NAMDRC

WASHINGTON WATCHLINE

PHYSICIAN ADVOCACY FOR EXCELLENCE IN THE DELIVERY OF PULMONARY AND CRITICAL CARE

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The Proposed 2015 Medicare Physician Fee Schedule

2015 will mark a significant turning point in physician compensation for services provided to Medicare beneficiaries. The Medicare Physician Fee Schedule for 2015 continues to implement significant changes to CMS policies and the regulatory environment. This is the year that CMS transitions from payment incentives for satisfactory participation in the Physician Quality Reporting System (PQRS) and Meaningful Use Program to payment penalties that will be imposed on some medical practices for not meeting the requirements of these programs as well as the addition of penalties under the Value Based Modifier program.

On July 3, 2014, the Centers for Medicare & Medicaid Services (CMS) posted on its website the proposed rule that would update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) for 2015. The proposed rule was published in the Federal Register on July 11, 2014 and CMS will accept comments until Sept. 2, 2014.

In 2001 the agency administering the Medicare program changed its name from the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS) signaling the beginning of a significant policy and culture change within the agency. With that name change, CMS began the conversion from a pass through, check writing agency to one focused on transforming the healthcare system. Beginning with the Medicare Modernization Act of 2003 there has been a steady restructuring of the laws governing the Medicare program through the activities of the CMS Office of Legislation, in cooperation with key Congressional committees. Subsequent legislation authorized CMS to establish quality metrics, establish quality benchmarks, collect and compare provider performance, establish financial incentives based on provider performance and

The WASHINGTON WATCHLINE is published monthly and provides timely information to NAMDRC members on pending legislative and regulatory issues that impact directly on the practice of pulmonary medicine

NAMDRC's primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

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NAMDRC 38th Annual Meeting and Educational Conference will be held:
March 12-14, 2015
FireSky, a Kimpton Hotel
Scottsdale, AZ

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publish evaluations of provider performance in a public forum. Recently, the CMS Administrator has communicated a vision of CMS as a public health agency seeking to use its influence, reimbursement systems, regulatory authority and leadership to seek widespread transformation of the entire United States healthcare framework. The proposed 2015 PFS continues implementation of those goals.

Electronic Medical Records:

Federal mandates such as *The Meaningful Use of Electronic Medical Records* (EMR) and implementation of ICD-10 signal a deliberate effort to establish a standardized, electronic based, infrastructure for our healthcare system. The Department of Health and Human Services (HHS) has made clear the commitment to accelerating health information exchange, and thus its ability to track the cost of a provider's care and clinical quality measures. Advances in interoperable software will allow Medicare and commercial payers to collect accurate real-time data on providers and grade them by resource use and clinical outcome. The new healthcare infrastructure will increase control of physician activity through reimbursement tied to specific performance measures, patient management protocols and the public reporting of the degree of compliance with these metrics. Interestingly, Massachusetts has recently announced that By Jan. 1, 2015, demonstrated proficiency in health IT will be a requirement to renew a physician's license, and that all providers must fully implement interoperable EHR systems that connect to the state health information exchange, by Jan. 1, 2017.

The 2015 proposed PFS reaffirms that beginning January 1, 2015, Medicare eligible professionals that do not attest successfully to meaningful use of certified technology will incur payment adjustments. Eligible professionals that do not demonstrate successfully meaningful use of certified EHR technology will be subject to a downward payment adjustment that starts at -1 percent in 2015 and increases each year that the individual does not demonstrate meaningful use, to a maximum of -5 percent of their annual Medicare billings.

The Physician Quality Reporting System:

The Affordable Care Act gave CMS the authority to implement payment programs that could reward or penalize physician compliance with a variety of regulations. While CMS believes that by implementing quality measurement they will improve health care quality and outcomes, they also believe in establishing strong financial incentives to encourage physician compliance. The Physician Quality Reporting System forms the core of the differential physician compensation policy. Eligible professionals who do not satisfactorily report data on quality measures for covered professional services will be subject to a payment reduction for non compliance beginning in 2015. The PQRS payment adjustment applies to all of the eligible professional's Part B covered professional services under the Medicare Physician Fee Schedule.

The 2015 PFS reaffirms that eligible professionals who did not participate or did not meet all the program requirements for the 2013 reporting year will experience a payment adjustment in 2015 of -1.5%. For 2016 and subsequent years, the payment penalty increases to -2.0%. The proposed PFS also contains a lengthy section reviewing current quality measures and makes proposals regarding additions and deletions. Those that are relevant to our membership are listed at the end of this document.

Value Based Payment Modifier:

The Affordable Care Act mandated that CMS begin applying the Value Based Payment Modifier (VBPM) under the Medicare Physician Fee Schedule by 2015. CMS has elected to phase in the

VBPM over three years. In order to do so they have divided providers into three groups:

1. Groups of 100 or more providers who submit claims to Medicare under a single TIN will be subjected to the VBPM in 2015 and will experience an upward, neutral, or downward payment adjustment.

2. Groups of 10 to 99 providers who submit claims to Medicare under a single TIN will be added in 2016. They will experience an upward or neutral payment adjustment but will not be subject to the payment reduction in that year.

3. Groups of 2 to 9 and solo providers will be added in 2017 but will also not be subject to a payment reduction their first year.

All Practices will become vulnerable in 2018 and the payment penalty from the modifier will be added on to all other penalties.

The PQRS forms the core of the VBPM program. Two categories will form the basis of the CMS evaluation. Category 1 includes all providers or provider groups that participated in the PQRS. Category 2 is comprised of all providers or provider groups that did not participate in PQRS. The latter group will be subject to an automatic negative value modifier applied to their Medicare revenue in addition to their PQRS penalty. For example, in 2016 providers that did not participate in the PQRS program in 2014 will receive an automatic 2% reimbursement cut. Groups of 10 or more eligible providers who did not report under PQRS will receive an additional automatic 2% cut under the VBPM program. In 2017, CMS intends to apply an automatic -4.0 % VBPM to groups with two or more eligible professionals and solo practitioners that fall into Category 2.

Those practices that fall into Category 1 will be evaluated by the "quality tiering" method which is based on the cost of care analysis. The providers' cost data will be acquired by the Medicare administration through analysis of claims for services under a group or solo practitioner's Tax Identification Number (TIN). Based on the cost of their care and quality performance, Medicare will assign physicians to different peer cohorts. Medicare will then adjust reimbursement for physicians in each cohort ranging from a 1% payment cut to roughly a 1% payment increase in 2015. The financial penalty increases to 2% in 2016. In 2017 the maximum financial penalty will increase to 4% of Medicare revenue.

TABLE 58: CY 2017 Value-Based Payment Modifier Amounts

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

While the penalties are set, the VBPM will be implemented in a budget neutral manner so the bonuses will depend on the pool of revenue created by the penalties. The funds derived from the application of the downward adjustments to groups and solo practitioners in both Category 1 and Category 2 would be distributed to all groups and solo practitioners eligible for VBPM upward payment adjustments. While the maximum penalty is 4% in 2017, the bonus may be more or less than that

depending on how many providers qualify for the bonus. Based on an analysis of CY 2012 claims, CMS estimates that approximately 6 percent of all eligible professionals are in a Category 1 TIN that would be classified in tiers that would earn an upward adjustment; approximately 11 percent of all eligible professionals are in a Category 1 TIN that would be classified in tiers that would receive a downward adjustment; and approximately 83 percent of all eligible professionals are in a Category 1 TIN that would receive no payment adjustment.

For 2015 and 2016, the Value Modifier will not apply to groups of physicians in which any of the group's physicians participate in the Medicare Shared Savings Program, Accountable Care Organizations (ACOs), the testing of the Pioneer ACO model or the Comprehensive Primary Care Initiative. However, in the 2015 proposed Physicians Fee Schedule CMS intends to apply the VBPM to groups and solo practitioners that participate in ACOs under the Shared Savings Program beginning January 1, 2017.

One of the principles governing the implementation of the VBPM is the CMS focus on shared accountability and their belief that physicians have significant control over the care provided to beneficiaries who are hospitalized. CMS will be exploring strategies to align incentives between hospitals and the physicians who practice in them. One of the strategies will be an effort to assess performance at the group practice level by focusing on the total costs of care, not just the costs of care furnished by an individual physician. CMS proposes to apply the VBPM at the group level to foster shared accountability among all of the eligible professionals in the group and encourage them to seek innovative ways to furnish high-quality, patient-centered, and efficient care to Medicare beneficiaries.

Misvalued CPT Codes:

In the 2015 proposed PFS, CMS reiterates that they have the final authority to assign work RVUs for services billed to Medicare. In response to the public criticism of the AMA Relative Value Update Committee (AMA RUC) process, CMS has increased its scrutiny of the RUC recommendations and have increasingly found cause to modify the values recommended by the RUC in establishing interim final values under the PFS. In addition to the contracts issued to the Urban Institute and the Rand Corporation to conduct studies of the actual inputs to the work values, CMS has been considering additional ways to broaden participation in the process of identifying misvalued codes. They have recently sought suggestions from the Medicare Administrative Contractor medical directors (CMDs) for codes to consider as potentially misvalued codes.

In the 2015 proposed rule, CMS intends to add about 65 codes to the list of potentially misvalued codes. Most of the codes have been identified by reviewing high-expenditure services by specialty. To develop the CY 2015 proposed list in this category, CMS began by identifying the top 20 codes by specialty in terms of allowed charges. The most significant impacts are for radiation therapy centers and radiation oncology for which there would be decreases of 8 and 4 percent, respectively. Included in the codes to be reviewed are:

36215 Place catheter in artery; 71010 Chest x-ray 1 view frontal; 71020 Chest x-ray 2 view frontal & lateral; 71260 Ct thorax w/dye; 94010 Breathing capacity test

Efforts increased Compensation for Primary Care:

Over the last several years CMS has expressed its commitment to supporting primary care providers and has increasingly recognized care management as one of the critical components of primary care

that contributes to reduced expenditure growth. In the 2014 PFS, CMS finalized its proposal to establish a code and make separate payment for chronic care management (CCM) services beginning in 2015.

In the proposed 2015 PFS, CMS has set a payment rate of $41.92 for the chronic care management code that can be billed no more frequently than once per month per qualified patient.

Hospital Outpatient Department vs Independent Office Billing:

As part of the effort to address issues of "misvalued CPT codes" CMS has identified two anomalies related to ambulatory patient billing and are making these a priority for action. The first relates to hospital acquisition of physician offices or "Provider-based billing" and the second to examples of independent office compensation exceeding that of a hospital facility for certain services.

The Department of Health and Human Services Office of Inspector General (OIG) has made provider-based billing a priority for investigation and has been reviewing and comparing Medicare payments for physician office visits in provider-based clinics and free-standing clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on the Medicare program of hospitals' claiming provider-based status for such facilities.

For 2015 CMS is proposing to collect this information on the type and frequency of services furnished in off-campus provider-based departments beginning January 1, 2015 by requiring hospitals and physicians to report a HCPCS modifier for those services furnished in an off-campus provider-based department on both hospital and physician claims.

On the other hand, Medicare has noted that there are codes for which the payment under the current fee schedule is higher in the free standing clinic than the hospital outpatient department due to an elevated practice expense (PE) assigned by the AMA RUC. The PE component relies heavily on the submission of information by individuals furnishing the service and who are paid at least in part based on the data provided. CMS has indicated that they do not believe that the standard process for evaluating potentially misvalued codes, including the use of the AMA RUC is an effective means of addressing these codes. In 2014, CMS identified nearly 200 codes that fell into this group. The great majority of these codes were for outpatient procedures. MedPAC has encouraged CMS to seek legislative authority to equalize the total payment rates for E&M office visits across settings and a survey of this issue is currently being conducted by the OIG.

In the 2014 PFS, CMS proposed to limit the nonfacility practice expense RVUs for individual codes so that the total nonfacility payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting. CMS proposed using hospital outpatient and ambulatory surgery center payment rates for comparison, however, there were many comments opposing that plan. CMS is not proposing a similar policy for the CY 2015 PFS. To address the issues of the billing discrepancies between off campus and campus based outpatient services, The Protecting Access to Medicare Act of 2014 (PAMA) gave CMS the authority to use alternative approaches to establish practice expense relative values. CMS will be exploring the best approaches for exercising this authority, including with respect to the use of hospital outpatient cost data. In the 2015 PFS CMS is requesting comments on the most appropriate way to establish values for these apparently over valued services.

The Open Payments Program:

In December 2011, CMS published the proposed rule implementing the Physician Payments

Sunshine Act, which was melded into the Affordable Care Act. The policy embodied in that legislation is now being referred to as the Open Payments program. This program establishes a system for annually reporting and increasing public awareness of financial relationships between drug and device manufacturers and health care providers by publishing information about these financial relationships on a publicly accessible website developed by CMS. In the initial proposal there was an exclusion for compensation for speakers at continuing education events.

In the 2015 PFS CMS is proposing to delete the Continuing Education Exclusion in its entirety. In addition to financial compensation, CMS also proposes to require the reporting of stock ownership, stock options, or any other ownership interests. When a manufacturer provides funding to a continuing education provider, but does not either select or pay the recipient speaker directly, or provide the continuing education provider with a distinct, identifiable set of individuals to be considered as speakers for the continuing education program, CMS will consider those payments to be excluded from reporting.

Proposals Regarding PQRS Metrics:

CMS recommends removal of the following measures due to the measure steward indicating they will no longer maintain this measure:

- Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation:
- Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy:
- Sleep Apnea: Assessment of Sleep Symptoms:
- Sleep Apnea: Severity Assessment at Initial Diagnosis:
- Sleep Apnea: Positive Airway Pressure Therapy Prescribed:
- Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy:

Measures Groups:

CMS is proposing to remove the Sleep Apnea measures group and the Chronic Obstructive Pulmonary Disease (COPD) measures group from reporting in the PQRS beginning in 2015 because, for a number of measures included in this group, the measure steward has indicated they will no longer maintain those measures. Should they learn that a measure owner/developer is able to maintain certain measures, or that another entity is able to maintain certain measures, such that the measure group maintains a sufficient number of measures for reporting under the PQRS for the CY 2017 PQRS payment adjustment, CMS will propose to keep the measure group available for reporting under the PQRS and therefore will not finalize the proposal to remove these measure groups.

CMS recommends removal of the following measures due to eligible professionals consistently meeting performance on the measure with performance rates close to 100% suggesting there is no gap in care:

- Bacterial Pneumonia (CAP): Empiric Antibiotic:
- Asthma: Assessment of Asthma Control – Ambulatory Care Setting

CMS recommends removal as these measures are duplicated within PQRS with current measure Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:

- Asthma: Tobacco Use: Screening - Ambulatory Care Setting
- Asthma: Tobacco Use: Intervention - Ambulatory Care Setting

Proposed Measures to be added:

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: 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.

Rationale: This measure has been identified as a cross-cutting measure as it represents a screening assessment for tobacco use that most eligible professionals may perform and is applicable to most adult patients.

Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

Rationale: This measure targets the documentation of current medications in the medical record, which is a clinical process that most eligible professionals may perform and is applicable to most adult patients. This measure is also applicable in various outpatient settings. For these reasons, this measure is identified as cross-cutting.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous 6 months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 6 months of the encounter.

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30; Age 18-64 years BMI ≥ 18.5 and < 25

Rationale: This measure has been identified as a cross-cutting measure as it represents a screening assessment for BMI that most eligible professionals may perform and is applicable to most adult patients in various outpatient settings.

Closing the Referral Loop: Receipt of Specialist Report: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

Rationale: This measure represents communication between a variety of eligible professionals and promotes positive outcomes for patients. It is reportable by a broad spectrum of providers. In addition,this measure is applicable to most adult patients, further enhancing its reportability across disciplines and specialties.

Pneumonia Vaccination Status for Older Adults: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

Rationale: This measure represents a screening assessment for pneumonia vaccination that most eligible professionals may perform and is applicable to most elderly patients. This measure is also applicable in various outpatient settings, which further enhances its reportability across various disciplines and specialties.

Optimal Asthma Care- Control Component: Patients ages 5-50 (pediatrics ages 5-17) whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools.

Rationale: This patient centered outcome measure will replace PQRS #064 (Asthma: Assessment of Asthma Control- Ambulatory Care Setting) as it represents a more robust clinical outcome for asthma care.

Tobacco Use and Help with Quitting Among Adolescents: Percentage of adolescents 13 to 20 years of age with a primary care visit during the measurement period for whom tobacco use status was documented and received help quitting if identified as a tobacco user.

Rationale: This measure represents a clinical gap in the program, targeting support of adolescent populations in quitting smoking. This preventive measure supports pediatric patients and is reportable by Pediatricians, Family Practice physicians, and Internists. This is also a cross cutting measure.

PRODUCT AND TECHNOLOGY NEWS!

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NAMDRC MEMBERSHIP BENEFITS *AT A GLANCE*…

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

http://www.namdrc.org/issue-advocacy

One of **NAMDRC**'s primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation's health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of **NAMDRC**'s key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, **NAMDRC** members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

ABOUT NAMDRC:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.

NAMDRC MEMBERSHIP APPLICATION

Two Easy Ways to become a NAMDRC member

1. Go to **www.namdrc.org** and register for membership online.
2. Mail this application to

NAMDRC
8618 Westwood Center Drive, Suite 210
Vienna, VA 22182-2222

Please print clearly or type:

Name(Last) (First) (MI)

Degree

Address

City State Zip

Telephone Fax

E-mail

Facilities with which you are affiliated

Please indicate the areas that apply to your practice:

- ☐ Respiratory Care Management
- ☐ Anesthesiology
- ☐ Sleep Disorders
- ☐ Pulmonary Rehabilitation
- ☐ Skilled Nursing Facility
- ☐ Hyperbaric Oxygen Therapy
- ☐ Critical Care
- ☐ Home Health Services
- ☐ Physiology Assessments

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Membership Dues Schedule

(Dues for the first year includes $75.00 Initiation Fee)

Individual and Small Group Membership Dues $350.00

Can include groups of up to 6. Please include contact information for additional members.

Group Membership Dues

(For larger groups, please attach a list of names. If a group member wishes to receive mailings at an address other than that indicated above, please attach appropriate information.)

Groups of 7-10	$1,100.00
Groups of 11-20	$1,460.00
Groups of 21-30	$1,805.00
TOTAL PAYMENT DUE	$_____

Payment

- ☐ Enclosed is a check payable to NAMDRC (US Dollars)
- ☐ Charge my credit card for total payment due
  - ☐ VISA
  - ☐ MasterCard

Credit Card Number Expiration Date

Name as it appears on Credit Card

Billing Address (if different from registration)

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In accordance with IRS Regulations, 95% of your 2014 Annual Dues are tax deductible. NAMDRC's Federal TAX ID # is 74-2020988.

For More Information, Contact NAMDRC

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