# AMA Summary of the 2016 Medicare Physician Fee Schedule Final Rule

On October 30, 2015, the Centers for Medicare & Medicaid Services (CMS) released the (1,358 page) 2016 Medicare Physician Fee Schedule (PFS) Final Rule with comment period. CMS has issued a general fact sheet and a PQRS payment adjustment fact sheet. Table 62 shows the impact of the rule on individual specialties. The AMA submitted detailed comments on the Proposed Rule on September 8, 2015. The Final Rule is scheduled for publication in the Federal Register on November 16, 2015. CMS will accept comments by 5 PM on December 29, 2015, regarding interim final relative value units (work, practice expense, and malpractice); interim final HCPCS codes (in the Preamble and Addendum C); and changes to the physician self-referral HCPCS/CPT codes (tables 50-51).

### Physician Payment Update & Misvalued Codes Target

The Medicare Access and Chip Reauthorization Act (MACRA) called for annual updates of 0.5 percent from July 2015 through 2019. The Protecting Access to Medicare Act of 2014 (PAMA) set an annual target for reductions in PFS spending, from adjustments to relative values of misvalued codes. Then the Achieving a Better Life Experience (ABLE) Act of 2014 accelerated those targets, increasing the target to 1 percent for 2016 and keeping it at 0.5 percent for 2017 and 2018.

The AMA opposed these targets as completely unnecessary. The RUC and CMS have been engaged in intensive efforts to identify and address misvalued services for many years, long before Congress got involved. CMS has recognized the RUC's vital role in helping value Medicare services. Since the RUC Relativity Assessment Workgroup began in 2006, the RUC and CMS have identified over 1,900 services through 16 different screening criteria for further review, and the RUC has recommended reductions and deletions for 1,045 services, leading to redistribution of nearly $4 billion.

In the final rule, CMS brought its methodology more in line with AMA and RUC recommendations, and rolled back planned payment reductions for both radiation treatment services (completely) and lower GI endoscopy (partially). Together with redistributions recommended by the RUC, this yields a net savings of 0.23 percent, requiring a 0.77 percent reduction to meet 1 percent target. Taking into account the 0.5 percent positive update (and a -0.02 percent budget neutrality adjustment), the 2016 Medicare conversion factor is reduced by 0.29 percent to $35.83, just 10 cents below the 2015 conversion factor of $35.93.

### Advanced Care Planning

CMS finalized separate Medicare payment for two CPT codes for advance care planning services, which include conversations between patients and their physicians before an illness progresses and during treatment. The rule specifically referenced the AMA recommendations. This represents not only a win for CPT, the RUC, and the AMA, but also a turning point towards a new approach to pay for advance care planning. The Medicare statute currently provides coverage for advance care planning under the "Welcome to Medicare" visit available to all Medicare patients, but they may not need these services when they first enroll. Separate payment for advance care planning codes recognizes the additional time needed to conduct these conversations, and provides a greater opportunity and more flexibility to have these planning sessions at the most appropriate time for patients and their families. CMS is also finalizing payment for advance care planning when it is included in the "Annual Wellness Visit."

### "Incident to" Services

In the 2014 PFS final rule, CMS set explicit requirements that "incident to" services must be furnished consistent with applicable state law, including state licensure and other requirements for the "auxiliary personnel" providing the services. In the 2016 PFS final rule, CMS is also requiring that "the

physician or other practitioner who bills for incident to service must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services." (Incident to services may also be billed by clinical psychologists, PAs, NPs, CNSs, and certified nurse-midwifes. General supervision is sufficient for chronic care and transitional care management services, except patient visits.) The AMA and other physicians expressed concerns that this requirement – and CMS' proposal to remove current regulatory language widely interpreted as allowing the supervising physician (or practitioner) to be someone different from the person who initiated the patient's treatment and is overseeing their general care – would adversely impact the physician community, particularly group practices and multispecialty clinics. Fortunately, CMS agreed to continue its policy that the supervising physician (or practitioner) for a particular incident to service does not have to be the same person who is "treating the patient more broadly" and is adding clarifying regulatory language to that effect. The rule also finalizes regulatory changes that prohibit auxiliary personnel from providing incident to services if they have been excluded from Medicare, Medicaid, or other federal health programs or have had their enrollment revoked.

### Other Payment Issues

- **Primary Care Bonuses End:** While not highlighted in the final rule, it is important to keep in mind that the 10 percent incentives – that section 5501(a) of the Affordable Care Act established for Part B services by primary care practitioners – are scheduled to end on December 31, 2015.
- **Phase-In of Significant RVU Reductions:** The PAMA specified that a decrease in value for a service of 20 percent or more, without a change in the underlying code for the service, must be phased-in over a two-year period. CMS is adopting its proposal to reducing the value for a service by 19 percent in the first year, and by the remainder in the second year.
- **Misvalued Code Changes/Lower GI Endoscopy Services:** CMS is adopting codes for lower gastrointestinal endoscopy as revised by the CPT Editorial Panel and related values "more closely tied" to the RUC's recommendations.
- **Misvalued Code Changes/Radiation Therapy:** CMS did not finalize the new code set for radiation therapy treatment. Changes will be implemented, over 2 years, to the utilization rate for capital equipment used in radiation therapy, to 35 hours per week (70 percent utilization) instead of 25 (50 percent utilization). CMS also seeks comment on the price and usage of linear accelerators.
- **Part B Drugs/Biosimilars:** Payment for a biosimilar biological product will be based on the average sale price of all biosimilar biological products within the same billing/payment code.
- **Technical Errors:** There are two errors in the Final Rule that will be corrected in a technical correction notice:
    - The 0.5 percent update was not applied to the Anesthesia conversion factor. With the appropriate application, we estimate that the correct 2016 Anesthesia conversion factor should be $22.4426.
    - The work GPCI (geographical practice cost index) floor, extended under MACRA until January 1, 2018, was not applied. The GPCI tables incorrectly list work GPCIs below 1.0 for 51 localities.

### Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

PAMA requires that providers who order advanced diagnostic imaging services consult with AUC via a clinical decision support mechanism. PAMA also requires CMS to specify AUC from among those developed or endorsed by national medical professional specialty societies and other provider-led entities; to approve clinical decision support mechanisms; to collect additional information on the Medicare claim form; and to develop a prior authorization program based upon the claims information. CMS is establishing which organizations are eligible to develop or endorse AUC, the evidence-based requirements for AUC development, and the process CMS will follow for qualifying provider-led

entities. Consistent with concerns expressed by the AMA, CMS says it will not have AUC in place and ready for consultation by ordering physicians by the January 1, 2017 deadline, so the requirement for consultation will be delayed. Also consistent with AMA advocacy, CMS is reconsidering application of the AUC to emergency departments, and will review this issue in next year's PFS rule.

### Medicare Opt-Out

Prior to MACRA, physicians and practitioners that wished to renew their opt-out were required to file new valid affidavits with their Medicare Administrative Contractors (MACs) every 2 years. CMS clarifies in the final rule that under MACRA, physicians and practitioners that filed valid opt-out affidavits on or after June, 16, 2015 are not required to file renewal affidavits. Such physicians and practitioners may cancel the renewal by notifying all MACs with which they filed an affidavit in writing, at least 30 days prior to the start of the new two-year opt-out period.

### Physician Quality Reporting System (PQRS)

Despite objections from the AMA and other physician specialty societies, CMS is maintaining the same strict minimum measure reporting requirements—of nine measures covering three National Quality Strategy domains—for the 2016 reporting period which determines the 2018 PQRS payment adjustment. Individual eligible professionals (EPs) or group practices that fail to satisfactorily report or otherwise participate in PQRS for 2016 will receive a 2 percent negative payment adjustment on covered professional services in 2018. CMS is finalizing additions to the PQRS measure set to fill gaps, and deleting measures considered "topped out," duplicative, or replaced. The 2016 PQRS measure set will have 281 measures and the GPRO Web Interface will have 18. CMS will allow group practices to report quality measure data using a Qualified Clinical Data Registry (QCDR), as required under MACRA.

### Physician Compare

All 2016 individual EP and group practice PQRS measures will be available for public reporting on Physician Compare. This includes ACO measures and "CAHPS for PQRS survey" measures for groups of two or more EPs that have the required sample size and collect data via a CMS-specified certified CAHPS vendor. CMS is withdrawing its plan to indicate (on profile pages) which EPs and which group practices receive a VM bonus, but is finalizing the inclusion on Physician Compare of:

- Certifying board, including the American Osteopathic Association Board;
- An indicator for individual EPs who satisfactorily report PQRS Cardiovascular Prevention measures in support of the Million Hearts initiative (on profile pages);
- Individual and group-level QCDR measures;
- In the downloadable database: Value Modifier tiers for cost and quality; whether the EP or group practice is high, low, or neutral on cost and quality; the resulting payment adjustment; which eligible EPs or group practices did not report quality measures to CMS; utilization data for individual EPs; and
- An item (or measure)-level benchmark based on the Achievable Benchmark of Care (ABC™) methodology, displayed as a five-star rating.

### Value-Based Payment Modifier (VM)

CMS will no longer apply an automatic VM penalty to TINs receiving a PQRS penalty, if on informal review at least 50 percent of EPs avoid the PQRS penalty. If CMS does not have sufficient data to calculate their VM quality score, they will be considered "average quality." CMS is finalizing the following key provisions for the 2016 reporting period/2018 payment adjustments:

- The VM will apply to nonphysician EPs who are Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Certified Registered Nurse Anesthetists (CRNAs) practicing either in groups or as solo practitioners.

- The quality-tiering methodology will apply to all groups and solo practitioners. However, PAs, NPs, CNSs, and CRNAs will not receive downward adjustments under quality-tiering in 2018.
- The maximum upward adjustment under quality-tiering will continue at:
  - +4.0 times the adjustment factor for solo physicians and groups with 10 or more EPs.
  - +2.0 times the adjustment factor, for solo physicians and groups with 2 to 9 EPs.
  - +2.0 times the adjustment factor for solo and groups of PAs, NPs, CNSs, and CRNAs.
- The amount of payment at risk is:
  - -4.0 percent for groups of physicians with 10 or more EPs.
  - -2.0 percent for solo physicians and groups with 2 to 9 EPs.
  - -2.0 percent for solo and groups of PAs, NPs, CNSs, and CRNAs.

Beginning with VM adjustments in 2017:

- The VM is waived for EPs and groups if at least one EP who billed for PFS items and services under their TIN participated in the Pioneer ACO Model, Comprehensive Primary Care Initiative, or other similar Innovation Center model (such as Comprehensive ESRD Care Initiative, Oncology Care Model, and the Next Generation ACO Model).
- The Medicare Spending per Beneficiary measure will only apply to EPs with at least 125 episodes.
- For solo practitioners and groups with 2 to 9 EPs, the All-Cause Hospital Readmissions measure will not be used in the quality calculation.

### Medicare Shared Savings Program (MSSP)

- The final rule adds a "Statin Therapy for the Prevention and Treatment of Cardiovascular Disease" measure in the Preventive Health domain to align with PQRS reporting.
- Measures can stay or revert to "pay for reporting" if a measure owner determines they no longer align with updated clinical practice or cause patient harm.
- The rule clarifies how EPs in an ACO can meet their PQRS requirements.
- "Primary care services" include claims submitted by Electing Teaching Amendment hospitals and exclude certain services furnished in Skilled Nursing Facilities.

### Physician Self-Referral Law

The physician self-referral law prohibits: (1) a physician from making referrals for certain "designated health services" (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship, unless the requirements of an applicable exception are satisfied; and (2) the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those DHS furnished as a result of a prohibited referral. The final rule establishes two new exceptions and clarifies certain terms and requirements.

**New Exceptions**: Permit payment to physicians by hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs), to compensate non-physician practitioners under certain conditions; and permit timeshare arrangements for the use of office space, equipment, personnel, items, supplies, and other services. CMS believes these will enhance access to care, particularly in rural and underserved areas.

**Physician-Owned Hospitals**: The ACA established new restrictions on physician-owned hospitals, including setting a baseline physician ownership percentage they cannot exceed, and requiring statements of physician ownership on websites and in advertising. CMS is clarifying that a broad range of actions comply with these requirements, and finalized changes to the physician ownership calculation, effective January 2017, to include all physicians, not just those who refer to the hospital.

**Clarifying Terminology and Policy Guidance**: Relating to settlement of overpayments resulting from physician self-referral law violations is designed to "reduce perceived or actual noncompliance."

- Compensation paid to a physician organization cannot take into account the referrals of *any physician* in the physician organization (as opposed to the referrals of *a physician who stands in the shoes of the physician organization*).
- Employees and independent contractors do not have to sign arrangements with the physician organization and a DHS entity.
- Exceptions to the referral and billing prohibitions can be based on a collection of documents.
- The terminology that describes these types of arrangements was made more consistent.
- The term of leases and personal service arrangements lasting at least 1 year, and otherwise compliant, does not have to be in writing.
- Expired lease and personal services arrangements can continue indefinitely if otherwise compliant.
- A 90-day grace period is allowed to obtain missing signatures, inadvertent or not.
- DHS entities can give physicians items used solely for a purpose identified in the statute.
- A financial relationship does not exist when a physician provides services to hospital patients in the hospital, if both the hospital and the physician bill independently for their services.
- The exception for ownership in publicly traded entities allows over-the-counter transactions.
- The definition of a locum tenens physician was simplified.
- Geographic service areas were clarified for FQHC and RHC physician recruitment exceptions.
- Under the retention exception, retention payments based on physician certification may be no more than 25 percent of the physician's current annual salary averaged over 24 months.