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CY 2016 Medicare Physician Fee Schedule Final Rule

OVERVIEW

On October 30th, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (PFS). The final rule includes modifications to existing physician quality reporting programs including the Physician Quality Reporting System (PQRS) and the Physician Value-Based Payment Modifier (Value Modifier). The final 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). MIPS is set to begin in CY 2019.

This document summarizes several major provisions of the final rule. The final rule is available here.

PQRS

The Physician Quality Reporting System (PQRS) tracks the quality of care provided to Medicare beneficiaries. CMS finalized its proposal to add new measures to the PQRS dataset and to remove measures that are topped out or duplicative. For 2016, there will be 281 PQRS measures and 18 measures in the Group Practice Reporting Option Web Interface.

CMS also finalized its proposal to add a reporting option that allows group practices to report quality measures using a qualified clinical data registry (QCDR).

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). CMS finalized its proposal to continue to phase-in public reporting on the Physician Compare website.

CMS finalized 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 on 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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CMS is not finalizing the proposal to include a visual indicator on profile pages for group practices and individual EPs who receive an upward adjustment for the Value Modifier.

ADVANCE CARE PLANNING

CMS finalized its proposal 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. The final rule recognizes two CPT codes for advance care planning services that can be billed separately and allow providers to engage patients in these conversations as needed.

CMS is also finalizing payment for advance care planning when it is included as an optional element of the "Annual Wellness Visit".

MISVALUED CODES

Under the Affordable Care Act (ACA), CMS is instructed to identify misvalued codes in the PFS. In the proposed rule, CMS identified the codes for radiation therapy as misvalued. CMS proposed to implement a new code set for payment of radiation therapy under the PFS and 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 is finalizing its proposal to change the utilization rate assumption. However, CMS is not finalizing the proposal to implement the new code set for payment of radiation therapy under the PFS and will work to address the codes and pricing in future years.

CMS finalized its proposal 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.

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 finalized key provisions to assist with the transition from Value Modifier to MIPS, including but not limited to:

- The value modifier will apply to non-physician EP-only groups who are Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists beginning with the CY 2018 payment adjustment period;
- The quality-tiering methodology will apply to all groups and individual practitioners that meet the criteria to avoid downward adjustment under the PQRS. Both groups and solo practitioners will be subject to upward, neutral, or downward adjustments based on quality-tiering methodology. Groups consisting of only non-physician EPs and non-physician solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology for CY 2018;
- 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

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