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D. Effect of Changes to Medicare Telehealth Services Under the PFS

As discussed in section II.E.3. of this final rule with comment period, we are finalizing our policy to refine our definition of rural as it applies to HPSAs eligible for telehealth services as well as add transitional care management services to the list of Medicare telehealth services. Although we expect these changes to increase access to care in rural areas, based on recent utilization of current Medicare telehealth services, including services similar to transitional care management, we estimate no significant impact on PFS expenditures from the additions.

E. Geographic Practice Cost Indices (GPCIs)

Based upon statutory requirements we are updating the GPCIs for each Medicare payment locality. The GPCIs incorporate the use of updated data and cost share weights as discussed in II.E. The Act requires that updated GPCIs be phased in over 2 years. Addendum D shows the estimated effects of the revised GPCIs on area GAFs for the transition year (CY 2014) and the fully implemented year (CY 2015). The GAFs reflect the use of the updated underlying GPCI data, and the revised cost share weights. The GAFs are a weighted composite of each area's work, PE and malpractice expense GPCIs using the national GPCI cost share weights. Although we do not actually use the GAFs in computing the fee schedule payment for a specific service, they are useful in comparing overall areas costs and payments. The actual geographic adjustment to payment for any actual service will be different from the GAF to the extent that the proportions of work, PE and malpractice expense RVUs for the service differ from those of the GAF.

The most significant changes occur in 22 payment localities where the fully implemented (CY 2015) GAF moves up by more than 1 percent (11 payment localities) or down by more than 2 percent (11 payment localities). The impacts on the GPCIs are primarily attributed to the expiration of the 1.000 work GPCI floor. The use of updated underlying GPCI data and cost share weights has a minimal impact on locality GAFs. The total impact of the GPCI revisions is shown in the 2015 GPCI values of Addendum E.

We note that the CY 2014 physician work GPCIs and summarized geographic adjustment factors (GAFs) published in Addenda D and E reflect the elimination of the 1.0 work GPCI floor provided in section 1848(e)(1)(E) of the Act, which is set to expire prior to the implementation of the CY 2014 PFS.

F. Other Provisions of the Final Rule With Comment Period Regulation

1. Rebasing and Revising Medicare Economic Index

We estimate that there is no impact of the changes to the MEI for CY 2014.

2. Coverage of Items and Services furnished in FDA-Approved Investigational Device Exemption (IDE) Clinical Trials

We are finalizing our proposal of a transparent centralized review process that would be more efficient by reducing the burden for stakeholders. Once the IDE coverage process is centralized, there will be a single entity making the IDE coverage decision. This also eliminates duplicative reviews by Medicare local contractors and the numerous applications sent to contractors by stakeholders requesting IDE coverage. We believe that a centralized review process will not significantly reduce the number of IDE devices currently covered.

3. Ultrasound Screening for Abdominal Aortic Aneurysms

As discussed in section III.B. of this final rule with comment period, section 1861(s)(2)(AA) of the Act, with implementing regulations at § 410.19, authorizes Medicare coverage of ultrasound screening for abdominal aortic aneurysms (''AAA screening''). We are finalizing our proposal to modify § 410.19 to allow coverage of one-time AAA screening without receiving a referral as part of the IPPE, for beneficiaries that meet certain other eligibility criteria (a family history of AAA or, for men aged 65–75, a history of smoking). Approximately 45 percent of men aged 65–75 have a history of smoking. It is unknown how many individuals have a family history of AAA or how many beneficiaries will avail themselves of this benefit. Therefore, the impact of this change is unknown for CY 2014.

4. Modification to Medicare Coverage of Colorectal Cancer Screening

As discussed in section III.C. of this final rule with comment period, sections 1861(s)(2)(R) and 1861(pp)(1) of the Act, and implementing regulations at 42 CFR 410.37 authorize Medicare coverage of screening FOBT. We are finalizing our proposal to modify § 410.37(b) to allow attending physicians, physician assistants, nurse practitioners, and clinical nurse specialists to furnish orders for screening FOBTs. Although there may be an increase in utilization, particularly in rural areas, it is unknown how many individuals will avail themselves of this benefit. Therefore, the impact of this change is unknown for CY 2014.

5. Ambulance Fee Schedule

As discussed in section III.D. of this final rule with comment period, section 604(a) through (c) of the ATRA require the extension of certain add-on payments for ground ambulance services and the extension of certain rural area designations for purposes of air ambulance payment. In addition, as discussed in section III.D. of this final rule with comment period, section 637 of the ATRA (which added section 1834(l)(15) of the Act) specifies that the fee schedule amount otherwise applicable under the preceding provisions of section 1834(l) of the Act shall be reduced by 10 percent for ambulance services furnished on or after October 1, 2013, consisting of non-emergency basic life support (BLS) services involving transport of an individual with end-stage renal disease for renal dialysis services (as described in section 1881(b)(14)(B) of the Act) furnished other than on an emergency basis by a provider of services or a renal dialysis facility. The ambulance extender provisions and the mandated 10 percent rate decrease discussed above are enacted through legislation that is self-implementing. We are finalizing our proposal to amend the regulation text at § 414.610 only to conform the regulations to these self-implementing statutory requirements. As a result, we are not making any policy proposals associated with these legislative provisions and there is no associated regulatory impact

6. Clinical Laboratory Fee Schedule

We are finalizing our proposal to add language to the Code of Federal Regulations to codify authority provided by statute and to establish a process under which we will systematically reexamine the payment amounts established under the CLFS to determine if changes in technology for the delivery of that service warrant an adjustment to the payment amount. We are also finalizing our proposal of a definition for the term technological changes. Adjustments made under the new process could both increase fee schedule amounts and provide for reductions in existing amounts. We cannot estimate a net impact at this time.