# Critical Changes in the 2016 Medicare Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) released its annual Medicare physician fee schedule final rule along with a factsheet. This rule implements a number of adjustments to Medicare physician payments as well as changes to Medicare policies and quality reporting programs for 2016. Below are the key changes from the rule that will affect Medicare Shared Savings Program (MSSP) ACOs in 2016.

**Slightly Lower 2016 Medicare Conversion Factor**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) put in place annual 0.5 percent Medicare physician payment increases for 2015 through 2019. Unfortunately, as a result of statutory requirements stemming from other laws passed by Congress and signed by the President, the Medicare conversion factor will not see a 0.5 percent increase in 2016 and will instead be slightly lower than in 2015.

New statutory requirements mandate that CMS must meet an annual target for net reductions in Medicare payment expenditures from adjustments to misvalued codes. In years when CMS falls below the required expenditure target, the conversion factor is lowered to reflect the difference between the target and the level that was achieved. As a result of this policy, the 2016 Medicare fee schedule conversion factor is $35.83, representing a 0.29 percent reduction from the 2015 conversion factor of $35.93. The 2016 anesthesia conversion factor is $22.33.

**RVU Files**

As a result of ongoing CMS evaluations of the work, practice expense and malpractice relative value units (RVUs) in the Medicare physician fee schedule, CMS modified a number of values for 2016. The updated Medicare physician RVU payment files are located on this CMS website.

**Changes to PQRS**

In preparation for the transition from the existing Medicare quality reporting programs to the Merit-based Incentive Payment System (MIPS), CMS made relatively minor changes to the Physician Quality Reporting System (PQRS) for 2016. The program remains in a penalty-only phase for providers who fail to meet the reporting requirements and 2016 PQRS performance could result in a 2 percent penalty applied to 2018 Medicare fee for service (FFS) payments. Eligible professionals (EPs) who bill through the tax ID number (TIN) of an ACO participant may continue to avoid downward payment adjustments in PQRS when the ACO satisfactorily reports the ACO Group Practice Reporting Option (GPRO) measures on their behalf using the GPRO web interface.

New MSSP Quality Measure

MSSP ACOs report PQRS through the GPRO web interface, and CMS has added a new MSSP GPRO web interface measure: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, bringing the total number of GPRO web interface measures to 18. The new pay-for-reporting measure is included in the MSSP preventive health domain, which increases the points in this domain from 16 to 18. CMS calls for an oversample of 750 beneficiaries, up from the typical 616 beneficiaries. The consecutive reporting requirement is 248 beneficiaries, which is the same as for other measures reported through the CMS web interface, and this increases the MSSP measure set from 33 to 34 quality measures. The measure is pay-for-reporting, but CMS indicates that is may consider shifting it to pay-for-performance in future rulemaking.

This measure is intended to support the prevention and treatment of cardiovascular disease by measuring the use of statin therapies according to updated clinical guidelines for patients with high cholesterol. The measure reports the percentage of beneficiaries who were prescribed or were already on statin medication therapy during the measurement year and who fall into any of the following three categories:

(1) High-risk adult patients aged greater than or equal to 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD);
(2) Adult patients aged greater than or equal to 21 years with any fasting or direct Low-Density Lipoprotein Cholesterol (LDL–C) level that is greater than or equal to 190 mg/dL; or
(3) Patients aged 40 to 75 years with a diagnosis of diabetes with a fasting or direct LDL–C level of 70 to 189 mg/dL who were prescribed or were already on statin medication therapy during the measurement year.

The measure contains multiple, equally weighted denominators to align with the updated clinical guidelines for cholesterol targets and replaces the low-density lipid control measures previously retired from the measure set.

For all MSSP measures, CMS finalized its proposal to maintain measures as pay-for-reporting or revert pay-for-performance measures to pay-for-reporting if the measure owner determines the measure no longer meets best clinical practice due to clinical guideline changes or clinical evidence suggesting that the continued collection of the data may result in harm to patients. CMS may propose to retire such a measure in the next rulemaking cycle.

**Value-based Payment Modifier**

CMS continues implementation of the Medicare value-based payment modifier (VM), which rewards or penalizes Medicare providers based on cost and quality performance with quality metrics based on PQRS. The VM has been phased in over the past few years, beginning with large group practices of 100 or more EPs who were evaluated in 2013 for payment adjustments in 2015. At that time, MSSP ACOs were excluded from the VM but were later added, beginning with 2015 reporting which, depending on performance, may affect Medicare FFS physician payments in 2017. To learn more about the 2017 VM based on 2015 performance, view this CMS factsheet.

Although CMS finalized most program details for the 2017 VM in the final 2015 Medicare physician fee schedule, thye made a few adjustments to the 2017 VM and finalized changes for the 2018 VM in the 2016 Medicare physician fee schedule.

2017 VM Modifications Based on 2015 Performance

Under the 2017 VM, groups of 10 or more EPs – including MSSP ACOs – who successfully meet 2015 PQRS reporting requirements will receive an upward, neutral, or downward payment adjustment ranging from -4 percent to +4x, where x is a budget-neutral payment adjustment factor to be determined by CMS. Groups that do not successfully meet PQRS requirements in 2015 will receive an automatic 4 percent VM penalty in 2017. While non-physician practitioners are counted to determine group size under the VM, the 2017 VM payment adjustment only applies to Medicare FFS payments to physicians.

CMS made the following program changes which go into effect starting with the 2017 VM:

- Applying an additional upward payment adjustment of +1.0x to Shared Savings Program ACO participant TINs that are classified as “high quality” under the quality-tiering methodology, if the attributed patient population of the ACO in which the TINs participated during the performance period has an average beneficiary risk score in the top 25 percent of all beneficiary risk scores nationwide, as determined under the VM methodology.
- For groups and solo practitioners that participate in two or more ACOs during the applicable reporting period, adjusting the VM performance to be based on the performance of the ACO with the highest quality composite score.

- Increasing the minimum episode count for the Medicare Spending per Beneficiary (MSPB) cost measure to 125.
- Waiving the VM for Pioneer ACOs and participants in the Comprehensive Primary Care Initiative (CPCI) if at least one EP bills for Physician Fee Schedule (PFS) items and services under the TIN during the applicable performance period participates in the Pioneer ACO model or CPCI. Because the VM is applied at the TIN level, this waiver also applies to EPs who do not participate in the Pioneer ACO model or CPCI, but bill under the same TIN as EPs who do participate and for whom the VM is waived.

2018 VM Based on 2016 Performance

Under the 2018 VM, groups of 10 or more EPs – including MSSP ACOs – who successfully meet 2016 PQRS reporting requirements will receive an upward, neutral, or downward payment adjustment ranging from -4 percent to +4x, where x is a budget-neutral payment adjustment factor to be determined by CMS. Groups that do not successfully meet PQRS requirements in 2016 will receive an automatic 4 percent VM penalty in 2018. The 2018 VM affects Medicare FFS payments to physicians and, new with the 2018 VM, payments to non-physician EPs who are Nurse Practitioners, Clinical Nurse Specialists, Physician Assistants, and Certified Registered Nurse Anesthetists (CRNAs).

CMS made the following program changes which go into effect starting with the 2018 VM:

- Waiving VM participation for those in the Next Generation ACO Model, Comprehensive ESRD Care Initiative, and the Oncology Care Model. This waiver may also apply to other similar Center for Medicare and Medicaid Innovation models specified by CMS. The waiver is applicable if at least one EP who bills for PFS items and services under the TIN participates in the model in 2016.
- Requiring the ACO Consumer Assessment of Healthcare Providers and Services (CAHPS) survey as an additional component of the VM quality composite for TINs participating in the MSSP.
- Providing MSSP ACOs an average VM cost composite score.
- Basing the ACO's quality composite on data submitted through GPRO web interface and data from the ACO all-cause hospital readmissions measure as calculated under the MSSP.
- Subjecting all groups and solo practitioners participating in an MSSP ACO to VM penalties should the ACO fail to successfully report MSSP quality data.
- Using a definition of index admission for the MSPB that includes inpatient hospitalizations at Maryland hospitals.

**Physician Compare**

CMS continues to expand the amount of information it shares with the public on the Medicare Physician Compare website, which has web pages for individual physicians, group practices and ACOs. The agency finalized its proposal to publicly report all MSSP ACO measures as well as all PQRS GPRO measures across reporting mechanisms for groups of two or more EPs and MSSP ACOs. The information will be added to Physician Compare following the close of the reporting year.

**MSSP Beneficiary Assignment**

CMS finalized its proposal to modify the definition of primary care services used for ACO beneficiary assignment to exclude services delivered to beneficiaries in skilled nursing facilities (SNFs). Specifically, CMS will exclude CPT codes 99304 through 99318 when the claim contains the place of service (POS) 31 modifier. This change is effective beginning with the 2017 MSSP assignment methodology. Primary care services delivered to nursing home (POS 32) residents will still count. CMS will adjust all benchmarks at the start of the first performance year in which the new assignment rules are applied so that the benchmark for an ACO reflects the use of the same assignment rules that apply in the performance year.

CMS finalized its proposal to codify its current practice and guidance regarding the treatment of claims for primary care services submitted by Electing Teaching Amendment (ETA) hospitals in the assignment process. As a

result, the agency formally amended the definition of primary care services by adding Healthcare Common Procedure Coding System (HCPCS) code G0463 for services furnished in an ETA hospital to the definition of primary care services for performance year 2016 and subsequent performance years.

**Advance Care Planning Services**
CMS finalized Medicare payment for two Current Procedural Terminology (CPT) codes to provide advance care planning (ACP) services, which promote conversations between patients and their physicians about treatment options and long-term planning. While specific payments vary based on Medicare geographic practice cost indices (GPCIs), the national Medicare payment rates for these services are approximately $86 for the first 30 minutes (CPT 99497) and $75 for each additional 30 minutes (CPT 99498). Beneficiary cost-sharing applies to these services, unless they are provided during an Annual Wellness Visit, in which case use of modifier -33 for preventive services is required.

ACP services may be billed separately on the same day as other evaluation and management services, during the same service period as transitional care management or chronic care management services and within global surgical periods. There are billing restrictions for providing ACP services on the same date of service as certain critical care services. ACP services are effective for Medicare beginning January 1, 2016.

**Incident to Billing**
CMS made a clarification to incident to billing rules to specifically stipulate that the supervising physician or non-physician practitioner must bill for the incident to service. Despite confusion in the proposed rule based on unclear language from the agency, CMS is not making a significant policy change to require the physician who establishes the plan of care to also be the supervising/billing physician for all related incident to services. To be consistent with other CMS regulations, the agency finalized language amending the definition of auxiliary personnel who are eligible to provide incident to services by prohibiting auxiliary personnel who have been excluded from federally funded healthcare programs (such as Medicare and Medicaid) from furnishing incident to services.

**Medicare Telehealth Services**
CMS made minor telehealth adjustments, and the Medicare telehealth originating site facility fee statutorily increases from $24.83 to $25.10 in 2016. Specifically, CMS added CRNAs to the list of distant site practitioners who can furnish Medicare telehealth services and added the following services to the 2016 approved list of Medicare telehealth services:

- Prolonged service (CPT codes 99356 and 99357)
- End-stage renal disease home dialysis (CPT codes 90963, 90964, 90965 and 90966)