American Hospital Association

Regulatory Advisory

November 30, 2017

Medicare Physician Fee Schedule: Final Rule for CY 2018

At a Glance

At Issue:

On Nov. 2, the Centers for Medicare & Medicaid Services (CMS) released its final rule for calendar year (CY) 2018 with changes to the Medicare physician fee schedule (PFS) and other revisions under Medicare Part B. In addition to the standard updates to PFS payment weights and rates, the rule:

- makes additional cuts in site-neutral payment rates for services furnished in certain off-campus provider-based departments (PBDs) of a hospital, lowering the rates from 50 percent of the outpatient prospective payment system (OPPS) amount to 40 percent;
- expands payment for telehealth services to include psychotherapy for crisis, health risk assessments, care planning for chronic care management, and counseling visits to determine low-dose computed tomography eligibility;
- delays until Jan. 1, 2020 the start of the educational and operations testing year for the requirement that professionals report on consultation of appropriate use criteria for advanced diagnostic imaging, as urged by the AHA; and
- makes retroactive changes to the Physician Quality Reporting System and requirements for performance year 2016, to better align with the Medicare Access and CHIP Reauthorization Act of 2015 quality payment program.

Our Take:

In this rule, CMS finalized a policy that adversely affects patient access to care by reducing Medicare rates for services hospitals provide in "new" off-campus hospital clinics. We are particularly concerned about the impact on rural and vulnerable communities that do not have sufficient access. We also remain troubled that the agency's continued short-sighted policies on the relocation of existing off-campus provider-based clinics will prevent patients and communities from having access to the most up-to-date, high-quality services. We will continue to urge CMS to provide adequate support to cover the costs of providing care so that we can continue to serve as the around-the-clock access point for community care. With respect to payment for physician services, the AHA is pleased by a number of the rules that CMS finalized, including new covered telehealth services and a delay in the implementation of appropriate use criteria for advanced diagnostic imaging to allow providers sufficient time to understand and implement the program requirements. However, we continue to urge the agency to take a more expansive approach toward coverage for telehealth services. require a formal written agreement among all members of the virtual group. Virtual groups that wish to use the option in the CY 2018 reporting period must elect it by Dec. 31, 2017.

What You Can Do:

- ✓ Share this advisory with your senior management team – including your chief medical officer, chief financial officer and other key physician leaders and nurse managers – and ask them to examine the impact of the rule on your organization for CY 2018.

- ✓ View this more detailed summary of the final rule for AHA members prepared by Health Policy Alternatives, Inc.

Further Questions:

Contact Shira Hollander, senior associate director for payment policy, at (202) 626-2329 or shollander@aha.org.

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MEDICARE PHYSICIAN FEE SCHEDULE: FINAL RULE FOR CY 2018

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BACKGROUND

On Nov. 2, the Centers for Medicare & Medicaid Services (CMS) released its final rule for calendar year (CY) 2018 with changes to the Medicare physician fee schedule (PFS) and other revisions under Medicare Part B. The final rule was published in the Nov. 15 Federal Register. Changes are generally effective Jan. 1, 2018.

CHANGES TO THE CY 2018 PFS

Conversion Factor

CMS finalized an overall update to payment rates of +0.41 percent in CY 2018. This increase reflects the 0.50 percent increase required under the Medicare Access and CHIP Reauthorizatiovn Act of 2015 (MACRA), a misvalued code adjustment required under the Achieving a Better Life Experience Act of 2014 and a budget neutrality adjustment. These adjustments result in an estimated conversion factor of $35.9996 for CY 2018.

Payment for X-ray Imaging

The Consolidated Appropriations Act of 2016 requires a 7 percent reduction in payment amounts under the PFS for the technical component of X-ray imaging taken using computed radiography technology (including when billed as a global service) beginning in CY 2018. It requires an additional 3 percent reduction (for a total of a 10 percent reduction) in payments for such services beginning in 2023. To implement this provision, CMS finalized, as proposed, the creation of modifier “FY” for X-rays taken using computed radiography technology. Beginning in 2018, modifier “FY” must be listed on claims for X-rays taken using computed radiography technology, which will trigger the applicable payment reduction.

Evaluation & Management (E/M) Guidelines

In the proposed CMS rule, CMS stated that, in recognition that documentation and coding guidelines for E/M services are unnecessarily burdensome and potentially outdated, it was soliciting comment on how the agency might reform the guidelines, reduce the associated burden and better align E/M coding and documentation with the current practice of medicine. In response to these comments and other input from stakeholders that CMS received on this topic, it now states that it will immediately focus on revising the current E/M guidelines to reduce unnecessary administrative burden.

Medicare Telehealth Services

New Telehealth Services. CMS finalized its proposal to add two services to the list of Medicare-payable telehealth services:

1) Counseling visit to determine low-dose computed tomography (LDCT) eligibility, which includes assessment of patient's risk for lung cancer, shared decision making, and counseling on the risks and benefits of LDCT (G0296); and

2) Psychotherapy for crisis (90839, first 60 minutes; 90840, each additional 30 minutes), provided that the distant site practitioner is able to communicate with and inform staff at the originating site to defuse crises and restore safety, where necessary.

CMS also finalized its proposal to add four services to the telehealth list that describe additional elements of services currently on the list and would only be considered telehealth services when billed as an add-on to codes already on the telehealth list:

1) Interactive complexity (90785)
2) Administration of patient-focused health risk assessment instrument (96160)
3) Administration of caregiver-focused health risk assessment instrument for the benefit of the patient (96161)
4) Comprehensive assessment of and care planning for patients requiring chronic care management services (G0506)

Elimination of the GT Modifier. To reduce redundancy with the telehealth point-of-service (POS) code distant site practitioners must use to identify services as telehealth that CMS adopted last year, CMS finalized its proposal to eliminate the requirement that distant site practitioners also report the GT modifier on professional claims. Because institutional claims do not use POS modifiers, distant site practitioners who bill under critical access hospital Method II billing must continue to use the GT modifier on institutional claims.

Telehealth and Remote Patient Monitoring. Patient monitoring services involve the interpretation of medical information without a direct interaction between practitioner and patient; thus, when provided remotely, these services are generally paid under the same conditions as in-person physician's services. However, in recognition of the significant contribution to ongoing medical care that remote monitoring services provide, CMS finalized a proposal to make separate payment for Current Procedural Terminology (CPT) code 99091, which describes collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver that requires a minimum of 30 minutes of time from the provider. This change will facilitate payment for these services in the immediate future, pending forthcoming changes to the CPT codes. CMS elected not to activate payment for CPT code 99090 (analysis of clinical data stored in computers).

CHANGES TO QUALITY PROGRAMS

The MACRA mandates that CY 2018 is the final year for payment adjustments under both the Physician Quality Reporting System (PQRS) and the Value Modifier (VM),

which will be supplanted by the new two-track physician quality payment program (QPP) beginning with CY 2019 payments. Additional resources on MACRA and the QPP can be found at www.aha.org/MACRA.

PQRS

The performance period for CY 2018 PQRS payment adjustment was CY 2016, and clinicians and groups had to submit performance period data to CMS by the end of March 2017. However, CMS will retroactively lower the number of measures required for reporting from nine measures to six measures, the same number of measures that will be required under the new Merit-based Incentive Payment System (MIPS) affecting PFS payment starting in CY 2019. CMS will also eliminate the PQRS requirement that clinicians and groups report a "cross-cutting" measure. Thus, those clinicians who did not meet the previous PQRS standard of nine measures (including a cross cutting measure), but did report at least six measures, will not be subject to the PQRS non-reporting penalty of 2.0 percent in CY 2018.

In explaining its changes, CMS stated it received stakeholder feedback that PQRS requirements were overly burdensome and that they should be more closely aligned with the MIPS to reduce confusion.

Physician VM

CMS previously finalized maximum negative payment adjustments for CY 2018 of -2.0 percent for individual clinicians and groups of 10 or fewer clinicians, and -4.0 percent for groups of 10 or more clinicians. These adjustments would have applied to those clinicians and groups that did not submit PQRS data as well as to poor performers in the program (i.e., those classified as "high cost" and "low quality" under the Quality Tiering Model, or QTM).

In order to provide a smoother transition into the QPP, CMS will lower the VM's CY 2018 maximum negative adjustment to -1.0 percent for individual clinicians and groups under 10 clinicians, and -2.0 percent for groups of 10 or more clinicians. **This maximum negative adjustment will apply only to those clinicians and groups that fail to meet PQRS reporting requirements. All other individual clinicians and group practices of all sizes will be held harmless from downward payment adjustments under the VM for CY 2018.**

MACRA Patient Relationship Categories and Codes

MACRA requires CMS to develop and update through rulemaking a set of "patient relationship categories and codes" that specify the relationship between clinicians and patients at the time a service is furnished. The purpose of these codes is to facilitate the attribution of patients and episodes of care to clinicians according to the varying roles in which clinicians serve patients. CMS notes these codes could be used in measuring the

costs of care. As deemed appropriate, CMS can also require clinicians to submit these codes with claims submitted starting on Jan. 1, 2018.

As required by MACRA, CMS has followed an iterative process that began in mid-2016 to develop and solicit input on the patient relationship categories and codes. The process is described in greater detail in a document posted to CMS's QPP website. In the proposed rule, CMS solicited comment on whether the following five "operational categories" appropriately capture the relationships between patients and clinicians:

- Continuous/broad Services: Clinicians who provide the principal care for a patient, with no planned endpoint of the relationship. Services in this category represent comprehensive care that deals with the entire scope of patient problems, either directly or in a care coordination role (e.g., primary care services and specialists providing comprehensive care to patients).

- Continuous/focused Services: Clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time (e.g., a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services).

- Episodic/broad Services: Clinicians who have broad responsibility for the comprehensive needs of the patients that is limited to a defined period and circumstance, such as a hospitalization (e.g., a hospitalist providing comprehensive and general care to a patient during a hospital stay).

- Episodic/focused Services: Clinicians who provide time-limited care. The patient has a problem-acute or chronic-that will be treated with surgery, radiation, or some other type of generally time-limited intervention (e.g., an orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period).

- Only as Ordered by Another Clinician: Clinicians who furnish care to the patient only as ordered by another clinician. CMS intends this category to be used for patient relationships that may not be adequately captured in the four categories described above (e.g., a radiologist interpretation of an imaging study ordered by another clinician).

In general, the comments regarding the categories were positive. Some commenters noted that these categories would be difficult to apply to certain specialties, to which CMS responded that the categories are broad enough to be widely applicable. Other commenters voiced concerns regarding the administrative burden of adding modifiers to the coding process.

As proposed, CMS will translate the five operational categories above into Healthcare Common Procedure Coding System (HCPCS) Level II modifiers that can be *voluntarily*

reported by clinicians with claims starting on Jan. 1, 2018. CMS acknowledged the potential administrative burden that may come with the introduction of these modifiers and emphasized the importance of the voluntary reporting approach. CMS states that this approach will provide the agency with information about the codes, allow for a long period of education and outreach to clinicians on the use of the codes and inform its ability to refine the codes as necessary.

CMS also noted that the MACRA requires any necessary revisions to the list of patient relationship categories and codes to be made by November 1st of each year, starting in 2018. CMS will engage with stakeholders through webinars, listening sessions, focus groups and targeted outreach to specialties and practice management organizations to gather feedback on the categories and modifiers.

OTHER FINALIZED CHANGES FOR CY 2018

Appropriate-use Criteria (AUC) for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act (PAMA) requires CMS to establish a program that promotes AUC for advanced diagnostic imaging. The statute requires that, beginning Jan. 1, 2017, payment may be made to the furnishing professional for an applicable advanced diagnostic imaging service only if the claim indicates that the ordering professional consulted with a qualified clinical decision support mechanism (CDSM) as to whether the ordered service adheres to applicable AUC. This policy applies only when applicable imaging services are provided in specific settings – a physician's office, hospital outpatient department (including an emergency department), an ambulatory surgery center and any other provider-led outpatient setting as determined by CMS. CMS took initial steps to implement this policy in the CY 2016 PFS rule by defining AUC and specifying the process for developing them. In the CY 2017 PFS rule, CMS finalized a definition of and requirements for CDSMs. CMS released the first qualified CDSMs on July 13, 2017, coinciding with the release of the CY 2018 PFS proposed rule.

In the CY 2018 final rule, CMS finalized a voluntary period from July 2018 to December 2019 for early adopters of AUC to report limited consultation information on Medicare claims forms. CMS states that during the voluntary reporting period, the consultation of specified AUC through a qualified CDSM and reporting of AUC consultation information will be optional. During this period, CMS will evaluate a simplified method of reporting using a single modifier and will work with stakeholders to explore using a standardized unique AUC consultation identifier.

As urged by the AHA, CMS delayed until January 1, 2020 the start date of the educational and operations testing period for AUC, which will extend through December 31, 2020. CMS stated that during the education and operations testing period, the agency will continue to pay claims whether or not they correctly include AUC information. CMS intends to use the educational and operations testing period to make

needed adjustments to the program as well as identify any needs for further guidance and education. CMS will also explore a plan to provide feedback and education to practitioners and engage stakeholders during the voluntary educational and operations testing periods. **The AHA urged CMS to allow providers adequate time to implement the AUC requirements before they begin impacting payment and supports the finalized policy.**

In an effort to align the AUC program with the Quality Payment Program (QPP), CMS stated that the CY 2018 QPP final rule finalized the availability of MIPS credit in the Improvements Activities Category for eligible clinicians for consulting specified applicable AUC (1) through a qualified CDSM for all applicable imaging services furnished in an applicable setting, (2) paid for under an applicable payment system, and (3) ordered on or after January 1, 2018.

CMS did not finalize proposed changes to significant hardship exceptions for AUC ordering professionals. CMS stated that during the voluntary reporting period the workflows of ordering and furnishing professionals will be considered along with the ability to apply statutorily available relief to ordering professionals and will be considered in CY 2019 rulemaking.

Changes to Site-neutral Payment Policy for Off-campus Provider-based Departments (PBDs)

Section 603 of the Bipartisan Budget Act of 2015 (BiBA) requires that services furnished in off-campus PBDs that began billing under the outpatient prospective payment system (OPPS) on or after Nov. 2, 2015 (referred to as "nonexcepted services") are no longer paid under the OPPS. Instead, these services are covered and paid under "another applicable Part B payment system." Emergency department (ED) services as well as services provided in outpatient departments meeting the additional "under development" exception in the 21st Century Cures Act are exempt. For CY 2017, CMS finalized the PFS as the applicable Part B payment system for most of nonexcepted services and set payment for most nonexcepted services at 50 percent of the OPPS rate.

Establishment of a Final Payment Rate for Nonexcepted Services in CY 2018. In the CY 2018 PFS final rule, **CMS reduced the site-neutral payment rate from 50 percent of the OPPS rate to 40 percent of the OPPS rate for most nonexcepted services.** The agency estimated that this change will save Medicare Part B $12 million in 2018 compared to 2017.

This final rule policy is a departure from the 25 percent of the OPPS payment rate that CMS had proposed for 2018 (referred to as a "PFS Relativity Adjuster" of 25 percent). The proposed CY 2018 PFS Relativity Adjuster of 25 percent was calculated based on a code-level comparison of the payment for a single hospital outpatient department service, the hospital outpatient clinic visit (the most commonly billed service in off-campus PBDs) and to the weighted average difference between the nonfacility and

facility PFS payment for outpatient visits in hospital outpatient departments. However, in establishing its final policy, CMS agreed with the AHA's expressed concern about the proposed payment rate for 2018 being based on a single code level comparison. In addition, CMS acknowledged that the proposed PFS Relativity Adjuster of 25 percent of the OPPS rate may be too low. The agency also agreed with commenters who expressed concern that it failed to account for the much greater packaging of payments for services under the OPPS compared to the PFS, but noted it is unable to fully calculate the effect of packaging under the OPPS.

CMS arrived at its final payment rate of 40 percent of the OPPS rate by comparing the payment rates under the PFS and OPPS for an updated list of the 22 most frequently billed major HCPCS codes with a "PO" modifier (signifying that the service was billed by an off-campus PBD that is not an ED), including the hospital outpatient clinic visit, which is reported using HCPCS code G0463. Table 10 in the final rule shows the services and data used in calculating the 2017 PFS Relativity Adjuster. The resulting utilization-weighted average comparison between the PFS and the OPPS is 35 percent. That is, the applicable payment amount under the PFS is 35 percent of the amount that would have been paid under the OPPS for these commonly billed services. CMS stated that because it is unable to fully calculate the effects of packaging under the OPPS, it believes it is appropriate to adjust the 35 percent calculation upwards to a 40 percent PFS Relativity Adjuster.

CMS also clarified that drugs and biological products that are unconditionally packaged under the OPPS will continue to be packaged when furnished in a nonexcepted off-campus PBD. Drug administration services subject to conditional packaging (identified by status indicator "Q1" under the OPPS) will be packaged under the OPPS if the relevant criteria are met; otherwise, they are separately paid. Drugs and biological products that are separately payable under the OPPS (identified by status indicator "G" or "K" under the OPPS) are paid consistent with payment rules in the physician office setting. **In addition, drugs that are acquired under the 340B program and furnished by nonexcepted off-campus PBDs are paid under the PFS and are therefore not subject to the OPPS drug payment reductions.**

Other Site-neutral Payment Policies. CMS made no additional changes to its site-neutral policy in CY 2018. This includes retaining its problematic policy that the relocation of an existing PBD will result in it losing its excepted status and being paid at the site-neutral rate, except in extraordinary circumstances. Further, for CY 2018, CMS continues policies under which:

- Hospitals bill on the institutional claim (UB04/837I) using the claim line modifier "PN" to indicate that the service is a nonexcepted item or service
- The geographic adjustments used under the OPPS will apply to nonexcepted payments
- The following OPPS payment adjustments are not applied to nonexcepted services: outlier payments, the rural SCH adjustment, the cancer hospital adjustments, transitional outpatient payments, the hospital outpatient quality

reporting (OQR) payment adjustment, and the inpatient hospital deductible cap to the cost-sharing liability for a single hospital outpatient service
- Nonexcepted hospital partial hospitalization (PHP) program services will be paid at the community mental health center (CMHCs) per diem rate
- The supervision rules that apply for hospitals will apply for nonexcepted services in off-campus PBDs
- Beneficiary cost-sharing rules that apply under the PFS apply for all nonexcepted items and services furnished by off-campus PBDs, regardless of the cost-sharing obligation under the OPPS.

For more detail on the final Medicare off-campus PBD site-neutral policies, see the CY 2017 OPPS final rule.

Payment in CY 2019 and Future Years. CMS continues to believe that by enacting Section 603 of the BiBA, Congress intended to eliminate the Medicare payment incentive for hospitals to purchase physician offices, convert them to off-campus PBDs and bill under the OPPS for services they furnish there. Therefore, the agency still intends that its payment policy ultimately equalize payment rates between nonexcepted off-campus PBDs and physician offices to the greatest extent possible, while allowing nonexcepted off-campus PBDs to bill in a straight-forward way for services they furnish.

CMS stated that its current approach does not result in payment rates being equal on a procedure-by-procedure basis, but rather only moves toward equalizing payment rates in the aggregate between physician offices and nonexcepted off-campus PBDs. Therefore, for certain specialties, service lines, and nonexcepted off-campus PBD types, total Medicare payments for the same services might be either higher or lower when furnished by a nonexcepted off-campus PBD rather than in a physician office. CMS remains concerned that such specialty-specific patterns in payment differentials could result in continued incentives for hospitals to buy certain types of physician offices and convert them to nonexcepted off-campus PBDs. However, continuing a policy similar to the one finalized will allow hospitals to continue billing through a facility claim form and allow for continuation of the other OPPS-like policies more suitable for hospital outpatient departments.

Therefore, for CY 2019 and for future years, CMS intends to examine updated claims data[1] in order to determine not only the appropriate PFS Relativity Adjuster, but also whether additional adjustments to the methodology are appropriate. The agency's goal is to attain site-neutral payments that promote a level playing field under Medicare between physician office settings and nonexcepted off-campus PBD settings, without regard to the kinds of services furnished by particular off-campus PBDs.

New Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

[1]A full year of claims data regarding the mix of services reported using the "PN" modifier (from CY 2017) will first be available for use in PFS rate-setting for CY 2019.

RHCs are paid an all-inclusive rate for medically necessary medical and mental health services and qualified preventive health services furnished on the same day (with some exceptions). FQHCs are paid under the FQHC prospective payment system (PPS), based on the lesser of the FQHC PPS rate or their actual charges. In the CY 2016 PFS final rule, CMS finalized a policy that allows RHCs and FQHCs to receive an additional payment for chronic care management (CCM) services outside of the RHC and FQHC payment methodologies. Now, in an effort to ensure that RHC and FQHC patients have access to the new CCM services included in the PFS, CMS established two new codes for use by RHCs and FQHCs, effective for services provided on or after Jan. 1, 2018.

First, CMS created a new general care management code, GCCC1, for RHCs and FQHCs. The payment amount will be set at the average of the three national non-facility PFS payment rates for the CCM and general behavioral health integration (BHI) codes and updated annually based on the PFS amounts. The three codes are:

- 20 minutes or more of CCM services (99490)
- At least 60 minutes of complex CCM services (99487)
- 20 minutes or more of BHI services (G0507)

RHCs and FQHCs should bill using GCCC1 when the requirements for any of these three codes are met. GCCC1 may be billed alone or in addition to other services furnished during the RHC or FQHC visit. However, it may only be billed once per month per beneficiary and cannot be billed if other care management services (such as transitional care management or home health care supervision) are billed for the same time-period. Additional detail on how RHCs and FQHCs may use code GCCC1 begins on page 53172 of the final rule.

Second, CMS created a psychiatric collaborative care model (CoCM) code for RHCs and FQHCs, GCCC2. The payment for this code will be set at the average of the two national non-facility PFS payment rates for CoCM codes, to be updated annually based on the PFS amounts. The two codes are:

- 70 minutes or more of initial psychiatric CoCM services (G0502)
- 60 minutes or more of subsequent psychiatric CoCM services (G0503)

RHCs and FQHCs should bill using GCCC2 when the requirements for either of these codes are met. GCCC2 may be billed alone or in addition to other services furnished during the RHC or FQHC visit. However, to prevent duplication of payment, this code may only be billed once per month per beneficiary and cannot be billed if other care management services, including the finalized GCCC1 code, are billed for the same time period. Additional detail on how RHCs and FQHCs may use code GCCC2 begins on page 53175 of the final rule.

Medicare Electronic Health Record (EHR) Incentive Program

CMS finalized the reporting requirement for eligible physicians (EPs) and groups that electronically reported clinical quality measures in the PQRS program for the 2016 reporting period and whose submissions met the quality measure reporting requirements of the EHR Incentive Program. Specifically, CMS finalized that reporting six electronic clinical quality measures (eCQMs) for the Medicare EHR Incentive Program without a domain requirement satisfies the 2016 PQRS reporting requirement as well as the MACRA QPP transition year reporting requirement. EPs and groups that satisfy the revised reporting criteria and other Medicare EHR Incentive Program requirements may avoid the downward payment adjustment in 2017 and/or 2018 depending on the EP's or group's applicable EHR reporting period. CMS stated that EPs and groups that successfully met the previously finalized reporting requirements would continue to have the status of successful reporters. CMS did not finalize changes for EPs reporting clinical quality measures as part of the Medicaid EHR Incentive Program.

Medicare Shared Savings Program (MSSP)

CMS finalized a number of changes to the MSSP aimed to better account for primary care services when assigning beneficiaries to an accountable care organization (ACO), reduce the application burden for ACOs and better align the quality reporting program with the MACRA QPP. Below is a summary of key changes.

Accounting for RHC and FQHCs in Beneficiary Assignment. CMS finalized, as proposed, its revisions to the assignment policies for services furnished in RHCs and FQHCs. Specifically, beginning in performance year 2019, CMS will no longer require ACOs that include an RHC or FQHC to attest to specific physicians' provision of primary care services. Rather, for the purpose of assigning beneficiaries to ACOs, CMS will treat *any* service reported by an RHC or FQHC as if it were a primary care service performed by a primary care physician.

Definition of Primary Care Services. CMS also finalized, without modification, its proposed additions to the definition of primary care services, including three new codes for chronic care management (99487, 99489, G0506) and four codes for behavioral health integration (G0502, G0503, G0504, G0507). For performance year 2019 and beyond, these services will factor into the calculation of the amount of primary care provided for purposes of beneficiary assignment.

Reducing MSSP Application Burden. CMS finalized its proposal to streamline certain documentation and certification requirement components of the MSSP program application and the application for Track 3 ACOs seeking a waiver of the skilled nursing facility (SNF) three-day stay rule. Specifically, CMS eliminated from the SNF waiver application the requirement of a narrative describing financial relationships between ACOs, SNF affiliates and acute care hospitals as well as documentation demonstrating that each SNF on an ACO's list of affiliates has an overall rating of three or more stars

under the CMS 5-star Quality Rating System. CMS also eliminated certain requirements for the submission of specific documents and narratives as part of an ACO's initial MSSP application but retained the right to request such information if it were needed to fully assess the ACO's program eligibility.

Web interface measures. CMS finalized as proposed its regulatory amendment to reserve the right for the agency to re-designate a measure as pay-for-reporting when a substantive change to a CMS web interface measure that is used to assess quality performance under the MSSP is made under the QPP program.

Validation of ACO Quality Data Reporting. CMS finalized, without modification, the following changes to ACO quality data reporting rules and requirements:

- Reduction of the match rate threshold from 90 percent to 80 percent, such that if an ACO has a match rate below 80 percent, absent unusual circumstances, CMS will adjust the ACO's overall quality score proportional to the ACO's audit performance;

- Replacement of the previous methodology used to calculate an ACO's audit-adjusted quality score under which CMS multiplied the ACO's overall quality score by the ACO's overall audit match rate with a new methodology whereby CMS reduces an ACO's overall quality score by one percent for each percentage point difference between the ACO's audit match rate and the 80 percent match rate threshold; and

- Implementation of a conforming change to reflect the 80 percent match rate threshold for potentially requiring a corrective action plan.

Medicare Diabetes Prevention Program (MDPP) Model

CMS finalized several elements of the permanent expansion of the MDPP, including an effective start date of April 1, 2018 for furnishing MDPP services:

- Covered Services. CMS finalized the MDPP Services Period as consisting of one year of core services (comprised of six months of core sessions and an additional six months of core maintenance sessions) and one year of ongoing maintenance services. CMS had originally proposed limiting its coverage of ongoing maintenance sessions to a two-year period, but agreed with commenters that requiring one year of ongoing maintenance rather than two years reduced the administrative burden and financial risk to MDPP suppliers.

- Beneficiary Eligibility. CMS finalized its proposal, without modification, that beneficiaries who are diagnosed with diabetes after the date on which they attend their first core session will remain eligible to continue receiving MDPP services.

- Supplier Payment. CMS also finalized its proposal to use a performance-based payment methodology with periodic payments tied to beneficiaries' achievement of performance goals, including weight loss associated with reduced incidence of Type 2 diabetes and attendance at a specified number of MDPP sessions. However, because CMS shortened the period of covered services from a total of three years to a total of two years, the agency also reduced the total maximum payment per beneficiary from $810 to $670, but increased the percentage of that payment available during the first 12 months of MDPP services (the "core services period"). To reduce burdens on MDPP suppliers, CMS also reduced the number of core maintenance sessions that beneficiaries must attend for MDPP suppliers to receive a performance payment for the core maintenance portion of the program, from three sessions to two during a three-month interval. Once the required minimum weight loss is achieved and the 12-month core services period ends, suppliers will receive three-month interval performance payments for ongoing maintenance sessions (again, provided beneficiaries attend at least two out of three ongoing maintenance sessions in a three-month interval). However, those payments will be made only when beneficiaries maintain the required weight loss. Finally, MDPP suppliers will receive an additional weight loss performance payment for beneficiaries that achieve additional specified weight loss.

- Beneficiary Incentives. CMS finalized rules allowing MDPP suppliers to provide in-kind patient engagement incentives to promote improved beneficiary health and reductions in Medicare spending. CMS finalized as proposed the requirements that the incentive must be reasonably connected to the curriculum taught by the MDPP supplier and be a preventive item or service, or an item or service that advances a clinical goal for an MDPP beneficiary. CMS added one additional requirement that the cost of the item or service furnished as a beneficiary engagement incentive must not be shifted to an MDPP beneficiary.

- Virtual DPP Services. CMS declined to finalize any policies related to MDPP services furnished 100 percent virtually, but rather is considering a separate model to test and evaluate virtual DPP services.

CMS also finalized policies and procedures related to supplier application and enrollment in the MDPP.

FURTHER QUESTIONS

Please contact Shira Hollander, senior associate director for payment policy, at (202) 626-2329 or shollander@aha.org with further questions.