

## Summary of the 2017 Final Medicare Physician Fee Schedule

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### Executive Summary

On November 2, 2016, the Centers for Medicare & Medicaid Services (CMS) released the [2017 final Medicare physician fee schedule](#). This regulation addresses changes to the physician fee schedule (PFS) and other Medicare Part B payment policies to ensure that Medicare payment systems are updated to reflect changes in medical practice and the relative value of services. This regulation is effective on January 1, 2017. As part of this release, CMS also posted a [press statement](#), [fact sheet](#), [fact sheet](#) specific to the Medicare Diabetes Prevention Program (MDPP) Expanded Model, and a [blog](#) by the CMS acting administrator titled, “A Healthier Medicare: Focusing on Primary Care, Mental Health, and Diabetes Prevention.”

The American Academy of Family Physicians (AAFP) sent a 56-page [comment letter](#) to CMS in response to the proposed version of this regulation on August 19, 2016. Upon the final rule release, the AAFP issued a [media statement](#) that:

- Commended the creation of new primary care codes;
- Strongly supported the expansion of the Medicare Diabetes Prevention Program;
- Expressed disappointment that CMS only finalized misvalued code changes that achieve 0.32 percent in net expenditure reductions. Since these changes do not fully meet the misvalued code target required by law, physicians will not receive the *Medicare Access and CHIP Reauthorization Act* (MACRA) positive 0.5 percent update in 2017. The 2017 Medicare PFS conversion factor will be \$35.89, an increase of only \$0.09 from the 2016 conversion factor. The AAFP statement called this a violation of the spirit of MACRA.

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- Expressed increasing concerns that CMS is adding regulatory burdens to primary care physicians. For instance, CMS is requiring primary care physicians to consult appropriate use criteria for advanced diagnostic imaging and not aligning this program with the Merit-Based Incentive Payment System (MIPS).

### **Conversion Factor for 2017**

To calculate the payment for each service, the relative value unit (RVU) components of the fee schedule (work, practice expense, and malpractice) are adjusted by geographic practice cost indices (GPCIs) to reflect the variations in the costs of furnishing the services. RVUs are converted to dollar amounts through the application of a conversion factor, which is calculated based on a statutory formula. The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU practice expense} \times \text{GPCI practice expense}) + (\text{RVU Malpractice} \times \text{GPCI Malpractice})] \times \text{conversion factor.}$$

For 2017, CMS had estimated the conversion factor to be \$35.7751, but ultimately finalized a conversion factor of **\$35.8887**. Included at the end of the AAFP summary is CMS Table 50, which illustrates how CMS calculated the 2017 conversion factor. Also, included at the end of the AAFP summary is Table 52 (Estimated Impact on Total Allowed Charges by Specialty). Family physicians, in aggregate and compared to other specialties, are projected to receive an estimated 1 percent increase in Medicare-allowed charges based on the provisions of the final rule.

### **Primary Care, Care Management, and Patient-Centered Services**

#### Background

Of particular significance to primary care physicians, CMS proposed increased payments for several care management services. Specifically, the regulation included proposals that:

- Make separate payments for certain existing current procedural terminology (CPT) codes describing non-face-to-face prolonged evaluation and management services.
- Revalue existing CPT codes describing face-to-face prolonged services.
- Make separate payments using new codes to describe the comprehensive assessment and care planning for patients with cognitive impairment (e.g., dementia).
- Make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions.
- Make separate payments using new codes to recognize the increased resource costs of furnishing visits to patients with mobility-related impairments.
- Make separate payments for codes describing chronic care management (CCM) for patients with greater complexity.
- Make several changes to reduce administrative burden associated with the CCM codes to remove potential barriers to furnish and bill for these important services.

#### AAFP Recommendations

The AAFP appreciated that CMS continued a multi-year effort to both prioritize and promote primary care as foundational to the Medicare program, but the AAFP asserted that to truly realize the value of family medicine and primary care, public and private payers cannot simply rely on fee-for-service (FFS) delivery system reforms. The AAFP called on CMS to fix problems with FFS and to make new investments in primary care to truly capture and realize the value proposition of family medicine and primary care.

### Final 2017 Policy

CMS finalized a number of coding and payment changes to better identify and value primary care, care management, and cognitive services. These include changes that:

- Make separate payments for certain existing CPT codes describing non-face-to-face prolonged evaluation and management services.
- Revalue existing CPT codes describing face-to-face prolonged services.
- Make separate payments using a new code to describe the comprehensive assessment and care planning for patients with cognitive impairment (e.g., dementia).
- Make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions.
- Make separate payments for codes describing CCM for patients with greater complexity.
- Make several changes to reduce administrative burden associated with the CCM codes to remove potential barriers to furnish and bill for these important services.

CMS estimates these new codes will result in an estimated \$140 million in additional funding in 2017 to physicians and practitioners providing these services. Over time, if the clinicians qualified to provide these services were to fully provide these services to all eligible beneficiaries, the increase could be as much as \$4 billion or more in additional support for care coordination and patient-centered care.

Included at the end of this summary is an AAFP-created table that shows the national Medicare allowed amount unadjusted by geographic payment factors for these new services. Actual payment allowances for an individual physician will vary geographically and based on any other payment adjustments (Physician Quality Reporting System, value-based payment modifier, etc.) that apply to the individual.

### **Identification and Review of Potentially Misvalued Services**

#### Background

Section 3134(a) of the *Affordable Care Act* requires CMS to periodically identify potentially misvalued services and to review and make appropriate adjustments to the RVUs for those services. Through the *Achieving a Better Life Experience Act*, Congress set a target for adjustments to misvalued codes in the fee schedule for 2016, 2017, and 2018. The target was one percent for 2016 and 0.5 percent for each of 2017 and 2018. If the net reductions in misvalued codes in 2017 are less than 0.5 percent of the total revenue under the fee schedule, a reduction equal to the percentage difference between 0.5 percent and the percent of expenditures represented by misvalued code reductions (i.e. the “target recapture amount”) must be made to all fee schedule services.

CMS proposed misvalued code changes that achieve 0.51 percent in net expenditure reductions. Had they been finalized, these changes would have met the misvalued code target of 0.5 percent, thereby avoiding an overall reduction in Medicare payments.

#### AAFP Recommendation

The AAFP was pleased to see that CMS estimated there would be no “target recapture amount,” by which CMS would reduce 2017 payments made under the fee schedule.

### Final 2017 Policy

CMS finalized misvalued code changes that only achieve 0.32 percent in net expenditure reductions. These changes do not fully meet the misvalued code target of 0.5 percent, thus requiring an adjustment to the 2017 overall physician update of 0.18 percent (i.e., 0.5 to 0.32). After applying this and other adjustments required by law, the 2017 conversion factor is \$35.89. The AAFP media statement called this a violation of the spirit of MACRA, and the AAFP is frustrated that CMS was unable or unwilling to identify the full 0.5 percent reduction in RVUs required in 2017.

## **Medicare Telehealth Services: End-Stage Renal Disease (ESRD) and Advanced Care Planning**

### Background

CMS proposed to add codes to the list of services eligible to be furnished via telehealth under Medicare. Those services included:

- ESRD-related services for dialysis;
- Advanced care planning services;
- Critical care consultations using new Medicare G-codes.

CMS also proposed payment policies related to the use of a new place-of-service code for reporting services furnished via telehealth.

### AAFP Recommendations

The AAFP supported revisions to policies that create unnecessary barriers to the responsible and appropriate use of telehealth services. Regarding the CPT codes added to the list of Medicare approved telehealth services, the AAFP supported the addition of those added codes and services.

### Final 2017 Policy

CMS finalized the addition of codes to the list of services eligible to be furnished via telehealth. These include:

- ESRD-related services for dialysis;
- Advance care planning services;
- Critical care consultations furnished via telehealth using new Medicare G-codes.

CMS also finalized payment policies related to the use of a new place of service code specifically designed to report services furnished via telehealth.

## **Updated Geographic Practice Cost Indices (GPCIs)**

### Background

CMS is required to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three components—physician work, practice expense, and malpractice—of the fee schedule. The agency must review and adjust the GPCIs, as necessary, every three years at a minimum. Since 2009, a permanent 1.5 work GPCI floor for services furnished in Alaska has existed. Since 2011, there has also been a permanent 1.0 practice expense GPCI floor for services furnished in “frontier states” (defined as at least 50 percent of the state’s counties have a population density of less than 6 persons per square mile). CMS has identified five frontier states: Montana, Wyoming, North Dakota, Nevada, and South Dakota.

As required by law, CMS proposed new GPCIs using updated data to be phased in over 2017 and 2018. In conjunction with this proposed update, CMS proposed to revise the methodology used to calculate GPCIs in the U.S. territories for consistency among the Pacific and Caribbean islands. This proposed revision would increase overall fee schedule payments in Puerto Rico.

The *Protecting Access to Medicare Act* requires that CMS use new locality definitions for California, based on a combination of Metropolitan Statistical Areas (MSAs) as defined by the Office of Management and Budget (OMB) and the current locality structure. The California locality provision is not budget-neutral, meaning that payments to physicians in California will increase in the aggregate without across-the-board reductions in physician services elsewhere. The movement to the new locality structure in California may increase payments to many physicians in urban parts of California without

any reductions in specified counties that the law “holds harmless” from payment reductions. In a few areas of California, the new locality structure may decrease Medicare fee schedule payments.

#### AAFP Recommendations

As a matter of [policy](#), the AAFP supports the elimination of all geographic adjustment factors from the Medicare physician fee schedule, except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). As such, the AAFP opposes use of the GPCIs in setting Medicare physician fees. However the AAFP recognized the law requires use of the GPCIs and also requires CMS to review and, if necessary, update those GPCIs at least once every three years. The AAFP appreciated CMS’s efforts to comply with the law in this regard and supported its intention to use more current data in all three GPCIs.

#### Final 2017 Policy

CMS finalized new GPCIs using updated data to be phased in over 2017 and 2018. In conjunction with this update, CMS is revising the methodology used to calculate GPCIs in the U.S. territories for consistency among the Caribbean islands. This revision will increase overall fee schedule payments in Puerto Rico. Regarding California localities, CMS finalized policy as proposed and required by law.

### **Collecting Data on Resources Used in Furnishing Global Services**

#### Background

Under the misvalued code initiative in the 2015 final rule, CMS finalized a policy to transform all 10- and 90-day global codes to zero-day global codes, beginning in 2018. Under this policy, CMS would have valued the surgery or procedure to include all services furnished on the day of surgery and paid separately for visits and services furnished after the day of the procedure. Subsequently, Congress intervened and prohibited CMS from implementing this AAFP-backed policy. Instead, CMS is required to gather data on visits in the post-surgical period that could be used to accurately value these services.

In the 2017 proposed Medicare PFS, CMS proposed a data collection strategy, including claims-based data collection and a survey of 5,000 practitioners, to gather data on the activities and resources involved in furnishing these services. To the extent that this data results in proposals to revalue any surgical services, that revaluation will be done through future rulemaking.

#### AAFP Recommendations

The AAFP letter argued that evaluation and management (E/M) services are undervalued relative to procedural services, especially procedures with 10- and 90-day global periods. The AAFP strongly challenged and expected CMS to hold providers of global surgical services to the same documentation standards and guidelines as providers of E/M services when providing a visit. The AAFP agreed with CMS that there is a dearth of information regarding the actual resources that go into providing procedural services as compared to what CMS assumes they include when setting their current relative values. The AAFP characterized CMS’s three-pronged data collection effort as a much-needed first step in more appropriately valuing 10- and 90-day global surgical services, especially relative to existing E/M codes.

#### Final 2017 Policy

CMS finalized a data collection strategy that:

- Requires reporting of post-operative visits only for high-volume/high-cost procedures;
- Uses existing CPT code 99024 instead of the proposed, time-based G-codes;
- Requires reporting only from a sample of practitioners consisting of those in larger practices (10 or more practitioners) in specified states; and
- Allows all others to report voluntarily.

In addition, CMS is only encouraging practitioners to begin reporting post-operative visits for procedures furnished on or after January 1, 2017. CMS will require practitioners to report for services related to global procedures furnished on or after July 1, 2017. To the extent that these data result in proposals to revalue any global packages, that revaluation will be done through public rulemaking at a future time.

## **Zero-day Global Services That Are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25**

### Background

Because CMS assumes that the valuation of codes with zero-, 10-, and 90-day global periods includes a certain amount of evaluation and management of the patient, Medicare only makes separate payment for E/M services that are provided in excess of those considered included in the global procedure. In such cases, the physician would report the additional E/M code with Modifier 25 appended, which is defined as a significant, separately identifiable E/M service performed by the same physician on the same day of a procedure or other service. Modifier 25 allows physicians to be paid for E/M services that would otherwise be denied as bundled.

CMS noted that several high-volume procedure codes are typically reported with a modifier that unbundles payment for visits from the procedure, even though the modifier should only be used for reporting services beyond those usually provided. Therefore, CMS believed the services may be misvalued. As a result, CMS proposed to prioritize 83 services for review as potentially misvalued.

### AAFP Recommendations

The AAFP applauded CMS for its diligence in identifying and reviewing potentially misvalued codes and appreciated the update on its efforts to validate RVUs of potentially misvalued codes via contracts with the Urban Institute and RAND Corporation. The AAFP supported CMS's efforts in this regard and encouraged it to continue this excellent and much needed work.

### Final 2017 Policy

After discussing codes that were requested to be removed from the list of potentially misvalued services, CMS is prioritizing only 19 services for review as potentially misvalued and intends to investigate this policy concern in future rulemaking. Included at the end of the AAFP summary is CMS Table 8 that lists these 19 services.

## **Medicare Diabetes Prevention Program**

### Background

The Medicare Diabetes Prevention Program (MDPP) is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. The clinical intervention consists of 16 intensive "core" sessions of a curriculum 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. After the 16 core sessions, less-intensive monthly follow-up meetings help ensure that participants maintain healthy behaviors. The primary goal of the intervention is at least 5 percent average weight loss among participants.

In March 2016, the Department of Health and Human Services (HHS) announced that the CMS Office of the Actuary certified that expansion of the MDPP model would reduce net Medicare spending. The expansion was also determined to improve the quality of patient care without limiting coverage or benefits. These are the requirements a CMS Innovation Center model must meet to be eligible for expansion. The MDPP is the second CMS Innovation Center—and the first preventive—model to meet these requirements.

Therefore, CMS proposed to expand the MDPP within Medicare beginning January 1, 2018. The agency proposed to designate services in the MDPP as “additional preventive services” under Medicare Part B since CMS considers the services of this program to be consistent with other types of additional preventive services. Through expansion, more Medicare beneficiaries will be able to access the benefits of the program.

#### AAFP Recommendations

The AAFP fully supported the expansion of the MDPP and was pleased that CMS proposed to designate the MDPP as an “additional preventive service” available under Medicare Part B, meaning that Medicare beneficiaries can utilize this service without being subjected to beneficiary cost sharing.

#### Final 2017 Policy

CMS finalized aspects of the expansion that will enable organizations, including those new to Medicare, to prepare for enrollment into Medicare as MDPP suppliers. Finalized policies include the definition of the MDPP benefit, beneficiary eligibility criteria, and supplier eligibility and enrollment criteria. Future rulemaking will address policies related to payment, virtual providers, and other program integrity safeguards.

Coverage of the MDPP services will be available for beneficiaries who meet the following criteria:

- Enrolled in Medicare Part B;
- Have, as of the date of attendance at the first core session, a body mass index (BMI) of at least 25 if not self-identified as Asian or a BMI of at least 23 if self-identified as Asian;
- Have, within the 12 months prior to attending the first core session, a hemoglobin A1c test with a value between 5.7 and 6.4 percent, a fasting plasma glucose of 110-125 mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test);
- Have no previous diagnosis of type 1 or type 2 diabetes with the exception of gestational diabetes; and
- Do not have ESRD.

MDPP supplier enrollment in Medicare is expected to begin following rulemaking in 2017, and ahead of implementation of the MDPP expanded model on January 1, 2018. Additional rulemaking is required to finalize enforcement activities related to supplier enrollment. CMS finalized the following policies specific to organizations seeking to enroll as MDPP suppliers:

- MDPP suppliers are obligated to comply with all statutes and regulations that establish generally applicable requirements for Medicare suppliers.
- At the time of enrollment, organizations must have full recognition by the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP). Due to timing issues with CDC standards updates, CMS is not finalizing any proposals for preliminary recognition at this time. CMS intends to address this issue in future rulemaking.
- All coaches who will be furnishing MDPP services on the organization’s behalf must obtain and maintain active and valid national provider identifiers (NPIs).
- Organizations must submit a roster of all coaches who will be furnishing MDPP services. The roster will include the coaches’ first and last names, Social Security number, and NPI.
- Upon enrollment as an MDPP supplier, organizations must pass application screening at a high categorical risk level per 42 CFR 424.518(c).
- All existing Medicare providers and suppliers are required to adhere to the same enrollment requirements as MDPP suppliers.

CMS will finalize the payment structure for the MDPP expanded model in rulemaking during 2017 and expect to begin payment for MDPP services in 2018.

## **Reports of Payments or Other Transfers of Value to Covered Recipients**

### Background

In 2013, CMS published the final rule, titled “Transparency Reports and Reporting of Physician Ownership or Investment Interests.” It requires manufacturers of covered drugs, devices, biologicals, and medical supplies (applicable manufacturers) to annually submit information about certain payments or transfers of value made to physicians and teaching hospitals (covered recipients). The law also requires applicable manufacturers and group purchasing organizations (GPOs) to disclose any ownership or investment interests in such entities, held by physicians or their immediate family members, as well as information on payments or other transfers of value provided to such physician owners or investors. Commonly referred to as either the CMS Open Payments program or Sunshine Act, this policy creates transparency around the nature and extent of relationships that exist between drug, device, biological, and medical supply manufacturers on one hand and physicians and teaching hospitals on the other.

In 2015, CMS issued final regulations that specifically:

- Deleted the definition of “covered device”;
- Removed the continuing medical education (exclusion);
- Expanded the marketed name reporting requirements to biologicals and medical supplies; and
- Required stock, stock options, and any other ownership interests to be reported as distinct forms of payment.

In the 2017 proposed Medicare physician fee schedule, CMS discussed that various stakeholders have provided feedback regarding aspects of the Open Payment program and that the agency has identified areas in the rule that might benefit from revision. CMS then asked specific questions to inform future rulemaking.

### AAFP Recommendations

In answering CMS’s questions, the AAFP recommended:

- Removing category xv - "Compensation for serving as faculty or as a speaker for an accredited or certified continuing education program."
- Reporting on past payments up to one year in order to minimize the reporting burden.
- The pre-vetting of payment information with covered recipients.

### Final 2017 Policy

CMS thanked the public for comments to their questions and the agency will consider the public comments received in the future through possible rulemaking or publication of subregulatory guidance. No Open Payments program changes were proposed or finalized within the final rule.

## **Medicare Advantage (Part C) Provider Enrollment**

### Background

To receive payment for a furnished Medicare Part A or Part B service or item, or to order, certify, or prescribe certain Medicare services, items, and drugs, a provider or supplier must enroll in Medicare. The enrollment process requires the provider or supplier to complete, sign, and submit—to its assigned Medicare contractor—the appropriate Form CMS-855 enrollment application. The CMS-855 application form captures information about the provider or supplier that is needed for CMS or its contractors to screen the provider or supplier and determine whether the provider or supplier meets all Medicare requirements. This screening prior to enrollment helps to ensure that unqualified individuals and entities do not bill Medicare and that the Medicare Trust Funds are accordingly protected. Data collected and verified during the enrollment process generally includes, but is not limited to:

- Basic identifying information (e.g., legal business name, tax identification number),
- State licensure information,

- Practice locations, and
- Information regarding ownership and management control.

CMS proposed to require physicians, providers, and suppliers to be screened and enrolled in Medicare in order to contract with a Medicare Advantage (MA) organization and subsequently provide Medicare-covered items and services to beneficiaries enrolled in MA health plans. This proposal creates consistency with enrollment requirements for all other Medicare (Part A, Part B, and Part D) programs, as well as a requirement that health care providers in a Medicaid managed care plan's network be screened and enrolled with the state Medicaid program. This proposal also prevents MA participation by health care providers or suppliers that have had their Medicare enrollment revoked or have been excluded by the Office of the Inspector General.

#### AAFP Recommendations

Though the AAFP was not concerned that the MA (Part C) Provider Enrollment policy would create significant impact on the numbers of providers, the AAFP expressed concern about network adequacy. Reducing the number of physicians participating in these networks could create access problems for patients.

While the AAFP supported this proposal, the Academy also expressed concern that physicians may be erroneously placed in an unapproved status and, therefore, urged CMS to ensure the process is accurate and provides physicians with 90 days to appeal the status.

#### Final 2017 Policy

The final rule requires health care providers and suppliers to be screened and enrolled in Medicare in order to contract with a MA organization to provide items and services to beneficiaries enrolled in MA health plans. This provision will begin in 2019 and will be effective on the first day of the plan year.

### **Release of Part C Medicare Advantage Bid Pricing Data and Part C and Part D Medical Loss Ratio Data**

#### Background

As part of the annual bidding process, MA organizations submit bids for each plan they wish to offer in the upcoming contract year. As required by law, data supporting medical loss ratios (MLR) are submitted annually to CMS by MA plans and Part D sponsors.

CMS proposed to release two new sets of data annually: MA bid pricing data and Part C and Part D MLR data. CMS hoped that making this data publicly available would assist public research, future policymaking efforts, and beneficiaries making enrollment decisions. The MA bid pricing data would be at least five years old and would exclude information treated as proprietary.

#### AAFP Recommendations

Consistent with AAFP policy on [transparency](#), the AAFP supported the purposes of this proposal. This information could help patients, caregivers, and others in determining health care costs. Regarding the data being at least five years old, the AAFP argued that a 5-year delay in information is not as useful to patients or others and that releasing the information earlier would provide more actionable data.

#### Final 2017 Policy

CMS finalized the release of data associated with bids on an annual basis. The data released would be at least five years old and would exclude certain information considered to be proprietary, as well as beneficiary-identifying information. CMS already makes commercial MLR data public, as required by

the *Affordable Care Act*. This rule finalizes the release of certain Medicare health and drug plan MLR data on an annual basis.

## **Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

### Background

The *Protecting Access to Medicare Act* establishes a program under the Medicare fee-for-service program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. This policy requires physicians ordering certain imaging services—magnetic resonance, computed tomography, nuclear medicine, and positron emission tomography imaging—for Medicare beneficiaries to consult with AUC applicable to the imaging modality.

In the 2016 proposed Medicare physician fee schedule, CMS stated that AUC “crosses almost every medical specialty and could have a particular impact on primary care physicians since their scope of practice can be quite vast.” The 2016 final Medicare physician fee schedule addressed the initial component of the AUC program by outlining requirements to use an evidence-based, transparent process for developing AUC and establishing a process to identify provider-led entities to become qualified to develop, modify, or endorse AUC.

In late June, CMS posted an initial list of qualified entities. These include:

- American College of Cardiology Foundation
- American College of Radiology
- Brigham and Women's Physicians Organization
- CDI Quality Institute
- Intermountain Healthcare
- Massachusetts General Hospital, Department of Radiology
- National Comprehensive Cancer Network
- Society for Nuclear Medicine and Molecular Imaging
- University of California Medical Campuses
- University of Washington Physicians
- Weill Cornell Medicine Physicians Organization

The 2017 proposed rule focused on the next component of the Medicare AUC program and included proposals for priority clinical areas, clinical decision-support mechanism (CDSM) requirements, the CDSM application process, and exceptions for ordering professionals for whom consultation with AUC would pose a significant hardship. CDSMs are the electronic tools through which a clinician consults AUC to determine the level of clinical appropriateness for an advanced diagnostic imaging service for that particular patient's clinical scenario.

CMS developed and proposed eight priority, clinical areas that it believes reflect both the significance and prevalence of some of the most disruptive diseases in the Medicare population. They are:

- Chest pain
- Abdominal pain
- Headache, traumatic and non-traumatic
- Low back pain
- Suspected stroke
- Altered mental status
- Lung cancer
- Cervical or neck pain

CMS proposed three exceptions to the AUC consultation and reporting requirements for an:

- Applicable imaging service ordered for an individual with an emergency medical condition,
- Applicable imaging services ordered for an inpatient and for which payment is made under Medicare Part A; and

- Ordering professional who CMS determines—on a case-by-case basis and subject to annual renewal—that consultation with applicable AUC would result in a significant hardship, such as in the case of a professional practicing in a rural area without sufficient Internet access.

### AAFP Recommendations

The AAFP expressed ongoing, significant concerns about the disproportional burden primary care physicians will face when trying to comply with AUC requirements, and therefore, strongly urged CMS to delay the implementation of this program so AUC would be aligned with the forthcoming MIPS program in 2019, versus being introduced as a stand-alone program. The AAFP strongly urged CMS to delay implementation of the AUC section until such time as the following conditions are fully met:

- There is evidence to demonstrate that AUC improve quality of care.
- MACRA is fully implemented.
- Any AUC requirements are fully aligned with MACRA.
- Sets of AUC for the same diagnostic imaging modality, developed by different PLE's, are standardized.
- CDSM are fully interoperable with electronic health records (EHRs).
- At least one CDSM with a comprehensive set of AUC, which is fully interoperable with certified-EHR technology (CEHRT), is freely available.
- CDSM communicate AUC information to the user and assists them in making the most appropriate treatment decision for a patient's specific clinical condition in an automated manner and do not require any separate action or use by a physician.

### Final 2017 Policy

CMS finalized the first eight priority clinical areas including:

- Coronary artery disease (suspected or diagnosed);
- Suspected pulmonary embolism;
- Headache (traumatic and non-traumatic);
- Hip pain;
- Low back pain;
- Shoulder pain (to include suspected rotator cuff injury)
- Cancer of the lung (primary or metastatic, suspected or diagnosed); and
- Cervical or neck pain.

CMS determined that chest pain was too broad as a clinical priority area and instead finalized coronary artery disease and suspected pulmonary embolism as clinical priority areas.

CDSM must incorporate specified, applicable AUC that comprise the entire clinical scope of all priority clinical areas. CMS finalized the CDSM application to allow for preliminary qualification or full qualification based on the whether the applicant can demonstrate that all requirements are met at the time of application. The application deadline for this first round of applications is March 1, 2017. Applicants that cannot demonstrate adherence to all requirements may provide documentation to include when and how they intend to meet the remaining requirements. These applicants are eligible for preliminary qualification.

## **Medicare Shared Savings Program**

### Background

The Medicare Shared Savings Program is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

CMS proposed to make several policy changes to the Medicare Shared Savings Program regulations, including:

- Updates to ACO quality reporting, including:
  - Changes to the quality measure set to better align with the MACRA/Quality Payment Program (QPP) proposed rule and recommendations from the Core Quality Measures Collaborative, a public-private effort aimed at aligning quality measures for reporting across payers to reduce provider reporting burden;
  - Changes to the quality validation audit, revisions to terminology used in quality assessment, revisions that would permit eligible professionals in ACOs to report quality apart from the ACO, and updates to align with the Physician Quality Reporting System (PQRS) and the proposed QPP, such as technical modifications to the EHR quality measure;
- Modifications to the assignment algorithm to align beneficiaries to an ACO when a beneficiary has prospectively (and voluntarily) designated an ACO professional as his or her “main doctor” responsible for their overall care using an automated approach;
- Establishing beneficiary protection policies related to use of the skilled nursing facility three-day waiver; and,
- Technical changes to certain rules related to merged and acquired tax identification numbers and for reconciliation of ACOs that fall below 5,000 beneficiaries.

#### AAFP Recommendations

The AAFP provided detailed comments and recommendations about proposed ACO changes. In summary, the AAFP supported changes to ACO measures as they correspond with the Core Quality Measure Collaborative Measure Set, which ensures alignment, harmonization, and the avoidance of competing quality measures among payers. In terms of primary care physician attribution, the AAFP strongly supported that patients be prospectively assigned a primary care physician or provider along with a simple process for the beneficiary to change the physician or provider to whom he or she was attributed. This approach promotes patient engagement and empowers beneficiaries and their families in directing their care.

#### Final 2017 Policy

The final rule includes the following several finalized policies specific to certain sections of the Shared Savings Program regulations, such as:

- Updates to ACO quality reporting requirements, including changes to the quality measure set and the procedures for quality validation audits, revisions to terminology used in quality assessment, revisions that would permit eligible professionals in ACOs to report quality separately from the ACO, and updates to align with PQRS and the final QPP;
- Modifications to the assignment algorithm to align beneficiaries to an ACO when a beneficiary has designated an ACO professional as responsible for their overall care; and
- Establishment of beneficiary protection policies related to use of the Skilled Nursing Facility three-day waiver.

CMS will incorporate new or revised beneficiary attestations and align such beneficiaries prospectively for all tracks at the beginning of each performance and benchmark year, provided the beneficiary is eligible for assignment to the ACO in which their designated main doctor is participating.

CMS noted their intent to monitor the implementation of voluntary alignment. CMS does not intend for the voluntary alignment process to be used as a mechanism for ACOs (or their ACO participants, ACO providers/suppliers, ACO professionals or other individuals or entities performing functions or services on behalf of the ACO) to target beneficiaries for whose treatment the ACO might expect to earn shared savings, or to avoid those for whose treatment the ACO might be less likely to generate shared

savings. However, CMS believes it is important to promote engagement and discussion between beneficiaries and their health care providers. Therefore, ACOs, ACO participants, ACO providers/suppliers, and ACO professionals are not prohibited from providing a beneficiary with accurate descriptive information about the potential patient care benefits of designating an ACO professional as responsible for the beneficiary's overall care.

## **Value-Based Payment Modifier and Physician Feedback Program**

### Background

Starting in 2015, CMS was required to establish a value-based payment modifier (VM) and apply it to specific physicians and groups of physicians. CMS is required to apply the VM to all physicians and groups of physicians by January 1, 2017. The VM is required to be budget neutral. In the 2016 final Medicare physician fee schedule, CMS discussed how MACRA stipulates that the VM shall not be applied to payments for items and services furnished on or after January 1, 2019, since MACRA establishes that the MIPS shall apply to payments for items and services furnished on or after January 1, 2019.

The agency proposed to update the VM informal review policies and establish how the quality and cost composites under the VM will be affected if unanticipated program issues arise. In addition, CMS proposed to permit eligible professionals that participate in a Medicare Shared Savings Program to report to the PQRS outside the ACO for purposes of the PQRS payment adjustment.

### AAFP Recommendations

The AAFP appreciated that CMS did not propose any significant changes to the reporting requirements for the VM, PQRS, and EHR Incentive Program, because 2016 is the last reporting year for those three programs. The AAFP also appreciated that CMS proposed to update the VM informal review policies and establish how the quality and cost composites under the VM would be affected for the 2017 and 2018 payment adjustment periods "in the event that unanticipated program issues arise."

However, the AAFP expressed alarm that, since CMS has already struggled in implementing this program, the need for proposed updates to the "informal" review of data are indicative of a trouble-ridden, overly-complicated, and error-prone system.

### Final 2017 Policy

CMS finalized updates to the VM informal review policies and established how the quality and cost composites under the VM would be affected for the 2017 and 2018 payment adjustment periods in the event that unanticipated program issues arise.

CMS acknowledged commenters' concerns about the complexity of the underlying data and suggestions that the agency correct the underlying issues, rather than establish policies to address these scenarios through the informal review process.

**TABLE 50: Calculation of the Final CY 2017 PFS Conversion Factor**

<b>Conversion Factor in effect in CY 2016</b>		<b>35.8043</b>
Update Factor	0.50 percent (1.0050)	
CY 2017 RVU Budget Neutrality Adjustment	-0.013 percent (0.99987)	
CY 2017 Target Recapture Amount	-0.18 percent (0.9982)	
CY 2017 Imaging MPPR Adjustment	-0.07 percent (0.9993)	
<b>CY 2017 Conversion Factor</b>		<b>35.8887</b>

**TABLE 8: List of Potentially Misvalued Services Identified through the Screen for 0-day Global Services that are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25**

<b>HCPCS</b>	<b>Long Descriptor</b>
11755	Biopsy of finger or toe nail
20526	Injection of carpal tunnel
20551	Injections of tendon attachment to bone
20612	Aspiration and/or injection of cysts
29105	Application of long arm splint (shoulder to hand)
29540	Strapping of ankle and/or foot
29550	Strapping of toes
43760	Change of stomach feeding, accessed through the skin
45300	Diagnostic examination of rectum and large bowel using an endoscope
57150	Irrigation of vagina and/or application of drug to treat infection
57160	Fitting and insertion of vaginal support device
58100	Biopsy of uterine lining
64405	Injection of anesthetic agent, greater occipital nerve
64455	Injections of anesthetic and/or steroid drug into nerve of foot
65205	Removal of foreign body in external eye, conjunctiva
65210	Removal of foreign body in external eye, conjunctiva or sclera
67515	Injection of medication or substance into membrane covering eyeball
G0168	Wound closure utilizing tissue adhesive(s) only
G0268	Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing

<b>Enhanced Payment for Primary Care, Care Management, and Patient-Centered Services</b>				
		<b>Medicare Allowances</b>		
<b>Code</b>	<b>Short Description</b>	<b>2016</b>	<b>2017</b>	<b>Notes</b>
99354	Prolong e&m/psycx serv o/p	\$ 100.97	\$ 131.35	Non-facility rate
99355	Prolong e&m/psycx serv o/p	\$ 98.10	\$ 99.05	Non-facility rate
99356	Prolonged service inpatient	\$ 92.73	\$ 93.31	Facility rate
99357	Prolonged service inpatient	\$ 92.02	\$ 93.31	Facility rate
99358	Prolong service w/o contact	\$ -	\$ 113.41	Bundled in 2016; non-facility payment rate in 2017
99359	Prolong serv w/o contact add	\$ -	\$ 54.55	Bundled in 2016; non-facility payment rate in 2017
99487	Cmplx chron care w/o pt vsit	\$ -	\$ 93.67	Bundled in 2016; non-facility payment rate in 2017
99489	Cmplx chron care addl 30 min	\$ -	\$ 47.01	Bundled in 2016; non-facility payment rate in 2017
G0501	Intensive serv during E/M	n/a	\$ -	Proposed code GDDD1; CMS decided to bundle this service.
G0502	Init psychiatric care man	n/a	\$ 142.84	New for 2017; non-facility rate; proposed code GPPP1
G0503	Subseq psychiatric care man	n/a	\$ 126.33	New for 2017; non-facility rate; proposed code GPPP2
G0504	Init/Subseq psych care mana	n/a	\$ 66.04	New for 2017; non-facility rate; proposed code GPPP3
G0505	Assesm for cognitive impair	n/a	\$ 238.30	New for 2017; non-facility rate; proposed code GPPP6
G0506	Assesm for CCM care plan	n/a	\$ 63.88	New for 2017; non-facility rate; proposed code GPPP7
G0507	Behavioral hea care month	n/a	\$ 47.73	New for 2017; non-facility rate; proposed code GPPPX

TABLE 52: CY 2017 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	\$89,866	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$231	0%	1%	0%	1%
ANESTHESIOLOGY	\$1,982	0%	0%	0%	0%
AUDIOLOGIST	\$61	0%	0%	0%	0%
CARDIAC SURGERY	\$324	0%	0%	0%	0%
CARDIOLOGY	\$6,485	0%	0%	0%	0%
CHIROPRACTOR	\$784	0%	0%	0%	0%
CLINICAL PSYCHOLOGIST	\$734	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	\$606	0%	0%	0%	0%
COLON AND RECTAL SURGERY	\$161	0%	0%	0%	0%
CRITICAL CARE	\$311	0%	0%	0%	0%
DERMATOLOGY	\$3,308	0%	0%	0%	0%
DIAGNOSTIC TESTING FACILITY	\$754	0%	-1%	0%	-1%
EMERGENCY MEDICINE	\$3,145	0%	0%	0%	0%
ENDOCRINOLOGY	\$460	0%	0%	0%	0%
FAMILY PRACTICE	\$6,110	0%	1%	0%	1%
GASTROENTEROLOGY	\$1,747	-1%	0%	0%	-1%
GENERAL PRACTICE	\$456	0%	0%	0%	1%
GENERAL SURGERY	\$2,172	0%	0%	0%	0%
GERIATRICS	\$213	0%	1%	0%	1%
HAND SURGERY	\$182	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	\$1,751	0%	0%	0%	0%
INDEPENDENT LABORATORY	\$706	0%	-5%	0%	-5%
INFECTIOUS DISEASE	\$656	0%	0%	0%	0%
INTERNAL MEDICINE	\$10,915	0%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	\$769	0%	-1%	0%	0%
INTERVENTIONAL RADIOLOGY	\$317	-1%	0%	0%	-1%
MULTISPECIALTY CLINIC/OTHER PHYS	\$129	0%	0%	0%	1%
NEPHROLOGY	\$2,210	0%	0%	0%	0%
NEUROLOGY	\$1,521	0%	0%	0%	0%
NEUROSURGERY	\$789	-1%	0%	0%	-1%
NUCLEAR MEDICINE	\$47	0%	0%	0%	0%
NURSE ANES / ANES ASST	\$1,214	0%	0%	0%	0%
NURSE PRACTITIONER	\$2,988	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	\$651	0%	0%	0%	0%
OPHTHALMOLOGY	\$5,492	-1%	-2%	0%	-2%
OPTOMETRY	\$1,219	0%	-1%	0%	-1%
ORAL/MAXILLOFACIAL SURGERY	\$49	0%	-1%	0%	-1%
ORTHOPEDIC SURGERY	\$3,695	0%	0%	0%	0%
OTHER	\$27	0%	0%	0%	0%
OTOLARNGOLOGY	\$1,210	0%	0%	0%	-1%
PATHOLOGY	\$1,135	0%	-2%	0%	-1%
PEDIATRICS	\$61	0%	0%	0%	0%
PHYSICAL MEDICINE	\$1,068	0%	0%	0%	0%
PHYSICAL/OCCUPATIONAL THERAPY	\$3,407	0%	1%	0%	1%
PHYSICIAN ASSISTANT	\$1,964	0%	0%	0%	0%
PLASTIC SURGERY	\$378	0%	0%	0%	0%
PODIATRY	\$1,972	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	\$106	0%	0%	0%	0%
PSYCHIATRY	\$1,265	0%	0%	0%	0%
PULMONARY DISEASE	\$1,765	0%	0%	0%	0%
RADIATION ONCOLOGY	\$1,726	0%	0%	0%	0%
RADIATION THERAPY CENTERS	\$44	0%	0%	0%	0%
RADIOLOGY	\$4,683	0%	0%	0%	-1%
RHEUMATOLOGY	\$537	0%	0%	0%	0%
THORACIC SURGERY	\$357	0%	0%	0%	0%
UROLOGY	\$1,772	-1%	0%	0%	-2%
VASCULAR SURGERY	\$1,046	0%	0%	0%	-1%

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