

Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year 2018

On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018.

The calendar year (CY) 2018 PFS final rule is one of several final rules that reflect a broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation.

Background on the Physician Fee Schedule

Payment is made under the PFS 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, payment is made under the PFS to a variety of practitioners and entities, including nurse practitioners, physician assistants, and 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 work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor. Payment rates are calculated to include an overall payment update specified by statute.

Patients Over Paperwork

CMS recently launched the “Patients Over Paperwork” Initiative, a cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. This effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients. The Medicare Physician Fee Schedule final rule includes the following as part of this initiative:

- reducing reporting requirements
- removing downward payment adjustments based on performance for practices that meet minimum quality reporting requirements

Payment Provisions

Changes in Valuation for Specific Services

CMS reviews the resource inputs for several hundred codes under the annual process referred to as the potentially misvalued code initiative. Recommendations from the American Medical Association-Relative Value Scale Update Committee (RUC) are critically important to this work. For CY 2018, CMS is finalizing the values for individual services that generally reflect the expert recommendations from the RUC without as many refinements as CMS made in recent years.

Overall Payment Update and Misvalued Code Target

The overall update to payments under the PFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014.

After applying these adjustments, and the budget neutrality adjustment to account for changes in RVUs, all required by law, **the final 2018 PFS conversion factor is \$35.99**, an increase to the 2017 PFS conversion factor of \$35.89.

Payment Rates for Nonexcepted Off-campus Provider-Based Hospital Departments Paid Under the PFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the OPFS beginning January 1, 2017. For CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

For CY 2018, CMS is finalizing a reduction to the current PFS payment rates for these items and services by 20 percent. CMS currently pays for these services under the PFS based on a percentage of the OPFS payment rate. Specifically, the final policy will change the PFS payment rates for these services from 50 percent of the OPFS payment rate to 40 percent of the OPFS rate. CMS believes that this adjustment will provide a more level playing field for competition between hospitals and physician practices by promoting greater payment alignment.

Medicare Telehealth Services

For CY 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:

- HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
- CPT code 90785 (Interactive Complexity);
- CPT codes 96160 and 96161 (Health Risk Assessment);
- HCPCS code G0506 (Care Planning for Chronic Care Management); and
- CPT codes 90839 and 90840 (Psychotherapy for Crisis).

Additionally, we are finalizing our proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners. We are also finalizing separate payment for CPT code 99091, which describes certain remote patient monitoring, for CY 2018. Lastly, we will consider the stakeholder input we received in response to the proposed rule's comment solicitation on how CMS could expand access to telehealth services, within the current statutory authority.

In the proposed rule, we sought comment on whether to make separate payment for CPT codes that describe remote patient monitoring or other existing codes that describe extensive use of communications technology. Some commenters raised concerns with our proposal, citing concerns that existing CPT codes were overly broad and not always reflective of current technology. Other commenters were supportive of the proposal generally but noted that CPT is currently working on codes that more accurately describe remote patient monitoring. In the final rule, we are finalizing separate payment for CPT code 99091 (Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, for 2018 pending anticipated changes in CPT coding.

Lastly, in the proposed rule, we sought comments on ways to further expand access to telehealth services within our current statutory authority. We appreciate the thoughtful input we received in response to this comment solicitation and will consider this input in future rulemaking.

Malpractice Relative Value Units (RVUs)

For CY 2017, we collected updated professional liability insurance data for the purposes of updating the malpractice geographic practice cost indices, but we did not propose to use the data to update the specialty risk factors used in the calculation of malpractice RVUs at that time. Rather, we solicited comment on whether we should consider updating the malpractice RVUs based on the updated professional liability insurance data prior to the next expected 5-year update (CY 2020).

After consideration of public comments received, for CY 2018, CMS is not finalizing its proposal to develop malpractice RVUs using the most recent data available. Additionally, we are not finalizing our proposal to align the update of malpractice premium data with the malpractice geographic practice cost index updates, which has been done once every three years, at this time. In principle, we continue to believe that more frequent updates are optimal, and we will consider this in future rulemaking.

Care Management Services

CMS is continuing efforts to improve payment within traditional fee-for-service Medicare for chronic care management and similar care management services to accommodate the changing needs of the Medicare patient population. CMS is finalizing its proposals to adopt CPT codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes. Also we are clarifying a few policies regarding chronic care management in this final rule. We are committed to working with stakeholders on any further refinements to the code set that may be warranted, especially describing the professional work involved in caring for complex patients in other clinical contexts.

Improvement of Payment Rates for Office-based Behavioral Health Services

CMS is finalizing an improvement in the way physician fee schedule rates are set that will positively impact office-based behavioral health services with a patient. The final policy will increase payment for these important services by better recognizing overhead expenses for office-based face-to-face services with a patient.

Evaluation and Management Comment Solicitation

Most physicians and other practitioners bill patient visits to the PFS under a relatively generic set of codes that distinguish level of complexity, site of care, and in some cases whether or not the patient is new or established.

These codes are called Evaluation and Management (E/M) visit codes. Billing practitioners must maintain information in the medical record that documents that they have reported the appropriate level of E/M visit code. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level.

We agree with continued feedback from stakeholders that these guidelines are potentially outdated and need to be revised.

CMS thanks the public for the comments received in response to the proposed rule's comment solicitation on the E/M guidelines and summarizes these comments in the final rule. Commenters suggested that we provide additional avenues for collaboration with stakeholders prior to implementing any changes. We will consider the best approaches for such collaboration, and will take the public comments into account as we consider the issues for future rulemaking.

Emergency Department Visits Comment Solicitation

CMS sought comment from stakeholders on whether emergency department visits are undervalued due to increasing heterogeneity of the settings under which emergency department visits are furnished and changes to the patient population. We received a number of comments that suggest these services are potentially misvalued, and we will be reviewing emergency department visits (CPT codes 99281-99385) as potentially misvalued for future rulemaking.

Solicitation of Public Comments on Initial Data Collection and Reporting Periods for Clinical Laboratory Fee Schedule

The Clinical Laboratory Fee Schedule (CLFS) final rule entitled "Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System" implements Section 1834A of the Social Security Act (the Act), which requires extensive revisions to the Medicare payment, coding, and coverage for Clinical Diagnostic Laboratory Tests (CDLTs) paid under the CLFS. Under the final rule, the payment amount for a test on the CLFS furnished on or after January 1, 2018, generally will be equal to the weighted median of private payer rates determined for the test, based on the data of applicable laboratories that is collected during a specified data collection period and reported to CMS during a specified data reporting period. The first data collection period was from January 1

through June 30, 2016, and the first data reporting period was from January 1, 2017, through March 31, 2017.

Laboratory industry feedback suggested that many reporting entities would not be able to submit a complete set of applicable information to CMS by the March 31, 2017 deadline. As a result, on March 30, 2017, we announced a 60-day period of enforcement discretion until May 30, 2017, with respect to the data reporting period for reporting applicable information under the Medicare CLFS and the application of the Secretary's potential assessment of civil monetary penalties (CMPs) for failure to report applicable information.

In the proposed rule, CMS solicited public comments from applicable laboratories and reporting entities to better understand applicable laboratories' experiences with the data reporting, data collection, and other compliance requirements for the first data collection and reporting periods under the new private payor rate-based CLFS. We thank the commenters for their feedback and will consider the stakeholders' comments for potential future rulemaking or publication of subregulatory guidance pertaining to the CLFS data collection and reporting periods.

Part B Drugs: Payment for Biosimilar Biological Products

In the CY 2016 PFS final rule with comment period, CMS finalized a proposal to make clear that biosimilar products that rely on a common reference product's biologics license application are grouped into the same payment calculation for determining a single average sales price payment limit, and that a single Healthcare Common Procedure Coding System (HCPCS) code is used for such biosimilar products.

In the CY 2018 PFS proposed rule, CMS asked for comments on the effects of its payment policy based on experience with the United States' biosimilar product marketplace.

CMS received numerous comments on this issue. In response to concerns raised in the comments, CMS is changing the policy to separately code and pay for biological biosimilar products under Medicare Part B. Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code.

CMS believes that a solution that increases provider

and patient choice is superior to existing policy and may lead to additional cost savings over the long-term. By encouraging innovation and greater manufacturer participation in the marketplace, we believe that this policy change will result in the licensing of more biosimilar products, thus creating a stable and robust market, driving competition and decreasing uncertainty about access and payment. Carrying out this policy change as early as possible, rather than waiting, is expected to bring more certainty to the new and developing marketplace.

Part B Drug Payment: Infusion Drugs Furnished through an Item of Durable Medical Equipment (DME)

The 21st Century Cures Act transitioned payment for infusion drugs or biologicals furnished through a covered item of DME from average wholesale price (AWP) to average sales price (ASP) pricing methodology on January 1, 2017. CMS is finalizing the proposed revision to 42 CFR §414.904(e)(2) to conform regulations with the statutory payment requirements in section 5004(a) of the 21st Century Cures Act.

New Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

CMS is finalizing the proposal to revise payment for chronic care management in RHCs and FQHCs, and establish requirements and payment for RHCs and FQHCs furnishing general behavioral health integration (BHI) services and psychiatric collaborative care model (CoCM) services. Effective January 1, 2018, RHCs and FQHCs will be paid for CCM, general BHI, and psychiatric CoCM using two new billing codes created exclusively for RHC and FQHC payment. This payment would be in addition to the payment for an RHC or FQHC visit.

Appropriate Use Criteria for Advanced Diagnostic Imaging

CMS is finalizing a start date for the Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging. The program will begin in a manner that allows practitioners more time to focus on and adjust to the Quality Payment Program before being required to participate in the AUC program. The Medicare AUC program will begin with an educational and operations testing year in 2020, which means physicians would be required to start using AUCs and reporting this information on their claims. During this first year, CMS is

proposing to pay claims for advanced diagnostic imaging services regardless of whether they correctly contain information on the required AUC consultation. This allows both clinicians and the agency to prepare for this new program.

CMS posted newly qualified provider-led entities and clinical decision support mechanisms in July of this year. Qualified provider-led entities are permitted to develop AUC, and qualified clinical decision support mechanisms are the tools that physicians use to access the AUC. Physicians may begin exploring these mechanisms well in advance of the start of the Medicare AUC program through the voluntary participation period that will begin mid-2018 and run through 2019. During this time CMS will collect limited information on Medicare claims to identify advanced imaging services for which consultation with appropriate use criteria took place.

In addition, by having qualified clinical decision support mechanisms available (some of which are free of charge) clinicians may use one of these mechanisms to earn credit under the Merit-Based Incentive Payment System as an improvement activity. This improvement activity was included in the 2018 Quality Payment Program final rule.

Medicare Diabetes Prevention Program Expanded Model

The final rule also implements the Medicare Diabetes Prevention Program (MDPP) expanded model starting in 2018. The MDPP expanded model was announced in early 2016, when it was determined that the Diabetes Prevention Program (DPP) model test through the Center for Medicare and Medicaid Innovation's Health Care Innovation Awards met the statutory criteria for expansion. The final rule includes additional policies necessary for suppliers to begin furnishing MDPP services nationally in 2018, including the MDPP payment structure, as well as additional supplier enrollment requirements and supplier compliance standards aimed to enhance program integrity.

Physician Quality Reporting System (PQRS)

Under the PQRS, individual eligible professionals and group practices who did not satisfactorily report data on quality measures for the CY 2016 reporting period are subject to a downward payment adjustment of 2.0 percent in 2018 to their PFS covered professional services. 2016 was the last reporting period for PQRS. The final

data submission timeframe for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. PQRS is being replaced by the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP). The first MIPS performance period is January through December 2017.

CMS proposed and is finalizing a change to the current PQRS program policy that requires reporting of 9 measures across 3 National Quality Strategy domains to only require reporting of 6 measures for the PQRS with no domain requirement. We are also finalizing similar changes to the clinical quality measure reporting requirements under the Medicare Electronic Health Record Incentive Program for eligible professionals who reported electronically through the PQRS portal.

We finalized these changes based on stakeholder feedback and to better align with the MIPS data submission requirements for the quality performance category. For MIPS, eligible clinicians need only report 6 quality measures for the quality performance category, except those reporting via the Web Interface, and there is no requirement to ensure that the measures span across 3 National Quality Strategy domains.

Patient Relationship Codes

In May 2017, CMS posted the operational list of patient relationship categories that are required under section 101(f) of MACRA. In this rule, we finalized certain Level II HCPCS modifiers to be used on claims to indicate these patient relationship categories. Further, we finalized a policy that the reporting of these HCPCS modifiers may be voluntarily by clinicians associated with these patient relationship categories beginning January 1, 2018. We anticipate that there will be a learning curve with respect to the use of these modifiers, and we will work with clinicians to ensure their proper use.

Medicare Shared Savings Program

CMS is finalizing several modifications to the rules for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program. These modifications are designed to reduce burden and streamline program operations. The new policies include the following:

- Revisions to the assignment methodology for ACOs that include FQHCs and RHCs by eliminating the requirement to enumerate each physician working in the FQHC or RHC on the ACO participant list;
- Reduction of burden for ACOs submitting an initial Shared Savings Program application or the application for use of the skilled nursing facility (SNF) 3-Day Rule Waiver; and
- The addition of three new chronic care management codes (CCM) and four behavioral health integration (BHI) codes to the definition of primary care services used in the ACO assignment methodology.

2018 Value Modifier

In order to better align incentives and provide a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program, we are finalizing the following changes to previously-finalized policies for the 2018 Value Modifier:

- Reducing the automatic downward payment adjustment for not meeting the criteria to avoid the PQRS adjustment from negative four percent to negative two percent (-2.0 percent) for groups of ten or more clinicians; and from negative two percent to negative one percent (-1.0 percent) for physician and non-physician solo practitioners and groups of two to nine clinicians;
- Holding harmless all physician groups and solo practitioners who met the criteria to avoid the PQRS adjustment from downward payment adjustments for performance under quality-tiering for the last year of the program; and
- Aligning the maximum upward adjustment amount to 2 times the adjustment factor for all physician groups and solo practitioners.
- Given final policy changes for the Physician Quality Reporting System and the Value Modifier, we finalized that we will not report 2018 Value Modifier data in the Physician Compare downloadable database as this would be the first and only year such data would have been reported. However, to promote transparency we will continue to make available the Value Modifier public use and research identifiable files.