

July 25, 2016

## MEDICARE PHYSICIAN FEE SCHEDULE: PROPOSED RULE FOR CY 2017

### *AT A GLANCE*

#### **At Issue**

On July 7, the Centers for Medicare & Medicaid Services (CMS) released its [proposed rule](#) for calendar year (CY) 2017 with changes to the Medicare physician fee schedule (PFS) and other revisions under Medicare Part B. In addition to the standard update to PFS payment weights and rates, the rule would:

- Expand payment for telehealth services to include certain end-stage renal disease-related services and advanced care planning;
- Provide for reimbursement of new primary care, care management and behavioral health services;
- Continue implementation of appropriate use criteria for advanced diagnostic imaging;
- Implement voluntary beneficiary alignment for attribution to an accountable care organization (ACO) in the Medicare Shared Savings Program (MSSP);
- Allow individual eligible professionals participating in MSSP to report quality data separately for the purposes of the Physician Quality Reporting System (PQRS) and to have that data used in PQRS in the event the MSSP ACO fails to report quality data.
- Updates the informal review process used in the physician value-based payment modifier program.

Changes proposed in the rule generally would be effective Jan. 1, 2017.

#### **Our Take:**

The AHA is pleased by a number of CMS's proposals, including new codes and payment for primary care and behavioral health care management services, and a measured approach to implementation of appropriate use criteria for advanced diagnostic imaging. In particular, the agency's proposed expansion of the list of approved telehealth services is a step in the right direction. However, we continue to urge the agency to take a more expansive approach toward coverage for telehealth services.

#### **What You Can Do:**

- ✓ Share this advisory with your chief medical officer, chief financial officer and other members of your senior management team, key physician leaders and nurse managers.
- ✓ Assess the potential impact of the proposed payment changes on your Medicare revenue and operations.
- ✓ Consider submitting comments by Sept. 6 to CMS to provide your feedback about the proposed policies and issues on which comment is requested.

#### **Further Questions:**

Contact Melissa Myers, senior associate director for policy, at (202) 626-2356 or [mmyers@aha.org](mailto:mmyers@aha.org).



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## **BACKGROUND**

On July 7, the Centers for Medicare & Medicaid Services (CMS) released its proposed rule for calendar year (CY) 2017 with changes to the Medicare physician fee schedule (PFS) and other revisions under Medicare Part B. The proposed rule was [published](#) in the July 15 *Federal Register*. Comments are due to CMS by Sept. 6. A final rule will be issued around Nov. 1, and changes generally will be effective Jan. 1, 2017.

## **CHANGES TO THE CY 2017 PFS**

### ***Conversion Factor***

CMS proposes a total decrease in payment rates of 0.08 percent in CY 2017. This includes an increase of 0.5 percent as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as a budget neutrality decrease of 0.58 percent. These adjustments result in a proposed conversion factor of \$35.7751 for CY 2017.

### ***Geographic Practice Cost Indices (GPCIs)***

Current law requires that CMS review and, if necessary, adjust the GPCIs at least every three years; the last update was made in CY 2014. CMS proposes to update the GPCIs for CY 2017 using more recent data. Statute requires that when more than one year has elapsed since CMS last updated the GPCIs, the next update must be phased in over two years by applying one half of the update in the first year and the remainder in year two. Therefore, CMS has proposed GPCIs for CY 2017 and CY 2018 in Addendum E of the rule, available at the agency's [PFS website](#).

In addition, by law, the current 1.0 work GPCI floor will expire on Dec. 31. The 1.5 work GPCI floor for Alaska and the 1.0 practice expense GPCI floor for the frontier states (defined as Montana, Nevada, North Dakota, South Dakota and Wyoming) are permanent and, thus, applicable for CY 2017.

### ***Payment for X-ray Imaging***

The Consolidated Appropriations Act of 2016 requires a 20 percent reduction in payment amounts under the PFS for the technical component of X-ray imaging taken using film (including when billed as a global service), beginning in CY 2017. To implement this provision, CMS proposes to create a modifier ("XX"), which must be listed on claims for X-rays taken using film, and to apply the payment reduction when the modifier is used.

### ***Multiple Procedure Payment Reduction (MPPR) for Imaging***

CMS is required by statute to reduce payment when multiple imaging procedures are performed by the same physician to the same patient, in the same session, on the same day (known as an MPPR). Specifically, CMS makes full payment for the highest-price imaging service and reduces payment for subsequent imaging services. CMS proposes to implement a provision of the Consolidated Appropriations Act of 2016 that revises the payment reduction from 25 percent to 5 percent, effective Jan. 1, 2017.

### ***Data Collection on Global Surgical Packages***

In the CY 2015 PFS rule, CMS expressed concerns about the accuracy of global surgery packages and finalized a policy that would have transitioned all 10-day and 90-day global surgery packages to zero-day global periods by 2018. The MACRA prohibited CMS from implementing this policy; instead, CMS must maintain the 10-day and 90-day global surgery packages. The MACRA also required CMS to establish through notice-and-comment rulemaking a process (to begin by Jan. 1, 2017) to gather from physicians information needed to more accurately value surgical services. CMS proposes a three-pronged approach:

- Comprehensive claims-based reporting on the number and level of pre- and post-operative visits furnished for 10- and 90-day global services. Specifically, CMS would require providers of services that are part of a surgical package to report new codes that identify post-operative services provided. The codes would be reported in 10-minute increments and would distinguish by setting (inpatient versus outpatient or in the physician's office) and whether the service was provided by a physician/non-physician practitioner or clinical staff.
- A survey of a representative sample of practitioners about the activities and resources used for pre- and post-operative visits.
- An in-depth study that would include direct observation of the pre- and post-operative care delivered in a small number of sites, including accountable care organizations (ACOs).

Beginning in 2019, the MACRA requires CMS to use these data to improve the accuracy of the valuation of surgical services in the PFS.

### ***Payment for Primary Care and Care Management Services***

New Services. In the proposed rule, CMS acknowledges that current evaluation and management (E/M) office and outpatient visit Current Procedural Terminology (CPT) codes may not reflect all of the services and resources required to furnish certain types of care – particularly comprehensive, coordinated care management for certain categories of Medicare beneficiaries. The agency thus proposes to create new codes to

pay for certain primary care, care management and cognitive services beginning in CY 2017. Specifically, the agency proposes the following new codes:

- GPPP6: This code would cover the billing practitioner's time spent assessing and creating a care plan for patients with cognitive impairment. It would include cognition-focused evaluation; functional assessment, including decision-making capacity; use of standardized instruments to stage dementia; medication reconciliation; evaluation for neuropsychiatric and behavioral symptoms, including depression; evaluation of safety, including motor vehicle operations, if applicable; identification of caregiver(s); advanced care planning and palliative care needs, if applicable; and creation of a care plan.
- GDDD1: CMS notes that valuation of E/M visits captures the resources associated with a "typical" E/M visit. However, when a beneficiary with a mobility-related disability receives such a visit, the resources required can exceed the typical visit. Practitioners therefore must choose whether to take the extra time necessary and to invest in the required specialized equipment for these visits, even though the payment rate does not account for it. This can lead to reduced access to care for beneficiaries with mobility-related disabilities. Therefore, the agency proposes a new G-code to pay for resource-intensive services for patients who require use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts and adjustable padded leg supports) during an E/M visit. This would be an add-on code that could be billed with new and established patient office/outpatient E/M codes, as well as transitional care management (TCM) codes.

In addition, the agency proposes to pay for CPT codes 99358 and 99359, for prolonged E/M services before and/or after direct patient care. The agency states this would better account for the additional resource costs of physicians and other practitioners when they spend time caring for the individual needs of their patients outside the in-person office visit.

Changes to Chronic Care Management (CCM) Payment. Since CMS implemented payment for CCM in the CY 2015 PFS, the agency has received significant stakeholder feedback that the services are underutilized because they involve burdensome service and billing requirements and are underpaid relative to the resources required. Therefore, CMS proposes several changes to CCM services. Specifically, the agency proposes to pay for new codes for complex CCM services (99487 and 99489). These codes, like the existing code for CCM (99490), could only be reported once per calendar month, and only by a single practitioner who provides care management for the beneficiary in that month. CMS notes that 99487 (initial complex CCM services) requires at least 60 minutes of clinical staff time during the month, and 99489 (subsequent CCM services) requires at least 30 minutes of clinical staff time. The agency proposes that these codes would have the same scope of service requirements as the existing CCM code.

In addition, to reduce the administrative burden associated with CCM services, CMS proposes the following changes to the CCM scope of service requirements:

- **Initiating visit:** CMS proposes to require that an initiating visit must precede billing for CCM services only for new patients or patients not seen within a year, rather than for all beneficiaries receiving CCM services. This would allow practitioners with existing patient relationships to initiate CCM services without a potentially unnecessary E/M visit. In addition, the agency proposes to pay for a new G-code, GPPP7 (Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring CCM services). This code would be billed as an add-on to the code billed for an initiating visit, and would cover additional work by the billing practitioner (beyond what is described in the code for the initiating visit) to perform a face-to-face assessment of a beneficiary requiring CCM services and to perform CCM care planning.
- **24/7 access to care:** CMS proposes to remove the requirement that practices providing CCM services must make the care plan available remotely to other professionals providing CCM services after-hours. CMS acknowledges stakeholder feedback that there are many models for providing after-hours care (such as arrangements between physician practices and other providers, extended office hours, physician call-sharing and telephone triage systems) and that 24/7 access to the care plan may not be feasible for all of them. Instead, CMS proposes to require that the practice must provide to physicians or other professionals/clinical staff and patients/caregivers the means to contact health care professionals in the practice to address urgent needs, regardless of the time of day or day of the week.
- **Electronic care plan:** CMS proposes to remove the current requirement that access to the electronic care plan be available on a 24/7 basis, but instead to require timely electronic sharing of care plan information within and outside the billing practice. Further, the agency proposes that transmission of the care plan by fax would satisfy this requirement.
- **Clinical summaries:** CMS proposes to modify the requirement that the billing practitioner who transitions a patient to another setting or provider of care, or refers the patient to another provider must provide electronically a clinical summary for each transition or referral. Based on stakeholder feedback, the agency has decided not to require the use of any specific technology. Instead, CMS proposes that the practitioner must create and timely exchange/transmit “continuity of care documents,” with no specific requirement on how the exchange or transmittal must occur.
- **Beneficiary receipt of care plan:** CMS proposes to modify the current requirement that the beneficiary must be provided with a hard copy or electronic

copy of the care plan. Instead, the agency would require the beneficiary or caregiver be provided with a copy of the care plan, without specifying the format.

- **Beneficiary consent:** CMS proposes to remove the requirement that the billing practitioner obtain a written agreement from the beneficiary to receive CCM services. Instead, the practitioner may note in the medical record that information regarding CCM services was provided to the beneficiary and whether the beneficiary accepted or declined CCM services.
- **Documentation:** CMS proposes to remove the requirement that billing practitioners use a qualifying certified electronic health record (EHR) to document certain information regarding the beneficiary's psychosocial needs and functional deficits and beneficiary consent. Instead, that information may be documented in the medical record.

CMS provides a complete overview of the CCM scope of service requirements and proposed modifications in Table 11 (pg. 46211 of the proposed rule).

### ***Behavioral Health Integration***

Psychiatric Collaborative Care Model (CoCM). CMS proposes to create three new G-codes (GPPP1, GPPP2, GPPP3) to pay for services provided under a psychiatric CoCM, beginning Jan. 1, 2017. A CoCM is a primary care team consisting of a primary care provider and a behavioral health care manager who work in collaboration with a psychiatric consultant, such as a psychiatrist. The behavioral health care manager – who must be a member of the treating physician's clinical staff with formal education or specialized training in behavioral health – furnishes services both face-to-face and non-face-to-face, and consults with the psychiatric consultant at least weekly. The psychiatric consultant does not typically see the patient or prescribe medications, except in rare circumstances. The treating physician directs the behavioral health care manager and continues to oversee the patient's care, including prescribing medications, treating medical conditions and referring to specialty care when needed.

CoCM services are provided when a patient has a diagnosed psychiatric disorder that requires a behavioral health assessment; establishment, implementation, revision or monitoring of a care plan; and provision of brief interventions. CMS notes that appropriate candidates for CoCM services are those who have newly diagnosed conditions; need help engaging in treatment; have not responded to standard care delivered in a non-psychiatric setting; or require further assessment and engagement prior to consideration of referral to a psychiatric care setting. CoCM services are treated as an episode of care that begins when the behavioral health care manager engages in care of the patient and ends with either attainment of targeted treatment goals; failure to attain targeted treatment goals, culminating in referral to a psychiatric care provider for ongoing treatment; or lack of continued engagement by the patient, with no CoCM services provided over a consecutive six-month period.

CMS notes that the CPT Panel has developed three new codes that parallel these new G-codes, but that the CPT codes will not be ready for valuation in CY 2017. The agency notes that the proposed G-codes are intended to be temporary codes, and that it will consider whether to adopt and establish values for the new CPT codes, likely for CY 2018.

General Behavioral Health Integration. CMS also proposes a new G-code (GPPPX) to pay for care management costs incurred by primary care practices that treat patients with behavioral health conditions under behavioral health integration (BHI) models other than the CoCM. The agency proposes to require an initiating visit that would establish the beneficiary's relationship with the billing practitioner and ensure the practitioner assesses the patient before initiating care management. CMS also proposes that the billing practitioner must obtain a general beneficiary consent, which would give the practitioner permission to consult with relevant specialists, including a psychiatric consultant. The agency is not proposing a specific consent for BHI services out of concern that such a requirement could reduce access due to stigma associated with behavioral health conditions.

### **Medicare Telehealth Services**

New Telehealth Services. CMS proposes to add several services to the list of Medicare-payable telehealth services:

- *End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day (90967, 90968, 90969, 90970).* CMS notes that the required clinical examination of the catheter access site must be furnished in person by a physician or other practitioner.
- *Advanced care planning (99497, 99498).* CMS began paying for these codes in the CY 2016 PFS and now proposes to add them to the list of telehealth services.
- *Critical care consultations (new codes GTTT1 and GTTT2).* In CY 2015, CMS received stakeholder requests to add E/M codes for critical care services to the list of telehealth-approved services. In the CY 2017 proposed rule, the agency notes that the critical care E/M codes include services that are not furnished by telehealth (such as gastric intubations and vascular access), and therefore are not appropriate for payment as telehealth services. However, it also acknowledges the potential benefit of critical care consultation services that are furnished remotely. Therefore, the agency proposes to create and pay for two new codes for critical care consultations. Such consultations would be provided to critically ill patients when a qualified health professional has in-person responsibility for the patient but the patient would benefit from additional services from a distant-side consulting practitioner specially trained to provide critical care services.

Clarification of Telehealth Payment. CMS also received requests from stakeholders to create a telehealth point-of-service (POS) code that practitioners who provide services



to patients remotely via telehealth would use to identify such services as telehealth. The agency notes that currently, there is confusion among practitioners regarding whether to report the POS where the patient or practitioner is located. As a result, there is inconsistency in whether practitioners receive the facility or non-facility rate under the PFS.<sup>1</sup> The telehealth POS code would be used for all telehealth services.

In response, CMS notes that the process for establishing POS codes is managed by its POS Workgroup and is outside the PFS rulemaking process. However, the agency now proposes payment rules that would apply to a telehealth POS code, with the expectation that such a code would be used as early as Jan. 1, 2017. Specifically, CMS proposes that when the telehealth POS code is used, the practitioner providing telehealth services would be paid the facility rate for those services.

## **PROPOSED CHANGES TO QUALITY PROGRAMS**

The agency proposes only minor changes to the Physician Quality Reporting System (PQRS) and value-based payment modifier (VM) programs that would affect payment in CYs 2017 and 2018. As required by the MACRA, CY 2018 is the final year for both the PQRS and the VM, which will be supplanted by the new two-track physician Quality Payment Program (QPP) beginning with CY 2019 payments. Additional resources on the MACRA and the QPP – including the proposed rule implementing the QPP – can be found at [www.aha.org/MACRA](http://www.aha.org/MACRA).

### ***PQRS Participation for Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) Participants***

Current MSSP regulations do not permit eligible professionals (EPs) in MSSP ACOs to participate in PQRS separately from their ACO. That is, EPs in ACOs may not submit their own quality data and receive their own PQRS payment adjustments. However, this policy means that if the ACO fails to submit quality data, EPs would automatically be subject to a negative payment adjustment. Thus, for CYs 2017 and 2018, CMS proposes to allow individual EPs participating in MSSP to report quality data separately for the purposes of PQRS, and to have that data used in PQRS in the event their MSSP ACO fails to report quality data. The EPs could participate in PQRS either as individual EPs or using the group practice reporting option (GPRO).

In the proposed rule, CMS notes that the performance period (CY 2015) and data submission deadlines (generally on or about March 31, 2016) for the CY 2017 PQRS payment adjustments have passed. To minimize duplicative reporting, CMS proposes that the reporting period and deadlines for EPs wishing to submit separate measure data for CY 2017 payment adjustment would be the same as those of the CY 2018 PQRS program. That is, the affected groups and EPs would submit performance from

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<sup>1</sup> The facility rate generally is lower than the non-facility rate, as it adjusts for the fact that physicians who practice in a facility setting typically do not have the same overhead outlays as those who practice in a non-facility setting. Instead, the facility bears responsibility for overhead.

CY 2016 by CMS's established deadline (generally in March 2017). All measure reporting options would be available, except for claims-based reporting, the CMS web interface and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS survey.

CMS further notes that any EPs in ACOs that failed to submit data for CY 2017 payment adjustments should expect to receive the -2.0 percent payment reduction mandated by the PQRS until CMS verifies that they have successfully submitted data for the CY 2018 PQRS program.

### ***Physician Value-based Payment Modifier***

#### Application of VM to MSSP ACO Participants whose ACOs Fail to Submit Data.

Consistent with the proposed policy for PQRS outlined above, CMS proposes that if an MSSP ACO fails to submit quality data, individual EPs and group practices could use their separately submitted PQRS data for VM performance determination. CMS would apply all other existing VM scoring policies to determining the EP or group practice's performance.

Informal Review Process. CMS proposes a number of updates to the "informal review" process used in the VM that allows individual EPs and group practices to appeal CMS's determination of their VM performance. In previous rulemaking, CMS established policies in which it would attempt to re-calculate the quality and cost composite scores when the informal review process found errors in the calculation. However, CMS states that re-calculating the quality composite score is operationally complex and makes it difficult to meet timelines for applying payment adjustments.

As a result, for the CYs 2017 and 2018 VM, CMS proposes to revise its policies to reduce the amount of recalculation. The agency specifically outlines four scenarios of how VM performance scores could change as a result of an informal review. These scenarios are outlined in Table 38 of the proposed rule, and are described in more detail below.

- **Moving from VM Category 2 to Category 1.** Individual EPs and groups are considered to be in "Category 1" of the VM when they successfully meet PQRS reporting requirements. They are considered to be in Category 2 when they do not submit PQRS data, and are automatically subject to the maximum negative adjustment under the VM. Individual EPs and groups that successfully appeal a determination of being in Category 2 would have their quality composite score under the Quality Tiering Model (QTM) reclassified from "low" quality to average quality. CMS also would calculate a cost composite score for these groups.
- **Adding additional EPs to a group practice using individual PQRS data reporting options.** Under existing VM policies, group practices billing under a single tax identification number (TIN) are not required to use the GPRO, and can instead participate as individual EPs. To remain in Category 1 of the VM, CMS

requires that at least 50 percent of the TIN's EPs successfully report PQRS data. If an informal review finds that CMS did not include some EPs that successfully meet PQRS reporting requirements, CMS would apply the following approach:

- If the TIN was initially classified as low quality, CMS would reclassify it as average quality.
  - If the TIN was initially classified as average or high quality, its quality score would remain unchanged.
  - The initial cost composite would remain unchanged.
- **Widespread quality data issues.** In cases where there are systematic issues affecting multiple groups that make it impossible to calculate quality scores, CMS proposes to classify the individual or group practice as average quality. CMS would apply the following approach to the cost composite:
    - If the TIN is initially classified as “high” cost, the agency would reclassify it as average cost.
    - If the TIN is initially classified as average or low cost, the cost score would remain unchanged.
  - **Widespread claims data issues.** In cases where there are systematic issues with claims data affecting cost or quality scores, CMS proposes to apply the following approach:
    - Individual EPs and groups initially classified as low quality and high cost would be reclassified as average cost and average quality.

Individual EPs and group initially classified as average or high quality, and average or low cost would retain their initial classifications

## **OTHER PROPOSED CHANGES FOR CY 2017**

### ***Appropriate-use Criteria (ACU) 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 will be made only to the furnishing professional for an applicable advanced diagnostic imaging service 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 will apply only when applicable imaging services are provided in certain 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 this year's rule, CMS proposes a definition of, and requirements for, CDSM as "an interactive, electronic tool for use by clinicians that communicates AUC to the user and assists them in making the most appropriate treatment decision for a patient's specific clinical condition." The agency also proposes that qualified CDSMs must:

- Make available to ordering professionals specified applicable AUC that reasonably encompass the entire clinical scope of all priority clinical areas;
- Be able to incorporate specified applicable AUC from more than one qualified provider-led entity (i.e., an entity approved by the Department of Health and Human Services (HHS) to develop AUC);
- Make available specified applicable AUC and related documentation supporting the appropriateness of the applicable imaging service ordered;
- Clearly identify the appropriate use criterion consulted if the tool makes available more than one criterion relevant to a consultation for a patient's specific clinical scenario;
- Provide to the ordering professional a determination, for each consultation, of the extent to which an applicable imaging service is consistent with specified applicable AUC or a determination of "not applicable" when the mechanism does not contain a criterion that would apply;
- Generate and provide to the ordering professional certification or documentation of which qualified CDSM was consulted; the name and National Provider Identification (NPI) of the ordering professional who consulted the CDSM; and whether the service ordered would adhere to applicable AUC, would not adhere, or whether the AUC were not applicable;
- Be updated at least every 12 months to reflect revisions or updates to AUC sets or to individual appropriate use criterion;
- Meet privacy and security standards under applicable provisions of law; and
- Provide ordering professionals aggregate feedback in the form of an electronic report on an annual basis regarding their consultations with specified applicable AUC.

The agency proposes a timeline and process for CDSM developers to apply to CMS for review and approval. In addition, CMS proposes eight priority clinical areas for AUC implementation – chest pain, abdominal pain, headache, low back pain, suspected stroke, altered mental status, cancer of the lung, and cervical or neck pain. CMS notes that these clinical areas account for roughly 40 percent of Part B advanced diagnostic imaging services paid for by Medicare in 2014. Finally, the agency proposes exceptions to the AUC consultation and reporting requirements, including imaging for patients with an emergency medical condition; for inpatients for whom payment is made under Part A; and by ordering professionals who the Secretary determines on a case-by-case basis that consultation with AUC would result in a significant hardship, defined as those who are granted a hardship exception for purposes of the Medicare EHR Incentive Program.

CMS notes that it will not meet the statutory requirement that ordering professionals must

consult qualified CDSMs by Jan. 1, 2017. Under the timelines proposed in this rule, the first qualified CDSMs will be specified on June 30, 2017. The agency anticipates that furnishing professionals may begin reporting on AUC consulted by the ordering professional as early as Jan. 1, 2018.

### ***Medicare Advantage (MA)***

MA Provider and Supplier Enrollment. CMS proposes to require that all health care providers and suppliers that contract with an MA plan to provide items or services to Medicare beneficiaries be screened and enrolled in Medicare. The proposed policy would apply to both MA and MA prescription drug (MA-PD) network providers and suppliers, including first-tier, downstream and related entities; providers and suppliers participating in the Program of All-Inclusive Care for the Elderly (PACE); providers and suppliers participating in demonstration or pilot programs; and incident-to suppliers; among others. This proposal is consistent with a recent change in CMS policy that requires Medicaid managed care network providers and suppliers be enrolled with the state Medicaid program.

If finalized, CMS would assume a greater role in MA network oversight by screening providers and suppliers prior to their ability to serve Medicare enrollees and conducting ongoing oversight for purposes of protecting beneficiaries and the Medicare Trust Funds from potential fraud, waste and abuse. While CMS acknowledges that MA plans are already required to screen and monitor network providers, MA organizations are not required to review or consider the full scope of information that CMS considers when enrolling and monitoring providers, including provider/supplier adverse action histories and practice locations and ownership, among other data elements.

MA plans would be required to demonstrate compliance with this provision and would be subject to disciplinary actions, including sanctions and possible program termination if they do not comply. CMS offers MA organizations some protections due to challenges in knowing in advance whether an enrollee has sought care from an out-of-network provider or supplier that is not enrolled in Medicare. In these instances, CMS proposes to allow for a one-time payment with notification that no further payments shall be made.

Release of MA Bid Pricing Data. CMS proposes to publically release a subset of data from MA plans' annual bids to support future policymaking and public research. The dataset would include information on the plans' enrollment, revenue and expenses for claims, administration and gain/loss margin that are used to set a plan's rates for future years; projected allowed per member per month costs, unit costs and utilization by service type; projected enrollee cost-sharing; projected revenue requirements; and beneficiary rebates; among other data elements.

CMS proposes to exclude certain information from these datasets. Specifically, CMS proposes to not release any bid information for Part D prescription drug benefits or for PACE or duals-demonstration plans. The agency also proposes to exclude any narrative and supporting documentation, information identifying Medicare beneficiaries

or other individuals (e.g., actuaries who reviewed the bid submission), and information on financial arrangements with providers.

CMS proposes to release this information annually after the first Monday in October. As proposed, information released would be from bids that are at least five years old. CMS notes, however, that the actual experience data included in bids is delayed by two years. Therefore, any data that capture an MA plan's actual utilization, cost or other data would be at least seven years old at the time of release.

CMS requests comment on the scope of the data to be released and other factors the agency should consider in making bid data available. Specifically, CMS is interested in whether the proposal compromises MA plan competitiveness or would otherwise discourage plans from participating in the MA program. CMS also seeks comment on the time period for releasing bid data. The agency points to a 2013 opinion, *Biles v. HHS*, that compelled the agency to release MA bid data to a researcher and the public that was less than five years old. As such, CMS says that it will consider whether to make bid data available sooner than five years.

Release of MA and MA-PD Medical Loss Ratios (MLRs). CMS proposes to publically release a subset of data from MA plan sponsors' MLR submissions no earlier than 18 months after the end of the applicable contract year. The agency would publish data on how much of a plan sponsor's revenue is used to pay for clinical services, quality improvement activities, premium rebates and administrative expenses. CMS proposes to exclude any narrative portions of the MLR submission, competitively sensitive bid data, information identifying Medicare beneficiaries or other individuals (e.g., plan contacts), and correspondence between the plan sponsor and CMS regarding the MLR submission. This proposal is consistent with current rules and agency practice with regard to publication of commercial plan MLRs.

## **MSSP**

CMS proposes a number of changes to the MSSP quality reporting program, in part to align it with the recommendations of the Core Quality Measures Collaborative as well as measures proposed for the QPP under the MACRA. The agency also proposes a process to incorporate beneficiary preference into ACO attribution. Below is a summary of several key proposed changes.

Changes to the Quality Measure Set. CMS would add, replace, revise or retire numerous measures. Table 36 on page 46421 of the proposed rule provides a full list of the 31 measures that would be required in the program for the 2017 performance year and beyond if CMS's proposals are finalized. The table includes the pay-for-performance phase-in schedule for each measure. Proposed new measures would be pay-for-reporting for the 2017 and 2018 performance years.

*Measure Additions.* CMS proposes to add the following measures:

- ACO-12, Medication Reconciliation Post-Discharge. ACO-12 was previously included in the MSSP measure set but was replaced by ACO-39, Documentation of Current Medications in the Medical Record. The Core Quality Measures Collaborative believes the original measure is better aligned with other quality reporting initiatives. CMS now proposes to replace ACO-39 with ACO-12.
- ACO-44, Use of Imaging Studies for Low Back Pain. CMS proposes to add this claims-based measure, which is specified for patients 18-50 years of age, to the Care Coordination/Patient Safety domain. The measure determines the percent of patients who did not have an imaging study within 28 days of a primary diagnosis of low back pain. CMS notes there may be small case sizes due to the measure specifications, and the agency seeks comment on whether the measure should remain pay-for-reporting for all three performance years.
- ACO-43, Ambulatory Sensitive Condition Acute Composite. CMS proposes to add ACO-43 to the Care Coordination/Patient Safety domain. This composite measure includes Prevention Quality Indicators for admissions related to dehydration, bacterial pneumonia, and urinary tract infections. CMS believes these admissions may occur due to inadequate access to ambulatory care or poor care coordination. The agency says the measure will be risk-adjusted for demographic variables and comorbidities.

*Measure Removals.* CMS proposes to retire two Agency for Healthcare Research and Quality (AHRQ) ambulatory sensitive conditions admission measures (ACO-9 and ACO-10) because they are redundant with two all-cause, unplanned admission measures for heart failure and multiple chronic conditions (ACO-37 and ACO-38).

CMS also proposes to retire the following measures in order to reduce provider reporting burden and align with recommendations of the Core Quality Measures Collaborative and QPP proposals:

- ACO-21, Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented;
- ACO-31, Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD); and
- ACO-33, Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%).

*Measure Modifications.* CMS would modify the title and specifications of ACO-11, Percent of PCPs Who Successfully Meet Meaningful Use Requirements. Currently, this measure assesses the level of certified EHR technology (CEHRT) use by primary care physicians (PCPs) who participate in an ACO. CMS would alter the specifications of the measure to assess an ACO on the level of CEHRT use by *all* providers and suppliers designated as eligible clinicians under the QPP proposed rule who participate in the ACO. CMS proposes to designate the measure as a new measure (thus it would be

pay-for-reporting for the 2017 and 2018 performance years) and change the title to remove the reference to PCPs. However, for the years in which ACO-11 is categorized as pay-for-reporting, at least one eligible clinician participating in the ACO would need to meet the reporting requirements under the Advancing Clinical Information (ACI) performance category under the QPP. CMS proposes this policy so that ACOs in Tracks 2 and 3 can demonstrate meaningful use, which is required to be an Advanced APM for purposes of physician payment. However, for those in the MSSP Track 1, this addition would mean that the use of EHRs was being double-counted as part of both the quality and the ACI categories.

Although the EHR measure is double-weighted, CMS is considering additional ways to enhance its importance and impact. For example, the agency is contemplating whether it should require the EHR measure to be pay-for-performance in all performance years, including the first year of the first agreement period, among other policies.

Changes to the Process for Validating ACO Quality Data Reporting. CMS validates the data ACOs enter into the web interface through a multi-step process called the quality measures validation audit. To start this process, CMS selects a subset of web interface measures as well as a random sample of 30 reported beneficiaries for each measure in the subset. After reviewing medical records provided by the ACO to verify that the records support the reported data, CMS calculates a measure-specific audit performance rate using the process described below.

<b>Current Process for Validating ACO Quality Data Reporting</b>	
Phase One	Eight randomly selected medical records for each audited measure are reviewed to determine if the medical record documentation supports what was reported (that is, a match). If all records reviewed support what was reported, the audit ends. If any records do not support what was reported (that is, a mismatch), the audit process continues to Phase 2 for any measure with a mismatch identified.
Phase Two	The remaining 22 medical records are reviewed for any measure that had a mismatch identified in Phase 1. If less than 90% of the medical records provided for a measure support what was reported, the audit process continues to Phase 3.
Phase Three	For each measure with a match rate less than 90%, CMS provides education to the ACO about how to correct reporting and the ACO is given an opportunity to resubmit the measure(s) in question.  If at the conclusion of Phase 3 there is a discrepancy greater than 10% between the quality data reported and the medical records provided during the audit, the ACO will not be given credit for meeting the quality target for any measure(s) for which the mismatch rate exists.

Source: CY 2017 Physician Fee Schedule Proposed Rule, 81 FR 46423 (July 15, 2016)



CMS proposes several changes to align this process more closely with other CMS quality audits such as the PQRS program and hospital quality reporting program audits. First, CMS proposes to increase the number of records audited per measure to increase confidence in the results. The agency states that the precise number of records would vary, but it does not expect that more than 50 records per audited measure would be requested.

Second, CMS proposes to streamline the audit process into a single step by reviewing all submitted medical records and then calculating a match rate. CMS would still provide education to ACOs and allow them to explain mismatches at the end of the audit. But ACOs would not have a chance to correct and resubmit data for measures with a greater than 10 percent mismatch. According to CMS, resubmitting data after the close of the CMS web interface is not feasible.

Third, the agency would assess an ACO's overall audit match rate across all measures, instead of focusing on the measure level. To do this, CMS would divide the total number of audited records that match the data reported by the total number of records audited. If an ACO fails an audit by having an overall audit match rate of less than 90 percent, CMS would adjust the ACO's overall quality score in proportion to its audit performance. (Currently, if there is a discrepancy of greater than 10 percent between the data reported and the medical records at the end of the audit, no credit is given to the ACO for meeting the quality target for any measures with that mismatch rate.) Specifically, CMS proposes to multiply the ACO's overall quality score by the ACO's audit match rate to calculate the audit-adjusted quality score. For example, an ACO with a quality score of 75 percent and an audit match rate of 80 percent would have an audit-adjusted quality score of 60 percent. This audit-adjusted score will be used to determine shared savings or accountable losses. CMS also proposes that ACOs with an audit match rate of less than 90 percent could be required to submit a corrective action plan.

Technical Changes Related to Quality Reporting Requirements. CMS proposes technical changes to clarify the definition of the quality performance standard, which is established in regulation and described in terms of performance year and agreement period. (For example, in the first performance year of an ACO's first agreement period, the quality performance standard is the level of complete and accurate reporting for all quality measures. In subsequent performance years of the first agreement period, an ACO will also be assessed on its performance on certain quality measures.)

CMS believes that revisions to the MSSP requirements have generated confusion. The agency seeks to clarify that there is one overall quality performance standard that must be met in each performance year, even though there also are standards that must be met for each measure and in each domain. Therefore, CMS would revise the introductory text of the regulations and make other clarifying changes.

CMS also addresses the concept of the minimum attainment level. The MSSP has quality performance requirements for measures as well as domains, and CMS will take compliance action if an ACO does not achieve the minimum attainment level on at least

70 percent of the *pay-for-performance* measures in each domain. In the rule, CMS proposes to change this policy and take *all* measures into account when determining whether a compliance action should be taken based on ACO quality performance at the domain level. The minimum attainment level for pay-for-performance measures would remain at the 30th percent or 30th percentile of the quality benchmark, and the minimum attainment level for pay-for-reporting measures would be at the level of complete and accurate reporting.

Alignment with the QPP. CMS also would make regulatory text changes to sunset MSSP alignment with the PQRS and EHR Incentive programs and promote alignment with proposed QPP requirements under the MACRA. To avoid duplication in rulemaking, the agency also proposes that future changes to the CMS web interface measures will be made through QPP rulemaking, but would still apply to MSSP quality reporting.

Beneficiary Attestation. CMS proposes to incorporate beneficiary preference into ACO assignment. Specifically, the agency would design a process by which beneficiaries could designate their “main doctor” or another health care provider that they believe is primarily responsible for their care. If that provider participates in an ACO, the beneficiary would be assigned to that ACO. CMS proposes to incorporate voluntary beneficiary alignment for all three MSSP ACO tracks, beginning in performance year 2018. Beneficiaries who select a Track 3 ACO provider as their “main doctor” would be prospectively assigned to the Track 3 ACO for the entire performance year, even if the beneficiaries change main providers during that year. For Track 1 and 2 ACOs, voluntary alignment would be incorporated on a quarterly basis, per the existing process for updating those ACOs’ assignment lists.

CMS proposes this change as conditional based on the agency’s ability to develop by spring 2017 an automated process for beneficiaries to designate their main doctor directly to CMS (e.g., via [www.MyMedicare.gov](http://www.MyMedicare.gov) or 1-800-Medicare). If not, the agency proposes to implement a manual process for voluntary beneficiary alignment for Track 3 ACOs only. The manual process would be similar to that used in the Pioneer ACO program, whereby an ACO would send letters to beneficiaries asking them to confirm that an ACO provider is their main doctor; the ACO would then notify CMS of which beneficiaries had agreed to voluntarily align with that ACO. CMS notes that this process is burdensome and resource-intensive, and was developed to be used in a prospective-assignment model, of which Track 3 is the only one. CMS would expand voluntary beneficiary alignment to Tracks 1 and 2 once an automated process became available.

Beneficiary Protections under Skilled-nursing Facility (SNF) Waiver. ACOs that enroll in Track 3 will be able to apply for waiver of the Medicare payment rule that requires a three-day inpatient stay before Medicare will cover SNF care. Based on its experience with similar waivers in the Pioneer and Next Generation ACO models, CMS proposes financial protections for certain beneficiaries who receive care from an ACO-affiliated SNF. Specifically, CMS proposes a 90-day grace period that would permit payment for SNF services for beneficiaries who are originally assigned to the ACO but are later

excluded during the quarterly exclusion process because they do not meet criteria for ACO assignment (for example, dropping Part B coverage). The grace period would begin on the date the ACO receives the quarterly exclusion list, and the services provided must fall in that 90-day period. The services must otherwise be payable under Medicare under the three-day rule waiver.

In addition, CMS proposes to make no payment to a SNF that is affiliated with a waiver-approved ACO, and to require the SNF to hold the beneficiary harmless, in the event that the SNF provides services to a beneficiary who was never assigned to the ACO (or assigned but later excluded and the 90-day grace period has lapsed) and the claim is rejected because of a lack of qualifying inpatient stay. CMS states this is appropriate because the SNF should know to verify beneficiary eligibility, either as a result of a 3-day inpatient stay or under the waiver.

### ***CCM and TCM Supervision Requirements in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)***

In the CY 2016 PFS rule, CMS finalized policies for payment of CCM services in RHCs and FQHCs, effective Jan. 1, 2016. The agency had previously finalized payment for TCM services furnished by a RHC or FQHC practitioner, effective Jan. 1, 2013. Currently, auxiliary staff – including nurses, medical assistants and other clinical staff who work under the direct supervision of a RHC or FQHC practitioner – may furnish these services incident to a RHC or FQHC visit.

Many RHCs and FQHCs indicated concern that this direct supervision requirement for auxiliary staff limited their ability to contract with third parties to furnish some components of the CCM and TCM services. As a result, CMS proposes to allow these services to be furnished under general supervision of RHC or FQHC practitioners. This proposed exception to the direct supervision requirement would apply only to auxiliary personnel furnishing CCM or TCM incident to services, and would not apply to other RHC or FQHC services.

### ***FQHC-specific Market Basket***

The ACA established a prospective payment system (PPS) for the costs of FQHC services under Medicare Part B, and as of Jan. 1, 2016, all FQHCs have transitioned to be paid under the FQHC PPS. The ACA also required that payment for the first year after the implementation year be increased by the percentage increase in the Medicare Economic Index (MEI). Therefore, in 2016, the FQHC PPS base payment rate was increased by the MEI.

Beginning in 2017, the ACA required that the FQHC PPS base payment rate be increased by the percentage increase in a market basket of FQHC goods and services, or, if such an index is not available, by the percentage increase in the MEI. Accordingly, CMS proposes to create a 2013-based FQHC market basket using Medicare cost report data submitted by freestanding FQHCs. CMS believes this proposed 2013-based

FQHC market basket will more accurately reflect the actual costs and scope of services that FQHCs furnish compared to the 2006-based MEI. Using the 2013-based FQHC market basket, the agency projects a FQHC market basket increase factor for 2017 of 1.7 percent.

The details related to development of the 2013-based FQHC market basket are discussed on pages 500 to 524 of the display copy of the proposed rule.

### ***Expansion of the Diabetes Prevention Program (DPP) Model***

CMS proposes to make the Center for Medicare & Medicaid Innovation (CMMI) Diabetes Prevention Program (DPP) demonstration a permanent program, beginning Jan. 1, 2018. This would be the second CMMI program certified by the CMS Actuary for expansion, based on meeting the ACA criteria that it is likely to improve quality of care without increased spending; would not increase Medicare spending; and would not deny or limit the coverage of Medicare benefits. The first program was the Pioneer ACO model.

CMS proposes a framework for a 12-month program that would include a Centers for Disease Control and Prevention (CDC)-approved DPP curriculum for Medicare beneficiaries with prediabetes. The curriculum is conducted in a group-based setting that provides practical training in long-term dietary change, increased physical activity and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. To be eligible to participate, CMS proposes that a beneficiary must be enrolled in Part B; have, as of the first day of attendance, a body mass index of at least 25 (or 23 if self-identified as Asian); be diagnosed as prediabetic (defined as a hemoglobin A1c test with a value between 5.7 and 6.4, a fasting plasma glucose of 110-125 mg/dL, or a 2-hour post-glucose challenge of 140-199 mg/dL) within the 12 months prior to participation; have no previous diagnosis of Type 1 or Type 2 diabetes; and not have ESRD. CMS proposes a payment structure tied to the number of DPP sessions attended and the amount of weight loss achieved by participating Medicare beneficiaries.

CMS also proposes that any organization recognized by the CDC to provide DPP services would be eligible to apply for enrollment in Medicare as a supplier beginning on or after Jan. 1, 2017. Existing Medicare providers and suppliers that wish to bill for Medicare DPP services would not need to enroll a second time, but would need to inform CMS of their intention to provide those services. Individuals who deliver Medicare DPP services – known as “coaches” – would need to obtain an NPI; CMS is considering whether to require coaches to enroll in Medicare.

If the proposal to expand the DPP is finalized, CMS will provide greater detail on a Medicare DPP in future notice-and-comment rulemaking.

## **NEXT STEPS**

The AHA encourages members to submit comments on how CMS's proposals would affect their facility. Watch for more information from the AHA that may assist you in preparing your organization's comment letter.

Comments are due Sept. 6 by 5 p.m. ET and may be submitted electronically at <http://www.regulations.gov>. Follow the instructions for "submitting a comment."

CMS also accepts written comments (an original and two copies) via regular or overnight/express mail.

### **Via regular mail**

Centers for Medicare & Medicaid  
Services  
Dept. of Health and Human Services  
Attention: CMS-1654-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

### **Via overnight or express mail**

Centers for Medicare & Medicaid  
Services  
Dept. of Health and Human Services  
Attention: CMS-1654-P  
Mailstop: C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

## **FURTHER QUESTIONS**

Please contact Melissa Myers, senior associate director of policy, at (202) 626-2356 or [mmyers@aha.org](mailto:mmyers@aha.org) with further questions.