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Post-Acute Care Center for Research

CMS Issues Physician Fee Schedule Final Rule

On Wednesday, November 2, CMS issued the 2017 Medicare Physician Fee Schedule (PFS) final rule that updates payment policies, payment rates, and quality provisions for services provided on or after January 1, 2017. The PFS focused on the importance of primary care by improving payment for chronic care management, mental and behavioral health issues, and cognitive impairment conditions. CMS estimates that the changes to the PFS will result in an estimated increase of $140 million to physicians and practitioners in 2017. If expanded over time to all eligible beneficiaries, CMS estimates that support for care coordination and patient-centered care could increase by as much as $4 billion.

The rule also expanded the Medicare Diabetes Prevention Program (MDPP) model test to all eligible Medicare beneficiaries, beginning in January 1, 2018. The MDPP is the first time a prevention model from the CMS Innovation Center (CMMI) will be adopted under the CMS authority to reach all eligible beneficiaries. In addition, the rule finalizes screening and enrollment requirements for providers and suppliers participating in Medicare Advantage, releases certain Medicare Advantage bid data and Part C and Part D Medical Loss Ratio (MLR) data, and updates certain quality reporting requirements and beneficiary protection policies in the Medicare Shared Savings Program.

Physician Fee Schedule: Just the Facts

- What does PFS Include: visits, surgical procedures, diagnostic tests, therapy services, and specified preventative services, among others
- Who is Paid Under PFS: physicians, nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities
- How is PFS Calculated: payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor, which is updated each year.
- 2017 Conversion Factor: $35.89, an increase from the 2016 PFS conversion factor of $35.80

Physician Fee Schedule: 2017 Key Payment Provisions

- Coding and Payment Changes: CMS finalized codes and payment changes that separately pay for chronic care management and transitional care management services to better identify and value primary care, care management, and cognitive services. These include creating separate payments for:
    - Certain Current Procedural Terminology (CPT) codes describing non-face-to-face prolonged evaluation and management services, as well as revaluing existing CPT codes on face-to-face prolonged services
    - Complex chronic care management and extra care management
    - Cognitive and functional assessment and care planning for patients with dementia
    - Specific behavioral health services furnished under the Psychiatric Collaborative Care Model, as well as creates a new code for approaches and practices not yet under the Collaborative Care Model
    - Make several changes to reduce administrative burden associated with the chronic care management codes to remove potential barriers to furnishing and billing for these important services
- Post-Surgical Resource Data Collection: MACRA required CMS to gather data on visits in the post-surgical period in order to accurately value these services. The final rule differs than the proposed rule, in the hope that the revisions significantly reduce the proposed burden on practitioners. Under the final rule, only a sample of practitioners in larger practices and in specified states are required to report and these practitioners are only required to report post-operative visits for high-volume/high-cost procedures. All other are permitted to report voluntarily. In addition, the reporting requirements will only be effective for services furnished on or after July 1, 2017.

Source: *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017*, Final Rule, CMS=1654-F. Press Release. Fact Sheet. CMS Blog.

- Moderate Sedation Services: CMS finalized values for the new CPT moderate sedation codes and expanded the new code with an endoscopy-specific moderate sedation code
- Eligible Telehealth Services: CMS added the following services to the list of services eligible to be furnished via telehealth: end-stage renal disease (ESRD)-related services for dialysis; advance care planning services; and critical care consultations furnished via telehealth using new Medicare G-codes.
- Mammography Services: CMS finalized a new coding framework based on new CPT coding for mammography services. It will be implemented through use of G-codes for Medicare.
- Geographic Practice Costs Indices (GPCI): CMS updated the GPCIs for each component of PFS payment—physician work, practice expense, and malpractice expense, to be phased in over CY 2017 and CY 2018. CMS also revised the methodology used to calculate GPCI in the U.S. territories, increasing payments in Puerto Rico.

Medicare Advantage Screening and Enrollment Requirements

The final requires health care providers and suppliers to be carefully screened and enrolled in Medicare in order to contract with a Medicare Advantage organization. This process will protect Medicare beneficiaries by helping to ensure that they receive appropriate or medically-necessary items and services from qualified providers. The rule is consistent with the requirements for all other Medicare programs, and the Medicaid Managed Care Plan. If a provider or supplier fails to meet the enrollment requirements, CMS may revoke enrollment and prevent them from billing Medicare Part A or B programs and from prescribing Part D drugs.

Medicare Advantage Data Release

CMS will release two sets of data related to Medicare Advantage plan participation and the Part D prescription drug program in order to assist public research and future policymaking efforts, as well as assist beneficiaries in making enrollment decisions.

The first data set is the Medicare Advantage organizations (MAOs) annual bid pricing data. Each year, MAOs apply to participate in the Medicare Advantage program through a bidding process, which includes submitting data reflecting the estimated costs associated with providing benefits to enrollees. CMS will release this bid pricing data on an annual basis, but the data released would be at least five years old and would exclude any proprietary information.

The second data set is the Medical Loss Ratio Data set for MAOs (Part C) and Part D plan sponsors. Under the ACA's minimum MLR standard, at least 85 percent of revenues must be attributed to claims and quality improvement activities. CMS will release certain Medicare health and drug plan MLR data on an annual basis.

Medicare Shared Savings Program Updates

CMS updated and revised several specific regulations of the Shared Savings Program, including:

- Updated certain ACO quality reporting requirements, such as the quality measure set and the procedures for quality validation audits; the terminology used in quality assessment; and alignment to the Physician Quality Reporting System and the final Quality Payment Program
- Permitting eligible professionals in ACOs to report quality separately from the ACO
- Modified the assignment algorithm to align beneficiaries to an ACO when a beneficiary has designated an ACO professional as responsible for their overall care
- Established beneficiary protection policies related to use of the Skilled Nursing Facility 3-day waiver

Source: *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017*, Final Rule, CMS=1654-F. Press Release. Fact Sheet. CMS Blog.