CMS Releases Proposed Medicare Payment Rules, HOPPS Rule Includes Proposal to Significantly Reduce 340B Drug Reimbursement

The Centers for Medicare and Medicaid Services (CMS) has issued two proposed 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 (OPPS). CMS will be accepting comments on these rules until September 11, 2017. The final rules are expected by November 1st and will be effective Jan. 1, 2018. Here are the highlights:

Payment Policy Changes
The CY 2018 PFS conversion factor is estimated to be $35.99. Changes in payment policy outlined in the proposed rule result in the overall average impact for the following specialties:

- Hematology/Oncology: 0%
- Radiation Oncology: +1%
- Radiation Therapy Centers: +1%
- Urology: -1%
- Rheumatology: 0%
- Gastroenterology: -1%
- Diagnostic Testing Facility: -6%
- Independent Lab: -2%
- Ophthalmology: 0%

Potentially Misvalued Codes
The Affordable Care Act requires the Secretary to periodically identify potentially misvalued services and to review and make appropriate adjustments to the relative values for those services. Through the Achieving a Better Life Experience (ABLE) Act of 2014, Congress set a target for adjustments to misvalued codes in the fee schedule for 2016, 2017, and 2018. The target will be 0.5 percent for 2018.

In this proposed rule, CMS has proposed misvalued code changes that would achieve 0.31 percent in net expenditure reductions. If finalized, these changes would not meet the misvalued code target of 0.5 percent, therefore requiring the -0.19 percent overall reduction to payments for PFS services.

After applying these adjustments, and the budget neutrality adjustment to account for changes in RVUs, all required by law, the proposed 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the PFS
Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments no longer paid under the OPPS beginning January 1, 2017. For CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

For CY 2018, CMS is proposing to reduce current PFS payment rates for these items and services by 50 percent. CMS currently pays for these services under the PFS based on a percentage of the OPPS payment rate. The proposal would change the PFS payment rates for these services from 50 percent of the OPPS payment rate to 25 percent of the OPPS rate. CMS believes that this adjustment will encourage fairer competition between hospitals and physician practices by promoting greater payment alignment.
**Medicare Telehealth Services**
CMS is proposing the addition of several codes to the list of services eligible to be furnished via telehealth. These include:

- Visit to determine low dose computed tomography (LDCT) eligibility;
- Interactive Complexity;
- Health Risk Assessment;
- Care Planning for Chronic Care Management; and
- Psychotherapy for Crisis.

CMS is also proposing to eliminate the required reporting of the telehealth modifier for professional claims in an effort to reduce administrative burden for practitioners.

**Care Management Services**
CMS is proposing to adopt Current Procedural Terminology (CPT) codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes. CMS is also seeking public comment on ways to further reduce burden on reporting practitioners for chronic care management and similar services.

**Evaluation and Management Comment Solicitation**
CMS is seeking comment from stakeholders on specific changes to update the guidelines, to reduce the associated burden, and to better align E/M coding and documentation with the current practice of medicine.

**Comments on Initial Data Collection and Reporting Periods for Clinical Laboratory Fee Schedule**
The Clinical Laboratory Fee Schedule (CLFS) final rule entitled “Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System” implements extensive revisions to the Medicare payment, coding, and coverage for Clinical Diagnostic Laboratory Tests (CDLTs) paid under the CLFS. Under the final rule, the payment amount for a test on the CLFS furnished on or after January 1, 2018, generally will be equal to the weighted median of private payer rates determined for the test, based on the data of applicable laboratories that is collected during a specified data collection period and reported to CMS during a specified data reporting period.

CMS is seeking comments from applicable laboratories and reporting entities regarding their experience with the first data collection and reporting periods under the new private payer rate-based CLFS. Comments received will be used to inform CMS regarding potential refinement to the CLFS for future data collection and reporting periods.

**Appropriate Use Criteria for Advanced Diagnostic Imaging Services**
CMS is proposing to implement the Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging in a manner that allows practitioners more time to focus on and adjust to the Quality Payment Program. The Medicare AUC program is proposed to begin with an educational and operations testing year in 2019, which means physicians would be required to start using AUCs and reporting this information on their claims. During this first year, CMS is proposing to pay claims for advanced diagnostic imaging services regardless of whether they contain information on the required AUC consultation. This allows both clinicians and the agency to prepare for this new program.

In conjunction with the proposed rule, CMS is posting newly qualified provider-led entities and clinical decision support mechanisms. Qualified provider-led entities are permitted to develop AUC, and qualified clinical decision support mechanisms are the tools through which physicians use to access the AUC. In addition, by having qualified clinical decision support mechanisms available (some of which are free of charge) clinicians may use one of these mechanisms to earn credit under the Merit-Based Incentive Payment System as an improvement activity. This improvement activity was included in the Quality Payment Program proposed rule that was released on June 20, 2017.

CMS is seeking comments related to whether the program should be delayed beyond the proposed start date of January 1, 2019.
Physician Quality Reporting System (PQRS)
Under the PQRS, individual eligible professionals and group practices who did not satisfactorily report data on quality measures in 2016 are subject to a downward payment adjustment of 2.0 percent in 2018 to their PFS services. The final data submission timeframe for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. PQRS is being replaced by the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP).

CMS is proposing to change the current PQRS program policy that requires reporting of 9 measures across 3 National Quality Strategy domains to only require reporting of 6 measures for the PQRS. CMS is also proposing similar changes to the clinical reporting requirements under the Medicare Electronic Health Record Incentive Program for eligible professionals.

2018 Value Modifier
CMS is proposing the following changes to previously-finalized policies for the 2018 Value Modifier:

- Reducing the automatic downward payment adjustment for not meeting minimum quality reporting requirements from negative four percent to negative two percent (-2.0 percent) for groups of ten or more clinicians; and from negative two percent to negative one percent (-1.0 percent) for physician and non-physician solo practitioners and groups of two to nine clinicians;
- Holding harmless all physician groups and solo practitioners who met minimum quality reporting requirements from downward payment adjustments for performance under quality-tiering for the last year of the program; and
- Aligning the maximum upward adjustment amount to 2 times the adjustment factor for all physician groups and solo practitioners.

Request for Information
The proposed rule includes a request for information on regulatory, sub-regulatory, policy, practice, and procedural changes to better accomplish these goals. CMS is seeking recommendations regarding payment system re-design; elimination or streamlining of reporting; monitoring and documentation requirements; operational flexibility; and feedback mechanisms and data sharing that would enhance patient care, support the doctor-patient relationship in care delivery, and facilitate patient-centered care. Recommendations could also include when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, providers, and suppliers.

2018 Medicare Hospital Outpatient Prospective Payment System Proposed Rule
Payment for Drugs and Biologicals (“Drugs”) Purchased with a 340B Program Discount
CMS is proposing to pay separately payable, non pass-through drugs purchased at a discount through the 340B drug pricing program at the average sales price (ASP) minus 22.5 percent rather than ASP plus 6 percent. ASP minus 22.5 percent was the Medicare Payment Advisory Commission’s (MedPAC’s) estimate of the average minimum discount eligible hospitals received for drugs acquired under the 340B program. Applicable drugs not purchased under the 340B drug program would continue to receive ASP plus 6 percent payment. Comments on the OPPS proposed rule are due September 11, 2017.

Please click here to access a fact sheet on the proposed rule. To read about how the new Physician Fee Schedule better supports site-neutral payments, read this article from the Alliance for Site Neutral Payment Reform.