



FACT SHEET

FOR IMMEDIATE RELEASE
November 27, 2013

Contact: CMS Media Relations
(202) 690-6145

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

OVERVIEW

On November 27, 2013, the Centers for Medicare & Medicaid Services (CMS) finalized updates to payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2014. In recognizing the importance of care that occurs outside of a face-to-face visit, CMS finalized policies that will allow us to make a separate payment to physicians for managing select Medicare patients' care needs beginning in calendar year (CY) 2015. The rule also finalizes changes to several of the quality reporting initiatives that are associated with PFS payments – the Physician Quality Reporting System (PQRS), as well as changes to the Physician Compare tool on the Medicare.gov website. Furthermore, the rule continues the phased-in implementation of the physician value-based payment modifier (Value Modifier), created by the Affordable Care Act, that will affect payments to certain physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare fee-for-service program. Finally, the rule addresses changes to a handful of other programs which are listed in the Table of Contents within the rule.

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

BACKGROUND

Since 1992, Medicare has paid for the services of physicians, non-physician 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 practice cost index to adjust the payment for variations in the costs of furnishing services in different

localities. The resulting relative value units (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 RVUs assigned to a service, the higher the payment.

Sustainable Growth Rate (SGR) and MPFS conversion factor for CY 2014: Under current law, physicians and non-physician practitioners (NPP) will face steep across-the-board reductions in payment rates, based on a formula—the Sustainable Growth Rate (SGR) methodology—which was adopted in the Balanced Budget Act of 1997. Without a change in the law, the conversion factor will be reduced by 20.1 percent for services in 2014. The President’s budget calls for averting these cuts and finding a permanent solution to this problem. The CY 2014 conversion factor is \$27.2006, which reflects a smaller reduction in the conversion factor than the 24.4 percent reduction that we projected in March 2013. The smaller reduction is due in part to a 4.72 percent adjustment to the conversion factor to offset the decrease in Medicare physician payments that would otherwise have occurred due to the CY 2014 rescaling of the RVUs so that the proportions of total payments for the work, PE, and malpractice RVUs match the proportions in the final revised Medicare Economic Index (MEI) for CY 2014. This issue is discussed further below. The overall 2014 reduction in physician fee schedule payments required under the SGR methodology is unchanged by this rescaling.

PROVISIONS INCLUDED IN THE CY 2014 PFS FINAL RULE

Primary Care and Chronic Care Management: As part of our ongoing efforts to appropriately value primary care services, Medicare will begin making a separate payment for 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 to the community setting. In this final rule, we further emphasize our support for advanced primary care through our establishment of policies to facilitate separate payment for non-face-to-face chronic care management services for Medicare beneficiaries who have multiple (two or more), significant chronic conditions. This reinforces Department of Health and Human Services (HHS) efforts to support care management through payment reform and incentives and is consistent with HHS’ Strategic Framework on Multiple Chronic Conditions. Chronic care management services 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 over 30-day periods.

The rule indicates that CMS intends to establish practice standards necessary to support payment for furnishing care management services through future notice-and-comment rulemaking.

Telehealth Services: We are modifying our regulations describing 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. We believe this change will more appropriately allow sites located within HPSAs in MSAs that have rural characteristics to qualify as originating sites and improve access to telehealth services in

shortage areas. We are also establishing a policy to determine geographic eligibility for an originating site on an annual basis, consistent with other telehealth payment policies. This change will avoid mid-year changes to geographic designations (sometimes without advance notice to Medicare beneficiaries and providers) that could result in unexpected disruptions to established telehealth originating sites and avoid the need to make mid-year Medicare telehealth payment policy changes. In addition, we are updating the list of eligible Medicare telehealth services to include transitional care management services.

Revisions To The Practice Expense Geographic Adjustment: As required by the Medicare law, CMS adjusts payments under the PFS to reflect the local cost of operating a medical practice as compared to the national average. CMS calculates separate geographic practice cost indices (GPCIs) to adjust the work, practice expenses (PE), and malpractice cost components of each payment. The law requires that we review the GPCIs every three years and adjust them as appropriate with a two-year phase-in of the new GPCIs. We are finalizing new GPCIs using updated data. The updated GPCIs will be phased in over CY 2014 and CY 2015. Additionally, we will apply the statutorily mandated 1.5 work GPCI floor in Alaska and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming), which have no expiration date. There is separate statutory 1.0 work GPCI floor that is scheduled to expire under current law on December 31, 2013. Therefore, the finalized GPCIs reflect the expiration of the 1.0 work GPCI floor.

Medicare Economic Index: CMS is finalizing proposed 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 the SGR determines the conversion factor that is used to determine payments made each year under the PFS. The final rule includes changes in the PFS RVU and GPCI weights assigned to the work and practice expense categories so that the weights used in the PFS payment calculation will continue to mirror those in the MEI. As a result, some payment is being redistributed to work from practice expense. In addition, we are updating the GPCI cost share weights consistent with the revised 2006-based MEI cost share weights.

Misvalued Codes: Consistent with amendments made by 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. We are continuing to make strides as the values for around 200 codes were finalized and approximately 200 additional codes had their work relative value units changed on an interim basis for 2014. Included in these are services for hip and knee replacements, mental health services and GI endoscopy services. These rates are open for public comment until January 27, 2014.

CMS is not finalizing its proposal to adjust relative values under the PFS to effectively cap the physician practice expense payment for procedures furnished in a non-facility setting at the total payment rate for the service when furnished in an ambulatory surgical center or hospital outpatient setting. Instead, CMS will take additional time to consider issues raised by the public commenters and plans to address this issue in future rulemaking. In addition, for CY 2014, we are finalizing 18 codes that we identified and proposed as potentially misvalued services in consultation with Contractor Medical Directors.

Revisions to the Clinical Laboratory Fee Schedule (CLFS): Under current law, payments on the CLFS remain static and are not revised once a test code has been added to the CLFS and its payment rate has been established. At this point, the CLFS is approximately 30 years old with payment rates that are outdated and potentially excessive. This rule indicates that CMS intends to explore an existing statutory provision that allows updates to the CLFS based on changes in technology. As a result, for the first time, CMS will conduct regular reviews and updates to the payments on the CLFS in order to ensure greater payment accuracy.

Application of Therapy Caps to Critical Access Hospitals: The law applies annual limitations or “therapy caps” on per beneficiary incurred expenses for outpatient therapy services—one for physical therapy and speech-language pathology services combined and another for occupational therapy services. Before the American Taxpayers Relief Act of 2012 directed us to count CAH services towards the caps, the caps were not applied to therapy services furnished in Critical Access Hospitals (CAH). We are finalizing our proposal to apply the therapy caps and related policies to outpatient therapy services furnished by a CAH beginning on January 1, 2014 in order to properly apply the law that established the therapy caps.

Compliance with State Law for Incident To Services: We are requiring as a condition of Medicare payment that “incident to” services be furnished in compliance with applicable state law. This policy strengthens program integrity by allowing Medicare to deny or recoup payments when services are furnished not in compliance with state law. We 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, reducing the regulatory burden and making it less difficult for practitioners to determine what is required in order to bill Medicare for “incident to” services.

The final rule will appear in the December 10, 2013, Federal Register.

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

###