The Centers for Medicare & Medicaid Services (CMS) published the final physician fee schedule (PFS) in the Federal Register on Nov. 16, 2015. The regulation finalized policies that affect Medicare Part B payments for physician services furnished on or after Jan. 1, 2016 and set the calendar year (CY) 2016 PFS conversion factor at $35.8279. The CY 2016 national average anesthesia conversion factor is $22.3309. MGMA created this analysis exclusively for members to help them understand the new and updated policies in place for the Medicare program next year.

**Medicare Part B beneficiary cost-sharing**

Medicare Part B beneficiaries who are “held harmless” from an increase in premiums because there will be no increase in the Social Security cost of living for 2016 will continue to pay the same monthly Medicare premium as last year, which is $104.90. As a result of the recently-enacted Bipartisan Budget Act of 2015, the remaining 30% of Medicare Part B beneficiaries not protected under the held harmless standard because they are either dually enrolled in Medicare and Medicaid, enrolling in Part B for the first time in 2016, do not collect Social Security benefits, or meet income-related exceptions, will see only a modest increase in monthly premiums to $121.80, rather than the previously-projected increase to $159.30. High-income beneficiaries will continue to pay an additional monthly amount. The annual deductible for all Part B beneficiaries will be $166.00 in 2016.

**RVU changes**

CMS finalized changes that will have a significant impact on payment for certain specialties. For example, overall payment reductions of 4% for gastroenterology and 2% for radiation oncology will occur. In contrast, there will be overall payment increases of 8% for pathology and 9% for independent laboratories. Table 62 displays the estimated impact on total allowed charges by specialty resulting from the finalized payment changes, and Table 63 shows the estimated impact of all changes on total payments for selected high volume procedures, as identified by CMS.

Recent statutory changes mandate that, beginning in 2016, CMS must phase-in any new payment reductions of 20% or more over a two-year period. For reductions of 20% or greater, CMS finalized the proposal to apply a 19% reduction in the first year and phase-in the remainder of the reduction in the second year.
Misvalued codes

CMS continued its ongoing efforts to evaluate and modify potentially misvalued codes and adjust RVUs.

This year, the agency reviewed a number of codes affecting various specialties. CMS proposed 118 codes as potentially misvalued based on the fact they account for a large portion of Medicare expenditures and have not been reviewed since 2010. As part of this “review of high expenditure services across specialties with Medicare allowed charges of $10,000,000 or more,” CMS assessed changes in physician work and updated direct practice expense (PE) inputs. CMS finalized 103 codes, listed in table 8, as potentially misvalued services under the high expenditures screen and seeks recommended values of these codes from the American Medical Association’s Relative Value Update Committee (RUC) and other stakeholder groups.

While CMS did not formally change the values of 10- and 90-day global surgical services, the agency continues to examine payments and consider comments for future rulemaking. As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress prohibited CMS from moving forward with its previously finalized plan to eliminate the use of 10- and 90-day global surgical codes. However, MACRA requires the agency to begin collecting data to value these services in 2017 and to use that data to improve payment accuracy of these services by 2019. The agency collected payment information on more than 400 services that include moderate sedation as an inherent part of furnishing the procedure, but has not yet provided any revised values.

Due to laws passed in recent years, beginning in 2016, CMS must meet annual targets for reductions of PFS expenditures by adjusting the RVUs of codes identified as misvalued by CMS. For 2016, the misvalued codes target is 1% of estimated PFS expenditures, and for 2017 and 2018, the annual target is 0.5%. If the estimated net reduction in expenditures resulting from RVU adjustments is equal to or greater than the target for the year, reduced expenditures attributable to adjustments will be redistributed in a budget-neutral manner within the PFS. If CMS falls below the target, that difference will be removed from the overall PFS pool and all payments will be reduced through a lower conversion factor.

The 2016 net reduction in expenditures resulting from adjustments to relative values of misvalued codes is 0.23%. Because this falls below the 1% target, payments under the PFS will be reduced by the difference between the target for the year and the estimated net reduction in expenditures. This will produce a 0.77% reduction to the conversion factor for 2016.
Determination of malpractice (MP) RVUs

Annual update of MP RVUs

CMS finalized its proposal to update MP RVUs on an annual basis, rather than every five years, to reflect changes in the mix of practitioners providing services and to adjust MP RVUs for risk. Specialty-specific risk factors will continue to be updated every five years using updated premium data and remain unchanged between the five year reviews. Overall, MP RVUs comprise a smaller portion (approximately 4%) of Medicare payments in comparison to work or PE RVUs.

MP RVU update for anesthesia services

CMS finalized adjustments to the anesthesia conversion factor to reflect the updated premium information collected for the five-year review, explaining that payment rates for anesthesia shall reflect MP resource costs relative to the rest of the PFS, including periodic updates to reflect changes over time.

Advance care planning (ACP) services

CMS established Medicare payment for two ACP services beginning in 2016, adopting CPT codes 99497 and 99498 and the RUC-recommended payment amounts. As a result, the agency set an average payment rate of $85.99 for 99497 and $74.88 for 99498 when billed in a physician’s office, and established the following RVUs:

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Description</th>
<th>Physician Work RVUs</th>
<th>Non-facility PE RVUs</th>
<th>Facility PE RVUs</th>
<th>Malpractice RVUs</th>
<th>Total Non-Facility RVUs</th>
<th>Total Facility RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>Advncd care plan 30 min</td>
<td>1.50</td>
<td>0.80</td>
<td>0.62</td>
<td>0.10</td>
<td>2.40</td>
<td>2.22</td>
</tr>
<tr>
<td>99498</td>
<td>Advncd care plan addl 30 min</td>
<td>1.40</td>
<td>0.59</td>
<td>0.58</td>
<td>0.10</td>
<td>2.09</td>
<td>2.08</td>
</tr>
</tbody>
</table>

ACP services involve face-to-face discussions of long-term treatment options and planning between a physician or other qualified health care professional and the patient, family member, or a surrogate. These services are not limited to particular physician specialties and may be furnished by physicians or non-physician practitioners (NPPs) whose scope of practice includes these services and who may independently bill Medicare.

ACP services may be billed on the same day as other evaluation and management services, during the same service period as transitional care management or chronic care management services and within global surgical periods. They may also be furnished during an annual wellness visit (AWV) when billed separately with modifier -33 (preventive services). When these services are provided as part of an AWV, the Medicare beneficiary’s Part B deductible and coinsurance will be waived; when furnished
separately from an AWV, beneficiaries will be responsible for standard Part B cost-sharing. ACP services may not be billed on the same day as certain critical care services, including neonatal and pediatric critical care.

Despite MGMA’s recommendation that CMS issue a national coverage decision (NCD) on ACP services, the agency will defer to Medicare Administrative Contractors (MACs) to establish local coverage determinations. However, the agency indicated that it may establish a controlling NCD in the future, after allowing time for implementation and experience with ACP services.

**Medicare telehealth services**

CMS added Certified Registered Nurse Anesthetists (CRNAs) to the list of distant site practitioners who can furnish Medicare telehealth services and added the following services to the 2016 approved list of Medicare telehealth services:

- Prolonged service (CPT codes 99356 and 99357)
- End-stage renal disease (ESRD) home dialysis (CPT codes 90963, 90964, 90965 and 90966)

For a complete list of 2016 Medicare telehealth services, download this chart.

Additionally, the Medicare telehealth originating site facility fee will be statutorily increased from $24.83 to $25.10 in 2016.

**Therapy caps**

As required by statute, CMS applies annual, per beneficiary limitations, or “therapy caps,” on expenses for outpatient therapy services under Medicare Part B. There is one therapy cap for physical therapy (PT) and speech-language pathology (SLP) services combined and a separate therapy cap for outpatient occupational therapy (OT) services. CMS finalized a slight increase in the therapy cap amount to $1,960 in 2016 from $1,940 in 2015. Congress has repeatedly extended an exceptions process to the therapy caps and did so most recently in MACRA. Without further congressional intervention, the exceptions process will conclude on Dec. 31, 2017.

Under existing statutory requirements, CMS applies a manual medical review process to claims when a beneficiary’s incurred expenses exceed $3,700 for PT and SLP services or $3,700 for OT services. As a result of MACRA, therapy claims exceeding the $3,700 threshold will no longer trigger automatic manual review. Rather, CMS will conduct more targeted medical reviews of these claims based on factors including high claims denial rates for therapy services or outlier billing practices. Without further congressional intervention, this review process will expire on Dec. 31, 2017.
Chronic care management (CCM) and transitional care management (TCM) services

In the proposed rule, CMS requested feedback about whether, and how, the agency should reduce the onerous administrative requirements for practices billing TCM and CCM services. In our comments, MGMA provided CMS with a number of recommendations to mitigate these burdensome requirements to allow more practices to provide these services to Medicare beneficiaries, including removal of the requirement that a practice must use EHR technology to furnish CCM services.

Unfortunately, CMS did not finalize any changes to CCM or TCM services for 2016. However, the agency did indicate that it will take steps to reduce the administrative requirements for furnishing these services in future years. Additionally, CMS will issue guidance clarifying CCM rules regarding the use of fax and revise existing guidance for TCM services to specify that the required date of service on the claim form should be the date of the face-to-face visit.

CMS also established payment for CCM and TCM services furnished in a rural health center (RHC) or federally qualified health center (FQHC) beginning in 2016.

Part B drugs - Biosimilars

CMS clarified that it will pay for biosimilar biological products based on the average sales price of all of the National Drug Codes assigned to that product plus 6%. Although many commenters urged the agency to pay for biosimilar products separately, the agency’s finalized payment policy will group biosimilars that reference the same biologic and are included within the same billing code.

Requirements for billing “incident to” services

One of the many requirements for billing incident to services is that the service must be performed under direct supervision of a physician or qualifying NPP. In group practices and multispecialty clinics, it is common for the supervising physician or NPP to differ from the physician or practitioner who is responsible for the patient’s overall treatment plan. CMS clarified that in these circumstances, only the supervising physician or NPP may bill Medicare for the incident to services.

In the proposed rule, CMS proposed to remove certain regulatory language regarding supervision of incident to services, which raised concerns that the agency intended to revise its long-standing policy to require that the referring, ordering, or treating physician supervise the subsequent incident to service. In response to opposition from MGMA and other provider organizations, CMS abandoned this proposal and added clarifying language to confirm its existing policy that the physician or NPP supervising the incident to service need not be the same physician or NPP who is treating the patient more broadly.
CMS also amended the definition of auxiliary personnel who may provide “incident to” services to explicitly bar auxiliary personnel who have been excluded from Medicare, Medicaid or any other federally-funded healthcare program, or have had their enrollment revoked for any reason. This is consistent with other CMS regulations, which prohibit excluded auxiliary personnel and auxiliary personnel whose enrollment has been revoked from providing services to Medicare beneficiaries.

**Colorectal cancer tests**

CMS finalized modified regulations relating to a 2015 policy change concerning colorectal cancer tests, confirming that the beneficiary deductible will be waived for anesthesia services furnished in conjunction with a colorectal cancer screening test even when a polyp or other tissue is removed during a colonoscopy. The agency reminds practitioners that they should report anesthesia services with the PT modifier in such circumstances.

**Appropriate use criteria (AUC) for advanced diagnostic imaging services**

Under the Protecting Access to Medicare Act of 2014 (PAMA), CMS is required to specify AUC for advanced diagnostic imaging services from among those developed or endorsed by national medical professional specialty societies and provider-led entities no later than Nov. 15, 2015. CMS finalized defining areas of the PAMA statute that required clarification, including provider-led entity, appropriate use criteria, and priority clinical areas. CMS finalized that entities seeking designation as a “provider-led entity” must submit an initial application by Jan. 1 and reapply every five years. Applications will be accepted on an annual basis but must be received by the Jan. 1 deadline. All qualified provider-led entities will be subsequently posted to the CMS website on June 30 of that year.

PAMA requires that beginning Jan. 1, 2017 physicians must consult AUC prior to ordering certain advanced diagnostic imaging services. The agency intends to address further implementation of the AUC program in future notice and comment rulemaking, taking into account the comments received on the proposed 2016 PFS.

**Computed tomography (CT) changes under PAMA**

CMS finalized the requirement that beginning on Jan.1, 2016 claims for CT scans under certain CPT codes (and any successor codes) that are furnished on Non-National Electrical Manufacturers Association (NEMA) Standard XR-29-2013 compliant CT scans must include the modifier “CT,” which will result in the applicable payment reduction for the service. This change stems from Section 218(a) of PAMA, which reduces payment for the technical component of PFS and Hospital Outpatient Prospective Payment System reimbursements (5% in 2016; 15% in 2017 onward) for CT services identified by certain CPT codes that are furnished using equipment that does not meet each of the attributes of the NEMA Standard XR-29-2013.
Physician Compare

CMS continues its phased approach to adding more information to the publicly available Physician Compare website. With the latest addition of group-level qualified clinical data registry (QCDR) measures (including PQRS and non-PQRS data) in the PFS, CMS completes its phasing-in of PQRS quality data so that all measures, regardless of reporting method and whether they were reported on behalf of an individual eligible professional (EP) or an entire group practice through the group practice reporting option (GPRO), will be made publicly available on the Physician Compare website. New five-star performance ratings for all group and individual-level PQRS measures reported via registry, EHR, claims, or web interface will also be added. These will be derived using the Achievable Benchmark of Care™ methodology and stratified by reporting mechanism. In addition, the agency will add additional Board Certification information (specifically for the American Board of Optometry and American Osteopathic Association), as well as visual indicators on the profile pages of EPs who satisfactory report cardiovascular prevention measures for the Million Hearts Initiative. All of these new additions will appear live on the website beginning in 2017. Following pressure from MGMA, CMS has decided not to finalize its proposal to include a visual indicator for upward payment adjustments received under the Value-Based Payment Modifier (VBPM) at this time.

The agency also plans to add new data to the separate Physician Compare downloadable database in 2017, including certain provider-level utilization data (focusing on the most common Healthcare Common Procedure Coding System codes), cost and quality tier performance and payment adjustment information under the VBPM, and an indicator if the provider or practice was eligible to report quality data but did not. This database is intended for research purposes and is not designed for consumer use.

CMS intends to begin collecting all of this new information for the Physician Compare website and database starting with the 2016 performance year and publish it for the first time in CY 2017, after which it will be collected and reported on an annual basis. After finding several inaccuracies in 2014 PQRS data reported via an EHR or QCDR, CMS decided not to include this information on the Physician Compare website in 2015, despite having previously finalized a decision to do so. However, the agency intends to publicly report this data on an annual basis moving forward starting with 2015 data, which will be added to the website next year.

Regarding wider data inaccuracies on the website and MGMA’s call for a more formal process to regularly verify demographic information, CMS admits to a “lag” in updating information on Physician Compare, but states that it is “necessary for data verification.” The agency vows to “further improve data timeliness” and encourages practices to maintain up-to-date demographic information in the internet-based Provider Enrollment, Chain and Ownership System (PECOS) database and to contact the Physician Compare support team directly at PhysicianCompare@Westat.com regarding updates to any information not derived from PECOS, including hospital affiliation.
Physician Quality Reporting System (PQRS)

Under MACRA, current federal quality reporting programs, including PQRS, will sunset on Dec. 31, 2018. On Jan. 1, 2019, a new payment system called the Merit-Based Incentive Payment System (MIPS) will take effect. While the framework of MIPS has yet to be determined through regulatory processes, in order to create stability prior to the transition, CMS has retained many aspects of the PQRS reporting requirements for individual and group reporting options for the 2016 reporting year. EPs and group practices that do not satisfactorily report PQRS quality measures data in 2016 will receive an automatic 2% penalty on their 2018 Medicare payments.

Individual reporting for the 2016 PQRS reporting year

To avoid the PQRS penalty in 2018, individual EPs can report PQRS quality measures data in 2016 via the following mechanisms: claims, individual measures or measures groups via a qualified registry, EHR data via direct submission or through a submission vendor, or individual measures submitted via a QCDR. Though specific requirements vary by reporting method, in general, EPs will need to report nine measures across three National Quality Strategy (NQS) domains in 2016 to avoid a 2% PQRS penalty in 2018. For specific reporting requirements for each of the 2016 PQRS individual reporting options, view Table 27.

Group Practice Reporting Option (GPRO)

Group practices can register to report via the group practice reporting option (GPRO) and report PQRS quality measures data in 2016 via the following mechanisms: individual measures via a qualified registry, QCDR, direct EHR or EHR data submission vendor, the GPRO Web Interface (only for groups of 25 or more EPs) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS via a certified survey vendor. Registering to report as a group via the GPRO is optional; therefore, individual EPs within a group have the option to report individually. Though specific requirements vary by reporting method, in general, groups reporting via the GPRO would need to report 9 measures across 3 NQS domains in 2016 to avoid a 2% PQRS penalty in 2018. For specific reporting requirements for each of the 2016 PQRS group practice reporting options, view Table 28.

CAHPS for PQRS data submitted by a certified survey vendor

Groups of 100 or more EPs that are participating in GPRO are required to report the CAHPS for PQRS survey data for the 2016 PQRS reporting year in addition to another selected reporting mechanism. Groups of 2-99 EPs that registered in the GPRO have the option of supplementing PQRS reporting with the CAHPS for PQRS survey. The CAHPS for PQRS survey will count for 3 measures and 1 NQS domain. Groups that report the CAHPS for PQRS survey must also report 6 additional measures across at least 2 NQS domains using another reporting mechanism in order to avoid a 2% PQRS penalty in 2018.
Individual measures via QCDR for GPRO

MACRA paved the way for groups to report individual PQRS measures via a QCDR. This is a new reporting option for groups in 2016. For 2016 PQRS reporting, groups must report nine measures covering at least three NQS domains, and report each measure for at least 50% of the group’s patients. Of the measures reported, the group will report at least two outcomes measures or, if two outcomes measures are not available, the group must report at least one outcomes measure and one of the following measures: resource use, patient experience of care, efficiency/appropriate use, or patient safety.

PQRS Measure Changes

Cross-cutting measures

For 2016 PQRS, there are four new cross-cutting measures, for a total set of 23 (Table 29).

Individual measures

CMS made the following changes to the individual PQRS measures available for 2016 reporting: (Tables 29–43)

- Added 37 and removed 12 individual PQRS measures
- Changed the NQS domain of five individual measures
- Changed the mechanism by which 17 individual measures are reported
- Added three new and amended three existing measures groups

GPRO Web Interface measures

CMS added one new measure to the GPRO Web Interface measures set— the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure. This brings the total number of measures in the GPRO Web Interface to 18.

Value-Based Payment Modifier (VBPM)

The VBPM is based on quality of care delivered and cost of providing care during an established performance year, two years prior to the payment adjustment year. The VBPM has been gradually phased-in since the 2015 payment year (2013 performance year).

2018 VBPM payment levels based on 2016 PQRS participation

The VBPM relies on PQRS participation for the purpose of determining quality performance. In 2018, the quality score under the VBPM will be based on 2016 PQRS
reporting, as well as CMS-calculated outcomes measures related to hospital readmissions and hospital admissions for certain chronic and acute conditions.

The 2018 VBPM payment adjustments will apply in the following manner:

- **Groups of 10 or more EPs** who successfully meet 2016 PQRS reporting requirements will receive an upward, neutral, or downward payment adjustment ranging from -4% to +4x, where x is a budget-neutral payment adjustment factor to be determined by CMS. Groups who have not successfully met PQRS requirements in 2016 will receive an automatic 4% VBPM penalty in 2018.

- **Groups of 2-9 EPs and physician solo practitioners** who successfully meet 2016 PQRS reporting requirements will receive an upward, neutral, or downward payment adjustments ranging from -2% to +2x, where x is a budget-neutral payment adjustment factor to be determined by CMS. Those who have not successfully met PQRS requirements in 2016 will receive an automatic 2% VBPM penalty in 2018.

- **Groups consisting exclusively of non-physician EPs and solo practitioners** who are PAs, NPs, CNSs, or CRNAs who successfully meet 2016 PQRS reporting requirements will receive an upward payment adjustment of 2x, where x is a budget-neutral payment adjustment factor to be determined by CMS, or a neutral payment adjustment. Because 2016 is the first performance year that these type of providers will be counted toward the VBPM, downward adjustments will not apply to these groups when they successfully participate in PQRS in 2016. Those who have not successfully met PQRS requirements in 2016 will receive an automatic 2% VBPM penalty in 2018.

**2018 VBPM adjustment based on 2016 PQRS participation**

Groups and solo practitioners will be designated under one of the following two categories for the purposes of determining payment adjustments under the VBPM in 2018.

- **Category 1**: Includes all solo practitioners who satisfactorily report PQRS quality measures as individuals and those in group practices that meet the criteria via GPRO for the purpose of avoiding the 2018 PQRS payment adjustment during the 2016 reporting year. Additionally, groups that do not self-nominate through GPRO under PQRS but have at least 50% of EPs who meet the criteria for satisfactory reporting for PQRS as individuals will be included. Groups and EPs participating in a Medicare Shared Saving Program (MSSP) ACO that successfully reports quality measures data will be part of Category 1.

- **Category 2**: Includes all groups and solo practitioners that do not fall under Category 1 and are subject to an automatic 2018 VBPM penalty. Groups and EPs participating in an MSSP-ACO that does not successfully report quality measures data will be part of Category 2.
Additionally, starting with the 2015 performance year, groups that registered in CY 2015 to participate in the PQRS GPRO who are unsuccessful with reporting via their chosen GPRO reporting mechanism will, starting with the 2017 VBPM, be considered as part of Category 1 if at least 50% of the group’s individual EPs successfully report PQRS.

**Application of the VBPM to non-physician EPs in 2018 based on 2016 performance**

In the 2015 PFS, CMS stated its intent to apply the VBPM to all non-physician EPs in 2018 based on the quality and cost of care provided in 2016. However, MACRA sunsets the current VBPM on Dec. 31, 2018, and the new MIPS will take effect on Jan. 1, 2019.

Under MACRA, MIPS will apply to items and services furnished on or after Jan. 1, 2019 by physicians, PAs, NPs, CNSs, and CRNAs. All other non-physician EPs will not be included in MIPS until at least 2021.

While the framework of MIPS has yet to be established through the regulatory process, in order to create consistency before the transition to MIPS, CMS will apply the 2018 VBPM (based on the quality of care and the cost of care provided in 2016) only to physicians and non-physician EPs who are NPs, CNSs, PAs, and CRNAs.

**Quality-tiering**

The quality-tiering methodology is used to determine whether a group or solo practitioner in Category 1 will receive an upward, neutral, or downward payment adjustment under the VBPM in 2018, based on 2016 reporting. Groups and solo practitioners that provide high-quality, low-cost care to Medicare beneficiaries can earn an upward adjustment, while groups and solo physician practitioners that provide low-quality, high-cost care may receive a downward adjustment.

For the 2018 payment year, the following quality-tiering methodology will be considered in determining the VBPM payment adjustment for those in Category 1. The adjustments will apply as follows:

<table>
<thead>
<tr>
<th>Physicians, PAs, NPs, CNSs, and CRNAs in groups of 10 or more EPs:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost/Quality</strong></td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Low Cost</td>
</tr>
<tr>
<td>Average Cost</td>
</tr>
<tr>
<td>High Cost</td>
</tr>
</tbody>
</table>

*Groups and solo practitioners will be eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores.
Physicians, PAs, NPs, CNSs, and CRNAs in groups of 2-9 EPs and physician solo practitioners:

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-1.0%</td>
<td>0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Groups and solo practitioners will be eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores.

PAs, NPs, CNSs, and CRNAs in groups consisting exclusively of non-physician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners:

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>0.0%</td>
<td>0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Groups and solo practitioners will be eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores.

Notably, group practices of 9 or fewer EPs and solo practitioners will be eligible for a 2% negative payment adjustment for the first time based on their 2016 performance. Because the VBPM is a budget-neutral program, the “x” upward adjustment factor will be established by the agency based on the projected aggregate amount of downward adjustments and automatic penalties.

Quality composite score metrics: All-cause readmission measure

CMS has determined that the all-cause hospital readmission measure does not yield reliable results for small groups and solo practitioners. Therefore, in a change that was not included in the 2016 proposed PFS, starting with the CY 2017 payment year (2015 performance year), groups of 2-9 EPs and solo practitioners will not see the all-cause hospital readmissions measure included in their quality composite score. Upward, downward, and neutral payment adjustments will still apply to these groups and solo practitioners.

Average quality and average cost designations

Starting with the 2017 payment year (2015 performance year), a group or solo practitioner’s quality composite score will be classified as average if they do not have at least one quality measure that meets the minimum number of cases required.

Starting with the 2016 payment year (2014 performance year), a group or solo practitioner’s cost composite score will be classified as average if they do not have at least one cost measure that meets the minimum number of cases required.

Electronically-reported Clinical Quality Measures (eCQMs)
CMS will exclude eCQMs from the overall VBPM benchmark and create separate benchmarks beginning with the 2016 performance year, used to determine the 2018 VBPM. Under this policy, 2016 benchmarks will be calculated using 2015 performance data.

**Medicare spending per beneficiary (MSPB)**

**Starting with the 2015 performance year affecting 2017 payments**, for purposes of applying the VBPM, a tax identification number (TIN) must have at least 125 MSPB episodes for the measure to be included in the cost composite.

**Informal review process**

Groups and providers will have 60 days following the release of a physician’s or group’s 2016 annual Quality and Resource Use Reports (QRURs) to request corrections of potential 2016 performance year VBPM miscalculations, which will impact 2018 reimbursements.

**Physician feedback and Quality and Resource Use Reports (QRURs)**

While CMS did not propose and ultimately finalize changes to the manner in which feedback reports and QRURs are distributed, the agency acknowledged it will expand mid-year QRURs to non-physician EPs, solo practitioners, and groups composed of non-physician EPs beginning in the spring of 2016.

**Additional upward adjustment under the VBPM for high-performing MSSP-ACOs**

In the 2015 PFS, CMS established that the 2017 VBPM will apply to physicians who participate in an MSSP-ACO in 2015. Beginning with the 2017 VBPM based on 2015 performance, an additional upward adjustment of +1.0x will apply to groups and solo practitioners that participate in MSSP-ACOs that provide “high quality” care to high-risk beneficiaries, determined by VBPM policies.

**ACO-CAHPS survey inclusion in 2018 VBPM calculations**

Beginning with the 2016 performance year, ACO-CAHPS survey scores will also be used to calculate the 2018 VBPM quality composite score.

**2017 VBPM waiver for participation in the Pioneer ACO model and Comprehensive Primary Care Initiative (CPCI)**

As established in the 2015 PFS, CMS considers a Pioneer ACO’s or CPCI’s quality and cost scores “average” to apply the 2017 VBPM based on the 2015 performance year. This means that a CPCI or Pioneer ACO participant’s VBPM adjustment would be zero.
Starting with the **2017 payment year, which is based on 2015 performance**, the VBPM will be waived altogether for groups and solo practitioners if at least one EP who bills for PFS items and services under the TIN during the applicable performance period participated in the Pioneer ACO model or CPCi. Because the VBPM is applied at the TIN level, this waiver will also apply to EPs who do not participate in the Pioneer ACO model or CPCi, but bill under the same TIN as EPs who do participate and for whom the VBPM is waived.

**2018 VBPM waiver for participation in the Comprehensive ESRD Care Initiative, Oncology Care Model, and Next Generation ACO Model**

Beginning with the 2016 VBPM performance year affecting payments in 2018, CMS will waive the VBPM for groups and solo practitioners who participate in the Comprehensive ESRD Care Initiative, Oncology Care Model, and Next Generation ACO model, or any other similar CMS Innovation (CMMI) model if at least one EP who bills for PFS items and services under the TIN participates in the model in 2016.

**Physician Self-Referral ("Stark") Law**

CMS finalized the clarification of key terms and requirements under the physician self-referral regulations, as well as added two new exceptions. These changes do not represent a significant departure from existing Stark requirements on group practices or their financial arrangements with hospitals. For a more detailed explanation of what you need to know related to the recent changes to Stark, you can download our member-benefit analysis prepared by MGMA’s Washington Counsel, Robert Saner.

**Clarification of key terms and requirements**

**Physician-owned hospitals:** In the final rule, CMS defined the categories of websites and forms of advertising that require disclosure that a hospital has physician ownership, and clarified the variety of disclosure statements that are sufficient to comply. The agency also finalized the clarification that when determining the baseline bona fide investment level for purposes of determining compliance, the ownership or investment interests held by both referring and non-referring physicians must be included. Further, CMS finalized special instructions for submissions to the Self-Referral Disclosure Protocol for failure to meet the public notice requirement for physician-owned hospitals.

**Writing, term and holdover arrangements:** CMS clarified the requirement that many Stark compensation exceptions for a “writing” or “written agreement” need not be satisfied by evidence of a single formal contact. The agency finalized a clarifying amendment explaining that exceptions requiring a signed “writing” do not require a signed formal contract. Instead, they can be substantiated by other contemporaneous documentation. In addition, CMS finalized clarifications that exceptions conditioned on the term of at least one year do not need a formal term provision in a single contract. Rather, an arrangement that lasts one year will meet the requirement. CMS finalized allowing parties to rely on
“hold over” provisions of the Rental of Office Space, Rental of Equipment and Personal Service Arrangements exceptions for an indefinite period of time.

Signature requirements: CMS finalized the proposal to allow parties 90 days to obtain required signatures to an agreement, whether or not the failure to secure a timely signature is inadvertent or advertent. Prior to the final rule, the non-compliance grace period lapsed at 30 days when the parties were aware of the missing signatures.

Stand in the shoes: CMS finalized an additional clarification that when one or more physician owners of a group “stand in the shoes” of the group for purposes of the direct compensation exceptions, the compensation under the exception must not take into account the volume or value of referrals from any physician in the group, not just referrals from the owner physicians. The “stand in the shoes” regulations generally provide that when a Designated Health Services (DHS) entity has a financial relationship with a physician group, the physician owners of the group are deemed to have the same financial relationship with the DHS entity as the group itself. Employees and contractors on the other hand can choose to be treated as having only an indirect compensation relationship for Stark purposes.

Remuneration: In the final rule, CMS clarifies that a hospital’s provision of space, equipment and staff for a physician to provide outpatient services does not constitute remuneration to the physician, as long as the hospital bills for the facility component of the service and the physician bills for the professional component. This is in response to a case from the United States Court of Appeals for the Third Circuit.

New Exceptions

Timeshare Arrangements: CMS established a new exception for qualifying timeshare arrangements between physicians or physician organizations and hospitals or otherwise unrelated physician organizations. The arrangement must be set out in writing, signed by the parties, and specify the premises, equipment, personnel, supplies and or, services covered. To qualify under the proposed exception, (i) the sharing physician or practice must use the host organization’s premises, equipment, personnel, items, supplies and services predominantly to furnish evaluation and management services to its own patients, and (ii) the arrangement cannot include advanced imaging equipment, radiation therapy equipment or clinical or pathology laboratory equipment (except that used only for CLIA-waived lab tests). The exception is limited to timeshare arrangements in which hospitals and physician organizations are the host organizations and will not protect similar arrangements offered by other types of healthcare organizations, including independent diagnostic testing facilities and clinical laboratories. The finalized exception is not available to protect part-time and exclusive leases of office space, which will continue to be measured under the long-standing exception for real property leases. Time-based payment arrangements (per hour, per other time block, per day, etc.) are eligible for protection but those based on a percentage of billings or collections are not. “Per click” pricing is not acceptable for services provided by a sharing practice to patients of the host hospital or practice.
Assistance to Employ Non-physician Practitioners (NPPs): CMS finalized a new exception for payments made by a hospital, FQHC or RHC to a physician to assist in the recruiting of a NPP to the donor's geographic service area. For purposes of the exception, NPPs include PAs, NPs, CNSs, certified nurse midwives, clinical social workers and clinical psychologists. It does not include CRNAs. The finalized exception applies only to situations in which the NPP is directly employed by or contracted with the physician or physician's practice receiving the support, and when the purpose of the employment is to provide primary care services or mental health services to patients of the physician's practice. Support arrangements for physician extenders employed by specialty practices will not be eligible for the exception unless the NPP was providing primary care or mental health services. In addition, the exception includes a cap on the amount of the recruitment incentive, set at 50% of the NPP’s salary, benefits and signing bonus measured over a two-year period. It also includes a three year frequency limitation on assistance. The three year frequency limitation on assistance includes an exception to permit a hospital, FQHC or RHC to provide assistance to a physician more than once every three years in the event that the recruited NPP does not remain with the practice for at least one year.

Medicare enrollment opt-out affidavits

MACRA stipulates that any valid Medicare opt-out affidavits filed on or after June 16, 2015 will automatically renew every two years. CMS confirms this change in the PFS, which is a departure from previous policy in which EPs were required to file new affidavits every two years. EPs who do not want their opt-out status to automatically renew at the end of this two-year period can cancel their renewal by notifying in writing all MACs with whom they have an affidavit on file at least 30 days prior to the start of the new opt-out period.