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CY 2016 Medicare Physician Fee Schedule Proposed Rule

OVERVIEW

On July 8th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (PFS). Provisions of the proposed rule include modifications to existing physician quality reporting programs including the Physician Quality Reporting System (PQRS) and the Physician Value-Based Payment Modifier (Value Modifier). The proposed rule also begins transitioning these programs into the Merit-Based Incentive Payment System (MIPS) created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to go into effect in 2018.

CMS will accept comments on the proposed rule until September 8th. The proposed rule is available here. This document summarizes several major provisions of the proposed rule.

PQRS

The Physician Quality Reporting System (PQRS) tracks the quality of care provided to Medicare beneficiaries. CMS proposes to add new measures to the PQRS data set. The modified PQRS measure set would include a total of 300 measures for 2016. CMS also proposes to add a reporting option that allows group practices to report quality measures using a qualified clinical data registry (QCDR). CMS proposes to make group practice level QCDR PQRS data that have been collected for at least a full year available for public reporting.

PHYSICIAN COMPARE

The Physician Compare website includes information on physicians enrolled in the Medicare program and other eligible professionals (EPs) who participate in the Physician Quality Reporting System (PQRS). As part of the proposed rule, CMS would continue to phase-in public reporting on the Physician Compare website.

CMS proposes several new policies:

- Displaying an item-level benchmark on Physician Compare, based on the Achievable Benchmark of Care (ABC) methodology, which would compare physicians to a benchmark, represented as a five-star rating;
- Including an indicator on profile pages for individual EPs who successfully report the PQRS Cardiovascular Prevention measures in support of Million Hearts and for individual and group EPs who receive an upward adjustment for the Value Modifier;
- Publically reporting individual-level QCDR measures and group-level QCDR measures;
- Including information such as the Value Modifier tiers for cost and quality and whether the group practice or EP is high, low, or neutral on cost and quality in the downloadable database; and
- Publically reporting utilization data for individual EPs in the downloadable database.

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ADVANCE CARE PLANNING

CMS proposes to cover advance care planning conversations between Medicare beneficiaries, their families, and their providers. Medicare currently covers end-of-life planning as part of a beneficiary's "Welcome to Medicare" visit. If finalized, the rule would recognize two CPT codes for advance care planning services that could be billed separately and allow providers to engage patients in these conversations as needed.

- CPT code 99497: Advance Care Planning including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health professional. This code would cover the first 30 minutes of a face-to-face interaction with the patient, family member, and/or surrogate; and
- CPT code 99498: an add-on code for any additional 30 minutes of explanation and discussion of advance directives.

PAYMENT PROVISIONS

Under the Affordable Care Act (ACA), CMS is instructed to identify misvalued codes in the PFS. In the proposed rule, CMS proposes to make the following revisions to misvalued codes:

- In 2012, CMS identified the codes for radiation therapy as misvalued. Over a two-year period, CMS proposes to change the utilization rate assumption used to determine the per-minute cost of the capital equipment by assuming that the equipment is generally used for 35 hours per week instead of 25 hours per week.
- CMS proposes to implement a revised set of codes with updated values for the lower endoscopy code set after identifying that some codes were potentially misvalued in CY 2015.

CMS also proposes to identify anesthesia codes 00740 and 00810 as potentially misvalued.

VALUE MODIFIER

The Value Modifier program adjusts payments under the PFS based on the quality and cost of the care furnished. The Value Modifier program will expire after CY 2018, when the MIPS begins in CY 2019. CMS proposes the following key provisions to assist with the transition from Value Modifier to MIPS:

- CY 2016 will be used as the performance period for the CY 2018 Value Modifier;
- The value modifier would apply to non-physician EP-only groups beginning with the CY 2018 payment adjustment period;
- The quality-tiering methodology would continue to apply to all groups and individual practitioners in Category 1 for the CY 2018 that adequately report PQRS. Both groups and solo practitioners would be subject to upward, neutral, or downward adjustments based on quality-tiering methodology. Groups consisting of only non-physician EPs and

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non-physician solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology for CY 2018;

- The maximum upward adjustment under the CY 2018 Value Modifier would continue to be set at: +4.0 times an adjustment factor for groups of 10 or more EPs; +2.0 times an adjustment factor for groups with between 2 and 9 EPs and physician individual practitioners; and +2.0 times an adjustment factor for groups of only non-physician EPs or non-physician solo practitioners.
- The amount of payment at risk under the CY 2018 Value Modifier would be set to: -4.0 percent for groups with 10 or more EPs, -2.0 percent for groups with between 2 and 9 EPs and individual practitioners, and -2.0 percent for groups of only non-physician EPs or non-physician solo practitioners.

MACRA REQUEST FOR INPUT

To implement the MIPS in future rulemaking, CMS is seeking input on the establishment of a low-volume threshold, clinical practice improvement activities, and a definition for a physician focused payment model.

- **Low-volume threshold:** MACRA requires a low-volume threshold to apply for purposes of excluding certain EPs from the definition of a MIPS EP. CMS is considering proposing a threshold to exclude EPs that do not have at least 10 percent of their patient volume derived from Medicare Part B encounters from participating in the MIPS. CMS seeks comments on the appropriateness of this low-volume threshold for the MIPS.
- **Clinical practice improvement activities:** Clinical practice improvement activities improve clinical practice or care delivery. Subcategories of such activities include, but are not limited to: expanded practice access; population management; and care coordination. CMS seeks comment on what activities could be classified as clinical practice improvement activities based on this definition.

It is anticipated that a Request for Information (RFI) will be released later this year. CMS intends to publish specific questions in the RFI on topics including, but not limited to, criteria for assessing physician-focused payment models and criteria and process for the submission of alternative payment models. In anticipation of the future RFI, CMS welcomes comments in response to the proposed rule on approaches to implementing these topics and any related concerns.

POTENTIAL COMPREHENSIVE PRIMARY CARE INITIATIVE EXPANSION

The Comprehensive Primary Care Initiative (CPCI) is a collaboration of 38 payers to coordinate care for Medicare beneficiaries through population-based care management fees and shared savings opportunities. The initiative is being tested in approximately 480 primary care practice sites in seven markets. In the proposed rule, CMS is seeking comment on potential issues related to the expansion of the program. CMS is not expanding the CPCI at this time.

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SHARED SAVINGS PROGRAM

The proposed rule includes updates to several sections of the Medicare Shared Savings Program regulations related to quality measures and quality performance. CMS proposes to add a new quality measure and to adopt a policy for addressing quality measures that no longer align with best clinical practice due to guideline updates. If a measure owner determines a measure no longer aligns with updated clinical practice or causes patient harm, it may revert to pay-for-reporting.