CY2017 Physician Fee Schedule Proposed Rule Issue Brief

August 2016

Summary

The Physician Fee Schedule (PFS) proposed rule establishes payment rates for physicians and makes other changes to the Medicare Part B program for calendar year 2017 (CY2017). As such, the provisions finalized will take effect January 1, 2017. Detailed analysis of the rule related to the comprehensive care management code, Medicare Shared Savings Program, telehealth codes for advance care planning, and the Diabetes Prevention Program are provided below.

Comments on the proposed rule will be accepted by CMS until 5pm EST September 6, 2016. A final rule is expected no later than November 1, 2016. Caravan Health is in the process of drafting a comment letter to express its support for many of the changes proposed by CMS.

Comprehensive Care Management (CCM)

CMS proposes several changes to its comprehensive care management (CCM) codes for CY2017. These proposals would apply to all CCM codes (CPT codes 99487, 99489, and 99490) and are part of an overarching effort by CMS to reduce the administrative burden of billing for CCM services and to increase provider utilization.

Initiating Visit

Current rules require that all CCM services are accompanied by an "initiating visit" such as a comprehensive E/M visit, annual wellness visit, or preventative physical exam, during which the provider must obtain patient consent for CCM. The proposed rule would simplify this prerequisite and instead require an initiating visit only for new patients or patients not seen within the past year. CMS also proposes to create an add-on to increase payment for the CCM initiating visit when the beneficiary requires extensive face-to-face assessment and care planning above and beyond the effort outlined in E/M or annual wellness visits.

Beneficiary Consent

Additionally, CMS proposes to simplify the requirement for the provider to obtain beneficiary consent prior to initiating CCM services. While CMS maintains that consent is important so beneficiaries are aware of cost-sharing obligations, the proposed rule would eliminate the requirement for a written agreement and allow providers to document the disclosures made and patient consent in the medical record.

Authorization to Share Medical Information

The proposed rule would eliminate the requirement for providers to obtain authorization to share medical information. CMS correctly notes that under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR 164.506), a covered entity is permitted to use or disclose protected health information for purposes of treatment without patient authorization.

A handful of other proposed changes are not discussed here but generally support CMS's stated goal of reducing redundancy and simplifying billing requirements. A comprehensive list of all proposed changes to CCM codes can be found in Table 11 of the proposed rule.

Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)

To assure that CCM requirements for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are not more burdensome than under the PFS, the proposed rule states that it would enact similar changes for CCM services furnished by RHCs and FQHCs. Specifically, for RHCs and FQHCs using the CCM codes CMS proposes to:

- Require an initiating visit for CCM services only for new patients or patients not seen within one year.
- Require 24/7 access to a RHC or FQHC practitioner or auxiliary staff with a means to make contact with a RHC or FQHC practitioner to address urgent health care needs rather than 24/7 access to a health care practitioner who has access to the patient's electronic care plan.
- Require timely electronic sharing of care plan information within and outside the RHC or FQHC, but not necessarily on a 24/7 basis, and allow transmission of the care plan by fax.
- Require that a copy of the care plan be given to the patient or caregiver, but remove the description of the format (written or electronic).
- Require that the RHC or FQHC practitioner documents in the beneficiary's medical record the elements of beneficiary consent, but remove the need for written agreement.

CCM Supervision Requirements in RHCs & FQHCs

Additionally, CMS proposes changes to supervision requirements to allow RHCs and FQHCs to contract with third parties for CCM and Transitional Care Management (TCM) services. Specifically, the proposed rule would allow services and supplies furnished incident to TCM and CCM services to be provided under the general supervision of a RHC or FQHC practitioner, eliminating the need for direct supervision. CMS notes that the proposed exception to the direct supervision requirement would apply only to personnel furnishing TCM or CCM incident to services, and would not apply to any other RHC or FQHC services.

Potential Future CCM Developments

Finally, CMS noted that a CPT code is under development that would potentially identify and separately pay for monthly CCM work that is personally performed by the billing physician or other practitioner. CMS indicated its interest in this code as it develops and potential to be included in future rulemaking.

Medicare Shared Savings Program

CMS proposes a number of mostly technical changes to the Medicare Shared Savings Program (MSSP), particularly around quality reporting by EPs and quality measure validation and audits.

Eligible Professional Participation in Physician Quality Reporting System

Current MSSP regulations do not allow eligible professionals (EPs) billing through the Taxpayer Identification Number (TIN) of an Accountable Care Organization (ACO) to independently report data in the Physician Quality Reporting System (PQRS) outside of their ACO. This policy was designed to ease reporting burden for individual providers and promote integration within ACOs. Unfortunately, under current rules if an ACO fails to satisfy the PQRS reporting requirements, the individual EPs and group practices participating in that ACO will receive the PQRS payment adjustment (i.e. withhold) along with an automatic downward VM payment adjustment.

CMS's proposed rule would amend this to allow EPs that bill under the TIN of an ACO to report separately for the PQRS payment adjustment if the ACO fails to report on behalf of its EPs. If

the ACO failed to report, CMS would consider the independently submitted data in determining whether the provider is subject to the PQRS payment adjustment. The proposed change would be effective beginning with the 2018 PQRS payment adjustment, based on a reporting period of January 1, 2016 through December 31, 2016. CMS also proposes a process by which EPs may apply for consideration for the 2017 PQRS payment adjustment if their ACO did not report PQRS information in CY2015. CMS states that less than 2% of ACOs fall into this category.

MSSP Quality Measures Set

CMS proposes a number of changes to its MSSP quality measure set to better align the program with measures recommended by the Core Quality Measures Collaborative. Specifically, CMS proposes to add the following measures:

- *ACO-12 Medication Reconciliation Post-Discharge (NQF #0097).* This measure addresses adverse drug events (ADEs) through medication reconciliation and would replace the Documentation of Current Medications in the Medical Record measure (ACO-39) in the Care Coordination/Patient Safety domain. In accordance with CMS policy for newly introduced measures, this measure would phase into pay for performance after two years as pay for reporting.
- *ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91).* This measure would be added to the Care Coordination/Patient Safety domain. The measure will be risk-adjusted for demographic variables and comorbidities and phase in with an initial two years of pay for reporting.
- *ACO-44 Use of Imaging Studies for Low Back Pain (NQF #0052).* This measure reports the percentage of patients with a primary diagnosis of low back pain that did not have an imaging study (for example, MRI, CT scan) within 28 days of the diagnosis for patients 18-50 years of age. CMS proposes adding this measure in the Care Coordination/Patient Safety domain. If finalized, the measure would be calculated using Medicare claims data without any additional provider reporting requirement. The measure would be designated as pay for reporting in 2017 and 2018, and phase into pay for performance the following year.

Tables 36 and 37 of the proposed rule provide the complete new measure set, domains, and domain weights.

Quality Measure Validation & Audit

CMS also proposes changes to the process for quality measure validation. Under current processes, 30 records per audited measure are selected randomly for review. If the medical records and reported data have a match rate below 90%, the ACO “fails” the audit and receives re-education and is not credited for meeting quality benchmarks.

The proposed rule would aim to increase the number of records audited to achieve a confidence interval within 5 percentage points of the result. CMS notes that the number of requested records will vary but states generally not more than 50 records will be requested per audited measure. CMS also proposes to conduct audits to determine an ACO’s overall match rate rather than calculating a measure-specific match rate.

CMS proposes to moderate the penalties for ACOs failing a quality audit. Under the proposal, an ACO with a match rate below 90% would have their overall quality score adjusted proportional to its audit performance, but could continue to receive credit for meeting benchmarks. However, CMS proposes that any ACO with the below-90% audit match rate may be required to submit a corrective action plan (CAP) for CMS approval. CMS notes it maintains

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

Voluntary Beneficiary Alignment

A beneficiary is eligible for assignment to an ACO if the beneficiary had a plurality of primary care services with an ACO participant. The current assignment process is purely claims-based, however, in the proposed rule CMS acknowledges the significant interest by ACOs in allowing beneficiaries to voluntary attest to their alignment with a particular entity.

In the proposed rule, CMS outlines a new, automated approach which may help determine beneficiary alignment. Under the proposed process, CMS would directly collect information from beneficiaries regarding which provider they believe is responsible for coordinating their overall care. CMS does not specify the system but suggests it could be through an established forum such as *MyMedicare.Gov* or 1-800-Medicare. Once the appropriate settings are in place, CMS would notify beneficiaries through its outreach materials and encourage them to designate a primary provider.

CMS proposes that its automated mechanism will be in place by early 2017, with voluntary beneficiary attestations taking effect for the 2018 performance year. In the event an automated process is not available, manual voluntary alignment will be allowed for Track 3 ACOs in 2018. Finally, CMS proposes that ACOs, ACO participants, ACO providers/suppliers, ACO professionals, and other individuals or entities performing functions or services related to ACO activities will be prohibited from beneficiary inducement activities or behaviors that may influence the decision to designate a provider.

Financial Reconciliation for ACOs That Fall Below 5,000 Assigned Beneficiaries

The MSSP requires that ACOs have a minimum of 5,000 Medicare FFS beneficiaries assigned for participation. However, beneficiary numbers may shift during the performance term, leading CMS to establish a sliding scale minimum savings rate (MSR) for ACOs with 3,000 to 4,999 aligned beneficiaries.

In the proposed rule, CMS addresses how it will handle ACOs that fall below 5,000 and have also selected a non-variable MSR/minimum loss rate (MLR) based on their participation in a two-sided risk model. CMS proposes that such an ACO will he held to the MSR/MLR established at the start of the agreement period. Note that ACOs in one-sided models (Track 1) are limited to the variable rate based on the number of assigned beneficiaries.

Telehealth for Advance Care Planning

The proposed rule would add two advance care planning services to the telehealth list. These new telehealth services include advance care planning including the explanation and discussion of advance directives such as standard forms by the physician a qualified health care professional. CPT code 99497 would apply to the first 30 minutes, face-to-face with the patient, while CPT code 99498 would be applicable for each additional 30 minutes of consultation.

Medicare Diabetes Prevention Program

CMS proposes to expand a Health Care Innovation program into Medicare beginning January 1, 2018. CMS refers to the new program as the Medicare Diabetes Prevention Program (MDPP) and notes that if finalized the agency would engage in additional rulemaking to further refine program requirements.

CMS proposes to introduce the MDPP as a 12-month program utilizing a CDC-approved curriculum that consists of 16 core sessions over a time period of 16-26 weeks.[1] Organizations could provide sessions to eligible beneficiaries either in-person or remotely, as currently permitted in the CDC-DPP. The proposed rule would allow any organization recognized by the CDC to provide DPP services would be eligible to apply as a Medicare supplier beginning on January 1, 2017.

Reimbursement would be tied to the number of sessions attended and achievement of a minimum weight loss of 5% of baseline weight (body weight recorded during the beneficiary's first core session). MDPP suppliers would be required to attest to beneficiary session attendance and weight loss at the time claims are submitted to Medicare for payment and document attendance through paper or electronic means. In order to receive Medicare payment, MDPP suppliers would be required to submit claims using standard Medicare claims forms and procedures, including HIPAA-compliant processes.

CMS seeks comments on program integrity and all proposed aspects of the MDPP.

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If you have any comments on the PFS proposed rule please contact LeeAnn Hastings at lhastings@caravanhealth.com.

[1] The full curriculum is available at *http://www.cdc.gov/diabetes/prevention/pdf/curriculum_toc.pdf.*