

Medicare's Proposed CY 2015 Physician Fee Schedule

Background

On July 11, 2014, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* the [proposed CY 2015 Medicare Physician Fee Schedule](#). This document proposes reimbursement updates and policy changes applicable to Medicare physician services provided on or after January 1, 2015. CMS released three fact sheets related to this proposed rule, providing a [basic overview](#), information on [quality programs](#) and information regarding a [value based payment modifier](#). The discussion below covers items of specific interest to midwifery contained in the proposed rule. Comments are due on September 2, 2014.

On Overview of Medicare's Physician Payment Methodology

Medicare beneficiaries make up a very small part of any given midwife's patient population. However, Medicare's physician fee schedule is used as the basis for payment by most payers, including Medicaid programs. In addition, other payers will often mirror Medicare's coverage and reimbursement policies. For these reasons, midwives should familiarize themselves with the content of this annual regulation.

An excellent, precise [summary](#) of Medicare's physician payment methodology is available from the Medicare Payment Advisory Commission ([MedPAC](#)).

For each of the 7,000+ physician services covered by Medicare, "relative value units" (RVUs) are calculated for the "physician work," "practice expense" and "malpractice costs" involved in providing that service.

Physician work RVUs represent the relative amount of physician time, effort, skill and stress involved in a given service. Practice expense RVUs measure the cost of office space, supplies, equipment and administrative and clinical staff involved. Malpractice RVUs measure the cost of insurance premiums associated with the service.

As the term indicates, RVUs are meant to be "relative" to each other. For example, the physician work RVU for a mid-level office visit (CPT code 99213) is assigned a value of 0.97, while the physician work for a six vein coronary artery bypass graft (CPT code 33516) is assigned a physician work RVU of 49.76, meaning that it takes roughly 50 times as much work for the bypass graft as it does for the mid-level office visit.

Each of the RVUs is multiplied by a "Geographic Practice Cost Index" (GPCI) to adjust for regional variations in costs. The national average GPCI is set at 1.0. Higher cost areas have higher GPCIs and lower cost areas have lower GPCIs. For example, the

San Francisco Practice Expense GPCI is 1.388 while the West Virginia Practice Expense GPCI is 0.836, meaning that the practice expense portion of Medicare's payment would be just over 55 percent higher in San Francisco than in West Virginia.

For some time, Congress has imposed a floor for the physician work GPCI so that no area falls below the national average GPCI. This provision is currently set to expire after March 31, 2015.

There are 89 different Medicare physician fee schedule localities, each with its own set of GPCIs. Most fee schedule localities cover an entire state, though in some states there are multiple localities. It is important to know which locality your commercial payers are using to calculate their rates. The GPCIs for each fee schedule locality are [available](#) in Addendum E of the fee schedule.

Once all of the RVUs are multiplied by their respective GPCI, they are totaled and then multiplied by the Conversion Factor (CF). The CF is a dollar figure that is updated each year. For 2014, the CF was set at \$35.8228.

To put it in mathematical terms, Medicare's physician payments are calculate thus:

$$[(\text{Work RVU} * \text{Work GPCI}) + (\text{PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{CF} = \text{Payment}$$

Payment Update

Ordinarily, CMS updates the CF every year, based on a complicated formula established in law. A key aspect of this formula is the establishment of spending targets and a comparison between actual spending and the target. If actual spending exceeds the target, then the formula calls for cuts the next year to recoup the spending that exceeds the target. The formula has an aggregating function, so that if there are several years running when excess spending occurs, then the following year is supposed to recoup all of the excess by imposing significant cuts. Congress has consistently applied patches to this situation, without revising the underlying formula. Thus, when their patch expires, the law requires a reversion to the underlying formula which calls for greater cuts than the prior year because of its aggregating function. That just makes the problem worse than it was and gives Congress even more motivation to stave off the cut.

CMS previously estimated that in CY 2015, the formula would result in a reduction in the CF of 20.9 percent. However, Congress' last action on physician payments was to hold the CF steady through March 31, 2015, regardless of the fact that the underlying formula calls for such a large cut. If no congressional action takes place by that date, then the cut in Medicare payments will take place beginning with services occurring on or after April 1, 2015. Keep in mind that any contracts with commercial payers that base their payment rates on Medicare's fee schedule may be impacted, depending on how those contracts are worded. However, Congress will almost certainly act before

then to revise physician payments, either with another patch, or more dramatic changes.

Telemedicine

CMS received a request to allow several gynecologic codes to the list of those that can be reimbursed if performed through telemedicine. The codes named in the request include:

- CPT code 57452 – colposcopy of the cervix including upper/adjacent vagina
- CPT 57454 – colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
- 57460 – colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix

Because these services do not meet the criteria that CMS has established for inclusion on the list of covered telehealth services, the agency has declined to add them to the list. They note, as well, that the requestor did not submit evidence supporting the clinical benefit of furnishing these services as telehealth services.

Incident-To Services Provided in a Rural Health Center

In a recent final rule, CMS removed a regulatory requirement that nurse practitioners (NPs), physician assistants (PAs), certified nurse-midwives (CNMs), clinical nurse specialists (CNSs) and clinical psychologists (CPs) furnishing services in a rural health center (RHC) must be employees of the RHC. RHCs are now allowed to contract with NPs, PAs, CNMs, CSWs, and CPs, as long as at least one NP or PA is employed by the RHC.

Services furnished in RHCs and federally qualified health centers (FQHCs) by nurses, medical assistants, and other auxiliary personnel are considered “incident to” a RHC or FQHC visit furnished by an RHC or FQHC practitioner. Current regulations state that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC. Since there is no separate benefit under Medicare law that specifically authorizes payment to nurses, medical assistants, and other auxiliary personnel for their professional services, they cannot bill the program directly and receive payment for their services, and can only be remunerated when furnishing services to Medicare patients in an “incident to” capacity.

To provide RHCs and FQHCs with as much flexibility as possible, CMS is proposing to remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC. This would allow nurses, medical assistants, and other auxiliary personnel to furnish incident to services under contract in RHCs and FQHCs.

Physician Compare

For some years, CMS has been making public data related to Medicare providers, including CNMs (note that CMs are not yet recognized Medicare providers). These data are available through the agency's [Physician Compare](#) website. The site already offers a significant array of data on these providers. For 2015, CMS proposes to include results of a broader array of measures than previously available, including those reported by groups as small as two providers. CMS will also report on measures collected under the Medicare Shared Savings program (the program for Accountable Care Organizations). CMS will also report on data related to consumer experience of care, as gathered through CAHPS surveys. Finally, CMS proposes to make available on Physician Compare, 2015 Qualified Clinical Data Registry (QCDR) measure data, aggregated to the individual level or a higher level of the QCDR's choosing.

Physician Quality Reporting System (PQRS)

CMS has, for several years, required providers under Medicare to report quality measures through its Physician Quality Reporting System ([PQRS](#)). Providers select a small subset of measures on which to report from an extensive list of nearly 300 measures supplied by CMS and may report through a variety of mechanisms. For 2015, CMS is proposing to remove two measures related to maternity care from the list of measures which providers might potentially report. The first is a measure of early elective delivery without medically indicated justification prior to 39 weeks of gestation. The second measure relates to the percent of patients who were seen postpartum. CMS is removing both of these measures from the list because the entity that maintains the measure, the AMA's Physician Consortium for Performance Improvement is no longer maintaining the measure. The Joint Commission, however, has obtained endorsement from the National Quality Forum for a measure of early elective delivery without medical indication that could be used as a replacement for the first measure CMS proposes to remove from its list. ACNM will comment to that effect.

Under the PQRS system, eligible professionals, including CNMs, have been paid an incentive amount for adequate reporting. However, this amount has been quite small for CNMs. The mean incentive for CNMs in 2012 was \$7 and the maximum incentive paid to any single CNM was \$148. In 2012, only 539 CNMs qualified for any type of bonus, out of 1,810 CNMs that could potentially have participated in the program. Among the many measures that CNMs could have chosen to report in 2012, the top five reported by them were:

1. Whether the provider has adopted and is using health information technology
2. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
3. Documentation of Current Medications in the Medical Record
4. Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months
5. Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if

the most recent BMI is outside of normal parameters, a follow-up plan is documented

(see: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2012-PQRS-and-eRx-Experience-Report.zip>)

In future years, there will not be an incentive payment made, instead, providers who do not adequately report will see an “adjustment,” meaning, a 2% cut, to their Medicare payments.

The reality is that since CNMs see very few Medicare patients, the PQRS payment adjustment is not likely to have a significant economic impact on them. However, the data on PQRS performance are being made public and simply demonstrating that one is participating in the program may have an impact on patients’ choice of providers.

Physician Value Based Payment Modifier

A provision of the Affordable Care Act requires CMS to begin modifying Medicare payments to physicians based on the comparative quality and cost of the care they provide. The law allows the agency to extend this same value based payment modifier to other practitioners, including CNMs, as early as 2017.

In the proposed fee schedule, CMS indicates it plans to extend the physician value based payment modifier (VM) to all eligible professionals in 2017, including CNMs. This means that performance in 2015 will impact payments in 2017. Performance will be evaluated using data reported through the PQRS. The payment adjustment under the VM is in addition to that incurred for adequate PQRS reporting. In addition to applying the VM to all eligible professionals in 2017, CMS proposes to increase the adjustment amount to 4 percent of payments. This increase in the percent of payments at risk is significant. When the program began two years ago, the amount at risk was only 1 percent. CMS increased it the next year to 2 percent and has again proposed doubling it for the third performance year. There is no limit on what percent that the agency may put at risk and they have received comment that they may need to put as much as 10 percent of payments at risk in order to truly motivate higher performance on the quality measures used by the program.

For those in groups of up to 9 professionals, they will be penalized for failing to report through PQRS, but will not be penalized for poor performance on the measures, so long as they do report, and may earn a bonus if they perform well. For eligible professionals in groups of 10 or more, they will be penalized for either failure to report, or for poor performance, but may also earn a bonus for high performance. Both groups may experience no adjustment in payment, either positive or negative, if their performance is average, or if they do not treat enough Medicare beneficiaries to generate statistically valid data.

Unless a CNM generates a significant proportion of her income from Medicare patients, this program is unlikely to have a major economic impact. However, as noted above, these data will be made public and could influence patient provider choice.