



Highlights of the 2018 Medicare Physician Fee Schedule (MPFS) Final Rule

Physician Payment Update & Misvalued Codes Target

The update to payments under the PFS in 2018 will be +0.31 percent. This reflects the 0.5 percent update factor established under the Medicare Access and CHIP Reauthorization Act (MACRA), minus 0.09 percent, due to the misvalued codes target recapture amount, required under the Achieving Better Life Experience (ABLE) Act of 2014. The conversion factor was reduced by an additional 0.10 percent to offset spending on newly covered services, include new coverage of prolonged preventive medicine services (G0513 and G0514) and remote monitoring (CPT 99091). CMS finalized a 2018 conversion factor of 35.9996 (2017 conversion factor was 35.89). The Medicare anesthesia conversion factor for 2018 is 22.1887

Physician Work and Practice Expense

CMS finalized valuation for individual services in 2018 based consistent with recommendations of the AMA/Specialty Society RVS Update Committee (RUC). The RUC recommendations for 2018 included resource estimates for new/revised CPT codes and services identified as potentially misvalued. To date, the RUC's efforts to address misvaluations have resulted in \$5 billion in annual redistributions. In response to an AMA House of Delegates request and RUC recommendations, CMS has published relative values for several non-covered/bundled physician services, including interprofessional consultations.

Professional Liability Insurance

CMS did not finalize its proposal to use updated premium data in computing the professional liability insurance relative values. CMS will work to address the premium data shortcomings identified by the AMA and RUC prior to updating this information in 2020 CMS finalized its proposal to utilize the RUC and specialty recommendations related to expected specialties for low volume codes, a change long advocated by the RUC.

Physician Quality Reporting System (PQRS) and Meaningful Use (MU) Quality Reporting

The AMA and other members of the Federation urged CMS to revise CY2016 PQRS and MU quality reporting requirements to only require physicians to report six measures with no domain or cross-cutting measure requirements. CMS finalized this change which aligns the CY 2016 PQRS and MU quality reporting requirements with the new quality reporting requirements for physicians under the Merit-Based Incentive Payment System (MIPS). CMS estimates that this change will result in approximately \$22 million in reduced penalties for physicians.

To further align with the MIPS requirements, CMS finalized making the CAHPS for PQRS survey optional under GPRO for practices of 100 or more eligible clinicians in 2016.

Value Modifier (VM)

CMS finalized several changes to better align the VM program with the MIPS program including:

- Holding all groups and solo practitioners who met 2016 PQRS reporting requirements harmless from any negative VM payment adjustments in 2018.
- Halving penalties for those who did not meet PQRS requirements to -2 percent for groups with 10 or more eligible professionals, and to -1 percent for smaller groups and solo practitioners.
- Reducing the maximum upward payment adjustment to 2 times an adjustment factor that is set at the rate needed to keep penalties and bonuses budget neutral.
- Dropping its earlier proposal to publicly report 2016 value modifier data on its Physician Compare web site.

Patient Relationship Categories

MACRA directed CMS to create new patient relationship codes that physicians would be required to report on claims starting in 2018 for the purposes of determining which physician would be held accountable for a patient's cost of care. CMS finalized the use of Level II Healthcare Common Procedure Coding System (HCPCS) modifiers as the patient relationship codes. The HCPCS modifiers may be voluntarily reported beginning January 1, 2018. CMS notes that by allowing for a voluntary approach to reporting, it will gain information about patient relationship codes and allow for education and outreach to physicians on the use of the codes.

Diabetes Prevention Program (DPP)

Addressing pre-diabetes is one of the AMA's strategic focus areas, so we are strongly supportive of CMS moving forward with the Medicare DPP. CMS finalized a maximum payment per beneficiary of \$670 (a decrease from \$810 in the proposed rule) over three years for the set of MDPP core and maintenance services. CMS also revised the payment amount to shift a higher percent to the core service period (especially the first six months of the MDPP services period) from what it had previously proposed.

CMS also finalized a two-year time limit on Medicare coverage for ongoing maintenance sessions, specifically finalizing that after year one, suppliers of MDPP would have to offer one year of ongoing maintenance sessions to beneficiaries who continue to meet attendance and weight loss goals. CMS also finalized that a diabetes diagnosis exclusion only applies as of the date of attendance at the first core session.

CMS finalized a delay of the start date of the MDPP for three months until April 1, 2018, noting it believes the 90-day period will allow eligible organizations adequate time to enroll in Medicare as MDPP suppliers. CMS also finalized the establishment of new HCPCS G-codes for reporting MDPP services.

Virtual DPP

CMS stated in the proposed rule that expansion of the MDPP benefit to virtual services could not be considered because it was not a modality evaluated in the original MDPP demonstration. The

AMA urged CMS to expand MDPP to include virtual services in the expansion. Instead, CMS indicated that virtual MDPP would only be considered as part of a future demonstration.

Digital Medicine

CMS finalized a number of proposed expansions of telehealth and remote patient monitoring services coverage. The AMA strongly supported expanded coverage of both, and the expanded coverage of remote patient monitoring is not subject to the same geographic and originating site restrictions as Medicare telehealth services. This represents a seminal decision by CMS to expand coverage of remote patient monitoring services in the Medicare program. Further, CMS welcomed the development of new remote patient monitoring codes by the CPT Editorial Panel that will be ready for consideration in the 2019 Medicare proposed PFS. In addition, CMS has extended support for digital medicine to MIPS, so now physicians can get credit in the MIPS Improvement Activity category and be reimbursed for using digital medicine.

Remote Patient Monitoring

CMS finalized coverage of remote patient monitoring services by unbundling and activating CPT code 99091 (collection and interpretation of physiologic data) for separate payment under Medicare for 2018 as a short term measure until new CPT codes have been valued and considered as part of the Medicare 2019 Physician Fee Schedule. CMS specified that 99091 requires a minimum of 30 minutes of time in a 30-day period. CMS will utilize the RVUs (\$59) for CPT code 99091. CMS noted that separate payment for this code will not mitigate the need for coding revisions. Until the new CPT codes are considered through future rulemaking, CMS will apply some of the current requirements regarding chronic care management services including advance beneficiary consent, a face-to-face with the billing practitioner for new patients and those who have not seen their practitioner one year prior to billing the code, for example.

Appropriate Use Criteria (AUC)

The Protecting Access to Medicare Act (PAMA) of 2014 required CMS to create a program that effective January 1, 2017, would have denied payment for advanced imaging services unless the physician ordering the service had consulted AUC. In response to advocacy by the AMA and other members of the Federation, CMS previously delayed implementation until 2018. In this final rule, CMS again responded positively to advocacy by the AMA and other physician organizations and finalized a further delay of the AUC program until January 1, 2020. In 2020, the program will begin with an educational and operations testing period, during which CMS will pay claims for advanced diagnostic imaging services regardless of whether they correctly contain information on the required AUC consultation. CMS is also implementing a voluntary reporting period beginning July 2018 through 2019.

Biosimilars

As recommended by the AMA, CMS reversed previous proposed policy on coding and payment for biosimilars and will now provide for separate coding and payment for each approved biosimilar product. Previous policy would have grouped all biosimilars for a single originator product into a single HCPCS code and payment amount. CMS noted that most commenters believed that the previous proposed policy of including all grouping biosimilars into the same code/payment would decrease incentives for biosimilar development and limit provider choices.

The agency noted it supports a healthy biosimilar marketplace that promotes innovation, competition, and options for providers and patients.

Data Collection and Pricing for Clinical Laboratory Testing

CMS requested feedback on the experience of clinical laboratories that were required to submit information on private payer payments as part of the data collection and pricing exercise mandated by PAMA. The AMA submitted comments expressing strong concern that the data collection process was flawed and urging CMS to initiate a market segment survey to ascertain whether the rates were accurate. Throughout the regulatory process, the AMA raised tremendous concern about the impact of this policy on physician office labs. Due to statutory constraints, CMS declined in the final rule to modify the effective date and the rates.

Payment Rates under the Medicare PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments (PBDs) of a Hospital

Last year CMS finalized a PFS payment rate for nonexcepted off-campus PBD services of 50 percent of OPPS payment. In the final 2018 PFS CMS reduced the current payment rates to 40 percent of the OPPS payment.

Evaluation and Management (E/M) Documentation Guidelines

In the 2018 proposed rule, CMS asked for comments on revisions to the E/M documentation guidelines that would reduce administrative burden to physicians. CMS relayed that commenters did not agree on how the current standards should be changed, and different specialties expressed different challenges and recommendations regarding the guidelines. However, the agency also noted that it continues to believe revised documentation guidelines could reduce clinical burden, and it is considering the best approach for collaboration to develop and implement potential changes going forward.

Medicare Shared Savings Program (MSSP)

CMS finalized its proposal to reduce the document submission requirements for the MSSP initial application by eliminating the requirement to submit supporting documents or narratives unless CMS requests the materials. CMS also finalized changes to the Skilled Nursing Facility (SNF) 3-day waiver application procedures to reduce documentation submission requirements.

CMS also finalized reducing the burden placed on ACOs that include Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) by treating a service reported on an RHC or FQHC institutional claim as a primary care service furnished by a primary care physician for purposes of assignment methodology. In addition, CMS finalized its proposal to revise the definition of primary care services to include three additional Chronic Care Management codes and four Behavioral Health Integration (BHI) codes.

Highlights of the 2018 ASC/OPPS Final Rule

OAS CAHPS Measures

CMS finalized its proposal to delay the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey measures beginning

with the calendar year 2020 payment period. The AMA supports the delay of the OAS CAHPS survey measures.

Medicare Part B Laboratory Date of Service (DOS) Policy

After advocacy from AMA and other stakeholders, CMS finalized a new exception to the laboratory DOS policy which permits laboratories to bill Medicare directly for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests excluded from OPSS packaging policy if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and was performed following the patient's discharge from the hospital outpatient department.

340B Drug Pricing

CMS finalized reducing the payment rate for separately payable drugs and biologicals under the 340B program from Average Sales Price (ASP) plus six percent to ASP minus 22.5 percent. Rural sole community hospitals, children's hospitals and PPS-exempt cancer hospitals are excluded from this payment adjustment in 2018. CMS also established two modifiers to identify whether a drug billed under the OPSS was purchased under the 340B program, one for hospitals subject to the payment adjustment and one for hospitals not subject to the payment adjustment. CMS says it may revisit the 340B payment policy in CY 2019 rulemaking.

Medicare Site of Service Price Transparency

21st Century Cures required that the Secretary make publicly available the estimated payment amount for an item or service under either the OPSS or ASC payment system for an appropriate number of items and services. CMS plans to establish the searchable website in early 2018. Further details regarding the website will be issued through subregulatory guidance.

ASC Payment Reform

CMS did not make any changes to the ASC payment update methodology, but stated that given supporting alternative update methodologies, such as the hospital market basket, and given its interest in site neutrality and the efficiency of care, it intends to explore this issue further.