AMERICAN ACADEMY OF FAMILY PHYSICIANS
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Summary of the 2018 Final Medicare Physician Fee Schedule

On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) released a final rule that changes the Medicare physician fee schedule (MPFS) and other Medicare Part B payment policies for calendar year 2018. The policies are effective on January 1, 2018.

Conversion Factor for 2018
To calculate the Medicare allowance for each service, CMS adjusts the relative value unit (RVU) components (work, practice expense, and malpractice) of the service by geographic practice cost indices (GPCIs) and converts them to dollar amounts through the application of a conversion factor, which CMS calculates based on a statutory formula.

CMS finalized the final 2018 conversion factor to be $35.999, a slight increase (0.3%) to the 2017 conversion factor, $35.887. Since CMS was not able to fully meet the misvalued code target required by law, physicians will not receive the full positive 0.5% update in 2018 called for in the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA). Table 50 from the final rule, located at the end of this summary, shows CMS' estimated impact on total allowed charges by specialty.

Evaluation and Management (E/M) Documentation Guidelines and Care Management Services
In the proposed rule, CMS sought feedback on how to overhaul and modernize E/M documentation guidelines, as well as reduce documentation burden and confusion for other, new primary care codes. In the final rule, CMS agreed with the AAFP and others that these guidelines are outdated and need to be revised, however CMS noted that comments did not agree on how the current standards should be changed. Without making any changes, CMS thanked the public for the comments received, indicated the agency would consider future stakeholder collaboration, and stated that the agency will consider policy changes in future regulations.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services
CMS announced that the AUC program will begin with an educational and operations testing year in 2020. Physicians may begin exploring the AUC through a voluntary participation period that will begin mid-2018 and run through 2019. In addition, CMS reminded physicians that they may use one of the qualified clinical decision support mechanisms to earn credit under the Merit-based Incentive Payment System (MIPS) as an Improvement Activity in the 2018 performance period.

Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
CMS finalized proposals to add payment for chronic care management in RHCs and FQHCs, and established requirements and payment for RHCs and FQHCs furnishing general behavioral health integration (BHI) services and psychiatric CoCM. Effective January 1, 2018, RHCs and FQHCs will be paid for chronic care management (CCM), general BHI, and psychiatric collaborative care model (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.

Medicare Diabetes Prevention Program (MDPP)
The MDPP is a structured intervention with the goal of preventing type 2 diabetes in individuals with an indication of prediabetes. The clinical intervention consists of a minimum of 16 intensive "core" sessions

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of a Centers for Disease Control and Prevention (CDC) approved curriculum furnished over six months 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.

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. Initially announced in 2016, the MDPP expanded model tests Medicare beneficiary access to evidence-based diabetes prevention services.

Establishing Payment Rates for Nonexcepted Items and Services Furnished by Nonexcepted Off-campus Provider-based Departments of a Hospital
For 2018, CMS finalized a reduction of 20% to the current MPFS payment rates for these items and services. CMS currently pays for these services under the MPFS based on a percentage of the outpatient prospective payment system (OPPS) payment rate. Specifically, the final policy will change the MPFS payment rates for these services from 50% of the OPPS payment rate to 40% of the OPPS rate. This policy is part of CMS efforts to align payment policies for physicians in independent practice with those owned by hospitals.

Physician Quality Reporting System (PQRS) Criteria
CMS finalized a retroactive change to the current PQRS program policy that reduces the reporting requirement from nine measures across three National Quality Strategy domains to six measures with no domain requirement. CMS finalized these changes based on stakeholder feedback and to better align with the MIPS data submission requirements for the quality performance category. Since there are no 2018 upward-payment adjustments associated with 2016 PQRS reporting (only downward-payment adjustments), there will be no negative impact because of these changes, and additional physicians may avoid 2018 downward adjustments.

Medicare Electronic Health Record (EHR) Incentive Program
Like the PQRS changes and to align with MIPS data submission requirements, CMS finalized changes to the clinical quality measure reporting requirements under the Medicare EHR Incentive Program for physicians who reported electronically through the PQRS portal.

Medicare Shared Savings Program (MSSP)
CMS finalized new policies for the MSSP program including:

- Revisions to the assignment methodology for accountable care organizations (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 3-Day Rule Waiver; and
- The addition of three new CCM and four BHI codes to the definition of primary care services used in the ACO assignment methodology.

Value-based Payment Modifier and the Physician Feedback Program
Citing the need to better align incentives and provide a smoother transition to MIPS, CMS finalized the following changes:

- Reducing the automatic downward payment adjustment for not meeting the criteria to avoid the PQRS adjustment from negative four percent to negative 2% (-2.0%) for groups of 10 or more clinicians; and from negative 2% to negative 1% (-1.0%) 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 two times the adjustment factor for all physician groups and solo practitioners.

CMS indicated they will not report 2018 Value Modifier data in the Physician Compare downloadable database, since it would be the first and only year such data would have been reported.

MACRA Patient Relationship Categories and Codes
CMS finalized certain Level II Healthcare Common Procedure Coding System (HCPCS) modifiers to be used on claims to indicate patient relationship categories required by MACRA. CMS also finalized a policy that the reporting of these HCPCS modifiers is voluntary beginning January 1, 2018. CMS noted their anticipation that there will be a learning curve with respect to the use of these modifiers.

Initial Data Collection and Reporting Periods for Clinical Laboratory Fee Schedule (CLFS)
In the proposed rule, CMS sought to understand the applicable laboratories' experiences with the data reporting, data collection, and other compliance requirements for the first data collection and reporting periods and asked specific questions.

Without making any changes, CMS thanked the public for feedback and will consider comments for potential future rulemaking or sub-regulatory guidance pertaining to the CLFS data collection and reporting periods.

Misvalued Codes
For 2018, CMS finalized the values for individual services that generally reflect the recommendations from the RUC. After discussing comments received on the valuation of emergency department visits, CMS indicated it would review these codes as potentially misvalued in future rulemaking.

Request for Information on CMS Flexibilities and Efficiencies
Stating a commitment to transforming the health care delivery system by reducing burdens for hospitals, physicians, and patients; CMS invited commenters on the proposed rule to submit recommendations regarding when and how CMS-issued regulations and policies can be simplified. CMS particularly requested ideas to address opioid use disorder and other substance use disorders.

CMS did not react to public comments in the final rule, but is expected to consider these recommendations in future rulemaking or through sub-regulatory guidance. However, CMS materials related to the 2018 final MPFS highlight that CMS recently launched the "Patients Over Paperwork" initiative, which CMS intends to be a cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience.

AAFP Resources
- Regulatory comment letter in response to the 2018 proposed Medicare physician fee schedule
- Summary of the 2018 proposed Medicare physician fee schedule
- Press statement regarding the 2018 proposed Medicare physician fee schedule

CMS Resources
- Press release and fact sheet about the regulation
- Website containing related files and addenda for the 2018 final Medicare physician fee schedule

TABLE 50: CY 2018 PFS Estimated Impact on Total Allowed Charges by Specialty*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
TOTAL	$93,149	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$247	0%	-3%	0%	-3%
ANESTHESIOLOGY	$2,018	-1%	0%	0%	-1%
AUDIOLOGIST	$66	0%	0%	0%	0%
CARDIAC SURGERY	$312	0%	0%	0%	0%
CARDIOLOGY	$6,705	0%	-1%	0%	1%
CHIROPRACTOR	$779	0%	1%	0%	1%
CLINICAL PSYCHOLOGIST	$762	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	$670	0%	3%	0%	3%
COLON AND RECTAL SURGERY	$167	0%	0%	0%	0%
CRITICAL CARE	$334	0%	0%	0%	0%
DERMATOLOGY	$3,485	0%	1%	0%	1%
DIAGNOSTIC TESTING FACILITY	$773	0%	-4%	0%	-4%
EMERGENCY MEDICINE	$3,191	0%	0%	0%	0%
ENDOCRINOLOGY	$480	0%	0%	0%	0%
FAMILY PRACTICE	$6,350	0%	0%	0%	0%
GASTROENTEROLOGY	$1,801	0%	0%	0%	0%
GENERAL PRACTICE	$458	0%	0%	0%	0%
GENERAL SURGERY	$2,170	0%	0%	0%	0%
GERIATRICS	$212	0%	0%	0%	0%
HAND SURGERY	$201	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	$1,809	0%	0%	0%	0%
INDEPENDENT LABORATORY	$690	0%	-1%	0%	-1%
INFECTIOUS DISEASE	$656	0%	0%	0%	1%
INTERNAL MEDICINE	$11,107	0%	0%	0%	0%
INTERVENTIONAL PAIN MGMT	$834	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	$360	0%	0%	0%	0%
MULTISPECIALTY CLINIC/OTHER PHYS	$140	0%	0%	0%	0%
NEPHROLOGY	$2,270	0%	0%	0%	0%
NEUROLOGY	$1,554	0%	0%	0%	0%
NEUROSURGERY	$811	0%	0%	0%	0%
NUCLEAR MEDICINE	$50	0%	0%	0%	0%
NURSE ANES / ANES ASST	$1,243	-2%	0%	0%	-2%
NURSE PRACTITIONER	$3,566	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	$662	0%	0%	0%	0%
OPHTHALMOLOGY	$5,498	0%	1%	0%	0%
OPTOMETRY	$1,269	0%	0%	0%	0%
ORAL/MAXILLOFACIAL SURGERY	$57	0%	-1%	0%	-1%
ORTHOPEDIC SURGERY	$3,801	0%	0%	0%	0%
OTHER	$29	0%	0%	0%	0%
OTOLARNGOLOGY	$1,237	0%	-1%	0%	-2%
PATHOLOGY	$1,154	0%	0%	0%	-1%
PEDIATRICS	$64	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,112	0%	0%	0%	0%
PHYSICAL/OCCUPATIONAL THERAPY	$3,807	1%	-2%	0%	-2%
PHYSICIAN ASSISTANT	$2,242	0%	0%	0%	0%
PLASTIC SURGERY	$384	0%	0%	0%	1%
PODIATRY	$1,994	0%	1%	0%	1%
PORTABLE X-RAY SUPPLIER	$102	0%	1%	0%	1%
PSYCHIATRY	$1,247	0%	1%	0%	1%
PULMONARY DISEASE	$1,761	0%	0%	0%	0%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	$1,745	0%	1%	0%	1%
RADIOLOGY	$4,896	0%	0%	0%	0%
RHEUMATOLOGY	$554	0%	1%	0%	1%
THORACIC SURGERY	$358	0%	0%	0%	0%
UROLOGY	$1,777	0%	0%	0%	-1%
VASCULAR SURGERY	$1,125	0%	-1%	0%	-1%

* Column F may not equal the sum of columns C, D, and E due to rounding.