American Hospital Association

Special Bulletin

Friday, November 3, 2017

CMS Releases CY 2018 Physician Fee Schedule Final Rule

On Nov. 2, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2018 physician fee schedule (PFS) final rule. In addition to the standard update to the payment system, the rule finalizes CMS's proposal to make significant additional site-neutral cuts in payment for services furnished in off-campus provider-based departments (PBDs) of a hospital that began billing under the outpatient prospective payment system (OPPS) on or after Nov. 2, 2015.

The AHA is concerned that CMS's new "site-neutral" payment policies will adversely impact patient access to care by reducing Medicare rates for services hospitals provide in "new" off-campus hospital clinics. We also remain troubled that the agency's continued short-sighted policies on the relocation of existing off-campus provider-based clinics will prevent patients and communities from having access to the most up-to-date, high-quality services. We will continue to work to ensure CMS provides adequate support to cover the costs of providing care so that we can continue to serve as the around-the-clock access point for community care.

However, we are pleased that, as urged by the AHA, CMS implemented a further delay, until Jan. 1, 2020, of the requirement that providers consult appropriate use criteria for advanced diagnostic imaging. This will help ensure that providers have sufficient time to understand and implement the program's requirements. We also are supportive of the agency's policies to make payment for new telehealth services, although we urge a more expansive approach toward telehealth coverage.

Highlights of the final rule follow.

Payment Update: The rule includes a total increase in payment rates of 0.41 percent in CY 2018. This includes an increase of 0.5 percent as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), in addition to a mis-valued code adjustment required under the Achieving a Better Life Experience Act of 2014.

Reduction in Payments for Non-excepted Services in Certain Off-campus Hospital PBDs: Section 603 of the Bipartisan Budget Act of 2015 requires that, with the exception of dedicated emergency department services, services furnished in off-campus provider-based departments that began billing under the OPPS on or after Nov. 2, 2015, or that could not meet the 21st Century Cures "mid-build" exception, will no longer be paid under the OPPS, but under another applicable Part B payment system. For CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services and set payment for most non-excepted services at 50 percent of the OPPS rate. For CY 2018, CMS had proposed to

pay hospitals at 25 percent, rather than 50 percent, of the OPPS rate for non-excepted services. However, the agency finalized a rate of 40 percent of the OPPS amount for CY 2018 non-excepted services.

Telehealth Services: CMS finalized its proposal to add to the list of Medicare-payable telehealth services the codes for psychotherapy for crisis, health risk assessments, care planning for chronic care management and counseling visits to determine low-dose computed tomography eligibility.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging: The Protecting Access to Medicare Act of 2014 requires professionals furnishing advanced diagnostic imaging services to report on the Medicare claim information about AUC reviewed by the ordering professional. Although statute required the program to begin Jan. 1, 2017, CMS has taken a measured approach by establishing different components of the AUC program framework through rulemaking over the past couple of years. The agency proposed to begin the AUC reporting requirements on Jan. 1, 2019, but further delayed this start date in the final rule until Jan. 1, 2020. In addition, 2020 will be considered an "educational and operations testing year," and CMS will pay claims regardless of whether they contain information on the required AUC consultation. The agency also plans to implement an 18-month voluntary reporting period beginning mid- 2018. The AHA had urged CMS to allow providers adequate time to implement the AUC requirements before they begin affecting payment, and we are pleased with this policy.

Care Coordination by Rural Health Clinics (RHCs) and Federally-qualified Health Centers (FQHCs): CMS finalized its proposal to establish payment for chronic care management services, general behavioral health integration services and psychiatric collaborative care model services provided by RHCs and FQHCs. This payment will be in addition to the payment for an RHC or FQHC visit.

Medicare Shared Savings Program (MSSP): CMS finalized its proposal to consider all services provided by RHCs and FQHCs to be primary care services for purposes of MSSP beneficiary assignment. This change, which will be effective for performance years beginning Jan. 1, 2019, and beyond, complies with a provision of the 21st Century Cures Act. CMS also will streamline certain documentation and certification requirements for the MSSP program application and the application for Track 3 Accountable Care Organizations seeking a waiver of the skilled nursing facility three-day stay rule.

Medicare Diabetes Prevention Program (MDPP): CMS finalized some new components of the permanent expansion of the MDPP, which begins April 1, 2018. Specifically, CMS will pay MDPP using a performance-based payment structure, which will tie payment to performance goals based on beneficiary attendance and/or weight loss. In addition, the agency will allow MDPP suppliers to provide in-kind patient engagement incentives to promote improved beneficiary health and reductions in Medicare spending.

Physician Quality Measurement: As required by MACRA, CY 2018 is the final year for payment adjustments under both the physician quality reporting system (PQRS) and the value modifier (VM), which will be supplanted by the new two-track physician quality payment program (QPP) beginning with CY 2019 payments. For a summary of the CY 2018 MACRA final rule, see our Special Bulletin. Additional MACRA resources, including a MACRA Decision Guide, are available at www.aha.org/MACRA.

PQRS. While the data submission for the CY 2018 PQRS has passed, CMS will retroactively lower the number of required measures from nine to six to more closely align the program with the new Merit-based Incentive Payment System that will affect payment starting in CY 2019. Those clinicians that did not meet the previous PQRS standard of nine measures, but did report at least six measures, will therefore not be subject to the PQRS non-reporting penalty of 2.0 percent in CY 2018.

VM. CMS previously finalized maximum negative payment adjustments for CY 2018 of -2.0 percent for individual clinicians and groups of 10 or fewer clinicians, and -4.0 percent for groups of 10 or more clinicians. In order to provide a smoother transition into the QPP, CMS will lower the VM's CY 2018 maximum negative adjustment to -1.0 percent for individual clinicians and groups under 10 clinicians, and -2.0 percent for groups of 10 or more clinicians. **This maximum negative adjustment will apply only to those clinicians and groups that fail to meet PQRS reporting requirements. All other individual clinicians and group practices of all sizes will be held harmless from downward payment adjustments under the VM for CY 2018.**

NEXT STEPS

The final rule will be published in the Nov. 15 Federal Register, and the policies and payment rates will generally take effect Jan 1. Watch for a more detailed analysis of the final rule in the coming weeks.

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