AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Executive Summary of the 2018 Proposed Medicare Physician Fee Schedule

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) released the 2018 proposed Medicare Physician Fee Schedule, as well as a related press release and fact sheet. The American Academy of Family Physicians (AAFP) issued a media statement with an initial reaction that recognized that CMS included several AAFP-recommended administrative simplification provisions. If finalized, these provisions will significantly reduce the burden of primary care practices when participating in the Medicare program. These favorable steps include CMS proposals to:

- Overhaul and modernize Medicare's evaluation and management (E/M) documentation guidelines.
- Begin implementing site-neutral provisions to 'new' off-campus provider-based departments.
- Delay the Appropriate Use Criteria (AUC) program for advanced diagnostic imaging services until January 1, 2019.
- Lower the maximum amount of risk under the 2018 Value Modifier program from 4.0 percent to 1.0 percent for practices of less than 10 physicians.
- Retroactively reduce the number of 2018 Physician Quality Reporting System (PQRS) measures from nine to six to further align with Merit-based Incentive Payment System (MIPS) quality measure reporting requirements.

Despite these favorable proposals, the AAFP expressed disappointment that CMS failed, yet again, to achieve the required, minimum net expenditure reduction through identifying misvalued codes. Since these changes do not fully meet the misvalued code target required by law, physicians will not receive the full positive 0.5 percent update in 2018 called for in the *Medicare Access and CHIP Reauthorization Act* (MACRA). As shown in the table at the end of this document, the proposed 2018 Medicare conversion factor is estimated to be $35.9903, an increase of only $0.10 (0.31 percent) from the 2017 conversion factor of $35.8887. The AAFP will continue to remind CMS to strengthen the primary medical care that supports the system-wide reforms taking place. Table 40 from the proposed rule, located at the end of this summary, shows CMS' estimated impact on total allowed charges by specialty.

In addition, the proposed rule includes discussions and proposals regarding:

- Evaluation and Management (E/M) Documentation Guidelines and Care Management Services – As suggested by the AAFP, but without making any actual changes, this proposed regulation seeks broad stakeholder 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. CMS states that E/M documentation guidelines should be substantially revised over a multi-year, collaborative effort in order to both reduce clinical burden and improve documentation in a way that would be more effective in clinical workflows and care coordination. CMS recognizes that updated E/M documentation guidelines, coupled with technological advancements in voice recognition, natural language processing, and user-centered design of electronic health records (EHRs) could improve documentation for patient care, while also meeting requirements for billing and population health management.

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- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services – CMS proposes delaying the AUC program until January 1, 2019, which the AAFP has repeatedly expressed concern to CMS due to the disproportional burden this program would place on primary care physicians.
- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) – CMS proposes to begin paying RHCs and FQHCs for regular and complex chronic care management (CCM) services, general behavioral health integration (BHI) services, and psychiatric collaborative care model services.
- Medicare Diabetes Prevention Program (MDPP) – CMS proposes to further implement the MDPP expanded model, which starts in 2018. Initially announced in 2016, the MDPP expanded model tests Medicare beneficiary access to evidence-based diabetes prevention services. In this regulation, CMS proposes additional policies necessary for suppliers to begin providing MDPP services in 2018. These policies include the MDPP payment structure, as well as additional supplier enrollment requirements, supplier compliance standards, and new proposals on beneficiary engagement incentives.
- Establishing Payment Rates for Nonexcepted Items and Services Furnished by Nonexcepted Off-campus Provider-based Departments of a Hospital – Supported by the AAFP, CMS proposes further reduced payments to "new" off-campus provider-based departments. The rates would be reduced from 50 percent to 25 percent of the current payment rate.
- Physician Quality Reporting System (PQRS) Criteria – Among other changes, CMS proposes to retroactively lower the number of required measures from nine to six to more closely align the program with MIPS.
- Medicare EHR Incentive Program – While CMS is not proposing to collect any additional data for 2016, the agency proposes to change the reporting criteria for those that choose to electronically report clinical quality measures (CQMs) through the PQRS Portal for purposes of the Medicare EHR Incentive Program. CMS proposes to change the reporting criteria from nine CQMs covering at least three National Quality Strategy (NQS) domains to six CQMs with no domain requirement. This aligns the reporting criteria for the Medicare EHR Incentive Program with the modified requirement proposed for the final 2016 PQRS reporting period, as well as aligning with the Quality Payment Program (QPP). Furthermore, CMS proposes that those who satisfy the proposed reporting criteria may qualify for the 2016 incentive payment and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the reporter's applicable EHR reporting period for the payment adjustment year.
- Medicare Shared Savings Program (MSSP) – Containing many changes, CMS proposes further refinements to the MSSP rules. These include changes to the beneficiary assignment methodology to reflect requirements from the *21st Century Cures Act* that includes assignment to accountable care organizations (ACOs) based on utilization of services furnished by RHCs or FQHCs. CMS also proposes to include new CCM and BHI service codes.
- Value-based Payment Modifier and the Physician Feedback Program – CMS seeks comments on lowering the maximum amount of payment at risk under the 2018 Value Modifier program from 4.0% to 1.0% for individual clinicians and groups under 10 clinicians, and to 2.0% for groups of 10 or more clinicians.
- MACRA Patient Relationship Categories and Codes – CMS seeks comments on the operational list of patient relationship categories and proposes Level II Healthcare Common Procedure Coding System (HCPCS) modifiers (found in the table below) to be the patient relationship codes, which CMS would add to the operational list if CMS adopts them in the final rule.
- Initial Data Collection and Reporting Periods for Clinical Laboratory Fee Schedule – After rehashing recent efforts to address clinical lab payments, the regulation seeks 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 asks nine detailed questions.

- Telehealth Services – CMS proposes to add seven services to the Medicare telehealth list:
  - G0296 - Counseling visit to discuss need for lung cancer screening using low-dose CT scan
  - 90839 - Psychotherapy for crisis, first 60 minutes
  - 90840 - Psychotherapy for crisis, each additional 30 minutes
  - 90785 - Interactive complexity
  - 96160 - Administration of patient-focused health risk assessment (HRA) instrument
  - 96161 - Administration of caregiver-focused HRA instrument for the benefit of the patient
  - G0506 - Comprehensive assessment of and care planning for patients requiring chronic care management (CCM) services
- Misvalued Codes – CMS requests feedback on several potentially misvalued codes, including emergency department visits.

The AAFP is currently analyzing the regulation's impact on family physicians and will provide extensive feedback to CMS before their comment deadline of September 11, 2017. The agency is expected to issue the final version of this regulation in the fall of 2017.

Conversion Factor in effect in CY 2017		**35.8887**
Update Factor	0.50 percent (1.0050)	
CY 2018 RVU Budget Neutrality Adjustment	-0.03 percent (0.9997)	
CY 2018 Target Recapture Amount	-0.19 percent (0.9981)	
CY 2018 Conversion Factor		**35.9903**

No.	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

TABLE 40: 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	$92,628	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$245	0%	-3%	0%	-3%
ANESTHESIOLOGY	$2,009	-1%	0%	0%	0%
AUDIOLOGIST	$66	0%	0%	-1%	-1%
CARDIAC SURGERY	$311	0%	0%	-1%	-2%
CARDIOLOGY	$6,671	0%	-1%	-1%	-2%
CHIROPRACTOR	$772	0%	1%	0%	1%
CLINICAL PSYCHOLOGIST	$756	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	$664	0%	3%	0%	3%
COLON AND RECTAL SURGERY	$166	0%	0%	-1%	-1%
CRITICAL CARE	$332	0%	0%	0%	0%
DERMATOLOGY	$3,475	0%	0%	-1%	-1%
DIAGNOSTIC TESTING FACILITY	$765	0%	-6%	0%	-6%
EMERGENCY MEDICINE	$3,176	0%	0%	-1%	-1%
ENDOCRINOLOGY	$477	0%	0%	0%	0%
FAMILY PRACTICE	$6,307	0%	0%	0%	0%
GASTROENTEROLOGY	$1,792	0%	0%	-1%	-1%
GENERAL PRACTICE	$452	0%	0%	0%	0%
GENERAL SURGERY	$2,154	0%	0%	0%	-1%
GERIATRICS	$211	0%	0%	0%	1%
HAND SURGERY	$200	0%	0%	0%	1%
HEMATOLOGY/ONCOLOGY	$1,802	0%	0%	0%	0%
INDEPENDENT LABORATORY	$684	0%	-1%	0%	-2%
INFECTIOUS DISEASE	$651	0%	0%	1%	1%
INTERNAL MEDICINE	$11,022	0%	0%	0%	0%
INTERVENTIONAL PAIN MGMT	$830	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	$357	0%	-1%	0%	-1%
MULTISPECIALTY CLINIC/OTHER PHYS	$139	0%	0%	0%	0%
NEPHROLOGY	$2,257	0%	0%	0%	0%
NEUROLOGY	$1,545	0%	0%	0%	0%
NEUROSURGERY	$805	0%	0%	-1%	-1%
NUCLEAR MEDICINE	$50	0%	0%	0%	0%
NURSE ANES / ANES ASST	$1,238	-1%	0%	1%	-1%
NURSE PRACTITIONER	$3,541	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	$658	0%	0%	-1%	-1%
OPHTHALMOLOGY	$5,480	0%	0%	0%	0%
OPTOMETRY	$1,259	0%	0%	0%	0%
ORAL/MAXILLOFACIAL SURGERY	$57	0%	-2%	0%	-2%
ORTHOPEDIC SURGERY	$3,784	0%	0%	0%	0%
OTHER	$28	0%	0%	0%	0%
OTOLARNGOLOGY	$1,232	0%	-1%	0%	-2%
PATHOLOGY	$1,147	0%	0%	0%	-1%
PEDIATRICS	$63	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,105	0%	0%	0%	1%
PHYSICAL/OCCUPATIONAL THERAPY	$3,780	1%	1%	0%	1%
PHYSICIAN ASSISTANT	$2,232	0%	0%	0%	0%
PLASTIC SURGERY	$379	0%	0%	0%	0%
PODIATRY	$1,973	0%	1%	1%	1%
PORTABLE X-RAY SUPPLIER	$100	0%	-1%	0%	-1%
PSYCHIATRY	$1,233	0%	1%	0%	1%
PULMONARY DISEASE	$1,753	0%	0%	0%	0%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	$1,784	0%	1%	1%	1%
RADIOLOGY	$4,863	0%	-1%	0%	-1%
RHEUMATOLOGY	$553	0%	0%	0%	0%
THORACIC SURGERY	$356	0%	0%	-1%	-1%
UROLOGY	$1,772	0%	-1%	0%	-1%
VASCULAR SURGERY	$1,115	0%	-1%	0%	-2%

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