Critical Issues in the Final 2017 Medicare Physician Fee Schedule

On October 14 the Centers for Medicare & Medicaid Services (CMS) released the final 2017 Medicare Physician Fee Schedule (PFS) along with a factsheet. This rule finalizes a number of adjustments to Medicare physician payments as well as changes to Medicare policies and quality reporting programs for 2017. Below are the key changes from the rule that affect Medicare Shared Savings Program (MSSP) ACOs.

General Payment Updates

CMS estimates a 2017 PFS conversion factor (CF) of $35.8887, which is slightly higher than the 2016 CF of $35.8043. 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 2017 CF reflects this budget neutrality adjustment as well as a 0.5 percent update as required under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS establishes a separate CF for anesthesia services and estimates the national average 2017 Anesthesia CF to be $22.0454, a slight increase from the 2016 Anesthesia CF of $21.9935. CMS's collective policies finalized in this rule result in very modest payment adjustments for almost all specialties. The vast majority of specialties will have either a neutral payment adjustment or a slight increase or decrease (plus/minus 1 percent) in their 2017 physician fee schedule payments. For more detail on specialty specific estimated payment adjustments, please refer to Table 52: CY 2017 PFS Estimated Impact on Total Allowed Charges by Specialty (pg. 80544).

MSSP Quality Reporting

ACO Measure Set

CMS finalized numerous changes to the MSSP quality measure set to better align with the Core Quality Measures Collaborative and the measures finalized in the MACRA Quality Payment Program (QPP) final rule with comment period. The finalized measure set changes include:

- Replace ACO measure 39 (Documentation of Current Medications in the Medical Record) with the previously used ACO measure 12 (Medication Reconciliation) in the Care Coordination/Patient Safety domain. This measure will be phased into pay for performance after two years as a pay-for-reporting measure.
- Add ACO measure 44 as proposed (Use of Imaging Studies for Low Back Pain) to align with the Core Quality Measures Collaborative core measure set. This measure will be analyzed using administrative claims data and no additional reporting would be required. To address concerns about the applicability of this measure to the Medicare population, this measure will be pay for reporting in all three years.
- Retire 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); and ACO-33 (Angiotensin-Converting Enzyme Inhibitor or Angiotensin Receptor Blocker Therapy for Patients with Coronary Artery Disease and Diabetes or Left Ventricular Systolic Dysfunction [LVEF less than 40 percent]) to reduce provider reporting burden and align with Core Quality Measures Collaborative for purposes of QPP.
- Retire ACO measures 9 and 10 (Agency for Healthcare Research and Quality [AHRQ] Ambulatory Sensitive Conditions Admissions) from the measure set to continue to remove redundancies as ACO-37 and 38 report on similar population with similar conditions.

- Add ACO measure 43 (Ambulatory Sensitive Condition Acute Composite) to the Care Coordination/Patient Safety domain as a composite measure. This measure will be risk-adjusted for demographic variables and comorbidities. This measure will be phased into pay for performance after two years as a pay-for-reporting measure. This measure is AHRQ Prevention Quality Indicator 91.

Table 42 (p. 80488) outlines the MSSP quality measure set that will be used to assess quality performance starting with the 2017 performance year including the new measures adopted in the final rule. Each measure that is indicated as a new measure will be assessed as a pay-for-reporting measure for the 2017 and 2018 performance years. After that, the measure will be assessed based on the phase-in schedule noted in Table 42.

As a result of these final measure changes, the four domains will include the following number of quality measures, which will reduce the total 2017 MSSP quality measures to a total of 31 (see Table 43):

- Patient/Caregiver Experience of Care – 8 measures
- Care Coordination/Patient Safety – 10 measures
- Preventive Health – 8 measures
- At-Risk Population – 5 measures (3 individual measures and a 2-component diabetes composite measure)

Validation Process for ACOs Submitting Quality Measures

CMS finalized their proposed changes to the audit process, specifically to audit enough medical records to achieve a 90 percent confidence interval; to conduct the audit in a single phase; and to calculate an overall audit performance rate. Implementation of the new streamlined audit process will begin in spring 2017 to validate data received from ACOs for the 2016 performance year.

In order to achieve a 90 percent confidence interval for each measure, although initially anticipated to be no more than 50 records per measure, CMS now suggests that the agency would have to request a much larger number of records (approximately 200 per measure) from the ACO during a quality validation audit of individual measures to achieve the desired level of statistical certainty.

If an ACO has an overall audit match rate of less than 90 percent, absent unusual circumstances, CMS will adjust the ACO's overall quality score proportional to its audit performance. The match rate would be derived by dividing the total number of audited records that match the information reported in the Web Interface by the total number of records audited. If an ACO fails an audit (match rate less than 90 percent), the ACO's overall quality score will be adjusted proportional to the ACO's audit performance. The audit-adjusted quality score will be calculated by multiplying the ACO's overall quality score by the ACO's audit match rate. The audit-adjusted quality score will be used to determine the percentage of any earned savings that the ACO may share or the percentage of any losses for which the ACO is accountable.

A new requirement is that in addition to the adjustment of the ACO's overall quality score, any ACO with an audit match rate of less than 90 percent may be required to submit a corrective action plan (CAP). In the CAP the ACO will be required to explain the reasons for the low audit match rate and how it plans to improve accuracy of its quality reporting in the future. CMS still maintains the right

to terminate or impose other sanctions on any ACO that does not report quality data accurately, completely or timely.

Technical Changes

To be more consistent with CMS policy goals, all measures will be taken into account when determining whether a compliance action should be taken against an ACO based on its quality performance in one or more domains. CMS will revise and replace the use of the term "quality performance standard" and the application of "minimum attainment level" to determine whether an ACO has met the quality performance standard for a performance year. Minimum attainment level will apply to both pay-for-reporting and pay-for-performance measures. The minimum attainment level for pay for performance measures is set at the 30th percent or 30th percentile of the quality performance benchmark and for pay for reporting measures at the level of complete and accurate reporting.

CMS also clarifies that only pay-for performance measures will be assessed on a sliding scale, while pay-for-reporting measures will earn the maximum number of points for a measure when the minimum attainment level is met. CMS will no longer use flat percentages to set the quality performance benchmark for quality performance measures that are calculated as ratios. Such measures will be clearly identified in operational documents posted on the CMS website.

Alignment with Other Quality Reporting Requirements and MACRA Provisions

Due to the fact that the Physician Quality Reporting System (PQRS) and Electronic Health Record (EHR) Incentive Program payment adjustments are sun-setting in 2018 (based on 2016 reporting), CMS made several technical changes to regulatory language to reflect this. Starting in 2019, the MACRA QPP will take the place of these programs. ACOs, on behalf of Eligible Clinicians (ECs) who bill under the Tax Identification Number (TIN) of an ACO participant, must submit all CMS Web Interface measures required by the Shared Savings Program using a CMS Web Interface to meet reporting requirements for the quality performance category under the QPP.

In the MACRA final rule, CMS finalized a policy to address rare instances in which an ACO fails to report quality as required, which would adversely impact the Merit-Based Incentive Payment System (MIPS) final score of all MIPS eligible clinicians billing under ACO participant TINs. Accordingly, in the event that an ACO does not report quality measures as required by the Shared Savings Program, scoring under the MIPS Alternative Payment Model (APM) scoring standard would be calculated at the ACO participant TIN level for MIPS eligible clinicians in that ACO, and each of the ACO participant TINs would receive its own TIN-level final score instead of an APM Entity-level final score. This policy does not cancel or mitigate any of the negative consequences associated with non-reporting on quality as required under the Shared Savings Program, including ineligibility for shared savings payments and/or potential termination of the ACO from the program.

Additionally, effective for 2017 reporting, in the final 2017 Medicare PFS, CMS modified the EHR measure (ACO-11) to align with the QPP. This change applies to all Medicare ACOs. Specifically, ACO participants must report data on the Advancing Care Information performance category on behalf of all ECs billing through the TIN of the ACO participant, according to the MIPS requirements for purposes of ACO-11. Not only will the title and specifications of the EHR quality measure ACO-11 align with QPP, but CMS is also changing the specifications in order to assess the ACO on the degree of Certified EHR Technology (CEHRT) use by all providers and suppliers designated as ECs under the

QPP, rather than narrowly focusing on the degree of CEHRT use by primary care physicians participating in the ACO. Although certain ECs are exempt from reporting under MIPS, CMS will require all ACO participant TINs, regardless of track, to submit data for the advancing care information performance category.

Because the specifications for ACO-11 are changing, CMS is considering it a newly introduced measure and will require complete and accurate reporting for the first two reporting periods. The measure will remain double-weighted and will be pay for reporting for all ACOs for the 2017 and 2018 performance years. An additional requirement is being included, namely that during years in which ACO-11 is designated as a pay-for-reporting measure in order for an ACO to meet the requirements for complete and accurate reporting, at least one EC participating in the ACO must meet the reporting requirements under the Advancing Clinical Information performance category under the QPP. Beginning in the 2019 performance year, ACO-11 will be assessed according to the phase-in schedule noted in Table 42. During pay-for-performance years, assessment of EHR adoption will be measured based on a sliding scale.

Lastly, CMS is finalizing a policy that any future changes made to the CMS Web Interface measures will be adopted through rulemaking for the QPP, and such changes will be applicable to ACO quality reporting under the MSSP.

ACO Participants Who Report PQRS Measures Separately

To address concerns about eligible professionals (EPs) who are unable to avoid PQRS penalties when their ACO fails to successfully report PQRS on their behalf, CMS is finalizing its policies as proposed, to allow affected EPs who participate in an ACO to report separately for the 2017 PQRS payment adjustment. A secondary PQRS reporting period for the 2017 PQRS Payment adjustment will be limited to EPs and group practices that bill through the TIN of an ACO participant in an ACO that failed to satisfactorily report. The secondary reporting period for the 2017 PQRS payment adjustment will coincide with the reporting period for the 2018 PQRS payment adjustment, January 1, 2016 through December 31, 2016. Individual EPs or Group practices would be able to report using one of the registry, Qualified Clinical Data Registry (QCDR), direct EHR, or EHR data submission vendor reporting options. EPs do not need to register for the PQRS GPRO for the 2017 PQRS payment adjustment. If the secondary reporting period is used for the 2017 PQRS payment adjustment, the EP or group practice should expect to receive a PQRS payment adjustment for services furnished in 2017 until CMS can determine the EP or group practice satisfactorily reported for purposes of avoiding the 2017 payment adjustment. The informal review submission periods for these affected EPs or group practices would occur during the 60 days following the release of the PQRS feedback reports for the 2018 PQRS payment adjustment.

Other MSSP Changes

Voluntary Beneficiary Alignment

In response to repeated requests from NAACOS and others, CMS finalized a modification to the MSSP beneficiary assignment algorithm to allow beneficiaries to designate an ACO professional as responsible for their overall care. This designation will result in the beneficiary being assigned to the designated provider, and as long as certain criteria are met, this will take precedence over assignment based on plurality of their primary care. Voluntary beneficiary alignment does not obligate a beneficiary to receive care from a particular ACO, and the beneficiary still retains freedom to receive services from the Medicare provider of their choice. CMS finalized use of an

automated approach to voluntary alignment, and the agency plans to have this available for ACOs in all MSSP tracks beginning in 2018. Voluntary alignment will supplement the current assignment process and is designed to help ACOs increase patient engagement, which can aid in broader goals such as improved care management and health outcomes and lower expenditures for beneficiaries. Supplementing the claims-based assignment algorithm with beneficiary attestations will further ensure that beneficiaries are assigned to ACOs based on their relationship with providers and suppliers that they believe to be truly responsible for their overall care.

If a beneficiary designates an ACO professional that he or she believes is responsible for coordinating their overall care as their "main doctor," the beneficiary will be assigned to the ACO in which that ACO professional is participating, as long as the following criteria are met:

- The beneficiary must have had at least one primary care service during the assignment window with a physician who is an ACO professional in the ACO and who is a primary care physician (as defined by the following specialty types: internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine) or who has one of the primary specialty designations included in §425.402(c).
- The beneficiary must meet the assignment eligibility criteria established in §425.401(a) and must not be excluded by the criteria at §425.401(b). Such exclusion criteria shall apply to all tracks for purposes of alignment based on beneficiary designation information.
- The designation must be made in the form and manner and by a deadline determined by CMS (specific details will be issued at a later date).

The requirement detailed in the first bullet, that a beneficiary must have had a primary care service during the assignment window, addresses concerns raised by NAACOS about beneficiary attestation remaining in place even if the beneficiary no longer has a relationship with the ACO. This will ensure that a beneficiary cannot remain aligned to an ACO for an extended period if the beneficiary's designation is outdated and the beneficiary is no longer receiving services from any ACO providers/suppliers in the ACO. If a beneficiary designates a physician in an ACO, but the beneficiary did not receive at least one primary care service during the assignment window from a physician in that ACO, the voluntary alignment would not be used. Similarly, if a beneficiary designates an ACO professional whose specialty is not used in assignment, the voluntary alignment would not be effective and the claims-based assignment methodology would be used.

CMS responded to NAACOS' concerns about the proposed timing of the alignment, which the agency had proposed to update on a quarterly basis for ACOs in Track 1 or 2 and annually for those in Track 3. We expressed concerns that adding beneficiaries late in the performance year would not provide ACOs with information in a timely manner. Therefore, CMS finalized a process that will take beneficiary attestations into account to voluntarily align beneficiaries annually and prospectively to ACOs participating in all MSSP tracks at the beginning of each performance year, provided the beneficiary is eligible for assignment to the ACO. Specifically, beneficiaries who voluntarily align to an ACO participating in Track 1 or Track 2 will be prospectively assigned to that ACO for the entire performance year even if they would not be retrospectively assigned to the ACO under the claims-based assignment methodology or if they later align with another provider or supplier outside the ACO during the performance year. CMS notes that in such cases, the change in designation would be taken into account at the beginning of the next performance year. CMS also clarifies that the assignment methodology also applies to benchmarking years. Accordingly, when determining

beneficiary assignment for a benchmark year, CMS will incorporate beneficiary designations that were in place during the assignment window for the benchmarking year.

In the proposed rule, CMS provided examples by which the voluntary alignment process could be conducted in an automated manner, such as through use of MyMedicare.gov, 1-800-Medicare, or the Physician Compare website. However, in the final rule CMS notes that they anticipate that for the first year, the agency will enable beneficiaries to voluntarily align with an ACO by designating a "main doctor" through MyMedicare.gov. CMS plans to consider expanding the use of 1-800-Medicare or other mechanisms at a later time. Leading up to 2018, CMS will implement voluntary alignment and develop program guidance and outreach activities for beneficiaries and ACOs.

CMS emphasizes that they do not intend for voluntary alignment to be used as a mechanism for ACOs to target beneficiaries for whose treatment the ACO might expect to earn shared savings or to avoid those for whose treatment the ACO might be less likely to generate shared savings. The agency will monitor implementation of this process to protect against this. However, CMS also explains that it is important to promote engagement and discussion between beneficiaries and their healthcare providers. Therefore, ACOs and ACO professionals are not prohibited from providing a beneficiary with accurate descriptive information about the potential patient care benefits of designating an ACO professional as responsible for the beneficiary's overall care.

CMS finalized its proposal that the ACO and its ACO participants, ACO providers/suppliers, ACO professionals, and other individuals or entities performing functions or services related to ACO activities are prohibited from providing or offering gifts or other remuneration to beneficiaries as inducements to influence a beneficiary's decision to designate or not designate an ACO professional through voluntary alignment. CMS also notes that withholding or threatening to withhold medical services and limiting or threatening to limit access to care in relation to voluntary alignment decisions are all prohibited.

CMS will notify beneficiaries of the opportunity to voluntarily align to a provider, and CMS will encourage beneficiaries to designate their "main doctor" or primary healthcare provider responsible for coordinating their overall care. CMS explains how to do this through beneficiary outreach materials, such as the Medicare & You Handbook and the required MSSP beneficiary outreach activities or materials. The agency intends to issue, either directly or indirectly through template language, written communications to beneficiaries detailing the automated process for voluntary alignment.

SNF 3-Day Rule Waiver Beneficiary Protections

The Social Security Act requires that Medicare beneficiaries have a prior inpatient hospital stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient Skilled Nursing Facility (SNF) care. Pioneer and Next Generation ACOs currently have a waiver that allows beneficiaries to receive SNF care without having the required inpatient stay, and this waiver of the 3-day SNF rule will be available to MSSP Track 3 ACOs beginning in 2017. CMS is concerned that in limited circumstances, such as when a beneficiary is no longer enrolled in Medicare Part B, the beneficiary may be held financially liable for non-covered Part A SNF services related to use of the ACO 3-day SNF waiver. It is not operationally feasible for CMS to notify the ACO and for the ACO to notify its SNF affiliates, ACO participants, and ACO providers/suppliers immediately of the beneficiary's exclusion. The lag in communication may cause the SNF affiliate to unknowingly admit a beneficiary who no longer qualifies for the waiver. In these instances, beneficiaries would appear

to qualify for the waiver but would actually be ineligible and could be held financially liable for these services.

As a new beneficiary protection, CMS finalized its proposal to modify the SNF 3-day rule waiver to include a 90-day grace period that permits payment for SNF services provided to beneficiaries who were initially on the ACO's prospective assignment list for a performance year but were subsequently excluded and are therefore not eligible for the waiver. In such instances where SNF services are not covered but would have been covered under the SNF 3-day rule waiver, CMS will make payments for these SNF services, provided certain conditions are met. The Pioneer and Next Generation model already has a similar 90-day grace period.

CMS finalized its policy that a SNF affiliate approved for the waiver will be held financially responsible if it admits a beneficiary that was never prospectively assigned to the Track 3 ACO or who was assigned but later excluded and the 90-day grace period has lapsed and the claim is rejected only for lack of a qualifying inpatient hospital stay. In addition, the SNF may not charge the beneficiary for the non-covered SNF services, even if the beneficiary explicitly requested or agreed to being admitted to the SNF in absence of a qualifying 3-day hospital stay. Further, should the SNF 3-day rule waiver be misused, the ACO may be required to submit a corrective action plan (CAP) to ensure that the waiver is not misused in the future. The CAP would address what actions the ACO will take to ensure that the SNF 3-day rule waiver is not misused in the future. CMS finalized that the misuse of the waiver could result in CMS taking remedial action against the ACO, up to and including termination of the ACO from the MSSP.

CMS recognizes that ACOs and their SNF affiliates could be reluctant to enter into a SNF affiliate agreement without clarity about their potential responsibility for non-covered SNF services related to the waiver. For these reasons, CMS is developing a process for Track 3 ACOs that have already applied for the SNF 3-day rule waiver for the 2017 performance year to confirm that they and their SNF affiliates agree to comply with all requirements related to the SNF 3-day rule waiver, including the new requirements finalized in this rule. ACOs and SNF affiliates that do not agree to comply with all requirements will be ineligible to offer services under the SNF 3-day rule waiver. CMS notes that this confirmation process may delay approval of ACOs' applications for the SNF 3-day rule waiver for the 2017 performance year. However, CMS does not anticipate approval will be delayed beyond the first quarter of 2017.

Technical Changes

CMS finalized a policy clarification for MSSP Track 2 or 3 ACOs that chose a non-variable Minimum Savings Rate (MSR)/ Minimum Loss Rate (MLR) at the start of the agreement period but subsequently fall below 5,000 assigned beneficiaries at the time of financial reconciliation. In these instances, CMS will allow the ACO to remain eligible for shared savings (or losses) and the MSR/MLR used for financial reconciliation would still be the MSR/MLR the ACO selected at the start of the agreement period and would not change as a result of the population falling below 5,000. If the ACO selected a variable MSR/MLR based on its number of assigned beneficiaries, CMS will use the same approach it currently uses for Track 1 ACOs in this situation, which relies on an expanded sliding scale for the MSR/MLR to match the number of assigned beneficiaries, should that population fall below 5,000.

To address confusion from an issue in CMS's final June 2015 rule, the agency finalized its proposal to adjust regulatory language to clarify that in instances where an ACO acquires a TIN or there is a

merger, the merged/acquired TIN is not required to remain Medicare enrolled after it has been merged or acquired and is no longer used to bill Medicare.

Primary Care and Care Coordination Changes

Payment for New Services

In an effort to better serve beneficiaries with multiple chronic conditions and the providers who furnish their care, CMS finalized a number of payment changes and new codes, which are listed in Table 1 below.

Table 1: New Primary Care and Care Coordination Codes

Proposed Codes	Overview of Service
G0502 G0503 G0504	Psychiatric collaborative care management through three new G-codes based on the psychiatric Collaborative Care Model
G0507	Care management services for behavioral health conditions
G0505	Assessment and care planning for beneficiaries with cognitive impairment (such as from Alzheimer's disease or dementia, at any stage of impairment)
99358, 99359	Payment for CPT codes for non-face-to-face Prolonged Evaluation and Management (E/M) services that are currently bundled and increase payment for face-to-face Prolonged E/M services

CMS finalized certain limitations regarding when certain code combinations can or cannot be billed. For example, a single practitioner may not bill for non-face-to-face prolonged services, CPT codes 99358 and 99359, when performed during the service time of Transitional Care Management (TCM) (CPT codes 99495 and 99496).

CMS finalized its proposal to amend regulations to allow general supervision, rather than direct supervision, for the non-face-to-face portion of designated care management services. General supervision is already allowed for Chronic Care Management (CCM) and the non-face-to-face portion of TCM services. This new change allows general supervision to apply to other non-face-to-face services, including G0502, G0503, G0504, G0507, CPT code 99487 and CPT code 99489. CMS also finalized its proposal to allow services and supplies furnished incident to CCM and TCM services to be furnished under general supervision of a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) practitioner.

Chronic Care Management

CMS finalized several changes related to Medicare CCM, including payment for complex CCM CPT codes 99487 and 99489, effective in 2017. The separate payments for complex CCM services are designed to support care management for the most complex and time-consuming cases of beneficiaries with multiple chronic conditions. While the CCM service elements will generally be the same for all CCM codes, the key differences include the amount of clinical staff time spent furnishing the services, the complexity of medical decision-making as defined in the E/M guidelines, and the nature of care planning that is performed (establishment or substantial revision of the care

plan for complex CCM versus establishment, implementation, revision or monitoring of the care plan for noncomplex CCM).

In an effort to encourage broad utilization of CCM codes, CMS finalized several changes to simplify the scope of service elements for CCM. These amended scope of service elements will apply to all three CCM codes beginning in 2017. The final CCM requirements are detailed in Table 11 on page 80251, and some of the key changes include:

- Introducing an add-on code (G0506) that accounts for additional work of the billing practitioner in personally performing a face-to-face assessment of a beneficiary requiring CCM services and personally performing CCM care that is not already reflected in the initiating visit itself (nor in the monthly CCM service code).
- Fewer requirements for when a qualifying face-to-face initiating visit is necessary, including no longer requiring a qualified face-to-face initiating visit for existing patients who have been seen within the past year. The qualifying initiating visit requirement remains in place for new patients or those not seen within one year prior to the commencement of CCM services. Specifically, those patients must have CCM initiated during an Annual Wellness Visit, Initial Preventive Physical Examination, or face-to-face E/M visit.
- Simplifying revisions to the health IT use requirements for CCM codes. While still requiring use of a certified EHR, there is new flexibility around the 24/7 access requirements to address urgent patient needs and more options - including fax - to share comprehensive care plans and continuity of care documents (i.e., clinical summaries) used in relation to care transitions.
- Flexibility related to beneficiary consent, including removing the requirement for written beneficiary consent and allowing consent to be given verbally and documented in the medical record. CMS notes that the revised beneficiary consent requirements do not affect any written agreements that are already in place for CCM services and practitioners can still elect to obtain written consent rather than verbal consent.
- Simplifying requirements related to providing care plans by allowing providers to give the care plan in hard copy or electronic form in accordance with patient preferences and allowing the care plan to be shared with the caregiver (in accordance with applicable privacy and security rules and regulations).

Telehealth

CMS finalized the addition of new telehealth services including: end stage renal disease (ESRD) related dialysis services (90967-90970), advanced care planning explanation and discussion of advanced directives (99497-99498), and critical care consultation (new codes G0508-G0509). The agency also finalized its proposal to use a newly developed place of service (POS) code for telehealth services, which must be reported in addition to the GT and GQ telehealth modifiers. Specifically, the new code, POS 02: Telehealth (Descriptor: The location where health services and health related services are provided or received, through telecommunication technology) will be used for services furnished on or after January 1, 2017 and more information from CMS is available here. CMS will use the facility practice expense RVUs to pay for telehealth services reported by practitioners with the telehealth POS code beginning in 2017.

Expansion of the Diabetes Prevention Program

The final rule expands the Medicare diabetes prevention program (MDPP) model test for pre-diabetic patients to prevent the onset of type 2 diabetes. The expanded model will allow MDPP services to be covered as an additional preventive service under Medicare Part B and will be provided by coaches, such as trained community health workers or health professionals, in community and health care settings. The MDPP training will include a core-benefit of 12-months of sessions. At the end of the 12-month program, if a required 5 percent of weight loss is achieved there is potential for ongoing maintenance sessions for as long as the weight loss is maintained. The MDPP expanded model will become effective nationwide beginning on January 1, 2018.

CMS will require all Diabetes Prevent Program (DPP) organizations, regardless of any existing enrollment in Medicare, to enroll in Medicare as MDPP suppliers in order to furnish and bill for MDPP services. CMS expects to begin enrollment for organizations seeking to be MDPP suppliers after the next round of rulemaking is complete in 2017. CMS indicates they will also issue subregulatory guidance in this area before subsequent rulemaking is finalized.

Lastly, CMS expects to finalize the payment structure for the MDPP expanded model in rulemaking during 2017 and expects to begin payment for MDPP services in 2018. Payment will be tied to the number of sessions attended as well as additional payments for weight loss achievement. Additional MDPP payment model details can be found in Table 41 (pg. 1106).

Value-Based Payment Modifier

The Medicare Value-Based Payment Modifier (VM) initially excluded MSSP ACOs, but they were added beginning with 2015 reporting, which may affect Medicare FFS physician payments in 2017, depending on performance. 2016 is the last reporting period for the VM, which corresponds to payment adjustments in 2018. Next Generation ACOs are excluded from the VM. The VM generally rewards or penalizes Medicare providers based on quality performance with most quality metrics based on PQRS and on cost, but ACOs are only evaluated on quality and considered neutral on cost. For detailed information about how the 2018 VM affects ACOs based on 2016 reporting, please refer to this NAACOS resource. CMS finalized minor modifications to the 2017 and 2018 VM, and the program ends in 2018 as providers move to new quality reporting criteria under MACRA.

CMS finalized its policy to allow EPs or groups to report PQRS outside of the ACO to avoid automatic 2017 and 2018 PQRS and VM penalties. This opportunity is only available when an ACO fails to report PQRS on behalf of its providers. In these situations, quality information reported by these EPs or groups would be used to determine payment adjustments for the VM. Please see the section *ACO Participants Who Report PQRS Measures Separately* for more details on reporting timeframes.

CMS finalized changes to the informal VM review process to offer protection to providers without necessitating CMS recalculate all bonuses and penalties across the VM, which is a budget-neutral program. Specifically, CMS finalized that in cases where there is a widespread claims data issue or a systematic issue with quality data submitted for PQRS that renders it unusable for calculating a TIN's composite scores for quality (or cost for non-ACOs), CMS would classify the TIN's quality (or cost for non-ACOs) composite as "average." Widespread issues would include those affecting multiple TINs which prevent CMS from being able to determine the accuracy of the data submitted. Further, when errors are discovered for a TIN's payment calculation, CMS will reclassify EPs as "average quality" when originally classified as "low quality," as "average cost" when originally

classified as “high cost,” and will allow EPs to retain their original classification when classified as “high quality,” “average quality,” “low cost” or “average cost.”

Collecting Data on Resources Used in Furnishing Global Services

CMS has had long-standing concerns about the valuation of global service packages, including 0-day, 10-day and 90-day global packages. To support appropriate packaging and valuation of these services, CMS wants to learn more about how post-operative care is delivered, including details about pre- and post-operative visits, complications, and supplies. MACRA requires CMS to develop a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection begin in 2017 to improve the accuracy of valuation of surgery services beginning in 2019.

Therefore, beginning in 2017 CMS will require practitioners furnishing 10- and 90-day global services to report on post-operative visits furnished during the applicable global periods. CMS did not finalize its proposed eight G-codes for reporting and instead finalized use of CPT code 99024 (*Postoperative follow-up visit, normally included in the surgical package, to indicate that an E/M service was performed during a postoperative period for a reason(s) related to the original procedure).* This reporting requirement will become mandatory for post-operative services related to procedures furnished on or after July 1, 2017 rather than as of January 1, 2017, as proposed. CMS also limited the scope of reporting to practitioners in certain states and practice sizes. Specifically, CMS finalized that reporting is only required for:

- Practitioners located in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island
- Practitioners in group practices that include 10 or more practitioners
- Particular 10- and 90-day global surgical codes (CMS will publish that list on its website)

In addition to claims-based reporting, CMS finalized its proposal to conduct two surveys to capture detailed information related to global surgical services. One survey will include a representative sample of practitioners and another will be for those in ACOs. These surveys will help CMS gain information on post-operative activities beyond what is captured with the claims-based reporting, and specific survey questions will be further developed by CMS in the coming months. By separately surveying ACOs, CMS hopes to investigate whether there are differences in pre- and post-operative care in ACO settings compared to non-ACO settings. The ACO survey effort will begin with an initial phase of primary data collection using a range of methodologies in a small number of ACOs; development, piloting, and validation of an additional survey module specific to ACOs.

Appropriate Use Criteria for Certain Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 (PAMA) required CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. The 2016 Medicare PFS specified applicable AUC for the program and established an evidenced-based process and transparency requirements for the development of AUC. The rule also defined provider-led entities (PLEs) that may develop, modify or endorse AUC. CMS has published the first list of approved PLEs, available here. AUC consultation will be required by ordering professionals through a qualified Clinical Decision Support Mechanisms (CDSMs) for all applicable imaging services. Reporting on AUC consultation by furnishing professionals will be required January 1, 2018 and CMS will address this requirement through PFS rulemaking for CY 2018.

In this rule, CMS finalized a list of eight priority clinical areas for use in the AUC program. Priority clinical areas are intended to be the areas of focus for future outlier calculations when determining which ordering professionals will be subject to prior authorization. CMS indicates this will be further addressed in future rulemaking. The eight priority clinical areas finalized include: 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); and cervical or neck pain.

Physician Self-Referral Updates

CMS finalized its physician self-referral (Stark Law) updates included in the proposed rule without modification. Concerning unit-based compensation in arrangements for the rental of office space or equipment, CMS will prohibit per-unit of service rental charges where the lessor generates payment from the lessee, either through a referral to the lessee for a service to be provided in the rented office space, or through use of the rented equipment. This means that per-unit of service rental charges for the rental of office space or equipment are permissible, so long as the referral for the service to be provided in the rented office space or using the rented equipment did not come from the lessor.