Physician Fee Schedule and Quality Payment Program – Final Rules

November 3, 2017

On November 2, the Centers for Medicare & Medicaid Services (CMS) issued a final rule for the 2018 Physician Fee Schedule and final rule with comment period for the Quality Payment Program. We are reviewing both rules and will provide additional information.

Physician Fee Schedule Final Rule

Click here for the CMS Fact Sheet on the Physician Fee Schedule. Click here for the final rule on the Physician Fee Schedule.

Highlights of the Physician Fee Schedule Final Rule

- The final 2018 PFS conversion factor is $35.99, verses the 2017 PFS conversion factor of $35.89.
- Changes the PFS payment rates for nonexcepted off-campus provider-based hospital departments from 50% of the OPPS payment rate to 40% of the OPPS rate.
- Adds several codes to the list of telehealth services, including HCPCS code G0506 (Care Planning for Chronic Care Management).
- Finalizes proposals to adopt CPT codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes.
- Effective January 1, 2018, RHCs and FQHCs will be paid for CCM, general BHI and psychiatric CoCM using two new billing codes created exclusively for RHC and FQHC payment. This payment is in addition to the payment for an RHC or FQHC visit.
- Medicare Shared Savings Programs
    - Revisions to the assignment methodology for ACOs that include FQHCs and RHCs by eliminating the requirement to enumerate each physician working in the FQHC or RHC on the ACO participant list.
    - Addition of three new CCM codes and four BHI codes to the definition of primary care services used in the ACO assignment methodology.

Quality Payment Program Final Rule

Click here for the CMS Fact Sheet on the Quality Payment Program. Click here for the final rule with comment period and the interim final rule with comment period. Note that the provisions of the final rule with comment period and the interim final rule with comment period are effective January 1, 2018. Comments on both are due by 5:00 PM ET on January 1, 2018.

Highlights of the Quality Payment Program – Year 2:

- Weighs the MIPS Cost performance category to 10% of your total MIPS final score and the Quality performance category to 50%. Note that the proposed rule had weighed Cost at 0%.
- Raises the MIPS performance threshold to 15 points in Year 2 (from 3 points in the transition year).
- Allows the use of 2014 Edition and/or 2015 CEHRT in Year 2 for the Advancing Care information performance category; bonus for using only 2015 CEHRT.
- Awards up to 5 bonus points on your MIPS final score for treatment of complex patients.
- Adds 5 bonus points to the MIPS final scores of small practices.
- Adds Virtual Groups as a participation options for MIPS.
- Excludes individual MIPS eligible clinicians or groups with less than/equal to $90,000 in Part B allowed charges or less than/equal to 200 Medicare Part B beneficiaries.
- Provides more detail on how eligible clinicians participating in selected APMs (MIPS APMS) will be assessed under the APM scoring standard.
- Creates additional flexibilities and pathways for the All Payer Combination Option beginning in performance year 2019.
- Interim final rule with comment makes allowances for clinicians impacted by Hurricanes Harvey, Irma and Maria.

If you have any questions, please contact our policy lead Devon Seibert-Bailey or our General Counsel Diane Turpin at 202-266-2600.