Critical Issues in the Proposed 2018 Medicare Physician Fee Schedule

In mid-July, the Centers for Medicare & Medicaid Services (CMS) released its 2018 proposed Medicare Physician Fee Schedule (PFS) rule along with a factsheet. This rule proposes a number of adjustments to Medicare physician payments as well as changes to Medicare policies and quality reporting programs for 2018. Below are the key changes from the rule that would affect Medicare ACOs. The agency is also soliciting feedback on solutions to better achieve transparency, flexibility, program simplification, and innovation related to Medicare. This feedback will inform the discussion on future regulatory action related to the PFS. CMS will accept public comments on the proposed rule through September 11, 2017 and those interested in submitting feedback to the agency may do so by going to this webpage. We encourage NAACOS members to share their feedback with us on this proposed rule by emailing advocacy@naacos.com.

General Payment Updates and RVUs

CMS estimates the 2018 PFS conversion factor (CF) to be $35.99, which is a very small increase from 2017's CF of $35.89. The estimated 2018 Anesthesia CF is $22.04. As required by law, if revisions to the Relative Value Units (RVUs) would cause expenditures for the year to change by more than $20 million, CMS must make adjustments to ensure that expenditures do not increase or decrease by more than $20 million. The agency must also meet statutory requirements for annual reductions in PFS expenditures resulting from adjustments to relative values of misvalued codes. The estimated 2018 CF reflects the budget neutrality adjustment, a reduction for not meeting the misvalued code target and a 0.5 percent update required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As a result of CMS's collective proposals in this rule, most specialties would receive neutral or very minor payment adjustments. For more detail on specialty specific payments, refer to Table 40: CY 2018 PFS Estimated Impact on Total Allowed Charges by Specialty (p. 34177).

As with every year, CMS proposes a myriad of minor modifications to the inputs and RVUs of particular codes. More notable on a macro level is that CMS proposes to use professional liability insurance data recently collected for updating the malpractice Geographic Practice Cost Indices (GPCI) for the purposes of also updating the malpractice (MP) RVUs for 2018. The agency also proposes to align the update of MP premium data and MP GPCIs to once every three years.

Evaluation and Management (E/M) Services and Chronic Care Management (CCM)

CMS acknowledges the need to revise guidelines and documentation requirements for billing E/M services. The agency is seeking feedback on ways to reform the guidelines, reduce associated burdens, and better align E/M coding and documentation with the current practice of medicine. The agency plans to focus initial changes to the guidelines on requirements related to a patient's history and physical exam, including consideration of removing documentation requirements for the history and physical exam for E/M visits, regardless of level. CMS also seeks comments on how to update medical decision-making guidelines.

Effective for 2017, CMS previously finalized payment for new care management codes including those related to complex CCM, behavioral health integration (BHI) and psychiatric collaborative care model (CoCM). CMS established four G codes for the BHI (G0507) and psychiatric CoCM services (G0502, G0503 and G0504) and explained the agency would consider adopting associated Common Procedural Terminology (CPT) codes when those became available. For CY 2018, the CPT Editorial Panel is creating CPT codes 994X1, 994X2, 994X3, and 99XX5 to describe these services. Therefore, CMS proposes to use the CPT codes beginning in 2018. The agency would establish Relative Value Scale Update Committee (RUC) recommended RVUs with a minor refinement and the resulting values would match the current values for the existing G-codes. CMS also seeks public comment on ways the agency could further reduce the burden on reporting practitioners for chronic care management and similar services, for example, through stronger alignment between CMS requirements and CPT guidance for existing and potential new codes.

CCM in Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes revisions to the CCM payment for RHCs and FQHCs and proposes requirements and payment for general behavioral health integration (BHI) and psychiatric CoCM services furnished in RHCs and FQHCs, beginning on January 1, 2018. The agency is responding to feedback about concerns that RHCs and FQHCs cannot bill for complex CCM, a policy which CMS finalized last year and is not proposing to change. The agency proposes to establish two new G-codes for use by RHCs and FQHCs:

- GCCC1 would be a General Care Management code for RHCs and FQHCs with the payment amount set at the average of the national non-facility PFS payment rates for CCM codes 99490 and 99487 and general BHI code G0507.
- GCCC2 would be a Psychiatric CoCM code with the payment amount set at the average of the national non-facility PFS payment rates for psychiatric CoCM codes G0502 and G0503.

Based on the 2017 payment amounts for the codes comprising the newly proposed codes, the approximate payments would be $61 for GCCC1 and $135 for GCCC2. RHCs and FQHCs could bill GCCC1 when the requirements for any of these three codes (CPT codes 99490, 99487, or HCPCS code G0507) are met and could bill GCCC2 when the requirements of either G0502 or G0503 are met. Beginning on January 1, 2018, CMS proposes that RHCs and FQHCs would use the new G code GCCC1 when billing for CCM or general BHI services, and the new psychiatric CoCM G code GCCC2 when billing for psychiatric CoCM services. Claims submitted using CPT 99490 on January 1, 2018 or after would not be paid. CMS proposes that these new codes could be billed alone or in addition to other services furnished during an RHC or FQHC visit, and these codes could only be billed once per month per beneficiary. Each of the new codes could not be billed if other care management services are billed for the same time period and only GCCC1 or GCCC2 could be billed for a particular beneficiary each month. Billing to these new codes would be permitted under general supervision requirements for incident-to claims, rather than requiring direct supervision.

Changes to the Medicare Shared Savings Program (MSSP)

Reducing burdens with applications and SNF 3-day rule waiver

3-day Skilled Nursing Facility (SNF) Waiver

While CMS generally believes the waiver application is reasonable, the agency acknowledges two current requirements that impose an unnecessary burden on applicants. CMS proposes to end requiring the narrative describing any financial relationships that exist between the ACO, SNF affiliates, and acute care hospitals. The waiver does not protect or require such a relationship nor does it permit any relationship that would otherwise be liable under current fraud and abuse laws and therefore the narrative is not useful

for the purposes of whether to grant a waiver. Second, CMS believes requiring the applying ACO to demonstrate that each of their intended SNF affiliates has a 3 or higher star rating under the CMS 5-star Quality Rating System is unnecessary because CMS checks that themselves when the application is reviewed. Therefore, the agency proposes removing this requirement as part of the SNF waiver application. CMS also seeks suggestions on other ways in which they agency may further decrease the burden for ACO requesting a SNF waiver.

Initial Application

CMS proposes to remove the requirement to submit supporting documents or narratives and alternatively CMS would request these materials if additional information is needed. This includes narratives corresponding to required processes and patient centeredness criteria, the ACO's organization and management structure, how the ACO would distribute shared savings and how the ACO's proposed plan would achieve the specific goals of shared savings. CMS intends to retain all requirements related to ACO eligibility and public reporting.

New Primary Care Codes for MSSP Assignment

MSSP assignment is based on where beneficiaries receive the plurality of their primary care, which is defined by a specific set of billing codes identified and periodically updated by CMS. The agency proposes to modify the list of primary care codes used for MSSP assignment to include new primary care codes that were added to Medicare in recent years. Specifically, beginning in 2018 for performance year 2019 and subsequent years the agency proposes to add the following codes to the list of primary care codes used for MSSP assignment:

- Complex CCM codes 99487 and 99489, CCM add on-code G0506
- Behavioral health integration codes G0502, G0503, G0504, G0507

Assignment Modifications for ACOs with RHC and FQHC Participants

The 21st Century Cures Act requires the Secretary of Health and Human Services to assign beneficiaries to MSSP ACOs based on their utilization of primary care services furnished by physicians and also increasingly on their utilization of services furnished by RHCs and FQHCs, effective beginning with the 2019 performance year. Therefore, CMS proposes the following modifications to the MSSP assignment process:

- Remove the requirement that ACOs attest to the physicians who directly provide primary care services in each RHC or FQHC that is an ACO participant and/or provider/supplier in the ACO. Submission of National Provider Identifiers (NPIs) or other identifying information would no longer be necessary.
- Use all RHC and FQHC claims to establish beneficiary eligibility to be assigned to the ACO in the assignment pre-step
- Include all RHC and FQHC claims in step one of assignment
- Remove revenue center codes from the definition of primary care services

By removing the attestation requirement, CMS would treat a service reported on an RHC or FQHC institutional claim as a primary care service furnished by a primary care physician. CMS notes that in considering all services billed under the TIN of the ACO participant RHC or FQHC, the agency would include services that do not meet the definition of primary care services, and such services would not be limited to those provided by a primary care physician, as defined under current program rules. Therefore, a beneficiary could be furnished services in an RHC and FQHC only by a nurse practitioner, physician assistant, clinical nurse specialist, or any other practitioner in an RHC and FQHC and still be eligible for assignment to the ACO. CMS proposes to adjust all ACO benchmarks at the start of 2019 so

that the ACO benchmarks reflect the use of the same assignment rules as will apply during that performance year.

Compliance with MSSP ACO TIN Exclusivity Requirement

MSSP guidelines require an ACO participant Tax Identification Number (TIN) that submits claims for primary care services used to determine an ACO's assigned beneficiary population to be exclusive to one ACO. A participant TIN that does not bill for those services does not have to be exclusive to one ACO. As part of the MSSP application and annual update process, CMS checks TINs that are being added to an ACO to determine if the TIN may participate with multiple ACOs or if it needs to be exclusive to one ACO. During the performance year, CMS also monitors TIN/ACO overlap as part of its assignment algorithm process. In rare instances as a result of CMS monitoring, the agency has discovered that ACO participant TINs that had been approved to participate in multiple ACOs subsequently began billing for primary care services used in assignment during a benchmark or performance year. In response, CMS required the overlapping TIN to select one ACO and then the agency recalculated program methodologies including assignment and benchmarks as necessary for affected ACOs.

The agency acknowledges that this could have a significant effect on an ACO during a performance year and with the proliferation of more ACOs, these situations could occur more frequently in the future. Therefore, if it is discovered during a performance year that a participant TIN previously determined as eligible to participate in multiple ACOs begins billing primary care codes used in MSSP assignment and should therefore be exclusive to one ACO, CMS proposes the agency would allow the TIN to remain on the ACO participant lists for all affected ACOs for the remainder of the performance year. To ensure that the TIN overlap does not inadvertently result in assignment of the same beneficiaries to multiple ACOs, CMS proposes the agency would exclude any claims for services furnished by the overlapping TIN from the assignment methodology when conducting final beneficiary assignment for any benchmark or performance year in which the TIN bills Medicare for services used in the assignment methodology. ACOs with overlapping TINs may be subject to compliance actions from CMS, such as having to submit a corrective action plan for how the ACO intends to address the overlap issue. Finally, the affected ACOs would be required to resolve the overlap prior to recertification of their ACO participant lists for the subsequent performance year.

Quality Provisions

CMS does not propose changes to the MSSP Web Interface measure set in this proposed rule. Instead, they propose a conforming change to the regulation text to clarify that going forward, CMS has the authority to re-designate a measure as pay for reporting when significant changes to the CMS Web Interface measure set are made in the Quality Payment Program (QPP). CMS also proposes adjustments to the quality reporting data validation process for ACOs, acknowledging that the changes CMS finalized in 2017 resulted in standards that may inappropriately penalize ACOs that make quality data reporting errors that are unrelated to care quality and instead are due to misunderstandings in the measure reporting requirements.

Therefore, CMS proposes to set the audit match rate threshold based on the median match rate (80 percent) for ACOs audited in calendar year 2016 rather than the mean match rate because the median match rate would be less affected by data outliers. As proposed, if an ACO has a match rate below 80 percent, absent unusual circumstances, CMS would adjust the ACO's overall quality score proportional to the ACO's audit performance.

CMS also proposes to amend the method by which they will adjust an ACO's overall quality score to reflect the ACO's audit performance. Specifically, CMS proposes that for each percentage point

difference between the ACO's match rate and the match rate considered passing the audit, the ACO's overall quality score would be adjusted downward by 1 percent. For example, should CMS finalize the proposal to establish an 80 percent match rate as the threshold for passing the quality validation audit, and the ACO's match rate is 75 percent, then under this proposal CMS would adjust the ACO's overall quality score downward by 5 percent. CMS provides the following illustration: assuming a match rate threshold of 80 percent, an ACO with an overall quality score of 90 percent would have an audit-adjusted quality score of 85.50 percent, that is, (90 – [.05×90]) = 85.50. CMS would continue the policy that if after the audit process CMS determines there is an audit match rate of less than 80 percent, the ACO may be required to submit a Corrective Action Plan (CAP).

Excluding Interim-Payments Made Under Demonstrations, Pilots or Time Limited Programs

CMS believes that use of interim payments made under a demonstration, pilot or time limited program could have an increasingly large effect on ACO benchmarks and performance year expenditure calculations in the future given widespread stakeholder interest in participating in alternative payment models and CMS interest in testing and expanding additional payment models that may lead to higher quality and more coordinated care at a lower cost to Medicare. CMS conducted a preliminary analysis which suggests that interim non-claims based payments (that is, payments that are subject to reconciliation at a later date) made under a demonstration, pilot, or time limited program can fluctuate significantly from quarter to quarter and may not reflect the actual final reconciled payment amount. Therefore, CMS proposes that going forward, only final non-claims based payments made under a demonstration, pilot or time limited program should be included in financial calculations related to benchmarks and performance year expenditures under the Shared Savings Program.

Therefore, CMS proposes to revise the applicable regulations to make clear that CMS would include only final individually beneficiary identifiable payments made under a demonstration, pilot or time limited program in financial calculations related to establishing and updating benchmarks and determining performance year expenditures under the Shared Savings Program. CMS proposes that this policy would be applied to calculations that are necessary to determine ACO performance for the 2018 performance year and subsequent performance years. For ACOs that are in the middle of an agreement period when this revised policy takes effect, CMS would adjust the benchmarks for these ACOs at the start of the 2018 performance year and each subsequent performance year so that the benchmark for the ACO reflects the use of the same payment information that would apply in expenditure calculations for the performance year.

Specifically, CMS proposes that: (1) when establishing benchmarks for agreement periods before 2018, CMS will include all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot, or time limited program, (2) for agreement periods beginning in 2018 and subsequent years, CMS would only include individually beneficiary identifiable payments made under a demonstration, pilot or time limited program that are final and not subject to further reconciliation, and (3) For the 2018 performance year and subsequent performance years in agreement periods beginning in 2015, 2016 and 2017, the benchmark would be adjusted to reflect only individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

Additionally, CMS proposes that when calculating expenditures for performance years before 2018, they would include all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot, or time limited program. When calculating expenditures for performance year 2018 and subsequent performance years, CMS would only include individually beneficiary identifiable payments made under a demonstration, pilot or time limited program that are final and

not subject to further reconciliation. To be consistent with treatment of claims-based payments, such final payments would have to be available in the separate CMS system by the end of the 3-month claims run out period.

Telehealth Services

CMS proposes to add the following codes to the list of covered Medicare telehealth services beginning in CY 2018 on a category one basis:

- Healthcare Common Procedure Coding System (HCPCS) code G0296 (Counseling visit to discuss need for lung cancer screening using low dose CT scan (ldct) (service is for eligibility determination and shared decision making))
- HCPCS code G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service))
- CPT code 90785 (Interactive complexity (List separately in addition to the code for primary procedure))
- CPT codes 90839 and 90840 (Psychotherapy for crisis; first 60 minutes) and (Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary procedure))
- CPT codes 96160 and 96161 (Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument) and (Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument)

Category one Services are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.

Proposed Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital

In the CY 2017 OPPS final rule, CMS finalized the Medicare PFS as the "applicable payment system" for most non-excepted items and services furnished by off-campus provider-based departments (PBDs). The current Medicare PFS payment rate for these services in non-excepted PBDs is 50 percent of the Outpatient Prospective Payment System (OPPS) payment rate. CMS proposes to lower that payment to 25 percent of the OPPS rate. The adjustment is referred to as the "Medicare PFS Relativity Adjuster." CMS notes that the Medicare PFS Relativity Adjuster for 2017 was intended to be a transitional policy until the agency collected more precise data to identify and value services furnished in non-excepted off-campus PBDs. CMS does not anticipate having such data until the end of 2017 but feels modifying the current Medicare PFS Relativity Adjuster to 25 percent would better meet the goals of obtaining site-neutrality. CMS is requesting comments on whether the agency should adopt a different Medicare PFS Relativity Adjuster such as 40 percent. For CY 2018, CMS proposes to continue to apply geographic adjustments used under the OPPS.

Appropriate Use Criteria (AUC) for Diagnostic Imaging Services

Section 218(b) of the Protecting Access to Medicare Act (PAMA) directs CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. The 2016 Medicare PFS final rule with comment period addressed the initial component of the new Medicare AUC program, specifying applicable AUC and established the process by which provider-led entities (PLEs) may become qualified to develop, modify or endorse AUC. The first list of qualified PLEs was posted on the CMS website at the end of June 2016. The 2017 Medicare PFS final rule established

specifications of qualified clinical decision support mechanisms (CDSMs) for use in the AUC program and specified the first list of priority clinical areas for the program. The first list of qualified CDSMs are available on the CMS website here. For more information on these proposals, please see our 2017 Final Medicare PFS Rule Summary.

In this proposed rule, CMS establishes the start date of the Medicare AUC program for advanced diagnostic imaging services. Specifically, CMS proposes that ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2019. CMS anticipates that implementation of the prior authorization component of the AUC program will be delayed and will discuss details around outlier calculations and prior authorization in the 2019 Medicare PFS proposed rule. CMS also proposes to establish a series of HCPCS level 3 codes. These G-codes would describe the specific CDSM that was used by the ordering professional. According to CMS, there would be one G-code for every qualified CDSM with the code description including the name of the CDSM. CMS also proposes to establish a G-code to identify circumstances where there was no AUC consultation through a qualified CDSM. The description of this code would indicate that a qualified CDSM was not consulted by the ordering professional. G-codes would be a line-item on both practitioner claims and facility claims. One AUC consultation G-code would be reported for every advanced diagnostic imaging service on the claim. For example, if there are two codes billed for advanced imaging services on the claim, two G-codes would be required on the claim. Each G-code would be expected, on the same claim line, to contain at least one new HCPCS modifier. CMS also proposes to develop a series of modifiers to provide necessary information as to whether, when a CDSM is used to consult AUC: (1) the imaging service would adhere to the applicable appropriate use criteria; (2) the imaging service would not adhere to such criteria; or (3) such criteria were not applicable to the imaging service ordered. CMS proposes to create additional modifiers to describe situations where an exception applies and a qualified CDSM was not used to consult AUC: (1) the imaging service was ordered for a patient with an emergency medical condition or (2) the ordering professional has a significant hardship exception. Based on this proposal CMS specifically seeks comments on any additional HCPCS modifiers that might be needed to separately identify allowable scenarios for which a qualified CDSM was not consulted by the ordering professional.

CMS will next implement a voluntary reporting period will begin July 2018. The timing for this opportunity for voluntary reporting is dependent on the readiness of the Medicare claims system to accept and process claims that include AUC consultation information. More information on the AUC program is available on the CMS website.

2018 PQRS, Medicare Meaningful Use and Value-Based Payment Modifier Changes

Physician Quality Reporting System (PQRS)

CMS proposes to modify the satisfactory reporting criteria for the CY 2016 reporting period for purposes of the 2018 PQRS payment adjustment. Specifically, CMS proposes to lower the requirement from 9 measures across 3 National Quality Strategy (NQS) domains, to 6 measures with no domain or cross-cutting measure requirement. For group practices, this would apply to the following reporting mechanisms: qualified registry; Qualified Clinical Data Registry (QCDR); direct Electronic Health Record (EHR) product; and EHR data submissions vendor product. CMS also proposes to remove the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS survey requirement for group practices comprised of 100 or more eligible professionals (EPs). CMS does not propose to collect any additional data for the CY 2016 reporting period, as the data submission period for the CY 2016 reporting period has already ended. It is important to note that no changes are being proposed for the Web Interface criteria.

These changes will allow more clinicians to avoid the 2018 PQRS penalty and aligns reporting requirements (retroactively to the 2016 reporting year) with the MACRA Merit-Based Incentive Payment System (MIPS) quality reporting requirements. Tables 20 and 21 summarize the proposed modifications to the requirements for avoiding the 2018 PQRS penalty for individual and group reporting (pages 34100, 34101). CMS clarifies that these changes would also apply to individual EPs and group practices using the secondary reporting period available to clinicians if an ACO fails to report quality measures on behalf of such individual EPs or group practices for the applicable reporting period, during the CY 2016 reporting period for purposes of the 2017 and 2018 PQRS payment adjustments, as applicable. For more information on this policy, please refer to our 2017 Medicare PFS rule Summary.

Meaningful Use Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record (EHR) Incentive Program for 2016

Similar to the proposed modifications to 2018 PQRS penalty requirements, CMS proposes to change the reporting criteria for eligible professionals and groups who chose to electronically report clinical quality measures (CQMs) through the PQRS Portal for purposes of the Medicare EHR Incentive Program (Meaningful Use). Specifically, CMS proposes to change the reporting criteria from 9 CQMs covering at least 3 NQS domains to 6 CQMs with no domain requirement to better align criteria with the modified requirement CMS proposes for the 2016 PQRS reporting period in this proposed rule, as well as the transition year requirements of the Quality Payment Program (QPP). CMS proposes that an eligible professional or group who satisfies the proposed reporting criteria may qualify for the 2016 incentive payment and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the eligible professional or group's applicable EHR reporting period for the payment adjustment year.

CMS does not propose changes to the Medicaid EHR Incentive Program criteria, however the agency did propose corresponding changes in the 2018 proposed Hospital Inpatient Prospective Payment System rule. In this rule, CMS proposes that for 2017, Medicaid eligible professionals would only be required to report on any six CQMs that are relevant to the EP's scope of practice.

Value-Based Payment Modifier

CMS proposes the following changes to the Value-Based Payment Modifier (Value Modifier) requirements for the 2018 payment year, applicable retroactively to the 2016 reporting year:

- Reduce the automatic downward adjustment for groups and solo practitioners in Category 2 (those who do not meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group's EPs meet the criteria as individuals) to negative 2 percent for groups with 10 or more EPs and at least one physician, and negative 1 percent for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.
- Hold all groups and solo practitioners who are in Category 1 (those who meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group's EPs meet the criteria as individuals) harmless from downward payment adjustments under quality tiering for the last year of the program (the 2018 payment year).
- To provide a smoother transition to the MIPS and to align incentives across all groups and solo practitioners, reduce the maximum upward adjustment under the quality-tiering methodology to two times an adjustment factor (+2.0x) for groups with 10 or more EPs.

This is the same maximum upward adjustment under the quality-tiering methodology CMS finalized and will maintain for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs.

See Tables 22-25 (page 34127) for a summary of these proposals as compared to previous requirements finalized by CMS. As a reminder, CMS waives Value Modifier participation for those in the Pioneer and Next Generation ACO Models, as well as the Comprehensive ESRD Care Initiative, and the Oncology Care Model. In general, on behalf of its ACO participant TINs, an ACO submits PQRS quality data using the Group Practice Reporting Option (GPRO) Web Interface. Successful reporting allows the ACO, and its participant TINs, to avoid penalties and potentially earn bonuses under PQRS and the Value Modifier. For more information on how Value Modifier policies apply to ACOs, please visit our Value Modifier resource page including our Value Modifier resource which provides an overview of the 2018 Value Modifier requirements for ACOs.

MACRA Patient Relationship Codes

The MACRA requires CMS to develop care episode and patient condition groups, and classification codes for such groups for use in MIPS cost analysis. To facilitate the attribution of patients and episodes to one or more clinicians, section 1848(r)(3) of the Act requires the development of patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. The categories are required to include different relationships of the clinician to the patient and reflect various types of responsibility for and frequency of furnishing care. CMS posted the operational list of patient relationship categories on May 17, 2017 and they are as follows:

- Continuous/Broad Services
- Continuous/Focused Services
- Episodic/Broad services
- Episodic/Focused Services
- Only as Ordered by Another Clinician

In this proposed rule, CMS seeks comment on these categories in preparation for potential subsequent revisions which must be made by the agency no later than November 1, 2018. Section 1848(r)(4) of the Act requires that claims submitted for items and services furnished by a physician or applicable practitioner include the applicable codes established for care episode groups, patient condition groups, and patient relationship codes beginning on or after January 1, 2018, as determined appropriate by the Secretary. Claims must also include the National Provider Identifier (NPI) of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). Applicable practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. CMS has submitted an application for CPT modifiers for this reporting of patient relationship codes on Medicare claims. The CPT Editorial Panel, at their June 2017 meeting determined that American Medical Association (AMA) would not include the modifiers in the CPT code set, pending future finalization of the modifiers by CMS, whereby CMS publishes the modifiers as Level II HCPCS Modifiers. Therefore, CMS proposes the Level II HCPCS Modifiers listed in Table 26 (p. 553) as the patient relationship codes, which would be added to the operational list if adopted in the final rule. Please refer to Table 26 for a complete list of the proposed patient relationship HCPCS modifiers and categories on page 34129 of the proposed rule.

Specifically, CMS proposes that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, would include the applicable HCPCS modifiers listed in Table 26, as well as the NPI of the ordering physician or applicable practitioner (if

different from the billing physician or applicable practitioner) on a voluntary basis. CMS plans to provide more clinician education on use of the modifiers during this time. CMS also clarifies the modifiers would also not be tied or related to intensity of services (E/M services).

Medicare Diabetes Prevention Program (MDPP)

Program Overview

The MDPP expanded model is an expansion of CMS' Center for Medicare and Medicaid Innovation's (Innovation Center) Diabetes Prevention Program (DPP) model test under the authority of section 1115A of the Act. The Secretary expanded the DPP model test under the authority of section 1115A(c) of the Act. For further information on the DPP model test, and the associated National DPP administered by the Centers for Disease Control and Prevention (CDC), please review our 2017 MPFS final rule summary and the Innovation Center and CDC websites. The aim of the MDPP expanded model is to continue to test a method of prevention of the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes as defined by the MDPP beneficiary eligibility criteria which was finalized in the 2017 Medicare PFS rule. Services available through the MDPP expanded model are MDPP services furnished in community and health care settings by coaches, such as trained community health workers or health professionals. The MDPP services are covered as preventive services under Medicare.

In the 2017 PFS final rule, CMS established a January 1, 2018 start date for the MDPP. In this proposed rule, CMS proposes MDPP services would instead be available on April 1, 2018 to provide more time for the agency to ensure MDPP suppliers have sufficient time to enroll in Medicare after the effective date of the final rule. CMS also makes proposals regarding eligibility criteria, payment for MDPP services, and MDPP supplier enrollment and compliance requirements. More detailed information on these proposals is available here.