

Proposed Policy and Payment Changes to the Medicare Physician Fee Schedule for Calendar Year 2014

OVERVIEW

On July 8, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after Jan. 1, 2014. Currently, Medicare only pays for primary care management services as part of a face-to-face visit. In the proposed rule, in order to support primary care, **CMS proposes to make a separate payment to physicians for managing select Medicare patients' care needs beginning in 2015.** The proposed rule also proposes changes to several of the quality reporting initiatives that are associated with PFS payments – the Physician Quality Reporting System (PQRS), the Medicare Electronic Health Record (EHR) Incentive program, as well as changes to the Physician Compare tool on the Medicare.gov website. Finally, the rule continues the phased-in implementation of the physician value-based payment modifier (Value Modifier), created by the Affordable Care Act, that would affect payments to physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare fee-for-service program.

This fact sheet discusses the proposed changes to payment policies and payment rates for services furnished under the PFS. A separate fact sheet, also issued today, discusses the proposed changes to the quality reporting programs, the Medicare EHR Incentive program, and the proposals for implementing the Value Modifier.

BACKGROUND

Since 1992, Medicare has paid for the services of physicians, nonphysician practitioners (NPPs), and certain other suppliers under the PFS, a system that pays for covered physicians' services furnished to a person with Medicare Part B. Under the PFS, relative values are assigned to each of more than 7,000 services to reflect the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing that service. Each of these three relative value components is multiplied by a geographic adjustment factor to adjust the payment for variations in the costs of furnishing services in different localities. The resulting RVUs are summed for each service and then are multiplied by a fixed-dollar conversion factor to establish the payment amount for each service. The higher the number of relative value units (RVUs) assigned to a service, the higher the payment.

Sustainable Growth Rate (SGR): The proposed rule does not include any provisions on the physician fee schedule update or SGR as these calculations are determined under a prescriptive statutory formula that cannot be changed by CMS. The final figures are announced in the final rule in November. **In March, CMS estimated the physician fee schedule update would be -24.4 percent.** In prior years, Congress has taken action to avert a large reduction in physician fee schedule rates before they went into effect. The Administration supports legislation to permanently address the flaws in the SGR that would provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care. The percent change to the

physician fee schedule conversion factor may be different than the update because of various required budget neutrality adjustments described in the rule.

PROVISIONS INCLUDED IN THE CY 2014 PFS PROPOSED RULE

Primary Care and Complex Chronic Care Management: Medicare continues to emphasize primary care management services with a proposal for separate payment for complex chronic care management services beginning in 2015. In last year's final rule, we established separate payment for transitional care management services for a beneficiary making the transition from a facility stay back to the community. We also solicited comment on establishing separate payment for advanced primary care—ongoing care management and continuous assessment that occurs outside of a face-to-face visit with a patient.

In this proposed rule, we emphasize advanced primary care through our **proposal to pay separately for complex chronic care management services, beginning in CY 2015**. Specifically, we propose to pay for non-face-to-face complex chronic care management services for Medicare beneficiaries who have multiple, significant chronic conditions (two or more). Complex chronic care management services include regular physician development and revision of a plan of care, communication with other treating health professionals, and medication management. Medicare will make separate payment to physicians through two G-codes for establishing of a plan of care and furnishing care management over 90-day periods. To be eligible for these services, we propose that beneficiaries also must have had an Annual Wellness Visit (or an Initial Preventive Physical Examination (IPPE), if applicable) -- as the Annual Wellness Visit can serve as an important foundation for establishing a plan of care. We also propose that a single practitioner furnish these services and that they must have the beneficiary's consent to receiving these services over a one-year period.

The proposed rule indicates that CMS intends to establish practice standards necessary to support payment for furnishing complex care coordination management services. Potential standards include access at the time of service to Electronic Health Records (EHR) that meet the HHS certification criteria and written protocols for many aspects of care management implementation, such as specific steps for monitoring medical and functional patient needs. The rule solicits comment on the potential for CMS to recognize a patient-centered medical home (PCMH) designation by private organizations as one means for a practice to demonstrate that it has met the requisite practice standards. We plan to address policy regarding the practice standards, including PCMH recognition, through separate notice-and-comment rulemaking.

Telehealth Services: We are proposing to modify our regulations describing 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. We believe this change will more appropriately identify sites within urban HPSAs that have rural characteristics and improve access to telehealth services in shortage areas. In addition, we are proposing to add transitional care management services to the list of eligible Medicare telehealth services.

Revisions To The Practice Expense Geographic Adjustment: As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice cost components of each of more than 7,000 physicians' services. Also, the law requires that we assess the GPCIs every three years and adjust them as appropriate with a two-year phase-in of the new GPCIs. **We are proposing new GPCIs using updated data. In addition, we are changing the weights assigned to each GPCI (work, PE and malpractice) consistent with the recommendations of the Medicare Economic Index (MEI) Technical Advisor Panel (see below) that increases the weight of work and reduces the weight of practice expense. These new GPCIs would be phased in over CY 2014 and CY 2015.** These changes are budget neutral. The statutory work GPCI "floor" of 1.0 is scheduled to expire under current law on December 31, 2013. The proposed GPCIs reflect the elimination of the work "floor" and as a result 51 localities will have a work GPCI below 1.

Medicare Economic Index: **CMS is proposing revisions to the calculation of the MEI, which is the price index used to update physician payments for inflation.** The changes are in response to recommendations by a Technical Advisory Panel that met during CY 2012. Application of the MEI along with sustainable growth rate determines the total amount of payment made each year under the physician fee schedule. The proposed rule includes proposed changes in the RVU and GPCI weights assigned to work and practice expense so that the weights in the payment calculation would continue to mirror those in the MEI if the proposed revisions are adopted. **As a result, the proposal is to re-distribute some payment to work from practice expense.**

Misvalued Codes: Consistent with amendments to the Affordable Care Act, CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and make adjustments where appropriate. **In the proposed rule, CMS is proposing to adjust payment rates for more than 200 codes where Medicare pays more for services furnished in an office than in an outpatient hospital department or ASC.** We generally expect the resource costs required to furnish a service to be higher in a hospital or ASC, which have to meet conditions of participation and conditions for coverage, respectively. Hospitals also must have stand-by capacity. **We are proposing to limit the PFS payment in the situation described above to the total payment that Medicare would make to the practitioner and the facility when the service is furnished in a hospital outpatient department or ASC.** In addition, for CY 2014, we are proposing potentially misvalued codes that we identified with the assistance of the Contractor Medical Directors based on their personal experience in paying for Medicare services.

Application of Therapy Caps to Critical Access Hospitals: The law applies two per beneficiary limits to outpatient therapy services—one for physical therapy and speech-language pathology services and another for occupational therapy services. Before the American Taxpayers Relief Act passed earlier this year, the caps did not previously apply in Critical Access Hospitals (CAH). We propose to apply the therapy cap limitations and related policies to outpatient therapy services furnished in a CAH beginning on January 1, 2014 to conform Medicare's regulations to current law.

The proposed rule will appear in the July 19, 2013, Federal Register. **CMS will accept comments on the proposed rule until Sept. 6, 2013**, and will respond to them in a final rule with comment period to be issued on or about Nov. 1, 2013.

For more information, see: www.federalregister.gov/inspection.aspx#special

#