

## **Summary of the Proposed 2016 Medicare Physician Fee Schedule (PFS)**

### **General Overview**

The Social Security Act (the Act) requires the Centers for Medicare & Medicaid Services (CMS) to establish payments under the Physician Fee Schedule (PFS) based on national uniform relative value units (RVUs) that account for the relative resources used in providing a service. The Act requires that RVUs be established for three categories of resources: work, practice expense and malpractice expense. The Act also requires CMS to establish by regulation each year's payment amounts for all physicians' services paid under the PFS, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS for more than 7,400 services.

In this proposed rule released on July 8, 2015, CMS establishes RVUs for Calendar Year (CY) 2016 for the PFS and other Medicare Part B payment policies to ensure that CMS payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute. In addition, this proposed rule includes discussions and proposals regarding:

- Potentially Misvalued PFS Codes
- Telehealth Services
- Advance Care Planning Services
- Establishing Values for New, Revised, and Misvalued Codes
- Target for Relative Value Adjustments for Misvalued Services
- Phase-in of Significant RVU Reductions
- "Incident to" policy
- Portable X-Ray Transportation Fee
- Updating the Ambulance Fee Schedule regulations
- Changes in Geographic Area Delineations for Ambulance Payment
- Chronic Care Management Services for RHCs and FQHCs
- HCPCS Coding for RHCs
- Payment to Grandfathered Tribal FQHCs that were Provider-Based Clinics on or before April 7, 2000
- Payment for Biosimilars under Medicare Part B
- Physician Compare Website
- Physician Quality Reporting System
- Medicare Shared Savings Program
- Electronic Health Record Incentive Program
- Value-Based Payment Modifier and the Physician Feedback Program

CMS is accepting comments on the proposed rule until 5 p.m. ET on September 8, 2015. The final rule will be released by November 1, 2015 and will go into effect on January 1, 2016.

### **MACRA**

The 2016 proposed PFS is the first since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which was enacted on April 16, 2015. MACRA makes

several changes to the Act, including but not limited to:

1. Repealing the sustainable growth rate (SGR) update methodology for physicians' services and encouraging participation in alternative payment models.
2. Revising the PFS update for 2015 and subsequent years.
3. Making changes to quality reporting programs by establishing a Merit-based Incentive Payment System (MIPS) under which eligible professionals (initially including physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists) receive annual payment increases or decreases based on their performance in a prior period beginning in 2019. MACRA eliminates the Physician Quality Reporting Program (PQRS) in 2018, however certain aspects of PQRS may be incorporated under MIPS. EHR Meaningful Use incentive payments will be made under MIPS and value-based payment modifier adjustments will be combined under MIPS.

CMS is requesting comments on certain elements of MACRA including the low volume threshold (the threshold at which certain eligible professionals are excluded from the definition of a MIPS eligible professional), clinical practice improvement activities (activities that could be classified as clinical practice improvement activities under the Act) and a new framework to promote incentive payments for participation in eligible alternative payment models.

### **Proposed 2016 PFS - Coding & Reimbursement Issues**

#### **How RVUs and Payments are Calculated:**

- Work RVUs constitute the portion of the resources used in providing the service that reflects physician time and intensity.
- Malpractice (MP) RVUs are based on commercial and physician-owned insurers' malpractice insurance premium data from all the states, the District of Columbia, and Puerto Rico.
- Practice Expense (PE) RVUs are developed by considering the direct and indirect practice resources involved in furnishing each service. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expense, and all other expenses.
- To calculate the payment for each service, the work, PE, and MP RVUs are adjusted by geographic practice cost indices (GPCIs) to reflect the variations in the costs of furnishing the services. The GPCIs reflect the relative costs of work, PE, and MP in an area compared to the national average costs for each component. RVUs are converted to dollar amounts through the application of a conversion factor, which is calculated based on a statutory formula by CMS's Office of the Actuary.

#### **Overall Impact to RVUs**

The greatest impact of RVU changes to specialties are generally related to two major factors. The first factor is the number of changes to RVUs for specific services resulting from the Misvalued Code Initiative, including the establishment of RVUs for new and revised codes. Several specialties, including radiation therapy centers, radiation oncology, and gastroenterology,

will experience significant decreases to payments to services that they frequently furnish as a result of widespread revisions to the structure and the inputs used to develop RVUs for the codes that describe particular services. Other specialties, including pathology and independent laboratories, will experience significant increases to payments for similar reasons.

The second factor relates to a technical improvement that refines the malpractice RVU methodology, which CMS is proposing to make as part of their annual update of malpractice RVUs. This technical improvement will result in small negative impacts to the portion of PFS payments attributable to malpractice for gastroenterology, colon and rectal surgery, and neurosurgery.

#### Changes to RVUs and Reimbursements for Spine Codes

ISASS staff looked at commonly used CPT codes for spine and compared the 2015 final RVUs and reimbursements to the proposed 2016 RVUs and reimbursements in the attached Excel spreadsheet. There are approximately 205 codes listed. If you are curious about a procedure you do not see listed in the spreadsheet, please email ISASS/IASP Director of Health Policy and Advocacy, Liz Vogt ([liz@isass.org](mailto:liz@isass.org)) and she will pull the information for you. Be sure to pay particular attention to Column M as it shows the difference in reimbursement from 2015 to 2016. The following is a list of codes with a change in reimbursement greater than \$100:

- CPT 22112 (remove part thoracic vertebra) -\$152.35
- CPT 22586 (pre-sacral fuse with instrumentation L5-S1) -\$228.64
- CPT 22812 (anterior fusion, 8 or more vertebral segments) +\$236.99
- CPT 22857 (lumbar artificial discectomy) +\$211.29
- CPT 22862 (revise lumbar artificial disc) +\$651.32
- CPT 27279 (MIS SIJ fusion) +\$148.71
- CPT 27280 (open SIJ fusion) +\$303.03
- CPT 63182 (laminectomy and section of dentate ligaments, with or without dural graft, cervical, more than 2 segments) -\$298.76
- CPT 63195 (laminectomy with cordotomy, thoracic) +\$432.74
- CPT 63250 (laminectomy for excision or occlusion of arteriovenous malformation of spinal cord, cervical) -\$198.20
- CPT 63306 (vertebral corpectomy, intradural, thoracic by thoracolumbar approach) +\$351.10
- CPT 63307 (vertebral corpectomy, intradural, lumbar or sacral by transpirational or retroperitoneal approach) +\$151.34

#### Changes to Direct Practice Expense Inputs for Vertebroplasty Codes- Clinical Labor Input Inconsistencies

After the publication of the CY 2015 PFS final rule with comment period, stakeholders alerted CMS to several clerical inconsistencies in the clinical labor nonfacility intraservice time for several vertebroplasty codes with interim final values for CY 2015, based on CMS' understanding of RUC recommended values. CMS is proposing to correct these inconsistencies in the CY 2016 proposed direct PE input database to reflect the RUC recommended values, without refinement, as stated in the CY 2015 PFS final rule with comment period. For CY 2016, CMS is proposing the following adjustments:

- For CPT codes 22510 (percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic) and 22511 (percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral), a value of 45 minutes for labor code L041B (“Radiologic Technologist”);
- CMS is proposing to assign for the “assist physician” task and a value of 5 minutes for labor code L037D (“RN/LPN/MTA”) for the “Check dressings & wound/home care instructions/coordinate office visits/prescriptions” task; and
- For CPT code 22514 (percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar), CMS is proposing to adjust the nonfacility intraservice time to 50 minutes for L041B, 50 minutes for L051A (“RN”), 38 minutes for a second L041B, and 12 minutes for L037D.

Potentially Misvalued Codes under the PFS –Review of High Expenditure Services across Specialties with Medicare Allowed Charges of \$10,000,000 or More

In the CY 2015 PFS rule, CMS proposed and finalized the high expenditure tool as a way to identify potentially misvalued codes in the statutory category of “codes that account for the majority of spending under the PFS.” CMS is proposing 118 codes as potentially misvalued codes, identified using the high expenditure tool. Specific to spine codes, CMS proposes four codes as potentially misvalued:

<b>HCPCS</b>	<b>Short Descriptor</b>
22614	Spine fusion extra segment
22840	Insert spine fixation device
22842	Insert spine fixation device
22845	Insert spine fixation device

Spinal Instability (CPT Code 7208A, 7208B, 7208C, and 7208D)

For CY 2015, the CPT Editorial Panel deleted codes 72010 (radiologic examination, spine, entire, survey study, anteroposterior and lateral), 72069 (radiologic examination, spine, thorocolumbar, standing (scoliosis)), and 72090 (radiological examination, spine; scoliosis study, including supine and erect studies), revised one code, 72080 (Radiologic examination, spine; thoracolumbar junction, minimum of 2 views) and created four new codes which cover radiologic examination of the entire thoracic and lumbar spine, including the skull, cervical and sacral spine if performed. The new codes were organized by number of views, ranging from one view in 7208A, two to three views in 7208B, four to five views in 7208C, and minimum of 6 views in 7208D.

CMS disagrees with the RUC’s work RVU recommendations for these four codes. For 7208A CMS noted that the one-minute increase in time resulted in a larger work RVU than would be expected when taking the ratio between time and RVU in the source code and comparing that to the time and work RVU ratio in the new code. Using the relationship between time and RVU

from deleted code 72069, CMS is proposing a work RVU of 0.26 for 7208A, which differs from the RUC-recommended value of 0.30. Using an incremental methodology based on the relationship between work and time in the first code CMS is proposing to adjust the RUC-recommended work RVUs for CPT codes 7208B, 7208C and 7208D to, respectively, 0.31, 0.35, and 0.41.

#### Establishing Separate Payment for Collaborative Care

CMS believes that the care and management for Medicare beneficiaries with multiple chronic conditions, a particularly complicated disease or acute condition often requires extensive discussion, information-sharing and planning between a primary care physician and a specialist. For CY 2014, four CPT codes were created that describe interprofessional telephone/internet consultative services (CPT codes 99446-99449). Because Medicare pays for telephone consultations with or about a beneficiary as a part of other services furnished to the beneficiary, CMS currently does not make separate payment for these services. However, in considering how to improve the accuracy of payments for care coordination particularly for patients requiring more extensive care, CMS is seeking comment on how Medicare might accurately account for the resource costs of a more robust interprofessional consultation within the current structure of PFS payment. For example, CMS is interested in stakeholders' perspectives regarding:

- Whether there are conditions under which it might be appropriate to make separate payment for services like those described by these CPT codes;
- The parameters of, and resources involved in these collaborations between a specialist and primary care practitioner, especially in the context of the structure and valuation of current evaluation/management services. In particular, CMS is interested in comments about how these collaborations could be distinguished from the kind of services included in other evaluation/management services, how these services could be described if stakeholders believe the current CPT codes are not adequate, and how these services should be valued on the PFS;
- Whether those interprofessional consultations should be tied to a beneficiary encounter and on developing appropriate beneficiary protections to ensure that beneficiaries are fully aware of the involvement of the specialist in the beneficiary's care; and
- Key technology supports needed to support collaboration between specialist and primary care practitioners in support of high quality care management services, on whether CMS should consider including technology requirements as part of any proposed services, and on how such requirements could be implemented in a way that minimizes burden on providers.

CMS strongly encourages stakeholders to comment on this topic in order to assist them in developing potential proposals to address these issues through rulemaking in CY 2016 for implementation in CY 2017. CMS anticipates using this approach in order to facilitate broader input from stakeholders regarding details of implementing such codes, including their structure and description, valuation, and any requirements for reporting.

#### Advance Care Planning Services (This section of the proposed rule has generated a lot of media attention.)

For CY 2015, the CPT Editorial Panel created two new codes describing advance care planning (ACP) services:

- CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate); and
- An add-on CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure)).

In the CY 2015 PFS final rule with comment period, CMS assigned a PFS interim final status indicator of “I” (Not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services) to CPT codes 99497 and 99498 for CY 2015. In CY 2016, CMS is proposing to assign CPT codes 99497 and 99498 PFS status indicator “A,” which is defined as: “Active code. These codes are separately payable under the PFS. There will be RVUs for codes with this status.” The presence of an “A” indicator does not mean that Medicare has made a national coverage determination regarding the service. Contractors remain responsible for local coverage decisions in the absence of a national Medicare policy. CMS is proposing to adopt the RUC-recommended values (work RVUs, time, and direct PE inputs) for CPT codes 99497 and 99498 beginning in CY 2016 and will consider all public comments received on this proposal.

#### RVUs in the First Year of the Phase-In

The Act states that adjustments in work, PE, and MP RVUs must be phased-in over a 2-year period when the RVU reduction for a code is estimated to be equal to or greater than 20%. CMS presents two ways to determine the portion of the reduction to be phased-in for the first year. Most recent RVU transitions have distributed the values evenly across several years. For example, for a 2-year transition CMS would estimate the fully implemented value and set a rate approximately 50% between the value for the current year and the value for the update year. CMS believes that this is the most intuitive approach to the phase-in and is likely the expectation for many stakeholders. However, CMS notes that the 50% phase-in in the first year has a significant drawback. For instance, since the statute establishes a 20% threshold as the trigger for phasing in the change in RVUs, under the 50% phase-in approach, a service that is estimated to be reduced by a total of 19% for an update year would be reduced by a full 19% in that update year, while a service that is estimated to be reduced by 20% in an update year would only be reduced 10% in that update year.

An alternative approach is to consider a 19% reduction as the maximum 1-year reduction for any service not described by a new or revised code. This approach would be to reduce the service by the maximum allowed amount (that is, 19%) in the first year, and then phase in the remainder of the reduction in the second year. Under this approach, the code that is reduced by 19% in a year and the code that would otherwise have been reduced by 20% would both be reduced by 19% in the first year, and the latter code would see an additional 1% reduction in the second year of the phase-in. For most services, this would likely mean that the majority of the reduction would take place in the first year of the phase-in. However, for services with the most drastic reductions (greater than 40%), the majority of the reduction would take place in the second year of the phase-in.

CMS is proposing to consider the 19% reduction as the maximum 1-year reduction and to phase-in any remaining reduction greater than 19% in the second year of the phase-in. CMS believes that this approach is more equitable for codes with significant reductions but that are less than 20% and is seeking comment on this proposal.

#### Proposal to Eliminate the Refinement Panel

Beginning in CY 2016, CMS is proposing to permanently eliminate the refinement panel and instead publish the proposed rates for all interim final codes in the PFS proposed rule for the subsequent year. For example, CMS will publish the proposed rates for all CY 2016 interim final codes in the CY 2017 PFS proposed rule. With the change in the process for valuing codes adopted in the CY 2015 final rule with comment period, proposed values for most codes that are being valued for CY 2016 will be published in the CY 2016 PFS proposed rule. Only a small number of codes being valued for CY 2016 will be published as interim final in the 2016 PFS final rule with comment period and be subject to comment. CMS will evaluate the comments they receive on these code values, and both respond to these comments and propose values for these codes for CY 2017 in the CY 2017 PFS proposed rule.

Stakeholders will have two opportunities to comment and to provide any new clinical information that was not available at the time of the RUC valuation that might affect work RVU values that are adopted on an interim final basis. CMS believes that this proposed process, which includes two opportunities for public notice and comment, offers stakeholders a better mechanism and ample opportunity for providing any additional data for consideration, and discussing any concerns with the interim final values, than the current refinement process. It also provides greater transparency because comments on CMS rules are made available to the public at [www.regulations.gov](http://www.regulations.gov). CMS asks for comments on this proposed change to eliminate the use of refinement panels in the process for establishing final values for interim final codes.

#### **Proposed 2016 PFS- Changes to Quality Reporting Programs**

##### Physician Quality Reporting System (PQRS)

CMS tracks the quality of care provided to Medicare beneficiaries through the PQRS. The proposals for this year reflect CMS' intent to continue to implement the PQRS by proposing requirements for the 2018 PQRS payment adjustment consistent with the requirements for the 2017 PQRS payment adjustment. CMS proposes to establish the same criteria for satisfactory reporting and, in lieu of satisfactory reporting, satisfactory participation in a qualified clinical data registry, that was established for the 2017 PQRS payment adjustment, which is generally to require the reporting of nine measures covering three National Quality Strategy domains. If an individual EP or group practice does not satisfactorily report or satisfactorily participate while submitting data on PQRS quality measures, a 2% negative payment adjustment would apply in 2018. The adjustment would apply to covered professional services furnished by an individual EP or group practice during 2018.

CMS proposes to make changes to the PQRS measure set to add measures where gaps exist, as well as to eliminate measures that are topped out, duplicative, or are being replaced with a more robust measure. CMS proposes 46 new measures for individual reporting, 3 new measure groups (cardiovascular prevention, diabetic retinopathy and multiple chronic condition), 1 new measure for GPRO web interface and new National Quality Strategy domains (2 person and caregiver-

centered experience outcomes, 4 community/population health, 20 effective clinical care, 4 communication and care coordination, 10 patient safety, and 6 efficiency and cost). CMS proposes the removal of 12 measures from Claims or Registry and proposes changes to 4 National Quality Strategy domain measures. If all measure proposals are finalized, there will be 300 measures in the PQRS measure set for 2016. Also, as recently authorized under MACRA, CMS proposes to add a reporting option that will allow group practices to report quality measures data using a qualified clinical data registry.

Please note that the 2018 PQRS payment adjustment is the last adjustment that will be issued under the PQRS. Following the 2018 PQRS payment adjustment, adjustments to payment for quality reporting and other factors will be made under MIPS, as required by MACRA.

#### Electronic Health Record (EHR) Incentive Program

ARRA authorizes incentive payments under Medicare and Medicaid for the adoption and meaningful use of certified EHR technology. The Act requires that in selecting clinical quality measures for eligible professionals (EPs) to report under the EHR Incentive Program, and in establishing the form and manner of reporting, the Secretary of CMS shall seek to avoid redundant or duplicative reporting otherwise required. As such, CMS has attempted to take steps to establish alignments among various quality reporting and payment programs that include the submission of clinical quality measures.

CMS is proposing to revise the definition of certified EHR technology to require certification of EHR technology in accordance with criterion proposed by the Office of the National Coordinator for Health Information Technology in relation to CMS's form and manner requirements for electronic submission of clinical quality measures certified electronic health record technology.

#### Value-Based Payment Modifier

The Act requires CMS to establish a value-based payment modifier (VM) and apply it to specific physicians and groups of physicians the Secretary of CMS determines appropriate starting January 1, 2015, and to all physicians and groups of physicians by January 1, 2017. On or after January 1, 2017, the Act provides the Secretary discretion to apply the VM to eligible professionals (EPs). The VM provides for differential payments under the PFS to physicians, groups of physicians, and other eligible professionals (EPs) based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare Fee-for-Service program. The Act requires the VM to be budget neutral.

Under the VM Program, performance on quality and cost measures can translate into payment incentives for EPs who provide high quality, efficient care, while EPs who underperform may be subject to a downward adjustment. This program is set to expire in CY 2018, as a new comprehensive program, MIPS begins in CY 2019.

This year, CMS proposes the following key provisions:

- To use CY 2016 as the performance period for the CY 2018 Value Modifier;
- To apply the VM to nonphysician EP-only groups (e.g. Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists and nonphysician EP solo practitioners) beginning with the CY 2018 payment adjustment

- period;
- To continue to apply the CY 2018 VM based on participation in the PQRS by groups and solo practitioners;
  - To apply the quality-tiering methodology to all groups and solo practitioners that satisfactorily report PQRS and are determined to be in Category 1 for the CY 2018 payment adjustment period. Groups and solo practitioners would be subject to upward, neutral, or downward adjustments derived under the quality-tiering methodology, with the exception finalized in the CY 2015 PFS final rule with comment period --that groups consisting only of nonphysician EPs and solo practitioners who are nonphysician EPs will be held harmless from downward adjustments under the quality-tiering methodology in CY 2018;
  - To waive application of the VM for groups and solo practitioners, as identified by Tax Identification Number (TIN), if at least one EP who billed for PFS items and services under the TIN during the applicable performance period for the VM participated in the Pioneer ACO Model, CPCI, or other similar Innovation Center model during the performance period, beginning with the CY 2017 payment adjustment period;
  - To continue to set the maximum upward adjustment under the CY 2018 VM at: +4.0 times an adjustment factor (to be determined after the conclusion of the performance period), for groups with ten or more EPs; +2.0 times an adjustment factor, for groups with between two to nine EPs and physician solo practitioners; and +2.0 times an adjustment factor for groups and solo practitioners that consist only of nonphysician EPs; and
  - To set the amount of payment at risk under the CY 2018 VM to -4.0 percent for groups with ten or more EPs, -2.0 percent for groups with between two to nine EPs and physician solo practitioners, and -2.0 percent for groups and solo practitioners that consist only of nonphysician EPs who are PAs, NPs, CNSs, and CRNAs.

### **Proposed 2016 PFS – Other Proposals that Impact Physician Practice**

#### **Physician Self-Referral Updates**

The physician self-referral law prohibits: (1) a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship, unless the requirements of an applicable exception are satisfied; and (2) the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those designated health services furnished as a result of a prohibited referral.

*Recruitment and Retention:* The ACA expanded access to health care coverage to those previously uninsured, increasing the need for primary care providers (including nonphysician practitioners), particularly in remote and underserved areas. CMS is proposing to establish a new exception to permit payment to physicians for the purpose of employing nonphysician practitioners. CMS also plans to clarify the geographic service area for federally qualified health centers and rural health centers using the physician recruitment exception.

*Updating Physician-Owned Hospital Requirements:* The ACA established new restrictions on physician-owned hospitals, including setting a baseline physician ownership percentage that they cannot exceed and requiring them to state on their websites and in their advertising that they are

owned by physicians. CMS proposes to update the regulations to clarify that a broad range of actions comply with the website and advertising requirements. CMS also proposes conforming changes that better align the regulations to the statute so that the baseline physician ownership percentage includes all physicians rather than only those physicians who refer to the hospital.

*Reducing Burden Through Clarifying Terminology and Providing Policy Guidance:*

The ACA established a self-disclosure protocol that allows CMS to settle overpayments resulting from physician self-referral law violations. Review of self-disclosures indicates that clarifying terminology and providing policy guidance could reduce perceived or actual technical noncompliance without risk of abuse.

CMS proposes the following changes:

- To clarify that the writing required in the exceptions can be a collection of documents and make the terminology that describes the types of arrangements consistent throughout the regulations;
- To clarify that the term of a lease or personal services arrangement need not be in writing if the arrangement lasts at least 1 year and is otherwise compliant;
- To allow expired leasing and personal services arrangements to continue on the same terms if otherwise compliant;
- To allow a 90-day grace period to obtain missing signatures without regard to whether the failure to obtain the signature was inadvertent;
- To clarify that designated health services entities can give items used solely for certain purposes to physicians;
- To clarify that a financial relationship does not necessarily exist when a physician provides services to patients in the hospital if both the hospital and the physician bill independently for their services;
- To update obsolete language in the exception for ownership in publicly traded entities to allow over-the-counter transactions;
- To establish a new exception to permit timeshare arrangements for the use of office space, equipment, personnel, supplies and other services that will benefit rural or underserved areas;
- To clarify that compensation paid to a physician organization cannot take into account the referrals of any physician in the physician organization, not just a physician who stands in the shoes of the physician organization; and
- To seek comments on physician self-referral changes and guidance needed to advance alternative payment models and value-based purchasing.

Physician Compare

The Affordable Care Act required by January 1, 2011 a Physician Compare website with information on physicians enrolled in the Medicare program as well as information on other eligible professionals (EPs) who participate in the Physician Quality Reporting System (PQRS). CMS launched the first phase of Physician Compare on December 30, 2010. In the initial phase, CMS posted the names of EPs that satisfactorily submitted quality data for the 2009 PQRS. CMS is proposing to expand public reporting on Physician Compare by making an even broader set of quality measures available for publication on the website in CY 2016 CMS and adding new data elements to the individual EP and/or group practice profile pages. CMS is seeking comment on

several aspects of Physician Compare:

- Assigning stars for the Physician Compare five star rating by utilizing an item or measure-level benchmark derived using the Achievable Benchmark of Care (ABC™) methodology annually based on the PQRS performance rates most recently available;
- Including new data elements on the individual EP and group profile pages of Physician Compare;
- Adding Medicare Advantage information to Physician Compare individual EP and group practice profile pages. Specifically, CMS is seeking comment on adding information about which Medicare Advantage health plans the EP or group accepts and making this information a link to more information about that plan on the Medicare.gov plan finder website;
- Including additional value modifier (VM) cost and quality data on Physician Compare. Specifically, CMS is seeking comment on including in future years an indicator for a downward and neutral VM adjustment and VM quality composite or other quality performance data on group practice and individual EP profile pages;
- Including Open Payments data on individual EP profile pages on Physician Compare; and
- Including individual EP and group practice-level quality measure data stratified by race, ethnicity, and gender on Physician Compare, if feasible and appropriate. Additionally, CMS is seeking comment on potential quality measures, including composite measures, for future postings on Physician Compare that could help consumers and stakeholders monitor trends in health equity.

#### Private Contracting/Opt-Out

Effective January 1, 1998, the Act permits certain physicians and practitioners to opt out of Medicare if certain conditions are met, and to furnish through private contracts services that would otherwise be covered by Medicare. For those physicians and practitioners who opt out of Medicare in accordance with the Act, the mandatory claims submission and limiting charge rules do not apply. As a result, if the conditions necessary for an effective opt-out are met, physicians and practitioners are permitted to privately contract with Medicare beneficiaries and to charge them without regard to Medicare's limiting charge rules.

The private contracting/opt out section of the Act was recently amended by MACRA. Prior to the MACRA amendments, the law specified that physicians and practitioners may opt out for a 2 year period. Individuals that wished to renew their opt-out at the end of a 2-year opt-out period were required to file new affidavits with their Medicare Administrative contractors (MAC). MACRA amends the Act to require that opt-out affidavits filed on or after June 16, 2015, automatically renew every 2 years. Therefore, physicians and practitioners that file opt-out affidavits on or after June 16, 2015 will no longer be required to file renewal affidavits in order to continue their opt-out status. The amendments further provide that physicians and practitioners who have filed opt-out affidavits on or after June 16, 2015, and who do not want their opt-out status to automatically renew at the end of a 2 year opt-out period may cancel the automatic extension by notifying us at least 30 days prior to the start of the next 2 year opt-out period.

#### Next Steps

CMS is accepting comments on the proposed rule until 5 p.m. ET on September 8, 2015. The

final rule will be released by November 1, 2015 and will go into effect on January 1, 2016.

**Important Links**

Proposed Rule: <https://www.federalregister.gov/articles/2015/07/15/2015-16875/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#page-41830>

Fact Sheet: <http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-08.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>

CMS Power Point Presentation: <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-07-16-PQRS-Presentation.pdf>

Submit Individual Comments to the Proposed Rule at:

<http://www.regulations.gov/#!documentDetail;D=CMS-2015-0081-0002>

Note: Click on the blue “Comment Now!” button in the upper right hand corner.