

Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year (CY) 2017

On July 7, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that updates payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (MPFS) on or after January 1, 2017. This year, CMS is proposing a number of new physician fee schedule policies that will improve Medicare payment for those services provided by primary care physicians for patients with multiple chronic conditions, mental and behavioral health issues, and cognitive impairment or mobility-related disabilities.

CMS is proposing to expand the Diabetes Prevention Program model starting January 1, 2018. This is the second CMS Innovation Center – and first preventive services – model that has been certified for expansion. Expansion of this model will enhance access to these important services for Medicare beneficiaries who are at risk for developing diabetes.

In addition CMS is also:

- Proposing modifications to the Medicare Shared Savings Program to update the quality measures set and align with the proposals for the Quality Payment Program, changes to take beneficiary preferences for ACO assignment into consideration, and changes that would improve beneficiary protections when ACOs are approved to use the skilled nursing facility (SNF) 3-day waiver rule;
- Requiring health care providers and suppliers to be screened and enrolled in Medicare in order to contract with Medicare Advantage health plans to provide Medicare-covered items and services to beneficiaries enrolled in Medicare Advantage;
- Increasing transparency of Medicare Advantage pricing data and medical loss ratio (MLR) data from Medicare health and drug plans, and;
- Continuing to implement Appropriate Use Criteria for advanced diagnostic imaging services, including proposals for priority clinical areas and clinical decision support mechanism (CDSM) requirements, among other proposals as detailed in this fact sheet.

The 2017 MPFS proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a health care system that results in better care, smarter spending, and healthier people.

Background on the Physician Fee Schedule

The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include but are not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services.

In addition to physicians, the physician fee schedule pays a variety of practitioners and entities, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.

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, updated each year as specified in the statute.

PAYMENT PROVISIONS

Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services

CMS is continuing the Agency's ongoing efforts to improve payment within traditional fee-for-service Medicare for primary care and patient-centered care management. CMS is proposing several revisions to the MPFS billing code set to more accurately recognize the work of primary care and other cognitive specialties to accommodate the changing needs of the Medicare patient population.

Historically, care management and cognitive work has been "bundled" into the evaluation and management visit codes used by all specialties. This has meant that payment for these services has been distributed equally among all specialties that report the visit codes, instead of being targeted toward practitioners who manage care and/or primarily provide cognitive services.

To improve payment accuracy for such care, in recent years, CMS created new codes that separately pay for chronic care management and transitional care management services, and solicited public comment on additional policies the Agency should pursue. Consistent with the public comments received, for 2017, CMS is proposing a number of coding and payment changes to better identify and value primary care, care management, and cognitive services:

- Make separate payments for certain existing Current Procedural Terminology (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 new codes to describe the comprehensive assessment and care planning for patients with cognitive impairment (e.g., dementia).
- Make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions. Several of these codes describe services within behavioral health integration models of care, including the Collaborative Care model that involves care coordination between a psychiatrist or behavioral health specialist and the primary care clinician, which has been shown to improve quality.
- Make separate payments using new codes to recognize the increased resource costs of furnishing visits to patients with mobility-related impairments. Like several of these proposed codes, this is especially relevant for the Medicare-Medicaid dually-eligible population.
- 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 to remove potential barriers to furnishing and billing for these important services.

CMS believes that these coding and payment changes could improve health care delivery for the types of services holding the most promise for healthier people and smarter spending, and advance our health equity goals.

CY 2017 Identification and Review of Potentially Misvalued Services

Section 3134(a) of the Affordable Care Act requires the Secretary to periodically identify potentially misvalued services and to review and make appropriate adjustments to the relative values for those services.

Through the Achieving a Better Life Experience (ABLE) Act of 2014, Congress set a target for adjustments to misvalued codes in the fee schedule for 2016, 2017, and 2018. The target was one percent for 2016, and will be 0.5 percent for 2017 and 2018.

If the net reductions in misvalued codes in 2017 are less than 0.5 percent of the total revenue under the fee schedule, a reduction equal to the percentage difference between 0.5 percent and the percent of expenditures represented by misvalued codes reductions must be made to all MPFS services.

In this proposed rule, CMS has proposed misvalued code changes that would achieve 0.51 percent in net expenditure reductions. If finalized, these changes would meet the misvalued code target of 0.5 percent, therefore avoiding a broad overall reduction to MPFS services.

Valuation of Moderate Sedation Services

In prior rulemaking, CMS noted that it appeared that practice patterns for certain endoscopic procedures were changing, with anesthesia increasingly being separately reported for these procedures even though payment for sedation services was automatically included in payment to the physician furnishing the primary procedure.

In response to CMS' requests in prior rulemaking, the American Medical Association CPT Editorial Panel created separate codes for reporting moderate sedation, and the Specialty Society Relative Value Update Committee provided CMS with recommended values for the moderate sedation codes and recommended adjustments to valuation of the procedure codes.

In the 2017 proposed rule, CMS is proposing values for the new CPT moderate sedation codes and proposing a uniform methodology for valuation of the procedural codes that currently include moderate sedation as an inherent part of the procedure. CMS is also proposing to augment the new moderate sedation CPT codes with an endoscopy-specific moderate sedation code, and proposing valuations reflecting the differences in physician survey data between gastroenterology and other specialties.

Medicare Telehealth Services: End-Stage Renal Disease (ESRD) and Advanced Care Planning

CMS is proposing to add several codes to the list of services eligible to be furnished via telehealth. These include:

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

CMS is also proposing payment policies related to the use of new place of service code specifically designed to report services furnished via telehealth.

Payment for Mammography Services

CMS is proposing to implement new CPT coding for mammography services. The coding revision reflects use of current technology used in furnishing these services, including a transition from film to digital imaging equipment and elimination of separate coding for computer aided detection services. CMS is proposing to maintain current valuation for the technical component of mammography services in order to implement coding and payment changes over several years.

Updated Geographic Practice Cost Indices (GPCI) for CY 2017

General GPCI Update

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs using GPCIs for each component of MPFS payment—physician work, practice expense, and professional liability insurance. Consistent with the law, CMS is proposing new GPCIs using updated data to be phased in over CY 2017 and CY 2018.

In conjunction with this proposed update, CMS is proposing to revise the methodology used to calculate GPCIs in the U.S. territories for consistency among the Pacific and Caribbean islands. This proposed revision would increase overall PFS payments in Puerto Rico.

California Localities

The Protecting Access to Medicare Act of 2014 requires that, beginning in 2017, CMS use new locality definitions for California based on a combination of Metropolitan Statistical Areas as defined by the Office of Management and Budget and the current locality structure. The California locality provision is not budget-neutral, meaning that payments to physicians in California will increase in the aggregate without across-the-board reductions in physician services elsewhere.

The movement to the new locality structure in California may increase payment to many physicians in urban parts of California without any reductions in specified counties that the law “holds harmless” from payment reductions. In a few areas of California, the new locality structure may decrease Medicare MPFS payments.

Collecting Data on Resources Used in Furnishing Global Services

Under the misvalued code initiative in the 2015 final rule, CMS finalized a policy to transform all 10- and 90-day global codes to 0-day global codes, beginning in CY 2018. Under this policy, CMS would have valued the surgery or procedure to include all services furnished on the day of surgery and paid separately for visits and services furnished after the day of the procedure. Subsequently, Congress enacted Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 prohibiting CMS from implementing this policy and requiring the agency to gather data on visits in the post-surgical period that could be used to accurately value these services. In this year’s proposed rule, CMS proposes a data collection strategy, including claims-based data collection and a survey of 5,000 practitioners, to gather data on the activities and resources involved in furnishing these services. To the extent that this data results in proposals to revalue

any surgical services, that revaluation will be done through notice and comment rulemaking at a future time.

0-day Global Services that are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25

CMS has noted that several high volume procedure codes are typically reported with a modifier that unbundles payment for visits from the procedure, even though the modifier should only be used for reporting services beyond those usually provided. Therefore, CMS believes the services may be misvalued. As a result, CMS is proposing to prioritize 83 services for review as potentially misvalued.

MEDICARE DIABETES PREVENTION PROGRAM

The Diabetes Prevention Program is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. The clinical intervention consists of 16 intensive “core” sessions of a curriculum in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. After the 16 core sessions, less intensive monthly follow-up meetings help ensure that the participants maintain healthy behaviors. The primary goal of the intervention is at least 5 percent average weight loss among participants.

In March 2016, the Department of Health and Human Services announced that the CMS Office of the Actuary certified that expansion of the Diabetes Prevention Program model would reduce net Medicare spending. The expansion was also determined by the Secretary to improve the quality of patient care without limiting coverage or benefits. These are the requirements a CMS Innovation Center model test must meet in order to be eligible for expansion as outlined in Section 1115A of the Social Security Act. The Diabetes Prevention Program is the second CMS Innovation Center – and the first preventive – model to meet these requirements.

Today, CMS is proposing to expand the Diabetes Prevention Program into Medicare beginning January 1, 2018. Through its expansion, more Medicare beneficiaries would be able to access the benefits of the Diabetes Prevention Program, which could lead to the prevention of diabetes, improved health, and reduced costs. The Medicare Diabetes Prevention Program section included in the PFS proposal specifically seeks comment on the following:

Medicare Diabetes Prevention Program Supplier Enrollment: CMS seeks comment on a proposal to allow CDC-recognized Diabetes Prevention Program organizations to enroll in Medicare beginning on January 1, 2017. CMS is contemplating requiring each person who provides services as part of a CDC-recognized Diabetes Prevention Program organization delivering these services to obtain a National Provider Identification number in order to provide Medicare Diabetes Prevention Program services.

Payment Structure: CMS seeks comment on a Medicare Diabetes Prevention Program payment structure, which ties payment to the number of sessions attended and the achievement and maintenance of a minimum weight loss. Claims for payment under the Medicare Diabetes Prevention Program would be submitted following the achievement of core session attendance and minimum weight loss, and following maintenance session attendance and maintenance of minimum weight loss.

IT Considerations and Capabilities: CMS seeks comment on requiring CDC-recognized Diabetes Prevention Program entities to submit claims to Medicare using standard claims forms and procedures, submitted electronically in batches. Claims submitted would be required to be traceable to care documented by the entity's beneficiary records, which should include the requisite amount of detail associated with participation. Entities would also be required to maintain and handle any beneficiary Protected Health Information or Personally Identifiable Information, in compliance with HIPAA and CMS standards.

Eligible Beneficiaries: CMS seeks comment on defining an eligible pre-diabetic patient as a beneficiary having a body mass index (BMI) of 25 or greater (a BMI of 23 or greater for Asian beneficiaries) in addition to a hemoglobin A1c test with a value of 5.7-6.4 percent, or a fasting plasma glucose of 110-125 mg/dL within the last 12 months, or 2-hour plasma glucose of 140-199 mg/dl after the 75 gram oral glucose tolerance test, and no previous diagnosis of diabetes or life-threatening conditions, mobility issues, etc. that would prohibit them from participating in the program.

Program Integrity Initiatives: CMS intends to develop policies to monitor and audit Medicare Diabetes Prevention Program entities and is seeking comment on approaches to mitigate program integrity risks.

Site of Service Requirements: CMS seeks comment on allowing service delivery in-person or virtually, clarifying that virtual services would not be considered part of current telehealth benefits.

Learning and Technical Assistance Requirements: CMS seeks comment on providing education, training, and technical assistance on Medicare enrollment, data security, claims submission, and medical record keeping for Medicare Diabetes Prevention Program entities.

Quality Measurement and Reporting: CMS seeks comment on the quality metrics that should be reported by Medicare Diabetes Prevention Program entities in addition to the reporting elements required on Medicare claims submissions outlined above (attendance and weight loss) or by the CDC recognition program. CMS specifically seeks comment on what quality metrics should be considered for public reporting (not for payment) to guide beneficiary choice of entities.

Timeframe: CMS seeks comment on whether the Medicare Diabetes Prevention Program should be expanded nationally in the first year of the program or whether it should be phased in. If it is phased in, then the rule proposes that the Medicare Diabetes Prevention Program would be offered initially for a period in certain geographic markets or regions or to a subpopulation of provider/suppliers. The goal of the phased-in approach will be to anticipate and refine technical issues prior to consideration of broader model scaling. CMS seeks comment on such an approach generally, and specifically on what factors the agency should consider in the selection of initial sites or Medicare Diabetes Prevention Program entities.

MEDICARE ADVANTAGE (PART C) PROVIDER AND SUPPLIER ENROLLMENT

The proposed regulations will require health care providers and suppliers to be screened and enrolled in Medicare in order to contract with a Medicare Advantage organization to provide Medicare-covered items and services to beneficiaries enrolled in Medicare Advantage health plans.

Background on Medicare Advantage Provider and Supplier Enrollment in the MPFS

This proposal creates consistency with CMS's current health care provider and supplier enrollment requirements for all other Medicare (Part A, Part B, and Part D) programs. It is also consistent with a recently published Medicaid Managed Care Rule that requires health care providers in a Medicaid managed care plan's network to be screened and enrolled with the state Medicaid program.

CMS believes this proposed rule is necessary to help ensure that Medicare enrollees receive appropriate or medically-necessary items or services from health care providers and suppliers that fully comply with Medicare enrollment requirements. The Medicare enrollment process helps to protect Medicare beneficiaries and the Medicare Trust Funds by carefully screening health care providers and suppliers, especially those that could pose an elevated risk to Medicare, to ensure that they are qualified to furnish Medicare items and services.

Medicare beneficiaries, the Medicare Trust Funds, and the program at large are at risk when providers and suppliers that have not been adequately screened and enrolled. We believe our program integrity efforts in the Medicare enrollment process should be extended to all health care providers that receive Medicare payments, even when payment is received through an intermediary source such as a Medicare Advantage plan.

For instance, Medicare Advantage network providers that perform medically unnecessary tests, treatments, or procedures could threaten enrollees' welfare, as could a physician who routinely overprescribes prescription drugs. Requiring providers and suppliers that contract with a Medicare Advantage organization and furnish Medicare-covered items and services to enroll in Medicare allows CMS to provide more robust and consistent oversight of these health care providers and suppliers. Anytime a health care provider or supplier fails to meet CMS requirements or violates federal rules and regulations, CMS may revoke enrollment and prevent them from billing Medicare's Part A or B programs and from prescribing prescription medications covered by Medicare and Medicare Advantage Prescription Drug (MA-PD) Part D programs. This proposed rule also prevents Medicare Advantage participation by health care providers or suppliers that have had their Medicare enrollment revoked or have been excluded by the Office of the Inspector General.

Health care providers or suppliers – either as individuals or entities – can enroll in Medicare programs in accordance with the Social Security Act. For Medicare Advantage, the proposed enrollment and approved status requirement applies to:

- Network providers and suppliers;
- First-tier, downstream, and related entities (FDR);
- Health care providers and suppliers in Program of All-inclusive Care for the Elderly (PACE) plans;
- Suppliers in Cost Health Maintenance Organizations (Cost HMOs) and or competitive medical plans (CMPs). Medicare Cost HMOs and CMPs are types of Medicare health plans available in certain areas of the country. Some Cost HMOs or CMPs only provide coverage for Part B services. These plans do not include Medicare Part D prescription drug benefits; they are sponsored by employer or union group health plans or offered by companies that do not provide Part A services;
- Health care 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; and,
- Incident-to-suppliers that furnish integral, but incidental, professional services in the course of diagnosis or treatment of an injury or illness.

As part of the proposed changes, the enrollment provisions would be included in CMS contracts with MA and MA-PD plans. Plans that do not meet these requirements may be subject to contract actions ranging from intermediate sanctions to contract termination. When final, these provisions will begin two years after publication of the final rule and will be effective on the first day of the plan year.

MEDICARE ADVANTAGE DATA TRANSPARENCY

Consistent with the Administration's commitment to transparency and making data publicly available, CMS is proposing to release two new sets of data related to plan participation in Medicare Advantage and the Part D prescription drug program. CMS hopes that making this data publicly available will assist public research that will support future policymaking efforts in the Medicare program and provide valuable information to beneficiaries in making enrollment decisions.

Medicare Advantage Bid Pricing Data

Each year, Medicare Advantage organizations (MAOs) apply to participate in the Medicare Advantage program through a bidding process. MAOs submit bids to CMS that reflect the MAO's estimated costs associated with providing benefits to enrollees. CMS approves bids that meet a variety of statutory and regulatory conditions.

CMS is proposing to release data associated with these bids on an annual basis. The data released would be at least five years old and would exclude information treated as proprietary. CMS is also soliciting comment on what factors CMS should consider when proposing to release data that is more recent than five years old.

Medical Loss Ratio Data

The Affordable Care Act created a Medical Loss Ratio (MLR) for Medicare Advantage organizations and Part D plan sponsors, comparable to the standard created for commercial plans. Under the MLR standard, at least 85 percent of revenues must be attributed to claims and quality improvement activities.

The Affordable Care Act required CMS to make commercial MLR data public, but did not require publication of Medicare MLR data. CMS is proposing to release Medicare health and drug plan MLR data on an annual basis for use by beneficiaries making enrollment decisions.

APPROPRIATE USE CRITERIA FOR ADVANCED IMAGING SERVICES

Section 218(b) of the Protecting Access to Medicare Act (PAMA) of 2014 establishes a new program under the statute for fee for service Medicare to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services.

CMS established the first of the four components of this program in the CY 2016 Physician Fee Schedule final rule focusing on requiring an evidence-based and transparent process for developing AUC. AUC under this program may only be developed by qualified provider-led entities (the initial list of qualified entities is posted on the CMS website at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html>). This year's proposed rule focuses on the next component of the Medicare AUC program and includes proposals for priority clinical areas, clinical decision support mechanism (CDSM) requirements, the CDSM application process, and exceptions for ordering professionals for whom consultation with AUC would pose a significant hardship. CDSMs are the electronic tools through which a clinician consults AUC to determine the level of clinical appropriateness for an advanced diagnostic imaging service for that particular patient's clinical scenario. CMS has indicated in this proposed rule that the third component of the program (when ordering professionals must begin consulting CDSMs and furnishing professionals must append AUC related information to the Medicare claim) will not begin earlier than January 1, 2018.

MEDICARE SHARED SAVINGS PROGRAM

The 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 Accountable Care Organization (ACO). The CY 2017 MPFS proposed rule includes the following proposed policies specific to certain sections of the Shared Savings Program regulations:

- Updates to ACO quality reporting, including changes to the quality measure set and the quality validation audit, revisions to terminology used in quality assessment, revisions that would permit eligible professionals in ACOs to report quality apart from the ACO, and updates to align with the Physician Quality Reporting System and the proposed Quality Payment Program;
- Modifications to the assignment algorithm to align beneficiaries to an ACO when a beneficiary has designated an ACO professional as responsible for their overall care;
- Establishing beneficiary protection policies related to use of the SNF 3-day waiver; and,
- Technical changes to certain rules related to merged and acquired TINs and for reconciliation of ACOs that fall below 5,000 beneficiaries, and other program refinements.

CMS will accept comments on the proposed rule until September 6, 2016, and will respond to comments in a final rule. The proposed rule will appear in the July 15, 2016, Federal Register and can be downloaded from the Federal Register at: <https://www.federalregister.gov/public-inspection>.