spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

CY 2017 Medicare Physician Fee Schedule Proposed Rule

OVERVIEW

On July 7th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update the Physician Fee Schedule (PFS) and other Medicare Part B payment policies for CY 2017. CMS estimates that these changes would provide $900 million in additional funding to physicians and practitioners, and would increase payments to geriatricians and family practice physicians by two to three percent in 2017. Other provisions of the rule include: enrollment and data transparency updates to the Medicare Advantage (MA) program, modifications to the Medicare Shared Savings Program (MSSP), and the expansion of the Diabetes Prevention Prevention Program to Medicare.

CMS will accept comments on the proposed rule until September 6th. This document summarizes several major provisions of the proposed rule. The proposed rule is available here.

MISVALUED CODES

Under the Affordable Care Act (ACA), CMS is instructed to identify misvalued codes in the PFS. The Achieving a Better Life Experience (ABLE) Act further requires CMS to achieve targeted net reductions in misvalued codes for 2016, 2017, and 2018. For 2016 the target was one percent and for 2017 and 2018 the target will be 0.5 percent. The rule proposes changes that would achieve an estimated 0.51 percent in net expenditure reductions from misvalued codes in 2017 to comply with the ABLE Act.

PAYMENT PROVISIONS

The rule proposes a number of new codes and payment updates to improve reimbursement accuracy for the following services.

Mobility-Related Impairment Care Payments

Under the proposed rule, CMS would increase payments to physicians for care that is delivered to patients with mobility-related impairments. Payments would increase from $73 to $119.

Sedation Services

CMS proposes new codes for moderate sedation services. The new codes would include an endoscopy-specific moderate sedation code and would reflect the difference in physician survey data between gastroenterology and other specialties.

Telehealth Services

Under the proposed rule, CMS would add the following codes to the list of services eligible to be delivered via telehealth:

- End-stage renal disease (ESRD) related services for dialysis;
- Advanced care planning services; and

- Critical care consultations.

CMS is also proposing a "place of service" code for the reporting of services that are delivered via telehealth. As early as January 1, 2017, providers would be required to report the telehealth place of service code.

Mammography Services

The rule proposes new codes for mammography services. The code set would be updated to reflect the current use of technology in providing mammography services.

Chronic Care Management

The rule proposes new care management payment codes for comprehensive assessment and care planning that are provided by a physician or practitioner to patients with multiple chronic conditions. The add-on codes would be billed separately from monthly care management services.

Behavioral Health

Under the proposed rule, CMS would pay for behavioral health services that are delivered through the Collaborative Care Model. Under the Collaborative Care Model, a primary care practitioner, behavioral health care manager, and psychiatric consultant would provide integrated care to the patient.

Cognitive Impairment Care

The rule proposes a new code to reimburse for cognitive and functional assessment and care planning for patients with cognitive impairments.

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 in CY 2019, when the Merit-based Incentive Payment System (MIPS) begins. To support the transition to MIPS, CMS proposes to update the VM informal review process and establish how the quality and cost composites under VM would be affected if unanticipated program issues arise in 2017 and 2018.

MA UPDATES

The proposed rule makes several changes to enhance data transparency and data and supplier enrollment in the MA program.

Provider and Supplier Enrollment

Under the proposed rule, health care providers and suppliers would be required to enroll in Medicare to provide covered services to MA beneficiaries. Providers or suppliers that fail to meet CMS requirements may have their enrollment revoked and be prevented from billing Medicare. Providers and suppliers that have had their Medicare enrollment revoked or have been excluded by the Office of the Inspector General would be barred from participating in MA. These changes would be reflected in CMS contracts

with MA and MA Prescription Drug (MA-PD) plans. Plans that fail to meet these requirements may be sanctioned or have their contracts terminated. These provisions would begin two years after the rule is finalized and would be effective on the first day of the plan year.

Data Transparency

CMS proposes to release two new datasets on plan participation in MA and MA-PD:

- **MA Bid Pricing Data** – CMS proposes to release pricing data that is submitted by plans for the MA bid process. The dataset would be released annually, but would contain data that is at least five years old and would exclude any proprietary information. 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 (MLR) Data** – CMS proposes to make MA and MA-PD MLR data publicly available on an annual basis.

MSSP

The proposed rule would make several changes to the MSSP. CMS proposes to update the MSSP quality measure set so that it is aligned the Physician Quality Reporting System and the proposed Quality Payment Program. The rule would enhance to the Quality Measure Validation audit process.

The rule would also modify the beneficiary assignment algorithm so that beneficiaries may elect to be assigned to the ACO that their provider participates in.

MEDICARE DIABETES PREVENTION PROGRAM

The National Diabetes Prevention Program (DPP) is a health behavior change model that was developed by the Centers for Disease Control and Prevention (CDC) to provide preventive care to individuals who are at risk of Type 2 diabetes. Through the DPP, care is delivered in community and health care settings by trained community health workers or health professionals.

The rule proposes to expand the program by implementing the Medicare DPP (MDPP) on January 1, 2018. Under the proposed rule, authorized DPP suppliers would be eligible to submit claims to Medicare for delivering diabetes prevention services. Payments would be tied to the beneficiary's session attendance and weight loss. Any organization that is authorized by the CDC to provide DPP services would be eligible to apply for Medicare enrollment beginning on January 1, 2017.

CMS is requesting information from stakeholders on the implementation of MDPP. Specifically, CMS is seeking comment on whether the MDPP should be implemented nationally or limited to certain geographic areas for its first year.

ADVANCED CARE IMAGING SERVICES

The Protecting Access to Medicare Act requires fee-for-service Medicare to establish appropriate use criteria for advanced diagnostic imaging services. The rule proposes certain clinical decision support

mechanism (CDSM) requirements and notes that providers will not be required to consult CDSMs for appropriate use criteria before January 1, 2018.