PUBLICATION

Summary of Major Provisions in the Proposed 2017 Physician Fee Schedule [Ober|Kaler]

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The proposed Physician Fee Schedule for 2017 (PFS) [PDF] includes several changes covering a litany of topics spanning from telehealth services to expanding the Diabetes Prevention Program Model. The following is a high-level summary of a number of notable provisions in the PFS. The deadline to submit comments to CMS regarding the PFS is 5:00 p.m. on September 6, 2016.

1. Collecting Data on Resources Used in Furnishing Global Services

The PFS is implementing part of the Medicare Access and Chip Reauthorization Act of 2015 (MACRA) that requires CMS to collect data on global packages. CMS believes that it may have misvalued these global packages because CMS lacks accurate data on the services provided to Medicare beneficiaries during the 10 day and 90 day post-surgery period.

CMS pays for global packages by grouping the procedure and services in periods both before and after the procedure. Currently, CMS does not have data to indicate the number, or value, of services provided as part of the global package, particularly the pre and post-operative services. Prior to MACRA, CMS had proposed to require physicians to bill all 10 and 90 day global surgery packages as 0 day global surgeries and then bill separately the post-operative care, which would normally be included in the 10 and 90 day episode. The reason for this 0 day requirement was to allow CMS to collect the data necessary to increase the accuracy of Medicare's payments for the 10 and 90 day surgery packages in the future. One provision in MACRA prohibited CMS from implementing its 0 day strategy and also requires CMS to collect claims-level data to more accurately value, and pay for, services that are paid as part of a global package.

CMS proposes that all practitioners who bill 10 day and 90 day global surgery packages use specific G-codes for documenting in 10-minute intervals their time providing patient care during the global package period. The PFS lists activities included in a typical visit for the proposed G-codes, including taking interim patient history; managing medications; writing progress notes, post-operative orders, prescriptions, and discharge summaries; coordinating care with clinical staff; and, in general, completing forms. Reporting of these activities in 10-minute intervals is required. MACRA provides CMS the authority to impose a 5% payment withhold for practitioners who do not comply with the required claims-based information. CMS, however, is proposing that it would not immediately implement its authority for payment withholds but might do so depending on whether there is an acceptable level of participation.

2. Proposed Expansion of the Diabetes Prevention Program Model

Perhaps the most sweeping change towards preventative medicine in the PFS is the proposal to expand the Diabetes Prevention Program Model (DPP). The DPP started as a model tested by CMS' Center for Medicare & Medicaid Innovation and is the first preventative service model to be expanded nationally under the Medicare

program. With diabetes affecting more than 25% of Americans age 65 or older, the DPP aims to curtail the increasing costs of diabetes treatment (approximately $104 billion annually) by encouraging appropriate lifestyle changes for preventable forms of Type 2 diabetes. As currently proposed, the PFS includes an effective date for the DPP beginning January 1, 2018. CMS outlines payment in the DPP based on eligible Medicare beneficiaries attending coaching sessions and achieving weight loss goals in comparison to a baseline.

3. Improving Payment Accuracy for Primary Care, Care Management Services, and Patient-Centered Services

CMS acknowledges the conflicting incentives of providing coordinated care while reimbursement for primary care and patient-centered care management remains discrete and per procedure. To help address this, CMS is unbundling certain E/M services for prolonged patient encounters that previously were bundled with other payment codes (CPT codes 99358 and 99359), adding separate payment for integrating and coordinating behavioral health, and revising the payment rules for chronic care management services to improve payment for the professional work of care management services and care collaboration.

4. Medicare Advantage Provider Enrollment

Currently, Medicare Advantage plans may include in their networks providers and suppliers that are not enrolled in Medicare. However, CMS proposes to require providers and suppliers to enroll in Medicare in order to provide healthcare items or services to Medicare enrollees receiving benefits through a Medicare Advantage organization. The proposed rule would require locum tenens suppliers, incident-to suppliers and suppliers participating in demonstration and pilot programs to enroll in Medicare. The new enrollment requirements would also apply to Medicare Advantage organizations that provide drug coverage.

5. Additions to Medicare Telehealth Services

CMS proposes to add end-stage renal disease related services for dialysis, advance care planning, and critical care consultation and management to the list of Medicare-reimbursed telehealth services.

6. Medicare Shared Savings Program

The PFS includes several proposed policies to align the quality reporting requirements of ACOs with the Quality Payment Program (QPP) implemented by MACRA. Specifically, the PFS proposes to sunset the Shared Savings Program alignment with the Physician Quality Reporting System and the Electronic Health Record Incentive Program. Instead, the Shared Savings Program will transition to the QPP for annual assessments of Certified Electronic Health Record Technology and for reporting of certain quality measures to satisfy the quality performance category on behalf of eligible clinicians who bill under the Taxpayer Identification Number of an ACO participant.

7. Physician Self-Referral Updates

In June 2015, the D.C. Circuit Court of Appeals concluded in *Council for Urological Interests v. Burwell* that CMS' previous attempts to administratively codify a prohibition on “per click” leases for offices and equipment was based on an unreasonable interpretation of the Stark law. In the PFS, CMS is re-proposing this prohibition with additional information supplementing its decision to prohibit arrangements involving the rental of office

space or equipment based on per-unit (or “per click”) service charges when the lessor of office space or equipment generates payment from a lessee through a referral to lessee for a service to be provided in the rented office space or using the rented equipment. If the referral for the rented office space or rented equipment did not come from the lessor, per-unit of service rental charges will remain permissible according to CMS.