The Centers for Medicare & Medicaid Services (CMS) published the proposed 2016 Medicare fee schedule for physician services on July 8, 2015. The regulation discusses policies that affect Part B payments for physician services furnished on or after Jan. 1, 2016. CMS will accept public comments on the rule until Sept. 8, 2015, and intends to issue a final rule by Nov. 1, 2015. MGMA will submit formal comments and share them with members through the MGMA Washington Connection newsletter.

**RVU changes**

CMS proposes changes that could have a significant impact on the payment for certain specialties. For example, if finalized, proposals would result in overall payment reductions of 5% for gastroenterology, 3% for radiation oncology and 9% for radiation therapy centers. In contrast, other proposals would result in overall payment increases of 8% for pathology and 9% for independent laboratories. Table 45 displays the estimated impact on total allowed charges by specialty resulting from the proposed payment changes, and table 46 shows the estimated impact of all proposed changes on total payments for selected high volume procedures, as identified by CMS.

Recent statutory changes mandate that, beginning in 2016, CMS must phase-in any new payment reductions of 20% or more over a two-year period. For reductions of 20% or greater, CMS proposes to apply a 19% reduction in the first year and phase in the remainder of the reduction in the second year.

**Misvalued codes**

CMS continues its ongoing efforts to evaluate and modify potentially misvalued codes and adjust RVUs.

This year, the agency plans to review a number of codes affecting various specialties. Of note, CMS proposes 118 codes, listed in table 8, as potentially misvalued based on the fact they account for a large portion of Medicare expenditures and have not been reviewed since 2010. As part of this “review of high expenditure services across specialties with Medicare allowed charges of $10,000,000 or more,” CMS plans to assess changes in physician work and update direct practice expense (PE) inputs. Due to the significant impact these codes have on physician fee schedule (PFS) payments at the specialty level, the agency plans to review the codes to ensure that the work and PE RVUs are appropriately valued relative to other codes.

While not formally proposing changes to values of 10- and 90-day global surgical services, CMS states it will examine payment of these services in the coming years. As
part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress
prohibited CMS from moving forward with its previously finalized plan to eliminate the
use of 10- and 90-day global surgical codes. However, MACRA requires the agency to
begin collecting data to value these services in 2017 and to use that data to improve the
payment accuracy of these services by 2019. The agency also outlines its intent to collect
payment information on more than 400 services that include moderate sedation as an
inherent part of furnishing the procedure, but the agency is not formally proposing any
revised values at this time.

As a result of laws passed in recent years, beginning in 2016, CMS must meet annual
targets for reductions of PFS expenditures as a result of RVU adjustments for misvalued
codes. For 2016, the misvalued codes target is 1% of the overall PFS, and for 2017 and
2018, the annual target is 0.5%. If the estimated net reduction in expenditures is equal to
or greater than the target for the year, reduced expenditures attributable to adjustments
would be redistributed in a budget-neutral manner within the PFS. If CMS falls below the
target, that difference would be removed from the overall PFS pool and all payments
would be reduced through a lower conversion factor. CMS proposes a methodology for
how the agency plans to calculate the net reduction of RVU adjustments for misvalued
codes in this year’s rule.

**Determination of malpractice (MP) RVUs**

*Proposed annual update of MP RVUs*

CMS proposes updating MP RVUs on an annual basis, rather than every five years, to
reflect changes in the mix of practitioners providing services and to adjust MP RVUs for
risk. Specialty-specific risk factors would continue to be updated every five years using
updated premium data and would remain unchanged between the five year reviews.
Overall, MP RVUs comprise a smaller portion (approximately 4%) of Medicare
payments in comparison to work or PE RVUs.

**MP RVU update for anesthesia services**

CMS proposes adjustments to the anesthesia conversion factor to reflect the updated
premium information collected for the five-year review, explaining that payment rates for
anesthesia should reflect MP resource costs relative to the rest of the PFS, including
periodic updates to reflect changes over time.

**Advance care planning services**

CMS proposes to establish payment for two advance care planning services for Medicare
beneficiaries who elect to discuss this with their physicians. For 2015, the American
Medical Association CPT Editorial Panel and Relative Value Update Committee (RUC)
finalized two new advance care planning CPT codes (99497 and 99498) and associated
payment amounts. CMS did not make these new codes payable for Medicare in 2015, but
the agency proposes to do so for 2016.
Medicare telehealth services

CMS proposes to make the following additions to the 2016 approved list of Medicare telehealth services:

- Prolonged service CPT codes 99356 and 99357
- End-stage renal disease (ESRD) home dialysis CPT codes 90963, 90964, 90965 and 90966

The agency is also soliciting public requests to add services to the list of Medicare telehealth services. Additionally, CMS proposes to add Certified Registered Nurse Anesthetists (CRNAs) to the list of eligible professionals (EPs) for telehealth services.

Requirements for billing “incident to” services

One of the myriad requirements for billing “incident to” services is that the service must generally be performed under direct supervision of a physician or qualifying non-physician practitioner. Under the proposed rule, the billing physician or practitioner would have to be the individual supervising the service. CMS would also remove a sentence from the “incident to” regulations which specifies that the supervising physician need not be the same physician upon whose professional service the “incident to” service is based. Because this sentence is understood to be part of the policy foundation for the agency’s long-standing guidance that any physician member of a group practice may supervise “incident to” services furnished in a physician-directed clinic, CMS’ proposal to delete this sentence created confusion about whether the agency intended to revise the group practice supervision policy to require that the physician who furnished the initial service also supervise the “incident to” service.

To better understand the intention behind deleting this sentence, MGMA reached out to CMS for more clarification. In direct correspondence to MGMA, CMS confirmed that the proposal is limited to stipulating who should bill for “incident to” services, and that the physician who furnished the initial service to the beneficiary and “the supervising physician or other practitioner DO NOT need to be one in the same.”

CMS also proposes to explicitly prohibit auxiliary personnel from providing “incident to” services if they have been excluded from Medicare, Medicaid or any other federally-funded healthcare program, or have had their enrollment revoked for any reason. This would be consistent with current CMS regulations, which prohibit excluded auxiliary personnel and auxiliary personnel whose enrollment has been revoked from providing services to Medicare beneficiaries.

Colorectal cancer tests

CMS proposes modified regulations relating to a 2015 policy change concerning colorectal cancer tests. Following confusion earlier this year with certain Medicare administrative contractors (MACs) that has since been resolved, CMS’ proposal confirms
that the beneficiary deductible would be waived for anesthesia services furnished in conjunction with a colorectal cancer screening test even when a polyp or other tissue is removed during a colonoscopy. CMS reminds practitioners that they should report anesthesia services with the PT modifier in such circumstances.

**Appropriate use criteria for advanced diagnostic imaging services**

Under the Protecting Access to Medicare Act of 2014 (PAMA), CMS is required to specify appropriate use criteria for advanced diagnostic imaging services from among those developed or endorsed by national medical professional specialty societies and provider-led entities no later than Nov. 15, 2015. In the proposed rule, CMS defines areas of the PAMA statute that require clarification, including “provider-led entity” and “priority clinical areas.” In defining “provider-led entity,” CMS proposes that entities seeking designation as a provider-led entity would have to submit an application by Jan. 1 and reapply every six years. Applications would be accepted each year but would have to be received by the Jan. 1 deadline. All qualified provider-led entities would be posted to the CMS website the following June 30.

**Computed tomography (CT) changes under PAMA**

CMS proposes to require claims for CT scans under certain CPT codes (and any successor codes) that are furnished on Non-National Electrical Manufacturers Association (NEMA) Standard XR-29-2013 compliant CT scans would include the modifier “CT” which would result in the applicable payment reduction for the service. This change stems from Section 218(a) of PAMA, which reduces payment for the technical component of the PFS service and Hospital Outpatients Prospective Payment System (OPPS) (5% in 2016 and 15% in 2017 and subsequent years) for CT services identified by certain CPT codes that are furnished using equipment that does not meet each of the attributes of the NEMA Standard XR-29-2013.

**Physician Compare**

CMS plans to continue adding more information about individual physicians and group practices to the Physician Compare website. For example, the agency proposes including a check mark to signify receipt of an upward payment adjustment under the Value-Based Payment Modifier (VBPM), additional Board Certification information, and new information regarding individual and group practice performance on quality measures. CMS plans to make data on quality measure performance available for public reporting, but as in previous years, proposes determining at a later date which measures would be reported based on consumer testing and additional stakeholder feedback. This proposal would apply to quality measures reported by individuals and group practices across reporting mechanisms in PQRS, including Qualified Clinical Data Registries (QCDRs) and accountable care organizations (ACOs) in the Medicare Shared Savings Program (MSSP). Patient experience of care measure performance data reported by group practices through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS would be made available for Physician Compare reporting.
CMS also proposes to publicly report a new five-star rating, based on an item- or measure-level benchmark derived using the Achievable Benchmark of Care (ABC™) methodology, which evaluates data from a previous reporting period and ranks providers based on specific measure performance. In addition to proposing more information be added to the Physician Compare website, the agency proposes adding more detailed, related information to the Physician Compare downloadable database, such as specific VBPM cost and quality tier performance and Medicare Part B utilization data. This database is used for research purposes and is not designed for consumers.

**Physician Quality Reporting System (PQRS)**

Under MACRA, current federal quality reporting programs, including PQRS, will sunset on Dec. 31, 2018. On Jan. 1, 2019, a new payment system called the Merit-Based Incentive Payment System (MIPS) will take effect.

While the framework of MIPS has yet to be determined through regulatory processes, in order to create stability prior to the transition, CMS proposes to retain many aspects of the PQRS reporting requirements for individual and group reporting options for the 2016 reporting year.

To view current reporting methods and criteria for PQRS, view MGMA’s [2015 Final Medicare PFS Analysis](#).

The agency proposes maintaining the 2% PQRS penalty for the 2018 payment year. EPs and group practices that do not satisfactorily report PQRS quality measures data in 2016 would receive an automatic 2% penalty on their 2018 Medicare payments.

**Individual reporting for the 2016 PQRS reporting year**

CMS proposes to retain all current individual reporting options and criteria required under each option for satisfactory reporting. To avoid the PQRS penalty in 2018, individual EPs would continue to report PQRS quality measures data in 2016 via the following mechanisms: claims, individual measures or measures groups via a qualified registry, EHR data via direct submission or through a submission vendor, or individual measures submitted via a QCDR.

**Group Practice Reporting Option (GPRO)**

For the 2016 reporting year, CMS proposes to retain all current GPRO mechanisms. In addition, CMS would allow groups to report measures via a QCDR and proposes changes related to the CAHPS for PQRS survey, which is specifically required for groups of 100 or more EPs and for groups of 25 or more EPs that elect the Web Interface reporting.

To avoid the PQRS penalty in 2018, group practices would be able to report PQRS quality measures data in 2016 via the following mechanisms: individual measures via a
qualified registry, direct EHR or EHR data submission vendor, the GPRO Web Interface (only for groups of 25 or more EPs) and CAHPS for PQRS via a certified survey vendor. Groups would still have the additional option to have EPs report individually.

For the 2016 reporting year, CMS proposes the following changes for group reporting:

Certified survey vendor—Groups of 25 or more EPs that register to participate in GPRO and select the GPRO Web Interface reporting method would be required to report CAHPS for PQRS measures via a certified survey vendor in addition to the criteria required for successfully reporting using the Web Interface.

- Groups of 100 or more EPs that are participating in GPRO would still be required to report the CAHPS for PQRS survey for the 2016 reporting year, regardless of the additional selected reporting mechanism.

- For groups of 25-99 EPs that registered in the GPRO via a registry, EHR, or a QCDR, the CAHPS for PQRS survey is an optional, supplementary reporting mechanism. Those that choose to report via the GPRO Web Interface would be required to report CAHPS for PQRS measures in addition to Web Interface measures.

- For groups of 2-24 EPs, the GPRO Web Interface reporting option would not be available as a reporting method. These groups could still report CAHPS for PQRS survey measures in addition to reporting via a registry, EHR, or QCDR.

Groups that elect to report some 2016 PQRS data through the CAHPS for PQRS survey would generally report six additional measures across at least two National Quality Strategy (NQS) domains using another reporting mechanism in order to avoid a 2% PQRS penalty in 2018.

Individual measures via QCDR for GPRO – MACRA paved the way for groups to report PQRS measures via a QCDR. For 2016 PQRS reporting, CMS proposes that groups would report at least nine measures covering at least three NQS domains and report each measure for at least 50% of the group’s patients. Of the measures reported, the group would report on at least two outcomes measures or, if two are not available, the group would report on at least one outcomes measure and at least one of the following measures: resource use, patient experience of care, efficiency/appropriate use, or patient safety.

Proposed changes to cross-cutting measures

CMS proposes adding four new cross-cutting measures (table 22).

Proposed changes to individual measures

CMS proposes the following changes (see tables 23-29) to the PQRS measures available for 2016 reporting:
Proposed changes to GPRO Web Interface measures

CMS proposes adding one new measure to the GPRO Web Interface measures set (table 30).

Medicare Shared Savings Program (MSSP)

MSSP and the VBPM

As finalized in the 2015 Medicare PFS, CMS would apply the VBPM to physicians and non-physician EPs who participate in an MSSP-ACO in 2017. In this year’s rule, CMS proposes several clarifications pertaining to participation in multiple ACOs. Please see the VBPM section of this analysis for more details.

Value-Based Payment Modifier (VBPM)

The VBPM is based on quality of care delivered and cost of providing care during an established performance year two years prior to the payment adjustment year. Having been gradually phased in since its inception, the VBPM will apply to all groups of physicians and physician solo practitioners in payment year 2017, based on performance on quality and cost metrics in 2015.

For additional information on current VBPM policies, view MGMA’s 2015 Final Medicare PFS Analysis.

2018 VBPM payment levels based on 2016 PQRS participation

The VBPM relies on PQRS participation for the purposes of determining quality performance. In 2018, the quality score under the VBPM will be based on 2016 PQRS reporting.

CMS proposes to apply the 2018 VBPM payment adjustments in the following manner:

Groups of 10 or more EPs: Upward, neutral, or downward payment adjustments ranging from -4% to +4x, where x is a budget-neutral payment adjustment factor to be determined by CMS. EPs who have not successfully met PQRS requirements would receive an automatic 4% VBPM penalty in 2018 for not successfully reporting for 2016 PQRS.

Groups of 2-9 EPs and physician solo practitioners: Upward, neutral, or downward payment adjustments ranging from -2% to +2x, where x is a budget-neutral payment adjustment factor to be determined by CMS. Those who have not successfully met PQRS
requirements would receive an automatic 2% VBPM penalty in 2018 for not successfully reporting 2016 PQRS.

Groups consisting exclusively of non-physician EPs and solo practitioners who are physician assistants (PAs), nurse practitioners (NPs), certified nurse specialists (CNSs), and CRNAs: Upward payment adjustment of 2x, where x is a budget-neutral payment adjustment factor to be determined by CMS, or a neutral payment adjustment. Downward adjustments would not apply to these EPs when they successfully participate in PQRS in 2016, but those who do not successfully meet 2016 PQRS requirements would receive an automatic 2% VBPM penalty in 2018.

2018 VBPM adjustment based on 2016 PQRS participation

CMS proposes to continue its policy to designate all groups and solo practitioners under one of two categories for the purposes of determining payment adjustments under the VBPM in 2018.

- Category 1: Includes all solo practitioners who satisfactorily report PQRS quality measures as individuals and those in group practices that meet the criteria via GPRO for purposes of avoiding the 2018 PQRS payment adjustment during the 2016 reporting year. Additionally includes all EPs in groups that do not self-nominate through GPRO under PQRS but have at least 50% of EPs who meet the criteria for satisfactory reporting for PQRS as individuals.

- Category 2: Includes all groups and solo practitioners that do not fall under Category 1 and are subject to the 2018 VBPM penalty.

For the 2016 performance year (2018 payment year), CMS proposes to consider groups that register to participate in the PQRS GPRO who are unsuccessful with reporting via the GPRO reporting mechanism to be part of Category 1 for the purposes of the VBPM if at least 50% of the group’s individual EPs report successfully for PQRS.

Also, for the 2016 performance year (2018 payment year), CMS proposes to include EPs and groups participating in an MSSP-ACO that does not successfully report quality measures data in Category 2.

Application of the VBPM to non-physician EPs in 2018 based on 2016 performance

In the 2015 PFS, CMS stated its intent to apply the VBPM to all non-physician EPs in 2018 based on the quality and cost of care provided in 2016. However, MACRA sunsets the current VBPM on Dec. 31, 2018, and the new MIPS will take effect on Jan. 1, 2019. Under MACRA, MIPS will apply to items and services furnished on or after Jan. 1, 2019 by physicians, PAs, NPs, CNSs, and CRNAs. All other non-physician EPs will not be subject to MIPS until 2021.

While the framework of MIPS has yet to be established through the regulatory process, in order to create consistency before the transition to MIPS, CMS proposes to apply the
2018 VBPM (based on the quality of care and the cost of care provided in 2016) only to physicians and non-physician EPs who are NPs, CNSs, PAs, and CRNAs.

If a group is comprised of a mix of physician and non-physician EPs, only physicians and NPs, CNSs, PAs, and CRNAs would see their 2018 payments modified by the VBPM based on their quality and cost of care in 2016.

**Quality-tiering**

The quality-tiering methodology is used to determine whether a group or solo practitioner in Category 1 would receive an upward, neutral, or downward payment adjustment under the VBPM in 2018, based on 2016 reporting. Groups and solo practitioners that provide high-quality, low-cost care to Medicare beneficiaries could earn an upward adjustment, while groups and solo physician practitioners that provide low-quality, high-cost care could receive a downward adjustment.

CMS proposes the following quality-tiering methodology for determining the VBPM payment adjustment for those in Category 1. The adjustments would apply as follows:

**Physicians, PAs, NPs, CNSs, and CRNAs in groups of 10 or more EPs:**

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Groups and solo practitioners would be eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores.

**Physicians, PAs, NPs, CNSs, and CRNAs in groups of 2-9 EPs and physician solo practitioners:**

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-1.0%</td>
<td>0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Groups and solo practitioners would be eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores.

**PAs, NPs, CNSs, and CRNAs in groups consisting exclusively of non-physician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners:**

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>0.0%</td>
<td>0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Groups and solo practitioners would be eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores.
Because the VBPM is required to be a budget-neutral program, the upward adjustments would be established by the agency based on the projected aggregate amount of downward adjustments.

**Quality measures**

If finalized, CMS would include all quality measures and reporting mechanisms currently proposed under PQRS for the 2016 performance year for the purposes of determining the 2018 VBPM.

**Benchmarks for electronically-reported Clinical Quality Measures (eCQMs)**

CMS proposes to exclude eCQMs from the overall VBPM benchmark and create separate benchmarks beginning with the 2016 performance year used to determine the 2018 VBPM. If finalized, 2016 benchmarks would be calculated using 2015 performance data.

**Medicare spending per beneficiary (MSPB) measure for VBPM cost composite**

For performance year 2015 affecting 2017 payments, CMS proposes to increase the episode count from a minimum of 20 episodes to at least 100 episodes, meaning a TIN would have to have at least 100 MSPB episodes for the measure to be included in the cost composite.

**Informal inquiry process to allow corrections for the VBPM**

CMS proposes to maintain the current 60-day review period following the release of a physician’s or group’s Quality and Resource Use Reports (QRURs) to request corrections of potential 2016 performance year VBPM calculations.

**Physician feedback and QRURs**

In the proposed rule, CMS states its intent to expand mid-year QRURs to non-physician EPs, solo practitioners, and groups composed of non-physician EPs beginning in the spring of 2016.

**Additional upward adjustment for high-performing MSSP-ACOs**

In the 2015 PFS, CMS established that the 2017 VBPM will apply to physicians who participate in an MSSP-ACO in 2015.

CMS proposes that, beginning with the 2017 VBPM based on 2015 performance, an additional upward adjustment of +1.0x would apply to groups and solo practitioners that participate in high-performing MSSP-ACOs that provided “high quality” care to high-risk beneficiaries, as determined by VBPM policies.
A CO-CA HPS survey inclusion in 2018 VBPM calculations

CMS proposes to require that ACO scores on the ACO-CAHPS survey in performance year 2016 would be counted towards calculating the 2018 VBPM.

2017 VBPM waiver for participation in the Pioneer ACO model and Comprehensive Primary Care Initiative (CPCI)

As established in the 2015 Medicare PFS, CMS considers a Pioneer ACO’s or CPCI’s quality and cost scores “average” for purposes of applying the 2017 VBPM based on the 2015 performance year. This means that a CPCI or Pioneer ACO participant’s VBPM adjustment would be zero.

Starting with the 2017 payment year, CMS proposes to waive the VBPM altogether for groups and solo practitioners if at least one EP who billed for PFS items and services under the tax identification number (TIN) during the applicable performance period participated in the Pioneer ACO model or CPCI during the same performance period. Because the VBPM is applied at the TIN level, this waiver would also apply to EPs who do not participate in the Pioneer ACO model or CPCI, but bill under the same TIN as EPs who do participate and for whom the VBPM is waived.

2018 VBPM waiver for participation in the Comprehensive ESRD Care Initiative, Oncology Care Model, and Next Generation ACO Model

For the 2016 performance year affecting VBPM payments in 2018, CMS proposes to waive the VBPM for groups and solo practitioners who participate in the Comprehensive ESRD Care Initiative, Oncology Care Model, and Next Generation ACO model, or any other similar CMMI models if at least one EP who billed for PFS items and services under the TIN participated in the model during the applicable performance period.

Physician Self-Referral (“Stark”) Law

CMS proposes to clarify the application of key terms and requirements under the physician self-referral regulations, as well as add two new exceptions. These proposals do not represent a significant departure from existing Stark requirements on group practices or their financial arrangements with hospitals.

Clarification of key terms and requirements

Physician-owned hospitals: CMS proposes to define the categories of websites and forms of advertising that would require disclosure that a hospital has physician ownership, and clarify the variety of disclosure statements that would be sufficient to comply. The agency also proposes to clarify that when determining the baseline bona fide investment level for purposes of determining compliance, the ownership or investment interests held by both referring and non-referring physicians would have to be included. Further, CMS
proposes special instructions for submissions to the Self-Referral Disclosure Protocol for failure to meet the public notice requirement for physician-owned hospitals.

**Writing, term and holdover arrangements:** CMS clarifies that the requirement of many Stark compensation exceptions for a “writing” or “written agreement” would need not be satisfied by evidence of a single formal contact. The agency proposes a clarifying amendment explaining that exceptions requiring a signed “writing” would not require a signed formal contract. Instead, they could be substantiated by other contemporaneous documentation. In addition, CMS proposes to clarify that exceptions conditioned on the term of at least one year would not need a formal term provision in a single contract. Rather, an arrangement that lasts one year would meet the requirement. CMS also proposes to allow parties to rely on “hold over” provisions of the Rental of Office Space, Rental of Equipment and Personal Service Arrangements exceptions for an indefinite period of time, or alternatively 1-3 years.

**Signature requirements:** CMS proposes to allow parties 90 days to obtain required signatures to an agreement, whether or not the failure to secure a timely signature is inadvertent or advertent. Currently, the non-compliance grace period lapses at 30 days when the parties are aware of the missing signatures.

**Stand in the shoes:** CMS proposes additional clarification that when one or more physician owners of a group “stand in the shoes” of the group for purposes of the direct compensation exceptions, the compensation under the exception must not take into account the volume or value of referrals from any physician in the group, not just referrals from the owner physicians. At present, the “stand in the shoes” regulations generally provide that when a Designated Health Services (DHS) entity has a financial relationship with a physician group, the physician owners of the group are deemed to have the same financial relationship with the DHS entity as the group itself. Employees and contractors on the other hand can choose to be treated as having only an indirect compensation relationship for Stark purposes.

**Remuneration:** CMS clarifies that a hospital’s provision of space, equipment and staff for a physician to provide outpatient services would not constitute remuneration to the physician, as long as the hospital bills for the facility component of the service and the physician bills for the professional component. This is in response to a case from the United States Court of Appeals for the Third Circuit.

**New Exceptions**

**Timeshare lease exception:** CMS proposes to establish a new exception for qualifying timeshare arrangements between physicians and hospitals or physician organizations. The arrangement would have to be set out in writing, signed by the parties, and specify the premises, equipment, personnel, supplies and services covered. To qualify under the proposed exception, (i) a licensee would be required to use the licensed premises, equipment, personnel, items, supplies and services predominantly to furnish evaluation and management services to patients of the licensee, and (ii) the arrangement could not
involve advanced imaging equipment, radiation therapy equipment or clinical or pathology laboratory equipment. The exception would be limited to timeshare arrangements in which hospitals and physician organizations are the licensors and would not protect timeshare arrangements offered by other types of healthcare organizations, including independent diagnostic testing facilities and clinical laboratories. The proposed exception would not be available to protect part-time and exclusive leases of office space, which would continue to be measured under the long-standing exception for real property leases.

**Assistance to employ non-physician practitioners:** CMS proposes to establish a new exception for payments made by a hospital, Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) to a physician to assist in the recruiting of a non-physician practitioner to the donor’s geographic service area. For the purposes of the exception, non-physician practitioners would include PAs, NPs, CNSs and certified nurse midwives. It would not include CRNAs. The exception would apply only to situations in which the non-physician practitioner is directly employed by the physician or physician practice receiving the support, and when the purpose of the employment is to provide primary care services to patients of the physician practice. Physician extenders employed to support specialty practices would not be eligible for the exception. In addition, this proposed exception includes a cap on the amount of the recruitment incentive and a two-year limit on assistance.

**Medicare enrollment opt-out affidavits**

CMS proposes modifying regulations to conform with recently enacted changes stemming from MACRA that pertain to physicians who opt out of Medicare. As a result, Medicare physician opt-out affidavits filed on or after June 16, 2015 automatically renew every two years. Therefore, physicians and practitioners that file opt-out affidavits on or after this date are no longer required to file renewal affidavits to continue their opt-out status. Those who do not want their opt-out status to automatically renew at the end of a two year opt-out period may cancel the automatic extension by notifying their MAC at least 30 days prior to the start of the next two year opt-out period.