

Summary of the Final 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 in the *Federal Register* the CY 2017 Medicare Physician Fee Schedule Final Rule on November 15, 2016. This final 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 final rule to maintain budget neutrality for the policy updates, the 2017 conversion factor (CF) will be \$35.8887. With this CF, the impact for internal medicine is one percent.

Specialty Impacts for Internal Medicine

For internal medicine and its subspecialties, the overall changes are included in the table below:

Table 1: Impact Analysis for IM and IM subspecialties

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
TOTAL	\$89,866	0%	0%	0%	0%
ALLERGY/ IMMUNOLOGY	\$231	0%	1%	0%	1%
CARDIOLOGY	\$6,485	0%	0%	0%	0%
CRITICAL CARE	\$311	0%	0%	0%	0%
ENDOCRINOLOGY	\$460	0%	0%	0%	0%
GASTROENTEROLOGY	\$1,747	-1%	0%	0%	-1%
GERIATRICS	\$213	0%	1%	0%	1%
HEMATOLOGY/ ONCOLOGY	\$1,751	0%	0%	0%	0%
INFECTIOUS DISEASE	\$656	0%	0%	0%	0%
INTERNAL MEDICINE	\$10,915	0%	0%	0%	1%
NEPHROLOGY	\$2,210	0%	0%	0%	0%
NEUROLOGY	\$1,521	0%	0%	0%	0%
PEDIATRICS	\$61	0%	0%	0%	0%
PULMONARY DISEASE	\$1,765	0%	0%	0%	0%
RHEUMATOLOGY	\$537	0%	0%	0%	0%

Medicare Telehealth Services

CMS received several requests in calendar year (CY) 2015 to add various Medicare telehealth services effective for CY 2017. The Agency will 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. CMS also will be adding the 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 also will be adding to the list a new set of codes related to telehealth consultations for a patient requiring critical care services (G0508 and G0509) which also are on a Category 1 basis beginning in CY 2017. These codes will be limited to once per day per patient. 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 felt they do not have the statutory authority as these types of clinicians were not included in the list of telehealth clinicians within the law. It is important to note that if consultative telehealth services are required for patients where emergency department or observation care services would ordinarily be reported, multiple codes describing consultative services are currently on the telehealth list and can be used to bill for such telehealth services.

A new telehealth Place of Service (POS) code has been created and finalized by CMS. The new POS 02 for telehealth services is described as: "The location where health services and health related services are provided or received, through telecommunication technology." CMS requires clinicians use the telehealth POS code to report that telehealth services were furnished from a distant site in order to improve payment accuracy and consistency in telehealth claims submission. The Agency believes that payment using the facility practice expense (PE) RVUs for telehealth services is consistent with their belief that the direct PE costs are generally incurred at the location of the beneficiary and not by the distant site clinician. Further, CMS finalized revisions to regulation §414.22(b)(5)(i)(A) that addresses the PE RVUs used in different settings; however, they did not finalize the proposed change that would have resulted in the payment of the non-facility rate for services furnished in off-campus Provider Based Departments (PBDs) that are not excepted under Section 603 of the Bipartisan Budget Act (BBA) of 2015. This proposal was not finalized because payments to such non-excepted PBDs will be made under the PFS.

The purpose of the new POS code is to assist in determining proper payment and also will help CMS to more accurately track telehealth utilization and spending. The new telehealth POS code has no bearing on state licensure requirements or other state regulations. However, the POS code would be used in addition to the GT and GQ modifiers.

Potentially Misvalued Services Under the Physician Fee Schedule

Medicare claims data for CY 2015 indicated 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 showed that 50 percent of the time additional E/M services are billed along with global services using a Modifier 25 (significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service). 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.

CMS has significantly reduced the number of codes identified as potentially misvalued. The list of codes in the final rule reflected the Agency's intention to include codes that have been recently reviewed. CMS does not believe that they should include codes reviewed in the past five years on this list of misvalued codes, given the limited nature of the review. Regarding the accuracy of which codes are typically reported with E/M codes, the Agency noted that their review and analysis was based on more recent, full claims data that had not yet been made public. In the interest of transparency, CMS is finalizing the list of services based on the publically available data.

Table 2: List of Potentially Misvalued Services Identified through the Screen for 0-day Global Services that are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25

HCPCS	Long Descriptor
11755	Biopsy of finger or toe nail
20526	Injection of carpal tunnel
20551	Injections of tendon attachment to bone
20612	Aspiration and/or injection of cysts
29105	Application of long arm splint (shoulder to hand)
29540	Strapping of ankle and/or foot
29550	Strapping of toes
43760	Change of stomach feeding, accessed through the skin
45300	Diagnostic examination of rectum and large bowel using an endoscope
57150	Irrigation of vagina and/or application of drug to treat infection
57160	Fitting and insertion of vaginal support device
58100	Biopsy of uterine lining
64405	Injection of anesthetic agent, greater occipital nerve
64455	Injections of anesthetic and/or steroid drug into nerve of foot
65205	Removal of foreign body in external eye, conjunctiva
65210	Removal of foreign body in external eye, conjunctiva or sclera
67515	Injection of medication or substance into membrane covering eyeball
G0168	Wound closure utilizing tissue adhesive(s) only
G0268	Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing

End-Stage Renal Disease (ESRD) Home Dialysis Services (CPT codes 90963 through 90970)

CMS finalized 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 finalized the proposal 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

Section 3134(a) of the Affordable Care Act (ACA) requires the Secretary to periodically identify potentially misvalued services and to review and make appropriate adjustments to the relative values for those services.

Through the Achieving a Better Life Experience (ABLE) Act of 2014, Congress set a target for adjustments to misvalued codes in the fee schedule. The target was one percent for 2016, and 0.5 percent for 2017 and 2018. If the net reductions in misvalued codes in 2017 are less than 0.5 percent of the total revenue under the fee schedule, a reduction equal to the percentage difference between 0.5 percent and the percent of expenditures represented by misvalued codes reductions must be made to all PFS services.

CMS finalized misvalued code changes that achieve 0.32 percent in net expenditure reductions. These changes do not fully meet the misvalued code target of 0.5 percent, thus requiring an adjustment to the 2017 overall physician update. After applying this and other adjustments required by law, the 2017 PFS conversion factor is \$35.89 – an increase compared to the 2016 PFS conversion factor of \$35.80.

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.

Section 1848(c)(9) of the Act (added by section 523(b) of the MACRA) authorizes the Secretary, through rulemaking, to delay up to 5 percent of the PFS payment for services for which a physician is required to report information under section 1848(c)(8)(B)(i) until the required information is reported. Section 1848(c)(8)(C), which also was added by section 523(a) of the MACRA, requires that, beginning in CY 2019, the Agency must use the information collected as appropriate, along with other available data, to improve the accuracy of valuation of surgical services under the PFS.

The Agency initially proposed a three-pronged approach to collect timely and accurate data on the frequency and inputs involved in furnishing global services. However, the Agency finalized a claims-based data collection that differs from the proposal in the following significant ways:

- CPT code 99024 will be used for reporting post-operative services rather than the proposed set of G-codes. CMS will not, at this time, require time units or modifiers to distinguish levels of visits to be reported. Reporting will not be required for pre-operative visits included in the global package or for services not related to patient visit.
- The Agency finalized a requirement that teaching physicians will be subject to the reporting requirements in the same way that other physicians are. Such physicians should report CPT code 99024 only when the services furnished would meet the general requirements for reporting services and should use the GC or GE modifier as appropriate.
- Reporting will be required only for services related to codes reported annually by more than 100 clinicians' codes reported more than 10,000 times; or codes with allowed charges in excess of \$10 million annually.
- Clinicians are encouraged to begin reporting post-operative visits for procedures furnished on or after January 1, 2017, but the mandatory requirement to report will be effective for services related to global procedures furnished on or after July 1, 2017.
- Only clinicians who practice in groups with 10 or more clinicians in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island will be required to report. Clinicians who only practice in smaller practices or in other geographic areas are encouraged to report data, if feasible.
- CMS finalized the proposal to conduct a survey of clinicians to gain information on post-operative activities to supplement the claims-based data collection. The agency expects the survey will be in the field mid-2017.
- CMS states they are not proposing to withhold payment for non-compliance at this time. However, if compliance with required claims-based reporting is not acceptable, CMS will consider in future rulemaking imposing up to a 5 percent payment withhold as authorized by the statute.

Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services

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

- Improved 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.
- Improved payment for cognition and functional assessment, and care planning for beneficiaries with cognitive impairment.
- Payment adjustments for routine visits furnished to beneficiaries whose care requires additional resources due to their mobility-related disabilities.
- Medicare will reimburse 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.
- Changes in the requirements to bill CCM including: 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 CCM updates are described further in the “Reducing the Administrative Burden for CCM” section of this summary).
- Medicare will now reimburse 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 a brief synopsis of the proposed changes to improve the payment accuracy for primary care:

Addendum B – Relative Value Units and Related Information Used in CY 2017 NPRM

CPT¹/ HCPCS	Description	Work RVUs²	Total Non- Facility RVUs²	Global	CY 2017 NF Payment Rate	CMS Cross-walked Code	Billing with other Codes
G0502	Initial psychiatric collaborative care management	1.70	3.98	XXX	\$142.84	99487 and 99489	If eligible, the following may be reported with G0502, G0503, G0504, and G0506 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.
G0503	Subsequent psychiatric collaborative care management	1.53	3.25	XXX	\$126.33	99487 and 99489	Same as G0502
G0504	Initial or subsequent psychiatric collaborative care management	0.82	1.84	ZZZ	\$66.04	99487 and 99489	Same as G0502

CPT ¹ / HCPCS	Description	Work RVUs ²	Total Non- Facility RVUs ²	Global	CY 2017 NF Payment Rate	CMS Cross-walked Code	Billing with other Codes
G0505	Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment	3.44	6.64	XXX	\$238.30	Combination of 99204 and half work RVU from G0181 (RUC recommendation 3.44)	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)
G0506	Assessment for CCM care plan	0.87	1.78	ZZZ	\$63.88	Half of the work and time of G0181	Finalized 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.
G0501	Intensive service during E/M	0.00	0.00	ZZZ	\$0.00	99212	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

CPT ¹ / HCPCS	Description	Work RVUs ²	Total Non- Facility RVUs ²	Global	CY 2017 NF Payment Rate	CMS Cross-walked Code	Billing with other Codes
							care. Code G0501 will not be payable under the Medicare PFS for CY 2017, though practitioners will be able to report the code, should they be inclined to do so.
99358	Prolonged service without contact	2.10	3.16	XXX	\$113.41	RUC Value	CMS finalized separate payment of the non-face-to-face prolonged service codes (CPT 99358, 99359) and adopted the CPT code descriptors and prefatory language for reporting these services. Should NOT be reported during the same service period as complex CCM (99487, 99489) or TCM (99495, 99496).
99359	Prolonged service without contact additional time	1.00	1.52	ZZZ	\$54.55	RUC Value	Same as 99358.
G0508	Initial Telehealth consult	4.00	N/A	XXX	N/A	work RVU and physician intra-service time of 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor)	There is no additional information in the rule on billing G0508 with other codes.
G0509	Subsequent telehealth consult	3.86	N/A	XXX	N/A	G0427	Same as G0508
99487	Complex CCM without patient visit	1.00	2.61	XXX	\$93.67	RUC Value	For CPT codes 99487, 99489, 99490 a given beneficiary would be classified as eligible to receive either complex or non-complex CCM

CPT ¹ / HCPCS	Description	Work RVUs ²	Total Non- Facility RVUs ²	Global	CY 2017 NF Payment Rate	CMS Cross-walked Code	Billing with other Codes
							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 G0505 and G0506
99489	Complex chronic care additional 30 minutes	0.50	1.31	ZZZ	\$47.01	RUC Value	Same as 99487
99490	Chronic care management services - 20 minutes	0.61	1.19	XXX	\$42.71		Same as 99487
G0507	Behavioral health care month	0.61	1.33	XXX	\$47.73	99490	Same as G0502
90792	Psych diagnostic evaluation with medical services	3.25	4.13	XXX	\$148.22		See G0502
99212	Office/outpatient visit established patient	0.48	1.23	XXX	\$44.14		N/A
99213	Office/outpatient visit established patient	0.97	2.06	XXX	\$73.93		N/A
99214	Office/outpatient visit established patient	1.50	3.03	XXX	\$108.74		N/A
99215	Office/outpatient visit established patient	2.11	4.08	XXX	\$146.44		N/A
¹ CPT codes and descriptors only are copyright 2016 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.							
² If 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 acknowledged that the PFS did not adequately recognize activities that were essential to the care and management of Medicare beneficiaries with behavioral health conditions. Thereby, CMS finalized new service codes for 2017. All of the codes require the billing clinician to 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 will 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:

- G0502 (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),
- G0503 (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
- G0504 (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 G0502, G0503, and G0504, CMS is basing 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 G0502, G0503, and G0504 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: G0502 - \$142.84 / G0503 - \$126.33 / G0504 - \$66.04)

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 finalized 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:

- G0507 (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 G0507 (value \$47.73), CMS is using 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 G0507, CMS used clinical labor type L045C, which is the labor type for social workers/psychologists and has a rate of \$0.45 per minute.

Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management (CCM) Services

In CY 2015, CMS implemented separate payment for CCM services that 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 information technology (health IT). Since the Agency has not required adoption of certified or non-certified 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 removed this requirement for CCM service elements. Specifically, CMS finalized the following revisions:

- Removed the requirement that the physicians or health care professionals providing CCM after hours must have access to the electronic care plan.
- Removed 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.
- Removed 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.*)
- Removed 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.).
- Removed 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.
- Removed 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.

Summary of CY 2017 Chronic Care Management Service Elements and Billing Requirements

Initiating Visit
Initiation during an AWW, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of chronic care management (CCM) services.
Structured Recording of Patient Information Using Certified EHR Technology
Structured recording of demographics, problems, medications and medication allergies using certified EHR technology. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.

24/7 Access & Continuity of Care

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week.
- Continuity of care with a designated member of the care team with whom the beneficiary is able to schedule successive routine appointments.

Comprehensive Care Management

Care management for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.

Comprehensive Care Plan

- Creation, revision and/or monitoring (as per code descriptors) of an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues.
- Must at least electronically capture care plan information, and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the beneficiary's care.
- A copy of the plan of care must be given to the patient and/or caregiver.

Management of Care Transitions

- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
- Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers.

Home- and Community-Based Care Coordination

- Coordination with home and community based clinical service providers.
- Communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record.

Enhanced Communication Opportunities

Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

Beneficiary Consent

- Inform the beneficiary of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month).
- Document in the beneficiary's medical record that the required information was explained and whether the beneficiary accepted or declined the services.

Medical Decision-Making

Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).

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.

Addenda D and E to the final rule for the CY 2017 GPCIs and summarized geographic adjustment factor (GAFs) are available on the CMS website under the supporting documents section of the CY 2017 PFS final rule located at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>

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 2017 PFS final rule outlines specifications for qualified CDSMs; identifies the initial list of priority clinical areas; and establishes requirements and consulting/reporting exceptions related to CDSMs. CMS finalized 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.
 - Posting, no later than June 30, 2017, the first list of qualified CDSMs.
- The priority list of clinical areas has been revised by CMS. The final list of priority clinical areas is as follows:
 - Coronary artery disease (suspected or diagnosed).
 - Suspected pulmonary embolism.
 - Headache (traumatic and non-traumatic).
 - Hip pain.
 - Low back pain.
 - Shoulder pain (to include suspected rotator cuff injury).
 - Cancer of the lung (primary or metastatic, suspected or diagnosed).
 - 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 finalized the proposal to release specific information within the MA bid pricing data that have not previously been released to the public. CMS hopes that the release of this information 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 release finalized by the agency 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 will 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 will 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.

CMS finalized the proposal 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. However, the following two modifications were also finalized regarding the release MLR data:

- First, CMS will revise the exclusion, with respect to Part C MLR data and Part D MLR data, to exclude from release any MLR data submitted for a single-plan contract.
- Second, CMS will add a new exclusion, with respect to Part C MLR data and Part D MLR data, to exclude from release any MLR data submitted for a contract year for which the contract is determined to be non-credible.

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

All Medicare physicians and other clinicians 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>)

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>)

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, physician organization, or supplier in writing of their intention to fully or partially offset or recoup payment as well as the reasons for the offset or recoupment. Currently, the written demand letter sent to a clinician, physician 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 notification process 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 final rule amends the

notice requirement in §405.373. Specifically, CMS finalized the proposal to create a new paragraph (f) in §405.373 to state that §405.373 (a) additional notification does not apply in instances where the Medicare Administrative Contractor (MAC) intends to offset or recoup payments 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 finalized the requirement for physicians or suppliers that furnish health care items or services to a Medicare enrollee who receives benefits through an MA organization to be enrolled in Medicare and be in an approved status. The term “MA organization” refers to both MA plans and also MA plans that provide drug coverage, otherwise known as MA-PD plans. Out-of-network physicians and suppliers are excluded from this proposed regulation. CMS will implement this new requirement the first day of the next plan year that begins two years from the date of publication of the CY 2017 PFS final rule.

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 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 finalizes expansion of this program beginning January 1, 2018 under the name of the Medicare Diabetes Prevention Program (MDPP), following an expected series of additional rulemaking. The rule provides a framework for this proposed new preventive service to be offered under Medicare Part B. The finalized framework includes the following:

- Program description: The MDPP is finalized as a 12-month program using the CDC-approved, 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 states 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 finalized 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 finalized 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 finalized requiring 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 also is 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 finalized 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 finalized 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 finalized 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 choose to report quality measures using the CMS Web Interface are required to report on all measures in the Web Interface. CMS finalized the proposed 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 reporting for the Web Interface in the Quality Payment Program (QPP). CMS finalized reducing the current 34 ACO quality measures to 31 measures. All newly introduced measures will be pay-for-reporting for performance years 2017 and 2018 before being phased into pay-for-performance. The Agency finalized the addition or replacement of ACO measures as follows:

- ACO-12 Medication Reconciliation Post-Discharge (NQF #0097): This measure intends to address adverse drug events through medication reconciliation. CMS will replace the current ACO-39 (Documentation of Current Medications in the Medical Record) with ACO-12. This 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 is adding this measure 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 will be calculated using Medicare claims data with no additional reporting required. Due to the possibility of small case sizes for this measure, CMS finalized keeping this measure as pay-for-reporting for all three performance years.
- ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91): CMS is adding this measure to the Care Coordination/Patient Safety domain. It will be risk adjusted for demographic variables and comorbidities.
- CMS finalized retiring 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 finalized to retiring or replacing 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 finalized its proposal to increase the number of medical records audited per measure to achieve a high level of confidence (90 percent confidence interval) that the true audit match rate is within 5 percent of the calculated result. The Agency finalized streamlining 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 will occur at the conclusion of the audit, but ACOs will 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 finalized its proposal 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 will 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. These policies will be applied to quality validation audits beginning in 2017 with quality reporting data for the 2016 performance period.

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 finalized its proposal 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 sunsetted and QPP begins. Similar to MSSP reporting under PQRS, CMS will 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 finalized maintaining 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 for the purposes of MSSP assessment.

CMS also finalized its proposed changes to the EHR quality measure used in MSSP, ACO #11, in order to align with the policies in the QPP 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 rule, CMS will use EC-reported data under the Advancing Care Information Performance Category to assess the ACO's overall use of CEHRT. In the PFS rule, CMS finalized modifications to 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 is revising 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 will consider ACO #11 a newly introduced measure. As such, it will 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 finalized its proposal 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, the measure will 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 than 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 finalized the proposal 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 will implement this beneficiary attestation process across all three MSSP ACO tracks. Assignment via beneficiary voluntary alignment will occur prospectively for all tracks at the beginning of each performance and benchmark year for those beneficiaries who are eligible for assignment.

CMS will 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’s goal is that the 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. However, CMS did not finalize its proposal to allow a manual voluntary alignment process if an automated process is not available. Therefore, if an automated process is not available during the assignment window for the 2018 performance year, voluntary beneficiary alignment will not be available in 2018. Beneficiaries will 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.

Beginning in 2018, if an electronic system is available to allow beneficiaries to designate the physician/clinician responsible for coordinating their overall care, beneficiaries that have voluntarily aligned with an ACO by selecting an eligible main doctor who is part of the ACO will be prospectively assigned under the following conditions:

- The beneficiary has had at least one primary care service during the assignment window with a physician in the ACO who has a primary care or primary specialty designation.
- The beneficiary meets assignment eligibility criteria.
- The beneficiary designated an ACO clinician who is a primary care physician or eligible specialty designation.
- The designation is made in the form and manner and by the deadline determined by CMS.

The beneficiary voluntary alignment process overrides the claims-based two-step assignment process. If a beneficiary designates a clinician outside of the ACO as responsible for coordinating his/her overall care, 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. Additional information on the voluntary beneficiary alignment process will be provided through sub-regulatory guidance.

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 will 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 finalized 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 will 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 finalized its proposal 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. For Track 3 ACOs that have already applied for the SNF 3-day rule waiver for 2017, CMS is developing a process that will allow ACOs and their SNF affiliates to confirm that they agree to comply with the revisions made in this rule.