Issue Brief

FEDERAL ISSUE BRIEF • November 3, 2017

KEY POINTS

- The rule is scheduled for publication on Wednesday, Nov. 15.
- The overall update to payments will be 0.41 percent. This update reflects the 0.50 percent update established under the *Medicare Access and CHIP Reauthorization Act* of 2015, reduced by 0.09 percent, due to CMS missing the misvalued code target recapture amount required under the *Achieving a Better Life Experience Act of 2014*.

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CMS Issues CY 2018 Updates to the PFS and Other Part B Services; Medicare Shared Savings Program Requirements; and the Medicare Diabetes Prevention Program

The Centers for Medicare and Medicaid Services issued a final rule regarding revisions to payment policies and payment rates under the Medicare Physician Fee Schedule for calendar year 2018. A copy of the 1,250-page document is currently available on the ***Federal Register*** website at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23953.pdf.

The rule is scheduled for publication on Wednesday, Nov. 15.

The PFS Addenda, along with other supporting documents and tables referenced in the final rule, are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html. For the CY 2018 PFS Final Rule, refer to item CMS-1676-F.

COMMENT

Once again, the PFS is a long and complex document. It is somewhat difficult to follow exactly what CMS proposed, and more importantly, what final actions CMS has taken. This is another rule that "cries" for the adoption of clear "final action/decision sections."

Major changes address the following:

- Overall Payment Update and Misvalued Code Target
- Potentially Misvalued Codes
- Telehealth Services
- Establishing Values for New, Revised and Misvalued Codes
- Establishing Payment Rates under the PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital
- Evaluation & Management Guidelines and Care Management Services
- Care Coordination Services and Payment for Rural Health Clinics and Federally Qualified Health Centers
- Part B Drug Payment: Infusion Drugs Furnished Through an Item of Durable Medical Equipment
- Solicitation of Public Comments on Initial Data Collection and Reporting Periods for Clinical Laboratory Fee Schedule
- Payment for Biosimilar Biological Products under Section 1847A of the Act

continued

- Appropriate Use Criteria for Advanced Diagnostic Imaging Services
- PQRS Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment
- Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record Incentive Program for 2016
- Medicare Shared Savings Program
- Value-Based Payment Modifier and the Physician Feedback Program
- MACRA Patient Relationship Categories and Codes
- Changes to the Medicare Diabetes Prevention Program Expanded Model
- Physician Self-Referral Law: Annual Update to the List of CPT/HCPCS Codes
- Therapy Caps

Note: The material that follows does not reflect all of the items above.

PAYMENT UPDATES AND CONVERSION FACTORS

The overall update to payments will be 0.41 percent. This update reflects the 0.50 percent update established under the *Medicare Access and CHIP Reauthorization Act* of 2015, reduced by 0.09 percent, due to CMS missing the misvalued code target recapture amount required under the *Achieving a Better Life Experience Act of 2014.*

Calculation of the CY 2018 PFS Conversion Factor		
CY 2017 Conversion Factor CY 2017		**35.8887**
Statutory Update Factor	0.50 percent (1.0050)	
CY 2018 RVU Budget Neutrality Adjustment	-0.10 percent (0.9990)	
CY 2018 Target Recapture Amount	-0.09 percent (0.9991)	
CY 2018 Conversion Factor		**35.9996**

Calculation of the CY 2018 Anesthesia Conversion Factor		
CY 2017 National Average Anesthesia Conversion Factor		**22.0454**
Update Factor	0.50 percent (1.0050)	
CY 2018 RVU Budget Neutrality Adjustment	-0.10 percent (0.9990)	
CY 2018 Target Recapture Amount	-0.09 percent (0.9991)	
CY 2018 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	+0.34 percent (1.0034)	
CY 2018 Conversion Factor		**22.1887**

I. Major Provisions of the Rule

A. Determination of Practice Expense Relative Value Units

Practice expense is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice expenses.

This material, extending some 75 pages, provides technical and detailed information about

the methodology, inputs and resources involved in transforming each service into service-specific PE RVU.

The PE RVUs are displayed in Addendum B on the CMS website.

B. Determination of Malpractice Relative Value Units

For CY 2018, CMS will continue basing the malpractice RVUs on premium data that was collected for the CY 2015 MP RVU

Like the PE discussion, this area is technical in that it discusses the factors used in deriving the MP RVUs.

The resource-based MP RVUs are shown in Addendum B.

C. Medicare Telehealth Services

The list of telehealth services is included in the downloads section to this rule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFSFederal-Regulation-Notices.html.

CMS proposed to add the following services to the telehealth list for CY 2018:

- HCPCS code G0296: Counseling visit to discuss need for lung cancer screening using low dose CT scan (service is for eligibility determination and shared decision making), and
- 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 service).

CMS also proposed to add four additional services. All four of these codes are add-on codes that describe additional elements of services currently on the telehealth list and would only be considered telehealth services when billed as an add-on to codes already on the telehealth list. The four codes are:

- CPT code 90785: Interactive complexity (list separately in addition to the code for primary procedure),
- CPT codes 96160 and 96161: Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument and Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
- 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).

CMS is finalizing its proposals and will add these services to the list of Medicare telehealth services for CY 2018 on a Category 1 basis.

Additionally, CMS is finalizing its proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners.

CMS is finalizing a separate payment for CPT code 99091, which describes certain remote patient monitoring, for CY 2018.

D. Potentially Misvalued Services Under the Physician Fee Schedule

Section 1848(c)(2)(K) of the Act requires the secretary to periodically identify potentially misvalued services using

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certain criteria and to review and make appropriate adjustments to the relative values for those services.

CMS notes that after reviewing the range of public comments, it agrees with commenters that CPT code 27279 is potentially misvalued and believes that a comprehensive review of the code values are warranted.

CMS is finalizing the CY 2017 RUC-recommended work RVUs for CPT codes 36901 to 36909, consistent with the requests of public commenters.

E. Valuation of Specific Codes

CMS reviews the resource inputs for several hundred codes under the annual process referred to as the potentially misvalued code initiative. CMS says recommendations from the American Medical Association-Relative Value Scale Update Committee are critically important to this work. For CY 2018, CMS is changing the values for individual services that generally reflect the expert recommendations from the RUC.

The material in this section covers nearly 300 pages.

The table below identifies specific codes that CMS has reviewed in this final rule.

In red is the rule's display copy page on which the code(s) discussion begins.

1	Anesthesia Services for Gastrointestinal Procedures (CPT codes 00711, 00712, 00811, 00812 and 00813) **Page 234**
2	Acne Surgery (CPT code 10040) **Page 238**
3	Muscle Flaps (CPT codes 15734, 15736, 15738, 15730 and 15733) **Page 239**
4	Application of Rigid Leg Cast (CPT code 29445) **Page 242**
5	Strapping Multi-Layer Compression (CPT codes 29580 and 29581) **Page 244**
6	Resection Inferior Turbinate (CPT code 30140) **Page 246**
7	Control Nasal Hemorrhage (CPT codes 30901, 30903, 30905 and 30906) **Page 248**
8	Nasal Sinus Endoscopy (CPT codes 31254, 31255, 31256, 31267, 31276, 31287, 31288, 31295, 31296, 31297, 31241, 31241, 31253, 31257, 31259 and 31298) **Page 251**
9	Tracheostomy (CPT codes 31600, 31601, 31603, 31605 and 31610) **Page 260**
10	Bronchial Aspiration of Tracheobronchial Tree (CPT codes 31645 and 31646) **Page 262**
11	Cryoablation of Pulmonary Tumor (CPT codes 32998 and 32994) **Page 266**
12	Artificial Heart System Procedures (CPT codes 33927, 33929 and 33928) **Page 267**
13	Endovascular Repair Procedures (CPT codes 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34709, 34710, 34711, 34712, 34713, 34812, 34714, 34820, 34833, 34834, 34715 and 34716) **Page 269**
14	Selective Catheter Placement (CPT codes 36215, 36216, 36217 and 36218) **Page 273**
15	Treatment of Incompetent Veins (CPT codes 36470, 36471, 36482, 36483, 36465 and 36466) **Page 273**
16	Therapeutic Apheresis (CPT codes 36511, 36512, 36513, 36514, 36516 and 36522) **Page 276**
17	Insertion of Catheter (CPT codes 36555, 36556, 36620 and 93503) **Page 281**
18	Insertion of PICC Catheter (CPT code 36569) **Page 283**
19	Bone Marrow Aspiration (CPT codes 38220, 38221, 38222 and 20939) **Page 284**

continued

20	Esophagectomy (CPT codes 43107, 43112, 43117, 43286, 43287 and 43288) **Page 288**
21	Transurethral Electrosurgical Resection of Prostate (CPT code 52601) **Page 292**
22	Peri-Prostatic Implantation of Biodegradable Material (CPT code 55874) **Page 294**
23	Colporrhaphy with Cystourethroscopy (CPT codes 57240, 57250, 57260 and 57265) **Page 299**
24	Injection of Anesthetic Agent (CPT code 64418) **Page 301**
25	Nerve Repair with Nerve Allograft (CPT codes 64910, 64911, 64912 and 64913) **Page 301**
26	Correction of Trichiasis (CPT Code 67820) **Page 305**
27	CT Soft Tissue Neck (CPT Codes 70490, 70491 and 70492) **Page 307**
28	Magnetic Resonance Angiography Head (CPT codes 70544, 70545 and 70546) **Page 308**
29	Magnetic Resonance Angiography Neck (CPT codes 70547, 70548 and 70549) **Page 309**
30	CT Chest (CPT Codes 71250, 71260 and 71270) **Page 311**
31	MRI of Abdomen and Pelvis (CPT codes 72195, 72196, 72197, 74181, 74182 and 74183) **Page 312**
32	MRI Lower Extremity (CPT codes 73718, 73719 and 73720) **Page 312**
33	Abdominal X-ray (CPT codes 74022, 74018, 74019 and 74021) **Page 314**
34	Angiography of Extremities (CPT codes 75710 and 75716) **Page 315**
35	Ophthalmic Biometry (CPT codes 76516, 76519 and 92136) **Page 316**
36	Ultrasound of Extremity (CPT codes 76881 and 76882) **Page 317**
37	Flow Cytometry Codes (CPT codes 88184 and 88185) **Page 319**
38	Pathology Consultation during Surgery (CPT codes 88333 and 88334) **Page 323**
39	Radiation Therapy Planning (CPT Codes 77261, 77262 and 77263) **Page 327**
40	Tumor Immunohistochemistry (CPT codes 88360 and 88361) **Page 328**
41	Cardiac Electrophysiology Device Monitoring Services (CPT codes 93279, 93281, 93282, 93283, 93284, 93285, 93286, 93287, 93288, 93289, 93290, 93291, 93292, 93293, 93294, 93295, 93296, 93297, 93298 and 93299) **Page 336**
42	Transthoracic Echocardiography (CPT codes 93306, 93307 and 93308) **Page 341**
43	Stress Transthoracic Echocardiography Complete (CPT codes 93350 and 93351) **Page 343**
44	Peripheral Artery Disease Rehabilitation (CPT code 93668) **Page 344**
45	INR Monitoring (CPT codes 93792 and 93793) **Page 346**
46	Pulmonary Diagnostic Tests (CPT codes 94621, 94617 and 94618) **Page 350**
47	Percutaneous Allergy Skin Tests (CPT code 95004) **Page 355**
48	Continuous Glucose Monitoring (CPT codes 95250 and 95251) **Page 357**
49	Parent, Caregiver-Focused Health Risk Assessment (CPT codes 96160 and 96161) **Page 360**
50	Chemotherapy Administration (CPT codes 96401, 96402, 96409 and 96411) **Page 361**
51	Photochemotherapy (CPT code 96910) **Page 364**
52	Photodynamic Therapy (CPT codes 96567, 96573 and 96574) **Page 367**
53	Physical Medicine and Rehabilitation (CPT codes 97012, 97016, 97018, 97022, 97032, 97033, 97034, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, 97542 and HCPCS code G0283) **Page 371**
54	Cognitive Function Intervention (CPT code 97127) **Page 376**
55	Management and/or Training: Orthotics and Prosthetics (CPT codes 97760, 97761 and 977X1) **Page 383**
56	Assessment of and care planning for patients with cognitive impairment (CPT code 99483) **Page 389**
57	Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493, 99494 and 99484) **Page 390**
58	Hyperbaric Oxygen Therapy (HCPCS code G0277) **Page 393**
59	Payment Accuracy for Prolonged Preventive Services (HCPCS codes G0513 and G0514) **Page 396**

continued

60	Physician Coding for Insertion and Removal of Subdermal Drug Implants for the Treatment of Opioid Addiction (HCPCS codes G0516, G0517, and G0518) **Page 402**
60	Superficial Radiation Treatment Planning and Management (HCPCS code GRRR1) **Page 405**

[yes, there are two number 60s]

The rule's table 12 also contains the CPT code descriptors for all proposed, new, revised and potentially misvalued codes discussed in this section. **Pages 413-436**

F. Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Imaging Services

Section 502(a)(1) of the **Consolidated Appropriations Act of 2016** provides for a 7 percent reduction in payments for the technical component for imaging services made under the PFS that are X-rays (including the technical component portion of a global service) taken using computed radiography technology furnished during CYs 2018, 2019, 2020, 2021 or 2022, and for a 10 percent reduction for the technical component of such imaging services furnished during CY 2023 or a subsequent year.

CMS is adopting, as proposed, that beginning Jan. 1, 2018, a modifier will be required when reporting imaging services for which payment is made under the PFS that are X-rays (including the X-ray component of a packaged service) taken using computed radiography technology. The modifier is "FY."

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

Section 603 of the **Bipartisan Budget Act of 2015** requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer to be paid under the OPPS beginning Jan. 1, 2017. For CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

CMS is finalizing a PFS Relativity Adjuster of 40 percent for CY 2018. The current payment reduction for CY 2017 is 50 percent of the OPPS rate. The adjustment was proposed at 25 percent.

For CY 2018, CMS will continue using its authority under section 1848 (e)(1)(B) of the Act to maintain a class-specific set of Geographic Practice Cost Indices for these site-specific technical component rates that are based both on the hospital wage index areas and the hospital wage index value themselves.

CMS will continue to adopt the CMHC per diem rate for APC 5853 as the PFS payment amount for nonexcepted off-campus PBDs providing three or more PHP services per day in CY 2018.

COMMENT

Based on the text of this section, it is clear that CMS is stumbling to arrive at so-called proper payments for services provided in nonexcepted off-campus provider-based departments of a hospital. CMS admits that many adjustments to rates are still lacking.

H. Evaluation & Management Guidelines and Care Management Services

Most physicians and other billing practitioners bill patient visits to the PFS under a relatively generic set of codes that distinguish level of complexity, site of care, and in some cases between new or established patients. These codes are the Evaluation and Management visit codes.

Billing practitioners must maintain information in the medical record to document that they have reported the appropriate level of E/M visit code. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level.

In the CY 2018 PFS proposed rule, CMS solicited public comments on ways it might further reduce administrative burden for these and similar services under the PFS.

CMS says it agrees with continued feedback from stakeholders that these guidelines are potentially outdated and need revising. However, no actions are currently being made.

I. Therapy Caps

The therapy cap amounts under section 1833(g) of the Act are updated each year based on the Medicare Economic Index. Specifically, the annual caps are calculated by updating the previous year's cap by the MEI for the upcoming calendar year and rounding to the nearest $10.00. Increasing the CY 2017 therapy cap of $1,980 by the CY 2018 adjusted MEI of 1.4 percent and rounding to the nearest $10.00 results in a CY 2018 therapy cap amount of $2,010.

II. Other Provisions of the Rule

A. New Care Coordination Services and Payment for Rural Health Clinics and Federally-Qualified Health Centers

To ensure that RHC and FQHC patients have access to new care management services in a manner consistent with the RHC and FQHC per diem payment methodologies, CMS proposed the establishment of two new G codes for use by RHCs and FQHCs. The first new G code, 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 Chronic Care Management codes 99490 and 99487 and general behavioral health integration code G0507. The second new G code for RHCs and FQHCs, GCCC2, would be a Psychiatric collaborative care model

continued

code, with the payment amount set at the average of the national non-facility PFS payment rates for psychiatric CoCM codes G0502 and G0503.

CMS is finalizing its proposal to revise payment for chronic care management in RHCs and FQHCs and establish requirements and payment for RHCs and FQHCs, furnishing general behavioral health integration services and psychiatric collaborative care model services. Effective Jan. 1, 2018, RHCs and FQHCs will be paid for CCM, general BHI and psychiatric CoCM using the two new billing codes. This payment would be in addition to the payment for an RHC or FQHC visit.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

B. Part B Drug Payment: Infusion Drugs Furnished through an Item of Durable Medical Equipment

The ***21st Century Cures Act*** changed the payment methodology for infusion drugs or biologicals furnished through a covered item of DME from being based on average wholesale price to average sales price. This change was modified by the Social Security Average Sales Price and was effective Jan. 1, 2017. CMS proposed to revise 42 CFR §414.904(e)(2) to conform regulations with the new payment requirements in section 5004(a) of the ***21st Century Cures Act***.

CMS is adopting its proposal.

C. Solicitation of Public Comments on Initial Data Collection and Reporting Periods for Clinical Laboratory Fee Schedule

The Clinical Laboratory Fee Schedule final rule, "Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System," implements Section 1834A of the Social Security Act, which requires extensive revisions to the Medicare payment, coding and coverage for Clinical Diagnostic Laboratory Tests. Under the final rule, the payment amount for a test on the CLFS furnished on or after Jan. 1, 2018, generally will be equal to the weighted median of private payer rates determined for the test, based on the data of applicable laboratories that is collected during a specified data collection period and reported to CMS during a specified data reporting period. The first data collection period was from Jan. 1 through June 30, 2016, and the first data reporting period was from Jan. 1 through March 31, 2017.

Laboratory industry feedback suggested that many reporting entities would not be able to submit a complete set of applicable information to CMS by the March 31, 2017 deadline. As a result, on March 30, 2017, CMS announced a 60-day period of enforcement discretion until May 30, 2017, with respect to the data reporting period for reporting applicable information under the Medicare CLFS and the application of the Secretary's potential assessment of civil monetary penalties for failure to report applicable information.

While approximately 40 comments were received, CMS is not taking any actions at this time.

D. Payment for Biosimilar Biological Products under Section 1847A of the Act.

In the CY 2016 Physician Fee Schedule final rule, CMS finalized a proposal to amend the regulation text at §414.904(j) to make clear that the payment amount for a biosimilar biological product is based on the ASP of all national drug codes assigned to the biosimilar biological products included within the same billing and payment code.

CMS requested comments regarding its Medicare Part B biosimilar biological product payment policy. This comment solicitation sought new or updated information on the effects of the current biosimilar payment policy that is based on experience with the United States marketplace. CMS is particularly interested in obtaining material, such as market analyses or research articles that provide data and insight into the current economics of the biosimilar market place. This includes patient, plan and manufacturer data, both domestic and, where applicable, from European markets that may be more established than, and provide insight for, the current United States' market.

CMS is finalizing a policy to separately code and pay for biological biosimilar products under Medicare Part B; CMS is not changing regulation text at §414.904(j). Effective Jan. 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same HCPCS code.

E. Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Section 218(b) of the ***Protecting Access to Medicare Act*** amended Title XVIII of the Act to add section 1834(q) of the Act directing CMS to establish a program to promote the use of appropriate use criteria for advanced diagnostic imaging services.

The impact of this program is extensive, as it will apply to every physician or other practitioner who orders or furnishes advanced diagnostic imaging services, for example, magnetic resonance imaging, computed tomography or positron emission tomography.

CMS proposed 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 Jan. 1, 2019.

CMS sought comments related to whether the program should be delayed beyond the proposed start date of Jan. 1, 2019 and was interested in comments regarding how long, if longer than one year, such a period of educational and operations testing should be available.

CMS is delaying the start date for the Medicare Appropriate Use Criteria Program for Advanced Diagnostic Imaging. The program will begin in a manner that allows practitioners more time to focus on and adjust to the Quality Payment Program before being required to participate in the AUC program. The Medicare AUC program will begin with an educational and operations testing year in 2020, which means

physicians would be required to start using AUCs and reporting this information on their claims.

During this first year, CMS will pay claims for advanced diagnostic imaging services regardless of whether they correctly contain information on the required AUC consultation. This allows both clinicians and the agency to prepare for this new program.

CMS posted newly qualified provider-led entities and clinical decision support mechanisms in July of this year. Qualified provider-led entities are permitted to develop AUC, and qualified clinical decision support mechanisms are the tools that physicians use to access the AUC. Physicians may begin exploring these mechanisms well in advance of the start of the Medicare AUC program through the voluntary participation period that will begin mid-2018 and run through 2019. During this time, CMS will collect limited information on Medicare claims to identify advanced imaging services for which consultation with appropriate use criteria took place.

In addition, by having qualified clinical decision support mechanisms available, (some of which are free of charge) clinicians may use one of these mechanisms to earn credit under the Merit-Based Incentive Payment System as an improvement activity. This improvement activity was included in the 2018 Quality Payment Program final rule.

F. Physician Quality Reporting System Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

The final reporting period for the PQRS was CY 2016. The Quality Payment Program, authorized by MACRA, consolidates and replaces three existing programs: the Medicare EHR Incentive Program for Eligible Professional, the PQRS and the Value-Based Payment Modifier. Eligible clinicians participate two ways in this program: (1) through the Merit-Based Incentive Payment System and (2) through Advanced Alternative Payment Models.

CMS is adopting, as proposed, the previously finalized satisfactory reporting criteria for the CY 2016 reporting period to lower the requirement from nine measures across three national quality strategy domains, where applicable, to only six measures with no domain or cross-cutting measure requirement. CMS also proposed similar changes to the clinical reporting requirements under the Medicare Electronic Health Record Incentive Program for eligible professionals.

Under the PQRS, individual eligible professionals and group practices who did not satisfactorily report data on quality measures for the CY 2016 reporting period are subject to a downward payment adjustment of 2.0 percent in 2018 to their PFS covered professional services.

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COMMENT

This item is more complex than the material above would suggest. CMS has included the following tables reflecting reporting requirements:

TABLE 21: Summary of the Finalized Modifications to the Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

TABLE 22: Summary of Finalized Modifications to the Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

G. Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record Incentive Program for 2016

Sections 1848(o), 1853(l) and (m), 1886(n), and 1814(l) of the Act provide the statutory basis for the Medicare incentive payments made to eligible professionals, Medicare Advantage organizations (for certain qualifying EPs and hospitals), subsection (d) hospitals, and critical access hospitals that demonstrate meaningful use of certified electronic health record technology.

CMS has adopted its proposed change regarding the reporting criteria from nine Clinical Quality Measures covering at least three NQS domains to six CQMs with no domain requirement.

H. Medicare Shared Savings Program

CMS proposed two modifications to the Shared Savings Program beneficiary assignment methodology for performance years beginning on or after Jan. 1, 2019: (1) revisions to the assignment methodology under 42 CFR part 425, subpart E to reflect the requirement under section 17007 of the ***21st Century Cures Act*** (Pub. L. 114-255, December 13, 2016), that the Secretary determine an appropriate method to assign Medicare FFS beneficiaries to an ACO, based on their utilization of services furnished by rural health clinics or federally qualified health centers, and (2) addition of new chronic care management and behavioral health integration service codes to the definition of primary care services.

Further, CMS proposed to remove the burdensome attestation requirement and instead treat a service reported on an RHC or FQHC institutional claim as a primary care service furnished by a primary care physician for purposes of the step-wise assignment methodology.

CMS is finalizing the revisions to its assignment policies for services furnished in FQHCs and RHCs as proposed. Specifically, (1) CMS will remove §425.204(c)(5)(iii) and modify §425.404 to eliminate the requirement, for performance year 2019 and subsequent performance years, for ACOs that include an RHC or FQHC as an ACO participant to provide an attestation identifying physicians who directly provide primary care services in each RHC or FQHC that is an ACO participant and/or ACO provider/supplier in the ACO, and make conforming changes to the definition of

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primary care physician at §425.20; and (2) for performance year 2019 and subsequent performance years, to: (a) treat a service reported on an RHC or FQHC claim as if it were a primary care service performed by a primary care physician under the assignment methodology in §425.402, and (b) remove revenue center codes from the definition of primary care services.

CMS is adopting, as proposed, the addition of three new chronic care management and behavioral health integration service codes to the definition of primary care services. The CCM service codes are 99487, 99489 and G0506, and the BHI service codes are G0502, G0503, G0504 and G0507.

CMS is finalizing its proposals to: (1) revise §425.500(e)(2) to indicate that if an ACO has a match rate below 80 percent, absent unusual circumstances, CMS will adjust the ACO's overall quality score proportional to the ACO's audit performance; (2) revise the methodology used to calculate an ACO's audit-adjusted quality score to provide for a 1 percent reduction to the ACO's overall quality score for each percentage point difference between the ACO's audit match rate and the 80 percent match rate; and (3) make a conforming change to §425.500(e)(3) to reflect the 80 percent match rate.

The Medicare SNF benefit is for beneficiaries who require a short-term intensive stay in a SNF, requiring skilled nursing or skilled rehabilitation care, or both. Under section 1861(i) of the Act, beneficiaries must have a prior inpatient hospital stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care.

To qualify to use the SNF three-day rule waiver, ACOs must submit a SNF Three-Day Rule Waiver application that includes supplemental information sufficient to demonstrate that the ACO has the capacity to identify and manage beneficiaries who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospitalization of fewer than three days.

CMS will remove the requirement at §425.612(a)(1)(i)(A)(4) under which ACOs applying for the SNF three-day rule waiver must submit a narrative describing any financial relationships between the ACO, SNF affiliate and acute care hospitals.

COMMENT

There is much information being identified in this section, and for ACOs, the material requires in-depth review. The material extends more than 50 pages.

I. Value-Based Payment Modifier and Physician Feedback Program

In order to better align incentives and provide a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program, CMS is finalizing the following changes to previously-finalized policies for the 2018 Value Modifier:

- Reducing the automatic downward payment adjustment for not meeting the criteria from negative 4 percent to negative 2 percent for groups of ten or more clinicians, and from negative 2 percent to negative 1 percent for physician and non-physician solo practitioners and groups of two to nine clinicians;
- Holding harmless all physician groups and solo practitioners who met the criteria to avoid the PQRS adjustment from downward payment adjustments for performance under quality-tiering for the last year of the program; and
- Aligning the maximum upward adjustment amount to two times the adjustment factor for all physician groups and solo practitioners.

Given final policy changes for the Physician Quality Reporting System and the Value Modifier, CMS finalized that it will not report 2018 Value Modifier data in the Physician Compare downloadable database, as this would be the first and only year such data would have been reported. However, to promote transparency, CMS will continue to make available the Value Modifier public use and research identifiable files.

J. MACRA Patient Relationship Categories and Codes

In May 2017, CMS posted the operational list of patient relationship categories that are required under MACRA. CMS proposed the use of Level II HCPCS modifiers on claims to indicate patient relationship categories. Further, CMS proposed that the HCPCS modifiers may be voluntarily reported by clinicians beginning Jan. 1, 2018. CMS says it anticipates that there will be a learning curve with respect to the use of these modifiers and will work with clinicians to ensure their proper use.

CMS is adopting its proposal.

Patient Relationship HCPCS Modifiers and Categories

No.	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

K. Changes to the Medicare Diabetes Prevention Program Expanded Model

The final rule implements the Medicare Diabetes Prevention Program expanded model starting in 2018. The MDPP expanded model was announced in early 2016 when it was determined that the Diabetes Prevention Program model test through the CMS Health Care Innovation Awards met the statutory criteria for expansion. The final rule includes additional policies necessary for suppliers to begin furnishing MDPP services nationally in 2018, including the MDPP payment structure, as well as additional supplier enrollment requirements and supplier compliance standards aimed to enhance program integrity.

continued

COMMENT

This is an extensive provision. It covers some 375+ pages. The CMS fact sheet contains only a pertinent summary.

FINAL THOUGHTS

This is a difficult rule to navigate. It is not well structured, and as noted earlier, without clear final action/decision sections.

It is easy to criticize the agency, but this and the other extensively long yearly regulations need an overhaul to make them more user-friendly and to basically state the issue and the actions being taken.

It's time for CMS to redevelop its approaches in writing rules. Try moving away from too much past history and simply state the issue at hand and the result. CMS says it wants to reduce burdens. CMS should start with its own regulatory process.

It's time to stop saying "thank you" and "we appreciate." Neither convey substance, but simply extend unnecessary verbiage. In this rule, CMS said thanks 49 times and appreciate 223 times. Please understand that if commenters agree with statements, you need not have to say "thank you" or "we appreciate."

MHA
MISSOURI HOSPITAL ASSOCIATION