

AAHCM Summary of CMS CY 2015 Physician Fee Schedule Final Rule

- **Chronic Care Management (CCM)**
- **Value Based Payment Modifier (VBPM)**
- **Advance Care Planning (ACP)**
- **Telehealth**
- **Removal of Employment Requirements for Services Furnished “Incident to” Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Visits**
- **Resource-Based Practice Expense (PE) Relative Value Units (RVUs) and Off Campus Provider Based Departments**
- **Transition of 10- and 90-day Global Packages into 0-day Global Packages**

Chronic Care Management (CCM)

CMS finalized CPT 99490 as a monthly code with a national allowed amount of \$42.60 beginning 2015.

This code:

- Is for the non face to face chronic care management service of at least 20 minutes per month for eligible beneficiaries.
- Requires documented beneficiary consent and the 20% beneficiary co-payment applies.
- Requires the use of an EHR in addition to other elements.
- Requires choice of code between CCM/CPO, and CCM/TCM where CPO or TCM are service options as only one of the 3 codes will be paid to one provider per beneficiary per month.

CMS did not choose at this time to cover and pay for more extensive complex chronic care management including non-face to face services for high cost multimorbid beneficiaries. “We will evaluate the utilization of this (CCM) service to evaluate what types of beneficiaries receive the service described by this CPT code, what types of practitioners are reporting it, and consider any changes in payment that may be warranted in the coming years. We are maintaining the status indicator “B” (Bundled) for CY 2015 for the complex care coordination codes, CPT codes 99487 and 99489.”

Academy commended CMS for:

- Recognizing the importance of care management services to the care of Medicare beneficiaries and for its decision to start to pay for non face-to face services without onerous and irrelevant (PCMH-like practice) standards.
- Its proposal to count clinical staff time furnished incident to a physician’s service under general (versus direct) physician supervision and that incident to services be countable whether the staff is a direct practice (W-2) employee or not.

The Academy:

- Added an additional code is needed this year to better reflect the care and cost of the complex patient whose complex care coordination needs greatly exceed 20 minutes per month. We noted signing on to the proposal of the multispecialty group including AGS.
- Stated it was important for CMS to consider learning from the Independence at Home Demonstration as it considers and potentially develops more advanced payment models for meeting the needs of high risk, high cost Medicare beneficiaries.
- Offered CMS the guidance it needs to create an effective practice management and payment structure.

The Academy will continue to work on coverage and payment for complex care management services (such as IAH and ACO housecalls illustrate). There is a sick more expensive population that requires more service to provide optimal care and to save cost. This care requires interdisciplinary staff and takes more time and thus needs additional payment for the service to be available to those who need.

Value Based Payment Modifier (VBPM)

CMS finalized aspects of its VBPM program. The VBPM will bonus or penalize practices according to quality and cost measures reported 2 years prior in comparison to one's specialty. The program begins 2015 (on 2013 data) for practices of 100 or more, adds practices 10 to 99 in 2016 and moves down practice size through to solo physicians as of 2017.

This was also to include nurse practitioners and physician assistants as of 2017 though CMS has decided to delay moving to NPs and PAs until 2018.

CMS has also modified the amount of bonus or penalty that will apply. Bonus will be paid from a pool of penalty/non-paid amount from the Medicare Fee Schedule and as such is presented in plus or minus up to 2X for solo to 9 physicians and plus or minus 4X for groups 10 or more by 2017. CMS continues to implement the VBPM with PQRS (and approved derivatives) serving to develop the quality numerator of the quality over cost calculation. From the CMS Final Rule

TABLE 88: Final CY 2017 VM Payment Adjustment Amounts for Groups with Two to Nine Eligible Professionals and Solo Practitioners

Cost/Quality	Low quality	Average quality	High quality
Low cost	+0.0%	+1.0x*	+2.0x*
Average cost	+0.0%	+0.0%	+1.0x*
High cost	+0.0%	+0.0%	+0.0%

* Groups and solo practitioners eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

TABLE 89: Final CY 2017 VM Payment Adjustment Amounts for Groups with Ten or More Eligible Professionals

Cost/Quality	Low quality	Average quality	High quality
Low cost	+0.0%	+2.0x*	+4.0x*
Average cost	-2.0%	+0.0%	+2.0x*
High cost	-4.0%	-2.0%	+0.0%

* Groups eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

Background - The Academy supported the development of additional means to support and assess value in the Medicare program. We commented as in prior years, that Part B providers who treat the sickest of Medicare beneficiaries will be unintentionally, yet uniquely, disadvantaged and penalized by the VBPM unless 1) applicable measures are developed for the high cost multimorbid population and until 2) risk adjustment methods are developed that fully take into account the health and social status of beneficiaries, particularly the sickest, highest cost beneficiaries

The Academy offered the following recommendations.

1. CMS could defer increasing the amount of payment to be gained or at risk until 2018 or after.
2. CMS could exempt practices caring for high risk, high cost patients (such as those who by medical necessity reside in homes and domiciliary care facilities, have HCC scores of 2.5 or above, or more than x number of chronic conditions/plus ADL dependencies, etc).
3. CMS could deal with the high risk, high cost patient issue by adopting the correct methodology to eliminate the bias against such patients.
4. CMS could add to the VBP program recognition of savings from expected costs, to reward applicable providers for saving the Medicare program, not just penalizing them for taking care of high cost, high risk patients.

CMS believes its methodology is sufficient on the risk adjustment side/wants proof that it is not and that on measure side the self nominated QCDR process provides adequate opportunity for field to develop its own measures.

The Academy will continue to work with other associations and on its own to demonstrate that the risk adjustment is inadequate to account for the sickest most expensive beneficiary population and continue to support development of measures that are applicable to the multimorbid population treated by Academy members. Additionally,

Advance Care Planning (ACP)

CMS, despite the recommendation of the Academy and others is not covering and paying for ACP as of 2015. However, CMS has adopted 2 codes to describe ACP.

CPT code 99497 (Advance care planning including the explanation and discussion of advance directives) and an add-CPT code 99498 for each additional 30 minutes.

Academy members engage in ACP that is currently not paid and yet provides value to beneficiaries and to the Medicare Program. The Academy is also aware that patient preference (an element of ACP) is a payment measure in IAH that contributes to practice success and program savings.

CMS will consider “whether to pay for CPT codes 99497 and 99498 after we have had the opportunity to go through notice and comment rulemaking.”

The Academy will continue to work with CMS on the coverage and payment for service.

Telehealth

CMS finalizes its proposal to add psychotherapy services CPT codes 90845, 90846 and 90847; prolonged service office CPT codes 99354 and 99355; and annual wellness visit HCPCS codes G0438 and G0439 to the list of Medicare Telehealth services.

CMS notes that (the Academy) interest to have the home and domiciliary locations covered as Telehealth services is outside of CMS authority and is a matter for Congress.

The Academy supported the CMS proposal to expand coverage for the following services when rendered under Telehealth.

- Psychotherapy services CPT codes 90845, 90846 and 90847.
- Prolonged service office CPT codes 99354 and 99355.
- Annual wellness visit HCPCS codes G0438 and G0439.

We also recommended that home and domiciliary care be added to the originating site because it would improve quality, reduce beneficiary and family stress, and reduce costs to beneficiaries and CMS. CMS acknowledges that Telehealth sources of origination for payment is beyond the scope of CMS authority and rests with Congress.

Removal of Employment Requirements for Services Furnished “Incident to” Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Visits

CMS finalized the proposal as written to eliminate the requirement for services furnished incident to RHC and FQHC visits be rendered by employed staff.

Academy support was based on the view that this would contribute to arrangements to provide care where this was not previously (organizational and geographically) available and will provide RHCs and FQHCs with additional flexibility without adversely impacting the quality or continuity of care.

This is similar to the finalized provision to remove the employment requirement of incident to services for CCM and TCM. This provides opportunities for Academy members to provide services on a contractual basis with RHCs/FQHCs and presents an opportunity to communicate the benefits of home care medicine to these centers.

Resource-Based Practice Expense (PE) Relative Value Units (RVUs) and Off Campus Provider Based Departments

CMS, despite the recommendations of the Academy and others, finalized its proposal to create a HCPCS modifier to CMS will begin to collect data on services furnished in off-campus provider-based departments.

This accomplished by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other billing practitioners to report these services using a new place of service code on professional claims. Data collection will be voluntary in 2015 and required beginning on January 1, 2016.

The Academy supported the principal for equity in payment for Part B services across all sites of service. This is in accordance with the MedPAC recommendation that Medicare seek to pay similar amounts for similar services across a variety of payment settings, only taking into account differences in the definitions of service and patient severity.

The Academy expressed concern that this requirement will cause confusion and could result in detrimental underpayment as some Academy members work in practices and render house calls based out of practices that are owned by a hospital or health system and yet provide all or some of their services in the home.

Providers may believe that all services require use of a modifier believing that since some services are rendered in outpatient space, or because the administrative offices of the practice are located at the health system provider based location. This would result in underpayment with practices receiving payment at facility based rates rather than non-facility rates where the service was rendered.

Transition of 10- and 90-day Global Packages into 0-day Global Packages

CMS finalized policy to transform all 10 and 90-day global codes to 0-day codes. This will begin with 10-day global services in 2017 and follow with the 90-day global services in 2018. CMS will assess whether there is a better construction of a bundled payment for surgical services that provides incentives for care coordination and care redesign across an episode of care.

Medically reasonable and necessary visits to be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure.

CMS proposed this based on concern that efforts to validate RVUs in the fee schedule do not go far enough to assess whether the valuation of global surgical packages reflects the number and level of post-operative services that are furnished, to identify and review potentially misvalued services and to respond to the OIG suggestion that global surgical payments are misvalued.

Academy expressed concern that on an intermediate basis that beneficiary care transition and the incentive of providers to assure necessary follow-up will deteriorate as CMS disaggregates surgical bundles. This could exacerbate issues of care coordination and readmission avoidance. We observed this as an area where the well architected TCM and proposed CCM services come into play and where Academy members can help to assure the timely delivery of care to beneficiaries. Academy offered its expertise to CMS analysis.

The Academy will continue to offer its expertise in areas of care transitions to inform Medicare payment policy. This is also important as 1) CMS assesses whether there is a better construction of a bundled payment for surgical services that provides incentives for care coordination and care redesign across an episode of care and 2) that as market leader Medicare coverage and payment policy is looked upon by private payors as the benchmark for claims processing rules and for provider contracts.