

### **PAYMENTS TO FAMILY PHYSICIANS INCREASE IN 2013**

#### **PHYSICIAN FEE RULE PART OF NEW DRIVE TO REWARD SAVINGS, FOSTER COLLABORATION**

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2012 for Medicare's payments for physician fees for 2013. It includes a new policy to pay a patient's physician or practitioner to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility stay. Recognizing the work of community physicians and practitioners in treating a patient following discharge from a hospital or nursing facility will ensure better continuity of care for these patients and help reduce patient readmissions. The changes in care coordination payment and other changes in the rule are expected to increase payment to family practitioners by seven percent—and other primary care practitioners between three and five percent—if Congress averts the statutorily required reduction in Medicare's physician fee schedule.

The final rule with comment period also includes a statutorily required 26.5 percent across-the-board reduction to Medicare payment rates for more than 1 million physicians and non-physician practitioners under the Balanced Budget Act of 1997's Sustainable Growth Rate (SGR) methodology. However, Congress has overridden the required reduction every year since 2003. The Administration is committed to fixing the SGR update methodology and ensuring these payment cuts do not take effect. Predictable, fiscally-responsible physician payments are essential for Medicare to sustain quality and lower health care costs over the long-term.

In addition, the final rule with comment period continues the careful implementation of the physician value-based payment modifier by phasing in application of the modifier and enabling physicians in larger groups to choose how to participate. The value modifier provides differential Medicare payments to physicians based on comparison of the quality of care furnished to beneficiaries and the cost of care. The statute allows CMS to phase in the value modifier over three years from 2015 to 2017. For the 2015, the final rule applies the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above. This change was adopted to gain experience with the methodology and approach before expanding to smaller groups.

The final rule also provides an option for these groups of physicians to choose how the value modifier is calculated based on whether they participate in the Physician Quality Reporting System (PQRS).

For physicians and groups of physicians who elect to participate in 2015, common sense incentives will improve the care that beneficiaries receive; physicians with higher quality and lower costs will be paid more, and those with lower quality and higher costs will be paid less. The performance period for the application of the value modifier in CY 2015 was previously established as CY 2013 in the CY 2012 MPFS final rule.

The final rule continues efforts by CMS to align quality reporting across programs to reduce burden and complexity. The rule makes changes to the PQRS and the Electronic Prescribing (eRx) Incentive Program, the two quality reporting programs

applicable to the MPFS, and updates the Medicare Electronic Health Records (EHR) Incentive Pilot Program. These changes will simplify reporting and align the various programs' quality reporting approaches so they support the National Quality Strategy.

The final rule also lays out next steps to enhance the Physician Compare website, including posting names of practitioners who, as part of the Million Hearts campaign, successfully report measures to prevent heart disease. These are recommended measures under PQRS as well.

Among other changes, the final rule also expands access to services that can be provided by non-physicians practitioners. The rule allows Certified Registered Nurse Anesthetists (CRNAs) to be paid by Medicare for providing all services that they are permitted to furnish under state law. This change will allow Medicare to pay CRNAs for services to the full extent of their state scope of practice. The rule also allows Medicare to pay for portable x-rays ordered by nurse practitioners, physician assistants and other non-physician practitioners.