Executive Summary: CMS 2018 PFS Proposed Rule

Key Financial and Operational Impacts from the Proposed 2018 PFS Rule:

The 2018 Physician Fee Schedule (PFS) proposed rule was made available on July 13, 2018. A detailed summary of the rule will be available here shortly.

1) **Conversion Factor**: While MACRA mandates a .5% update to the PFS for calendar year (CY) 2018, adjustments for mis-valued codes result in a net increase of .31%. Therefore, the proposed CY 2018 conversion factor is $35.9903. This is a slight increase from the CY 2017 conversion factor of $35.8887.

   The anesthesia conversion factor is $22.0353 (compared to CY 2017's $22.0454). The negative increase results from CMS's additional proposed adjustment to the Anesthesia Fee Schedule Practice and Malpractice Expense factors.

2) **Specialty Specific Impact**: Relative value unit (RVU) repricing and other policies in the proposed rule had a significant negative impact on the following specialties:

	Allowed Charges (Millions)	Impact of WRVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Diagnostic Testing Facility	765	0%	-6%	0%	-6%
Allergy/Immunology	245	0%	-3%	0%	-3%
Otolaryngology	1,232	0%	-1%	0%	-2%
Cardiology	6,671	0%	-1%	-1%	-2%
Cardiac Surgery	311	0%	0%	-1%	-2%
Independent Lab	684	0%	-1%	0%	-2%
Oral/Maxillofacial Surgery	57	0%	-2%	0%	-2%
Vascular Surgery	1,115	0%	-1%	0%	-2%

   The following specialties will see an increase in payment greater than 1% resulting from policy changes in the proposed rule:

	Allowed Charges (Millions)	Impact of WRVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Clinical Social Worker	664	0%	3%	0%	3%
Clinical Psychologist	756	0%	2%	0%	2%

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

3) **Non-Exempt Provider Based Sites of Service**: CMS reduces payments to non-exempt provider based clinics (new clinics that were not in process by November 2, 2015) from 50% of the OPPS payment for the service in question to 25% of the service in question.

4) **Physician Relationship Modifier**: MACRA requires that physician claims submitted for items and services on or after January 1, 2018, include the physician relationship Healthcare Common Procedure Coding System (HCPCS) modifier(s) which were recently developed. The rule proposes that for an undefined "initial period" the modifiers may be reported on a voluntary basis to allow physicians and other clinicians to gain familiarity with them. During the voluntary period, claims submitted without the modifier will continue to be paid if they are otherwise "clean." CMS notes that in future years, it intends to incorporate the relationship modifiers into the quality payment program.

   Below is a list of proposed modifiers.

No.	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

   CMS seeks additional comment on the modifiers for potential revisions for CY 2019. Additional information is available here.

5) **Changes to Medicare Shared Savings Program (MSSP)**: CMS proposes minor changes to the MSSP program. These include:

   a. *Modification of Application Requirements to Reduce Administrative Burden*: Rather than requiring every applicant to submit detailed supporting documents or narratives for all application requirements, CMS would request supporting documents or narratives only if additional information is needed to fully assess an accountable care organization (ACO's) application before making a decision to approve or deny the application. CMS makes a similar change to the documentation requirements for MSSP Track 3 participants applying for the "SNF 3-day waiver."

   b. *Tax identification numbers (TINs) Participating in Multiple ACOs:* If, during a benchmark or performance year, an ACO participant that participates in more than one ACO begins billing for services that would be used in assignment, CMS will not consider any services billed through that TIN during the relevant performance year when performing beneficiary assignment for the applicable benchmark or performance year. The ACOs in which the overlapping TIN is an ACO participant may be subject to compliance action or termination.

   c. *Beneficiary Assignment:* CMS will consider all services furnished in federally qualified health centers and rural health clinics in the assignment methodology as primary care services starting in the 2019 performance year.

      Additionally, CMS proposes to include three complex condition management service codes (99487, 99489, and G0506) and four BHI service codes (G0502, G0503, G0504 and

G0507) in the definition of primary care services, and to utilize these codes in the beneficiary assignment methodology under the Shared Savings Program beginning in 2018, for performance year 2019, and subsequent years.

6) **Diabetes Prevention Program (DPP)**: CMS proposes to incorporate a pay for performance system into the DPP. In the proposal, payments to providers will vary based on whether or not beneficiaries participating in the program achieve selected weight-loss targets. Below is a summary of the proposed payment levels based on goal attainment:

Performance Goal	Performance Payment Per Beneficiary (*with* the required minimum weight loss)	Performance Payment Per Beneficiary (*without* the required minimum weight loss)
1st core session attended	$25	
4 total core sessions attended	$30	
9 total core sessions attended	$50	
3 sessions attended in first core maintenance session interval (months 7-9 of the MDPP core services period)	*$60	$10
3 sessions attended in second core maintenance session interval (months 10-12 of the MDPP core services period)	*$60	$10
5 percent weight loss achieved	$160	$0
9 percent weight loss achieved	$25	$0
3 sessions attended in ongoing maintenance session interval (eight consecutive 3-month intervals over months 13-36 of the MDPP ongoing services period)	*$50	**$0
Total performance payment	**$810**	**$125**

7) **Telehealth Services**: CMS proposes to add the following Current Procedural Terminology (CPT) and HCPCS codes in CY 2018:

- HCPCS code G0296 (Counseling visit to discuss need for lung cancer screening using low dose CT scan (ldct) (service is for eligibility determination and shared decision making))
- HCPCS code G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service))
- CPT code 90785 (Interactive complexity (list separately in addition to the code for primary procedure))
- CPT codes 90839 and 90840 (Psychotherapy for crisis; first 60 minutes) and (Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary procedure))

- CPT codes 96160 and 96161 (Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument) and (Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument)

8) **Imaging Appropriate Use Criteria (AUC)**: CMS continues to implement the requirement[1] that professionals who furnish advanced imaging services report on the claim information about the appropriate use criteria reviewed by the ordering professional. The rule proposes that CY 2019 (the first year the modifier is required) will be an education and operations year. Therefore, CMS will pay claims for impacted services regardless of whether the required information is included on the claim. Additionally, assuming Medicare claims processing systems are ready, CMS proposes to make a separate voluntary reporting period available for professionals beginning on July 1, 2018.

9) **Physician Quality Reporting Program (PQRS)**: CMS proposes to revise the previously finalized criteria for the CY 2016 reporting period to lower the requirement from 9 measures across 3 National Quality Strategy domains, where applicable, to only 6 measures with no domain or cross-cutting measure requirement. This will align PQRS with the Quality Payment Program.

   For individual eligible professionals (EPs), this would apply to the following reporting mechanisms: claims, qualified registry (except for measures groups), qualified clinical data registry, direct electronic health record (EHR) product, and EHR data submissions vendor product.

   CMS is not proposing to collect any additional data for the CY 2016 reporting period, as the data submission period for the CY 2016 reporting period has already ended.

10) **Physician Value Modifier (VM)**: CMS proposes the following modifications to the VM program:

    a. Reduce the automatic downward adjustment for groups and solo practitioners in Category 2 (those who do not meet the criteria to avoid the 2018 PQRS payment adjustment) to negative 2 percent (from negative 4 percent) for groups with 10 or more EPs and at least one physician, and negative 1 percent (from negative 2 percent) for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.

    b. Hold all groups and solo practitioners who are in Category 1 (those who meet the criteria to avoid the 2018 PQRS payment adjustment) harmless from downward payment adjustments under quality tiering for the last year of the program.

    c. Reduce the maximum upward adjustment under the quality-tiering methodology to two times an adjustment factor (+2.0x) for groups with 10 or more EPs. This is the same maximum upward adjustment under the quality-tiering methodology that CMS finalized

[1] Included Protecting Access to the Medicare Act of 2014 (PAMA)

and will maintain for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.

Appendix I: Specialty Specific Payment Impact of Proposed FY 2018 PFS Rule

	Allowed Charges (Millions)	Impact of WRVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact**
Diagnostic Testing Facility	765	0%	-6%	0%	-6%
Allergy/Immunology	245	0%	-3%	0%	-3%
Otolaryngology	1,232	0%	-1%	0%	-2%
Cardiology	6,671	0%	-1%	-1%	-2%
Cardiac Surgery	311	0%	0%	-1%	-2%
Independent Lab	684	0%	-1%	0%	-2%
Oral/Maxillofacial Surgery	57	0%	-2%	0%	-2%
Vascular Surgery	1,115	0%	-1%	0%	-2%
Audiologist	66	0%	0%	-1%	-1%
Obstetrics/Gynecology	658	0%	0%	-1%	-1%
Neurosurgery	805	0%	0%	-1%	-1%
Pathology	1,147	0%	0%	0%	-1%
Urology	1,772	0%	-1%	0%	-1%
Gastroenterology	1,792	0%	0%	-1%	-1%
Dermatology	3,475	0%	0%	-1%	-1%
Radiology	4,863	0%	-1%	0%	-1%
Emergency Medicine	3,176	0%	0%	-1%	-1%
General Surgery	2,154	0%	0%	0%	-1%
Interventional Radiology	357	0%	-1%	0%	-1%
Thoracic Surgery	356	0%	0%	-1%	-1%
Portable X-Ray Supplier	100	0%	-1%	0%	-1%
Nurse Anesthetist Asst.	1,238	-1%	0%	1%	-1%
Colon and Rectal Surgery	166	0%	0%	-1%	-1%
Anesthesiology	2,009	-1%	0%	0%	0%
Other	28	0%	0%	0%	0%
Pediatrics	63	0%	0%	0%	0%
Endocrinology	477	0%	0%	0%	0%
Rheumatology	553	0%	0%	0%	0%
Optometry	1,259	0%	0%	0%	0%
Neurology	1,545	0%	0%	0%	0%
Hematology/Oncology	1,802	0%	0%	0%	0%
Nephrology	2,257	0%	0%	0%	0%
Ophthalmology	5,480	0%	0%	0%	0%
Critical Care	332	0%	0%	0%	0%
Family Practice	6,307	0%	0%	0%	0%

General Practice	452	0%	0%	0%	0%
Internal Medicine	11,022	0%	0%	0%	0%
Multi-specialty Clinic	139	0%	0%	0%	0%
Nuclear Medicine	50	0%	0%	0%	0%
Nurse Practitioner	3,541	0%	0%	0%	0%
Orthopedic Surgery	3,784	0%	0%	0%	0%
Physician Assistants	2,232	0%	0%	0%	0%
Plastic Surgery	379	0%	0%	0%	0%
Pulmonary Disease	1,753	0%	0%	0%	0%
Interventional Pain Mgmt	830	0%	0%	0%	0%
Geriatrics	211	0%	0%	0%	1%
Chiropractor	772	0%	1%	0%	1%
Psychiatry	1,233	0%	1%	0%	1%
Radiation Onc and Therapy Centers	1,784	0%	1%	1%	1%
Podiatry	1,973	0%	1%	1%	1%
Hand Surgery	200	0%	0%	0%	1%
Infectious Disease	651	0%	0%	1%	1%
Physical Medicine	1,105	0%	0%	0%	1%
Physical/Occup. Therapy	3,780	1%	1%	0%	1%
Clinical Psychologist	756	0%	2%	0%	2%
Clinical Social Worker	664	0%	3%	0%	3%