Executive Summary: CMS 2017 PFS Proposed Rule

Key Financial and Operational Impacts from the Proposed 2017 Physician Fee Schedule (PFS) Rule:

The 2017 PFS proposed rule was made available on July 7, 2016. A detailed summary of the rule will be available here shortly.

1) **Conversion Factor**: The proposed PFS conversion factor for 2017 is $35.7751. This is a decrease from calendar year 2016 (CY16) ($35.8043). The proposed anesthesia factor is $21.9756.

2) **Specialty Specific Impact**: RVU repricing and other policies in the proposed rule had a significant negative impact on the following specialties:
    a. Interventional radiology (-7%)
    b. Independent laboratory (-5%)
    c. IDTF (-2%)

    The following specialties will see an increase in payments as a result of policy changes in the proposed rule:
    a. Family practice (3%)
    b. Internal medicine (2%)
    c. Hem/Onc (2%)
    d. Geriatrics (2%)
    e. General practice (2%)
    f. Immunology (2%)

    Please see the appendix at the end of the document for a complete list of impacts by specialty.

3) **Changes to MSSP**: CMS proposes numerous tweaks to the Medicare Shared Savings Program (MSSP) program which include:
    a. *Changes to Quality Measures*: CMS proposes modifications to the quality measure set that an accountable care organization (ACO) is required to report in order to better align the MSSP quality measure set with the measures recommended by the Core Quality Measure Collaborative, and proposed for reporting in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rule. Overall, CMS proposes to add three measures and retire or replace six measures. The total number of measures would decrease from 34 to 31 measures.

    b. *Aligning MSSP Policies with Policies in the New Quality Payment Program*: CMS identified several modifications to program rules to better support and align CMS' efforts related to the Quality Payment Program (MACRA proposed rule). These modification include sunsetting MSSP alignment with Physician Quality Reporting System (PQRS) and Electronic Health Record Incentive Program.

    c. *Beneficiary Attestation*: CMS proposes to implement an automated approach to help determine which healthcare provider a fee for service (FFS) beneficiary believes is responsible for coordinating their overall care (their "main doctor") using information that is collected directly from beneficiaries. Currently, in the Pioneer and Track 3, ACOs participants directly obtain this information from beneficiaries annually, and then

communicate it to CMS. This beneficiary attestation approach would be available for ACOs participating in Track 1, 2, or 3 unless such an automated system is not available by spring of 2017. In this case, the voluntary alignment process will be limited to ACOs participating in Track 3 until an automated system is available. These changes would be effective for assignment for the 2018 performance year.

d. *Beneficiary Protections Related to the SNF 3-Day Waiver*: CMS has become concerned about potential beneficiary financial liability for non-covered Part A skilled nursing facility (SNF) services that might be directly related to use of the SNF 3-day rule waiver under the Shared Savings Program. CMS proposes to modify the waiver to include a 90-day grace period to allow sufficient time for CMS to notify the ACO of any beneficiary exclusions, and for the ACO then to inform its SNF affiliates, ACO participants, and ACO providers/suppliers of those exclusions.

   CMS also proposes that it would make no payment to the SNF. The SNF may not charge the beneficiary for the non-covered SNF services, in the event that a SNF affiliate of a Track 3 ACO has been approved for the SNF 3-day rule waiver, admits a FFS beneficiary who was never prospectively assigned to the waiver-approved ACO (or was assigned but later excluded and the 90 day grace period has lapsed), and the claim is rejected only for lack of a qualifying inpatient hospital stay.

e. *Financial reconciliation issues for ACOs that fall below 5,000 assigned beneficiaries*: CMS proposes that in the event an ACO participating under a two-sided risk track falls below 5,000 assigned beneficiaries at the time of financial reconciliation, and the ACO is eligible to share in savings (or losses), the minimum savings rate/minimum loss rate (MSR/MLR) will be set at a level consistent with the choice of MSR/MLR that the ACO made at the start of the agreement period.

4) **Medicare Advantage Plan Enrollment**: CMS proposes providers or suppliers would have to be enrolled in Medicare and be in an "approved status" in order to provide health care items or services to an enrollee who receives his or her benefits through a Medicare Advantage (MA) plan. MA plans that fail to ensure compliance on the part of their providers and suppliers would be subject to sanctions and termination.

   An MA plan would be prohibited from paying, directly or indirectly, on any basis, for items or services (other than emergency or urgently needed services) furnished to a Medicare enrollee by any individual or entity that is excluded by the Office of the Inspector General or is revoked from the Medicare program.

   As a condition of contracting with CMS, an MA plan would have to agree to provide documentation that all providers and suppliers in the MA or MA-Part D plan who could enroll in Medicare, were enrolled in an approved status. The authorized individual would have to thoroughly describe how the entity and MA plan met, or will meet, all the requirements including providing documentation that all providers and suppliers are enrolled in Medicare in an approved status.

5) **Diabetes Prevention Program**: Under Section 1115(A) of the Affordable Care Act (ACA), CMS proposes to expand the Medicare Diabetes Prevention Program (MDPP). MDPP is a 12-month program using the Centers for Disease Control and Prevention (CDC)-approved Diabetes Prevention Program (DPP) curriculum, which consists of 16 core sessions over 16-26 weeks and an option for monthly core maintenance sessions over the subsequent six months if the beneficiary achieves and maintains a minimum weight loss in accordance with the CDC DPP Standards and Operating Procedures.

   CMS proposes payment for MDPP services tied to the number of services attended and the achievement of a minimum weight loss of five percent of baseline weight. For example, payment per beneficiary for one core session would be $25, payment for 4 sessions attended would be $50 and payment for a beneficiary with a weight loss of 5% from baseline would be $160. Table 35 of the rule lists the proposed reimbursement for MDPP.

   CMS proposes that any organization recognized by the CDC to provide DPP services (preliminary or full recognition) would be eligible to apply for enrollment in Medicare as a supplier beginning on or after January 1, 2017. MDPP suppliers would be subject to enrollment regulation set forth in 42 CFR part 424, subpart P. In addition, CMS proposes that potential MDPP suppliers would be screened according to the high categorical risk category defined in §424.518(c). As suppliers, enrolled MDPP organizations would be obligated to comply with all statutes and regulations that establish applicable requirements for Medicare suppliers.

   CMS proposes to require personnel who would deliver MDPP services (referred to as "coaches") to obtain a National Provider Identifier (NPI) to help ensure coaches meet CMS program integrity standards. CMS is also considering requiring coaches to enroll in the Medicare program in addition to obtaining an NPI.

6) **Telehealth Services**: CMS proposes to add the following Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System codes in CY17:

   a. End-Stage Renal Disease (ESRD)-related services (CPT codes 90967-90970). These four codes describe ESRD-related services for dialysis for less than a full month of service, per day, broken down into four age groups: < 2 years, 2-11 years, 12-19 years, and ≥ 20 years.

   b. Advanced care planning services (CPT codes 99497-99498). These two codes describe the first 30 minutes, and each additional 30 minutes, respectively, during which a qualified health care professional explains and discusses advance directives with the patient, family member(s), or surrogate; advance directive form completion time is included if performed during the encounter.

   c. Critical care (CPT codes 99291 and 99292). CMS proposes to add to the telehealth list for 2017 two new codes for initial and subsequent critical care consultations furnished via telehealth. CMS proposes that these services be limited to once per day per patient and that they be valued by comparisons to other evaluation and management services.

7) **Imaging Appropriate Use Criteria (AUC)**: The rule proposes the requirements and process for specifications of qualified clinical decision support mechanisms (CDSMs) under the Medicare AUC program; the initial list of clinical priority areas; and exceptions to the requirement that ordering professionals consult specified applicable AUC when ordering applicable imaging services. CMS proposes to announce the first list of qualified CDSMs no later than June 30, 2017, and anticipates that furnishing providers could begin reporting AUC information starting January 1, 2018.

8) **Physician Self-Referral**: In response to the D.C. Circuit opinion in Council for Urological Interests v. Burwell, CMS re-proposes certain requirements for arrangements involving the rental of office space or equipment. CMS is proposing a requirement that rental charges for the office space or equipment are not determined using a formula based on per-unit of service rental charges to the extent that such charges reflect services provided to patients by the lessor to the lessee.

   CMS emphasizes that it is not proposing an absolute prohibition on rental charges based on units of services furnished; in general, per-unit of service rental charges for the rental of office space or equipment are permissible. CMS states it is proposing to limit the general rule by prohibiting per-unit of service rental charges where the lessor generates the payment from the lessee through a referral to the lessee for a service to be provided in the rental office space or using the rented equipment. Per-unit of service rental charges for the rental of office space or equipment would be permissible, but only in those instances where the referral for the service to be provided in the rental office, or using the rented equipment did not come from the lessor.

9) **Transition to Digital Imaging**: Effective for services furnished beginning January 1, 2017, payment for the technical component (TC) (including the TC of a global service) of imaging services that are X-rays taken using *film* is reduced by 20 percent. The reduction is made prior to any other adjustment under this section. Beginning January 1, 2017, a new modifier would be required on claims for X-rays that are taken using film.

10) **Recoupment of Offset of Payments to Providers Sharing the Same Taxpayer Identification Number:** CMS notes it has historically used the Medicare provider billing number (NPI) to recoup overpayments until these debts were paid in full or eligible for referral to the Department of Treasury for further collection action. However, the ACA allows the Secretary to make any necessary adjustments to the payments of an "*applicable provider*" of services or supplier to satisfy any amount due from an obligated provider of services or supplies. The statute defines an applicable provider of services or supplier (*applicable provider*) as a provider of services or supplies that has the same Tax Identification Number (TIN) as the one assigned to the obligated provider of services or supplier. The statue defines the obligated provider of services or supplier (*obligated provider*) as a provider of services or supplier that owes a past-due overpayment to the Medicare program. CMS states that for purposes of this provision, the applicable and obligated providers must share a TIN, but may possess a different billing or NPI than one another.

    CMS provides the following example: A health care system may own a number of hospital providers, and these providers may share the same TIN, but have different NPI numbers. If one of the hospitals in the system receives a demand letter for a Medicare overpayment, then the hospital (Hospital A) will be considered the obligated provider, while the other hospitals in the

same TIN (Hospital B and C) will be considered the applicable providers. CMS states this authority allows it to recoup the obligated provider Hospital A, against any or all of the applicable providers, Hospital B and C, with which it shares a TIN.

Appendix I: Specialty Specific Payment Impact of Proposed FY 2017 PFS Rule

(A)	(B)	(C)	(D)	(E)	(F)
Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact**
INTERVENTIONAL RADIOLOGY	$315	-1%	-5%	0%	-7%
INDEPENDENT LABORATORY	$701	0%	-5%	0%	-5%
DIAGNOSTIC TESTING FACILITY	$750	0%	-2%	0%	-2%
GASTROENTEROLOGY	$1,744	0%	0%	0%	-1%
TOTAL	$89,467	0%	0%	0%	0%
ANESTHESIOLOGY	$1,977	0%	-1%	0%	0%
CARDIAC SURGERY	$322	0%	0%	0%	0%
CHIROPRACTOR	$779	0%	0%	0%	0%
CLINICAL PSYCHOLOGIST	$727	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	$601	0%	0%	0%	0%
COLON AND RECTAL SURGERY	$160	0%	0%	0%	0%
CRITICAL CARE	$308	0%	0%	0%	0%
EMERGENCY MEDICINE	$3,133	0%	0%	0%	0%
GENERAL SURGERY	$2,157	0%	0%	0%	0%
HAND SURGERY	$182	0%	0%	0%	0%
INTERVENTIONAL PAIN MGMT	$767	1%	0%	0%	0%
AUDIOLOGIST	$61	0%	0%	0%	1%
CARDIOLOGY	$6,461	0%	0%	0%	1%
DERMATOLOGY	$3,305	0%	0%	0%	1%
INFECTIOUS DISEASE	$652	0%	0%	0%	1%
MULTISPECIALTY CLINIC/OTHER PHYS	$128	1%	1%	0%	1%
ALLERGY/IMMUNOLOGY	$230	0%	1%	0%	2%
ENDOCRINOLOGY	$458	1%	1%	0%	2%
GENERAL PRACTICE	$451	1%	1%	0%	2%
GERIATRICS	$211	1%	1%	0%	2%
HEMATOLOGY/ONCOLOGY	$1,746	1%	1%	0%	2%
INTERNAL MEDICINE	$10,849	1%	1%	0%	2%
FAMILY PRACTICE	$6,087	1%	1%	0%	3%

The following is an explanation of the information for Table 43:

- Column A (Specialty): Identifies the specialty for which data is shown.
- Column B (Allowed Charges): The aggregate estimated PFS allowed charges for the specialty based on 2015 utilization and 2016 rates. Allowed charges are the Medicare fee schedule amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all specialties to arrive at the total allowed charges for the specialty.
- Column C (Impact of Work RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the proposed changes in the work RVUs, including the impact of changes due to potentially misvalued codes.

- Column D (Impact of PE RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the proposed changes in the PE RVUs.
- Column E (Impact of MP RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the proposed changes in the MP RVUs.
- Column F (Combined Impact): This column shows the estimated 2017 combined impact on total allowed charges of all the changes in the previous columns