



Thursday, November 3, 2016

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Alliance for Site Neutral Payment Reform Commends CMS for Finalizing Site Neutral Policy in HOPPS

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CMS Re-opens Applications for Certain APMS, Extends Oncology Care Model's Availability to Cover 2017 Performance Year

The Centers for Medicare & Medicaid Services recently announced that applications for the CPC+ and Next Generation ACO payment models will reopen for the 2018 performance year, while the Oncology Care Model with two-sided risk will now be available for the 2017 performance year. [Read below.](#)

Senate Finance Members Released Bipartisan Proposal on Chronic Care Improvement

Last week, the Senate Finance Committee's Chronic Care Working Group released a discussion draft of bipartisan proposals to improve health outcomes for Medicare beneficiaries living with chronic conditions. [Read below.](#)

CBO Submits Answers on Budgetary Effects of the Center for Medicare & Medicaid Innovation

On October 28, the Congressional Budget Office submitted responses to a series of questions to the House Committee on the Budget addressing the CBO's estimates of the budgetary effects of the Center for Medicare & Medicaid Innovation following a September 7 hearing at which CBO Deputy Director Mark Hadley testified. [Read below.](#)

CMS Releases Final Medicare Payment Rules for 2017



The Centers for Medicare & Medicaid Services (CMS) has issued two final rules to update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) and the Hospital Outpatient Prospective Payment System (HOPPS). These policies are set to go into effect on January 1, 2017. Here are the highlights:

2017 Medicare Physician Fee Schedule Final Rule Payment Policy Changes

The CY 2017 PFS conversion factor is estimated to be \$35.8887. Changes in payment policy outlined in the final rule result in the overall average impact for the following specialties:

- Hematology/Oncology: 0%
- Radiation Oncology: 0%
- Radiation Therapy Centers: 0%
- Urology: -2%
- Rheumatology: 0%
- Gastroenterology: -1%
- Diagnostic Testing Facility: -1%
- Independent Lab: -5%
- Ophthalmology: -2%

Potentially Misvalued Codes

After consideration of public comments, CMS finalized misvalued code changes that achieve 0.32 percent in net expenditure reductions. These changes do not fully meet the misvalued code target of 0.5 percent, thus requiring an adjustment to the 2017 overall physician update. After applying this and other adjustments required by law, the 2017 PFS conversion factor is \$35.89, an increase to the 2016 PFS conversion factor of \$35.80.

Medicare Telehealth Services

CMS is finalizing the addition of several codes to the list of services eligible to be furnished via telehealth. These include:

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

CMS is also finalizing payment policies related to the use of a new place of service code specifically designed to report services furnished via telehealth.

Payment for Mammography Services

CMS is finalizing a new coding framework based on new CPT coding for mammography services. The coding revision reflects current technology used in furnishing these services, including a transition from film to digital imaging equipment and elimination of separate coding for computer aided detection services. CMS is maintaining the current valuation for the technical component of mammography services in order to implement coding and payment changes over several years. Due to operational issues involving claims processing for preventive services, CMS is implementing the new coding framework and descriptors through use of G-codes for Medicare.

Medicare Advantage Data Transparency

CMS is finalizing a proposal to release two sets of data related to plan participation in Medicare Advantage and the Part D prescription drug program. CMS hopes that making this data publicly available will assist public research that will support future policymaking efforts in the Medicare program and provide valuable information to beneficiaries in making enrollment decisions.

Medicare Advantage Bid Pricing Data

Each year, Medicare Advantage organizations (MAOs) apply to participate in the Medicare Advantage program through a bidding process. MAOs submit bids to CMS that reflect the MAO's estimated costs associated with providing benefits to enrollees. CMS approves bids that meet a variety of statutory and regulatory conditions. CMS is finalizing the release of data associated with these bids on an annual basis. The data released would be at least five years old and would exclude certain information considered to be proprietary, as well as beneficiary-identifying information.

Medical Loss Ratio Data

Under the Medical Loss Ratio (MLR) standard for Medicare Advantage and Part D, at least 85 percent of revenues must be attributed to claims and quality improvement activities.

CMS already makes commercial MLR data public, as required by the Affordable Care Act. This rule finalizes the release of certain Medicare health and drug plan MLR data on an annual basis.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 established a new program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services under fee for service Medicare.

This year's final rule focuses on the next component of the Medicare AUC program and includes policies for priority clinical areas, clinical decision support mechanism (CDSM) requirements, the CDSM application process, and exceptions for ordering professionals for whom consultation with AUC would pose a significant hardship.

Priority clinical areas are intended to be the areas of focus for future outlier calculations when determining which ordering professionals will be subject to prior authorization. This will be discussed in future rulemaking. CMS finalized the first eight priority clinical areas including: (1) Coronary artery disease (suspected or diagnosed); (2) Suspected pulmonary embolism; (3) Headache (traumatic and non-traumatic); (4) Hip pain; (5) Low back pain; (6) Shoulder pain (to include suspected rotator cuff injury); (7) Cancer of the lung (primary or metastatic, suspected or diagnosed); and (8) Cervical or neck pain.

CMS finalized the CDSM application to allow for preliminary qualification or full qualification based on whether the applicant can demonstrate that all requirements are met at the time of application. The application deadline for this first round of applications is March 1, 2017. Applicants that cannot demonstrate adherence to all requirements may provide documentation to include when and how they intend to meet the remaining requirements. These applicants are eligible for preliminary qualification.

2017 Medicare Hospital Outpatient Prospective Payment System Final Rule

The OPPS final rule includes implementation of site neutral payment policy in any new or acquired off-campus hospital outpatient department (HOPDs) as required by the Bipartisan Budget Act of 2015. CMS determines that new or acquired HOPDs will be paid under the Physician Fee Schedule in 2017. The rule finalizes limitations on the relocation of off-campus outpatient departments that are not covered by the site neutral law allowing an exception only for "extraordinary circumstances that are outside a hospital's control, such as natural disasters." The final rule does not permit change of ownership unless the new owner accepts the existing Medicare provider agreement from the prior owner. CMS did not, however, finalize limiting the expansion of services offered at off-campus facilities that are not covered by the site neutral pay law.

To view the CMS fact sheet on the PFS final rule, [CLICK HERE](#).

To view the PFS final rule in its entirety, [CLICK HERE](#).

To view the CMS fact sheet on the OPPS final rule, [CLICK HERE](#).

To view the OPPS final rule in its entirety, [CLICK HERE](#).

Alliance for Site Neutral Payment Reform Commends CMS for Finalizing Site Neutral Policy in OPSS

The Alliance for Site Neutral Payment Reform commended CMS for equalizing payments for the same care provided in the hospital off-campus facility and physician office settings, yet expressed disappointment that CMS did not finalize limitations on the expansion of services in the hospital outpatient setting.

“We were pleased to see CMS finalize this important first step toward payment parity, however Medicare, taxpayers and patients will continue to pay more for the same services provided depending on the setting of care. The shift of physicians to the hospital setting will only escalate unless site neutral payments are adopted more broadly,” said Dr. Debra Patt, Medical Director for The US Oncology Network, in an Alliance statement. “We will continue to push Congress and the Administration to further site neutral payments in the outpatient space to achieve billions of dollars in saving for patients, employers and American taxpayers.”

To view the Alliance’s press statement, [CLICK HERE](#).

CMS Reopens Applications for Certain APMS, Extends Oncology Care Model’s Availability to Cover 2017 Performance Year

Earlier this month, the Centers for Medicare & Medicaid Services (CMS) [announced](#) that it will be reopening applications for new practices to participate in the Comprehensive Primary Care Plus (CPC+) and Next Generation Accountable Care Organization (ACO) models for the 2018 performance year. Furthermore, the Oncology Care Model with two-sided risk will now be available for the 2017 performance year.

As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which significantly altered the way providers are reimbursed through Medicare, CMS introduced the Quality Payments Program policy which allows providers to choose from several Medicare payment models. Starting in 2017, practices can earn a 5% incentive payment between 2019 and 2024 if they have sufficient participation in at least one of several Advanced APMS.

While the list isn’t final, CMS currently estimates that the following models will be considered Advanced APMS for the 2017 performance year:

- Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) arrangement)
- Comprehensive ESRD Care Model (non-LDO arrangement)
- CPC+
- Medicare Shared Savings Program ACOs – Track 2
- Medicare Shared Savings Program ACOs – Track 3

- Next Generation ACO Model
- Oncology Care Model (two-sided risk arrangement)

For the 2018 performance year, the following Advanced APMs will be available in addition to those listed above:

- ACO Track 1+
- New voluntary bundled payment model
- Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology (CEHRT) track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track)

CMS estimates that approximately 70,000 to 120,000 clinicians will participate in Advanced APMs in 2017, qualifying them for the 5% incentive payment.

To read more about the Quality Payment Program, [CLICK HERE](#).

Senate Finance Members Released Bipartisan Proposal on Chronic Care Improvement



Last week, the Senate Finance Committee's Chronic Care Working Group (CCWG) released a [discussion draft](#) of bipartisan proposals to improve health outcomes for Medicare beneficiaries living with chronic conditions. The CCWG, headed by co-chairs Johnny Isakson (R-GA) and Mark Warner (D-VA), as well as Finance Committee Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR) spent over a year developing evidence-based solutions to improve care delivery for a variety of chronic illnesses. The draft document released this week is expected to serve as the basis for the CHRONIC Act of 2016. It includes a number of proposals such as:

- Promoting High Quality Care in the Home;
- Advance Team Based Care;
- Expand Healthcare Innovation and Technology;
- Better Identify Chronically Ill Populations; and
- Empower Individuals and Caregivers in Care Delivery.

The discussion draft report also includes language directing the Government Accountability Office (GAO) to develop a Medicare payment code that would cover the planning of longitudinal care for a beneficiary diagnosed with a severe, life-threatening illness such as cancer or Alzheimer's.

To view the section-by-section breakdown of the report, [CLICK HERE](#).

CBO Submits Answers on Budgetary Effects of the Center for Medicare & Medicaid Innovation

On October 28, the Congressional Budget Office (CBO) submitted responses to a series of questions to the House Committee on the Budget addressing the CBO's estimates of the budgetary effects of the Center for Medicare & Medicaid Innovation (CMMI) following a September 7 hearing at which CBO Deputy Director Mark Hadley testified.

Chairman Tom Price, MD (R-GA), specifically raised how the Part B demonstration proposed by CMMI would likely lead to further consolidation among providers and serve to increase costs as patients move from a clinical setting to a hospital setting to receive cancer care, specifically with regards to payment differentials for chemotherapy administration. He asked if CBO takes into account the real world economic impact that occurs as a result of mandatory demonstrations.

The CBO replied, "As for the specific issue of the consolidation of physicians' practices with hospitals, that development has increased Medicare spending because Medicare pays the same amount for services delivered in a hospital-owned physician's practice as it pays for services provided in the hospital's outpatient department; those payment rates are higher than the amounts paid for services delivered in an independent physician's practice. However, a provision of the Bipartisan Budget Act of 2015 eliminated that disparity for physicians' practices acquired by hospitals after the legislation was enacted. Although CBO anticipates that the consolidation of physicians' practices and hospitals will continue regardless of the incentives created under the proposed Part B demonstration, that development will not lead to higher Medicare spending as it has in the past."

The CBO responses also state that it met with several physician stakeholders to explore concerns over consolidation and concluded that, even if the pace at which physicians' practices are acquired by hospitals was affected by the demonstration, there would be no significant effect on Medicare spending.

To download the full set of CBO answers, [CLICK HERE](#).