OVERVIEW OF THE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) FINAL RULE FY 2017

SUMMARY OF CALCULATION ELEMENTS

Issued November 2, 2016
Rule to take effect January 1, 2017

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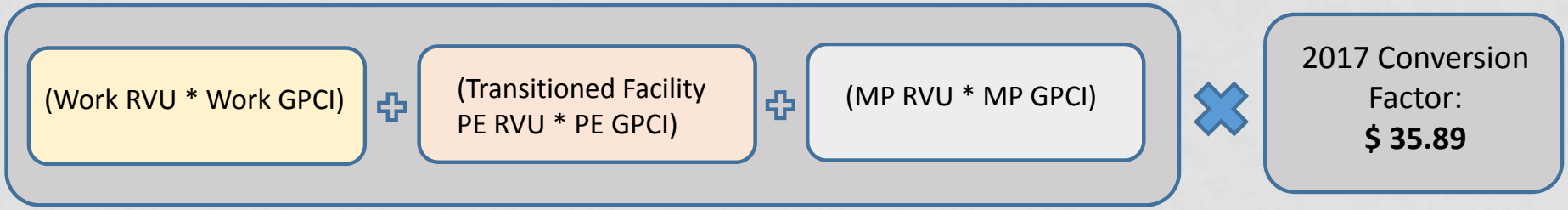
BACKGROUND

- Pays for services furnished by physicians and other practitioners in all sites of service:
  - Office visits
  - Surgical procedures
  - Diagnostic tests
  - Therapy services
  - Certain preventive services
- Payments are based on the relative resources typically used to furnish the service

FORMULA

Relative Value Units (RVUs) are applied to each service based on geographical location, physician work, practice expense (PE) and malpractice (MP), becoming payment rates when a conversion factor is applied.

Physician Fee Schedule Calculation =



CODING AND PAYMENT CHANGES

Intended to better identify and value primary care, care management, and cognitive services

• Make separate payments for certain CPT codes describing non-face-to-face prolonged evaluation and management services
• Revalue existing CPT codes describing face-to-face prolonged services
• Make separate payments using a new code to describe the comprehensive assessment and care planning for patients with cognitive impairments
• Make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions
• Make separate payments for codes describing chronic care management for patients with greater complexity
• Make several changes to reduce administrative burden associated with the chronic care management codes

PAYMENT PROVISIONS: MISVALUED CODES

Target for adjustments to misvalued codes in the fee schedule for CY 2017 and 2018:

0.5%

- CMS finalized misvalued code changes that achieve **0.32 percent in net expenditure reductions**
- Since these changes do not meet misvalued code target of 0.5 percent, the 2017 PFS conversion factor is **$35.86**

VALUATION OF MODERATE SEDATION SERVICES

Finalizing values for new CPT moderate sedation codes

- Adopting a uniform methodology for valuation of the procedural codes that include moderate sedation as an inherent part of the procedure
- Augmenting new moderate sedation CPT codes with an endoscopy-specific moderate sedation code
- Finalizing valuations reflecting the differences in physician survey data between gastroenterology and other specialties

MEDICARE TELEHEALTH SERVICES

CMS is finalizing the addition of several codes to the list of services eligible to be furnished via telehealth:

- End-stage renal disease (ESRD)-related services for dialysis
- Advanced care planning services
- Critical care consultations furnished via telehealth using new Medicare G-codes

PAYMENT FOR MAMMOGRAPHY SERVICES

CMS is finalizing a new coding framework based on new CPT coding for mammography services

Coding revision reflects current technology used in furnished these services:

- Transition from film to digital imaging equipment
- Elimination of separate coding for computer aided detection services

CMS is implementing the new coding framework and descriptors through use of G-codes for Medicare due to operational issues of claims processing for preventative services

UPDATED GEOGRAPHIC PRACTICE COST INDICES

General GPCI Update

CMS adjusts payments under PFS to reflect local differences in practice costs using GPCIs for each component of PFS payment: physician work, practice expense, malpractice expense

CMS is finalizing new GPCIs using updated data for CY 2017 and 2018

DATA ON RESOURCES USED IN GLOBAL SERVICES

MACRA requires CMS to gather data on visits in the post-surgical period to accurately value these surgical services

To reduce burden on practitioners, CMS has finalized the following data collection strategy:

- Require reporting of post-operative visits only for high-volume/high-cost procedures
- Using existing CPT code 99024 instead of proposed G-codes
- Requiring reporting only from a sample of practitioners in larger practices
- Allowing all others to report voluntarily

Practitioners are encouraged to begin reporting on services furnished **on or after January 1, 2017**, but the requirement will become effective for services furnished **on or after July 1, 2017**

MEDICARE ADVANTAGE (PART C) PROVIDER/SUPPLIER ENROLLMENT

Requires health care providers and suppliers to be screened and enrolled in Medicare in order to contract with a Medicare Advantage organization

Final rule creates consistency with CMS's current health care provider and supplier enrollment requirements for all other Medicare programs.

Requirements:

- Medicare Advantage network providers and suppliers
- First-tier, downstream, and related entities
- Health care providers and suppliers in Program of All-Inclusive Care for the Elderly (PACE) plans
- Suppliers in Cost Health Maintenance Organizations and/or competitive medical plans
- Healthcare providers and suppliers participating in demonstration and pilot programs
- Locum tenens suppliers that provide physician staffing services for hospitals, outpatient medical centers, government and military facilities, group practices, community health centers, and correctional facilities
- Incident-to-suppliers that furnish integral, but incidental, professional services in the course of diagnosis or treatment

MEDICARE ADVANTAGE DATA TRANSPARENCY

CMS is finalizing a proposal to release two sets of data related to plan participation in Medicare Advantage and the Part D prescription drug program.

Medicare Advantage Bid Pricing Data

Each year Medicare Advantage organizations (MAOs) apply to participate by submitting bids. CMS is finalizing the release of data associated with these bids on an annual basis. Data released would be at least 5 years old.

Medical Loss Ratio Data

ACA created minimum Medical Loss Ratio (MLR) for MAOs and Part D plan sponsors– at least 85% of revenues must be attributed to claims and quality improvement. Rule finalizes release of certain Medicare health and drug plan MLR data on an annual basis.

APPROPRIATE USE CRITERIA FOR ADVANCED IMAGING SERVICES

CMS established first four components of appropriate use criteria (AUC) in the CY 2016 MPFS final rule

2017 final rule focuses on next component and includes polices for **priority clinical areas**, **clinical decision support mechanism (CDSM) requirements,** the **CDSM application process**, and **exceptions for ordering professionals** for whom consolations with AUC would pose a significant hardship

- CMS finalized the **first eight priority clinical areas**:
  - Coronary artery disease (suspected or diagnosed)
  - Suspected pulmonary embolism
  - Headache (traumatic or non-traumatic)
  - Hip pain
  - Low back pain
  - Shoulder pain (to include suspected rotator cuff injury)
  - Cancer of the lung (primary or metastatic, suspected or diagnosed)
  - Cervical or neck pain

CMS finalized the CDSM application deadline of March 1, 2017 for first round

MEDICARE SHARED SAVINGS PROGRAM

Medicare Shared Savings Program was established to **promote accountability** for a patient population, **coordinate items and services** under parts A and B, **and encourage investment** in infrastructure and redesigned care processes for high quality and efficient service **delivery through provider and supplier participation in an ACO**

The CY 2017 MPFS final rule includes the following finalized policies

- Updates to ACO quality reporting requirements
- Modifications to the assignment algorithm to align beneficiaries to an ACO when beneficiary has designated ACO professional responsible for care
- Establishment of beneficiary protection polices related to use of the Skilled Nursing Facility 3-day waiver

MEDICARE DIABETES PREVENTION PROGRAM

CMS finalized expansion of the Medicare Diabetes Prevention Program (MDPP)

Program is a structured behavioral change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries diagnosed with pre-diabetes

Payment for MDPP services expected to begin in 2018

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