CY2017 Physician Fee Schedule Final Rule Issue Brief
Medicare Shared Savings Program

November 2016

Summary

The Physician Fee Schedule (PFS) final rule establishes payment rates for physicians and makes other changes to the Medicare Part B program for calendar year 2017 (CY2017). This issue brief covers provisions of the final rule specific to the Medicare Shared Savings Program (MSSP). Among these changes, CMS finalized its proposals to allow independent eligible professionals to report quality scores if their ACO failed to do so, updated the quality measure set, changed processes for quality measure audits, and established voluntary beneficiary alignment with ACOs to be effective beginning in 2018.

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 receive the PQRS payment adjustment (i.e. withhold) along with an automatic downward Value Modifier payment adjustment.

In response to concerns about EPs whose ACO fails to report quality data, CMS finalized that EPs that bill under the TIN of an ACO participant may report quality data for purposes of PQRS apart from the ACO. This independent reporting is exclusively for determining any adjustments under the PQRS and will not impact the calculation of the ACO's quality score. CMS also stated in the final rule that the independently submitted quality data will be considered only if the ACO fails to report on behalf of the practitioner.

Impacted practitioners will be allowed to take advantage of the secondary reporting option for the 2017 and 2018 PQRS payment adjustments, based upon the ACO's failure to report quality data in 2015 or 2016, respectively. For the 2018 adjustment, the regular reporting period of calendar year 2016 will be used. For practitioners seeking to correct non-reporting for the 2017 PQRS adjustment, CMS will accept a secondary reporting period of calendar year 2016 (i.e. the same reporting period as the 2018 adjustment). EPs may utilize the secondary reporting period either as an individual EP or as a group practice using one of the registry, QCDR, direct EHR product, or EHR data submission vendor reporting options.

Importantly CMS also finalized its proposal to sunset PQRS at the end of the 2016 performance year and 2018 payment year as the agency transitions to a streamlined Quality Payment Program (QPP). CMS will continue to require that ACOs report quality data via the CMS web interface for use in both the MSSP and QPP in 2017 and beyond. However, in keeping with the flexibility discussed above, CMS will allow clinicians in an ACO to independently report their quality data if the ACO fails to do so on their behalf for purposes of the QPP. Quality data submitted by an individual clinician will only be considered for QPP scoring, and will not impact the ACO's quality score.

MSSP Quality Measure Set

In the PFS final rule, CMS confirmed the updated quality measure set for ACO reporting in 2017. All proposed additions and deletions were finalized consistent with the proposed rule. The four finalized new measures will be assessed as pay-for-reporting in 2017 and 2018. One new measure, *ACO-44 Use of Imaging Studies for Low Back Pain*, was finalized as pay-for-reporting all three years of the ACO agreement period due to potential for small case sizes.

Additionally, the specifications of *ACO-11 Use of Certified EHR Technology* were finalized to align with the QPP by measuring CEHRT use by all providers participating in the ACO rather than just CEHRT use by primary care physicians in the ACO.

A full list of the measure set can be found on Table 42 of the final rule. Table 43 specifies the updated scoring and quality measure domains for 2017 as follows:

- 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)

Finally, CMS commented that any future changes to the ACO quality measure set submitted via the CMS web interface will be adopted through rulemaking for the QPP.

Quality Measure Validation & Audit

In addition to updating the MSSP quality measure set, CMS also finalized changes to its quality measure validation and audit processes. The proposals were designed to improve the confidence level of audits while simplifying the process for ACO participants.

The final rule changes the quality audit process from a two-step to a single step as well as shifts the focus to overall accuracy, rather than measure-specific. CMS proposed requesting one set of records upon audit, enough to achieve a 95 percent confidence interval based upon the size of the ACO. In the final rule, CMS confirmed it will make a single request per audit, but reduced the number of records required to enough for a 90 percent confidence interval.

CMS will also calculate an overall match rate as opposed to a per-measure match rate. Organizations that have a match rate below 90 percent will have their overall quality score adjusted downward by that proportion. CMS noted in the final rule that the agency retains discretion to determine that an ACO with a below 90 percent match rate should not have its quality score adjusted, based upon unique circumstances. The final rule reiterated that any ACO with a below-acceptable match rate may be asked to submit a corrective action plan (CAP) and could be subject to termination from the ACO program.

The new processes for quality validation audits will begin in 2017 with review of quality measures submitted for the 2016 performance year.

Voluntary Beneficiary Alignment

Today, Medicare beneficiaries are aligned with an ACO based upon receiving a plurality of primary care services with an ACO participant. The assignment process relies exclusively on claims, and for

Track 1 participants, is reviewed retrospectively. In the proposed rule, CMS acknowledged the interest by ACO participants in allowing beneficiaries to voluntary attest to their alignment with a particular entity, and providing participants with greater certainty as to their aligned patient population. In the proposed rule, CMS declined to specify how the system would work but outlined several avenues it would explore.

In the final rule, CMS once again declared its intention to offer voluntary beneficiary attestation for the 2018 performance year, but remained vague regarding operational details. CMS was careful to remain non-committal, stating that voluntary attestation would be allowed "if a system is available" and noting that such a system must be electronic. In contrast to the proposed rule, CMS stated it would not use a manual process for voluntary attestations.

CMS did elaborate on the required conditions for voluntary attestation, specifying that in order to voluntarily attest to a particular provider, the beneficiary must:

- Be eligible for assignment into an ACO;
- Have had at least one primary care service during the assignment window with a primary care physician in the ACO; and
- Have designated an ACO professional in the form and manner and by a deadline determined by CMS.

Beneficiaries that meet the applicable conditions will be aligned with their chosen provider, even if the claims-based determine would result in alignment with another ACO.

CMS also clarified that patients designated through this system will be prospectively assigned to the ACO and known in advance of the performance year. CMS will therefore require all attestations to be completed prior to the performance year. Attestations provided during the year will not apply until the following performance period.

Further operational information and implementation timelines will be provided through sub-regulatory guidance and other outreach activities to beneficiaries.

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