Summary of the Proposed Rule for the Medicare Physician Fee Schedule for CY 2017

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## Glossary

**ABLE:** Achieving a Better Life Experience  
**ACE:** Angiotensin-Converting-Enzyme  
**ACO:** Accountable Care Organization  
**AHIP:** America’s Health Insurance Plans  
**AHRQ:** Agency for Healthcare Research and Quality  
**ARB:** Angiotensin II Receptor Blockers  
**AUC:** Appropriate Use Criteria  
**AWV:** Annual Wellness Visit  
**BHI:** Behavioral Health Integration  
**CAD:** Coronary Artery Disease  
**CCM:** Chronic Care Management  
**CDC:** Centers for Disease Control and Prevention  
**CDSM:** Clinical Decision Support Mechanisms  
**CEHRT:** Certified Electronic Health Record Technology  
**CF:** Conversion Factor  
**CMS:** Centers for Medicare and Medicaid Services  
**CMMI:** Center for Medicare & Medicaid Innovation  
**CoCM:** Collaborative Care Model  
**CPT:** Current Procedural Terminology  
**CY:** Calendar Year  
**DPP:** Diabetes Prevention Program  
**EC:** Eligible Clinician  
**EHR:** Electronic Health Record  
**E/M:** Evaluation and Management  
**ESRD:** End-Stage Renal Disease  
**GAO:** Government Accountability Office  
**GPCI:** Geographic Practice Cost Indices  
**GPRO:** Group Practice Reporting Option  
**HCPCS:** Healthcare Common Procedure Coding System  
**Health IT:** Health Information Technology  
**HPC:** Hematopoietic Progenitor Cell  
**IPPE:** Initial Preventive Physical Exam  
**MA:** Medicare Advantage  
**MACRA:** Medicare Access and CHIP Reauthorization Act of 2015  
**MAO:** Medicare Advantage Organization  
**MAC:** Medicare Administrative Contractor  
**MDPP:** Medicare Diabetes Prevention Program  
**MLR:** Medical Loss Ratio  
**MSSP:** Medicare Shared Savings Program  
**NPI:** National Provider Identifier  
**NPP:** Non-physician Provider  
**NPRM:** Notice of Proposed Rulemaking
PCP: Primary Care Physician
PE: Practice Expense
PFS: Physician Fee Schedule
PQRS: Physician Quality Reporting System
QMB: Qualified Medicare Beneficiary
QPP: Quality Payment Program
RUC: Relative Value Scale Update Committee
RVU: Relative Value Unit
SNF: Skilled Nursing Facility
TCM: Transitional Care Management
TIN: Taxpayer Identification Number
VM: Value-based Modifier Program
Introduction

The Centers for Medicare and Medicaid Services (CMS) published on the Federal Register the CY 2017 Medicare Physician Fee Schedule Notice of Proposed Rulemaking (NPRM) on July 7, 2016. The proposed rule updates payment policies, payment rates, and other provisions for services supplied under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2017.

Regulatory Impact Analysis

For this proposed rule to maintain budget neutrality for the proposed policies, the estimated 2017 conversion factor (CF) will be $35.7751. If this CF holds throughout the year, the impact for internal medicine is 2 percent.

Specialty Impacts for Internal Medicine

The specialty impact table is included below. For internal medicine and its subspecialties, the overall changes are:

<table>
<thead>
<tr>
<th>(A) Specialty</th>
<th>(B) Allowed Charges (mil)</th>
<th>(C) Impact of Work RVU Changes</th>
<th>(D) Impact of PE RVU Changes</th>
<th>(E) Impact of MP RVU Changes</th>
<th>(F) Combined Impact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>$89,467</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>ALLERGY/ IMMUNOLOGY</td>
<td>$230</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>CARDIOLOGY</td>
<td>$6,461</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>CRITICAL CARE</td>
<td>$308</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>ENDOCRINOLOGY</td>
<td>$458</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>$1,744</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>GERIATRICS</td>
<td>$211</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>HEMATOLOGY/ ONCOLOGY</td>
<td>$1,746</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>INFECTIOUS DISEASE</td>
<td>$652</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>INTERNAL MEDICINE</td>
<td>$10,849</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>NEPHROLOGY</td>
<td>$2,205</td>
<td>0%</td>
<td>-1%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>NEUROLOGY</td>
<td>$1,514</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>PEDIATRICS</td>
<td>$61</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>PULMONARY DISEASE</td>
<td>$1,759</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>RHEUMATOLOGY</td>
<td>$536</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
</tbody>
</table>

** Column F may not equal the sum of columns C, D, and E due to rounding.
**Medicare Telehealth Services**

CMS received several requests in calendar year (CY) 2015 to add various Medicare telehealth services effective for CY 2017. The Agency proposes to add four Current Procedural Terminology (CPT) codes related to end-stage renal disease (ESRD) services for dialysis (90967-90970) to the list of telehealth Medicare services on a Category 1 basis beginning in CY 2017. Category 1 involves services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. Although not specifically requested, CMS also proposes to add two CPT codes for advance care planning services (99497 and 99498) to the telehealth Medicare services list on a Category 1 basis beginning in CY 2017. Additionally, the Agency proposes to add to the list a new set of codes related to telehealth consultations for a patient requiring critical care services (GTTT1 and GTTT2) which are also on a Category 1 basis beginning in CY 2017. The Agency recognizes that the current set of CPT codes does not adequately distinguish between telehealth and in-person services provided for critical care.

CMS declined to add codes for observation care, emergency department visits, and psychological testing because the evidence provided for these services did not clearly demonstrate clinical benefit when the services are provided via telehealth. The Agency also declined to add codes related to physical and occupational therapy and speech-language pathology because they feel they do not have the statutory authority as these types of clinicians are not included in the list of telehealth clinicians within the law. Requests for services to be considered during the PFS rulemaking for CY 2018 must be submitted and received by December 31, 2016.

**Potentially Misvalued Services Under the Physician Fee Schedule**

Medicare claims data for CY 2015 may indicate a possible problem with the valuation of 0-day global services. Routine evaluation and management (E/M) is included in the valuation of 0-day global services and the claims data shows that 50 percent of the time the E/M is billed with global services with Modifier 25. Reviewing the procedure codes typically billed with an E/M with modifier 25 as potentially misvalued may be one avenue to improve valuation of these services.

To prioritize the review of these potentially misvalued services, CMS will identify the codes that have not been reviewed in the last five years, and with greater than 20,000 allowed services. There are 83 codes indicated by CMS that meet these review criteria and are proposed as potentially misvalued codes for 2017. The Agency is requesting public input on additional ways to address appropriatevaluations for all services that are typically billed with an E/M with Modifier 25.
**End-Stage Renal Disease (ESRD) Home Dialysis Services (CPT codes 90963 through 90970)**

CMS created a monthly payment rate for managing the dialysis care of home patients, which requires a single in-person visit, that is approximately equal to the rate for managing and providing two to three visits to ESRD center-based patients. The Agency’s intent was to incentivize physicians to prescribe home dialysis. However, the Government Accountability Office (GAO) found that, in 2013, the rate for managing home patients was lower than the average payment for managing ESRD center-based patients.

The GAO recommended that CMS examine Medicare policies for monthly payments to physicians to manage the care of dialysis patients and revise them if necessary to ensure that these policies are consistent with CMS’ goal of encouraging the use of home dialysis among patients for whom it is appropriate. CMS is proposing to identify CPT codes 90963 through 90970 as potentially misvalued codes based on the volume of claims submitted for these services relative to those submitted for facility ESRD services.

**Physician Payment Update & Misvalued Codes Target**

The estimated net reduction in expenditures done by CMS for 2017 from proposed adjustments to the relative values of misvalued codes is 0.51 percent. This exceeds the 0.5 percent target set by the Achieving a Better Life Experience (ABLE) Act, therefore, no additional reduction will be applied.

**Collecting Data on Resources Used in Furnishing Global Services**

Under the PFS, certain services, such as surgery, are valued and paid for as part of global packages that include the procedure and the services typically furnished in the periods immediately before and after the procedure.

In the 2015 PFS, CMS finalized a policy to transform all 10-day and 90-day global codes to 0-day global codes in 2018, to improve the accuracy of valuation and payment for the various components of global packages. Section 523(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibits the Secretary from implementing the policy and requires CMS to collect data to value surgical services. The Agency is required to develop, through rulemaking, a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period. This information must be reported on claims at the end of the global period or in another manner specified by the Secretary.
In this rule, the Agency is proposing a three-pronged approach to collect timely and accurate data on the frequency and inputs involved in furnishing global services.

First, CMS proposes:
- Comprehensive claims-based reporting about the number and level of pre- and post-operative visits furnished for 10- and 90-day global services. Physicians would be required to report a set of time-based G-codes that distinguish between the setting of care (e.g., hospital, office, email/telephone, etc.) and whether the services are furnished by a physician or by their clinical staff. Physicians would be required to report the G-codes for every 10 minutes dedicated to a patient before and after a procedure or surgery. CMS is proposing the following codes be used for reporting on claims the services actually furnished but not paid separately because they are part of global packages:

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>GXXX1</th>
<th>Inpatient visit, typical, per 10 minutes, included in surgical package</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GXXX2</td>
<td>Inpatient visit, complex, per 10 minutes, included in surgical package</td>
</tr>
<tr>
<td></td>
<td>GXXX3</td>
<td>Inpatient visit, critical illness, per 10 minutes, included in surgical package</td>
</tr>
<tr>
<td>Office or Other Outpatient</td>
<td>GXXX4</td>
<td>Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package</td>
</tr>
<tr>
<td></td>
<td>GXXX5</td>
<td>Office or other outpatient visit, typical, per 10 minutes, included in surgical package</td>
</tr>
<tr>
<td></td>
<td>GXXX6</td>
<td>Office or other outpatient visit, complex, per 10 minutes, included in surgical package</td>
</tr>
<tr>
<td>Via Phone or Internet</td>
<td>GXXX7</td>
<td>Patient interactions via electronic means by physician/non-physician providers (NPP), per 10 minutes, included in surgical package</td>
</tr>
<tr>
<td></td>
<td>GXXX8</td>
<td>Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package</td>
</tr>
</tbody>
</table>

Second:
- Survey a representative sample of clinicians about the activities involved and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks. The Agency expects to obtain data from approximately 5,000 clinicians.

Third:
- Conduct a more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some Accountable Care Organizations (ACOs).

CMS states they are not proposing to withhold payment for non-compliance at this time, but may do so in the future.
**Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services**

For 2017, CMS is proposing changes to a number of coding and payment policies for primary care under the PFS. The proposals in this rule include policy updates in these areas:

- Improve payment for care management services provided in the care of beneficiaries with behavioral health conditions (including services for substance-use disorder treatment) through new coding, including three codes used to describe services furnished as part of the psychiatric collaborative care model (CoCM) and one to address behavioral health integration (BHI) more broadly.
- Improve payment for cognition and functional assessment, and care planning for beneficiaries with cognitive impairment.
- Adjust payment for routine visits furnished to beneficiaries whose care requires additional resources due to their mobility-related disabilities.
- Recognize for Medicare payment the additional CPT codes within the Chronic Care Management (CCM) family (for Complex CCM services) and adjust payment for the visit during which CCM services are initiated (the initiating CCM visit) to reflect resources associated with the assessment for, and development of, a new care plan.
- Make changes in the requirements for the initiating visit, 24/7 access to care and continuity of care, format and sharing of the care plan and clinical summaries, beneficiary receipt of the care plan, beneficiary consent, and documentation (these updates are described further in the “Reducing the Administrative Burden for CCM” section of this summary).
- Recognize for Medicare payment CPT codes for non-face-to-face prolonged E/M services by the physician (or other billing clinician) that are currently bundled, and increase payment rates for face-to-face prolonged E/M services by the physician (or other billing clinician) based on existing Relative Value Scale Update Committee (RUC) recommended values.
The following table is brief synopses of the proposed changes to improve the payment accuracy for primary care:

<table>
<thead>
<tr>
<th>CPT¹/HCPCS</th>
<th>Description</th>
<th>Work RVUs²</th>
<th>Total Non-Facility RVUs²</th>
<th>Global</th>
<th>P CY 2017 NF Payment Rate</th>
<th>CMS Cross-walked Code</th>
<th>Billing with other Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPPP1</td>
<td>Initial psychiatric collaborative care management</td>
<td>1.59</td>
<td>3.80</td>
<td>XXX</td>
<td>$135.93</td>
<td>99487 and 99489</td>
<td>If eligible, the following may be reported with GPPP1, GPPP2, GPPP3, and GPPPX in same month: psych. evaluation (90791, 90792), psychotherapy (90832, 90833, 90834, 90836, 90837, 90838), psychotherapy for crisis (90839, 90840), family psychotherapy (90846, 90847), multiple family group psychotherapy (90849), group psychotherapy (90853), smoking and tobacco use cessation counseling (99406, 90407), and alcohol or substance abuse structured screening and brief intervention services (99408, 99409). Time spent by Behavioral Health Care Manager on activities for services reported separately may not be included in the services reported using time applied to GPPP1, GPPP2, and GPPP3.</td>
</tr>
<tr>
<td>GPPP2</td>
<td>Subsequent psychiatric collaborative care management</td>
<td>1.42</td>
<td>3.35</td>
<td>XXX</td>
<td>$119.83</td>
<td>99487 and 99489</td>
<td>Same as GPPP1</td>
</tr>
<tr>
<td>GPPP3</td>
<td>Initial or subsequent psychiatric collaborative care management</td>
<td>0.71</td>
<td>1.67</td>
<td>ZZZ</td>
<td>$59.74</td>
<td>99487 and 99489</td>
<td>Same as GPPP1</td>
</tr>
<tr>
<td>CPT^1/HCPCS</td>
<td>Description</td>
<td>Work RVUs(^2)</td>
<td>Total Non-Facility RVUs(^2)</td>
<td>Global</td>
<td>P CY 2017 NF Payment Rate</td>
<td>CMS Cross-walked Code</td>
<td>Billing with other Codes</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>GPPP6</td>
<td>Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment</td>
<td>3.30</td>
<td>6.08</td>
<td>XXX</td>
<td>$217.48</td>
<td>Combination of 99204 and half work RVU from G0181 (RUC recommendation 3.44)</td>
<td>CANNOT be billed with 90785 (Psych treatment complex interactive), 90791 (Psych diagnostic evaluation), 90792 (Psych diagnostic evaluation with medical services), 96103 (Psych testing administered by computer), 96120 (Neuropsych test administered w/computer), 96127 (Brief emotional/behavioral assessment), 99201-99215 (Office/outpatient visits new patient), 99324-99337 (Domiciliary/rest home visits new patient), 99341-99350 (Home visits new patient), 99366-99368 (Team conference with patient by health care professional), 99497 (Advanced care plan 30 minutes), 99498 (Advanced care plan additional 30 minutes)</td>
</tr>
<tr>
<td>GPPP7</td>
<td>Assessment for CCM care plan</td>
<td>0.87</td>
<td>1.78</td>
<td>ZZZ</td>
<td>$63.67</td>
<td>Half of the work and time of G0181</td>
<td>Proposing that when the billing clinician initiating CCM personally performs extensive assessment and care planning outside of the usual effort described by the billed E/M code (or Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE] code), the clinician CAN bill GPPP7 in addition to the E/M code for the initiating visit (or in addition to the AWV or IPPE), and in addition to the CCM CPT code 99490 (or proposed 99487 and 99489) if all requirements to bill for CCM services are also met.</td>
</tr>
<tr>
<td>CPT¹/HCPCS</td>
<td>Description</td>
<td>Work RVUs²</td>
<td>Total Non-Facility RVUs²</td>
<td>Global</td>
<td>P CY 2017 NF Payment Rate</td>
<td>CMS Cross-walked Code</td>
<td>Billing with other Codes</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------</td>
<td>------------</td>
<td>--------------------------</td>
<td>--------</td>
<td>---------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>GDDD1</td>
<td>Intensive service during E/M</td>
<td>0.48</td>
<td>1.24</td>
<td>ZZZ</td>
<td>$44.35</td>
<td>99212</td>
<td>CAN be billed with new and established patient office/outpatient E/M codes (99201-99205, and 99212-99215), as well as Transitional Care Management [TCM] (99495, 99496), when the additional resources described by the code are medically necessary and used in the provision of care. CMS is seeking input.</td>
</tr>
<tr>
<td>99358</td>
<td>Prolonged service without contact</td>
<td>2.10</td>
<td>3.17</td>
<td>XXX</td>
<td>$113.39</td>
<td>RUC Value</td>
<td>Propose to require the services to be furnished on the same day by the same physician or other billing clinician as the companion E/M code. Should NOT be reported during the same service period as complex CCM (99487, 99489) or TCM (99495, 99496).</td>
</tr>
<tr>
<td>99359</td>
<td>Prolonged service without contact additional time</td>
<td>1.00</td>
<td>1.52</td>
<td>ZZZ</td>
<td>$54.37</td>
<td>RUC Value</td>
<td>Same as 99358.</td>
</tr>
<tr>
<td>GTTT1</td>
<td>Initial Telehealth consult</td>
<td>4.00</td>
<td>4.00</td>
<td>XXX</td>
<td>$143.08</td>
<td>G0427</td>
<td>There is no additional information in the rule on billing GTTT1 with other codes.</td>
</tr>
<tr>
<td>GTTT2</td>
<td>Subsequent telehealth consult</td>
<td>3.86</td>
<td>3.86</td>
<td>XXX</td>
<td>$138.07</td>
<td>G0427</td>
<td>Same as GTTT1.</td>
</tr>
<tr>
<td>99487</td>
<td>Complex CCM without patient visit</td>
<td>1.00</td>
<td>2.59</td>
<td>XXX</td>
<td>$92.64</td>
<td>RUC Value</td>
<td>For CPT codes 99487, 99489, 99490 a given beneficiary would be classified as eligible to receive either complex or non-complex CCM</td>
</tr>
<tr>
<td>CPT¹/HCPCS</td>
<td>Description</td>
<td>Work RVUs²</td>
<td>Total Non-Facility RVUs²</td>
<td>Global</td>
<td>P CY 2017 NF Payment Rate</td>
<td>CMS Cross-walked Code</td>
<td>Billing with other Codes</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>during a given service period (calendar month), not both, and only one professional claim could be submitted to the PFS for CCM for that service period by one clinician. See also billing for GPPP6 and GPPP7</td>
</tr>
<tr>
<td>99489</td>
<td>Complex chronic care additional 30 minutes</td>
<td>0.50</td>
<td>1.31</td>
<td>ZZZ</td>
<td>$46.86</td>
<td>RUC Value</td>
<td>Same as 99487</td>
</tr>
<tr>
<td>99490</td>
<td>Chronic care management services - 20 minutes</td>
<td>0.61</td>
<td>1.18</td>
<td>XXX</td>
<td>$42.21</td>
<td></td>
<td>Same as 99487</td>
</tr>
<tr>
<td>GPPPX</td>
<td>Behavioral health care month</td>
<td>0.61</td>
<td>1.23</td>
<td>XXX</td>
<td>$44.00</td>
<td>99490</td>
<td>Same as GPPP1</td>
</tr>
<tr>
<td>90792</td>
<td>Psych diagnostic evaluation with medical services</td>
<td>3.25</td>
<td>4.13</td>
<td>XXX</td>
<td>$147.73</td>
<td></td>
<td>See GPPP1</td>
</tr>
<tr>
<td>99212</td>
<td>Office/outpatient visit established patient</td>
<td>0.48</td>
<td>1.22</td>
<td>XXX</td>
<td>$43.64</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>Office/outpatient visit established patient</td>
<td>0.97</td>
<td>2.05</td>
<td>XXX</td>
<td>$73.33</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit established patient</td>
<td>1.50</td>
<td>3.03</td>
<td>XXX</td>
<td>$108.38</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>Office/outpatient visit established patient</td>
<td>2.11</td>
<td>4.08</td>
<td>XXX</td>
<td>$145.94</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

¹CPT codes and descriptors only are copyright 2016 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

²If values are reflected for a code with a status indicator other than "A", "R", or "T", the RVUs generally reflect recommendations submitted to CMS processed through the PFS methodology without modification.
Behavioral Health Integration (BHI)

CMS recognized in the 2016 PFS Final Rule that the current PFS did not adequately recognize activities that were essential to the care and management of Medicare beneficiaries with behavioral health conditions. As a follow-up to that discussion, CMS is proposing the following service codes in the 2017 proposed rule. All proposed codes require that the billing clinician must document in the beneficiary’s medical record that the beneficiary’s consent was obtained to consult with relevant specialists including a psychiatric consultant, and that, as part of the consent, the beneficiary is informed that there is beneficiary cost-sharing, including potential deductible and coinsurance amounts, for both in-person and non-face-to-face services that are provided. The initiating visit that is required to bill for these codes parallels the requirements under the CCM code 99490 (see ACP’s CCM toolkit page for more information at: https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf).

a) Psychiatric Collaborative Care Model (CoCM) codes:

CoCM is a specific, evidence-based, Behavioral Health Integration (BHI) model that is typically provided by a primary care team, consisting of a primary care clinician and a care manager (e.g. social worker, psychologist) who works in collaboration with a psychiatric consultant. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

CMS is proposing to begin making separate payment for services furnished using the psychiatric CoCM codes beginning January 1, 2017. Specifically, CMS is proposing to establish and make separate Medicare payment using the following three new Healthcare Common Procedure Coding System (HCPCS) G-codes related to services provided under the CoCM position:

- GPPP1 (Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional),
- GPPP2 (Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional), and
- GPPP3 (Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional).
To value HCPCS codes GPPP1, GPPP2, and GPPP3, CMS is proposing to base the portion of the work relative value unit (RVU) that accounts for the work of the treating physician or other qualified health care professional on a direct crosswalk to the proposed work values for the complex CCM codes, CPT codes 99487 and 99489. To value the portion of the work RVU that accounts for the psychiatric consultant, CMS is estimating ten minutes of psychiatric consultant time per patient per month and a value of 0.42 work RVUs, based on the per minute work RVUs for the highest volume codes typically billed by psychiatrists. Since the behavioral health care manager in the services described by HCPCS codes GPPP1, GPPP2, and GPPP3 should have academic and specialized training in behavioral health, CMS is proposing a new clinical labor type for the behavioral health care manager, L057B, at $0.57 per minute, based on the rates for genetic counselors in the direct practice expense (PE) input database. CMS is seeking comment on all aspects of these proposed valuations. (Proposed valuations: GPPP1 - $135.93 / GPPP2 - $119.83 / GPPP3 - $59.74)

The above are considered temporary codes and will likely be replaced in fiscal year (FY) 2018 by new codes currently being developed through the CPT process.

b) General Behavioral Health Code

CMS recognizes that there are primary care practices that are incurring, or may incur, resource costs inherent to treatment of patients with behavioral health conditions based on models other than the CoCM and are not currently reflected in the PFS. Thus, CMS is proposing the use of the following G-code that describes care management for beneficiaries with diagnosed behavioral health conditions under a broader application of integration in the primary care setting:

- GPPPX (Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, for collaborative care and care management for beneficiaries with behavioral health conditions)
  - To value HCPCS code GPPPX (proposed value $44.00), CMS is proposing a work value based on a direct crosswalk from CPT code 99490 (CCM services), which is a work value of 0.61 RVUs. To account for the care manager minutes in the direct PE inputs for HCPCS code GPPPX, CMS is proposing to use clinical labor type L045C, which is the labor type for social workers/psychologists and has a rate of $0.45 per minute.

CMS is seeking stakeholder input on whether to consider requiring a longer duration of time for this code or an add-on to the code that would allow, for example, additional 20-minute increments. Feedback is also sought on the proposed valuation reference above.
Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management (CCM) Services

In CY 2015, CMS implemented separate payment for CCM services which incorporated many service elements and billing requirements that the physician or non-physician clinicians must satisfy in order to fully furnish these services and report these codes. These elements and requirements were relatively extensive and generally exceeded those for other E/M and similar services. CMS has recognized through comments from numerous professional societies and underutilization of the codes that some of the service elements and billing requirements are too burdensome and have proposed a number of changes to the current elements required to provide and bill CCM.

Health IT-related Updates to CCM

Previously, CMS required multiple CCM service elements be completed via certified or non-certified health IT. Since the Agency has not required adoption of certified or non-certified health information technology (health IT) as a condition of payment for any other PFS service—and other CMS programs already incentivize adoption of health IT (e.g., EHR Incentive Program or “Meaningful Use”)—they propose to remove this requirement for CCM service elements. Specifically, they propose the following revisions:

- Remove the requirement that the physicians or health care professionals providing CCM after hours must have access to the electronic care plan.
- Remove the requirement for 24/7 electronic sharing of the care plan information but instead require timely electronic sharing of the electronic care plan information within and outside the billing practice and to also allow transmission of care plan by fax.
- Remove the requirement for standardized content for clinical summaries and the requirement that the clinical summaries be transmitted electronically but instead require the physician billing CCM to create and exchange/transmit a continuity of care document(s) timely with other physicians or health care professionals. (Note: CMS also proposes to change the previous “clinical summaries” term to “continuity of care document(s)” so physicians can distinguish between the requirements for “clinical summaries” under the EHR Incentive Program.)
- Remove the requirement that the care plan be provided to the beneficiary in electronic form and instead require that the care plan be shared with the beneficiary based on preference (e.g., electronic, hard copy, sharing with caregiver, etc.).
- Remove the requirement that the beneficiary authorize electronic communication of their medical information with other treating clinicians – as this authorization is covered under appropriate HIPAA rules and regulations.
- Remove the requirement that the billing physician use a qualifying certified EHR to document communication to and from home- and community-based physicians and other clinicians regarding the patient’s psychosocial needs and functional deficits as this type information is already required to be captured in the medical record.
Geographic Practice Cost Indices (GPCIs)

Section 201 of MACRA extended the 1.0 work geographic practice cost index (GPCI) floor for services furnished through December 31, 2017. Therefore, the proposed 2017 work GPCIs and summarized geographic adjustment factors (GAFs) reflect the 1.0 work floor. Additionally, as required, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier states are permanent, and therefore, applicable in 2017.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to establish a program to promote the use of appropriate use criteria (AUC) for clinicians who order advanced diagnostic imaging services through clinical decision support mechanisms (CDSMs). The 2016 PFS rule first addressed the initial components of the AUC program through identifying relevant and applicable AUC. The current 2017 PFS proposed rule outlines specifications for qualified CDSMs; identifies the initial list of priority clinical areas; and establishes requirements and consulting/reporting exceptions related to CDSMs. Specifically, CMS proposes the following for this second phase of the AUC program:

- Timing and processes necessary to implement the AUC program including:
  - Pushing back the overall start date for the AUC program to January 1, 2018, since necessary aspects of the AUC program have not yet been finalized and published.
  - Publishing in the 2017 PFS Final Rule with Comment Period on or around November 1, 2016 the final qualified CDSM requirements and processes.
  - Posting, no later than June 30, 2017, the first list of qualified CDSMs.

- The priority list of clinical areas will include: Chest Pain, Abdominal Pain, Headache (traumatic and non-traumatic), Low Back Pain, Suspected Stroke, Altered Mental Status, Lung Cancer, and Cervical or Neck Pain.

- A long list of specific, and very stringent, requirements that must be met in order for CDSMs to be considered “qualified.” (e.g., CDSMs must include applicable AUC that encompass the scope of the proposed clinical priority areas listed above and CDSMs must apply through the established CMS application process to be specified as a qualified CDSM.)

- Exceptions to the AUC consultation and reporting requirements including exceptions for imaging services ordered for someone with an emergency medical condition or exceptions similar to those under the EHR Incentive Program (e.g., inadequate internet access).

Release of Part C Medicare Advantage (MA) Bid Pricing Data

In an effort to align with Presidential initiatives for transparency of federal information as well as to allow for public evaluation and research of the Part C Medicare Advantage (MA) program, CMS is proposing to release specific information within the MA bid pricing data that have not previously been released to the public. CMS hopes that these proposals will allow for research
and a better understanding of the patterns of health care utilization and how managed care in the Medicare population differs across regions and from other beneficiary populations.

The definition of the MA bid pricing data that CMS proposes to release will include only CMS-accepted bids and contains the following elements:

- estimated revenue required by an MA plan for providing original Part A and B Medicare benefits and mandatory supplemental benefits, if any (including direct medical costs by service type, administrative costs, and return on investment);
- the plan pricing of enrollee cost-sharing for original Part A and B Medicare benefits and mandatory supplemental benefits; and
- beneficiary rebate amounts

CMS proposes to exclude specific proprietary information that could put MA plans at a competitive disadvantage including: supporting documentation for actuarial basis of bid; strategic pricing and contracting information; information identifying Medicare beneficiaries; and any bid review correspondence between CMS and the MA plan or MA Organization (MAO). The Agency also proposes to standardize the timing of the annual release of MA bid data. Additionally, CMS will release the data no sooner than five years after the MA contract year as another effort to safeguard competition within the MA marketplace.

**Release of Part C and Part D Medical Loss Ratio (MLR) Data**

Since 2014, all MA and Part D sponsors have been required to submit their medical loss ratio (MLR) data to CMS. The MLR is a ratio representing the percentage of revenue used for patient care rather than other administrative costs or profit. The MLR numerator is the sum of all amounts reported as claims or as health care quality improvement expenses and the MLR denominator is the total revenue after subtracting the sum of any licensing or regulatory fees, federal and state taxes, and allowable community benefit expenditures. MA plans and Part B sponsors are subject to financial or other penalties if they do not reach at least an 85 percent MLR.

In this proposed rule, CMS proposes to release this MLR data to the public – which the Agency has not previously done. They believe this data will help the public and beneficiaries review the relative value of MA plans. The MLR data would be released 18 months after the contract year as CMS feels it will no longer be competitively sensitive. As with the MA bid data discussed previously, CMS proposes to exclude any narrative information used to describe methods for allocating expenses as well as exclude plan-level data, information identifying beneficiaries, and any correspondence between CMS and the MAO or Part D sponsor.

**Prohibition on Billing Qualified Medicare Beneficiary Individuals for Medicare Cost-Sharing**

All Medicare physicians and providers of services defined in section 1861 of the Act are reminded that federal law prohibits them from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments, from beneficiaries enrolled in the Qualified Medicare
Beneficiaries (QMB) program (a Medicaid program which helps certain low-income individuals with Medicare cost-sharing liability).

Physicians and other clinicians should take steps to educate themselves and their staff about QMB billing prohibitions and to exempt QMB individuals from Medicare cost-sharing billing and related collection efforts. For more information about these requirements, steps to identify QMB patients, and ways to promote compliance. (See: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/se1128.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/se1128.pdf))

Medicare clinicians may also serve MA enrollees; the 2017 MA Call Letter reiterates the billing prohibitions applicable to dual eligible beneficiaries (including QMBs) enrolled in MA plans and the responsibility of plans to adopt certain measures to protect dual eligible beneficiaries from unauthorized charges. (See pages 181-183 at: [https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf))

**Recoupment or Offset of Payment to Clinicians and Provider Organizations Sharing the Same Taxpayer Identification Number**

When CMS or a Medicare contractor decides to put into effect an offset or recoupment, they are required to notify the clinician, provider organization, or supplier in writing of their intention to fully or partially offset or recoup payment and the reasons for the offset or recoupment. Currently, the written demand letter is sent to a clinician, provider organization, or supplier serves as notification of the overpayment and intention to recoup or offset from the obligated clinician, and to repay the overpayment in a timely manner.

This could be interpreted as requiring the Medicare contractor to provide notification to both the obligated provider organization (Hospital A) and the applicable provider organization (Hospital B) of its intention to recoup or offset payment.

The Agency does not think it is necessary to provide separate notice to both the obligated provider organization and the applicable provider organization. The rule is proposing to amend the notice requirement in §405.373. Specifically, CMS proposes to create a new paragraph (f) in §405.373 to state that §405.373 (a) does not apply in instances where the Medicare Administrative Contractor (MAC) intends to offset or recoup payments to the applicable provider of services or supplier to satisfy an amount due from an obligated provider of services or supplier when the applicable and obligated provider of services or supplier share the same Taxpayer Identification Number (TIN).

**Medicare Advantage (MA) Clinician Enrollment**

In the past, CMS has not required that physicians participating in MA plans be enrolled in the Medicare program. In order to prevent fraud, waste, abuse and ensure that beneficiaries receive services from physicians and suppliers that are fully compliant with the Medicare program enrollment requirements, the Agency proposes to now require MAO clinicians and
suppliers to be enrolled in Medicare in an approved status – meaning they are actively enrolled and their status has not been previously revoked. Out-of-network physicians and suppliers are excluded from this proposed regulation. CMS proposes to implement this new requirement the first day of the next plan year that begins two years from the data of publication of the CY 2017 PFS final rule with comment period.

**Proposed Expansion of the Diabetes Prevention Program (DPP)**

A diabetes prevention program is an evidence-based intervention targeted to individuals at risk for diabetes. The risk of progression to Type 2 diabetes in an individual who is at risk is about 5-20 times higher than in individuals with normal blood glucose. The National Diabetes Prevention Program (DPP) administered by the Centers for Disease Control and Prevention (CDC), is a structured health behavior change program delivered in community and health care settings by trained community health workers or health professionals. The National DPP consists of 16 intensive “core” sessions of a CDC-approved curriculum 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. After the 16 core sessions, monthly maintenance sessions help to ensure that the participants maintain healthy behaviors. The primary goal of the intervention is to reduce incidence of Type 2 diabetes by achieving at least 5 percent average weight loss among participants.

The DPP model was tested through the CMS Innovation Center (CMMI) and was determined to meet the legislatively-defined requirements for expansion by the Secretary throughout the Medicare program. The rule proposes expansion of this program beginning January 1, 2018 under the name of the Medicare Diabetes Prevention Program (MDPP), following an expected series of additional rule-making. The rule provides a framework for this proposed new preventive service to be offered under Medicare Part B and is requesting feedback of all aspects of the proposed framework. The proposed framework includes the following:

- **Program description:** The MDPP is proposed as a 12-month program using the CDC-approved DPP curriculum over 16-26 weeks and the option for monthly core maintenance sessions over 6 months thereafter if the beneficiary achieves and maintains a minimum weight loss (5 percent of baseline) in accordance with the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. CMS proposes that those beneficiaries who complete the 12-month program and achieve and maintain a required minimum level of weight loss would be eligible for additional monthly maintenance sessions for as long as the weight loss is maintained.

- **Enrollment of New Medicare Suppliers:** CMS proposes that any organization recognized by the CDC to provide DPP services would be eligible to apply for enrollment in Medicare as a supplier of these services beginning on or after January 1, 2017. CMS further proposes that all new MDPP suppliers enrolling in Medicare, must have either preliminary or full CDC recognition status and if an organization loses its CDC recognition status at any point, or withdraws from the CDC recognition program at any point, or fails to move from preliminary to full recognition within 36 months of applying for CDC
recognition, the organization would be subject to revocation of its Medicare billing privileges for MDPP services. Existing Medicare clinicians and suppliers that wish to bill for MDPP services would have to inform CMS of that intention and satisfy all other requirements.

- **Requirements for MDPP Coaches:** CMS proposes to require personnel who would deliver MDPP services, referred to as “coaches”, to obtain a National Provider Identifier (NPI) to help ensure the coaches meet CMS program integrity standards. CMS is also considering requiring that coaches enroll in the Medicare program in addition to obtaining an NPI. CMS further proposes to require MDPP suppliers to submit the active and valid NPIs of all coaches who would furnish MDPP services on behalf of the MDPP supplier as an employee or contractor. If MDPP suppliers fail to provide active and valid NPIs of their coaches, or if the coaches fail to obtain or lose their active and valid NPIs, the MDPP supplier may be subject to compliance action or revocation of MDPP supplier status.

- **Expected MDPP Reimbursement:** CMS proposes a reimbursement plan that is tied to number of sessions attended and achievement of a minimum weight loss of 5 percent of baseline weight (body weight recorded during the beneficiary's first core session.) The proposed reimbursement schedule provides a maximum payment per eligible beneficiary of $360 for meeting all goals for the first 6 months of the program, an additional $90 per beneficiary for full achievement of all goals over the second 6-month period, and a maximum of an additional $180 per beneficiary for meeting all the goals after the first year.

- **MDPP Eligible Beneficiaries:** CMS propose that coverage of MDPP services would be available for beneficiaries who meet the following criteria:
  1. Are enrolled in Medicare Part B;
  2. Have as of the date of attendance at the first Core Session a body mass index (BMI) of at least 25 if not self-identified as Asian and a BMI of at least 23 if self-identified as Asian;
  3. Have within the 12 months prior to attending the first Core Session a hemoglobin A1c test with a value between 5.7 and 6.4 percent, or a fasting plasma glucose of 110-125 mg/dL, or a 2-hour post-glucose challenge of 140-199 mg/dL (oral glucose tolerance test);
  4. Have no previous diagnosis of Type 1 or Type 2 diabetes. A beneficiary with previous diagnosis of gestational diabetes is eligible for MDPP; and
  5. Does not have ESRD.

**Medicare Shared Savings Program (MSSP)**

Changes to the Quality Measure Set

Groups that (are eligible to) report quality measures using the CMS web interface are required to report on all measures in the web interface. CMS proposes modifications to the quality measures set that an ACO is required to report to better align MSSP with the America’s Health Insurance Plans (AHIP) Core Quality Measures Collaborative and proposed reporting for the web interface in the Quality Payment Program (QPP). Under these proposals, the current 34
ACO quality measures will be reduced to 31 measures. All newly introduced measures would be pay for reporting for performance years 2017 and 2018 before being phased into pay for performance. The Agency proposes to add or replace ACO measures as follows:

- **ACO-12 Medication Reconciliation Post-Discharge (NQF #0097):** This measure intends to address adverse drug events through medication reconciliation. CMS proposes to replace the current ACO-39 (Documentation of Current Medications in the Medical Record) with ACO-12. This proposed change is being done to align ACO measures with the Core Quality Measures Collaborative and the QPP web interface measures.

- **ACO-44 Use of Imaging Studies for Low Back Pain (NQF #0052):** This measure reports the percentage of patients with a primary diagnosis of low back pain that did not have an imaging scan within 28 days (patients ages 18-50). CMS proposes to add this in the Care Coordination/Patient Safety domain to address a gap in measures pertaining to resource utilization as well as to align with the Core Quality Measures Collaborative and QPP. This measure would be calculated using Medicare claims data with no additional reporting required. CMS proposes to phase this measure in as pay for performance in year 2 of an ACO’s first agreement period. However, due to the possibility of small case sizes for this measure, the Agency seeks comment on whether it should remain pay for reporting for all three performance years.

- **ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91):** CMS proposes to add this measure to the Care Coordination/Patient Safety domain. It will be risk adjusted for demographic variables and comorbidities.

- **CMS proposes to retire the two AHRQ Ambulatory Sensitive Conditions Admission measures because they report on a similar population with similar conditions as ACO-37 and ACO-38 (all-cause unplanned admission measures for heart failure and multiple chronic conditions).**

- **CMS proposes to retire or replace the following measures because they do not align with the Core Quality Measures Collaborative and QPP web interface:***
  - ACO-39 Documentation of Current Medications in the Medical Record;
  - ACO-21 Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented;
  - ACO-31 Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction;
  - ACO-33 Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and diabetes or Left Ventricular Systolic Dysfunction.

**Process to Validated ACO Quality Data reporting**

CMS utilizes a 3-phase Quality Measures Validation audit to validate the data that ACOs enter into the Web Interface. The Agency selects a random subset of Web Interface measures to audit, and then selects a random sample of 30 beneficiaries for each measure being audited. Audit process:

- **Phase 1:** Eight randomly selected medical records for each measure being audited are reviewed to determine if medical record documentation matches what was reported. If
any records are identified that do not support what was reported, then the audit moves to phase 2 for measures with mismatched data.

- Phase 2: The remaining 22 medical records are reviewed for measures with mismatched data. If less than 90 percent of the medical records for a measure under audit support what was reported, the audit moves to phase 3.
- Phase 3: For each measure with less than a 90 percent match rate, CMS provides education about how to correct reporting and the ACO is given an opportunity to resubmit any measures in question.

After phase 3, if there is still a discrepancy of more than 10 percent between the quality data and the medical record support, the ACO will not be given credit for meeting the quality target for that measure.

CMS proposes to increase the number of medical records audited per measure to achieve a high level of confidence that the true audit match rate is within 5 percent of the calculated result. The number of records audited would vary, but CMS does not anticipate more than 50 records will be requested per measure audited. The Agency proposes to streamline the process into a single step under which CMS would review all of the medical records that were submitted and calculate the match rate. The education process that is currently a part of phase 3 would occur at the conclusion of the audit, but ACOs would not have the opportunity to correct and resubmit data because CMS has determined that resubmission of data after the Web Interface closes is not feasible.

CMS also proposes to assess the ACO’s overall audit match rate rather than assessment at the individual measure level. The Agency believes that this change is necessary to minimize the number of records that must be requested to achieve the desired level of statistical certainty and better align with the methodology used in other CMS quality program audits. For ACOs that have an audit match rate of less than 90 percent, CMS proposes to adjust the ACO’s overall quality score proportional to its audit performance and use that audit-adjusted overall quality score in determining shared savings/losses for which the ACO is accountable. Additionally, those ACOs with an audit match rate of less than 90 percent may be required to submit a corrective action plan.

*Changes to Align with Other Quality Reporting Programs*

Current MSSP rules prevent eligible clinicians (ECs) who bill under the TIN of an ACO participant from participating in the Physician Quality Reporting System (PQRS) outside of MSSP participation. If an ACO fails to satisfactorily report on all ACO Group Practice Reporting Option (GPRO) measures through the Web Interface for each EC who bills under the TIN of an ACO participant, each EC who bills under the TIN will receive a downward payment adjustment under PQRS. CMS proposes to modify this by lifting the prohibition on separate reporting for the 2017 and 2018 payment adjustment. If an EC chooses to report apart from the ACO, the EC’s data may be used for PQRS and VM purposes only when complete ACO-reported data is not available.
Following the 2018 payment adjustment period, PQRS, the Value-based Modifier Program (VM), and the EHR Incentive Program are sunnetted and QPP begins. Similar to MSSP reporting under PQRS, CMS proposes to require ACOs to report quality measures through the CMS Web Interface on behalf of the ECs who bill under the TIN of an ACO participant in order to satisfy the quality performance category under MIPS. ACOs must report all of the measures required by MSSP through the Web Interface to meet quality performance category requirements. The Agency also proposes to maintain the flexibility to allow ECs to report quality performance data separately from the ACO, though separately reported data cannot count in the assessment of the ACO’s quality performance.

CMS also proposes changes to the EHR quality measure used in MSSP, ACO #11, in order to align with the policies in the QPP proposed rule. ACO #11, currently titled Percent of PCPs Who Successfully Meet Meaningful Use Requirements, assesses the degree of certified electronic health record technology (CEHRT) use by primary care physicians (PCPs) participating in the ACO. This measure is given twice the weight of other quality measures in MSSP for scoring purposes. In the QPP proposed rule, CMS proposes to use EC-reported data under the Advancing Care Information performance category to assess the ACO’s overall use of CEHRT. In the PFS proposed rule, CMS proposes to modify the specifications of the EHR measure to assess the ACO on the degree of CEHRT use by all ECs who are participating in the ACO rather than limiting it to PCPs. To align with this modification, CMS would revise the title of the measure to remove the reference to PCPs.

Additionally, because the modification to the specifications is a significant change in the measure, CMS proposes to consider ACO #11 a newly introduced measure. As such, it would be considered pay for reporting for performance years 2017 and 2018, meaning it is measured at the complete and accurate reporting level. In order to meet the complete and accurate requirement, CMS proposes that at least one EC who is participating in the ACO must meet the reporting requirements under the Advancing Care Information performance category. Beginning in 2019, it would be phased in as pay for performance in the second performance year of an ACO’s first agreement period. During pay for performance years, the assessment of EHR adoption will be measured based on a sliding scale. This measure will continue to remain double weighted, and data will be derived using EC-reported EHR data through the MIPS requirements.

**Incorporating Beneficiary Preference into Assignment**

Under current MSSP assignment rules, beneficiary assignment occurs through a two-step process. In step one a beneficiary is assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary by primary care physicians in the ACO are greater than the allowed charges for primary care services furnished by clinicians who are not participants in the ACO. Step two applies to beneficiaries who received at least one primary care service from a specialist in the ACO but none from primary care clinicians either inside or outside of the ACO. These beneficiaries are assigned to the ACO if the allowed charges for primary care services furnished by physicians with a specialty designation who are ACO participants are greater that
the allowed charges for primary care services furnished by physicians with a specialty designation outside of the ACO.

For ACOs in MSSP Tracks 1 and 2, beneficiaries are preliminarily assigned at the beginning of a performance year, but final assignment is determined at the end of the performance year based on where the beneficiary chose to receive a plurality of primary care services. Track 3 ACOs use the same two-step process, but the prospective assignment is binding. The ACO is held accountable for beneficiaries that are prospectively assigned, regardless of whether the beneficiary received most or all primary care services in the performance year outside of the ACO. Beneficiaries cannot be added to the prospective assignment list during the performance year even if they receive a plurality of primary care services from ACO participants.

CMS proposes to add an additional option for assignment to allow beneficiaries to voluntarily align with the clinician who they believe is responsible for coordinating their overall care (their “main doctor”). The Agency proposes to implement this beneficiary attestation process across all three MSSP ACO tracks. CMS proposes to use an automated mechanism to allow beneficiaries to select their primary care physician rather than requiring the ACO or the physician to collect the information and communicate it back to CMS. The Agency is considering options for how this automated process for selecting a physician could occur. For example, a beneficiary could select their “favorite” physician through www.mymedicare.gov, Physician Compare, or 1-800-Medicare. This voluntary alignment option would be available to beneficiaries starting in early 2017, and the beneficiary attestations would be used for assigning beneficiaries to ACOs beginning in performance year 2018. If an automated voluntarily alignment process for beneficiary attestation is not available by spring 2017, CMS proposes to allow a manual voluntary alignment process for Track 3 ACOs only until an automated process is available. Beneficiaries would continue to be assigned to ACOs based on the current two-step process if they have not designated a physician through the voluntary alignment process. The beneficiary voluntary alignment process overrides the claims-based two-step assignment process. If a beneficiary voluntarily aligns with a physician who is outside of an ACO, he/she cannot be added to the ACO’s list of assigned beneficiaries even if a plurality of primary care services are provided by a physician in the ACO. Physicians are prohibited from adopting any policy that coerces or otherwise influences a beneficiary’s decision to designate or not designate an ACO physician through the voluntary alignment process.

**SNF 3-Day Rule Waiver Beneficiary Protections**

CMS policy on the skilled nursing facility (SNF) benefit in Medicare requires beneficiaries to have a prior inpatient hospital stay of at least three days in order to be eligible for Medicare coverage of inpatient SNF care. Beginning on January 1, 2017, CMS will allow additional flexibility with regards to SNF coverage for Track 3 ACOs by allowing them to apply for a waiver of the SNF 3-day rule. This waiver would apply to a Track 3 ACO’s prospectively assigned beneficiaries when they are admitted to a SNF that has an affiliate agreement with the ACO. In order to provide some additional protections for beneficiaries from financial liability for non-covered Part A SNF services, CMS proposed additional modifications to the SNF 3-day rule waiver policy. For beneficiaries who are prospectively assigned to an ACO with a waiver and
subsequently excluded from assignment to an ACO, CMS proposes to allow a 90-day grace period to allow coverage of SNF services through the 3-day rule waiver. This 90-day grace period would begin on the date that the ACO receives the quarterly exclusion list. The Agency also proposes that a SNF may not charge the beneficiary and CMS will make no payment for non-covered services if a SNF affiliate admits a beneficiary who was not prospectively assigned to a Track 3 ACO with SNF 3-day rule waiver authority.

**Conclusion**

CMS established a 60-day public comment period for the CY 2017 Medicare PFS proposed rule which will help inform the basis of the final rule released on or around November 1, 2016. All comment letters are due to CMS by September 6, 2016.