



Special Bulletin

Thursday, November 3, 2016

CMS RELEASES FINAL RULE FOR CY 2017 PHYSICIAN FEE SCHEDULE

The Centers for Medicare & Medicaid Services (CMS) on Nov. 2 released the physician fee schedule (PFS) [final rule](#) for calendar year (CY) 2017. In addition to standard updates to the PFS payment rates and policies, the rule also makes changes related to Medicare Advantage (MA) and the Medicare Shared Savings Program (MSSP). The provisions in the rule generally are effective Jan. 1, 2017.

The AHA is pleased that CMS finalized proposals to expand the list of approved services provided via telehealth, new codes and payment for primary care and behavioral health care management services, and a measured approach to implementation of appropriate use criteria for advanced diagnostic imaging. We will continue to review the final rule to determine its potential impact on hospitals and the physicians with whom they partner.

HIGHLIGHTS OF THE PHYSICIAN FEE SCHEDULE FINAL RULE

Payment Update: Physician payment rates will increase 0.24 percent in CY 2017. This includes an increase of 0.5 percent as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and an overall budget neutrality decrease of 0.19 percent. CMS also is applying a 0.07 percent budget neutrality cut to offset projected increases in expenditures related to implementation of a decrease in the multiple procedure payment reduction on the professional component of imaging services from 25 percent to 5 percent as required by the Consolidated Appropriations Act of 2016.

Telehealth Services: CMS finalized its proposal to add to the list of Medicare-payable telehealth services the codes for certain end-stage renal disease-related services and advanced care planning. In addition, the agency created new codes to pay for critical care consultation furnished via telehealth.

Payment for Primary Care, Care Management and Behavioral Health: CMS finalized its proposal to create new codes to pay for certain primary care, care management and cognitive services beginning in CY 2017. Specifically, the agency will pay for:

- Time spent by physicians caring for the individual needs of a patient outside of an in-person visit.

- Services provided under a psychiatric collaborative care model, which is a primary care team consisting of a primary care provider and a care manager who work in collaboration with a psychiatric consultant, such as a psychiatrist.
- Costs, such as care management, incurred by primary care practices that treat patients with behavioral health conditions.
- Complex chronic care management, which involves moderate or high complexity medical decision-making.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging: The Protecting Access to Medicare Act of 2014 requires professionals furnishing advanced diagnostic imaging services to report on the Medicare claim information about AUC reviewed by the ordering professional. CMS continues its stepwise approach to implementation of this requirement. Specifically, the agency finalized a modified list of priority clinical areas for AUC implementation and requirements for clinical decision support mechanisms. CMS also noted that, because of the complexity of implementing this program, the earliest it expects furnishing professionals to begin reporting on AUC is Jan. 1, 2018.

Data Collection on Global Surgical Packages: CMS finalized with modifications its proposal to collect data from surgical professionals that will allow the agency to revalue surgical services, as mandated by MACRA. Beginning July 1, 2017, practitioners from a sample consisting of those in larger practices (10 or more practitioners) in specified states will be required to report post-operative visits for high-volume/high-cost procedures using existing Current Procedural Technology code 99024. Practitioners not included in the sample may report voluntarily.

Diabetes Prevention Program: CMS finalized its proposal to make the Center for Medicare & Medicaid Innovation (CMMI) Diabetes Prevention Program (DPP) demonstration a permanent program, beginning Jan. 1, 2018. Specifically, Medicare will cover a 12-month program that would include a Centers for Disease Control and Prevention-approved DPP curriculum for Medicare beneficiaries with prediabetes. This is the second CMMI program to be certified for expansion, based on meeting the statutory criteria that it is likely to improve quality of care without increased spending; would not increase Medicare spending; and would not deny or limit the coverage of Medicare benefits.

MSSP: CMS finalized its proposal to incorporate beneficiary preference into Accountable Care Organization (ACO) assignment. The agency will design an automated process by which beneficiaries could designate their “main doctor” or another health care provider that they believe is primarily responsible for their care. If that provider participates in an ACO, the beneficiary would be assigned to that ACO. CMS plans to incorporate voluntary beneficiary assignment for all three MSSP ACO tracks, beginning in performance year 2018, as long as the agency is able to create an automated attestation process before that time.

MSSP Quality Reporting. CMS finalized several changes to the MSSP quality measure set. Specifically, the agency added, replaced or retired various measures, which together reduce

the total number of measures from 34 to 31. CMS also changed the way it validates the data that ACOs enter into the Web Interface, including finalizing a policy to audit enough medical records to achieve a 90 percent confidence interval, streamlining the audit process into a single phase and calculating an overall audit performance rate. CMS says it is also finalizing a policy to “adjust an ACO’s overall performance score to reflect audit findings when the ACO has an audit mismatch rate of greater than 10 percent.” However, the agency will use discretion to avoid applying this adjustment in unusual circumstances where it would be inappropriate to do so. CMS also may require an ACO to submit a corrective action plan if it has an audit match rate of less than 90 percent, among other new policies.

MA Provider and Supplier Enrollment: CMS finalized its proposal to require that all health care providers and suppliers that contract with an MA plan to provide items or services to Medicare beneficiaries be screened and enrolled in Medicare. The policy will go into effect two years after publication of the final rule on the first day of the plan year and will apply to both MA and MA prescription drug (MA-PD) network providers and suppliers. This policy increases CMS’s role in MA network oversight, which it believes is necessary to protect beneficiaries and the Medicare Trust Fund from potential fraud, waste and abuse. CMS does not expect that this rule will have a significant impact on MA plans’ ability to establish networks, as the agency’s analyses showed that a large percent of MA providers and suppliers are already enrolled in Medicare.

MA Transparency Initiatives: CMS finalized with minor modifications two initiatives to increase access to MA data for purposes of supporting future policymaking and public research. Specifically, CMS will release annually information from MA organizations’ annual bids that are at least five years old and also publish information on MA organizations’ medical loss ratios (MLRs) for both their MA and MA-PD plans. New in the final rule, CMS will exclude from release any MLR data submitted for a single-plan contract and for any contract determined to be non-credible in a given contract year.

Quality Measurement: The agency adopts mostly minor changes to the Physician Quality Reporting System (PQRS) and Value-based Payment Modifier (VM) programs that would affect payment in CYs 2017 and 2018. As required by MACRA, CY 2018 is the final year for both the PQRS and the VM, which will be supplanted by the new two-track physician Quality Payment Program (QPP) beginning with CY 2019 payments. Additional resources on MACRA and the QPP can be found at www.aha.org/MACRA.

PQRS Participation for MSSP ACO Participants. Current MSSP regulations do not permit eligible professionals (EPs) in MSSP ACOs to participate in PQRS separately from their ACO. That is, EPs in ACOs may not submit their own quality data and receive their own PQRS payment adjustments. However, this policy means that if the ACO fails to submit quality data, EPs would automatically be subject to a negative payment adjustment. Thus, for CYs 2017 and 2018, CMS will allow individual EPs participating in MSSP to report quality data separately for the purposes of PQRS, and to have that data used in PQRS in the event their MSSP ACO fails to report quality data.

Physician VM. CMS adopts a number of updates to the “informal review” process used in the VM that allows individual EPs and group practices to appeal their VM performance determination. For example, EPs and groups who successfully appeal a determination that they have not reported sufficient quality data will have their quality composite score reclassified from “low” quality to “average” quality.

NEXT STEPS

The PFS final rule will be published in the Nov. 15 Federal Register and provisions in the rule will generally take effect Jan. 1, 2017. Watch for an AHA Regulatory Advisory with further details in the coming weeks.