Issue Brief

FEDERAL ISSUE BRIEF • July 17, 2017

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

The Centers for Medicare and Medicaid Services has issued a proposed rule regarding revisions to payment policies and payment rates under the Medicare physician fee schedule for calendar year 2018. A copy of the 815-page document is available on the *Federal Register* web site at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-14639.pdf.

The rule is scheduled for publication on July 21. The above link will change upon publication.

The PFS Addenda along with other supporting documents and tables referenced are available on the CMS website at: CMS-1676-P.

CMS is proposing to establish RVUs for CY 2018 and other Medicare Part B payment policies to reflect changes in medical practice and the relative value of services, as well as other changes mandated in the statute.

Major changes include the following.

- Rates would increase by 0.31 percent. This includes a 0.50 percent update as mandated by the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015, and a reduction of 0.19 percent as mandated by the Achieving a Better Life Experience Act of 2014.
- Nonexcepted off-campus provider-based hospital department payments would be reduced from 50 percent to 25 percent of the outpatient PPS rate.
- Addition of certain new telehealth services.
- Increased payment rates for office-based behavioral health services to better recognize overhead expenses.
- Solicitation for comments about revising evaluation and management visit codes.
- Solicitation for comments to determine if emergency department visits are undervalued.
- Payments for regular and complex chronic care management for services provided in rural health clinics or

continued

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federally qualified health centers.

- Changes to the physician quality reporting system.
- Proposed implementation of the Medicare Diabetes Prevention Program expanded model.

COMMENT

As always, the PFS rule is a long, complex and detailed document. Rather than having too long a table of contents (without page numbers), this proposal has a very short table of contents. As such it difficult to find specific items.

CONVERSION FACTORS

CMS estimates the CY 2018 PFS conversion factor to be **35.9903**, which reflects a budget neutrality adjustment, a 0.50 percent update adjustment factor as established under MACRA, and a -0.19 percent target recapture amount required under section 1848(c)(2)(O)(iv) of the Act.

CMS estimates the CY 2018 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.31 percent. Since this amount does not meet the 0.5 percent target established by the Achieving a Better Life Experience Act of 2014, payments under the fee schedule must be reduced by the difference between the target for the year and the estimated net reduction in expenditures, known as the target recapture amount. As a result, CMS estimates that the CY 2018 target recapture amount will produce a reduction to the conversion factor of -0.19 percent.

Calculation of the Proposed CY 2018 PFS Conversion Factor		
Conversion Factor in effect in CY 2017		**35.8887**
Update Factor	0.50 percent (1.0050)	
CY 2018 RVU Budget Neutrality Adjustment	-0.03 percent (0.9997)	
CY 2018 Target Recapture Amount	-0.19 percent (0.9981)	
CY 2018 Conversion Factor		35.9903

CMS estimates the CY 2018 anesthesia conversion factor to be 22.0353, which reflects the same overall PFS adjustments, as well as an additional adjustment due to an update to the malpractice risk factor for the anesthesia specialty.

Calculation of the Proposed 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	-0.03 percent (0.9997)	
CY 2018 Target Recapture Amount	-0.19 percent (0.9981)	
CY 2018 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	-0.33 percent (0.9967)	
CY 2018 Conversion Factor		22.0353

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continued

I. PROVISIONS OF THE PROPOSED 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 38 pages provides detailed information about the methodology for translating the resources involved in furnishing each service into service-specific PE RVUs. A number of adjustments are both being made and being proposed with respect to the construct of practice expense data values.

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

B. Determination of Malpractice Relative Value Units

For CY 2018, CMS is proposing malpractice RVUs developed using the most recent data available and calculated based on such updated malpractice premium data obtained from state insurance rate filings by a CMS contractor.

CMS is also proposing to align future updates with the geographic practice cost index updates, which has been done once every three years. Additionally, CMS is seeking comments regarding the availability of supplemental data sources for future updates.

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

C. Medicare Telehealth Services

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

CMS is proposing to add the following services to the telehealth list on a category 1 basis 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 is also proposing 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 (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

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- 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 says it believes its use of the GT modifier for telehealth services is redundant and would eliminate it.

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

See below and refer to the rule's tables 10 and 11 for extensive and detailed information on potentially misvalued codes.

E. 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 (TC) 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 proposing that beginning January 1, 2018, a modifier would be required to be used 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.

F. 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

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 paid under the OPPS beginning January 1, 2017. For CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

All nonexcepted items and services furnished by nonexcepted off-campus PBDs and billed by a hospital on an institutional claim with modifier "PN" (Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital) are currently paid under the PFS.

For CY 2018, CMS is proposing to reduce current PFS payment rates for these items and services by 50 percent. CMS currently pays for these services under the PFS based on a percentage of the OPPS payment rate. The proposal would change the PFS payment rates for these services from 50 percent of the OPPS payment rate to 25 percent of the OPPS rate.

For CY 2018, CMS is proposing to 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.

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CMS believes it is necessary to incorporate the OPPS payment policies for C-APCs, packaged items and services, and the multiple procedure payment reduction in order to maintain the integrity of the PFS Relativity Adjuster because the adjuster is intended in part to account for the methodological differences between the OPPS and the PFS rates that would otherwise apply.

CMS is proposing to 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.

G. Proposed 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. Recommendations from the American Medical Association- Relative Value Scale Update Committee are critically important to this work. For CY 2018, CMS is proposing the values for individual services that generally reflect the expert recommendations from the RUC without as many refinements as CMS has proposed in recent years.

The material in this section covers nearly 250 pages. The following is a list of the proposed valuations of specific codes for CY 2018:

1	Anesthesia Services for Gastrointestinal (GI) Procedures (CPT codes 007X1, 007X2, 008X1, 008X2, and 008X3)
2	Acne Surgery (CPT code 10040)
3	Muscle Flaps (CPT codes 15734, 15736, 15738, 157X1, and 157X2)
4	Application of Rigid Leg Cast (CPT code 29445)
5	Strapping Multi-Layer Compression (CPT codes 29580 and 29581)
6	Resection Inferior Turbinate (CPT code 30140)
7	Control Nasal Hemorrhage (CPT codes 30901, 30903, 30905, and 30906)
8	Nasal Sinus Endoscopy (CPT codes 31254, 31255, 31256, 31267, 31276, 31287, 31288, 31295, 31296, 31297, 31XX1, 31XX2, 31XX3, 31XX4, and 31XX5)
9	Tracheostomy (CPT codes 31600, 31601, 31603, 31605, and 31610)
10	Bronchial Aspiration of Tracheobronchial Tree (CPT codes 31645 and 31646)
11	Cryoablation of Pulmonary Tumor (CPT codes 32998 and 32X99)
12	Artificial Heart System Procedures (CPT codes 339X1, 339X2, and 339X3)
13	Endovascular Repair Procedures (CPT codes 34X01, 34X02, 34X03, 34X04, 34X05, 34X06, 34X07, 34X08, 34X09, 34X10, 34X11, 34X12, 34X13, 34812, 34X15, 34820, 34833, 34834, 34X19, and 34X20)
14	Selective Catheter Placement (CPT codes 36215, 36216, 36217, and 36218)
15	Treatment of Incompetent Veins (CPT codes 36470, 36471, 364X3, 364X4, 364X5, and 364X6)
16	Therapeutic Apheresis (CPT codes 36511, 36512, 36513, 36514, 36516, and 36522)
17	Insertion of Catheter (CPT codes 36555, 36556, 36620, and 93503)
18	Insertion of PICC Catheter (CPT code 36569)
19	Bone Marrow Aspiration (CPT codes 38220, 38221, 382X3, and 2093X)
20	Esophagectomy (CPT codes 43107, 43112, 43117, 432X5, 432X6, and 432X7)
21	Transurethral Electrosurgical Resection of Prostate (CPT code 52601)
22	Peri-Prostatic Implantation of Biodegradable Material (CPT code 55X87)
23	Colporrhaphy with Cystourethroscopy (CPT codes 57240, 57250, 57260 and 57265)
24	Nerve Repair with Nerve Allograft (CPT codes 64910, 64911, 64X91 and 64X92)
25	CT Soft Tissue Neck (CPT codes 70490, 70491, and 70492)
26	Magnetic Resonance Angiography (MRA) Head (CPT codes 70544, 70545, and 70546)

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27	Magnetic Resonance Angiography (MRA) Neck (CPT codes 70547, 70548, and 70549)
28	CT Chest (CPT Codes 71250, 71260, and 71270)
29	MRI of Abdomen and Pelvis (CPT codes 72195, 72196, 72197, 74181, 74182, and 74183)
30	MRI Lower Extremity (CPT codes 73718, 73719, and 73720)
31	Abdominal X-ray (CPT codes 74022, 740X1, 740X2, and 740X3)
32	Angiography of Extremities (CPT codes 75710 and 75716)
33	Ophthalmic Biometry (CPT codes 76516, 76519, and 92136)
34	Ultrasound of Extremity (CPT codes 76881 and 76882)
35	Radiation Therapy Planning (CPT codes 77261, 77262, and 77263)
36	Pathology Consultation during Surgery (CPT codes 88333 and 88334)
37	Tumor Immunohistochemistry (CPT codes 88360 and 88361)
38	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)
39	Transthoracic Echocardiography (TTE) (CPT codes 93306, 93307, and 93308)
40	Stress Transthoracic Echocardiography (TTE) Complete (CPT codes 93350 and 93351)
41	Peripheral Artery Disease (PAD) Rehabilitation (CPT code 93668)
42	Pulmonary Diagnostic Tests (CPT codes 94621, 946X2, and 946X3)
43	Percutaneous Allergy Skin Tests (CPT code 95004)
44	Continuous Glucose Monitoring (CPT codes 95250 and 95251)
45	Parent, Caregiver-Focused Health Risk Assessment (CPT codes 96160 and 96161)
46	Chemotherapy Administration (CPT codes 96401, 96402, 96409, and 96411)
47	Photochemotherapy (CPT code 96910)
48	Photodynamic Therapy (CPT codes 96567, 96X73, and 96X74)
49	Physical Medicine and Rehabilitation (PM&R) (CPT codes 97012, 97016, 97018, 97022, 97032, 97033, 97034, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, 97542, and HCPCS code G0283)
50	Management and/or Training: Orthotics and Prosthetics (CPT codes 97760, 97761, and 977X1)
51	Cognitive Function Intervention (CPT code 97X11)
52	INR Monitoring (CPT codes 993X1 and 993X2)
53	Psychiatric Collaborative Care Management Services (CPT codes 994X1, 994X2, 994X3, and HCPCS code G0507
54	Hyperbaric Oxygen Therapy (HCPCS code G0277)
55	Physician Coding for Insertion and Removal of Subdermal Drug Implants for the Treatment of Opioid Addiction (HCPCS codes GDDD1, GDDD2, and GDDD3)
56	Superficial Radiation Treatment Planning and Management (HCPCS code GRRR1)
57	Payment Accuracy for Prolonged Preventive Services (HCPCS codes GYYY1 and GYYY2)

The rule's Table 10 (21 pages) contains a list of codes for which CMS has proposed work RVUs; this includes all codes for which CMS received RUC recommendations by February 10, 2017. The proposed work RVUs, work time and other payment information for all proposed CY 2018 payable codes are available on the CMS website under downloads for the CY 2018 PFS proposed rule at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html. Table 10 also contains the CPT code descriptors for all proposed, new, revised, and potentially misvalued codes discussed in this section.

The rule's Table 11 (111 pages) details the proposed refinements of the RUC's direct PE recommendations at the code-specific level.

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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 called 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.

According to these documentation guidelines, there are three key components to selecting the appropriate level:

- History of Present Illness (HPI or History);
- Physical Examination (Exam); and
- Medical Decision Making (MDM).

CMS is seeking input from a broad array of stakeholders, including patient advocates, on the specific changes CMS should undertake to reform the guidelines, reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine.

II. OTHER PROVISIONS OF THE PROPOSED 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 is proposing 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 (CCM) codes 99490 and 99487 and general behavioral health integration (BHI) code G0507. The second new G code for RHCs and FQHCs, GCCC2, would be a Psychiatric collaborative care model (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.

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 the methodology average sales price. This change was modified by the Social Security Average Sales Price and was effective January 1, 2017. CMS is proposing 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.

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

The Clinical Laboratory Fee Schedule final rule entitled "Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System" implements Section 1834A of the Social Security Act (the Act), which requires extensive revisions to the Medicare payment, coding, and coverage for Clinical Diagnostic Laboratory Tests paid under the CLFS.

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Under the final rule, the payment amount for a test on the CLFS furnished on or after January 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 January 1 through June 30, 2016, and the first data reporting period was from January 1, 2017, 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.

CMS is seeking comments from applicable laboratories and reporting entities regarding their experience with the first data collection and reporting periods under the new private payer rate-based CLFS.

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 is requesting comments regarding its Medicare Part B biosimilar biological product payment policy. This comment solicitation is seeking 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.

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 (AUC) 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, computer tomography or positron emission tomography.)

This rule proposes the start date of the Medicare AUC program for advanced diagnostic imaging services. It is on and after this date that ordering professionals must consult specified applicable AUC using a qualified clinical decision support mechanism when ordering applicable imaging services and furnishing professionals must report consultation information on the Medicare claim. This rule also proposes to modify the policy related to significant hardship

exceptions and requests public feedback on details regarding how AUC consultation information must be included on the Medicare claim.

CMS is proposing 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 is specifically seeking comments related to whether the program should be delayed beyond the proposed start date of January 1, 2019, and is interested in comments regarding how long, if longer that one year, such a period of educational and operations testing should be available.

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). There are two ways eligible clinicians can participate in this program: (1) through the MIPS; and (2) through Advanced Alternative Payment Models.

CMS is proposing to revise the previously finalized satisfactory reporting criteria for the CY 2016 reporting period to lower the requirement from 9 measures across 3 national quality strategy domains, where applicable, to only 6 measures with no domain or cross-cutting measure requirement. CMS is also proposing similar changes to the clinical reporting requirements under the Medicare Electronic Health Record Incentive Program for eligible professionals.

CMS says it is proposing these changes based on stakeholder feedback and to better align with the MIPS data submission requirements for the quality performance category.

COMMENT

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

TABLE 19: Summary of Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

TABLE 20: Summary of Proposed 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 21: Summary of Proposed 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.

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CMS is proposing to change the reporting criteria from 9 Clinical Quality Measures covering at least three NQS domains to six CQMs with no domain requirement. CMS is proposing this change so that the reporting criteria for the Medicare EHR Incentive Program would be in alignment with the modified requirement that CMS is proposing for the final PQRS reporting period (2016).

H. Medicare Shared Savings Program

CMS is proposing the following changes:

(1) revisions to the assignment methodology to reflect the requirement of the 21st Century Cures Act that for performance years beginning on or after January 1, 2019, the Secretary determines an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of services furnished by rural health clinics or federally qualified health centers, and

(2) 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.

In addition, CMS proposes to revise the methodology used in the quality validation audits and the manner in which the results of these audits may be used to adjust an ACO's sharing rate. CMS also proposes to reserve the discretion to redesignate a measure reported through the CMS web interface as pay-for-reporting when substantive changes are made to the measure under the Quality Payment Program.

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 3 days.

CMS is proposing to 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.

CMS is also proposing to remove the ACO documentation requirement demonstrating that each SNF included on their list of SNF affiliates has an overall rating of three or higher under the CMS 5-star Quality Rating System.

COMMENT

Besides the above shared services changes, the proposal has additional items. These include (1) compliance with ACO participant TIN exclusivity requirement, and (2) the treatment of individually beneficiary identifiable payments made under a demonstration, pilot, or time limited program.

There is much information being identified in this section, and for ACOs the material requires in-depth review.

I. Value-Based Payment Modifier and Physician Feedback Program

Section 1848(p) of the Act requires the establishment of a value-based payment

continued

modifier that applies to specific physicians and groups of physicians the Secretary determines appropriate starting January 1, 2015, and to all physicians and groups of physicians by January 1, 2017.

CMS says that 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 proposing the following changes to previously-finalized policies for the 2018 Value Modifier:

- 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 (-2.0 percent) for groups with 10 or more EPs and at least one physician, and negative 1 percent (-1.0 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.
- 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 that 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.

J. MACRA Patient Relationship Categories and Codes

In May 2017, CMS posted the operational list of patient relationship categories that are required under MACRA. In this rule, CMS is proposing the use of Level II HCPCS modifiers on claims to indicate these patient relationship categories. Further, CMS is proposing that the HCPCS modifiers may be voluntarily reported by clinicians beginning January 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.

Proposed 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

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K. Proposed Changes to the Medicare Diabetes Prevention Program Expanded Model

The proposed rule also makes additional proposals to implement 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 Center for Medicare and Medicaid Innovation's Health Care Innovation Awards met the statutory criteria for expansion.

The proposed rule proposes 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 ensure program integrity. Please see the fact sheet on the MDPP expanded model for more information: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-3.html.

COMMENT

This is an extensive provision. It covers some 150+ pages. The above fact sheet contains a pertinent summary.

FINAL THOUGHTS

This annual update continues to grow each year. Much emphasis is moving from a simple payment agenda to one involving both payments and so-called quality requirements. The quality aspects are complex and detailed. Failure to acknowledge will result in payment reductions.

The whole issue of quality is subject to debate. CMS is on a huge learning curve as evidenced by the many proposed changes it is addressing. While, the quality outcome is still debatable, it cannot be ignored.

There are certain elements in this proposal that impact all physicians and other providers. However, there are many items that have a specific audience, for example ACOs. As a result, it is difficult to address all aspects in this analysis. Individual's with particular interest need to review material in-depth related to their concerns.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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