CMS Releases Final Rule on 2016 Medicare Fee Schedule Changes

With the release of the 2016 Medicare Physician Fee Schedule changes, the American Academy of Ophthalmology (AAO) has indicated that Ophthalmologists will experience deep cuts in some important procedures performed throughout the specialty under the final 2016 Medicare Fee Schedule released by the Centers for Medicare & Medicaid Services (CMS).

Overall, payments to ophthalmologists are will see a slight reduction compared with their 2015 levels – including a 1-percent reduction to cataract.

CMS also released the final 2016 rule for outpatient prospective payment system/ambulatory surgical center payment system with updated payment policies and rates for hospital outpatient departments and ASCs.

**Misvalued code review prompts 2016 conversion factor reduction**

CMS is under a congressional mandate to identify $1 billion in misvalued codes annually for the next three years. When the target is not met, there is an automatic reduction to the conversion factor in the following year. This year CMS is reducing the conversion factor by .79 percent to account for missing the target and a budget neutrality adjustment.

This wipes out the .50 percent Jan. 1, 2016, update that was scheduled to happen because of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

That is the legislation that eliminated the sustainable growth rate formula. In this final rule, CMS declared that the target was not met and the reduction will be triggered. (The 2016 conversion factor will be 35.8279, down from the 2015 rate of 35.9335.) The majority of ophthalmology’s services will remain similar to this year’s rate.

**Targeted cuts to retina and glaucoma procedures**

In addition to the slightly decreased conversion factor, for all codes some ophthalmologists will see substantial cuts related to specific retina and glaucoma procedures in Medicare’s 2016 fee schedule also. This is also part of the misvalued code initiative.

CMS did not accept the American Medical Association’s Relative Value Scale Update Committee recommendations, instead opting for deeper cuts. The Academy and fellow specialty societies are outraged that CMS did not accept these recommendations. These recommendations were the result of a rigorous consensus effort.

Three glaucoma procedures will see cuts between 11 and 30 percentage points. Five retina procedures also face significant reductions, most of which will also be in the double digits. The Academy, the American Glaucoma Society and the American Society of Retina Specialists sought to ensure fairness through a vigorous defense last year before the RUC. Anticipating the cuts targeted to ophthalmology, however, the Academy helped create a mechanism for spreading out the pain when severe cuts are enacted by successfully adding a provision in the MACRA. MACRA allows cuts greater than 20 percent to be phased-in over two years with 19 percent for the first year and the remainder of the reduction the second year.
The AAO will post a list of the 2016 payments as compared to 2015 for the top 25 ophthalmology codes as well as more specific payment information on the targeted retina and glaucoma codes.

A brief summary of other proposed quality changes follows and updates will be provided as they continue to review the final fee schedule proposal.

**Addition of new diabetic measures group to PQRS**
CMS finalized its proposal to keep the program’s current reporting requirements and measures primarily unchanged. In 2016, however, providers can report on a new diabetic retinopathy measures group developed by the Academy.

The new measures group will significantly help retina specialists succeed in PQRS—particularly those without an electronic health record system.

Similar to the Cataracts Measures Group, ophthalmologists will be able report this group of measures on just 20 patients—11 of which must be Medicare patients.

**Value-Based Modifier Applied to All Providers Based on 2016 Performance**
The value-based modifier will continue to apply to all providers in 2018, based on their 2016 performance.

The adjustment amount will depend on the size of the physician practice.

In addition to the potential for penalties, practices could earn a bonus for high quality and low cost, based on a yet-to-be-determined formula.

**Solo practitioners and small practices**

Despite the Academy’s strong opposition, CMS finalized its proposal to put groups with fewer than 10 eligible professionals or solo practitioners at risk for VBM penalties, even when successfully participating in Physician Quality Reporting System. In 2015, groups of this size were held harmless from penalties, as long as they successfully participated in PQRS.

The 2018 VBM penalty for smaller practices will remain at 2 percent, based on 2016 cost and quality data.

Failure to participate in PQRS would result in a 4-percent total 2018 penalty -- an automatic 2-percent value-based modifier penalty, plus the 2-percent PQRS penalty.

**Large practices**

The penalty for practices with 10 or more eligible professionals will remain at 4 percent, based on 2016 cost and quality data.

Failure to participate in PQRS would result in a 6-percent total 2018 penalty for larger
practices—an automatic 4 percent value-based modifier penalty, plus the 2-percent PQRS penalty. CMS will end the value-based modifier in 2019. As part of SGR repeal, the agency will replace it with the new Merit-Based Incentive Payment System.

**Public Reporting**
CMS finalized its proposal to continue its rollout of publicly posting individual physician quality and cost of care on its Physician Compare website in 2017. In addition, the agency will add a green check mark on Physician Compare. This indicates whether a physician earned a bonus under the value-based modifier program in 2016.

**CMS also releases the final 2016 ASC Payment Rule**
ASCs to see 0.3-percent increases in 2016 but CMS eliminates pass-through for glaucoma procedures that use cornea tissue

Centers for Medicare and Medicaid Services will move forward to increase payments to ambulatory surgery centers slightly more than those to outpatient hospitals according to the final 2016 ASC payment rule also released today. Hospital outpatient services will be cut by 0.3 percent.

ASCs’ 2016 conversion factor will depend on their 2014 performance on quality reporting measures.

- ASCs that failed to report successfully will receive a 2-percent penalty.
- ASCs that reported successfully will be paid based on the full 2016 conversion factor.

Questions on these issues can be directed to Matt Daigle at the Academy’s Government Affairs Office at mdaigle@aaodc.org

Or, for guidance on this issue, contact us through the Third Party Insurance Help Program.