COLON AND RECTAL SURGERY	\$159	0%	0%	0%	0%
06-CRITICAL CARE	\$276	0%	0%	2%	2%
07-DERMATOLOGY	\$3,123	-1%	1%	-2%	-2%
08-EMERGENCY MEDICINE	\$2,946	0%	0%	2%	2%
09-ENDOCRINOLOGY	\$449	0%	0%	0%	0%
10-FAMILY PRACTICE	\$6,402	0%	0%	0%	0%
11-GASTROENTEROLOGY	\$1,909	-1%	-1%	0%	-2%
12-GENERAL PRACTICE	\$536	0%	0%	0%	0%
13-GENERAL SURGERY	\$2,254	0%	0%	0%	0%
14-GERIATRICS	\$235	0%	0%	1%	1%
15-HAND SURGERY	\$151	0%	0%	-1%	-1%
16-HEMATOLOGY/ONCOLOGY	\$1,896	0%	0%	-2%	-2%
17-INFECTIOUS DISEASE	\$639	0%	0%	2%	2%
18-INTERNAL MEDICINE	\$11,503	0%	0%	1%	1%
19-INTERVENTIONAL PAIN MGMT	\$644	-1%	-2%	-1%	-4%
20-INTERVENTIONAL RADIOLOGY	\$221	-1%	0%	-1%	-2%
21-MULTISPECIALTY CLINIC/OTHER PHY	\$80	0%	-1%	1%	0%
22-NEPHROLOGY	\$2,134	0%	0%	1%	1%
23-NEUROLOGY	\$1,509	0%	-1%	0%	-1%
24-NEUROSURGERY	\$718	0%	0%	0%	0%
25-NUCLEAR MEDICINE	\$51	0%	0%	0%	0%
27-OBSTETRICS/GYNECOLOGY	\$693	0%	2%	-1%	1%
28-OPHTHALMOLOGY	\$5,609	0%	0%	0%	0%
29-ORTHOPEDIC SURGERY	\$3,702	-1%	-1%	0%	-2%

(A) Specialty	(B) Allowed Charges (mil)	Impact of RVU Changes		(E) Impact of Adjusting the RVUs to Match the Revised MEI Weights	(F) Combined Impact
		(C) Impact of Work and MP RVU Changes	(D) Impact of PE RVU Changes		
30-OTOLARNGOLOGY	\$1,133	0%	-1%	-1%	-2%
31-PATHOLOGY	\$1,141	-4%	-2%	0%	-6%
32-PEDIATRICS	\$64	0%	0%	0%	0%
33-PHYSICAL MEDICINE	\$1,007	0%	-1%	0%	-1%
34-PLASTIC SURGERY	\$372	0%	0%	0%	0%
35-PSYCHIATRY	\$1,181	4%	1%	1%	6%
36-PULMONARY DISEASE	\$1,783	0%	0%	1%	1%
37-RADIATION ONCOLOGY	\$1,788	0%	3%	-2%	1%
38-RADIOLOGY	\$4,655	0%	-2%	0%	-2%
39-RHEUMATOLOGY	\$553	0%	-2%	-2%	-4%
40-THORACIC SURGERY	\$335	0%	0%	1%	1%
41-UROLOGY	\$1,864	0%	-1%	0%	-1%
42-VASCULAR SURGERY	\$931	0%	-1%	-1%	-2%
43-AUDIOLOGIST	\$57	0%	1%	-1%	0%
44-CHIROPRACTOR	\$729	5%	6%	1%	12%
45-CLINICAL PSYCHOLOGIST	\$587	6%	-1%	3%	8%
46-CLINICAL SOCIAL WORKER	\$414	6%	-2%	4%	8%
47-DIAGNOSTIC TESTING FACILITY	\$790	0%	-6%	-5%	-11%
48-INDEPENDENT LABORATORY	\$818	-2%	0%	-3%	-5%
49-NURSE ANES / ANES ASST	\$1,061	0%	0%	3%	3%
50-NURSE PRACTITIONER	\$1,954	0%	0%	1%	1%
51-OPTOMETRY	\$1,116	0%	0%	-1%	-1%
52-ORAL/MAXILLOFACIAL SURGERY	\$45	0%	1%	-2%	-1%
53-PHYSICAL/OCCUPATIONAL THERAPY	\$2,818	0%	1%	-1%	0%
54-PHYSICIAN ASSISTANT	\$1,414	0%	0%	0%	0%
55-PODIATRY	\$1,998	0%	0%	-1%	-1%
56-PORTABLE X-RAY SUPPLIER	\$113	0%	2%	-4%	-2%
57-RADIATION THERAPY CENTERS	\$63	0%	5%	-6%	-1%
98-OTHER	\$25	0%	0%	1%	1%