CMS was unable to identify enough reductions in misvalued codes to reach the 0.5 percent savings it was aiming for in its update to the physician fee schedule (PFS) for 2018, and proposed a conversion factor of $35.99, a 0.31 percent increase over 2017. In an advance release of a Proposed rule, CMS addressed the conversion factor, misvalued code target, PFS payment rates to off-campus provider-based departments (PBDs), and telehealth services. The agency also proposed to expand the Medicare Diabetes Prevention Program (MDPP), which is being tested through the Patient Protection and Affordable Care Act’s (ACA) (P.L. 111-148) Innovation Center. The Proposed rule, which will publish in the Federal Register on July 21, 2017, also included a Request for Information (RFI) seeking feedback on Medicare as part of what the agency called “a national conversation about improving the healthcare delivery system.” Comments on the Proposed rule are due by September 11, 2017.

**Misvalued codes and conversion factor.** The HHS Secretary is required by Sec. 3134(a) of the ACA to review Relative Value Units (RVUs) under the PFS and to identify potentially misvalued services. Once identified, potentially misvalued services are evaluated, and appropriate RVU adjustments are made as needed. The target reduction in expenditures resulting from RVUs of misvalued codes was 0.5 percent; because CMS was only able to identify 0.31 percent net reduction in expenditures, payments under the PFS had to be reduced as required by the Achieving a Better Life Experience (ABLE) Act of 2014 (part of P.L. 113-295). As a result, the proposed PFS conversion factor for 2018 is 35.99 and the proposed anesthesia conversion factor is 22.04. Both calculations include required adjustments for budget neutrality and a 0.5 percent update required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10).

**Off-campus PBDs.** Section 603 of the Bipartisan Budget Act of 2015 (P.L. 114-74) changed payments for items and services furnished in Off-campus PBDs from the Hospital Outpatient Prospective Payment System (OPPS) (see *Congress’s new provider-based provision—hospitals face significant changes and many unanswered questions*, December 10, 2015). CMS determined that the applicable payment system for most off-campus PBDs is the PFS. CMS is proposing a 50 percent reduction on PFS payment rates for off-campus PBD items and services. American Hospital Association (AHA) Executive Vice President Tom Nickels condemned the proposal, saying it “appears to have a questionable policy basis” and will deny access to many patients in vulnerable communities.

**Additional telehealth codes.** The Proposed rule would add six new codes to the list of telehealth services, including those for health risk assessment and care planning for chronic care management. The proposal would also eliminate required reporting of the telehealth modifier, and seeks comment on ways to further expand access to telehealth services.

**Diabetes prevention.** Under the Proposed rule, the MDPP would expand to allow suppliers to begin furnishing MDPP services nationally in 2018. The MDPP provides beneficiaries with a structured intervention designed to prevent individuals with an indication of pre-diabetes from progressing to type 2 diabetes. The program offers participant beneficiaries practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. The Proposed rule includes policies for the expansion of the program, including the program’s payment structure, and supplier enrollment requirements, and would delay the program’s effective date from January 1, 2018 to April 1, 2018.
Other proposed changes. The Proposed rule includes changes to chronic care management services, and to the way rates are set for office-based behavioral health services. It would create new billing codes for rural health clinics and federally qualified health centers to encourage care coordination for chronic care management, general behavioral health, and psychiatric care. It would change the planned implementation of the Medicare Appropriate Use Criteria (AUC) program for Advanced Diagnostic Imaging, and to allow qualified entities to develop and use AUC before the program begins in 2019; having these mechanisms available would be eligible for improvement activity credit under the Quality Payment Program’s (QPP) Merit-Based Incentive Payment System (MIPS).

In addition, the Proposed rule includes changes to physician quality reporting, the value modifier, and clinical reporting requirements under the Medicare electronic health record (EHR) incentive programs under MIPS. Accountable care organizations (ACOs) would see modifications to their requirements for participation in the Medicare Shared Savings Program (MSSP).

Comment solicitation and RFI. In addition to requesting comments from stakeholders on all the proposed payment and policy changes, CMS specifically requested comments on the following:

- updating the evaluation and management (E/M) visit codes;
- whether emergency department visits are undervalued;
- the timeline for reporting applicable information under the Clinical Laboratory Fee Schedule (CLFS);
- Medicare Part B payments for biosimilar biological products and infusion drugs furnished through an item of durable medical equipment; and
- whether the AUC should be delayed beyond its scheduled 2019 start to allow additional education and operational testing.

CMS also released an RFI looking for ideas that would promote transparency, flexibility, program simplification, and innovation. The agency would like ideas on regulatory, sub-regulatory, policy, practice, and procedural changes that could be made to make the Medicare program more effective, simple, and accessible while maintaining program integrity and preventing fraud.

Companies: American Hospital Association