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Overview:
Proposed Medicare Physician Fee Schedule Update CY 2018

July 2017

Overview

- **Proposed Rule: 2018 Medicare Physician Fee Schedule (PFS) [CMS-1676-P]***
  - Posted: July 13, 2017
  - Federal Register Published: July 21, 2017
  - Comment Deadline: September 11, 2017
  - Final Rule Expected: On or about November 1, 2017

* The final year (CY 2018) of the legacy physician quality programs such as PQRS, Meaningful Use and the Value Based Modifier (VBM) are addressed in this PFS. The 2018 Quality Payment Program (QPP) Proposed Rule published in the *Federal Register* on June 30, 2017, includes proposals related to the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), the current PFS quality programs for clinicians.

PFS Payment Overview

- Payment is made under the PFS for services furnished by physicians and other practitioners in all sites of service
  - Types of services: Services include, but are not limited to, visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services.
  - Providers: Physicians and other practitioners and entities including but not limited to nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.
  - Payment methodology: Payments are based on the relative resources typically used to furnish the services. 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.*

Payment Methodology by Site of Service

Site of Service	Payment Methodology (Payment System/Payment Unit)
Office/Nonfacility	• Professional/Technical Payments: PFS global payment/RVUs
Outpatient	• Professional Payment: PFS/RVUs • Technical Payment: Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC)
Inpatient	• Professional Payment: PFS/RVUs • Technical Payment: Inpatient Prospective Payment System (IPPS)/Diagnosis Related Group (DRG)

Source: CMS Factsheet, 2018 PFS Proposed Rule; https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-2.html

Medicare Physician Conversion Factor (CF)

2018 Medicare Physician CF

The 2018 proposed PFS CF is **$35.9903**. If finalized, this would be a slight increase from the 2017 conversion factor of $35.8887.

- The Protecting Access to Medicare Act (PAMA) required CMS to establish an annual target for reductions in PFS expenditures from adjustments to misvalued codes.
- The target was 1.0 percent for 2016 and 0.5 percent for 2017 and 2018.
- For 2018, CMS proposed code value changes that would reduce overall expenditures 0.31 percent. If finalized, these code value changes would not meet the 0.5 percent target, so CMS must further adjust payments to achieve target reductions.

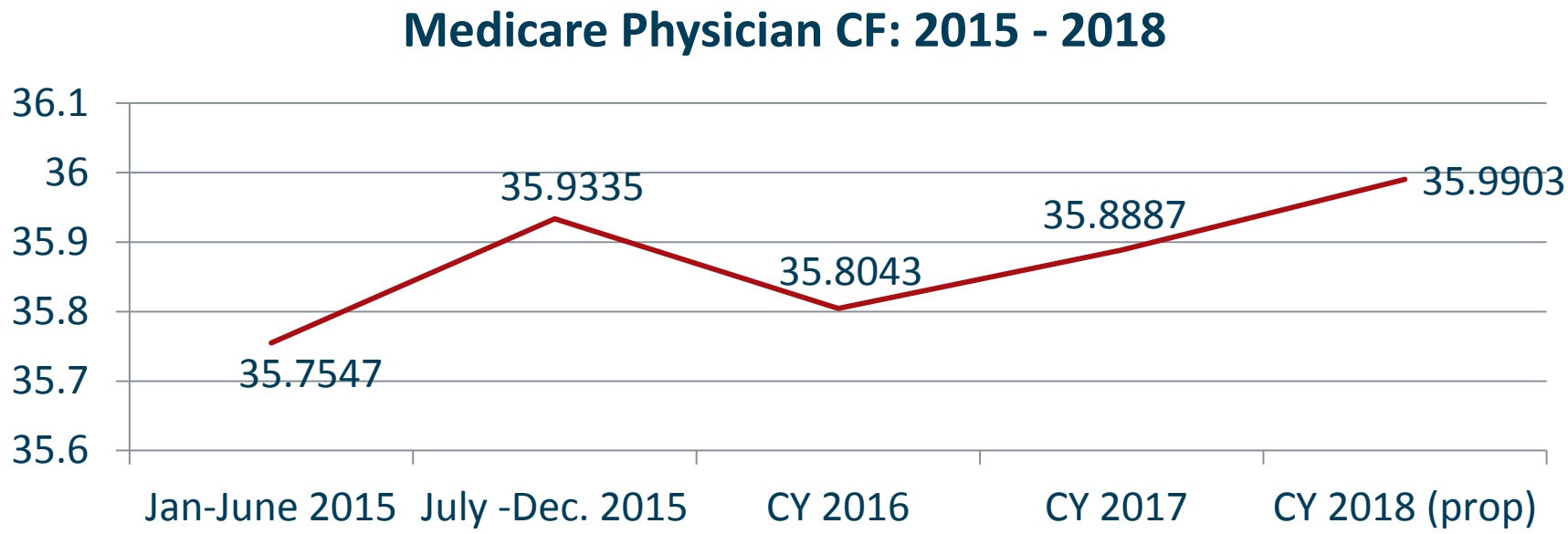
Calculation of the Proposed CY 2017 PFS CF		
CF in effect in CY 2017		**$35.8887**
Update Factor	0.50 percent (1.0050)	
CY 2018 RVU Budget Neutrality Adjustment	-0.03 percent (0.9997)	
CY 2018 Target Recapture Amount	-0.19 percent (0.9981)	
Proposed CY 2018 CF		**$35.9903**

Source: Table 38, 2018 Proposed PFS

Medicare Physician Conversion Factor (CF)

Physician CF since the passage of the Medicare Access CHIP Reauthorization Act (MACRA)

MACRA requires a 0.5 percent annual CF update from July 2015 - December 2019. The CF may also be impacted by a variety of other adjustments as required by statute.



Impact of 2018 Proposed PFS

Impact of 2018 proposed PFS varies by specialty

The overall impact of the changes varies by specialty. CMS estimates that the impact changes range from negative 6 percent for diagnostic testing facilities to positive 3 percent for clinical social workers.

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Overall Impact
Total	$92,628	0%	0%	0%	0%
Clinical Social Worker	$664	0%	3%	0%	3%
Diagnostic Testing Facility	$765	0%	-6%	0%	-6%

Source: Table 40, 2018 Proposed PFS

What is Driving these Changes?

Clinical social workers and other behavioral health providers are benefitting from a proposal to modify how CMS calculates overhead expenses for office based face-to-face services with a patient. This proposed change impacts less than 50 codes primarily provided by behavioral specialists.

The estimated negative impact on diagnostic testing facilities is also driven by practice expense changes.

Significant Proposals and Key Issues

CY 2018 PFS Proposed Rule focuses on reducing clinician financial risk and administrative burden.

Request for Information (RFI)

Request for comments on increasing flexibility, program simplification and innovation.

Appropriate Use Criteria (AUC)

Proposal to delay start date of program to January 1, 2019.

RUC* Recommendations

CMS acceptance rate of RUC recommendations described as highest in recent years.

Rollback on Legacy Quality Programs for CY 2018

Proposed modifications to reduce PQRS requirements and the VBM downward payment adjustment.

E/M Guidelines

Request for comments on updating E/M guidelines.

Medicare Diabetes Prevention Program (MDPP)

Proposed changes that would limit the role of virtual providers but would expand program in other areas such as value-based purchasing structures.

Off-Campus Provider Based Hospital Departments (PBD) Paid Under the PFS

Proposal to reduce payments from 2017 rate of 50% of OPPS rate to 25% of OPPS payment rate.

* RUC = American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee

RUC Recommendations

- √ **CMS accepts 100% of RUC work RVU recommendations**
- The RUC submits recommendations for work RVUs and direct practice expense inputs to CMS for new and revised codes in the support of the annual update of the PFS
- As summarized in Table 10 of the Proposed Rule, CMS is proposing to accept 100% of all RUC work RVU recommendations
  - While proposing to accept RUC recommendations, in some instances CMS also is suggesting alternative values for comment and consideration
  - CMS is proposing numerous modifications to direct PE recommendations (in some cases CMS is proposing greater inputs than were recommended by the RUC)
- While historically, CMS has had a very high acceptance rate of RUC recommendations, in recent years this rate has declined; the CY 2018 acceptance rate marks a return to deference to the RUC

Payment for Off-Campus PBD Services

√ CMS proposes to reduce off-campus PBD rates paid under the PFS

Background: Section 603 of the Bipartisan Budget Act of 2015 required that certain items and services by non-exempt off-campus PBDs could no longer be paid under the OPPS. In 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

Proposal: For 2017, CMS established rates for the technical portion of these services performed in the off-campus PBDs at ***50 percent of the OPPS payment rate***. For 2018 CMS is proposing to reduce the payment rate to ***25 percent of the OPPS payment rate***.

CMS Analysis*:* While in the OPPS there is only one code for a clinic visit (G0463), in the PFS there are 10 codes that describe outpatient visits (5 for new patients and 5 for established patients). CMS compared the CY 2017 OPPS national payment rate or HCPCS code G0463 ($102.12) to the difference between the office and facility PFS payment amounts using a weighted average of outpatient visits (99201-99205 and 99211-99215).

Estimated $25 million in Medicare Part B savings

Legacy Quality Programs

√ CMS rolls back 2018 PQRS requirements and reduces 2018 VBM negative payment adjustment

2018 PQRS Adjustment: The CY 2016 PQRS reporting period will impact 2018 payment adjustments. CMS is proposing to lower measure reporting requirements to avoid the 2018 PQRS negative payment adjustment. Table 20 in the Proposed Rule summarizes proposed modifications to previously finalized reporting criteria.

2018 VBM Payment Adjustment: CY 2016 is also the reporting period for the 2018 VBM. For CY 2018, CMS is proposing to reduce the downward payment adjustment for certain clinicians who do not meet the minimum quality reporting requirements; increasing the pool of clinicians held harmless from the downward payment adjustment; and reduce the maximum upward payment adjustment under the quality-tiering method.

CMS Proposes Modifications with An Eye Towards Transition to MIPS

CMS indicates in the Proposed Rule that they are proposing these modifications to better align incentives and provide a smoother transition to the new MIPS program under the QPP.

Flexibilities and Program Simplification

√ CMS issues Request for Information seeking ideas for flexibility, program simplification and innovation

CMS included similar requests in other recent proposed payment rules such as the IPPS, OPPS, and the Quality Payment Program Proposed Rule. This solicitation reflects the agency's stated priority of system improvement, reducing clinician burden and program simplification.

Request: CMS is soliciting ideas for regulatory, sub-regulatory, policy, practice, and procedural changes.

Potential Topic Areas: Suggested ideas include recommendations regarding payment system re-design; elimination or streamlining of reporting, monitoring and documentation requirements; operational flexibility; and feedback mechanisms and data sharing that would enhance patient care, support the doctor-patient relationship in care delivery, and facilitate patient-centered care.

√ Request for comments on E/M documentation guidelines

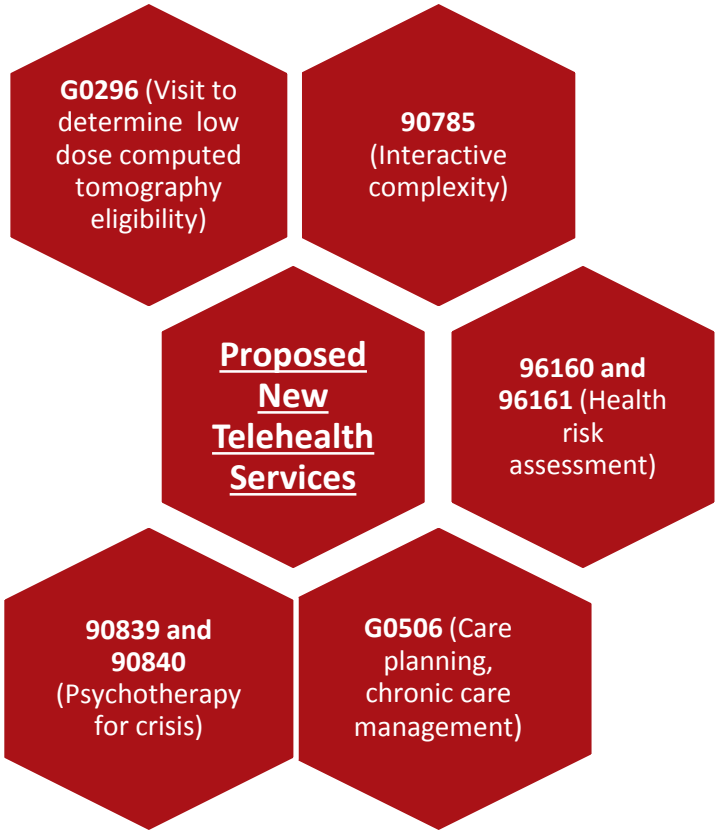
Another example of CMS seeking to reduce clinician burden

Background: CMS maintains guidelines that specify the type of documentation required to report E/M visit codes. Feedback from stakeholders over the years has consistently been that these guidelines are potentially outdated and need to be revised, especially the history and exam components.

Request: CMS is seeking comments on specific changes to update the guidelines, to reduce documentation burden and to better align E/M coding and documentation with the current practice of medicine.

New Telehealth Services Proposed

√**CMS proposes to expand the list of approved telehealth services**



Other Telehealth Services Proposals

√ Eliminate the required reporting of the telehealth modifier for professional claims

√ Request for comments on ways to further expand telehealth services

AUC Implementation Delayed

√ CMS proposes to delay AUC reporting

CMS is proposing to once again delay the implementation date of AUC reporting requirements. CMS is proposing to delay implementation to January 1, 2019, for when providers need to begin appending AUC information to claims.

CMS also is seeking comments related to whether the program should be delayed beyond the proposed start date of January 1, 2019. They are also interested in comments regarding how long it should be delayed; and if longer than one year, if educational and operations testing should be available.

PAMA

PAMA directed CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services.

- **2016 PFS**: CMS finalized the requirements and process for establishment and specification of applicable AUC, along with relevant aspects of the definitions of various terms.
- **2017 PFS**: CMS delayed the implementation date to January 1, 2018.

Modifications to MDPP

√ CMS proposes a number of modifications to the Medicare Diabetes Prevention Program

Background: The MDPP will allow Medicare beneficiaries to access evidence-based diabetes prevention services. The CY 2017 PFS established that MDPP services would be available on January 1, 2018.

- CMS is proposing to delay the start date to April 1, 2018
- If a beneficiary develops diabetes during the service period, beneficiary could continue receiving services
- Two-year limit placed on ongoing maintenance sessions
- Performance-based payment structure proposed
- Establishes standards to mitigate fraud, waste and abuse
- Exclude providers who furnish services exclusively through remote technology

Part B Drugs

√ CMS proposes change in payment policy for DME infusion drugs

Background: Current payment policy for Part B DME infusion drugs is 95% of the Average Wholesale Price (AWP).

Proposal: CMS proposes a change to Average Sales Price (ASP) plus 6% to conform with Section 5004(a) of the 21st Century Cures Act.

Estimated Savings: CMS estimates a 10 year total of Medicare Part B savings of $960 million (summarized in Table 43 in the Proposed Rule).

√ Soliciting comments on Biosimilar Payment Policy

- In the CY 2016 PFS, CMS finalized a policy to group biosimilar products that rely on a common reference product's biologics license application into the same payment calculation, and these products will share a common payment limit and HCPCS code.
- CMS is soliciting comments on the effects of its payment policy based on experience with the United States' biosimilar product marketplace since the regulations went into effect on January 1, 2016. CMS is particularly interested in new or updated material, such as market analyses or research articles that provide evidence which supports positions expressed in comments.

Other Proposals of Note

- **Potentially misvalued codes**: CMS is seeking comment from stakeholders on whether emergency department visits are undervalued, direct practice expense inputs for 88184-5 (Flow cytometry), and the best approach for developing new screens for identifying potentially misvalued codes.

- **Clinical Laboratory Fee Schedule (CLFS)**: CMS is seeking comments from laboratories on their experience with the first data collection and reporting periods under the new private payer rate-based CLFS. Comments received will be used to inform CMS regarding potential refinement to the CLFS for future data collection and reporting periods.

- **Malpractice RVU update**: Development of malpractice RVUs developed using the most recent available data as well as some a variety of other proposals related to technical modifications are proposed.

- **Medicare Shared Savings Program**: Proposed expansion of codes captured under "Primary Care" billing codes which are used for assignment under the accountable care organization program.

Helpful Links

Proposed Rule: 2018 Medicare Physician Fee Schedule (PFS) [CMS-1676-P]

Proposed Rule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html

CMS Fact Sheet

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-2.html

CMS Fact Sheet on Medicare Diabetes Prevention Program

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-3.html

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