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Key Provisions of Physician Fee Schedule Proposed Rule for 2015

Background

The annual proposed rule to govern Medicare physician payment policy in 2015 was published in the Federal Register on July 11 by the Centers for Medicare & Medicaid Services (CMS). Comments are due on Tuesday, September 2, with a final rule to be issued on or around November 1 for implementation on January 1, 2015. The list below of key provisions is not exhaustive. The AMA will circulate draft comments to states and specialties prior to the comment deadline.

Sustainable Growth Rate

The proposed rule does not address the Sustainable Growth Rate (SGR) but a press release accompanying the rule reiterates CMS' support for legislation to permanently address the SGR. It notes that legislation passed earlier this year prevents any SGR physician pay cuts through March 2015, and CMS projects that payments would be reduced by 20.9 percent when the current temporary pay patch expires.

Chronic Care Management

CMS plans to reimburse chronic care management (CCM) services at $43.67 per patient per month in a physician's office and $32.58 in a facility, starting in 2015. The American Medical Association (AMA) has long supported CPT codes and RUC recommendations for Medicare reimbursement of these crucial services. As described in G codes developed by CMS, the services involve non-face-to-face care coordination for Medicare beneficiaries with two or more chronic conditions expected to last at least 12 months, or until death, which pose significant risk of death, decline in function, or acute exacerbation or decompensation. At least 20 minutes of services must be furnished per 30-day billing interval, usually by clinical staff. Responding to input from physician groups including the AMA, CMS plans to drop several planned restrictions on who can bill for these services. Physicians and other practitioners would be able to employ clinical staff either directly or under contract, and could provide general supervision at all times, not just after hours. Requirements such as 24-hour coverage, medication review, ongoing coordination, and a patient-centered care plan will continue, but CMS no longer plans to adopt broad practice standards to ensure the capability to provide CCM services. However, CMS is now proposing to require the use of certified electronic health record technology (CEHRT) which is certified to at least 2014 Edition certification criteria and includes an electronic care plan. AMA comments will point out that apart from general concerns with CEHRT standards, applying them to reimbursement for CCM services will likely harm the very beneficiaries who need these services the most.

Elimination of Global Surgical Packages

The proposed rule includes a lengthy discussion of a CMS proposal to radically change the way Medicare pays for surgical care by eliminating all 10- and 90-day global surgical packages by 2018. CMS underscores the difficulties in obtaining available data to verify the number, type and relative costs of postoperative visits included in global payments, thus generating agency concerns that postoperative care is overvalued or, at a minimum, no longer accurately reflects the postoperative care provided to the typical patient for each service. Moreover, CMS does not believe it is possible to either validate the current or accurately establish new global surgical packages for postoperative care, so it instead proposes

reducing all surgical packages to cover preoperative care and care on the day of surgery only. CMS states that it will seek stakeholder assistance in establishing accurate values for 0-day global surgical services, allowing it to eliminate 10-day global periods in 2017 and 90-day global periods in 2018. The AMA has longstanding policy protesting CMS efforts to lower surgical payments by redefining surgical global periods (see AMA Policy H-79.948 and D-385.993) and will be working with the RUC and affected specialties to respond to this CMS proposal.

RUC/CPT

CMS has proposed to adopt several RUC recommendations primarily related to direct practice expense costs, including a transition of film technology to digital technology and called for a review of 65 "potentially misvalued" services that are associated with high Medicare spending and have not been reviewed since 2009. In addition, the proposed rule lays out a new timeline and process for the publication and implementation of changes in physician codes and relative values.

Currently, changes for new, revised and misvalued codes are first announced in a final fee schedule rule around the beginning of November and implemented on January 1 of the following year. As part of the misvalued codes initiative, some codes have experienced significant payment cuts in recent years, raising concerns that implementation on an interim final basis precludes adequate public comment, particularly in cases where CMS imposes cuts that are larger than recommended by the RUC. In response to these concerns, the AMA and CMS discussed potential modifications in the timelines for CPT and RUC submissions to the agency and the AMA submitted a timeline to CMS that would have taken effect in 2017 and allowed changes in existing codes to be published in a proposed rule without disrupting reporting and adoption of codes for new technology.

In the proposed rule, CMS observes that "The RUC recommendations are an essential element that we consider when valuing codes. Likewise, we recognize the significant contribution that the CPT Editorial Panel makes to the success of the potentially misvalued code initiative through its consideration and adoption of coding changes. Although we have increased our scrutiny of the RUC recommendations in recent years and accepted fewer of the recommendations without making our own refinements, the CPT codes and the RUC recommendations continue to play a major role in our valuations. For many codes, the surveys conducted by specialty societies as part of the RUC process are the best data that we have regarding the time and intensity of work. The RUC determines the criteria and the methodology for those surveys. It also reviews the survey results. This process allows for development of survey data that are more reliable and comparable across specialties and services than would be possible without having the RUC at the center of the survey vetting process. In addition, the debate and discussion of the services at the RUC meetings in which CMS staff participate provides a good understanding of what the service entails and how it compares to other services in the family, and to services furnished by other specialties. The debate among the specialties is also an important part of this process. Although we increasingly consider data and information from many other sources, and we intend to expand the scope of those data and sources, the RUC recommendations remain a vital part of our valuation process."

The agency then proposes an alternative timeline that has major ramifications for the CPT and RUC process. Under CMS's proposed timeline, the new process would begin in 2016 rather than 2017 and there would be a January 15, 2015 deadline for the RUC Recommendations, meaning that no recommendations received after this date would be part of the payment schedule. This increases the CMS total review time, while leaving only the May 2014 CPT Panel meeting and the September 2014 RUC meeting relevant for the 2016 payment schedule. The agency acknowledges that this would create serious administrative problems and seeks comments on its feasibility.

The new process outlined in the Proposed Rule results in several harmful effects. First, it would mean that the only actions that would be a part of the 2016 payment schedule are those from the May 2014 CPT Panel Meeting and the September 2014 RUC meeting. There are a number of very important applications pending for the October 2014 Panel meeting, and presumably the February 2015 Panel meeting, that in the current process would be part of the 2016 payment schedule. This proposal would mean none of the codes and RVUs from the current cycle beyond those coming from the May 2014 Panel meeting would be a part of the 2016 fee schedule. CMS has proposed creating HCPCS G codes to cover these services until the 2017 payment schedule. Creation of G codes would compete with CPT codes and cause administrative hassles for physicians, required to maintain one coding system for Medicare, while another for other payors utilizing the most recent CPT.

Another harmful effect is the AMA's ability to process new technology in an efficient manner. In an era where the most public and political criticism of the AMA and CMS code processes is that they take far too much time, this proposal dramatically increases the time from code creation to inclusion in the fee schedule. Currently, it can take between 10 and 20 months for a code to go from approval by the CPT Panel to the payment schedule. The CMS proposal would increase this to 20 to 27 months.

Telehealth

Each year Medicare seeks input on the types of telehealth services stakeholders believe should be considered for reimbursement. Medicare has proposed further expansions beginning in 2016 around telehealth reimbursable services. Specifically, they have proposed paying for: psychotherapy services (CPT codes 90845-7 and 90846); prolonged services (CPT codes 99354-5); annual wellness visit (HCPCS G0438-9). If finalized, these services would still need to adhere to the existing Medicare criteria outlined for telehealth reimbursement which includes: service must be provided using an interactive telecommunications system; practitioner providing the service must meet telehealth requirements and the usual Medicare requirements; service must be provided to an eligible telehealth individual; and the person receiving the services must be in an eligible originating site. The law defines eligible services as consults, office visits, office psychiatry services, and additional services as specified by the Secretary. Effective January 1, Medicare made changes that added coverage for several telehealth benefits including broadening the definition of "originating sites" to include more rural locations.

Value-Based Payment Modifier

ACA required CMS to implement a budget neutral adjustment to some physicians' Medicare payments in 2015 and all physicians in 2017. Despite continued AMA protests, however, CMS has essentially pushed up the deadlines by two years by basing each year's payment adjustment on quality and cost data from two years earlier. Groups of 100 or more become eligible for Value-Based Payment Modifier (VBM) penalties or bonuses in 2015 based on 2013 cost and quality performance and groups of 25 to 100 will be eligible in 2016 based on 2014 performance. Continuing this timeframe, as well as ignoring AMA calls for a slower phase-in, **the proposed rule would double potential VBM penalties to 4%, subject ALL physicians to 2017 VBM adjustments based on performance in 2015, extend the modifier to ACOS and other alternative payment models, and include limited license practitioners as well as physicians.** The proposed rule also would maintain the current process where those who do not participate in a PQRS program are automatically subject to both a PQRS and a VBM penalty. Successful PQRS participants are then placed in a mandatory "tiering" competition where they could come out with a positive, negative or neutral adjustment. Tiering penalties would only be applied to practices that weren't previously subject to the VBM—i.e. those with fewer than 10 practitioners.

Quality and Resource Use Reports

To get an idea of how they are likely to score in the VBM competition, physicians should review the confidential feedback reports that were also required by law and are known as Quality and Resource Use

Reports (QRURs). Reports based on 2012 data became available to groups of 25 or more last fall and are still open for review. Starting in the fall of 2014, reports based on the prior year's data will be made available for all groups and solo physicians. In addition, reports for groups of 100 or more will contain information on the size of their 2015 VBM adjustments.

Clinical labs

CMS proposed to make substantive changes to the local coverage decision (LCD) process for clinical lab tests. In short, the current process would be dismantled and replaced with what they are calling a more "streamlined" process that: 1) shortens the public comment period for physicians and others to respond to changes in coverage from 45 days to 30 days; 2) makes Carrier Advisory Committee (CAC) meetings optional at the MAC's discretion with no requirement for open stakeholder meetings; 3) would require MACs to respond to all comments and publish a final LCD within 45 days with the LCD becoming effective immediately as opposed to allowing 45 days before it became effective. The new process would not apply to LCDs that are being revised for the purpose of liberalizing the coverage, being issued for a "compelling reason," making non-substantive changes, changing diagnosis coding that does not make policy more restrictive, or changes stemming from Administrative Law Judge rules. The AMA is deeply concerned that this proposal restricts stakeholder input, limits the quality of relevant clinical information, and based on the pilot program performance the proposal is modelled on restrict access to tests representing the standard of care. We are equally concerned that this process will be applied to other services, which will further restrict physician's ability to meaningfully impact coverage policies and limit access to CACs which has already been eroded over the past several years.

Physician Quality Reporting System

CMS proposes that Eligible Professionals (EPs) who do not satisfactorily report in Physician Quality Reporting System (PQRS) through one of the reporting mechanisms in 2015 will receive a -2% penalty to the fee schedule amount in 2017. CMS proposes to increase the requirements for satisfactory reporting in 2015 PQRS and avoiding the 2017 PQRS penalty. CMS, however, maintains all of the reporting options (claims, registry, qualified clinical data registry (QCDR), group practice reporting option and EHR submission via a direct EHR that is CEHRT or an EHR data submission vendor that is CEHRT) for 2015.

If an individual EP reports through *claims* or a *registry* they must report nine measures, covering three national quality strategy (NQS) domains, plus report on at least two measures in the newly proposed PQRS cross-cutting measure set.

For 2015, CMS proposes that for at least 50 percent of the EP's applicable patients, an EP must report at least nine measures under the QCDR covering at least three of the NQS domains. In an effort to move towards the reporting of outcomes measures, CMS proposes that an EP report on at least three outcomes measures. If three outcomes measures are not available, the EP must report on two outcomes measures and at least one of the following types of measures—resource use, patient experience of care, or efficiency/appropriate use.

In addition, in an effort to ease the reporting burden CMS proposes several reporting options (GPRO web-interface, registry and certified survey vendor) for group practices.

For 2015, CMS proposes to add 28 new individual measures and two measures groups to fill existing measure gaps. However, there are 73 measures which currently have no identified measure owner and CMS is proposing to eliminate those measures from PQRS. The proposed rule allows more time for AMA-convened Physician Consortium for Performance Improvement (PCPI) to identify owners for measures where PCPI is no longer the measure steward. If an identified owner is not determined prior to

the publication of the Final 2015 Physician Fee Schedule Rule, CMS will eliminate the measures from the program.

Critical Access Hospitals
Beginning in 2015, EPs in Critical Access Hospitals (CAHs) may participate in the PQRS using ALL reporting mechanisms available, including the claims-based reporting mechanism.

Informal Review
Currently CMS is proposing to reduce the period from 90 to 30 days that an EP has to request an informal review of the PQRS penalty.

Medicare Shared Savings Program
CMS proposes to revise the quality scoring strategy to recognize and award ACOs that make year-to-year improvements in quality performance scores on individual measures. The proposed changes also increase the number of measures calculated through claims and decrease the number of measures reported by the ACO through the GPRO Web Interface.

Physician Compare Website
CMS proposes to expand public reporting of group-level measures by making all 2015 PQRS GPRO web interface, registry, and EHR measures for group practices of 2 or more EPs and ACOs available for public reporting on Physician Compare in 2016. If it is technically feasible, CMS also proposes to expand measures for individual EPs by making all 2015 PQRS individual measures collected via registry, EHR, or claims available for public reporting on Physician Compare in late 2016.