**Initial Summary of the 2017 Medicare Physician Fee Schedule (PFS) Proposed Rule**

**American Medical Association**

On July 7, 2016, the Centers for Medicare & Medicaid Services (CMS) released the [2017 Medicare Physician Fee Schedule (PFS) proposed rule](https://www.gpo.gov/fdsys/pkg/FR-2016-07-15/pdf/2016-16097.pdf) with comment period, and on July 15, 2016 it was posted in the *Federal Register*. CMS has also issued a [fact sheet](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-07-2.html) on the proposed rule. CMS is accepting comments on the proposed rule through September 6, 2016. The final rule is expected to be released in early November.

**2017 MPFS Proposed Rule**

**Physician Payment Update & Misvalued Codes Target**

The Medicare Access and CHIP Reauthorization Act included 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 from adjustments to relative values of misvalued codes. The Achieving a Better Life Experience (ABLE) Act of 2014 accelerated those targets, setting the target at 0.5 percent for 2017 and 2018. CMS estimates the 2017 net reduction in expenditures from proposed adjustments to relative values of misvalued codes to be 0.51 percent. Since this exceeds the 0.5 percent target, there is no additional reduction.

Nonetheless, it is estimated that the 2017 conversion factor will be reduced to 35.7751 (2016 conversion factor was 35.8043), based on the budget neutrality adjustment and the 0.5 percent update factor. This budget neutrality adjustment is primarily computed to capture the increased Medicare costs to a new add-on payment to office visits for patients with mobility impairments.

**2017 Potentially Misvalued Codes List**

CMS proposes a list of 2017 potentially misvalued codes for review by the AMA/Specialty Society Relative Value Scale Update Committee (RUC), and possible adjustment in 2018. To develop the list, CMS identified 0-day global codes that were billed with an E/M code 50 percent of the time or more, on the same day of service, with the same physician and same beneficiary. To prioritize review of these potentially misvalued services, CMS identified codes that have not been reviewed in the last five years and have greater than 20,000 allowed services. There are 83 codes that CMS indicates meet these review criteria and are proposed as potentially misvalued codes for 2017.

**Diabetes Prevention Program Expansion**

CMS proposes to expand the duration and scope of the Diabetes Prevention Program (DPP) model test, and refer to the new program as the Medicare Diabetes Prevention Program (MDPP). The proposed rule provides a basic framework for the MDPP, and CMS notes that if finalized, they will engage in additional rulemaking within the next year to establish specific MDPP requirements.

CMS proposes MDPP will be a 12-month program using the Centers for Disease Control (CDC)-approved DPP curriculum. CMS’ overview of the MDPP program includes the following proposals:

* A program with 16 core sessions over 16-26 weeks, and the option for monthly core maintenance sessions over six months thereafter if beneficiaries achieve and maintain a minimum weight loss.
* Any organization recognized by the CDC to provide DPP services would be eligible to apply for enrollment in Medicare beginning on January 1, 2017.
* Full implementation of the MDPP expansion would begin on January 1, 2018.
* Payment for MDPP services would be tied to the number of sessions attended and achievement of a minimum weight loss of five percent of baseline weight.
* MDPP suppliers would be required to attest to beneficiary session attendance and weight loss at the time claims are submitted to Medicare.
* MDPP is available to Medicare beneficiaries who: 1) are enrolled in Medicare Part B; 2) have a body mass index of at least 25 or at least 23 if self-identified as Asian; and 3) have within 12-months prior to attending the first core session a hemoglobin A1c test with a value between 5.7 and 6.4, or a fasting plasma glucose of 110-125 mg/dL, or a 2-hour post-glucose challenge of 140-199 mg/dL.
* Providers could deliver DPP services in-person or via remote technologies.

In addition, the DPP raises questions related to conferring NPIs on non-providers and coding.

**New Primary Care Payments**

In this rule, CMS proposes numerous policy updates for primary care services. . The proposed policy updates in this rule include:

* Recognizing two new CPT codes for separate payment for non-face-to-face prolonged E/M services, which are currently considered to be bundled under the PFS.
* Establishing a separate payment for behavioral health integration models including the Psychiatric Collaborative Care Model (CoCM). CMS is proposing to make separate payments for a broader application of care management for beneficiaries with diagnosed behavioral conditions in a primary care setting, for those physicians that are not using the Psychiatric CoCM.
* Increasing payment for Chronic Care Management (CCM) services, by accepting recommendations from CPT and the RUC to recognize payment for existing CPT codes and adding a G-code that improves payment for visits that qualify as initiating visits for CCM services.
* Proposing a G-code that would provide separate payment to a physician for assessing and creating a care plan for beneficiaries with cognitive impairment. The CPT code will be available for this service in 2018.

**Medicare Telehealth Services**

While the Agency received a large number of requests to increase the Medicare services that could be delivered via telehealth, CMS is proposing to add a relatively small number of codes including two services that had not been proposed by the public.  In addition, CMS is also proposing payment policies related to the use of a new place of service code specifically designed to report services furnished via telehealth.  These new services CMS is proposing to include are:

* End-stage renal disease (ESRD) related services for dialysis;
* Advance care planning services;
* Critical care consultations furnished via telehealth using new Medicare G-codes.

The use of G-codes will be carefully scrutinized because the CPT Editorial Panel has established a Telehealth Services Workgroup that is charged with reviewing proposed changes to existing codes or establishment of new codes where appropriate to support telehealth services and remote patient monitoring.

**Add-On Payment for Patients with Mobility Impairments**

CMS is proposing an add-on code that could be billed with E/M codes for physicians treating people with mobility-related impairments. While the AMA supports improving access to care for patients with mobility impairments, we are exploring alternative approaches to better serve patients with mobility impairments. This proposal is funded with an across-the-board cut in payment rates.

**Open Payments Program**

Despite statements made by a current and former CMS official in a *New England Journal of Medicine* *(NEJM)* article earlier this year, CMS did not propose to revise existing regulatory language concerning independent continuing medical education (CME) in the Open Payment Program (Sunshine Act) reporting requirement for manufacturers.  In the article, the authors asserted that independent CME would be subject to reporting in 2017.  CMS has issued two proposed and final rules concerning the Sunshine Act program and each time appeared to exclude independent CME from the reporting requirement.

While the proposed rule solicits input concerning a host of issues, a number of key areas of note including request for information on: (1) allowing physicians to review manufacturer reports prior to submission to CMS; (2) whether the categories used by the Agency to identify the nature of the payments is adequate; and (3) recommendations on how to streamline and improve accuracy of the program.  The failure of the Agency to streamline the review process has prevented the overwhelming majority of physicians from reviewing the reports and seeking correction.  The data currently lacks validation and cannot be reasonably relied upon to provide information about physician and industry financial interactions.

**ACO Participants Who Report PQRS Data Separately**

CMS proposes to allow physicians who bill under the Tax Identification Number (TIN) of an ACO participant to report separately for the purposes of the 2018 PQRS payment adjustment, when the ACO fails to successfully report on behalf of the physician. Since the deadline for participating in the PQRS Group Practice Reporting Option (GPRO) is June 30 of the applicable reporting period, CMS proposes physicians would not need to register for PQRS GPRO for the 2018 PQRS payment adjustment, but rather mark the data as group data in their submission.

In addition, CMS is proposing relief for physicians who billed through the TIN of an ACO participant in an ACO that failed to satisfactorily report on behalf of physicians during the 2015 reporting period to avoid the 2017 payment adjustment. These physicians have the option to use a secondary reporting period- January 1, 2016 through December 31, 2016- to report PQRS data to avoid the 2017 payment adjustment. Physicians can use 2016 data as a secondary reporting period for the 2017 payment adjustment, for the 2018 payment adjustment, or for both payment adjustments if the ACO failed to satisfactorily report PQRS measures for both years.

**Medicare Advantage / Medicare Part D**

CMS has made a number of proposals related to Medicare Advantage (MA), including requiring physicians to be enrolled in Medicare in order to contract with MA organizations and provide services. To the extent physicians are not, the MA plan sponsors will be subject to sanctions.  This is an expansion of a similar requirement that CMS mandated for physicians who prescribe for Medicare beneficiaries enrolled in the Medicare Part D drug program even if the prescriber was not reimbursed for services by Medicare.  The Agency has not identified the scope of program integrity risks that this added administrative burden would address.

In addition, the Agency has proposed to provide to the public bid data for MA plans and medical loss ratios submitted by both Part D drug plan sponsors and MA plan sponsors in order to promote public evaluation of the plans.  This information would provide additional transparency to support physician efforts to ensure adequate access to services for MA beneficiaries.

**MSSP ACOs**

CMS proposes changes to the quality measure set that ACOs are required to report in order to better align the MSSP quality measure set with the measures recommended by the Core Quality Measures Collaborative. CMS also proposes a new process allowing beneficiaries to voluntarily align with an ACO by designating an ACO professional as responsible for their overall care.

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

CMS proposes to update the Value Modifier (VM) informal review policies and establish how the quality and cost composites under the VM would be affected if unanticipated issues arise for the 2017 and 2018 payment adjustment periods.

CMS proposes methods of recalculating the cost score for physicians and groups when there are widespread quality data issues or widespread claims data issues. When claims or data issues arise, CMS has assigned any physician with data issues an “average” quality composite score. Under this proposal, if a physician earns an “average quality” score due to systematic quality issues or widespread claims data issues, and also earned a “high cost” composite score, CMS would recalculate their cost composite score to “average cost.” This proposal would alleviate concerns from stakeholders, that a physician or group could receive a downward VM adjustment as a result of being classified as average quality and high cost.

**10- and 90-Day Global Codes - New Reporting Requirements**

Under the misvalued codes provision in the 2015 MPFS final rule, CMS finalized a policy to convert all 10- and 90-day global codes to 0-day global codes beginning in 2018. Subsequently, Section 523 of MACRA prohibited CMS from implementing this policy and instead required the agency to gather information needed on surgical services from a representative sample of physicians.

In this rule, CMS proposes a three-pronged approach to collect data on the frequency of, and inputs involved in global services. First, CMS proposes comprehensive claims-based reporting regarding the number and level of pre- and post-operative services furnished for 10- and 90-day global services. Specifically, physicians would be required to report a set of time-based, G-codes that distinguish between the setting of care (hospital, office, email/telephone) and whether the services are furnished by a physician or by their clinical staff. Physicians would be required to report the G-codes for every 10 minutes dedicated to a patient before and after a procedure or surgery.

Second, CMS proposes to survey 5,000 physicians about the activities involved and resources used in providing pre- and post-operative visits. Third, CMS proposes to conduct an in-depth study, including direct observation of pre- and post-operative care delivered at a certain number of sites, including ACOs. CMS states they are not proposing to withhold payment for non-compliance at this time, but may do so in the future.