CMS unveils 2017 physician fee schedule proposed rule

Primary care physicians will be the biggest beneficiaries of the 2017 Medicare Physician Fee Schedule (PFS), according to an analysis of the PFS proposed rule by The ENT Voice. Still, ENT practices can still look forward to better reimbursement for prolonged services, chronic care management, and overall flat Part B payments.

Overall payments will remain stable – the proposed rule sets the 2017 conversion factor at $35.7751, which is down from the current 2016 conversion factor of $35.8043. This change, which essentially keeps Part B payments flat, is mandated by the budget neutrality requirements in the Medicare Access and CHIP Reauthorization Act (MACRA), the law that repealed the longstanding Medicare payment formula known as the Sustainable Growth Rate (SGR).

MACRA requires CMS to establish positive or flat payment updates from 2016 through 2019, at which point the Merit-Based Incentive Program (MIPS) will begin to adjust payments based on provider performance.

Now let’s take a look at the highlights of the 856-page proposed rule, which CMS released on July 7.

- **Flat payment update.** As mentioned above, the 2017 conversion factor is projected to be $35.7751, which is essentially flat and continues the series of minor payment updates CMS is required to establish as part of MACRA.

- **Restoring endoscopy RVUs.** CMS proposes to add the cost of xenon light sources, used on flexible endoscopes, into its calculation of practice expense Relative Value Units (RVUs) for endoscopy procedures. In its 2016 PFS final rule, CMS had removed xenon light sources from the practice expense RVUs, which reduced the Part B payment for CPT codes 30300, 31295-31297, and 92511. This change will affect these codes differently. For example, 92511 had a national payment amount of $137.66 in 2015 that fell to $113.86 in 2016, while 31295 had a national payment amount of $2,087 in 2015 vs. $2,089.90 in 2016. If CMS returns these codes to pre-2016 values in 2017, 92511 will see a 20% bump while 31295 will see a 0.7% bump.

- **Further revaluation of endoscopies.** Your endoscopies will likely see additional payment changes in the 2017 final rule, and CMS wants the AMA’s Relative Value Update Committee (RUC) to weigh...
in. CMS notes that there are 45 pieces of endoscope-related equipment and 25 pieces of endoscope-related supplies that are used for endoscopy procedures, which are relatively few in number. “We believe that this unusual degree of variation is likely to result in code misvaluation,” the agency writes in the proposed rule. “To facilitate efficient review of this particular kind of misvaluation, and because we believe that stakeholders will prefer the opportunity to contribute to such standardization, we request that stakeholders like the RUC review and make recommendations on the appropriate endoscopic equipment and supplies typically provided in all endoscopic procedures for each anatomical body region, along with their appropriate prices.” The proposed rule itself contains no suggestions on RVU changes to endoscopies, so look for CMS to make changes based on feedback received during the public comment period.

- **Global surgical data-gathering.** CMS was committed to turning all codes that currently have 10-day and 90-day global periods into 0-day global codes, a change finalized in the 2015 PFS. However, the MACRA law required CMS to first gather data on post-surgical visits so the agency could accurately value these codes. Thus for the 2017 PFS, CMS is proposing to collect data via claims along with a representative survey of 5,000 randomly sampled providers. All providers that currently perform services with 10-day and 90-day global periods will be required to report additional information on those claims about all services rendered during the global periods. This will be mandatory and while CMS won’t withhold payments from providers who fail to participate, the agency warns it is authorized to withhold up to 5% of Medicare payments and could implement this in a future rule if participation rates aren’t high enough.

- **Primary care payment increase.** CMS aims to increase payment for primary care services in several different ways with the proposed rule. Overall, CMS wants to increase how much primary care physicians are paid for their bread-and-butter E/M services, and the agency is asking for feedback on RVU increases in the proposed rule.

- **Chronic care management boost.** One leg of CMS’ push to increase primary care pay is a proposal to pay more for the existing chronic care management (CCM) codes, as well as add two new CCM codes for complex cases where patients require extra management. Specialists are eligible to report CCM codes and would benefit from this proposal if they specifically treat chronic conditions relevant to their clinical focus, though the codes are only reportable once per month per beneficiary.

- **Prolonged services.** Related to the above bullet, CMS proposes increasing payment for existing prolonged service E/M codes (CPT 99354-99357) and also adding new prolonged service codes for non-face-to-face evaluation and management.

- **Mobility-related disability code.** CMS wants to create a new HCPCS code, GDDD1, that can be billed for E/M encounters where the patient has a mobility-related disability that increases the amount of time the physician must spend with the patient (e.g. moving the patient over
stairs or other obstacles). This code would have roughly the same RVUs and payment as a level established patient visit (99212). Though again aimed at primary care providers, ENT providers could benefit from this code whenever they happen to see patients with mobility issues.

- **Expansion of diabetes prevention services.** In a potentially significant change for many patients and providers, CMS wants to expand its Diabetes Prevention Program (DPP) to all states. The program, which is only currently operational in eight states, provides counseling, education, and support services to pre-diabetic patients and those at increased risk of becoming diabetic. Providers who participate receive additional payments for these services.

- **New Medicare Advantage enrollment rules.** CMS wants to require all providers who participate with Medicare Advantage plans to be subject to its enrollment and revalidation process. This would affect only those providers who are currently non-par with Medicare but do participate with private-payer Medicare Advantage (Part C) plans.

Proposed OPPS/ASC rule offers 90-day EHR reporting

You would only have to report meaningful use measures from your electronic health record (EHR) for 90 days in 2016 instead of the full year if CMS’ proposed Outpatient Prospective Payment System and Ambulatory Surgical Center (OPPS/ASC) rule for 2017 is finalized.

The meaningful use proposal would apply to all eligible providers, including critical access hospitals (CAHs), and means any contiguous 90-day period between Jan. 1, 2016 and Dec. 31, 2016, could be used for reporting. “We believe it would continue to assist health care providers by increasing flexibility in the program,” CMS stated in a fact sheet accompanying the proposed rule, which dropped July 6.

This provision is the biggest in an otherwise uneventful proposed rule for most physician practices. Below is a bullet-point list of other highlights from the 2017 proposed rule.

- **OPPS and ASC payment rates.** CMS proposes to update OPPS payments by 1.55%, and the agency estimates an overall 1.6% payment increase for hospitals paid under OPPS in 2017. For ASCs, the payments are updated annually based on increases to the Consumer Price Index for urban consumers. In 2017, CMS is projecting an overall 1.2% increase in ASC payments.

- **90-day meaningful use reporting period.** As mentioned earlier, the reporting period for 2016 is proposed to be any 90-day contiguous period for eligible providers. Additionally, CMS admits in the proposed rule that it would not be “technically feasible” for those eligible providers that have not successfully demonstrated meaningful use yet (i.e. new participants) to attest to the Stage 3 objectives and measures. CMS proposes that these providers attest to modified stage 2 objectives and measures by Oct. 1, 2017.

- **EHR hardship exceptions.** For new providers – again those who have not yet attested to meaningful use – CMS is proposing a new hardship exception that would allow them to be exempt from the 2018 payment adjustment. These providers would be required to transition to meaningful use reporting under the Merit-Based Incentive Payment System (MIPS) in 2017, under the MACRA proposed rule.

- **New ASC quality measures.** The existing Ambulatory Surgical Center Quality Reporting Program (ASCQR) would get seven new quality measures under the 2017 OPPS/ASC proposed rule. There is a new measure anesthesia and one for cataract surgery. The remaining five have to do with patient satisfaction and experience.

The OPPS/ASC final rule is typically released around the beginning of November.

Final rule expected this fall

You have until Sept. 6 to submit any comments to Regulations.gov during the public comment period for the proposed 2017 PFS. Typically CMS releases the PFS final rule at the end of October or during the first week of November.

How MIPS rule will affect ENT payments

CMS has finally unveiled its vision for the future of Medicare’s incentive programs in the form of the long-
awaited Merit-Based Incentive Payment System (MIPS) proposed rule, released April 27. Experts are still breaking down its many provisions, but in this article The ENT Voice will cover the highlights, which include more specialty-friendly quality measures, but not as much flexibility as many physician practices would have preferred.

The payment adjustments under MIPS are slated to begin in 2019, though you’ll be affected far sooner, starting on Jan. 1, 2017, which is the beginning of the first MIPS performance period that will determine the 2019 payment adjustments. All providers who are enrolled in Medicare Part B will be subject to MIPS, with a handful of exceptions for those newly enrolled, those with 100 or fewer Part B patients and $10,000 or less in charges.

**Note:** A key requirement of the law that authorized MIPS is that MIPS must be budget-neutral with respect to the program’s cost to Medicare. The table below shows the payment adjustment schedule established in the MIPS proposed rule.

Positive adjustments can be greater than the corresponding negative adjustment, and the law allocates a special $500 million fund for additional performance bonuses to providers for the first five MIPS payment years. This amount is exempt from budget neutrality to incentivize providers to perform as well as they can.

**Note:** CMS projects that 47.4% of otolaryngologists will see a negative payment adjustment due to MIPS, while 52.3% of otolaryngologists will see a positive adjustment. In this same estimate, CMS projects that the negative adjustments for ENT will amount to -$13 million while positive adjustments will amount to $18 million – which means the agency expects the ENT specialty to see a net Part B payment change of $5 million in 2019. You can find a table containing these projections on page 674 of the PDF text of the proposed rule.

To determine whether a provider gets a positive, negative, or neutral adjustment, CMS will calculate a MIPS score based on four components, which are basically rebranded versions of Medicare’s existing and ongoing incentive programs. Below is a breakdown of these four components and their contribution to a provider’s overall MIPS score.

### Quality Category (previously PQRS)

This component replaces the Physician Quality Reporting System or PQRS. It’s the single biggest piece of the MIPS score, accounting for 50% of the score in 2019, the first MIPS payment year. In a major improvement for providers, the Quality Category **requires six quality measures to be reported, down from nine** in PQRS. In its official fact sheet, CMS promises “more than 200 measures to pick from and more than 80% of the quality measures proposed are tailored for specialists.”

CMS is also proposing 23 preset measure sets that are designed for 23 different specialties, ranging from primary care specialties such as internal medicine and OB/GYN to highly specialized taxonomies such as thoracic surgery. These measure sets simply replace the six-measure requirement and are an effort by CMS to respond to complaints that its quality programs cater only to primary care and leave specialists without clinically relevant measures.

### Advancing Care Information Category (previously Meaningful Use)

One of the most-touted CMS reforms has been the promise, by CMS Acting Administrator Andy Slavitt, to replace the meaningful use EHR Incentive Program. Meaningful use will indeed be gone, and replaced with the Advancing Care Information Category under MIPS. This category accounts for 25% of the MIPS score in 2019.

The biggest change is that this quality program won’t be “all-or-nothing” like meaningful use, in which providers either attested successfully and received the entire incentive payment, or failed to...

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<tr>
<td><strong>Negative adjustment</strong></td>
<td>Up to 4%</td>
<td>Up to 5%</td>
<td>Up to 7%</td>
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* Positive adjustments can be less than or greater than the amount specified per year, based on budget neutrality needs.
meet all the necessary criteria, and received nothing.

Instead, the Advancing Care Information Category of MIPS gives providers a point score of up to 131 points based on the measures they report, all of which are adapted from existing stage 3 meaningful use criteria. This allows for partial credit, which still boosts the overall MIPS score.

Clinical Practice Improvement Activities Category
This component covers a number of options such as care coordination, patient engagement, and patient safety. It’s also an umbrella category for all manner of existing alternative payment programs, such as patient-centered medical homes and accountable care organizations. For 2019, this component is worth 15% of the total MIPS score. Each improvement “activity” is weighted with a different point score. CMS will prioritize certain activities as high or medium, though the specifics remain unclear.

Some of the proposed activities include:

- **Expanded practice access.**
  Same day appointments for urgent needs and after-hours access to clinician advice.

- **Population management.**
  Monitoring health conditions of individuals to provide timely healthcare interventions or participation in a QCDR.

- **Care coordination.**
  Timely communication of test results, timely exchange of clinical information to patients and other MIPS eligible clinicians or groups, and use of remote monitoring or telehealth.

- **Achieving health equity.**
  High quality healthcare for underserved populations including persons with behavioral health conditions, racial and ethnic minorities, sexual and gender minorities, people with disabilities, people living in rural areas, and people in geographic HPSAs.

- **Emergency preparedness and response.**
  Eligible clinician or group participation in the medical reserve corps, registration in the Emergency System for Advance Registration of Volunteer Health Professionals, reserve and active duty military MIPS clinicians and group activities, group and clinician participation in domestic or international humanitarian medical relief work.

Cost Category (previously Value-based Modifier)
This category, also referred to as “resource use,” replaces the existing Value-based Modifier (VBM) program and will account for 10% of the total MIPS score in 2019. Unlike the other three categories, the Cost Category is calculated by CMS based on Medicare claims data. Providers don’t have to perform any separate submission process, according to the proposed rule. To calculate cost score, CMS will use a methodology similar to the one created for the VBM.

Closing thoughts and possible MIPS delay
Many physician groups have objected to the short timeframe providers have to prepare for the first MIPS reporting year, which again is slated to begin in less than five months on Jan. 1. Recently, CMS suggested that a delay might be possible.

During Congressional testimony, CMS Acting Administrator Andy Slavitt acknowledged that providers have little time to prepare for MIPS’ sweeping changes. The agency is statutorily required to make 2019 the first MIPS payment adjustment year, but it has the leeway to alter the reporting period. CMS could shorten the reporting period from the entire calendar year to a much easier 90-day contiguous period, as it has done in the past for meaningful use, Slavitt said. Nothing has been confirmed, but a decision is expected either before the final rule is released, or as part of the changes in the MACRA final rule.

In an official comment letter to CMS, the AOA is asking the agency to postpone the beginning of the data-gathering period for MIPS from Jan. 1, 2017 to Oct. 1, 2017. The AOA has also asked CMS to consider limiting the data-gathering period to 90 consecutive days for each year of the program.

The official public comment period for the MACRA rule ended June 27. However, you may view submitted comments to the proposed rule by visiting The Federal Register page for MIPS.
Feds move to block 2 massive insurance mergers

Your practice won’t have to worry about the impact of two massive, impending insurance company mergers just yet. The U.S. Department of Justice has launched a lawsuit to stop a $37 billion Humana/Aetna merger and an even larger $54 billion acquisition of Cigna by Anthem Healthcare, claiming that the moves would violate federal antitrust laws.

“If allowed to proceed, these mergers would fundamentally reshape the health insurance industry,” U.S. Attorney General Loretta Lynch said in a press conference announcing the suit. “They would leave much of the multitrillion-dollar health insurance industry in the hands of three mammoth insurance companies, drastically constricting competition in a number of key markets that tens of millions of Americans rely on to receive health care.”

ENT practices, like physicians in general and specialists in particular, would be hurt by narrower provider networks and tougher contract negotiations if the mergers were allowed to go through, says Robin Wagner, executive director of the AOA. “They’re going to prefer lower-cost providers and narrower networks in order to return more value to their shareholders.”

The insurance companies announced their intentions last year, and the moves were seen as part of the ongoing trend toward consolidation in the healthcare industry. Aetna, Humana, Cigna, and Anthem have said that they will defend against the lawsuit. The Aetna-Humana merger will go to trial first, since the contract for the merger has a deadline of Dec. 31. The acquisition of Cigna by Anthem has a deadline of April 30, 2017, so its trial will take place later.

In the meantime, ENT practices can only wait and watch from the sidelines. The only benefit to the mergers, if approved, would be fewer contracts to negotiate, but “the only win will be for the insurance companies,” Wagner says. “It’s not going to be beneficial for the patients or practices.”

Editorial: Will Medicare’s MIPS program really reward “merit”?

When President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA) on April 16, 2015, Medicare providers nationwide breathed a collective sigh of relief. They would no longer have to wait every year for Congress to implement a “doc fix” to avoid cuts to the conversion factor ranging from 21% to 27%. While not having to develop annual contingency plans for potentially steep reimbursement cuts was certainly good news, we all knew, or should have known, that the permanent repeal of the Sustainable Growth Rate (SGR) formula would lead to another cost-control program. After all, the SGR was created to limit the growth rate of spending on physician services.

When the Medicare growth rate fell below the national GDP growth rate, the SGR increased payments. When Medicare’s growth rate grew more rapidly than GDP, SGR cut payments. The fatal flaw of the SGR was its reliance on physicians as a whole to reduce utilization in a fee-for-service environment. As everyone soon realized, that was never going to happen.

Medicare has replaced SGR with a new way of paying physicians: the Merit-Based Incentive Payment System (MIPS), which definitely addresses the failings of the SGR. Although MIPS establishes automatic payment increases for all physicians from 2015 through 2018, their reimbursement rates from 2019 through 2025 will be based on their performance under MIPS. Because MIPS is budget-neutral, some physicians will see payment increases while others will see payment decreases, and some will see neither an increase nor a decrease. As its name implies, MIPS should reward physicians in the form of payment increases for improving healthcare quality. Not surprisingly, the components of MIPS are essentially composed of Medicare programs with the same purpose.

However, have the physicians who have been successful in Physician Quality Reporting System (PQRS), Meaningful Use (MU), and the Value-based Modifier (VBM) truly provided better quality care? I would argue that most have not.

Participating in PQRS and MU has largely been an exercise in configuring information technology
and workflow processes to collect the right data to meet reporting requirements. Some physicians even selected PQRS measures they knew they could successfully report rather than measures that were clinically relevant to their specialty, or those that might lead to improvements in care. Many physicians considered success in PQRS and MU to be reporting data and earning an incentive or avoiding a penalty, without utilizing this data to change practice patterns. Perhaps the most important element of MU in regards to improving care is sharing clinical information with patients and collaborating physicians. However, CMS had to scale back the measures related to this goal once the agency learned how difficult it was for physicians to implement them. While access to a patient’s complete record of care is undoubtedly valuable, an incentive program doesn’t actually make this task any easier to accomplish.

The VBM hasn’t been any better in the achieving its intended purpose; in fact, it might be an even greater disappointment. The VBM is a combination of quality and cost/resource use, with quality based on a group’s PQRS performance, and I have argued above that PQRS has mostly failed in actually improving outcomes. The more frustrating aspect of the VBM is that its emphasis on cost and resource use measurement gives physicians, especially specialists like ENTs, little ability to affect their performance. Instead, costs and resources are driven by the patient mix and population. The cost of each patient can be assigned to a physician based on one office visit. If a patient has an expensive inpatient episode, even for a condition unrelated to the physician’s specialty, the group’s VBM is negatively impacted. The purpose of the VBM shouldn’t be to ask all physicians to treat all conditions.

I firmly believe that controlling costs and improving healthcare quality are worthwhile goals. However, we shouldn’t pretend that MIPS will accurately identify those physicians who best achieve these goals. Instead, groups with the most resources to build the most robust systems and processes will “win” by generating the highest MIPS scores. Whether CMS understands this or not, the agency has already acknowledged their expectation of this outcome: In its proposed rule for MIPS, CMS projects 87% of solo physicians and 69.9% of practices nine or fewer physicians will receive payment decreases. As a result, MIPS is less likely to achieve its stated goals and more likely to achieve an unintended effect: widespread practice consolidation and the growth of very large physician groups.

— Kevin Watson (kwatson@coloradoent.com). The author is the 2015-2016 President of the Association of Otolaryngology Administrators and also Practice Administrator at Colorado ENT & Allergy in Colorado Springs.