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Proposed Medicare Physician Fee Schedule Changes for 2016

The *Medicare Physician Fee Schedule* (MPFS) is the payment system that sets payments for physicians and other practitioners who treat Medicare beneficiaries. In making payments to physicians, Medicare utilizes the *Resource Based Relative Value Scales* (RBRVS) system, which assigns *Relative Value Units* (RVUs) to individual procedures based on the resources required to perform each procedure. Under this system, each procedure in the MPFS is assigned RVUs for three categories of resources: (1) *physician work*; (2) *practice expense* (PE); and, (3) *malpractice* (MP) expense. Furthermore, each procedure's RVUs are adjusted for local geographic differences using *Geographic Practice Cost Indexes* (GPCIs) for each RVU component. Once the procedure's RVUs have been modified for geographic variance, they are summed, and the total is then multiplied by a *conversion factor* (CF) to obtain the dollar amount of governmental reimbursement. On July 8, 2015, the *Centers for Medicare and Medicaid Services* (CMS) released its proposed *Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year 2016* rule, with a final rule expected by November 1, 2015.[1] This update includes many notable changes, including some *Stark Law* alterations.

I. REGULATORY UPDATES FOR PAYMENTS AND COMPLIANCE

The *Patient Protection and Affordable Care Act* (ACA) included provisions to increase provider participation in remote and underserved areas. In response to these provisions, CMS proposes two approaches to define a geographic area for the *Federally Qualified Health Centers* (FQHCs) and *rural health clinics* (RHCs) that use the physician recruitment exception.[2] Further, to assist with the expansion of primary care physicians into rural areas, CMS proposes a *Stark Law* exception that will permit hospitals to pay physicians to employ nonphysician practitioners (limited to physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives).[3] CMS limits this exception to include only nonphysicians who provide primary care services, which consist of: general family practice; general internal medicine; pediatrics; geriatrics; and, obstetrics and gynecology.[4] In order for the payment arrangement to qualify for this new exception, CMS proposes that the minimum amount of primary care provided by the nonphysician must be either at least 90% or substantially all (75% or more) of the patient care services furnished by the nonphysician.[5] CMS seeks commentary on which of these percentages is more appropriate and also on what kind of documentation is necessary to measure these nonphysician services.[6]

To meet the proposed *Stark* exception, CMS also proposes that the payment from the hospital must either be the lower of: (1) 50% of the salary, benefits, and bonus paid by the physician to the nonphysician during a period no greater than the first two consecutive years of employment; or, (2) the amount remaining after reducing the total salary, benefits, and bonus by the amount of receipts attributable to nonphysician services provided.[7] Further, the compensation provided to the nonphysician practitioner must not consider referrals or kickbacks, and must not exceed fair market value for the patient care services provided.[8] Finally, the nonphysician practitioner must be a *bona fide* employee of the physician; must only provide patient care services to that physician's patients; and, must not have practiced or been employed to provide patient care services in that geographic area for three years prior to the nonphysician's employment with the physician.[9]

To combat fraud and abuse concerns, the ACA established restrictions and additional requirements that hospitals must follow to avoid self-referral violations. Relevant to the CMS proposal, the ACA set a baseline physician ownership percentage that hospitals cannot exceed, and required hospitals owned by physicians to advertise that they are physician-owned.[10] The baseline physician ownership percentage restricted future physician ownership of a hospital to no more than the "*percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors*."[11] CMS proposes to clarify that a variety of actions will guarantee compliance with the website and advertising requirements (the entity must disclose the fact that it is physician-owned on public websites and advertisements) required by the ACA.[12] CMS also proposes to change the requirements of physician-owned hospitals so that the baseline bona fide investment level and the current bona fide investment level used to determine the physician ownership percentage include *all* physicians with an ownership interest instead of *only referring* physicians with an

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ownership interest.[13] CMS proposes that the baseline ownership percentage should now include direct and indirect ownership and investment interests held by physicians as long as each physician satisfies the definition of "*physician*" in Section 1861(r) of the *Social Security Act.*[14]

The ACA also included protocol for physicians who self-disclose self-referral violations to settle with CMS.[15] After receiving numerous questions about potential violations, CMS determined that clarification of the *Stark Law* terminology and additional policy guidance regarding the *Stark Law* could reduce technical noncompliance without risking abuse;[16] therefore, CMS proposes the following changes:

(1) Clarifying that the writing requirement in the exceptions can be satisfied by using a collection of documents;

(2) Clarifying 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.

(3) Allowing holdover arrangements for leasing and personal services to continue as long as the arrangement is otherwise compliant;

(4) To allow a 90-day grace period to obtain missing signatures;

(5) To clarify that DHS entities can give items used solely for certain purposes to physicians;

(6) 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;

(7) To allow over-the-counter transactions for the exception of ownership in publicly-traded entities;

(8) To establish a new exception for rural and underserved areas that will permit timeshare arrangements for the use of office space, equipment, personnel, supplies and other services;

(9) To clarify that compensation paid to a physician organization prohibits the consideration of *any* physician's referrals in the physician organization; and,

(10) To seek commentary on physician self-referral changes and guidance needed to advance alternative payment models and value-based purchasing.[17]

II. PAYMENT PROVISIONS

CMS proposes to update previous regulations on biosimilar drugs to clarify that the payment amount for a biosimilar biological drug product is based on the average sales price of all biosimilar products that reference a common product's license application.[18] The MPFS also includes a proposal to change the utilization rate assumption used to determine the per-minute cost of the capital equipment for radiation therapy from 50% to 70%, due to a determination by CMS, in 2012, that radiation therapy codes may be misvalued because the equipment is now "*typically used in a significantly broader range of services and that would increase its overall usage in comparison to the previous assumption*."[19]

CMS reimburses practitioners for "*incident to*" services, meaning services provided to patients by a non-physician (auxiliary provider) who is under the supervision of a physician. CMS proposes to clarify that, for 2016, the physician/practitioner *billing* for "*incident to*" services must also be the *supervising* physician/practitioner.[20] CMS also proposes to require that the auxiliary provider of "*incident to*" services cannot have been excluded from Medicare, Medicaid, or other federal healthcare programs or have had their enrollment revoked while providing such services.[21]

III. ADVANCE CARE PLANNING

CMS seeks feedback for its proposal to include separately payable codes for two advance care planning services provided to Medicare beneficiaries.[22] This proposal would give Medicare beneficiaries additional opportunities later on to receive advance care counseling beyond the initial "*Welcome to Medicare*" visit.[23] The advance care planning and counseling services would consist of an explanation and discussion of advance directives for end-of-life care with a physician or other qualified health professional.[24]

IV. QUALITY PROVISIONS

The *Physician Quality Reporting System* (PQRS) is a system through which CMS tracks the quality of care provided to Medicare beneficiaries by physicians. CMS intends to continue using the PQRS payment adjustment through 2018, after which the *Merit-Based Incentive Payment System* (MIPS) will be implemented.[25] Eligible individuals and group practices that do not satisfactorily report or participate while submitting data on PQRS quality measures will be subject to a 2% negative payment adjustment in 2018, an increase of .5% from 2015.[26] CMS also proposes to add new measures and eliminate others as needed to fill gaps or avoid repetition, bringing the total number of measures to 300 measures in 2016.[27]

CMS seeks commentary on all of its proposed changes until September 8, 2015. After that time, CMS will consider each of the comments submitted and determine whether or not it will amend its proposals based on consumer feedback or finalize them as they are written currently. The final MPFS rule is expected to be issued no later than November 1, 2015.

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1 "Proposed policy, payment, and quality provisions changes to the Medicare Physician Fee Schedule for Calendar Year 2016 Fact Sheet" CMS, July 8, 2015, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-08.html (Accessed 7/13/15).

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2 "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016" CMS, July 8, 2015, https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-16875.pdf (Accessed 7/13/15), p. 621-622.
3 Ibid, p. 618, 686-687.
4 Ibid, p. 613.
5 Ibid, p. 614.
6 Ibid.
7 "Medicare Program; Revisions" Fed. Reg. Vol. 80, No. 135, (July 15, 2015), p. 41957.
8 Ibid.
9 Ibid.
10 "The Social Security Act" § 1395nn(i) (2010).
11 § 1395nn(i)(1)(D)(i).
12 Ibid; CMS, July 8, 2015, p. 654-661.
13 CMS, July 8, 2015, p. 662-664.
14 Ibid, p. 663-665.
15 "Patient Protection and Affordable Care Act" § 6409 (2010).
16 CMS, July 8, 2015, p. 606-608.
17 Ibid p. 626-679; CMS, "Proposed Policy Fact Sheet," July 8, 2015.
18 CMS, July 8, 2015, p. 346-350.
19 Ibid, p. 106-111, 241.
20 Ibid, p. 284-293.
21 Ibid, p. 293-294.
22 Ibid, p. 246-248.
23 Ibid.
24 Ibid, p. 246.
25 Ibid, p. 397.
26 Ibid, p. 416-417.
27 Ibid, p. 394; CMS, "Proposed Policy Fact Sheet," July 8, 2015.

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