



Executive Summary: CMS 2017 PFS Final Rule

Key Financial and Operational Impacts from the Final 2017 PFS Rule:

The 2017 physician fee schedule (PFS) final rule was made available on July 7th. A detailed summary of the rule will be available on HFMA's [Regulatory Resources](#) page shortly.

- 1) **Conversion Factor:** The final PFS conversion factor for 2017 is \$35.8887. This is a slight increase from calendar year 2016 (CY16) (\$35.8043). The final anesthesia factor is \$22.0454.
- 2) **Specialty Specific Impact:** relative value unit repricing and other policies in the final rule had a significant negative impact on the following specialties:
 - a. Independent laboratory (-5%)
 - b. Ophthalmology (-2%)
 - c. Urology (-2%)

The following specialties will see an increase in payments as a result of policy changes in the final rule:

- a. Physical therapy/Occupational therapy (1%)
- b. Multispecialty Clinic (1%)
- c. Family practice (1%)
- d. Internal medicine (1%)
- e. Geriatrics (1%)
- f. General practice (1%)

Please see the appendix at the end of the document for a complete list of impacts by specialty.

- 3) **Changes to MSSP:** CMS finalizes numerous tweaks to the Medicare Shared Savings Program (MSSP) which include:
 - a. *Changes to Quality Measures:* CMS finalizes modifications to the quality measure set that an ACO is required to report in order to better align the MSSP quality measure set with the measures recommended by the Core Quality Measure Collaborative and final for reporting in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rule. Overall, CMS finalizes the addition of three measures, and retires or replaces six measures. The total number of measures would decrease from 34 to 31 measures.
 - b. *Aligning MSSP Policies with Policies in the New Quality Payment Program:* CMS identified several modifications to program rules to better support and align its efforts related to the Quality Payment Program (MACRA final rule). These modifications include sunseting MSSP alignment with the Physician Quality Reporting System (PQRS) and the Electronic Health Record Incentive Program.
 - c. *Beneficiary Attestation:* CMS finalizes the implementation of an automated approach to help determine which healthcare provider a fee-for-service (FFS) beneficiary believes is responsible for coordinating their overall care (their “main doctor”) using information that is collected directly from beneficiaries. Currently, in the Pioneer and Track 3 accountable care organizations (ACOs), participants directly obtain this information



Executive Summary: CMS 2017 PFS Final Rule

from beneficiaries annually and then communicate it to CMS. This beneficiary attestation approach would be available for ACOs participating in Track 1, 2 or 3. These changes would be effective for assignment for the 2018 performance year, unless an automated process is not available.

CMS will incorporate these updates prospectively on an annual basis for all tracks.

- d. *Beneficiary Protections Related to the SNF 3-Day Waiver:* CMS has become concerned about potential beneficiary financial liability for non-covered Part A skilled nursing facility (SNF) services that might be directly related to use of the SNF 3-day rule waiver for Track 3 participants of the MSSP. CMS modifies the waiver to include a 90-day grace period to allow sufficient time for it to notify the ACO of any beneficiary exclusions, and for the ACO then to inform its SNF affiliates, ACO participants, and ACO providers/suppliers of those exclusions.

CMS also finalizes that it would make no payment to the SNF. The SNF may not charge the beneficiary for the non-covered SNF services, in the event that a SNF affiliate of a Track 3 ACO has been approved for the SNF 3-day rule waiver, admits a FFS beneficiary who was never prospectively assigned to the waiver-approved ACO (or was assigned but later excluded and the 90 day grace period has lapsed), and the claim is rejected only for lack of a qualifying inpatient hospital stay.

- e. *Financial reconciliation issues for ACOs that fall below 5,000 assigned beneficiaries:* CMS finalizes that in the event an ACO participating under a two-sided risk track falls below 5,000 assigned beneficiaries at the time of financial reconciliation, and the ACO is eligible to share in savings (or losses), the minimum savings rate/minimum loss (MSR/MLR) rate will be set at a level consistent with the choice of MSR/MLR that the ACO made at the start of the agreement period.

- 4) **Medicare Advantage Plan Enrollment:** CMS finalizes providers or suppliers would have to be enrolled in Medicare and be in an “approved status” in order to provide health care items or services to an enrollee who receives his or her benefits through a Medicare Advantage Prescription Drug (MA-PD) plan. MA plans that fail to ensure compliance on the part of their providers and suppliers would be subject to sanctions and termination.

An MA plan would be prohibited from paying, directly or indirectly, on any basis, for items or services (other than emergency or urgently needed services) furnished to a Medicare enrollee by any individual or entity that is excluded by the Office of the Inspector General or is revoked from the Medicare program.

As a condition of contracting with CMS, an MA plan would have to agree to provide documentation that all providers and suppliers in the MA or MA-PD plan who could enroll in Medicare, were enrolled in an approved status. The authorized individual would have to thoroughly describe how the entity and MA plan met, or will meet, all the requirements, including providing documentation that all providers and suppliers are enrolled in Medicare in an approved status.



Executive Summary: CMS 2017 PFS Final Rule

- 5) **Diabetes Prevention Program:** Under Section 1115(A) of the Affordable Care Act (ACA), CMS expands the Medicare Diabetes Prevention Program (MDPP). MDPP is a 12-month program using the Centers for Disease Control and Prevention (CDC)-approved DPP curriculum, which consists of 16 core sessions over months 1 – 1-6 and at least six monthly core maintenance sessions over months 6-12, furnished regardless of weight loss. CMS also finalizes that beneficiaries have access to ongoing maintenance sessions after the 12-month core benefit if they achieve and maintain the required minimum weight loss of 5 percent. CMS modifies its proposal and finalizes that MDPP suppliers must use any CDC-approved curriculum. CMS notes the CDC-preferred curriculum is available at <http://www.cdc.gov/diabetes/prevention/lifestyle-program/curriculum.html>.

CMS has deferred any decisions about the reimbursement structure for the MDPP program to the final rule. Following is the current proposed payment model from Table 41 in the final rule.



Executive Summary: CMS 2017 PFS Final Rule

TABLE 41—MDPP EXPANSION PAYMENT MODEL

	Payment per beneficiary (non-cumulative)
Core Sessions	
1 Session attended	\$25
4 Sessions attended	\$50
9 Sessions attended	\$100
Achievement of minimum weight loss of 5% from baseline weight	\$160
Achievement of advanced weight loss of 9% from baseline weight	\$25 (in addition to \$160 above)
Maximum Total for Core Sessions	\$360
Core Maintenance Sessions (Maximum of 6 monthly sessions over 6 months in Year 1)	
3 Core Maintenance Sessions attended (with maintenance of minimum required weight loss from baseline)	\$45
6 Core Maintenance Sessions attended (with maintenance of minimum required weight loss from baseline)	\$45
Maximum Total for Maintenance Sessions	\$90
Maximum Total for First Year	\$450
Ongoing Maintenance Sessions After Year 1 (Minimum of 3 sessions attended per quarter/no maximum)	
3 Ongoing Maintenance Sessions attended plus maintenance of minimum required weight loss from baseline	\$45
6 Ongoing Maintenance Sessions attended plus maintenance of minimum required weight loss from baseline	\$45
9 Ongoing Maintenance Sessions attended plus maintenance of minimum required weight loss from baseline	\$45
12 Ongoing Maintenance Sessions attended plus maintenance of minimum required weight loss from baseline	\$45
Maximum Total After First Year	\$180

CMS finalizes its proposal that diabetes prevention program organizations must enroll in Medicare to become MDPP suppliers, and that coaches will not enroll in Medicare for purposes of furnishing MDPP services. CMS finalizes that coaches must obtain national provider identifiers (NPIs). In addition, MDPP suppliers must submit the active and valid NPIs of all coaches who will furnish MDPP services on behalf of the MDPP supplier as an employee or contractor. Upon enrollment, MDPP suppliers must submit, and update within 30 days of any changes, a roster of coaches, including individual’s first and last name, social security number and NPI to CMS. CMS notes this will help ensure the coaches meet program integrity standards.

- 6) **Telehealth Services:** CMS adds the following current procedural terminology (CPT) and healthcare common procedure coding system codes in CY17:



Executive Summary: CMS 2017 PFS Final Rule

- a. ESRD-related services (CPT codes 90967-90970). These four codes describe end-stage renal disease (ESRD)-related services for dialysis for less than a full month of service, per day, broken down into four age groups: < 2 years, 2-11 years, 12-19 years and \geq 20 years.
 - b. Advanced care planning services (CPT codes 99497-99498). These two codes describe the first 30 minutes and each additional 30 minutes, respectively, during which a qualified health care professional explains and discusses advance directives with the patient, family member(s), or surrogate; advance directive form completion time is included if performed during the encounter.
 - c. Critical care (codes G0508 and G0509). CMS adds to the telehealth list for 2017 two new codes for initial and subsequent critical care consultations furnished via telehealth. CMS finalizes that these services be limited to once per day per patient, and that they be valued by comparisons to other evaluation and management services.
- 7) **Imaging Appropriate Use Criteria:** The rule finalizes the requirements and process for specifications of qualified clinical decision support mechanisms (CDSMs) under the Medicare Appropriate Use Criteria (AUC) program; the initial list of clinical priority areas; and exceptions to the requirement that ordering professionals consult specified applicable AUC when ordering applicable imaging services. CMS will announce the first list of qualified CDSMs no later than June 30, 2017, and anticipates that furnishing providers could begin reporting AUC information starting January 1, 2018.
- 8) **Physician Self-Referral:** In response to the D.C. Circuit opinion in Council for Urological Interests v. Burwell, CMS finalizes requirements for arrangements involving the rental of office space or equipment. CMS requires that rental charges for the office space or equipment are not determined using a formula based on per-unit of service rental charges to the extent that such charges reflect services provided to patients by the lessor to the lessee.
- CMS emphasizes this is not an absolute prohibition on rental charges based on units of services furnished; in general, per-unit of service rental charges for the rental of office space or equipment are permissible. CMS states it is limiting the general rule by prohibiting per-unit of service rental charges where the lessor generates the payment from the lessee through a referral to the lessee for a service to be provided in the rental office space or using the rented equipment. Per-unit of service rental charges for the rental of office space or equipment would be permissible, but only in those instances, where the referral for the service to be provided in the rental office or using the rented equipment did not come from the lessor.
- 9) **Transition to Digital Imaging:** Effective for services furnished beginning January 1, 2017, payment for the technical component (TC) (including the TC of a global service) of imaging services that are X-rays taken using *film* is reduced by 20 percent. The reduction is made prior to any other adjustment under this section. Beginning January 1, 2017, modifier FX is required on claims for X-rays that are taken using film. The modifier will be required on claims for the TC of the X-ray service, including when the service is billed globally. The use of this modifier will



Executive Summary: CMS 2017 PFS Final Rule

result in a 20-percent reduction for the TC of the X-ray service. This reduction is exempt from budget neutrality.

10) **Recoupment of Offset of Payments to Providers Sharing the Same Taxpayer Identification**

Number: CMS notes it has historically used the Medicare provider billing number (NPI) to recoup overpayments until these debts were paid in full or eligible for referral to the Department of Treasury (Treasury) for further collection action. However, the ACA allows the Secretary to make any necessary adjustments to the payments of an “*applicable provider*” of services or supplier to satisfy any amount due from an obligated provider of services or supplies. The statute defines an applicable provider of services or supplier (*applicable provider*) as a provider of services or supplies that has the same tax identification number () as the one assigned to the obligated provider of services or supplier. The statute defines the obligated provider of services or supplier (*obligated provider*) as a provider of services or supplier that owes a past-due overpayment to the Medicare program. CMS states that for purposes of this provision, the applicable and obligated providers must share a TIN, but may possess a different billing or NPI than one another.

CMS provides the following example: A health care system may own a number of hospital providers and these providers may share the same TIN, but have different NPI numbers. If one of the hospitals in the system receives a demand letter for a Medicare overpayment, then the hospital (Hospital A) will be considered the obligated provider while the other hospitals in the same TIN (Hospital B and C) will be considered the applicable providers. CMS states this authority allows it to recoup the obligated provider Hospital A, against any or all of the applicable providers, Hospital B and C, with which it shares a TIN.



Executive Summary: CMS 2017 PFS Final Rule

Appendix I: Specialty Specific Payment Impact of Final FY17 PFS Rule

The following is an explanation of the information for Table 43:

- Column A (Specialty): Identifies the specialty for which data is shown.
- Column B (Allowed Charges): The aggregate estimated PFS allowed charges for the specialty based on 2015 utilization and 2016 rates. Allowed charges are the Medicare fee schedule amounts for covered services, and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all specialties to arrive at the total allowed charges for the specialty.
- Column C (Impact of Work RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the final changes in the work RVUs, including the impact of changes due to potentially misvalued codes.
- Column D (Impact of PE RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the final changes in the PE RVUs.
- Column E (Impact of MP RVU Changes): This column shows the estimated 2017 impact on total allowed charges of the final changes in the MP RVUs.
- Column F (Combined Impact): This column shows the estimated 2017 combined impact on total allowed charges of all the changes in the previous columns